



A working partnership

A guide to developing integrated statutory and voluntary sector mental health services

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Introduction

Increasingly, the NHS and the voluntary and community sector (VCS) are being expected to work together to shape and deliver integrated mental health (and other health) services. There is huge potential in these collaborations, both to transform the mental health system and to provide people with mental health problems with more relevant, holistic and effective support.

However, there is a lack of guidance for NHS and VCS providers, or for the system leaders and commissioners who are shaping these partnerships, regarding how to go about it. There are challenges and pitfalls in developing integrated services that are common and arguably inevitable. This document explores the issues and approaches to managing them effectively.

This guide has been developed drawing on the experiences of a significant number of people actively involved in the development of integrated mental health services across the country from a range of perspectives. It reflects the many common themes and suggestions they shared.

Scope

This briefing focuses on the development of integrated mental health services which involve staff from both the NHS and VCS working together as part of the same team. This is likely to involve elements of cross-organisational management and overlapping caseloads. It is not focused on strategic partnership working between discrete NHS and VCS services, or on integrated services involving partners from just one of these sectors. In some cases local authorities may also be part of the partnership delivery, and they are likely to be important stakeholders, but these relationships are not the primary focus of this guide.

These principles and approaches are likely to be relevant and useful for other integrated health services. However, this has been written from a mental health perspective and is primarily for a mental health audience.

Drivers

NHS England has a clear expectation that local health care systems (through Integrated Care Systems) will develop integrated mental health services, to enable the effective implementation of the NHS Long Term Plan. There are opportunities to do this in a range of mental health service areas, including inpatient, crisis and community. Perhaps the most significant area in which integrated services are currently being developed is driven by the transformation agenda for community mental health services (NHS England, 2019).

Workforce issues in the NHS provide another driver. Many mental health trusts are struggling to recruit to qualified clinical roles and carrying significant vacancies (BMA, 2019). In this context, using the additional funding for mental

health services (£1bn per annum for community services transformation by 2023-24) to create more band 5 and 6 nursing roles simply doesn't make sense. The VCS is more flexible, has access to a different workforce and can often enable funding to go further as a result of lower costs, particularly in relation to pensions.

Alongside this, and perhaps most importantly, there is an increasing recognition of the need for a holistic approach to meeting the needs of people with mental health problems. While clinical interventions remain important, they are more likely to be effective when complemented with non-clinical support that addresses the social determinants of poor mental health, and supports people to manage the issues of life and progress on their recovery journey.

Challenges

Given this context, developing integrated mental health services is desirable and probably inevitable. However, as anyone with experience of partnership working will tell you, it is more difficult and complicated than working alone as an organisation. It comes with both greater challenges and greater rewards. Some of the key challenges in this context are:

Culture: The NHS has a strong, medically-driven culture and language and is a huge, highly bureaucratic network of inter-connected clinically-focused organisations. The VCS is a diverse, sprawling collection of organisations, which often also have a strong culture, usually rooted in a more holistic social model. Staff from both sectors often identify strongly with the identity and values of their roles and their employing organisations. There is the potential for real creativity and learning from bringing these cultures together, but there are also likely to be tensions. There may also be fundamental misunderstandings about each organisation's approach, governance and drivers.

Capacity: Both the NHS and most VCS organisations are stretched, and often do not have staff with the capacity to take forward the

transformation required to develop effective integrated services, particularly within the often short timelines which are expected.

Capability: Staff working in leadership and management roles in the NHS and VCS are not equally well equipped to undertake transformation or manage complex partnerships, and may not have been recruited with the expectation they would need to do so. Amongst other things, this task requires a flexibility and ability to hold uncertainty.

Resistance to change: This may be found at a range of levels in both NHS and VCS organisations, including in leadership, management and amongst frontline staff. Many people do find change difficult, and in a sector where staff often have an emotional relationship to their jobs, this can have particular power.

Inequity: It is always going to be a challenge to create a sense of equity when one partner is often between 10 and 100 times the size of the other(s). VCS organisations often worry that they will lose their identity as their staff become subsumed into the NHS culture. Steps

need to be taken at the outset (and ongoing) to ensure a healthy power dynamic and that the benefits of both organisations are brought to the partnership.

Pay and Conditions: In addition to the potential for organisational inequity, the NHS and VCS usually have different rates of pay, approaches to pay scales, and terms and conditions (particularly but not exclusively relating to pensions). This can lead to VCS staff feeling less valued and to tensions within integrated teams.

It can also be difficult for staff to move between sectors, which can limit the opportunities available for career development.

Engagement: At times, forming the partnerships which underpin integrated delivery can itself feel like a challenge. The NHS doesn't always know how to engage with the VCS and may struggle to navigate the politics of a different sector or to decide the best mechanism for engagement.

Before you start

There are many things that can be done to help ensure a positive partnership and effective integrated delivery, although none of these will guarantee success. Arguably the most important thing to remember is that this type of partnership development takes time, both over a period of weeks, months and years, and in terms of people having capacity to dedicate to it. Alliance building in particular, which is so key to involving smaller VCS organisations and those working with under-served communities, takes time and investment. It is worth all parties going in with their eyes open, understanding that it won't all be plain sailing and being willing to work at it and make compromises.

The development of new services or transformation of existing provision starts well before the model has been agreed and providers have been identified. It will help address some of the challenges outlined above if VCS organisations are engaged in the

discussions from the outset, rather than being brought in at a later stage. NHS providers will automatically be involved as a result of their central role in local systems, but if this is the only provider perspective it can lead to an incomplete or unbalanced picture.

In addition to this, involving leaders from the VCS in mental health system leadership can ensure that relationship building between both organisations and individuals is well progressed before the development of integrated services starts. These relationships are the foundation on which all the other secrets of success are built, and their significance is a theme running throughout the remainder of this briefing. Involvement in system leadership also provides an opportunity for the VCS to make a wider contribution to mental health system governance and development, bringing a valuable perspective to many discussions, even when they may not have a direct involvement.

VCS engagement in Greater Manchester

Greater Manchester (GM) Integrated Care System has been funding a VCS lead for mental health to operate at a strategic level for the system since 2020. The postholder previously worked as a VCS chief executive and was familiar with operating at a senior level, helping to give the credibility and influence which was crucial to the role being effective.

In addition to representing the VCS at partnership boards and in transformation discussions, the VCS lead is responsible for coordinating a GM VCS Mental Health Forum. Over 20 organisations are paid for their involvement in this group (£2,000 per annum each), enabling them to free up the capacity to contribute and be responsive, which is particularly significant for smaller providers with limited resources.

The basics

It is worth spending some time on getting the basics right. They are not necessarily easy or to be taken for granted, and time well spent on this can help avoid a lot of pain later on.

1. Shared values & vision

As with any partnership, having shared values, an agreed commitment to change and a common vision is key. Depending on how well the partners involved know each other, this may take a while to establish, but it can help determine whether the collaboration will work and provides something to come back to if there are issues or disagreements later on. A component of this work is laying out clearly any ‘red lines’ for the partners (which can be formalised within a partnership agreement), and having a willingness to compromise outside of these.

It is expected that the shared values will not exactly mirror those of any of the partners but will reflect elements of each. A focus on those values that are shared by all partners can be helpful. For example, whatever perspective organisations are coming from, they are likely to be aligned on the importance of working in a person-centred and holistic way. A note of caution though: sometimes people from different organisational contexts may use the same terminology, but ascribe quite different meanings to those words – for instance, the terms ‘coproduction’, ‘recovery’, ‘peer support’ and ‘person-centred’. It is worth ensuring that there is agreement about what the values mean in practice.

2. Equity & diversity

One of the reasons for developing integrated services is the benefits accrued from the diversity of thought, perspective, expertise and experience that the NHS and VCS providers bring. However, it is important that this diversity is matched by an equity between the partners. With the organisations usually being of very different sizes and influence, this can be a challenge, but it is the only way to ensure the maximum benefits of partnership working are delivered.

There are a number of practical steps that can assist with delivering this equity, such as:

- Co-chairing arrangements for steering or implementation groups between the NHS and VCS
- Hosting of a project manager within the VCS rather than NHS
- Ensuring both sectors are represented on more strategic mental health boards, for example within the Integrated Care Partnership (ICP) and Integrated Care Board (ICB) structures, and in governance arrangements
- Taking models from both the NHS and VCS as a starting point for the development of service models, operational policies and job descriptions, and combining them rather than relying on one or the other
- Equality of treatment regarding contracting arrangements, such as the award of inflationary uplifts on contract values, and over accountability for performance
- Being open about challenges within each organisation, helping to build trust
- Ensuring that opportunities for training and reflective practice are available to staff regardless of their employer.

Another important aspect of diversity within provider partnerships relates to the significant value added by involving both individuals and organisations representing racialised communities and others who have been historically let down or under-served by mental health services. This will help to address inequities in service design and delivery, and ensure that all those who need the service experience it as accessible and relevant to them.

3. Playing to organisational strengths

Equity does not of course mean the two organisations having the same role, and it is important that the structures and service models developed draw on the respective

experience and strengths of the partners. Each should be clear what is expected of them, and these expectations should reflect their areas of expertise. For example, an NHS provider is likely to be best placed to provide clinical leadership and deliver clinical interventions, whilst a VCS provider is likely to be best placed to deliver social prescribing or peer support. VCS organisations may also be seen as more

accessible and trusted by communities who are reluctant to access statutory services.

However, these different roles can and should be ascribed equal value. Co-location and co-working of staff across organisational and role boundaries within the service can support this, enabling people to get to know their colleagues and see the skills that they bring in practice.

SEL suicide bereavement service

This service was established in 2021 as a partnership between three local Minds in south east London (SEL) and South London & Maudsley NHS Foundation Trust (SLaM), funded by SEL CCG. It covers the six Boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, providing holistic support to friends and relatives who have been recently bereaved by suicide. The partnership is governed by a partnership working agreement, and overseen by a steering group involving senior representatives from each of the organisations at which significant decisions are made.

Staffing for the service consists of:

- A manager, employed by Bromley, Lewisham & Greenwich (BLG) Mind
- Two suicide bereavement support workers (BLG Mind and Lambeth & Southwark Mind)
- Two community chaplains (SLaM)
- Two part-time suicide bereavement counsellors (Mind in Bexley)
- A part-time administrator (BLG Mind).

Despite being employed by different organisations, the staff work together as one team. The service manager provides supervision to all staff and the team regularly come together for in-person meetings.

Service-level procedures are generally guided by the policies and procedures of the lead partner, BLG Mind, while HR matters sit with each staff member's employing organisation. The partnership structure has meant that the team has access to meeting spaces across SE London, which is crucial in offering clients choice over how their support is delivered. The team has also utilised partners' contacts to promote the service and access local resources. Challenges of the partnership structure have included ensuring integrated access to files and calendars across different email domains, and sensitively managing differences in partner organisations' pay structures and leave procedures.

The range of staff and providers involved enables the service to provide a combination of practical, emotional, and spiritual support, including:

- Helping sort through personal possessions and dealing with the affairs of the person who died
- Support with registering the death and planning a funeral
- Offering information and resources during an inquest into the death

- Support with any changes in personal circumstances, such as finance or housing
- Listening and understanding responses to grief
- Support and advice in breaking the news to other people
- Information and advice on managing your own wellbeing
- Trauma-informed bereavement counselling
- Support groups providing an opportunity to connect with others who can relate to the experience.

Most referrals into the service come through the Thrive LDN Real Time Surveillance System of suspected suicides, which is populated by the police. This enables people who have given consent to be proactively contacted by the service, often within days of the bereavement

In the first nine months of delivery the service supported 160 people, mostly the parents, children, siblings and friends of the deceased, as well as some members of the public who witnessed a suicide.

The service aims to be alongside people while they face the deeply painful and shocking experience of losing someone to suicide. It tries to help people cope with the situation and to feel less alone in navigating it. The ultimate goal is for people to leave the service more resilient than they would have been without it, and more able to face the future. Early outcomes data has been promising, suggesting that the service has increased mental resilience and reduced signs of depression and anxiety. Client feedback indicates that there is a real need for this kind of support and that it has helped people to cope.

4. Partnership agreement

While relationships and cultural issues will generally trump anything on paper, the process of developing a robust partnership agreement can ensure clarity and appropriate allocation of roles outlined above. It can also provide a helpful reference point when the individuals involved in the partnership formation and implementation have moved on.

There are countless approaches to developing a partnership agreement, and no one right way. It is worth considering issues such as accessibility, how the agreement will contribute to good partnership behaviours and achieving a balance between making it strategic and practical. Regular reviews of the agreement help ensure it remains relevant and can adapt as things change.

5. Commissioning arrangements

A potentially thorny issue in developing integrated services is how they are commissioned and contracted. In most cases, the NHS provider will be obvious, dictated by who the local provider of the relevant statutory services is. Deciding on VCS partners, however, may be more difficult or political. It is worth noting that this in itself creates a further inequality between the partners, with some awarded the work on a long-term basis without discussion and others expected to compete hard for a short-term contract.

The right approach will need to be determined at a local level, informed by local needs, the provider landscape, and financial protocols and timelines, among other factors. It may be appropriate to run a full or more limited

tendering exercise, to contract a pilot with existing system partners, or another approach. Whichever approach is taken, those responsible should consider how they can mitigate the associated risks. For example, an open competitive tender is a time consuming and resource-intensive process which may delay implementation, whilst a non-competitive process may be more open to challenge.

With all the options, there is scope for larger VCS providers to act as lead providers, sub-contracting some delivery to smaller, more specialist organisations. The commissioning process has the potential to require or facilitate this.

Whichever approach is selected, it is beneficial to put clear contracting arrangements in place so that everyone is clear as to their responsibilities. It is also important that VCS providers are not just seen as a cheap option, and that adequate funding is allocated for the management, supervision and infrastructure support of the staff employed in integrated services.

During 2022 the Government is planning to introduce the Provider Selection Regime which will move responsibility for commissioning many health services to a range of bodies that will include NHS foundation trust-led Provider Collaboratives. It will also shift the emphasis from procurement through formal tendering processes to other, more relationship-based models of commissioning.

Who?

Developing integrated NHS/VCS services requires both breadth and depth of commitment and engagement to be successful. This section focuses on engagement within the partnership, but ensuring understanding and involvement from external stakeholders, such as primary care networks (PCNs) and local authorities, is also important.

In addition to the involvement of different roles, consideration should be given to including a diversity of perspectives, to help ensure that the new services are accessible and effective in meeting the needs of the diverse communities they serve.

6. Senior-level commitment

Ensuring there is genuine buy-in to the approach at senior levels within commissioning and all provider organisations is a critical success factor. There will be challenges and bumps in the road, and these are likely to require senior managers to get involved and identify solutions. It is also important that there are well-functioning relationships between

these leaders, enabling them to constructively engage with each other and develop solutions that work for the service and system as a whole, rather than just for their organisation.

Senior leaders also have a role to play in driving culture change and unblocking issues within their organisation; modelling collaborative behaviours and giving permission for staff to work in the flexible and creative way that integration often requires.

Sometimes senior leaders who have been crucial to the success of an integrated service development will move on from their role or organisation, meaning that new relationships need to be developed with their replacements. As strong relationships within the system leadership are a key ingredient for success, this should be prioritised to ensure that staff changes don't risk impeding progress.

7. Drivers and champions

Integrated service development is complex and requires people who have the skills and commitment to drive this forward, and for them

to be given the time to do so. If resources allow, it is worth considering employing a dedicated Project Manager who can lead on this (see page 9).

Equally important are existing staff taking a leadership role in driving implementation. They should be sufficiently senior to command respect and be able to effect change, but close enough to the ground to understand the detail of operations. It is worth identifying champions for integrated working who have a real understanding and passion that makes them valuable contributors.

8. Frontline engagement

Often some of the staff who deliver integrated services will be transferred into these roles from within one of the delivery partners. When this happens, the engagement of these staff is vital. Getting the timing of this engagement right can be a challenge: too soon and there may be insufficient clarity of the model and expectations; too late and the benefit of their perspective may be missed. In general though, it is advantageous to engage frontline staff at an early opportunity and to keep this going throughout.

It is worth recognising that the change process may be unwelcome or anxiety-provoking for staff. Supporting them on the journey and helping them manage and overcome their fears will help reduce operational implementation problems. Hearing about positive experiences from people who have gone through a similar transition can be a powerful way of communicating the benefits of the new approach.

Frontline engagement needs to be cross-organisational, too. Staff and managers within the new integrated services need time to understand the roles of their colleagues from the other delivery partners, and to build relationships with them, taking a collaborative approach and working together to address issues as they arise. There is no substitute for frontline staff spending time together, working across organisational boundaries (ideally based in the same places) to enable them to understand and value each other's roles and skills.

9. Client involvement

This engagement is critical to creating a client-centred service. There are a range of ways to involve people with lived experience who may benefit from the service being developed. For example:

- Client representatives on the implementation steering group can bring a valuable perspective. However it is important that they are properly briefed and provided with support that equips them to make a meaningful contribution
- Surveys or interviews (ideally peer-led) with clients can provide a breadth of views
- Involving people with lived experience on staff recruitment panels and in staff induction and training
- Encouraging people with lived experience of mental health problems to apply for paid roles by recognising lived experience as 'desirable' experience in person specifications.

How?

This section outlines some of the practical approaches to implementation of integrated services in particular.

10. Model development and coproduction

The development of the service model for integrated delivery can be critical to the success of the service, so it is worth taking time and ensuring the right people are involved in this process. The process itself can also be a valuable one, helping to develop understanding and working relationships between some of the stakeholders identified above. This is likely to benefit from the creation of reflective spaces in which people can share ideas, explore culture and experiment. It is an area in which commissioners and system leaders or an independent facilitator can play a valuable role, creating the right environment for the discussions to take place and psychologically holding the space.

Integrated mental health services usually incorporate both clinical and non-clinical support, and it is important that expertise in both these areas, as well as expertise drawn from lived experience, helps inform the service model. Coproduction is often a misused concept, but when done well it can be powerful. The National Development Team for Inclusion (2016) have developed a helpful framework which could be used by organisations wishing to use this approach.

Service design processes should seek to achieve a balance of people involved in developing the model. Equity should be given to the contributions of all participants, and care taken to prevent the process being dominated by one provider or perspective. It is helpful to create some structure and discipline to this process, providing boundaries within which creative work can be undertaken.

The development of a successful service model is more likely if due consideration is given to the local needs and context. Bringing in evidence

from what has worked in other areas can be valuable, but there is almost always a need to adapt to ensure there is a good fit with other services in the locality, and to avoid gaps and duplication in service provision.

11. Organisational development and team building

Integrated services will often include staff already employed by one or more of the providers who are not used to working alongside colleagues from another organisation. When this isn't the case, the staff may be new to both the partnership and their employer.

As a result, staff need to be equipped to work differently, to understand their colleagues' roles and to form as a team. Organisational development (OD) and team building support can be useful tools in helping to facilitate this transition.

The shape of this support will vary depending on local needs, meaning that an iterative process that takes the time to understand the issues of the organisations and individuals involved is more likely to be effective. However, there may also be a benefit to using external OD consultants and trainers who bring expertise in working with similar situations and systems.

12. Dedicated project management resource

Managing the implementation of integrated mental health services is a complex task. To create capacity and maintain progress, a dedicated project manager can be a valuable resource. Whoever employs this person, it is important that they work on behalf of the system and partnership as a whole, and are not seen as being too closely aligned with any provider. At the same time, they need to have sufficient authority and influence at a range of levels within each organisation to hold the different parts of the system to account for their contribution to the work.

The workplan of the project manager should be set by the local steering group, but it is likely to include a strong emphasis on coordination of different workstreams (covering areas such as operational policy development, recruitment, outcomes framework, premises, IT) and on communication, both within and beyond the partnership.

13. Piloting

Undertaking pilots of either the entirety or aspects of the model can be a good way to test the approach of a new integrated provision. This enables learning to be applied before full roll-out and can also help manage capacity challenges which may result from trying to do too much all at once.

However, it is worth being aware of the potential limitations. Pilots can take place in a limited geographical area, though any evaluation should consider whether the context is typical or if there are any factors which might limit wider application of the learning. Alternatively, they might be limited in timeframe, giving an opportunity to make adjustments to the model, but in this case should be given enough time to get up and running and demonstrate effectiveness. When piloting only part of the model, there is a risk that the expected benefits will not accrue due to the way in which service components interact with each other.

14. Monitoring and evaluation

As with any new service, it is helpful to be clear at the outset regarding the key performance indicators and intended outcomes, so that the monitoring and evaluation framework can reflect this and data systems can be set up to enable reporting. Using joint performance and outcome measures for the service as a whole, rather than breaking these down by provider, can help to foster a collaborative approach between providers. There is a value to including qualitative measures such as client experience and narrative case studies, but also to quantitative measures which enable progress to be tracked over time and comparison with other services and areas.

It is worth considering investing in an external evaluation of the service, particularly if it is utilising an innovative approach. A robust evidence base will help make the case for continued investment and, if the measures are sensitive enough, to understand what aspects of the delivery are making the difference. This can include qualitative evidence, drawing on techniques such as peer research and evaluation to develop a deeper understanding of how services add value and any areas for improvement. This, in turn, enables targeted service improvements to be implemented.

15. Sharing successes and learning

Integrated mental health services are being introduced all over the country (and beyond), meaning that there are plenty of opportunities to learn from others. There are also opportunities to share successes if things have gone well, and the process of articulating impact and celebrating achievements can be very positive for team morale.

In some cases, however, learning is not shared effectively even within a local area. This can lead to the same frustrations being experienced repeatedly by those involved in implementing services, for example in areas such as HR processes for honorary NHS contracts and IT systems. Greater efficiency and a more positive experience for staff can be achieved by solving a problem once and then ensuring the learning from that is shared.

16. Home organisation belonging

Enabling all staff to retain a sense of identity and belonging with their employing organisation is an important part of retaining the benefits of an integrated model.

Even when staff are receiving clinical supervision or client management support from another partner, ongoing management from their host organisation helps ensure that people retain their sense of role identity and the specialism that comes with this. It also provides a stronger position to manage any performance issues, particularly when combined with regular communication between those involved in providing supervision to a staff member.

The following arrangements can help ensure staff feel connected to their home organisation:

- Creating points of connection with the rest of the organisation, including time spent there on a regular basis and informal networking opportunities
- Ensure they are included in organisational communication
- Provide them with training and development opportunities specific to their role
- Develop Action Learning Sets or Communities of Practice for staff in integrated services
- Induction, supervision and away days to facilitate this
- Give them protected time to develop in their role and maintain their specialism.

17. Managing risk

The management of risk can be an issue that causes tension between partners, particularly when their approaches and risk appetites differ. This can relate to both client risk and risk-taking in service development and delivery.

NHS Trusts usually have robust processes and infrastructure to manage client risk, and as a result it often makes sense for them to have oversight of this area through clinical leadership of service delivery. However, the NHS may also need to show some flexibility regarding ordinarily rigid processes, to ensure that VCS delivery can keep its valuable flexibility and innovation and is not pushed into operating as though the NHS were the sole provider. In addition, VCS organisations also need good, strong governance which provides reassurance to NHS partners that risks are being well managed.

At a service level, there is a strong case for transformation requiring the development of an approach to positive risk taking. Openness, vulnerability and trust can all help contribute to a culture of shared risk taking, leading to a willingness to try different approaches and better decision-making. There may be a role here for system leaders to take responsibility for decisions and a willingness to hold the risk, freeing up providers to do things differently.

18. VCS system leadership and provider diversification

In some instances, it may be that there is a single VCS provider who is best placed to deliver an integrated mental health service with the NHS. However, there is often a benefit in more than one VCS organisation being involved. In particular this can enable the expertise and local community connections of smaller and more specialist VCS providers to contribute, who may otherwise be excluded (see Bell and Allwood, 2019).

It is worth recognising here that while the VCS has a long and rich tradition of collaborative working, providers are also often in competition with each other and there may be politics between VCS organisations. As a result, it may be useful to bring these organisations together (before money is on the table or services are being implemented) to encourage the development of collaborative relationships. In addition, systemic change that moves away from processes which encourage competition between VCS providers (such as frequent competitive tendering processes) is likely to facilitate a more positive environment for collaboration.

Diversifying the VCS contribution to integrated delivery may be approached through:

- The development of a sector-specific alliance or partnership, which may become a separate legal entity enabling it to hold contracts
- Larger VCS providers playing a role as lead contractors who sub-contract components of the service delivery to other organisations. Assuming the relationships are good, they are often well-placed to do this as they have a good understanding of the issues, pitfalls and sector, enabling them to provide sub-contractors with the support they require.

Either of these approaches should make collaborating with the VCS easier for commissioners and trusts, meaning that they have only one contract to manage and a clear line of accountability for the VCS delivery.

Rookery Gardens, Birmingham

Rookery Gardens is an integrated inpatient rehabilitation and recovery mental health service delivered in partnership between Birmingham Mind and Birmingham & Solihull Mental Health Foundation Trust which opened in 2017.

Sited in hospital grounds in Erdington, but as a row of houses on an ordinary street, the service has capacity for 25 people in a combination of seven houses, four flats and two assessment houses. Everyone has their own front door. Length of stay with at Rookery Gardens is up to 18 months.

Staffing includes 14 FTE recovery navigators (employed by Birmingham Mind) and a range of clinical staff employed by the Trust, including psychologists, occupational therapists, community psychiatric nurses, dieticians, psychiatrists and social workers. There are usually three recovery navigators and three nurses on each shift, plus other professionals. Collectively the staff team take a holistic approach, and communication between the recovery navigators and trust staff is crucial to ensuring this works in practice.

Key tasks for the recovery navigators include person-centred planning and supporting people to navigate their own recovery. This starts with building a rapport and a comprehensive initial assessment, which includes looking at skills for daily living, aspirations and interests. The support they provide may cover practical issues such as shopping, cooking, using public transport and support with future accommodation, alongside areas such as education, leisure activities, employment and relationships.

Managers from the trust and Birmingham Mind operate together as a leadership team for the service and have benefited from working very closely together, with frequent meetings (at least weekly) to ensure the channels of communication are always open. The managers undertook joint recruitment and staff training from the beginning of the service and use their close relationship to ensure that issues are resolved quickly and collaboratively.

Key differences from other mental health rehabilitation wards:

- A physical environment which gives people privacy and independence
- The introduction of a coproduction approach and a role for peer support
- A less medical model, with a real focus on recovery.

An external evaluation of the service found that outcomes for service users included:

- Being well-prepared for discharge, leading to successful move on
- Increased autonomy, insight and control as a result of the recovery-focused model
- Confidence and skills to access community resources
- An openness to change and willingness to set and work towards personal goals
- Increased confidence and hopefulness.

“Using our shared values as a framework for discussing differences of approach is what has made our partnership so special and so successful” – Helen Wadley, CEO, Birmingham Mind.

City and Hackney Wellbeing Network

This collaboration is between East London Foundation Trust (ELFT) and the City and Hackney Wellbeing Network. It involves nine VCS providers who bid to be involved in delivering the service as a collaborative, including some connected to and based in specific neighbourhoods. Mind in the City, Hackney & Waltham Forest (CHWF) is the lead provider and sub-contracts to the other eight organisations, who are mainly smaller and more specialist.

The VCS providers employ community connectors and financial inclusion workers to work alongside ELFT staff (community psychiatric nurses, social workers, occupational therapists, psychologists, peer support workers and psychiatrists) in neighbourhood-based community mental health teams.

Mind CHWF provide management, development and quality improvement capacity, including creating a space for planning service developments, and connecting to wider transformation work. They also help with capacity-building for the other VCS partners, including through providing training, reflective practice supervision and problem solving.

Alongside neighbourhood-based community connectors, there are specialist roles to work with older adults (provided by Age UK East London) and racialised communities (provided by Irie Mind, Derman and Bikur Cholim).

The team is now working with around 2,000 people a year, and has supported a culture of reflecting via storytelling and collecting client feedback through Dialog+. The wider neighbourhood team have co-developed a more inclusive, non-hierarchical way of working to support service users.

19. Staffing issues

The recruitment and retention of an appropriately skilled workforce is crucial to the success of integrated mental health services. Therefore, successfully managing the issues associated with staff working in the same team who are employed in different sectors is a key challenge of delivering these services.

Pay and conditions

VCS organisations are generally unable to match the rates of pay and terms and conditions (particularly pensions) of the NHS. When the roles are not equivalent this is more manageable. However, when they are effectively the same – for example staff in Improving Access to Psychological Therapies or Individual Placement and Support employment services – recruitment and retention may be aided by equalising pay as far as possible. However, it is worth recognising that this can cause issues

of inequity within VCS providers, with staff potentially paid at higher rates if they work in an integrated service.

Another way of helping to manage this discrepancy is to ensure that the advantages of working in the VCS (such as flexibility, creativity and community connectedness) are protected within integrated teams.

Recruitment

NHS recruitment processes usually take longer than those in the VCS. This should be taken into account to ensure that staff coming into post have the support and infrastructure to give them a positive initial experience in the role.

Having staff from both sectors on the recruitment panels for new staff, alongside people with lived experience, can be a valuable way of building relationships and ensuring the shared values and approach of the integrated provision are translated to new recruits.

Induction, training and development

Staff within integrated teams should receive an induction and training that reflects both their role and employing organisation. However, there are also clear benefits to components of an induction and training plan being delivered across organisational boundaries. This can deliver efficiencies (through the sharing of resources), develop mutual understanding, and give staff from different organisations time together outside of the office.

Staff working in non-clinical roles are particularly likely to benefit from having development opportunities and career pathways to aid retention. One approach to this is to ensure the staffing structure includes roles (such as senior practitioners) into which frontline staff can progress.

Potential role of Integrated Care Partnership (ICP) workforce leads

Workforce leads within the mental health system (for example working for ICPs) can play a useful role in addressing some of the issues identified above, facilitating systemic change regarding getting the right workforce, developing that workforce, and addressing issues on pay and conditions.

20. IT systems

Delivering integrated services is made much easier if all staff are using the same client database for recording. This means that information is easily shared amongst the team (and where appropriate can be shared with professionals outside the team) and helps create a sense of equality between colleagues. It also makes reporting on the impact of the service as a whole easier.

However, it is worth recognising that NHS systems are often not set up to be used by other organisations, meaning that honorary contracts and NHS email addresses may be required for VCS staff. Therefore involving IT and HR staff early on in implementation planning can really help, and it is important for the organisation managing the database to put adequate resource into the set up and data extraction and management. There are also benefits to sharing other IT systems, for example where this facilitates sharing of online diaries.

Final words

Developing integrated mental health services takes a huge amount of perseverance because of the time it takes and the complexity of the task. However, this investment is justified by the outcomes that can be achieved.

All partnerships involve compromise, and a willingness to do so needs to be evident from all parties.

The theme that came up most in discussions with those involved in developing integrated

services was the importance of good relationships between both organisations and individuals. These relationships are fuelled by people operating with honesty, openness, vulnerability and self-reflection.

Finally, this work has a much greater chance of success if it remains authentically client-centred and if those involved always keep this in mind when making decisions, actively engaging people with lived experience throughout.

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Appendix: Self-assessment

How well is your integrated service development performing against the ideas outlined in this briefing?

This tool has been developed to help those involved in developing integrated services evaluate their progress and identify next steps. It may be helpful for a range of people involved to undertake the self-assessment and compare notes to identify where there are differing perspectives on how well things are progressing. The actions identified could then be incorporated into an implementation plan.

Issue	RAG rating*	Further action required
Shared values and vision		
Equity & diversity of providers		
Playing to organisational strengths		
Partnership agreement		
Commissioning arrangements		
Senior level commitment		
Drivers and champions		
Frontline engagement		
Client involvement		
Model development & coproduction		
Organisational development & team building		
Dedicated project management resources		
Piloting		
Monitoring & evaluation		
Sharing successes & learning		
Home organisation belonging		
Managing risk		
VCS system leadership & provider diversification		
Staffing issues		
IT systems		

* RAG ratings are used to visually illustrate progress or performance using traffic light colours (red, amber, green), with green indicating that things are on track, amber that there are some issues or delays and red that there are more significant problems or lack of progress.

A working partnership

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A working partnership

A guide to developing integrated statutory and voluntary sector mental health services

Ben Taylor

Introduction

Increasingly, the NHS and the voluntary and community sector (VCS) are being expected to work together to shape and deliver integrated mental health (and other health) services. There is huge potential in these collaborations, both to transform the mental health system and to provide people with mental health problems with more relevant, holistic and effective support.

However, there is a lack of guidance for NHS and VCS providers, or for the system leaders and commissioners who are shaping these partnerships, regarding how to go about it. There are challenges and pitfalls in developing integrated services that are common and arguably inevitable. This document explores the issues and approaches to managing them effectively.

This guide has been developed drawing on the experiences of a significant number of people actively involved in the development of integrated mental health services across the country from a range of perspectives. It reflects the many common themes and suggestions they shared.

Scope

This briefing focuses on the development of integrated mental health services which involve staff from both the NHS and VCS working together as part of the same team. This is likely to involve elements of cross-organisational management and overlapping caseloads. It is not focused on strategic partnership working between discrete NHS and VCS services, or on integrated services involving partners from just one of these sectors. In some cases local authorities may also be part of the partnership delivery, and they are likely to be important stakeholders, but these relationships are not the primary focus of this guide.

These principles and approaches are likely to be relevant and useful for other integrated health services. However, this has been written from a mental health perspective and is primarily for a mental health audience.

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