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Evaluation of the Sheffield Primary and Community Mental Health Transformation Programme

Final Report:

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Foreword by Professor Tim Kendall

The commitments to transform community mental health services for people with severe mental health problems were some of the most ambitious in the NHS Long Term Plan.

In 2019, we began making the biggest investment into community mental health services in the history of the NHS. With an additional investment of almost £1bn per year by 2023/24, the NHS committed itself not just to increasing the number of people able to access help – although that is a key aim. It also asked every area of the country to rethink what ‘help’ looks like and to reconsider how they provide that help so that people from all parts of their communities can more easily and quickly access support.

These are big ambitions, and I do not underestimate the task that twelve early implementer sites, Sheffield included, embarked upon in 2019. Of course, this challenge was made even harder with the Covid-19 pandemic, and it is the result of an extraordinary effort that so much progress was made in spite of such unforeseen obstacles.

I am pleased to say that Sheffield has risen to the challenge and can rightfully be proud of its key achievements in delivering the new models of care, closer to home to greater numbers of people. Community mental health services are now embedded in Primary Care Networks with an increase in the workforce and access to evidence-based treatments. I am particularly pleased that this includes increased reach into communities previously under-served by existing services. As the report makes clear, strong collaborative bonds have established across organisations in Sheffield, with primary, secondary and voluntary sector partners amongst others working closer than ever. These relationships are surely the key building blocks upon which further improvements to services will be built.

Of course, the transformation programme in Sheffield has experienced setbacks and learned important lessons. The scale of under-met need is clear and demand for support has increased. While significant investment has been made, there is a need to invest more and to further expand the clinical and non-clinical mental health workforce, whilst continuing to work in new ways with primary care, local authority and voluntary sector partners. Important steps forward have also been made to embed co-production but there is always more we can do in this area to make sure we are getting the most out of the vital input that people with lived experience of using services can bring.

Undoubtedly, Sheffield’s report will be a valuable resource for others delivering similar transformations across the country, supporting them to improve the provision of community mental health support. Moving forwards, we’ll be focusing on addressing key challenges raised by our programme teams as part of the next phase of transformation. This includes ensuring our programme is meeting the scale of demand in Sheffield, how we can bring together different organisational cultures to work seamlessly as one team and ensuring this programme is seen as a key priority in the emergent ICB structure.

As National Clinical Director for Mental Health I have been clear of the importance of this work and while these are the first steps on a longer journey, I am pleased to say these first steps have been confidently taken in Sheffield.

Professor Tim Kendall,
National Clinical Director for Mental Health, NHS England

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Executive Summary

Background and Context to the Programme

- The Community Mental Health Framework for Adults and Older Adults (hereafter, “the Framework”), published in September 2019, seeks to overcome multiple identified problems with existing provision of mental health care.
- The Framework builds on the NHS Long Term Plan and seeks to support new models of “integrated, personalised, place-based and well-coordinated care” for people with severe mental illness.
- The Framework encourages models of care which break down barriers between mental health and physical health, between health, social care, voluntary, community and social enterprise (VCSE) organisations and local communities, and between primary and secondary care.
- The Sheffield Primary and Community Mental Health Transformation Programme (hereafter, “the Programme”) is one of 12 early implementer sites testing the Framework across England
- The Sheffield Programme was designed to test and inform a new way of delivering services for adults and older adults with serious mental illnesses, with a particular focus on people with a diagnosis/characteristics of personality disorder.
- The priority was to offer care at neighbourhood level, built around Primary Care Networks (PCNs), strengthening relationships with VCSE organisations, and addressing health inequalities across the city of Sheffield.
- The Sheffield Programme was established as a partnership between NHS Sheffield Clinical Commissioning Group, Sheffield Health and Social Care NHS Foundation Trust (SHSC), Primary Care Sheffield (PCS), Sheffield City Council and Sheffield Mind.
- Sheffield Mind were selected as a partner to lead the commissioning of the VCSE sector, leading to a total of 6 further VCSE partners across the 4 PCNs.
- The Sheffield Programme was initially tested across 4 Primary Care Networks in Sheffield, representing one third of the city’s population. Test sites were selected based on inequalities (socio-economic deprivation and ethnic minority populations) and degree of mental health need.
- Multi-disciplinary teams were created in the four participating PCNs, including 5 Mental Health Practitioners, 3 Clinical Psychologists, 2 Psychotherapists, 10 trainee Clinical Assistant Psychologists (CAPs), 4 Community Connectors, 3 Health Coaches, 1 Occupational Therapist, and 1 Pharmacist.
- The programme governance arrangements included a programme board, with partners from the CCG, SHSC, PCS, Sheffield Mind, Local Authority, Primary Care, NHS England, and South Yorkshire & Bassetlaw Integrated Care System (ICS).
- Implementation was impeded by the COVID-19 pandemic but was nonetheless launched in June 2020.
- In total, 2,692 referrals were made into the Programme; around 60% of people referred were female. The vast majority of the referrals were people of working age (18-65) with only 3.6% over 65. 20% of the total seen were of minority ethnic backgrounds.

Evaluation Methodology and Methods

- The evaluation team were commissioned in January 2021 to conduct a process evaluation of the Programme; this was conducted between March 2021 and July 2022, structured as five 3-month cycles. At the end of each cycle, an update of findings was shared with the Programme steering committee and the Programme Board.
- The evaluation sought to identify lessons learned through the implementation and to share actionable learning with partners in a timely manner.
- A panel of Experts by Experience, recruited from Rethink, provided feedback on the evaluation design, and contributed to producing service user friendly information sheets and consent forms.
- Data was generated through semi-structured interviews with 20 senior staff (defined as key informants), 42 staff working within the Programme (including all 36 staff directly employed through the Programme) and 10 service users.
- Key informants were selected through a combination of purposive and snowball sampling to ensure representation of all partner organisations and to include senior staff not directly involved but affected by the Programme.
- Service users interviewed were nominated by clinical leads to ensure no vulnerable individuals were approached. Services users all had meaningful experience of the Programme and leads were asked to nominate users with a range of experiences, not only those with positive views.
- Interviews took place online or via telephone and were recorded, transcribed, anonymised and stored securely on University of Sheffield servers.
- Researchers also observed and took field notes at the monthly Programme Board and on invitation, team meetings, and reviewed Programme documentation.
- Interviews were analysed using NVivo qualitative data analysis software. Data was coded according to a framework derived from the evaluation objectives, which was iteratively refined through discussion by the evaluation team. Ethical approval was received from the University of Sheffield.

Summary of Cycle 1 Evaluation Findings

- A rapid lessons-learned report was produced during the first evaluation cycle, based on the first 14 key informant interviews.
- The cycle 1 findings reported that the Programme was delivering on its objectives (despite the pandemic) and was showing evidence of the potential for collaborative or integrated working across health, care and other systems.
- Achievements were ascribed to the widespread recognition of a problem with current mental health provision, the focus afforded by a dedicated Programme, the strength of the core Programme team at both leadership and operational levels, and a general openness and commitment to learning through the Programme.
- Three challenges were identified in the cycle 1 report, which was presented to the Programme Committee in September 2021
- Firstly, that the scale and nature of undermet need in mental health was greater and more complex than many anticipated, presenting challenges of workload and capacity.
- Secondly, that cultural differences between the different partners in the Programme, in particular between primary and secondary care, between NHS and non-NHS providers, and between public sector providers and VCSE providers, impacted on the ability to deliver care in a coordinated way.
- Thirdly, that work needed to be done to raise the visibility of the Programme at senior levels in Sheffield City Council, Sheffield Health and Social Care NHS Foundation Trust, and within the emergent Integrated Care System for South Yorkshire and Bassetlaw.

Evaluation Findings

- The findings are organised around 5 sections: Context, Achievements, Challenges and Barriers, Enablers, and Roll-out and Sustainability.
- These themes reflect the coding framework developed from the evaluation protocol and used to analyse both Programme staff interviews and service user interviews.

Context:

- We found a widespread perception that there was a high level of undermet mental health need in all four sites, from both the professional and service user perspective.
- This degree of need provided strong motivation for the kind of provision offered by the Programme, but gauging and responding to this demand resulted in significant pressure on the Programme.
- This pressure was also experienced by the local mental health Trust, and over time these system pressures had led to tensions between primary and secondary care.
- In this context, the prioritisation of PCNs with the highest mental health need by the Programme was logical.
- Interviewees also emphasised the significant variation between the sites in terms of demographics, resulting in different profiles of mental health need in each PCN, and noted that sites also varied in terms of the strength of engagement with VCSE organisations.
- The COVID-19 pandemic had a significant impact at the start of the Programme and throughout on the design, management and delivery of care through the Programme.

Achievements:

- We found widespread and deep pride in the achievements of the Programme across all staff involved in delivery and leadership, reflecting a strong conviction that the Programme had extended the reach of mental health services and had a palpable impact.
- Many felt that the success in helping under-served groups was facilitated by the flexible approaches adopted through the Programme, a view echoed by the majority of services users interviewed.

- Furthermore, Programme staff and GPs described in detail how the service had provided valuable support to GPs, directly and indirectly.
- The Programme also described success in building strong collaborative bonds across professional and organisational boundaries, although this appeared to vary somewhat between the sites.

Barriers and Challenges:

- We found that there were multiple and sometimes inconsistent views of what the Programme was, which partly reflected the process by which the focus was gradually refined.
- Nonetheless, as this ambiguity persisted, there was a risk of scope creep and of unrealistic expectations being placed on the Programme.
- Some described issues with vertical communications and with communication and engagement with VCSE partners.
- The ability of the Programme to build internal coherence limited by a lack of estates provision and the inability of staff to co-locate, and gaps in administrative infrastructure led to less efficiency overall as clinical staff dealt with administrative tasks themselves.
- The estates and administrative issues also led to demotivation as some staff felt this reflected a lack of value placed on the Programme.
- More broadly, staff highlighted challenges engaging with secondary mental health care and IAPT, suggesting work was needed to position the Programme more clearly within the wider system.
- Finally, staff discussed concerns about caseloads and the need to balance workload more equitably across the team, and the need for attention to be paid to certain HR issues, such as equity in employment conditions and availability of training and development opportunities.

Enablers

- We found several specific enabling factors to have made a difference.
- Flexibility was seen to be one of the great strengths of the service, with several dimensions including flexibility in access, in how time and space were used when working with service users, and in the degree of creativity in treatments which were possible and encouraged, an approach which was already quite normal among the VCSE providers.

- The depth of commitment to the Programme, reflecting both the acute awareness of undermet need and belief in the Programme to make a difference, was a powerful motivating factor.
- The Programme further benefited from the quality of staff recruited, their 'fit' with the ethos of the Programme and their willingness to support each other.
- This extended to the leadership team also, where some felt the composition, including the representation of GPs, was critical.

Roll-out and Sustainability:

- Reflections on roll-out and sustainability focused on two themes.
- The first was the appropriate design of work. This covered important but arguably universal Human Resources (HR) and Organisational Development (OD) concerns such as supportive leadership, staff involvement and engagement, and opportunities for continuing professional development.
- More specifically, there was a need for greater role clarity, particularly for Mental Health Practitioners (MHPs) and Clinical Associates in Psychology (CAPs); a need to ensure the right composition of teams at a neighbourhood level (reflecting local need and potentially including additional new roles); and the need to align the service more effectively alongside new mental posts recruited between mental health providers and primary care under the Additional Roles Reimbursement Scheme (ARRS).
- The second theme related more to sustainability at scale, ensuring sufficient capacity and sufficient funding, again tailored to local need at a PCN level.
- Many recognised the importance of focusing at an early stage on capturing meaningful data and evidence in order to justify investment in mental health provision of this kind.

Discussion

- The Discussion section draws together seven themes which cut across the different Findings sections, summarised in seven points below.
- The Programme demonstrated an ability to reach marginalised groups and to tailor mental health care to match local need. This was enabled by the location of care within communities, the insights provided by general practices and third sector organisations who were familiar with local needs, and the flexible way in which care was made accessible and delivered.
- The Programme was also strengthened by effective engagement with general practice, despite a degree of scepticism among some GPs who had experienced difficulty accessing mental health services for their patients. This engagement ensured that it reflected the mental health needs of patients and the pressures experienced in general practice seeking to support these patients.
- The scale and complexity of demand presented various challenges, including perceptions of inequitable workload among teams and requiring tailored support reflecting local demographics in each PCN. The primary care model of 'patient lists' did not fit neatly with the intensive referral-treatment-discharge model of secondary care, presenting challenges in how caseloads were managed and how services users and staff understood referrals and discharges.
- While the discrete nature of the Programme enabled focus, challenges were encountered positioning the Programme within secondary and specialist mental health services. Effective integration of the Programme would require clarification and coordination of policies and processes with other providers, and strategic engagement at a senior level, with SHSC and South Yorkshire and Bassetlaw ICS.
- The contribution of VCSE providers to date, and the potential for greater contribution, was widely recognised, although various challenges and barriers to involvement were also identified. VCSE leads requested greater involvement in the design and oversight of Community Mental Health services and several highlighted variable experiences when seeking to engage with MDTs in places, suggesting a need to strengthen relationships between VCSE providers and general practices to maximise the contribution of the third sector.
- Staff and service users attested to the importance of flexibility in the delivery of care, with staff feeling empowered to develop innovative solutions to meet service users needs, and service users welcoming the flexibility which they felt valued their own autonomy and choices. However, some felt this presented certain challenges to consistency and parity of care and clinicians discussed the need to balance innovation with evidence-based care.

- The challenge of sustainability for the service as the scale expanded was seen to be significant, with four aspects being highlighted; the financial viability of the service at scale; the work needed to be done to ensure good staff could be recruited and retained; the importance of embedding the service within the wider health and care system; and the need to identify reliable and appropriate evidence of the impact of the service going forwards.

Recommendations

1. Estates

- 1.1 Ensure the service delivers care within neighbourhoods and in convenient locations for service users.
- 1.2 In each PCN, a set of options should be developed for estates provision, addressing space for clinical consultations and other meetings, and for a physical base or hub for the service teams.
- 1.3 The impact of the service on primary care estate should be considered at ICS level where capital investment in estates is considered.
- 1.4 Given pressures on estates in general practice, alternative spaces should be considered, such as council premises and Third Sector buildings.

2. Administrative support

- 2.1 A plan should be developed stipulating necessary administrative support for service teams at a PCN level.
- 2.2 This plan should be developed in discussion with GP practices or other premises used, recognising pressures on existing GP administration and the peripatetic nature of work for staff within service teams.

3. Communications

- 3.1 A targeted briefing should be composed for delivery to GP practices and VCSE organisations in remaining PCNs across the city of Sheffield and, if appropriate, more widely to summarise and communicate lessons learned from Programme.

4. Mental Health Needs Analysis and Mapping at PCN level

- 4.1 Analysis should be commissioned at PCN level to establish the level and nature of mental health need in each locality.

4.2 This analysis should draw on data and expertise from primary care, secondary care, the city council and the Third Sector.

4.3 The analysis should also be informed by the experience of the Programme and the insights of Programme team leads, including VCSE providers.

5. Team Composition

- 5.1 Using the Needs Analysis (Recommendation 4), further work is required to ascertain the appropriate and affordable design of service provision required to deliver an equitable level of care in each PCN.
- 5.2 This work would also need to take into account any changes in secondary care provision as well as emergent contribution of any ARRS mental roles.

6. Caseload Review

- 6.1 An assessment should be undertaken to review caseload distribution across teams, with senior clinical input, to confirm appropriate and manageable workloads for each group within the teams.
- 6.2 This review should determine and articulate an agreed approach to caseload management, recognising the different expectations of primary and secondary care.
- 6.3 This review should inform a training intervention to address conflicting assumptions across teams about expectations of caseload and associated issues of risk and staff capacity.
- 6.4 This review may also form the basis for explicit policy as regards safe and sustainable caseloads.

7. Engagement with Secondary Mental Health Services

- 7.1 A strategy for clear and direct engagement with SHSC at senior level to articulate formation and impact of the Programme, presented in the light of national policy and CMHF expectations, and to share lessons learned through the Programme.
- 7.2 This will involve the creation of a focused briefing clarifying the mission, focus and achievements of the Programme which should be delivered to relevant senior boards in other parts of the health and care provider system, including acute trusts, social care providers and, critically, the secondary mental health care provider.

- 7.3 This communication should focus on the impact of the Programme and the expected contribution the service can make to the goals and objectives of secondary mental health services.

8. Organisational Development

- 8.1 An OD (Organisational Development) initiative should be considered, ideally delivered collaboratively with SHSC, to build mutual understanding between primary and secondary care mental health providers (and should include ARRS mental health workers who are not part of Primary and Community Mental Health teams).
- 8.2 This intervention should aim to explore cultural differences and risks of miscommunication across mental health services, to support clinicians and managers to work collaboratively across primary and secondary care.
- 8.3 This intervention could be extended to incorporate other partners, in particular VCSE organisations and local authority staff and support whole-system collaboration and integration.

9. System Integration

- 9.1 Collaborative discussions should be initiated with SHSC also required at a system level (between primary and secondary care as well as commissioners) to agree processes and criteria for service users to transition to/from more specialist/intensive care and to/from lower intensity IAPT care.
- 9.2 This discussion may also encompass work to clarify eligibility criteria for the service, which should be consistent with those applied by other MH providers.

10. Governance and Multi-Partner Engagement

- 10.1 The design of the board or oversight committees for the future service should ensure representation from all partners, including the secondary mental health provider, local council, general practice and VCSE organisations.
- 10.2 In particular, the board/committee design should ensure that the range of VCSE providers have input into the design and operation of Primary and Community Mental Health services; engaging with VCSE provider alliance may facilitate a wide range of engagement, including smaller VCSE organisations.

11. VCSE and General Practice Liaison

- 11.1 A targeted initiative should be undertaken to improve communication between VCSE organisations and GP practices, potentially supported at scale by the establishment of a VCSE provider alliance.
- 11.2 This work may take place at scale, to share evidence of effective support provided through VCSE organisations, and at a PCN level to strengthen two-way communication between local VCSE providers and general practices.
- 11.3 Community Mental Health Teams and PCNs should consider ways in which to strengthen VCSE partnerships across primary care at a neighbourhood level, including opportunities for collaborative applications for funding, to enhance capacity to provide care, support and treatment through Third Sector providers.

12. Facilitation of MDT Participation between Partners

- 12.1 Guidance should be developed on the operation of MDT meetings to facilitate participation of different providers, both clinical and non-clinical.
- 12.2 Respecting the clinical autonomy of GP practices, it would be helpful for GPs and GP leads to share experiences of MDT operations and evidence of positive impact of more inclusive practices.

13. Commitment to Flexibility, Innovation and Learning

- 13.1 The service should develop a clear statement of principle on the issue of flexibility and innovation in service delivery, including a definition of the positive dimensions of flexibility that the service will embrace and encourage.
- 13.2 Given the high value placed on flexibility and patient-centred care by both staff and services users, guidance should be developed to ensure staff have the confidence to explore adaptive, patient-centred care but do so safely and informed by evidence where available.
- 13.3 To ensure lessons are learned and innovations are assessed and shared, processes should be established to facilitate rapid sharing and assessment of innovative practice between clinicians, with checks and balances to ensure safe care.

- 13.4 This is likely to require a dedicated, clinician-led piece of work to develop guidance and to identify the processes by which innovation should be assessed and shared.

14. Recruitment and Retention of Staff

- 14.1 Attention to certain key elements of the job offer is necessary to optimise ability to recruit and retain staff, in terms of both agreeing policy and communicating this to existing and prospective staff. These include;
- 14.2 Clear articulation and communication of the ethos, mission, and expected impact of the service, in both recruitment and selection, and through induction processes.
- 14.3 Clarification of roles and responsibilities, particularly for new roles such as MHP and CAPs as well as relevant ARRS roles, to ensure a shared understanding of respective responsibilities and to support smooth collaboration across teams
- 14.4 Work to ensure appropriate estates space for teams, potentially including a home-base to enable a degree of co-location and access to good quality spaces for meetings and consultations.
- 14.5 Standardisation of employment conditions as far as possible given multiple employer organisations
- 14.6 Clarification and articulation of provision of development and training opportunities.

15. Measurement of impact

- 15.1 A detailed project is needed to measure the impact of the Programme and current/future Primary and Community Mental Health provision, potentially with an economic impact evaluation.
- 15.2 To inform this work, a focused project would be necessary involving clinical leads, service leads, technical leads and commissioners to establish appropriate measures of impact, which may include patient reported measures and prescription rates for psychotropic medication or antidepressants
- 15.3 Equally, mechanisms should be put in place to routinely capture feedback from service users and from staff on a regular basis, and to demonstrate to users, staff and commissioners how the service learns from and acts upon this feedback.
- 15.4 This work should however recognise the points made above about the scale of undermet need, the degree to which the Programme may have reached under-served groups, and the likely identification of need at an early stage through the Programme, all of which will affect the degree of impact measured.
- 15.5 There would be substantial value in a broader commissioned piece of research drawing together learning on implementation and impact across the 12 CMHF early implementer sites at a national level.
- 15.6 Similarly, given the number of new roles being introduced across mental health services, there is a need for a broader evaluation of the impact, challenges and benefits of these new roles implemented as part of the Community Mental Health Framework.



Background and Context to Programme

A. Background and Context to Programme

In this section, the broad policy context leading up to the Sheffield Primary and Community Mental Health Transformation Programme (henceforth, “the Programme”) will be described, before presenting the structure and implementation of the Programme. Data will then be presented summarising the activity which took place within the Programme.

1. The Community Mental Health Framework

The Community Mental Health Framework for Adults and Older Adults¹, published in September 2019, was developed by NHS England, NHS Improvement, and the National Collaborating Centre for Mental Health (NCCMH). The Framework responds to the NHS Long Term Plan which promised investment and a radical transformation in the care, support and treatment for people with severe mental illness (SMI).

The NHS Long Term Plan describes the need for new and integrated models of primary and community mental health care, support and treatment, stating that local areas will be “supported to redesign and reorganise core community mental health teams to move towards a new place-based, multidisciplinary service across health and social care aligned with primary care networks.”² (NHS Long Term Plan, p.69). These changes have the aim of addressing health inequalities and avoidable variation in care, giving “370,000 adults and older adults with severe mental illnesses in England greater choice and control over their care and support them to live well in their communities by 2023/24”³.

The Community Mental Health Framework (hereafter, “the Framework”) takes this forward, recommending the development of new models of “integrated, personalised, place-based and well-coordinated care” for people with severe mental illness. The Framework seeks to overcome multiple identified problems with existing provision, including mental health system fragmentation and risks of discontinuity of care, the limitations of the Care Programme Approach (CPA), high barriers to access and long waiting times for specialist secondary care in many areas, and the damaging effect of multiple transitions between services. Instead, the Framework seeks to encourage models which can break down barriers between;

- Mental health and physical health,
- Health, social care, voluntary, community and social enterprise (VCSE) organisations and local communities, and
- Primary and secondary care.

The Framework states that people with mental health problems will be enabled to be active participants in their care, and that this will be delivered in the community. It suggests that health and social care commissioners should collaborate with providers “on a sustainably-funded partnership basis – that is, without recurrent short-term tendering cycles and complex contract management processes”⁵, and aims to direct more resources into community-based services according to agreed local priorities.

1. NHS England, NHS Improvement and National Collaborating Centre for Mental Health. *The Community Mental Health Framework for Adults and Older Adults*. NHS England; 2019 <https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf>.

2. NHS England (2019) *The NHS Long Term Plan* London: England <https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/p.69>

3. Ibid. p.73

4. NHS England, NHS Improvement and National Collaborating Centre for Mental Health. *The Community Mental Health Framework for Adults and Older Adults*. NHS England; 2019. <https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf> p.4

5. Ibid. p.5

Community Mental Health Framework for Adults and Older Adults: Key Aims

People with mental health problems will be enabled as active participants in making positive changes rather than passive recipients of disjointed, inconsistent and episodic care. Delivering good mental health support, care and treatment in the community is underpinned by the following six aims:

1. Promote mental and physical health, and prevent ill health.
2. Treat mental health problems effectively through evidence-based psychological and/ or pharmacological approaches that maximise benefits and minimise the likelihood of inflicting harm, and use a collaborative approach that:
 - builds on strengths and supports choice;
 - is underpinned by a single care plan accessible to all involved in the person's care.
3. Improve quality of life, including supporting individuals to contribute to and participate in their communities as fully as possible, connect with meaningful activities, and create or fulfil hopes and aspirations in line with their individual wishes.
4. Maximise continuity of care and ensure no “cliff-edge” of lost care and support by moving away from a system based on referrals, arbitrary thresholds, unsupported transitions and discharge to little or no support. Instead, move towards a flexible system that proactively responds to ongoing care needs.
5. Work collaboratively across statutory and non-statutory commissioners and providers within a local health and care system to address health inequalities and social determinants of mental ill health.
6. Build a model of care based on inclusivity, particularly for people with coexisting needs, with the highest levels of complexity and who experience marginalisation.

Source: The Community Mental Health Framework for Adults and Older Adults. NHS England; 2019

The Framework argues for “a renewed focus on people living in their communities with a range of long-term severe mental illnesses, and a new focus on people whose needs are deemed too severe for Improving Access to Psychological Therapies (IAPT) services but not severe enough to meet secondary care ‘thresholds’”⁶. However, it is intended that the Framework will be more widely applicable to people irrespective of their SMI diagnosis/presentation, and should cover those with coexisting frailty, coexisting neurodevelopmental conditions, eating disorders, anxiety or depression, personality disorder, drug or alcohol-use disorders and other addictions, and severe mental illnesses such as psychosis or bipolar disorder⁷.

2. The Sheffield Primary and Community Mental Health Transformation Programme

The Sheffield Primary and Community Mental Health Transformation Programme (hereafter, ‘the Programme’) is one of 12 early implementer sites⁸ selected through a competitive process to pilot how the Framework could be applied through the development and delivery of new models of mental health care.

The Programme in Sheffield was designed to be a new way of delivering services for adults and older adults with serious mental illnesses, with a particular focus on people with a diagnosis/characteristics of personality disorder. The priority was to offer care, support and treatment in a ‘place-based way’ built around Primary Care Networks (PCNs), strengthening relationships with VCSE organisations, and addressing health inequalities across the city of Sheffield.

The Sheffield Programme was therefore established as a partnership between NHS Sheffield Clinical Commissioning Group, Sheffield Health and Social Care NHS Foundation Trust (SHSC), Primary Care Sheffield (PCS), Sheffield City Council, South Yorkshire & Bassetlaw Integrated Care System and Sheffield Mind (ICS).

6. Ibid. p.3

7. Ibid. p.8

8. Details of the CMHF early implementer programme, including the list of all twelve sites, can be found at <https://www.england.nhs.uk/mental-health/adults/cmhs/>

The Sheffield Programme set out distinctive five elements of the new provision;

1. A single 'right door' for all
2. Reduced waiting times
3. An integrated team within primary care
4. Enhanced voluntary sector support
5. Improved physical health⁹

The Programme, along with other early implementers, also sought to develop and test methodologies to establish new 4-week waiting time metrics, in line with NHSE/I expectations.

This approach to providing support, care and treatment was tested within 4 Primary Care Networks in Sheffield, representing one third of the city's population, with the intention to expand the offer across the city in the future.

These networks were selected based on; inequalities (measured by Index of Multiple Deprivations and Public Health Fingertips¹⁰ data) and degree of mental health need (measured by referrals to Single Point of Access to secondary mental health services for under 65s (SPA)), prescription of psychotropic medications and the number of patients on GP Serious Mental Illness registers (SMI registers).

3. Programme implementation

The Sheffield Programme therefore brings together health, social care and VCSE partners, with collective accountability for the success of the programme. Clear objectives and requirements were established at the outset, informed by the Framework, and a small core team of executive leads, clinical leads and management were established to lead delivery of the Programme.

The programme governance arrangements included a programme board, with partners from the CCG, SHSC, PCS, Sheffield Mind, Local Authority, Primary Care, NHS England, and South Yorkshire & Bassetlaw ICS. The programme board was created to reflect the joint integrated governance of the multi organisational partnership of the early implementer bid. Sheffield Mind were selected as a partner to support the commissioning of the VCSE sector, leading to a total of 6 further VCSE partners across the 4 PCNs.

The Programme leadership team comprises 2 part time Senior Responsible Officers (based in Primary Care Sheffield and Sheffield Health and Social Care NHS Foundation Trust, respectively), 2 Senior Managerial Leads and sessional clinical leadership input.

Multi-disciplinary teams were created in the four participating PCNs, including 5 Mental Health Practitioners, 3 Clinical Psychologists, 2 Psychotherapists, 10 trainee Clinical Assistant Psychologists (CAPs), 4 Community Connectors, 3 Health Coaches, an Occupational Therapist, and a Pharmacist. In addition, the leadership team included 3 team lead roles; a principal clinical psychologist leading the psychologists/psychotherapists, a lead Mental Health Practitioner, and a Community Connector manager (see Table 1: Programme Roles and Staffing Numbers).

Table 1: Programme Roles and Staffing Numbers during the period of evaluation (2021-22)

Role	Number of posts
Mental Health Practitioner	5
Psychological therapists	5
CAP	10
Community Connector	4
Health Coach	3
Occupational Therapist	1
Pharmacist	1
Leadership team (inc. team leads)	7
TOTAL	36

Each of the PCNs therefore had a dedicated team, composed of 1-2 Mental Health Practitioners, 1 Psychologist or Psychotherapist, 2 trainee CAPs, and 1 community connector. The OT, pharmacist and health coaches operated across all four PCNs.

9. Source: Sheffield Primary & Community Mental Health Transformation Programme presentation (April 2020)

10. <https://fingertips.phe.org.uk/>

One of the aims of the programme and wider national policy was to improve the physical health of people with severe mental illness, given reduced life expectancy. To meet this aim, the programme took a whole-system approach to ‘making every contact count’, employing band-3 health coaches to work with people with SMI who have identified physical health needs (doing work around behaviour change, motivation, nutrition, and exercise).

It should be noted that Sheffield did not have existing primary care mental health infrastructure for SMI at Programme inception, so these roles needed to be created and recruited through the Programme as new services were designed “from scratch”. As the timeline below shows (**Figure 1: Programme Timeline 2019-2022**), this work was carried out between November 2019 (NHSE funding awarded) and June 2020 when activity commenced and the first patients/service users¹¹ were seen.

It is important to note that the Programme implementation period coincided with the COVID-19 pandemic across the world. This not only impeded implementation processes such as staff recruitment, team-building and forging relationships at the PCN level, but also restricted the scale of care which could be offered through certain elements of the Programme. The pandemic also meant that staff had to engage with patients and service users in different and unfamiliar ways, often virtually while working from home due to social distancing and during lockdowns. At the same time, pressure across broader health and care services was intense and many people living with mental illness faced severe challenges, resulting in an increase in demand for support. Older adults, those with learning difficulties

and autism were particularly affected here, and the Programme was asked by NHSE/I to maintain contact and increase online care and self-harm assessments through 2020-21. In parallel, there was clearly pressure from the pandemic on other parts of the health and care system, which continued as the vaccination programme took up time and resources through 2021.

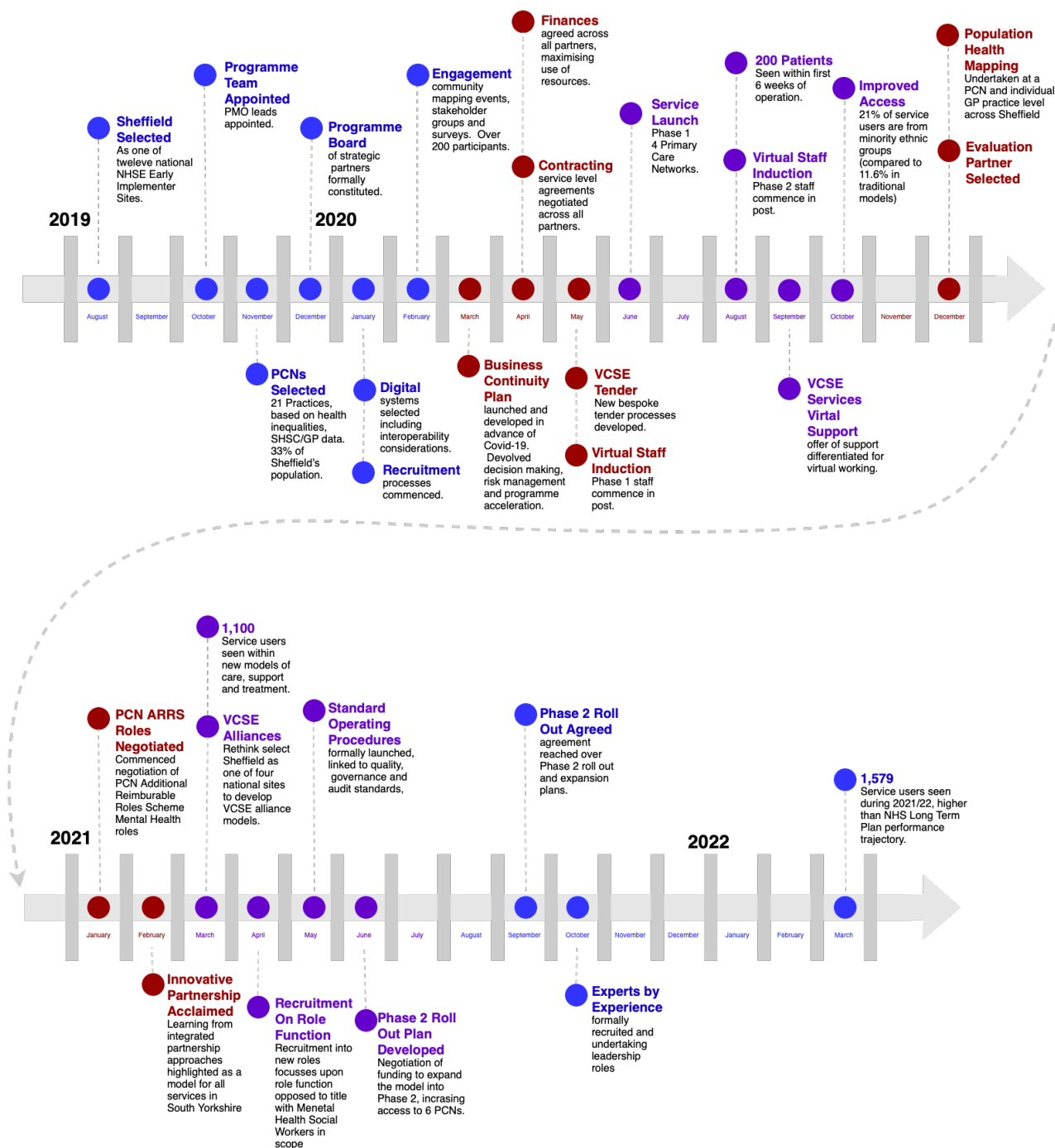
While many of the other Framework pilot sites postponed implementation during this period, the Sheffield Programme managed to recruit to and set up many services despite the challenges of COVID-19 and social distancing regulations, aided by their business continuity plan. As discussed below, this did however result in severe pressures affecting leadership, management, administration, and the delivery of care.

A parallel initiative which complemented and supported the Programme was the involvement of Rethink Mental Illness, who selected Sheffield as one of four national sites in which to develop a VCSE alliance model. With additional funding from the Charitable Aid Foundation (and match funding provided by Sheffield CCG), Rethink Mental Illness appointed staff to roles in Sheffield from March 2021. Working with SHSC, CCG, NHS England and other stakeholders, Rethink Mental Illness went on to build relationships with over 90 VCSE organisations. From February 2022, meetings were held involving all VCSE partners and a statement of intent was drafted to frame the vision and intended outcomes of a VCSE alliance in the city from August 2022.

The Programme was shortlisted for a Health Service Journal Award in 2021 in the category of Provider Collaborative of the Year, and was nominated for a British Medical Journal award in 2021.

11. Hereafter we have adopted the convention, common in mental health, of identifying those people using Primary and Community Mental Health services as service users from the point at which they access the service. However GP practices and primary care services more commonly refer to those on their practice lists as patients and many of the quotes in the report reflect this.

Figure 1: Programme Timeline 2019-2022



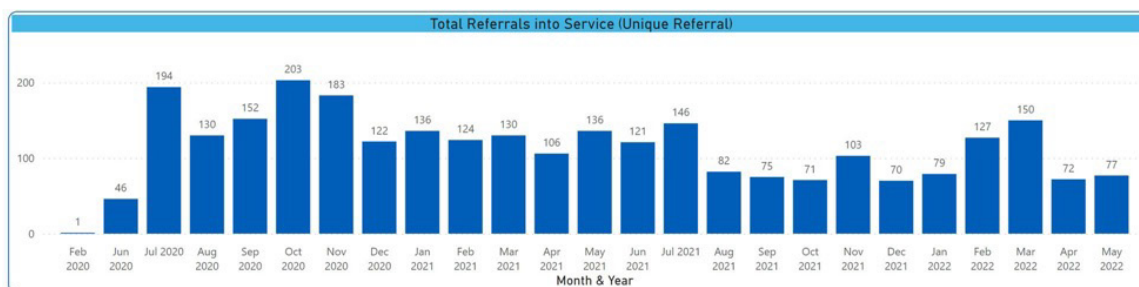
Key:

- Denotes non-Covid restrictions in effect
- Denotes times of UK National Covid lockdowns
- Denotes times where social distancing/tiering was in effect in regards to Covid

4. Programme Activity

The number of unique referrals into the service by month from June 2020 until May 2022 can be seen in **Figure 2: Referrals into Service by Month (Jun 2020-May 2022)**.

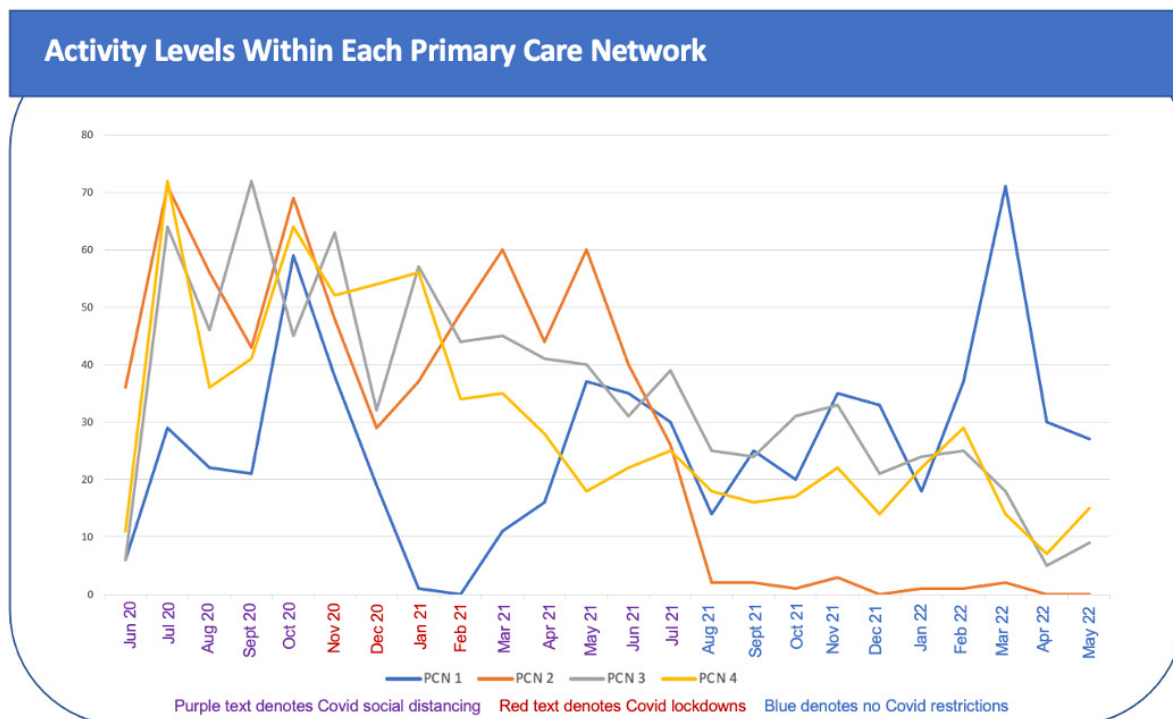
Figure 2: Referrals into Service by Month (16 Jun 2020-31 May 2022)



The breakdown of referrals by network can be seen in **Figure 3: Activity by PCN**, with additional colour-coding to clarify the impact of COVID through the implementation period.

This graph shows fluctuations in each PCN but a general picture of around 50-60 referrals per month in each PCN from June 2020 to June 2021, then a lower average of around 20-30 referrals per month from July 2021 onwards which is largely consistent across networks.

Figure 3: Activity by PCN (16 Jun 2020-31 May 2022)



Three points where referrals depart from this pattern merit some explanation;

- PCN1 shows a dip in referrals in January-February 2021. The reason for this was due to a staff member leaving their role and the programme not having any floating resources to back fill the role while the staff member was replaced.
- PCN1 also shows an erroneous data point in March 2022. This was caused by new referrals not being processed in January/February 2022. When this issue was identified the backlog of referrals were processed resulting in the spike in March 2022. A more realistic plot would be increased referrals in January and February and fewer in March 2022

leading to a more controlled activity rate for PCN1 during this time period.

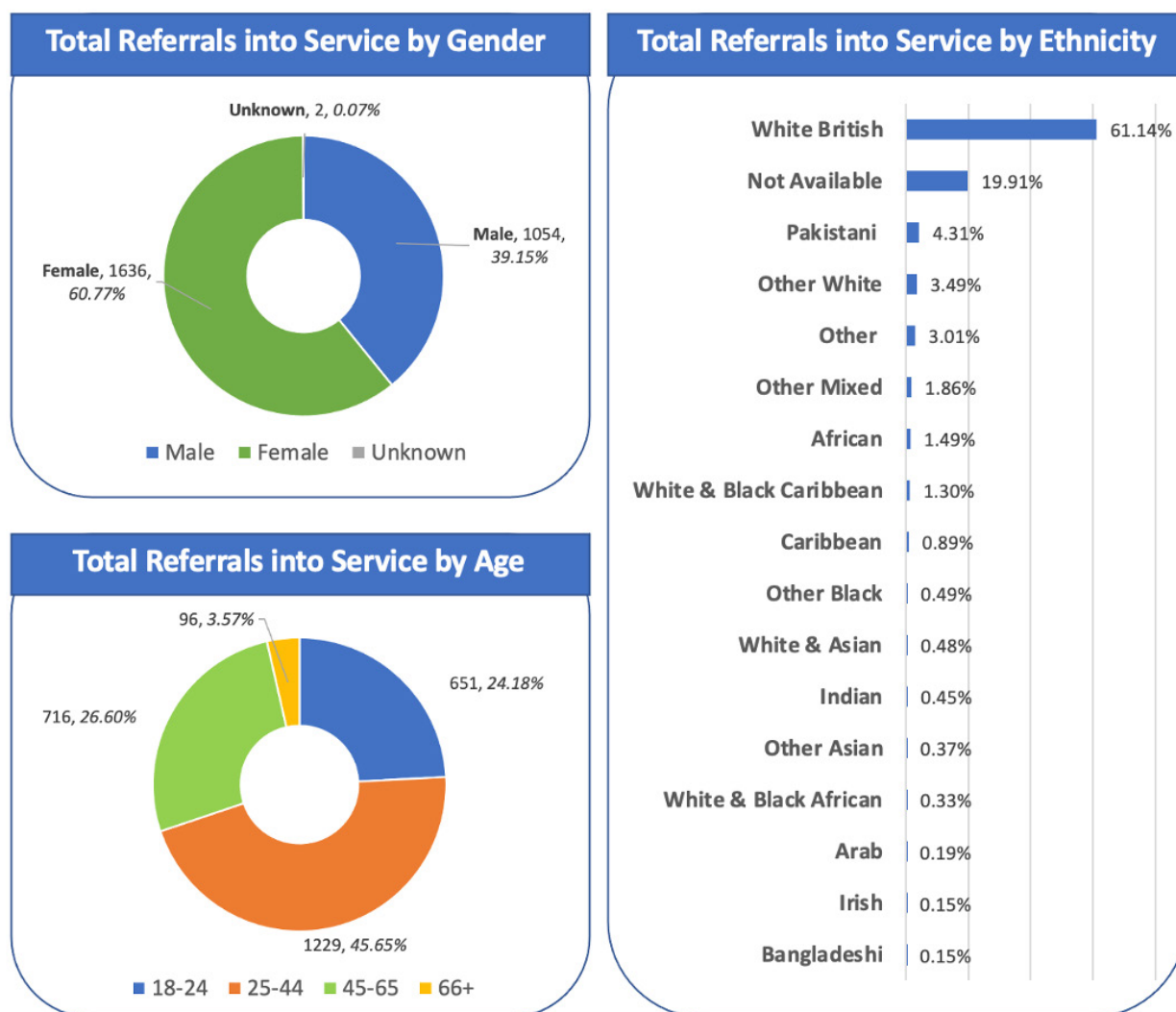
- PCN2 shows a reduction in activity from August 2021. There are two reasons for this reduction, firstly, this PCN had historically had high numbers of referrals, with many of the individuals having additional needs such as interpreters (where English was not a first language). Agreement was reached in August 2021 to temporarily pause new referrals to enable a historic backlog to be addressed, which coincided with a staff member

being off sick for a period of time. In early 2022, a staff member left their role in PCN2 which reduced the capacity of the team and resulted in a further pause on new activity whilst a new member of staff was recruited.

a. Summary of Activity by Gender, Age and Ethnicity

Demographic information on all patients referred to the Programme across the Programme can be seen in **Figure 4: Total Referrals into Service (by Gender, Age and Ethnicity)**.

Figure 4: Total Referrals into Programme (by Gender, Age and Ethnicity) Jun 2020-May 2022



As Figure 4 shows, around 60% of people referred to the Programme across all sites were female, and the vast majority were of working age (18-65), with the largest group being in the 25-44 age-range. Around 20% of those using the service were of minority ethnic

backgrounds. The demographic breakdown of service users by PCN is presented (**Figure 5: Gender of service users by PCN; Figure 6: Age of service users by PCN; and Figure 7: Ethnicity of service users by PCN**).

Figure 5: Gender of service users by PCN (Jun 2020-May 2022)

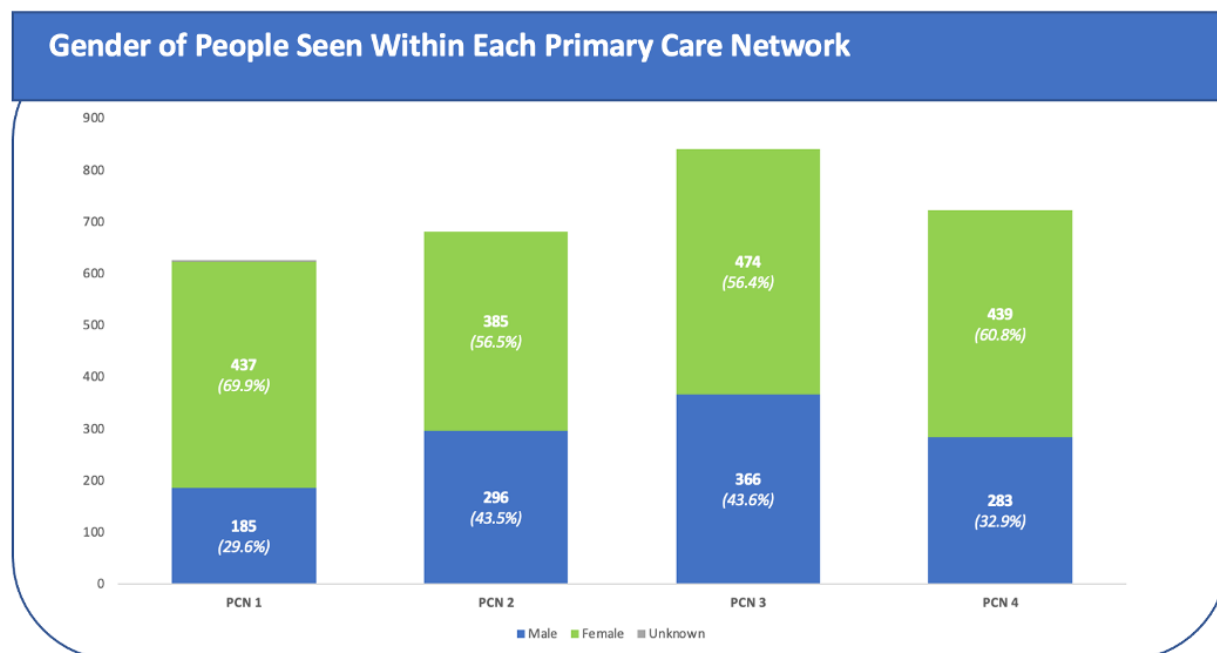


Figure 6: Age of service users by PCN (Jun 2020-May 2022)

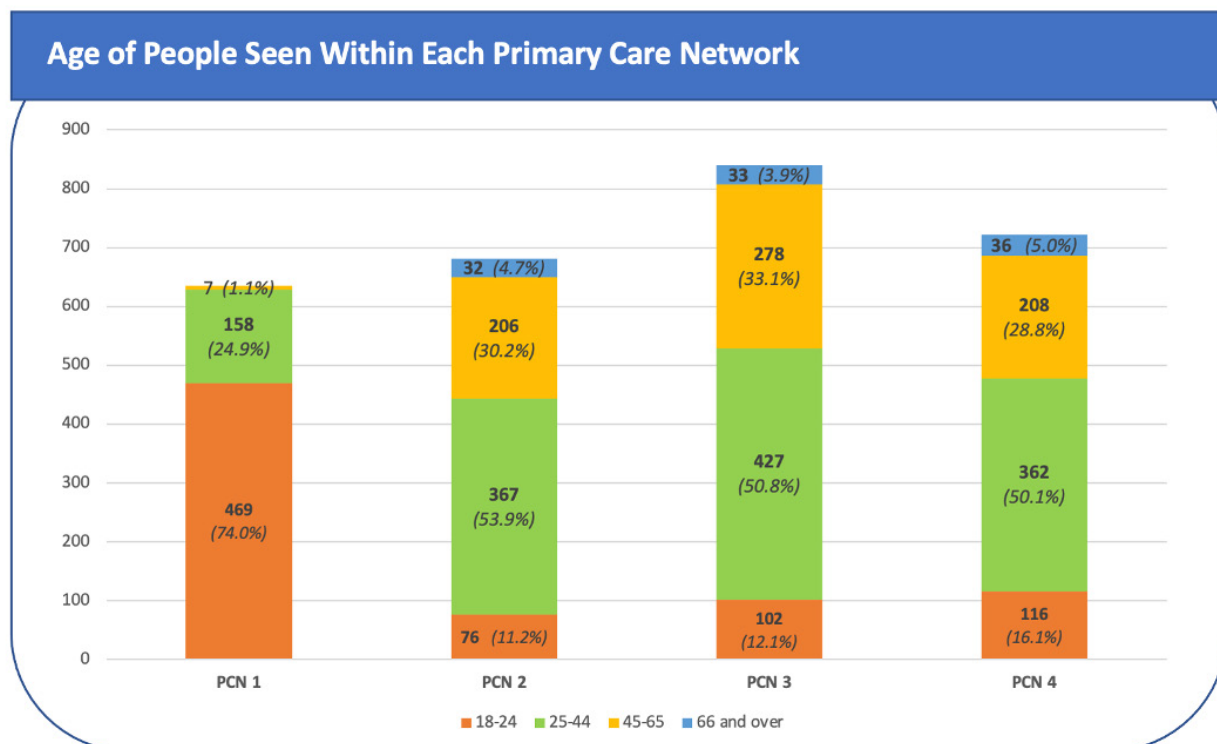
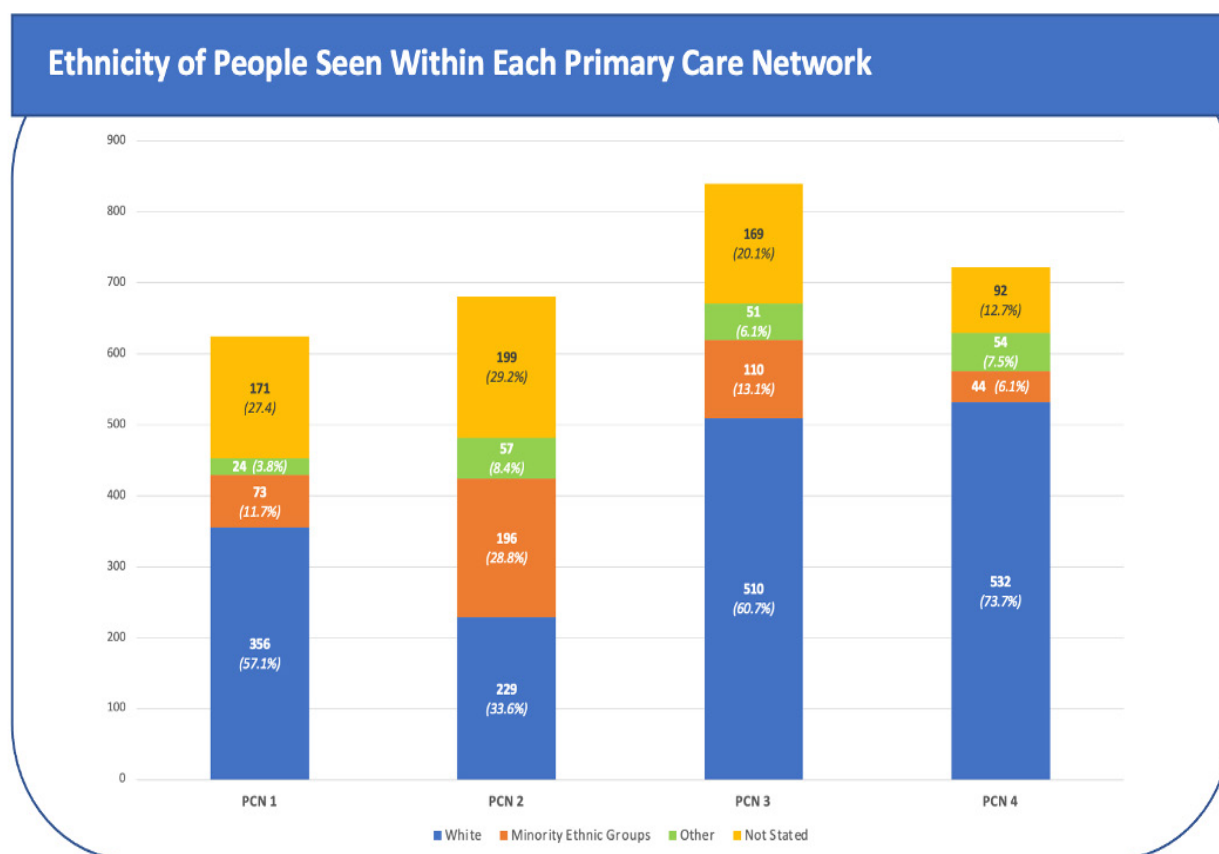


Figure 7: Ethnicity of service users by PCN (Jun 2020-May 2022)



b. Community Connector Activity

Throughout the project 278 people were seen by community connectors (Jun 2020 - Mar 2022), including 120 males and 158 females (see Table 2: Breakdown of Community Connector activity).

In addition, 305 referrals were made to VCSE organisations over the same period, who offered a diverse array of support as described in Table 2: Breakdown of VCSE activity.

Table 2: Breakdown of Community Connector activity

Age	Number of people seen
18-29	78
30-39	65
40-49	51
50-59	40
60+	36

c. VCSE Activity

Table 3: Breakdown of VCSE activity

Provider	Staff involved	WTE	Referrals	Male	Female	Type of support provided
VCSE1	1	0.4	135	60	75	18 Debt Advice, 95 social welfare advice, 7 other advice
VCSE2	2	0.8	53	26	27	46 holistic needs assessment, 47 full benefits check, housing support 26, caring support 11, physical health support 51, fuel poverty 22
VCSE3	2	1.6	49	17	32	40 volunteering opportunities, garden self-care group 31, social groups 49, walk and talk sessions 29
VCSE4	2	1.6	15	11	4	Exercise sessions, debt support, personal development planning
VCSE5	2	1.6	44	24	18	28 health training/social prescriber, 11 community garden, 25 walk to talk, 39 1:1 personal development sessions
VCSE6	2	1.5	9	3	6	Training/education, volunteering/employment support, hobbies/interest groups, activities to support physical health
Total			305	141	162	

B

Evaluation Methodology and Methods

B. Evaluation Methodology and Methods

1. Research Approach and Methodology

This report presents the findings of an evaluation of the Sheffield Primary and Community Mental Health Transformation Programme, commissioned in January 2021 and conducted by the evaluation team based in the University of Sheffield between March 2021 and July 2022.

The evaluation was designed as a formative process evaluation, based on the following principles;

- The co-production of evaluation protocol with all programme partners,
- A process evaluation to focus on ‘how’ rather than ‘why’,
- An emphasis on rich and deep qualitative analysis,
- Emphasis on timely feedback and recommendations through rapid cycles of learning,
- Both a retrospective and prospective orientation, with a view to informing the wider roll-out of the service.

The evaluation therefore had three aims;

1. To **identify lessons learned** in the implementation of the Sheffield Primary and Community Mental Health Transformation Programme, covering as a minimum the following themes¹²:
 1. leadership
 2. governance
 3. infrastructure
 4. workforce
 5. impact (including accessibility, acceptability, and stakeholder experience)
 6. sustainability (including wider roll-out),

2. To ensure **actionable learning is shared with partners in a timely manner** throughout the evaluation period through briefings and interactive events, including lessons learned report and final report,
3. To generate **recommendations on the sustainable use of current dashboard and new software** in Sheffield, incorporating process flow mapping¹³.

2. Methods

Data was generated through various methods, including:

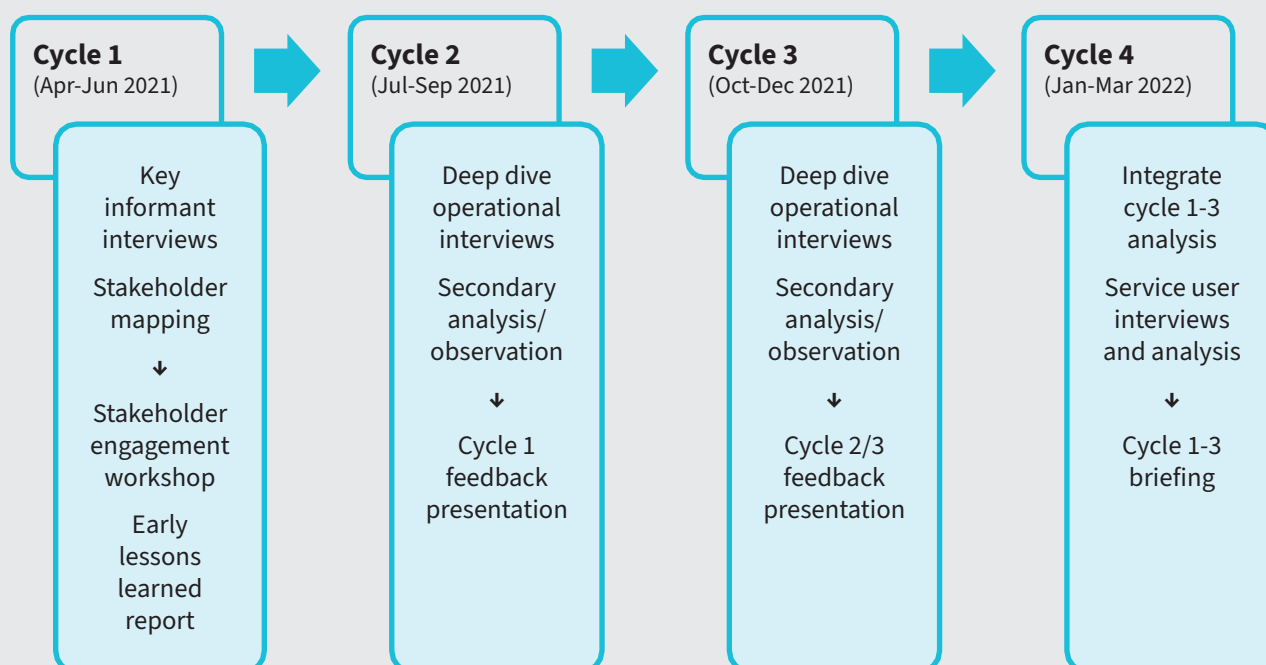
1. Semi-structured individual or group interviews with all Programme staff plus wider leadership in health, care and VCSE organisations involved with or affected by the Programme (referred to as “key informants”),
2. Semi structured interviews with service users,
3. Observation of relevant staff meetings,
4. Secondary analysis of relevant documentation, summary activity and outcome data as collected by partners.

This formative process and how findings were reported iteratively to the programme leadership team is represented in Figure 8: Evaluation Timeline and Deliverables.

12. Themes 1-4 highlighted as key enablers in the Community Mental Health Framework for Adults and Older Adults

13. The process flow mapping was not conducted, as a dashboard solution developed in Somerset was presented to South Yorkshire and Bassetlaw Transformation Board and taken forward for consideration.

Figure 8: Evaluation Timeline and Deliverables



a. Interviews:

In total, we interviewed 73 individuals across 52 interviews lasting between 30 and 75 minutes; this total is comprised of 46 individual interviews and 6 group interviews.

We organised the interviews into three groups.

Key informants/stakeholders:

First, in Cycle 1, we interviewed 20 “key informants”. We defined key informants as staff in leadership roles across primary care, secondary care, healthcare commissioning, local council and VCSE organisations who were not directly involved with the operational delivery of the Programme but were either involved in a leadership capacity or were indirectly involved or affected by the Programme. Thus all key informants could be expected to be familiar with the Programme but to bring different perspectives to it. These interviewees were selected by a combination of purposive and snowball sampling; some were nominated by the Programme leads, others were approached later on the recommendation of other key informants due to specialist knowledge of a certain aspect, or their representation of a certain stakeholder/partner. **See Table 4: Key informant interviewees, by employing organisation** for a breakdown of key informants by organisation.

Table 4: Key informant interviewees, by employing organisation (Cycle 1)

Key Informant Organisation	Number interviewed
Primary Care Sheffield (PCS)	3
NHS Sheffield CCG (CCG)	4
Sheffield Health and Social Care (SHSC)	8
Sheffield City Council (SCC)	2
Sheffield Mind (SM)	1
Other	2
TOTAL	20

Programme Staff

In Cycle 2 and 3, we interviewed all clinical and VCSE staff involved in an operational capacity in the Programme, including patient-facing and team leads, across all four PCNs. No sampling techniques were employed as all Programme staff took part in the interviews; 42 staff in total. **See Table 5: Operational interviewees, by employing organisation and by role** for a breakdown of interviewees by site and by role.

Table 5: Operational interviewees, by employing organisation and by role (Cycle 2/3)

Site (PCN)	Number interviewed
PCN1	8
PCN2	10
PCN3	8
PCN4	8
Across all PCNs	8
TOTAL	42

Operational interviewees by role	Number interviewed
GP	5
VCSE	5
MHP	6
Psychologist/Psychotherapist	6
Trainee CAP	10
OT/Pharmacist	2
Community Connector	5
Health Coach	3
TOTAL	42

The operational interviews were semi-structured and followed an interview schedule informed by the evaluation aims defined above, covering context, achievements of Programme, enablers, barriers and challenges, and roll-out and sustainability. They were conducted by either 1 or 2 interviewees via Google Meet.

The 21 operational interviews included 15 individual interviews of between 30-60 minutes, either with sole practitioners or clinical leads, and 6 group interviews of around 90 minutes. Group interviews were employed when there were multiple practitioners performing the same role across different sites and were used to maximise representation of staff and minimise demands on their time. In total, 27 staff took part in the 6 group interviews which covered the psychologists/psychotherapists, mental health practitioners, community connectors, health coaches, and CAPs (split into two groups to keep group size manageable).

Service Users

In Cycle 4 we interviewed 10 service users using purposive sampling. Service users were nominated and approached by clinical leads across the four PCNs to ensure no vulnerable individuals are put forward based on clinical professional judgement. Participants were selected if they were 18 or over, and had meaningful experience of the programme, defined as having attended 2 or more sessions. With the aid of clinical leads, we sought to ensure that participants had experience of a range of services through the programme and aimed to maximise diversity across the sample in terms of gender, ethnicity, and age. We also asked clinical leads to ensure that service users invited had a range of views and were not “cherry-picked” for their positivity towards the programme. **See Table 6: Demographic information on service user interviewees** for demographic information on the service users interviewed:

Table 6: Demographic information on service user interviewees

Site (PCN)	Number interviewed
PCN1	1
PCN2	3
PCN3	2
PCN4	4
TOTAL	10

Sex	Number
Male	3
Female	7
TOTAL	10

Age	Number
21-30	3
31-40	2
41-50	2
51-60	2
61+	1
TOTAL	10

Ethnicity	Number
White British	9
Asian other	1
TOTAL	10

Service user interviews were carried out by telephone or using Google Meet, according to the service user's preference, by one interviewer experienced in patient and service user interviewing. Translators were available for service users who were not confident in communicating in English, however, these were not needed.

Informed consent was collected for all participants. The Information Sheet, Consent form and Interview Schedule for service users was reviewed by an Experts by Experience panel and a Patient Participation Group, and changes made accordingly, to ensure these materials were appropriate.

Individual and group interviews were recorded and then transcribed by approved University of Sheffield transcription services, before being anonymised and stored on secure University servers. Summary notes were made throughout the interviews, which were also stored on secure University servers.

b. Observation and Documentary Analysis

Researchers attended the monthly Programme Board and on invitation, team meetings, with the agreement of the partners. Field notes were generated and anonymised. These notes were not included in the coding, being handwritten, but were reviewed at regular intervals and thus informed the interviews indirectly.

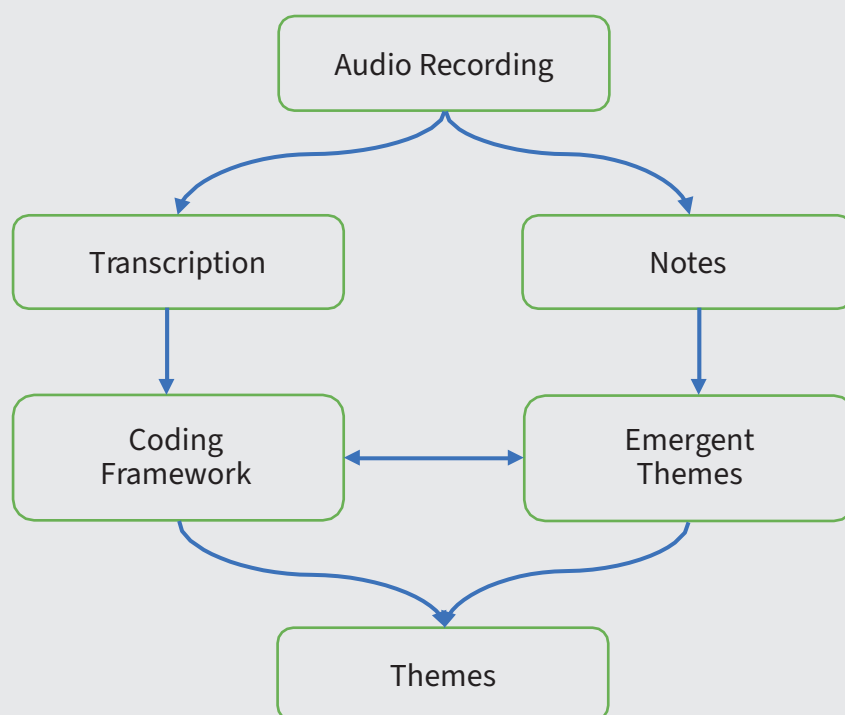
Relevant documentation was provided by the partners. Activity data have been identified in discussion with partners and cited in the previous section (**A: Background and Context to Programme**), to describe the scale and timeline of Programme activity and to provide demographic information on service users across the four PCNs.

c. Data Analysis

An initial coding framework was developed by the evaluation team, based on summary notes of interviews, and informed by the evaluation framework. Inductive thematic analysis was then carried out on interview transcripts using NVIVO qualitative analysis software, which further developed the Framework. See **Figure 9: Data Generation and Analysis Process** for a simplified representation of the data generation and analysis process.

Themes were generated by identifying underlying commonalities between all participants (key informants, programme staff and service users) and organising them in a way which relates to the original research questions. The aim was to incorporate the full range of viewpoints, including positive and negative experiences, to generate a balanced understanding of each theme. In order to present these themes within the report, we describe the themes and use verbatim quotes to illustrate the views expressed. Due to the limits of space, we select those quotes which best represent the range of views expressed and through commentary explain where these views were widely held, or where they were largely held by particular groups of interviewees.

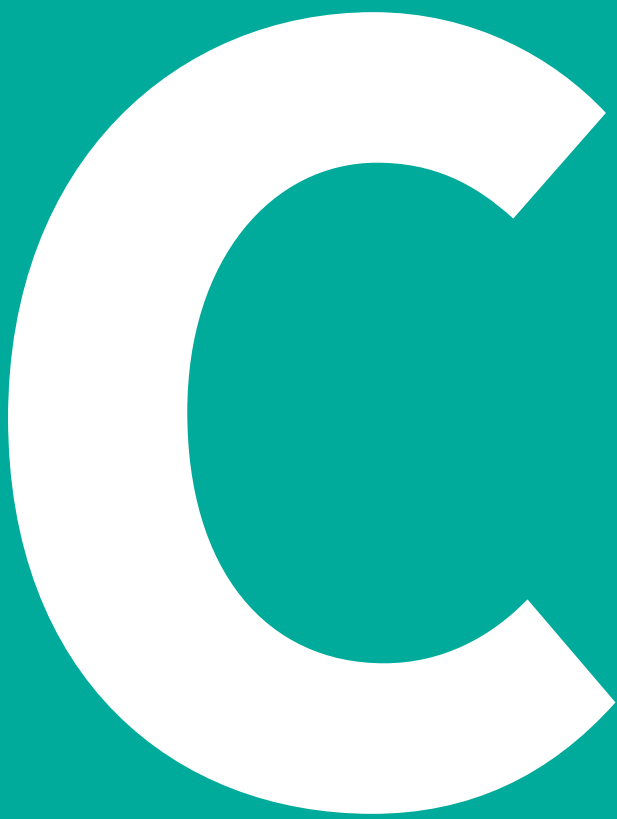
Ethical approval: This study was a service evaluation and did not require NHS ethics approval or research governance. However, ethical approval was sought from the University Ethics Committee and granted by the University of Sheffield, on 19 July 2021 (ref. 039619). An amendment to the ethics to enable interviews with service users was approved on 14 Mar 2022 (ref. 045370).

Figure 9: Data Generation and Analysis Process

3. Anonymisation of Interviewees

In the Evaluation Findings (section D below), it is important that interviewee anonymity is protected but also that information is provided to ensure that the meaning of statements can be understood. We have therefore adopted the following protocol to refer to organisations and interviewees;

- All organisations are represented by pseudonyms with the exception of the key partners; Sheffield Health and Social Care NHS Foundation Trust, Primary Care Sheffield, and Sheffield Mind. The four PCNs are also represented by pseudonyms (PCN1, 2, 3, and 4).
- Key informants interviewed are referred to by code (KI1-KI20) and by their employer (SHSC, PCS, CCG, SCC, or SM – see Table 2 for abbreviations)
- Operational interviewees are referred to by code (P1-P15) and either by their profession (e.g. GP) or more broadly by sector (e.g. VCSE).
- There are three exceptions to this rule.
 - o First, the team leads, where identifying their profession would compromise anonymity (as there is only one team lead for each professional group) – they are therefore only described as “team leads”.
 - o The second exception is where a PCN is named or referred to in a quote, where naming the professional and their PCN would also compromise anonymity.
 - o The third exception relates to participants in group interviews who are referred to collectively by professional group, as we did not seek to identify individuals in group interviews; hence MHPGI for the mental health professionals; PsychGI for the psychologists and psychotherapists; CCGI for the community connectors; HCGI for the health coaches; and CAP1GI or CAP2GI for the two CAP group interviews.
- The service user interviews are simply referred to by code to ensure anonymity (SU1-SU11).



Summary of Cycle 1 Evaluation Findings

C. Summary of Cycle 1 Evaluation Findings

In Cycle 1, a rapid ‘Lessons Learned’ report was produced to capture learning and to offer rapid, interim feedback to inform the development of the Programme. The content of this report is summarised briefly here. All of the themes identified in this report are explored at length in the **D. Evaluation Findings** section which follows.

1. Cycle 1 Methods

Fourteen key informant interviews were conducted from March-May 2021 and were analysed for this report. Six further key informants were later interviewed, hence 20 in total.

Efforts were taken to ensure the different partners in the Programme were represented here, with interviewees from Primary Care Sheffield, Sheffield CCG, Sheffield Health and Social Care NHS Foundation Trust, Sheffield City Council, Sheffield Mind and other regional and national partners involved in the Programme.

Interviewees were all in strategic or leadership roles and noted that the depth of their knowledge of the Programme varied depending on their role and degree of involvement. Those involved at the oversight level had less awareness of the challenges and barriers faced, for instance, compared to those with more direct leadership responsibilities, and some due to their position had a greater focus on the position of the Programme in the wider system. None were involved in patient/service user-facing roles in the Programme.

The average interview length was 55 minutes although interviews ranged from 11 minutes to 101 minutes in duration. All interviews were recorded and transcribed (with one exception due to technical issues). Extensive notes were also taken in all interviews.

The interview schedule was structured around 5 key themes;

1. Role and involvement in the Programme
2. Perceived achievements of Programme to date
3. Perceptions of main challenges or barriers encountered by Programme
4. Enablers and lessons learned
5. Perceptions of challenges going forward as wider roll-out is initiated.

2. Cycle 1 Findings

The Lessons Learned report captured a widespread perception that setting up the service and delivering care through the COVID-19 pandemic was a remarkable achievement, that the Programme was demonstrating that there was a substantial undermet need in SMI, and that on a broader level, the Programme was not only delivering on its objectives but also demonstrating the potential of more collaborative and integrated working across health, care and other services.

The achievements to date were ascribed to;

1. the widespread recognition of a problem with current mental health provision,
2. the focus afforded by a dedicated Programme,
3. the strength of the core Programme team and clinical leads,
4. the composition and quality of the strategic leadership and programme management,
5. the openness and commitment to learning through the Programme.

Three key issues were identified in the Cycle 1 Lessons Learned report.

1. Undermet need and implications for workload management

It was noted that the size and nature of undermet need was unclear until the service was set up. While it was understood that there was a high level of need, many felt it was found to be greater and more complex than anticipated. This presented an immediate challenge of large caseloads and a need to decide how to allocate work fairly between different frontline staff. This generated reflections on the nature of service that could be offered at scale after a wider rollout.

2. Differences between partners and other stakeholders

Differences were noted between the different partners in the Programme, in particular between primary and secondary care, between NHS and non-NHS providers, and between public sector providers and VCSE providers. These differences were cultural but also institutional and built into working practices (IT systems, salary, etc). These differences were sometimes obscured by good working relationships within the Programme, and there was a need to surface and address these issues in order to ensure effective and coordinated delivery.

3. Networking and engagement with wider system

Some interviewees raised the question of the visibility of the Programme at a strategic level, particularly outside primary care i.e. in the City Council and within Sheffield Health and Social Care NHS Foundation Trust, and also within the emergent Integrated Care System for South Yorkshire and Bassetlaw.

Engagement with these organisations would be essential if the Programme were to form a part of the strategy for mental health at a city and regional level, which would require understanding the priorities, pressures and strategies of each organisation and a concerted effort to communicate with each about the Programme.

These findings were presented in a report to the Programme Committee in September 2021.



Evaluation Findings

D. Evaluation Findings

The findings below are organised around 5 sections: Context, Achievements, Challenges and Barriers, Enablers, and Roll-out and Sustainability. Each section is then structured around a number of subthemes.

1. Contextual Factors

a. Undermet need

Throughout the interviews and group interviews, when discussing the Programme and its goals, the dominant sentiment was surprise at the volume of demand which was not being addressed by either specialist secondary care or through IAPT, and the complexity of needs encountered exemplified by the following quotes;

I think the programme has demonstrated the amount of need and the unmet need that was there, a lot more complexity, I think, than what was ever imagined (P14, team lead)

Just the vast quantity of people with kind of mental health issues that have been bounced around services and not really settled anywhere because don't quite fit the criteria for IAPT or secondary care... but have quite significant mental health difficulties that's really impacting functioning (P13, team lead)

Many suggested greater resource was needed to address this demand;

The sheer volume of people that we have cared for and are caring for, it is overwhelming and it's too much and we need more staffing, there's no two ways about it. (MHPGI)

For others, however, the range and complexity of mental health needs provoked a more challenging question, demanding a greater understanding of the nature of mental health need;

Oh, my god, we've got more resource! It's great that this is here, it's great that this resource is here, but "what would be enough?" I guess is the question, because we still don't, genuinely don't understand the need. (P12, team lead)

Some felt that they were seeking to support people with needs which were too complex for primary care;

The intention of the service and what we're actually working with and doing and delivering are poles apart. We're working with patients with a level of complexity that sits them within secondary care (MHPGI)

But others felt that while needs were often complex, most cases were not too complex to receive support in primary care;

People would need so much support in order to go through therapy because their lives aren't stable enough that it's just unachievable for patients, whereas actually what's happening is people are learning to live. A lot of it is past abuse, childhood trauma is key, living in poverty, criminology, drug and alcohol use, it's a lot of early parental death. You know, these are not issues that therapy is going to take away, these are issues that are lifelong that you live with, which is where social prescribing and having community and context and understanding flare-ups in sadness and low mood is really key (P02, GP)

More broadly, the challenge of introducing new arrangements for the provision of mental health care was described succinctly by one interviewee as "like trying to knit a jumper whilst you're wearing it" (KI16, SHSC). Doing so at a time of intense and unremitting demand was seen as extremely challenging;

How do you continue to think about service development integration when you've got huge waiting lists? So you're having to deal with the past as well as the future. (KI20, SHSC)

b. Service issues and institutional differences

There was a general perception among staff that the provision of health and care services across the city was “disjointed” (CAP2GI) or “fragmented” (PsychGI). This perception was echoed by service users, one of whom described her experience of mental services prior to the programme as “spotty” (SU03). While it was recognised that this was not specific to Sheffield or to mental health services, some felt this particularly affected the relationship between primary and secondary care;

Historically there’s very much been a ‘them and us’ sort of primary care and secondary care feeling - not, you know, no blame on either side, but I think part of that is just to do with the way things have been contracted and commissioned, because... the way contracting works is it creates silos (KI16, SHSC)

Some however perceived a gradual improvement as different parts of the health and care sector shifted to a greater recognition of collective responsibility;

It’s getting there. It’s been really frustrating, but it feels like finally there’s starting to become a realisation that, oh, this is about a system, it’s not about the “them and us”. (KI16, SHSC)

It was emphasised that patients were not interested in the reasons for this fragmentation, but simply wanted cohesive care, support and treatment at the point of delivery;

There just needs to be more cohesion. As far as the patients are concerned, we’re a mental health service. They don’t care if we’re primary or secondary care, they’ve got a need that needs to be satisfied. And pressure of caseloads and things like that is not an excuse not to give somebody care. (MHPGI)

The most palpable example of this kind of disconnect or tension between primary care and other mental health services related to the process by which service users were referred either to IAPT or to specialist support from the Health and Social Care Trust. Both were seen to maintain strict criteria for acceptance of referrals, perceived by some both within SHSC and outside as being a form of demand management;

Systems that were set in place which really worked because systems are overwhelmed, to keep people out rather than have people in. Because if you’ve got a waiting list of 200 people, everyone’s very besieged and so almost unconsciously, you’re working to try and manage the flow rather than

hear the desperation. Because the system can’t function to work with desperation anymore (KI20, SHSC)

They’re not saying no because there aren’t needs. They’re saying no because they’ve got a thousand people on a waiting list for EWS and it’s now 12 months for a routine assessment with SPA. It’s not the right reasons to be saying no. (P11, team lead)

While thresholds and referral criteria clearly play an important role in ensuring that people receive appropriate care, there was a more general sense of frustration with this process, and this exacerbated divisions and tensions between primary and secondary care. Service users we interviewed also reported their frustrations with the services previously available, describing waiting times for appointments and their struggles with the time-limited nature of the services, offering a limited number of sessions. Our interviewees said that the service they were referred to previously often did not meet their needs, and some had experiences that they felt worsened their mental health. This resulted in a reluctance to seek help when needed: as one explained, “I’d lost all faith in services” (SU09). Patients’ past experiences with mental health services impacted their response to the programme. While for some, the programme represented a continuation of good care, for others, they entered into the programme with low expectations. For those whose experiences in the programme had been positive, there was a fear that this care could come to an end before they were ready:

I’m always [thinking because of] previous experiences with others that I’m not... I’m going to be left with nothing (SU07)

This system-wide pressure was aggravated at SHSC by a number of challenges faced by SHSC. This included bedding-in a recent significant restructuring and an extensive “Back to Good” programme in response to a 2020 Care Quality Commission (CQC) rating of some of SHSC’s core services as Inadequate, as well as the mental health and workforce impact of COVID 19. .

There was wide recognition that the challenges faced in recent years placed even greater pressure on operations and had potential implications for capacity to engage in the Programme;

I think (the CQC rating) increases the sense of threat for staff, and anxiety, at a time where you’re trying to do this organisational change (...) That really does impact on how willing people are to take the risk to do something different. (KI19, SHSC)

It was felt by some that engagement may be happening within SHSC at executive level but not at managerial or clinical teams;

The exec team within SHSC (...) they get it, but it's that middle management, and then the clinical teams, that it's not, it's not being fed down through, and they're the ones that are in charge of the recommendations for change and a new service model. (KI16, SHSC)

Nonetheless, most of the senior leadership across different organisations were clear that a systems view was vital, and the Programme could not be seen in isolation as the new Community Mental Health Framework implied change for all parts of mental health provision in the city and region;

For us it is about a system approach, a warm handover as opposed to 'this is our service in isolation, this is your service, and here is how they pass through that gate'. So it is quite challenging having those conversations, and especially within those three services that I mentioned (...) they are reviewing their service models currently, so they are also in a period of change and flux (KI16, SHSC)

c. Variation between sites

As noted above, the four sites selected for the Programme were chosen on the basis of health inequalities and population diversity. The rationale was agreed across system partners in line with the expectation of a PCN based service described in the Framework. However, key differences were noted between each Primary Care Network in terms of local population, profile of mental health need, and infrastructure, including GP and VCSE provision, which will be discussed below.

Demographic differences and varying inequalities between local populations were widely discussed, primarily relating to age, social class and ethnicity. While three of the PCNs primarily served deprived communities, one (**PCN1**) focused largely (but not exclusively) upon students, who were significantly younger and generally not from deprived backgrounds. For many in **PCN1** this was the first experience with adult mental health services, although some had experience of CAMHS in other areas.

Differences also were observed between the other networks. **PCN2** was described as very ethnically diverse with multiple separate communities, a large number of non-English speakers and a significant community of asylum seekers. PCN3 and PCN4 were described by interviewees as far less

ethnically diverse, with high levels of deprivation and unemployment, in particular PCN3 where most of the area was in the most deprived decile of population in the 2019 Index of Multiple Deprivation (IMD2019).

Interviewees explained in detail the ways in which the composition of the local population, culturally and demographically, informed the profile of mental health need in each network.

PCN1: We actually see a lot of students coming through who perhaps have perhaps neurodivergence, So, they kind of also tend to have diagnoses of autism and ADHD

PCN1: I would say the majority of the people that we see in **PCN1** as well tend to be people from the LGBT community who are perhaps struggling with their identity.

PCN2: It has got the highest rate of severe mental illness in the city. There's a lot of trauma, you know. We've got a lot of people who've come from various other countries and, you know, lots of history of war and persecution and torture and that sort of thing in the area. And even those who haven't, there's a lot of childhood trauma

PCN3/PCN4: (compared to **PCN2**): My area is predominantly white but also the issues might be different as well, like drug and alcohol issues.

PCN4: It's a kind of white working class with quite a bit of deprivation, unemployment and mental health issues that often attach to that group of patients.

The precise demographics of the various communities, and associated presentation of mental health problems, has implications for the kinds of services which can or should be provided in each area. So cultural issues or differences may affect uptake of certain services, for instance, or limit the impact of particular offerings;

A lot of cultural differences in the area as well, which mean that it can sometimes be quite hard to link people in with activity in their local area. We often hear from people that they don't want to go to a specific group or activity where mental health may be mentioned. (P15, team lead)

There wasn't a community to connect people to (...) especially for the demographic that I have which is young white men who don't want to be part of a yoga class or a knitting group (CCGI)

This cultural and demographic diversity then presents particular and distinctive challenges to the staff working in each area, but also underlines the value of network or neighbourhood services;

And yeah, I think it's also having the time to learn about all of those different presentations and what the evidence base would be for all of those. So I think it kind of comes back down to time and training as well. (...) the evidence base that we don't necessarily have for certain groups of people (...) like X mentioned earlier about the Roma Slovak community, we're kind of trying to learn what works, but we're not really sure yet. (PsychGI)

Finally, it was noted that the sites may have very different degrees of engagement with VCSE organisations. At one end of the spectrum, staff in both primary care and VCSE in PCN2 described a strong relationship between general practice and a local voluntary organisation. The VCSE were valued in part because they had an understanding of the local needs of the communities they worked with;

There's quite strong community sector partners in PCN2. So, we've got [names local voluntary organisations] and, you know, so a lot of those groups which are great and really important to the community. So, so it's been really important to us to use those. (GP)

Some interviewees explained that the approach adopted by the Programme to directly fund VCSE staff, in the form of community connectors, was vital to move beyond arms-length referrals to VCSE toward a more equal partnership and integration of VCSE into health and care;

What we've done is we've developed a model over time that's changed, that's predicated around the GP surgeries in PCN2. And that's about building relationships and it's about increasing referrals. And then when the new contracts came in and they could fund workers themselves, that's when it went from a relationship about communication and just referrals, to actually contractual relationship. So that's why we're much more embedded, and that's why this transformation programme is a big deal for us, because it's integrated working. (VCSE)

In contrast, other areas were perceived as having limited VCSE provision which in turn limited the kind of contribution that Community Connectors could make to the Programme;

There's not an awful lot of voluntary sector or other activity in that area... so I think it has been quite challenging for some of those clients to really know what there is to engage with. (P15, team lead)

d. Impact of COVID

Interviewees described a range of challenges caused by the COVID-19 pandemic, both directly and indirectly. An immediate difficulty was presented as the pandemic hit while the Programme was in the midst of recruiting staff and engaging with local partners, which impacted on the recruitment process;

COVID slightly scuppered the implementation. (...) So the intention had always been to start hitting the ground running with all the staff. (...) we'd managed to appoint four mental health practitioners before COVID, but COVID stopped anything else (...) We started off with mental health practitioners and some psychology support, but certainly not the whole full gamut of what we'd hoped. (P01, GP)

Similarly, the challenges of lockdown, social distancing and the pressure on general practices meant that it was particularly challenging to engage with GP practices;

I think we would've been more integrated in GP practices if it weren't for COVID (PsychGI)

I don't really have that much of a relationship with the GPs themselves. And that is an issue I think generally. But also, I totally respect that, you know, we approached this programme in the middle of a pandemic and the GPs are ridiculously busy (CCGI)

The pandemic had also impacted on related activities across the NHS, such as team building and training, in terms of availability or a need to use alternative modes of delivery;

I think that a lot of the NHS teams, not just my organisation but more broadly, have been starved of training and input over the last two years while we've been working with COVID. (KI19, SHSC)

We did a lot of training and obviously with COVID and stuff, a lot of it was remote (HCGI)

How care was delivered was directly impacted, as face-to-face activities such as assessments or consultations were shifted to telephone or conducted online.

The idea was that we'd be integrating into community hubs, bases, venues. COVID then threw a big spanner in those works I believe, because of social distancing, venues closed (P14, team lead)

Some service users preferred to wait until it was possible to meet face-to-face, and the mode of delivery had implications for the quality of care which could be provided;

You definitely miss a lot of things on the phone, but I think that goes wider than even just our service. I saw a patient last week face-to-face and definitely it's much easier to build that rapport and you're just...that's how you would normally assess a patient, quite holistically... from what they're saying, but also there's a lot of non-verbal stuff that you would pick up, even if it's just how someone dresses or how they...even how they smell (...) I know that may sound a little bit...But you might smell that somebody smells of alcohol or cannabis, for example, and it's all forming sort of part of your assessment (P13, team lead)

Some roles which were more reliant on face-to-face interaction were particularly affected, although some staff pointed to some positives in the shift to telephone consultations, in terms of accessibility and staff efficiency;

With COVID I think it's forced us as therapists to be more flexible in what we offer. And obviously there's still things that govern that, but certainly there's people that I've done initial appointments via telephone, which is not anything I would ever do before, and for some people that has been the difference, I believe, almost in them engaging. (...) So I think that's been a real success, I think it has made us a lot more accessible. (PsychGI)

I can certainly do more, my time's more efficient, yeah, I can't imagine what it would be like now face-to-face and how I'd deal with being in 22 GP practices. (P13, team lead)

Other staff were less affected by this; for example, some VCSE providers had already established workarounds to keep in touch with their clients under social distancing;

At my organisation even for the first lockdown we were seamless. We carried on keeping in touch, doing online meetings with staff and with some clients, doing doorstep chats, doing walk and talks, so with all of our clients (P10, VCSE)

The work of the community connectors was particularly affected. As their focus was on linking people with community activities, the cancellation of such activities during lockdowns or groups moving online-only due to social distancing restrictions severely curtailed options;

The biggest challenge with the Connector service is the fact that we've not been able to properly test the service because of COVID. So, the service started beginning of October last year, but I would say it's only really been in these last few months that the team have been able to kind of sort of do their roles in earnest (P15, team lead)

In practice, this led to many community connectors working instead in support worker/peer support functions, in an attempt to offer some service to their clients;

One of the difficulties that we found was that the connectors fell slightly more into a support worker role instead where...you know, so we were seeing a lot of people that needed support with benefits and housing and financial situation sometimes because of the impact of COVID on their work and life. So, I think they fell slightly more into that role where they were kind of supporting people around filling in those applications and that side of things (P15, team lead)

An unintended consequence of this, one team lead argued, was to identify a pressing need for advocacy-based support among the people the Programme was helping;

I think it has highlighted that there is a massive need in terms of that more advocacy-based support role for people. It's not really part of the connectors role to be doing those applications. I know a lot of the nurses in the team find themselves doing those kinds of things as well because there genuinely isn't anyone else to do it (team lead)

Fundamentally, though, this has limited the opportunity for learning about the community connectors through practical experience;

Our biggest difficulty has just been COVID and we've not been able to test how this is going to work in a non-COVID world. So, we don't yet know kind of what those other difficulties we might face will be (P15, team lead)

In a more general sense, the pandemic represents a complicating factor when seeking to identify lessons from the early implementation, which left some interviewees noting that it would be difficult to neatly establish the impact of the Programme due to the timing of its implementation;

It's so tricky to know what COVID has complicated and what would have been tricky even if it wasn't COVID (P12, team lead)

I guess, again, the pandemic impact, it's difficult to pull out what's positively and negatively impacting on that, kind of, referral rate. (KI15, CCG)

Summary: Contextual Factors

- We found a widespread perception that there was a high level of undermet mental health need in all four sites, from both the professional and service user perspective.
- This degree of need provided strong motivation for the kind of provision offered by the Programme, but gauging and responding to this demand resulted in significant pressure on the Programme.
- This pressure was also experienced by the local mental health Trust, and over time these system pressures had led to tensions between primary and secondary care.
- In this context, the prioritisation of PCNs with the highest mental health need by the Programme was logical.
- Interviewees also emphasised the significant variation between the sites in terms of demographics, resulting in different profiles of mental health need in each PCN, and noted that sites also varied in terms of the strength of engagement with VCSE organisations.
- The COVID-19 pandemic had a significant impact at the start of the Programme and throughout on the design, management, and delivery of care through the Programme.

2. Achievements

a. Good patient care

There was a powerful sense across all groups involved in the Programme, and particularly among those in patient-facing roles, that they were making a real difference to those receiving care. This generated a very strong sense of pride in the achievements of the Programme:

I think we're making a massive difference and I feel very proud to work for the service (CAP1GI)

I can honestly say, I don't think I've ever been in a qualified nurse role where I've felt like I've had such an impact on people's lives and actually felt, like, wanted as a nurse. (MHPGI)

This was on the whole reflected in the service user interviews. Out of 10 patients interviewed, only 1 described a bad experience, and for 7 of the 9 service users describing good and integrated care, this was in contrast to their previous experiences within mental health services. However, this should be understood in the context that those with positive experiences may have been more likely to be willing to be interviewed.

Those who described good experiences had received support from a range of staff disciplines, including from the VCSE sector, and described these in very positive terms such as “really good” (SU06) and “they couldn't have done any more” (SU05). They described being treated with dignity and respect;

I've never been treated so good (SU09).

For such patients the impact of the programme was transformational. They described lives that had been completely changed, and futures that looked much more hopeful:

It's made such a difference in my life (SU09)

One patient used the analogy of being in a darkened room, and the MHP drawing back the curtain to let in the light: “they really have completely changed my perspective of life” (SU03).

These views expressed by the patients support the views of those delivering care, that good care had been provided and for several that their experience of mental health care was different and better through the Programme. They particularly valued the flexibility and responsiveness of staff, as discussed in Findings: 4a below).

Exploring the reasons for this sense of achievement, for some this reflects the sense of offering care where it was not available before;

I think every single patient we've seen is an achievement because that person may have just been sat not having any service. (CAP1GI)

Specifically, several described having overcome deep scepticism among people who had lost faith in the health and care system;

I've built up some really good relationships with people that have really struggled with mental health services previously that are now... you know, the anecdotal evidence I'm getting from them is that their perception has changed now that they're able to access mental health care at a GP practice. (MHPGI)

To support this, various interviewees attested to positive feedback received directly from service users, which they linked to the specific approach adopted within the Programme.

And I just think that the way that we approach people and the culture that we've adopted within, especially the psychology part of the team, that's something that my clients have commented on to me and says that "I've been through CAMHS, I've talked to my GP of them, this and that, but this is the first time that I've really felt a service has properly listened to what I want and what I need". (CAP1GI)

b. Understanding and addressing undermet need

Given the size, complexity and unquantified level of undermet mental health need (discussed in **Findings: 1a** above), even before the impact of COVID, a key achievement for many was the progress made in identifying and better understanding this need.

What I think the primary care transformation group have picked up has been unmet need, or where people are falling through the gaps and they just think 'oh, had enough of SHSC, they can't provide for me, they're not giving me what I need', so people have been circling around primary care that have got a serious mental illness (KI19, SHSC)

Many involved in the programme felt they were addressing a marginalised and often invisible community;

Patients who really are marginalised, and for years with every (service) reconfiguration in Sheffield have just been further marginalised, you know, the people who are not mentally ill enough for SHSC. (MHPGI)

Several argued that the effectiveness in reaching this community could be explained by the location of care within general practice,

What we've done is tapped into huge amounts of need that would never have breached the doors of mental health services, but because we're in GP practices, and because people trust their GPs and they're used to going there for any sort of health need, and GPs have said, "well do you know, actually, we do have someone that you can probably talk to about that now", whereas before they might have said, "oh, no, I'm not going to the City Centre or whatever, I'm not seeing strangers who are going to ask me loads of questions", is we've tapped into a huge amount of unmet need in people who probably were really, really struggling, and who just never shouted up. (P11, team lead)

However, some felt the Programme had gone further and was reaching people in need who were alienated from the GP practices also;

A lot of patients that we've seen, they don't come into GPs, they won't ring the GP, they won't come in if they need to. (HCGI)

Many pointed to the flexibility and proactivity of the service to explain this success;

People are saying there are certain groups of people who have been quite difficult to engage that we're able to work with a little bit differently, so maybe we've got better engagement from some groups of people. (CAP2GI)

This was supported by the service users interviewed, who described a wide variety of support provided, which had enabled service users to engage in ways that were sustainable for them. For example, SU03 went on local walks with her MHP, until she felt able to engage outside of her own locality:

I met up with him a few times and we'd just walk in the local area so I was getting used to going out (SU03).

The issue of flexibility will be examined in more detail in **Findings 4 (Enablers)**.

The consequence of this approach, however, is that it is likely to identify a large amount of need previously unrecognised by NHS services, much of this at an early stage when people with mental health problems may not yet have been seen by mental health services. The management of demand for early intervention then generates its own difficulties, a point explored below under **Findings 3 (Challenges and Barriers)**.

c. Local responsiveness and under-served communities

As noted above (**Findings: 1c**), there are significant differences between the four sites, resulting in different profiles of mental health need which require different resources, as “one shoe doesn’t fit all” (P14, team lead). Another interviewee expanded on this;

The good thing about working locally is, you obviously can focus on the particular concerns in each area, can’t you, (...) and, hopefully, the team that can be built around that can be tailored to that need. (MHPGI)

Thus for many, a key achievement lay in the capacity of the Programme to be flexible, develop local understandings and adapt care to fit local needs;

We’ve managed to reach those pockets, and I guess that some of that is the point of this isn’t it, is bringing care into people’s communities, rather than expecting people to travel to points of care (P11, team lead)

In particular, the uptake of care through the Programme among minority ethnic groups was seen to be significantly higher;

In our area there’s quite a dramatic increase in the percentage of people from non-white British backgrounds who are now accessing mental health support (MHPGI)

The explanation for this, for several interviewees, was the localism of provision. Key to this was the positioning of services within local communities, reflecting the practical and personal barriers many people may face to travelling to central services;

The nature of our location is that accessing city-wide services is difficult for patients actually, some of them never go anywhere, very limited. (...) it’s costly to travel, isn’t it, their IT access isn’t brilliant, (they are) really reliant on local services. (P2, GP)

The majority of people (are) on benefits, so there is a financial element as well. So not many people can afford to go somewhere outside the local area to access services because of the bus fare and all these things. (CCGI)

The provision of care through GP practices was also highlighted as

There is still a lot of stigma around mental health, particularly in certain cultures and certain areas of the city, so in a sense (people) may be happy to come into a GP practice because it’s just a GP practice rather than (...) a primary care mental health base that they’re going into (P13, team lead)

Moreover, the strong links to local primary care, as well as to VCSE providers with their community connections, was seen to play a key role in enhancing provision to people from minority ethnic backgrounds;

There’s a greater proportion of people from BAME backgrounds who are coming through the primary care transformation. I think it’s because they’re out there, they’re connected with primary care, they’re linked properly with local communities. (KI19, SHSC)

The specific factors which supported this will be examined in more detail below under **Findings: 4a below**.

d. Addressing GP needs or pressures

As noted above (**Findings: 1b**), current system challenges resulted in a situation where many GPs did not have confidence that traditional MH referrals to secondary care or to IAPT would be successful. This led to a reluctance to refer many serious cases, despite lack of expertise or resources to deal with SMI in general practice;

I wonder whether there is an element of our referral patterns having shifted to, because of the kind of lack of ability to get people into secondary care services. My understanding before we started was that 50 per cent of referrals to secondary care were rejected from SHSC. So, you know, once you’ve had that for a little while you sort of stop trying unless there’s very extreme need. (P01, GP)

All of the GPs interviewed therefore described the value of a referral route which could break this cycle;

One person in particular, a patient who I had regular contact with... (with) very difficult consultations. I was struggling to help him really and at the end of each consultation, it was very prolonged and I felt we’d not really got anywhere. So, for a GP, that workload has been taken off me (...) And it looks like they’ve been making progress with him, which has saved me a lot of time and energy when I didn’t really feel I was making any improvement to his mental health anyway. (P03, GP)

For the past 18 months, we haven't referred any patients directly into SPA, even though a lot of them have got significant mental health problems, the first port of call would be through to the (Programme) (...) I guess, that does mean we're managing more in primary care, aren't we? (P04, GP)

Many members of the Programme Team mentioned experiencing very positive feedback from GPs and practice managers on their contribution, both in providing care directly with patients and indirectly as an informal source of advice on diagnosis or medication;

GPs will grab me, knock on the door, I've just seen this person, what do you think? And it can be a ten-minute conversation, like 'right, blah, blah, blah, that sounds like IAPT, try them with IAPT, if IAPT say no for whatever reason, come back to me'. And that would have saved a referral to SPA, Lord knows how many weeks or months waiting for SPA to say no (P11, team lead)

The last two quotes indicate a potential impact on secondary and specialist health services as referrals are redirected from SPA to Programme teams and inappropriate referrals are prevented.

Several noted with pride that the team had been nominated by local GPs for a British Medical Journal award. It was noted how unusual it was for a new initiative to receive such widespread support given pressures and tensions in the system;

I think SHSC have been tarred with a brush of 'well as soon as you try and get to mental health it's just a nightmare, you can't get any patients anywhere, they just bounce through the system'. You know, we try and send them to IAPT and they say "well they drink two drinks a night so therefore they're an alcoholic, they don't fit in IAPT" so they bounce them back. So for this service as a mental health service with SHSC involved to be seen in such a positive manner I think is a huge achievement for them. (KI18, PCS)

e. Interdisciplinary or interorganisational working

Supporting all of these achievements was a general sense that the Programme had been successful at breaking down boundaries. Given concerns about the fragmented state of care (Findings: 1b above), it was notable that the majority of interviewees spoke of the progress made in building strong relationships between different roles and role holders across the Programme.

For example, the Mental Health Practitioners described in some detail the range of close relationships they maintained with other members of the team;

Ad hoc supervision with psychologists, they're part of our fortnightly MDTs. We have really close relationships, they'll text, they'll ring us if they need a bit of advice about a situation that feels too complex for them. We have tasked our community connectors with attending the local social prescribing monthly meeting, which I started attending when we started but, obviously, sharing and delegating, that went to the community connectors. So yeah, there's a lot of work that goes on, kind of, direct joint work, indirect supervision, talking through different cases and the more, kind of, direct attending groups and referring people into those services, and it goes both ways. So yeah, quite a lot of joined up work, which is good, it's great. (MHPGI)

Similarly, the psychologist and psychotherapists discussed a "unique relationship" they were building with the voluntary sector, as well as much stronger direct relationships with GPs than experienced in secondary care, with one participant stating;

Rather than it just being tokenism, it's actively very robust in terms of actually wraparound care and kind of making sure that it's very integrated. (PsychGI)

These sentiments were echoed across most of the professional groups involved in the Programme, with the community connectors being the key exception (discussed in 3: Challenges and Barriers below). One of the CAPs stressed the range of connections and the philosophy of care this engendered;

There's nobody I haven't worked with jointly within PCN3. I've done a piece of work jointly with everyone. And I think I get it now; that's the stuff around scaffolding: if there's something I can't provide, if I can't provide it, they're going to drop out, but then another professional will step in simultaneously and do a joint piece of work. (CAP2GI)

In term of process, one GP underlined the importance of the multidisciplinary team meetings (MDTs) in forging and supporting this interdisciplinary and collaborative approach, with benefits for staff as well as patients;

The regular meeting at the MDT and again reinforcing that. And feeling like everybody involved in that discussion actually has a seat around the table and is valuable. That it isn't like a hierarchy of who's the boss who makes the decisions; it feels like actually everybody there is putting the patient at the centre. So I think that's good. Not only good, I think for the patient, but I think also good for us as team members, because it feels like the sole responsibility for decision making doesn't stay or rest with one person in terms of risk and things (P05, GP)

One MHP differentiated, however, between sites where there was genuine collaborative work with GPs and others where there was a more distant process by which patients are referred on by GPs;

Where they've got the Programme Teams, I think GPs feel like they've made a referral into that team, and they step back, and the GPs don't have much accountability for that patient's care anymore, and they, for them, feel like they've handed it over whereas for me (...), really embedded into that network, there isn't that sense, GPs won't just say, "oh it's up to you now to sort all this out". They're asking me for an assessment or, and a bit of an opinion, to triage something, and so it's a shared accountability where we were individual practitioners, and it doesn't happen in the other networks (P11, team lead)

Many also spoke positively of experiences of successful collaboration across organisational boundaries in different parts of the sector, including local voluntary organisations and other parts of local government;

Relationship building, I'm very proud of the... you know, we put a lot of effort into forging and maintaining the complex relationships with the PCN, the wider VCSE sector. (MHPGI)

I volunteered to be the bridging person between an employment service and our service. And that might mean things like sharing statistical information, number of referrals, frequency of dropouts with each other. (CAP2GI)

Experiences of this approach led some to describe this collaborative provision as central to mental health services in the future, with the involvement of VCSE organisations critical;

I think that is the future in terms of working with secondary mental health services, by the way, having those kinds of meetings and having a shared understanding. (MHPGI)

The voluntary sector organisations that we work with have worked in the public health realm, that's what they do, working with local communities and inequalities around health and wellbeing. So, they are experts in that field and in their community. So, if we want to have a community-based programme, there's just no way that we can do that without them. (P15, team lead)

Summary: Achievements

- We found widespread and deep pride in the achievements of the Programme across all staff involved in delivery, reflecting a strong conviction that the Programme had extended the reach of mental health services and had a palpable impact.
- Many felt that the success in helping underserved groups was facilitated by the flexible approaches adopted through the Programme, a view echoed by the majority of services users interviewed who particularly valued the flexibility and responsiveness in the care they received.
- Furthermore, Programme staff and GPs described in detail how the service had provided valuable support to GPs, directly and indirectly.
- The Programme also described success in building strong collaborative bonds across professional and organisational boundaries, although this appeared to vary somewhat between the sites.

3. Challenges and Barriers

a. Divergent Understandings of the Mission and Scope of the Programme

Given the novelty of the Programme and the dispersed partners involved, it is perhaps to be anticipated that there may be differing or even contradictory conceptions of what the Programme was intended to be and what it aimed to achieve. As one team lead explained;

I hold my hands up, it could be totally me that sort of misunderstood it, but I think, talking to X, she had a slightly different idea of what it would look like as well, so I don't think it is just me that's stitched the information together incorrectly, I think we've all been given slightly different versions of what was going to happen, which has just made it a really difficult thing on the ground to try and manage (P11, team lead)

At a deeper level, there were inevitably different views on what the Programme might mean;

Is this an opportunity or threat? I just see that kind of dissonance between different bits of (the partners) and how they think of it. (KI15, CCG)

The challenge presented by this ambiguity appeared to be the risk of raising expectations that could not be met. Similar terms were used by various interviewees to define the principles of the programme, described as follows by one GP;

It was supposed to be a service that (...) didn't turn anybody away and no wrong front door, you could access services and not be discharged all the time (P02, GP)

This definition is clearly broader than the remit of the Community Mental Health Framework (see **A. Background and Context**) but it was repeated sufficiently frequently in interviews to indicate it had become a widespread shorthand for the Programme in Sheffield. Several of the clinical staff noted the difficulty this posed for managing expectations;

Our criteria very much was the gap between IAPT and secondary mental health services (...) And we're never going to be able to fill that gap, so I think managing expectations (...) I feel it's really disingenuous to go in promising things that you can't deliver (P12, team lead)

The big difficulty is managing expectation and to a degree while there is no wrong door, also normalising things with GPs... I think sometimes (...) they come to us for our advice and often what they want is (for us) to take it away and solve it. And that's what we're doing and it's not our remit (...) And initially it came to the point where we suddenly became almost the de facto bin for all things mental health. (MHPGI)

It seemed some staff found it difficult to set boundaries on the scope of their work, a situation not helped by the degree of ambiguity in Programme definition. Communication difficulties between different parts of the Programme, and particularly with some general practices, meant that an operational level it was sometimes difficult to clarify what the Programme was and what it offered;

We still get the odd clinician saying, "Oh I don't really know how to refer to you, who do you work with?" We've had engagement events, we've had drop-in Q&As, we hold a regular MDT meeting... So there's lots of comms that get sent out all the time and we're actively working with hundreds of people, so I don't understand that. (MHPGI)

Certain groups described this as a much more significant barrier; the health coaches and community connectors in particular found it very difficult to secure time with practice managers or GPs to explain what they offer. While the CAPs found engagement with GPs variable, they also found it particularly challenging to explain their role and that of the Programme when interacting with secondary care. These barriers to communication are likely to have led to enduring misconceptions about the Programme.

Fundamentally, though, there was an appeal by many for greater clarity on scope and for this to be communicated clearly outside of the Programme;

What I'm asking for is to tell people what the doors are and what they aren't, what the remit is. Because if you throw the net out too far, you're going to catch too many people (CAP2GI)

b. Vertical Communication issues

In a similar vein, several team members raised questions or expressed concerns about the degree of vertical communication;

I feel like there's a bit of a disconnection between higher up managers and us on the ground clinicians. Things change and decisions are made and sometimes it feels like we're the last people to find out about that. (CAP2GI)

Several interviewees described being uncertain about the roles and responsibilities of Programme leadership;

Who are the managers, what are the job titles, what are their responsibilities? And I suppose I feel like we've still not got that, and almost like it would be easily solved but it's not really been addressed (CAP2GI)

Some recognised that this lack of clarity was linked to the fact that some key individuals left and were replaced, but nonetheless emphasised the need to clearly identify lines of communication;

I think it would be helpful if there was a clearer understanding of who is in charge or who to go to with those kinds of queries. Clinical queries, fine, but it's the system queries that seems that names have changed, somebody might be involved in that actually it's shifted to somebody else, and you never quite know about that. Which can be frustrating. (P05, GP)

While this situation is far from unique within the NHS and other large organisations, there were certain implications of this for the Programme in Sheffield, relating not only to cascading information down the chain but also to upward communication and more reciprocal engagement between staff and leadership;

We've already got some really helpful ideas around this that may actually be a better fit. So maybe, moving forwards, having more opportunity for that information sharing, bottom up, top down, I think would be really helpful. (PsychGI)

The danger of a failure to clearly consult and engage was articulated by one lead, who stressed the importance of capturing the expertise and proactive commitment of the team members;

They're a great team, they're really, really committed and enthusiastic, but they're also incredibly intelligent and knowledgeable (...) We've recruited the sort of people that aren't just going to come in, do a job and go home. They're committed to the service, to the patients, and they want to make it work, and if we don't keep them up to speed with everything that's going on, we'll lose them, and if we don't listen to them as well, we'll lose them. (KI16)

There were perceptions among some of the VCSE sector leadership of a lack of consultation in the design of the Programme, and a desire for more involvement in the operation of the service;

We've had these discussions, but nothing is ever, ever really being done about it, because they've designed it up there and they haven't worked out how it's delivered there, and it's two different things. And because they haven't communicated with us in the middle, that's why it's totally the wrong way round (P06, VCSE)

Some interviewees in general practice and commissioning suggested there was a lack of clinical input at senior levels, and perhaps unfamiliarity with the reality of the situation in general practice;

It felt like the decision makers were non-clinical and therefore, perhaps couldn't or wouldn't or it wasn't possible to understand the actual nuances of how it feels on the ground. So sometimes it felt like, and still does feel like rules are made for rules sake and it's hard to see actually how that fits into the real life dealing with people who are struggling. So it felt like decision makers were management and with less clinical input than I think perhaps would be helpful. (P05, GP)

c. Limited engagement with VCSE

Despite the achievements in establishing inter-organisational working (described in **Findings: 2e** above), some interviewees attested to ongoing challenges and problems communicating and coordinating work between different organisations, particularly relating to the degree of engagement with the VCSE providers.

This was seen to reflect the wider challenges that Third Sector providers generally face working with PCNs, with several VCSE representatives expressed frustration at the extent of engagement;

We try our best to have strategic relationships, but it is very challenging, it's like skinning an onion working with PCNs, you know, you might have a good relationship with the clinical director or management lead, or a partner GP – because the communication structures are not the best – so it's a constant struggle trying to keep them engaged, try to tell them what you're doing (P06, VCSE)

Others discussed the broader difficulty of communicating what VCSE organisations can offer to general practice;

I sat and I wrote just about everything, just bullet points, everything that they can refer into. And (the practice nurse) said “I just don’t know, I didn’t know this was happening.” And yet they’ve got posters on the wall, we’ve sent infographics out to every member of staff in the GPs surgery! (P09, VCSE)

These communication difficulties also affected the Programme despite good person-to-person relationships in many places, pointing to underlying structural issues;

I think there’s still a little bit of distance between voluntary sector and primary care... but that’s not coming from voluntary sector. Like they so desperately want to be more involved with primary care and be seen as that equal partner. But when it comes to kind of... you know, even things like data sharing and what information they’re able to access and, therefore, which meetings they’re able to sit in because we might be talking about patients (...) It is the more structural barriers that tend to be the reason for that, that disconnect between primary care and the voluntary sector in terms of what they’re able to access and feel like they’re actually able to feed into in terms of that decision making. I would say in terms of the relationships with the staff in primary care, definitely within the team we see really good relationships (P15, team lead)

A key example of such structural barriers were the contrasting policies and approaches in different areas about whether, or how, to involve VCSE organisations in multi-disciplinary team (MDT) meetings in general practice. While in some practices full involvement was routine, this was not consistently the case;

In **PCN2** (...) they have an MDT meeting, mental health. It took us ages to get a seat round that table, so the worker who leads our [social cafe] there, funded through the transformation programme (...) trying to get to that mental health network was a nightmare (...) We (VCSE) couldn’t get in to make that transformation because we couldn’t get into that MDT (VCSE)

(In **PCN3**) It’s only recently we’ve been allowed to go to the multidisciplinary meetings and we don’t understand why that wasn’t set up at the beginning of the project (...) we were queried and questioned about data protection and about sharing of information (...) which I challenged. Early days, people wouldn’t even say the first name of the person and I said, “I can’t do this”. (VCSE)

The result in practice was that some VCSE staff complained that they had received few referrals, despite appointing staff to deal with clients referred through the programme, which underlined the importance of involvement and communication to understand how VCSE could shape their offering;

I think having a better understanding of the demand, in terms of the numbers and kind of what we might expect to see in terms of the clients, you know, what kind of needs people might be coming with, or what kind of level of illness or wellness as well, if you like, and the kind of diagnoses we’ve not even got into that yet. We’re kind of just desperate for them to send us any clients and then we’ll work out what we can do with them, and if, you know, they’re in our scope even. (P09, VCSE)

Another VCSE partner felt that in part, the communication difficulties and the limits on engagement reflected the model adopted in the Programme of having one lead charity acting as a partner. This meant that communications between smaller, local VCSE providers were often indirect, as they were mediated through Sheffield Mind who had limited capacity to coordinate with multiple providers;

You are very much reliant on Sheffield Mind understanding what we do and being able to share that. And I suppose if there are challenges it’s how they are escalated (...) our usual relationships are we have funding from ‘x’ source, and we will have a direct relationship with them (P08, VCSE)

This may have reflected the pragmatic decision taken on commissioning VCSE organisations in the Programme, in view of the understanding that smaller or more organic VCSE organisations may struggle to conform with the administrative and bureaucratic demands of CCG commissioning processes;

The CCG’s way of commissioning was very much around how well an application was written rather than necessarily what the offer itself was. (...) So, we ended up offering the contracts to the bigger voluntary sector organisations in the area (...) which are great and they all do fantastic work. But it did mean that some of the smaller organisations, (...) who offer like allotment-based groups and specifically work with people with sort of mental health issues, they missed out on the funding because their bid just wasn’t quite as technical, I guess as some of the other ones. (P15, team lead)

However, several VCSE providers argued that direct representation in the governance structure at board level was important, despite the valuable system contribution of Sheffield Mind;

You want a (VCSE) provider there, not as a tokenistic, but they need a proper remit to say, from our perspective this is what's working, this isn't, this is what can change. So okay, it might be an operational input rather than a strategic input, but that operational is just as important as strategy, because how do you know it's working if you don't get a provider sat round the table? (P05, VCSE)

d. Coordination of services and staff

Co-location, estates and physical infrastructure

Many staff interviewed spoke at length about their difficulties securing space to work with patients in general practices, and the broader challenges and sense of isolation created by the lack of a base or a shared hub. Clearly lockdowns, social distancing and the use of GP premises to deliver the vaccination programme affected the availability of space for the Programme. While staff noted the impact of COVID, the persistence of this issue caused great frustration for all staff, but perhaps most acutely among the psychology team and the CAPs.

Going back to the (physical) base thing, you know, I've never felt so isolated in a job I don't think. And also, I've never worked with such complexity and trauma. So that kind of worries me when you have those two things together (PsychGI)

I think we might need to get some tents and just take them with us (MHPGI)

While space was made available to staff struggling to work from home in response to this concern, staff felt that the issue of estates provision, compounding long-term lack of investment in primary care estates, had a profound impact on staff wellbeing as well as on the service they could provide.

On a practical level, staff discussed the challenges of lacking dedicated space: the time taken to negotiate a room to see a patient or for a meeting, describing experiences of working on laptops in GP waiting rooms, the reluctance of some practice staff to allow access to printers and basic stationery. Others described the difficulty of conducting challenging consultations online and on occasion not seeing patients because space could not be found.

We're all over the place trying to run around and sort the bits out. Then we might say to an admin and a GP, can you just print me this letter out, I've put it on the system, and they look at you as if you're an alien in the building that, why would I do that for you? (P14, team lead)

This impacted on patients, as seen in our service user interviews. One patient described how he received letters for appointments after they had happened, resulting in him being discharged from the service for non-attendance. Despite being happy with the service she received overall, when asked how the service could be improved SU07 mentioned: "the whole part of being able to probably maybe contact them a lot more easier" (SU07). While staff described their efforts to protect service users from the organisational challenges of the programme, the service user we interviewed who had a negative experience of the programme saw his experience as a result of organisational problems, seeing the programme as having "no backbone, no organisation or joined up thinking" (SU02).

Beyond this general frustration and the inefficiency caused, this situation was also experienced as demeaning to many staff, underlining a sense of separation from "proper" primary care and reinforcing an outsider status, perhaps implying a broader lack of esteem;

It's a visual representation of how mental health is the poorer cousin of physical health because I've got like the broom cupboard (MHPGI)

More fundamentally, staff discussed the sense of intrusion caused when they were required to work from their own home conducting virtual consultations with patients;

I can't really speak about this in any more clear terms, but it's really difficult having stories about abuse in your house. The worst things that people can do to each other, to their kids. (KI20, SHSC)

The main thing is psychological safety for staff, so being able to separate the level of trauma and the complexity of the work that we do from your own home, or even doing that alone in a GP practice. You know, this kind of work isn't designed for us to just do and then be left with on our own. (PsychGI)

The strength of feeling about estates provision is partly explained by this sense of intrusion and the need to separate challenging therapeutic work from home life, to protect personal well-being.

This also related to the collegial support within teams, both at an emotional level and in sharing knowledge, insight and good practice between new staff, some still in training, in what were often new roles in an emergent service. The lack of a common hub, or else co-location with other parts of the healthcare system, was seen to have impeded this collegial support and the generation of a shared understanding and set of practices. This has implications not only for staff wellbeing and system functionality, but also the critical issue of recruitment and retention;

People have said to me quite openly, if I'd have known that we weren't going to have a base then I wouldn't have come for the job. (P12, team lead)
It's really made me very seriously think about getting another job, because it's made me realise how much I value colleagues around me when I'm doing the heaviness of the work that we're doing at the moment, which we just don't have. (PsychGI)

Interviewees emphasised that location was critical, as the Programme delivery needed meeting or consultation space to be locally situated and thus accessible to service users;

It's not that we're trying to put someone on a desk for five days a week, it's not that, but it is something about we do need some clinical rooms because there are some people that need to be seen face to face. And if we start making them move across the city, then actually we're not centring around the PCN and we're breaking away from what we actually wanted to do in the first place (KI18, PCS).

Some felt this to be an intractable, nationwide issue and expressed pessimism that this could ever be resolved. Others offered potential solutions, including a consideration of greater use of VCSE premises, or exploring the possibility of working with other public services and city council property.

Organisational infrastructure

A related issue raised across different groups was the lack of infrastructure in the early stages of the Programme, in terms of staffing for operational and clinical management as well as a lack of established processes and standard operating procedures.

Putting clinicians on their own into networks without an MDT around them is pretty, well, risky on lots of different levels and I don't think it's particularly fair. (PsychGI)

The pressure resulting from the COVID pandemic, discussed in **section A: Background and Context** and in **Findings: 1d**, clearly affected the set-up significantly. Some interviewees also felt this reflected the early priority given to appointing clinical roles to deliver the service;

The focus, rightly, had been clinical practitioners. The difficulty with that is there was nobody doing anything on the operational side, so there was no one sorting out where they sat, there was no one sorting out how they'd get their IT, the processes behind all that; because it's not a clinician's forte (KI18, PCS)

...you've got strategy is good, the operational is good (but) that sponge and that jam in the middle of that cake, which is your middle management, it's not existing really (P06, VCSE)

Most staff groups recognised that this had been gradually addressed through the appointment of staff to operational management and administrative roles, and the development of procedures and responsibilities, such as the identification of a duty on-call manager, or a number for patients to use to cancel appointments.

I think the passing of time rectified a lot of things really, and things were changed along the way and little iterative changes were made. And uncertainty I think, is to be expected in a new service. (CAP1GI)

In the early stages, however, this gap generated practical difficulties for each professional group. The newer roles, such as the health coaches and CAPs, described delays taking up duties, for instance as staff waited for Hepatitis B vaccinations, or due to more general uncertainty;

I think having ten new trainees is all like "what are we doing?" was very confusing for all of us but also, I think our supervisors and things realised that there was less clarity than they maybe thought (CAP1GI)

Other groups suggested that, while some degree of space was beneficial in allowing professionals to define their own roles (see Findings: 4a), a vacuum could also create tensions and negative behaviours;

Because we went in and hit the ground running before structures were set up, it's left individual clinicians to argue "what should we be doing?" And that could be a beautiful discussion where people come together and two minds meet, or it can be bullying. (PsychGI)

Systems and process barriers

Many staff raised issues around the flow of patients into and through the mental health system as a whole, in particular with referrals to and from IAPT and SPA, reflecting a recognition that the Programme formed part of a larger, complex system of care, support and treatment. Reflecting the divergent views of the Programme (see Findings: 3a) it was noted that even terms such as "referral", which were taken-for-granted in secondary care, may need to be challenged through the Programme;

It's really difficult, because we're kind of trying to change a whole system and culture through one service (KI16, SHSC)

Therefore addressing the challenge of appropriate referrals to the Programme implied also considering impacts on referrals to IAPT and to secondary and specialist mental health services.

We've got an inordinate amount of people that fit our broad criteria, but (in the Programme) we are trying to work to a primary care model [without] inclusion or exclusion criteria, everyone is available, you know, everyone is accepted (KI16, SHSC)

This seems to have been reflected in the service user's experiences of being referred into the programme. Most seem to have been referred in by their GP, but many were unclear on the exact mechanism of referral or had been bounced back from IAPT. One patient described her referral process as: "a bit of a hoo-haa" (SU10), though for others, it has been smoother.

Many staff perceived a problem with the presentation of the service as 'no wrong door' (or to be precise "a single right door for all" (Section A3: Programme Implementation), despite often agreeing with this aim in principle;

The ethos of no wrong door and having very few exclusion criteria has meant that we've become very overwhelmed very quickly and our area, our PCN, is currently closed to referrals because of how saturated we've become. (MHPGI)

We had this phrase, 'no wrong door' and it sounds very ambitious and very moral, it's what we all kind of live for I guess in a way as therapists, we want to help everyone we can. But (...) sometimes you think to yourself why are they getting referred to us? (...) In essence the GP is saving time by sending the referral to mental health nurse or our team, even though they know they're not for us. But no wrong door is interpreted as, 'oh we'll take it and do something with that person'. And I think that going forward is dangerous. (CAP2GI)

Several also pointed to the system effects of offering mental health care through the Programme without the strict thresholds or referral criteria applied by other providers in the system;

It's like water, water has to go somewhere, and it will find a way to get somewhere; and clients are the same, GPs will find a way to get somebody to the system so they can move on with the other stuff. And we are those people there those clients are fed to; so they need to look at it and manage expectations and be really clear about stuff. (P06, VCSE)

For some, the cross-referral of service users would be an example of the system working as it should, with step-up and step-down care to more or less specialist/intensive services. However, some felt referrals from the Programme to IAPT or SPA remained difficult, while perceiving that referrals from IAPT or SPA into the Programme had been made easier.

This linked to a broader concern expressed, that other services might see the Programme as a way to reduce their own waiting lists.

Our pool of patients is getting bigger and bigger and bigger as the other services tighten more and more with regards to what they accept and won't accept (MHPGI)

Among some VCSE providers, the opposite problem was raised; that lack of clarity about referral criteria to VCSE was leading to very small numbers of referrals from general practice, suggesting a mismatch between provision and need, or lack of familiarity with VCSE capability (as noted in Findings: 3c above).

I can't believe there isn't enough demand for mental health support that we shouldn't be massively busy. So, surely there've got to be clients there that we can support and that we're equipped to support, you know, at our level of expertise, our scope of expertise, surely. So, there's something amiss with the model somewhere. (P09, VCSE)

The question of appropriate referrals again relates to a wider question of balancing focus with appropriate flexibility, which will be addressed in more detail under **Findings: 4a** below.

e. Work Allocation and Staffing

Challenges relating to staffing raised in interviews centre very much upon caseload issues, reflecting in large part the fundamental challenge presented by the scale of undermet need (as discussed in 1A and 2B). Several interviewees described extremely high caseloads and patient contacts and this was perceived to be particularly acute for the MHPs, described as the “workhorses” of the system;

The nurses are under far too much pressure and it's not okay, it's not sustainable and it's not something that's going to keep them in the job a long time.

The heart's there and in the right place but the workload is just completely unreasonable (CAP2GI)

We were seeing a ridiculous amount of patients in one day. (...) And so now we're kind of around ten and 12, which in itself is a massive amount of new assessments in one day, whereas before, I mean, I know I was touching 20–22 at times, maybe even 25 (MHPGI)

In some respects, this reflected the high commitment to their patients by MHPs;

We've all got clients on our caseloads that really should not be on our caseloads, but because no-one else is going to see them, so having us is better than having nothing. (MHPGI)

We're all working at over capacity because we do not want patients to have to wait for any longer than they possibly can. (MHPGI)

Other groups also described experiences of intensity of caseload; the psychologists and psychotherapists discussed pressure to increase their clinical contacts alongside other responsibilities for supervision of CAPs and indirect service development, and the CAPs, while protected as trainees, expressed concern at the impact of moving to five-day working once qualified.

Associated with the volume of work is, in many cases, the intensity and the impact of the content of the work with many patients, leading to a risk of burnout;

And I think that takes its toll (...) their days are so intense and tough, because, you know, that's all they're hearing, you know. Torture and abuse and all the rest of it, case after case after case without a break. (P01, GP)

Apart from the direct consequences on staff, wide consequences of this including growing waiting lists for the Programme, resulting in temporary suspension of referrals in some instances, risking replicating issues elsewhere in the MH system;

I think in some respects what we've done is moved the holding from the GP and all we've done is just transfer the problem and given it to the mental health practitioners to hold (KI16, SHSC)

Exploring the nature of the caseload, some interviewees suggested there was a need to differentiate between active and inactive cases more clearly, and also to focus explicitly on the discharge criteria;

If you speak to any of them, they're like “well, I've got 400 people on my caseload”, and it's like, you can't possibly have 400 people on. You might have 400 people on a list that need to see you, but you can't be actively working with 400 people, and that's not safe. (KI16, SHSC)

More fundamentally, some suggested a need to clarify the distinction between the primary and secondary care approaches to caseloads, reflecting different fundamental understandings of the Programme (as noted in **Findings: 3a**) contrasting the referral-treatment-discharge model of secondary care to the general practice approach to patient lists and “discharge”;

I think that's been a big part of the, one of the challenges that we've had is the secondary care mind-set versus the primary care mind-set. Because we are used to not discharging. We are used to just supporting no matter what, and people coming and going over periods of time and needing more support at some point, and then dropping off for a while and then coming back. And that's how we're used to working. And actually, you know, do you have this service having referrals and discharges? Because obviously there's a limit to what they can do, in more of the secondary care model, or are they part of primary care and it is in the same way that people will come and go, but they never get discharged? (P01, GP)

In addition to the question of individual caseload, recruiting and retaining staff is key to ensuring a sustainable service can be provided. In this regard, one challenge raised by staff was the difference in conditions of employment between different partners in the service.

Some of us are employed by PCS, some people are employed by SHSC. We have different conditions, so holidays, rights to pay, carer's leave for those of us who have children, and families indeed, that you might need carer's leave for. That again, for me is a huge, you know, why am I going to continue to work here if I don't have the same conditions as my colleague who's sitting next to me. (MHPGI)

Differences related to specific employment policies, as described above, as well as availability of funding for training and development, and less tangible issues but equally important issues such as differences in employer attitudes towards sick leave due to stress. Temporal flexibility, in terms of working hours, was also highly valued by staff;

I really appreciate the management because they allowed me to work my hours over three days. And I think that's one of the really, really wonderful strands to this organisation that they have been really receptive to what people are asking in that respect (PsychGI)

The other key concern raised which was seen to have a particular impact on the attractiveness of the roles, and the willingness of staff to remain in post, was the ability of staff, in particular the MHPs, to benefit from training and development opportunities.

I just think the training offer is quite poor in comparison to what I've had previously (elsewhere in the NHS). I feel that it's not (a) priority (...) training is really important, and about not having to spend all your own free time doing work so that you can clinically deliver a really effective treatment and you're up to speed with everything. (PsychGI)

(Some) business cases and requests for training (...) haven't come to fruition. I know that's a wider issue, but I think in terms of staff retention, professional development, enjoyment of a job and actually developing rather than just feeling like absolute assessment treadmills, that we just get strapped into our hamster wheels each day and off we go, and we finish and start it all again the next day. (MHPGI)

Summary: Challenges and Barriers

- found that there were multiple and sometimes inconsistent views of what the Programme was, which partly reflected the process by which the focus was gradually refined.
- Nonetheless, as this ambiguity persisted, there was a risk of scope creep and of unrealistic expectations being placed on the Programme.
- Some described issues with vertical communications and with communication and engagement with VCSE partners.
- The ability of the Programme to build internal coherence limited by a lack of estates provision and the inability of staff to co-locate, and gaps in administrative infrastructure led to less efficiency overall as clinical staff dealt with administrative tasks themselves.
- The estates and administrative issues also led to demotivation as some staff felt this reflected a lack of value placed on the Programme.
- While staff generally absorbed these challenges and maintained good patient care, one interviewee's description of his negative experiences with the programme demonstrated the potential of these issues to impact upon patient care.
- More broadly, staff highlighted challenges engaging with secondary mental health care and IAPT, suggesting work was needed to position the Programme more clearly within the wider system.
- Finally, staff discussed concerns about caseloads and the need to balance workload more equitably across the team, and the need for attention to be paid to certain HR issues, such as equity in employment conditions and availability of training and development opportunities.

4. Enablers

a. Flexibility

Staff across the different roles and professional groups spoke very positively of the value of flexibility in how care was organised and delivered. Flexibility here related to various aspects of the service; firstly, there was a major focus on flexibility in access criteria, with many arguing this was critical to engaging many marginalised communities;

I think it's the flexibility of criteria to access the service, I think it means we don't exclude them. But I wouldn't say it's just around the Slovak community, I think we work with a lot of people from black and minority ethnic groups, including we've worked with quite a lot of asylum seekers and refugees up in PCN2, which I know would really struggle to access the kind of pre-existing provision that was in the city. (PsychGI)

We don't have these same kinds of boundaries, we are more inventive with re-engaging people. We're not, you know, one strike and you're out or, you know, you miss one telephone call and that's it, you can't possibly have a life outside of the mental health care that we're delivering to you (MHPGI)

The service users interviewed also suggested that flexibility was valuable to them, for example, in knowing how to reconnect with the service in future if they needed to, or being able to get in contact in an emergency. This was described by multiple interviewees as a "safety net", which gave them reassurance without them necessarily needing to use it.

Staff also appreciated perceived flexibility in the time and space allowed to work with patients,

Sometimes it's been... I've imposed care upon people, whereas here it's very... it's not transactional, you know, it's very relational the support that I give with my clients. We're not time-limited, you know, we've not got one eye on discharge, we don't use the D-word [discharge]. (MHPGI)

I think we've been able to do such valuable work because we've had the space to do it. (HCGI)

It was well received, and I think that's because we had time to spend with clients. So, we're never kind of cutting anybody short, if you like. And because we always see clients when and where suits them, we're really flexible like that (P09, VCSE)

Service users also valued the continuity of care that this has enabled. SU10 described how having regular appointments with an MHP over a long period of time meant that the MHP had a lot of contextual knowledge, and could easily identify if she needed extra help, rather than her having to "reach out" which she often wouldn't do if she was struggling more than usual.

At the heart of this was a perceived encouragement of creativity and innovation across the Programme, and a degree of trust in professionals to understand and adapt to local need;

As senior clinicians we've had a lot of autonomy in shaping and saying that this is what the need is, this is... And we've had a lot of trust, I believe, that we can go and create what the service offer is for the patients that we're then working with... I've had the scope to do that and the support from the management team to do that, I think. (P14, team member)

We've been granted the autonomy to shape services to an extent, which has always kept me going. (PsychGI)

This flexibility was described by all the VCSE partners interviewed as central to their approach, as their work was often responsive and adaptable, ranging from connecting clients to boxing clubs to help accessing food banks;

Everything that we do, is in response to our service users. And we will try new things, and we'll soon be told if they're not right. You know, so you go right, okay, then, what do you think? How should...how can we change it? What would be better? And so... and that's how we have kind of operated all along (P07, VCSE)

The value of this approach to patients was evident in our service user interviews. Patients described being given choices and feeling like they were in control of their own care: "My priorities were valued" (SU03). They described how they were not pressured into taking steps for which they were not prepared and being given a range of options from which to choose: "he gave me an opportunity and gave me a choice" (SU04).

Staff also provided concrete examples of the benefits of taking “positive risks” in therapy;

We’re running a group at the moment that is informed by practice-based evidence and (...) what does it really mean truly to belong. And we’re running a group at the moment. We’ve got a service user that’s been part of services for 35 years and she said, “I’ve been attending groups all my life and this is the most meaningful group I’ve had – it feels authentic, it feels compassionate, it’s something that really feels as if it’s got such a significant value to me.” (...) We’re getting some really, really interesting and, you know, really meaningful feedback in the fact that we’ve been able to be creative about the way that we operate within that group structure (PsychGI)

Flexibility and ability to think innovatively about therapies, as well as the links to broader social care and community activities, was seen as important to ensure the service addressed the needs of the local population;

To have something different in each network I think is really important (P02)

While flexibility was generally described positively, some of the psychologists and psychotherapists warned against too much flexibility. They highlighted the need to balance flexibility and structure in terms of interventions; allowing space for innovation but seeking to ensure innovations were evidence-based, with processes to share effective innovations to ensure system learning;

I just think sometimes we’re almost being so flexible and responsive we’re kind of forgetting some of the stuff that we would bring, which is the evidence-based and tried-and-tested therapeutic interventions. (PsychGI)

I think when there’s too much space and openness to something it can fill people with anxiety at times. And I think we work with really complex individuals, like the clients, fantastic but complex individuals. And I think that if there isn’t a structure to hang something on that feels very complex, that can lead to feeling really quite overwhelmed. So I think it’s important that you have the space for creativity, but I feel like there’s been an absence of structure (PsychGI)

b. Commitment to Mission and Programme

Throughout the interviews, we encountered powerful statements of commitment to the principles of the Programme. It was notable how widely and deeply held were these commitments among front-line staff, articulated with passion across all of the focus groups. For instance;

I love the role, it’s very varied and challenging but fulfilling at the same time. (MHPFG)

We’re all very, very passionate, and I think that’s why the service has worked so well so quick because we got a really strong team from the beginning that are still really, really passionate. (MHPFG)

People genuinely are thinking, this is how I want to work, if it could be the model that we hope it could be and genuinely strong MDT working, thinking about linking with community services as well, I think that’s a huge thing for people, I think it’s a big pull. (P12, team lead)

Drilling into the source of this deep commitment, it was possible to identify two complementary elements; a wide recognition of the limitations of the existing system and therefore a problem to be addressed (as discussed in **Findings: 1a Undermet Need**), and conviction that the philosophy and approach embodied in the programme had the potential to make a real difference in addressing this problem or gap.

Many spoke of how the philosophy of the Programme aligned with their own values and beliefs about how mental health provision should work, often keeping them in role despite the challenges discussed;

I have carried on with it because I love the definition of a service, I really personally agree with and professionally agree with it, that there’s just nothing there for people who don’t just have mild, moderate anxiety and depression or who are at risk of suicide, there’s nothing in between. And I’ve personally been in that gap, so I really agree with it. (CAP1GI)

I just think the ethos of the service is really aligned with my own values and that’s something that... yeah, when I applied for the job that’s what motivated me (...) And it still keeps me there, like the hope that... I really want to see where the service is going to get to and I don’t want to miss out. I think that’s the other thing, I think I’d get like proper FOMO [Fear of Missing Out] if I ended up going to another service and thinking, oh I could’ve just seen where it had gone. Like, I really do hold that excitement and hope for the programme really and I want to be a part of that. (PsychGI)

It was also notable that the recognition of the problem with existing provision was shared by the different groups, from GPs to VCSE leads to professional staff who had worked in other mental health services;

We wanted to be first wave because we were the most deprived network in the city, and I wanted to make sure that it was a service that met the needs of the patients in our network. (PO2, GP)

I'd heard about the... is it the Community Mental Health Framework, the paper? So I'd come across that because I think everyone in IAPT at the time was like, "Oh my God it's the answers to our prayers!" (CAP1GI)

Equally important, then, is the conviction among most of those interviewed that the Programme has the potential to do something new or different, which would make a difference to the mental health care received, often by the most marginalised in society;

I could see that if that was real, that (it) would work, because we've been doing it for years, or trying to (P10, VCSE)

There's a lot of potential to be helping the patients because the patients that we will be working with are hard to reach and not very... They don't go to the doctors, they don't leave the house or anything. (HCGI)

In addition, staff talked about the rewarding (if challenging) nature of the work, comparing it positively with experiences in other mental health services and the innate excitement of building something new;

You had this huge thing to deliver, to make a difference in people's lives, and that was still a privilege at the beginning, if that makes sense. That was, being involved in that was exciting. And I think staff felt empowered and wanted to do it. (KI20, SHSC)

The work is much more rewarding than secondary, in that you get to see people getting better (MHPGI)

What motivates me is the service users and I do feel like the service makes sense and I feel like the service makes a difference. I think for me my wellbeing is mostly tied to feeling valued and I certainly do feel very valued by the service users (PsychGI)

c. Core Team Qualities

Many interviewees who were not involved directly in the leadership, management and delivery of the Programme) spoke of the distinctive quality of the core team i.e. those recruited into that team in team lead and patient-facing roles, with a particular focus on the values of staff;

It's very exciting. I think we've brought together a group of people who were interested in working in a different way. (KI19, SHSC)

I remember being on the recruitment panel (...) So you start there, who do you get, who do you recruit and you recruit according to really a set of values. And it starts really at the beginning. And then those people, hopefully if you've recruited well, enact those values (KI20, SHSC)

Service users emphasised the importance of the personal attributes of the staff in the programme they had contact with, describing a high level of trust: "right from the very beginning I trusted him" (SU10), and feeling connected with those providing the service: "it's professional, but there's more of a connection" (SU07). The MHPs were particularly praised for their personal qualities: "it's not what he does, it's who he is" (SU04).

Within the teams themselves, many mentioned the strength of peer support and the importance of this support;

I have to have wholeheartedly hold up my hand and say that could've crushed me, not being allowed to do it, and these guys were so supportive and I will be forever grateful for the respect you gave me, like, that meant a huge amount. (PsychGI)

Similarly, the CAPs spoke positively of the value of collegial support within teams, identifying particular activities such as a WhatsApp group which enhanced communication and a sense of belonging;

...just like having a chat on WhatsApp and if someone says like, I'm struggling with this specific thing of if a supervisor is not available, like I've had a difficult session, anyone free for a chat, there's always, like, jump in to help someone out. And it does feel that we're very much a group of CAPs. (CAP1GI)

The Health Coaches mentioned shadowing each other as critical to developing confidence to practice independently;

I feel confident doing either together or separate, now that we've had a bit of time doing it together, but I think it will work well, say if we do it separate and then (...) if there's any more health coaches come in, they can shadow either one of us and then there's still two of us anywhere for a period of time. (HCGI)

The quality of collegial support was explicitly referred to by several interviewees as the thing which “keeps people in place”.

Outside of the core team, some interviewees emphasised the qualities of the Programme leadership team, in terms of both capabilities, the organisations they represented and their networks;

There's been something about how that team of people putting, implementing it have been across secondary care and primary care and representation for Sheffield Mind and the community services as well to make sure that all of, there is sort of fair representation across the board. (P01, GP)

Having a leadership group that was connected and had long standing relationships outside of the primary care framework, was important. So you had SHSC relationships that were well formed at the top. So you had a leadership group that were going to get the job done but were also connected to the people who needed to be connected. (KI20, SHSC)

Many also emphasised the importance of good communication other groups, and GPs in particular, identifying strong GP connections as one of the key benefits of the Programme as currently set up;

...having that real, like, direct communication and link with GPs, so even if we're not offering direct support to the person or we need to kind of, like, discharge from our care, we can always have that direct conversation with the GP. And it feels a lot more connected to GPs than, yeah, when I've been in secondary care (PsychGI)

It was also noted, however, that experiences of GP engagement varied between roles, and also by PCN/ GP practice and individual practitioner;

In terms of GP talk, like again each area's different. I haven't really had many discussions with GPs at all, to be honest. Most of the discussions I have are with the MDT that I work in and the mental health nurse practitioner (...) acts as, I guess, like a firewall really to take on any sort of enquiries and will filter them down through triage into the wider MDT. (CCGI)

A number of the GPs tend to have a special interest in mental health. I really notice the difference when I've spoken to GPs who have that interest whereas those who don't (CAP2GI).

Summary: Enablers

- We found several specific enabling factors to have made a difference.
- Flexibility was seen to be one of the great strengths of the service, with several dimensions including flexibility in access, in how time and space were used when working with service users, and in the degree of creativity in treatments which were possible and encouraged, an approach which was already quite normal among the VCSE providers.
- The depth of commitment to the Programme, reflecting both the acute awareness of undermet need and belief in the Programme to make a difference, was a powerful motivating factor.
- The Programme further benefited from the quality of staff recruited, their 'fit' with the ethos of the Programme and their willingness to support each other.
- This extended to the leadership team also, where some felt the composition, including the representation of GPs, was critical.

5. Roll-out and Sustainability

Through our interviews, respondents shared a number of reflections on the future of the Programme as it transitions from a Programme to a stable and ongoing service, in terms of how it might be rolled-out across the city and region and how it might be made sustainable in the longer term. From the service users' perspective, most emphasised the urgent need for the wider roll out and greater accessibility of the service. Many staff made concrete suggestions about how to deal with or avoid such dangers, which we have attempted to collate below.

a. Work Design and Sustainability

To some degree, the longer-term sustainability of this service as a human system depends primarily upon having sufficient staff, with appropriate expertise and competency, able to deliver care as specified. This is challenged by failure to recruit or retain the right staff, or the inability of staff to cope with impossible workloads, both of which were discussed in some detail in **Findings: 3e**. This discussion will not be repeated in detail here, other than to flag up the key themes of this section; supportive leadership, staff involvement and engagement, a balance of structure and space to innovate, and opportunities for continuing professional development.

Additional themes raised in interviews which were seen to be important to ensure the teams could be sustained related to Role Clarity, Team Composition and the integration of ARRS roles.

Role Clarity

Similarly, many argued that more work was needed to clarify some roles, in particular the MHP and the CAP role, and to communicate this to stakeholders, from GPs and practice managers to others involved in mental health services.

(The MHP role) has morphed into being essentially anything and everything – mental health advisers for GPs. I'm frequently referred to as a therapist or a counsellor or a psychologist. (MHPGI)

A key area of uncertainty related to the CAP role, reflecting in part the novelty of the role. The role was a new Health Education England role being tested by Sheffield, but with a commitment to recurrently fund the roles beyond the apprenticeship;

The new trainee clinical associate psychologists and that, they're going to be a really, really valued profession once we're really up and running. But that's been a real challenge, again, a huge part of the workforce, there were ten people who were apprentices on a new, completely new programme trying to understand what it is, who they can work with, what are the parameters, what's the suitability? (P12, team lead)

Both the CAPs and the psychology team who supervise the CAPs discussed ways in which the CAP role could be better managed, through better communication with university about the clinical work of CAPs, and with the services about their capabilities, as well as more time allocated for the supervision of CAPs, which many felt to have been underestimated.

Team Composition

Looking forward toward a sustainable team, interviewees discussed various additional roles which they felt would improve the service, such as a family therapist, a support worker, a care coordinator, or a first-contact mental health worker in general practice. Some also underlined the danger of neglecting administrative roles;

I think the senior, senior team have had to really fight to make sure that we've had roles that aren't clinical. So it's, like, the sense of, we can't, everybody can't do everything (P12, team lead)

The importance of having an admin team is massive. Because we've only just got that in place and it's been so hard to not have them (CAP2GI)

Others argued that what would be needed were more of the existing roles, with many citing a need for more MHPs, and some citing need for more psychology and MH pharmacist support. Some staff, describing the importance of broader specialist input, reinforced the importance of embedding the primary care services within specialised pathways and SHSC;

Everybody hates this concept whenever I've suggested it before, because it sounds like secondary services, but having secondary central teams of psychology, but who maybe had developed specific pathways, so trauma informed pathway, PTSD, OCD, whatever it is, that everybody can then sort of refer into, but still making that really clear that this is still a primary care offer, and that there are other services for more complex things, feels like it might be fairer (P11, team lead)

Link to Additional Roles Reimbursement Scheme (ARRS) staff

Relatedly, team members described their sense of responsibility for staff recruited through the Additional Roles Reimbursement Scheme (ARRS) to mental health roles in parts of the city which were not involved in the first phase of the Programme. While other ARRS roles already existed in general practice, mental health ARRS roles are new positions, jointly funded by PCNs and mental health providers but with limited guidance in terms of job descriptions.

Staff emphasised the importance of ensuring that ARRS roles were also supported, despite being separate to the Programme.;

I think these new people are going into these roles completely on their own, like X really put it really well, canaries, lowering them very slowly. And I just feel like they're going to get battered actually and I feel like they're not very well protected at all. And it's our role to protect them but given what you've already heard about our workload and being the work horses, it's difficult to put all of our energy into that as well. (MHPGI)

It was felt to be important that lessons learned through the Programme were also used to inform the implementation of these ARRS roles;

What worries me is that we're not learning from that initial period where the nurses were accepting all these referrals and now, we're asking the ARRS to go and do the exact same thing. And it feels really... I feel really guilty when I'm supervising one of my satellite workers and I'm like, "I'm over here in my MDT and, you know, I'm doing fine but you crack on". And it just feels wrong. (MHPGI)

b. Sustainability at scale

Given this likely need to scale the investment across a broader area, and a perception that existing resources may need to be spread more thinly as a consequence, several interviewees reflected on the need to tailor provision and staffing to match needs in each area.

We're either going to end up in two situations, that we've spread ourselves too thinly that we can't really do anything, or we've got inequality of service across the city. So we've got the four that we've rolled out to with this gold standard, lovely multidisciplinary team, and then we've got other people, other networks (..) that have got slightly less because, well, we haven't actually quite got as much money, or you've got less mental health needs, so therefore you're not going to get as much (KI16, SHSC)

This was linked by some to the argument that each area or PCN did not need the same provision in terms of staffing team composition, but rather "equitable" provision, reflecting discussions above in **Findings: 2c** regarding local need;

Different communities are different and have different levels of need, you know. Not feeling the need to have equal provision but having equitable provision. So, you know, actually provision that goes to need rather than just, well everybody has to have exactly the same because that's there (...) That is something I feel the programme has at the heart of what they do, is an understanding that actually, health inequalities means that different areas will need different levels of service. (P01, GP)

Several drew on their experience to explain the detailed work necessary to effectively determine provision which matched need but also took into account other local services, including social provision and VCSE offerings in each area;

They're so different, the PCNs, honestly, that I work in... It's getting to know the area that you work in and who else is working there, what else are they doing. So that might be (...) social prescribers, it might be initiatives that are up and running in various areas of the city that might be supporting mental health, it's GPs with specialist interest in mental health... So it's trying to network and find out. But you've got to go and do that for each individual area. (P13, team lead)

It was noted by many that financial sustainability for a wider roll-out relied on the service being able to measure not only activity but impact. Several felt that it would be challenging to capture impact in a way which would be meaningful but would also hold weight with commissioners and partner organisations. After describing the rich contribution made by the Programme and the VCSE partners, one interviewee asked;

How do you convey everything that I've said in the last hour? How do you actually convey that into little boxes with numbers? (P08, VCSE)

While some felt that evidence of impact would be found in Patient Reported Outcome Measures such as ReQoL (to be replaced with DIALOG¹⁴) or other measures such as prescription rates of psychotropic medication, other interviewees discussed the expectation that the impact would be seen in terms of referrals to SPA;

If the conversion rates end up where you've got just as many people going to SPA having been through primary care, then something's not quite right there (KI15, CCG)

While some noted that this impact may only be felt over the longer term, others were clear that impact evaluation based on referrals to specialist services would not be an appropriate or valid measure of success;

There is a tendency to want to measure referrals into secondary care, and is this making a difference by reducing your referrals in secondary care? But a lot of the people that we're dealing, or they are dealing with, actually we wouldn't necessarily have referred to second care (P01, GP)

Nonetheless, all recognised that strategic decision would depend on the generation of robust data, and that financial uncertainty in itself was an obstacle to success. The financial uncertainty was a particularly acute concern for the VCSE partners in Sheffield who were keen to argue that even a moderate VCSE investment could have a substantial impact;

Just a little bit of investment in an individual has such a massive impact, not just on the individual but on the community that they live in, their neighbours, and everybody. But it's only a tiny bit of investment, really, but it needs to be quality. It can't be just cheap as chips, it has to be quality investment. And it has to be an equal playing field. (P10, VCSE)

The long-term sustainability of the Programme as a service depended on the ability of VCSE partners to plan and commit over a meaningful period, in line with the other partners involved, which was in turn reliant on a model of commissioning which could provide stability beyond a 12-month cycle.

One of the biggest issues we find is sustainable funding for these groups (...) if these groups don't have sustainable funding, it's really difficult for us to plan how we work with them. And what they're doing is, they get funding for a year and then they're having to reapply and they're spending six months working and six months desperately trying to find money to keep going. (P01, GP)

Summary: Roll-out and Sustainability

- Reflections on roll-out and sustainability focused on two themes.
- The first was the appropriate design of work. This covered important but arguably universal HR and OD concerns such as supportive leadership, staff involvement and engagement, and opportunities for continuing professional development.
- More specific to the national policy framework and local workforce plans, there was a need for greater role clarity (particularly for MHPs and CAPs).
- Specific to the local Programme and roll out was the need to ensure the right composition of teams at a neighbourhood level (reflecting local need and potentially including new roles) and the need to align the service more effectively alongside new ARRS roles in PCNs.
- The second theme related more to sustainability at scale, ensuring sufficient capacity and sufficient funding, again tailored to local need at a PCN level.
- Many recognised the importance of focusing at an early stage on capturing meaningful data and evidence in order to justify investment in mental health provision of this kind.

14 <https://www.elft.nhs.uk/dialog>



Discussion

E. Discussion

Below we draw together key themes which cut across the different Findings sections set out above. It is important to note that some of these issues were initially raised in the Cycle 1 Lessons Learned report (summarised in **Section C: Summary of Cycle 1 Evaluation Findings** above). We are aware therefore that some are issues which the Programme team have already begun to address, which was the intention of the rapid cycle learning approach adopted in the evaluation.

Lessons learned through evaluations frequently focus on what needs to change, or what else needs to be done. The most valuable place to start, however, is by recognising what has gone well in implementation, and thus what elements of the Programme should be preserved and nurtured, alongside what may need to be changed or developed. The summary of Achievements above identifies several successful elements which should be preserved as far as possible in the wider roll-out of the Framework in the area. Two in particular are highlighted here, which we identified as key strengths of the Sheffield Programme.

1. Success in reaching marginalised groups and tailoring care to local need

There was a strong and widely held perception among those interviewed that better mental health care had been provided to many groups whose needs were not met by existing services. This is reflected in the activity data (see **Section A: Background and Context**) which indicates that 20% of service users were from minority ethnic backgrounds (data is not routinely collected on the economic or social status of service users). How the Programme managed to meet the needs of people with serious mental illness is explained by staff and supported by many of the experiences described by the service users interviewed (see **Findings: 2c; 4a**).

A key advantage of the Programme was that many felt the provision of care was more effectively tailored to the needs of local populations (**Findings: 1c; 2b**). This was thanks in part to the involvement of general practices, who knew their patients well, and of local VCSE providers, set up to reflect the local populations and address their specific concerns (**Findings: 2c**).

The physical localisation of services also played a major role here. Several interviewees including service users noted the significant barriers they faced which limited their access to centralised specialist services, beyond the challenges of the referral process. These included practical challenges such as physically accessing care in a central location, discomfort moving outside local communities and the stigma of engaging with specialist mental health care (**Findings: 2c**). By contrast, local provision of care (linked to the

familiar GP practice or other community facilities) was experienced as more accessible, less threatening and distant, and was not seen to risk the same social stigma in their communities. The impact of these barriers was most severe for vulnerable people or those in more deprived communities, with very acute need of mental health support (**Findings: 2c**; see also **point 4** below on the need for appropriate estates provision at a local level).

Effective reach at a local level also requires appropriate provision of estates for meetings and consultations within each PCN area (**Findings: 3d**). Ideally this would enable some co-location for local teams, with accessible and sufficient administrative support. The Programme leadership have been aware of estates and administration issues and progress has been made here as the evaluation has continued. However, the clear importance of these issues for local responsiveness, efficient functioning of the service and indeed for staff morale justifies their reiteration here.

Beyond local knowledge and location, this success in reaching marginalised groups also relied on the flexibility in care delivery. Staff in patient-facing roles were afforded more autonomy in deciding how to engage service users and to tailor care to meet individual needs. This issue of flexibility/variability is addressed below (**point 6**).

2. Effective engagement with general practice

A second key strength of the Programme is the extent to which the Programme successfully managed to engage with general practice. This is not a given, as the experience of other Framework pilots nationally suggests¹⁵. The success of the Sheffield Programme in this regard reflects the formation of the Programme as a partnership, with a leadership team and Programme board with effective representation of both secondary mental health trust and primary care providers (Section C; Findings 2b), and the efforts made to engage with the concerns of general practice (Findings 2d).

One consequence of this partnership is that the Programme was implemented with a clear understanding of the needs of patients with mental health needs being treated in primary care and was designed with these in mind. This was no doubt facilitated by the selection of PCNs with particular high levels of need in the area of mental health. Nonetheless, this is particularly important given the scepticism which may have developed among GPs who have struggled to successfully refer patients to specialist mental health services in the past, and who therefore may be distrustful when approached by new initiatives driven by specialist mental health trusts (Findings: 1b). Engagement is likely to be weaker in other PCNs not involved in the early implementation and is likely to require focused attention to communicate lessons learned and to support wider roll-out.

While it is important that this engagement and confidence among general practice should be maintained through wider roll-out, perhaps the inevitable corollary is that the perceived 'ownership' of the initiative by secondary mental health services may be diluted (Findings 2a; 3d). There is therefore a need to ensure that other partners, in particular the mental health trust but also the VCSE sector and the city council, feel equally represented and not only engaged but involved as the Programme becomes embedded as an ongoing service in the wider health and care system (Findings: 3c) see also point 4 below).

Beyond these strengths, there were other aspects to the Programme in Sheffield and its implementation which were more double-sided; strengths or achievements of the Programme which also presented potential limitations or challenges, or where solutions may generate new challenges. These more complex issues are discussed below.

3. Challenges of managing scale of demand

One of the most consistent themes raised by interviewees was the scale and complexity of mental health need being managed within general practice (Findings: 1a). A key achievement of the Programme, as noted, was the success in identifying this need and finding innovative ways to meet the need drawing on clinical and non-clinical staff, including VCSE providers of care and support.

However, the scale of demand and its complexity also presented a major challenge, which at times required exceptional degrees of effort and commitment from the staff to maintain a safe and effective level of care (Findings: 2e). Some staff noted that the burden of this caseload did not fall evenly across the team. We do not have activity data to assess these claims, but collaborative working may be undermined by a perception of inequity. This is clearly an issue which requires transparency and careful management, recognising that it may take time for newer roles to become familiar and normalised within a primary care setting.

It was also clear that the scale and complexity of need varied by neighbourhood (Findings: 1c), reflecting various factors including demographics and deprivation. The prevalence of particular conditions similarly varies between PCNs; for example, some areas with higher numbers of asylum-seekers observed much higher levels of trauma, while others encountered more widespread anxiety and depression. Reflecting local need, then, and informed by local clinical priorities, the composition of teams may be expected to vary by PCN. Detailed understanding of local need, drawing on the expertise of the full range of partners in each PCN, is therefore needed to ensure that team composition reflects the profile of demand.

15. Kings Fund Transforming community mental health services: Lessons from early implementer sites May 2021

There is also a challenge of ensuring adequate capacity and capability to carry caseloads as rates of referral and discharge fluctuate (**Finding: 3e**). The formal model of referral-diagnosis-treatment-discharge familiar in secondary and specialist healthcare did not fit neatly with the ‘patient list’ model, which is the basis of general practice, as the former assumed high-intensity treatment and the latter, more episodic and intermittent periods of more or less intensive care. Arguably, the chronic nature of some aspects of SMI demands a fluid process of stepping-up and stepping-down of care intensity, rather than a time-consuming and difficult process of referral or re-referral. As well as absorbing staff time, it is noted that the “cliff edge” of discharge may generate anxiety among service users and thus exacerbate conditions. Uncertainty about the model of care adopted here (**Findings: 3a**) is a barrier to smooth cooperation between mental health services, and is also likely to prevent the effective measurement of activity, caseload and team capacity (**Findings: 5b**).

4. Integration with secondary and specialist mental health services

The Programme benefited in several ways from its status as a discrete project, with dedicated and effective project management support and a clear mission which could be maintained despite the competing pressures of the COVID-19 pandemic (**Section C: Findings: 1d**). This project focus inevitably also generates a degree of separation between the Programme and existing systems and services, however (**Findings: 3d**). The challenge for all successful policy pilots is therefore to (re-) embed themselves at some point within the wider system if they are to transition from a standalone pilot to form part of ‘business as usual’ in public services.

The process of embedding the Programme in the wider health and care system also requires the service going forward to be clearly positioned within or around other standard system processes, such as patient pathways and the referral procedures of other services such as SPA and IAPT. As the Programme aims to ‘fill a gap’ for people with needs too severe for IAPT but who do not meet thresholds for secondary care (**see Section A: Background and Context**), there is a need to clarify eligibility criteria for the Programme in the context of criteria applied in other mental health services, ideally avoiding gaps and also overlaps (**Findings: 5b**). Equally, attention needs to be paid to the escalation/de-escalation process between the different services and the referral of people ‘up’ to more intensive care and also ‘down’ to less intensive or specialist care.

Both issues will require coordinated action with specialist mental health providers, to ensure consistency with policies of other providers and pathways and to ensure the system implications of these decisions are considered (**Findings: 3d**; see also **point 3 above**).

Clarification of policies and processes (**Findings: 5a**) are also likely to result in some tension with one of the key advantages of the Programme: the degree of flexibility afforded to staff in tailoring care to local needs. This is considered under **point 6 below**.

Secondly, embedding the Programme at scale as a service within the broader health and care system will require strategic engagement at a senior level, involving different parts of the health and care system including not only primary and secondary care providers but also system integrators such as the ICS. This was raised as a priority in the Cycle 1 Lessons Learned report (**see Section C**) but bears repeating here as the South Yorkshire and Bassetlaw ICS is now staffed and formally operational from 1 July 2022, which was not the case when the earlier report was produced.

5. Importance of local community assets and VCSE

As noted, a particular focus of the Framework is to ensure greater use of community assets and VCSE providers in local communities (**Section A: Background and Context**). There was evidence throughout this Programme of the distinctive contribution that VCSE organisations could make to the lives of people living with SMI, and also a clear sense that VCSE providers felt they had more to contribute (**Findings: 2e**).

The Programme also provided insight into the challenges of integrating VCSE meaningfully in the design, organisation and delivery of community mental health services. Firstly, interviewees in some VCSE providers would have liked greater involvement in the design of the Programme, recognising that it was set up in a very short timeframe and consultation processes were affected by pandemic pressures on the health and care system (**Findings: 3c**). A related challenge is to engage meaningfully with the diversity of VCSE organisations, some of whom are large while others are small and have limited capacity or experience to engage with commissioners or complex policy initiatives. The work of Rethink Mental Illness in supporting the development of a VCSE provider collaborative in the area (described in **Section A: Background and Context**) is therefore invaluable, to

ensure the full range of VCSE organisations are visible, represented, and supported to engage in important initiatives such as this.

Beyond this, engaging VCSE in the organisation of mental health care, rather than merely the delivery of care, requires the representation of VCSE organisations in key oversight as well as operational meetings (**Findings: 3c**). This may pose challenges to smaller and even larger VCSE organisations with limited or zero managerial capacity, and arguably needs consideration as part of the funding of VCSE here. The formation of a VCSE provider collaborative is likely to facilitate strategic engagement here.

We also observed variation between sites in terms of how far VCSE or other non-clinical staff were able to participate in MDT meetings (**Findings: 3c**). While this is likely to remain a decision for practices to make, with a view on their responsibilities to patients, where VCSE were not able to be involved in such meetings directly they felt there was a clear limit on their ability to identify cases where they could provide care, or tailor care to meet need.

Finally, involving VCSE providers in the delivery of care is often limited by a lack of awareness across primary care of what providers offer. VCSE interviewees described the difficulty of communicating their offering to general practice, even at a local level (**Findings: 3c**). Clearly, awareness of a VCSE provider is only the first step and it will take time for GPs and other staff to have experience of successful care delivered by voluntary organisations, and to know for whom this care would be suitable. The development of social prescribing infrastructure may play a key role here. However, a key first step is to improve communication paths between VCSE and healthcare providers and commissioners. Again, the Rethink Mental Illness work is likely to make a positive contribution here.

6. Importance of flexibility and innovation in delivery

Both Programme staff and services users attested to the importance of flexibility in the delivery of care, as discussed above. Several aspects to flexibility were described, which related to how patients accessed the service, how staff worked with and adapted to patients, and SHSC placed in staff to develop innovative solutions to meet individual need. Staff explained how this trust and autonomy led to greater job satisfaction and encouraged them to commit to the Programme, and the service users interviewed

explained how they felt their views and choices were better valued as a result of this flexibility, and this gave them a sense of autonomy in their treatment and recovery (**Findings: 4a**). Given the importance of this flexibility to both staff and service users, there is a strong sense that this should be preserved.

This however presents challenges to the need for consistency and parity across the service. Flexibility in clinical care delivery also may conflict with the parallel need for treatment to be evidence-based. As noted by clinical staff, due to their size and marginal status, there may not be an existing evidence base for some groups (for example, the Slovakian Roma community) and staff may need to innovate with existing models to develop appropriate care (and in so doing, start to build an evidence base for treatment).

The issue of consistency and parity is not only a clinical matter but also managerial, as parity of provision should be built into the design and mission of the service, particularly as it expands. There is therefore a need to ensure that the form, nature and importance of this 'flexibility' should be articulated and this statement used to ensure policy and practice continue to support and defend an appropriate degree of flexibility.

The issue of evidence-based care is primarily a clinical matter, raised mainly by the psychologists, psychotherapists and mental health professionals, with a view to also ensuring successful innovations are rapidly shared across the service. The correct balance is therefore a matter for clinical and professional judgement but there is a need to dedicate time to reflect on this. This may form part of the reflexive continual professional development described as a priority by these groups (see **Section E: Findings and point 7** below). Systems and processes will also be needed to change clinical practice in a structured manner over time.

7. Challenge of sustainability at scale

Given the limited financial and human resources available within the healthcare system, there was an acute awareness among all those interviewed of the need to make the service sustainable at greater scale. Four aspects of sustainability were highlighted; financial viability, staff recruitment and retention, integration within the wider health and care system, and the need to ensure appropriate evidence of impact was captured (**Findings: 5b**).

Financial viability: As the evaluation has not conducted an economic evaluation or analysed budgetary records, it is not appropriate to advise here in detail on funding or necessary/minimal staff resourcing. We would however underline the need for provision tailored to local need at a PCN level, and to reiterate that given variation in need, as noted, equitable provision at scale would not imply equal provision (**Findings: 1c**). The service will be facilitated by parallel and separately-funded initiatives such as the ARRS roles; however, the challenge of aligning services alongside any ARRS mental health provision at PCN level may be complex (**Findings: 5a**). Targeted work at PCN level and between PCNs (potentially supported by the ICS) on job description and scope of work is critical, to avoid duplication or gaps in provision, and to ensure ARRS roles are connected to other Primary and Community Mental Health teams for knowledge sharing and peer support.

Recruitment and retention: The ability of the service to retain staff and to attract qualified and experienced staff is also critical given widespread and well-documented shortages of healthcare staff, particularly in the field of mental health. The perception of the Programme as something new which responds to a pressing need has been an important factor in recruitment and retention, but this factor may dissipate as the service becomes a standard component of mental health care. Many staff explained their commitment to the ethos and mission of the Programme and the impact this had on their willingness and ability to invest in their role (**Findings: 4a**). Demotivating factors were highlighted as having the opposite effect and leading staff to consider leaving; these included a lack of a physical home base, difficulty in securing appropriate consultation space when meeting service users, and obstacles to continuing professional development (**Findings: 3d**). As far as possible, standardisation of employment conditions for staff in similar roles would be desirable, recognising that this is limited by the policies and practices of different employing organisations. Finally, but most importantly, work to ensure that the caseload for staff is manageable and perceived to be equitable across the team is essential (**Findings: 3e**). Without this, recruitment and retention will prove challenging, particularly as the Community Mental Health Framework is implemented across other areas and regions and will seek to recruit from the same pool (**Findings: 5a**).

Integration in wider system: This has been covered at some length above under **points 1, 4 and 5**, but to briefly reiterate; important progress has been made in engaging general practice, which is vital for this kind of provision, although degree of engagement with VCSE varies in some areas and this requires attention through comms and engagement, ideally driven by PCN leadership (**Findings: 5b**). Work remains to be done to raise awareness of the Programme within SHSC at all levels. This should focus not only on how the Primary and Community Mental Health Team in Sheffield can improve the reach and impact of mental health care as a whole, but also on how it can support SHSC in achieving its own goals - for example, by reducing inappropriate referrals to SPA and IAPT, by building local knowledge of mental health demand across the city, and by offering a step-down option for SPA and a step-up option for IAPT. For this to be effective, there needs to be careful consideration of the collective, systemic impact of the service and to ensure 'warm handovers' are feasible in practice as users move between services. This would entail a substantial commitment given documented challenges and tensions between different parts of the mental health care system (**see Findings: 1b**) but is critical work to build on the achievements and to develop a sustainable mental health system for the city as a whole.

Evidencing impact: Finally, interviewees made a number of valuable and pragmatic points about the inevitable need for strong evidence not only of activity but of the impact of the services, and also the danger of looking for impact in the wrong places (**Findings: 5b**). An important warning was that given the effectiveness of the Programme in identifying mental health need at an earlier stage and reaching marginalised groups who may never have received care due to a range of barriers, the immediate impact on referrals to SPA, for example, may be limited - although this may become apparent in the longer term. Impact on Patient Reported Experience Measures or Patient Reported Outcome Measures are more appropriate measures of impact, as well as prescription rates for psychotropic medication or antidepressants. Beyond this, work to ensure the validity and reliability of patient data and also budgetary data is vital, and potentially a more rigorous economic evaluation of impact at an appropriate point in time.



Recommendations

F. Recommendations

Recommendations below are presented in an order which reflects the structure of the Discussion section, rather than in order of importance. The Discussion section is identified in column 2 (point), but the importance of each is defined in column 3.

Recommendation	Source (Discussion)	Importance	Sheffield service/ rollout	PCN	Local providers/ commissioners	ICS	Clinical Networks	National
1. Estates								
1.1 Ensure the service delivers care within neighbourhoods and in convenient locations for service users.	1	High						
1.2 In each PCN, a set of options should be developed for estates provision, addressing space for clinical consultations and other meetings, and for a physical base or hub for the service teams.	1	High						
1.3 The impact of the service on primary care estate should be considered at ICS level where capital investment in estates is considered.	1	Medium						
1.4 Given pressures on estates in general practice, alternative spaces should be considered, such as council premises and Third Sector buildings.	1	High						
2. Administrative support								
2.1 A plan should be developed stipulating necessary administrative support for service teams at a PCN level.	1	High						
2.2 This plan should be developed in discussion with GP practices or other premises used, recognising pressures on existing GP administration and the peripatetic nature of work for staff within service teams.	1	Medium						
3. Communications								
3.1 A targeted briefing should be composed for delivery to GP practices and VCSE organisations in remaining PCNs across the city of Sheffield and, if appropriate, more widely to summarise and communicate lessons learned from Programme.	2	High						

Recommendation	Source (Discussion)	Importance	Sheffield service/ rollout	PCN	Local providers/ commissioners	ICS	Clinical Networks	National
4. Mental Health Needs Analysis and Mapping at PCN level								
4.1 Analysis should be commissioned at PCN level to establish the level and nature of mental health need in each locality.	3	High						
4.2 This analysis should draw on data and expertise from primary care, secondary care, the city council and the Third Sector.	3	Medium						
4.3 The analysis should also be informed by the experience of the Programme and the insights of Programme team leads, including VCSE providers.	3	High						
5. Team Composition								
5.1 Using the Needs Analysis (Recommendation 4), further work is required to ascertain the appropriate and affordable design of service provision required to deliver an equitable level of care in each PCN.	3	High						
5.2 This work would also need to take into account any changes in secondary care provision as well as emergent contribution of any ARRS mental roles.	3	Medium						
6. Caseload Review								
6.1 An assessment should be undertaken to review caseload distribution across teams, with senior clinical input, to confirm appropriate and manageable workloads for each group within the teams.	3	High						
6.2 This review should determine and articulate an agreed approach to caseload management, recognising the different expectations of primary and secondary care.	3	Medium						
6.3 This review should inform a training intervention to address conflicting assumptions across teams about expectations of caseload and associated issues of risk and staff capacity.	3	Medium						
6.4 This review may also form the basis for explicit policy as regards safe and sustainable caseloads.	3	Medium						

Recommendation	Source (Discussion)	Importance	Sheffield service/ rollout	PCN	Local providers/ commissioners	ICS	Clinical Networks	National
7. Engagement with Secondary Mental Health Services								
7.1 A strategy for clear and direct engagement with SHSC at senior level to articulate formation and impact of the Programme, presented in the light of national policy and CMHF expectations, and to share lessons learned through the Programme.	4	High						
7.2 This will involve the creation of a focused briefing clarifying the mission, focus and achievements of the Programme which should be delivered to relevant senior boards in other parts of the health and care provider system, including acute trusts, social care providers and, critically, the secondary mental health care provider.	4	High						
7.3 This communication should focus on the impact of the Programme and the expected contribution the service can make to the goals and objectives of secondary mental health services.	4	High						
8. Organisational Development								
8.1 An OD (Organisational Development) initiative should be considered, ideally delivered collaboratively with SHSC, to build mutual understanding between primary and secondary care mental health providers (and should include ARRS mental health workers who are not part of Primary and Community Mental Health teams).	4	High						
8.2 This intervention should aim to explore cultural differences and risks of miscommunication across mental health services, to support clinicians and managers to work collaboratively across primary and secondary care.	4	High						
8.3 This intervention could be extended to incorporate other partners, in particular VCSE organisations and local authority staff and support whole-system collaboration and integration.	4	Medium						

Recommendation	Source (Discussion)	Importance	Sheffield service/ rollout	PCN	Local providers/ commissioners	ICS	Clinical Networks	National
9. System Integration								
9.1 Collaborative discussions should be initiated with SHSC also required at a system level (between primary and secondary care as well as commissioners) to agree processes and criteria for service users to transition to/from more specialist/intensive care and to/from lower intensity IAPT care.	4	High						
9.2 This discussion may also encompass work to clarify eligibility criteria for the service, which should be consistent with those applied by other MH providers.	4	Medium						
10. Governance and Multi-Partner Engagement								
10.1 The design of the board or oversight committees for the future service should ensure representation from all partners, including the secondary mental health provider, local council, general practice and VCSE organisations.	4	High						
10.2 In particular, the board/committee design should ensure that the range of VCSE providers have input into the design and operation of Primary and Community Mental Health services; engaging with VCSE provider alliance may facilitate a wide range of engagement, including smaller VCSE organisations.	5	High						

Recommendation	Source (Discussion)	Importance	Sheffield service/ rollout	PCN	Local providers/ commissioners	ICS	Clinical Networks	National
11. VCSE and General Practice Liaison								
11.1 A targeted initiative should be undertaken to improve communication between VCSE organisations and GP practices, potentially supported at scale by the establishment of a VCSE provider alliance.	5	High						
11.2 This work may take place at scale, to share evidence of effective support provided through VCSE organisations, and at a PCN level to strengthen two-way communication between local VCSE providers and general practices.	5	Medium						
11.3 Community Mental Health Teams and PCNs should consider ways in which to strengthen VCSE partnerships across primary care at a neighbourhood level, including opportunities for collaborative applications for funding, to enhance capacity to provide care, support and treatment through Third Sector providers.	5	Medium						
12. Facilitation of MDT Participation between Partners								
12.1 Guidance should be developed on the operation of MDT meetings to facilitate participation of different providers, both clinical and non-clinical.	5	High						
12.2 Respecting the clinical autonomy of GP practices, it would be helpful for GPs and GP leads to share experiences of MDT operations and evidence of positive impact of more inclusive practices.	5	Medium						

Recommendation	Source (Discussion)	Importance	Sheffield service/ rollout	PCN	Local providers/ commissioners	ICS	Clinical Networks	National
13. Commitment to Flexibility, Innovation and Learning								
13.1 The service should develop a clear statement of principle on the issue of flexibility and innovation in service delivery, including a definition of the positive dimensions of flexibility that the service will embrace and encourage.	6	High						
13.2 Given the high value placed on flexibility and patient-centred care by both staff and services users, guidance should be developed to ensure staff have the confidence to explore adaptive, patient-centred care but do so safely and informed by evidence where available.	6	High						
13.3 To ensure lessons are learned and innovations are assessed and shared, processes should be established to facilitate rapid sharing and assessment of innovative practice between clinicians, with checks and balances to ensure safe care.	6	Medium						
13.4 This is likely to require a dedicated, clinician-led piece of work to develop guidance and to identify the processes by which innovation should be assessed and shared.	6	High						

Recommendation	Source (Discussion)	Importance	Sheffield service/ rollout	PCN	Local providers/ commissioners	ICS	Clinical Networks	National
14. Recruitment and Retention of Staff								
14.1 Attention to certain key elements of the job offer is necessary to optimise ability to recruit and retain staff, in terms of both agreeing policy and communicating this to existing and prospective staff. These include;	7	High						
14.2 Clear articulation and communication of the ethos, mission, and expected impact of the service, in both recruitment and selection, and through induction processes.	7	High						
14.3 Clarification of roles and responsibilities, particularly for new roles such as MHP and CAPs as well as relevant ARRS roles, to ensure a shared understanding of respective responsibilities and to support smooth collaboration across teams	7	Medium						
14.4 Work to ensure appropriate estates space for teams, potentially including a home-base to enable a degree of co-location and access to good quality spaces for meetings and consultations.	7	High						
14.5 Standardisation of employment conditions as far as possible given multiple employer organisations	7	Medium						
14.6 Clarification and articulation of provision of development and training opportunities.	7	Medium						


Recommendation	Source (Discussion)	Importance	Sheffield service/ rollout	PCN	Local providers/ commissioners	ICS	Clinical Networks	National
15. Measurement of impact								
15.1 A detailed project is needed to measure the impact of the Programme and current/future Primary and Community Mental Health provision, potentially with an economic impact evaluation.	7	High						
15.2 To inform this work, a focused project would be necessary involving clinical leads, service leads, technical leads and commissioners to establish appropriate measures of impact, which may include patient reported measures and prescription rates for psychotropic medication or antidepressants.	7	High						
15.3 Equally, mechanisms should be put in place to routinely capture feedback from service users and from staff on a regular basis, and to demonstrate to users, staff and commissioners how the service learns from and acts upon this feedback.	7	High						
15.4 This work should however recognise the points made above about the scale of undermet need, the degree to which the Programme may have reached underserved groups, and the likely identification of need at an early stage through the Programme, all of which will affect the degree of impact measured.	7	Medium						
15.5 There would be substantial value in a broader commissioned piece of research drawing together learning on implementation and impact across the 12 CMHF early implementer sites at a national level.	7	Medium						
15.6 Similarly, given the number of new roles being introduced across mental health services, there is a need for a broader evaluation of the impact, challenges and benefits of these new roles implemented as part of the Community Mental Health Framework.	7	Medium						

The recommendations contained within the evaluation report were developed over the period March 2021-July 2022.

Independent to this evaluation, in March 2022, NHS England published a national roadmap for Community Mental Health Transformation. The roadmap spans the core community mental health offer, together with key focus areas of eating disorders, personality disorder and community rehabilitation.

The recommendations of this evaluation have therefore been mapped against the NHS England roadmap (**Figure 10: Priorities for CMHT Transformation**, below), to compare this evaluation's recommendations and the national strategy. Priorities which match this evaluation's Recommendations are highlighted in blue.

Figure 10: Priorities for CMHT Transformation

2023/24 - Priorities for CMHT transformation for Mental Health Trusts, Primary Care, Social Care, VCSE providers, Community Leaders, Underserved Community representatives' 

Dedicated focus⁶

Model development	Care provision	Workforce	Data & outcomes	CEN / 'personality disorder'	Community rehab	Eating disorders
Joint governance with ICB oversight ¹	"Must have" services ³ commissioned at PCN level tailored for SMI ²	Recruitment in line with indicative 21/22 MH workforce profile	Record access data from new model (inc. primary, secondary and VCS orgs)	Dedicated function linked to core model: increased access to dedicated function and consultation, support, supervision and training to core model		
Model design coproduced with service users, carers & communities	"Additional" services ⁴ commissioned at PCN level tailored for SMI ²	Expand MHP ARRS roles in primary care	Interoperable standards for personalised and co-produced care planning	Embed experts by experience in service development and delivery		
Integration with primary care with access to the model at PCN level ⁵	Improved access to evidence-based psychological therapies	Staff accessing national training to deliver psychological therapies	Routine collection of PROMs using nationally recommended tools	Development of trauma-specific support, drawing on VCSE provision	Ensure a strong MDT approach ⁵	No barriers to access e.g. BMI or weight thresholds
Commissioning and partnership working with range of VCSE services	No wrong door approach means no rejected referrals recorded	Multi-disciplinary place-based model ⁶ in place	Waiting time measured for CMH services (core & dedicated focus areas)	Co-produced model of care in place support for a diverse group of users	Clear milestones are in place to reduce reliance on inpatient provision	Early intervention model (e.g. FREED) embedded
Integration with Local Authority services	Tailored offer for young adults and older adults	Staff retention and well-being initiatives	Interoperability for activity from primary, secondary and VCSE services		Co-produced care and support planning is undertaken	Clear arrangements in place with primary care for medical monitoring
100% PCN coverage for transformed model	Principles for advancing equalities embedded in care provision	Dedicated resource to support full range of lived experience input	Impact on advancing equalities monitored in routine data collection		Supported housing strategy delivered in partnership with LAs	Support across spectrum of severity and type of ED diagnoses
Shift away from CPA towards personalised care	Support for co-occurring physical needs & substance use	Staff-caseload ratios to deliver high quality care				Joint working with CYP ED services including transitions
Alignment of model with IAPT, CYP & perinatal	Trauma-informed & personalised care approaches	Place-based co-location approaches				Accept self-referrals, VCS referrals and Primary Care referrals.

1. Governance to include commissioners, primary care (inc. PCN leadership), mental and physical health services, local authorities, VCSE, service users and carers.
2. "PCN level" defined as a footprint of typically 30,000 and 50,000 people (this can also be thought of as "sub-place", "localities", or "clusters of wards"). More targeted, intensive and longer-term input for people with more complex needs can be provided at the wider community or "place" level of around 250,000-500,000 people (this can also be thought of as a "PCN-cluster").
3. Must-have: physical health checks, EIP, employment support, psychological therapies, social prescribing, personalised care planning, care coordination, peer support, outreach for inequalities.
4. Additional: advocacy services, carer support, community assets, culturally competent services, financial advice, housing, social care, support groups, volunteering & education.
5. Should include clinical psychologists; MH nurses; MH pharmacists; occupational therapists; primary care staff; psychiatrists; psychological therapists; social workers; community connectors; paid peer support workers.
6. Systems should have commenced work on 2 of 3 dedicated focus areas in 2021/22, meeting relevant expectations. Where appropriate, aspects of core transformation model should be applied to dedicated focus areas in this context. SMI² covers a range of needs and diagnoses, including but not limited to; psychosis, bipolar disorder, personality disorder diagnosis, eating disorders, severe depression and mental health rehabilitation needs – some of which may be co-existing with other conditions such as frailty, cognitive impairment, neurodevelopmental conditions or substance use.
7. In place by end of year
In progress by end of year
Planning underway by end of year

As can be seen, there is strong correlation between the recommendations in this evaluation and the NHS England roadmap which underlines the relevance of this evaluation to national guidance and support toolkits. The recommendations of this report are primarily focused upon the 'core community' offer as shown above.

