

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

## Appendices

Online PDF version

© **Copyright:**

National Collaborating Centre for Mental Health, 2021

**Cite as:**

National Collaborating Centre for Mental Health. The Framework for Community Mental Health for Adults and Older Adults: Support, Care and Treatment. Appendices. London: National Collaborating Centre for Mental Health; 2021.

# Contents

---

<b>Appendix 1. Experiences of care</b>	<b>1</b>
1.1 My story	1
1.2 Our story	3
<b>Appendix 2. Positive practice examples</b>	<b>5</b>
2.1 Promoting mental and physical health and preventing ill health	6
2.2 Effective care of mental health problems	12
2.3 Improving quality of life	22
2.4 Addressing health inequalities	32
2.5 Community assets mapping databases and digital support and resources	41
<b>Appendix 3. Quality measures, NICE recommendations and outcome measures</b>	<b>43</b>
3.1 Quality measures	43
3.2 NICE recommendations and relevant NICE guidance	45
3.3 Outcome measure recommendations	56
<b>Appendix 4. Evidence reviews summary</b>	<b>59</b>
4.1 Review areas and questions	59
4.2 Review area 1: Risk assessment	60
4.3 Review area 2: Assessment	62
4.4 Review area 3: Formulation	63
4.5 Review area 4: Care coordination	65
4.6 Review area 5: Care delivery functions	67
<b>Appendix 5. Expert Reference Group members</b>	<b>70</b>
5.1 Who developed this framework and guidance?	70

# Appendix 1. Experiences of care

## 1.1 My story

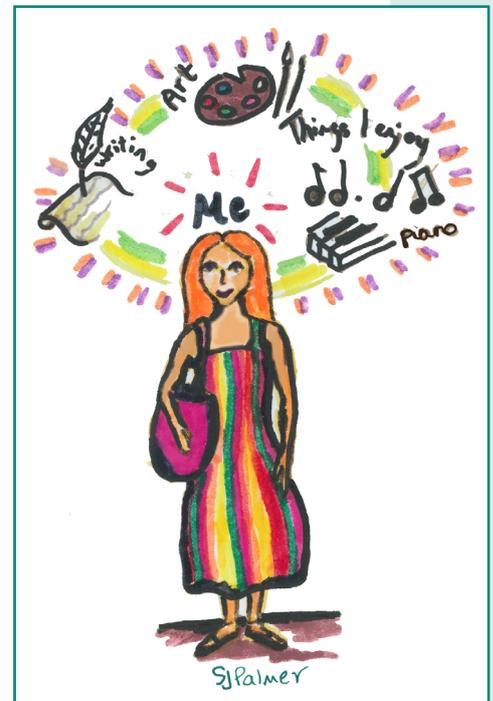
*This story was written by Sarah Jane Palmer, a National Collaborating Centre for Mental Health (NCCMH) National Adviser with lived experience. It is based on her personal experiences and discusses her illustration (see detail, right), which is shown in full on the inside front cover of [Part 1](#).*

Each journey is unique, but all will follow the key principles that take a person at the centre of their journey through a system of support. This requires a flow of positive communication from one service to another, and the knowledge, support and kindness of those at each stage who interact with the individual. The new framework aims to do this by improving understanding of mental illness within the community, and by improving the ease of access to services within the community (known as community assets and voluntary and community sector).

Then, when someone presents to their GP, they are able to access a multitude of services that may benefit them before their symptoms have time to worsen and ultimately lead to a referral to acute services. The person can gain a sense of ownership of their symptoms whereby they can be motivated to help themselves, alongside the ongoing support of their GP, in line with medication and a care plan tailored to their needs. A care navigator or recovery support worker can help guide the person through the system, taking the burden from the GP, and reducing the stress levels and symptoms of the person they are helping.

My journey unfortunately followed a reactive approach, which the new framework aims to avoid. A proactive approach some years ago, when I repeatedly saw my GP with a range of symptoms, would have been desirable. Therefore, within the illustration I have addressed the start of my journey as that of my acute admission to St Ann's Hospital, Tottenham. I would count this as one of the worst experiences of my life. I then remained under the care of the crisis resolution and home treatment services for some months in the wake of a psychotic episode which was queried at the time to be a diagnosis of full-blown mania.

Luckily, I received the care and attention of a very good psychiatrist who wrote a thorough and long formulation. A formulation is the most thorough form of assessment and incorporates the person's full background including their interests, skills, qualifications, full history of all mental health symptoms, family, social, housing and so on. Without this, I would not have been guided in the way I was, through a system of community, third sector and NHS services. Without this psychiatrist, my GP would be less well informed.



I was started on a variety of medications that suited my needs. This psychiatrist also referred me for family network meetings with him and a family therapist, which have been helping my family to understand me better in order to support me instead of hindering my progress. My friends are included in the illustration as they have been an enormous source of support while I have become very ill and then spent a long while recovering. Work also have been supportive, including financially which has allowed me to continue living in my beautiful flat. While accessing addiction services I became aware of the benefits of mindfulness and meditation.

Since then, I have become a Buddhist, thoroughly enjoying the benefits of regular meditation and mindfulness, and becoming part of a community, meeting kind, friendly people who have also supported me in overcoming my difficulties. Another community service I was referred to was Solace Women's Aid and the North London Rape Crisis charity, who put me on a domestic abuse course and referred me for 16 specialist counselling sessions.

I have also seen my key worker, regularly, who has supported me fully through the entire process. She has communicated with the complex care team and helped me in any way that she can with advice and support, and communication with other services. The benefits of the voluntary and community sector are shown in my illustration. Starting a treatment plan of mentalisation-based treatment for underlying symptoms of borderline personality disorder has also been of great help, but was a reaction to my admission to hospital. The new framework aims to encourage proactive assessment for treatment such as this, for people to receive care sooner. Finally, in the middle of this whole ring of interconnected services and community assets is me, as I embody every single part of my journey through the system, as I become stronger and mentally well again. The mind area of the illustration demonstrates my unique qualities and the characteristics that make me who I am, that contribute to who I see myself as, while not losing my sense of identity to the self-fulfilling negative prophecy of the labels and stigma of mental illness. I should have included my work as a national adviser for the Community Mental Health Framework in this illustration, as I feel this also helped me truly recover and put my terrible but also positive range of experiences to good use, for the meaningful and rewarding task of helping others who may also face the journey that I have had.

Being a national adviser has been an incredible experience for me, as I have met some of the most amazing people, those who have lived experience and those who are the leaders of their fields of work, inspiring others to follow them in working with positive practice and co-production principles.

## 1.2 Our story

*This was written by a member of the service user and carer reference group.*

Being a carer, one's life often seems on hold. I am a mum and hate the term carer that is given to me, as a result of being involved in my son's care. My son first came into what he describes as the 'mental health system' when he was 18 and had just started university.

Thinking back to the initial few weeks, what was really helpful to us was the kindness of staff to our son. Staff listened to and answered questions from my husband and me in what was a truly awful, frightening time. We weren't sleeping, we were so worried. We were trying anything, and constantly searching for information about mental illnesses through reading books, information sheets, visiting various websites and so on.

Due to being between two different health trusts, good communication was vital. What would have been really helpful would have been signposting to an appropriate support group and who to contact for out-of-hours support. We were completely out of our depth; we didn't know what was happening to our son, who was presenting differently on a daily basis. He was finding what he was experiencing terrifying. We needed help to understand both what was happening to him and how we could best support him.

My son has had a number of care coordinators and we have been really lucky in how they have treated us as a family. I appreciate that they are really busy and have only contacted them when I am very worried and need advice, and they have always phoned back, listened and offered advice, visited or made an emergency appointment with the psychiatrist. The only difficult times have been if they are on leave or off sick. A duty person would have been very helpful, and out-of-hours contact, particularly over bank holiday weekends. It is vital that information about who to contact is given in the form of a care plan or service leaflet. On one occasion we were told to access an out-of-hours doctor. My son was clearly very poorly and subsequently needed a hospital admission. It had taken hours to get him to agree to go and this was after a weekend of no sleep for him and us, and no help when seeking and trying to access help. What made the situation even worse was a receptionist asking us to 'remove your son, there are ill people here and they shouldn't have to put up with him!'. I asked her to speak to my son and was greeted with, 'No, I'm not trained to speak to someone like him!'.

I think that sometimes it can seem that we are in a battle trying to get the right care and services for our loved one. I was delighted recently when a staff member referred to the Triangle of Care. I am aware that sometimes people do not want you to share information and I would always respect the confidentiality of my son. However, I would also expect that staff involved in his care would listen to my concerns even if they felt unable to comment.

My son now has an advance directive and I would urge anyone with a serious mental illness to consider this at an appropriate time. It's wonderful knowing what my son's wishes are. When his consultant discussed this at a Care Programme Approach meeting, my son felt empowered, and we as a family felt a huge sense of relief.

I have had a number of recent experiences that highlight excellent engagement with carers from services, where I felt truly listened to; my opinion was sought and mattered. I felt respected as the person who knows my son the best. I was also asked how I was coping, was I OK, did I need further support? I could be referred for a carer's assessment if I did. I was told that my wellbeing mattered, too. I really appreciate the kindness and compassion I was shown. It's those little things that truly make a difference to people like me caring for loved ones. Staff not only make a difference to people using services but also to carers, families and friends.

I want carers to feel supported in the workplace, and for managers to think about how they support staff with carer responsibilities. Carers also need support from mental health trusts so that they can support their loved one as well as continue with their work commitments. I know from our experience the difference that having these things in place can make.

## Appendix 2. Positive practice examples

Encouraging developments are taking place in community mental health services across England. Since summer 2019, 12 'early implementer' sites in the sustainability and transformation partnership (STP)/integrated care system (ICS) areas have been funded by NHS England to test new and integrated models of primary and community mental health care for adults and older adults with severe mental health problems, in line with this framework and the NHS Long Term Plan. From April 2021, all STP/ICS areas in England will begin to implement new models.

The services described in this section are examples of positive practice that have already implemented elements of the framework, grouped by topic, including parity of mental and physical health, addressing inequalities, quality of life and community assets mapping.

The three framework documents were prepared in 2019, and a summary of the framework was published by NHS England in the short guide [The Community Mental Health Framework for Adults and Older Adults](#). Since then, the impact of the COVID-19 pandemic, including the social restrictions, have led to many services altering the way they deliver their services and provide support. In December 2020, the NCCMH contacted the services included in this section asking for general and COVID-related updates to how they function and provide care. The write-ups for services in the sections below were then updated where possible, and the date when the information was updated has been added to the left-hand sidebars in the pages below. Please note that while every effort has been made to provide up-to-date information, some services may have made further innovations and changes that aren't described here.

The community assets mapping databases and digital support and resources in [Section 2.5](#) were last updated in 2019.

### Early implementer sites

Cambridgeshire and Peterborough STP  
Cheshire and Merseyside STP  
Frimley Health and Care ICS  
Herefordshire and Worcestershire STP  
Hertfordshire and West Essex STP  
Humber, Coast and Vale Health and Care Partnership  
Lincolnshire STP  
North East London STP  
North West London STP  
Somerset STP  
South Yorkshire and Bassetlaw ICS  
Surrey Heartlands Health and Care Partnership

## 2.1 Promoting mental and physical health and preventing ill health



### Community Living Well

*A primary care mental health service that brings together a robust, vibrant menu of services to wrap around the individual and improve the mental, physical and social resilience of those with mental health needs*

**Commissioned by** West London clinical commissioning group (CCG)

**Demonstrates positive practice in:**

- Integrated care
- Co-production
- Integrated community hubs

**Population:** 16+

**Location:** London

- Royal Borough of Kensington and Chelsea
- Queen's Park and Paddington areas of Westminster

**Information updated:** December 2019

For more information, see [here](#)

Community Living Well is an integrated service for people aged 16+ with stable mental health needs who are, or can be, supported in primary care and by their families and carers. It is available to people registered with a GP in the Royal Borough of Kensington and Chelsea or the Queens Park and Paddington areas of Westminster.

The overall aim of the service is: 'To improve the mental and physical wellbeing ... and provide better social support so that people are able to maintain good health and wellbeing, maintain independence and achieve their self-determined goals'.

Community Living Well brings together new and established NHS clinical services with voluntary sector wellbeing services. Working together in a multidisciplinary team (MDT), these services provide wrap-around support, with the GP as the Accountable Clinician.

Community Living Well services include Improving Access to Psychological Therapies (IAPT) and psychology in specialist mental health settings, Mother Tongue (Arabic and Farsi) Counselling, Primary Care Liaison Nurses providing short-term case management, Employment Support, Navigators and Peer Support. Staff from all the services are co-located in two hubs, which incorporate physical care services, and in other locations.

The outline service model for Community Living Well was developed through a co-production process involving people who use services, carers, voluntary and statutory sector providers, and GPs. Co-production has continued during implementation, in the development of the website and service leaflets, and the design of a new service hub.

West London is currently part of an NHS England 'early implementer' site delivering new models across certain boroughs within the North West London STP footprint.





## Integrated community services

**Provided by:** Cambridgeshire and Peterborough NHS Foundation Trust.

**Demonstrates positive practice in:**

- Advancing equality
- Multi-agency working
- Integrating mental and physical health
- Reduction in referrals to acute hospitals
- Response to COVID-19

**Population:** 18+

**Location:** Cambridgeshire and Peterborough

**Information updated:** January 2021

For more information, see [here](#) and [here](#)

These services offer community-based care for people of all ages in Cambridgeshire and Peterborough that integrates mental health, physical health and social care support. The services stand out for their older adults' care provision in particular.

Having a single provider for all older adult services has facilitated joint working between mental and physical health services and other specialist teams. This allows staff to address the needs of the elderly population who may also present with frailty or multimorbidity. At any one time, a third of the patients receiving mental health care are also receiving care from the physical teams due to this integrated way of working.

This arrangement has led to multiple beneficial outcomes for patients:

- Input from consultant geriatricians to the old-age psychiatry wards has decreased transfers to acute hospitals, and access to a variety of professionals has addressed the high rate of falls on these units.
- Physical health rapid response teams have been created as a result of learning from the culture of home treatment in the psychiatric service. These are now providing rapid medical care for patients in their own home, avoiding the need for admission to an acute medical bed.

They made extensive changes to their services and operations in response to the COVID-19 pandemic, which are captured in this publication: <https://pubmed.ncbi.nlm.nih.gov/32475376/> (link to full article is to the left).

They were also made a site for trialling the Oxford coronavirus vaccine – something made possible by the integration.

Peterborough, where the Trust operates, is now an NHS England 'early implementer' site, implementing a new model within the Cambridgeshire and Peterborough STP footprint.



## Living Well in Lambeth

*A collaborative and co-produced approach to commissioning which has facilitated a single funding stream for local adult mental health services*

**Provided by:** The Lambeth Collaborative

**Demonstrates positive practice in:**

- A single funding contract for adult mental health services
- System-wide transformation

**Population:** 18+

**Location:** Lambeth

**Information updated:** December 2019

For more information, see [here](#)

Established in 2010, this innovative partnership comprises service users, carers, primary care professionals, secondary mental health care professionals, community services, voluntary organisations, commissioners and the local council. It co-produces an effective operating framework for the commissioning and delivery of services with a shared goal of improving experiences and outcomes of people with mental health problems in Lambeth.

This unique commissioning process adopts an assets-based approach, recognising that people are not passive recipients of a service but hold expertise that can help drive the improvement of the service. This collaborative approach has been developed with community at the forefront and emphasises that a dynamic and effective relationship with the community is required to fund and guarantee meaningful and efficient mental health care and support. This focus on community connection has enabled The Collaborative to support the co-production of peer support, crisis, supported housing and community-based services.

The Collaborative was the driving force behind the 'Living Well Network', focusing on the mental health provision of inpatient and community care, and the 'Integrated Personalised Support Alliance', which supports people to live independently. These projects enabled the formation of the 'Living Well Network Alliance' in July 2018. The creation of this alliance has gathered the funding for Lambeth's adult mental health services under a single contract, with a shared set of outcomes. This single funding stream facilitates transparent and effective communication between organisations and improves the ability to tailor local services to best meet the needs of the community.





## Primary Care Mental Health Liaison Team

**Provided by:** Mersey Care NHS  
Foundation Trust

**Commissioned by:** Liverpool,  
Sefton and Kirkby CCGs

**Demonstrates positive practice in:**

- Multi-agency working
- Outcomes evaluation

**Achievements:**

- Shortlisted for an innovation award at the 2018 Skills Development Network
- Winner of the 'Best Nursing Technology Award' at the 2017 EHI Awards for healthcare innovation.
- Finalist in the 'Technology and Data in Nursing' category for the 2017 Nursing Times Award

**Population:** Everyone

**Location:** Liverpool

**Information updated:** December  
2019

The Primary Care Mental Health Liaison Team supports people across community mental health and primary care services, for both mental and physical health.

The service aims to encourage integrated treatment of mental and physical health needs, and promote collaborative working between mental and physical health services. Integrating work between GPs, mental health practitioners and physical health workers has led to patient care being tailored in a more holistic, co-produced and recovery-focused way, resulting in favourable outcomes for people receiving care. The service also encourages cooperation between statutory and voluntary, community and social enterprise (VCSE) providers, as well as with families, carers, local authorities and other support services.

Internal evaluations of outcomes have identified an overall improvement in collaboration between the Primary Care Mental Health Liaison Team and primary care providers. The CQUIN for Improving Collaborative Working between Primary and Secondary Mental Health Care has consistently supported and funded this service, allowing for reinvestment and growth. The team continually conducts audits to identify ways of increasing access to physical health checks for people with mental health needs. The team ensures continued delivery of mental health care through ongoing discussions with CCGs and GPs, identifying areas of need and keeping the service in line with local and national guidance. Regular training and specialised education events on mental health and suicide awareness are offered to people in the team, with the aim of reducing the stigma associated with mental illness.





## Primary Care Wellbeing Service, Bradford

**Provided by:** Bradford District Care Foundation Trust

**Funded by:** Bradford and Airedale CCGs

**Demonstrates positive practice in:**

- Integrated working
- Holistic care
- Peer working
- Inclusion
- Community-based care
- Response to COVID-2019

**Achievements:**

- Outcomes evaluations report measurable long-term cost savings since the development of the service
- Improved quality of life and rehabilitation

**Population:** People with complex mental health needs, long-term conditions and persistent physical symptoms, as well as those with chronic fatigue syndrome/myalgic encephalomyelitis and long COVID symptoms.

**Location:** Bradford

**Information updated:** January 2021

For more information, see [here](#)

The Primary Care Wellbeing Service is an expert multidisciplinary team specialising in complex mental and physical health. The team is a psychological liaison model with clinical leadership from Dr Suzanne Heywood-Everett who is a consultant clinical psychologist. The team comprises:

- clinical psychology
- occupational therapy
- physiotherapy
- dietetics
- personal support navigator
- peer support workers
- links to existing providers, including community services
- counselling.

The team have expertise in trauma-informed care, neuropsychology and neurophysiology, complex and persistent symptoms (including functional neurological disorder and persistent pain), and post-viral fatigue (in particular, chronic fatigue syndrome).

There are four pathways within the service:

- *Intensive Therapy Pathway for highly complex medically unexplained symptoms and persistent physical symptoms. Patients receive a biopsychosocial formulation that informs a detailed, integrated care plan for home-based care and one to five contacts per week.*
- *Standard Therapy Pathway, for complex persistent physical symptoms. Patients receive a biopsychosocial formulation and multidisciplinary team interventions.*
- *The Chronic Fatigue Pathway is a specialist diagnostic and therapy pathway*
- *The COVID-19 Rehab Pathway is a new specialist multidisciplinary team pathway offering:*
  - *specialist multidisciplinary team interventions for people with complex COVID-19 rehabilitation needs, connecting to key agencies in people's care*
  - *digital self-management group for people with long COVID symptoms.*





## Sheffield Mental Health Transformation Programme

*A transformational programme that has fostered collaborative care across wider care pathways, facilitating holistic mental health prevention and intervention*

**Commissioned by:** Sheffield CCG

**Demonstrates positive practice in:**

- A single delivery plan
- Holistic care
- Response to COVID-19

**Achievements:**

- Reductions in onward referrals
- Cost savings

**Population:** 18+

**Location:** Sheffield

**Information updated:** January 2021

For more information, see [here](#)

The Sheffield Mental Health Transformation Programme was born from a collective need to secure better outcomes and better value for money. The overarching aim of the programme is to ensure services are far more localised, individualised and focused on prevention and early intervention.

The programme is overseen by a multi-agency Delivery Board supported by director-level sponsorship from each partner organisation. The sponsors were initially supported by a jointly funded deputy director post, and has the continued benefit of executive-level clinical director support. Eight different organisations were directly involved in the development and delivery of the programme. However, since this time, the partnership has extended through procurement to work formally with wider VCSE sector partners. This multi-agency approach recognises the extensive benefits of functioning as a collaborative system rather than separate, autonomous entities.

By adopting a collaborative approach across wider care pathways, traditional organisational boundaries are no longer perceived as barriers. This facilitates the creation of seamless pathways, allowing people to receive care, support and treatment in the most appropriate and least restrictive environment, and reducing the need for onward referrals. This collaborative system also means that the provision of care is much more holistic, and uplifts individual patient outcomes as the primary way to jointly measure success.

The Transformation Programme has demonstrated that genuine transformational change across complex care pathways is possible through collaboration, positive working partnerships and trust. However, this programme has also involved significant work in terms of breaking down organisational and structural barriers. Through the development of a single delivery plan, underpinned by a risk and benefit share agreement which is overseen by a single governance structure, the programme has been able to enact projects that would have historically been difficult to even consider.

In 2017/18, the Adult Mental Health Transformation Programme delivered £2.5 million in efficiency savings, with an expansion of services that are more targeted towards prevention and early intervention, underpinned by a focus on recovery. While the Transformation Programme was aimed at adult (18+) services, Sheffield CCG and Sheffield City Council aimed to adopt an all-age approach to the oversight of mental health services in 2019/20 through a number of its joint programmes. The Transformation Programme is now viewed locally as an exemplar approach to care, with many other local work streams planning to adopt a similar approach.

Building on this collaborative culture, Sheffield partners successfully bid to be one of NHS England's 'early implementer' sites, to implement a new model of Primary and Community Mental Health Care delivery to Sheffield, and is sharing learning across the South Yorkshire and Bassetlaw ICS footprint, and nationally.





## St Peter's Medical Centre

**Provided by:** Sussex Partnership NHS Foundation Trust

**Demonstrates positive practice in:**

- Community connection
- Integrating physical and mental health
- Increasing awareness of mental health within primary care settings

**Achievements:**

- Improved user experience and outcomes

**Population:** 18+

**Location:** Sussex

**Information updated:** December 2019

For more information, see [here](#)

The Assessment and Treatment Service (ATS) Pilot Screening Clinic was a pilot study that set up a weekly mental health clinic within a local GP surgery. The clinic was developed by Sussex Partnership Foundation Trust working in collaboration with St Peter's Medical Centre, a primary care practice. The clinic ran an ATS one morning a week, enabling people to access support for their mental and physical health care in a single setting. The study aimed to respond to the needs identified by both primary and secondary care, as well as increase awareness of mental health among primary care staff to prevent inappropriate referrals to secondary care.

The care offered at the pilot site was grounded in the principles of the biopsychosocial and occupational models, with an emphasis on non-judgemental, supportive listening and goal setting. The pilot team held weekly focus groups with all staff, to reflect on and discuss complex cases, particularly those surrounding comorbid mental and physical health needs. This approach aimed to improve the uptake of physical health screening for patients with serious mental illness and improve integration between mental and physical health care. The pilot site also hosted a focus group of people using the service to explore barriers to uptake of care, to further inform this approach.

The pilot was effective in improving community connection. Communication between the GP practice and secondary mental health services improved, resulting in practitioners gaining a wider knowledge of other services within the city, as well as referral pathways and criteria. St Peter's also liaised with housing, young people's services, VCSE services and other primary care services to ensure people are referred to the appropriate services in the community. The ATS clinic was likely to have a positive impact on health inequalities because people were being directed to the appropriate services at an earlier opportunity. Preliminary data analysis of the pilot project identified a reduction in onward referrals and a significantly lower 'Did Not Attend' rate for those engaged with the pilot project compared with standard care. In 2019, the pilot team collected and evaluated data regarding outcomes and experiences, from people receiving care as well as from staff, with an aim to inform the movement from pilot phase to wider implementation across additional surgeries.



## 2.2 Effective care of mental health problems



### *Certitude Solidarity in a Crisis*

**Commissioned by:** Lambeth CCG, Southwark CCG and Lewisham CCG

**Demonstrates positive practice in:**

- Peer-led service
- Co-production
- Partnership working
- Response to COVID-2019

**Achievements:**

- Community peer evaluation indicates that most people found the service reduced their own feelings of distress
- Reduced reliance on A&E for mental health support

**Population:** 18+

**Location:** Lambeth

**Information updated:** January 2021

For more information, see [here](#)

The Solidarity in a Crisis service provided by Certitude in South London can be accessed by anyone over the age of 18 who is experiencing a mental health crisis or emotional distress. The service offers support across the boroughs of Lambeth, Southwark and Lewisham. This project provides a peer-led out-of-hours crisis support telephone line and one-to-one peer support to people across the community (which has been suspended during the restrictions of the COVID-19 pandemic), seven days a week. The service aims to provide support to people within 24 hours of referral. It conducts initial comprehensive assessments with the person, including questions on physical health, to allocate a suitable worker for every person.

Co-production has been paramount in the design and implementation of a person-centred out-of-hours crisis service. The service is peer and carer led with support delivered by people with lived experience. People using the service are involved in designing and reviewing new services. Certitude integrates carers and family networks into care, as well as offering support to carers by means of listening and through support and carer events. Solidarity in a Crisis also demonstrates a great partnership between people with lived experience, the voluntary sector and statutory services.

Solidarity in a Crisis works closely with people who use services and commissioners to identify performance levels and challenges. Ongoing evaluation and feedback from service users, commissioners and other professionals contribute to continually delivering effective mental health support. The service provides a robust training programme and development plan for team members, which includes training them on the values of peer support, mental health first aid, suicide skills intervention training and basic counselling skills.





## City and Hackney Community Rehabilitation Service

*A multidisciplinary, community-based service for adults experiencing severe and enduring mental illness.*

**Provided by:** East London NHS Foundation Trust (ELFT)

**Demonstrates positive practice in:**

- Community connection
- Positive risk taking

**Achievements:**

- 'Outstanding' Care Quality Commission (CQC) rating
- Quality Improvement approach

**Population:** 18+

**Location:** East London

**Information updated:** December 2019

For more information, see [here](#)

The City and Hackney Community Rehabilitation Service (East London NHS Foundation Trust) integrates mental health and social care to support the rehabilitation of people with severe and enduring mental illnesses. The MDT includes medical, nursing, social work, occupational therapy, psychology and support work input.

The service has focused on the development of positive relationships with organisational and community partners, and positive risk taking. The team care coordinates 70 people (with prominent positive and negative symptoms, treatment resistance and poor activities of daily living function) and provides clinical input to run an occupational therapist-led rehabilitation programme in the community (11 beds) in partnership with a support provider.

The service carries out annual reviews of all funded placements (150 per year) on behalf of the local authority and CCG using a placement review tool, and also plans step-down. If required, the service also provides case management for transitions and moves, or when changes in needs are identified. The service also provides acute inpatient liaison and assessment to facilitate timely discharge by identifying placements and signposting housing panel processes swiftly. They have developed pre-panel consultation sessions for discussion about appropriate accommodation options for community teams (including forensic). They co-facilitate the Mental Health Supported Accommodation Panel, liaising with providers across the pathway and managing housing quota allocation.

In addition, the service makes effective use of the Quality Improvement approach, running a project which aims to increase throughput along the mental health supported accommodation pathway by 25% over an 18-month period. A range of outcome measures are evaluated frequently to improve the process in an iterative manner.

This is in the context of City and Hackney having had no inpatient rehabilitation beds for over five years, lower than national average length of stay on acute adult wards and not needing any acute adult extra contractual referral/out of area beds for many years. They have meanwhile maintained a CQC rating of Outstanding in 2018 and 2019. Moving to community rehabilitation services and providing good-quality acute inpatient care appear to have demonstrated a way to provide rehabilitation psychiatry away from inpatient rehabilitation and long-stay wards.

East London, where ELFT operates, is now an NHS England 'early implementer' site, implementing a new model within the North East London STP footprint.





## *Integrated mental health review in primary care*

**Provided by:** *New Invention Health Centre in Willenhall and Dudley and Walsall Mental Health Partnership NHS Trust*

**Demonstrates positive practice in:**

- *Multidisciplinary working*
- *Integrating mental and physical health*

**Achievements:**

- *Strong patient satisfaction outcomes*
- *Reduction in Did Not Attend (DNA) rates (missed appointments)*

**Population:** *18+*

**Location:** *Willenhall*

**Information updated:** *December 2019*

The integrated mental health review is a monthly, multidisciplinary meeting that brings together various professionals involved in a person's care, including GPs, practice nurses, psychiatrists, social workers and care coordinators. In doing so, this service aims to better integrate primary and secondary care services, through fostering communication and joint decision-making in the person's best interests. A total of 3 hours is allocated to discuss caring arrangements for six people who are currently being supported by community mental health teams (CMHTs). In addition, 30 minutes of each meeting is dedicated to discussing the needs of people who are not currently being supported by a CMHT.

In review meetings, a comprehensive biopsychosocial assessment is completed collaboratively, with the benefit of a range of perspectives. When appropriate, decisions are made about a person's care, with the agreement of the person, their GP and other agencies involved in their care. A clear follow-up plan is then devised jointly with the person and the people supporting them, which may signpost them to other agencies that can provide additional support to the person when required.

Despite requiring little additional resource, it has demonstrated good outcomes, particularly in improving patient satisfaction and reducing DNA rates. It has also enabled people to consider, from a wide range of options, which source of support would best fit their needs. As a result, referrals to specialist teams have decreased as more people access suitable support in the community.





## Islington Mental Health Community Rehabilitation team

*An integrated MDT, working closely with the VCSE sector and primary care, to provide recovery-oriented treatment and to support people with complex psychosis to live in 24-hour supported accommodation*

**Provided by:** Camden and Islington NHS Foundation Trust

**Demonstrates positive practice in:**

- *Integration with primary care and the VCSE sector*
- *Proactive management of mental health and physical comorbidities*

**Achievements:**

- *The team has supported over 60% of people to move on to more independent accommodation without relapse or placement breakdown*
- *High service satisfaction*

**Population:** 18+

**Location:** North London

**Information updated:** December 2019

For more information, see [here](#)

The Islington Mental Health Community Rehabilitation team was set up in 2013 in response to the observation that many individuals with complex psychosis who had received treatment in the trust's inpatient rehabilitation services appeared to plateau in their recovery once discharged to supported accommodation. This was felt to be due to a lack of rehabilitative expertise in the local teams who provided care coordination for this group of people and whose stretched resources limited their ability to focus on them. As a result, this MDT was resourced through reorganisation of existing staff and additional funding from commissioners. The team provides care coordination for 150 people with psychosis living in local, 24-hour supported accommodation.

The service provides specialist clinical rehabilitation input with a central aim of ensuring the clients' ongoing recovery and successful movement towards independent accommodation. Most contact takes place at the persons' home to promote effective communication and information exchange between the team and the supported accommodation staff. All clients have a full MDT Care Programme Approach (CPA) review meeting at their accommodation every six months, which is attended by the team consultant, care coordinator, keyworker from their supported accommodation and any family members the client wishes to invite. This facilitates involvement of all relevant parties in reviewing the person's progress and agreeing changes to any care plans. The supported accommodation staff also assist people in preparing an agenda for these reviews.

The service adopts an effective evaluation framework, and regularly reports to commissioners on their key performance indicators and standardised routine outcome measures. For the last two years, the team has achieved all its key performance indicator targets (in 2018, 86% of people attended their CPA meetings, 100% had six monthly MDT reviews, >96% eligible carers were offered a carer assessment, 95% clients had medication changes reviewed within 8 weeks, 76% had an annual health check, 77% had physical health care plans specific to any conditions). There has also been clear improvement shown on measures of social function and unmet needs. Satisfaction with the service is high (70% of service users and 88% of supported accommodation staff rated it 4 or 5 out of 5 in 2018).





## Oxfordshire Mental Health Partnership

*All-round support and information*

**Provided by:** Oxford Health NHS Foundation Trust and five local VCSE sector organisations

**Demonstrates positive practice in:**

- *Multi-agency collaboration*
- *Shared systems*
- *Workforce*

**Achievements:**

- *Reduced repeat assessments between organisations*
- *Growing peer-support network*
- *Opportunities for paid employment for peer-support workers*

**Population:** Everyone

**Location:** Oxfordshire

**Information updated:** December 2019

For more information, see [here](#)

Oxfordshire Mental Health Partnership consists of Oxford Health NHS Foundation Trust and five local VCSE sector organisations, working together to make it easier for people with mental health problems to get the best possible support when and where they need it. The close relationships between the organisations mean that a person who accesses one service in the partnership should find it much easier to receive holistic support from the other member entities. Rather than making repeated referrals, people are 'passported' to the appropriate organisation, saving time for both the person and professionals involved in their care. This ensures that all aspects of the person's life are fully incorporated into their support, care and treatment, in a smooth and timely manner.

The partnership operates Oxfordshire Recovery College, which applies an empowering and educational approach to mental health recovery and is jointly run by people with lived experience of mental health problems.

Workers from the VCSE sector are also embedded within the trust's adult mental health teams. This increases knowledge across all organisations and improves access to services. It also fosters cross-cultural learning between organisations and better understanding of partner organisations. All of this contributes to a better, seamless service for people.

The Partnership's peer-support project offers opportunities to people with lived experience of mental health problems to be trained and recruited as paid peer-support workers for the trusts' adult inpatient and community teams. This ensures that the Partnership has a stable peer-support network, and that people are being empowered to engage in meaningful work and activities.

The Partnership also runs a crisis service, [Oxford Safe Haven](#), which offers a safe space for people over the age of 18 who are experiencing a mental health crisis during the weekend or late at night.

The Partnership is dedicated to keeping people at the centre of its developments. Through their Outcomes-Based Contract, they regularly review their performance using outcomes co-produced with people who use mental health services.





## **Pathfinder clinical service, part of Pathfinder West Sussex**

*Pathfinder offers ‘timely short-term interventions with the aim of helping people get back on the road to recovery’*

**Provided by:** *Sussex Partnership NHS Foundation Trust*

**Demonstrates positive practice in:**

- *Community Connection*
- *Single point of access to mental health and wellbeing support*

**Achievements:**

- *Improved mental health and wellbeing outcomes*
- *Cost savings*

**Population:** *18+*

**Location:** *West Sussex*

**Information updated:** *December 2019*

*For more information, see [here](#)*

Pathfinder West Sussex is an alliance of ten community/voluntary sector organisations and one NHS foundation trust (Sussex Partnership) working in partnership with each other. The alliance works towards a set of shared principles to promote consistency of care and smooth transition between services. Pathfinder primarily aims to improve the experiences of people seeking mental health care support by providing a more integrated and community-based service. Crucially, Pathfinder was developed through consultation with local people as well as the professional experience of local services, and, as a result, offers a service tailored to meet the needs of the local community.

While the Pathfinder clinicians are employed by the NHS, they are based within the non-statutory partners, enabling better access to clinical support for people engaged with Pathfinder services. If a person’s mental health deteriorates, clinical support can be accessed rapidly through a step-up (Protective Intervention) pathway, with group or one-to-one interventions offered, depending on individual need. If required, the clinical team can also escalate a referral to secondary care or straight to crisis teams. This novel approach provides a unique point-of-entry so that people can access appropriate care quickly. Alternatively, the step-down (Transition Intervention) pathway is implemented for people who have completed treatment in secondary care NHS services but may require an extension of support during the difficult post-treatment transition. This innovative, time-limited pathway allows the lead secondary care practitioner to remain involved in a person’s care for 3–4 weeks post-treatment, in a condensed transfer of care to the Pathfinder clinician. This approach aims to help the person to feel supported, while also encouraging them to take an active role in their own recovery to foster self-management.

The Pathfinder website directory also supports engagement within the local community and offers a range of mental health and wellbeing resources, such as local service information and self-help tools. In addition, Pathfinder has recently joined the West Sussex ‘Time to Change’ hub to embed anti-stigma and anti-discrimination in the local community. The Pathfinder clinical service has demonstrated a range of positive outcomes. People have reported better mental health and wellbeing; improved confidence, self-esteem and optimism; a more meaningful structure to daily routines; improved social connections; and greater use of other local resources. It has also contributed to saving costs through a reduction in the use of secondary mental health services by providing an alternative route to support ([Royal College of Occupational Therapists, 2018](#)). Ultimately, this innovative approach has empowered staff to provide effective and efficient mental health support to people in the community.





## **Peterborough Exemplar (formerly known as PRISM)**

*Mental and social support all in one place*

**Provided by:** Cambridgeshire and Peterborough NHS Foundation Trust

**Demonstrates positive practice in:**

- Access
- Multi-agency working
- Integration
- Response to COVID-19

**Achievements:**

- Great satisfaction among service users
- Reduced waiting times between GP request and first appointment
- Reduction in referrals to secondary care
- Reduced tendency for in-silo working
- Reduced GP workload

**Population:** 18–65

**Location:** Cambridgeshire and Peterborough

**Information updated:** January 2021

For more information, see [here](#)

The Exemplar pilot is attempting complex system change through infrastructural and clinical innovation, as opposed to a linear increase in the number of patients seen in direct proportion to the number of new staff. The extra investment is transforming an existing system to achieve our high-level goal, which is, 'People with severe mental illness are better supported overall'.

The Cambridgeshire and Peterborough transformation model builds on its radical Primary Care Mental Health Service (implemented in 2016), which put relationships of trust between primary and secondary care at the core of its theory of change. The Peterborough Exemplar has extended this model (2019/21) by creating multiple new senior liaison clinical roles to better integrate the mental health pathways across primary and secondary care, and by contracting the local authority, third sector, VCSE services, grassroots organisations and Greater Peterborough Network (GP Federation) to introduce new transition roles to enable further integration of our mental health workforce across the community, binding these organisations more closely together. This more broadly based system approach to mental health care was driven by its second core principle of change – the right service at the right time in the right place. People with severe and enduring mental health conditions need support to access, step down from, and live without services, and so it is essential that support comes from as wide a base as possible. To best support people with severe mental health challenges in Peterborough, the service believes that the support provided must be accessible to all people seeking better mental health.

### **A local mental health team**

Their Primary Care Mental Health Service in Peterborough has expanded from three sectors to six, aligning to the local GP PCNs, to provide six locally based teams of mental health specialists – plus physical health care workers, pharmacy and social care support – who will be embedded in local communities to provide much-valued continuity of care for patients, families and primary care colleagues.

They are changing the way they monitor patients to create a person-centered model that gives an overview of the whole patient-journey. They are 'joining the dots' by monitoring the teams coming in and out of a person's care, rather than only looking at patients coming in and out of individual teams.

### **Widening the options for mental health support, linking with the wider Peterborough community**

They are widening the available options for mental health support. This will result in more Peterborough residents getting their needs met, be that from their GP, the Primary Care Mental Health Service, secondary care teams, new co-facilitated group programmes from Cambridgeshire, Peterborough and South Lincolnshire Mind and the Cambridgeshire and Peterborough NHS Foundation Trust Personality Disorder Community Service in Peterborough, new group programmes supported by our Peterborough Adult Locality Team or by supported connections to local community assets that support mental wellbeing.





## Surrey Heath CMHT – older adults

**Commissioned by:** Surrey Heath CCG

**Provided by:** Surrey and Borders Partnership NHS Foundation Trust

**Demonstrates positive practice in:**

- Integrated care
- Continuity of care
- Response to COVID-19

**Achievements:**

- Reduced waiting times to below the local targets
- Consistently high dementia diagnosis rates in the CCG due to the improvements in care
- Winner of the Psychiatric Team of the Year: Older Age Adults in the Royal College of Psychiatrists Awards 2018

**Population:** Older adults (65+)

**Location:** Surrey Heath, Surrey

**Information updated:** January 2021

For more information, see [here](#)

Surrey Heath CMHTs have been demonstrating integration of community services since 2016. The older adults' team is part of a joined-up system that includes colleagues in community services, social care, primary care and the VCSE sector. This ensures that the older residents of Surrey Heath receive seamless support. The local area has an over 65 population of approximately 16,500 people.

The team prioritises continuity of care and accepts referrals for people with both functional and organic presentations. People can choose to be seen in a number of settings such as in their home, in their GP surgery or in a clinic.

The team offers a comprehensive range of group and individual therapeutic interventions to meet a range of differing needs, including for those with young onset dementia. They also offer specialist care home input, including joint GP and older adult ward rounds and the provision of detailed formulations. The team has access to a Voluntary Services Coordinator who matches the person to available VCSE sector support that best meets the person's needs

The success in integrated working among the system can be seen through their joint referral-triage system, which is taken up by all community partners so that 'no door is the wrong door'. Additionally, joint working ensures that it is easier to share information, with consent, across the Surrey Heath system, so that trusted assessments do not need to be duplicated.

An innovative Frailty Panel made up of community partners, a geriatrician and mental health staff meets weekly to identify people who might need preventative and anticipatory interventions. Additionally, there is an integrated community MDT meeting where staff can discuss the provision of care for people with multiple complex needs who often use community services. It has been shown that following discussion at this MDT, these people are less likely to attend A&E or have an unplanned admission.

The core team is made of an Integrated Care Manager, a Team Lead, consultant psychiatrists, a consultant nurse, community mental health nurses, occupational therapists, psychologists, associate practitioners and admin staff.

Surrey, where Surrey and Borders Partnership NHS Foundation Trust operates, is now an NHS England 'early implementer' site implementing a new model within the Surrey Heartlands Health and Care Partnership footprint.

During the COVID-19 pandemic, safety measures have been put in place, including: the introduction of virtual contact and assessments; remote working; risk assessments prior to any face-to-face contact; and use of personal protective equipment. When made possible by COVID-19 restrictions easing, the service increases face-to-face contacts and offers more support to the people with young onset dementia.





## **Westminster Older Adults Integrated Community Mental Health and Home Treatment Team**

**Provided by:** Central and North West London NHS Foundation Trust

**Demonstrates positive practice in:**

- Integrated working
- Co-production
- Older adults care

**Achievements:**

- Seamless transitions between crisis care and community mental health care

**Population:** Older adults (referrals are not based on age but based on needs)

**Location:** Westminster, London

**Information updated:** December 2019

For more information, see [here](#)

The Westminster Older Adults Integrated Community Mental Health and Home Treatment Team specialises in the care of older adults and frailty; however, referral criteria are based on needs rather than age.

The team provides treatment and care to older adults with a range of need complexities that could benefit from specialist interventions. They also provide advice to other professionals, such as GPs or other primary care clinicians, on the appropriate management of mental health problems and ensure that the correct referrals are made.

The integrated team is multidisciplinary and includes psychology, social work, psychiatry, occupational therapy, nursing and support work, as well as receiving regular input from arts psychotherapists and Admiral Nurses who specialise in dementia care. The wider team provides medical, pharmacological, psychological and social interventions. They also work with others such as care agencies, social services, primary care providers, VCSE sector services, police, housing associations and environmental health services. The integration of the team with the Home Treatment Team allows transitions in care to be timely and seamless, minimising duplication of work. This means people do not have to be referred to a distinct crisis team when their needs change, and their care can be kept within the team that knows them best.

The wider service operates a bespoke care planning model, which means that all people who use services and their carers receive personalised, recovery-focused care plans.

The service is always actively seeking user experience feedback through their bespoke, validated patient-reported experience measure (PREM) survey and through a monthly group meeting for active service users.

Westminster, where Central and North West London NHS Foundation Trust operates, is now an NHS England 'early implementer' site implementing a new model within the North West London STP footprint.



## 2.2.1 Working together with families and carers



### Essex Partnership Family Group Conference

**Provided by:** Essex Partnership  
University NHS Foundation Trust

**Demonstrates positive practice in:**

- Working with personal support networks
- Personal decision-making support with family and friends

**Population:** Adults

**Location:** Essex

**Information updated:** December  
2019

For more information, see [here](#)

The Adult Mental Health Family Group Conference is a service for adults in Essex receiving secondary mental health care. It is a collaborative service that supports people to make plans and decisions related to their care and wellbeing.

The concept was developed in New Zealand in the 1980s, and involves around integrating a wide group of stakeholders (extended family, friends, neighbours, community members and professionals) to make plans and decisions where individuals or close family members experience difficulty. Consequently, decision-making is conducted collaboratively with the person's wider support network.

The person chooses who is invited to the sessions, and the dialogue between family members and professionals occurs on the family's own terms. The strengths and needs of the person, their family and the wider system are discussed, primarily in the context of relationships, with the overall goal of a shared understanding between all parties. The service is designed to ensure that treatment is provided on the person's terms, while involving family and friends, decreasing stress on the system and reducing personal stress and isolation. By the end of their involvement with this service, the person and their family should have a unique and flexible care plan.

Areas in Essex, where Essex Partnership University NHS Foundation Trust operates, form part of the NHS England 'early implementer' site, delivering new models within the Hertfordshire and West Essex STP footprint.



### Your Health Your Life

Peer support for people who have  
caring responsibilities

**Provided by:** Essex Partnership  
University NHS Foundation Trust

**Demonstrates positive practice in:**

- Supporting families and carers
- Co-produced

**Achievements:**

- Improvements have been seen in empowerment and social inclusion

**Population:** 18+

**Location:** Essex

**Information updated:** December  
2019

Your Health Your Life is a free, 6-week self-management and wellbeing programme aimed at carers aged 18 and over. Carers are defined as anyone who gives help and support to a relative or friend who is ill, disabled, elderly or in need of emotional support.

Delivered in community settings, the programme comprises weekly 3-hour groups facilitated by trained peer tutors who have lived experience in a caring role. Their primary aim is to support carers to re-evaluate their caring roles and responsibilities, share experiences, learn skills and improve their own health and wellbeing. A carer may attend the wellbeing group alone or with the person they care for (who also attends their own wellbeing group).

The group sessions focus on a range of topics such as skill development, health education, welfare advice, therapeutic activities, advice and support with accessing further mainstream education or employment opportunities, and connecting with community assets.

A number of carers create their own peer-support groups following attendance of the programme.

Evaluation of the programme has shown significant improvement in empowerment, social inclusion and wellbeing, with carers taking up hobbies, education and employment as well as inspiring other groups to start up.



## 2.3 Improving quality of life



### Bridge Collective, Devon

*Mutual support and activity group*

**Demonstrates positive practice in:**

- Social inclusion
- Democratic support
- Response to COVID-19

**Achievements:**

- Involves 150–200 people a year

**Population:** Everyone

**Location:** Devon

**Information updated:** January 2021

For more information, see [here](#)

The Bridge Collective Community Interest Company is a peer-support mental health project in Exeter. The project is centred around ‘helping ourselves and each other, building a community of support by developing and taking part in activities together’. These activities include art, nature, walks, writing, music, poetry and much more.

The Bridge Collective also enables people to take part in activities that might help them better understand mental health issues, make new friends and even learn new skills. People are also given the opportunity to run participator-led projects together with the collective.

Because of the coronavirus pandemic, all activities since March 2020 have been online. There is a peer support group available – Open Minds for people who see, hear or sense things that other people might not.

The Bridge Collective is open to all people with personal experience of mental health, including their family, friends and supporters.



### Brunsmeer Awareness Mental Health Football Project

*Weekly football and social sessions*

**Provided by:** Sheffield Health and Social Care NHS Foundation Trust

**Demonstrates positive practice in:**

- Integrating mental and physical health
- Social inclusion

**Achievements:**

- Expanding to 7- and 11-a-side and women’s football
- Won Yorkshire and Humber Academic Science Network Innovation, Improvement and Impact Award for Partnership Working

**Population:** 18+

**Location:** Sheffield

**Information updated:** December 2019

For more information, see [here](#)

The programme is a Sheffield-based scheme, running for over seven years, which focuses on the integration of mental and physical health care. It began as a weekly football group at one of Sheffield Health and Social Care NHS Foundation Trust’s inpatient sites and has now become city-wide through collaboration with local community groups and charities. The project’s partners, which include Brunsmeer Athletic, Sheffield Flourish, Sheffield and Hallamshire Football Association and Sheffield United Community Foundation, provide venues, transport and football coaches to guide and inspire players. The project now offers frequent sessions and tournaments which family and friends can attend.

The football sessions help people to maintain social networks, with some people meeting up outside of sessions and maintaining friendships. The sessions provide a non-judgemental platform for people to speak to their peers in confidence, share experiences and reach those who otherwise may not have utilised mental health services. The project offers an opportunity for improving physical health, reducing social isolation and reducing stigma around mental health and use of mental health services, with some players moving on to join other local teams. People have reported particularly enjoying the camaraderie and group identity, the team work and the respect and patience they are treated with, especially by the integration of players, coaches and healthcare professionals.





## Charlton Athletic Community Trust

**Provided by:** Oxleas NHS  
Foundation Trust

**Demonstrates positive practice in:**

- *Social inclusion*
- *Physical health*
- *Organised activities in the community*

**Achievements:**

- *Core 10 and Warwick-Edinburgh Mental Wellbeing Scale measures show the programme to have been highly successful in improving outcomes*
- *Positive service user experience feedback*
- *'Highly commended' at the Positive Practice in Mental Health Awards 2017*

**Population:** 65+

**Location:** Charlton, London

**Information updated:** December 2019

For more information, see [here](#)

Charlton Athletic Community Trust (CACT) and Oxleas NHS Foundation Trust devised a pilot project working with over 65-year-olds with mental health diagnoses. The programme was designed to improve participants' physical health and wellbeing through activities within the community, such as sporting, leisure, art and cultural activities. The pilot was so successful that it has been continued through to 2020.

Activities are personalised, and both CACT and Oxleas are committed to ensuring that these activities meet people's goals and wishes. Achieving this includes adapting activities as necessary to be age-appropriate. In 2018, ten people took a trip to the coast – for some, this was their first holiday since their diagnosis.

The programme is managed, scheduled and delivered by two members of the CACT team, with support from a designated Oxleas staff member. The two organisations meet frequently to ensure the smooth delivery of the project. The project is innovative in that it is delivered by non-clinical staff in non-clinical settings, providing a sense of 'normality'. The programme has been successful in supporting people to look forward, set new goals, participate in community activities and develop meaningful relationships.

Every 10 weeks, the team conducts a welcome session for people and their families and carers, creating an inclusive atmosphere that is less intimidating for first-time attendees.

CACT also offers an early intervention, non-clinical programme for people aged 16–65 who have experienced their first episode of psychosis. People trust and engage with this programme – one of the few of its kind to be offered through a football organisation, in collaboration with mental health services.





## Community Restart (Restart Social Inclusion Service)

**Provided by:** Lancashire Care  
NHS Foundation Trust

**Demonstrates positive practice in:**

- *Advancing equality*
- *Community connection*
- *Heightens social inclusion and provides employment and housing support*
- *Effective mapping of community needs*
- *Opportunities for work offered through service user development team*
- *Response to COVID-2019*

**Population:** Everyone

**Location:** Central Lancashire

**Information updated:** January 2021

For more information, see [here](#)

**Up to September 2019:** East Lancashire Community Restart was a social inclusion service, led by registered mental health nurses, to provide non-clinical support to people with mental health difficulties. A person could access the service through referral from a GP or mental health service that supported the person. Community Restart's primary function was to integrate people who feel socially excluded back into their local communities, by supporting them to take part in meaningful activities, strengthening social networks and building resilience. Intensive support was provided to people presenting with high levels of complexity related to mental health and social care needs. Community Restart supported integration at the system level, by developing or encouraging partnerships between community and statutory agencies.

The service consisted of integrated teams for social inclusion, employment, housing and service user development, in addition to specialist community development, carer support and rural development roles. Employment teams worked closely with employers in Lancashire to raise awareness of mental health, facilitate placements and support retention. Housing teams worked collaboratively with local housing providers, councils, and statutory and voluntary mental health services to prevent delayed discharge from inpatient units.

**From September 2019:** The Community Restart service went through organisational change due to changes to commissioning in September 2019 and was renamed The East Lancashire Community Prevention and Engagement team. It is now primarily a social inclusion service, operating on a recovery-based model, with a rural development worker role to maintain links in local communities and support the development of community-based assets for rural and hard to reach communities. The primary function is to integrate people who feel socially excluded back into their local communities, by supporting them to take part in meaningful activities, strengthening social networks and building resilience. Intensive support is provided to people presenting with high levels of complexity related to mental health and social care needs. Community Restart also supports integration at the system level, by developing or encouraging partnerships between community and statutory agencies.

The service is no longer able to offer support with housing, benefits, debt and employment, and now focuses on education, volunteering, group activities/support groups, arts and crafts, leisure, exercise, gardening and rural, and ecotherapy related activities. They signpost service users to appropriate services for problems that they are now unable to provide support for.

Because of the COVID-19 pandemic, the service has continued to see service users on a face-to-face basis and, as community services re-open, they link people into these where appropriate. They are also engage people in 1:1 and small-group walks and ecotherapy activities, and any current volunteering opportunities or online education. Unfortunately, the COVID-19 pandemic severely restricted the options that the service is able to offer.





## Connecting People intervention

**Led by:** University of York

**Demonstrates positive practice in:**

- Improved social inclusion and access to social capital
- Community connection
- Actively challenges the social stigma and exclusion often faced by people with a mental illness and facilitates improved community connections and social inclusion.

**Achievements:**

- Improved practitioner and service user partnership

**Population:** 18+

**Location:** Multi-region

**Information updated:** December 2019

For more information, see [here](#)

Connecting People is an evidence-informed social intervention developed and evaluated in a series of studies led by the University of York. The current study, in collaboration with the McPin Foundation, University of Central Lancashire and the London School of Economics, is evaluating its implementation in five diverse NHS mental health foundation trusts (Essex; Bradford; Hertfordshire; Avon and Wiltshire; and Tees, Esk and Wear Valleys). Connecting People is underpinned by social capital theory, and the recognition of positive social connections for the enhancement of physical and mental wellbeing. The primary aim of this intervention is to enhance the quality and diversity of people's social networks.

Connecting People employs a unique and dynamic model, which is grounded in lived experience and places community connection at the heart of the intervention. In particular, Connecting People aims to establish an equal, positive partnership between the person and the practitioner; the maintenance of the equality and balance of this partnership is central to the intervention.

Connecting People adopts a logical, eight-step method of non-prescriptive and individualised care to facilitate movement towards improved social networks and social inclusion. This systematic approach encompasses the preliminary mapping of existing connections; identification of aspirations and goals; taking initial practical steps; identifying personal and structural barriers and corresponding solutions; embedding social connection in organisational culture; and reviewing and reflecting on the process. This approach ultimately creates a 'cycle of discovery' for both the practitioner and the person to further develop networking, interaction and community knowledge. Furthermore, this model has been applied in response to a range of diagnoses; for example, the Essex site has also applied the intervention in the specialist psychosis pathway.

Connecting People has been well-received by both the people who use services and practitioners. On average, the pilot study reported improved feelings of social inclusion and greater access to social capital for people ([Webber et al., 2018](#)). The intervention has also since been culturally adapted for use in international settings, with diverse social, economic and cultural contexts, such as Nepal and Sierra Leone. Preliminary results from the implementation study suggest that when fully implemented, the Connecting People Intervention can improve social outcomes for people with a mental health problem or learning disability.





## Head and Hands

*Mindful craft groups for the community. 'Busy the hands and quiet the mind through artistic practice'*

### **Demonstrates positive practice in:**

- *Staying well in the community*
- *Social inclusion*
- *Supports small independent artists and creatives*
- *Improves community wellbeing*
- *Response to COVID-2019*

**Population:** Everyone

**Location:** London

**Information updated:** January 2021

For more information, see [here](#)

Head and Hands is a London-based workshop programme 'founded on the art of slowing down'. The programme is produced by artist Amanda Wayne, inspired by her experiences navigating chronic illness. The workshops encourage participants to embrace self-care and are all centred around the therapeutic value of slowing down and connecting with yourself.

Head and Hands curates several workshops each month with different practitioners exploring slow crafting and self-discovery; examples include tapestry weaving, bullet journaling, mindful mandalas, embroidery and natural dyeing. Most classes are focused on tactile crafting, but others explore physical wellbeing, such as learning about which herbs support your hormones from a herbalist, or learning about immunity and winter wellness from a naturopathic nutritionist.

Head and Hands have also been invited by a number of larger organisations to deliver mindful creative workshops to boost workplace wellbeing. Some of these organisations include The British Museum, Adidas and Great Ormond Street Hospital. In response to the COVID-19 pandemic, all activity was moved online via activity kits and video conferencing.

Head and Hands enables individuals to wind down and connect with each other, as well as benefitting the wider community through external workshops.



## Let's Live Well in Rushcliffe (LLWiR)

*Facilitated by ImROC (Implementing Recovery through Organisational Change)*

### **Demonstrates positive practice in:**

- *Social Inclusion*
- *Community integration*
- *All-round support for those at risk of, or with, long-term health conditions*

### **Achievements:**

- *A hundred and thirty-five referrals received in the first 6 weeks of operation*
- *Started mental health workshops, walking groups, yoga and healthy eating groups*

**Population:** Everyone

**Location:** Rushcliffe, Nottinghamshire

**Information updated:** December 2019

For more information, see [here](#)

LLWiR aims to improve the wellbeing, social engagement and self-management of people in Rushcliffe with long-term conditions, thereby reducing the demands on primary and secondary services.

LLWiR is suitable for people who would benefit from support to manage long-term physical or emotional wellbeing, who are socially isolated or inactive or are at risk of ill health. People can self-refer or can be referred by a GP or any other community group. The service helps people to understand their condition, identify their goals, work out how to keep well, start doing things they enjoy and find local groups to take part in.

The service has health coaches and link workers within their team. Each health coach sees a minimum of four new people a day, whom they will coach for up to six sessions and then, where appropriate, introduce to integrated link workers who can facilitate further community engagement.

As well as providing individual support, LLWiR works with the local facilities, churches, cafes and businesses to create a more supportive community with support groups and activities. For example, they have facilitated football in three leisure centres in collaboration with Nottinghamshire County Football Club and increased the number of accessible courses in libraries.

LLWiR are currently co-producing the protocol for the LLWiR Time Bank's volunteering service and are partnering in a bid to secure Big Lottery funding for further developments.





## London Buddhist Centre

### **Demonstrates positive practice in:**

- Community inclusion
- Staying well in the community
- Integrated working with NHS mental health services, drug and alcohol services, local VCSE sector services

**Population:** Everyone

**Location:** London

**Information updated:** December 2019

For more information, see [here](#)

The London Buddhist Centre teaches meditation and Buddhism in Bethnal Green and other parts of London in a way that is relevant to modern life. The centre has been open since 1978 and is a public space for all to attend, with no expectation for individuals to be Buddhist. The centre runs classes and courses on meditation and runs regular retreats for those who attend the centre. There are also yoga classes, poetry evenings, festivals and school visits, all of which foster a strong sense of community, promote friendship and inclusion.

The centre also runs specific programmes on mindfulness for health and wellbeing in the community, at businesses and in schools. The mindfulness programme at the London Buddhist Centre is called Breathing Space and offers Mindfulness for Health, Mindfulness for Stress, Mindfulness for Schools (Breathing Space in Schools), Mindfulness for Depression and a number of other areas. It was founded by an NHS consultant psychiatrist, and all mindfulness teachers are trained and supervised under his programme, as well as being linked with several mental health services and organisations. This allows them to accept referrals from a wide range of professionals.

Many of the events run by the London Buddhist Centre are free, with teachers and class teams volunteering their time and skills. The centre runs on a culture of generosity and is largely supported through donations.



## Northern Heartlands – Durham Great Place Scheme (GPS)

Supported with funding from National Lottery Heritage Fund and Arts Council England.

### **Demonstrates positive practice in:**

- One of 16 GPSs across England
- Championing community empowerment
- Delivering cultural activities

### **Achievements:**

- Winner of Best Event Durham in 2019 North East Culture Awards
- Cultural and creative engagement is now integral to policy development and community consultation in a number of areas

**Location:** South and West County Durham

**Information updated:** December 2019

For more information, see [here](#)

The Durham GPS pilots new approaches that enable cultural and community groups to work more closely together, working at grassroots level to transform people's understanding of the places they live in, building confidence, their sense of identity and belonging, and their ability to influence policy and decision-making.

As well as enabling more people to engage in creative, cultural and heritage activities, the 16 GPSs across England share outcomes including tackling social issues, re-igniting pride and ambition, improving wellbeing and enhancing employment.

Northern Heartlands works in a deeply rural area with hill-farmers and isolated village communities, as well as the deprived but resilient communities of the former Durham coalfield area. While many GPSs are embedded in local authorities, Northern Heartlands' relative independence enables strong community engagement with an emphasis on long-term relationships and building trust. Through partnership-working with a wide range of different groups and sectors, including the voluntary sector, local authority, non-governmental organisations and funded arts and heritage institutions, the GPS is enabling genuine communication between individuals and whole communities, and those who are responsible for making the decisions, strategies and policies that affect them.

Health and wellbeing has not been the main driver for Northern Heartlands, but the profound impact of engagement in arts, heritage and culture on mental health is becoming increasingly evident. There are clear links with the national Culture, Health and Wellbeing Alliance and with the recommendations cited in the inquiry report Creative Health: The Arts for Health and Wellbeing – the result of a 2-year All Parliamentary Group inquiry 2015–17.





## The Pod, Coventry

Coventry local authority and part CCG-funded

### **Demonstrates positive practice in:**

- Community connection
- Highly personalised, goal-based support
- Social cohesion
- Response to COVID-19

### **Achievements:**

- Manager of The Pod won the UK mental health leader prize 2014
- They have reduced pressure on other services

**Population:** Everyone

**Location:** Coventry

**Information updated:** January 2021

For more information, see [here](#)

The Pod is a local authority service in Coventry co-funded by the Coventry and Rugby Clinical Commissioning Group. The Pod supports people's mental health recovery journey through social brokerage and manages two city-wide social activism programs, Time Union and Food Union.

A full brokerage service is available for people with severe and enduring mental ill-health, through a referral from the local CMHT (Integrated Practice Unit). It is a model of collaborative practice that starts with the CPA referral, moves to the co-completion of the statutory Care Act 2014 assessment and may end with the person achieving self-defined mixed economic outcomes, often through the management of a direct payment. The work of Pod development workers with an individual is rights based – focused on social advocacy, self-determined outcomes and connecting with communities of interest and industry experts, while the referring CPA care coordinators monitor symptoms and medication and provide support in terms of the legal framework.

Pre-COVID-19, The Pod's assistant manager was located at the Integrated Practice Units (the community mental health team base) 2 days a week in a solution-focused role, creating a community of integrated professional practice and enabling responsibilities to be effectively deployed and understood. The Pod quickly adapted in response to the pandemic, developing a new social advocacy pathway and played a pivotal role in taking pressure away from IPUs, absorbing risk and enabling (unlikely) outcomes by adapting and mobilising social brokerage skills – connecting to statutory professionals and asserting people's rights.

The Pod maintains an innovative approach to recovery planning, where knowledge of community assets is spread primarily through word of mouth. This ensures that both the referred citizens and the Pod team take the initiative to know their communities well, which further instils a culture of social interdependence.

All of the above has been proven to increase self-esteem and individual resilience, reducing people's dependency on, or revolving usage of, secondary mental health and specialist health services, as well as on social care services.





## Spirit in Mind

**Provided by:** South West Yorkshire Partnership NHS Foundation Trust

**Demonstrates positive practice in:**

- Community connection
- Social inclusion
- Draws upon the strong presence of faith groups within the community

**Achievements:**

- Qualitative research published in the *Journal of Advanced Nursing*

**Population:** Everyone

**Location:** Yorkshire

**Information updated:** December 2019

For more information, see [here](#)

Spirit in Mind is an innovative project that brings together community-based spiritual organisations in collaboration with the local NHS trust. Working together with local mental health providers, Spirit in Mind and their partners hope to provide a more holistic response to mental health needs. The service operates through 'hubs' – local alliances that provide shared responses to needs in the community.

Their approach has several advantages, some of which are outlined below:

- Access to the large networks available to faith services, particularly in areas of social inequality
- Collaboration with existing social and community initiatives
- Opportunities for research into spirituality and disseminating this to the wider public
- Encouraging more favourable attitudes between mental health providers and faith-based groups
- Use of physical infrastructures which are often embedded in central locations or close to the person's home
- Working together to share the values, strengths and experiences that a faith-based approach may offer

The service also recognises that spiritual organisations are central to many people's wider network and are often the first places where they seek support. A person in the community with a strong faith background may volunteer as a lay chaplain for mental health, to work with people of all faith traditions (or none) and ensure their spiritual needs are being met.



## 2.3.1 Peer-led services



### Choice and Control peer coaching service

**Provided by:** Camden and Islington NHS Foundation Trust.

**Demonstrates positive practice in:**

- Social care
- Community collaboration
- Links user with peer coach
- Response to COVID-2019

**Achievements:**

- Creation of personal care plans and personal health budgets through the personal peer-user relationship

**Population:** People with long-term physical conditions, mental health diagnoses and social care needs

**Location:** Camden and Islington

**Information updated:** January 2021

For more information, see [here](#)

Choice and Control is a new service that sees 250 people each year. Initially in collaboration with Age UK, the service helped in the creation of personal health budgets and helps people who have long-term physical and mental health conditions to plan and implement positive change, connect with local services and advocate for personalised care. The service helps people achieve better health outcomes and improve their quality of life, by improving their self-management and motivation.

The programme links people with a peer coach (trained in techniques tested in the UK and Africa, and supervised by two facilitators). The peer coaches have experience of mental health services, so are well placed to understand and motivate people. The peer coaches do not generally come from a professional background and, as a peer of the person being supported, they often form a very personal connection and a personal primary relationship with them. These empathic relationships allow for personalised care planning, increased hope and realistic goal planning. The peer coach offers up to ten 1-hour sessions and will travel to wherever the person feels comfortable, be it their home, parks or public places. During the COVID-19 pandemic, the peer coaches have worked within the limitations of existing restrictions to deliver continuity via face-to-face, phone and virtual means. They also provided a COVID-19 check-in service for previous clients known to be vulnerable, to help meet practical needs.

People who use services were involved from the start, co-producing the service and the care planning documents, and there is a regular feedback and supervision system overseeing governance. A McPin Foundation report in May 2019 showed that peer coaches were greatly valued by clients and offered a highly personalised approach. The team are central to Trust plans for community services, helping to develop further initiatives linking with voluntary services, promoting an enhanced service for a local PCN and complementing GP efforts to focus on the wellbeing of clients with severe mental illness.



### Chester Plus

**Funded by:** partially by West Cheshire CCG

**Demonstrates positive practice in:**

- Peer-led
- Advocacy and empowerment
- All-round support

**Achievements:**

- Successful engagement of young, marginalised people
- Thorough co-production from the start

**Population:** Everyone

**Location:** Chester

**Information updated:** December 2019

For more information, see [here](#)

Chester Plus is a registered charity partially funded by West Cheshire CCG. It offers a peer-led support centre for people over 18 for a variety of different mental health needs, focusing on empowerment and independence. Support is available 4 days a week, reaching over 100 people per year, with an annual cost of about £12,000.

Co-production between people who use services and volunteers is at the centre of this service. It is a peer-led charity entirely facilitated by people with lived experience of mental illness. These volunteers offer their time and commitment to supporting those with mental health needs. It is peer-led and peer-driven at all levels, with all services provided at the request of the users. They accept all volunteers, who then take part in roles such as peer support, fundraising or campaigning for mental health. The service is committed to training and upskilling volunteers and, together with Rethink Mental Illness, fulfils any training needs.

Chester Plus has developed a wellbeing programme that produces favourable outcomes and quality assurance. There have also been positive results from mindfulness programmes, and positive qualitative service user stories. The service welcomes members of the community to visit with family, friends or supporters. It welcomes contact by phone, email, social media, and in person when possible. It has strong connections to the community through signposting and local community events.

There is a strong multi-agency element and the service is frequently visited by members of local CMHTs, local police, street triage, signposting to drug and alcohol services, and local charities.





## PeerTalk

### **Demonstrates positive practice in:**

- Volunteer-facilitated peer-support meetings
- Advocacy and empowerment
- Peer-led
- Response to COVID-2019

### **Achievements:**

- Raise awareness about depression
- Encourage good practice in the community

**Population:** 18+

**Location:** Network across the UK

**Information updated:** January 2021

For more information, see [here](#)

PeerTalk is an independent charitable foundation which has created a network of volunteer-facilitated peer-support group meetings for people who live with depression in communities all over the UK. At these meetings, people offer support and encouragement from their own experience of living with depression as others share their stories. Meetings operate within a given structure, the framework around confidentiality is explained and boundaries are made clear; however, there is no particular agenda for sessions in terms of subject matter.

Some of the group members are also recruited and trained to contribute further as peer facilitators throughout the UK, which constitutes a minimum 18-month commitment to volunteering. These facilitators are provided with ongoing support, training and supervision, while robust policies and procedures ensure safeguarding is in place.

This network operates widely and demonstrates how well an independent organisation can provide support on a large scale.

In response to COVID-19 and the accompanying restrictions, support groups followed government guidelines when meeting face-to-face, in a COVID-secure setting with measures in place to keep all attendees as safe as possible. They also developed a full [risk assessment policy and procedures](#). A summary of the changes to the group meetings can be seen [here](#).



## ReCoCo (Recovery College Collective)

**Provided by:** Northumberland, Tyne and Wear NHS Foundation Trust

### **Demonstrates positive practice in:**

- Peer-led education and support
- Community connection
- Response to COVID-19

### **Achievements:**

- Trust rated as 'Outstanding' by the CQC for Community mental health services for adults and older adults

**Population:** Everyone

**Location:** Northumberland, Tyne and Wear

**Information updated:** January 2021

For more information, see [here](#)

ReCoCo (the Recovery College Collective) is a peer-led and – delivered education and support service that serves people who live in Northumberland, Tyne and Wear. The collective offer various classes to their students, ranging from psychological intervention workshops to tailored support groups and community events or campaigns. Courses are generally accessible to anyone in the community, free of charge. In addition to social support, students can learn a range of skills that may further benefit their wellbeing in the community. ReCoCo is 'open source' or non-proprietary, working across organisations within the locality, and brings together the NHS and the VCSE sector. This reduces the strain on local NHS mental health services by performing some of its functions, while offering a level of inclusiveness and innovation from the VCSE sector.

It has a strengths-based approach for reciprocal and maximal benefit and a transparent, mutually assistive way of operating. It is open to all-comers from every mental health group (interpreted in a broad inclusive fashion, including drug and alcohol services, family services, learning disability and autism spectrum agencies, LGBTQ+ bodies, Black, Asian and Minority Ethnic groups, and so on), all being welcome to use ReCoCo's space and its resources.

In response to the impact of the COVID-19 pandemic, ReCoCo moved much of their service functions online in 2020, and have redoubled their partnership work (for example, with food banks and mutual aid groups) to meet people's immediate needs.





## Speakeasy

**Provided by:** Hertfordshire Partnership University Foundation NHS Trust

**Demonstrates positive practice in:**

- Reducing inequality
- Peer support
- Conversations with mentors with lived experience
- Supports men in times of crisis
- Mentors encourage men to talk and develop highly personalised support plans

**Population:** Men 18–65

**Location:** Ware, Cheshunt, Hertford and Broxbourne

**Information updated:** December 2019

Speakeasy is a 12-month pilot service provided in partnership with Hertfordshire Mind Network. Speakeasy aims to reduce deaths by suicide in adult men by supporting them in times of crisis and to empower them to make their own decisions about their care and treatment, through conversations with mentors with lived experience.

The service is for men aged 18 to 65 who are currently receiving care from adult mental health services within Hertfordshire Partnership University Foundation NHS Trust.

Mentors with lived experience work within the service as they are best able to encourage other men to talk, provide informal support, support the accessing of mental health services and recognise risk issues that they can share with the person's care coordinator. The mentors are trained by Mind in suicide awareness and prevention, confidentiality and safeguarding, and have monthly supervisions.

At the end of the 12-month pilot, the project will be evaluated and a decision made whether to expand the service to Welwyn Hatfield and Bishop's Stortford in Hertfordshire.



## 2.4 Addressing health inequalities



### Black Thrive

*Addresses the disproportionality in mental health outcomes experienced by Black, African and Caribbean residents by catalysing change across a diverse range of service provision to promote wellbeing, improve access and provide excellence in care*

**Provided by:** South London and Maudsley NHS Foundation Trust

**Demonstrates positive practice in:**

- Advancing equality
- Community connection

**Population:** Black residents of African or Caribbean descent

**Location:** Lambeth

**Information updated:** December 2019

For more information, see [here](#)

Black Thrive in Lambeth is a partnership between several organisations including NHS Lambeth CCG, The Metropolitan Police, Healthwatch Lambeth, Lambeth Council, and South London and Maudsley NHS Foundation Trust. The partnership was formed to address the inequity faced by Black communities when it comes to mental health and mental illness. Co-production sits at the heart of their approach, by equally drawing upon the knowledge and expertise of the people who use services, their families and professionals, and striving for equality of voice.

Members of the local community share decision-making authority with statutory organisations, including strategic leadership and governance of the programme. Black Thrive also has a small staff team that works with services to support and enable better collaboration with the community to improve mental health and related outcomes.

Black Thrive is committed to openness and transparency, exercised through its shared measurement system which collects and disseminates information across the community of Lambeth.

Working groups have been set up to support transformation in services and outcomes, focused on four key areas: improvement in service user experience, access to appropriate services, prevention of mental ill health, and mental health of children and young people from the Black community. The working groups aim to embed change within existing services as well as identify opportunities to innovate with new projects. The working groups are supported by the Black Thrive staff team who provide facilitation and project management.





## Certitude Lower Road Forensic Service

**Commissioned by:** Lewisham local authority and NHS commissioners from Lambeth, Southwark and Lewisham

**Provided by:** Certitude

**Demonstrates positive practice in:**

- Advancing equality
- Community connection
- Promoting independence

**Achievements:**

- 95% referral acceptance in 2017

**Population:** Men aged 18–65 with a forensic history

**Information updated:** December 2019

**Location:** Lewisham

For more information, see [here](#)

The Certitude Lower Road Forensic Service is a supported living service that provides support for men aged 18–65 who have been discharged from restrictive forensic inpatient settings into the local community. The service can house nine men at a time, who have a forensic history, and has the primary objective to promote recovery and community connection, and to help people learn skills to live independently. This service provides personalised support to live in the community, which might include harm minimisation, safety management and relapse prevention approaches.

Men can access this service through a referral from CMHTs or recommendations from panel members. The acceptance rate has been very high.

The service is passionate about co-production and involving friends, family, carers and mental health professionals in the development of services and delivery of care. All the people who are important to the person are involved in activities, review meetings, information sharing and carer support.

This service also offers opportunities for volunteering across Certitude services, to help people gain experience and skills and to provide an entry point into employment.

Since the service opened in 2017, a number of men have moved into more independent forms of support and many of them have secured work and had their talents recognised, such as their artwork being displayed in local galleries.



## Converge and the Discovery Hub

*An innovative partnership which offers high-quality educational opportunities to people who have experienced, or are experiencing, a mental health problem*

**Provided by:** York St John University and Tees, Esk and Wear NHS Foundation Trust

**Demonstrates positive practice in:**

- Community connection
- Academic collaboration
- Response to COVID-2019

**Population:** 18+

**Location:** York

**Information updated:** January 2021

For more information, see [here](#)

Converge is a collaboration between Tees, Esk and Wear NHS Foundation Trust and York St John University, running since 2008. It delivers high-quality educational opportunities for people with mental health problems and, as a result, enhances the employability of the individual. Converge's core principle is to challenge the dynamics of social exclusion that make it difficult for people who have used mental health services to access quality education and employment. The project also aims to engage and enhance the university and wider community, maintain a supportive and inclusive environment, and support the development of further innovations in the field.

Diverse classes are offered, including music, art, theatre, horticulture, textiles and creative writing. The classes are typically taught by undergraduates and postgraduates, allowing local students to expand their skill set and engage with valuable volunteering opportunities. The relational nature of the project uplifts community connection as a key principle. Increasingly, the classes are taught by people with lived experience of mental health problems.

The Discovery Hub offers information and access support for anyone who has experienced mental health illness and wishes to use learning opportunities as part of their recovery journey. The service offers free one-to-one sessions to support people in connecting to local learning opportunities, and so facilitates opportunities that may have been financially out of reach.

Ultimately, the Converge project – augmented by the Discovery Hub – supports people to rebuild their identity and relationships, and to foster independence, personal growth and recovery.

During the restrictions of the COVID-19 pandemic, Converge and the Discovery Hub developed online courses and ways to support people. Continuing to practice during this period has given them the opportunity to reach out more widely via online and postal learning. The Discovery Hub continued to provide face-to-face contact and support, and have supported individual wellbeing and recovery throughout 2020.





## Essex County Council's Adult Mental Health and Wellbeing Team

*Provides information on accessing appropriate local services*

### **Demonstrates positive practice in:**

- Social care
- Personalised support
- Accessibility
- Provision of practical help and information
- Response to COVID-2019

### **Achievements:**

- Evidence of positive case studies

**Population:** 18–65

**Location:** Southend, Essex and Thurrock

**Information updated:** January 2021

For more information, see [here](#)

The Adult Mental Health and Wellbeing Team at Essex County Council is a short-term prevention/early intervention team made up of social workers, community support workers, a mental health occupational therapist and a targeted employment officer. They work with people aged 18–65 who are experiencing a mental health difficulty within a social context. Self-referrals are welcomed by the team.

The service provides advice and information on mental health, short-term intervention and practical support, to support people to manage their mental health in a positive way. The team focuses on assisting people to become more independent by building confidence and knowledge. The service works with people for 3–6 months to improve mental health by teaching people-skills and helping them achieve their goals and aspirations. The team also supports carers and works with parental mental health. They use solution-focused techniques, psychoeducation, CBT techniques and trauma-informed practice to support people.

Prior to COVID-19, the team provided a social prescribing service in community venues, which they will return to when circumstances allow to promote mental health awareness and community engagement. Since COVID 19, the team have worked with people directly using electronic means, delivered webinars to support colleagues' mental health and carried out face-to-face visits where there has been a therapeutic need/safeguarding issue

The following is an example of how the service works: A young mother with a daughter in primary school was struggling with anxiety. The daughter was failing to attend school, and was withdrawn and appeared to be sad. The mother created a joint plan with the mental health wellbeing team and family solutions, taking a non-medical approach to reducing early morning tiredness, which in turn re-established her daughter's morning routine and school attendance. The mother attended distress tolerance workshops and understanding emotions sessions, receiving support to re-establish her career, improve self-care and achieve a position of hope.



## Essex: evidence-based employment support

**Provided by:** Essex Partnership University NHS Foundation Trust (EPUT)

### **Demonstrates positive practice in:**

- Employment assistance

### **Achievements:**

- Largest of its kind in the UK
- Has found employment for 441 people

**Population:** Everyone

**Location:** Essex

**Information updated:** December 2019

For more information, see [here](#)

EPUT, in partnership with the charity Employ-Ability, provide Individual Placement Support (IPS) services across the county. It is a high-quality, award winning service that is recognised as a 'National Centre of Excellence', and the first ever 'IPS Centre of Excellence for Veterans' by the Centre for Mental Health who state 'the IPS Centres of Excellence are exemplary in their use of the IPS model and the job outcomes they achieve for people with severe and enduring mental illness'.

The EPUT service is the largest of its kind in the UK and consistently supports high numbers of people into employment; in 2017/18 the service helped 441 people find employment and supported 361 more to retain employment. The team of employment specialists are integrated into CMHTs where they work in a multidisciplinary capacity, alongside clinical colleagues. This collaboration allows the employment specialists to maintain a sharp focus on job-related support and the [IPS fidelity scale](#).

The success of the service lies in its simplicity, but also its sophistication. The simplicity is that there are zero exclusion criteria, so anyone expressing an interest in finding work can access support; the team's fundamental principle is 'anyone who wants to work, can work, with the right support'. The sophistication is strict adherence to the complex IPS fidelity scale, managing high and competing demands and delivering KPIs.





## The Life Rooms

**Provided by:** Mersey Care NHS Foundation Trust

**Demonstrates positive practice in:**

- Wellbeing, learning, recovery and social inclusion
- Community assets-based approach
- Access
- Response to COVID-19

**Achievements:**

- Positive Practice Awards 2017: reducing inequality
- North West Coast Innovation Awards 2018: Partnerships in Innovation
- Healthcare Transformation 2018: Innovation in Mental Health award
- Positive Practice Awards 2018: Innovation in Community Mental health
- NHS parliamentary Awards 2019 and 2020: Excellence in Mental Health

**Population:** Everyone

**Location:** Liverpool City Region

**Information updated:** January 2021

For more information, see [here](#)

The Life Rooms is an NHS-run service, operating in three different community locations in the Liverpool City Region, as well as offering outreach opportunities and online and telephone provision. The Life Rooms has a central focus on wellbeing, learning, recovery and social inclusion. Each Life Rooms has its own identity and takes an assets-based approach, responding to the unique needs of the community in which it is situated.

Learning and social prescribing provision are two of the key Life Rooms services, as well as a host of community and social amenities. All their services are accessible to anyone in the community, with or without a referral. It has proven to be a valuable signposting resource for a range of partners, including GPs, community health practitioners, educational, social and welfare organisations, both statutory and voluntary.

One of the service's main strengths is its co-production, with involvement embedded from the initial stages to ongoing service design, implementation and evaluation.

A wide range of learning experiences are available within the learning provision, including health self-management opportunities as well as creative and social offerings. Social prescribing support is offered on a one-to-one basis via the Pathways Advisory service. Pathway advisors provide support with social and practical issues via access to a network of more than 100 partners and professional organisations, supporting people to build a life beyond diagnosis.

Due to COVID-19, The Life Rooms has developed its offer to deliver learning and social prescribing services via telephone and using online video conferencing. The Life Rooms has also developed an online learning platform where learning opportunities can be accessed remotely at any time.





## Liverpool Advice on Prescription in Primary Care (Liverpool APP)

**Commissioned by:** Liverpool CCG

**Provided by:** South Liverpool Citizens Advice

**Demonstrates positive practice in:**

- Integrated working
- Employment
- Social inclusion
- Alleviates poverty

**Achievements:**

- In 2016/17, households referred to Liverpool APP were on average £2,150 a year better off

**Population:** Everyone

**Location:** Liverpool

**Information updated:** December 2019

For more information, see [here](#)

Liverpool APP is a new model of primary mental health care that integrates support for some of the social determinants of health.

It allows primary care teams and mental health services to help their patients address any social causes of ill health such as financial difficulties, debt, housing difficulties, relationship breakdowns, bereavement, domestic abuse, unemployment and social isolation. Primary care teams and some mental health services (including child and adolescent mental health services) can directly refer someone to Liverpool APP. There are shared referral protocols and strong pathways between services.

To deliver this model, the Liverpool APP has established a strong relationship with general practitioners, including regular visits with all practices, to ensure that clinicians are familiar with the model and are continuing to refer people to the service. They also operate a hub-and-spoke model that provides 50 drop-in advice clinics over several sites to improve access for people who might not already have access to healthcare services. By networking with primary care providers, mental health teams and the local authority, all services can operate a 'no wrong door' approach to support, care and treatment. Additionally, the Liverpool APP is integrated with the statutory services and the VCSE sector, meaning that there can be seamless transitions between services.

Liverpool APP is committed to ensuring that as many people as possible can access their service. In addition to the hub-and-spoke model, they have recruited volunteers from a Black, Asian and Minority Ethnic background, who collectively speak 16 different languages, to improve access for diverse communities.





## Project Future

**Provided by:** Project Partners: MAC-UK (2014–2018), Barnet Enfield and Haringey Mental Health Trust, Mind in Haringey, Haringey Council

**Demonstrates positive practice in:**

- Advancing equality
- Co-production
- Psychologically informed approaches
- All-round support

**Achievements:**

- Reduction in mental health needs
- Increased access to other health, social care and welfare services
- Increased access to education, employment and training
- Reduction in offending

**Population:** Young men 16–25

**Location:** Haringey, London

**Information updated:** December 2019

For more information, see [here](#)

Project Future is a community-based, youth-led mental health service that seeks to transform mental health delivery for young men who have been involved in offending and been affected by serious youth violence. The service helps people who may otherwise find it difficult to access regular support, particularly due to difficulties associated with poverty and cycles of offending.

Project Future is delivered in partnership with Mind in Haringey, the local mental health trust and the local council. The project is jointly funded by Big Lottery, Comic Relief, NHS England, Haringey Council and other private funders.

The service has been co-produced by the young people who would use this service and have been involved in co-design at every stage to ensure the service meets their needs. The service is run by mental health staff and specialist youth workers, who share some experiences of the issues the young people may have lived through, and is also supported by education and employment services. The service uses evidence-based care and strength-based approaches in its care and provides a space that is supportive, safe, accepting, empowering and rooted in the community.

Rather than a formal referral process from services, people typically access the service through peer referrals or through their drop-in sessions. People who have accessed this service have opportunities to become staff (community consultants), empowering them as experts in their own lives and communities.

For its next phase, the project hopes to expand its support to include under 16s, to provide further early intervention and prevention functions.





## Psychology in Hostels project

Highly accessible coordinated support for homeless people

**Provided by:** South London and Maudsley NHS Foundation Trust

**Demonstrates positive practice in:**

- Outcomes
- Advancing equality
- Multi-agency working

**Achievements:**

- Very strong internal data monitoring procedures
- Service users involved at every stage

**Population:** Homeless people

**Location:** Lambeth, Westminster and Greenwich

**Information updated:** December 2019

For more information, see [here](#) and [here](#)

The Psychology in Hostels project focuses on socially integrating and providing accessible support to people living in homeless hostels within Lambeth's, Westminster's and Greenwich's vulnerable adults housing pathways. The people they see have complex needs, which may include physical and mental health, as well as substance misuse difficulties. Led by clinical psychologists, the project works directly with residents, and indirectly through VCSE sector hostel staff, to address both mental health and physical health inequalities through promoting trauma-informed and psychologically informed environments.

The service is accessible through self-referral by hostel residents. By having onsite psychologists, the usual barriers to accessing mental health services are reduced and the residents can become familiar with the professionals, allowing them to engage informally before they are offered more formal psychological therapy. A general assessment of needs and a psychological formulation is made for all hostel residents, while more specialist assessments (for example, neuropsychological) are available when clinically indicated.

As many of the people they work with have complex needs, multi-agency collaboration is also vital and is achieved through co-location and integration of NHS Psychology in Hostels staff with the housing sector. Assessments, formulations and treatment plans are shared alongside mental and physical health services, to encourage smooth transitions into mainstream services as and when it is appropriate for the person. Consequently, Psychology in Hostels has demonstrated cost effectiveness and has achieved notable results in mental health improvement.



## Rainbow Alliance

**Provided by:** Leeds and York Partnership NHS Foundation Trust

**Demonstrates positive practice in:**

- Advances mental health equality focusing on LGBTQ+ people
- Multi-agency collaboration
- Response to COVID-2019

**Achievements:**

- Won the Trust award for Staff Health and Wellbeing
- Shortlisted for the Health Equality award by Positive Practice in Mental Health

**Population:** LGBTQ+ community

**Location:** Leeds

**Information updated:** January 2021

For more information, see [here](#) and [here](#)

The Rainbow Alliance creates a social movement in which Trust staff, people who use services and carers collaborate and network, to enhance the quality of care across the organisation to the LGBTQ+ community. They are accountable to the Trust's Equality and Inclusion Group, and provide an opportunity for members of the Alliance to lead on LGBTQ+ service improvement projects in their areas.

The Alliance achieves these functions by establishing effective working partnerships with NHS trusts across Leeds, with the local authority and with VCSE support services. They ensure that the Alliance has a visible presence in the Trust by inviting members to quarterly meetings, to share good practice and progress. The Alliance also promotes, supports and represents the Trust during key events involving the LGBTQ+ community.

Contributions from all members are equally valued and encouraged, and members are provided with regular updates via social media, quarterly meetings, emails from Alliance leads and Trust-wide communications. The impact of the Alliance is regularly measured and the results shared across the organisation and reported to the Equality and Inclusion Group.

Membership to the Alliance is open to all Trust staff, the LGBTQ+ communities of Yorkshire, anyone who has accessed Trust services, and their carers. Formal Alliance meetings are held quarterly (dates here: [www.leedsandyorkpft.nhs.uk/get-involved/rainbow-alliance/](http://www.leedsandyorkpft.nhs.uk/get-involved/rainbow-alliance/)).

In response to COVID-19, the quarterly meetings take place online. Plans were also made to deliver the awareness training online. The Alliance is also designing a consultation to engage with the LGBT+ community about their accessing the Trust and, as part of this, are planning to explore the impact of COVID.





## SIFA Fireside

Drop-in centre support for homeless people

### Demonstrates positive practice in:

- Social inclusion
- Self-care
- Community integration

### Achievements:

- Provides 100 clothing packs, 400 showers and 3,000 meals a month

**Population:** Homeless and vulnerable adults

**Location:** Birmingham

**Information updated:** December 2019

For more information, see [here](#)

SIFA (Supporting Independence From Alcohol) Fireside provides a drop-in service for vulnerably housed and homeless adults. The visitors can access food, showers and clothing as well as support for wellbeing, mental health and physical health needs. There is an onsite psychological wellbeing worker who can assess and refer people to specialist services as well as the homeless nursing team from the Birmingham and Solihull Mental Health NHS Foundation Trust, who run a twice-weekly clinic.

As well as mental health support, the team provide physical health support in eye care, chiropody, sexual health and general health, as well as offering advice on welfare, benefits, accommodation, money and legal issues. People can also access different group programmes including art, music, computing, and a women's group. There is also employment support through help with CV writing and interview techniques, as well as a weekly Job Club where people can look for jobs online and create applications.

The service also partners with Shelter and Birmingham Mind to deliver a Lead Worker and Peer Mentor Service. The service is funded by the Big Lottery's Fulfilling Lives Programme through Birmingham Voluntary Service Council to support individuals who have disengaged from other services.



## Southdown IPS Supported Employment

**Provided by:** Sussex Partnership Foundation Trust

### Demonstrates positive practice in:

- Social inclusion
- Unemployment
- Response to COVID-19

### Achievements:

- Secured 383 paid opportunities, 85 educational opportunities and 79 voluntary opportunities in 2016/17
- IPS centre of excellence

**Population:** 16+

**Location:** Southdown

**Information updated:** January 2021

For more information, see [here](#)

In partnership with the Sussex Partnership NHS Foundation Trust, Southdown's Sussex-wide Supported Employment service has been providing IPS for 10 years, supporting people with severe and enduring mental health challenges to secure and retain paid work.

Forty employment specialists work within NHS Mental Health Recovery Teams and Early Intervention Services to provide tailored support for individuals based on their needs, goals and aspirations.

Once in work, people continue to receive support to sustain their jobs, including individual wellness plans and intensive support for them and their employers during periods of ill health.

Southdown's Supported Employment service has been a Centre for Mental Health IPS Centre of Excellence since 2015, and is the largest provider of IPS in the UK. In addition to delivery of Southdown's core Supported Employment service, the organisation works in partnership with the NHS and Department for Work and Pensions to expand the provision of IPS services, both across Sussex and nationally.

Through their joint working with the Sussex Partnership NHS Foundation Trust, they regularly share the successes and challenges of their work, sitting on several forums, partake in [IPS Grow](#) and run workshops at many national events including the British Association for Supported Employment conference. They also host IPS Open Days and regularly contribute to national reports on IPS to share their successes and learning.

During the COVID-19 pandemic, support has been provided digitally (via online video conferencing). All services adhere to government guidelines, observe lockdown requirements and use personal protective equipment during face-to-face visits.





## Southend Community Hub

*A community space where people can access support for a wide range of social issues*

**Commissioned by:** Southend Borough Council

**Demonstrates positive practice in:**

- Community connection
- Social care

**Achievements:**

- Numerous testimonies of positive experience of early intervention through support with existing social issues

**Population:** Anyone

**Location:** Essex

**Information updated:** December 2019

For more information, see [here](#)

The Community Hub project identifies existing assets and spaces in Southend and utilises them as community points of contact for local residents. The hubs range from housing and advice centres, to churches and charity sector offices. The hubs enable people to access and volunteer support for a wide range of social problems, including personal finance, budgeting advice, housing, special educational needs, IT (information technology) support, English language learning and social issues. The hubs are an innovative response by the local council to discharging their duties under the Care Act – in particular, the principle of promoting wellbeing for all people in the community, working in partnership with health, housing and other partners, and supporting their prevention and early intervention responsibilities under the Care Act.

Social workers are based at the hubs alongside specialists such as dementia navigators, occupational therapists and mental health practitioners. The hubs provide additional street-level social work, applying a preventative approach for the borough's residents. In addition, the council has used electronic and interactive mapping to identify a wide range of community assets, increasing community literacy regarding support available to help with social determinants of physical and mental health.

Since their inception, there have been numerous stories of benefits arising from an early intervention, strengths-based approach to managing problems, in collaboration with multi-agency colleagues.

The hubs are seeing significant numbers of people with mental health needs and providing social work and community connection to enable people to remain in their communities and preventing or delaying the need for secondary mental health care. As a result, the council are working to identify other key sites within each Southend locality to develop similar models.



## Thurrock local area coordination

*Support for people who feel marginalised for any reason*

**Commissioned by:** Southend Borough Council

**Demonstrates positive practice in:**

- Community connection
- Social care

**Population:** Anyone

**Location:** Essex

**Information updated:** December 2019

For more information, see [here](#)

Launched in June 2013, Thurrock local area coordinators work to strengthen local communities to welcome and include more people and to make services more personal, flexible and accountable. The main aims are to support local residents to stay strong, safe, well, resilient, independent and connected as contributing citizens in their local communities.

The local area coordinators aim to build more welcoming, inclusive and supportive communities through connecting people and places together. They support people to find ways of living a better life.

Local area coordinators build partnerships with local people, communities, organisations and services – nurturing and sharing resources within the communities and ensuring that anybody who might be marginalised is active and valued.

They cover all areas in Thurrock and are based in both towns and villages. They know the local communities and people well, supporting them to find their own practical, no-cost/low-cost, sustainable solutions to improving their own lives and the community around them. The local area coordinators believe in the strength and contribution of all local people, including those with lived experience of mental health or social care services, to build and pursue a positive vision for Thurrock.

Local area coordination is a long-term, person-centred, strength- and evidence-based approach to supporting people who may be socially isolated, lonely, excluded or marginalised.





## Wellbeing Health Improvement Service (WHISe)

**Provided by:** NAViGO Health and Social Care Community Interest Company

**Commissioned by:** NHS England and North East Lincolnshire CCG

**Demonstrates positive practice in:**

- Physical health assessment
- Physical health intervention
- Social inclusion
- Tackle health inequalities
- Fast-tracked health services
- Reduce stigma
- Response to COVID-19

**Population:** Adults, with severe mental illness

**Location:** North East Lincolnshire

**Information updated:** January 2021

For more information, see [here](#)

WHISe is a community mental health service provided by NAViGO Health and Social Care CIC. WHISe was set up to tackle the health inequalities faced by people with severe mental health issues. The service provides annual health and lifestyle checks to all those within the service, and enables individuals to participate in numerous wellbeing activities provided by the service. The activities have different levels of difficulty, such as ambles, hikes and badminton. All of the walks and activities are aimed at social inclusion, reducing mental health stigma, tackling health inequalities and reducing mortality rates by improving physical wellbeing.

In addition, WHISe has good links with local health and social care services and other local facilities, and can quickly process referrals to oral health, smoking cessation, weight management and exercise services. The service has developed a 12-week 'WHISe Choices' course to educate people on healthy eating and exercise. WHISe groups are currently run by trained professionals, but they hope class management will be taken over by previous service users in the future.

WHISe was evaluated by the Yorkshire and Humber Academic Health Sciences Network and York Economic University in 2016. During the COVID-19 pandemic, the groups moved to take place virtually and provided 'tablets' to those without access to digital devices. As restrictions eased, face-to-face groups slowly returned in line with national guidance, including walking and social groups with extensive COVID-19 risk assessments in place.



## 2.5 Community assets mapping databases and digital support and resources

### 2.5.1 Community assets mapping

**Table 1: Examples of community asset maps, 2019**

Asset map	Description
<a href="#">Connect to Support</a>	A database of available resources including services addressing health and social care needs. It also includes repair and maintenance services, transport and miscellaneous products in the local area. These sites also host locally relevant information and advice, such as what to do if someone is concerned about a vulnerable adult, and information on assessments. Many local councils in England have developed their own Connect to Support websites. This example site was developed by Birmingham City Council.
<a href="#">Keep Your Head</a>	A database of available resources and useful information specifically for mental health and wellbeing across all ages in Cambridgeshire and Peterborough. This was co-produced by Cambridgeshire County Council, Peterborough City Council, Cambridgeshire and Peterborough CCG, Cambridgeshire and Peterborough NHS Foundation Trust and the local service user network
<a href="#">MindWell Leeds</a>	A database of information and available mental health resources in Leeds. MindWell has specific sections for people seeking help for themselves, for people seeking help for another person and for a range of professionals. This database also allows people to complete NHS surveys around the development of mental health services in the area. The MindWell website has accessibility features including the option for text to be translated, enlarged, read aloud or converted to an MP3 file. MindWell is commissioned by Leeds CCG.

**Table 1: Continued**

Asset map	Description
<a href="#"><u>Sheffield Flourish</u></a>	A database of resources specifically for those with mental health problems in Sheffield. Sheffield Flourish has a calendar view as well as a search function, and can be filtered for applicability. This was co-produced by stakeholders in Sheffield, including Sheffield City Council, Sheffield Health and Social Care NHS Foundation Trust, The University of Sheffield and other local charities and organisations, including those specialising in digital and information technology.
<a href="#"><u>Southend's Adults Information Point</u></a>	A database of social activities available in Southend for all ages, abilities and interests. This information point is searchable and can be filtered by locality. Users can also contribute to the listings. This has been supported by Southend on Sea Borough Council, Southend CCG, Southend Association of Voluntary Services and Vibrance, a local charity providing services to adults with disabilities.
<a href="#"><u>The Waiting Room</u></a>	A database of local services around Birmingham and Solihull, as well as national services within the UK. It includes a wide range of health and social care resources, categorised by need, together with a large number of community resources such as faith groups and leisure groups. The Waiting Room has been developed by Common Unity, a local not-for-profit social enterprise with a mental health focus.

## 2.5.2 Digital and online support

**Table 2: Examples of digital and online support, 2019**

Digital and online support	Description
<a href="#"><u>Side by Side</u></a>	A supportive online community run by Mind for people experiencing mental health difficulties. The community is a safe place to listen, share and be heard.
<a href="#"><u>Healthlocker</u></a>	A personal, health record developed by South London and Maudsley NHS Foundation Trust. Healthlocker enables people to send confidential secure messages to their care team, access their care plan, create and manage personal goals, access and create coping strategies, track sleep and symptoms and share them with their care team, and access recovery stories and wellbeing tips.
<a href="#"><u>Calm Harm</u></a>	A private and password-protected free app designed to help people resist or manage the urge to self-harm. It is based on the principles of dialectical behaviour therapy and provides tasks that encourage users to distract themselves from urges to self-harm, and to help manage their 'emotional mind' in a more positive way.

# Appendix 3. Quality measures, NICE recommendations and outcome measures

## 3.1 Quality measures

[Table 3](#) outlines the key elements of good-quality community mental health care. These measures will help support local areas set standards for community mental health care and how care should be delivered within the framework. People’s experiences of care, support and treatment are essential in measuring the quality of services and determining priorities for improvement.

Collecting the right data in the right parts of the system at the right time is crucial as it helps identify where service improvements and service developments are needed.

Assessment of individual measures depends on the specific measures used, although generally they are most robust when triangulated with other parameters. Many process measures for mental health services are already captured in the [Mental Health Services Data Set](#).

**Table 3: Quality measures for services that deliver good-quality mental health care**

Domain	Structure and process of care to be measured	How can this be measured?
<b>Individual level</b>	<p>The person has access to:</p> <ul style="list-style-type: none"> <li>• NICE-recommended and effective mental health interventions</li> <li>• social care interventions</li> <li>• physical health interventions</li> </ul>	<p>Availability of NICE-recommended and other effective interventions</p> <p>A system in place for capturing routine outcomes (symptoms, functioning, quality of life, experience of/satisfaction with care)</p>
<b>Community level</b>	<p>The following are in place:</p> <ul style="list-style-type: none"> <li>• Community support services e.g. leisure, education and so on, to meet the mental health needs of the local population</li> <li>• Employment support</li> <li>• Housing or other accommodation</li> <li>• Help for people to find and make use of the local resources and support services that may be of value to them</li> </ul>	<p>Uptake of services listed on the left</p> <ul style="list-style-type: none"> <li>• Evidence of collaboration between CCGs, clinicians, public health, local authorities, health and wellbeing boards, and Primary Care Networks</li> <li>• Outcomes linked to objectives of the number of referrals with services – secure housing, qualifications gained</li> <li>• Inclusion of community assets and social resources in care plans</li> </ul>

Domain	Structure and process of care to be measured	How can this be measured?
<b>Service/organisational level</b>	<p><b>Joint working</b></p> <p>The following are in place:</p> <ul style="list-style-type: none"> <li>• A governance structure that will support the model</li> <li>• Community mental health services in place to meet the needs of the population</li> <li>• The ability to collaborate across traditional boundaries between health, social care and the VCSE sector</li> </ul> <p><b>Continuity of care</b></p> <p>The following are in place:</p> <ul style="list-style-type: none"> <li>• Policy and service structures that support continuity of care</li> <li>• Effective care management appropriate to need in place</li> <li>• Streamlined assessment and care planning in place</li> </ul> <p><b>Access</b></p> <ul style="list-style-type: none"> <li>• There are systems to promote access, especially for people who may have access problems (e.g. older people)</li> <li>• Pathways into care are in place</li> <li>• Community connectors in post</li> </ul> <p><b>Physical health</b></p> <p>The following are in place:</p> <ul style="list-style-type: none"> <li>• A register of people with more complex physical health needs and physical health monitoring</li> <li>• Physical health needs are considered in all assessments</li> <li>• Strategies for preventing physical health problems and addressing risk factors</li> </ul>	<ul style="list-style-type: none"> <li>• Evidence of effective board and governance structures</li> <li>• Information sharing mechanisms and policies</li> <li>• Agreed ‘trusted assessment’ process</li> <li>• Shared education and training across organisations</li> <li>• Degree of integration of mental health teams</li> <li>• Workforce numbers and composition</li> </ul> <ul style="list-style-type: none"> <li>• Number of referrals with and between services</li> <li>• Dropout from services</li> <li>• Experience of care (PREM)</li> <li>• Number of people entering and staying in care (health, social and community interventions)</li> </ul> <ul style="list-style-type: none"> <li>• Number of sub-groups entering and staying in care (health, social and community interventions)</li> <li>• Number of community connectors</li> <li>• Evidence of local equality and diversity policies</li> <li>• Experiences of care (PREM)</li> </ul> <ul style="list-style-type: none"> <li>• Uptake of physical health interventions</li> <li>• Use of public health services (emergency department and inpatient)</li> <li>• Mortality rates</li> <li>• Evidence of shared care policies and shared care records with physical health providers</li> </ul>

## 3.2 NICE recommendations and relevant NICE guidance

### 3.2.1 NICE quality statements and recommendations – high-level summary

This section contains a high-level summary of the NICE quality statements and recommendations most relevant to the framework. It has been separated into 19 domains to support local areas in implementing the quality measures outlined in [Section 3.1](#). This summary of key recommendations for process and delivery of care was compiled by the NCCMH with advice from the Expert Reference Group (ERG), and should not be used as an exhaustive list of National Institute for Health and Care Excellence (NICE) standards and recommendations, which are available on the [NICE website](#).

NICE guidelines and quality standards (see [Section 3.2.2](#) for a list of all relevant NICE publications) provide the basis for defining evidence-based care, and can be used to measure the quality of mental health care delivered in the community. Each quality standard consists of a prioritised set of specific, concise and measurable statements, designed to support the measurement of improving care.

Further information about NICE guidance and quality standards for specific diagnoses, interventions, settings or populations can also be found on the NICE website.

**Table 4: High-level summary of the NICE quality statements and recommendations**

Domain	Summary statement
<b>1. Experience and equality</b>	Community-based mental health services should be accessible to everyone. Care should be person-centred, needs-based and strengths-focused, irrespective of protected characteristics, taking into account any other aspects of identity, socioeconomic status or coexisting conditions.
	All people using services, and their families or carers, should be treated with compassion, empathy, dignity and respect, and without stigma, throughout all stages of their care.
	People using services, and their families or carers, should be able to express their views about their experience of care. This should be done in a way that allows the person to feel safe to express their views, even if their views are critical.
<b>2. Getting help and support</b>	When they need it, all adults and older adults should have timely access to support, care and treatment from professionals with appropriate expertise, across a range of health and social care providers. This includes access to assessments, interventions and specialist services.
	Access to support, care and treatment is determined by need and is unrelated to location, socioeconomic status and any protected characteristics.
	People should not be excluded from treatment because of physical or other mental health problems, substance or alcohol use, disabilities or because of a coexisting need.
	Commissioners and providers should take into account the way people may experience different types of stigma and how this influences access to services. They should also recognise that specific populations may be at greater risk of not using or losing contact with services.
	Services should be located in the local community and seek to identify ways of offering flexible access and increasing accessibility.
	Service settings and environments should be experienced as welcoming, accessible, safe and discreet by the people who use them.

**Table 4: Continued**

Domain	Summary statement
<b>3. Psychosocial education and information</b>	<p>Families and carers are provided with information to enable them to understand a person's strengths and needs and support the person using mental health services. This may include:</p> <ul style="list-style-type: none"> <li>• information about mental health, physical health and social needs</li> <li>• with consent, sharing information about assessments and care plans with families and carers</li> <li>• providing information and advice or signposting to other resources and services</li> <li>• offering carer-focused education or support programmes.</li> </ul>
<b>4. Understanding my needs (assessment)</b>	<p>Local authorities must ensure that care and support needs assessments under the Care Act 2014 focus on the person's needs and how these impact on their wellbeing, and the outcomes they want to achieve in their day-to-day life. Services should make sure people are aware of their entitlement to an assessment under the Care Act.</p> <p>Families and carers have their own needs identified. Ensure family, carers or significant others who provide care are aware that they are entitled to, and offered, an assessment of their own needs, in line with the Care Act.</p>
<b>5. Co-produced care planning</b>	<p>People are actively involved in shared decision-making and supported in self-management.</p> <p>Care plans are collaboratively developed with the person and their families or carers (if appropriate), as well as any other professionals or support people they want involved, to ensure it is tailored to meet their needs. There is an agreed date to review the care plan, including information on who is involved and how these reviews are carried out.</p> <p>Ensure the care plan:</p> <ul style="list-style-type: none"> <li>• Is based on a discussion with the person about how their abilities can help them engage with services and recover</li> <li>• Takes into account the person's past experiences and any concerns of their family or carers</li> <li>• Lists how the person will be supported to meet their identified needs and goals, including any support around transport to get to appointments</li> <li>• Recognises and, if possible, reconciles any goals the person may have decided for themselves, if they differ from those identified by the service</li> <li>• Is optimistic about the person's recovery</li> <li>• Records and addresses the person's specific needs in relation to equality and diversity issues.</li> </ul> <p>The person should be given a copy of their care plan. The care plan can also be shared with the person's family or carers, if the person agrees, and with any other services as needed (in line with local information sharing agreements).</p>
<b>6. Receiving support, care and treatment</b>	<p>Interventions are initiated, delivered and reviewed by professionals with the appropriate expertise and competence, and in accordance with NICE guidance.</p>
<b>7. Physical health</b>	<p>People with a diagnosed mental health problem (including bipolar disorder, psychosis or schizophrenia), have a comprehensive physical health assessment or health check regularly (at least annually).</p> <p>People from Black, Asian and Minority Ethnic backgrounds with a serious mental illness often have worse physical health and/or are less likely to receive physical health checks, so services should make extra efforts because of this. Record any actions identified by the annual health check in the person's care plan.</p> <p>People with a mental health problem and comorbid physical health problem receive collaborative care and an appropriate psychological intervention.</p> <p>People with a mental health problem are offered combined healthy eating and physical activity programmes, including help to stop smoking (if relevant) and information about oral health.</p> <p>Explore any barriers to self-care to help the person look after their own physical health. Address these barriers in the care plan.</p>

**Table 4: Continued**

Domain	Summary statement
<b>8. Review</b>	People's needs and the impact of health, social and environmental factors are reviewed, and care plans are updated in response to changing needs or circumstances throughout all care, or within agreed timeframes.
	Review the needs of carers at least once a year, or if something significant happens.
<b>9. Advocacy and empowerment</b>	Respect people's right to make their own decisions and do not make assumptions about people's capacity to be in control of their own care and support.
	Actively involve the person in all decisions that affect them.
	People are enabled (and empowered) to: <ul style="list-style-type: none"> <li>• maintain and develop their personal identity</li> <li>• maintain their independence</li> <li>• engage in activities that improve wellbeing and create a sense of belonging or purpose</li> <li>• make decisions and be a central part of the decision-making process around their care; they may need support to express their views and make decisions in relation to their care and support.</li> </ul>
	People's needs and preferences are prioritised and are not overshadowed by the decisions or preferences of others.
	People are given clear information on advocacy services and, if the person needs it and consents to it, they are provided with an independent advocate. At a minimum, independent advocacy must be offered as described in the Care Act 2014, Mental Capacity Act 2005 and Mental Health Act 2007.
	Advocates will accompany people to appointments, help them with decision-making and care planning, help people participate in care and support needs assessments, and help people express their views.
<b>10. Safety</b>	Ensure safeguarding needs are assessed for all people who are using services, as well as their families, dependents, carers and significant others; appropriate procedures must be put in place where necessary, according to local safeguarding procedures.
	People accessing support, care and treatment for mental health are: <ul style="list-style-type: none"> <li>• offered a crisis and risk management plan. Crisis plans are kept up to date to reflect the person's changing circumstances</li> <li>• regularly assessed and monitored if there are issues around safety or risk</li> <li>• provided with additional support and strategies around safety or risk when they move between services, settings or agencies</li> <li>• proactively followed up if there is loss of contact or non-attendance at appointments; this is immediate (or within 24 hours) if there is a risk of self-harm or suicide, or other existing concerns.</li> </ul>
	Ensure people who are prescribed medicines know how to identify and report medicines-related patient safety incidents.
	Domestic abuse and violence is identified and responded to appropriately.
	People who have self-harmed: <ul style="list-style-type: none"> <li>• while in health care settings, receive care in a safe physical environment where they can be monitored to reduce the risk of further self-harm</li> <li>• have a collaboratively developed risk management plan to ensure safety if continued support is required.</li> </ul>
	People accessing crisis support have a comprehensive assessment undertaken by a professional competent in crisis working.
	People in contact with mental health services who have been violent or aggressive are supported to identify triggers and early warning signs for these behaviours, as well as successful de-escalation techniques and advance statements for use of restrictive practice.
	People with a mental health problem who experience restraint, rapid tranquillisation or seclusion are involved in an immediate post-incident debrief; their physical safety is monitored during and after these instances.

**Table 4: Continued**

Domain	Summary statement
<p><b>11. Care coordination</b></p>	<p>People are offered a named person to coordinate the care and support they need. This includes:</p> <ul style="list-style-type: none"> <li>• People with a mental health problem who may also have autism, a learning disability, or behaviour that challenges</li> <li>• People with multiple diagnoses or comorbid problems</li> <li>• Older people with multiple long-term conditions, including social care needs</li> <li>• Young people who are moving from children’s to adults’ services and require support before, during and after transfer.</li> </ul> <hr/> <p>The named care coordinator’s role is to:</p> <ul style="list-style-type: none"> <li>• Act as a contact for the person or their family or carer, using proactive, flexible approaches</li> <li>• Liaise and work with the person, their families, carers and advocates, as well as any other services across health, social care, housing, and the VCSE sector that may be involved</li> <li>• Help the person to develop a care plan, and ensure the care plan is reviewed</li> <li>• Work collaboratively with other services (including shared responsibilities and regular communication) to address the person’s social care, physical health and mental health needs, and provide any other support they may need</li> <li>• Help people who may find it difficult to engage with services to get into and stay connected with services</li> <li>• Work with the person and with other services when the person requires a transfer of care between services</li> <li>• Ensure that any referrals required are made and are actioned.</li> </ul> <hr/> <p>Commissioners and managers across all settings should ensure continuity of care and support for people.</p> <hr/> <p>Have proactive follow-up processes for non-attendance or loss of contact. This may include:</p> <ul style="list-style-type: none"> <li>• contacting the person to rearrange an appointment</li> <li>• visiting the person at home</li> <li>• contacting other practitioners involved in their care or family or carers, as identified in a person’s care plan</li> <li>• contacting the person’s care coordinator.</li> </ul> <p>Follow-up is immediate (or at least within 24 hours) if there is a risk of self-harm or suicide, or other existing concerns.</p> <p>Ensure that people continue to have access to services at times of transition between services and localities. In particular:</p> <ul style="list-style-type: none"> <li>• transition from children’s to adult’s services</li> <li>• where people live in different places at different times of the year (e.g. at university in term time), moving home or do not have permanent or secure accommodation.</li> </ul>

**Table 4: Continued**

Domain	Summary statement
<b>13. Necessary transfers and transitions</b>	<p>People going from one service to another need:</p> <ul style="list-style-type: none"> <li>• Proactive planning for the transition, with input from family members, carers, or advocates (as appropriate)</li> <li>• A collaboratively developed plan describing how support will be provided during the transition</li> <li>• A reconciled list of their medicines (in GP record), before any new prescription is issued (if relevant)</li> <li>• A service to take the lead for subsequent assessment and care planning (if required)</li> <li>• Clear information about which service to contact and which service is providing the right ongoing support</li> <li>• Support to make decisions about moving to a new service or different setting.</li> </ul>
	<p>People's needs are reassessed when they are at a transition point to ensure continuity of care, and that they receive any additional support required during the transition. The needs of their family members or carers should also be considered.</p>
	<p>Before a person moves between services, settings or agencies, ensure:</p> <ul style="list-style-type: none"> <li>• All practitioners who have been, or who will be, involved are invited to the multi-agency and multidisciplinary meetings, and to the discharge or transfer meeting</li> <li>• There is support to meet the person's housing needs</li> <li>• The care plan includes strategies for ongoing safety planning and risk management, and details on how they can get back in contact with services (if leaving a service rather than transitioning to a new service)</li> <li>• There are crisis plans in place if the person's mental or physical health deteriorates</li> <li>• Services share information on how to manage challenging or risky situations.</li> </ul>
	<p>Young people who are moving from children's to adults' services:</p> <ul style="list-style-type: none"> <li>• Have a named person to coordinate care and support before, during and after transfer</li> <li>• Meet a practitioner from each adults' service that they will move to before they transfer</li> <li>• Are contacted by adults' services if they do not attend their first meeting or appointment, to give them further opportunities to engage</li> <li>• Have an annual meeting to review transition planning</li> <li>• Have transition arrangements discussed and in place before the transition occurs</li> </ul>
	<p>Care plans outlining support for transitions are shared with all services and staff involved in the person's care, as well as with the person, their family or carers (if appropriate), and any advocates who may be involved in their ongoing care.</p>
	<p>Before the person moves to another service, they agree on a structured, phased plan before their care or support changes.</p>
<b>14. Co-produced service development, planning and evaluation</b>	<p>Services should consider using a range of approaches to gather people's views and experiences on the care they receive, and provide clear information on how these will be used, including making public how they have responded to people's feedback.</p>
	<p>Services should provide opportunities for professionals to learn from the experiences of people who use services.</p>

**Table 4: Continued**

Domain	Summary statement
<b>15. Commissioning</b>	Commissioners and service providers must make reasonable adjustments to health, social care and housing services to ensure they are fully accessible in line with the Equality Act 2010.
	Ensure referral processes and care pathways within and across agencies are consistent and that governance arrangements are in place. This includes local care pathways to meet the physical health, social care, housing and support needs of people with coexisting severe mental illness and substance misuse.
	Agree a protocol for information sharing between secondary care mental health services and substance misuse, health, social care, education, housing, and VCSE services
	Local information sharing agreements relevant to people’s care across services (in line with the Caldicott principles and the Health and Social Care (Safety and Quality) Act 2015) will: <ul style="list-style-type: none"> <li>• Enable appropriate sharing of the person’s care plan (with consent of the person)</li> <li>• Assist in communication about the person and any support, care or treatment they are receiving.</li> </ul>
	Commissioners and providers should ensure that the results of research with people are used to inform improvements to services.
	Mental health commissioners should develop protocols to ensure that people with learning disabilities, including people in later old age, have access to mainstream mental health services appropriate to their age/life stage, including dementia support where appropriate.
<b>16. Commissioning: knowing your population</b>	Commissioners should have an understanding of the needs of people in their area, and know what mainstream and specialist services are available locally to support them and meet their needs.
	Commissioners and providers should seek advice from organisations with expertise in equality and diversity issues to ensure they provide and deliver services that meet the needs and preferences of the whole community.
<b>17. Joint/ collaborative working between agencies</b>	People with a mental health problem and comorbid physical health problem receive collaborative care to support effective treatment of physical and mental health comorbidities.
	Good communication between professionals and people, and across services, is essential to providing effective support, care and treatment.

**Table 4: Continued**

Domain	Summary statement
<b>18. Parents, carers, families, friends, support network</b>	<p>Families and carers are offered information on how to access services in the community, and receive support tailored to their needs, including:</p> <ul style="list-style-type: none"> <li>• carer-focused education programmes</li> <li>• support programmes</li> <li>• respite care or support to access recreational activities to improve their wellbeing or have a break from caring duties</li> <li>• information on how to get financial advice, including access to personal budgets</li> <li>• carer’s assessments</li> <li>• access to community support groups.</li> </ul> <p>In line with the Care Act 2014, local authorities must provide information about care and support services for people and their carers.</p>
	<p>Families and carers have their own needs identified (an assessment of their needs). If the carer wishes, make a referral to their local authority for a carer’s assessment (in line with the Care Act 2014). Based on the carer’s assessment, provide families and carers with support that meets their needs, including any support to access childcare or respite care. The needs of families and carers should be included in any reviews (as appropriate).</p>
	<p>Families and carers are actively involved in care planning, decision-making and information sharing, as agreed by the person and as stated in their care plan. Regularly check families’ and carers’ willingness and ability to be involved in this way.</p>
	<p>Families and carers are offered family intervention (where appropriate).</p>
	<p>Be aware that some people do not have close family members, friends or carers.</p>
	<p>Discuss with families and carers any concerns they may have about the person’s mental health condition and how this may impact on them and other family members.</p>
	<p>Actively encourage carers to register themselves as a carer, for example, with their GP.</p>
	<b>19. Staff competence/ skills</b>
<p>Staff who deliver pharmacological, psychological or psychosocial interventions receive regular supervision and professional development to ensure they are competent to understand people’s needs and deliver care. Staff have access to professionals with specialist knowledge if they require further advice or consultation.</p>	
<p>Staff in care coordinator roles are supervised and receive professional development to provide or coordinate flexible, personalised care.</p>	
<p>Commissioners and providers across all settings should review staffing numbers and skill mix regularly to ensure that staffing and skill levels are sufficient to meet people’s needs.</p>	
<p>Services have a transparent and fair recruitment and selection process that uses values-based interviews and approaches to identify the personal attributes and attitudes essential for a caring and compassionate workforce.</p>	
<p>Services should consider involving people who use services, as well as their families or carers, in the recruitment and training of staff. People who use services, and their families or carers, should also be considered for peer support or volunteering roles.</p>	

## 3.2.2 List of NICE guidance and quality standards

### NICE guidelines

#### Guidelines on mental health diagnoses and coexisting needs

[Alcohol-use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence \(CG115\)](#)

[Antisocial Personality Disorder: Prevention and Management \(CG77\)](#)

[Attention Deficit Hyperactivity Disorder: Diagnosis and Management \(NG87\)](#)

[Autism Spectrum Disorder in Adults: Diagnosis and Management \(CG142\)](#)

[Bipolar Disorder: Assessment and Management \(CG185\)](#)

[Borderline Personality Disorder: Recognition and Management \(CG78\)](#)

[Care and Support of People Growing Older with Learning Disabilities \(NG96\)](#)

[Challenging Behaviour and Learning Disabilities: Prevention and Interventions for People with Learning Disabilities Whose Behaviour Challenges \(NG11\)](#)

[Coexisting Severe Mental Illness \(Psychosis\) and Substance Misuse: Assessment and Management in Healthcare Settings \(CG120\)](#)

[Coexisting Severe Mental Illness and Substance Misuse: Community Health and Social Care Services \(NG58\)](#)

[Common Mental Health Problems: Identification and Pathways to Care \(CG123\)](#)

[Depression in Adults with a Chronic Physical Health Problem: Recognition and Management \(CG91\)](#)

[Depression in Adults: Recognition and Management \(CG90\)](#)

[Drug Misuse in Over 16s: Psychosocial Interventions \(CG51\)](#)

[Drug Misuse Prevention: Targeted Interventions \(NG64\)](#)

[Eating Disorders: Recognition and Treatment \(NG69\)](#)

[Generalised Anxiety Disorder and Panic Disorder in Adults: Management \(CG113\)](#)

[Learning Disabilities and Behaviour that Challenges: Service Design and Delivery \(NG93\)](#)

[Mental Health Problems in People with Learning Disabilities: Prevention, Assessment and Management \(NG54\)](#)

[Obsessive-compulsive Disorder and Body Dysmorphic Disorder: Treatment \(CG31\)](#)

[Older People: Independence and Mental Wellbeing \(NG32\)](#)

[Post-traumatic Stress Disorder \(NG116\)](#)

[Preventing Suicide in Community and Custodial Settings \(NG105\)](#)

[Psychosis and Schizophrenia in Adults: Prevention and Management \(CG178\)](#)

[Self-harm in Over 8s: Long-term Management \(CG133\)](#)

[Self-harm in Over 8s: Short-term Management and Prevention of Recurrence \(CG16\)](#)

[Service User Experience in Adult Mental Health: Improving the Experience of Care for People using Adult NHS Mental Health Services \(CG136\)](#)

[Social Anxiety Disorder: Recognition, Assessment and Treatment \(CG159\)](#)

### **Guidelines included in other mental health care pathways**

[Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance \(CG192\)](#)

[Dementia: Assessment, Management and Support for People Living with Dementia and their Carers \(NG97\)](#)

[Dementia, Disability and Frailty in Later Life – Mid-life Approaches to Delay or Prevent Onset \(NG16\)](#)

[Mental Wellbeing at Work \(PH22\)](#)

### **Other relevant guidelines**

[Behaviour Change: Digital and Mobile Health Interventions \(NG183\)](#)

[Behaviour Change: General Approaches \(PH6\)](#)

[Behaviour Change: Individual Approaches \(PH49\)](#)

[Community Engagement: Improving Health and Wellbeing and Reducing Health Inequalities \(NG44\)](#)

[Decision-making and Mental Capacity \(NG108\)](#)

[Domestic Violence and Abuse: Multi-agency Working \(PH50\)](#)

[Multimorbidity: Clinical Assessment and Management \(NG56\)](#)

[Older People with Social Care Needs and Multiple Long-term Conditions \(NG22\)](#)

[People's Experience in Adult Social Care Services: Improving the Experience of Care for People using Adult Social Care Services \(NG86\)](#)

[Rehabilitation for Adults with Complex Psychosis \(NG181\)](#)

[Smoking: Acute, Maternity and Mental Health Services \(PH48\)](#)

[Supporting Adult Carers \(NG150\)](#)

[Violence and Aggression: Short-term Management in Mental Health, Health and Community Settings \(NG10\)](#)

### **Medication management**

[Community Pharmacies: Promoting Health and Wellbeing \(NG102\)](#)

[Managing Medicines for Adults Receiving Social Care in the Community \(NG67\)](#)

[Managing Medicines in Care Homes \(SC1\)](#)

[Medicines Adherence: Involving Patients in Decisions about Prescribed Medicines and Supporting Adherence \(CG76\)](#)

[Medicines Optimisation: the Safe and Effective Use of Medicines to Enable the Best Possible Outcomes \(NG5\)](#)

### **Service transitions**

[Transition between Inpatient Hospital Settings and Community or Care Home Settings for Adults with Social Care Needs \(NG27\)](#)

[Transition between Inpatient Mental Health Settings and Community or Care Home Settings \(NG53\)](#)

[Transition from Children's to Adults' Services for Young People using Health or Social Care Services \(NG43\)](#)

### **Guidelines in development at time of publication**

[Depression in Adults: Treatment and Management \(GID-CGWAVE0725\)](#)

[Safeguarding Adults in Care Homes \(GID-NG10107\)](#)

### **Quality standards**

#### **Quality standards relating to mental health diagnoses and coexisting needs**

[Alcohol-use Disorders: Diagnosis and Management \(QS11\)](#)

[Anxiety Disorders \(QS53\)](#)

[Attention Deficit Hyperactivity Disorder \(QS39\)](#)

[Autism \(QS51\)](#)

[Bipolar Disorder in Adults \(QS95\)](#)

[Coexisting Severe Mental Illness and Substance Misuse \(QS188\)](#)

[Depression in Adults \(QS8\)](#)

[Drug Misuse Prevention \(QS165\)](#)

[Drug Use Disorders in Adults \(QS23\)](#)

[Eating Disorders \(QS175\)](#)

[Learning Disability: Care and Support of People Growing Older \(QS187\)](#)

[Learning Disabilities: Behaviour that Challenges \(QS101\)](#)

[Learning Disabilities: Identifying and Managing Mental Health Problems \(QS142\)](#)

[Mental Wellbeing and Independence for Older People \(QS137\)](#)

[Mental Wellbeing of Older People in Care Homes \(QS50\)](#)

[Multimorbidity \(QS153\)](#)

[Personality Disorders: Borderline and Antisocial \(QS88\)](#)

[Psychosis and Schizophrenia in Adults \(QS80\)](#)

[Self-harm \(QS34\)](#)

[Suicide Prevention \(QS189\)](#)

## **Quality standards included in other mental health care pathways**

[Antenatal and Postnatal Mental Health \(QS115\)](#)

[Dementia \(QS184\)](#)

## **Other relevant quality standards**

[Community Engagement: Improving Health and Wellbeing \(QS148\)](#)

[Domestic Violence and Abuse \(QS116\)](#)

[Medicines Management for People Receiving Social Care in the Community \(QS171\)](#)

[Medicines Management in Care Homes \(QS85\)](#)

[Medicines Optimisation \(QS120\)](#)

[People's Experience using Adult Social Care Services \(QS182\)](#)

[Promoting Health and Preventing Premature Mortality in Black, Asian and Other Minority Ethnic Groups \(QS167\)](#)

[Service User Experience in Adult Mental Health Services \(QS14\)](#)

[Social Care for Older People with Multiple Long-term Conditions \(QS132\)](#)

[Smoking: Supporting People to Stop \(QS43\)](#)

[Transition between Inpatient Mental Health Settings and Community or Care Home Settings \(QS159\)](#)

[Transition between Inpatient Hospital Settings and Community or Care Home Settings for Adults with Social Care Needs \(QS136\)](#)

[Transition from Children's to Adults' Services \(QS140\)](#)

[Violent and Aggressive Behaviours in People with Mental Health Problems \(QS154\)](#)

### 3.3 Outcome measure recommendations

[Table 5](#) contains key recommendations regarding the use of outcome measures in practice, reproduced from the guidance on the left.

**Table 5: Recommendations for using outcome measures**

Guidance	Recommendation
<p><a href="#">Outcome Measures Implementation Best Practice Guidance</a> (P Fonagy, R Matthews &amp; S Pilling, 2005)</p>	<ul style="list-style-type: none"> <li>• Trusts should integrate outcome measures within local IT electronic systems</li> <li>• Trusts encouraged to explore use of other clinician rated measures and self-reported measures, including quality of life measures</li> </ul> <p>Principal domains that should be included within measures:</p> <ul style="list-style-type: none"> <li>• Symptom distress</li> <li>• Social functioning</li> <li>• Quality of life</li> <li>• How well services met perceived needs</li> <li>• Whether the individual felt adequately informed</li> <li>• Whether the individual felt engaged in care planning and given choices about treatment</li> <li>• How the individual felt about the nature of the relationship with key healthcare professionals</li> </ul>
<p><a href="#">IAPT outcomes toolkit</a> (NHS, 2008)</p>	<p><b>Checklist:</b></p> <ol style="list-style-type: none"> <li>1. Identify a data collection lead/information manager</li> <li>2. Understand what information should be collected (<a href="#">Chapter 3</a>)</li> <li>3. Conduct a baseline assessment:             <ol style="list-style-type: none"> <li>a. What is your current level of data collection?</li> <li>b. How does this differ from the IAPT requirement?</li> <li>c. Are you capable of collecting the full requirements, what systems are in place?</li> <li>d. What is your data collection model (that is, who does what and how)?</li> <li>e. Will your model need to be adapted to meet the requirement?</li> </ol> </li> <li>4. Agree a data collection approach/model (<a href="#">Chapter 4</a>)</li> <li>5. Identify delivery constraints and resource requirements (including workforce impact and training issues)</li> <li>6. Develop local delivery arrangements.</li> </ol>

Guidance	Recommendation
<p>IAPT outcomes toolkit (continued)</p>	<p>Principles:</p> <ul style="list-style-type: none"> <li>• The primary purpose of outcomes measurement is to improve people’s experience and benefits from the service and is part of ongoing, collaborative service evaluation, with feedback from people using the service at its heart</li> <li>• Outcomes feedback to clinicians helps improve the quality of their interventions</li> <li>• Outcomes feedback to supervisors supports case reviews, and collaborative treatment planning</li> <li>• Routinely collected outcomes data helps managers monitor and improve overall service performance</li> <li>• Service performance data informs managers who set national standards to what to aim for</li> <li>• Intelligent use of aggregate outcomes data by experts aims to define best practice models of service delivery</li> <li>• The requirement for data collection should be proportionate to the treatment being offered and integrated with clinical priorities. Data is more useful if a complete set of minimum data is obtained for each session.</li> </ul> <p>The <a href="#">IAPT implementation Plan: National Guidelines for regional delivery</a> sets out service standards and outcomes to be monitored as part of service level performance indicators.</p>
<p><a href="#">The Health Foundation’s No. 18: Measuring patient Experience: Evidence scan</a> (D de Silva, 2013)</p>	<ol style="list-style-type: none"> <li>1. Consider how patient experience is being defined to inform exactly what needs to be measured.</li> <li>2. Think about why patient experience is being measured and how the information will be used.</li> <li>3. Assess whether it would be useful to combine approaches so that both qualitative and more quantitative material is collected.</li> <li>4. Consider whether to ask everyone using the services or only a sample to provide feedback.</li> <li>5. Think about whether the best time to collect feedback is immediately after using the services, when experiences are fresh in people’s minds.</li> <li>6. Allocate enough time at the outset to plan and test measurement methods, particularly if these will be used for many years to monitor change over time.</li> <li>7. Think about how the end-result needs to be presented for various audiences as this may shape how data are collected. Potential outputs include statistical averages, in-depth quotes or graphs.</li> <li>8. Make sure that there is appropriate infrastructure at an organisational level to analyse and use patient experience information.</li> <li>9. Make sure that patients, carers, managers and health professionals are all comfortable with why feedback is being collected and how it will be used. Staff need to be on board as well as patients.</li> <li>10. Ensure that patient experience measures are seen as one component of a broader framework of measurement and that all of the approaches work well together, without excessive burden for either staff or patients.</li> </ol>

Guidance	Recommendation
<p><a href="#">‘How to Guide. The BCF Technical Toolkit Section 3: Outcomes and Impact Measurement</a> (Better Care Fund Task Force, 2014)</p>	<p>Defining outcome measures allows you to:</p> <ul style="list-style-type: none"> <li>• align commissioners and providers around the impact of planned schemes. This makes sure that everyone locally is aiming to deliver a common set of outcomes</li> <li>• measure progress over time. Setting outcome measures at suitable time intervals allows initiatives to be tracked. Initiatives can be monitored to see whether they are delivering the expected outcomes and will highlight if changes to the scheme need to be made where they are not delivering</li> <li>• provide a basis for aligning incentives. Schemes are most successfully implemented when all incentives (for example, payments) within the system are aligned with the agreed outcomes</li> </ul> <p><i>Notes:</i></p> <ol style="list-style-type: none"> <li>1. Identify possible outcomes and targets</li> <li>2. Define outcome goals for the agreed population (local agreed metrics can be included if relevant)</li> <li>3. Routinely collect data to measure progress against goals</li> </ol>
<p><a href="#">The NHS Long Term Plan</a> (NHS England, 2019)</p>	<p>A new ICS accountability and performance framework will consolidate the current amalgam of local accountability arrangements and provide a consistent and comparable set of performance measures.</p> <p>It will include a new ‘integration index’ developed jointly with patient groups and the voluntary sector. This will measure the extent to which (from the point of view of patients, carers and the public) the local health service and its partners are providing joined up, personalised and anticipatory care.</p>

# Appendix 4. Evidence reviews summary

Reviews of the available evidence were conducted alongside the development of the framework, and their findings were integral to its development.

The summaries of the following five review area topics are included in this section:

## 4.1 Review areas and questions

1

### **Risk assessment**

What are the most effective methods for assessing the risk of self-harm, suicide and violence in community mental health services?

2

### **Assessment**

What is the best structure and content for a mental health assessment in community mental health services?

3

### **Formulation**

What methods support effective formulations in community mental health services?

4

### **Care coordination**

Which models of care coordination are associated with better outcomes for the person, increased cost effectiveness and improved service engagement?

5

### **Care delivery functions**

What functions of mental health care in community mental health services are needed for care to be effective?

What type(s) of team organisation are effective/how is care best organised?

How do services effectively integrate care

- between service users, carers and families?
- between professionals, services and agencies?

## 4.2 Review area 1: Risk assessment

### ***What are the most effective methods for assessing the risk of self-harm, suicide and violence in community mental health services?***



#### **Background**

In the UK, initiatives to manage the risk of self-harm, suicide and violence have been at the forefront of mental health policy. As a result, risk assessments have been central in the drive to promote safer practice. Risk assessments typically incorporate multiple perspectives, including that of the person, to identify whether their safety is being ensured. A professional or team then uses this to inform a care plan and safety plan (often referred to as risk management plan), which typically include strategies to keep the person safe using the least restrictive methods. Standardised risk assessment tools are widely used in clinical practice to facilitate this process, producing a summative description or estimate of the person's risk. However, it is the current view that such tools do not possess enough predictive validity to be clinically useful. Despite extensive research in inpatient settings, little is known about risk assessment in community settings, where the risk factors for self-harm, suicide and violence, and their management, are likely to differ substantially. This review of reviews explores the methods that are most effective for assessing risk of self-harm, suicide or violence in community settings.



#### **Method**

This was a review of existing systematic reviews. A search was conducted using the databases Embase, MEDLINE and PubMed for systematic reviews or meta-analyses published between January 2001 and September 2017. Each record ( $n = 4,274$ ) was screened for relevance (following predefined protocols) and queries were resolved by consensus. Studies were eligible if at least a subset of the sample included adults with mental health problems in the community. Thirteen studies for predicting risk of self-harm ( $n = 3$ ), suicide ( $n = 7$ ) and violence ( $n = 7$ ) were included for narrative synthesis.



#### **Results**

##### **Risk assessment of self-harm and suicide**

Of the seven reviews that looked at tools for assessing the risk of suicide, three also evaluated tools for assessing the risk of self-harm. None of the reviews indicated that any risk assessment tool performed better than any other, nor did they indicate that any specific tool could accurately predict risk. Out of the reviews that looked at positive predictive value, the range was very large, with the lowest reported positive predictive value being 1.3% and the highest 84%.

The identified studies showed that evaluated self-harm and suicide risk assessment tools were not directly comparable, although low sensitivity rates were observed across studies. Many focused on inpatient samples, with no review looking solely at community samples. All of these reviews noted limitations in risk assessments and four directly expressed concern about their use in clinical practice.

## Risk assessment of violence

Of the seven reviews that investigated violent outcomes, there was no evidence that any risk assessment tool could adequately predict risk to a clinically useful standard. When excluding tools with fewer than five independent samples, the highest pooled area-under-the-curve value reported for a tool was 0.78. Restricting the search further, to tools with at least a 1-year follow-up, the highest pooled area-under-the-curve value reported for any tool was 0.72. Reported values may have been inflated by methodological sources of bias, including:

- author allegiance to a tool
- variation in cut-off thresholds
- duration of follow-up periods
- retrospective study designs
- a lack of exclusively mental health samples
- insufficient detail of the nature and extent of a person's previous history of mental health problems and service use.

Where there was inadequate control for bias, these reviews may have overestimated the effectiveness of risk assessment tools.

Actuarial risk assessment tools did not significantly outperform structured professional judgement tools in any study. Further, although no review utilised samples exclusively in the community, heterogeneity analyses, where conducted, suggested that the type of setting did not significantly bias results.



## Conclusion

In practice, clinicians typically use tools devised by their service rather than those included in this review. However, when considering the best-evidenced tools under a range of conditions, the results of this review suggest that it is poor practice to base clinical decisions on risk stratification founded on risk assessments. Over-reliance on any tool may result in false conclusions on safety, inappropriate care decisions and misallocated resources. These tools offer no advantages over a well-informed judgement of risk.

Assessment of risk and safety should be incorporated into all assessments in community mental health services. The extent of the assessment will be related to the complexity of a person's needs and the presence of any known indicator of risk. This should take place through a comprehensive biopsychosocial assessment that is strengths-based and specific to the person's needs.

Tools that are structured around professional judgement might be preferable to practitioners rather than actuarial risk tools, as this better incorporates clinical judgement and provides more comprehensive and contextual information to share with others.

## 4.3 Review area 2: Assessment

**What is the best structure and content for a mental health assessment in community mental health services?**



### Background

The primary objective of this review was to have a comprehensive understanding of the structure and content of an effective mental health assessment, as well as to identify the various types of assessments.



### Method

This was a literature review. Initial searches for good-quality systematic reviews of assessment methods identified no such reviews. Two literature searches were conducted: NICE recommendations relevant to primary care or community mental health services were extracted from NICE guidelines published between December 2002 and September 2017. Also, a list of other information sources (textbooks, journal articles, policy documents and competence frameworks) was compiled during the scoping phase of The Framework for Community Mental Health for Adults and Older Adults: Support, Care and Treatment and included if relevant to either primary care mental health or community mental health services.

A narrative synthesis combined this information into three main areas focusing on the different types, processes and contents of an assessment. We also sought expert opinions to assist with the interpretation of this evidence.



### Results

Assessments could be categorised as initial, generalist or specialist.

*An initial brief assessment* may be used in any setting when a person first presents with a problem or unmet need. Its function is to assist the practitioner and the person in making a prompt decision about the priorities for treatment or further assessment.

*Generalist assessments* are relatively standardised, designed to be more comprehensive than a triage assessment and aim to fully clarify how a mental health need might be met. They should be completed with a biopsychosocial framework in mind, by a person with the appropriate skills and experience. Its function is to assist in decision-making, to open a dialogue and to identify the person's strengths and needs.

*Specialist assessments* are more intensive than generalist assessments and typically involve a greater depth of understanding and a wider range of information sources. These are more likely to be face-to-face consultations and should further help the person to identify their problems and plan their care arrangements.

Some information sources focused on the processes that run alongside any assessment. Effective engagement with the person was most often cited as an important factor, given that the assessment is usually a person's first contact with services. An assessment should be considered a continuing process. Positive risks should be balanced with the risk of disengagement, and if the person is unhappy about an aspect of their care a practitioner should provide the opportunity for discussion. Engaging families, carers and support networks is integral to all assessments and a practitioner should ensure that carers are aware of their entitlement to a carer assessment. Co-production and formal assessment tools were identified as other processes that may facilitate an effective assessment.

With appropriate training, people from a wide range of community settings can undertake an initial brief assessment. More skills are needed to undertake a generalist or specialist assessment. Most assessments will also incorporate risk and safety, the presence of mental and physical health problems and drug and alcohol use, as well social and personal circumstances. Other types of assessment should always be undertaken by a professional with relevant specialist competence. These include crisis assessments, assessments for specialist interventions, capacity assessments, Mental Health Act assessments and neuropsychiatric assessments.



### Conclusion

This review has mapped out the different categories of assessment as well as the functions of assessments relevant to mental health care, which vary by the type and level of expertise required. Many assessments do not have to take place in a particular setting and can be performed, to some extent, by practitioners with limited but specific training. Some basic principles and competences are shared across all assessments. For example, professionals working in mental health should be able to talk to a person or their carer about the person's mental health, consider risk, identify when further help is needed, where it is best provided and whether a specialist should be involved. This should be the minimum basic requirement for a practitioner working in community mental health services. Specialist expertise should be readily accessible when a person may benefit from it and should be closely associated with all generalist assessment providers.

## 4.4 Review area 3: Formulation

### *What methods support effective formulations in community mental health services?*



#### Background

Formulation (also known as case conceptualisation) is a collaborative process between one or more practitioners and a person seeking to understand their mental health problem and what may be helpful. It has been suggested that individualised formulation-based treatment can produce better therapeutic outcomes than if treatment is assigned without the completion of a formulation. Despite this widely held belief, the evidence in support of this view is still relatively scarce.

This systematic review of reviews aimed to identify methods that facilitate the development of effective formulations for adults with mental health problems by linking clinical practice methods to desirable formulation outcomes, and evaluating how formulation methods or outcomes may vary as a function of different needs or the settings in which a formulation is developed.



#### Method

A search was conducted of four online bibliographic databases (Embase, MEDLINE, PsycINFO and the Cochrane Database of Systematic Reviews) for systematic reviews or meta-analyses published between January 2007 and August 2017 (n = 693). A forward citation and reference list search was also conducted using Scopus. Reviews were included if they focused on the use of formulation in any mental health setting and had some implication for best practice. Five reviews met our inclusion criteria and were included. These reviews examined formulations conducted by clinical psychologists (n = 3), cognitive behavioural therapists (n = 1) and mental health nurses (n = 1).



## Results

Training was proposed as an essential method for improving the quality of formulation, with more experienced and better-trained mental health professionals producing higher quality formulations. However, competing demands on time and skills threatened to reduce the provision of training, which could lead to a decline in the quality of the formulation. Supervision was proposed as a means to develop the skills of junior mental health professionals. This may allow more professionals to practice individualised psychological thinking where opportunities may otherwise be limited. Transformational and transactional leadership<sup>a</sup> approaches were suggested to support the implementation of formulation training, and collaboration between the person and clinician was also cited as an important way of helping the person better recognise and understand how their own actions may contribute to treatment outcomes. Two reviews focused on the specific components of a formulation, though there was a relative lack of research in the field and results were inconclusive.

Positive outcomes relating to formulation included promoting a therapeutic relationship and shared understanding, however there was insufficient evidence of formulation efficacy and its relation to improved outcomes, despite its perceived importance to psychological treatment outcomes.



## Conclusion

Overall, reviews of formulation supported widespread practitioner training in psychological and narrative skills, regular supervision with an experienced clinician, effective leadership and collaboration between the person and those involved in their care. This review is limited by the available research on the topic; there was insufficient data to address how formulation may vary in terms of the professional constructing it, the settings in which it is used or the needs being assessed. Furthermore, only one review provided satisfactory data overall of all methods in formulation, and all reviews were of low or critically low quality. This casts doubt on the conclusions drawn. The review could not establish whether a formulation-based treatment results in more favourable outcomes for the person, relative to a manualised treatment. This significant gap in the research is something to be addressed if formulation is to continue to be recommended as part of many psychological treatments.

---

<sup>a</sup> Transformational leaders focus on engaging or motivating individuals using a vision or goal for future change or development. They look to help individuals reach their potential by building on their strengths and working on their weaknesses. Transactional leaders focus on providing rewards and evaluation based on individual or group task performance and achieved outcomes. The goals are usually already established within the boundaries of the organisation.

## 4.5 Review area 4: Care coordination

***Which models of care coordination are associated with better outcomes for the person, increased cost effectiveness and improved service engagement?***



### Background

Care coordination (or case management) usually refers to the direct management or organisation of a person's activities related to their care, normally by a single person who is involved in their care and facilitates the appropriate delivery of, and access to, different types of support, care and treatment. Care coordination is a critical factor in ensuring care continuity for people with mental health needs in the community. However, at present, the variation in the delivery of mental health care in the community may have a negative impact on the outcomes and experience of people receiving care, and has led to uncertainty over the standard model of care that should be used. This review aimed to determine which models of care coordination are associated with improved clinical and cost effectiveness outcomes, and whether care coordination overall is effective in supporting people who need mental health care in the community to improve uptake and engagement with services.



### Method

This was a systematic review of reviews. A search was conducted across five databases (MEDLINE, Embase, PsycINFO, CINAHL and the Cochrane Library) for systematic reviews or meta-analyses published from inception to February 2018 ( $n = 2,330$ ). Studies were deemed eligible if they focused on adults (aged 18+) receiving mental health care in the community, where a form of case management or care coordination was included as an intervention. Twenty-three papers met the inclusion criteria for the review. Due to the nature of this meta-review, and the variation in quality of included systematic reviews, a narrative analysis was conducted.



### Results

Most reviews focused on analysing the outcomes of three main models: standard case management, intensive case management and assertive community treatment.

**Standard case management:** Standard case management interventions appeared to demonstrate generally positive effects on outcomes across a number of reviews, particularly around reducing hospital use, symptom improvement and increased patient satisfaction, when compared with standard care without case management. However, some reviews indicated that there was insufficient data regarding other clinical and social outcomes.

**Intensive case management:** Mixed results were found for intensive case management, with some reviews demonstrating positive outcomes, including reducing hospitalisation, improvements in social and general functioning and greater housing stability. Other studies indicated little or no clinical or social impact for intensive case management when compared with standard case management. Overall, intensive case management appeared to work better for people with high rates of hospitalisation, but was less effective when hospital use was already low.

*Assertive community treatment:* This is typically offered to people with more complex needs who have significant problems engaging with services. Assertive community treatment appeared to consistently reduce rates of hospitalisation across studies, particularly when compared with treatment as usual. This model of case management was also associated with higher retention rates, improved engagement and greater patient satisfaction. However, when compared with models of standard case management, assertive community treatment did not consistently demonstrate differential effects across clinical or social outcomes.

*Service use:* Few reviews examined improved engagement with services as an outcome of case management or care coordination. Where service engagement was measured, assertive community treatment and intensive case management appeared to consistently produce positive outcomes, to a much greater extent than they did across clinical and social outcomes where comparable improvements were not seen. Where care coordinators were considered as a model of care, they were associated with improved continuity of care and better subsequent quality of life.

*Cost effectiveness:* Standard case management may be seen as more cost effective than care without case management, through reduced hospital readmissions, where admissions are directly related to the total cost of care. Intensive case management can be cost effective when the alternative is a lengthy inpatient admission; otherwise, it was found to be either cost neutral or more expensive than treatment as usual.



## Conclusion

Overall, the reviews point to the greater effectiveness of case management over care without any form of care coordination. Standard case management appears to demonstrate the most consistent positive outcomes, while both intensive case management and assertive community treatment show mixed results across most clinical and social outcomes. This suggests that more intensive and costly forms of case management are not necessary for positive treatment outcomes. Case management also appears to be cost effective, as the associated benefits far outweigh any economic costs. While standard case management appears to be the most consistent model, services providing care to populations with high rates of hospitalisation may consider implementing assertive or intensive functions into their case management roles; however, this may require further evaluation to determine the outcomes pertinent to the service.



## Limitations

This review is limited by the variable quality of evidence, and insufficient data related to clinical or social outcomes by model, particularly with regard to direct comparisons of care coordination.

Further research is required to fully explore the characteristics of care coordination and case management that may result in positive effects, and how these may differ across settings and populations. Nevertheless, care coordination, or case management, can provide much-needed continuity of care, which is critical to obtaining positive outcomes for people who need mental health care in the community.

## 4.6 Review area 5: Care delivery functions

**What functions of mental health care in community mental health services are needed for care to be effective?**



### Background

The aim of this review was to synthesise data from existing systematic reviews that explored the literature on the different functions of mental health care in the community and their impact on care. Given the broad scope of this topic, the following areas of focus were chosen:

- What type(s) of team organisation are effective/how is care best organised?
- What models of care are effective?
- How do services effectively/better integrate care
  - between service users, families and carers?
  - between professionals, services and agencies?



### Method

This was a meta-review. A comprehensive literature search was conducted across five databases: MEDLINE, Embase, PsycINFO, CINAHL and the Cochrane Library. This search identified a total of 1,916 articles (after removing duplicates). Following a review of titles and abstracts, 1,797 articles were excluded on the basis of a predesigned search protocol containing specific, strict inclusion and exclusion criteria. Queries were resolved by consensus. Studies were eligible only if they looked specifically at adults (aged 18+) with mental health problems who were receiving mental health support, care or treatment in the community. The full texts of the remaining 119 articles were assessed; 76 were excluded and 43 articles were included for narrative synthesis. Of the 43 systematic reviews included, 12 looked at team organisation methods, 30 at models of care delivery, 17 at care integration between service users, families, carers and services, and nine looked at care integration between professionals, services and agencies. Some reviews explored more than one of these areas.



### Results

Given the broad scope of this meta-review, the variation in quality of included systematic reviews and how findings are reported, only a narrative analysis of the results was possible.

**Team organisation methods:** The collective key themes derived from reviews looking at types of team organisation include: the role of nurses (including nurses within the structure of the MDT), the benefits of working in a CMHT and the effectiveness of integrating different organisational concepts and models.

**Models of care delivery:** The majority of these reviews assessed models of care delivery to some degree. Many of the reviews focused on collaborative care, while others looked at intensive case management, assertive community treatment or assertive outreach and strength-based models.

*Care integration between service users, carers, families and services:* Several reviews looked at how community mental health services work with service users, families and carers to better involve them in the planning and delivery of care. Peer support was also discussed across several reviews. All but one of these reviews came to generally positive conclusions that the involvement of service users, families and carers can improve experiences of care and outcomes for people.

*Care integration between professionals, services and agencies:* The included reviews tended to focus on integrated care or joint working between primary care and secondary mental health services. Few of the included studies discussed joint working between social care and health care, and none of them focused specifically on the integration of physical and mental health care services.



## Conclusions

*Team organisation methods:* Reviews concerning team organisation methods show that nurse-led care or care that involves a high level of nurse involvement is beneficial in supporting people with mental health problems in the community. Nurses can play a vital and valuable role in mental health support, care and treatment in the community, including within primary care settings, and appear to be integral to the success of several care approaches.

Team working (within a CMHT) may be more effective than non-team-based care in improving the acceptance of treatment, in helping to reduce mortality, in reducing rates of readmission to hospital, improving patient satisfaction and in reducing costs.

Innovation and changes in the way care is organised can lead to positive outcomes for people, such as reduction in symptoms and better functioning in the community.

*Models of care delivery:* Reviews looking at collaborative care models and approaches suggest that these are effective in supporting people who use services. Collaborative care models and approaches may lead to better outcomes for people than standard care in terms of symptom reduction, medication adherence, mental and physical quality of life, and social functioning. The most successful collaborative care approaches seem to be those that focus on collaboration between different professionals and between primary and secondary care services. However, successful collaborative care relies on staff attitudes and (re)structuring of services to support a collaborative care approach. There also need to be adequate resources and organisational support, as fragmented and poorly coordinated care can present barriers.

There are inconsistencies in the reported benefits of intensive case management in the literature. However, there is some evidence to show that it may be more effective than standard care in some cases, depending on a person's individual needs and circumstances.

As with intensive case management, the reported effectiveness of assertive community treatment and assertive outreach approaches are varied and inconsistent in the literature reviewed, thus hindering the possibility of making firm conclusions. However, available data indicate that, in some situations, it may be beneficial in reducing rates of admission to hospital, increasing patient satisfaction, improving quality of life and reducing symptoms.

Although strength-based approaches were not widely present in the selected literature, they were viewed positively in general. A strength-based approach may be more beneficial than more traditional 'deficit-oriented' programmes of care, particularly in the support, care and treatment of older adults.

*Care integration between service users, families, carers and services:* Reviews concerning the involvement of service users, families and carers in the planning and delivery of care show that this may support positive outcomes for people having mental health support, care and treatment in the community. Positive outcomes may be linked to an increased awareness, education and understanding of mental health problems and treatment that results from involving people in their own care.

There are inconsistencies in the reported effectiveness of peer support or peer-administered care in the community, rendering it difficult to draw firm conclusions. However, in some studies, peer-support approaches do appear to produce reductions in symptoms and improve engagement with services.

While the results were mixed, the included reviews make a case for service user involvement in care and treatment, with the majority of reviews reporting beneficial outcomes, and none reporting negative or harmful outcomes of service user involvement, shared decision-making and peer-support approaches.

*Care integration between professionals, services and agencies:* Reviews looking at integrated working between primary care and secondary mental health care services suggest that this is beneficial to people undergoing mental health support, care and treatment in the community, especially in the treatment of depression in primary care. The involvement of pharmacists in mental health care can have positive effects including cost saving, medication adherence and patient satisfaction.

The subject of integration between social care and mental health care was not discussed in detail in the included reviews, making it difficult to arrive at a conclusion about its effectiveness. However, joint working across different agencies and sectors (such as for people with co-occurring mental health and substance use problems) may result in benefits such as improvements in symptoms of mental health problems.

While it can be concluded that integrated working can be beneficial for people using services, these positive outcomes rely on a good understanding of roles and responsibilities between services and sectors as well as mutual respect between professionals. Good communication between professionals and services is vital to successful integrated working. Integrated care may be key to the delivery of a holistic, socially inclusive and effective mental health system.



## Limitations

The review was broad in scope, which somewhat limited the relevance of results. Inclusion criteria at the abstract assessment level was based upon the four topic areas as an attempt to maintain relevance. However, it is possible that by limiting the inclusion of reviews only to those that explicitly explored one or more of the predefined topic areas, reviews containing more subtle information relevant to care delivery functions may have been missed. The fact that the meta-review unexpectedly failed to return results on some areas of care delivery (for example, none of the included reviews focused on integration between physical and mental health care) could be indicative of such methodological flaws in this review of reviews.

# Appendix 5. Expert Reference Group members

---

## 5.1 Who developed this framework and guidance?

NHS England commissioned NICE to provide a package of implementation support for mental health care pathways, including implementation guidance, and NICE asked the NCCMH to develop this framework. The [short version of the framework](#) was derived from this work and published in September 2019.

For the work, the NCCMH established a technical team with national advisers including experts by experience, carers and commissioning, clinical, operational and service leaders across health, social care, primary care and the VCSE. The NCCMH Technical Team worked with an Expert Reference Group, the members of which had a wide range of backgrounds and experience. Focus groups were held with experts by experience and carers, who guided the direction of the work.

Key stakeholders were involved at every step, including arm's-length bodies and the Department of Health's VCSE Health and Wellbeing Alliance, which conducted survey and engagement work with their members. This engagement process obtained views around key aspects and experiences of community mental health care, and the responses helped shape and inform the framework.

The quality measures and recommendations were developed based on NICE guidelines and quality standards, published literature, existing positive practice by services and expert consensus from stakeholders. Evidence reviews were completed to inform the framework recommendations (see [Appendix 4](#) for a summary).

### 5.1.1 NCCMH Technical Team

**Tom Ayers** (Facilitator), Senior Associate Director, NCCMH

**Steve Pilling** (Facilitator), Director NCCMH

**Shubulade Smith** (Facilitator), Clinical Director, NCCMH

**Kevin Ariyo**, Research Assistant, NCCMH

**Laura-Louise Arundell**, Lead Researcher and Developer, NCCMH

**Alex Bailey**, Consultant Old Age Psychiatrist, Central and North West London NHS Foundation Trust

**Jessica Barrett**, Lead Researcher and Developer, NCCMH

**Michelle Costa**, Lead Researcher and Developer, NCCMH

**Subodh Dave**, Honorary Associate Professor, University of Nottingham and Consultant Psychiatrist

**Elizabeth England**, Mental Health Clinical Lead, Sandwell and West Birmingham CCG; Royal College of General Practitioners Mental Health Lead

**Nuala Ernest**, Editor, NCCMH

**Wanda Fernandez**, Project Manager

**Carla Fourie**, Associate Director of Social Care (Partnerships and Equality) Equality and Inclusion Lead, Approved Mental Health Professional

**Rebecca Gate**, Lead Researcher and Developer

**Helen Greenwood**, Research and Design Officer, NCCMH

**Stephanie de la Haye**, Expert by Experience

**Lucy Heard**, Expert by Experience

**Paulina Jozwiak**, Research Assistant, NCCMH

**Sridevi Kalidindi**, Consultant Psychiatrist in Rehabilitation and Recovery, South London and Maudsley NHS Foundation Trust

**Kate Lorrimer**, Editor

**Chris Lynch**, Expert by Experience

**Maryla Moulin**, Head of Programme Management and Operations, NCCMH

**Kate O'Regan**, Programme Director, Think Ahead

**Sarah Jane Palmer**, Expert by Experience

**Mary Ryan**, Expert by Experience

**Alan Simpson**, Professor of Collaborative Mental Health Nursing, Centre for Mental Health Research, School of Health Sciences, City, University of London

**David Smith**, Chief Executive, Hull and East Yorkshire Mind

**Clare Taylor**, Associate Director – Quality and Research Development

**Steve Thomas**, GP and Clinical Director, NHS Sheffield CCG

**Emma Tiffin**, Cambridgeshire and Peterborough STP/CCG Clinical Mental Health Lead

**Conor Whelan**, Project Manager

### 5.1.2 Expert Reference Group

**Mandy Stevens** (Chair), Chair, Service user, Previous Director of Nursing across various NHS Trusts

**Robert Dudley**, Consultant Clinical Psychologist, Northumberland Tyne and Wear NHS Foundation Trust

**Liz Durrant**, Director of Mental Health, Certitude

**Tom Howell**, Head of Joint Commissioning, Birmingham and Solihull CCG

**Shireen Hussain-Roy**, Team Manager, East Haringey Community Support and Recovery Team, Barnet, Enfield and Haringey Mental Health NHS Trust

**Helen Killaspy**, Professor of Rehabilitation Psychiatry UCL; Honorary Consultant in Rehabilitation Psychiatry, Camden and Islington NHS Foundation Trust

**Catherine Kinane**, Executive Medical Director, Caldicott Guardian, Kent and Medway NHS and Social Partnership Trust

**Andrew Lawrie**, Consultant Psychiatrist, Associate Medical Director, Monkwearmouth Hospital, Sunderland, Northumberland Tyne and Wear NHS Foundation Trust

**Steven Livingstone**, Principal Clinical Psychologist, Haringey Early Intervention Service

**Shaun Monk**, Social Worker/Approved Mental Health Professional, South Mental Health Team, Birmingham City Council

**James Osborne**, Consultant Psychologist, Lead Psychologist for Secondary Care Mental Health Services, East Kent

**Julie Parker**, Social Care Team Manager, Bradford Metropolitan district council

**Robin Partridge**, Programme Manager, Mental Health-embedded support for the North-West London STP

**Karen Persaud**, Carer Representative on the Royal College of Psychiatrists Service Users and Carers Forum

**Peter Pratt**, NHS England and NHS Improvement Head of Mental Health and Learning Disabilities Medicines Strategy

**Ranga Rao**, Consultant Psychiatrist, Psychological Medicine and Integrated Care Clinical Academic Group, South London and Maudsley NHS Foundation Trust

**Russell Razzaque**, Consultant Psychiatrist, Director of Research, Associate Medical Director North East London NHS Foundation Trust

**Bibi Senthinathan**, Expert by Experience

**Akhoury Shanker**, General Practice Partner, Pleck Health Centre, Walsall

**David Smart**, General Practitioner, Leicester Terrace Health Care Centre

**Sally Smith**, Expert by Experience Coordinator, Tees, Esk and Wear Valleys NHS Foundation Trust

**Darren Summers**, Acting Chief Operating Officer/Deputy Chief Executive and Director of Strategy and Business Development, Camden and Islington NHS Foundation Trust

**Glenn Westrop**, Allied Health Professions Clinical Fellow: Mental Health

**Faye Wilson**, Approved Mental Health Practitioner contracted to North Tyneside Council

### 5.1.3 Service User and Carer Reference Group members

**Zuleka Alawi**

**Remi Apata-Omisore**

**Deborah Bhatti**

**Stella Branthonne-Foster**

**Leroy de Costa- Simpson**

**Amber Dobinson**

**Lara Ferguson**

**Pippa Jones**

**Hameed Khan**

**Tracy Lang**

**Jordan Lees**

**John Lucas**

**Jessica Parker**

**Bhavna Ranchhod**

**Isaac Samuels**

**Derek Sanders**

**Prisha Shah**

**Katie Siobhan**

**Mark Smith**

### 5.1.4 NHS England, NICE, CCQI and other special advisers

**Alison Brabban**, Expert Adviser to the Adult Mental Health Programme, NHS England, Recovery Lead, Tees Esk and Wear Valleys NHS Foundation Trust

**Anthony Gildea**, Standards Commissioning Manager, Quality Programme

**Sarah Holloway**, Programme Lead, Mental Health Clinical Policy Team

**Viral Kantaria**, Senior Programme Manager, Adult Mental Health, Mental Health Team

**Deborah Moore**, Assistant Head and Policy Lead, Personalised Care Group, Strategy and Innovation Directorate

**Colbert Ncube**, Programme Manager, Adult Mental Health

**Lea Renoux-Wood**, Project Manager, Adult Mental Health and Dementia

**Mark Trewin**, Mental Health Social Work Lead, Department of Health and Social Care

**Kate Townsend**, Deputy Programme Manager, CCQI

**Victoria Betton**, Digital Adviser, Managing Director mHabitat

**Nicola Byrne**, Deputy Medical Director, Caldicott Guardian, Chief Clinical Information Officer, South London and Maudsley NHS Foundation Trust

## 5.1.5 VCSE Health and Wellbeing Alliance

**Age UK**

**Carers Partnership**

**Citizen's Advice**

**Clinks, Nacro**

**Complex Needs Consortium**

**End of Life Care Consortium**

**FaithAction**

**Friends, Families and Travellers**

**Homeless Link**

**Maternity Action**

**Men's Health Forum**

**Mental Health Consortium**

**National Voices**

**National Association for Voluntary and Community Action**

**National Council for Voluntary Organisations**

**Race Equality Foundation**

**The National LGB&T Partnership**

**The Valuing People Alliance**

**UK Health Forum**

**Young People's Health Partnership**

**Win-Win Alliance**

### 5.1.6 Other NCCMH contributors

**Saiqa Akhtar**, Research Fellow

**Helen Baldwin**, Research Assistant, NCCMH

**Phoebe Barnett**, Research Assistant

**Anna Lawes**, Research Fellow

**Kaycee Meads**, Project Manager

**Aiden Selsick**, Editor

# Abbreviations

Abbreviation	Full term
APP	Advice on Prescription in Primary Care
ATS	Assessment and Treatment Service
CACT	Charlton Athletic Community Trust
CCG	clinical commissioning group
CMHT	community mental health team
CPA	Care Programme Approach
CQC	Care Quality Commission
EPUT	Essex Partnership University NHS Foundation Trust
ESCaSS	Effective, Safe, Compassionate and Sustainable Staffing
GPS	Great Place Scheme
IAPT	Improving Access to Psychological Therapies
ICS	integrated care system
IPS	Individual Placement Support
KPI	key performance indicator
LGBTQ+	lesbian, gay, bisexual, transgender, 'queer' and other
LLWiR	Let's Live Well in Rushcliffe
MDT	multidisciplinary team
NCCMH	National Collaborating Centre for Mental Health
NICE	National Institute of Health and Care Excellence
PCN	Primary Care Network
PREM	patient-reported experience measure
PRISM	Primary Care Service for Mental Health
ReCoCo	Recovery College Collective
STP	sustainability and transformation partnership
VCSE	voluntary, community and social enterprise
WHISe	Wellbeing Health Improvement Service