Camden Resilience Network

Response to Covid-19: Impact and systems change

August 2020

Contents

Links to resources

Links are *highlighted like this* throughout the report and can be accessed by clicking on those links

Executive summary

Camden's Resilience Network consists of integrated commissioners from the Camden Directorate of North Central London CCG and Camden Council, the Camden and Islington NHS Trust, and local VCS mental health organisations. At the outbreak of Covid-19 they came together to design and deliver a service the would:

A. Meet the needs of the most vulnerable people in the borough with Serious Mental Illness (SMI) during the pandemic

B. Implement significant systems change to better respond to the social determinants of mental wellbeing, reduce the burden on an over-stretched NHS, and create a much more person-centred approach to mental health care across the borough.

This evaluation takes learning from the past 3 months to understand where the Resilience Network has been successful in this and where more work is needed. The first section looks specifically at impact and client experience, whilst the second section looks at broader systems change.

Impact

Key numbers (20 April – 24 July 2020)

- 121 people with SMI supported
- 31 shielded referrals
- 32% of referrals are BAME (compared to 34% of Camden's SMI population)
- 63% of questionnaire respondents had no contact with voluntary community services prior to this intervention
- 91% satisfaction rate
- 0 new hospitalisations for those that have been with the service for 4 weeks or more

Information from output data, interviews and questionnaires was broken into 4 themes to consider success and areas for improvement, from which learning, considerations, and suggestions for further work were built.

Theme 1: Someone to talk to

- Having someone to talk to seems to be the most universal benefit for clients, breaking up isolation.
- Impact includes the security of knowing someone is there for them; the value of 'therapeutic' conversation; the value of 'normal' conversation and relationships; motivating and encouraging more activity.
- Talking therapies are highly valued but, based on previous experience in the borough, there is an anxiety they will quickly become over-subscribed.
- The lack of security around when the project might end is potentially damaging.
- There is risk of key worker dissatisfaction in the fleeting contact with light touch referrals.
- It does not seem this impacts client experience, but more data is needed.

Theme 2: Meeting needs

- Providing food and medication has had significant impact on those who received it and also greatly reassured those who might need that moving forwards.
- Key worker flexibility was key to impact, delivering diverse outcomes.
- Key workers found assessment challenging. It took considerable time to work out many people's needs.
- A better assessment tool would support meeting need quicker.
- Key workers were dealing with a lot of long-standing issues, pointing to the gap in the borough for this kind of support.

- More work is needed to find out why certain people have not engaged at all with the service, both at the level of pre-referral and post-referral.

Theme 3: Making use of the community network

- Referral success is variable, but this doesn't seem to diminish from overall service satisfaction.
- There remains a desire for more in-person activity and physical activity.
- Several interviews felt the combination of SMI stigma and discomfort around mental-health specific services, reducing desire to engage in both support groups and mainstream services.
- The physical side effects of medication were a key area of concern for client interviewees, but there was no support around this.
- Key workers also noted gaps in support around housing, advocacy and debt, but did their best to improvise.
- Referral routes may be limited to what key workers know and trust, potentially limiting options.
- Key workers found several services were slow to respond and difficult to refer to. This was less often the case when there was person-person contact with that service.
- Key workers felt unclear around the boundaries of their new roles. This includes not knowing when a care co-ordinator should be involved and knowing what contact is expected with light-touch referrals.
- Key workers tended to work in ways they had previously, pointing to a need to broaden inter-organisational contact and knowledge.

Theme 4: Reaching the whole community

- Key areas for the project to work on include: listening to and building relationships with local community groups; translating key information.
- Developing more place-based working would support community engagement.

- Changing funding structures around minority communities may allow for broader impact

- The wider Resilience Network could be better at creating real connection between organisations – reflection and work on this has already begun.

- Reflective practice seems to be a very useful and potentially key feature of this kind of connection.

Systems change

- In a very short time, the network has fundamentally altered the way it interacts – shared purpose and language have flourished alongside genuinely mutual relationships.

- Three key structural factors have allowed this:
  - The absence of competitive tender
  - The create-as-we-go approach
  - The capacity for people to flex in their roles

- Four behavioural factors have also been key:
  - Common purpose
  - Transparency and the ability for 'difficult conversations'
  - Humility
  - Reflective practice

- Several risks or needs have been identified that the network can work on:
  - The risk of reverting back to the 'norm' as a result of the re-emergence of individual agendas, high workloads limiting space for collective efforts, or diverting purposes.
  - The need to 'spore' new ways of working out to the frontline of the Network and bring learning from those spaces in.
  - Learning and Evaluation needs to be embedded in practice rather than intermittent and abstracted.
  - Service-user involvement should be re-thought and better prioritised

The learning and presentation of this evaluation needs itself to be evaluated to consider a) what is useful and what is not, b) what needs further investigation, and c) how this learning can be best shared to continue the progress that has begun.

Key numbers

20 April – 24 July 2020

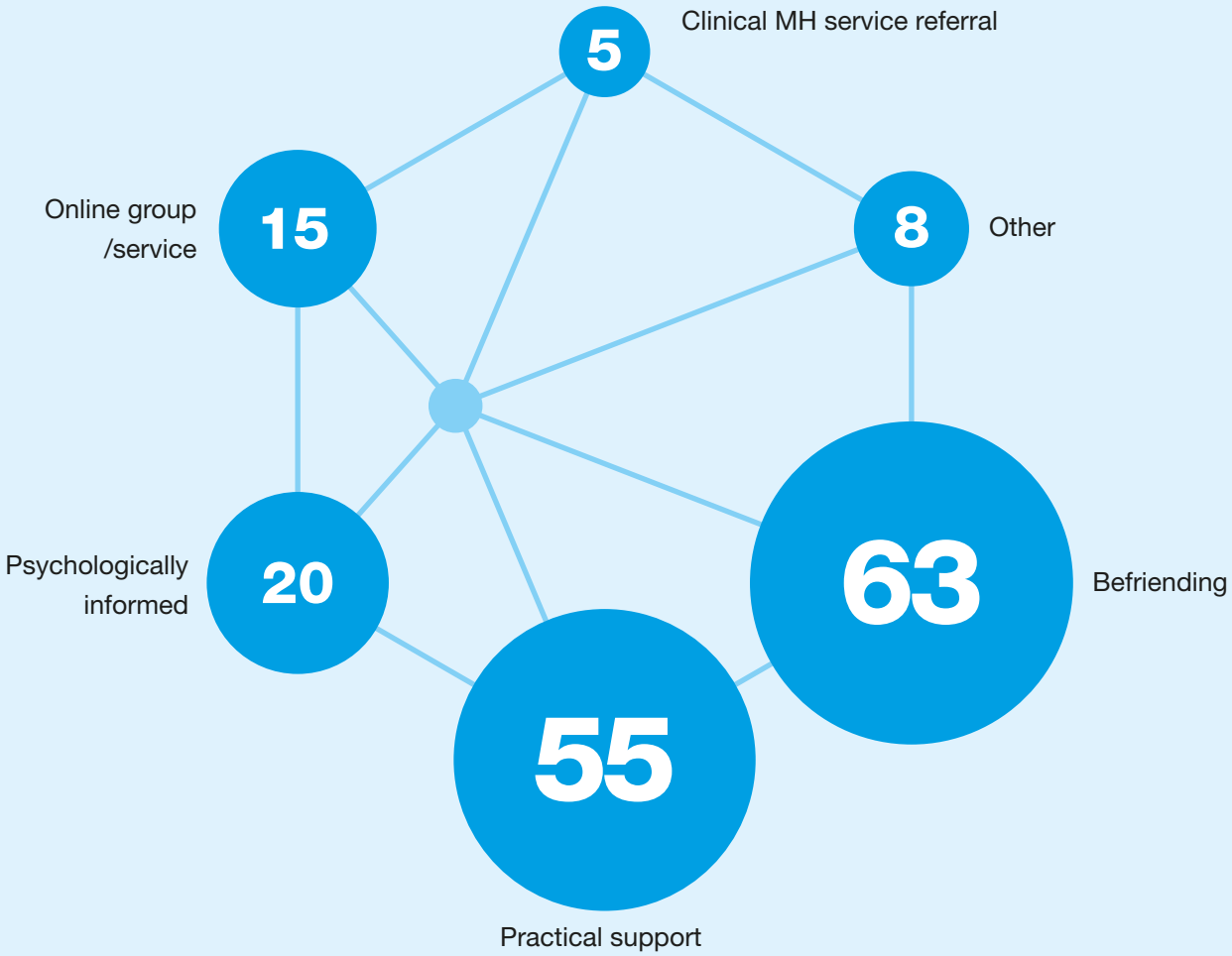
Referrals

Total referrals **167**

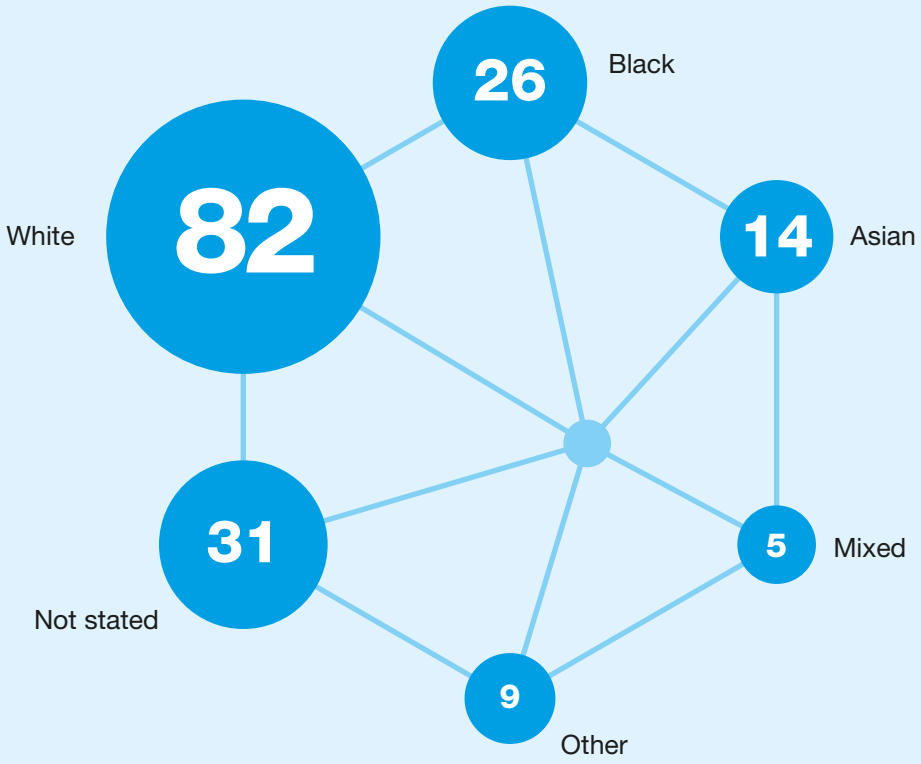
Number receiving support **121**

Number declined support **18**

Support offers



Ethnicity



Providers

Mind	64
Likewise	67
Voiceability	4
Hillside	1
Dr Hopkins (psychotherapist)	2
External befriending organisation	2
Mutual aid group	4
Other	1
Not stated	21

Referring team

North Camden R&R	85
South Camden R&R	65
Primary Care	4
Other	5
Not stated	8

Total referrals

Mind hub	83
Likewise hub	84

Introduction

During the Covid-19 pandemic, Camden Commissioning Group (CCG), the Resilience Network (VCS organisations working in mental health), and the Camden and Islington NHS Trust came together to design a service that was able to quickly work with those people living with Serious Mental Illness (SMI) who needed support during these unprecedented times. The service has several key aims:

- Reaching and supporting the most vulnerable people living with SMI during the pandemic, including people who don't usually engage with services and those isolated or disconnected.
- Working to a 'whole person' approach, supporting people not only with mental health specific concerns but with the social determinants of wellbeing such as social contact, welfare, physical activity and beyond. During the pandemic, this includes food and medication supplies.
- Ensuring any referrals between different partners are smooth, efficient, and do not repeat the same assessment processes.
- Utilising the skills of the VCS organisations in Camden to make sure everyone referred felt heard, understood, and treated like a full person.
- Using the above to support Camden residents living with mental ill health to be as safe and as well as possible in their homes and in their communities.

The service was set up to create impact both in the immediate and the long-term. In doing this, it recognised the need for significant systems change – given the complexity of mental health and they hugely diverse social determinants of mental wellbeing, creating good outcomes for people with SMI means developing a system appropriate for working in such complexity.

The new service is seen as a vital first step into creating a stronger mental health system that reaches far beyond clinical services and into the community, ensuring that people are supported based on the diversity of their needs, be they clinical, social, physical, or anything else that is meaningful to them.

As such, this evaluation is designed to understand how successful the initial workings of this project have been, and to help it improve in the future. It tries to evaluate relative success on two levels:

- the impact on and experience of people using the service;
- the development of a more cooperative, joined-up network of partners for a better overall community mental health system.

The first section is an overview of impact evaluation. It looks at what is and isn't working at the frontline for clients and for key workers, understanding how the service is being experienced and thus where it needs work or can improve.

The second section focuses on the systems change that has already occurred, highlighting principles and ways of working that have allowed for such rapid change. It then points out potential risks, questions, or concerns regarding maintaining and developing that progress.

The fundamental function of this evaluation is learning in order to improve the system. The system changes the current network have already made are testament to the importance of honesty, focus, and continual development, and to avoid the need to inflate or sell anything – we want to deal with reality.

With that in mind, it is important to note the limitations of the evaluation. The service is very new, and changing by the day. Time restraints meant questionnaire and interview samples are small. Conclusions drawn are thus highly tentative. This is more of a pilot – testing what can be learnt, considering how useful it might or might not be, and paving the way for further, longer-term investigation.

Methodology

Impact data

- Referral and output data recorded by key workers based on all clients referred.
- Hospitalisation and service contact data were take from Care Notes, based on a sample of 63 clients (selected for having been part of the service for 4 weeks or more)
- Client Questionnaires were completed by 20 clients. The sample is a combination of self-selecting and opportunity. Questionnaires were either completed with key workers or over email, based on client preference. All respondents had been in the service for 4 weeks or more.
- Semi-structured Interviews were completed with 7 clients. After a randomly selected sample provided only 2 interviews (due to unwillingness to engage or difficulty of contact within the time restraints), 5 interviews were attained through opportunity sampling.
- 3 semi-structured focus groups took place with 10 key workers from Mind and Likewise.
- 2 peer coaches and 2 key workers took part in semi-structured interviews.

Systems analysis comes from conversations, focus groups, semi-structured interviews and observations with 11 members of the team who designed the service (with members across the Local Authority, the C and I Trust, and VCS organisations), 10 VCS key workers, 2 peer coaches, 2 community leaders, and 2 VCS members of the broader Resilience Network.

Impact

The main aim of the project is to provide a high quality, relational, holistic service to people living with SMI in Camden. The hypothesis is that more joined-up working across the network, alongside being given a single point of access for each person to find the support that is most meaningful to them, will produce several outcomes. In this section we go through these one by one, looking briefly at current outcome measures.

1. Provide pandemic-related support (around issues such as food, medication, anxiety and isolation)

- 121 people supported in the last 3 months
- 18% of referrals had 'shielded' status
- 62% felt support was either extremely (33%) or very (29%) valuable, with the rest feeling it was either fairly (29%) or a little (10%) valuable.
- Qualitative feedback on the high value of food and medicine during lockdown, and the importance of breaking isolation though phone and in-person contact.

2. Make individual's contact with primary and secondary care more efficient by handling the determinants of health that are linked to community or social support.

- Sample contact with services slightly higher than average. This could be because referrals are coming through based on the fact that such clients need more support. Qualitative analysis of the Care Notes needed to establish nature of contact.
- Run rates being designed and monitored (looking at number and quality of primary and secondary care contact for a specified time before and after service entry)

3. Reduce the need for hospitalisation

- 0 new hospitalisations for those that have been referred for at least a month
- More data needed (current sample only represents the past 4 weeks – longer-term, larger sample being monitored)

4. Reach the whole community

- Currently working with BAME clients at rates roughly equal to BAME representation in the SMI population (33% of clients are BAME).
- Interviews with Cultural Advocacy and community group leaders have pointed the way towards developing place-based, culturally-informed offers.

5. Increase the amount of community and social support people with SMI are receiving

- 62% of questionnaire respondents were receiving no community support prior to this service; a further 19% were receiving it only occasionally.

6. Provide a service people living with SMI appreciate, value, and benefit from in a way meaningful to them.

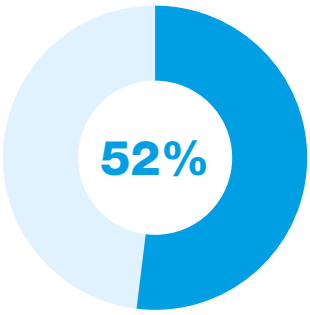
- 91% satisfaction rate for questionnaire respondents
- 86% felt they were supported with what they needed
- 95% of people able to build good relationships with their key workers
- Qualitative feedback found a diverse range of outcomes: joining support groups; physical health walks; counselling; increased motivation; decreased isolation; core needs (food, medication) met.
- Qualitative feedback identified areas for further support, including: side effects of medication; physical health offers; housing; advocacy and welfare; debt.

7. Improve overall well-being

- SWEMWBS being monitored – these will be examined at 3 monthly intervals.

Whilst this data is promising, there is much more to learn. The next section breaks down data from questionnaires and interviews to paint a more nuanced picture of what is and is not working in the service – it is this learning that paves the way for improvement, identifying failings, gaps, and things to build on.

Theme 1: Someone to talk to



... of referrals are receiving befriending support

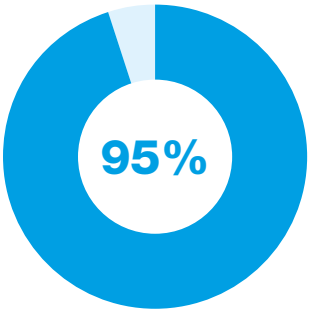
Key points

- Having someone to talk to seems to be the most universal benefit for clients, breaking up isolation.
- Impact includes the security of knowing someone is there for them; the value of 'therapeutic' conversation; the value of 'normal' conversation and relationships; motivating and encouraging more activity.
- Talking therapies are highly valued but, based on previous experience in the borough, there is an anxiety that they will quickly become over-subscribed.
- The lack of security around when the project might end is potentially damaging.
- There is risk of key worker dissatisfaction in the fleeting contact with light touch referrals.
- It does not seem this impacts client experience, but more data is needed.

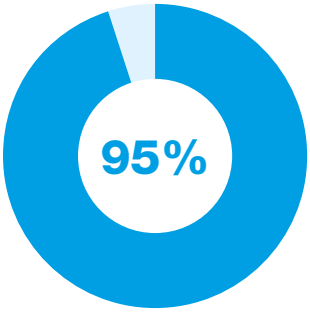
The most common interview feedback was the value and sense of relief in having someone to talk to. The majority of respondents included feedback about how they felt heard and understood, valued knowing someone was for their for them, and valued someone to break up the boredom and isolation. Whilst for some this isolation was a direct result of Covid-19, several clients actively pointed to the fact that not much had changed for them – isolation was a norm prior to the the pandemic.

> I have fun, it's like when you talk to someone like a friend, you can just be yourself, express yourself. It's really helpful.

> Me and the volunteer from Voiceability, we just talk generally. For me that seems to be working. It's a talking therapy, it's an alternative to my medication… it stops my depression.



... felt either mostly (38%) or very much (57%) heard and understood



... of client respondents felt they were either mostly (33%) or very much (62%) able to build good relationships with their key workers

There was split between those who saw the value of talking as a directly 'therapeutic intervention,' and other respondents who valued 'normal' conversations that are not 'heavy or taxing' or 'all about my diagnosis.' Whether understanding these talks as a replacement for clinical support or as something more normalising, it was felt by 6 of the 7 interviewees as very beneficial to wellbeing.

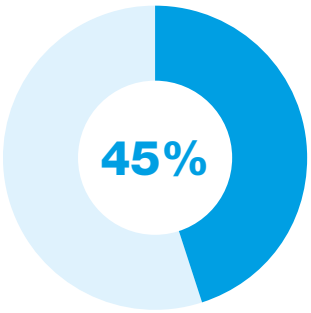
Clients highly valued referrals to volunteer-led counselling with Mind. Referrals were initially slow into one-to-one trauma therapy with clients, but this has started to pick up. Given the potential value of the service, it was noted that VCS orgs were initially cautious about who they referred – there was a sense that these kinds of services could become quickly overwhelmed, so they were being held back for those who really needed them. This sense came from experience (shared by clients and key workers) that, outside of Mind, talking therapies in the borough – including iCope – were over-subscribed, slow and difficult to access for people with SMI.

The conversational support from key workers and volunteers also seemed to increase motivation – several respondents spoke about the structure and encouragement it provided to do 'different' things such as going for walks or meditating. One person spoke of the 'sense of freedom' this provided in difficult times.

Key workers felt that relationships were able to be built in most cases, and worked hard to develop them – several were working with people with no phone, so were visiting homes to make sure contact was made. The overall lack of in-person contact was, of course, very challenging – good relationships were built, but it took more time and effort. This was further exacerbated by not knowing the overall timing of the project – giving vague answers about how long the project might last was felt to reduce trust and there was a real fear that were the service taken away it would be very damaging.

Key workers also felt relationship building was harder for lighter touch clients – specifically those in the green (less urgent/ lighter touch) categories. The usual process was to pass them onto befriending volunteers or other organisations like VoiceAbility. Where relational work was previously the norm, this felt particularly difficult, as for many key workers, passing people over quickly reduced the sense of connection and engagement (this was not echoed in client interviews, but the sample was too small to draw any conclusions). This is particularly prescient given that key worker job satisfaction is known to be key to both *quality service delivery* and *staff retention*.

Theme 2: Meeting needs



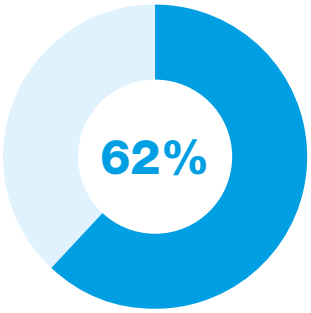
55 people (45%) referred to practical support

Key points

- Providing food and medication has had significant impact on those who received it and also greatly reassured those who might need it moving forwards.
- Key worker flexibility was key to impact, delivering diverse outcomes.
- Key workers found assessment challenging. It took considerable time to work out many people's needs. A better assessment tool would support meeting need quicker.
- Key workers were dealing with a lot of long-standing issues, pointing to the gap in the borough for this kind of support.
- More work is needed to find out why certain people have not engaged at all with the service, both at the level of pre-referral and post-referral.

The second key element referred to in client interviews was meeting basic needs, in particular the food and medication support provided early on. Even in the cases where people did not take up these offers, participants spoke enthusiastically about the fact that they were there – knowing that they could use them if they became unwell was a great relief.

Assessment of need remains a challenge for key workers. The lack of face-to-face contact, the difficulty in reaching people over the phone, technical issues, and the lack of clarity and firmness over what the service can actually offer make it harder to build relationships – some felt the lack of clarity in particular risked a loss of trust and engagement. Interesting comparisons were made with other services key workers had provided in which it is made clear that understanding need happens through the relationships and takes weeks or longer – knowing those parameters provided more clarity. Nonetheless, key workers have made clear that a better assessment tool or structure combined with more service clarity would be a benefit.



... felt support was either extremely (33%) or very (29%) valuable, with the rest feeling it was either fairly (29%) or a little (10%) valuable.

Part of the challenge here is diversity of need. Client interviewees clearly needed and wanted different support done different ways at different times – each interviewee had a different desire and a different expectation. Some wanted someone simply to listen to them as a substitute for their clinical care; some wanted someone to take their minds off all things clinical; some wanted direction and suggestion as to what was available; and yet others wanted very specific kinds of support such as boxing gyms or music groups.

> It's been good as far as I am concerned – you got me the food which was the main thing as I was starving – now I'm putting on weight which is good

> Mainly I liked how I would get phone calls seeing how I was – that was really helpful. It was really sweet when they offered to do my shopping. It's nice to know that is there if I ever need it

Impressive flexibility was demonstrated by key workers in adapting to needs. Examples include supporting someone to reconnect with long lost family, meeting need by connecting with organisations as varied as the Royal Courts of Justice and Food For All, or using websites like Money Saving Expert to work with a client on debt management when direct debt support could not be found. Value emerges from first recognising those social determinants of wellbeing and then adopting a pragmatic, flexible, 'why not' attitude to care.

Key workers also pointed out that much of what they were dealing with was not Covid-19 related – they seemed to be working on long-term issues for most of their clients. This points out the previous gap in the borough around social determinants of wellbeing that this service seems to be filling.

Particular investigation is required to understand why people didn't engage in the service (those contacted did not want to be interviewed), particularly as service-user groups highlighted the problem of cold calling and the anxiety this brings to many people.

Theme 3: Making use of the community network

Key points

- Referral success is variable, but this doesn't seem to diminish from overall service satisfaction.
- There remains a desire for more in-person activity and physical activity.
- Several interviews felt the combination of SMI stigma and discomfort around mental-health specific services, reducing desire to engage in both support groups and mainstream services.
- The physical side effects of medication were a key area of concern for client interviewees, but there was no support around this.
- Key workers also noted gaps in support around housing, advocacy and debt, but did their best to improvise.
- Referral routes may be limited to what key workers know and trust, potentially limiting options.
- Key workers found several services were slow to respond and difficult to refer to. This was less often the case when there was person-person contact with that service.
- Key workers felt unclear around the boundaries of their new roles. This includes not knowing when a care co-ordinator should be involved and knowing what contact is expected with light-touch referrals.
- Key workers tended to work in ways they had previously, pointing to a need to broaden inter-organisational contact and knowledge.

Client interviews suggested that referral success is variable. Some found them highly valuable, with two interviewees suggesting they were better than clinical care (largely for the fact that they were able to link in with support rapidly, whereas they had waited for a long time – sometimes years – without such success in clinical services), and questionnaire responses showed real appreciation around the activities accessed and the counselling referred to.

Referrals to RN offers:

138

Referrals to external offers:

14

Others found little value in their referrals – for example, whilst one interviewee spoke very highly about peer mentor support, another felt that that conversations with their mentor weren't particularly helpful. Half of interviewees were looking for more in-person activities, particularly around physical exercise, and felt that they had to wait until things opened up more to engage.

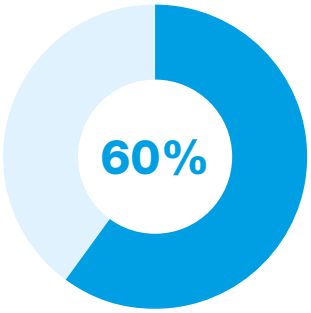
> I just wasn't doing anything before the service. It has been fantastic. I have gone to loads of places and done lots of good stuff

Whilst some took great comfort from support groups – appreciating the structure, social contact, and in one case therapeutic nature of the support – several felt they did not want what was on offer. Reasons given were not wanting to be pigeon-holed as mentally ill, finding that meeting people who were also unwell had a negative impact on their wellbeing, or wanting to be with a similar demographic (younger people). At the same time, people also felt the stigma of SMI in particular remained a challenge for engagement in mainstream activities. There is a bind here – a desire to escape the boundaries of mental health specific services, but an anxiety about doing so.

More data will be needed is in terms of how people for whom referrals don't work out are then supported down the line. At present it is too early to tell – of the 20 questionnaire respondents, only 7 were referred onto secondary support. However, 6 of those felt that the second referral was either very or extremely valuable. Furthermore, not liking initial referrals did not diminish overall service satisfaction in interviewees.

> Being at the support group I felt a bit depressed, everyone seemed like me, down and out. I feel low myself so it's no good… but the key workers do a really good job, they're very understanding, very helpful. We connected on the stuff we were talking about

The most common form of support referred to by key workers – usually based on recognition of isolation – was through in-house befriending services or their own one-to-one support. Mind staff found that Healthy Minds and Mind volunteer counselling referrals were particularly useful



... felt the initial support referred to was either extremely or very valuable to them

(although one staff member pointed out a lag in referral-contact time was emerging). Peer coaches noted VoiceAbility as a useful referral point, and Likewise appreciated their in-house Art Therapy offer. It seems that, broadly, key workers tend towards referring to what they know. This means there will be gaps in accessing broader networks until key workers are better acquainted with other services.

Some of the activity around referrals was a result of the nature of contact with external services. Key workers felt most of those they referred into were somewhat distant. External referral routes could be obscure, time consuming, and slow, particularly when there was little human contact – where there was a person spoken to, there was more confidence in that service. This highlights the need to continue building personal relationships between services – until then, whilst this service is theoretically an 'open door,' it sometimes opens onto a poorly lit room.

Key workers pointed out key gaps in borough support around housing, advocacy (particularly for welfare benefits), and debt. In all of these, they found themselves spending a lot of time trying to access services that might be ultimately fruitless and then improvising themselves, for example through building experience of PIP appeals processes or sharing debt management tips from websites. Housing was commonly the most challenging, and an issue that seemed to impact upon a significant number of clients.

> That's the one thing that lacks – something for young people who are putting on weight just because of medication. Dr's just talk about portion control and stuff. It's not given to you regarding nutrition or health regimes, and the weight can bring a whole other level of depression

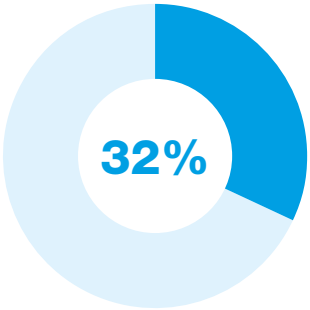
In client interviews, there was a gap in support around the physical side effects of medication. Tiredness, weight gain, and the indignity of certain side effects came up in conversation and was at the forefront of almost every persons mind. One interviewee noted that she would love support groups around this, but had not found any.

These gaps also point to the somewhat blurry role of key workers. For them, questions emerged around the extent to which they are supposed to be responsible for holding certain issues (clinical, social care, housing and advocacy issues), the extent to which they were supposed to be in contact with light-touch referrals, and how their

role fitted alongside care co-ordinators. Given the importance of worker flexibility, there is a question of how to define these boundaries without limiting the possibility for pragmatic creativity in this role.

Perhaps as a result of this blurriness, key workers seemed to be reverting to type based on the services they had experience in. Broadly, this meant Likewise workers talking more about relationship-building and Mind workers talking more about building referral pathways and options. Work on this has already begun, as Likewise and Mind key workers have recently been brought together to share learning and ways of working with the aim of improving everyone's practice.

Theme 4: Reaching the whole community



... of referrals are BAME (compared to 34% of Camden's SMI population)

Key points

- Key areas for the project to work on include: listening to and building relationships with local community groups; translating key information.
- Developing more place-based working would support community engagement.
- Changing funding structures around minority communities may allow for broader impact
- The wider Resilience Network could be better at creating real connection between organisations – reflection and work on this has already begun.
- Reflective practice seems to be a very useful and potentially key feature of this kind of connection.

A long-standing challenge of this crisis in on the unequal impact of Covid-19 on BAME populations, which further exacerbates long-standing inequalities in mental health. As such, we spoke to community centres and people working with minority groups to understand what is and isn't working.

Through the Cultural Advocacy Project, significant work has been done to understand and support particular minority communities with their mental health. This has started with listening – learning

from communities and building support offers from their starting points. This is particularly important in communities that may not have much experience in talking about mental health in order to not immediately isolate people (here it was noted that younger generations tend to be more willing to have those conversations).

Another key issue for minority communities, particularly during the pandemic, was the lack of translation – whilst it eventually came, that it emerged weeks after English-language information led to a further sense of alienation and otherness. Rapid translation seems to be a must.

There were also myriad stories of individual encounters with GP's, mental health workers, and other key staff (housing officers, customs officials) that displayed cultural insensitivity and reinforced otherness, or were misinterpreted as such. This spoke to a broader need for staff training, as well as a need for people to understand the legalities and functions of particular services. The very term BAME could also be problematic – some community members felt it actually enhanced a sense of otherness. Finally, these experiences pointed to a need for more trusting, human relationships between minority communities and key social actors to avoid distrust and misunderstanding.

Housing was again noted as a key issue affecting people in the communities CAP worked in.

Place-based working

The experience of both the Cultural Advocacy Project and other community centres working with minority groups points to the importance of genuinely place-based working. People find it very difficult to step into a new space, but if services can enter their spaces there is a history of more success. There was a sense that the Resilience Network project could improve by working directly with community groups themselves, whether faith groups, national identity groups, or community centres. Given those people know the community best, they can 'translate' – sometimes literally – the service into something that could work for their community. Peer support in particular seemed to be a successful route through which people who might not be used to having conversations about mental health can start.

This also touches on how to reach people as part of their communities. Based on these initial conversations, there remains a significant gap between many community spaces and the Resilience

Network offers. Community centres do not know what is out there, and have to work hard to find out and bring it into their own space – one manager noted that she only knows the Crisis Team as a point of referral, but would much rather be able to support someone and refer them on prior to that being necessary.

Another repeated challenge here is the need for personal relationships with services – community centres wanted to both trust the service they were referring to and know that any referral would be quickly picked up. This seemed only to have happened with services that staff had personal contact and experience with.

Structural challenges

Two points of the RN structure emerged that might make this work more difficult. Firstly, funding models for working with minority communities target particular communities – this means when opportunities arise linked to working with communities not specified in the contract, it is harder to take advantage of them.

Secondly, it was felt that the broader RN could more meaningfully link organisations together – interactions were experienced by several partners as only 'surface level.' This meant that actors working with communities across the network were more likely to miss opportunities to get people support that would work for them. Here, change seems to be on the way – the broader systems changes have given the broader RN the impetus to re-evaluate how they are connecting with each other. This change has already been opened up in a meeting by partners emboldened by experience (CCG, Mind and Likewise).

Reflective practice and Clinical/Community Boundaries

As part of this offer, a psychotherapist who used to work in the NHS has been available to lend a clinical perspective and skillset to the Resilience Network and the community. This represents a shift in the way clinical work is conceptualised and used in Camden, bringing it into communities rather than asking communities into clinical spaces.

This role has so far covered three areas. Most directly, there is one-to-one therapeutic support with clients (at the time of writing, this had only just begun so has not been evaluated). Secondly, there is work with the Recovery College to deliver specific modules on trauma and

how to cope with it, again bringing a whole new level of expertise and experience into the community. Finally, the psychotherapist is facilitating a reflective space for community practitioners and managers who, both as part of their day-to-day work and as a result of the pandemic, are dealing with a vast range of stresses and difficulties.

These activities have already started to show their potential to bring people together across the network. Community Centre Managers from the reflective space valued the opportunity to step back and reflect on their work and their self-care.One interviewee felt particularly strongly that a space where people tell her what to do would be uncomfortable – there was a sense that this was about connection and reflection rather than problem solving. These managers are often drivers of community action – providing such a space seems to help people stay engaged in their work and reduce emotions such as overwhelm and guilt, which can only help broader system functioning.

This linked into the experience of the first key-worker group meeting, joining together Likewise and Mind. Participants valued having a space to express themselves and hear others' experience, feeling less siloed and more connected. Reflective practice may be a key to making the RN a genuine network rather than a set of loosely aligned organisations.

Impact evaluation – overall considerations

Given the early stage of the data and the project, we can not draw firm conclusions. Instead, the learning here raises considerations – things to think about, question, work on, or further investigate in order to directly enhance impact.

Considerations

- What kind of changes might increase meaning for key workers working with light touch referrals? To what extent should this be prioritised?
- Given the high value of key worker flexibility and pragmatism, how do we better define their roles to give them more clarity without reducing creativity and the quality of relationships?
- How can the network better link in or develop physical activity offers both as lockdown eases and in the case of another lockdown?

- How can the service find or create space for people living with SMI who want to move into more mainstream spaces but don't yet feel accepted?
- How can more person-person links be developed across different organisations to enhance referral options and build links to harder to reach communities?
- Could the network link in with any other organisations to support housing, advocacy (particularly regarding welfare benefits), and debt issues? To what extent should these be held by key workers and care co-ordinators?
- What support could the RN provide to support with the side effects of medication?
- In order to work with community groups where they are, how is more place-based working possible?
- Is the funding model for working with specific hard to reach communities limiting?
- What role could reflective practice play in ensuring the network stays connected?

Things to work on

- Securing funding for the future of the project may reduce confusion and increase the capacity for key workers to build on the good relationships they have already developed
- A stronger assessment tool should be developed (this is already in progress)
- Increase cross-organisational contact of key workers to enhance learning and support (already in progress)
- Increased sense of connection and shared learning between wider Resilience Network partners (already in progress)
- Translation of key Covid-19 and Resilience Network information might help engage hard to reach communities

Future impact learning

- Comparing experiences and outcomes of particular client groups – e.g. green/amber/red; substance abuse; learning difficulties; age; ethnicity
- Developing better understanding of why people do not engage
- Run rates
- SWEMWBS

Systems change

Overview

In a very short time, the network has fundamentally altered the way it interacts – shared purpose and language have flourished alongside genuinely mutual relationships.

Three key structural factors have allowed this:

- The absence of competitive tender
- The create-as-we-go approach
- The capacity for people to flex in their roles

Four behavioural factors have also been key:

- Common purpose
- Transparency and the ability for 'difficult conversations'
- Humility
- Reflective practice

Several risks or needs have been identified that the network can work on:

- The risk of reverting back to the 'norm' as a result of the re-emergence of individual agendas, high workloads limiting space for collective efforts, or diverting purposes.
- The need to 'spore' new ways of working out to the frontline of the Network and bring learning from those spaces in. Learning and Evaluation needs to be embedded in practice rather than intermittent and abstracted.
- Service-user involvement should be re-thought and better prioritised

When dealing with complexity – a key feature of mental health – it is well recognised that outcomes, such as those above, are very rarely the result of simple cause and effect. Instead, they emerge from a myriad of forces, actors, and networks. In these conditions, successful systems need to be continually learning, quickly responsive, and should strike the balance between flexibility and stability.

We've kept the theory brief. For more, it is worth looking at *Lankelly Chase's System Behaviours* and the *Human Learning Systems* approach.

As such, this section draws on interviews, focus groups and observations to look into the system of the Resilience Network, examining how Covid-19 allowed for considerable system change, how the positives of this change might be maintained, and how the system needs to further evolve and adapt to maximise its potential.

Knocking down barriers

Long before the pandemic, the NHS England Community Mental Health Framework had set out the desire for more integrated mental health services that put people before diagnoses and recognised the social determinants of mental health. Locally, networks were set-up to enhance the collaboration and partnership building necessary for a significant shift in the way mental health services operated. These networks were making progress, with partners broadly agreeing with the principles of the framework. However, there remained many challenges to more significant change.

Interviews with various Resilience Network partners drew out many of those challenges:

- Anxiety about change across various organisations and institutions
- Protection of roles (in part a result of heavy workloads that made expansion particularly daunting)
- Cultural differences between organisations making cross-network understanding difficult – eg. VCS organisations finding clinical language and shorthand impenetrable
- Suspicion of service reduction and the impact on local organisations (a result of austerity policies reducing services over the previous decade).

- A sense of unequal footing (VCS and service-user organisations feeling that they were perceived as lower-status than clinical organisations)

- The power imbalance of contracting – as arbiter of finance and services, the CCG and C and I Trust became entities which contracted organisations felt they had to impress. This dynamic seeped into relationships between VCS organisations due to the competition for contract tender. Honesty, challenge and co-operation were risky in a context where upsetting the norm could result in the loss of vital contracts.

Many of the key actors in Camden's mental health picture were on the same page in believing Camden would benefit from a much more joined-up, holistic approach to mental health that recognised, fundamentally, the importance of social determinants. The barriers listed above meant that whilst a space for this commonality was created and the beginnings of connections and relationships were starting to form, they struggled in the power dynamics and structures of the borough.

The pandemic response

Despite these barriers, the existence of these networks were the fundamental building block to a more significant and promising shift during the pandemic. The network enabled commissioners to bring the key VCS, clinical and commissioning groups together quickly and provide the basis for a rapid response, and the urgency of the situation made space for a new way of working and thinking about the network. The need to reduce the burden on NHS services and make sure those most at risk in the borough had their basic needs met meant 'ego was put aside' and the shared desire to help meant co-operation was rapid and productive.

The grounds for this change was based on three structural shifts:

- Co-operative service design instead of competitive contracts
    - Allowed for all partners to consider what the needs were, what the resources were, and build from the ground up (rather than for VCS organisations to bend their skills and resources into a pre-determined contract)
    - Removed the anxiety of zero-sum contract tenders – not having to compete for limited resources meant it was safer and more productive to share learning and challenge each other.

- Created a greater sense of equality for partners – the sense that clinical services were further up the hierarchy than VCS had been eroded as the value of VCS organisations was clearly recognised and articulated.

- Building the service on-the-go instead of a pre-determined contractual obligation
  - The uncertainty forced partners to continually learn and adapt to rapidly changing circumstance – this was freeing, and allowed for mutual discussion and creativity based on actual need.
  - Given the unprecedented nature of the situation, each partner had to listen to and understand one another to get a grasp of need, resource, and opportunity – this created genuine mutuality. It also highlighted the value of community organisations and their understanding of on-the-ground need.

- Role Flexibility
  - The urgency and unprecedented nature of the pandemic meant people felt freed up to engage differently, being held account less to a particular job title, network role, or network process and instead to serving the needs on the ground.

These structural shifts were supported by several behavioural features:

- Common purpose
  - All partners shared a desire for change, a desire to work differently, and a similar sense of how mental health provision could improve.
  - All partners wanted to maximise the response to the pandemic.
  - Interviews suggested language played a significant role. Prior to the pandemic, VCS organisations felt isolated from the language of clinical organisations and commissioning teams. During these interviews, language seemed to be much more shared – terms such as ‘holistic care’ and ‘whole-person working’ were notable for their consistency.

- Importantly, this language issue has been addressed directly by CCG partners who recognise the need to adapt their language and make it more accessible. Open conversations occurred around definitions and titles, and recognising the complex web of different organisations and the layers of acronyms and shorthand allowed for both more care of expression and more questioning for clarity.

- Difficult conversations
  - Several partners talked about the value of having challenging conversations that addressed real problems in the way they had been previously relating to each other. These cleared the path for more honest and productive relationships.
  - There were several examples of changed practice through this: for example, conversations around perceived rivalry opened the door for shared learning between VCS organisations, and conversations around service-user frustrations with co-production resulted in more shared power during co-production meetings.

- Humility
  - Partners showed humility in recognising previous flaws and in 'leaving egos at the door.' This allowed for better communication, created real change, and is a clear sign of people prioritising the needs of a bigger system.

- Reflective capacity
  - Partners seemed to have a genuine willingness to reflect on both the service and the process of partnership engagement.
  - This was matched by a willingness to change, meaning much more productive systems functioning.
  - Reflective capacity also played into the sense of shared purpose and connection between services.

Underlying these behaviours were a few other implicit features observed but not named in interviews:

- Trust
    - At several points, partners showed considerable trust in each other – for example, VCS organisations taking the risk of delivering a service before funding was guaranteed, and the C and I Trust taking the risk of not recouping funding from NHS England. Commissioners and VCS organisations supported each other throughout these risks.
    - Whilst there was an expectation that each actor would get on with their role, this was not heavily monitored or managed, providing the freedom for creativity and flexibility.
- Conviviality
    - The network had come together in a way that seemed to nurture general good will and genuinely warm relations – such an atmosphere makes honesty, information sharing, concern-raising, and communication far more fluid.

Systemic risks, gaps, and opportunities

At the level of project development, key barriers have been knocked down and new practices have been developed that point to a much healthier system. However, many challenges need to be addressed in order to maintain the progress that has occurred and to further develop the kinds of system behaviours that are most likely to create impact.

Reverting back

Partners noted a risk that things go back to where they were. A few key factors could come into play here:

- Workload – interviewees noted that when workloads get overwhelming, people struggle to find the time or motivation to do anything beyond their job remit. As caseloads and scope grow, this will need to be monitored.

- Individual agendas – the shared purpose up to this point has been promising, but partners are aware of the risk of losing the sense of the whole and starting to work from their own perspective or to their own benefit. The network needs to be careful to avoid structures that might encourage this, and will need to actively maintain it's open culture and willingness for difficult conversations.

- Hierarchy – One thing noted in interviews was more sharing of power and decision-making between clinical, commissioning, and VCS organisations. If imbalances were to re-emerge – particularly given the funding dynamics – it would be problematic. More information on avoiding this can be found here.

- Shared purpose – continual checks on shared purpose and each partner's function will be necessary given the scope of the project. This will require more accountability mechanisms.

- Language – there were terms less shared across the network, such as 'whole population health.' Similarly, whilst SPA (Single Point of Access) became commonly used in the core design team, it was less understood outside of this. This risks exclusivity.

Co-production

- Co-production was not as much part of the service design as it should have been.

- At this point, it is not something that can be 'bolted on' (which would risk tokenism and box-ticking).

- Serious thought is needed on how client input can be productively incorporated. Service co-design might be a better model.

'Sporing' from the middle

- Whilst changes in ways of working were substantial amongst those most involved in developing and running the offer, there is a risk that this progress stays within the core team.

- An example is the lack of clarity and shared purpose at the frontline – key workers are keen to support people as best they can, but are unclear as to the frame and function of their role.

- Work is needed to spread the structural and behavioural patterns established out whilst bringing in the learning from frontline workers and clients.

- Some of this work is in its early stages – joint meetings between Mind, Likewise and Peer Coaches are promising.

- There is a risk that the initial core group becomes more rigid and less fluid as time continues and relationships cement, making a sense of shared belonging harder for anyone coming into that space.

Who's at the table?

- There was a sense that 'the right people were around the table,' but this evaluation has found out that engaging further groups could bring real benefits. Examples from interviews include wider Resilience Network partners; community centres; religious groups; carers groups.

- This brings its own risk. The core design group was usually around 12 people, which made space for most people to feel involved and have significant input. More people might reduce the sense of ownership, or make it more chaotic and less tangible.

Learning and response

- Actors need to feel empowered to make changes based on feedback at various different levels (eg. VCS leaders; key workers). The boundaries of that decision-making process have not yet been defined.

- Whilst the value of this evaluation process remains to be seen, work is needed to embed continual feedback into the system rather than intermittently insert it – reports and methodical evaluations can easily be forgotten and ignored in a way that committed and authentic mutual learning cannot.

- This could take the form of either structured learning groups at different points in the system, or having designated systems monitors to continually start conversations and collate learning from different spaces.

- Building space for consistent reflection and mutual accountability will be integral for ensuring learning and action.

- Several voices were missing from this initial evaluation: referrals who chose not to engage in the service; care co-ordinators and clinical staff; members of the RN who have been less involved in the development of this project; and people living with specific complex challenges that can be barriers to service entry (eg. substance abuse and learning difficulties). These voices will need to be integrated to better understand and respond as a whole system.

The next stage of systems development is for reflective consideration of the above. The evaluation needs itself to be evaluated to consider a) what is useful and what is not, b) what needs further investigation, and c) how this learning can be best shared to continue the progress that has begun.

Case studies

Terry

Terry came to Likewise very isolated and in need of both social contact and practical support. He had spent many years homeless and, alongside his schizophrenia diagnosis, found it difficult to engage with people and get practical tasks completed. Covid-19 had exacerbated this as he was shielded, so unable to go shopping or to the GP surgery. The first step was thus to set him up with regular food parcels and make sure he was able to stay on top of his physical health care. His Likewise Key Worker, Marie, continues to support him with this.

The first few sessions were challenging – Terry does not find communication easy, particularly with new people, and finds it difficult to trust professionals. However, Marie was able to provide consistency by turning up at the same time every week, and slowly more trust was built – this enabled them to find more out about each other whilst Terry eventually gave Marie consent to work on practical issues. This was supported by partnership with Terry's social worker, which ensured the most pressing matters (such as the need for various medical appointments) were dealt with first, whilst other issues emerged through the relationship – eventually Terry asked Marie to look at his mail, through which it became apparent he had several unpaid bills which she then supported him manage.

Through their regular contact, it also emerged that Terry hadn't spoken to his family for 25 years. When Marie asked whether Terry would want to try and get in touch with them, he took a few weeks to think about it. Marie was careful to set expectations – there was no guarantee they would have any success, and even if they did there might be a lot of emotional difficulty in this process. Terry decided to press ahead, so together they considered how they might do this – Marie brought her laptop to their next visit to set up a social media account and look for names Terry could remember. Within a week, they had received a message from one of Terry's cousins, and within three weeks he was having an online video call with his long-lost parents, siblings, nieces and nephews.

This contact has continued with the support of Marie, and Terry has become more and more open, moving from one word answers to dialogue regarding the care relationship and the care he wants to receive. There is still a way to go, but providing consistency, creative and practical thinking, and working in partnership with other health and social care providers has supported Terry through the worst of the lockdown, kept him on top of his physical health and his practical challenges, and – through a pragmatic, trusting relationship – delivered change that was entirely unpredictable at the start of the service.

Rehman

Rehman was referred during the pandemic as someone who was isolated and struggling. He has often had problems with his neighbours as he consistently believes that they are plotting against him. This causes him huge amounts of stress and leads to some very challenging behaviours that have led to him being continually moved around. Visits from emergency services have been common, and he is in regular contact with the Crisis Line as he has felt he has had no-one else to talk to, particularly since his one safe social space – a mental health day centre – has been shut since the pandemic.

Since being referred to the service, he has been receiving weekly home visits from a Likewise Key Worker. It became clear that much of his stress comes from a lack of social contact and the resultant rumination this brings. They have been working together to help shift Rehman from fixation on his neighbours into other kinds of activities – they have been doing chair exercises (as Rehman finds things like yoga too physically strenuous), have planned art sessions to do together, and have been talking openly and constructively about Rehman's beliefs and how to manage them. They've also started looking into other social spaces that Rehman might feel safe and understood – the pandemic has limited these opportunities, but they have found a few community spaces to try out as soon as they open.

For Rehman, the social contact has relieved some of the stress, rumination, and 'acting out' that happens when he is isolated, also reducing the reliance he feels on the Crisis line. There are still many complexities and challenges to work on as the support and the relationship develops.

Monique

Monique came into the service struggling with lockdown. She was finding it hard to get out of bed, let alone out of the house, and was upset about the impact this was having. When she spoke to her key worker, she decided she predominantly wanted accountability – someone to report to and encourage her to do the stuff she knew was good for her wellbeing.

Alongside these weekly accountability calls, she was keen to try the Art Therapy offer with volunteers at Likewise. She developed a great relationship with the volunteer, sharing a love of the same music and talking about how Monique might get more active. These relationships and check-ins made space for positivity within Monique's life – she has felt more upbeat and optimistic, and ready to take advantage of opportunities as lockdown has eased.

Through using the support to explore what she wanted and needed, she decided she wanted to find volunteer work and get support in using computers. She used the service as a springboard, planning and then spending an afternoon going down her high street looking for volunteer opportunities, and then working with her key worker to find and sign up to digital inclusion advice and training. Along the way, they also found that Monique's local cultural centre was offering activities that she wants to join when they re-open. Monique has used the service in a way that suits her, building a range of activities that support her wellbeing both now and in the future.