

**EXPLORING THE IMPLICATIONS FOR THE VOLUNTARY SECTOR IN
RURAL COMMUNITIES OF A CHANGING COMMISSIONING ENVIRONMENT
IN MENTAL HEALTH**

by

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CHAPTER 1

INTRODUCTION

What drove this research?

What is it about rural communities, mental health services and local Mind

Associations that drove this study?

This study was driven by the many recent changes in the way publically funded community mental health services are provided, how decisions are made about who provides them, how they are funded and how these changes have impacted on smaller voluntary and community organisations that provide mental health services in rural communities. This study was also driven by: changes in the way rural communities are defined; the difficulties providing mental health services in rural communities; challenges to the concept of the rural idyll and the wider discussion about the role of voluntary and community organisations in the provision of public services.

During the past 30 years Mind has facilitated the development of a network of local independent affiliated local Mind associations throughout England and Wales many of whom by the time this study began ran publically funded community mental health services. Some local Mind associations had become significant providers of mental health services, particularly those located in cities and towns. However a significant part of the network remained small, and heavily reliant on volunteers and a small team of paid staff.

Before continuing with this introduction it would be helpful to explain what Mind is, what it does, what local Mind associations are, what they do and how Mind and local Mind associations relate to each other.

Mind and Local Mind Associations

Mind also known as the National Association for Mental Health is a national voluntary organisation, which is both registered as a charity, with the Charity Commission and registered as a company with limited liability, with Companies House.

Local Mind associations are local voluntary organisations, also registered with the Charity Commission as charities, but which may or may not be also registered as companies.

All charities have a defined area of benefit, which is the geographical area in which they are permitted to operate under charity law. Mind's area of benefit is the whole of England and Wales, whereas the area of benefit of local Mind associations in England is usually co-terminus with a whole, a part or a combination of local authority districts.

Mind and local Mind associations have common charitable objects, which is the term used to describe the purpose for which a charity was set up.

Local Mind associations generally provide local community mental health services whereas Mind does not provide local services, but supports services provided by local Mind associations. In addition Mind also campaigns for the rights of people

affected by mental health issues, provides grants for local services and activities and offers public mental health information services.

Services provided by local Mind associations are dependent on local grants, service contracts with local statutory bodies and to a more limited extent on voluntary fund-raising, whereas Mind's activities are largely supported by national voluntary fund-raising and to a lesser extent by funding through contracts and grants from statutory bodies. Voluntary fund-raising includes: donations from the general public; income from sales e.g. charity shops and grants from grant giving voluntary trust and foundations.

Changes to the way Rural Communities are Defined

Changes to the way rural communities are defined, has led to a revision in the way rural population statistics are analysed and a new rural definition said to be more reliable; which it is argued provides a sounder basis for public policy.

Changes to thinking about rural communities as always ideal places to live came about because the concept of the 'rural idyll' an idealised stereotype of country life was repeatedly challenged.

People with mental health problems are often stigmatised in rural communities which results in a negative impact on mental health because people are unwilling to access support or confide in supportive individuals. There have also been concerns about anonymity and confidentiality in rural communities.

There have also been changes over time to the way community mental health services are commissioned and funded with service contracts replacing grant funding, competition between organisations wanting to provide community mental health services, changes to the ways these services are delivered by both the statutory sector and voluntary organisations including the recent moves to modernize services, with services tailored to individual need and the possibility of personal budgets, controlled by service users. Competition has heightened awareness between voluntary providers of potential collaborators and partners and potential competitors.

The inadequacy of rural data

'Sound evidence is the key to understanding the nature and dynamics of rural areas and of the issues they present. Rural policy is likely to be more effective if the decisions involved in the design and operation of public programmes are based on reliable information about the problems the policy is attempting to tackle and how they are changing over time.' (Bonnen, 1975, 1977) (Cited in Hill. B, 2003, p 5)

In the UK, one-fifth of the population live in rural areas – though definitions of what count as 'rural' have until recently often remained unclear, with measures such as population density, complex indices and arbitrary judgement all being used at various times and in different ways. Hill's (2003) report on rural data and rural statistics suggested that the inadequacy of rural data to service scientific enquiry and inform policy had been a longstanding concern and that an agri-centric view of the rural world in statistics was demonstrably inadequate and potentially misleading. This was because; the proportion of people living in the countryside who work in agriculture and forestry had shrunk to only two per cent of the population in England. The statistical provision for rural policy as a result had until recently been weak and

fragmented because statistics which separate the rural from the non-rural had not been available.

Changes in the rural definition used by government

Some clarity was introduced in 2005, following a review, when The Department for Environment, Food and Rural Affairs (Rural Evidence Research Centre/Defra, 2005) published new definitions for rural and urban which differed by focussing exclusively on land use. The new definitions identified patterns of rural settlement and encompassed the diversity of rural England and Wales that could be applied to help target policy to those groups and communities who most required support. The new definitions were subsequently applied to local authorities created a six-fold grouping of local authority districts called: rural 80; rural 50; major urban; large urban; significant rural and other urban (see Table 1.1 below).

Changes resulting from the new rural definition

It was felt that the new definitions might conflict with the look or feel of the area from the perspectives of local people (Countryside Agency, 2004) because the application of the definition to population settlement data had resulted in the classification of 50% of all the local authority districts in England as rural. However no longer was it unclear which communities in England were rural and which were urban.

Rural/Urban classification scheme for local authority districts:	Definitions
Rural 80 LADs	A local authority district, with at least 80% of its population in rural settlements.
Rural 50 LADs	A local authority district with at least 50% but less than 80% of its population in rural settlements.
Significant Rural LADs	A local authority district with more than 37,000 people or more than 26% but less than 50% of their population in rural settlements and larger market towns.
Other Urban LADs	A local authority district with fewer than 37,000 people or less than 26% of their population in rural settlements and larger market towns.
Large Urban LADs	A local authority district with a minimum of 50,000 people or a minimum of 50% of its total population resident within a large urban area.
Major Urban LADs	A local authority district with a minimum of 100,000 people or a minimum of 50% of its total population resident within a major urban area.

Table 1.1: The criteria for identifying groups of local authority districts, extracted from Defra Classification of Local Authority Districts and Unitary Authorities in England, A Technical Guide, Defra, 2005 and developed by Rural Evidence Research Centre, Birkbeck College, University of London

Challenges to the concept of a 'rural idyll'

The widely recognised benefits of life in the countryside it has been argued have led to the misconceived concept of the 'rural idyll', described as an idealised stereotype of country life that ignores the real difficulties faced by some people in rural communities. Such difficulties include poverty, lack of services, poor public transport and traumatic social or economic change at local level.

Poverty is a reality across rural UK, but often dispersed over large, sparsely populated districts, with people in poverty living close to those more affluent and therefore less visible. Shucksmith (2003) (cited in Robertson, Elder and Coombs, 2010, p 58) refers to the greater proportion of men and women in rural areas who earn lower wages than the rest of the UK and that one in three individuals experienced at least one period of poverty during 1991-1996. This hidden poverty has a major impact on the health of individuals and families.

Difficulties providing mental health services in rural settings

Craig and Manthorpe (2000) refer to difficulties providing mental health services in rural settings including: access to services; low levels of health and social care service provision; isolation; higher product costs and lack of choice or quality of these products, all of which contribute to health and social care problems. A joint Mind/National Mental Health Partnership project to rural proof government mental health policy (Elder, 2004), confirmed these difficulties by identifying the significant rural factors associated with implementing government mental health policy in rural areas including: the reluctance of people to seek help and therefore problems remaining hidden; absence of rural sensitivity in measuring health needs; difficulties accessing services and the high levels of suicide. The Report went on to identify the measures which either produce the desired outcomes in rural areas or avoid/mitigate any rural impacts.

Changes in the commissioning environment

When this study began in 2007, Government policy in health and social care was increasingly looking to voluntary organisations as providers of community mental

health services. Many Primary Care Trusts were combined resulting in many co-terminus with the local authorities with whom they jointly commissioned services. Joint Commissioners were consequently looking to commission services over wider areas, which were often extended to cover counties containing more than one local voluntary provider. This was particularly evident in counties where Joint Commissioners related to a range of local voluntary providers in various communities and towns.

Also when this study began Joint Commissioners were seeking more consistent service provision across the whole of their area through consultation around the modernisation of mental health day services. In addition alternatives to medication were being proposed through the introduction of Improved Access to Psychological Therapies (IAPT). Also new rights to independent advocacy i.e. Independent Mental Capacity Advocacy and Independent Mental Health Advocacy were becoming available.

The commissioning environment was also becoming increasingly competitive, and to maintain and develop services, local voluntary mental health providers it was argued would need to collaborate with each other in order to out compete larger regional or national providers to secure contracts. Collaboration was proposed because there was evidence that small organisations would not experience a level playing field with their private and public sector competitor's when competing for contracts. Also that 'value for money' criteria would adversely impact on small rural organisations because physical and social infrastructure costs per head of population are generally higher in rural communities. Further it was argued that small voluntary organisations

would find it difficult to satisfy commissioner's performance management and monitoring processes.

The formation of a new Coalition Government in 2010 heralded further changes including a wide-scale programme of public expenditure reduction. In addition proposals were introduced for change to the National Health Service, including dismantling Primary Care Trusts and replacing them by General Practitioner led Commissioning Consortia. However there was further change when it was announced that Primary Care Trusts would be replaced by 'Clinical Commissioning Groups' alongside an assurance that healthcare commissioning would not only be led by General Practitioners but would also involve patients, carers, the public and other healthcare professionals.

Local Mind associations

I referred earlier in this Chapter to Local Mind associations, operating across a local area of benefit. Local Mind associations offer specialised community support and care to people with mental health problems based on the needs of the local communities they support. Community support and care might include: mental health day services; advice and information; advocacy, befriending; counselling and group activities. Some local Mind associations specialise providing for example: supported housing; work with adolescents and children; work with the elderly etc.

It is not known how many local Mind association services are currently accessed by people in rural communities. However, a number of local Mind association's are located in rural communities and there are others whose area of benefit includes a

rural community. Mind does hold limited centralised information about the services and activities of its affiliates. Anecdotally rural mental health work has been subject to short-term funding, which cannot, it is frequently stated, be sustained longer than a one, two or three-years. Can the funding of rural services and activities be measured? Are rural services sustainable?

Changes in the relationship with local Mind associations

Over the past 10 years the relationship between Mind and its affiliated network of local Mind associations has gone through significant change. In 1999 Mind introduced a Membership Agreement which set out the terms of the affiliation relationship between Mind and local Mind associations. This was followed in 2001, by a quality assurance framework (Quality Management in Mind) and in 2003 an external quality review process was introduced with local Mind associations expected to meet certain minimum standards within the quality assurance framework to remain affiliated.

During the course of the external quality review process not all of the 209 LMA's allocated for review in 2003 met the minimum standard and by January 2007, Mind's trustees were informed that '*smaller LMA's are finding quality review more challenging and are leaving the network*' (Mind, 2007). By the final report to trustees (Mind, 2008) it was reported that 25 LMA's had left the network, because they had either: merged with a neighbour; dissolved or did not meet the requirement for continuing affiliation. The number of local Mind association's leaving the network is shown in Chart 1.1 below over the period of the quality review.

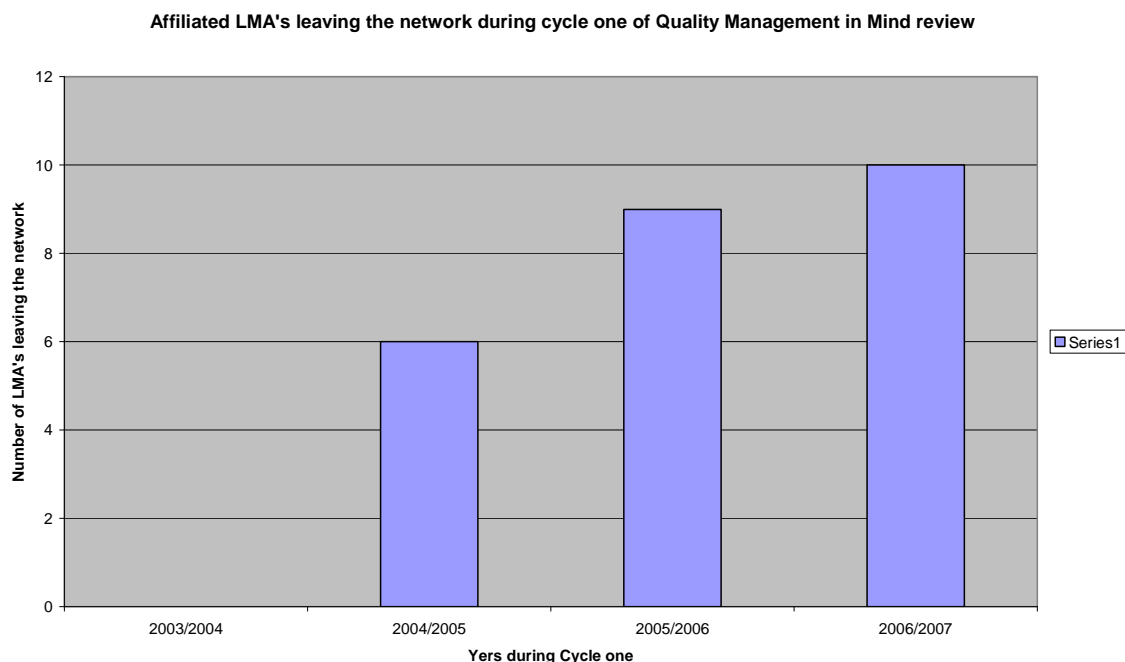


Chart 1.1. Numbers of local Mind associations leaving the network from 2003/2004 to 2006/2007. (Extracted from Quality Review Cycle One Final Report, Table One, 29 April 2008)

Local Mind association’s categorised by annual turnover

Local Mind association’s can be categorised by the most recent financial turnover declared in the annual return to the Charity Commission. Mind uses the turnover of local Mind association’s to set an annual affiliation fee. Table 4.4 in Chapter 3 (p 64) shows the relationship between turnover and affiliation fees, with those in Fee Group 1 paying the smallest affiliation fee and those in Fee Group 8 paying the highest affiliation fee.

This research study will suggest that these affiliation fee groups can be brought together into two broad groupings, i.e. those with an annual turnover less than £250,000 which the Charity Commission, the regulatory body for charities describes as small charities and those with an annual turnover greater than £250,000. Various

measures of charities based on annual turnover have been explored and these will be discussed further in Chapters 2, 4, 5 and 6.

Many commentators take the view that voluntary organisations that provide public services with an annual turnover less than £250,000 lack the capacity to survive in an increasingly competitive contract culture. This view would seem to have some validity when the outcomes of Mind's quality assurance review are examined. I referred on p 9 to twenty five local Mind associations leaving the network between 2003 and 2007, however it was also reported all those that left had an annual turnover of less than £250,000 and that no associations with a turnover greater than £250,000 had disaffiliated. This issue will be explored further in Chapters 2, 4, 5 and 6.

Propositions on which this research is based

The proposition on which the first part of this research study was based is that there is a widening division between large, well placed and organised voluntary organisations and smaller community based voluntary organisations. But, can the proposition be applied to affiliated local Mind associations? What are the implications for rural communities? Do local Mind association's services currently benefit rural communities? How are local Mind association rural services funded and sustained? How do we measure large and small local Mind associations? Can a baseline for small and large local Mind associations be developed? Is a £250,000/annum turnover or less a meaningful measure of a small voluntary and community organisation?

The second part of the research study traced the effects of the new commissioning environment on voluntary and community organisations, and in particular to local Mind associations in rural communities, in order to explore three further propositions. Firstly the retreat of services to urban settings, secondly the expansion of partnership working by the rural voluntary sector and thirdly whether voluntary organisations with an annual turnover less than £250,000 can survive in an increasingly competitive contract culture.

The following Chapters describe the research study. Chapters 2 and 3, review the relevant literature about the voluntary and community sector, about rural communities, about the new commissioning environment and about the recent changes to the delivery of community mental health services. Chapter 4 describes the methodology followed in the quantitative research and subsequent qualitative research. Chapter 5 describes the data gathered from both the quantitative and qualitative research. Chapter 6 discusses the data in relation to the propositions, the research questions and the literature review and Chapter 7 draws some conclusions and implications for policy.

CHAPTER 2:

LITERATURE REVIEW: THE VOLUNTARY AND COMMUNITY SECTOR AND RURAL COMMUNITIES

The literature is reviewed over two chapters. Chapter 2 reviews the voluntary and community sector and in particular in relation to rural communities and Chapter 3 will review the wider environment in which the voluntary and community sector has operated over time. Some conclusions from the literature review and any implications for the quantitative and qualitative research from both Chapters 2 and 3 are described at the end of Chapter 3.

The proposition on which the first quantitative research was based is that there is a widening division between large, well placed and organised voluntary organisations and smaller community based voluntary organisations. Can the proposition be applied to affiliated local Mind associations? What are the implications for rural communities? Do local Mind association's services currently benefit rural communities? How are local Mind association rural services funded and sustained? Is a £250,000/annum turnover or less a meaningful measure of a small voluntary and community organisation?

The qualitative research traced the effects of the new strategic commissioning environment on voluntary and community organisations and in particular on local Mind associations, in order to explore three further propositions. Firstly the retreat of services to urban settings, secondly the expansion of partnership working by the rural

voluntary sector and thirdly whether voluntary organisations with an annual turnover less than £250,000 can survive in an increasingly competitive contract culture.

Before we can begin to test the first proposition and the three further propositions we need to know: how voluntary and community organisations are defined, mapped and measured and particularly the differences between voluntary organisations and community organisations; the impact on a voluntary and community organisation of working in a rural community and the often asserted barriers to service delivery; and partnership and collaborative work by small voluntary organisations.

The first part of this chapter will review the various attempts to define, map and measure the sector, including attempts to differentiate between voluntary and community organisations and the terms: third sector organisations and civil society organisations. The search for an endogenous definition of the sector will be described as well as the more recent pursuit of an exogenous definition.

The second part of this chapter will review the voluntary and community sector in rural communities including evidence for significant rural factors which it has been argued impact on the ability of the sector to deliver services in rural communities. The final part of this chapter will review evidence of partnership and collaborative work by small voluntary organisations.

Defining, mapping and measuring the voluntary sector

Knight (1993) (cited in Elsdon et al, 1995, p2) estimated the mean incidence of voluntary organisations in relation to population. Based on social services

organisations and charities, he describes a mean incidence of one voluntary organisation to every 204 to 349 individuals of all ages in the population. Research by Elsdon et al (1995, p2) indicated an incidence of 1:39.5 voluntary organisations in a rural location and 1:62 in a small town. When these ratios were projected for the total population of the UK 1.3 million voluntary organisations he estimated based on the small town and 1.5 million voluntary organisations based on the rural location. Elsdon qualified these very large numbers by arguing that if '*every church group, every political party and all their daughter organisations, every cub scout group, first aid or rugby team*' that these totals would be exceeded substantially.

The National Council for Voluntary Organisations (NCVO) reviews data on the voluntary and community sector. In their recent analysis of charitable giving (NCVO, 2011) NCVO has calculated that charities had a total income of £35.5bn of which £12.8bn income came from government grants and contracts and £8bn from charitable donations and fundraising . These figures showed a significant increase on figures published in the 2004 NCVO Almanac (Wilding et al, 2004) which showed an already growing sector with total income having risen from £11 billion to around £21 billion from 1995 to 2001. A similar increase in the voluntary sector workforce is also described by NCVO (Clark et al 2011) with the sector now employing 2.7% of the United Kingdom workforce, a proportion that has increased from 2% in 2001.

A dual role for the voluntary and community sector is often argued. Firstly the voluntary sector has a role in the provision of public services which were defined by HM Treasury (2003) (cited in Cairns, B., Harris, M. and Hutchinson, R. 2006, p 13) as

services that are wholly or partly funded, or could be funded, from the public purse, including national, regional and local government and statutory agencies at all levels.

Secondly the voluntary sector has a role in civil renewal which is defined by the Home Office (2003) (cited in Cairns et al 2006, p 14) as '*a way to empower people in their communities to provide answers to our contemporary social problems*'. Civil renewal, has three ingredients, the then Home Secretary, argued (2003) (cited in Cairns et al 2006, p 14) which he suggested are: active citizens; strengthened communities in which people work together to find solutions to problems and partnership between local people and public bodies to improve the planning and delivery of local services.

Defining the voluntary and community sector has been said by Kendall & Knapp (1996 cited by Alcock & Scot 2007, p 85), to be '*inherently impossible*' and so much so that they have described the sector as '*a loose and baggy monster*'. Alcock & Scott (2007) have argued that to search for an endogenous definition of the sector i.e. one arising from within the sector may ultimately be fruitless. However many have tried to explain the sector in this way.

An endogenous approach to defining the sector

Chanan, West et al (1999) have argued that a clear distinction can be made between voluntary organisations, and community organisations. They refer to voluntary organisations providing beneficial public services on a not for profit basis, but they are not they argue public or local authorities. Whereas community organisations are run by people who get together on a voluntary basis to pursue common interests or

tackle joint problems and engage in meeting their own needs, under their own control.

Stewart (2007) distinguished between voluntary groups that are philanthropic i.e. those that give charitable relief to particular groups and those which are mutual, i.e. those where individuals come together to provide for their own welfare through collective endeavour. Mind in Birmingham is an example of a philanthropic voluntary organisation in that its works to relieve the distress of people with mental health problems by providing support services. Perton Pre-school Playgroup was an example of a mutual organisation in that it was established by parents of pre-school children living in a community with no pre-school facilities. Stewart points out that the distinction between philanthropic and mutual organisations also existed in the 19th century roots of the voluntary sector.

The Audit Commission (2007) in a report on commissioning from the voluntary sector developed this distinction further by describing three distinct groupings of voluntary and community organisations. Firstly small, volunteer-only community based groups providing specific services on a modest scale, primarily under grant funding arrangements. Secondly small to medium-sized voluntary organisations delivering or wanting to deliver services, but finding difficulty competing for contracts because they lacked the skills and experience to formulate successful bids. Thirdly they refer to large or regional voluntary organisations already delivering services under contract.

The current Coalition Government includes voluntary and community sector within the umbrella title of civil society organisations, and in The Coalition: our programme

for Government (HM Government, May 2010, p29) committed itself to '*support the creation and expansion of mutual's, cooperatives, charities and social enterprises, and enable these groups to have a much greater involvement in the running of public services*'.

The previous Government used the term third sector organisations (HM Treasury, 2004 & 2006), which extended the scope of the voluntary and community sector to also include: trade unions, not-for-profit trade associations, political organisations, most co-operatives and social enterprises, private clubs, most sports organisations, places of worship, and grant-making trusts. The 2006 Treasury Report (p.5-6) defined the third sector as '*non-governmental organisations which are value driven and which principally invest their surpluses to further social, environmental or cultural objectives*'.

Blackburn et al (2003) developed a working definition of voluntary organisations during a literature review research project, undertaken for the Department of Environment, Food and Rural Affairs (Defra). The review aimed to understand the needs of rural communities and how they could be delivered through the voluntary sector. Blackburn's et al's definition (p 2) referred to '*the totality of organisations and groups characterised by an altruistic or mutual support ethic, a high proportion of non-profit elements and in most cases, a low proportion of paid staff*'.

Blackburn et al referred in her literature review (p 4) to the significant distinctions between voluntary organisations and community organisations identified by Chanan West et al (1999). Chanan West et al describe different types of function in relation to

policy i.e. *'the Community Sector is an aggregate of those groups that contribute to a strengthening of community, to mutual aid and public spirited action whereas the 'professional part of the voluntary sector delivers specialist services and can act like a public service rather than a representation of community interests'.*

Chanan West et al also suggested that their development needs differ. They describe a community group having an economy which *'may consist of 60-100% volunteering with the controlling roles being voluntary'*, whereas the professional voluntary organisations *'may be 60-100% paid work with the controlling roles being professional'*. It therefore follows that the two groups require different types of management and training. They went on to argue for different relationships between community groups and professional voluntary organisations in relation to the state and business i.e. those voluntary organisations that provide services in exchange for funding have an increasing tie to the state, whereas in community organisations it is less prevalent.

Blackburn et al's literature review concluded (p 54) that within the broad working definition of voluntary organisations (described above) *"two groupings could be distinguished: 'Voluntary Organisations and Community Groups', which are different for the following three reasons,,: they perform different types of function in relation to policy; their development needs differ; and they possess different relationships to state and business"*. She went on to conclude that as a result of this differentiation, *"certain types of group will be better suited to the role of being a mechanism for delivering services to the wider rural area, than others"*. Blackburn's conclusion also went on to suggest (p 54) that the voluntary sector should not only be evaluated as a

vehicle for service delivery but also as a sounding board and for its role in social capacity building.

The National Council for Voluntary Organisations definition of general charities includes organisations registered as charities but excludes housing associations, independent schools; government controlled charities and religious groups. Earlier (see page 17) I referred to analyses of the voluntary sector published by NCVO which described a significantly expanded sector as well as a significantly expanded role for charities also described by NCVO (Clark et al, 2009) since the first benchmark was established in 1991. Those with an income less than £10,000/annum, NCVO argued constituted the vast bulk of the sector, however there has been a significant increase in the number of large charities, particularly those with an income greater than £1M per annum plus the emergence of a small number of super charities with incomes greater than £100M.

Salamon & Anheier (1996) attempted to develop a universal international definition of the not-for-profit or voluntary sector which they called the structural-operational definition. This definition identified five key characteristics (see Table 2.1 overleaf) which non-profit or voluntary organisations must share. Morris (2000) has critiqued this attempt at a universal definition, citing the exclusion of the friendly societies and mutual organisations which have played a key historical role in development of the voluntary sector.

Key Characteristics	Explanation
Organised	Institutionalised to some degree in terms of their organisational form or system of operation
Private	Institutionally separate from Government
Non-profit distributing	Not returning any surpluses to their owners or directors but ploughing them back in to the basic mission of the organisation
Self-governing	Equipped with their own internal apparatus for governance
Voluntary	Involving some meaningful degree of voluntary participation, either in the operation or management of the organisation's affairs

Table 2.1: Five Key Characteristics of the Structural Organisations Definition of the Non-Profit Sector, Morris (2000) after Salamon & Anheier (1996)

Measuring the sector by income

In Chapter 1 I suggested that local Mind associations could be meaningfully divided into two broad groupings, i.e. those with an annual turnover less than £250,000 and those with an annual turnover greater than £250,000. This was because many commentators had taken the view that voluntary organisations that provide public services and with an annual turnover less than £250,000 lack the capacity to survive in an increasingly competitive contract culture. This view, I argued would seem to have some validity when the outcomes of Mind's quality assurance review are examined (see Chapter 1 p 10).

Kane et al (2009) (cited in McCabe (2010, p 4) referred to the National Council for Voluntary Organisations describing voluntary and community organisations with an income of less than £10,000 per annum as micro-charities charities. Reference is also made by McCabe (2010, p4) to Thompson (2008) and his description of two funding thresholds i.e. less than £250,000 income per annum which he describes as

'small, relative to the big children's charities' and those with an income less than £50,000 per annum described as *"smaller" under the radar organisations'*.

An exogenous approach to defining the sector

To define the voluntary and community sector requires, Alcock and Scott (2007) contended (p 84) *'reflection on the nature of British society itself'*. They referred to the various dimensions of Britain, which as a developed capitalist state include: the state, the market and civil society. Civil society they went on to suggest is *'somewhere between, and separate from the market and the state'* with voluntary and community sector organisations and their activities as essential elements of civil society.

Alcock & Scott characterised voluntary and community organisations by what they are not, rather than by what they are i.e. they adopted an exogenous approach to defining the sector. Voluntary organisations are not part of the state, they contended, with no formal public status, neither are they part of the market and nor do they exist only to trade and produce an economic profit.

An exogenous approach was adopted by Evers & Laville, (2004 cited in Alcock & Scott, 2007, p 85)) who focussed on *'tension fields'* where the voluntary and community sector, in relation to the provision of welfare, is placed within a tri-angular inter-sectoral landscape comprising the private & commercial, public and informal welfare sectors (see Figure 2.1 overleaf).

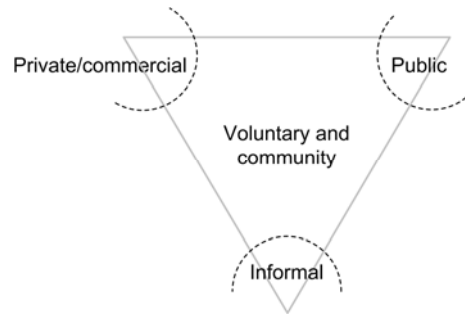


Figure 2.1: Inter-sectoral landscapes: from Alcock & Scott, 2007 Voluntary and Community Sector Welfare, p 85, Chapter 5 in Understanding the Mixed Economy of Welfare, Editor Powell, Policy Press

Within this landscape voluntary and community organisations take up different locations within the tri-angle in relation to the public, informal and commercial sectors depending what they do and how they operate. Some examples of organisations which take different locations include, The Big Issue, cited by Alcock and Scott, and others such as Mind in Birmingham and Perton Pre-school Playgroup are taken from my own experience.

The Big Issue is a voluntary organisation that generates personal income for homeless people through the sale of the Big Issue magazine by homeless people to members of the public. The organisation operates on the boundary of the private & commercial sector and as such needs to reconcile the tensions between the commercial imperative to make a profit from magazine sales against the imperative to fulfil the organisations social mission in relation to homeless people.

Mind in Birmingham is a local charity that delivers services to people with mental health problems. It operates on the boundary of the state sector and as such needs to reconcile the tension between fulfilling its contractual obligations to provide mental

health services to specific people against its social mission to advocate on behalf of all people with mental health problems.

Perton Pre-school Playgroup was a community organisation managed by the parents of pre-school children in a new community with no pre-school provision or community facilities. The Playgroup operated on the boundary of the informal sector, and as such needed to reconcile the provision of weekday playgroup sessions against sustaining the informal reciprocities inherent in a group run by parents with all the conflicting demands relating to work and child-care.

The voluntary and community sector is all these different examples and many more each with its own tensions and differences. Alcock and Scott (2007) argued that any analysis of the sector must focus on the tensions and differences between them.

Defining and differentiating between voluntary and community organisations

Earlier in this Chapter I quoted an assertion that to define the voluntary and community sector was inherently impossible. Despite this assertion many have tried using a range of different criteria; however an endogenous approach struggles to encompass the range of organisations and groups represented in the sector.

Similarly much of the evidence seemed to show that differentiating between voluntary organisations and community organisations comes down to a discussion about the organisations mission, its size and capacity to engage with the environment in which it operates. However, Blackburn et al drew a distinction between voluntary organisations and community groups suggesting that each performs different types of function in relation to policy; with different development needs and different

relationships to the state and business and she concluded that certain types of group i.e. voluntary organisations would be better suited to delivering services to rural areas. This distinction may be helpful in the discussion about the future role of voluntary organisations and community organisations in relation to the new commissioning environment and will be discussed again in Chapter 6.

An exogenous approach based on inter-sectoral landscapes would seem more satisfactory because of the sheer diversity of the network including, encompassing Blackburn et al's distinction. An inter-sectoral landscape provides a means of mapping the tensions within and the differences between voluntary organisations and community organisations depending on the different locations they take up in relation to the public, informal and private sectors. However many organisations for example Charity Commission and Mind continue to use endogenous criteria to manage their networks.

The voluntary sector in rural communities

The previous Government published two rural white papers (1995 & 2000) both of which touched on the significant role of the voluntary sector in rural communities.

The first Rural White Paper (DETR/MAFF, 1995) recognised the significance of the sector in rural communities. Self-help and independence were portrayed as the traditional strengths of rural communities and the White Paper referred to the long standing tradition of volunteering through organisations such as the Women's Institute, Women's Royal Voluntary Service and village hall committee's. It went on to

suggest that informal volunteering is a particular feature of rural communities and an indicator of the health of these communities.

The second Rural White Paper (DETR, 2000) portrayed rural areas as often having a strong sense of community and a valuable network of community groups but suggested that these are under threat as ways of life, people and attitudes change. It went on to advocate for support, to established local and voluntary networks in rural communities.

Significant rural factors for the voluntary sector

Blackburn et al's review, referred to earlier, pointed to a number of urban-rural distinctions. Firstly the resourcing of rural voluntary organisations was directly related to their capacity to deliver. She referred to (p 56) research evidence, which showed that there are *'concerns that in rural areas voluntary groups are smaller, are less well resourced than their urban counterparts and that their support needs are less well met'*. Blackburn et al went on to suggest that the *'differences between rural and urban voluntary organisations tend to be those associated with their self-definition as rural, as well as geography and low population densities, all of which impact on organisational attitudes and ways of working'*.

Barriers to delivery in rural communities

Blackburn et al identified, in her literature review that there are characteristics particular to rural communities that can act as a potential barrier to change. These included, the problems associated with making partnerships work effectively and ensuring adequate and socially inclusive representation. In addition, factors

associated with the under-development and lack of capacity of the sector created obstacles to involvement at a community level. Further there are factors associated with the nature of the 'rural community' i.e. the tendency for self-reliance, suspicion of outside assistance and lack of awareness of gender and racial issues and of the bigger picture.

Earlier in this Chapter I discussed annual income being used to measure the voluntary sector. Income was chosen as the key characteristic to define a small charity in a study published on the Charity Commission web site in (Strength in Numbers, 2011). This study explored collaboration amongst small charities and the differences joint working can make to smaller charities. Small charities in the study were defined as all registered charities with annual incomes of £250,000 or less.

Partnership and collaborative working by small charities

The issues investigated by the Strength in Numbers (Charity Commission and GfK NOP, 2011) research are pertinent to one of the propositions in this study i.e. the expansion of partnership working by the rural voluntary sector. This is because Strength in Numbers set out to explore the extent to which small charities were engaged in collaborative activity and their experiences of collaboration and work in partnership with others charities. Strength in Numbers defined collaborative working (p 3) as '*joint working by two or more organisations in order to better fulfill their purposes, whilst remaining separate organisations*'. The study found that for the 25% sample of the 10,000 small charities that responded collaboration usually worked well. However successful collaboration was dependent on several key ingredients

which included: strong relationships; shared organisational aims and values; effective leadership and planning and communication.

The study also reported that informal partnership arrangements generally took a flexible, open and innovative approach to work with others whereas in more complex or high risk collaboration, small charities were more likely to have the necessary formal arrangements in place. A minority of small charities faced difficulties with collaboration however the majority of these took sensible steps to overcome them. Strong governance; effective monitoring and evaluation processes and accessing external support were key features, in overcoming difficulties, the study argued.

Joint bidding for contracts was identified in the study as collaborative working which was most likely to run into difficulty, however joint bidding for contracts was not found to be particularly widespread amongst small charities. The Charity Commission Strength in Numbers research study recommended (p 7) that small charities take a pro-active, self-help approach to collaborative working, because when asked, non-collaborating charities said that they *'had never been approached by another charity or that there was a lack of suitable partners'*.

When the small charities in the study were asked about their needs they requested information, advice and guidance, however it was also found that support was required to: access funding for collaborative working; overcome legal complications; managing organisational change and dealing with clashes between staff and trustees.

Chapter 3 goes on to review the literature in relation to the voluntary and community sectors changing relationships with the external environment over time.

CHAPTER 3

LITERATURE REVIEW: EXTERNAL RELATIONSHIPS, POLICY AND COMMISSIONING

Chapter 3 focuses on the voluntary and community sectors changing relationships with the external environment over time.

The voluntary and community sector has had a long involvement in the provision of public services and particularly in the development of health care services. However the role of the sector has changed substantially during the course of the last two hundred years. The first part of this chapter reviews the voluntary sectors changed relationship with the state, over time and in particular in healthcare, including changed financial relationships. In addition the review encompasses the development of healthcare commissioning, changes to the commissioning of healthcare both under the previous government and more recent changes under the Coalition Government as a result of a new policy direction.

The second part of this chapter will review the changing national mental health policy environment in which the voluntary sector operates. This includes the replacement of The National Service Framework for Mental Health by a focus on wellbeing and recovery described in the previous Governments guidance New Horizons (Department of Health, 2009) and its more recent successor No Health without Mental Health (Department of Health, 2011) issued by the Coalition Government.

Also discussed are the recent changes to the way in which community based mental health services are delivered, including moves towards personalisation and in particular modernisation of mental health day services, both of which aim to promote integration rather than perpetuate the segregation of mental health service users. Integrating service users it is argued will ensure that people become less reliant on mental health services and support people on a journey towards recovery. This discussion is important because many local Mind associations provide community mental health services, and particularly mental health day services. It is also important because for a Government that seeks to reduce public expenditure, people recovering and leaving the mental health system could mean substantial savings to the mental health budget.

The third part of this chapter will review the impact of the changes in commissioning practice on the voluntary and community sector. In particular, the attitudes of commissioners to working with the sector, and the evidence of progress towards a level playing field between private, public and voluntary sectors, during competition for contracts. The final part of this chapter will draw some conclusions and raise questions for voluntary sector providers that have arisen from Chapters 2 and 3; their relationship to the propositions and questions on which this research is based and any implications for the research programme that followed.

Changing relationships with the state

Lewis. K (1995 & 1999) (cited by Alcock & Scott 2007, p88) characterised the early relationship with the state as 'parallel bars' where the state and voluntary sector operated in separate but complimentary fields. For example workhouses provided by

the state for the poor and destitute in the 19th and early 20th century worked in parallel with the (voluntary) Salvation Army.

Later the relationship shifted as the welfare state began to develop with voluntary sector activities built on basic state services and described by Lewis (1995 & 1999) (cited by Alcock & Scott 2007, p88) as the 'extension ladder'. For example state funded county asylums such as St George's Hospital, Stafford which provided 'institutional care' were supported by voluntary organisation, for example the Staffordshire Association for Mental Welfare which provided social and recreational activities for hospital patients. Beveridge, often described as the architect of the welfare state and welfare provision, identified a significant role for voluntary activity in this extension ladder model.

At the end of the 20th century the move towards healthcare commissioning, competitive tendering and outsourcing of contracts for service delivery formed part of a further significant shift in state and voluntary sector relations. Alcock and Scott (2007, p 89) cite the 1990 NHS and Community Care Act as '*probably having the greatest impact on the voluntary sector*' when local authority social services departments and National Health Service agencies were enjoined to work collaboratively but delivery was to be provided by a range of organisations, including public, private and voluntary agencies, through a contract which specified which services were to be delivered, to whom and over what period of time. This legislation Alcock and Scott argued led to a significant change in the nature of funding relationships between Government, particularly between local government and

voluntary organisations which they described as '*a shift from support to regulation and control*'.

Changes in Local Government

Various studies have looked at the impact of local government re-organisation in the 1990's, and the creation of large numbers of small local authorities. Research by Craig (1993) (cited by Craig and Manthorpe, 2000, p 1) predicted increased difficulties for local voluntary agencies involved in service provision in small local authorities. This prediction was confirmed by Craig and Manthorpe, (1999b) (cited by Craig and Manthorpe, 2000, p 2) who described '*a further marginalisation of voluntary agencies, users and carers*' as a consequence of the smaller sized local authorities.

Before bringing the changing relationship with the state up to date during the last years of the previous Government and the changed priorities of the Coalition Government the origins of healthcare commissioning are reviewed.

Changes in health care commissioning

Health care commissioning has its origins in the 'internal market' reforms of the NHS in the 1990s, when health authorities and primary care organisations funded health care providers, specifying the levels of activity and quality expected in return for the investment. Various terms were used to describe the commissioning process including commissioning, contracting and purchasing which Ovretveit (1995) (cited by Smith & Goodwin 2002, p 6) differentiated as follows: contracting is the narrow process of negotiating, writing and monitoring annual contracts with providers of

health services; whereas purchasing is buying the best value for money services, to achieve maximum health gain for those most in need.

Commissioning is a more inclusive and far-reaching process whose purpose is *'to maximise the health of the population and minimises illness, by purchasing health services and by influencing other organisations to create conditions, which enhance people's health'*. Woodin (2006) (cited by Wade et al, 2006 p 3) confirmed the strategic role of commissioning, extending the definition as follows:

'Commissioning...tends to denote a proactive strategic role in planning, designing and implementing the range of services required, rather than a more passive purchasing role. She argued that 'a commissioner decides which services or health care interventions should be provided, who should provide them, and how they should be paid for, and may work closely with the provider in implementing changes'. She went on to explain that purchasing differs from commissioning in that it is a more operational activity i.e. buying what is on offer or reimbursing a provider.

Woodin extended Ovretveit's differentiation of the whole process to also include procurement, which she described as the process of identifying a supplier, involving for example competitive tendering, competitive quotation or single sourcing. It may also involve stimulating the market through awareness raising and education.

Procurement and contracting are activities that focus on one specific part of the wider commissioning process that is the selection, negotiation and agreement with the provider on the exact terms the service is to be supplied. In an exploration of the policy challenges posed by the Department of Health in a *Commissioning a Patient-*

Led NHS Wade et al (2007) used the term ‘commissioning’ to embrace the various activities identified by Woodin i.e. contracting, purchasing and commissioning.

Three levels of commissioning	Examples of commissioning and practical examples
Macro-level	National Commissioning pan-Primary Care Trust specialist commissioning
Meso-level	PCT commissioning Joint commissioning with local authorities for example local Mind association day care services
Micro-level	Practice based commissioning, Direct payments, Patient choice for example personalisation

Table 3.1: Three levels of commissioning and examples of each level

In addition three main levels of commissioning have been identified Wade et al (2006) using an international analysis of commissioning i.e. Macro-level; meso level and micro level at which strategic commissioning takes place within the NHS. Macro level commissioning is not directly relevant to this study because it takes places at a national level for specialist services. Meso level commissioning relates for example to the commissioning of community mental health services by the voluntary and community sector where a specific service is to be provided in a local community. This contrasts with micro-level commissioning including personal budgets which, empowers citizens ‘*to shape their own lives and the services they receive*’, and thereby increasing esteem and confidence. These levels of commissioning are shown with examples in Table 3.1 above.

Primary Care Trusts taking responsibility

Primary Care Trusts took responsibility for commissioning all acute and specialised services for their populations with the implementation by the Department of Health of *Shifting the Balance of Power* (2002). However, arrangements for Joint Commissioning of many community mental health services between Primary Care Trusts and local authorities remained in place.

NHS changing from provider to commissioner

However the policy context in which Primary Care Trusts operated continued to evolve following the publication of *Commissioning a Patient Led NHS* (2005). Until this point in time PCT's were expected to both commission and provide healthcare services. Commissioning a Patient Led NHS heralded a step change with the NHS moving from being a provider driven service to a commissioning driven service with an expectation that provider services would be reduced to a minimum. In this respect Primary Care Trusts were expected to explore the potential for greater value for money and increased flexibility through new health care providers, including those from the voluntary sector. There was also to be an increased emphasis on access to and choice for patients of high quality services through performance management of providers. In addition Primary Care Trusts were expected to separate their commissioning and providers arms, with the provider arms subject to the same level of performance management and monitoring as an external provider. Further there was to be improved co-ordination with social services and a universal role out of practice based commissioning i.e. where GP practices take delegated indicative budgets from their Primary Care Trust to become more involved in commissioning decisions for their patients.

All change again

Following the election of the Coalition Government in 2010 the new Government decided to disband Primary Care Trusts and transfer commissioning to GP Commissioning Consortia supported by an independent NHS Commissioning Board to '*best meet the needs of local people*'. These proposals were set out in a Government White Paper, Equality and Excellence: Liberating the NHS (2010) and were to be taken forward in a new Health & Social Care Bill, however further development was paused in 2011 pending a two month public listening exercise. At the conclusion of the listening exercise revised proposals were put forward, cited in a Mind LMA Briefing (2011) which included replacing GP Commissioning Consortia with Clinical Commissioning Groups which would also involve patients, carers, the public and other healthcare professionals.

Relationships with Government

In 2004, the then Chancellor of the Exchequer spoke, at the NCVO Annual Conference (quoted in Alcock & Scott, 2007, p90) about the '*transformation of the third sector to rival the market and the state, with a quiet revolution in how voluntary action and charitable work serves the community*'. Around this time Government began to make significant commitments to support the sector through institutional development and the investment of resources. One such commitment arose as a result of HM Treasury's, 2006 interim report on the future of the third sector in social and economic regeneration, which described a voluntary sector at the heart of reforms to improve public services including as contractors of public services. The Local Government White Paper in (DCLG, 2006) went further suggesting that

voluntary sector providers should be placed on a level playing field with mainstream providers, when it came to local service provision.

The landscape has however now changed following the General Election in May 2010 and the formation of a Coalition Government and their Programme for Government (2010) which made a commitment to *'support the creation and expansion of mutual's, co-operatives, charities and social enterprises and enable these groups to have much greater involvement in the running of public services'*.

The voluntary and community sector and commissioning

Commissioning practices and attitudes to third sector involvement in public sector commissioning were explored in an evaluation led by the Cabinet Office (Shared Intelligence, 2008). Conclusions from the evaluation reflected; openness amongst commissioners to work with the voluntary sector, and recognition that the sector could add value to commissioning. However the evaluation report suggested that meaningful and consistent engagement with the voluntary sector had not yet flown from this openness and recognition because commissioners' did not fully understand the impact of the barriers to commissioning on the voluntary sector.

Voluntary organisations and particularly small voluntary organisations are disadvantaged the Report concluded by commissioning processes, so that in contrast to the private and public sector there is no level playing field for the sector when competing for contracts. Also that a 'sector blind' approach would not increase involvement by the voluntary sector because treating all potential providers the same does not give the sector an equal chance, when competing for contracts. The

evaluation recommended promoting equality of access to commissioning opportunities for example through capacity building as well as through equality of opportunity.

Changing mental health policy environment

Recent years have also witnessed significant change in the national mental health policy environment with the replacement of compulsory nationally driven standards for local mental health services i.e. The National Service Framework for Mental Health by a focus on wellbeing and recovery described in New Horizons: launched by the last Government in 2009. New Horizons was superseded when the current Coalition Government launched No Health without Mental Health in 2011, however the focus on wellbeing and recovery was retained.

Personalisation

The personalisation agenda is one of the key changes and particularly relevant to this study because many local Mind associations provide community mental health services. Personalisation has the potential to offer very different services to those which have been previously delivered, however personalisation is not, it has been argued a coherent model, (Dickinson & Glasby, 2010) and therefore is best interpreted across a spectrum, with definitions adopted at local levels important. Dickinson & Glasby went on to refer to the confusion over the concept of personalisation and quoting Bartlett and Leadbeater (2008) who argued in a report for the think tank Demos that *“many third sector organisations were still not fully aware of the implications of this reform and how they should react to it”*.

The previous Governments Strategy Unit defined personalisation as *'the way in which services are tailored to meet the needs and preferences of citizens'* with the state empowering citizens *'to shape their own lives and the services they receive'*. (2007 cited in Dayson, 2010, p 4) Empowering citizens in this way, Dickenson and Glasby contended, is closely aligned to the values advocated by many voluntary organisations. Morris (2006) (cited in Dayson, 2010, p 4) argues that personalisation is a response to the growing limitations of existing welfare services, which *"prevent individuals with disabilities or support needs from living independently"*.

Lewis, the Personalisation Programme Lead at the Department of Health's National Mental Health Development Unit, speaking at a Mind conference in November 2010, argued that holding a personal budget empowered the citizen referring to growing evidence that personalisation increases esteem and confidence. There was also an impact on State services, which he felt had proved slow to change. Personalisation encourages responsiveness he argued, by withdrawing funding from the state.

If personalisation was closely allied to the values of many voluntary organisations why was the sector thought not to be ready for personalisation and why was the concept not well understood? This may have been due to relatively few people in receipt of self-directed health and social care services so perhaps the lack of preparation and understanding by the voluntary sector was not surprising. This supposition was confirmed by Dayson (2010) who reported that only 7% of users of health and social care services have access to self-directed support following research on the implications of the personalisation agenda in public services for voluntary organisations by the Centre for Regional Economic and Social Research.

This situation, he argued may change when all eligible social care users having the option of a personal budget by 2012.

Dayson suggested that although personalisation was relatively new, the concept of a more personalised approach to public services had been around for some time for example Mental Health Day Service Modernisation. He went on to suggest that personalisation was seen as a threat to some traditional care providers; however this could not be evidenced from the evaluation of the individual budgets pilot (IBSEN, 2008).

On the contrary, Dayson (2010, p10) has argued that the '*nature of self-directed support has enabled recipients to use their funding in more innovative ways to shape the types of support they receive*' and he went on to identify a number of examples of third sector innovation that had developed as a result. One example he identified (citing Spandler and Vick, 2004) is of an art group, formed by people with mental health problems, which operated in an isolated rural location and which had struggled to survive financially. Spandler and Vick (2005) referring to the same art group described five people who used direct payments to collectively pay for a creative arts worker to facilitate a regular arts group in a community centre. Dayson (2010) concluded that this example demonstrated that self-directed support has the potential to foster innovative service user centred services in new or existing third sector settings.

The voluntary and community sector could play a vital role in personalisation, Harlock (2010) has argued in supporting service users to exercise their voice and autonomy

in the planning and managing their support. She goes on to suggest that there is considerable potential for the sector to play a major role to enable service users to obtain appropriate and accessible information; plan their own care; secure access to services and as advocates in negotiations with service providers.

Mental health day service modernisation

In 2006, in commissioning guidance written by the National Institute for Mental Health England (NIMHE) for the Department of Health entitled: From Segregation to Inclusion (NIMHE, 2006) it was argued that existing mental health day services perpetuated segregation and as a consequence failed to meet people's needs. The vast majority of people with serious mental health problems now live, NIMHE suggested in the community rather than in isolated asylums. However, they remained segregated from the community: living; working and spending their leisure time in a range of specialist mental health services. The report went on to argue that segregating people in this way limits their opportunities and it was therefore proposed that mental day service services should be re-focussed on integration, recovery, choice, mutual support and self-determination and move away from segregation and isolation by utilising facilities in the wider community.

Implications of the literature review for this research

A widening division between large and small voluntary organisations

The literature review has indicated that although small voluntary organisations still constituted the vast bulk of the sector, there has been a significant increase in the number of larger regional and national charities plus an emergence of a small number of super larger charities. Small and medium voluntary organisations; face

difficulties competing for contracts to manage public services however there may be a role for small charities in maintaining social cohesion.

The rural voluntary sector and public service delivery

The literature review has also indicated that there was evidence for a significant rural voluntary sector, with a higher incidence of volunteering compared to urban communities but that community organisations lack the capacity to engage with the new healthcare commissioning environment. However commissioners were open to work with the sector and recognised the added value that the sector can contribute.

Recent evidence from the Charity Commission has indicated that those small charities that collaborate do it well, particularly if key features, including strong relationships; shared organisational aims and values; effective leadership and planning and communication are in place. There is also evidence that small voluntary organisations do not experience a level playing field with their private and public sector competitor's when competing for contracts. In addition 'value for money' criteria may also adversely impact on small voluntary organisations in rural communities because physical and social infrastructure costs per head of population are generally higher in rural communities.

Collaboration between small charities may be seen as a way forward however evidence from the Charity Commission suggested that for small voluntary organisations joint bidding for contracts was most likely to run into difficulty. Also joint bidding for contracts was not found to be particularly widespread amongst small voluntary organisations. A further indication that, lack of capacity, discussed earlier

militates against small voluntary organisation involvement in the commissioning process. Further small voluntary organisations may find it difficult to satisfy commissioner's performance management and monitoring processes. There is therefore considerable evidence that small voluntary organisations will experience difficulties securing contracts for public healthcare services. In addition characteristics particular to rural communities, identified by Blackburn et al, can act as a potential barrier to service delivery by the voluntary and community sector in rural communities.

Small organisations at a disadvantage in the future

There is no evidence from the review of a retreat of services to urban settings, although the review suggests that small voluntary organisations in rural areas are at a disadvantage due to particular barriers to change and their lack of capacity. These barriers and lack of capacity impact on making partnership work effectively and on ensuring adequate and socially inclusive representation and so when combined with the new commissioning environment small charities are further disadvantaged in tendering for future healthcare contracts.

A broader role in rural communities

Personalisation would seem to favour organisations that can provide services which are personal, sensitive to local need, maintain independence and personal dignity. Also favoured are services that are more accessible and that offer a choice. The Department of Health argued under the previous Government that to ensure continuous improvement in future healthcare, the demand side needs strengthening

through a much stronger voice for patients. These factors required a range of organisations, which can perform different functions in relation to policy.

Small voluntary organisations Blackburn et al argued are not just a vehicle for service delivery, but also have an important role in maintaining social cohesion, strengthening community and mutual aid. They can also act as a sounding board to reflect opinion. But can these functions be performed by one organisation? Blackburn et al's review would seem to indicate that these different functions are carried out by different sorts of organisations.

The evidence from the review would seem to support the proposition that there is a widening division between large, well placed and organised voluntary organisations and smaller community based voluntary organisations. Also that differentiating between large voluntary organisations and smaller community organisations came down to a discussion about the organisations mission, size and capacity to engage with the environment in which it operated and that an exogenous approach to defining the sector based on inter-sectoral landscapes would seem more satisfactory because of the sheer diversity of the network.

The review also indicated that although small voluntary organisations still constituted the vast bulk of the sector, they lacked the capacity to engage with the new commissioning environment including difficult satisfying performance management and monitoring processes. This was despite their recognised added value and ability to work with volunteers. Further they faced difficulties making partnership work effectively and ensuring socially inclusive representation.

These factors contrasted with large and super large regional and national charities, who brought to the contract negotiating table the economies of scale and an ability to meet 'value for money' and performance management criteria. There may however be opportunities for small community organisations as a result of personalisation and improving access and choice. Small organisations may also have a role in maintaining social cohesion, strengthening community and mutual aid and as a sounding board locally to strengthen the rural service user voice. However these different roles may not necessarily be inter-changeable within the same organisation.

The literature review indicated that the broad propositions outlined at the beginning of Chapter 2 need supplementary research questions i.e. Is there any evidence for a retreat of services to urban settings within Mind's network? Is there any evidence for an expansion of partnership working within Mind's network? Can voluntary organisations with an annual turnover less than £250,000 survive in an increasingly competitive contract culture?

Also that an additional proposition should be explored i.e. that small rural voluntary and community organisations have a broader role in the new commissioning environment, beyond service delivery: i.e. is there a role for small local Mind associations in maintaining social cohesion, strengthening community and mutual aid and as a sounding board? Are these roles recognized by commissioners? Do these organisations have a role to play in more personalised services improving access and choice? What is the likely impact of the personalisation and improving access and choice on small local Mind associations? Do these organisations have a role in more personalised services improving access and choice? What creative

opportunities might be grasped for partnership working by small local Mind associations?

CHAPTER 4

METHODOLOGY

At the end of Chapter 3 I concluded that the evidence from the literature review would seem to support the proposition that there is a widening division between large, well placed and organised voluntary organisations and smaller community based voluntary organisations. Although small voluntary organisations still constituted the vast bulk of the sector, they lacked the capacity to engage with the new commissioning environment including difficult satisfying performance management and monitoring processes, making partnership work effectively and ensuring socially inclusive representation. This was despite their recognised added value and ability to work with volunteers. These factors contrasted with large and super large regional and national charities, who brought to the contract negotiating table the economies of scale and an ability to meet 'value for money' and performance management criteria.

The literature review indicated that broader research questions outlined at the beginning of Chapter 2 needed to include supplementary questions i.e. is there any evidence for a retreat of services to urban settings within the local Mind network? Is there any evidence for an expansion of partnership working within Mind's network? Can voluntary organisations, including local Mind associations with an annual turnover less than £250,000 survive in an increasingly competitive contract culture?

In addition it was concluded that an additional proposition should be explored i.e. that small rural voluntary and community organisations could have a broader role in the new commissioning environment, beyond service delivery: i.e. is there a role for small local Mind associations in maintaining social cohesion, strengthening community and mutual aid and as a sounding board? However these different potential roles for small voluntary organisations may not necessarily be inter-changeable or possible to run in parallel, within the same organisation. Are these wider roles for small voluntary organisations recognized by commissioners?

Also in the new commissioning environment do small local Mind associations have a role in more personalised community services? What is the likely impact of personalisation and improving access and choice on small local Mind associations? What creative opportunities might be grasped for partnership working by small local Mind associations?

The research study

Chapter 4 describes the application of the research questions to local Mind associations, including a description of the quantitative and qualitative methodologies followed. The primary research questions and supplementary research questions are described in the following table (Table 4.1). In addition there is a discussion about why a quantitative methodology was adopted for the first research programme and why a qualitative methodology adopted for the second.

First 'Quantitative' Study	
Primary research questions	Supplementary research questions
Is there evidence of a widening division between large and small voluntary and community organisations?	<p>Can the evidence for a widening division between large and small voluntary and community organisations be applied to local Mind associations?</p> <p>What are the implications for rural communities? Do local Mind association services currently benefit rural communities? Are local Mind association rural services funded and sustained?</p> <p>Can a baseline for small and large Local Mind associations be developed? How do we measure large and small groups? Is there an accepted standard that we can use to measure the size of an organisation? Is a £250,000/annum turnover or less a meaningful measure of a small local Mind association?</p>
Second 'Qualitative Study	
Primary research questions	Supplementary research questions
What is the impact of recent changes in commissioning environment on local Mind associations working in rural communities?	<p>Is there a role for small rural local Mind associations in maintaining social cohesion, strengthening community and mutual aid and as a sounding board?</p> <p>Are these roles recognized by commissioners?</p> <p>What is the likely impact of personalisation and improving access and choice on small local Mind associations?</p> <p>Do these organisations have a role to play in more personalised services improving access and choice?</p>
Is there evidence of mental health services retreating to urban settings?	
Can voluntary and community organisations with an annual turnover less than £250,000 survive in an increasingly competitive funding environment?	Can a local Mind association with an annual turnover of less than £250,000 survive in an increasingly competitive funding environment?
Is there evidence of increased partnership working?	What creative opportunities might be grasped for partnership working by small local Mind associations?

Table 4.1: Primary and Supplementary Research Questions from the Quantitative Study and the Qualitative Study

Chapter 4 will also describe the various approaches adopted for both the quantitative study i.e. postal questionnaire, analysis of published statistics and interrogation of internal records and the singular approach adopted for the qualitative study i.e. semi-structured interview guided by a schedule. Also the data expected from both methodologies and approaches. In the following table (Table 4.2) the primary research questions and the supplementary research questions are related to various approaches adopted and to all the data expected.

Primary Research Questions	Supplementary Research Questions	Approach Adopted	Data Expected
First 'Quantitative' Study			
Is there evidence of a widening division between large and small voluntary and community organisations?	<p>What are the implications for rural communities?</p> <p>Do local Mind association's services currently benefit rural communities?</p>	Postal questionnaire to all local Mind Associations	<p>Data about the range of local Mind associations services that benefit rural communities.</p> <p>Data about local Mind associations perception of the area of benefit in which they work.</p> <p>Data about the rurality of Local Mind associations areas of benefit</p> <p>Data about local Mind association services that are accessible to people in rural communities.</p>
	<p>Can a baseline for small and large local Mind associations be developed?</p> <p>How do we measure large and small groups?</p> <p>Is there an accepted standard that we can use to measure the size of an organisation?</p> <p>Is a £250,000 or less per annum turnover a meaningful measure of a small local Mind association?</p>	<p>Interrogation of Mind's internal quality review records</p> <p>Interrogation of Mind's internal membership records and in particular the records of the sliding scale of affiliation fees based on annual turnover.</p> <p>Analysis of publically available statistics about the financial turnover of local Mind Associations produced by the Charity Commission</p>	<p>Data about the size of local Mind associations based on annual turnover</p> <p>Data about affiliation fees paid in relation to the financial size of the local Mind association.</p>
	How are local Mind associations rural services	Postal questionnaire to all local Mind associations	Data about the main sources of funding secured by local Mind associations for rural services.

Primary Research Questions	Supplementary Research Questions	Approach Adopted	Data Expected
	funded and sustained?		Data about the period of time, using a 6 year time frame these rural services have been funded. Data about rural services that have closed.
Second 'Qualitative Study			
What is the impact of recent changes in commissioning environment on local Mind associations working in rural communities?	Is there a role for small rural local Mind associations in maintaining social cohesion, strengthening community and mutual aid and as a sounding board?	Qualitative interviews using a semi-structured questionnaire and guided by an interview schedule with a purposive sample of local Mind associations and their respective mental health Joint Commissioners located in two neighbouring counties.	Data from Local Mind associations about their perceived role.
	Are these roles recognized by Joint Commissioners?		Data from Joint Commissioners about the role of local Mind associations and the third sector generally.
	What is the likely impact of personalisation and improving access and choice on small local Mind associations?		Data from local Mind associations about the impact of the personalisation and improving access and choice.
	Do these organisations have a role to play in more personalised services improving access and choice?		Data from Joint Commissioners about the role of small local Mind associations in more personalised services, and improving access and choice. Data from local Mind associations about their role in more personalised services, and improving access and choice.

Primary Research Questions	Supplementary Research Questions	Approach Adopted	Data Expected
Is there evidence of mental health services retreating to urban settings?			Data from local Mind associations about their current and recent services and their predictions for the future. Data from Joint Commissioners about their current and recent commissioning priorities and predictions about future priorities.
Is there evidence of increased partnership working?	What creative opportunities might be grasped for partnership working by small local Mind associations?		Data from local Mind associations about their relationships with neighbouring local Mind associations and other voluntary organisations. Data from local Mind associations about planned partnership working. Data from local Mind associations about partnerships working. Data from Joint Commissioners about third sector organisations collaborating in the future.
Can voluntary and community organisations with an annual turnover less than £250,000 survive in an increasingly competitive funding environment?	Can a local Mind association with an annual turnover of less than £250,000 survive in an increasingly competitive funding environment?		Data from Joint Commissioners about their expectations of voluntary and community organisations in the new commissioning environment? Data from local Mind associations about their knowledge of the new commissioning environment and its implications for their organisations?

Table 4.2: The Primary and Supplemental Research Questions, showing the various approaches adopted in the Quantitative and Qualitative Studies and the Data expected from all

THE QUANTITATIVE RESEARCH

The proposition, on which the first study is based, that there is a widening division between large, well placed and organised voluntary organisations and smaller community based voluntary organisations, would seem well founded based on the evidence from the literature review. Can the proposition be applied to local Mind associations? This part of the research programme will explore the perspectives of Mind, local Mind associations and utilise census information published by the Office for National Statistics.

Supplementary research questions

Supplementary research questions (see Table 4.1. Page 58) were related to the impact of a widening division, on the provision of services to rural communities i.e. whether local Mind association's services currently benefit rural communities; whether a baseline can be developed for small & medium Local Mind associations and large Local Mind associations; whether large, medium and small local Mind associations can be measured; whether there is an accepted standard that we can use to measure the size of a local Mind association and whether local Mind associations rural services can be funded and sustained.

Choosing a methodology

During the first stage of the research programme data was collected using a quantitative approach. Data was collected in three ways: firstly through analysis of statistics published by the Office for National Statistics; secondly by interrogation of Mind's internal management reports relating local Mind

association affiliation and Quality Management in Mind review records and thirdly through a structured self completed questionnaire posted to all affiliated local Mind associations.

Methods chosen to collect the data

The Office for National Statistics is the central producer of official statistics in the UK, collecting and analysing data about the population of the UK through an official census every 10 years. The Office has analysed in tabular form the population data from the 2001 census by settlement based on every English local authority district, using the urban and rural classification scheme. This methodology was chosen because it helped to understand the relationship between the provision of rural services by local Mind associations and the rurality of their area of benefit.

Mind's internal records were interrogated because Mind has produced useful data on the outcomes of its quality assurance framework, Quality Management in Mind. All 209 affiliated local Mind associations, in 2003, were subject to quality review using Quality Management in Mind over a five year period, and records of the outcomes were analysed and reported in internal management reports and are therefore part of the official record of the organisation. Similarly Mind collects statistics about its affiliates and in particular their annual turnover. This is because annual turnover is used to set an annual affiliation fee and therefore the annual turnover and affiliation fee for each local Mind association forms part of official records which can be interrogated.

A structured questionnaire was posted to all local Mind associations because Mind holds no information about the range and reach of mental health services provided by local Mind associations with rural communities. Mind does hold centralised information about the range of services and activities of its affiliates; however this information was not analysed by local authority district.

Choosing a quantitative approach

The proposition, on which the first part of this research programme is based, is that there is a widening division between large, well placed and organised voluntary organisations and smaller community organisations. A quantitative approach, using the three methods described above tested and measured whether the proposition can be applied to local Mind associations working in rural communities. Firstly because specific evidence gathered about local Mind associations working in rural communities could be compared with evidence gathered from the literature review about the wider voluntary and community sector. Secondly because evidence gathered from Mind about large and small local Mind associations could be compared with evidence from the literature about large and small voluntary and community organisations.

Thirdly because a comparative tool can be developed to measure large, medium and small local Mind associations using criteria developed by the Charity Commission and others organisations gathered from the literature. Lastly because the data gathered from local Mind associations about the

funding and closure of rural services could be used to test the sustainability of rural services.

The table overleaf (Table 4.3) relates the research questions to the three quantitative methods to be used.

Research questions	Methods		
	Analysis of published statistics	Postal Questionnaire	Interrogation of Mind's internal records
Can the proposition that there is a widening division be applied to local Mind associations?	There are no published statistics available for this question		Outcomes of Quality Management in Mind review of affiliated local Mind associations 2003-2007
What are the implications of a widening division for rural communities? Do local Mind association services currently benefit rural communities?	There are no published statistics available for this question	Specific questions in the postal questionnaire about the type and accessible rural services	
Can a baseline for small, medium and large local Mind associations be developed? How do we measure big and small groups? Is there an accepted standard that we can use to measure the size of an organisation?	Charity Commission records of the annual turnover of registered charities are published on the Commissions web site.		Mind's differentiates between large and small local Mind associations by applying an affiliation fee on a sliding scale relating to the annual turnover of the association. Mind keeps records of the numbers of local Mind association in each affiliation fee group.
What are the implications of a widening division for rural communities? How are rural services which local Mind associations manage, funded and sustained?	There are no published statistics available for this question	Specific questions about the funding of rural services	Mind's internal records do not differentiate between the urban and rural services of its affiliated local Mind association network

Table 4.3: Relating the research questions to the quantitative methods used

How the quantitative data was collected

Population settlement data analysed

The statistics analysed were population settlement data published by the Office for National Statistics (2006), which is the central producer of official statistics in the UK. The vast bulk of official statistics are designated as 'National Statistics' which is an accreditation, which means that statistics produced by the Office for National Statistics are compliant with the National Statistics Code of Practice.

Population settlement data informed the research questions in the first study by helping to understand the relationship between the provision of local Mind association rural services and the rurality of the area of benefit of each association. I referred in Chapter 1 (p 4-5) to the way the DEFRA has classified each local authority district in England by population settlement to produce a six-fold grouping of local authority districts called: rural 80; rural 50; major urban; large urban; significant rural and other urban. The rurality or otherwise of each local Mind associations area of benefit could therefore be mapped against this classification of local authority districts to identify the types of population settlements in which local Mind associations operated.

Interrogation of Mind's affiliation records

Mind's internal management reports relating to affiliated local Mind association were interrogated to inform those research questions which are about the size of local Mind association's, the number of affiliates over time and outcomes from Quality Management in Mind review.

Mind collects information annually about the financial turnover of each affiliated local Mind association and then uses this information to set an annual affiliated fee based on a sliding scale relating to turnover. Mind also requires each affiliate to submit a self-assessment for Quality Management in Mind review, every three years and to reach a minimum standard to remain affiliated. Some local Mind association leave the network or are disaffiliated because they do not meet the required standard. Information about local Mind associations that had left the network or are disaffiliated was recorded.

Local Mind Association Annual Turnover	Fee Group
Up to £10,000	1
£10,001 - £50,000	2
£50,001 - £150,000	3
£150,001-£250,000	4
£250,001- £500,000	5
£500,001-£1,000,000	6
£1,000,001 - £2,000,000	7
£2,000,000 & over	8

Table 4.4: The Relationship between Local Mind Associations Annual Turnover and the Annual Affiliation to Mind

Mapping of local Mind associations by annual turnover

Mind uses a sliding scale based on annual turnover (see Table 4.4 above) to set an annual affiliation fee for local Mind association's and therefore records the turnover of its affiliates year by year to set the affiliation fee. Those with

the smallest turnover pay the smallest fee and those with the largest turnover pay the biggest fee.

Quality Management in Mind

In 2001, Mind introduced a quality framework (Quality Management in Mind) for its affiliated network and in 2003, achieving the minimum standard during an external review process became a requirement of continuing affiliation.

From 2003 to 2008 every affiliated local Mind association was subject to the same external review process. The local Mind association's that met the minimum standard and maintained their affiliation to the Mind were recorded as were those that failed to meet the minimum standard and left the Mind network.

All affiliated local Mind associations are also registered charities and as such are regulated by the Charity Commission. The Charity Commission definition of a small charity (see Chapter 2, p 29) and Mind's affiliation categories were used to analyse Mind's affiliation records over time to assess the impact of a new commissioning environment on affiliations to Mind and on the number of affiliates in each affiliation category.

Postal questionnaire to local Mind associations

Target population

Many local Mind associations have a rural community within their area of benefit because the application of the new rural and urban definitions to local

authority districts (see Chapter 1, p 3-4) resulted in the classification of 50% of all the local authority districts in England as rural.

Sampling: Why sample the whole population?

It was decided to sample the whole population i.e. all 183 affiliated Local Mind associations in 2008 because of the broad rural definition and also because a charity's name and therefore presumed area of benefit may not reflect its true area of benefit registered with the Charity Commission. For example Darlington Mind is based within the urban local authority district of Darlington however its area of benefit includes Rural 80 and Rural 50 local authority districts in County Durham and North Yorkshire. In addition, sampling the whole population had the added advantage of gathering data from both large, medium and small Local Mind associations and the possibility of useful data which could be related to the size of the association.

Designing a postal questionnaire

Prior to designing the postal questionnaire; data which might be expected to be gathered from a questionnaire to local Mind associations was considered alongside that to be gathered from the interrogation of Mind's internal; records and analysis of publically available statistics and then some draft questions developed. A table was used to complete the analysis and develop the questions as it provided a useful way of relating the research questions to outcomes, the quantitative study as a whole and identifying gaps and overlaps. The table used was eventually extended to also include the

qualitative study however the quantitative study section (see Table 4.2. p 55 - 57), illustrates the method used to develop the first draft postal questionnaire.

Pilot study

A detailed structured postal questionnaire designed to be self completed was then drafted (Appendix 4.1) based on the questions developed using the table. The first draft postal questionnaire was then piloted with a local Mind association and a Joint Commissioner. Arthur & Nazroo (2003, p135) described piloting as a critical part of research, which they suggested shows whether or not the research instrument is working i.e. is the draft postal questionnaire generating the clarity, scope or depth of data sought? If not then it needs to be revised.

Piloting the draft postal questionnaire enabled the questions to be checked for clarity and understanding, and also provided a means of identifying any omissions or potential misunderstandings. In addition piloting provided an opportunity to estimate the completion time of the postal questionnaire which if too long might have an impact on the response rate.

The individuals involved in the pilot study were asked to review the postal questionnaire and then meetings were organised with them individually to receive feedback. The feedback indicated that the questionnaire was too long, and over complicated which was likely to lead to misunderstandings and therefore a poor response and poor data. The revised schedule of questions which followed as a result of the feedback from the pilot is shown in the table

overleaf (Table 4.5) along with the feedback received to each of the subject areas of the questionnaire.

Subject area in the pilot postal questionnaire	Feedback from the pilot – Is the question working? Action taken	Revised Main & Supplemental Questions
<p>Pilot Question 1 Area of Benefit</p>	<p>The pilot indicated that most of the data could be obtained using other quantitative methods i.e. published statistics and Mind’s internal records. I.e. mapping the relationship between Local Mind association’s area of benefit and rural local authority district using ONS and Mind’s internal data.</p> <p>The revised Question 1 is straightforward capturing information about local Mind association’s knowledge and awareness of the geographical area in which it works.</p>	<p>Revised Question 1 How would you describe the area where your local Mind association is active?</p>
<p>Pilot Question 2 Rural Services & Activities</p>	<p>The pilot indicated that data requested went beyond that required for the research questions.</p> <p>The new Question 2 relates directly to the research questions asking whether or not the local Mind association provided services or activities which people in rural communities can access.</p>	<p>Revised Question 2 If your local Mind association’s area includes a rural community do you provide services or activities which people in rural communities can access?</p>
<p>Pilot Question 3 Funding of Rural Services & Activities</p>	<p>The pilot indicated that these questions were over complicated and took too long to complete and they were deleted.</p> <p>The new Question 3 asked about rural services or activities provided or identified as needed. They were classified using the services area defined in Quality Management in Mind and therefore very familiar to the local Mind association network.</p> <p>Recovery, which has been defined by Rethink (2005) as ‘<i>a personal process of tackling the adverse impact of experiencing mental health problems, despitecontinuing or long-term presence</i>’, was added because, it is a widely accepted focus of current mental health services delivery.</p> <p>In addition service user group, recruiting volunteers and recruiting trustees were also added because these three areas are activities that underpin the performance and governance of any local voluntary mental health service activity.</p> <p>A much broader classification developed for use on Mind's web site was reviewed but found to be potentially confusing and difficult for local Mind association respondents to</p>	<p>Revised Question 3 Please tell us about your services or activities for people in rural communities? Which of these services or activities do you provide? Have you identified a need for any of these services in your rural communities?</p>

Subject area in the pilot postal questionnaire	Feedback from the pilot – Is the question working? Action taken	Revised Main & Supplemental Questions
	use. This was because the local Mind association network was both unfamiliar with the classification scheme used and because many local services could be categorised under a number of the headings and therefore cause confusion if used.	
Pilot Question 4 Closing Services Pilot Question 7 Funding of Rural Services & Activities	<p>The questions about closure in the pilot postal questionnaire were deleted.</p> <p>The questions relating to funding in the pilot questionnaire (pilot Question 3) were re-introduced using both questions from Questions 3 & 7 as Question 4 using a grid system which cross referenced funding bodies and the period of time funded.</p> <p>The completion time was shortened because local Mind associations could respond by circling the box that applied to their particular circumstances rather than producing an individual narrative for each funding body.</p>	Revised Question 4 How are your rural services or activities funded? Who funds your rural service? For how many years has the service been funded?
Pilot Question 5 Relationship with the NHS & Local Authority	<p>The feedback indicated that the relationship between local Mind associations and local authorities, the NHS, healthcare commissioners, GP's could be a lot more complicated and therefore vital data about the relationship would be lost if a quantitative approach was followed in Questions 5, 6 & .</p>	Revised Question 5 Please tell us if any of your rural services or activities have closed or ceased in the last 5 years?
Pilot Question 6 Contact with Commissioners	<p>It became clear during the pilot that in addition to formal contractual relationships around a particular service there may be more informal relationships between local Mind association's and healthcare commissioners and that these relationships might be better understood from a qualitative approach.</p>	Which of these services or activities closed or ceased in the past 5 years?
Pilot Question 8 Relationships with GP's	<p>The questions about closure of services were re-introduced as Question 5.</p>	Why did the rural service or activity close or cease?
Pilot Question 9 Relationships with neighbouring Local Mind associations		

Table 4.5: Subject area covered used in the pilot Postal Questionnaire, Feedback from the Pilot Study and the Revised Questions

Final draft postal questionnaire

A postal questionnaire (Appendix 4.2) designed to be completed by representatives of local Mind associations without assistance, was posted to all affiliated local Mind associations with: a stamped addressed return envelope; a covering letter (Appendix 4.3) which explained the purpose of the study and a set of guidance notes with a detailed explanation of each question in the postal questionnaire (Appendix 4.4). The data expected from each of the questions is detailed in the table (Table 4.6) overleaf.

At the end of the postal questionnaire each respondent was asked to complete their contact details i.e.: name of the LMA; name of the person completing the postal questionnaire; address, telephone number; email and the date the postal questionnaire was completed.

Final Questions	Data expected
1. How would you describe the area where your local Mind is active?	How local Mind associations describe the area in which they are active. Whether it is predominantly an urban area, a mixture of urban and rural areas, a rural area or predominately rural area. This question tested local Mind association's awareness and perception of the characteristics of the area of benefit in which they work using simplified features of the rural/urban classification and enabled a comparison of local Mind association's perceptions against the classification of the area of benefit using the local authority districts rural/urban categories.
2. If your local Mind's area includes a rural community do you provide services or activities which people in rural communities can access?	This question will provide data about which local Mind associations provide rural services and which do not.
3. Please tell us about your services or activities for people in rural communities?	<p>This question will provide data about the range of the rural services or activities provided by the local Mind associations identified in 2) above. The services and activities are differentiated using the following categories:</p> <ul style="list-style-type: none"> • The eight local Mind association service areas identified in the first edition of Quality Management in Mind (Mind, 2001), i.e. advice and information services, advocacy, community support, counselling, crisis services, day services, employment services, and supported housing. • The more recent and now widely accepted concept of recovery. • Service user group, recruiting volunteers and recruiting trustees. <p>This question will also provide data about whether local Mind associations have identified a need for a rural service or activity using the same criteria.</p>
4. How your rural services or activities are funded?	This question will provide data about the primary sources of funding for local Mind associations i.e. local authority, NHS, Big lottery fund, own funds, grant giving trust or foundation or other and, the period of time, in a range from less than one year, up to six years or more.
5. Please tell us if any of your rural services or activities have closed or ceased in the last 5 years?	This question will provide data about rural services or activities that have closed or ceased in the last 5 years, using the categories used in question 3. In addition the question will provide data about why they have ceased to function.

Table 4.6: Final Questions for the Postal Questionnaire and the Data Expected

Period when data was collected and the policy context

The postal questionnaire was sent to local Mind associations in February 2008 and the completed questionnaires were returned later in February and in March 2008. The internal management reports which were interrogated covered the financial years 2004/2005 to 2008/2009.

The modernisation of community mental health services, (described in Chapter 3 p 44-45), including moves towards personalisation and particularly compulsory competitive tendering had yet to be introduced when Mind's internal management reports, referred to above, were compiled and the postal questionnaire sent to local Mind associations. However by 2008 significant changes to commissioning practice were coming into place (described in Chapter 3 p 36-39) including mental health commissioners deciding what services were required and where they were required. Also grants were being replaced by service contracts which specified the service the provider organisation was expected to provide, with commissioners beginning to monitor progress against the contract specification routinely.

THE QUALITATIVE RESEARCH

The qualitative research traced the impact of the new commissioning environment on small local Mind associations working in rural communities in order to explore three propositions i.e. firstly the retreat of services to urban settings, secondly the expansion of partnership working by the rural voluntary sector and thirdly whether voluntary organisations with an annual turnover less than £250,000 can survive in an increasingly competitive contract culture.

This part of the study was explored through semi-structured interviews with Joint Commissioners and local Mind associations.

The qualitative research traced the impact of the new commissioning environment by reviewing the changing relationships between two Joint Commissioning Units and four local Mind associations' in two predominantly rural and neighbouring English midland counties.

Primary research questions for the qualitative research

1. What is the impact of recent changes in commissioning environment on local Mind associations working in rural communities?
2. Is there evidence of mental health services retreating to urban settings?
3. Can voluntary and community organisations with an annual turnover less than £250,000 survive in an increasingly competitive funding environment?
4. Is there evidence of increased partnership working?

Supplementary questions for the qualitative research

Supplementary research questions (see Table 4.1 p 53). explored the additional proposition that small local Mind associations could have a broader role in the new commissioning environment i.e. in maintaining social cohesion, strengthening community and mutual aid and as a sounding board; whether the potential for a broader role was recognized by commissioners; the likely impact on small Local Mind associations of personalisation and improving access and choice and whether small local Mind associations had a role in

more personalised services. Further supplemental questions related to: whether a local Mind association with an annual turnover of less than £250,000 could survive in an increasingly competitive funding environment and whether there were creative opportunities for partnership working by small local Mind associations.

Choosing a methodology

The second study followed a qualitative approach to explore the working relationship between local Mind associations and Joint Commissioners. Pilot quantitative data indicated such relationships could be complicated and therefore vital data about the qualities of the working relationships would be gained by a qualitative approach. The distinctive characteristics of qualitative research (Snape & Spencer, 2003) is that it produces '*data which are very detailed information rich and extensive*' and *analysis which is open to emergent concepts and ideas and which may produce detailed descriptions and classification, identify patterns of association or develop typologies and explanations*'. Qualitative research is particularly well suited, they suggested to issues that hold some complexity and processes that occur over time and therefore appropriate for developing an in-depth understanding of the new healthcare commissioning environment.

The following sections consider choice of data collection, sampling, ethical issues, developing and piloting the schedule and data analysis.

How the qualitative data was collected

Why an in-depth interview

Lewis J (2003) suggested that the key types of generated data in qualitative research are the result of in-depth interviews and focus groups. Choosing between in-depth interviews and focus groups will turn on three key factors Lewis argues i.e.: type of data sought; subject area and the nature of the study group.

In-depth interviews provide an opportunity for detailed investigation from a personal perspective and for detailed subject coverage, whereas there is less opportunity to do this in a focus group. An in-depth interview was chosen because detailed data was required about the working relationship between Joint Commissioners and local Mind associations. Also because the subject matter, is complex i.e. a variety of different players in an evolving policy environment. Focus groups were rejected because members need to attend a common location and it was felt that this would inhibit the selected sample from attending.

Qualitative interviews

Qualitative interviews have been described by Kvale (2007) as an '*attempt to understand the world from the subject's point of view*'. Robson (1993) defined a qualitative interview as a '*conversation with a purpose*'. Qualitative interviews can be semi-structured or focussed or unstructured. In semi-structured interviews the focus of the interview is decided by the researcher, using some open ended questions and guided by a topic outline or interview

schedule. The researcher tries to understand issues from the respondent's perspective rather than make generalisations. The process is like a conversation, where the researcher links issues and therefore the wording of questions may vary but continue to have a particular focus in each interview which is linked to the research questions. Semi-structured interviews are the most common approach used in qualitative research.

A purposive sample

The second study reviewed the changing relationship between two neighbouring Joint Commissioning Units and their co-terminus four local Mind associations in two predominantly rural English midland counties. The local Mind associations and Joint Commissioning Units were chosen because they were located in geographical areas classified either as Rural 80, or Rural 50 or Significantly Rural local authority districts.

The sample selected for interview was therefore small and purposive i.e.: one Joint Commissioning Unit operated across the same rural county as a county wide local Mind association and the other Joint Commissioning Unit operated across a neighbouring county with three local Mind associations each with separate areas of benefit within the same county. A small sample, purposive on the basis of salient criteria is one of the distinctive features of qualitative research. Table 4.7 on p 79, relates the local Mind associations to their total populations, local authority urban/rural classification and the Joint Commissioning Units.

Local Mind association's involved in the qualitative research

All of the four local Mind associations operated in rural communities because each of their areas of benefit is defined as rural by population settlement.

Their areas of benefit have however some significant differences for example, A Mind's area of benefit was formerly co-terminus with five local authority districts now combined with the former County Council into a single unitary authority, but excluding a new town. All five former districts were classified as Rural 80 districts using the urban/rural classification except for one classified as Significantly Rural. The area of benefit included: an urban county town; a number of large market towns & rural market towns and a significant population living in villages and scattered communities. The LMA served a total population of 283,393 people.

B Mind is co-terminus with three local authority districts all of which contain significant urban populations including a county town, a larger market town associated with former mining communities as well as large urban fringe villages most of which have strong economic links with nearby towns and cities. However all three districts are classified as Significantly Rural. The LMA serves a total population of 318,943 people.

C Mind and D Mind areas of benefit are both within one local authority district which is classified as Significantly Rural. C Mind is based in a market town and D Mind in an urban town. The two local Mind associations share a total population of 103,643 people.

LMA	Population	Local Authority Classification	Local Authority District	Joint Commissioning Units
A Mind	52,468	Rural 80	LAD1Y	Y Joint Commissioning Unit
	57,234	Rural 80	LAD2Y	
	37,320	Rural 80	LAD3Y	
	95,932	Significantly Rural	LAD4Y	
	40,439	Rural 80	LAD5Y	
B Mind	92,308	Significantly Rural	LAD1X	X Joint Commissioning Unit
	106,059	Significantly Rural	LAD2X	
	120,578	Significantly Rural	LAD3X	
C Mind	103,643	Significantly Rural	LAD4X	
D Mind				

Table 4.7: The local Mind Associations in the study, in relation to their populations, local authority administrative districts, local authority urban/rural classification and the Joint Commissioning Units. In 2009 the five local authority districts co-terminus with A Mind and Y JCU were combined into a single unitary local authority

Mental health Joint Commissioners in the qualitative research

Two mental health Joint Commissioners were interviewed from County X. In County Y the manager with responsibility for mental health commissioning was interviewed and the former mental health commissioning manager involved in piloting the quantitative postal questionnaire.

In County X the Joint Commissioning Unit is hosted by the County Council.

Two mental health Joint Commissioners were interviewed because the two managers had different functional responsibilities within the Unit. One commissioner took responsibility for commissioning i.e. needs analysis, planning of services, service specifications, carer and service user

involvement, decisions about best use of resources and best value for money etc, and the other for procurement i.e. monitoring performance of services against the contract awarded.

For the purposes of this study the Joint Commissioner responsible for commissioning is referred to as N and the Commissioner responsible for procurement as D. Both managers had a background in mental health and one had previously managed a voluntary day centre. Both managers were interviewed in order to give a full and complete picture of the Joint Commissioner role.

In County Y, the Joint Commissioner had responsibility for both commissioning and procurement of mental health services and the Joint Commissioning Unit was hosted by the local Primary Care Trust (PCT). When this study began the Joint Commissioner in County Y had been in post for many years. However the Commissioner departed shortly after the A Mind interviews and the mental health commissioning role was eventually incorporated, after a six month interregnum within the role of the Head of Partnership & Business Planning within the Joint Commissioning Unit. The new Joint Commissioner explained her role during the interview as '*providing cover – not a mental health specialist – filling a gap*' which had come about as a result of management cuts. For the purposes of this study the Joint Commissioner interviewed was designated as S.

Sampling approach

This sampling approach was chosen because the qualitative study is primarily looking at new commissioning arrangements and the changes in community mental health service delivery some of which came into place during the course of the research. In this instance the research was not focussed on whether the proportion of the joint commissioning or local Mind association population gives a particular response to the research questions but rather as De Vaus (2002) argues '*obtaining an idea of the range of responses or ideas people (local Mind association's and Joint Commissioners) have*'.

Ethical considerations

The Joint Commissioners and the representatives of local Mind associations selected by the researcher for interview were contacted by email and/or telephone: invited to participate in the study; informed of the purpose of the study and about the researcher; informed how the data gathered was to be used and the subject areas to be covered and informed of the time required for the interview. Each interview was recorded, and participants informed that the recording would be transcribed for the purposes of content analysis but would remain confidential to the researcher and eventually deleted.

There was no discussion with participants about whether they would be identified personally or whether any comments would be personally attributed in the research report. In these circumstances the researcher has anonymised those interviewed and the organisations they represent in the report. X Joint Commissioning Unit and Y Joint Commissioning Unit have been substituted

for the real names of the Joint Commissioning Unit's interviewed to anonymise the individuals and organisations involved. Similarly the names A Mind, B Mind, C Mind and D Mind have been substituted for the real names of the Local Mind associations interviewed. Also, the identities of Chief Officers and Trustees from the four Local Mind associations have been anonymised in the table below (Table 4.8).

LMA	LMA chief officers & trustees interviewed	Joint Commissioning Units	Joint Commissioning Managers Interviewed or referred to
A Mind	Chief Officer F & Trustee H	County Y Joint Commissioning Unit	Commissioner C & Commissioner S
B Mind	Trustee L & Chief Officer P	County X Joint Commissioning Unit	Commissioner L & Commissioner N
C Mind	Chief Officer J		
D Mind	Chief Officer M		

Table 4.8: Anonymising those interviewed from the Local Mind Associations e Joint Commissioning Units and their relationships to each other.

In Chapter 5 reference is made to two local voluntary mental health providers and two national mental health providers identified during the interviews with representatives of local Mind associations and referred to in the quotes. The names of all four organisations have also been anonymised, because to do so would help to identify the two Joint Commissioning Units and the local Mind associations interviewed. The four organisations are described as TT, PP, CC and EE.

Why use a semi-structured schedule

The second study had some specific questions to ask both the Joint Commissioners and the local Mind associations, which arose from the original proposition, the primary research questions and the supplementary research questions. The interviews with Joint Commissioners and local Mind associations were therefore not only conversations with a specific purpose but had a specific focus i.e. to discover: the impact of changes in commissioning on local Mind association's working in rural communities; evidence for the retreat to urban settings and evidence of increased partnership working. In addition the subject matter was complex, i.e. within an evolving policy environment which encompassed: modernising community mental health services; moves towards personalisation and at the time of the majority of the interviews compulsory competitive tendering about to be introduced. The final Joint Commissioner interview took place after the election of a new Coalition Government, when it was becoming clear that some significant changes in the organisation of health commissioning plus substantial cuts in public expenditure were about to be announced.

The use of a semi-structured schedule allowed emergent issues to be explored through a flexible approach which enabled the impact of a new healthcare commissioning environment on local Mind associations to be explored and better understood. The interview was guided by an interview schedule or topic guide that enabled the researcher to organise topics and questions to be explored. The interview schedule or topic guide served Burgess (1984) suggested as an interview agenda, guide or aide-memoire.

Prompts are used to elicit a fuller response or to enable a struggling respondent to understand the question. The guide sets and orders the agenda for the interview i.e. introducing the project and the researcher; the purpose of the study and the ground to be covered.

Designing an interview schedule

Arthur and Nazroo (2003) described the process of interview schedule design beginning by establishing the topics to be covered. In this study this process began by the development of a table which set out the topics to be covered i.e. the primary research questions and the supplementary research questions. Against these topics a series of issues for Joint Commissioners and issues for local Mind associations were devised. Using the issues as a guide, questions for Commissioners and questions for local Mind associations were then drafted. The table used to develop the interview schedule questions is shown in the table overleaf (Table 4.9). Interview schedules for both local Mind associations and Joint Commissioners were then drafted comprising: the research questions; a prompt for the researcher to explain the background and focus of the study; a series of headings followed by main questions; subsidiary questions and/or prompts for particular issues.

Research Questions and follow ups	Issues for Joint Commissioners	Questions for Joint Commissioners	Issues for Local Mind associations	Questions for Local Mind associations
<p>What is the impact of recent changes in commissioning environment on local Mind associations working in rural communities?</p> <p>Is there a role for small rural local Mind associations in maintaining social cohesion, strengthening community and mutual aid and as a sounding board?</p> <p>Are these roles recognized by commissioners?</p> <p>What is the likely impact of the personalisation and improving access and choice on small</p>	<p>Commissioners, knowledge, views and opinions about their role in the new commissioning environment</p> <p>Voluntary and community organisations in the new commissioning environment</p> <p>World class commissioning the 2007 White Paper 'Commissioning Framework for Health and Well Being' including a strategic shift towards promoting health and well being</p> <p>What role for the voluntary sector?</p>	<p>1) How long have you worked as a mental healthcare commissioner locally?</p> <p>2) What range of services do you commission?</p> <p>PROMPT: WHAT TYPE OF SERVICE? COUNTY-WIDE AND LOCAL? WHAT IS THE BIGGEST EXAMPLE? WHAT IS THE SMALLEST? EXAMPLE?</p> <p>3) How would you describe your role as a commissioner locally?</p> <p><u>Supplemental</u></p> <p>a) Has your role changed recently?</p> <p>PROMPTS: WHAT CHANGES? COMPARISON TO ONE YEAR AGO? TWO YEARS? THREE YEARS AGO?</p> <p>4) What has been the impact of the Commissioning Framework for Health & Well</p>	<p>Local Mind associations knowledge, views and opinions about the new commissioning environment</p> <p>Local Mind associations views and opinions about the likely impact of the new commissioning environment on Local Mind associations</p> <p>Local Mind associations views and opinions about the sustainability of their Association in the next 5 years</p>	<p>1. How long has (NAME) LMA been established?</p> <p>2. How would you describe your role locally?</p> <p>PROMPT: SERVICE PROVIDER? ADVOCATE? LOCAL VOICE?</p> <p>Relationship between your LMA and local mental healthcare commissioners?</p> <p>PROMPT: GOOD, DISTANT, CLOSE</p> <p>Changing relationship?</p> <p>Likely impact of these changes on your LMA in the next 3 years?</p> <p>Knowledge of the new arrangements for commissioning mental health services/activities?</p> <p>PROMPT: COMMISSIONING FRAMEWORK FOR HEALTH & WELL BEING</p>

Research Questions and follow ups	Issues for Joint Commissioners	Questions for Joint Commissioners	Issues for Local Mind associations	Questions for Local Mind associations
<p>Local Mind associations? Do these organisations have a role to play in more personalised services improving access and choice?</p> <p>Is there evidence of mental health services retreating to urban settings?</p> <p>Is there evidence of increased partnership working?</p>		<p>being?</p> <p>5) What has been the impact of day service modernisation</p> <p>6) What has been the impact of IAPT?</p> <p>7) What has been the impact of moves towards working more with the third sector?</p> <p><u>Supplemental</u></p> <p>a) How would you describe your relationship with local Mind association?</p> <p>b) How would you describe your relationship with other VCS in area?</p> <p>8) How do the particular characteristics of the area impact on commissioning?</p> <p>PROMPT: ECONOMIC CULTURAL, GEOGRAPHICAL, SOCIAL CHARACTERISTICS,</p>		<p>How do the particular characteristics of the area impact on your work?</p> <p>PROMPT: GEOGRAPHICAL, SOCIAL, CULTURAL, ECONOMIC</p> <p>Working relationships with other Local Mind associations?</p> <p>Working relationships with local mental health organisations?</p> <p>PROMPT: CO-OPERATIVE, COLLABORATIVE, COMPETITIVE</p> <p>Biggest challenge/threat in the next 3 years?</p> <p>PROMPT: FUNDING, TENDERING, GOVERNANCE, QUALITY, LOCAL NEEDS, LOCAL SUPPORT, OTHER</p> <p>Biggest strength/opportunity?</p> <p>PROMPT: FUNDING, TENDERING, GOVERNANCE, QUALITY, LOCAL NEEDS, LOCAL SUPPORT, OTHER</p>

Research Questions and follow ups	Issues for Joint Commissioners	Questions for Joint Commissioners	Issues for Local Mind associations	Questions for Local Mind associations
				<p>How do you see the future for your LMA?</p> <p>PROMPT: GROWING, DECLINING, MERGING, PARTNERSHIP/COLLABORATIVE</p> <p>DISAPPEARING</p>

Table 4.9: Table used in the 2nd Study to identify ‘issues’ for Joint Commissioners and Local Mind associations and the main and subsidiary questions for the interview schedule

Legend: Bold: Main questions Standard: Subsidiary questions

Italics: Introductory questions: UPPERCASE: PROMPTS

Piloting the interview schedule

A Mind was contacted for interview first and used to pilot the local Mind association interview schedule. X Joint Commissioning Unit was the first commissioning unit to be contacted for interview and the interview schedule for Commissioners was used to pilot the Joint Commissioner interviews.

Interview with Chief Officers and trustees

Trustee, H was interviewed at A Mind along with the recently appointed Chief Officer, D in January 2009. These two individuals complemented each other in that the trustee as a former chair of trustees and long term volunteer had a wider knowledge and experience of the A Mind's development and organisation over a number of years whereas the new appointed Chief Officer had been reviewing A Mind's activities and was looking ahead at future opportunities. Both interviews, facilitated discussion and gathered a considerable amount of data, and it was therefore concluded that the interview schedule for local Mind associations had an appropriate mix of main and subsidiary questions. The remaining interviews at C Mind with Chief Officer J, at B Mind with Trustee N and Chief Officer P and at C Mind with Chief Officer M were completed between January and August 2009.

Interviews with Joint Commissioners

The first interview with a Joint Commissioner D, from X Joint Commissioning Unit was more problematic. It became clear 5 minutes into the interview that although local Mind associations in County X identified this Joint Commissioner as their principle contact with the Unit, the Commissioner D's

knowledge of commissioning new services was limited,. This was because in X Joint Commissioning Unit, two mental health commissioning managers had different functional responsibilities within the Joint Commissioning Unit team: one manager took responsibility for commissioning whereas the other took responsibility for procurement.

The interview with D provided much data about the procurement and monitoring process and particularly about the process followed during the review of local mental day services but there was little data about the new mental health policy environment or about the role of the commissioner in the new environment. Following this interview the Joint Commissioner responsible for commissioning mental health services was identified as Commissioner N.

External advice sought

In addition advice was sought from a Mental Health Service Development Specialist in the local Strategic Health Authority about the developing policy environment and the likely impact on local commissioners. The Development Specialist agreed to be interviewed to inform the study on condition that his views were not included in study report. The Development Specialist's responses during the subsequent interview did not therefore add to data collection, but did enable a better understand of the developing policy environment and the Joint Commissioner's role within that developing environment.

Revising the interview schedule

The interview with the Development Specialist led to a revision of the section in the schedule about the role of Joint Commissioners which was revised to include additional questions about: the range of services which are commissioned; day service modernisation, impact of Improving Access to Psychological Therapies (IAPT) programme locally and the impact of moves towards working more with the third sector. The final interview schedule used for the remainder of the interview is shown in Appendix 4.5 and was used in the subsequent interviews with Joint Commissioners.

Final Joint Commissioner interview and the political context

The remaining interviews: with Joint Commissioner N was completed in January 2010 and with Joint Commissioner S in June 2010. The last interview was undertaken much later than the others because there was a long gap between C leaving the post and S taking up the mental health brief with the County Y Joint Commissioning Unit.

The final interviews occurred just after the election of the Coalition Government in 2010 and Government announcements about public sector expenditure cuts but just before announcements were made about the demise of Primary Care Trusts and their replacement. However it was clear that the Joint Commissioner expected substantial change to the commissioning process and that public expenditure cuts would have an impact on her work.

Analysing data

Data management and analysis

Data analysis was described by Spencer, Ritchie and Connor (2003, p199) as '*a challenging and exciting stage of the qualitative research process*'. Analysis is a continuous and repetitive or iterative process which is characterised by two key but inter-linked stages i.e. managing the data and making sense of the data through descriptive or explanatory accounts. Managing the data precedes making sense of the data because unless the data is managed or organised it will be almost impossible to understand the data collected. To make sense of the data a method is required to order and categorise it.

Whatever method is used to make sense of the data Spencer et al (2003) argued for important 'hallmarks' to look for in any methodology used to interrogate qualitative data. These 'hallmarks' should include they suggested: analytic ideas and concepts which remain rooted within the data; reduction of original data so that the original terms, thoughts and ideas of the study participants are not lost; data organised and sorted so that it can be inspected in related blocks of subject matter; facilities for searching for patterns within the whole data set; analysis which can be systematically applied across the full data set; flexibility at any stage and transparency which permits others to review the analytic building blocks as well as the final output.

The analytic hierarchy

Spencer et al (2003) referred to an analytical hierarchy made up of a series of 'viewing' platforms, each of which involves different analytical tasks, enabling

the researcher to gain an overview and make sense of the data. Similarly, Miles and Huberman (1994) (cited in Spencer et al 2003, p213) described qualitative analysis as a process of *'moving up a step on the abstraction ladder'*. However the analytical hierarchy does not just involve movement up from one analytical step to the next but also involves looking down, which Spencer et al (2003, p213) argued enabled the analyst to see what is *'emerging and reflect on how much sense this is making in terms of representing the original material'*. The ability of the researcher is *'to move up and down the analytical hierarchy, thinking conceptually, linking and nesting concepts in terms of their level of generality'* lies at the heart of good qualitative analysis, Spencer et al (2003, p213) argued. Table 4.10 below, adapted from Table 8.1 in Spencer et al (2003, p212) illustrates the analytic hierarchy showing the stages and processes involved in qualitative analysis.

Adopting framework for data analysis

The method chosen to analyse the data in this study was framework, a matrix based analytic method. Framework was chosen because it facilitates rigorous and transparent data management allowing the analyst to move back and forth between different levels of abstraction without losing sight of the data. The rigor and transparency of the method arises from a thematic framework which is central to the method of analysis.

In Framework, a thematic framework is used to classify and organise data according to particular key themes, concepts and emergent categories. Each individual study has a distinctive framework comprising a series of main

themes, sub-divided by a succession of related sub-topics. These themes and topics evolve and are refined through familiarisation with the data and cross sectional labelling.

A depiction of the stages and processes involved in qualitative analysis		
Seeking applications to wider theory/policy strategies	EXPLANATORY ACCOUNTS	Iterative process through analysis
Developing explanations (answering how and why questions)		Assigning data to refine concepts to portray meaning
Detecting patterns (associative analysis and identification of clustering)		Refining and distilling more abstract concepts
Establishing typologies	DESCRIPTIVE ACCOUNTS	Assigning data to themes/concepts to portray meaning
Identifying elements and dimensions, refining categories, classifying data		Assigning meaning
Summarising or synthesising data		Generating themes and concepts
Sorting data by theme or concept (in cross-sectional analysis)		
Labelling or tagging data by concept or theme	DATA MANAGEMENT	
Identifying initial themes or concepts		
RAW DATA		

Table 4.10: Analytical Hierarchy from Spencer, Ritchie and O'Connor (2003) Analysis: practices, principles and process, p 212, Chapter 8 in Qualitative Research Practice, Ed Ritchie & Lewis, Sage Publications

Developing a conceptual framework or index

The first step in the development of a conceptual framework or index is a through familiarisation and review of the range and depth of the data in the study. Familiarisation and review produce a list of recurring themes or ideas. These initial themes and ideas may be substantive i.e. attitudes, behaviours, motivations or views or more methodological i.e. general atmosphere of interviews or the ease or difficulty of exploring particular subjects.

A conceptual framework is produced by drawing together the recurrent themes with issues introduced into the interviews which produced the data through the interview schedule. A manageable 'index' is finally constructed by identifying the links between the recurring themes and ideas, then grouping them thematically and sorting them according to different levels of generality, to produce a hierarchy of main and sub-themes. Numbers are often assigned to the main and sub themes. Grouping of recurring themes and ideas and assigning numbers is illustrated in an example shown in the table below (Table 4.11)

Applying the index to the data

The index is then applied to the raw data, to show which theme or concept is being mentioned or referred to within a particular section of the material. This is done by tagging or labelling the data, using the assigned numbering scheme. In the case of textual data, the analyst will need to decide what each phrase, sentence and paragraph is about, to determine which parts of the index apply.

1. Commissioning Mental Health Services
1.1. NHS Commissioning
1.2. Local Authority Commissioning
1.3. Regional Commissioning
1.4.....
2. Mental Health Services
2.1. Day Services
2.2. Housing Services
2.3. Community Services
2.4.....
3. Local Authority Districts
3.1. Rural 80 Districts
3.2. Rural 50 Districts
3.3. Significantly Rural Districts
3.4.....

Table 4.11: Example of a conceptual framework or index for a study of mental health commissioning in rural communities which illustrates the grouping of recurring themes and ideas and assigning numbers

Sorting the data by theme or concept

The data is then sorted or clustered by theme or concept so that material with similar content or properties is located together. Clustering allows the analyst to focus on each subject in turn to enable the detail and distinctions within the material to be unpacked and scrutinised. It is important that during this process the material is not removed from its context i.e. that it stays close to the language and terms used in the data, remaining grounded in the data.

In addition there should be opportunities to sort the material to multiple locations, firstly because a particular section may have relevance to two conceptually different subjects and therefore to not so to do may destroy both

the meaning and coherence of the particular section and secondly because the juxtaposition of two apparently unrelated matters may give the first clues to some later insight or explanation.

Further the index may need some refinement after initial indexing because some categories may be found to be missing. Other categories may need sub-dividing to reflect re-current distinctions in material previously perceived to be closely related whereas others still may need to collapse because the categories are too refined at this stage of the analysis.

Local Authority District	2.1.	2.2.	2.3.	2.4
Local Mind association	R80 District	R50 District	Significantly Rural District	Notes / comments
Harborough Mind				
Shropshire Mind				
Uttoxeter Mind				

Table 4.12: An illustration of the allocation of themes to a thematic chart

Creating thematic charts

The next step within Framework is the construction of a set of thematic charts or matrixes based on the index and the learning arising from indexing. Each main theme and its associated sub-topics are plotted on a separate thematic chart, where the number of charts is determined by the number of main themes. Rows on the chart are allocated to particular respondents or cases in

the qualitative study and the columns allocated to each sub-topic. The allocation of themes to a thematic chart is illustrated in the example table above (Table 4.12).

Summarising, synthesising and placing the data on the thematic chart

The process of thematic charting involves summarising and synthesising the key points of each piece of data and placing it in the chart whilst retaining the context and essence of the point and without losing the language or voice of the respondent. This needs to be done systematically to ensure that all the content is considered. Once synthesised however, the content should be coherent and understandable without recourse to the original material.

In Framework, sorting and synthesising take place almost simultaneously after each tagged or labelled piece of data has been examined for its content. In contrast to other methods where synthesis can take place prior to sorting the data.

Applying framework to the data

This part of the Chapter will describe how the data collected from the purposive sample of local Mind Associations and Joint Commissioners was analysed using framework, i.e. how the data was managed and a framework was developed including: familiarisation and review of the data; identifying recurring themes or concepts and drawing them together; producing a manageable framework and then applying the data to it by labelling. The data was then sorted by theme and concept; so that data with similar content or

properties was located together. In addition some data was sorted to multiple locations, because of it's relevance to more than one theme or concept within the framework.

The framework was then further refined by creating new categories found to be missing, collapsing other categories where there was insufficient data and sub-dividing others to reflect distinctions not identified initially. A series of thematic frameworks were then created

Recording, ordering and organising the data

All the interviews were recorded on a data recorder, and then transcribed individually onto a simplified version of the interview schedule which was used as a written record to compare and contrast the data from each of the interviews (see Tables 4.13 & 4.14). Utilising these written records of data recorded under related headings, the process of review and familiarisation of the data collected from Joint Commissioners and from the Local Mind associations could begin.

Cross connections could also begin to be made between the Commissioner data and the local Mind association data i.e. between their respective responses to similar interview questions (see Table 4.15 below) and between emergent common concepts or ideas which had arisen from different parts of the interview schedules.

LMA Interview Schedule Questions	Responses from interview	Thematic Framework
How would you describe your role locally?		
Relationship with local healthcare commissioners		
Knowledge of the new arrangements for commissioning mental health services/activities		
How do the characteristics of the community in which you work impact on the work you do?		
Working relationships with other local Mind associations?		
Working relationships with local mental health organisations		
Biggest challenge/threat in the next 3 years?		
Biggest strength/opportunity?		
How do you see the future for your LMA?		

Table 4.13: Table used to record each LMA interview and sort by interview question heading

Joint Commissioner Interview Schedule Questions	Responses from interview	Thematic Framework
How long have you worked as a mental healthcare commissioner locally?		
What range of services do you commission?		
How would you describe your role as a commissioner locally?		
Has your role changed recently?		
What has been the impact of Commissioning Framework for Health and Well Being on commissioning?		
What has been the impact of day service modernisation?		
What has been the impact of IAPT?		
What has been the impact of move towards working more with the third sector?		
How would you characterise the communities in which you work?		
How do these characteristics impact on what you commission?		
How would you describe your relationship with the local Mind associations in your area?		
How would you describe your relationship with other voluntary and community organisations involved in mental health in your area?		

Table 4.14: Table used to record each Commissioner interview and sort by interview question heading

Local Mind associations	Commissioners
<p>How would you describe your role locally?</p> <p>What do you know of the new arrangements for commissioning mental health services?</p> <p>Biggest challenge/threat in the next 3 years?</p> <p>Biggest strength/opportunity?</p> <p>How do you see the future for your LMA?</p>	<p>What range of services do you commission?</p> <p>Has your role changed recently?</p> <p>What has been the impact of Commissioning Framework for Health and Well Being on commissioning?</p> <p>What has been the impact of day service modernisation?</p> <p>What has been the impact of IAPT?</p> <p>What has been the impact of move towards working more with the third sector?</p>
<p>How do the characteristics of the community in which you work impact on the work you do?</p>	<p>How would you characterise the communities in which you work?</p> <p>How do these characteristics impact on what you commission?</p>
<p>How would you describe your relationship with local healthcare commissioners?</p>	<p>How would you describe your relationship with the local Mind associations in your area?</p>

Table 4.15: Using similar/related questions from the interview schedules to compare and contrast responses from Local Mind associations and Joint Commissioners

Developing a thematic chart for the data

Organising both sets of data using the interview schedules enabled a series of the recurring themes and issues to be identified. A conceptual index or framework was created by identifying the links between the recurring themes and issues in the data. Then by grouping related themes and issues and sorting them to different levels of generality, a hierarchy of themes and sub-themes was produced. Themes and sub themes were assigned to neighbouring columns to show their relationship to each other (See table 4.16)

Numbers were then assigned to the main and sub themes but not then used to apply the index to the data. This was because, it seemed more straightforward to cut and paste the data from each written record to the thematic index, using a new column between the main and sub-themes

Applying the index to the data and sorting the data

The conceptual index was then applied to the interview data, to show which theme or concept is referred to or mentioned within a particular section of the material. This data was sorted by cutting and pasting sections of data from each interview record alongside the index using additional columns between the index themes and sub-themes. See sample in table below (Table 4.15). A further column was used to further refine concepts and portray meaning.

Categories	Data from Interviews	Sub-Categories	Refining the concepts and portraying meaning
Column 1	Column 2	Column 3	Column 4
ROLE OF THE LMA	A Mind Trustee H: <ol style="list-style-type: none"> To supplement the work of the statutory services. To offer a place for people who may never have access to any other service who know that we are here to help with emotional or mental problems. Broad remit. Here to help anyone who has emotional or mental distress – can walk off the street or telephone 	Role of local Mind associations Filling Gaps left by statutory services Providing locally accessible support A broad remit Supporting anybody who has a mental health problem	Local Mind associations having a broad not a specialist remit
	A Mind Chief Officer D: <ol style="list-style-type: none"> Support people with experience of mental or emotional distress to recovery. Provide signposting to appropriate other organisations Input into the policy formulation and strategy locally. Combat the stigma associated with mental health. Developing a preventative role for example well being – not just about people who are broke Enabling people to unwind. Enabling people to offer some basics for example relaxation & head massage. Then signposting various alternative therapies Giving people the opportunity to take time out and exercise – Extending walking groups 	Role of local Mind Associations Supporting people with experience of emotional or mental distress to recovery Signposting to other services Public advocacy role Public education role Combating stigma Promoting well being & alternatives Developing a preventative role for example time out, walking Promoting well being & alternatives	

Table 4.16: Extract from Appendix 3.8 Thematic Index showing themes in column 1, sub themes in column 3, data applied in column 2 and emerging refined concepts and meanings in column 4

CHAPTER 5

Results

Chapter 5 presents data gathered from the research programme outlined in Chapter 4. The first part of the research programme adopted a quantitative approach: combining population statistics published by the Office for National Statistics to map the areas of benefit of local Mind associations; internal management reports produced by Mind and the perspectives of local Mind associations across England. Local Mind associations perspectives were gathered through a self completed postal questionnaire in which they were asked to respond to a series of questions including: their perception of the rural or urban nature of their area of benefit; services provided organised for rural communities; how these services were funded and from which sources and the period of time they had been funded and whether any rural services had closed or ceased in the past 5 years.

The second part of the programme drew on a qualitative approach, comprising a series of semi-structured interviews with respondents from local Mind associations and their co-terminus Joint Commissioners, tracing the effects of the new commissioning environment on voluntary and community organisations, and in particular on local Mind associations, in order to explore three further propositions: firstly the retreat of services to urban settings; secondly the expansion of partnership working by the rural voluntary sector

and thirdly whether local Mind associations with an annual turnover less than £250,000 can survive in an increasingly competitive contract culture.

Also a fourth proposition was explored that is that small rural voluntary and community organisations have a broader role in the new commissioning environment, beyond service delivery. Is there a role for small local Mind associations in maintaining social cohesion, strengthening community and mutual aid and as a sounding board? Are these roles recognized by commissioners? Do these organisations have a role to play in more personalised services improving access and choice? What is the likely impact of personalisation and improving access and choice on small Local Mind associations? What creative opportunities might be grasped for partnership working by small Local Mind associations?

DATA FROM THE QUANTITATIVE RESEARCH

Mapping by annual turnover

Mind collects information annually about the financial turnover of each affiliated local Mind association. Mind then uses this information to set an annual affiliated fee based on a sliding scale (See Table 4.4 p 64) relating to annual turnover.

Applying the Charity Commissions definition of a small charity

By interrogating internal management reports (Mind 2006, 2007 and 2008) and collating information using the Charity Commissions definition of a small charity over 2004/5 to 2008/9 it can be shown (see Table 5.1. below) that local Mind associations with a turnover under £250,000 declined from 127 affiliates

(63% of the network) to 103 affiliates (54% of the network) whereas larger local Mind associations increased from 74 affiliates (37% of the network) to 85 affiliates (45% of the network) during the period 2004/5 to 2008/9.

Annual Affiliation Fee Categories (By Annual Turnover £)	2004/5	2005/6	2006/7	2007/8	2008/9
Up to £250,000	127 (63%)	131	112	116	103 (53%)
£250,001 and over	74 (37%)	75	84	83	85 (45%)
Total LMAs	201 (100%)	206	196	199	188 (100%)

Table 5.1: Numbers of Affiliated Local Mind Association's in each of the Annual Affiliation Fee categories for the five year from 2004 – 2008

Applying Mind's affiliation categories

If Mind's affiliation categories are applied to the same data (see Table 5.2 overleaf) it can be shown that local Mind associations with a turnover of less than £150K, have declined from 106 (78% of the network) in 2004/5 to 78 (41% of the network) in 2008/9. In contrast local Mind associations with a turnover of more than £500K have increased from 36 (17% of the network) in 2004/5 to 49 (26% of the network) in 2008/9 whereas those with a turnover between 150K and £500K have changed little as a percentage of the network over the period. These figures show that although the overall numbers of affiliated local Mind associations has declined from 201 (2004/5) to 188 (2008/9) those local Mind associations with a turnover above £500,000 have increased from 35 (2004/5) to 49 (2008/9). A preliminary conclusion from these figures is that there is evidence to show smaller local Mind associations

have declined in numbers whereas the number of larger local Mind associations has increased along with a commensurate increase in their annual turnover and that there has been little change in the middle bands.

Annual Affiliation Fee Categories (By Annual Turnover £)	2004/5	Percentage of the Network	2008/9	Percentage of the Network
Up to £10,000	17	8.46%	8	4.25%
£10,001 - £50,000	26	12.94%	21	11.17%
£50,001 - £150,000	59	29.35%	49	26%
£150,001 - £250,000	25	12.44%	25	13.29%
£250,001 - £500,000	39	19.4%	36	19.14%
£500,001 - £1,000,000	17	8.46%	29	15.42%
£1,000,000 & over	18	8.95%	20	10.63%
Total LMAs	201	100%	188	100%

Table 5.2: Change in the Numbers of Affiliated Local Mind Association's and as a percentage of the network in each of the Annual Affiliation Fee categories between 2004/5 and 2008/9

If these affiliation categories are then bundled into 3 bands (see Table 5.3 overleaf) that is Band 1: turnover 0-£150K, Band 2: £150K-£500K and Band 3: £500K and above, the decline in the lower band, the stability of the middle band and the increase in the higher band can be more clearly shown.

Annual Affiliation Fee Categories (By Annual Turnover £)	2004/5	Percentage of the Network	2008/9	Percentage of the Network
Band 1: Up to £150,000	102	50.8%	78	41.5%
Band 2: £150,001 - £500,000	64	31.8%	61	32.4%
Band 3: £500,001 and over	35	17.4%	49	26.1%
Total LMAs	201	100%	188	100%

Table 5.3: Change in the Numbers of Affiliated Local Mind Association's based on 3 turnover bands and as a percentage of the network between 2004/5 and 2008/9

Interrogating Quality Management in Mind records

In an internal report to Mind's trustees (Mind, 2008) it was report that all of the 25 local Mind's associations which disaffiliated, during the quality review cycle one from 2003 to 2008 had a turnover less than £250K, based on annual turnovers reported in 2005/2006. Unfortunately a more detailed analysis of the annual turnovers of the disaffiliated local Mind associations is not now available. However during the same quality review period it was also reported, that no local Mind associations with a turnover greater than £250,000 had disaffiliated.

Postal questionnaire: response rate from local Mind associations

A copy of the questionnaire with a covering explanatory letter was posted to all affiliated local Mind associations in February 2008. A stamped addressed envelope was included to encourage a high response. 43 local Mind

associations (23.8% of affiliated local Mind associations in 2008)) responded by returning a completed questionnaire.

Two questionnaires were returned from Local Mind associations in Wales which was outside the scope of the research programme. Both questionnaires were removed from analysis. In addition two questionnaires were returned from the same local Mind association but from two services working in geographically different patches. The data from these questionnaires was combined leaving 40 completed questionnaires which in 2008 was 21.3% of all affiliated local Mind associations.

Perception of the rurality of area of benefit

The first question asked local Mind associations to describe their area of benefit by ticking one of five boxes against a list of descriptions that is: predominantly urban; urban, a mixture of urban and rural; rural or predominantly rural. These terms were used because it was assumed that local Mind associations would be unfamiliar with the rural definition and the local authority classification scheme and because these descriptions could be more clearly distinguished. In this way respondents would provide a picture of how each local Mind association perceived the geographical area in which they operated.

Out of the 40 associations who responded: 8 (20%) perceived their geographical area as a rural i.e. either rural or predominantly rural, 11 (27.5%)

as urban i.e. either urban or predominantly urban and 21 (52.5%) as a mixture of both urban and rural (See Table 5.4 below).

The areas of benefit of the local Mind associations that responded were then mapped against local authority districts using the classification scheme for local authorities produced by the Office for National Statistics (see Table 1.1 Chapter 1 p 5). Local Mind associations were designated rural if their area of benefit matched exclusively one or more of the three rural classes of local authority district; designated urban if their area of benefit matched exclusively one or more of the three urban classes of local authority district and designated mixed if their area of benefit matched both one of the three rural classes and one of the three urban classes. Of the 40 Local Mind associations that responded: 18 (45%) were designated rural, 9 (22.5%) mixed and 13 (32.5%) urban.

	Local Mind Associations Perception of their Area of Benefit		Actual Classification of Local Mind Associations Areas of Benefit	
	Number	Percentage	Number	Percentage
Urban or predominantly urban	11	27.5%	13	32.5%
Mixture of urban and rural	21	52.5%	9	22.5%
Rural or predominantly rural	8	20%	18	45%
Local Mind Associations that responded	40	100%	40	100%

Table 5.4 Local Mind Associations Perception of their Area of Benefit compared to the actual classification of their Area of benefit based on the rural/urban classification of Local Authority Districts

A comparison of local Mind association perception of population settlement in their area of benefit with the actual population settlement pattern showed that many do not have a good understanding of the population settlement of their area of benefit. Interrogating the responses showed that the perception of those that worked exclusively in urban communities was closer to the actual population settlement of the area. Over half of the local Mind associations who responded perceived that their area of benefit was mixed whereas only a quarter were actually mixed. This contrasted with 45% of local Mind associations whose area of benefit was exclusively rural whereas only 20% perceived their area of benefit as exclusively rural.

Providing accessible rural services

The second question asked local Mind association's whether they provided services that people in rural communities could access. Respondents ticked either yes or no on the questionnaire, that is they ticked 'yes' if services were provided which people in rural communities could access or 'no' if not. 89% of rural respondents claimed to provide accessible services and 10% that they did not provide accessible services. 38% of urban respondents claimed that they provided accessible services. All mixed respondents claimed that they provided accessible services.

Providing or identifying a need for services and activities

The third question asked Local Mind associations about their rural services and those they had identified as needed for people in rural communities. Local Mind associations were asked to tick against a list, which rural services they

provided and which services they had identified as needed from the same list of services (See Postal Questionnaire Appendix 4.2 for a list of services). Chart 5.1 below, shows the range of services provided (blue) and those needed (magenta).

Funding and sustaining rural services

The fourth question asked how rural services are funded by requesting respondents to tick against a list of common funding sources (see Appendix 4.2 for list of funding sources) plus an ‘other’ category designed to capture information about other sources of funding. In addition local Mind associations were asked to indicate how long the rural service had been funded using a seven point scale from less than one year to 6 years or more.

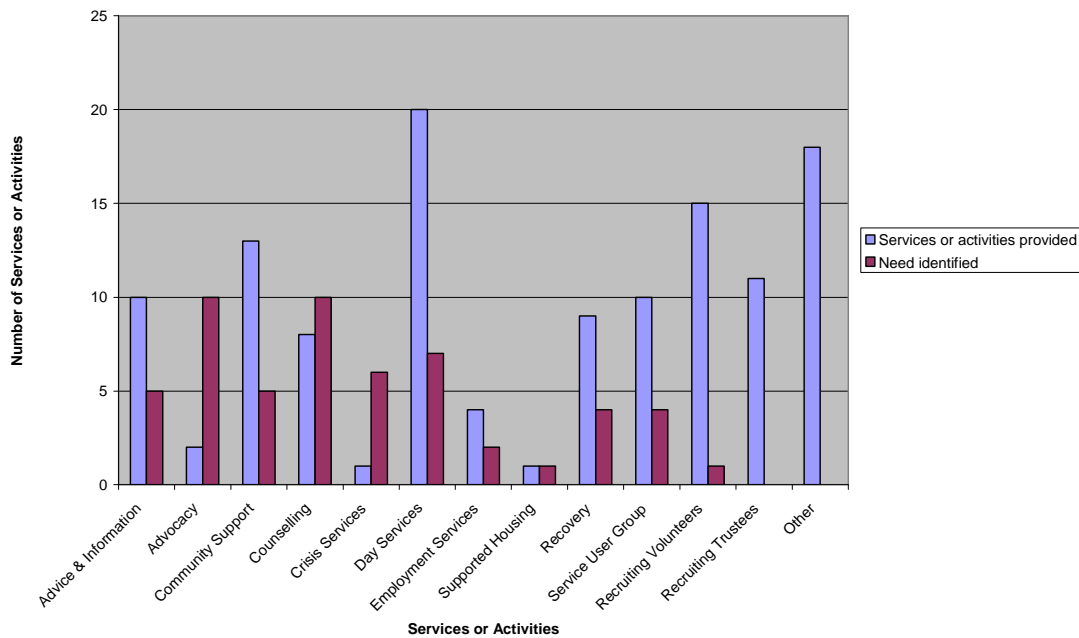


Chart 5.1: Local Mind Associations: Services Provided or Need Identified

Chart 5.2: below shows the length of time rural services had been funded and the sources of funding. The results suggest that the over whelming majority of local Mind association rural services had been funded for 6 years or more with funding provided from the local authority (16 responses), NHS (10 responses) or from the local Mind associations own funds (12 responses).

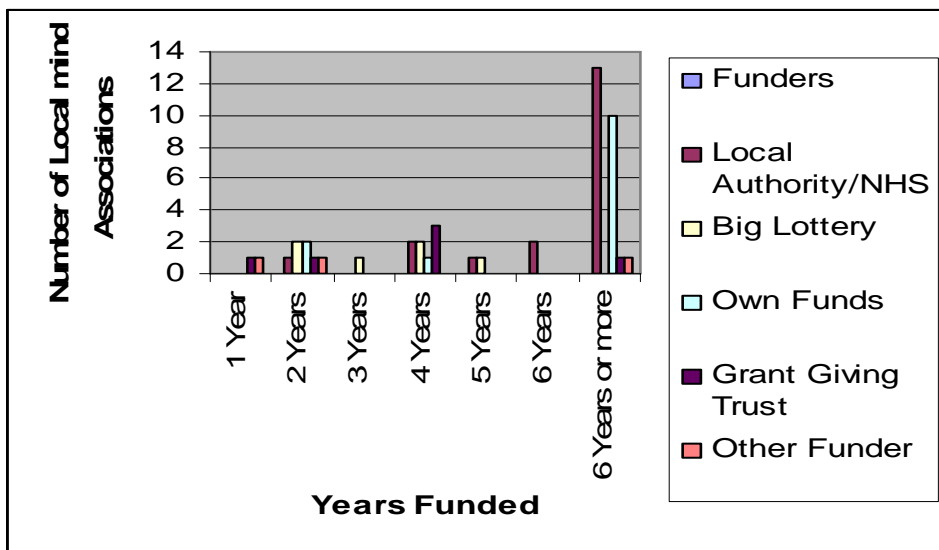


Chart 5.2: How rural services are funded

Rural services closing

The fifth question asked about rural services that had ceased to operate within the last five years and why the service had closed. The responses indicated that 9 Local Mind associations (4 Rural, 3 mixed & 2 urban) had closed 13 services during the past 5 years. The 13 services that had ceased to operate included: advice and information (3), advocacy (1), community support (2), counselling (2), crisis service (1), day services (2), employment services (2). The reasons given for closure included: funding ended (10), health & safety (1), lack of support (1), service moved to the primary care trust (1).

DATA FROM THE QUALITATIVE RESEARCH

The qualitative study sought to trace the impact of the new commissioning environment on four local Mind associations operating in two neighbouring midland counties. The perspective of chief officers and some trustees from four local Mind associations and their co-terminus mental health Joint Commissioners was explored.

Ethical considerations

The persons interviewed and the organisations they represented have been anonymised. The argument in support of anonymising the sample was discussed in Chapter 4 (p 81-82). For the purposes of this report, X or Y are substituted for the names of the counties in which the Joint Commissioning Units operated and C, S, D & N used for the names of Joint Commissioners to anonymise the organisations and individuals involved. The Joint Commissioners referred to in these qualitative results were primarily S and N because both at the time of the interviews had specific commissioning responsibilities. When the commissioners were interviewed C no longer worked in commissioning and D although responsible for the review of mental health day services and the consultation about day service modernisation in County X had procurement responsibilities only.

Similarly A, B, C and D were used to anonymise the local Mind associations, and H, L F, P, J and M, used to anonymise the trustees and the chief officers. Table 4.8 (Chapter 4 p 82) provides a full key to the letters used and how the

local Mind associations related to each other and to the Joint Commissioning Units.

The four local Mind associations

There were many similarities between the types of mental health services provided by each of the four local Mind associations in the study but also some differences in the geographical reach of the services they provided. All four local Mind associations provided day services, however the three County X local Mind associations provided coverage across their areas of benefit. B Mind provided a day service in each of the three local authority districts within its area of benefit; whereas C Mind and D Mind both provided a day service in each of the two towns in the local authority district they share. In contrast A Mind has experienced difficulty sustaining day services beyond the county town.

During the interviews the four local Mind associations identified their key roles; their strengths which they felt underpinned all their activities and the particular challenges which they felt might threaten their futures. All four local Mind associations described their roles in comparable terms. Firstly they all affirmed a long term commitment to the people and community in which they operated and secondly they described their key role as supplementing or filling service gaps left by the statutory mental health services.

There were gaps in services they suggested because: mental health services were not provided in some geographical locations; because statutory service

providers were selective about who could access particular services and because some people in distress preferred to avoid contact with statutory mental health services.

Thirdly all the trustees and chief officers interviewed described a similar range of core services they provided. The range included four out of the thirteen services listed in the quantitative study questionnaire i.e. advice and information; community support; counselling and day services. In addition they had each developed particular specialist activities.

Changing role of volunteers

A Mind's trustee referred in the interview to the importance they had attached over the years to volunteers and the important role they have played not only as trustees but also supporting group work and as befrienders. However she reported that both the numbers and background of these volunteers had changed. She said there are *"fewer volunteers today - 14 years ago when I joined there were about 50-60 volunteers, not always constantly active but they could be called upon – now we have a good body of befrienders, trained specifically to work outside on a one to one basis and a diminished number of volunteers who help in the centre. I train them. They are different we now get people who have finished a degree in psychology for example who want to stay with us for six months in contrast to people who stayed with us previously for 10 years or more.*

Raising the necessary finance

Raising the necessary finance to continue core services was cited by all four Local Mind associations as a particular challenge. A Mind referred to their particular reliance on funding, via Joint Commissioning and pointed out that currently this source was only guaranteed from one year to the next. D Mind felt that raising funds in the future through a tendering process linked to day service modernisation would be a particular challenge because they had no previous experience of raising funds in this way.

All those interviewed spoke of the importance of retaining and making more secure funding for core services because raising funds from other sources for example Big Lottery and grant making trusts was time consuming, taking time away from core services which resulted in producing income for additional services rather than core services.

Annual turnover

In Chapter 4 (p 64) reference was made to the way Mind uses a sliding scale based on the annual turnover of each affiliated local Mind association to set an annual affiliation fee. Table 4.4 on p 64 showed the relationship between local Mind association turnover and affiliation fees. Local Mind associations in Fee Group 1 pay the smallest affiliation fee and Local Mind associations in Fee Group 7 pay highest affiliation fee. In Chapter 1 p11 I suggested that local Mind associations can be categorised into two groupings as follows: small to medium associations with an annual turnover up to £250,000 and larger associations with an annual turnover above £250,000.

Many have taken the view that voluntary organisations with an annual turnover below £250,000 lack the capacity to survive in an increasingly competitive contract culture. This view would seem to have some validity when the outcomes of Mind's quality assurance review were examined i.e. that all of the 25 local Mind's associations which disaffiliated during the quality review cycle had a turnover less than £250,000 but that no association with a turnover greater than £250,000 had disaffiliated.

The annual turnover of the four local Mind associations in the qualitative study was sourced from annual accounts which are published on the Charity Commission web site and are shown in Table 5.8 below. The table illustrates that all four local Mind associations remained below the Charity Commissions small charity threshold i.e. an annual turnover less than £250,000 threshold over the 5 year period, except for B Mind in 2007/2008 and 2008/2009. The annual turnover of A Mind remained below the £150,000 threshold for the whole 5 year period. C Mind's annual turnover figure was not available for 2007/8, but confirmed with the Chief Officer that it remained below £250,000.

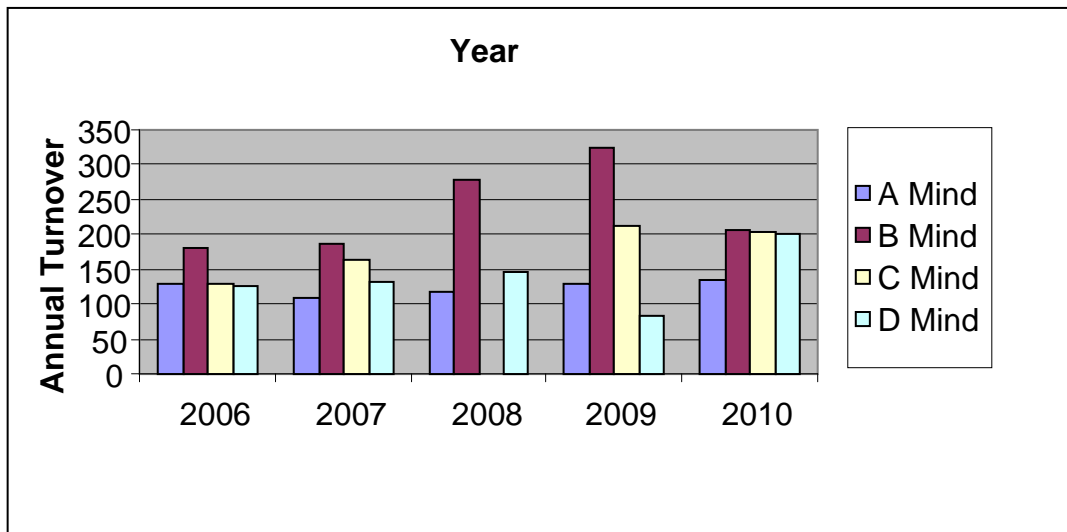


Table 5.5: Annual Turnover of the four local Mind associations in the Qualitative Study from 2005/06 to 2009/10

Changes in the commissioning environment

This section describes data from the Joint Commissioners and from the four local Mind associations in relation to the primary research question '*What is the impact of recent changes in the commissioning environment on local Mind associations working in rural communities*' and the four supplementary questions. These questions are set out in Table 4.1 on p 53 and the data expected in Table 4.2 on p 55-57.

In both counties Joint Commissioners were looking forward to developing more individualised and personalised approaches to community mental health services. The local Mind associations were in contrast primarily concerned about retaining and in one instance expanding their core services. This included concerns from one local Mind associations about retaining those core services already out posted from their main operating centres and from

another plans to develop sustainable out posted core services in order to reach a dispersed and scattered population.

**Impact of a Changing Mental Health Policy Framework –
Joint Commissioner and Local Mind Association quotes**

County X JCU, Joint Commissioner N *“Moving from the National Service Framework for Mental Health to New Horizons... puts the focus on the prevention end...where we’ve known it always needed to be- It’s a big shift. We need to stop people getting ill in the first place from a human as well as a cost effective basis. New Horizons will give commissioners more freedom but there will still be lots of must do’s in mental health, particularly in relation to mental health act requirements and the provision of in-patient facilities.”*

B Mind, Trustee L: *“Not aware of the changes in commissioning.”*

C Mind, Chief Officer J: *“Lot of changes within the commissioning process. Joint commissioners have not discussed well being with us locally, but are setting up a local well being centre with no reference to the well being work that we do and they fund.”*

D Mind, Chief Officer M: *“No mention by commissioners of commissioning for health and wellbeing.”*

A Mind, Trustee D: *“Wellbeing has considerable potential for Mind. I’m particularly interested in food and mood – I’d welcome money for a nutritionist.”*

A Mind, Chief Officer F: *“I am keen to develop outreach work with the lonely and recently bereaved and focus on well-being – given the pressure on budgets we need to demonstrate that our preventive work is having an impact. It is up to us to work smarter and not expect stuff on a plate and stop people becoming broke in the first place.”*

Impact of a changing policy framework

Both Joint Commissioners interviewed expected the configuration of community mental health services they commissioned to change imminently.

This was because the mental health policy framework, within which they commissioned mental health services at the time of the interviews, was due to

change; with compulsory nationally driven standards, replaced by a focus on wellbeing and recovery (see Chapter 3 p 42). The new focus on wellbeing and recovery would also prioritise moving people who used mental health services on from and out of mental health services as their recovery progressed. At the time of the interviews none of the Joint Commissioners knew whether the new policy would be compulsory, however they both looked forward to the change and hoped for more freedom to commission outside of what they were currently legally required to do.

One trustee was not aware of the changes proposed however all the other local Mind trustees and Chief Officers were aware that change was coming. A Mind's trustee was aware that Government had directed a more prominent role for the voluntary sector in mental health services and their Chief Officer felt that the new focus on wellbeing was potentially advantageous for their local Mind association. In particular both trustee and Chief Officer felt that there was considerable potential to develop health and well being outreach initiatives in partnership with others, using a variety of community spaces which included the natural environment. This was because they had evidenced many lonely and isolated people who lived in the many scattered and isolated settlements across the whole county.

No local Mind association, however, reported discussions with Joint Commissioners about the potential for their local Mind association involvement in health and well being initiatives. On the contrary one Chief Officer referred to work locally by commissioners to establish a well being

centre in the same community where the same commissioners already funded the local Mind association to work on well being.

Compulsory competitive tendering

Another significant and imminent change reported by Joint Commissioners was the introduction of compulsory competitive tendering for new community mental health service contracts once current contracts with providers, including the day services contracts provided by all four local Mind associations came to an end.

The new focus on competition required voluntary organisations to competitively tender for new contracts, which Commissioner S argued required a set of skills that smaller local organisations are less likely to possess; in contrast to larger national voluntary organisations. It would disadvantage small local voluntary sector organisations; she went on, because it would favour those organisations which had the capacity to tender. Another Joint Commissioner recognised that those local voluntary sector organisations that had not tendered previously would be at a disadvantage and as a consequence a mentoring scheme had been put in place to enable more equitable competition.

One of the Chief Officers recognised that support was needed, proposing preparatory training, because none of the local Mind associations had any previous experience of the tendering process. It was also reported by one

Chief Officer that Joint Commissioners had feedback that they did not know at that time what tendering arrangements might be put in place.

Compulsory Competitive Tendering and Competition for Contracts – quotes from Joint Commissioners

County X JCU, Joint Commissioner N: *“Voluntary providers could change significantly. Local organisations possess local knowledge - there is a risk that an outside group to whom we might award a contract would not have local knowledge - nobody would know who they were – providers could change significantly but might not. It’s likely that all current providers will tender but I don’t know if all will be successful. It is important we get what service users want right – some organisations may not provide what we want to provide.”*

County Y JCU, Joint Commissioner S: *“We need a more localised flexible community and third sector model of work - more tailored. That is a personal service rather than mental health day centres – every person receiving a social care service from this point on will be offered a personal budget – that will really drive change in contracts with voluntary organisations. There will be no more block contracts. In the future there will be increased competition as a result of compulsory competitive tendering, so the focus will be on third sectors organisations that can tender – unlikely to be local groups.”*

County X JCU, Joint Commissioner L: *“If you give the voluntary sector 1p they give you back 2p plus volunteer workers.”*

County Y JCU, Joint Commissioner S: *“Since the election of the Coalition Government the local voluntary sector has raised fears of cuts. I think the risks are elsewhere. An increased focus on competition and procurement means competitive tendering, so the risk goes off local voluntary organisations to organisations who can tender – that is a whole set of skills that local organisations may not have and larger organisation may have. Also there are risks if there are a lot of management cuts, how can we manage a proliferation of smaller contracts if we have less people to manage them. A colleague has suggested that they could all be put into a framework agreement and monitored once –very tempting. There must be trade off between stabilisation of the sector versus capacity to manage resources well for the public purse.”*

Competition for contracts

The potential for losing contracts to competitors was a concern to all of the local Mind associations interviewed. EE and TT were perceived by all the local Mind associations to be the primary competitors for each of their current contracts when they were renewed. However C Mind's Chief Officer was not so concerned because she felt that there were real difficulties for an outside organisation coming to work in a small market town where they were unknown, whereas C Mind had built a positive reputation. There was a risk one Joint Commissioner suggested that by not awarding a contract to local organisation local knowledge would be lost and an outside group might be unknown.

Compulsory Competitive Tendering and Competition for Contracts – quotes from local Mind associations

D Mind, Chief Officer M: *"All here are very concerned about the need to tender next year, because nobody has tendered here before – It's the mechanics of tendering that is scary - we need some training; however they (the Joint Commissioners) say they don't know themselves about the tendering arrangements."*

C Mind, Chief Officer J: *"Our competitors are TT, who took over a user led project in nearby ***** (name of town) some years ago and EE who run a similar service to C Mind in nearby **** (name of town),but we haven't thought too much about losing out to competitors. I feel that we have built our reputation and that's not easy to do in a small town like *****."*

A Mind, Chief Officer F: *"We are not in competition with social housing agencies such as PP."*

A Mind, Trustee D: *"One of our volunteers set up CC several years because we did not provide services in the evenings and weekends – some people may see them as potential competitors."*

A Mind's Chief Officer recognised that PP – A Social Business and a major provider of social housing, and care and support services in both the same county and regionally was not a competitor for those service provided by A Mind. However A Mind's trustee felt that some would view CC, a small day service provider that A Mind had fostered to run evening and weekend day services might be a potential; competitor for the day services contract.

Changes to mental health day services

Mental health day service modernisation formed a significant part of the change agenda for Joint Commissioners. There had been widespread consultation, about the modernisation of day services with the voluntary sector in County X, to which all three local Mind associations had contributed. One of the outcomes of the consultation had been the identification of a series of population, geographical and community factors which needed to be included in the commissioning of modernised day services commissioned in the future. These factors included: a growing elderly population; the presence of black and minority ethnic communities particularly in D Mind's area of benefit; increasing numbers of people with mild to moderate mental health needs and the sheer diversity of communities which constituted the county, some of which were poorly served.

Localised, flexible responsive and more consistent services

All four local Mind associations interviewed provided mental health day services open at least five days week with open access for people to drop-in as required. These day services were commissioned and funded by their

respective Joint Commissioners. Modernisation would replaced these open access services both Joint Commissioners agreed with more localised and flexible services; more responsive to individual need and which offered greater consistency across both counties.

Personalisation suited County X the Joint Commissioner argued because of the county's diversity and complex mix of communities that required a different approach from one place to another. Pathways to personalised services were required that comprised not only packages of care tailored to individual need but also tailored to the different communities in which people lived.

County Y's circumstances were different, because many services remained centralised in the old psychiatric hospital; but it was similarly argued that personalisation would enable better access to support and recovery across the whole of a large rural county.

Following the modernisation review in County X all mental health day service providers, including B Mind, C Mind and D Mind had been asked the Joint Commissioner to move towards providing a more modernised service and to await the go ahead for the new commissioning arrangements.

People moving on and out of the mental health system

The implementation of day service modernisation would not only lead, Joint Commissioners in both counties suggested to a more consistent and tailored

approach to people's care and support but also provide opportunities for people to recover and progressively move out of the mental health system as they recovered, including into voluntary work and employment. During the interview with County Y Joint Commissioner reference was made to recent service review case studies which had illustrated that some service users did not recover and leave mental health services despite accessing two or three voluntary sector providers and the statutory provider. This situation was not good value for money, she argued.

In future every person in County Y who currently received a social care service would be offered a personal budget. Personal budgets would have a significant impact on provider contracts because they would progressively drive change towards more personalisation. Personal budgets required brokerage she argued so that service users could be offered a choice of care and support services to purchase. This approach was better because in the future service users would begin to drive services rather than the provider organisations.

Currently County Y's community mental health day services were very variable in quality, it was contended, however there was some good provision, and particularly that which supported progression towards volunteering or employment. A community arts based community enterprise in the north of the county was highlighted in particular.

Modernising Day Services; Quotes from Local Mind Associations

B Mind, Chief Officer P: *“They produced a report two years ago about modernising day services into which everybody had input to tell them what we did – fitted B Mind within the new structure.”*

D Mind, Chief Officer M: *“Day services are changing...we completed a questionnaire and there were meetings, however not much has to change because the building is used by the wider community - would like us to work with black and ethnic minorities”.*

B Mind, Chief Officer P: *“Nobody’s talking about modernising day services – because nothing is happening.”*

In contrast to progress towards personalisation and the changes in day services illuminated by Joint Commissioners, three local Mind associations in County X reported no progress locally with modernisation and although they were aware that changes to day services were coming, there was no expectation that much of what they currently provided needed to change. D Mind had been asked to increase their one to one work and their work with black and ethnic minorities but felt that not much else needed to change because they had been told their building was used by the wider community. B Mind reported that they had been told by Joint Commissioners that their current day service fitted the new structure.

Modernising Day Services; Quotes from Joint Commissioners

County X JCU, Joint Commissioner N *“This county has a changing population with many unemployed and on incapacity benefit. The BME population is high in the east and the population projections for older people are phenomenal – personalisation suits that state of affairs.”*

County Y JCU, Joint Commissioner S: *“We need a more localised and flexible model of work - more tailored - a personal service rather than mental health day centres – although the continuing presence of the old psychiatric hospital stops new ways of doing things.”*

County X JCU, Joint Commissioner L: *“The day services review began in 2006 and we are now trying to put the modernised day services in place – current providers were asked to move in that direction.. Modernised services will lead to more consistent services across the districts reducing the impact of the post code lottery with more targeted outcomes which emphasise recovery and enabling people to move on from mental health services. Implementation is imminent – we are awaiting the green light to commission the new agenda”.*

County X JCU, Joint Commissioner N *“Personalisation will become embedded - currently working with third sector providers to enable them to make that transition.”*

County Y JCU, Joint Commissioner S *“good examples of a more personal working...an arts based social enterprise...where mental health service users can be routed into volunteering and possible employment.”*

County X JCU, Joint Commissioner N *“Voluntary sector plays a vital role currently. It offers a choice, is well placed to respond to the community and historically it listens to service users - innovates intuitively and reaches people who would never knock on a state door - better wired into local communities and therefore a good source of local intelligence and better value than statutory agencies because it can access other resources adding to the contract value, for example utilising volunteers.”*

Voluntary sector taking a more prominent role

Although one trustee was aware of that Government had advised commissioners that the voluntary sector should play a more prominent role in future mental health services, many of the local Mind associations interviewed were uncertain about what the future might hold for their organisations. One Chief Officer believed that mental health services would struggle locally if their association no longer existed. To mitigate possible loss of funding this particular local Mind association had been seeking independent financial support with mixed results.

Voluntary Sector taking a More Prominent Role – quotes from Local Mind Associations

A Mind, Trustee D: *“There are directives from Government that advised commissioners that the voluntary sector must take a more prominent role in mental health services in the future.”*

B Mind, Trustee L: *“We have little control over our own future because of our dependency on statutory funding. At one time commissioners would give you funding and then you could do with it what you wanted but now they expect you to do this and that...funding is for a specific purpose.”*

C Mind, Chief Officer J: *“Uncertain about the future– may struggle at this level.”*

Commissioner N felt that the voluntary sector was well placed to respond to more personalised and tailored services, referring to the voluntary sector being *“better wired in to local communities, innovating intuitively and reaching people that statutory services could not reach”*. Commissioner L referred to the added value of working with the sector which came from its ability not only

to contribute volunteers but also its ability to raise money in addition to the income received the NHS and Local Authority.

Commissioner S felt that the situation was much more complex for the voluntary sector, particular since the 2010 election and the Coalition Governments plans for public sector austerity and cuts. The voluntary sector had expressed their fears of cuts to the community mental health budget, directly to her, however she felt that their fears were misplaced. There were other risks, associated with the tendering process and the impact of reduced public expenditure and cuts, which were likely to have a greater impact.

These greater risks for the voluntary sector had their origins; Commissioner S argued not only in the new focus on competition in the procurement of health services but also in the capacity of the Joint Commissioners to manage resources after the management cuts which would be an outcome of reduced public expenditure. The impact of cuts to management within the Primary Care Trust and particularly to commissioning would directly impact, Commissioner S asserted on their capacity to manage public resources expended on community mental health services. She questioned how a proliferation of small contracts could be managed with less people to manage each contract, although a colleague had suggested to her that all the small contracts in the county could be put together into a framework agreement and managed together. She doubted that putting the small contracts together in this way would be viable inferring that attempts to manage public resources

well with a smaller Primary Care Trust had consequences and that the current mix of small providers was at risk.

Commissioner S predicted that change might affect one voluntary sector provider differently from another with smaller voluntary sector organisations finding it difficult to survive unless alliances were made with other providers.

Voluntary organisations needed to become more adaptable or very clearly meet individual needs if they were to continue to receive public money.

Consistency with the Primary Care Trust's priorities was clearly important as was the need to ensure that: the public money received was used effectively; that outcomes were clear and that voluntary providers were able to show value for money.

Impact of a changing commissioning environment

I referred earlier in this Chapter to Joint Commissioners expecting an imminent change to national mental health policy which would herald a change from nationally driven standards to an emphasis on personalisation, recovery and well being. Local Mind associations were aware of the changing policy and had begun to think about possible new developments which fitted with prevention but had not begun to consider the implications of modernisation on their existing services. On the contrary at least two local Mind associations believed that day service modernisation had no implications for their current day services.

Competitive tendering did concern local Mind associations, particularly so because they lacked of knowledge and experience of the tendering process and the possibility of large national organisations such as Rethink, winning contracts for community services which local Mind associations currently provided. There was no reference in the local Mind association interviews to the mentoring scheme which the Commissioners in County X had described putting in place. Little reference was made during the local Mind association interviews to personalisation and individual services, in contrast to interviews with Joint Commissioners who clearly welcomed the change in the way community mental health services were to be provided.

Services retreating to urban settings

This section describes data from both Joint Commissioners and from the four local Mind associations in relation to the primary research question: '*Is there evidence of mental health services retreating to urban centres?*' It was expected that data would be gathered from the four local Mind associations about their current and recent services as well as their predictions for the future. Similarly data was expected from Joint Commissioners about their current and recent commissioning priorities as well predictions about their future commissioning priorities.

Starting from a different place historically

In both counties although Joint Commissioners wanted to develop more individualised and personal services each of them was starting from a different place historically. County Y's services were still primarily centred on

the old psychiatric hospital in the centre of the county, whereas those in County X were already localised to some degree following the closure of three former old psychiatric hospitals many years previously and the more recent closure of local in-patient psychiatric units.

In County X, Joint Commissioners expected that mental health treatment would increasingly be home based and therefore more individual and personal services they argued would ensure greater geographical consistency to support home treatment as well as meeting the needs of a changing and diverse population. By a changing and diverse population Joint Commissioners were referring to increases in mental health problems faced by young people, a growing older population and therefore increased incidence of mental health problems associated with old age such as dementia and an increasingly diverse black and minority ethnic communities whose mental health needs needed to be better met.

The legacy of the former county psychiatric hospital

In County Y, mental health inpatient, community and home treatment services were still defined by the old hospital's physical structure, and which was described as the last surviving Victorian asylum in England. However all parties including the local Mind association, had now signed up, to a reconfiguration of services with the old hospital to close.

The savings from the closure of the old hospital were to be used strategically to create more personalised mental health services. This change it was

argued would not only impact on future provider contracts but was already beginning to impact on existing contracts which were being reviewed at that time. In future all services will be re-configured to support the new ways of working, and at no additional cost, it was argued.

Services Retreating to Urban Settings – Joint Commissioner quotes

Joint Commissioner C: *“S****.n (the name of the old hospital) stymies the opportunities for the mental health delivery you want. We need less reliance on a building based approach. We want a needs based population approach. A more localised and flexible model is what is wanted”.*

Joint Commissioner D: *“Day services review recommended modernisation. This will enable more consistency across the districts and enable people to move on from mental health services - reducing the impact of the post code lottery”*

Joint Commissioner N: *“X is a very large county: with a changing population including very diverse communities, phenomenal projections for old people and an increasing emphasis on home treatment. Being an in-patient is the last resort because hospital is not a nice place. Services must be tailored to needs - personalisation suits that state of affairs.”*

The Joint Commissioner in County Y considered the voluntary sector not good value for money because it spent too much time dealing with the complexity of current services centralised on the old hospital. I referred earlier to service level review case studies which had illustrated examples of service users still not progressing to recovery despite accessing two or three voluntary sector providers as well as the statutory provider. The old hospital hindered access to services throughout the county she argued because too many resources were centralised. Without the hospital and less reliance on buildings, there would be opportunities for earlier intervention and a better response to need.

Local Mind associations retaining their core services

The local Mind associations were primarily concerned about retaining their core services, which included for two, retaining services already out posted and for another developing a network of out posted services. For example B Mind has a main day centre base in one local authority district, a subsidiary centre in another local authority district and hoped to retain its recently established village based out reach in the third local authority district within its area of benefit.

Services Retreating to Urban Settings – Local Mind Association quotes

A Mind, Chief Officer D: *“We are very keen to develop outreach work but we don’t want to be buildings based. We need bases in different localities.”*

A Mind, Trustee H: *“We would like to have outposts throughout the county for one day a week at least.”*

B Mind, Chief Officer P: *“We have a main base in (urban town) C and a day service in (county town) S and outreach service busses people in from (village) K to our main base in C. There is also a day service open one day a week in (village) W. The services to K and W are funded by the PCT and we expect to loose this funding at the end of the year.”*

C Mind, Chief Officer J: *“Rural outreach collaboration does not operate any more because we don’t have the money – all collaboration is based in the market town.”*

D Mind, Chief Officer M: *“We have already outgrown the new building. If we develop new areas of work we shall need a new larger building.”*

In contrast A Mind wanted to develop sustainable out posted activities in each of the neighbouring four former local authority districts which surrounded the county town where it was based. C Mind wanted to restart the rural outreach

work that had been forced to cease operating because its core funds were cut. D Mind did not have any out posted activities but felt that the solution to increased demand for its services was a bigger building.

Is there evidence of a retreat to urban settings? A preliminary conclusion is that there is no evidence that Joint Commissioners are contemplating a retreat to urban settings. On the contrary there is evidence that Joint Commissioners in both counties wanted to extend both statutory and voluntary services so that people in need of mental health services could better access pathways to recovery which were more consistent with increasingly home based treatment. As for local Mind associations C Mind reported that its rural outreach work had ceased because the funds were not available. In contrast B had recently expanded its day services to a village setting in the local authority district where had not provided services previously and the new Chief Officer of A Mind was planning to expand their well being activities, funds being available to a number of settings outside of the county town.

Increased partnership working

This section describes data gathered from Joint Commissioners and four local Mind associations in relation to the primary research question '*Is there evidence of increased partnership working?*' and the linked question '*What creative opportunities might be grasped for partnership working by small local Mind associations?*' It was expected that data would be gathered from local Mind associations about their relationships with their neighbours and evidence of current or planned partnership working. Also there was an expectation that

data might be gathered from Joint Commissioners about their expectations of future collaboration by their current voluntary sector providers.

Collaboration between local Mind associations

Individuals from all local Mind associations interviewed referred to contact with individuals from neighbouring local Mind associations. The Chief Officer of D Mind spoke of regular contact with her counterpart from C Mind which was fostered she suggested by the close links between the two towns including working in the same local authority district. Similarly the trustee of A Mind spoke of her long standing friendship with a trustee of a neighbouring urban local Mind association not included in the study.

The trustee of B Mind spoke of consulting a trustee of D Mind about a difficult personnel related issue. Similarly the Chief Officer of C Mind referred to consulting the Chief Officer of another neighbouring urban local Mind association not included in the study, about the development of the organisations web site.

By way of contrast several local Mind associations interviewed referred to issues which made going beyond social contact or contact on specific issues particularly difficult. For example B Mind referred to prioritising the development of a counselling service, which it was suggested had led to a decline in contact with both C Mind and D Mind. Similarly the Chief Officer of D Mind referred to the cessation of regular meetings with B Mind and C Mind. She suggested that this was because of reduced capacity because income for

core activities had declined resulting in reduced opening hours and a cessation of rural outreach.

There was however evidence to suggest that all four local Mind associations wished to collaborate more with each other and with some other voluntary organisations. D Mind referred to the possibility of joining the two other local Mind associations to make a joint bid to the commissioners for all their day services. A Minds trustee referred to the inevitability of collaboration and even merger with the neighbouring local Mind association in the same county because there would be only single pot of money in future for both their day services.

A Mind's Chief Officer saw the potential for savings in overheads from joint working not only with a neighbouring local Mind association but also with other voluntary organisations where there was commonality of interest. For example he suggested that voluntary organisations which ran community alarm schemes could be potential partners because many of the service users supported by this service were lonely and isolated people. The Chief Officer recognised that commissioning which focused on prevention and wellbeing could well encompass attracting funding for services for those that were lonely and isolated and therefore potentially at risk of mental health problems. There might be financial savings for the various organisations that supported lonely and isolated people in different ways through collaborating and sharing costs.

Increased Partnership Working – quotes from Local Mind Associations and Joint Commissioners

D Mind, Chief Officer M: *“The possibility of merging with neighbouring Local Mind associations has not been discussed by trustees but the possibility of a joint bid with B Mind, C Mind and another local Mind association has been raised by a trustee.”*

B Mind, Chief Officer P: *“Relationship with C Mind and D Mind declined as B Mind developed its counselling service – our fault not there’s. Good relationships with other local voluntary organisations but these have also declined as counselling developed.”*

D Mind, Chief Officer J: *“Good relationships with neighbouring local Mind associations but regular meetings have ceased because all are so involved keeping their own organisations going. We have a close connection with D Mind – I talk regularly with Chief Officer M – there are lots of links between the two towns because we share the same local authority district. We do lots of work with other organisations including: Citizens Advice; Making Space; Homestart and Carers Association.”*

A Mind, Chief Officer F: *When I arrived I was told that we did things differently from our neighbouring local Mind association we are rigid they are more informal, however we can learn from each other. There is another voluntary group, which sprang from us which runs activities in the evenings and weekends and we may be able to work collaboratively in the future. There is potential for working with organisations that run community alarm schemes because many of their users are lonely/and isolated. Need bases in different localities – potential for sharing admin costs with other organisations.”*

A Mind, Trustee H: *“We don’t work collaboratively but it is probably the route for the future because there is only one pot of money. Looking forward to merging in the next four or five years with neighbours, however there are historic reasons why our neighbouring local Mind association does not want to merge with A – we have much more in common with the association in the next county.*

County X JCU, Joint Commissioner N: *“Size does not really matter, depends on what the organisation is providing. Small organisations are more wired into local communities and are able to support a wider range of activities, whereas larger organisations better wired into to corporate policies etc.”*

The evidence would suggest that beyond contact about specific issues and social contact between individuals there is no increase in partnership working between neighbouring local Mind associations. Also that although there is willingness to collaborate and to work in partnership none of the partners has the capacity currently to take joint work forward.

The implications of these results

Chapter 6 will discuss the results of the quantitative and qualitative research and in particular the preparedness of the four local Mind associations for the changes in community mental health services currently being implemented by Joint Commissioners. Also the implications of the findings which seem to suggest that, local Mind associations are poorly prepared for the current changes. Also discussed is the evidence for a widening division between large and small voluntary and community organisations and particular between large and small local Mind associations in rural communities. In addition there would seem to be evidence contrary to the initial proposition that mental health services are retreating to urban centres i.e. that personalisation may result in services becoming more accessible to people in rural communities. Further that there is little evidence of an expansion in partnership working by local Mind associations, because of a lack of capacity. Chapter 6 will explore these findings further.

CHAPTER 6

Discussion

Chapter 6 discusses the data from the quantitative and qualitative research described in Chapter 5 and what has been learnt from the data in relation to the initial and further propositions, the primary and subsidiary research questions, and to the literature review, which were discussed in Chapters 2 and 3.

At the end of Chapter 5, I suggested that the results seemed to show that the widening gap between large voluntary organisations and smaller community organisations concluded from the literature review also seemed to apply to large local Mind associations and smaller local Mind associations. Also that, small local Mind associations seemed to be poorly prepared for the current changes underway in the commissioning environment and particularly poorly prepared for a competitive funding environment and the move towards personalised and recovery focused community mental health services.

However the results also seemed to suggest that personalisation could result in more accessible community mental health services for people in rural communities which was directly contrary to the proposition that mental health services would retreat to urban settings. Further that the results seemed to show that there was little evidence of increased partnership working by local Mind association's in rural communities due to their lack of capacity i.e. lack of

capacity directly impacts on the capability of local Mind associations to work collaboratively and in partnership.

Limitations of the Study

Any research study will have limitations due to the methods used or to the limitations of the researcher. Those limitations arising from the methodology may be due to: the size of the sample; the availability and/or reliability of the data, prior research on the topic, or the measures used to collect the data.

Those limitations which relate to the researcher may be due to: problems with access to people, organisations or documents; the impact of longitudinal effects i.e. the time available to research the topic and measure the change within the sample or to any personal bias of the researcher.

The sample explored in the quantitative research through the postal questionnaire was potentially all the affiliated local Mind associations in the Mind network across England, however only 43 or 23.8% of local Mind associations responded, despite in the inclusion of a stamped addressed envelope. The response rate was a small sample of the whole network and therefore a limitation. A better response could have been achieved by following up the letter with reminder phone calls

In contrast the qualitative research used a small but purposive sample of four local Mind associations and two Joint Commissioning Units all of whom operated within a local authority districts classified as Significantly Rural, Rural 50 or Rural 80. This sample although small in number was not a

limitation because it was purposive on the basis of salient criteria which are the distinctive features of qualitative research.

In addition to the postal questionnaire, the quantitative research, interrogated internal Mind management reports and accessed publically available population settlement tables produced by the Office for National Statistics. Both these sources were reliable because Mind's internal management reports are subjected to internal scrutiny by managers and trustees and the Office for National Statistics produces official statistics which are designated 'National Statistics', an accreditation, which means that statistics it produces are compliant with the National Statistics Code of Practice.

Prior to the quantitative research Mind did not have any information about rural services operated by affiliated local Mind associations so there was no previous research on the topic to access. There had been research on rural services operated by the broader voluntary and community sector which was explored during the literature review and therefore the findings from the study could be compared with research about the broader voluntary and community sector and rural services.

The researcher experienced no particular problems accessing people, organisations or particular documents. This was because the researcher as a member of Mind's staff could access the same mailing list used by Mind for routine circulars to local Mind associations. Similarly internal management

reports used in the quantitative research could be accessed because the researcher as a member of staff had access to the relevant files.

In addition because the researcher had worked with local Mind associations in the midlands over many years he was known to both many of those he invited for interview. To access Joint Commissioners, who the researcher did not know he was either able to use 'introductions' from local Mind associations and/or explain his working connections with the local Mind associations to obtain an appointment for an interview..

Longitudinal effects did not impact adversely on the study. On the contrary because the research study was undertaken part-time, over a four year period during which time the healthcare commissioning environment changed continuously and there was also a change in Government, the researcher could take account of these changes and their impacts during the course of the research.

The researcher has had a working relationship with the four local Mind associations involved in the qualitative research and also with some of the local Mind associations who responded to the postal questionnaire. It could therefore be suggested that personal bias may be a limitation. It is hoped that the rigor of the academic research process limited any personal bias.

Widening division between local Mind associations

At the end of Chapter 1, I asked whether a baseline for local Mind associations could be developed. How could local Mind associations be measured? Is there an accepted standard to measure the size of an organisation? I also suggested in Chapter 1 (p 11) that local Mind associations could be categorised by the size of the association, where size is measured by annual financial turnover.

Annual turnover thresholds are used by the statutory regulator of charities, the Charity Commission to regulate the reporting requirements of charities and Mind uses annual turnover based on a sliding scale to set an annual affiliation fee for its local network. Various thresholds based on annual turnover have been used to measure the size of voluntary organisations, described in Chapter 1 (p 11) Chapter 2 (p 22-24), Chapter 4 (p 64-65) and then applied in Chapter 5 (p 106-108).

I also suggested in Chapter 1 (p 11) dividing local Mind associations into two categories: i.e. small/medium associations with an annual turnover less than £250,000 and larger associations with an annual turnover greater than £250,000. A £250,000 threshold was chosen not only because this is the threshold used by the Charity Commission to define a small charity but also because £250,000 has been described by many commentators as the threshold below which charities will find it difficult to survive in an increasing competitive funding environment.

The results showed that when the outcomes of Mind's quality review process were analysed using the small charity definition a decline in the affiliation of small local Mind associations i.e. those with a turnover less than £250,000 was described (Table 5.1 p 107) alongside an increase in larger affiliates i.e. those with an annual turnover greater than £250,000. However when the review process outcomes were analysed over the same period using Mind's affiliation categories a decline was observed in affiliates with an annual turnover of less than £150,000; an increase in affiliates with a turnover greater than £500,000 and that the numbers of affiliates with an annual turnover between £150,000 and £500,000 over the period had remained largely unchanged.

Unfortunately no longitudinal information was available to track specific local Mind associations over the same period. However it can be reasonably surmised that the decrease in smaller local Mind associations came about as a result of local Mind associations disbanding or disaffiliating over the period. This conclusion was confirmed from the same internal Mind reports that showed that no local Mind associations with an annual turnover more than £250,000 had disaffiliated during the period and that the twenty five local Mind associations that had disaffiliated all had an annual turnover less than £250,000.

This evidence would seem to lend support to the argument that not only is there a widening division between large and small voluntary and community

organisations evidenced in the literature review but that this widening gap can be applied to local Mind associations from data collected for this study.

Sustainable services benefitting rural communities

In the literature review (Chapter 2 p 28) I referred to Blackburn et al's suggestion that the particular differences between rural voluntary organisations as opposed to their urban counterparts tend to be those associated with their self-definition as rural. In order to test this difference local Mind associations were asked in the postal questionnaire about their perception of the geographical area in which they operated, their area of benefit. The responses were then compared to the population settlement pattern of the same geographical area using the rural and urban classification scheme derived from Office for National Statistics tables. Over half of respondents (52.5%) perceived their area of benefit as mixed i.e. a mix of rural and urban communities, just over a quarter (27.5%) as solely urban and only 20% as solely a rural community. These perceptions contrasted with the actual population settlement patterns of respondent's areas of benefit which showed that just under a half (45%) were rural, 32.5% were urban and 22.5% were mixed.

It can be inferred from these results that the contrast between perception and reality illustrates not only that the rural and urban classification scheme as it applies to local authority districts is poorly understood but also that a majority of the local Mind associations whose area of benefit is solely rural did not self-

define as rural. However 89% claimed to provide accessible public services to people in rural communities. The services provided were predominantly day related services plus recruiting volunteers, including recruiting trustees and service user groups. Advocacy and counselling were primarily identified as the services most needed. These responses showed that a high proportion considered that they provided accessible services to rural communities and that mental health day services in their broadest sense were the predominant services provided.

A third of respondents (13) reported that funding had been received for these services for six years or more and that two thirds (26) received funding from the local authority or the NHS. However in just under a third of local Mind associations (12) these activities were supported from their own fundraising. The results indicated that there had been recent stability in the funding of rural services suggesting that these services had been sustainable for a significant proportion of local Mind associations that responded to the questionnaire. However the results also indicated the importance of local voluntary fund raising to sustain community mental health services.

Community sector or professional voluntary sector

Before considering whether a baseline for small local Mind associations can be developed as a result of the discussion about annual turnover, I need to consider whether local Mind associations are part of the community sector or whether they form part of the professional voluntary sector. In Chapter 2 (p 20) I referred to Blackburn et al's reference to Chanan West et al's (1999)

argument that small voluntary organisations are not just a vehicle for service delivery but also have an important role in maintaining social cohesion, strengthening community and mutual aid. She questioned whether these different functions could be carried out the same organisation. Service delivery it was argued is a characteristic of a professional voluntary organisation whereas social cohesion, strengthening community and mutual aid are more typically a characteristic of community organisations.

Community groups contribute to the strengthening of community, mutual aid and public spirited action whereas professional voluntary groups deliver specialist services and can act like a public service. Also the economy of a community group may consist of 60-100% volunteering with the controlling roles being voluntary whereas with the economy of a professional voluntary group may consist of 60-100% paid work with the controlling roles being professional.

How do the local Mind associations who responded to the postal questionnaire and those who took part in the qualitative interviews compare with this distinction? Half of the local Mind associations who responded to the postal questionnaire provided a community mental health service; two thirds received public funding from their local authority and/or the NHS. All four local Mind associations who were interviewed for the qualitative study provided publically funded community mental health services, which were managed by a 'professional' paid chief officer and a small team of paid support staff. All of these features are characteristics of the professional voluntary sector.

However almost a third of the quantitative study respondents supported these activities from their own fund-raising, and also referred to the significance of recruiting volunteers all of which activities can be described as public spirited action, a characteristic of a community group. Two Joint Commissioners indicated that these characteristics were a key advantage of working with the voluntary sector i.e. *'if you give the voluntary sector 1p they give you back 2p plus voluntary workers'* (Chapter 5 quote p 124) and *'better value than statutory agencies because it can utilise other resources adding to the contract value, for example utilising volunteers'*.

I concluded Chapter 3 by arguing that the literature review seemed to show, that differentiating between voluntary organisations and community organisations came down to a discussion about the organisations mission, its size and capacity to engage with the environment in which it operated. This argument has some congruence with the characteristics of the local Mind associations that were involved in both the quantitative and qualitative studies i.e. that these local Mind associations possessed the characteristics of both community organisations and professional voluntary organisations as distinguished by Chanan West et al (1999) to whom I referred in Chapter 2 (p 18). However Blackburn et al has referred in Chapter 2 (p 21) to certain types of groups that are better suited to delivering rural services than others.

Exogenous approach to defining local Mind associations

In the conclusion to Chapter 3 (p 48) I asserted that an exogenous approach to define the sector was more satisfactory because it characterised voluntary

and community organisations by what they are not, rather than by what they are. Earlier in Chapter 2 (p 24-26) I described an exogenous approach based on '*tension fields*' where the voluntary and community sector, in relation to the provision of welfare, is placed within a tri-angular inter-sectoral landscape comprising the private & commercial, public and informal welfare sectors. Within this landscape voluntary and community organisations take up different locations within the tri-angle in relation to the public, informal and commercial sectors depending what they do and how they operate.

The local Mind associations in both the quantitative and qualitative studies have been characterised as professional voluntary organisations that deliver services to people with mental health problems under contract which is a product of public welfare. They have also been characterised as local community organisations that raise money, promote volunteering, advocate on behalf of mental health service users and engage in public spirited action which are all products of informal welfare.

An exogenous approach to understanding local Mind associations may therefore be more satisfactory because this approach teases out not only the quality of the relationship between an associations obligations to Joint Commissioners who fund it to provide a community mental health service to specific people but also the quality of the relationship to its social mission as an local advocate on behalf of all local people with a mental health problem.

Local Mind associations are expected to work towards their social mission with progress tested regularly through an internal self-assessment and external review process based on Mind's quality assurance framework, (Quality Management in Mind) which is rooted in Mind's values and mission. A series of standards in the quality assurance framework refers to various aspects of service user involvement in the local Mind association i.e. in governance, in policy and planning, in the provision of information, in the selection of workers, and with an expectation that service users will be involved.

Local Mind associations are also expected to work to particular operational standards demanded by relevant legislation for example in financial management, employee management, health and safety etc and which is also tested internally and externally regularly through the same quality assurance framework.

It is no coincidence therefore that some smaller local Mind associations that provide public services have found reconciling their obligations to public funders and their obligations to fulfil their social mission, which includes, the quality assurance processes particularly challenging.

Role in social cohesion, strengthening community and mutual aid

I referred in Chapter 3 (p 47-48) to an argument put forward by the Department for Health that that to ensure continuous improvement of health services in the future the demand side needs strengthening through a much

stronger voice for patients. Also that Blackburn et al had argued (Chapter 3, p 48) that small organisations have an important role in social cohesion, strengthening community and promoting mutual aid.

Is there a role for small local Mind associations maintaining social cohesion, strengthening community, promoting mutual aid and as a sounding board? I discussed earlier local Mind association's social mission as a local advocate on behalf of people with mental health problems. In that sense local Mind associations have a clear role as a local advocate as well as supporting mutual aid. The term maintaining social cohesion is however less clear in mental health.

One Commissioner referred to the voluntary sector "*historically listening to service users*" innovating intuitively, reaching "*people who would never knock on a state door*" and being "*better wired into local communities and therefore a good source of local intelligence*" (Chapter 5, quote p 130). This observation illustrated some understanding of a broader role for the sector. If the role of a local Mind association includes promoting mutual aid and support could that not be said to strengthen locally the community of mental health interest and bring that community together to support people with mental health problems. Also Local Mind associations referred to a specific role for themselves to fill gaps in statutory provision, which I can surmise has its origins in pioneering community mental health services when statutory provision was principally hospital based.

A preliminary conclusion is that local Mind associations do have a role in strengthening community and strengthening mutual aid, and as local advocate and that this broader role has some recognition.

Baselines for local Mind associations

Interrogation of Mind's internal reports showed that local Mind associations with an annual turnover less than £150,000 had declined as a proportion of affiliates over the period of the study, whereas those with an annual turnover greater than £500,000 had increased. I have referred earlier to voluntary organisation with an annual turnover less than £250,000 at risk in the new commissioning environment; however this study showed that the numbers of those local Mind associations with annual turnovers between £150,000 and £500,000 had remained largely unchanged of a five year period.

It can be argued that the use of the £250,000 baseline for understanding the local Mind association network is not particularly helpful because it does not produce meaningful data immediately above or below that baseline. More satisfactory baselines were identified at the £150,000 and £500,000 annual turnover threshold. This was because the £150,000 threshold was shown to be the point below which local Mind associations were at most risk of disaffiliation or disbanding whereas the £500,000 threshold was shown to be the point above which a local Mind association might grow and develop.

Impact of changes in the commissioning environment

At the end of Chapter 3 I argued that the evidence from the literature review suggested that the new commissioning environment would disadvantage smaller voluntary organisations and advantage larger voluntary organisations. The review also indicated that small community organisations often lacked the capacity to engage with the new healthcare commissioning environment, although commissioners were open to work with the voluntary sector and recognised the added value of the sector.

Impact of changes in commissioning practice

Management information about affiliations and records of Quality Management in Mind review outcomes, i.e. from 2004 to 2009 discussed earlier in this Chapter were compiled prior to and during the consultation on modernising community mental health services and before compulsory competitive tendering was introduced however significant changes in commissioning practice were underway. These changes included mental health commissioners deciding what community mental health services were required and where they were required. Also grants were being replaced by service contracts that specified the service expected to be provided with commissioners regularly monitoring progress by providers against the contract specification. Also some 'competition' had been introduced between voluntary providers, with Commissioners deciding at the point the contract was due for renewal whether the existing provider should continue to provide the service or it should be awarded to a new organisation. Local voluntary providers began to talk at this time of the larger national providers such as Rethink or

Making Space, 'competing' to provide local services. It is against these changes in commissioning practice that smaller local Mind associations began to decline and some larger associations began to grow and develop.

Changes in national mental health policy

The qualitative interviews took place at a time of imminent change for both Joint Commissioners i.e. in late 2009 and 2010. The national mental health policy framework against which they had worked was about to change with the compulsory nationally driven National Service Framework for Mental Health standards to be replaced by New Horizons and subsequently replaced by No health without Mental Health (see Chapter 3 p 33 and p 42). At the time neither Joint Commissioner knew whether this new national policy framework would be compulsory.

The new policy encompassed twin drivers: well-being and recovery. Although recovery, had been widely accepted as a focus of mental health delivery for some years it had been absent from the National Service Framework for Mental Health.

Change in Government and the Impact of public expenditure cuts

National Government changed in 2010, with the election of a new Coalition Government a few weeks before the last interview with a Joint Commissioner. At that time the new Government was committed to wide-scale public expenditure reductions and change within the NHS but the detail was not known. However one Commissioner had concluded that one of the

consequences of public sector austerity was the likelihood that the Joint Commissioning Units capacity to manage a proliferation of small contracts would be reduced considerably. A single contract with one organisation that encompassed a range of community services might be a manageable outcome for a Joint Commissioning Unit with reduced capacity. A reduction in the number of contracts would have consequences for small providers who might lose their core funding, unless they collaborated in some way. The potential for collaboration by small providers will be explored later in this Chapter. Loss of core funding might result in small organisations disbanding or deciding to explore other avenues of funding or other ways of working. Both these issues will be discussed further later in this Chapter.

The Coalition Government committed itself to ring fencing health spending; however one of the consequences of a reduction in public spending may be to reduce the capacity of Joint Commissioners to fulfil their function to both commission i.e. planning, designing and implementing the range of services required and procure and contract those services i.e. selection, negotiation and agreement with the provider on the exact terms the service is to be supplied. Reducing the capacity of Joint Commissioners may result in a single organisation providing all community mental health services required because Joint Commissioners will not have the capacity to do otherwise. Reducing the capacity of Joint Commissioners may by default further disadvantage small providers.

Modernisation of community mental health services

Alongside the change in mental health policy and reductions in public expenditure another series of changes was about to impact on the delivery of community mental health services at the time the qualitative interviews took place. This was the movement towards more individualised and personalised services, which had its origins Morris (2006) (cited in Dayson, 2010, p 4) in a growing dissatisfaction that existing welfare services had their limitations because they prevented people from living independently.

The most significant of these delivery changes for many local Mind associations is the modernisation of day services, including for the local Mind associations in the qualitative study. Modernisation of day services, sought to refocus day services on recovery, with service users less dependent as well as utilising facilities in the community. These changes will result in the two counties replacing open access drop-in/day centres with individually tailored flexible packages of support; which have a well-being and recovery focus; that do not need to be located with a single organisation or in a single location and that can operate alongside paid work or volunteering because a 5 day a week service is no longer to be offered.

Personalisation, the last Government's strategy unit had asserted would empower service users to make personal choices about how their needs were best met. This outcome if realised would be a significant change; replacing meso commissioning with micro commissioning (described in Chapter 3, p 38) i.e. replacing a supposedly one size fits all community mental health service

with personal budgets or self-directed support. Does the introduction of personalisation begin the transfer of the power to decide how a service users needs are best met away from Commissioners and away from service providers towards the service user? Or perhaps is it is not that straightforward because it has been argued that personalisation is not a coherent model which Dickinson and Glasby (2010) have argued is dependent on local definition.

Personalised or individualised approaches to public services have been around for some time and associated with the argument for modernised mental health day services. From Segregation to Inclusion (Chapter 3 p 45) argued that mental health day services segregate service users and fail as a consequence to meet people's needs. Thirty years ago people with mental health problems lived segregated lives in the old asylums; now people with mental health problems are treated either close to or increasingly in their own homes so to continue segregated support services is incongruous. Integrating service users is much preferred because it creates opportunities which are limited or denied if people remain segregated.

The evidence from the qualitative interviews would indicate that the favoured personalised approach in both counties is individually tailored support with more targeted outcomes which emphasises recovery and well being with service users progressing towards an exit from the mental health system. Although, it was not clear whether meso commissioning would be replaced by micro-commissioning, one commissioner did refer to "*every person receiving*

social care from this point on will be offered a personal budget” (Chapter 5 quote p 124) and that there would be no more block contracts offered in the future. However feedback from a range of voluntary community mental health service providers in Derbyshire and Cumbria during a Mind research study (Elder 2011) would seem to indicate that the eligibility bar for self-directed support will be raised as a result of reduced public expenditure and consequently maintain self-directed support at a comparatively low level.

Recovery was clearly a key driver for change in both counties at the time of the interviews and its importance supported by both Joint Commissioners and its role in underpinning personalised services has been referred to earlier in this discussion. One Joint Commissioner for example (Chapter 5, quote p 130) referred to *‘modernised services will lead to more consistent services...with more targeted outcomes which emphasise recovery and enabling people to on from mental health services’*.

Recovery has advantages in an era of public expenditure reduction because it may mean that the cost of providing care and support to individuals has an end point. This becomes all the more important when the methods of funding begin to change and block contracts for providers are replaced by costs linked to an individual i.e. the cost stops when the individual leaves the mental health system.

Recovery therefore needs to become a clear focus for existing voluntary providers, including the local Mind associations if they are to successfully re-

negotiate continuing funding. Another Joint Commissioner referred to a community arts social enterprise (Chapter 5, p 130) as good practice which should be encouraged because service users are routed into volunteering and possible employment. She also had a clear preference for organisations that focussed on pathways to recovery for service users i.e. an organisation which focussed on service user's personal goals rather than an organisation that provide open access support. This contrasted with A Mind's focus on recruiting volunteers which they had done successfully for many years but which are now largely recruited externally (Chapter 5 p 117) so that volunteering with A Mind did not provide a pathway to recovery for service users.

The Wellbeing Service in Oxfordshire (Oxfordshire Mind, 2011 & Elder, 2011) is an example of a single organisation, which operates an individually tailored well-being and recovery service from a range of locations across a large rural county. The wellbeing service provides a choice from a menu of options including: recovery focused peer support groups; short courses which may be therapeutic, or relate to life skills or activities such as creative arts, ICT skills or physical exercise; a late shift for those in day time employment or voluntary work; information and options sessions and recovery planning when individuals can discuss, plan and work on their personal goals. This structure has advantages for people in small communities because it is not tied to providing open access support or to specific buildings or locations and can therefore respond to small numbers of people through discrete activities tailored to specific needs.

Local drivers for change

Joint Commissioners were looking forward to the changes that modernisation and personalisation would bring in both counties but in each county the historical starting place for change was different. What were the local drivers for change?

Community mental health services in one county were already localised to some degree because in-patient units had closed, however more geographical consistency was required so that services reached more communities and individuals. The locations of community mental health services at the time of the interviews had developed historically whereas services were now required closer to where people lived, particularly so because service users were increasingly receiving mental health treatment at home.

Services in the other county were still defined by the continuing presence of the old psychiatric hospital building which the Joint Commissioner argued (Chapter 5: quote on p 136) had "*stymied the opportunities for the mental health delivery you wanted*" for many years. Modernisation and personalisation provided an opportunity for the Joint Commissioner to work with others to close the hospital thereby releasing resources for more local, individualised and tailored community mental health services.

Many of the long standing voluntary community mental health providers in County Y were not regarded by the Joint Commissioner as good value for money partly because of the complexity of the system created by the

presence of the old psychiatric hospital and because the people using the long term voluntary provider's services were not progressing service users to recovery. I referred earlier to one Commissioner's clear preference for a particular voluntary service provider service who routed service users into volunteering and employment rather than providing open ended support. However to accuse long standing voluntary providers of not being good value partly as a consequence of the enduring presence of the old hospital would seem unfair particularly so when that enduring presence was not of their making. However the voluntary provider who routed service users towards volunteering and employment was clearly preferred to the local Mind associations that recruited volunteers from an external pool providing the volunteer with valuable work experience.

Impact of local and national drivers

What is the likely impact of these local and national policy drivers on the local voluntary providers, and particularly on the local Mind associations? It became evident, during the interview with one Joint Commissioner that she not only viewed the long standing local voluntary mental health providers, including the local Mind association as not only not good value for money but she also questioned their capability to tender under new compulsory competitive tendering arrangements which were shortly to be introduced. This was because; she doubted their capacity to tender. Her counterpart in the other county recognised that the local voluntary providers, including the local Mind associations were disadvantaged because they had not tendered before and referred to a mentoring scheme put in place to enable more equitable

competition. However the local Mind associations in the same county made no reference to the mentoring scheme.

So it could be concluded that the hurdles for local Mind associations in the new competitive commissioning environment appeared to be getting higher. But what is it about a competitive environment that might threaten local Mind associations? Who are the competitors and why might they be a threat?

Impact of competition

It was clear from the interviews with local Mind associations that they feared the competitive tendering process much more than the competition from larger charities for example ***** a national mental health provider and ***** ***** a regional mental health provider. This was because the competitive tendering process was not within any of their experiences, and also because there was no evidence of the mentoring process for voluntary providers referred to earlier or any advice from Joint Commissioners about the tendering arrangements that would be put into place. In contrast local Mind associations knew people who worked or volunteered for ***** and ***** ***** because all these organisations had worked side by side for a number of years.

*****, and ***** *****, were identified as the principle competitors and already had a presence in County X and their strengths, including their experience managing day service contracts, were recognised by the local Mind associations.

Day services entering a new era

What is a new day services contract likely to ask those who tender to provide?

Mental health day services have entered a new era as a result of modernisation, and require a different set of knowledge and skills to successfully manage a well being and recovery focussed service. Compulsory competitive tendering which was due to be introduced for the day services contract in County X in 2010 would be about managing for personalisation, recovery and well-being rather than about managing an open access, open ended five or seven day a week day service as had been provided previously.

During the interviews with the local Mind associations it became clear that they were clearly strongly attached to the current model of working i.e. the majority had strong commitment to a particular building and to the community and the community of people who used their services. This contrasted, in the local Mind associations view with the competitors for the day services contract that it was said had no particular commitment to a particular place because they had no historical connection with the communities where the small voluntary providers were located. Similarly it was said they had no particular commitment to local service users because they had no historical connection to people who used local mental health services provided by the small voluntary providers.

There was little evidence of any awareness amongst the local Mind associations of the fundamental change day service modernisation would bring, although three of them had been involved in the consultation. At the

time of the interviews they reported no progress with implementation and some cynicism had set in about the length of time the process had been underway. None felt that modernisation would challenge in any major way how they currently provided day services and they did not seem to appreciate that the tendering process in 2010 would require them to tender for a personalised day service with a recovery and well being focus, replacing the open access, open ended drop-ins they currently provided.

All the local Mind associations seemed under the illusion that little change was required in the way their day centres were organised and that by opening up their buildings to the wider community and reaching out to for example black and ethnic minorities was all that was required. The interviews with local Mind associations elicited little information about personalisation, which contrasted with the interviews with Joint Commissioners where clearly it had high priority

In County Y, the local Mind association was aware that the closure of the old hospital and the re-distribution of resources which would result might benefit them too and enable them to also break out of the county town. In that sense they saw that a well-being agenda would provide them with an opportunity to support communities they had not reached before and to do it in a way that make good use of various community buildings that were available in these communities as well as making good use of an attractive natural environment.

Personalisation and values

I referred in Chapter 3 p 43, to several commentators who had argued that personalisation was closely allied to the values advocated by many voluntary organisations. There was evidence from the literature that many voluntary organisations were not fully aware of the implications of these changes and how they should react to them. This lack of awareness of personalisation was also evident from the qualitative interviews, and included a local Mind association trustee who was not aware of any of the changes to commissioning.

Survival of small voluntary organisations

One of the propositions which the qualitative research programme sought to answer was whether voluntary organisations, including local Mind associations with an annual turnover less than £250,000 can survive in an increasingly competitive contract culture.

The local Mind associations involved in the qualitative study were primarily concerned about the maintaining the mental health day services that they managed under contract. There was little evidence of awareness amongst the representatives of the local Mind associations of the fundamental change modernisation and personalisation would bring. One Chief Officer had been thinking ahead about the opportunities, that well being might bring, to extend the activities of the association to communities that the local Mind association had not reached before and in partnership with other organisations.

There was also a strong adherence to the current ways they were working, to the service users who used their services and to a particular place or building. Is that not surprising when all the local Mind associations involved in the study were set up by local people to meet needs in their local communities?

There were clearly larger voluntary competitors providers waiting in the wings, particularly in County X, both of whom had a local track record managing traditional community mental health services. But community mental health services were about to enter a new era in which capacity to tender was important but also the ability to provide a recovery focussed personal service was also important. In this respect the interest that the County Y Commissioner had shown in a small service user led community arts social enterprise because of its ability to route service users into volunteering and employment perhaps indicates that Joint Commissioners were beginning to look beyond the established voluntary providers, whether large or small, to populate personalised provision. Organisations which might provide a recovery focussed personal service to an individual could encompass a wide range of specialist services provided by private companies, sole traders, partnerships, social enterprises, cooperatives and mutual organisation and voluntary and community organisations.

Capacity to tender is clearly important in a competitive environment but so is an organisations ability to deliver a personalised service. Oxfordshire Mind, referred to earlier in this Chapter is an example of a large county wide organisation that scanned the horizon and evolved to meet changing needs and circumstances and had successfully made the transition from managing a

network of thirteen day centres to a wellbeing service, with their infrastructure still largely intact. However Oxfordshire Mind had the management capacity to horizon scan, plan the changes required and successfully renegotiate the competitive tendering process.

But can a small voluntary provider survive the loss of its contract to provide a day service? There is evidence from Cumbria, Derbyshire and Somerset (Elder 2011) of small voluntary provider's ability to change to survive. Mind in Sedgemoor has converted into a social enterprise, following the loss of a contract to provide day services, slimming down its staff and operations considerably and using its remaining capital reserves to invest in community and group work. The Federation for Mental Health in North Derbyshire already operates without long term commitments to buildings, expanding and contracting its operations as and when finances allow. Carlisle Eden Mind is eschewing the tendering process for mental health day services in Cumbria and concentrating on collaborative work with others including a befriending/mentoring service devised to meet the needs of chronically isolated people in rural areas and developed as a franchise. Perhaps some small voluntary organisations can survive the changes in the new commissioning environment.

No evidence of mental health services retreating to urban settings

One of the propositions on which this research programme was based is that there has been a retreat of community mental health services from rural to urban settings and this became as a result one of the primary questions in the

qualitative research programme. Data was expected from Local Mind associations and from Joint Commissioners which would together help to illuminate whether there was any evidence of any retreat.

Is there evidence to support a retreat? There is no evidence that local Mind associations were predicting a retreat to urban settings and neither were Joint Commissioners predicting a retreat in their current and future commissioning priorities. On the contrary there was evidence that Joint Commissioners in both counties wanted to extend both statutory and voluntary services from where the services were historically located so that a wider range of communities and individuals in need of mental health services could better access pathways to recovery. This extension of service locations was all the more important because treatment services were becoming increasingly home based.

Local Mind associations are dependent on statutory and voluntary income to operate services and one had lost a rural outreach service because there were insufficient funds to operate it, another had expanded its rural outreach and a third was planning rural outreach across the whole county. I referred earlier to mental health day centre modernisation leading to more localised services, offering more consistency across both counties. Each of the two Joint Commissioning Units were developing individual and personalised services from a different place historically with one *stymied* by resources locked up in an old hospital, whilst the other was looking to improve both its reach so that community mental health services are more accessible, enabling more service users to access pathways to recovery.

No evidence of increased partnership working

Lack of capacity, discussed earlier militates against small voluntary organisation involvement in the new commissioning environment. In the literature review (Chapter 2 p 46) I referred to recent evidence from the Charity Commission which indicated that small voluntary organisations that collaborate do it well, particularly if certain key features such as strong relationships; shared organisational aims and values; effective leadership and planning and communication are in place. For the minority of small charities that faced difficulties with collaboration; strong governance, effective monitoring and evaluation processes and accessing external support, the Commission found were the key features in overcoming these difficulties.

So this might suggest that collaboration is a way forward for small charities in the new commissioning environment particularly if the key features listed above are in place. Small providers making alliances was also a way forward suggested by one Commissioner during the interviews because it would reduce the need for Joint Commissioning Units to manage a proliferation of small contracts particularly if reductions in commissioner capacity resulted from reductions in public expenditure. I argued earlier that a single contract with one organisation, encompassing a range of community services might be one consequence of reduced capacity within commissioning.

A single contract with one organisation might create some opportunities for smaller charities to continue as sub-contractors to the main provider depending upon their particular area of expertise. Restore (Restore, 2011)

holds the contract for providing recovery to work services in Oxfordshire and is an example of a voluntary provider that in addition to providing recovery support through its various environmental projects throughout the county also sub-contracts part of its services to Bridewell Organic Garden, which is a separately constituted voluntary organisation.

Further evidence from the Charity Commission suggested that joint bidding for contracts was not found to be particularly widespread amongst small charities and was most likely to run into difficulty. Why is joint bidding amongst small charities not widespread and why is it most likely to run into difficulty when joint bidding does occur?

Evidence from the qualitative study (Chapter 5: p 139) showed close social contact and contact on specific issues between neighbouring local Mind associations over many years, so the strong relations criteria for partnership working referred to above could be met. Also local Mind associations shared organisational aims and values but close contact did not go further to encompass regular business meetings so that the effective leadership and planning and communication criteria were not in place. Strong governance and effective monitoring and evaluation processes should be a by-product of Mind's quality assurance process which places particular emphasis on strong governance standards as well as standards on measuring performance and on planning and policy development.

External support from Mind to its affiliates is limited and the ability of small local Mind associations to collaborate not only has a cost impact on a small organisation with limited by financial resources but also a time impact with limited personal resources.

Collaboration was thought by local Mind associations to be inevitable once there was only a single pot of money in each county to support their respective services. A variety of explanations for the absence of regular meetings was provided however all the explanations were rooted in their respective lack of capacity for meetings. Time was prioritised for managing their own services and sustaining their own organisations, although it was felt that collaborative work might save some overhead costs.

Conclusions

Chapter 7 will complete this research programme by drawing some conclusions and any implications for policy, based on the discussions in Chapter 6 and earlier Chapters.

CHAPTER 7

CONCLUSIONS

Chapter 7 will draw this research programme to an end by drawing some conclusions and implications for policy based on the discussion in Chapter 6 and earlier Chapters.

What is it about rural communities, mental health services and local Mind associations in rural communities that drove this study? There have been many changes over the last thirty years to the ways community mental health services are commissioned and provided. Also over the same period there have been changes to the way rural and urban communities are defined so that no longer are rural communities defined by communities of interest but by population settlement and based on the many diverse communities that live in the 50% of all local authorities in England which are now defined as rural.

The past thirty years has also seen the development of a widespread network of local voluntary and community mental health organisations, established on the basis of some particular local need for example counselling, advocacy, community support, supported employment, supported housing, closure of residential services, wellbeing etc. Some of these organisations are local Mind associations which are affiliated to Mind; and therefore registered as charities; with common objects, values and principles and which work to a common quality assurance framework called Quality Management in Mind.

A few local Mind associations have grown into significant providers of local mental health services whereas the overwhelming majority have remained small i.e. below the £250,000 annual turnover threshold used by the Charity Commission to define a small charity.

First proposition and research question

The proposition on which the first part of this research programme was based is that there was a widening division between large, well placed and organised voluntary organisations and smaller community based voluntary organisations and this became the first research question which was explored through a quantitative study, including interrogation of internal Mind management reports and a postal questionnaire sent to all local Mind associations.

Is there evidence of a widening division between large and small voluntary and community organisations? The literature review confirmed a widening division and particularly an increase in the number of large charities plus the emergence of a small number of super charities.

Can the evidence for a widening division between large and small voluntary and community organisations be applied to local Mind associations? The quantitative study indicated that during the period 2004 to 2009 there had been a decrease in the number of small local Mind associations with an annual turnover less than £150,000 as a result of these groups disaffiliating. In contrast those with an annual turnover over £500,000 had increased in number. It can therefore be concluded that there was evidence of a widening

division between larger local Mind associations that were growing bigger and smaller local Mind associations that were disaffiliating and reducing in number as a proportion of total affiliates.

Can a baseline for small and large local Mind associations be developed? Is the £250,000 per annum annual turnover threshold a meaningful measure of small and large local Mind associations? The outcomes from the quantitative study suggested that the Charity Commission small charity threshold of £250,000 turnover was not a meaningful measure of small local Mind associations. More satisfactory thresholds were identified at £150,000 and £500,000 because below the lower threshold local Mind associations were shown to be most at risk of disbanding and disaffiliating whereas above the higher threshold local Mind associations were shown to be likely to grow and develop.

Local Mind associations and rural communities

I referred in the introduction to this Chapter to the new rural definition which classified 50% of all local authorities in England as rural and in the literature review to the weight of evidence that indicated the real difficulties associated with providing mental health services in rural communities. At the end of Chapter 1, I asked whether local Mind association services benefitted rural communities classified using the new definition. It became clear that those local Mind associations that responded to the postal questionnaire and could be classified as rural did not define themselves as rural whereas in the literature review it was argued that the real differences between rural

voluntary organisations and their urban counterparts was their self-definition as rural. I inferred from this outcome that the rural definition as it applied to particular geographical areas was not only poorly understood but that the majority of local Mind associations did not define themselves as rural organisations despite two thirds being active in a rural community.

The rural definition and the classification scheme for local authorities which was developed subsequently enables organisations to better understand population settlement i.e. where and how people live, and providing a sounder base for policy, particularly so in mental health where increasing numbers of service users are treated at home. I suggest that those rural organisations that defined themselves as rural were a product of those voluntary and community organisations defined by a particular community of interest in rural communities i.e. those associated with agriculture and related industries. One of the consequences of defining 50% of all local authorities as rural has been to dilute that community of interest amongst a wide and diverse range of people and communities. It is for this reason I suggest that many rural local Mind associations do not self-define themselves as rural.

Do local Mind association's services benefit people in rural communities and are local Mind association services funded and sustained? 89% of the local Mind associations that responded to the survey claimed to provide services accessible to a rural community and the services provided were predominantly day related community mental health services, with a third funded for six years or more, two thirds funded by health or local authority and

a third funded from their own resources. It can be inferred from these findings that local Mind association provided services that benefitted rural communities and that many of these services had been sustainable up to 2009 and following the introduction of changes in commissioning practice.

Further propositions and further research questions

The second qualitative study firstly traced the impact of the new commissioning environment on small local Mind associations working in rural communities in order to explore a series of three propositions i.e. firstly the retreat of services to urban settings, secondly the expansion of partnership working by the rural voluntary sector and thirdly whether voluntary organisations with an annual turnover less than £250,000 can survive in an increasingly competitive contract culture. This part of the programme explored both the perspective of Joint Commissioners and local Mind associations in two English midland neighbouring counties. All together, these formed the basis of four primary questions (see Table 4.1 p 53).

The literature review indicated the need to also explore additional propositions i.e. firstly that small local Mind associations could have a broader role in the new commissioning environment maintaining social cohesion, strengthening community and mutual aid and as a sounding board and whether the potential for a broader role was recognized by commissioners; secondly the likely impact on small associations of personalisation and improving access and choice and whether small local Mind associations have a role in more

personalised services; thirdly whether an association with an annual turnover less than £250,000 can survive in an increasingly competitive funding environment and fourthly whether there are creative opportunities for partnership working by small local Mind associations. These additional propositions formed the basis of six supplementary questions.

Significant challenges for local Mind associations

All local Mind associations that receive public funds for community mental health services now face significant challenges as a result of recent moves by Joint Commissioners towards more personalised, recovery and well being focussed community mental health services; compulsory competitive tendering and latterly the impact of decisions by the Coalition Government to substantially reduce public expenditure. During the period when mental health commissioning practice changed i.e. when Joint Commissioners began to strategically commission community mental health services, small local Mind associations began to decline in number, however it was also a period in which larger local Mind association grew and there is evidence of stable public funding of rural services often secured by local fund-raising.

Defining local Mind associations

Before looking at the conclusions reached as a result of these significant challenges it may be helpful to draw some final conclusions about how local Mind associations can be satisfactorily defined and also some conclusions about the supplementary question relating to a broader role for local Mind associations beyond service provision.

In Chapter 6, I suggested that the local Mind associations in both studies comprised characteristics from both professional voluntary organisations and from community organisations and that the delivery of publically funded services is a product of formal welfare and that the public spirited actions in which they also engage are a product of informal welfare. It suggests therefore that to understand these groups better an exogenous approach is more satisfactory because it teases out the tensions between their formal and informal roles.

Local Mind associations informal roles includes: local advocacy on behalf of people with mental health problems; promoting mutual aid and support; strengthening locally the community of mental health interest and bringing that community together to support people with mental health problems. I questioned however the term maintaining social cohesion because I felt that its role in mental health is not clear. It can therefore be reasonably concluded that local Mind associations have a broader role in the new commissioning environment :strengthening community; promoting mutual aid and as a sounding board which go beyond the provision of public services and that this broader role has some recognition.

Personalisation, wellbeing and recovery

I argued in the literature review that personalisation had the potential to offer very different services to those that have been previously delivered but because personalisation was not a coherent model of working, it was best interpreted across a spectrum, with local definitions important. Two local

definitions of personalisation seemed potentially to be on offer; firstly individually tailored support and secondly self-directed support through personal budgets although evidence gathered from elsewhere would seem to indicate that the reduction of public expenditure would maintain self-directed support at a comparatively low level, although one commissioner recommended that direction of travel.

Whatever definition of personalisation was applied in the two counties it was clear that recovery, well being and targeted outcomes which enabled people to move on from mental health services would underpin personalised services. Recovery, well-being and moving on clearly had advantages during an era of declining public sector budgets by potentially limiting the liability of Joint Commissioners to provide ongoing mental health services to service users.

Local Mind associations it was found were primarily concerned about maintaining their current mental health day services provision and there was little evidence of awareness of the fundamental change modernisation and personalisation would bring. I referred in Chapter 6 to one local Mind association Chief Officer thinking ahead to the opportunities, arising from well being, but there remained a strong adherence in others: to current ways of working; to the service users who used their services and to a particular place or building.

Also that there were large voluntary competitors providers waiting to compete for contracts with a track record, but community mental health services were about to enter a new era in which an ability to offer a recovery focussed personal service was important as well as the capacity to tender. I suggested that Joint Commissioners were beginning to look beyond the established voluntary providers, to for example social enterprises, voluntary organisations and private businesses that could fulfil individuals' recovery objectives. Many of these organisations would not provide a comprehensive support but rather a specific support to a service user on a personal goal, which supported their pathway to recovery.

Smaller local Mind associations lacking capacity

I referred in previous Chapters to a lack of capacity militating against smaller voluntary organisation involvement in the commissioning process. Research from the Charity Commission, had indicated that although the local Mind associations involved in the qualitative study possessed many of the characteristics identified to make collaboration work well, their individual lack of capacity undermined any collaborative development. Similarly the importance of horizon scanning in order to ensure that local Mind association's activities evolved to meet changing needs and circumstances was undermined by a lack of capacity. Oxfordshire Mind had made the transition from managing a network of thirteen day centres to a well-being service, with their infrastructure still intact because they had the management capacity to horizon scan and plan for the tendering process and for the changes to come.

Joint Commissioners lacking capacity

One of the impacts of a reducing public sector budgets is the likelihood of a reduced capacity for commissioning and therefore a reduced capacity for Joint Commissioners to manage a proliferation of small contracts. In these circumstances a single contract with one organisation may be the realistic option.

Evidence of more accessible support for people in rural communities

Data collected from the qualitative study indicated that both Joint Commissioners were looking to develop more individualised and personalised approaches to community mental health services and it would therefore be counter-intuitive for services which resulted from this new approach moved to an urban setting. In contrast local Mind associations were mainly concerned about retaining community services already out posted from their main centres or in one instance developing new out posted services in order to reach a dispersed and scattered population that they were not currently reaching.

There was no evidence of a retreat of services to urban settings. On the contrary one of the outcomes of personalised, recovery and well being focused community mental health services; moves towards more home treatment and the impact of particular local drivers is more accessible individual support for people in rural communities.

No evidence of increased partnership working

Is there evidence of increased partnership working between local Mind associations? The evidence would suggest that beyond contact about specific issues and social contact between individuals there has been no increase in partnership working between neighbouring local Mind associations.

Are there creative opportunities which might be grasped for partnership working between small local Mind associations? The evidence would suggest that although some of the criteria for collaborative working identified by the Charity Commission were met, some key criteria were not met. There was a desire to collaborate, and work in partnership particularly with neighbouring local Mind associations and with some other voluntary organisations but none of the local Mind associations referred to their lack of capacity to do so.

Survival in a competitive funding environment

Can a local Mind association with an annual turnover of less than £250,000 survive in an increasingly competitive funding environment? The evidence from these studies would suggest that for organisations that currently provide publically funded mental health services the future is particularly challenging.

The quantitative study was undertaken at a time when changes to commissioning practice were taking place but prior to the implementation of modernised day services, the drive towards personalisation or the introduction of compulsory competitive tendering. The study indicted that organisations with a turnover less than £150,000 were at risk at that time. Unfortunately the

study did not encompass the introduction of modernisation and personalisation to discover whether an annual turnover of £250,000 gives an organisation sufficient management capacity to horizon scan, develop a new way of working, have an honest discussion with service users about the changes to come, tender for the new service and negotiate their way into the new funding world and keep their infrastructure in place.

It is not an imperative for local Mind association to provide publically funded mental health day services in order to survive. There may be other opportunities for local Mind associations arising from personalisation which support mental health service users towards recovery and well being which can be funded from a variety of sources. Can local Mind associations with an annual turnover of less than £250,000 survive in a competitive funding environment? It would be reasonable to conclude: that the survival of small local Mind associations is primarily about their ability to adapt to changed circumstances. A large Mind association has the time and management capacity to horizon scan and plan for change, whereas a small local Mind association may need to adapt and change quickly in the face of a failed bid. It does not augur well but there is evidence that some are not giving up.

Post script

Two years on from the interviews, in County X, two of the local Mind associations in the qualitative study were required to collaborate to tender for the day service contract and another tendered separately. All three local Mind associations were unsuccessful losing out to a regional voluntary provider

with particular expertise in recovery and well being and a national voluntary provider, neither of whom were the two large competitor voluntary providers referred to in this study.

One local Mind association has subsequently decided to disband and the two others have downsized considerably but continue to operate reduced services.

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Local Mind Association Rural Services & Rural Activities Questionnaire

A growing number of LMA's have recognised that the rural communities within their area of benefit have mental health needs, which they could be meeting. Some LMA's have established services and activities, targeted at people in rural communities. Other LMA services and activities benefit people in rural communities because they are accessible. The first section of this questionnaire is designed to find out what rural services and activities LMA's currently provide, when and why they were established and how people in rural communities access Mind's services?

Although there are many sources of funding for mental health services it is recognised that there is a lot more competition for the funding available. This first part of the second section of the questionnaire is designed to discover how rural services are funded and sustained, which groups and organisations fund rural services and for what period of time rural services and activities have been funded?

The flip side of a successful funding bid is an unsuccessful funding bid or the loss of funding after a service or activity has run successfully. The second part of the second section is about the loss of funding and the closure of services and activities.

There have been many changes in the organisation of statutory mental health services during the past ten years. In the last couple of years Primary Care Trusts have merged, in many areas the commissioning of mental health services and the provision of mental health services has been split between different NHS trusts. In a few areas joint commissioning arrangements are being established. In some areas Foundation Trusts have been established as well as changes in the organisation of local authority mental health services. The questions in the third section are designed to discover the impact of these changes on your LMA and particularly the impact on your rural services? Also whether there has been a change in the relationship between your LMA, the local NHS and local authority mental health services.

In recent years commissioning PCT's have merged so that mental health commissioners are looking to commission services over wider geographical areas, which often extend to cover areas containing a number of Local Mind Associations. However commissioners are expected to retain a local focus. The questions in the fourth section are design to discover the information commissioners maintain with your LMA's services and activities, what information they collect from you, contact maintained with the service users who use your services and contact with Mind staff and trustees. Government policy in health and social care is increasingly looking to the Third Sector as providers of services, commissioned by the NHS and Local Authorities. The series of questions in the fifth section of the questionnaire is designed to discover the impact of government policy on LMA's and the services they provide?

It has been predicted that the new commissioning arrangements will have a damaging impact on small & medium sized organisations. This is because an increasing emphasis on economies of scale/cheapest option/maximum benefit will favour larger organisations working from large population urban centres, and 'larger' services. This series of questions is about your relationship with your local primary care teams, including GP's, your area of benefit, where you are active and where you are not active and your relationship with neighbouring LMA's.

Name of your LMA?
Section 1
What is your area of benefit as defined in your governing instrument?
Are there rural communities within your area of benefit? (Please circle which applies) Yes/No/Don't know
If yes how are they described (please use local authority boundaries (e.g. county council, district council, parish council)?
Do you organise/promote your services & activities in all of your area of benefit or only in part? (Please circle which applies)
All of your area/part only If only in part which part(s)?
Does your LMA provide a service or activity for people in rural communities? (i.e. a service established for and targeted at people in rural communities) (Please circle which applies) Yes/No
If yes what is this service or activity?
When did this service or activity begin?
Why did your LMA establish this particular service or activity?
Do people from rural communities access any of your other services or activities? (Please circle which applies) Yes/No/Don't know
If yes, which services or activities do people from rural communities' access?
Do you know how many people from rural communities access the services or activities listed on average each day? (Please circle which applies) Yes/No/Don't know
If yes, how many?
How many people in total access your services? Do you know what proportion of the total number of people who regularly use your services and activities live in a rural community and travel to you? (Please circle which applies) Yes/No/Don't know
If yes, what proportion?
How do people from rural communities' travel to your services? (Please tick as many as apply)
Public transport Taxi Own vehicle NHS/Social transport service

Section 2	
Are the running/operational costs of your rural service or activity funded by statutory agencies? (e.g. PCT, Local Authority, Government Department, Healthcare Trust) (Please circle which applies) Yes/No If yes which statutory body?	
What services or activities do they fund? (Please include all services or activities which benefit people from rural communities)	
What period of time is these services or activities funded? (Please tick which applies) One year or less Two years Three years Four or more years	
Has the funding been renewed? (Please circle which applies) Yes/No	
If yes, how many times? (Please tick which applies) Once Twice More	
Are the running/operational costs of your rural services funded from the National Lottery/Big Lottery Fund (Please circle which applies) Yes/No If yes, which programme?	
What service/activity did they fund?	
How long is the funding for this service or activity? (Please tick which applies) One year Two years Three years	
Has the funding been renewed? (Please circle which applies) Yes/No	
If yes, how many times? (Please tick which applies) Once Twice More	
Are the running/operational costs of your rural services funded by Mind (Please circle which applies) Yes/No If yes which fund?	
What service did Mind fund?	
How long is the funding for this service or activity? (Please tick which applies) One year Two years Three years	
Has the funding been renewed? (Please circle which applies) Yes/No	
If yes, how many times? (Please tick which applies) Once Twice More	
Are the running/operational costs of your rural services funded by a grant giving trust or foundation (Please circle which applies) Yes/No If yes which Trust or Foundation?	
What service or activity did they fund?	
How long is the funding for this service or activity? (Please tick which applies) One year Two years Three years	
Has the funding been renewed? (Please circle which applies) Yes/No	
If yes, how many times? (Please tick which applies) Once Twice More	
Are the running/operational costs of your rural services funded by a private company or business? (Please circle which applies) Yes/No If yes what service did they fund?	
How long is the funding for this service or activity? (Please tick which applies) One year Two years Three years	
Has the funding been renewed? (Please circle which applies) Yes/No	
If yes, how many times? (Please tick which applies) Once Twice More	

Are the running/operational costs of your rural services funded from your LMA's reserves? (Please circle which applies) Yes/No If yes, what service or activity do you fund?
How long are you able to sustain funding from your own resources? (Please tick which applies) One year Two years Three years or more
If you have successfully obtained funding for the same service or activity from the same source more than once, please tell us why you think you were successful?
In the past 5 years, has your LMA closed any of your services or activities? (Please circle which applies) Yes/No If yes, which service or activity?
Why did the service or activity close?
Section Three
These are questions about the relationship between your LMA and the local NHS.
Name of Trust 1:
When was the last time you met a senior representative of the Trust? (Please tick as many times as apply) This month Last months Three months ago Six months ago Twelve months ago More than twelve months ago Never
How would you describe your LMA's working relationship with the Trust? (Please tick which applies) Good working relationship Poor working relationship No relationship
Has the relationship changed in the last five years or is it about the same? (Please circle which applies) Changed/Same
If the relationship has changed. How has it changed?
Who did you meet 5 years ago that you don't meet now?
Who do you regularly meet now?
What is the main reason for the contact?
Name of Trust 2:
When was the last time you met a senior representative of the Trust? (Please tick as many times as apply) This month Last months Three months ago Six months ago Twelve months ago More than twelve months ago Never
How would you describe your LMA's working relationship with the Trust? (Please tick which applies) Good working relationship Poor working relationship No relationship
Has the relationship changed in the last five years or is it about the same? (Please circle which applies) Changed/Same
If the relationship has changed. How has it changed?
Who did you meet 5 years ago that you don't meet now?
Who do you regularly meet now?
What is the main reason for the contact?
These are questions about the relationship between your LMA and the local authority mental health services.
Name of local authority:
When was the last time you met a senior representative of the Local Authority? (Please tick as many times as apply) This month Last months Three months ago Six months ago

Section Five	
If you receive income from a statutory agency is it awarded on the basis of a grant, a service level agreement or both? (Please tick which applies)	
Grant	Service level agreement Both
How much of your income from statutory agencies in the last financial year was received from grants and how much from service levels agreements?	
Grants	£
Service Level Agreements	£
Total Income	£
Has your local commissioner contacted your LMA about providing more mental health services locally? (Please circle which applies) Yes/No	
If yes, what services did they suggest you might provide?	
Section Six	
Do you have contact with GP's and/or primary care teams? (Please circle which applies) Yes/No	
If yes, how regular is the contact (Please tick as many times as apply)	
This month	Last months Three months ago Six months ago
Twelve months ago	More than twelve months ago Never
What is the nature of the contact?	
Section Seven	
Do you have contact with neighbouring LMA's? (Please circle which applies) Yes/No	
If yes, which LMA's:	
When was the last time you met a senior representative of a neighbouring LMA? (Please tick as many times as apply)	
This month	Last months Three months ago Six months ago
Twelve months ago	More than twelve months ago Never
How would you describe your LMA's working relationship with your neighbour LMA? (Please tick which applies)	
Good working relationship	Poor working relationship No relationship
Has the relationship changed or it about the same? (Please circle which applies)	
Changed/Same	
What is the nature of the contact?	
Does a neighbouring LMA organise any services/activities in your areas of benefit? (Please circle which applies) Yes/No	
If yes which LMA(s)?	
What services or activities does it organise?	
Do any of these services or activities benefit people in rural communities?	

Keith Elder
21 August 2007

Local Mind services and activities in rural communities' questionnaire

1. How would you describe the area where your local Mind is active? Please tick, which applies

Predominantly urban

Urban

A mixture urban and rural

Rural

Predominantly rural

Please tick, which applies

2. If your local Mind's area includes a rural community do you provide services or activities which people in rural communities can access? Please tick, which applies

Yes

No

Please tick, which applies

3. Please tell us about your services or activities for people in rural communities

Please tick those that apply

Rural service or activity Please tick those that apply	Which of these services or activities do you provide?	Have you identified a need for any of these services in your rural communities?
Advice and information service		
Advocacy		
Community support		
Counselling		
Crisis services		
Day services		
Employment services		
Supported housing		
Recovery		
Service user group		
Recruiting volunteers		
Recruiting trustees		
Other: Please state		

4. How are your rural services or activities funded?

Who funds your rural service or activity? Please tick those that apply		For how many years has the service been funded? Please circle, which applies						
Local authority		Less than 1 year	Less than 2 years	Less than 3 years	Less than 4 years	Less than 5 years	Less than 6 years	6 years or more
NHS		Less than 1 year	Less than 2 years	Less than 3 years	Less than 4 years	Less than 5 years	Less than 6 years	6 years or more
Big lottery fund		Less than 1 year	Less than 2 years	Less than 3 years	Less than 4 years	Less than 5 years	Less than 6 years	6 years or more
Your own funds		Less than 1 year	Less than 2 years	Less than 3 years	Less than 4 years	Less than 5 years	Less than 6 years	6 years or more
Grant giving trust or foundation		Less than 1 year	Less than 2 years	Less than 3 years	Less than 4 years	Less than 5 years	Less than 6 years	6 years or more
Other: please state		Less than 1 year	Less than 2 years	Less than 3 years	Less than 4 years	Less than 5 years	Less than 6 years	6 years or more

5. Please tell us if any of your rural services or activities have closed or ceased in the last 5 years

Which of these services or activities closed or ceased in the past 5 years? Please tick, which applies		Why did the rural service or activity close or cease?
Advice and information service	<input type="checkbox"/>	
Advocacy	<input type="checkbox"/>	
Community support	<input type="checkbox"/>	
Counselling	<input type="checkbox"/>	
Crisis services	<input type="checkbox"/>	
Day services	<input type="checkbox"/>	
Employment services	<input type="checkbox"/>	
Supported housing	<input type="checkbox"/>	
Recovery	<input type="checkbox"/>	
Service user group	<input type="checkbox"/>	
Recruiting volunteers	<input type="checkbox"/>	
Recruiting trustees	<input type="checkbox"/>	
Other: Please state	<input type="checkbox"/>	

Name of your Local Mind Association:

Name of the person completing the questionnaire:

Contact address:

Telephone:

Email

Date questionnaire completed:

Keith Elder
24, January 2008

Final questionnaire

Appendix 4.3

Dear Colleague

Mind services and activities in rural communities

I would be most grateful if you could spend a few minutes completing this questionnaire about Mind's services and activities in rural communities.

I am gathering this information for two reasons. Firstly I am undertaking an MSc by research at the Health Services Management Centre, University of Birmingham and this information is central to my research question about the future of mental health services in rural communities. Secondly because it will enable Mind to update and add to the information it holds about Mind services on its database.

Information held on the Mind database is shared from time to time with individuals and organisations outside of Mind. Please let me know whether you have any objection to Mind sharing any of the information you provide.

The questionnaire should take no longer than 15 minutes to complete.

If you are unable to complete the questionnaire either because your local Mnd is not active in a rural area or does not provide services for people in rural communities please return the partially completed questionnaire.

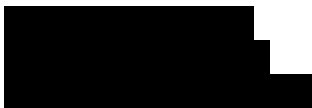
If you have any questions about the survey I can be contacted c/o the address, telephone or email below.

Thank you for spending time completing the questionnaire. Please return the questionnaire either in the envelope provided or if you have received it via LMA News by email.

I look forward to hearing from you.

Yours sincerely

Keith Elder
Rural Development Manager
Mind
PO Box 4831
Perton
Wolverhampton
WV6 6BD



Notes about the questionnaire

Question 1: This question is about the area in which your local Mind is active and in particular what sort of geographical area it is active.

Question 2: This question is about whether your local Mind provides a service or activity which people in rural communities can access. This may be because you provide a service or activity within a rural community or because you ensure that people in rural communities can access your services e.g. by providing transport.

Question 3: This question is about the type of rural services and activities you provide and also about whether you have identified a need for any of these services or activities. I have used the categories of service specified in Quality Management in Mind – Mind's quality framework for this purpose. In addition I have added:

- Recovery services, a term which has come to the fore since Quality Management in Mind was published.
- Service user group, i.e. a group that promotes/supports service user participation/consultation/involvement in local Mind activities.
- Recruiting volunteers, i.e. whether you actively recruit volunteers from rural communities or whether you have identified a need to recruit new volunteers from rural communities.
- Recruiting trustees, i.e. whether you have targeted rural communities for the recruitment of new trustees or whether you have identified a need to recruit new trustees from rural communities.

Question 4: This is a question about how rural services are funded and for how long they have been funded.

Question 5: This question is about rural services or activities that may have closed or ceased and why that happened.

Interview Schedule: Healthcare Commissioners

Background and focus of the study

Introductory Question

- 1) *How long have you worked as a mental healthcare commissioner locally?*

Main Questions

- 2) What range of services do you commission?

PROMPTS:

- WHAT TYPE OF SERVICE?
- COUNTY-WIDE AND LOCAL?
- WHAT IS THE BIGGEST? EXAMPLE?
- WHAT IS THE SMALLEST? EXAMPLE?

- 3) How would you describe your role as a commissioner locally?

Supplemental

- a) Has your role changed recently?

PROMPTS

- WHAT CHANGES?
- COMPARISON TO ONE YEAR AGO?
- TWO YEARS?
- THREE YEARS AGO?

- 4) What has been the impact of Commissioning Framework for Health and Well Being on commissioning?

- 5) What has been the impact of day service modernisation?

- 6) What has been the impact of IAPT?

- 7) What has been the impact of move towards working more with the third sector?

Supplemental

- a) How would you describe your relationship with the local Mind associations in your area?

- b) How would you describe your relationship with other voluntary and community organisations involved in mental health in your area?

- 8) How do the particular characteristics of the area impact on commissioning?

PROMPT:

- ECONOMIC,
- CULTURAL,
- GEOGRAPHICAL
- SOCIAL CHARACTERISTICS

Interview Schedule: Local Mind Associations

Background and focus of the study

Introductory Question

- 1) *When was (name) Mind set up?*

Main Questions

- 2) How would you describe your role locally?

PROMPTS:

- SERVICE PROVIDER?
- ADVOCATE?
- LOCAL VOICE?
- ANTI-STIGMA WORK?
- PROMOTING HEALTH & WELL BEING?

- 3) What is your relationship between your LMA and local joint commissioners?

PROMPTS:

- GOOD,
- POOR,
- DISTANT,
- CLOSE?

Supplemental

- a) Has the relationship changed?
- b) How and what has changed?
- c) Likely impact of these changes on your LMA looking ahead? One years? Two years? Three years?

- 4) What do you know of the new arrangements for commissioning mental health services?

PROMPTS:

- WORLD CLASS COMMISSIONING,
- SERVICES THAT ARE PERSONAL, SENSITIVE TO LOCAL NEED, MAINTAIN INDEPENDENCE AND DIGNITY
- COMMISSIONING FRAMEWORK FOR HEALTH & WELL BEING: WELL BEING RATHER THAN JUST ILLNESS,
- STRONGER VOICE FOR PATIENTS,
- SOCIAL COHESION,
- STRENGTHENING COMMUNITY,
- MUTUAL AID

- 5) How do the characteristics of the community in which you work impact on the work you do?

PROMPTS:

- ECONOMIC,
- CULTURAL,
- GEOGRAPHICAL,
- SOCIAL CHARACTERISTICS

- 6) What working relationships with other local LMA's?
PROMPTS:
- COOPERATIVE,
 - COLLABORATIVE,
 - COMPETITIVE
- 7) What working relationships with local mental health organisations?
PROMPTS:
- COOPERATIVE,
 - COLLABORATIVE,
 - COMPETITIVE
- 8) Biggest challenge/threat in the next 3 years?
PROMPTS:
- FUNDING,
 - TENDERING FOR CONTRACTS,
 - GOVERNANCE,
 - LOCAL NEEDS,
 - LOCAL SUPPORT,
 - MEETING MIND'S QUALITY STANDARDS,
 - QUALITY STANDARDS OF FUNDER,
 - OTHER?
- 9) Biggest strength/opportunity?
PROMPTS:
- FUNDING,
 - TENDERING FOR CONTRACTS,
 - GOVERNANCE,
 - LOCAL NEEDS,
 - LOCAL SUPPORT,
 - MEETING MIND'S QUALITY STANDARDS,
 - QUALITY STANDARDS OF FUNDER,
 - OTHER?
- 10) How do you see the future for your LMA?
PROMPTS:
- GROWING?
 - DECLINING?
 - MERGING?
 - WORKING IN PARTNERSHIP/COLLABORATIVELY?
 - DISAPPEARING?

Exploring the implications for the voluntary sector in rural communities of a
changing commissioning environment in mental health

Part 2: Qualitative Study

Labelling the Data from Joint Commissioners

Interview:

Name:

Date:

Interview Schedule	Responses from Interview	Thematic Framework
<ol style="list-style-type: none"> 1. <i>How long have you worked as a mental healthcare commissioner locally?</i> 2. <i>What range of services do you commission?</i> 3. <i>How would you describe your role as a commissioner locally?</i> 4. <i>Has your role changed recently?</i> 5. <i>What has been the impact of Commissioning Framework for Health and Well Being on commissioning?</i> 6. <i>What has been the impact of day service modernisation?</i> 7. <i>What has been the impact of IAPT?</i> 8. <i>What has been the impact of move towards working more with the third sector?</i> 9. <i>How would you characterise the communities in which you work?</i> 10. <i>How do these characteristics impact on what you commission?</i> 11. <i>How would you describe your relationship with the local Mind associations in your area?</i> 12. <i>How would you describe your relationship with other voluntary and community organisations involved in mental health in your area?</i> 		

Exploring the implications for the voluntary sector in rural communities of a changing commissioning environment in mental health

Part 2: Qualitative Study

Labelling the LMA Data

Interview:
Name:
Date:

Interview Schedule	Responses from Interview	Thematic Framework
<ol style="list-style-type: none"> 1. <i>When was (name) Mind set up?</i> 2. How would you describe your role locally? 3. Relationship with local healthcare commissioners 4. Knowledge of the new arrangements for commissioning mental health services/activities 5. How do the characteristics of the community in which you work impact on the work you do? 6. Working relationships with other local LMA's 7. Working relationships with local mental health organisations 8. Biggest challenge/threat in the next 3 years? 9. Biggest strength/opportunity? 10. How do you see the future for your LMA? 		

Creating a thematic chart

1. Local Mind associations
 - 1.1. Role of the LMA
 - 1.1.1. Supplementing statutory services
 - 1.1.2. 'Independent of statutory' services
 - 1.1.3. More prominent role in the local landscape
 - 1.1.4. Signposting & access to other services
 - 1.1.5. Combating stigma
 - 1.1.6. Input into local mental health strategy
 - 1.1.7. Promoting well being
 - 1.2. Working relationships with other LMA's, NHS Providers, Mind & Voluntary organisations
 - 1.2.1. Relationship with neighbouring LMA's
 - 1.2.1.1. Information exchange
 - 1.2.1.2. Coordinating activities
 - 1.2.1.3. Formal merger
 - 1.2.2. Relationship with NHS Providers
 - 1.2.2.1. with PCT provider
 - 1.2.2.1.1. Joint Management
 - 1.2.2.2. with Mental Health Trust
 - 1.2.2.2.1. Coordinating activities
 - 1.2.3. Working relationship with other voluntary organisations
 - 1.2.3.1. Collaborative relationships
 - 1.2.3.2. Competitive relationships
 - 1.3. LMA perspective on sustainability
 - 1.3.1. Use of volunteers
 - 1.3.2. Potential Role in well being
 - 1.3.3. Use of the natural environment
 - 1.3.4. Working collaboratively
 - 1.3.5. Working with young people
 - 1.3.6. Working with the elderly
2. Commissioners and commissioning
 - 2.1. Role of Commissioners

Creating a thematic chart

- 2.1.1. NHS/PCT Commissioning
- 2.1.2. LA/Joint Commissioning
- 2.2. Commissioning mental health services
 - 2.2.1. PCT Commissioning
 - 2.2.2. Joint Commissioning
 - 2.2.3. Local well being agenda
- 2.3. LMA working relationship with commissioners
 - 2.3.1. LMA relationship with NHS Commissioners
 - 2.3.2. LMA relationship with LA Commissioners
- 2.4. Commissioners working relationships with LMA's
 - 2.4.1. NHS/PCT Commissioners relationships with LMA's
 - 2.4.2. LA Commissioners relationships with LMA's
- 2.5. Commissioners working relationships with the voluntary and community sector
 - 2.5.1. Relationships with national/regional voluntary organisations
 - 2.5.2. Relationships with local voluntary organisations
 - 2.5.3. Relationships with small community organisations
- 3. Characteristics of the communities in which LMA & Commissioners work
 - 3.1. Social and Economic characteristics
 - 3.2. Spatial characteristics
 - 3.3. Population characteristics
 - 3.4. Age related characteristics**

Appendix 4.8: A Conceptual Framework or Index created for the qualitative study by identifying, organising and grouping the recurrent themes and issues in the data and then assigning numbers to the main and sub themes