NHS
Bedfordshire, Luton
and Milton Keynes
Integrated Care Board

Community and Mental Health Services

Transformation Programme
Testing the Case for Change and Transformation Priorities

Focus groups – Summer 2025

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Report includes supplementary feedback - addendum added 1 October 2025

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Appendix 1	Presentation 'Testing the Case for Change and Transformation Priorities'

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1 October 2025	Feedback from CCS's 'Luton and Bedfordshire Adult Services' – focus group with service users

1. Introduction / Background

Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB) and its partners are working together to review and reimagine how community health and mental health services are delivered across the area. This work formally began at the start of 2025 with the launch of the transformation programme.

As part of the early stages of the programme provider and Voluntary, Community and Social Enterprise (VCSE) organisations across BLMK shared a range of case studies and reports. These contributions offered valuable insights into service delivery, innovation, and lived experience, and helped to identify several recurring themes.

To build on this, the ICB's System Insight Network meeting in May 2025 focussed on community and mental health services and gathered further feedback and lived experience across four key areas.

These insights helped shape the draft Case for Change document. In August and September 2025, a series of focus groups with residents, patients, stakeholders, workforce and VCSE were held by the ICB and partner organisations to sense-check the ICB's thinking and test whether the ideas included in the draft Case for Change reflected people's real experiences.

The focus groups explored whether the areas we had identified felt relevant and whether the proposed priorities resonated with those who use and deliver services.

Participants were asked to share their views on the four core areas which had been reviewed at the System Insight Network meeting:

- Access to services
- Prevention services
- Crisis support
- Integrated working

They were also invited to comment on the six transformation priorities that had emerged at the time:

1. Develop teams in neighbourhoods to help improve health outcomes and the experience of care
2. Understand the needs of local communities to help prevent poor health
3. Co-design and co-deliver services focused on preventing poor health and helping people start, live and age well
4. Ensure services are personalised, with a single point of access for people using our services
5. Increase access to a wider range of services closer to home
6. Provide co-ordinated urgent care within the community

This report presents the findings from those focus groups and highlights the key themes, insights, and suggestions shared by participants.

2. Methodology

To lead the engagement for the programme, a Communications and Engagement Steering Group was established. This group comprised communications and engagement leads from the Integrated Care Board (ICB), VCSE lead, community and mental health providers, the four local authorities, and four Healthwatch organisations.

The group collaboratively agreed on a dual-method approach: conducting a series of focus groups and running a survey. The survey findings are presented in a separate report.

All partners were invited to support the programme by:

- Promoting the engagement opportunities through their networks.
- Hosting staff engagement workshops and service user workshops

To ensure consistency across all focus groups, we developed a facilitator briefing pack, a presentation slide deck outlining the programme focus, and data reporting templates. These materials were used uniformly across workforce, resident, and service user groups (see Appendix 1 for the presentation).

In addition to provider-led workforce and lived experience sessions, we organised a series of resident focus groups. We also engaged with Autism Bedfordshire and Deaf Access Bedfordshire to seek advice on inclusive engagement approaches. Following their guidance, we commissioned both organisations to deliver tailored engagement sessions.

From 8 August to Sunday 14 September we promoted the survey and focus groups. Promotion of engagement opportunities was carried out via the ICB website and social media channels. Messaging varied and included:

- Direct links to the website and survey.
- Dates and registration links for focus groups.
- Explanations of community and mental health services to support understanding.

Information was also disseminated via email to system-wide stakeholders, requesting they cascade details through their networks. These communications included:

- A summary of the programme and participation opportunities.
- Links to the website, survey, poster, and Eventbrite registration.
- Requests to share social media posts, with links provided.

Stakeholders included (but were not limited to): elected councillors, town and parish councillors, MPs, VCSE organisations, emergency services (fire, police, prison), faith leaders, GP practices, Chambers of Commerce, children's centres, Maternity Voices Partnerships, parent carer forums, those involved in the 'Denny – reducing health inequalities' and System Insights Network work, the ICB Learning Action Networks (LANs), BLMK Communications and Engagement Collaboratives, and local boards and committees such as Mental Health Alliances, Health and Care Partnerships, Health and Wellbeing Boards, and Place-Based Boards.

Additional requests were sent to umbrella VCSE organisations to share information via newsletters and networks, to local authorities to cascade details to their workforce, housing associations, care homes, and to organisations supporting seldom-heard communities.

Workshops were arranged both face-to-face in each of the four places and online, with sessions offered during the day and evening to maximise accessibility. Due to low registration at some face-to-face sessions, these were postponed and rescheduled to ensure broader participation. In instances where sessions were cancelled or postponed, individuals were offered alternative options to engage, including one-to-one conversations, joining another workshop, or providing feedback via the survey.

Feedback gathered from the workshops is presented in the main body of this report.

3. Engagement Activities

Details of the engagement activities are presented below

Resident Focus Groups – ICB led

Date	**Description**	**Status**	Attended	Registered, but did not join
18 August	Online – evening	Held	3	7
19 August	Luton – morning	Postponed		
20 August	Bedford – morning	Postponed		
21 August	Milton Keynes – morning	Held	9	3
21 August	Online - evening	Held	9	7
27 August	Central Bedfordshire - afternoon	Held	2	3
2 September	Bedford – morning	Cancelled		
5 September	Luton – morning	Cancelled		
8 September	Online - afternoon	Held	3	
9 September	Online – morning	Cancelled		
9 September	Online - evening	Held	6	5

Autism Bedfordshire and Deaf Access Bedfordshire led groups

Date	**Audience**	**Description**	Attended
6 August	Residents with autism	Face to face	3
22 August	Residents who are D/deaf	Face to face and online	4
28 August	Residents with autism	Face to face	4
5 September	Residents who are D/deaf	Face to face	7

Lived Experience Groups – Provider led *(See addendum)*

Provider	Group	Service	Attendees
CNWL	Peer and Lived Experience Workforce and Involvement Leads	CHS and MHS	5
ELFT	Bedford Borough Working Together Group	MHS	5
ELFT	Central Bedfordshire Working Together Group	MHS	6
ELFT	Luton Borough Working Together Group	MHS	7
ELFT	CAMHS Working Together Group – Mental Health	MHS	7
ELFT	Bedfordshire Older Peoples Working Together Group	MHS	3
ELFT	Bedfordshire Community Health Services Working Together Group	CHS and MHS	8

Workforce focus groups – Provider led

Provider	Workforce group	Service	Attendees
CNWL	Attendees from community and mental health services across MK.	CH and MH	26
CNWL	Attendees from community and mental health services across MK.	CH and MH	20
ELFT	**Two** workshops held with approximately 150 members of children and adults mental health, learning disability & autism staff.	MH	150
ELFT	Community Health Team	CH	45

Workforce focus groups – Local authority led

L.A.	Workforce group	Service	Attendees
Bedford Borough Council	Officers within Public Health, Children's Services and Adult Services Directorates	CH and MH	7

Primary Care workshop

Workforce group	Service	Attendees
Primary Care services across BLMK	CH and MH	28
Primary Care services across BLMK	CH and MH	23

4. Summary of findings

This section provides a summary of the key themes and insights shared during the focus groups. For a more detailed account of participant feedback, please refer to Section 5 of this report.

4.1. Residents, service users, carers, and people with lived experience

1. Access to Services

Access to services was widely described as fragmented, inconsistent. Many participants reported dismissive responses from primary care, an over-reliance on medication and unclear discharge pathways. Neurodivergent individuals faced significant barriers due to poor communication and a lack of reasonable adjustments.

Digital-first models were seen to exclude certain groups, especially older adults and those with limited digital literacy. While a single point of access was considered helpful, it often failed in practice. Carers felt overlooked, particularly during discharge and called for a central NHS directory and clearer contact points.

Navigation through services was difficult, with outdated or inappropriate referrals. Systemic inequalities such as cultural, language and geographic barriers further limited access. Children’s services were under-resourced and emotional support was often deprioritised in favour of medication. Participants advocated for more personalised care, consistent communication and timely 24/7 availability.

2. Crisis Services

Crisis support was described as inaccessible and poorly coordinated. Out-of-hours services were lacking, leaving vulnerable individuals with few options beyond A&E. Crisis teams were seen as unresponsive and lacking authority, often missing calls and redirecting people to GPs.

Strict eligibility criteria excluded those with complex needs, and delays especially for children and people with addiction led to missed opportunities. Telephone assessments were considered inadequate, particularly for neurodivergent individuals, who preferred face-to-face contact.

Voluntary and community organisations were praised but underutilised. Weekend closures and reliance on police responses were problematic for some. Carers and isolated individuals felt unsupported, and many fell between services due to poor integration. While there was strong interest in 24/7 digital support, concerns about safety and accessibility remained.

3. Prevention and Staying Well

Participants expressed a strong need for holistic, personalised approaches to prevention. Medication was often the default, with little attention given to emotional or social wellbeing. Continuity of care was lacking, and many felt abandoned after therapy.

Peer support and wellbeing sessions were valued but inconsistent. Cultural competence was seen as essential. Older adults were often excluded from health education, and those with complex needs required trusted relationships and non-medical support.

Empowerment through reliable information, physical activity, and community connectors was highlighted. Discharge processes were frequently rushed, with poor follow-up. A disconnect between lived experience and professional judgement led to fragmented care. Early intervention in schools and communities was recommended, along with public campaigns to reduce stigma.

4. Integrated Working

There was a clear call for more joined-up, person-centred working. Fragmentation between primary care, mental health, and social care created gaps in support. Staff lacked training in neurodiversity and cultural competence and peer support was underused.

Services should reflect local communities and involve patients in design and delivery. Concerns were raised about clinical decision-making and ineffective complaints processes. Poor IT integration led to repeated storytelling and re-traumatisation.

VCSE organisations were seen as essential partners but faced funding challenges. Pilot programmes lacked impact due to slow implementation and unclear planning. Carers felt excluded from strategic decisions. Relational services like Recovery College and CPNs were praised, and honest communication about service capacity and referral criteria was seen as vital.

5. What's Missing

Participants identified several gaps in service provision and strategic planning. Over-reliance on medication and digital solutions was seen as limiting, especially in crisis care. Reasonable adjustments for neurodiverse and disabled individuals were inconsistent.

Integration and collaboration across sectors were weak, and VCSE contributions felt undervalued. Communications must be accessible and inclusive, and feedback channels need to be more visible and responsive.

Terms like “neighbourhood” and “community” require clearer definitions. Specialist support for eating disorders was lacking, and spending should focus on impact rather than tradition. Transparency, co-production, and personalised care were seen as essential to building trust and improving outcomes.

6. What is working well and what needs improving? [ELFT focus groups]

ELFT asked participants to share what was working well and what needed improvement across services. Positive feedback included examples of co-production, improved GP responsiveness, better communication in specialist physical health services, and effective collaboration with VCSE partners.

However, participants identified several areas for improvement, including access to urgent care, long wait times, inconsistent communication, and limited support for neurodiverse individuals in primary care. Concerns were raised about fragmented systems, lack of clarity around care pathways, and insufficient provision for carers and young people. Suggestions included better training, more personalised and diverse services, improved transitions, stronger community response, and expanded non-clinical wellbeing opportunities. Please see section 5 for full details.

7. Summary of Feedback on Emerging Priorities

Service users, carers, residents, and people with lived experience shared support for the six draft emerging priorities and suggested the following.

Develop teams in neighbourhoods to improve health outcomes and care experience

- They asked for services to be more locally accessible, especially for carers and working families.
- They said that trust is built through face-to-face contact and continuity, and that neighbourhood teams can help reduce fragmentation.
- They suggested clearer definitions of "neighbourhood," stronger integration with VCSEs, and support for community groups to build capacity and contribute meaningfully.

Understand the needs of local communities to help prevent poor health

- They asked for services that reflect the complexity of people's lives, including health, housing and social care.
- They said that trauma, neurodiversity, and digital exclusion must be better understood and addressed.
- They suggested involving peer workers, community connectors, and trusted professionals to improve engagement and relevance.

Co-design and co-deliver services focused on prevention and helping people live well

- They asked for genuine co-design, with lived experience at the heart of service development.
- They said that prevention should happen in familiar, welcoming spaces, and that continuity and navigation support are essential.
- They suggested funding co-production properly, embedding wellbeing into everyday care, and supporting grassroots groups through peer learning and shared resources.

Ensure services are personalised, with a single point of access

- They asked for services that treat people as individuals, not just patients, with care plans that reflect their lives and goals.
- They said that current systems are fragmented and confusing, especially for carers and neurodivergent individuals.
- They suggested clearer referral pathways, culturally sensitive support, and accessible digital tools that complement, not replace face-to-face care.

Increase access to a wider range of services closer to home

- They asked for autonomy and choice, with access to tools and services that support self-care.
- They said that A&E is not suitable for many in crisis, and that services should be embedded in communities not just town centres.
- They suggested using digital platforms to promote services, funding VCSEs and improving data coordination to support planning.

Provide co-ordinated urgent care within the community

- They asked for urgent care options beyond standard hours, especially for those in pain or distress.
- They said that current systems are too rigid and slow, and that carers and isolated individuals often fall through the gaps.
- They suggested clearer definitions of urgent care, more crisis cafés and better coordination across sectors to deliver timely, compassionate support.

4.2 Feedback from Autism Bedfordshire's workshops

1. Access to Services

Autistic participants described significant barriers to accessing both community and mental health services. A lack of clear, straightforward information made it difficult to navigate the system, and phone-based communication was particularly challenging. Many preferred written or digital contact methods, such as email or text, but these were not consistently offered.

Communication challenges were a recurring theme. Written notes prepared for appointments were often ignored, and repetitive questioning by multiple professionals caused distress. Participants recommended a single shared document to reduce repetition and improve continuity. They also highlighted the importance of staff understanding autism-specific needs, including sensory sensitivities and non-verbal communication.

Experiences with GPs were mixed, with some feeling dismissed or misunderstood—especially during adolescence. There was a call for more personalised approaches and better recognition of underlying issues. Adult referrals for mental health support were described as extremely difficult, with long waits and limited therapy options. CBT was frequently offered but often ineffective for autistic individuals.

Recommendations included early intervention strategies, written follow-up after appointments, continuity of care with the same clinician, and improved coordination through centralised hubs or "One Stop Shops."

2. Crisis Care

Autistic individuals reported that traditional crisis services, such as emergency departments and phone-based helplines as unsuitable and anxiety-inducing. There was limited awareness of alternatives like Crisis Cafés, and contact information for mental health teams was often unclear or inaccessible.

Participants stressed the need for autism-friendly crisis spaces and professionals trained to understand and respond to autistic needs. Familiar and trusted support networks were seen as essential during crises. Suggestions included better autism awareness among staff, accessible contact numbers, and environments designed to reduce sensory overload.

3. Prevention and Staying Well

Mental health pathways for autistic individuals were described as often lacking the necessary understanding and flexibility to meet their needs. Referrals sometimes led to services with limited autism-specific expertise, and tailored non-clinical support was not always readily available.

Therapy options were limited, with Eye Movement Desensitisation and Reprocessing (EMDR) noted as beneficial but less accessible than CBT. Participants emphasised the importance of personalised, respectful support.

Ongoing wellbeing support should include mentors who understand autism, activities tailored to individual interests (e.g. walking or sports), and trusted networks that encourage help-seeking. A central hub for information and coordination was again recommended to streamline access.

4. Integrated Working

Autistic participants supported the idea of consolidating services to reduce complexity and improve access. Respecting communication preferences, especially avoiding phone contact and ensuring timely responses were seen as essential.

There was a continued need for increased availability of talking therapies, with long waiting times still a barrier. Participants called for better coordination between services, clearer referral pathways, and more autism-informed approaches across all levels of care.

4.3 Workforce

1. Access to Services

Access was described as fragmented, inconsistent, and often inequitable. Providers reported difficulties navigating complex systems, unclear referral criteria, and duplication of effort. Re-entering services after discharge was challenging, and high thresholds for support left many without help until reaching crisis point.

Geographic variation across BLMK created a “postcode lottery,” while cross-border anomalies restricted access based on GP registration. Although digital routes improved efficiency, they risked excluding older adults and those with limited digital access. Cultural, language, transport and disability-related barriers further limited access.

A single point of access and locally delivered clinics were praised for improving trust and continuity. However, workforce capacity remains a major constraint, affecting the reliability and reach of these services.

2. Crisis Services

Crisis support was seen as overstretched and inconsistent. Long waits and high thresholds for access were common concerns. Providers highlighted an over-reliance on digital and text-based solutions, which may not be safe for high-risk groups.

Face-to-face contact and community crisis teams were preferred. Rapid response services were valued for preventing hospital admissions, but follow-up care was often lacking. Crisis pathways for older adults and children were underdeveloped, and A&E was frequently the default option, despite being unsuitable for many in mental distress.

Voluntary sector services like crisis cafés were filling gaps but faced funding pressures. Rising demand and staff fatigue and strain were identified as challenges.

3. Prevention and Early Intervention

Prevention was strongly supported but under-resourced. Providers called for investment in early years support, school-based mental health services, and community-led wellbeing activities.

Limited-term funding and short-term initiatives were seen as affecting trust and long-term sustainability. Many prevention services were described as reactive rather than proactive, and often lacked thorough evaluation to demonstrate their effectiveness. To improve equity and impact, recommendations included mapping local assets, strengthening cross-sector collaboration, and enhancing communication pathways.

Staff delivering prevention work need more training, supervision, and career development opportunities to ensure quality and consistency.

4. Integrated Neighbourhood Working

There was strong support for integrated, place-based approaches. However, concerns were raised about fragmented systems, incompatible IT, and unclear definitions of “place.” Providers called for shared accountability, better data sharing, and stronger partnerships across health, social care, and the VCSE sector.

Co-production with communities and lived experience voices was seen as essential. Multidisciplinary working in neighbourhood teams was praised for enabling holistic care, but workforce issues and siloed operations continue to limit progress.

5. What’s Missing

Key gaps included the need for personalised support, better workforce retention, and more specialist services across BLMK. Providers warned against over-reliance on digital and AI-driven models, especially in crisis care, and stressed the importance of maintaining effective face-to-face options.

Transport barriers, digital exclusion, and lack of career progression were also highlighted. Concerns were raised about restructuring teams without adequate staffing, and the risk of losing the “human element” in care.

Participants emphasised the importance of supporting people to live well with long-term conditions—not just focusing on prevention or crisis. Standardised commissioning approaches and stronger cross-sector partnerships were seen as vital to improving equity and outcomes.

6. Summary of Feedback on Emerging Priorities

Staff across BLMK shared thoughtful and practical feedback on the six draft emerging priorities. While there was broad support for the direction of travel, concerns were raised around feasibility, workforce capacity, and the need for robust planning and resourcing.

Develop teams in neighbourhoods to improve health outcomes and care experience

- They said neighbourhood teams are widely supported and seen as a way to build trust, improve continuity, and reduce reliance on hospitals.
- They asked whether current workforce levels could sustain this model, and raised concerns about overstretched resources, diluted expertise, and limited opportunities for specialisation.
- They suggested placing specialist clinicians in community settings, avoiding a one-size-fits-all approach, and tailoring delivery to reflect local demographics.

Understand the needs of local communities to help prevent poor health

- They said services must be responsive to local demographic differences, and that public health intelligence should guide planning.
- They asked whether existing data is sufficiently current and accurate, noting that the lack of systematic tools limits the validity of planning assumptions.
- They suggested engaging specialist services in planning, co-designing with communities, and using robust evidence to shape needs-led service configuration.

Co-design and co-deliver services focused on prevention and helping people live well

- They said prevention is under-resourced and should include children and young people. Co-design was welcomed but must be properly funded to avoid becoming tokenistic.
- They asked how service-user involvement could be sustained beyond one-off events, and whether rigid commissioning structures might limit local adaptation.
- They suggested embedding resident voices, ensuring cultural sensitivity, and standardising commissioning approaches to spread best practice across BLMK.

Ensure services are personalised, with a single point of access

- They said a single point of access would reduce duplication and confusion, and improve patient experience through more personalised care.
- They asked for inclusive communication options, such as email for non-verbal patients, and flagged concerns about non-interoperable IT systems and information governance.
- They suggested shared records to support integration and cautioned that centralisation must not dilute specialist assessments.

Increase access to a wider range of services closer to home

- They said locally delivered clinics improve engagement and trust, and that reducing hospital reliance is beneficial.
- They asked whether service access could be based on residency rather than GP registration, and raised concerns about workforce capacity and transport barriers.

- They suggested addressing cross-border inequities and ensuring that efforts to equalise access don't unintentionally reduce services in some areas.

Provide co-ordinated urgent care within the community

- They said community crisis teams are effective, but clearer definitions and consistent follow-up are needed.
- They asked for urgent care options beyond standard hours to meet the needs of working-age adults, and questioned the capacity in the community to deliver urgent care safely.
- They suggested expanding urgent care capacity, standardising models across BLMK, and improving coordination to reduce unnecessary hospital admissions.

7. Additional Workforce Feedback on Emerging Priorities

When asked whether anything important had been left out of the six emerging priorities, members of the workforce advised that while they supported the priorities, there was a strong call for greater realism, clearer planning, and more inclusive delivery.

Strategic Concerns and Feasibility

- Staff felt the priorities resembled a "wish list" rather than a resourced, deliverable plan. There were concerns that overpromising could damage trust with communities and partners.
- A more focused approach was recommended - targeting resources where need is greatest and prioritising marginalised communities who often access services the least.
- Success was seen as dependent on realistic phasing, clear accountability, and transparent communication about what can be achieved within available resources.

Key Themes Raised:

1. Equity and Commissioning

- Equity of access across all BLMK localities was emphasised.
- Staff called for standardised commissioning and clearer commissioning specifications to reduce variation and improve transparency.
- Integration with social care was seen as essential, but current commissioning arrangements were described as limiting.

2. Workforce

- Workforce concerns were prominent, with calls for:
    - Improved staffing levels and distribution based on geography and population.
    - Better recruitment, retention and career progression across all bands.
    - Succession planning and investment in homegrown training pathways.
    - Recognition that community services are being asked to do more without adequate staffing or development support.

3. **GP Access and Primary Care**
    - Staff highlighted the need for:
        - Improved GP accessibility.
        - Better understanding of community services by GPs.
        - Direct referral pathways to diagnostics and psychology support.
        - Palliative care to be provided by all professional groups.
4. **Digital Infrastructure and IT Systems**
    - There were repeated calls for:
        - Joined-up IT systems across services and organisations.
        - Integrated clinical records to avoid patients repeating their stories.
        - Improved digital tools, including apps and AI, to streamline care.
5. **Integration and Partnership Working**
    - Staff stressed the importance of:
        - Joined-up working across health, social care, mental health, and community services.
        - Preserving partnerships with police, hospitals, and local authorities.
        - Better coordination in end-of-life care and mental health integration.
6. **Resources and Infrastructure**
    - Calls were made for:
        - Dedicated investment in community services—not just as a hospital avoidance tool.
        - More resources and patient-facing materials.
        - Upgrades to tired health centres that are no longer fit for purpose.
7. **Community Access and Inclusion**
    - Staff emphasised:
        - Improved access to services that support social mobility and community wellbeing.
        - Faster, more responsive services delivered in the home or community.
        - Greater engagement with isolated communities and services that reflect what people actually want and need.
        - Increased capacity in prevention, mental health, social prescribing, and wellbeing.
8. **Patient Outcomes**
    - Feedback included expectations for:
        - Better compliance, satisfaction, and trust.
        - More personalised care and quicker diagnoses.
        - Improved outcomes at lower cost through care closer to home.

9. Staff Morale and Experience

- Staff linked better morale and retention to:
    - Safer caseloads, quicker response times, and shorter waiting lists.
    - More training opportunities and recognition of staff wellbeing.
    - Happier families and improved service user experience.

10. Service Efficiency and Continuity

- Staff anticipated:
    - More streamlined and responsive services.
    - Reduced unnecessary workloads.
    - Stronger continuity of care for people with long-term or complex needs.
    - Fewer people falling through the gaps and reduced reliance on agency cover.

11. Hospital Avoidance

- There was strong support for:
    - Reducing unnecessary presentations to A&E and GP services.
    - Freeing up hospital capacity for those who truly need it.
    - Shifting resources toward community-based care.

12. Other Suggestions

- Staff also raised:
    - The need for trauma-informed care.
    - Greater emphasis on co-production and co-leadership with communities.
    - Better communication during provider transitions.
    - Services that promote dignity, independence, and long-term wellbeing.
    - Addressing loneliness in the elderly population.

5. Feedback from workshop 1

5.1. Resident Focus Groups – ICB led

At the start of each focus group session, residents were presented with the shared presentation titled *Testing the Case for Change and Transformation Priorities*. This presentation served as a consistent foundation across all sessions. Participants were then invited to reflect on whether the emerging themes and priorities aligned with their personal experiences of local services, and to highlight any areas they felt were missing or underrepresented.

The feedback below provides a comprehensive overview of the themes and perspectives shared across the ICB-led resident focus groups.

1. Access to services

1) **Barriers to Accessing Mental Health Services**
Participants described a fragmented and often frustrating experience when trying to access mental health support. Common barriers included dismissive GP responses, being offered medication without a holistic assessment, and being redirected to A&E during crises - an environment many found distressing and unsuitable, especially for neurodiverse individuals.

There was also concern about the lack of a clear route back into specialist care after discharge, leaving people unsupported during relapses or ongoing crises. Young people without advocates were seen as particularly vulnerable to falling through the cracks.

“Children need access to treatment therapies - if they don’t, they end up taking the wrong road and making wrong decisions… I feel we’re setting them up to fail”

2) **Neurodiversity and Reasonable Adjustments**
Neurodiverse individuals reported that services often failed to accommodate their needs. Participants highlighted the importance of clear, literal communication, preferred contact methods, and the need for staff to understand how neurodivergence affects interaction.

A “reasonable adjustment flag” in health records was suggested to reduce the burden on patients to repeatedly explain their needs.

“Professionals need to make reasonable adjustments… there are files on her saying she has autism, but she has to go through things over and over again. Professionals need to take time to pause to make she understands, stop using acronyms and make the time to talk to her.”

3) **Digital Access and Inclusion**
Digital-first approaches were seen as a double-edged sword. While useful for some, they excluded others - particularly older adults, those with limited digital literacy, or families experiencing digital poverty. Participants stressed the need for multiple access routes, including phone and face-to-face options. Suggestions included using QR codes, social media platforms like TikTok and Instagram for younger audiences, and peer-led support groups to help people navigate digital systems.

"… older people are not attending appointments, as they can't navigate the system as you need to book appointment online…. It needs to be accessible to all"

4) **Single Point of Access and System Failures**
While a single point of access can streamline services, participants warned it can also become a single point of failure describing being passed between organisations with no one taking responsibility. There were calls for clearer referral processes, safety mechanisms when trust breaks down, and learning from past service failures to drive improvement.

"There needs to be a safety mechanism around so if it is not working - also the referral process needs to be clear and understood by all those that are working in the services."

5) **Carers' Experience and Support**
Carers felt overlooked and unsupported. They described difficulties finding relevant NHS services and navigating complex discharge processes. One carer suggested a central NHS directory for carers, including what to expect when a loved one is discharged from hospital. Compassionate communication was seen as essential - one carer was told by a discharge nurse that the care package "was not her concern." A single point of contact for carers was suggested to reduce stress and improve coordination.

6) **Service Navigation and Signposting**
Participants frequently encountered unclear or inconsistent signposting. Many were referred to services that were unavailable or inappropriate, leading to delays and frustration. There was a strong call for clearer, more consistent information about what services are available, how to access them, and who to contact. This included ensuring that communication methods are kept up to date and that services are promoted effectively, especially those that are working well.

"It's not just about getting through the door - it's about what happens after. There's no follow-up, no continuity."

7) **Systemic Inequalities and Cultural Adaptation**
Feedback highlighted the need for services to reflect the diverse communities they serve. In areas like Luton, with high levels of rough sleeping and a transitory population, continuity of care is harder to maintain. Participants called for culturally adapted services, targeted outreach to underrepresented groups, and better understanding of digital literacy and poverty. Organisations like BLMK Mind, which work with Asian women in Bedford, were cited as examples of good practice.

"If you don't understand the community, you can't serve it properly."

8) **Children and Early Intervention**
Concerns were raised about the lack of parity between children's and adult services. Participants described children's services as under-resourced and overly reliant on parents to "muddle through." Early intervention was seen as critical, with trauma, parental addiction, and school exclusion identified as early warning signs. However, we were told that many professionals were unsure where or how to refer children for help, and long waits for social workers were common.

"There's very little available for children's services – things often moved on because the parents muddled through, rather than a service"

9) **Medication vs Emotional Support**
There was a strong feeling that medication is too often the default response, when what people really need is emotional support, advice, or someone to talk to. Voluntary and community sector organisations like Drug and Alcohol Family Support (DAFS) were seen as valuable but underutilised, with few referrals from statutory services. Participants called for a more holistic approach that includes social prescribing and peer support.

"Our beneficiaries say they go to their GP – they nearly always get offered medication – they're not depressed, they just need advice or support"

10) **Communication and Consistency**
Participants emphasised the importance of consistent, clear communication across services. This included ensuring that contact methods are up to date, using digital forums to share information, and avoiding jargon or acronyms. There was also concern about outdated or conflicting information in records, and a desire for a "single version of the truth" to improve trust and continuity of care.

"Ensure that all methods of communication are mapped, services sometimes change but the methods of contacting the service are not updated."

11) **Personalised Care and Empowerment**
True personalised care was seen as essential, especially for neurodivergent individuals. Participants wanted consistent contact with professionals, multidisciplinary assessments, and services that are responsive and flexible. There was a call for statutory services to be less restrictive in their eligibility criteria and to empower service users to take an active role in their care.

12) **Timeliness and Availability**
Timely access to services was a recurring theme. Participants wanted services to be available 24/7, with early intervention seen as key to preventing crises. Even a short face-to-face chat could make a big difference. Telephone-based assessments were criticised as ineffective for people with communication challenges such as situational mutism, ADHD, autism, dyslexia, or OCD.

2. Crisis Support

1) **Lack of Out-of-Hours Support**
A major concern was the absence of out-of-hours community support, particularly for housebound or end-of-life patients. We were told that after 6pm, options are severely limited often reduced to A&E or waiting for overstretched district nurses or ambulances. This leads to prolonged distress and inadequate care. Participants stressed the need for a dedicated out-of-hours model that includes urgent medication access and responsive care for those unable to travel.

"If the person is housebound they can't go in. How do we put a model in place for out of hours? Once it's past 6pm there are no services…between 9am and 5pm other services step in, this leaves the person in pain and needs medicalisation."

2) **Inadequate Crisis Response**
Participants shared troubling experiences with crisis services, including being ignored or dismissed. One person described calling the CMHT two weeks prior and never receiving a callback. Others noted that crisis teams often lacked authority to act, with patients being redirected back to GPs instead of receiving immediate support. There was a strong call for crisis teams to be staffed by professionals trained specifically in crisis intervention, with clear pathways for referral and action.

"… when he's having a melt-down, I wouldn't be able to get him to A&E"

3) **Service Gaps and Rigid Pathways**
Crisis support is not consistently available or integrated into care pathways. Individuals with complex needs, such as personality disorders, often find themselves excluded due to rigid eligibility criteria. For example, CHUMS was described as inaccessible unless families were in extreme crisis, despite its website suggesting broader support. Participants also highlighted the inflexibility of treatment pathways where refusal or non-engagement with standard options like CBT could result in being denied further help.

"Need to be able to step outside of the flow diagram – if 6 weeks of CBT [cognitive behaviour therapy] won't work, why would I do it? It's very tick box, and if you don't engage, you're not allowed to use other services"

4) **Delayed Access and Missed Opportunities**
Timely intervention is critical in crisis situations, yet delays were common. One participant reported waiting six weeks to see a children's social worker. For individuals dealing with addiction, there is often only a brief window of willingness to engage - if services aren't responsive, the opportunity is lost. Participants stressed the importance of flexible, responsive services that can adapt to individual needs and act quickly.

There's only a small window that addicts will talk to professionals… it's the carers who are dealing with this"

5) **Inconsistent Signposting and Navigation**
People are frequently referred to services that are unavailable, inappropriate, or already accessed, leading to frustration and delays. This inconsistency in signposting undermines trust and can escalate crises unnecessarily. Participants called for clearer, more reliable referral processes and better coordination between services.

6) **Risk Assessment and Face-to-Face Contact**
Telephone-based assessments were widely criticised as ineffective and potentially dangerous. One participant shared that they were downgraded the day before a suicide attempt because they masked their feelings over the phone. Face-to-face assessments were seen as essential for accurately identifying risk and providing appropriate support. There was a strong emphasis on personalised care and multidisciplinary assessments, especially for neurodivergent individuals.

"I just say I'm fine – sometimes the questions need to be more specific. I'm already stressed out, so it's very hard to say what's going on, they should know I'm neurodiverse."

"The day before I tried to commit suicide I was down-graded, because I know how to mask my feelings)"

7) **Recognition of VCSE Contributions**
Voluntary, community, and social enterprise (VCSE) organisations were praised for their crisis support, however participants felt that these contributions were often overlooked. A metaphor was shared comparing effective collaboration to Clarkson's Farm - where diverse expertise came together to create something exceptional *"crisis care needs the right people with the right skills, working together."*

8) **Weekend and Holiday Coverage**
Weekend closures of services were highlighted as a critical gap. Families often found themselves without support during these times, an example was given with children being seen by adult psychiatrists due to lack of appropriate care. Crisis support must extend beyond emergency care to include early intervention, nursing support, and consistent availability throughout the week.

"I could not get support for [name] at the weekend. We kept being signposted to a service we had already tried – we ended up getting an adult psychiatrist"

9) **Police Involvement and Trauma**
Some participants shared negative experiences involving the police during mental health crises, which added to their distress. These past traumas can make individuals reluctant to seek help if police involvement is likely. Services should be sensitive to this and offer alternatives that feel safe and supportive.

10) **Carer Experience in Crisis Situations**
Carers described feeling unheard and unsupported during crises, they asked that teams communicate better together and provide reliable information for carers, especially during high-stress situations.

"Consistency between teams when it comes to support for carers, particularly in crisis, is really important especially when that's a really stressful time… a carer doesn't know which way to turn to and what is reliable information and what isn't."

3. Prevention services

1) **Over-Reliance on Medication and Lack of Personalisation**
Participants expressed deep concern about the long-term use of multiple medications, which could lead to physical health deterioration, weight gain, and unaddressed side effects. They felt that medication was prescribed as a default, with little consideration for alternative or complementary approaches. Health checks were described as infrequent, and there was a lack of clear strategies for reviewing or reducing medication.

"I don't like the medication it's affecting my physical health. I'm now under so many services because of my physical health (weight related)… I didn't have these other problems before I came under mental health"

Underlying issues such as trauma, social isolation, or emotional distress were often left unaddressed due to limited access to talking therapies. They suggested more holistic, person-centred care that goes beyond symptom management.

2) **Communication and Navigation Challenges**

A recurring theme was the confusion around who to contact and the lack of continuity in care. Participants described being passed between GPs, psychiatrists, and therapy services without clear ownership or follow-up. Once therapy ended, they felt abandoned, with no clear route back into support. The absence of a named contact or single point of access meant individuals often had to start from scratch each time they sought help, which was particularly distressing for those already in vulnerable states.

"Needs to be a team that monitors people when they leave each level of the service… discharge happens and it seems like they're relieved to get person off the books. What are the safety nets for the individual? We don't want the people to fail again!"

3) **Gaps in Prevention Services**

While some Primary Care Networks (PCNs) have introduced health and wellbeing sessions, participants noted that some staff are unequipped to deal with the complexity of mental health needs they encountered. There was a strong call for better training and clearer role definitions. Participants emphasised the importance of early conversations - about language, self-awareness, and emotional wellbeing as a form of prevention. Peer support and community-based conversations were seen as empowering when facilitated by individuals with appropriate training and cultural understanding.

"Early intervention is key to any medical condition - no one knows where to sign people to, there needs to be clear directions"

4) **Cultural Competency and Human Connection**

The need for culturally appropriate services was strongly voiced. Participants wanted to engage with professionals who understood their background or were willing to learn. One participant, a Black woman, shared how meaningful it was when a professional admitted, "I don't know, but I can find out." This humility and willingness to connect on a human level were seen as essential. There was a call for investment in people, not just systems so that frontline staff could build rapport, show empathy, and provide culturally sensitive care.

5) **Health Promotion and Education for Older Adults**

Older adults were identified as a group often left out of health education efforts. One participant noted a lack of information on issues like skin cancer prevention and suggested that local forums could help bridge this gap. They suggested that older people are not receiving the information they need to manage their health proactively, and that this contributes to preventable health issues later in life.

"Older people aren't getting the information they need. We need to change that."

6) **Complex Needs and Trusted Relationships**

People often face overlapping challenges - frequent hospital admissions, multiple medications, and involvement with social care, housing, and employment services. Participants stressed that while the medical model has a role, it must be complemented by social and relational approaches. Trust in GPs was highlighted as central to how people engage with services, underscoring the importance of continuity and trusted voices in prevention.

7) **Empowerment and Community Support**

Empowering individuals to manage their own health was seen as a key prevention strategy. This included helping people find reliable information, promoting physical activity through care homes and community groups, and supporting peer-led initiatives. Participants valued the sense of community that came from being around others with similar experiences, but warned that untrained peer interactions could sometimes do more harm than good.

“Promoting physical activity as a core part of care by engaging care homes, hospitals, and communities to support both physical and mental well-being through integrated, routine-based activities”

8) **Discharge and Transition Support**

Transitions between services were described as risky moments where people fell through the cracks. Discharge processes were seen as rushed, with a sense of relief from services to “move people on” rather than ensure proper follow-up. Participants called for safety nets such as navigators and social prescribers to monitor transitions and provide continuity of care.

“My daughter has been in mental health services from the age of 13 to 30. The therapy ends, and no one checks up… you just get left. We did have a good experience with a GP who was mental health specialist who referred her to the primary care plus team and she saw a psychiatrist”

9) **Disconnect Between Professionals and Lived Experience**

There was a perceived gap between professional judgement and the realities of lived experience. Social workers and other professionals were sometimes seen as lacking the understanding or flexibility needed to respond effectively. Differences in approach between the NHS and Local Authorities were also noted, leading to fragmented support and missed opportunities for prevention.

10) **Importance of Early Intervention**

Participants emphasised that prevention must begin well before crisis point. Early intervention should be embedded in everyday interactions - whether through schools, community groups, or routine GP visits. They advised that the role of frontline staff was seen as critical: *“even when policies exist, it is the actions of individuals that determine whether prevention is successful.”*

11) **Awareness and Referral Gaps**

Participants advised that some frontline staff may avoid making referrals because they know services are unavailable or oversubscribed. They advised that this leads to missed opportunities and leaves service users feeling dismissed or unsupported. Participants called for better awareness of available services and more realistic planning to ensure that referrals lead to actual support.

“Do the front-line staff know the service isn’t available and that’s why they don’t refer to service or can’t be as helpful as they anticipate?”

12) **Support for Carers**

Carers felt overlooked in prevention strategies. Despite the existence of carer handbooks and strategies, these were often ignored by professionals. Participants suggested that providers with contracts should be required to follow carer strategies and that carers should be more formally recognised and supported as part of the care team.

13) **Multidisciplinary and Community-Based Approaches**
A multidisciplinary team (MDT) approach was seen as essential for supporting people as they age, particularly in communities where conditions like dementia may not even have a name. Building relationships over time, such as through wellbeing workers was seen as key to effective prevention. Initiatives like "knit and natter" groups were praised for addressing loneliness and building community resilience.

"I wasn't just a patient - I was a person with a life, a family, and goals. The care plan didn't reflect that."

14) **Public Awareness and Campaigns**
Participants called for more public campaigns focused on suicide prevention and mental health awareness. One participant noted that while few children die from meningitis, many young people die by suicide, yet public messaging does not reflect this reality. Campaigns should aim to reduce stigma and encourage early help-seeking.

"We spend a lot of money on statins, drugs etc… the major cause of death in young people is suicide – but we don't have good crisis services."

15) **Therapeutic Options and Flexibility**
There was criticism of the limited therapeutic options available. CBT and IAPT were described as ineffective for some, while services like psychotherapy and clinical psychology (e.g., BLMK Mind) were praised for being more impactful. Participants wanted services to offer a broader range of therapeutic approaches tailored to individual needs.

16) **Face-to-Face Contact**
Face-to-face interactions were seen as more effective than remote or telephone-based support, especially for building trust and assessing emotional wellbeing. Even short in-person conversations were valued for their ability to provide reassurance and connection.

"On a telephone doesn't work if person is situationally mute, had ADHD or autism or for dyslexic people and people with OCD [obsessive compulsive disorder]."

4. Integrated working

1) **Fragmented Systems and Poor Integration**
Participants described operational disconnection between services, particularly between primary care and mental health teams. Examples included the absence of a mental health link worker for months due to sickness, with no replacement provided, leaving patients unsupported. They suggested that integration must be more than structural, requiring shared goals, communication, and accountability across services.

"You can put everything in place – but it's the front line who delivers."

2) **Training and Competency Gaps**
There was concern about the competency of staff, especially in understanding neurodiversity and cultural differences. Participants shared experiences of being dismissed or misunderstood due to non-stereotypical presentations of autism or ADHD. They asked for training to go beyond clinical knowledge to include cultural competence, trauma-informed care, and lived experience.

“We need trauma informed professionals – the professionals often retrauma the individuals, making it worse”

3) **Peer Support and Community Integration**
Peer support was praised for its emotional and practical value. Participants highlighted the importance of community-based services and voluntary sector organisations in reducing demand for NHS services and offering tailored support. Better signposting is needed to ensure people can access these resources. Community and carer networks were recognised as essential sources of support and should be better integrated into formal care pathways.

“Unless you’ve been there you don’t have the connection. I got so much more from peer support… front line staff have not experienced it most of the time.”

4) **Cultural Competency and Patient Voice**
Participants stressed the importance of understanding local communities and cultural differences. Services must involve patients in training and service design, allowing them to share how they are impacted and what they need from staff. This includes being sensitive to race, gender, and neurodiversity.

“If you don’t understand the community, you can’t serve it properly”

“Ensure meaningful involvement of the ethnic communities in service development by prioritising cultural competency, providing accessible information, and targeted action to reduce health inequities across diverse populations.”

5) **Clinical Decision-Making and Accountability**
Participants raised concerns advising that clinical decisions were on occasion being made by non-clinical staff, leading to inconsistent care. In elderly care and complex care teams, inappropriate medication reviews and inexperienced staff were reported. Participants called for better performance management and clearer accountability structures. Whistleblowing and complaints processes were described as ineffective, with service users feeling unheard and unsupported.

“I wanted to complain about the service, but the staff did not about the PALS service. It needs to be accessible - dedicated telephone numbers for people to provide feedback.”

6) **Joined-Up Systems and Shared Platforms**
The lack of interoperability between systems was a recurring issue. Participants questioned why large databases like 111 couldn’t integrate with local platforms.

“GPs and Mental health providers need to be working on the same system”

7) **VCSE Sector as Core Partners**
The voluntary, community, and social enterprise (VCSE) sector was seen as vital to service delivery, not just as an add-on. Participants called for their role to be made more explicit in collaboration, co-design, and care pathways. However, funding challenges were noted - grants and trusts are diminishing, making it harder for VCSE providers to sustain services. Examples like Arts for Health working with CNWL were praised but had discontinued due to lack of funding.

"It's getting harder to resource - grants and trusts are lessening so a resource to support the VCSE providers is required otherwise the providers won't be there"

"Recognising VCSE Contributions: Voluntary, Community and Social Enterprise (VCSE) organisations are often picking up significant responsibilities, yet their input is not always acknowledged. Their role must be recognised and valued within the wider system."

8) **Pilot Programmes and Strategic Planning**
Participants expressed frustration with pilot programmes that spend too much time setting up and not enough time embedding or demonstrating impact. Clear referral pathways and proper planning from the outset are essential. The ICB was identified as having a key role in opening doors and supporting coordination to ensure pilots are successful. Financial pooling and joint strategies were recommended to support integrated working.

"Pilots must be planned with clear referral pathways from the outset, allowing time for proper setup and delivery. Often, pilots spend too much time getting organised and not enough time embedding or demonstrating impact."

9) **Carer Involvement and Support**
Carers felt excluded from strategic priorities and service planning. Despite existing carer strategies and handbooks, these were often ignored by professionals. Participants suggested that providers with contracts should be required to follow carer strategies and that carers should be recognised as core contributors to care.

10) **Value of Interpersonal Support**
Services like Recovery College, Community Psychiatric Nurses (CPNs), and counselling were praised for their interpersonal approach. Participants emphasised that relationships and lived experience often have a greater impact than purely clinical interventions. Building trust and rapport over time was seen as essential, especially for wellbeing workers and those supporting individuals with complex needs.

"… interpersonal relationships and lived experience are more beneficial than purely clinical interventions."

11) **Clear Communication and Transparency**
Participants called for services to be transparent about what they can and cannot offer. Managing expectations and building trust with service users and families requires honest communication. This includes ensuring that referral criteria are clear, contact methods are up to date, and service changes are communicated effectively.

5. Is there anything that you think is important, but has not yet been included?

1) **Overuse of Medication** Participants raised concerns about over-using medication, where medication is often prioritised over therapeutic or community-based interventions. There was a call to reassess the balance between clinical treatment and holistic care, especially in cases where long-term medication use may not address underlying issues or may contribute to physical health decline.

2) **Reasonable Adjustments and Inclusion**
There was uncertainty around how widely reasonable adjustments have been implemented across services. Participants questioned whether neurodiverse individuals and those with accessibility needs are consistently supported. This includes not only physical accommodations but also communication styles, appointment flexibility, and staff awareness of diverse presentations of conditions like autism and ADHD.

3) **Integrated Services and Collaboration**
Integration was seen as a cross-cutting principle that should underpin all aspects of service delivery. Joint pooling of resources and funding was suggested to reduce duplication, such as people having to repeat their stories and improve continuity of care. However, successful integration requires senior leadership buy-in, clear referral pathways, and better awareness between services. Participants highlighted that some professionals still don’t know how to refer to other services, which undermines collaboration.

4) **Recognition of VCSE Contributions**
Voluntary, Community and Social Enterprise (VCSE) organisations were praised for their significant contributions, often stepping in where statutory services fall short - their role however is frequently undervalued or overlooked. Participants called for VCSEs to be recognised as core partners in service design, delivery, and evaluation, not just as supplementary support.

5) **Accessible Digital Communication**
Digital inclusion was a key concern, especially given the UK’s average reading age of 9–11 years. Participants stressed that digital tools and communications must use clear, simple language to be truly accessible. This includes websites, feedback forms, and service directories. Tailoring digital content to the audience is essential to avoid exclusion.

6) **Feedback and Complaints Processes**
Concerns were raised about the visibility and effectiveness of feedback and complaints channels. For example, one participant noted that staff at a mental health provider were unaware of the PALS service in their organisation. Suggestions included dedicated telephone numbers for feedback, especially for those who struggle with digital forms. There was also scepticism about whether Friends and Family (F&F) feedback is genuinely used to inform service improvements.

7) **Clarifying Key Concepts**
Participants asked for clearer definitions of terms like “neighbourhood” and “community,” which are often used interchangeably but may have different implications

for service planning. There was also concern about data integrity - whether the information used to make decisions is accurate, current, and representative.

8) **Support for Eating Disorders**
Limited support for individuals with eating disorders was highlighted as a gap in current service provision. Participants called for more specialised services and better referral pathways to ensure timely and appropriate care for this group.

9) **Outcome-Focused Resource Allocation**
There was a call to reassess spending priorities. Participants suggested that investing in roles like physiotherapists or counsellors could lead to better outcomes than relying solely on medical professionals. The emphasis was on allocating resources based on impact and need, rather than tradition or convenience.

10) **Transparency and Expectation Management**
Services must clearly communicate what they can and cannot offer. This transparency helps manage expectations, build trust, and reduce frustration among service users and carers. Participants stressed the importance of honest dialogue and realistic planning to meet growing demand and complex needs.

5.2. Lived experience focus group – provider led

Provider organisations agreed to conduct focus groups with their service users and carers. To ensure consistency across sessions, all were supplied with the same presentation, discussion and reporting templates.

Service user and carer participants were invited to reflect on whether the emerging themes and priorities aligned with their own experiences of services, and to identify any areas they felt were missing or underrepresented.
(See addendum 1)

5.2.1. Cambridgeshire Community Health Services (CCS) – Community Health

The insights presented below are taken directly from CCS's focus group held with 6 service users, as shared with us.

1. Access to services

1) Frustration regarding GP access. It's difficult for patients to prevent illness if the regularity of contact is not there. Conversely, it's difficult for GPs to case find diabetics, hypertensive patients etc
2) Patients and families do value being empowered but still require navigation through the healthcare system. One participant quoted her experience of going between 111, her GP and the local hospital to receive treatment for a laceration.
3) The same participant described having to repeat her story to different providers over and over too. Questioned why in some parts of the NHS, IT systems do not share data with one another.

2. Prevention services

1) Participants welcomed this concept but sometimes patients are unaware of what services are available; their referral criteria; hours of operation etc.

5.2.2. Central and North West London NHS Foundation Trust (CNWL) – Community Health and Mental Health

The feedback presented below is taken directly from CNWLs workshop with 5 Peer and Lived Experience Workforce and Involvement Leads from CNWL, as shared with us.

1. Access to services

1) Communication between services and organisations could be further improved across the whole area.
2) CNWL Talking Therapies are very good at promoting their service, and other services could do more of this. We need to build on the community collaboration work; for example, until a recent CNWL outreach activity, some of the Hindu

community did not appear to know that CAMHS existed. We need to build on existing engagement work and make more use of stalls in community areas. This is an important aspect of prevention.

3) Support closer to home is important and a key priority of the Trust - clinics around things like lunch clubs, church services are helpful but resources don't aways allow for this.
4) Single point of access – our plan is to strengthen the cohesion between MK SPA and neighbouring SPA services.
5) Staff need access to better information about the various teams/pathways in the local area so they can better support residents.

2. Prevention services

1) An important aspect of prevention is helping people seek help early, before their needs become greater, more urgent and most costly. We know there are barriers for some members of the community.
2) CNWL community connector roles are very effective at capturing the local community voices and engaging with people. These roles could play a more extensive role in BLMK prevention work.
3) Capitalising on the diversity of staff workforce and linking existing staff with local groups/clubs where they have cultural links/connections. The CNWL EDI team would be well placed to support this Could this be included in Job Descriptions and make involvement/group/intervention facilitation part of CPD for staff?
4) The group would support the use of more peer roles in prevention services. Building on the existing peer workforce would be a cost-effective way to improve patient experiences and we know that patient feedback about peers is especially positive in terms of supporting recovery and helping to avoid crises. Further use of peers in Community (Physical Health) services would also be helpful.
5) We need to keep growing our workforce of community advocates / ambassadors - i.e. people from communities to work with us as key links.

3. Crisis support

1) Engaging with VCSE has been very helpful for mental health crisis support in other parts of CNWL and more could be done in BLMK along these lines. For example, involvement in Crisis Support, including SPA, A&E, Psych Liaison etc.
2) Crisis Houses in MK would be very beneficial (similar to the Retreat in Hillingdon: The Retreat - Hillingdon Crisis House :: Central and North West London NHS Foundation Trust and peer/lived experience staffing. This has been very well received by service users.
3) Family and carer involvement is essential in crisis care (both physical health and mental health) and services in BLMK should be signed up to the Triangle of Care standards or similar, as all services are in CNWL.
4) For those who do not have family or friend carers or support systems, more support is needed and the CNWL EDI and volunteer teams and the peer and lived experience workforce are key to this. There are resources in CNWL such as the Check in and Chat service, which offers a befriending service. A database of local people and groups willing to support socially isolated people could be further

developed. Asking people who are socially isolated, what support they would like to see would help improve services.

5) Question for BLMK ICB: What would 24/7 digital support and integration look like?

4. Integrated working

1) Agreement around points suggested – this requires resource, questions around how this will work?
2) Regarding translation services - could there be a local translation service? MK council used to provide this locally and it was brilliant, better than the generic providers.
3) Could we be resourcing inpatient services with advances in technology around translation for some situations, apps etc? Employing Bilingual Coworkers like they do in Kensington & Chelsea?

5.2.3. East London Foundation NHS Trust ELFT

ELFT used a different format for gathering feedback from their service users and carer groups.

The insights presented are taken directly from ELFT's focus group sessions, as shared with us

1. Bedford Borough, Central Bedfordshire and Luton Borough Working together Groups

The *Bedford Borough Working Together Group, Central Bedfordshire Working Together Group* and the *Luton Borough Working Together Group* are made up of adult service users with mental health needs. Five individuals participated in the Bedford focus group, six in the Central Bedfordshire focus group and seven took part in the Luton focus group.

The feedback from both sessions have been combined and detailed below.

1) What is working well from your perspective?

1. Coproduction – Including service users and carers in care.
2. Ongoing conversations around prevention.
3. Peer Support – However, there is a need to create more opportunities.
4. 111 Service – Physical health calls are going well with referrals and advice connecting with Local Organisations, GP, and Primary Mental Health Care.
5. 111 Service – Providing information on local Community Initiatives, CBT and Wellbeing now.
6. Luton VCSE Partners working well with Secondary Mental Health Services.
7. Urgent GP appointment times and booking are greatly improved in many but not all GP Practices.

8. GP referrals are increasingly more responsive, leading to faster tests, appointments and treatments.
9. Specialist Physical Health services have greatly improved communication with partner organisations, carers, loved ones and other staff.
10. More local Community and Primary Care options now available.
11. Having a voice to make a difference in how mental health can improve.
12. People participation involvement, one to one client support, events & rewards.

2) What needs improvement?

1. Out of hours/urgent care – Difficult to access.
2. Long wait times.
3. Service users are not always informed about care pathways and treatment options.
4. Reception services and freedom of speech platforms
5. 111 Services
    - ➢ Severe delays when calling 111 Option 2.
    - ➢ Referrals to ICB and Community Mental Health (non-secondary care) are rare, with many being told to attend Acute services.
6. Communication
    - ➢ Primary Care letters to service users often miss details such as whether an appointment is virtual or in-person.
    - ➢ Primary and Secondary Care (including VCSE) still struggle with incompatible systems and bureaucracy preventing record sharing and slowing joint projects.
    - ➢ Primary Care and Community Mental Health services unable to share important information, leading to delays or treatments not being implemented.
    - ➢ Primary Care referrals to Secondary Care can be slow where staff other than GPs make a referral (e.g., Mental Health Nurse).
    - ➢ No clear, identifiable pathway for complaints about Primary Care
    - ➢ Communication between CMHT and Crisis Teams. Not arguing about who has responsibility.

7. Community Incident Response
    - ➢ Improve education, awareness and public response to those in mental health crisis.
    - ➢ Promote local courses such as Mental Health First Aid and Autism Awareness to the local community.

- Provide more respirators and emergency support in local communities, especially given high populations of substance abuse and homelessness.

8. Neurodiversity & Autism
    - Greater competency in identifying Neurodiversity needs in Primary Care.
    - Improved Primary Care staff training in Autism and Neurodiversity.
    - Neurodiverse spaces or adjustments needed when attending Primary Care services.
    - Better provision for Neurodiverse service users, particularly those unable to use telephone booking systems.
9. Medications Provision
    - More promotion of medication alternatives to Mental Health Drugs such as Depot, with better Primary and Secondary care integration and support for service users.
    - More information provided with medications for service users and carers, particularly for those with limited mental capacity.
10. Specialist Support Services
    - Bereavement counselling referrals are very slow due to extensive waiting lists, placing more pressure on Secondary Care.
11. Primary Care & Acute Services
    - Service users often report being sent back and forth between hospitals and GPs when trying to seek help.
    - Serious physical health issues, such as cancer, are rarely discussed in Primary Care with GPs not engaging in basic enquiries.
    - Better Primary Care support for carers, including improved information, engagement and mental health support when dealing with issues such as dementia.

3) Are the ICB identified priorities the right ones?

- Yes – Key concerns are focussed on; Prevention, Access and Urgent Care.
    - There is a greater need for transparency, equity and inclusion along with firm focus on Mental Health Care.
- Overall, the group felt the priorities were accurate and covered some of the needs for the future, if the suggestions and comments above were included in any plans.

2. CAMHS Working Together Group – Mental Health

Seven individuals participated in the CAMHS *Working Together Group*.

1) What is working well from your perspective?

1. Free healthcare and the peace in knowing that a range of services meet different needs.

2) What needs improvement?

- **Improve waiting lists and early support**
    - Reduce stigma around CAMHS by enabling access to support before crisis.
    - Raise awareness of early intervention options beyond urgent care.
    - Provide accessible information to parents and families unfamiliar with mental health services.
    - Work with communities to understand preferred communication methods and raise awareness.
- **Promote social opportunities for wellbeing**
    - Expand non-clinical, skill-based services (e.g., cooking, numeracy, public speaking, training workshops).
    - Recognise that social opportunities contribute to mental health and wellbeing.
    - Encourage the concept of “lifelong learning” to reduce pressure on families and individuals.
- **Reduce stigma and improve accessibility**
    - Use social media to promote existing services and opportunities.
    - Challenge assumptions that all young people have positive role models to teach life skills.
    - Support those from difficult or negligent childhoods through accessible training and opportunities.
- **Improve transitions and signposting**
    - Make it less daunting for young people to re-engage with services after discharge.
    - Provide clear signposting, especially for the 18–25 age group.
    - Emphasise that there is “no shame in exploring different pathways.”
- **Personalise and diversify services**
    - Ensure services are reflective of community changes and embrace diversity.
    - Coproduce services with young people to reflect authentic experiences (e.g., interests like otaku culture or crafting).
    - Highlight the benefits of local, personalised, and specialised care.
- **Follow-up and continuity of care**
    - Check in with former service users after discharge.
    - Clarify the process for reapplying for support to ensure “the door is not shut.”

3) Are the ICB identified priorities the right ones?

Workshop question 1 – Lived experience workshops led by providers

- **Explicit priorities in services**
  - Focus on neurodiversity, suicide support, sexual assault (SA) support, and racism.
  - Explicitly include and prioritise the nine protected characteristics.
- **Accessibility in community services**
  - Ensure facilities are accessible (e.g., avoid locked disabled toilets).
  - Meet diverse community needs, including SEND (special educational needs and disabilities).
  - Make diversity more visible in resources and representation.
  - Share lived experiences and promote positive role models.
- **Competence of staff**
  - Improve staff training to enhance communication and cultural competence.
  - Use accurate and respectful terminology (e.g., not referring to autism as Asperger's).

3. Bedfordshire Older People's Working Together group – Mental Health

Three individuals participated in the focus group.

1) What is working well from your perspective?

- It's hard to say as many areas are being stretched due to funding or lack of funding.

2) What needs improvement?

- More staffing is needed.
- NHS professionals need to be trained in different pathways.
- The Trust needs to make services more cost effective.
- Some Trust buildings need to be refurbished.
- Appointments need to be more regular for service users.
- More stability is need with staff.
- More funding is needed for services.
- More inpatient beds are need in Beds and Luton as there is a shortage.

3) Are the ICB identified priorities the right ones?

- The priorities are very broad which is good as it can cover many areas.

4. Bedfordshire Community Health Services Working Together Group – both Community Health and Mental Health

Eight individuals participated in the Bedfordshire Community Health Services Working Together Group, users of both community health services and mental health services.

1. Access to services

1) Difficult to navigate all the different providers and how to access them
2) Waiting times are often too long and if on waiting list services need to keep patients updated
3) Criteria for Mental health services too high and people fall between services too often.
4) If waiting times are too long can people be referred to approved private providers?

2. Prevention services

1) Prevention services need to harness lived experience and services could be provided by peer support workers.
2) Referrals for mental health support (if in community services, for example) needs to be made early on before health deteriorates.

3. Crisis support

1) It is very difficult to access mental health crisis support. Very often people are falling through the cracks between services and not getting any support at all.
2) The gap between talking therapies and secondary mental health is too wide and often people end up not getting any help at all.

4. Integrated working

1) We need one IT system for all services so that patients do not have to keep repeating their story over and over, which can be re-traumatising.
2) Mental Health and physical health need to be integrated. Even within the same organisation, there is a deep division between the services. We need a holistic approach.
3) Multi-disciplinary team working would be better so that all aspects of health (physical and mental) and social care get addressed.
4) Real parity and working together between mental health and physical services as one affects the other and vice versa.
5) Awareness and support from professionals about medication and how multiple medication for different conditions interact together. More support for GPs.

5. Is there anything that you think is important, but has not yet been included?

Real co-production and involvement of patients/ service users and carers and what best practice for that is.

5.3. Lived experience focus group for people with autism – led by Autism Bedfordshire

1. Access to services

Barriers to accessing **Community Health Services**

- Participants emphasised the lack of clear information on how to access support, making it difficult for individuals and their family members to navigate the system.
- Phone-based communication was described as a significant barrier, particularly for autistic individuals who may find this method challenging.

Recommendations for improvement
- The need for clearer, straightforward information was highlighted, including knowing who the initial point of contact is when seeking support.
- Timely responses from social services were also stressed as a critical area for improvement.

Barriers to accessing **Mental Health Services**

1. Communication Challenges and Needs
    - The group reported difficulties in communicating needs to mental health teams, often resulting in inappropriate support.
    - Written notes prepared for appointments are sometimes ignored or misunderstood.
    - Flexibility in communication methods is crucial, as many autistic individuals prefer not to use the phone. Reasonable adjustments such as text or email responses were suggested.
    - Repetitive questioning by multiple professionals was a source of frustration. A single shared document was recommended to reduce repetition.

2. Staff Understanding and Adjustments
    - Staff understanding of autism complexities, including sensory sensitivities and non-verbal communication, is critical.
    - The use of hospital passports and better inter-team communication were also recommended to improve care coordination.

3. Experiences with General Practitioners
    - Participants emphasised the importance of being listened to by GPs, noting past experiences where feelings were dismissed as hormonal changes during adolescence—a challenge that continues into adulthood.
    - There is a call for more personalised approaches, moving beyond rigid criteria to better identify underlying issues and triggers.

4. Access to Mental Health Support
    - Adult referrals for mental health support are reportedly more difficult compared to childhood, with long waiting lists and limited therapy options.
    - Cognitive Behavioural Therapy (CBT) is often the default, but may not be effective for autistic people.

Recommendations for Improvement

- Early intervention strategies are seen as vital to prevent escalation, focusing on proactive coping mechanisms rather than reactive treatment.
- Written information following appointments is recommended to aid processing and recall, as verbal communication alone can be overwhelming.
- Continuity of care—seeing the same clinician—is desired to avoid repeating personal histories and to foster better understanding.
- Improved coordination among professionals and centralised information hubs, such
- as a "One Stop Shop", could enhance access and navigation of services.

2. Prevention services (Support to stay well)

1. Challenges in Mental Health Pathways
    - The pathway to mental health support was described as ineffective, with referrals often leading to services that do not understand autism or offer practical help.
    - Autistic individuals may require non-clinical support that differs from what is typically offered to neurotypical people.
    - Experiences included unresponsive social workers and difficulties managing personal assistants, largely due to administrative burdens.

2. Therapy and Treatment Options
    - Some participants found Eye Movement Desensitisation and Reprocessing (EMDR) therapy beneficial, though it is less commonly offered than Cognitive Behavioural Therapy (CBT).
    - Access to effective therapies beyond CBT is limited, with some individuals facing extended waiting lists.

3. Need for Personalised and Respectful Support
    - The group emphasised the importance of personalised support and of being taken seriously by professionals.
    - The name and framing of services, such as Recovery Colleges, may deter some autistic people from engaging due to perceived inappropriateness or stigma.

Recommendations for Ongoing Wellbeing

- Participants expressed the need for mentors who understand autism complexities to provide ongoing support.
- Tailoring support to individual interests, such as sports or walking, can encourage better self-care and help reduce social isolation.
- Trusted support networks are essential for encouraging individuals to seek help when needed.
- The concept of a central hub for information and support was reiterated as a way to improve access and coordination.

3. Getting help in a crisis

1. Barriers to Effective Crisis Support
    - Emergency departments and hospital environments were generally seen as unsuitable for autistic people, often increasing anxiety.
    - Telephone-based services, such as Samaritans, were less favoured due to phone aversion.
    - There is limited awareness of existing crisis services like Crisis Cafés.
    - Unclear or inaccessible contact information for mental health teams was noted as a barrier.

Recommendations for Improvement

- Staff need better autism awareness, and mental health facilities should be made more autism-friendly.
- Trustworthy and familiar support networks are essential for individuals to feel safe and supported during crises.
- The creation of separate, autism-friendly crisis spaces was recommended to help reduce anxiety and provide appropriate guidance.
- Access to professionals knowledgeable about autism who can understand and respond to individual needs is crucial.
- Having accessible contact numbers for mental health teams is also recommended to improve responsiveness and clarity.

4. Neighbourhood Working and Joined-up Care

1. Support for Consolidated Services
    - Participants expressed support for consolidating services in one place to improve ease of access and reduce the complexity of navigating multiple systems.

2. Communication and Responsiveness
    - Respecting communication preferences—such as avoiding phone-based contact where needed—and ensuring prompt responses to inquiries were highlighted as priorities.

3. Access to Therapies
    - There remains a need for increased availability of talking therapies, as some individuals continue to face long waiting times for support.

5.4. Workforce Focus Groups – Provider led

Provider organisations agreed to conduct focus groups with members of their workforce. To ensure consistency across sessions, all were supplied with the same briefing document, presentation, discussion and reporting templates.

Staff participants were invited to reflect on whether the emerging themes and priorities aligned with their own experiences of services, and to identify any areas they felt were missing or underrepresented.

5.4.1. Central and North West London NHS Foundation Trust (CNWL) – Community Health and Mental Health

The insights presented below are taken directly from CNWLs two workshops held with 46 members of staff across both community health services and mental health service, as shared with us.

1. Access to services

1) Challenges navigating complex systems; duplication of referrals and lack of continuity.
2) Difficulty re-entering mental health services after discharge; need for rapid access pathways.
3) Cross-border anomalies restrict access based on GP registration; inequities in service provision.
4) Barriers to linking physical and mental health services, particularly for repatriated patients and those with neurological conditions.
5) Referral criteria were described as unclear and inconsistent; staff emphasised the need for a transparent "core offer" to reduce ambiguity.
6) A single point of access was highlighted as beneficial to reduce duplication and prevent patients from repeatedly recounting their histories.
7) Locally delivered clinics in neighbourhood or community venues were valued for making services more accessible and trusted.
8) Workforce capacity was identified as a limiting factor, with staff warning that expanding access without additional resources is unrealistic.
9) Concerns were raised that variation in provision across Bedfordshire, Luton and Milton Keynes risks creating inequities and a "postcode lottery."
10) While digital routes may expedite referrals, participants cautioned that older adults and digitally excluded groups would be disadvantaged.

2. Prevention services

1) Current prevention capacity constrained; urgent needs take priority.
2) Call for increased resources for early intervention and education.
3) Gaps in prevention strategies for children and teenagers.

Workshop question 1 – Workforce focus group led by providers

4) Variation in commissioning across BLMK; need for equitable, evidence-based allocation.
5) Participants endorsed early intervention and “waiting well” initiatives as mechanisms to reduce crisis escalation.
6) Community-based resilience-building and co-designed programmes were viewed as opportunities to align care more closely with population needs.
7) There was recognition that prevention can improve long-term outcomes if supported with adequate capacity.
8) Staff stressed that prevention should not displace maintenance support for individuals with long-term conditions.
9) Concerns were voiced that current strategies assume greater staffing and resourcing than are presently available.
10) Some participants feared that prevention could be misinterpreted as reducing service intensity rather than reconfiguring care.

3. Crisis support

1) Concerns over reliance on digital/text-based crisis solutions; risk to clinical safety.
2) Mental health patients prefer face-to-face contact; community crisis teams effective in preventing hospital admissions.
3) Need for clearer definition of crisis support across mental and physical health.
4) Rapid response teams and community crisis lines were considered valuable tools for reducing hospital reliance.
5) Coordinating urgent care in community settings was welcomed as a way of supporting both patients and carers.
6) Crisis alternatives to hospital admission were regarded as enhancing recovery within familiar environments.
7) Follow-up care after crisis episodes was described as inconsistent, with long waits reported before initial contact.
8) Older adults were highlighted as a group for whom crisis pathways are underdeveloped, leaving some without appropriate options.

4. Integrated working

1) Importance of co-production balancing clinical expertise and lived experience.
2) Call for a single point of access across community, mental health, and acute care
3) Need for stronger cross-sector partnerships.
4) Workforce issues: recruitment, retention, and impact of team restructuring.
5) Participants supported integration across physical and mental health, as well as health and social care.

Workshop question 1 – Workforce focus group led by providers

6) Shared patient records were described as essential for avoiding duplication and improving coordination.
7) Multidisciplinary working in neighbourhood teams was perceived as a mechanism for holistic care.
8) The ICB's restricted remit over social care was seen as limiting genuine integration.
9) Incompatible IT systems and complex information governance processes were identified as obstacles to progress.
10) Concerns were expressed that digital-first models could exclude individuals without access to necessary technologies.

5. Is there anything that you think is important, but has not yet been included?

1) Concerns about over-reliance on digital and AI-driven solutions in crisis care, which may not be clinically safe for high-risk groups.
2) Need to preserve effective face-to-face crisis support models, as surveys show patients value personal interaction over digital-only options.
3) Importance of distinguishing between physical and mental health crises in planning, since the needs and responses differ significantly.
4) Workforce retention challenges caused by limited career progression pathways and lack of specialisation opportunities, leading to loss of trained staff.
5) Risks of restructuring teams into smaller neighbourhood hubs without adequate staffing, potentially diluting expertise and creating inefficiencies.
6) Variation in service setup and commissioning across BLMK has created inequities in patient experience, highlighting the need for standardised approaches.
7) Lack of specialist services in some areas, resulting in inequitable access to evidence-based treatments.
8) Cross-sector partnerships with agencies such as police, hospitals, and local authorities must be maintained, as broader commissioning could weaken valuable local relationships. Digital exclusion was emphasised as a significant barrier, with older adults and other vulnerable groups at risk of being left behind if digital-first pathways dominate.
9) Transport challenges were highlighted, as reduced public transport options limit attendance at even "local" clinics.
10) Participants noted the importance of supporting people to live well with long-term conditions, not solely focusing on prevention or crisis response.
11) Concerns were raised about workforce shortages and skill gaps, which jeopardise the feasibility of proposed changes.

5.4.2. East London NHS Foundation Trust (ELFT) - Mental Health

The feedback below summarises insights from ELFT following two workshops held with approximately 150 members of children and adults mental health, learning disability & autism staff.

Feedback was sought largely via Mentimeter (an interactive tool used to gather real-time, anonymous feedback from participants via their devices such as laptops, tablets and mobile phones).

The insights presented below are taken directly from ELFT's focus group sessions, as shared with us.

1. System Integration and Joined-Up Care

There is strong consensus around the need for better integration across the health and social care system. Staff consistently highlighted:

- **Gaps between services** requiring clearer pathways, particularly between CAMHS and adult services, and primary to secondary care transitions
- Need for **joint commissioning** with wider agencies including local authorities, education, and the voluntary sector
- **Single point of access** systems to reduce duplication and improve user experience
- Better **coordination between physical and mental health services**

2. Access, Equity and Population Health

Significant concerns were raised about equitable access to services:

- **Health inequalities** affecting people with learning disabilities, autism, and marginalised communities
- **Geographic disparities** in service provision across the BLMK footprint
- Need for **culturally competent services** that reflect local population diversity
- **Long waiting times** and insufficient alternatives during waits
- **Digital exclusion** risks for vulnerable populations as services move toward digital delivery

3. Prevention and Early Intervention

Strong support for the 10-year plan's prevention focus, with specific requests for:

- **Investment in early years** and school-based mental health support
- **Community-based preventative services** to reduce hospital admissions
- **Wider therapeutic offers** including arts, wellness, and alternative therapies
- **Trauma-informed and strengths-based approaches** rather than deficit models
- **Social prescribing** and community resources

4. Neurodiversity and Specialist Services

This emerged as a critical priority area:

- **Autism and ADHD support** that doesn't rely solely on formal diagnosis
- **Reasonable adjustments** across all services for neurodivergent individuals
- **Specialist pathways** in acute services for people suspected of neurodiversity
- **Educational support** for staff on neurodiversity awareness

5. Children and Young People's Services

Specific requirements identified include:

- **100% Mental Health Support Team coverage** in schools (with appropriate funding)
- **Transition support** from children's to adult services, particularly for looked-after children
- **Family and carer support** throughout care pathways
- **Age-appropriate environments** and approaches that don't take a "one size fits all" approach

6. Infrastructure and Digital Transformation

Key commissioning considerations:

- **Fit-for-purpose IT systems** that enable information sharing across providers
- **Community-based clinical spaces** accessible to local populations
- **Digital solutions** balanced with maintaining face-to-face contact where clinically indicated
- **Estates development** that creates welcoming, accessible environments

7. Financial Sustainability and Long-term Planning

Commissioners were urged to consider:

- **Sustainable long-term funding** rather than short-term commissioning cycles
- **Realistic expectations** about what can be delivered within financial constraints
- **Investment in prevention** as more cost-effective than crisis intervention
- **Market shaping** for specialist placements and services

8. Quality and Outcomes

Staff emphasized the importance of:

- **Meaningful quality indicators** that reflect patient outcomes rather than just activity
- **Service user involvement** in service design and evaluation
- **Evidence-based practice** and quality improvement initiatives

- **Learning from what works** and celebrating successes.

5.4.3. East London NHS Foundation Trust (ELFT) – Community Health

The feedback below summarises insights from ELFT's Bedfordshire Community Health Team following a workshop held with approximately 45 members of staff.

Feedback was sought largely via Mentimeter (an interactive tool used to gather real-time, anonymous feedback from participants via their devices such as laptops, tablets and mobile phones).

The insights they provided were regarding the emerging priorities and can be seen in the feedback for workshop 2.

5.5. Workforce focus groups led by local authorities

We approached the four local authorities to see if they would conduct focus groups with members of their workforce. To ensure consistency across sessions, all were supplied with the same briefing document, presentation, discussion and reporting templates.

Staff participants were invited to reflect on whether the emerging themes and priorities aligned with their own experiences of services, and to identify any areas they felt were missing or underrepresented.

5.5.1. Bedford Borough Council

The insights presented below are from the workshop Bedford Borough Council with 7 members of their workforce from Public Health, Children's Services and Adult Services Directorates, as shared with us.

1. Access to services

1) Long waiting times for mental health and crisis support services, with little or no interim support available. This leaves people without help during crisis periods or time where individuals are left unsupported with no diagnosis, worsening menta health etc..
2) Health inequalities significantly impact access; better information-sharing and targeted community engagement are needed to break down barriers and ensure equitable access.
3) Lack of clarity on access routes: many people do not know whether to approach their GP, council, social prescribers, or voluntary sector groups. This creates duplication, frustration, and drop-off before reaching the right service.
4) Need for clearer pathways: education for the public and training for community leaders/frontline workers is essential so that they can signpost confidently and individuals can self-navigate.
5) Digital inequality: while online access and self-referral systems can improve efficiency, they risk excluding those without digital skills, connectivity, or confidence. Investment in digital inclusion is needed.
6) Thresholds for support are too high; many people are turned away because they are not deemed "unwell enough," leading to deterioration and later crisis interventions.
7) Continuity and consistency of care: individuals often repeat their story multiple times to different professionals before receiving support, which delays care and causes distress.
8) Fragmented service landscape: better integration between health, adult social care, and the voluntary sector is needed so people don't fall through the gaps.
9) Cultural and language barriers: many communities face additional challenges in understanding, trusting, and accessing services. More culturally competent provision and translation support are needed.
10) Transport and geographical access: for those in rural or poorly connected areas, physical access to appointments and services is a significant barrier.

11) Accessibility for people with disabilities: services need to be physically and communication-accessible for people with mobility, sensory, or learning disabilities.

12) Early intervention and prevention: more community-based, low-level support is needed to prevent escalation to crisis point.

2. Prevention services

1) Short-term funding and "parachute projects": many initiatives are launched but cannot be sustained, leaving gaps and reducing trust in services.
2) Insufficient resources to meet demand: prevention services are overstretched, resulting in reactive crisis intervention rather than early, proactive support.
3) Unequal access to opportunities: many communities are unaware of, or unable to access, local prevention activities that could improve health and wellbeing.
4) Asset mapping is needed and should be shared widely (with professionals, community leaders, and residents) so that everyone knows what's available in their area.
5) Focus on early intervention: investment in preventative approaches (e.g. community groups, peer support, wellbeing activities) reduces long-term pressure on clinical services.
6) Workforce capacity: staff and volunteers delivering preventative services are under strain, with limited training, supervision, and progression opportunities.
7) Integration across sectors: prevention services must link better with GPs, adult care, schools, housing, and voluntary groups to avoid duplication and to create clear pathways.
8) Cultural competence and trust: prevention initiatives need to be designed with and for communities, ensuring they are inclusive, culturally relevant, and trusted.
9) Data and evaluation: prevention projects often lack robust measurement of impact, making it harder to secure ongoing funding or demonstrate long-term savings to the system.
10) Digital and communication barriers: many preventative opportunities are advertised online only; more accessible communication channels are needed to reach those not digitally active.
11) Inequalities in provision: prevention activities are more readily available in some areas than others, creating a postcode lottery effect.

3. Crisis support

1) Long waiting lists with little to no interim support, leaving people at high risk without timely care.
2) Gap between low-level support and crisis intervention: individuals with complex but non-crisis needs are left unsupported or bounced between inappropriate services.
3) System delays: multi-agency decisions can take weeks to be communicated, leaving service users in limbo. This undermines trust and creates further risk.
4) High thresholds for access: many referrals to CMHT result in little or no support until a crisis escalates (often a suicide attempt), due to capacity and funding constraints.

5) Over-reliance on voluntary sector alternatives: services like Mind BLMK crisis cafés have filled the gap, but reductions in funding have left communities with even fewer safe options.
6) Inappropriate default to A&E: for many people in severe mental distress, attending A&E is not realistic, safe, or accessible, yet it remains one of the only options available.
7) Lived experience evidence: residents report long waits (e.g. six months after contacting the Crisis Team) which is likened to “going to A&E with a broken leg and being told to wait six months for a cast.
8) Rising demand: services such as Open Door Counselling (for young people) have seen referrals grow from 150 to 1,000 per year in five years, showing the scale of unmet need.
9) Need for co-design: Must also actively consult local counselling services, voluntary mental health providers, and community-led initiatives who hold real-time insight into demand and gaps.
10) Workforce pressures: crisis services are overstretched, leading to burnout, high turnover, and reduced capacity to respond quickly or compassionately.
11) Children and young people: current crisis systems are failing both adults and children; urgent attention is needed to ensure CAMHS crisis support is timely and effective.
12) Continuity of care: crisis intervention often ends abruptly, with little follow-up support, increasing the risk of relapse or repeated crisis episodes.
13) Equity of access: some communities (e.g. minority ethnic groups, rural residents, those with disabilities) face additional barriers to reaching crisis support and need tailored approaches.

4. Integrated working

1) Progress in partnership working: engagement with partners and the VCSE sector has improved, but many services still operate in siloes, limiting the benefits of integration.
2) Clarity on place-based working: there needs to be a clear, shared definition of what “place-based” means in practice, including how assets, infrastructure, and services will be distributed across growing communities.
3) Community concerns: mental health services are already under strain; service users and providers worry that “integration” may be used to justify reducing provision rather than strengthening it.
4) Fragmented pathways: without joined-up systems, individuals are often passed between services with little continuity or coordination of care.
5) Shared accountability: integrated working should not just be about co-location or information sharing, but about shared responsibility for outcomes and experiences of service users.
6) Data and information sharing: better mechanisms are needed to share information safely across agencies, reducing duplication and helping people avoid retelling their story multiple times.

7) Role of VCSE sector: voluntary and community groups are often closest to residents, but they are not always treated as equal partners in system design and delivery.
8) Co-production with communities: integration should include lived experience voices and grassroots groups, ensuring services are built around real needs and not only organisational structures.
9) Workforce collaboration: professionals across health, social care, and VCSE need joint training and opportunities to build relationships, fostering a culture of integration rather than competition.
10) Measuring integration: there should be clear ways to evaluate whether integrated working is actually improving outcomes for people, not just efficiency for systems.
11) Geographic equity: integration must consider rural and under-served areas, ensuring consistent access and not concentrating assets only in urban centres..

Is there anything that you think is important, but has not yet been included?

- There should be a personalised approach to supporting individuals, many residents feel that the ‘human element’ of accessing mental health or adult services is lost, and they are treated with a one size fits all approach from professionals.

5.6. Primary care workshop

We held two workshops for staff employed within primary care to provide feedback on the transformation programme. They were all encouraged to attend the market engagement events

The sessions were attended by 51 primary care colleagues, the feedback and questions raised from the sessions is shown below:

1) The 6 transformation pillars are the same as the last 10 years, they are nothing that we have not heard before. The pillars are fine, but they are not new. So how will we make it different this time?

   Response: *We will ask providers to work differently to deliver the priorities, working collaboratively. We will commission for outcomes which will be set with input from partners.*

2. Who will be responsible for measuring outcomes? How will we ensure this is measured via contract management?

   Response: *The change in the role of the ICB will allow for greater focus on contract management. Providers will also have more responsibility to manage pathways together – moving towards collective accountability.*

3. In the new cluster of ICB's, some of the ICB's run their mental health services really well. So we are not starting from scratch can we learn from these ICB's.

   Response: *The Case for Change needs to be clear for our BLMK population, but in the larger cluster we have the opportunity to look across at what is working well in other areas*.

4. These are big transformation programmes. How do we maintain the current work as we transform services? We have had issues recently with current district nursing services struggling – what link is there between what we are aiming for with the transformation work and the services we need to deliver now?

   Response : *Learning from both programmes is informing what we do now – for example our commissioning intentions for next year – we are populating that with the learning from the case for change we are writing.*

   We have a process for managing service changes for existing services, we have a clinical advisory group that reviews proposed changes and should be agreed by the group before being implemented.

   We have also have agreed that any services changes need to be visible across the system.

Comment
CEO of Community Dental Services (referral service for high street family dentist) receive referrals children that require dental extraction and for elderly and Children and adults with learning disabilities. A county-wide service and an NHS referral service and would welcome an opportunity to link in with the transformation programme and across neighbourhood health.

Encouraged to register via the portal for the CMHS Transformation Programme

6. Feedback from workshop 2 – Emerging Priorities

The second part of the workshop focused on testing the draft emerging transformation priorities. We asked participants whether they agreed with the priorities and invited them to share anything they felt was missing.

6.1. Resident Focus Groups – ICB led

The feedback below provides a comprehensive overview of the insights shared across the ICB-led resident focus groups.

Draft emerging priority 1: Develop teams in neighbourhoods to help improve health outcomes and the experience of care

> *"Developing teams in neighbourhoods is absolutely fundamental… the real trust and understanding comes from the ground up."*

1) **Local access and carer support**: Services must be geographically accessible, especially for working carers. Long travel times create barriers to care.
2) **Service coordination**: Stronger local coordination is needed to prevent people feeling "forgotten." Integration with PCNs could improve efficiency and responsiveness.
3) **Neighbourhood definition and community voice**: Clear definitions of "neighbourhood" and "community" are needed. Empowering communities to shape services through co-design and grassroots involvement is essential.
4) **Inclusive and person-centred design**: Services should balance inclusivity with usability, offer clear signposting, and support continuity, especially for transient populations.
5) **Action over planning**: Participants urged a shift from discussion to implementation, learning through doing and involving VCSEs and patients in redesign efforts.
6) **Frontline delivery**: Compassionate, informed frontline staff are key to success - policies alone won't deliver outcomes.

Draft emerging priority 2: Understand the needs of local communities to help prevent poor health

> *"If you don't understand the community, you can't serve it properly."*

1) **Neurodiversity and trauma-informed care**: Services must be more neurodiverse-friendly and trauma-informed, with adjustments to communication, environments, and appointment systems.
2) **Digital exclusion**: Digital-first approaches exclude older adults and low-income families. Clear, accessible alternatives are needed to prevent disengagement.
3) **Community complexity**: Individuals often face overlapping challenges across health, housing, employment, and social care - services must reflect this complexity.

4) **Trusted relationships**: GPs play a central role in how people engage with support. Building trust at the local level is essential.
5) **Grassroots workforce development**: Community-based roles (e.g., youth workers, mental health assistants) are valuable but often under-supported. A peer learning network could enhance quality, regulation, and career pathways.
6) **Peer support and lived experience**: Peer-led support offers practical and emotional benefits. Growing teams from within communities fosters trust and sustainability.
7) **Clarity and coordination**: Clear definitions of "community" and better coordination across services are needed to ensure relevance and impact.

Draft emerging priority 3: Co-design and co-deliver services focused on preventing poor health and helping people start, live and age well

> *"Co-design starts to really happen if you bring in trusted partners - they know the need because it's their neighbours."*

1) **Genuine co-design and co-delivery**: Services must be shaped by those who use them - not just consulted. Co-design should involve meaningful input from individuals and grassroots VCSEs, not token gestures.

2) **Community based and comfortable settings**: Services should be delivered in familiar, welcoming environments, especially for neurodivergent adults. Peer support and community groups are vital for prevention and recovery.

3) **Continuity and navigation support**: Named contacts, ongoing support post-discharge, and roles like navigators and social prescribers are essential to prevent setbacks and ensure smooth transitions.

4) **Early intervention and root cause focus**: Participants want services that address underlying issues early, not just treat symptoms. Physical activity and wellbeing should be embedded across care settings.

5) **Feedback and evaluation**: People want their voices heard and their feedback acted upon. Service evaluation should be continuous and include lived experience oversight.

6) **Grassroots empowerment**: Small community groups often hold deep local insight. Supporting and connecting these groups through peer learning networks can build trust, sustainability, and future workforce pipelines.

Draft emerging priority 4: Ensure services are personalised, with a single point of access for people using our services

> *"I wasn't just a patient - I was a person with a life, a family and goals. The care plan didn't reflect that."*

Workshop question 2 – Resident focus groups led by ICB

1) **Reasonable adjustments and neurodiversity**: Services should accommodate neurodivergent individuals through tailored communication, sensory-friendly environments, and appointment systems. A “reasonable adjustment flag” in health records was widely supported to streamline support.
2) **Continuity and re-entry pathways**: Participants stressed the need for clear pathways to re-enter specialist care after discharge and ongoing support beyond therapy - people should not feel “left” once treatment ends.
3) **Simplified access and navigation**: A single point of access should reduce the need to repeat personal stories and improve system navigation. Clear referral pathways and signposting are essential.
4) **Cultural sensitivity and personalisation**: Services must be culturally competent and responsive to individual needs. Examples included tailored support for young Muslim women through culturally sensitive physical activity programmes.
5) **Digital accessibility**: Communication must be clear and accessible, especially considering the UK’s average reading age. Digital tools should be inclusive and easy to use.
6) **Support for carers**: Carers need consistent, coordinated support. Current systems were described as inadequate and fragmented.

Draft emerging priority 5: Increase access to a wider range of services closer to home

> *“People don’t want to go into the town centre - they want to get their service in their neighbourhood.”*

1) **Empowerment and self-management**: Participants want autonomy and choice, with access to non-NHS resources and tools that support self-care and reduce dependency on services.
2) **Out-of-hours and crisis support**: A&E is unsuitable for many in crisis, especially neurodiverse individuals. There’s a need for urgent care options within communities, available beyond standard hours.
3) **Localised and neighbourhood delivery**: Services should be embedded in neighbourhoods, not just town centres. Upskilling community members to deliver basic interventions was suggested as a sustainable model.
4) **Digital Inclusion and promotion**: Tools must use simple language and be tailored to the audience. Suggestions included using platforms like TikTok, Instagram, and QR codes to promote services locally.
5) **VCSE recognition and resourcing**: VCSE organisations provide vital support but need proper funding and integration into formal care pathways.
6) **Navigation and data coordination**: Services must be easy to navigate, with consistent pathways across regions. Support for data collection and centralisation was also recommended to improve service planning.

Draft emerging priority 6: Provide co-ordinated urgent care within the community

“Urgent care coordination depends on joined-up working across all sectors.”

1) **Out-of-hours and crisis support**: Participants highlighted the lack of urgent care after 6pm, leaving people in pain or distress with no immediate help. A&E and district nurses are overstretched and unsuitable for many.
2) **Joined-up working**: Effective urgent care requires coordination across services, with joint strategies, financial pooling, and clear referral pathways. Integration should be a cross-cutting principle, not a standalone effort.
3) **Timely and flexible intervention**: Urgent care must be responsive to brief windows of engagement, especially in addiction and mental health crises. Rigid, tick-box systems were seen as barriers to timely support.
4) **Community-based delivery**: Services should be delivered in familiar, comfortable spaces such as through Community Interest Companies and tailored to local needs.
5) **Clarity and purpose**: Participants asked for clearer definitions of what “co-ordinated urgent care” means and who it is for, to ensure services are designed with purpose and inclusivity.

Is there anything that you think is important, but has not yet been included?

1) **Choice and compassion in mental health**: Participants want more options in mental health care and to feel genuinely cared for, especially during vulnerable moments.
2) **Empowerment and self-care**: Peer support and self-management should be recognised as valid alternatives to clinical intervention.
3) **Cultural competency and equity**: Services must be culturally competent and explicitly address barriers faced by ethnic minorities. Language must clearly distinguish between mental health and general wellbeing.
4) **Visibility and communication**: New services and pathways must be well advertised. Clear, accessible communication including digital tools should enhance service navigation and user experience.
5) **Continuous learning and improvement**: Mistakes should be used as learning opportunities. A culture of improvement, not blame, is essential for better service delivery.
6) **Workforce planning and capacity**: To deliver these priorities effectively, we need to understand the skills and availability of the current workforce - identifying gaps, addressing staff shortages, and ensuring there are enough trained people to carry out the work in a sustainable way.
7) **Feedback and impact measurement**: Patient voice must go beyond Friends and Family tests. Feedback mechanisms should be meaningful, and service changes must consider their impact on users and carers.
8) **Inclusive VCSE engagement**: Smaller community groups and grassroots organisations are vital but often overlooked. Building trust with these partners is key to reaching marginalised communities.

Workshop question 2 – Resident focus groups led by ICB

9) **“Waiting Well” concept**: Participants appreciated the idea of offering softer, community-based support while people wait for formal services - helping maintain wellbeing during delays

6.2. Lived experience workshops – Provider led

The insights below are taken directly from the provider led lived experience sessions, as shared with us.

6.2.1. Cambridgeshire Community Health Services (CCS) – Community Health

Draft emerging priority 1: Develop teams in neighbourhoods to help improve health outcomes and the experience of care

1) Yes, but more formal relationships between voluntary sector partners and statutory agencies are required. Community groups support people out of benevolence but those groups are not well resourced and deliver services that are uncosted
2) Community groups would welcome system partner efforts to help groups capacity build, e.g. by offering training and sharing knowledge
3) This will help groups get to a point where they feel capable of pitching for a service delivery contract
4) Also, community groups and charities rely on goodwill from local businesses to provide spaces and venues to deliver critical services, e.g. a participant described the local support group they run for cancer survivors. The membership group is roughly 30 people and is hosted monthly by a local business which provides premises for the membership to meet.
5) Participants welcomed the idea of more face to face encounters with health professionals, rather than over digital platforms, neighbourhood teams were seen as a way of making this happen.

No feedback regarding the other 5 emerging priorities was included in the focus group notes.

Is there anything that you think is important, but has not yet been included?

1) Consider how NHS resources are being consumed – are we using resources in a sustainable way? Otherwise, we risk overspending our NHS budget.
2) Participants wanted to know how feasible the priority areas are? E.g., Working collaboratively with residents/patients in a co-produced manner, will support staff from comms and engagement be available to facilitate joint working?
3) Participants wanted to know how progress against the priorities areas will be measured?

6.2.2. Central and North West London NHS Foundation Trust (CNWL) – Community Health and Mental Health

Draft emerging priority 1: Develop teams in neighbourhoods to help improve health outcomes and the experience of care

1) Agreement, participants support neighbourhood teams but stressed the need for genuine integration between health and social care.
2) Noted that teams must be culturally competent and reflective of the communities they serve. CNWL has cultural competency training which is proving effective.

Draft emerging priority 2: Understand the needs of local communities to help prevent poor health

1) Participants emphasised involving community connectors, peer workforce, and ambassadors as a way of capturing local voices.
2) Highlighted the importance of tackling digital exclusion, socio-economic barriers and language barriers to avoid unequal access.

Draft emerging priority 3: Co-design and co-deliver services focused on preventing poor health and helping people start, live and age well

1) Strong support for co-production as a principle, with calls for dedicated budgets and clear payment systems for involvement.
2) Prevention also linked to practical initiatives, such as embedding staff in community venues (churches, lunch clubs) and supporting "waiting well."

Draft emerging priority 4: Ensure services are personalised, with a single point of access for people using our services

1) Agreement that this would improve consistency and reduce the "postcode lottery."
2) Current multiple access points are confusing; staff themselves need clearer guidance to support residents effectively.

Draft emerging priority 5: Increase access to a wider range of services closer to home

1) Supported, but participants questioned resources to deliver on this ambition.
2) Suggested building stronger partnerships with VCSEs to extend reach.

Draft emerging priority 6: Provide co-ordinated urgent care within the community

1) Strong support for crisis houses and crisis cafés.

2) Participants emphasised support for carers and also for individuals without support networks, to prevent isolation in crises.

Is there anything that you think is important, but has not yet been included?

1) Ensure robust and localised translation/interpretation services; explore technology (iPads, live translation) and in-house multilingual staff.
2) Develop stronger communications and marketing strategies so communities are aware of services.
3) Address structural barriers to co-production by funding involvement coordinators and embedding these roles in localities.
4) Clarify what is meant by "24/7 digital support" to ensure it complements, rather than replaces, face-to-face crisis care.

6.2.3. East London Foundation NHS Trust ELFT

ELFT's lived experience groups took a different approach to responding to this question, and voted on the six priorities, responses shown below

1. Bedford Borough and Luton Borough Working together Groups – Mental Health

What would your top three priorities be?

Responses from Bedford Borough Working Together Group

- Single point of access – Clear communication [draft emerging priority 4]
- Develop teams in neighbourhoods [draft emerging priority 1]
- Understand the needs of local communities. [draft emerging priority 2]

Responses from Central Bedfordshire Working Together Group

The group suggested the following priorities

1. Better Crisis help. Having a place to go when hitting a crisis. Things being under one umbrella. If carer believes family member needs to be safe that he/ she or "they" are listened to and actioned.

2. Quality of customer care, longevity of services, trust values, organisational credibility & high standard general presentability.

Responses from Luton Borough Working Together Group

The group identified priorities 3, 2, 1 and 4 as their top priorities:

Workshop question 2 – Lived experience focus groups led by providers

1. Draft emerging priority 1: Develop teams in neighbourhoods to help improve health outcomes and the experience of care - 43% of votes

2. Draft emerging priority 2: Understand the needs of local communities to help prevent poor health - 71% of votes

3. Draft emerging priority 3: Co-design and co-deliver services focused on preventing poor health and helping people start, live and age well - **100% of votes**

4. Draft emerging priority 4: Ensure services are personalised, with a single point of access for people using our services - 43% of votes

5. Draft emerging priority 5: Increase access to a wider range of services closer to home - 15% of votes

6. Draft emerging priority 6: Provide co-ordinated urgent care within the community - 14% of votes

Additional feedback

1) One of the main challenges will be that more people will be coming through Mental Health Services over the next few years
2) Infrastructure isn't there for new developments. This means that no more GPs surgeries are being built therefore adding the pressure to those services and the community mental health services.
3) Community services (MH) should be placed in places where there is no infrastructure. This is a particular challenge when Central Beds covers a wide geographical area and there is a significant lack of public transport
4) There's going to be an increasing demand on services with changes in peoples mental health conditions over time. Increase in time and resource to support relapses and to research service users' conditions
5) GP surgeries liaising with Mental Health services. Improved communication and referral / follow up processes
6) Better joint working between GPs and ELFT services
7) joined up systems where clinicians can access records from different professions.
8) Look at options under the 'Right to choose' system. Look at cost comparison between ELFT and private organisations. Offering the option 'Right to choose' may reduce waiting times whilst avoiding service users from spending a significant amount of money.
9) Provision of Crisis Houses – providing a safe family environment rather than just an institution

2. CAMHS Working Together Group – Mental Health

What would your top three priorities be?

The CAMHS Working Together Group suggested some different priorities

Workshop question 2 – Lived experience focus groups led by providers

1) **Youth workshops in schools**
    - Run workshops with parents and families present to create supportive, non-intimidating environments.
    - Work more closely with schools to embed mental health in resources and PSHE.
2) **Support for neurodivergent young people**
    - Help schools understand masking in ASC and neurodivergent young people.
    - Create safer spaces within schools to support this.
3) **Priorities and inclusivity**
    - Keep existing priorities while adding more (e.g., recognising *age* as a protected characteristic).
    - Prioritise and invest in research to strengthen these approaches.

Additional feedback

1) Other feedback suggested there is a gap that needs to be a larger priority – urgent community care.
2) It was felt amongst service users that this isn't addressed until someone is already in hospital, and the "damage is already done".
3) Many people make contact when it is urgent, but help doesn't arrive until it is too late. The suggestion from one service user was that "they don't take you seriously until you try to end your life".
4) Better systems for referrals could work against backlogs, removing stigma in the community.
5) One service user has been creating an app which can log data and is in draft-form until they learn healthcare management with informatics at university.
6) Overall, this service user feels there could be better systems for referrals and 'staff ratings'.
7) It was also suggested that a lot of stigma comes from practitioners themselves, and many have had bad experiences with them.
8) Feedback should come from young people attending these sessions, and one service user wants to create an app in the future where service users are able to provide anonymous star ratings on their practitioners.

3. Bedfordshire Older People's Working Together group – Mental Health

What would your top three priorities be?

- Increase access to a wider range of services closer to home – (priority 5).
- Co-design and co-deliver services focused on preventing poor health and helping people start, live and age well – (priority 3).
- Provide co-ordinated urgent care within the community – (priority 6).

5. Bedfordshire Community Health Services Working Together Group – both Community Health and Mental Health

Draft emerging priority 1: Develop teams in neighbourhoods to help improve health outcomes and the experience of care

- Is neighbourhood working same as MDT working? If so, yes.

Draft emerging priority 2: Understand the needs of local communities to help prevent poor health

- Yes, through co-production.

Draft emerging priority 3: Co-design and co-deliver services focused on preventing poor health and helping people start, live and age well

- Include co-production please.

Draft emerging priority 4: Ensure services are personalised, with a single point of access for people using our services

- Yes, with emphasis on joint working between Mental Health and community services. They work in silos at the moment.

Draft emerging priority 5: Increase access to a wider range of services closer to home

- Yes

Draft emerging priority 6: Provide co-ordinated urgent care within the community

- Yes

Is there anything that you think is important, but has not yet been included?

- Co-production

6.3. Workforce Focus Groups – Provider led

The insights below are taken directly from the provider led workforce focus groups, as shared with us.

6.3.1. Central and North West London NHS Foundation Trust (CNWL) – Community Health and Mental Health

Draft emerging priority 1: Develop teams in neighbourhoods to help improve health outcomes and the experience of care

1) Support in principle, but concerns about splitting teams into small hubs leading to inefficiencies and diluted expertise.
2) Workforce shortages and limited specialisation opportunities risk undermining neighbourhood team effectiveness; need robust staffing models with redundancy built in.
3) The ambition for neighbourhood teams was widely endorsed, with recognition that localised models enhance trust and outcomes.
4) Locating specialist clinicians within community settings was viewed positively.
5) Participants saw neighbourhood delivery as a way to reduce unnecessary reliance on hospitals.
6) Doubts were expressed about whether the existing workforce numbers could sustain this model.
7) Concerns were raised that without additional staff, resources would be overstretched.
8) A uniform approach across BLMK was considered inappropriate due to demographic variation.

Draft emerging priority 2: Understand the needs of local communities to help prevent poor health

1) Agreed; recommendation to engage specialist services in planning to shape effective models.
2) Data shows rapid population growth and increased complexity of needs; accurate and up-to-date data must guide local planning to avoid misinformed decisions.
3) Participants agreed that services must be responsive to local demographic differences, e.g. older populations in MK versus younger in Luton.
4) Using public health intelligence and needs assessment data was supported in principle.
5) Co-design with communities was welcomed as a way to ensure services are culturally relevant.
6) Questions were raised about whether existing data is sufficiently current or accurate.

7) The absence of systematic tools was noted as limiting the validity of planning assumptions.
8) Without robust evidence, staff doubted that needs-led service configuration could be delivered effectively.

Draft emerging priority 3: Co-design and co-deliver services focused on preventing poor health and helping people start, live and age well

1) Agreed; prevention capacity currently under-resourced. Calls for inclusion of children and teenagers in prevention planning.
2) Current variation in commissioning across BLMK means best practice is not spread consistently; a more standardised approach could ensure proactive care.
3) Participants supported co-production and emphasised the importance of embedding resident voices.
4) Cultural sensitivity was highlighted as critical to effective service design.
5) Local tailoring was regarded as a strength of co-design.
6) Staff warned that co-design may become tokenistic if not properly resourced.
7) Concerns were raised that rigid commissioning structures could stifle local adaptation.
8) Questions were asked about sustaining service-user involvement beyond one-off events.

Draft emerging priority 4: Ensure services are personalised, with a single point of access for people using our services

1) Strongly supported; would address current duplication, confusion, and integration challenges.
2) A single access point must also allow for multiple communication channels (including email for non-verbal patients), to ensure inclusivity and personalised care.
3) A single point of access was described as highly desirable for reducing duplication and confusion.
4) Personalised care was seen as essential for improving patient experience.
5) Shared records were valued as a tool for integration.
6) Barriers of non-interoperable IT systems were highlighted.
7) Information governance challenges were considered a major obstacle to implementation.
8) Concerns were voiced that centralisation could dilute specialist assessments if not carefully managed.

Draft emerging priority 5: Increase access to a wider range of services closer to home

Workshop question 2 – Workforce focus groups led by providers

1) Supported; cross-border barriers and inequities in service distribution must be addressed.
2) Service access should be based on residency rather than GP registration, to prevent patients being excluded from local care.
3) Delivering services closer to home was supported as a means of improving accessibility.
4) Locally provided clinics were described as improving engagement and building trust.
5) Participants agreed that reducing hospital reliance is beneficial.
6) Staff questioned whether current workforce levels could sustain a wider offer.
7) Some feared that attempts to equalise access might reduce services in certain areas.
8) Transport barriers were cited as a practical limitation to attending even “local” services.

Draft emerging priority 6: Provide co-ordinated urgent care within the community

1) Strong support; community crisis teams already effective, but need clarity on definitions and standardised models across BLMK.
2) Expanding urgent care capacity could reduce unnecessary hospital admissions and help intervene earlier for patients not yet in crisis.
3) Community-based urgent care was regarded as valuable in preventing unnecessary hospital admissions.
4) Rapid response and crisis alternatives were supported as effective approaches.
5) Carers were seen as beneficiaries of better coordinated urgent care.
6) Participants noted significant inconsistency in post-crisis follow-up.
7) Doubts were raised about the community's capacity to safely deliver urgent care.
8) Calls were made for services beyond 9–5 hours to meet the needs of working-age adults.

Is there anything that you think is important, but has not yet been included?

1) Equity of service access across all BLMK localities.
2) Standardised commissioning and appreciative inquiry to spread best practice.
3) Workforce recruitment, retention, and career pathways.
4) Partnership working with police, hospitals, and local authorities must be preserved.
5) Clinical safety concerns with digital-first models in crisis care.

Workshop question 2 – Workforce focus groups led by providers

6) Staff requested clarity on commissioning specifications, to ensure transparency and reduce inequity across BLMK.
7) Integration with social care was described as essential, yet participants noted that current commissioning arrangements limit this ambition.
8) The lack of interoperable IT systems was seen as a fundamental obstacle to delivering single-access and cross-area models.
9) Calls were made for services to operate outside traditional 9–5 hours to reflect the needs of working-age populations.

6.3.2. East London NHS Foundation Trust (ELFT) - Mental Health

No feedback regarding the emerging priorities was included in the focus group notes.

6.3.3. East London NHS Foundation Trust (ELFT) – Community Health

ELFT's Community health workforce group took a different approach to responding to this question, they asked the participants to select all priorities that they agreed with and given the option to choose as many as they said they felt were important

7. Draft emerging priority 1: Develop teams in neighbourhoods to help improve health outcomes and the experience of care – 16 out of 45 (36%)
8. Draft emerging priority 2: Understand the needs of local communities to help prevent poor health – 15 out of 45 (33%)
9. Draft emerging priority 3: Co-design and co-deliver services focused on preventing poor health and helping people start, live and age well – 14 out of 45 (31%)
10. Draft emerging priority 4: Ensure services are personalised, with a single point of access for people using our services – 15 out of 45 (33%)
11. Draft emerging priority 5: Increase access to a wider range of services closer to home – 19 out of 45 (42%)
12. Draft emerging priority 6: Provide co-ordinated urgent care within the community – 23 out of 45 (51%)

Is there anything that you think is important, but has not yet been included?

Co-production and co delivery – 11 responses

- Co-production of services with patients and local communities. This is fragmented at the moment and different between providers
- Prioritise as equal partners, not just support to hospitals
- Communication regarding contracts and better transition when providers change
- Trauma informed care
- Much of Bedfordshire is rural, yet strategies often lean toward urban-centric solutions.

- BLMK could go further in enabling real co-design and co-leadership — especially when reshaping services that affect vulnerable groups.
- Improved joined up care
- More homegrown training pathways
- The need for dedicated investment, not just as a "hospital avoidance tool," but as a core part of the health system.
- What about loneliness in elderly population. What can be done

Staffing – 7 responses

- Improved staffing levels in order to deliver those priorities
- workforce - we cannot deliver without a focus on our staff.
- Increased staffing, more funding, better progression routes for all bands
- Community services keep being told to increase service provision, whilst there is not the opportunities to develop staff within a timely manner or if at all, no extra staff
- Increasing experienced staff to meet the complexity of patients needs
- Better distribution of resources/staffing based on geography and population size
- Workforce succession planning

GP access – 7 responses

- GP accessibility
- GP services to be more accessible
- Ensuring that community services can directly access services. For example direct referral to diagnostic hubs.
- Have psychology support services available for our patients
- GP accessibility
- GPs understanding our service better and not using it to reduce their pressures
- Palliative services provided by all professional groups

IT systems – 7 responses

- Joined up IT across organisations
- IT to be joined across all services, including acute hospital care
- For patients not having to repeat their stories all the time because of IT systems not compatible
- Better ICB website, it’s difficult to navigate
- access to Improved IT and inclusion of AI to streamline and time save
- Integrated clinical records.
- Use of Apps and joined up systems for coexisting physical and mental health conditions.

Integration – 3 responses

- Much more integrated working in all services
- Invest early and prevent lifelong inequality
- Joined up end of life care

Resources 2 responses

- We need more resources
- Reading material for patients

Community access - 8 responses

- Accessibility improved
- Improved access to services better equipped for maintaining social mobility within our communities.
- Faster, more responsive services in the home or community.
- Put the resource in the right place. Community over acute
- Increased satisfaction and engagement from isolated communities.
- Less isolated individuals
- Services that reflect what people actually want and need.
- Increased capacity in prevention, mental health, social prescribing, and wellbeing.

Patient outcomes - 8 responses

- Better compliance with treatment and patient satisfaction
- Patients will get the support they need
- Better outcomes at lower cost through more care closer to home.
- improved quality and personalised care and treatment
- Better experience for service users
- Diagnosis picked up more quickly
- Better commissioned services that meet the needs of our service users.
- Improved trust and engagement from families.

Staff morale - 6 responses

- Better staff retention and morale
- Improved staff morale and retention
- Staff will be more satisfied with their work
- better staffing = quicker response times, shorter waiting lists. Improved morale and staff retention.
- More staff for safer patient care. More training courses to widen staff knowledge on all areas that may arise.
- Happier Families

Service efficiency - 5 responses

- Will improve efficiency
- Time efficiencies allowing us to support more service users
- More streamlined and effective service
- Reduce unnecessary high workloads
- More responsive services.

Continuity of care - 5 responses

- Stronger continuity of care for patients with long-term conditions or complex needs.
- Improved patient experience through consistent relationships.
- The right care from the right person in the right place
- Safer caseloads and reduced reliance on agency cover.
- Fewer people falling through the gaps

Hospital avoidance - 4 responses

- Unnecessary presentation to GP and A& E

- Free up hospitals for those who really need hospitalisation
- There will be less people going to A and E which costs more money
- Reduce unnecessary pressures on BCHS

Workforce skills - 1 response

- Upskilled workforce

Uncategorised - 8 responses

- Services that focus on dignity, independence, and long-term wellbeing — not just throughput. Gp working with community services
- Fully invest in sustained, multi-year funding.
- Everyone using the same system to access records
- Integration of community services with Mental health. It works in silos even though we are 1 organisation
- Tired Health Centres, not fit for purpose.
- Public and patient involvement (PPI) is often consultative, not co-productive.
- Promote self-management of health improvement. Releasing staff to provide for those that cannot support themselves safely

6.4. Workforce focus groups led by local authorities

6.4.1. Bedford Borough Council

Bedford Borough Council's workforce focus group did not comment on the individual priorities.

Is there anything that you think is important, but has not yet been included?

1) The six priorities outlined are widely supported in principle, but there is a strong sense that they currently resemble a "wish list" rather than a realistic, resourced plan.
2) Given the current strain on capacity and funding, the risk is that the plan promises too much and under-delivers, which could damage trust with communities and partners.
3) A more focused approach may be needed -targeting resources where the need is greatest and ensuring that the most marginalised communities, who often access services the least, are prioritised.
4) Success will depend on realistic phasing, clear accountability, and transparent communication about what can be achieved within available resources.
5) Without this focus, there is concern that inequalities will persist or deepen, despite the positive intentions of the plan.

6.5. Gypsy, Roma and Traveller (GRT) Mental Health – Recommendations

A representative from the Gypsy and Traveller community was planning to attend one of the focus groups but was unable to attend.

They put together some thoughts of what their community would like from community and mental health services.

1. **Make Services More GRT-Friendly**
   Ensure mental health services are welcoming, respectful, and co-designed with GRT communities to reflect their specific needs.
2. **Support GRT Youth**
   Develop programmes that promote mental wellbeing, confidence, and resilience among young GRT people.
3. **Focus on GRT Men's Mental Health**
   Create peer-led initiatives to support GRT men's mental health and encourage open dialogue.
4. **Prevent Suicide and Promote Mental Wellness**
   Allocate funding for suicide prevention, awareness campaigns, and training for professionals working with GRT communities.
5. **Train GRT Peer Support Workers**
   Equip GRT individuals with the skills to support peers in accessing mental health and addiction services.
6. **Provide Counselling and Advocacy**
   Establish and fund a national GRT counselling service and mental health advocacy programme.
7. **Use Data to Improve Services**
   Improve data collection (including ethnicity) to better understand GRT engagement with mental health services and identify areas for improvement.
8. **Ensure Funding and Oversight**
   Set up a dedicated budget and steering group to oversee GRT mental health initiatives, ensuring accountability and effectiveness.

7. Next steps

This report together with previous insights and feedback from the survey will be collated into a system wide insight and engagement report and shared with the Community and Mental Health Transformation Team for consideration.

They will be used to inform the development of the Case for Change.

This report will be made available online and shared with all of those that indicated they would like to receive a copy.

Ends.

Appendix A

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Community and Mental Health Services Transformation Programme:

Testing the Case for Change and Transformation priorities

August / September 2025

Why are we here today?

Bedfordshire, Luton
and Milton Keynes
Integrated Care Board

We are reviewing community and mental health services in BLMK and want to hear your views.

We have listened to staff and service users and now we want to test what we've heard with you.

How will we use your time?

Discussion areas	Timings
Welcome and Introduction	5 mins
Reviewing Community and Mental Health Services	15 mins
Workshop 1: What have we heard so far?	30 mins
Transition time – tea and coffee	5 mins
Workshop 2: Reviewing emerging transformational priorities	30 mins
Thank you and close	5 mins

Everyone's voice counts...

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There are no silly questions or comments – please ask if you are not sure about something

Please respect each others' views – even when we don't agree.

We will make sure we give time for everyone to speak – but we may move the conversation on, if we get short of time.

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What are we doing?

The ICB spends approximately £203 million per year on adult community services and a further £235 million on all-age mental health services **every year**.

In the last ten years, we've made **great progress** in the way these services are delivered locally.

A surge in demand for services, a **growing and aging population** and the introduction of Government's **10-Year Plan for Health** means we want to look at doing things differently.

That’s why we want to review how we deliver community and mental health services in BLMK.

We have extended existing contracts until 2028 to allow time for the review work.

The 10-Year Plan has set out a new approach to delivering health and care

Move from hospital to community – providing better care close to, or in people's own homes

from treatment to prevention – supporting people early on, to prevent people becoming unwell

from analogue to digital – using digital technology to improve care

If we don’t change how we work…

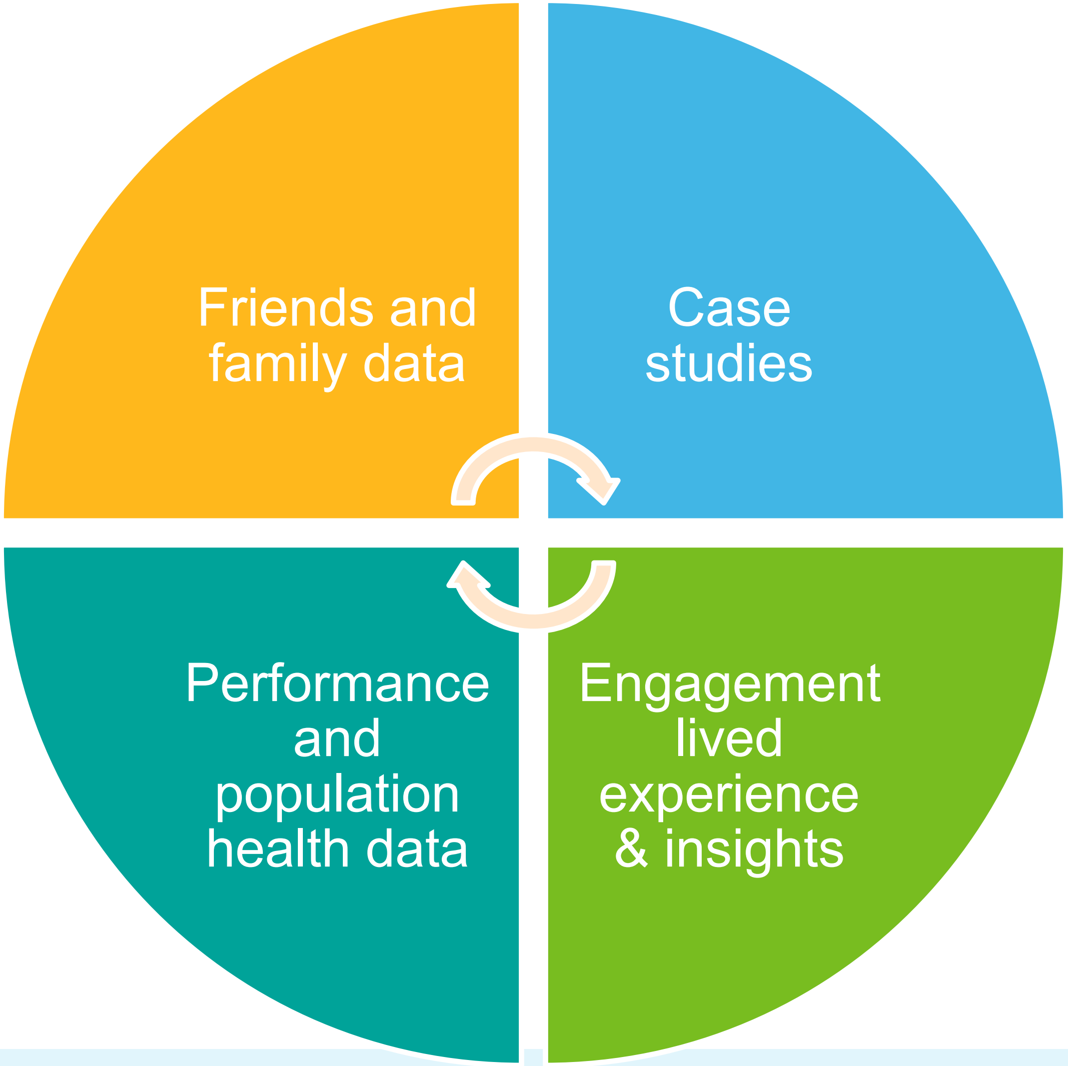
We could need approx. 300 more acute hospital beds by 2037

This demand could cost approx. £100m capital and an extra £60m year revenue per year

This is unaffordable and would reduce funds available to invest in community-based alternatives.

The proportion of people aged 16 - 64 is projected to decline, creating a mismatch between the number of people needing care and the workforce available to provide it.

Since the start of the year, we've been looking at data and listening to lived experiences….



Friends and family data

Case studies

Performance and population health data

Engagement lived experience & insights

Residents and front-line health and care professionals have told us we need to improve:

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Access to services

- We heard that better access to services is essential, with care delivered closer to home and greater availability for instance longer appointments for people who need BSL interpretation and translation. Access via digital integration is also important and cultural awareness to breakdown barriers to access.

Prevention services

- We heard that a ‘tick box’ approach to Talking Therapies was impacting long term recovery and that services in neighbourhoods, in trusted places could support the prevention agenda. There was agreement that early intervention was crucial, and communities needed to be empowered and educated. Consideration was also required on environmental factors, cultural sensitivity, collaboration and funding.

Crisis support

- We heard that rapid response community-based support is needed to prevent people requiring hospital treatment during times of crisis. Steps to establish crisis cafes in alternative settings within communities and safe places would support residents and their families. 24/7 digital support and integration with care records to ease communication was also raised, along with the need for training and awareness around holistic approaches and support for carers.

Integrated working

- Carers shared stories about intermediaries they had self funded to navigate complex systems and help improve communication with NHS providers. They recommended greater integration between different providers, and the funding of outreach support teams or champions to help especially during times of crisis. Digital integration and simplifying access to services to prevent re-telling their story is paramount. More was needed on education and awareness to build collaboration and trust.

What has the data told us so far?

Population Growth

- Our population is growing at a rapid rate (+25% by 2043) and is ageing (+63% over 65s by 2043).
- There is a rise in the number of people with more than one long term condition and a rise in complex needs.

Service Variation

- Services have been commissioned differently across BLMK
- This has led to differences in access, places of delivery, experience and outcomes

Finance

- The rising population age (and rising need) is expected to increase costs of community and mental health services by 50% by 2037. This is financially unsustainable

Workforce

- There are 4,200 people that work in community and Mental Health services across BLMK.
- The workforce is also ageing and there is a shortage of new trainees locally and nationally

And it’s helped us to identify some emerging priorities…

1. Develop teams in neighbourhoods to help improve health outcomes and the experience of care
2. Understand the needs of local communities to help prevent poor health
3. Co-design and co-deliver services focused on preventing poor health and helping people start, live and age well
4. Ensure services are personalised, with a single point of access for people using our services
5. Increase access to a wider range of services closer to home
6. Provide co-ordinated urgent care within the community

But we want to test what we've heard with you…

1. Does what we have heard sound correct?

2. Are the emerging priorities the right ones?

Workshop 1: What we have heard

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How much do you agree / disagree with what we have heard so far?

Is there anything that you think is important, but has not yet been included?

(30 mins)

Workshop 1 : What we have heard so far…. Access to services

- **Communication and Awareness**: Services are sometimes not well-publicised. Many people, including GPs and practice staff, aren't clear on referral criteria. Language barriers and literacy levels are also access hurdles.
- **Coordination and Integration**: There's a need for a **single point of access** and better **data sharing** across services. Patients shouldn’t have to tell their story multiple times.
- **Digital Integration**: Technology can help streamline this. People advocated for AI-driven tools, better digital health records, and IT systems that work with each other.
- **Equity and Inclusivity**: Access is uneven—particularly for neurodivergent individuals and minority groups. Services need to be culturally sensitive, equitable, and easy to navigate.
- **Care closer to home:** Services that are delivered locally to improve access.

Workshop 1 : What we have heard so far…. Integration

- **Integration of Health and Social Care** is still a major challenge. Differences in pay, contracts, and IT systems create silos that can limit collaboration.
- We need **shared care records**, **joint budgets**, and **trusted roles** like community connectors and social prescribers to bridge the gap between services and residents.
- **Digital integration** people want a single digital space where residents and professionals can access consistent, up-to-date information.
- **Simplifying access** a central hub or a single point of access was seen as essential—but complex to deliver.
- **Cultural competency** matters. Residents need translation services, British sign language support, and culturally safe spaces to feel welcome.

Workshop 1 : What we have heard so far…. Crisis Support

- There’s a strong case for **rapid response teams** that support people in their homes and a call to **promote existing crisis lines** more effectively.
- **Community-based support** is vital. Involving police community officers, especially those trained in mental health
- 24/7 digital support and integration with care records to ease communication was also raised.
- **Support for carers** needs to be strengthened. In many cases, carers are relied on heavily but aren’t given the tools or recognition they deserve.
- Participants suggested **preventive roles**, such as peer connectors with lived experience, to help intervene before a crisis escalates.
- Successful initiatives like **crisis cafés**—especially those with 365-day accessibility should be scaled up rather than down.

Workshop 1 : What we have heard so far…. Prevention

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- **Empowerment** and **self-management** were key. Residents want to play an active role in their own wellbeing through education, lifestyle changes, and tools like the NHS app.
- The concept of **"Waiting Well"** came up frequently—how can we support people with information and connection while they're on referral waiting lists?
- Early intervention is key, social and environmental factors were also highlighted. Infrastructure, nutrition, physical activity, and community space all play a role in helping people stay well.
- Services should reflect **cultural diversity**, offering tailored clubs or community groups that reduce social isolation.

Workshop 2: What we have heard

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Do you agree with the transformation priorities?

Is there anything that you think is important, but has not yet been included?(30 mins)

Workshop 2 - Do you agree with the emerging priorities.

1. Develop teams in neighbourhoods to help improve health outcomes and the experience of care
2. Understand the needs of local communities to help prevent poor health
3. Co-design and co-deliver services focused on preventing poor health and helping people start, live and age well
4. Ensure services are personalised, with a single point of access for people using our services
5. Increase access to a wider range of services closer to home
6. Provide co-ordinated urgent care within the community

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Next Steps

We are running focus groups throughout August and September 2025 and your feedback will be included as part of the Case for Change and transformation priorities.

The Case for Change will be discussed at the Integrated Care Board meeting in September 2025.

We will continue to engage with staff and service users/residents throughout the programme.

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Thank you

For more information, contact the Communications Team blmkicb.communications@nhs.net.

Addendum 1

1 October 2025

Following the submission of the original report to Board on 26 September, we received additional feedback from the Cambridgeshire Community Services focus groups on 29 September 2025. This supplements the original findings.

*Please note that page 6 of the original report, detailed 7 provider led lived experience groups. Following feedback from CCS, there were 8 provider led lived experience groups.

Lived Experience Groups – Provider led

Provider	Group	Service	Attendees
*CCS	Luton and Bedfordshire Adult Services	CHS	24
CNWL	Peer and Lived Experience Workforce and Involvement Leads	CHS and MHS	5
ELFT	Bedford Borough Working Together Group	MHS	5
ELFT	Central Bedfordshire Working Together Group	MHS	6
ELFT	Luton Borough Working Together Group	MHS	7
ELFT	CAMHS Working Together Group – Mental Health	MHS	7
ELFT	Bedfordshire Older Peoples Working Together Group	MHS	3
ELFT	Bedfordshire Community Health Services Working Together Group	CHS and MHS	8

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Testing the Case for Change and Transformation Priorities

Template for capturing feedback from focus group discussions (August 2025)

Organisation Name	**CCS Luton and Bedfordshire Adult Services**	
Discussion area (please tick as appropriate)	Community health services	✓
	Mental health services	☐
	Both	☐
Focus group with (please tick as appropriate)	Service users	✓
	Work force	☐
	Other (please advise)	
Name of team / description of group (i.e. service area, team, or service user group name)	Luton and Bedfordshire Adult Services	

Number of focus group participants	24
Facilitators name	
Facilitators email address	

Feedback from the focus groups will be shared with the ICB communications team for analysis. The findings will be compiled into a document and fed back to the transformation programme team, who will update the case for change and reflect any feedback in the emerging priorities.

- Please capture key points and themes rather than verbatim minutes
- After the session, pleased review your notes to ensure each point is clear and meaningful on its own for analysis.
- If using acronyms, please provide full definitions, as the ICB's communications and engagement team may not be familiar with terminology specific to our organisation or specialist field.

Please send agreed notes to [insert name and email address of person in provider organisation collating feedback] by [insert date], so they can share with BLMK ICB's communications and engagement team.

Workshop 1: What we have heard

1. How much do you agree / disagree with what we have heard so far?

i. Access to services

- Services need to be accessible for the times users need them, currently a lot of services are 9-5. Pop up clinics, using facilities across the area such as fire stations/schools to deliver some of our care.
- Self-directed routes into all services for everyone would support engagement and uptake.
- Not everyone can use online services so there needs to be a blended approach of online, automated and the availability to speak with someone.
- What do we mean by SPOA? We need to understand what need we are trying to deliver as this will be different for professionals and service users. There needs to be an expectation set with those contacting a SPOA that they don't need to speak with a "specialist clinician" as the first contact.
- We need a better understanding of the voluntary services as this can be inconsistent and almost be a postcode lottery and some voluntary services are only available in small parts. Is there an opportunity for the inconsistency to be managed.
- Access needs to be available for all who speak/read different languages and have different communication methods such as websites, letters, leaflets, speaking with staff otherwise this will continue to widen the gap for some of our populations.
- There needs to be a consideration for diagnostics hubs outside of hospital settings.

ii. Prevention services

- We need to understand who is completing the prevention work and who is paid to do this work – consideration should be given to having one centrally managed funding pot for this.
- This needs to be part of a wider co-ordinated piece of work and we need to understand what the priority areas are.
- Prevention work needs to be based on data and a strategy that aligns to the funding.

iii. Crisis support

- Understanding needs to be given to what is labelled as a "mental health crisis" as this will differ between health and social care providers.
- Funding needs to be considered to support the delivery of priority services and workforce planning around this.
- Rapid access to services such as mental health and resolutions needs to be available.
- An increased knowledge in "crisis response" services need to be shared so they are utilised rather than 999.

iv. Integrated working

- For the majority the group agreed with the health and social care challenge.
- The benefits of co-locating need to be understood, where does this add value and what do we give up to make this happen.
- There are currently multiple MDTs across the system, do these happen because of the digital challenge that we are not able to see everything.
- If all partners were on the same system these would solve many challenges and enable the patient to truly tell their story only once.
- There should be one pot of money for all the population that is controlled centrally.
- Making every contact count should be wider than just health, the value of this is not seen due to the multiple systems used.

2. Is there anything that you think is important, but has not yet been included?

Workshop 2:

1. Do you agree with the transformation priorities?

Whilst no-one disagreed with the priorities, the group felt the priorities were not specific enough with a lack of priority or direction. It was agreed that the priorities should be more meaningful so staff understand their role in delivering them with measurable outcomes so as a system we can evidence how we meet them.

The group were concerned that there wasn't a priority around workforce which should have included:
Upskilling, increasing the use of apprenticeships, developing a dynamic workforce to meet the needs of our local population.

The group suggested the following as a priority "Standardised and consistent care across the BLMK with digital systems that integrate and enable the service user to tell their story once"

i. Develop teams in neighbourhoods to help improve health outcomes and the experience of care

ii. Understand the needs of local communities to help prevent poor health

iii. Co-design and co-deliver services focused on preventing poor health and helping people start, live and age well

- Recommended change " The provision of services that are co-produced by all stakeholders to ensure delivery meets the needs of the local population"

iv. Ensure services are personalised, with a single point of access for people using our services

v. Increase access to a wider range of services closer to home to services

- Is this priory focusing on moving care out of hospital as this may not always be closer to home.
- A suggestion to make this priority more dynamic was "Delivery of non-acute services within community services and settings to enable care closer to home including diagnostics, clinics and virtual wards."

vi. Provide co-ordinated urgent care within the community

2. Is there anything that you think is important, but has not yet been included?