

Adopting inclusive digital transformation in mental health

Discovery Findings Report

A Thrive by Design project, commissioned by
NHS England and Improvement

March 2022



Contents

Acknowledgments	3
Executive summary	4
Introduction	4
Background	4
What we did	5
What we found	5
Discussion	7
Recommendations	10
Glossary of terms	11
Key definitions	11
Acronyms	14
1. Introduction	16
1.1 Purpose of report	16
1.2 Background	16
1.2.1 The journey towards Inclusive Digital Transformation	16
1.2.2 Policy context	17
2. What we did	19
2.1 Rapid literature review	19
2.2 Documentary analysis (ICSs)	20
2.2 Local provider survey	21
2.3 Interviews	22
3. What we found	23
3.1 Rapid literature review	23

3.1.1 Overview	23
3.1.2 Key themes	25
3.2 Documentary analysis	28
3.2.1 NHSE/I System Returns	28
3.2.2 Key Lines of Enquiry (KLOEs)	29
3.2.3 Landscape of IDT in mental health	31
3.3 Local provider survey	33
3.4 Interviews	35
3.4.1 System level interviews	35
3.4.1 People with living experience	36
4 Discussion	38
4.1 Overview	38
4.2 Understanding of assets, needs and gaps in the local population	39
4.3 Building digital capacity and capability across local areas	42
4.4 Working in partnership to identify solutions	43
4.5 Building capability through strategies and leadership	46
4.6 Developing a digitally enabled mental health workforce	48
4.7 Engaging clinical and non-clinical staff	50
4.8 Access to opportunities for investment and development	52
4.9 Learning and sharing	54
5 Recommendations	56
5.1 For national organisations	56
5.2 For integrated care systems and local providers	58
6 Conclusion	61
7 Bibliography	63

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Executive summary

Introduction

Thrive by Design was commissioned by NHS England and Improvement (NHSE/I) to explore ways in which to enable a more Inclusive Digital Transformation (IDT) approach to mental health services at a local, regional and national level. This report provides the summary findings and aims to provide evidence based insights into the conditions needed at a national, regional and local level to enable the adoption and spread of IDT across the country.

Background

Digital exclusion, both generally and in a mental health context, is a complex system issue and therefore a shift in focus from individual digital inclusion interventions to whole system cultural change is needed. There is a related emergent policy agenda around mental health and digital inclusion including within the NHS Long Term Plan (NHS LTP)¹, guidance developed by the [NHS Confederation Mental Health Network](https://www.nhsconfed.org/publications/digital-inclusion-mental-health)², the Advancing Mental Health Equalities Strategy³, the Patient and Carers Race Equalities Framework (PCREF), the ‘What Good Looks Like’ framework⁴ and the ‘Putting data, digital and tech at the heart of transforming the NHS’ review⁵

¹NHS, 2019a. *NHS Long Term Plan*. [Online] Available at: <https://www.longtermplan.nhs.uk/> [Accessed 20 October 2021].

² NHS Confederation Mental Health Network, 2020. *Digital inclusion in mental health: a guide to help increase choice and improve access to digital mental health services*. [Online] Available at: <https://www.nhsconfed.org/publications/digital-inclusion-mental-health> [Accessed 20 October 2021].

³NHS, 2020 *Advancing mental health equalities strategy* [Online] Available at: <https://www.england.nhs.uk/wp-content/uploads/2020/10/00159-advancing-mental-health-equalities-strategy.pdf> [Accessed 20 October 2021].

⁴NHSX, 2021. *What Good Looks Like framework* [pdf] Available at: <https://www.nhsx.nhs.uk/digitise-connect-transform/what-good-looks-like/what-good-looks-like-publication/> [Accessed 20 October 2021].

⁵Department of Health and Social Care, 2021. *Putting data, digital and tech at the heart of transforming the NHS*. [Online] Available at <https://www.gov.uk/government/publications/putting-data-digital-and-tech-at-the-heart-of-transforming-the-nhs/putting-data-digital-and-tech-at-the-heart-of-transforming-the-nhs> [Accessed 20 October 2021].

What we did

- We conducted a [rapid literature review](#)
- We undertook a [documentary analysis](#) of information provided by Integrated Care Systems (ICSs).
- We [surveyed](#) people providing mental health services from all sectors to find out what the current picture is at a regional and local level.
- We [interviewed](#) stakeholders across ICSs, Clinical Commissioning Groups (CCGs) and NHS/community based providers to understand enablers and barriers and identify case studies.
- We **spent time with** people living with mental health illness who use/need mental health services and people from their support networks to develop a better understanding of how people experience the digital transformation of services and the barriers and opportunities this may present.

What we found

The literature review

Barriers and Risk Factors:

The literature provided us with an understanding of the policy context, and the rapid digital transformation of health and care services including the interrelated and complex barriers and additional risk factors to people living with mental health illness accessing digitally enabled services (e.g. affordability, income, poverty, trust concerns and low digital skills/efficacy in people who use and deliver services). The evidence shows, for some digital transformation can be beneficial, and for others it can exacerbate mental health illness. Digital has a branding issue and unchecked assumptions are made about digital exclusion in practice.

Solutions:

There is limited evidence on solutions in a mental health context, on ICSs taking a systemic approach and on co-design with seldom heard communities being used to develop solutions. Local, cross-sector level long term solutions are more likely to be effective due to contextual differences and the importance of local level relationships and partnership working. There is a need to give greater recognition to the value of the voluntary sector and smaller grassroots communities and other trusted touchpoints in reaching more excluded groups. The person centred care agenda extends to IDT, choice and personalised approach to building skills, confidence and motivation are enablers to digital inclusion. Approaches should tackle access, technical ability and clinical and attitudinal factors.

Documentary analysis

System returns to NHSE/I from ICSs, including Key Lines of Enquiries (KLOEs), indicated an emergent collaborative and co-design approach to the digital transformation of mental health services.

The landscape of IDT maturity in mental health maps against the diffusion of innovation theory and model⁶. There is a group of innovators and early adopters who have taken a whole system approach to IDT and whilst there is much interest, the rest are yet to follow. It is important to acknowledge that each ICS will have a unique set of circumstances, e.g. resources, relationships and historical context. The spread of IDT beyond early adopters will require an understanding of this complexity and recognition that this will involve a change of culture, development of new skills and relationship building.

⁶Everett.M.R., 1962. *Diffusion of Innovation*. Free Press

The survey

Enablers include: funding, access to resources, knowledge and awareness on what is available, co-production, staff engagement, user friendly and easy to use solutions and seeing change/impact. Barriers include: lack of appropriate funding, lack of access to resources and equipment, digital poverty, lack of knowledge and awareness and workforce capacity and capability. 57% of respondents reported that digital inclusion activities are happening locally with a range of activities taking place. Activities reported seem to have started between 2020 and 2021.

Interviews

The interviews indicated that digital inclusion activities taking place in mental health within the NHS tend to be patchy, short term, single focus and are generally not embedded at a system level. There are projects that demonstrate good practice that are driven by passionate people in organisations and places, but challenges arise when needing support of colleagues from other functions (e.g. procurement or IT) and funding is not long term.

Key learning points from people with living experience of mental health illness includes that personalised is important, digital is not all good or all bad and things change over time.

Discussion

A window of opportunity has opened up as a result of the pandemic revealing stark inequalities exacerbated by digital exclusion. This has led to digital exclusion moving up the health and care agenda and there is local and national recognition that digital exclusion is a challenge which needs to be tackled but there are only a handful of pioneers who are taking a systemic IDT approach. There are pockets of good practice. Using the diffusion of innovation theory, the next steps would be to

create the conditions where the whole system 'pioneers' can influence the early majority. There were also some specific areas which merit further discussion:

Understanding assets, needs and gaps in the local population:

Understanding the level of digital exclusion prevalence and factors that can lead to digital exclusion is fairly well established at a national level, but the evidence we have gathered suggests that there is still work to do in collating and analysing the local and granular level of needs and asset mapping at an ICS level. Partnerships with trusted touchpoints, often organisations or groups rooted in communities, was offered as a potential tried and tested solution to engage people to better understand need and to help co-design IDT of local services.

Building digital capacity and capability across local areas:

There is evidence of generic digital inclusion resources and activities at a national level but this does not go far enough to ensure digital transformation is truly inclusive. In addition, there seems to be very little activities focused specifically on people living with mental health illness despite the knowledge that people in this group are often facing multiple inequalities and barriers.

Working in partnership to identify solutions:

Co-design as a practice is a work in progress for many ICSs. It is evident that there is a need for funding, cultural change and capacity building to provide resources to undertake authentic co-design and/or co-production.

Building capability through strategies and leadership:

ICSs agreed that IDT requires leadership and a clear message that this is a priority at the system level, with interviewees referencing focused work streams and ensuring it is on the agenda at board level. There was a call for national policy direction and leadership to encourage and influence local leadership.

Developing a digitally enabled mental health workforce:

Staff competency, cultural hurdles and lack of digital skills, confidence and motivation of the mental health workforce was identified as a barrier to IDT across the research. Suggestions for overcoming this barrier included making it an integral part of everyone's job through adding into job descriptions and into inductions and training programmes, providing informal real time training opportunities and ensuring that people understand the benefits.

Engaging clinical and non-clinical staff:

It is important to engage clinical and non-clinical staff in IDT including that digital exclusion may be an issue for staff and that staff sometimes make the wrong assumptions about digital exclusion of people who are using services.

Access to opportunities for investment and development:

Issues with current resourcing approach includes; short term capital funding models, time limited funding calls, and a tendency to focus on individual initiatives that are not linked across the patch. IDT needs long term revenue funding. The community and voluntary sector need to be funded to play a key role in engaging and providing wraparound support.

Learning and sharing:

There needs to be a more concerted systematic effort to share information. Understanding the power of informal networks and a known place for finding and sharing ideas, insights and good practice was also highlighted as important.

Recommendations

Whilst this report is focused on mental health, digital exclusion is a complex system issue, and therefore, some of the recommendations relate to the wider context in terms of the wider determinants of health/inequalities and care pathways. Further detail about the recommendations are in [Section 5](#).

For national organisations

1. Long term revenue funding models
2. Clear, directive policy with supporting, comprehensive guidance & tools
3. Better evaluation methods
4. Build local leadership understanding and buy-in
5. Improve the Digital Brand
6. Better and consistent data collection locally and at a national scale

For integrated care systems and local providers

1. Carry out a needs analysis
2. Start from where you are and start small
3. Co-design with key stakeholders
4. Build the skills, confidence and motivation of the mental health workforce
5. Develop specific job roles and/or objectives within job roles
6. Build in mechanisms to support robust and inclusive feedback and service evaluation
7. Frame IDT within the wider health inequality agenda
8. Secure regional and local leadership 'buy-in'
9. Develop an understanding of the complexity of barriers and factors
10. Work with trusted touchpoints
11. Acknowledge the responsibility the health and care system has for supporting the digital inclusion of people in communities
12. Ensure informed choice is factored in at every stage of a pathway

Glossary of terms

Key definitions

In this section we have included definitions and descriptions of terms that it may be useful to refer to when reading this report. Some of these will evolve over time with our thinking and learning.

Digital Exclusion has been defined as the circumstance where ‘a section of the population have continuing unequal access and capacity to use Information and Communications Technologies that are essential to fully participate in society’⁷. Fundamentally, it is the result of an inequitable society and is a complex, dynamic and multi-layered system issue. Factors and barriers include life context, e.g. income, age, health conditions, and precarious life circumstances, digital access, skills, confidence and motivation, trust and concerns related to security and privacy and system side issues such as staff access, skills, confidence and motivation and poor infrastructure.

Digital Inclusion refers to the interventions designed to support people who are not able to use digitally-enabled services and tools. The Government Digital Service⁸ defined digital inclusion as making sure that people have the capability to use the internet to do things that benefit them day to day. The NHS Digital ‘Digital Inclusion Guide’⁹ states that digital inclusion includes; digital skills, connectivity and accessibility.

⁷ Amit, S., Haush, B., Rivka, O. Noam, T., 2015. Re-theorizing the “digital divide”: Identifying dimensions of social exclusion in contemporary media technologies [online] Available at: <<https://eprints.qut.edu.au/86701/>> [Accessed 20 October 2021].

⁸ Government Digital Service, 2014. Government Digital Inclusion Strategy [Online] Available at: <<https://www.gov.uk/government/publications/government-digital-inclusion-strategy/government-digital-inclusion-strategy>> [Accessed 20 October 2021].

⁹ NHS Digital, 2019. *NHS Digital Inclusion Guide*. [Online] Available at: <<https://digital.nhs.uk/about-nhs-digital/our-work/digital-inclusion>> [Accessed 20 October 2021].

Inclusive Digital Transformation (IDT) is an approach developed by Thrive by Design following a co-design discovery process with many different partners across the English health and care system. It recognises that digital exclusion is a complex system issue and aims to build greater digital equity into the system. This means focusing on co-designing inclusion into digital transformation as far upstream as possible with people at risk of digital exclusion and other stakeholders. It involves cross-sector and collaborative leadership developing a shared strategy based on an understanding of local needs and assets. It recognises the importance of person-centred wraparound support and access to accessible technology and the internet both for people who use and deliver services. This approach recognises poverty is often a primary root issue and advocates a systemic approach to tackling digital and data poverty.

Diffusion of Innovation Theory is a theory developed in 1962 by E.M. Rogers¹⁰. The evidence based social change theory explains how people adopt innovation over time. There are five established adopter categories of people within this theory; innovators, early adopters, early majority, late majority and laggards. The theory explores the different behaviours and characteristics of these different categories which can be useful to understand when seeking to influence change and the adoption of an innovation.

Co-design and co-production are approaches for creating new (or improving existing) products, services, care pathways etc., by working in a collaborative way with people impacted by the problem. The two approaches are effectively on a spectrum of different participatory methods. Whilst both co-design and co-production should include shared decision making and shared power, co-production reaches further towards people with living and learned experience leading the process and authentically being part of the team.

¹⁰ Everett, M.R., 1962. Diffusion of Innovation. Free Press

Language and groups

We have purposefully chosen to use the following words and phrases in this report when talking about people. We recognise that dialogue and debate around language and improving intent and terminology is an important part of tackling inequity and inequality. We seek to actively and continuously improve our practices and welcome feedback on language we use here and throughout the report.

Seldom heard - not 'hard to reach'. We use the phrase 'seldom heard' because we want to acknowledge that it is the responsibility of the system and those of us that work within it to ensure that everyone can access services and have their voices heard. In a position paper¹¹ SCIE explains that the concept of 'hard to reach' suggests there is something about the individuals that prevents their engagement with services and that 'seldom heard' stresses the responsibility of agencies to reach out to excluded people, ensuring that they have access to (social care) services and that their voices can be heard. We also sometimes refer to the disadvantages some groups face due to the constructs of society and systems.

People who use/need services - not 'service users' or 'patients'. We choose to use person-first language. We say 'people who need services' in most cases as we recognise that sometimes people may not be actively using a service, however we alternate between these phrases as appropriate. We will also talk about people with living experience of using services or people living with mental health illness (see below).

¹¹Robson. P. et al, 2008. *Seldom heard: Developing inclusive participation in social care*. SCIE [Online] Available at: <<https://digital.nhs.uk/about-nhs-digital/our-work/digital-inclusion>> [Accessed 20 October 2021].

(People living with) **mental health illness** - not 'mental ill health', or 'mental health difficulty' or other similar terms. Where relevant, we also refer to specific mental health illnesses or categories that are well recognised, e.g. people living with severe mental illness (SMI).

Acronyms

We know that acronyms can be excluding and so they are described at first mention, and an overview provided here for reference:

Acronym	Description	Acronym	Description
BSL	British Sign Language	ICT	Information Communication Technology
CAMHS	Child and Adolescent Mental Health Services	IDT	Inclusive Digital Transformation
CCG	Clinical Commissioning Group	KLOE	Key Lines of Enquiry
CCIO	Chief Clinical Information Officers	LDA	Learning Disability and Autism
CNIO	Chief Nursing Informatics Officer	NHSE/I	NHS England and Improvement
CYP	Children and Young People	NHS LTP	NHS Long Term Plan
EPR	Electronic Patient Record	PCN	Primary Care Network
FT	Foundation Trust	PTSD	Post-traumatic stress disorder
GDE	Global Digital Exemplars	SMI	Severe Mental Illness

IAPT	Improving Access to Psychological Therapies		VCSE	Voluntary, Community & Social Enterprise
ICS	Integrated Care System		PCREF	Patient and Carers Race Equalities Framework

1. Introduction

1.1 Purpose of report

Thrive by Design were commissioned by NHS England and Improvement (NHSE/I) to explore ways in which to enable a more Inclusive Digital Transformation (IDT) approach to mental health services at a local, regional and national level.

This report provides the summary findings of a discovery process which involved an evidence review and primary research fieldwork. Draft versions of this report offered a starting point for co-design work to develop a guide for people involved or interested in the inclusive digital transformation of mental health services. This report is now being published for wider audiences to provide evidence based insights into the conditions needed at a national, regional and local level to enable the adoption and spread of IDT across the country.

Alongside this report, more detailed write-ups of individual activities have also been produced. These are included in a separate Appendices document, available on request.

1.2 Background

1.2.1 The journey towards Inclusive Digital Transformation

There are a number of stakeholders seeking to achieve widespread recognition that in order to tackle digital exclusion we need to acknowledge it is a complex system issue which needs to be tackled at a system level. This involves a shift from a focus on individual digital inclusion interventions to whole system cultural change. The current national and local picture is a mix between the two. Both the language and approaches are still emergent, and therefore, the reader of this report will notice

some movement across the terminology. One of the ambitions for this programme is to help move the health and care community and system further along the journey towards Inclusive Digital Transformation (IDT).

1.2.2 Policy context

The policy agenda around mental health and digital inclusion and inclusive digital transformation is growing both in terms of being part of wider and more specific policies around reducing health inequalities and digital transformation of health and care services. .

The NHS Long Term Plan (NHS LTP)¹² sets out an ambition for mental health to fully mainstream digitally enabled care by 2024 to improve personalisation of care and patient choice. One example is implementing remote models of therapy for Improving Access to Psychological Therapies (IAPT), perinatal and children and young people (CYP). The NHS Mental Health Implementation Plan¹³ builds on these recommendations. The NHS LTP highlights the need to act to drive down health inequalities, recognise the central role of Voluntary, Community and Social Enterprise (VCSE) organisations and the upskilling of staff.

The NHS LTP predates Covid-19, and due to the acceleration of digital delivery of healthcare devices, inequity of digital access has become more prominent across health-related policy and guidance. There is also, arguably, an increased emphasis on supporting underserved communities. For example, NHS health providers have

¹²NHS England and Improvement, 2019a. *NHS Long Term Plan*. [Online] Available at: <<https://www.longtermplan.nhs.uk/>> [Accessed 20 October 2021].

¹³NHS England and Improvement, 2019b. *NHS Mental Health Implementation Plan 2019/20–2023/24*. [Online] Available at: <<https://www.longtermplan.nhs.uk/>> [Accessed 20 October 2021].

been urged to work collaboratively across sectors to reduce health inequalities and ensure that those in the greatest need are enabled to access them¹⁴¹⁵

The 'What Good Looks Like' framework¹⁶ is targeted at NHS leaders and sets out what good looks like at both a system and organisational level. The framework is included in the Integrated Care System Design Framework¹⁷ and NHS Priorities and Operational Planning Guidance¹⁸ to accelerate digital and data transformation. The seven success measures that make up the framework (well led, ensure smart foundations, safe practice, support people, empower citizens, improve care and healthy populations) are intended to allow leaders to identify the gaps and prioritise areas for improvement.

There is also the Advancing Mental Health Equalities Strategy¹⁹ which aims to ensure access to timely high quality mental health care, providing systems with the tools and enablers they need as described in the NHS LTP. The strategy covers the core actions NHSE/I will take with the support of Advancing Mental Health Equalities Taskforce (a group of sector experts including patients and carers). An important part of strategy is also the Patient and carers race equalities framework (PCREF) as it will be used to support NHS trusts to improve ethnic minority community experiences of care in mental health services.

The Advancing Mental Health Equalities Strategy aligns with the NHS mental health Implementation Plan 2019/20 - 2023/24 as well as playing an important part

¹⁴NHS England and Improvement, 2020. *Implementing phase 3 of the NHS response to the COVID-19 pandemic*. [pdf] Available at:

<<https://www.england.nhs.uk/wp-content/uploads/2020/08/20200807-Implementing-phase-3-ib.pdf>> [Accessed 20 October 2021].

¹⁵NHS England and Improvement, 2020. *Third Phase of NHS Response to Covid-19*. [pdf] Available at:

<<https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/20200731-Phase-3-letter-final-1.pdf>> [Accessed 20 October 2021].

¹⁶NHSX, 2021. *What Good Looks Like framework* [Online] Available at:

<<https://www.nhsx.nhs.uk/digitise-connect-transform/what-good-looks-like/what-good-looks-like-publication/>> [Accessed 20 October 2021].

¹⁷NHS England and Improvement, 2021. *Integrated Care Systems: design framework* [pdf] Available at:

<<https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf>> [Accessed 20 October 2021].

¹⁸NHS, 2021. *2021/22 priorities and operational planning guidance* [Online] Available at:

<<https://www.england.nhs.uk/publication/2021-22-priorities-and-operational-planning-guidance/>> [Accessed 20 October 2021].

¹⁹NHS (2020) *Advancing mental health equalities strategy* [pdf] Available at:

<<https://www.england.nhs.uk/wp-content/uploads/2020/10/00159-advancing-mental-health-equalities-strategy.pdf>> [Accessed 20 October 2021].

in the NHS plans to action health inequalities in the next stage of responding to the Covid-19 crisis.

The ‘Putting data, digital and tech at the heart of transforming the NHS’ review which included a specific related recommendation: ‘2. Consider and mitigate digital inequality in all service transformations. Expand the role of the SRO for Health Inequalities to include digital inequality’²⁰

There has been some recent activity across the Government, such as the Department for Digital, Culture, Media and Sport, which is running a cross government initiative on digital inclusion as part of the HM Government Covid-19 mental health and wellbeing recovery action plan²¹. The Department has also funded a range of digital inclusion initiatives and produced a practical toolkit to support organisations to evaluate digital inclusion initiatives to demonstrate social impact²².

2. What we did

2.1 Rapid literature review

A rapid literature review of academic and grey literature explored insights of relevance to IDT and digital inclusion for mental health services and people that need these services, including:

- A review of the current local, regional and national research, policy and practice (including strategies and delivery) landscape. Specific regard was given to identified barriers and drivers, level of maturity, local digital inclusion activities and good practice case stories.

²⁰Department of Health and Social Care, 2021. *Putting data, digital and tech at the heart of transforming the NHS*. [Online] Available at <<https://www.gov.uk/government/publications/putting-data-digital-and-tech-at-the-heart-of-transforming-the-nhs/putting-data-digital-and-tech-at-the-heart-of-transforming-the-nhs>> [Accessed 20 October 2021]

²¹HM Government, 2021. *COVID-19 mental health and wellbeing recovery action plan* [pdf] Available at: <http://allcatsrgrey.org.uk/wp/download/public_health/mental_health/covid-19-mental-health-and-wellbeing-recovery-action-plan.pdf> [Accessed 20 October 2021].

²²GOV.UK, 2017. *Digital Inclusion Evaluation Toolkit* [Online] Available at: <<https://www.gov.uk/government/publications/digital-inclusion-evaluation-toolkit>> [Accessed 20 October 2021].

- Examples of where IDT and digital inclusion are taking place at different levels to support people with mental health illness across different groups (particularly people who are more socially and digitally excluded) to access digital health-based services.

While mental health was the chief focus of this review, IDT ultimately requires a system level approach, and a commitment to work across organisations and individuals who support underserved groups across communities. For this reason, broader evidence was also considered, where deemed relevant.

The rapid literature review was conducted between April and May 2021. Findings from the rapid literature review are summarised in [Section 3.1](#) with a full overview in Appendix 1 (see separate Appendices document, available on request).

2.2 Documentary analysis (ICSs)

A review of relevant data and documentation that was already available to NHSE/I as part of routine returns at an ICS level was completed. These documents were analysed for insights relevant to the IDT and digital inclusion agenda both more widely and also with a focus on mental health pathways. ICSs had also recently been invited to answer a Thrive by Design survey on the wider topic of IDT and digital inclusion as part of NHSX funded mapping work (2020).

The documentation reviewed included:

- **NHSE/I System Returns** from ICSs completed between August 2020 and March 2021. Thrive by Design analysed the returns and scored based on work carried out in mental health and digital inclusion.
 - ICSs were required to show what actions are being taken to measure, design and implement digitally enabled care pathways and support digital inclusion. System reviews, with agreed actions, were published by 31 March 2021.

- **Key Lines of Enquiry (KLOE) responses** completed by ICSs during June to July 2021. The KLOE responses were already analysed but due to the nature of this report, this research completed a further analysis of two most relevant KLOE question responses. The questions were:
 - Does the redesign of mental health pathways involve ongoing cross-discipline collaboration including engagement with digital, clinical, service user and change management expertise, and joint working across health and social care?
 - Does the redesign of mental health pathways adopt a user-centred (clinician and service user led) and digitally inclusive approach?

This data was analysed between June and August 2021. Findings from the documentary analysis are summarised in [Section 3.2](#) with a full overview in Appendix 2 (see separate Appendices document, available on request).

2.2 Local provider survey

We invited people working in mental health services from all sectors to complete a survey to find out what digital inclusion activities were happening at an ICS and local level across England and to understand where people currently are in terms of some of the component parts of IDT (e.g. understanding of needs in locality, co-design and involvement of people who use services). Questions covered:

- Existing and planned local digital inclusion delivery activity
- The resources currently focused on digital inclusion
- The nature of funded digital inclusion activities
- The barriers and drivers, level of maturity, local digital inclusion activities and good practice case stories.

Survey data was collected between June and July 2021. The survey was distributed through Thrive by Design and NHSE/I networks and via social media. Findings from

the local provider survey are summarised in [Section 3.3](#) with a full overview in Appendix 3.

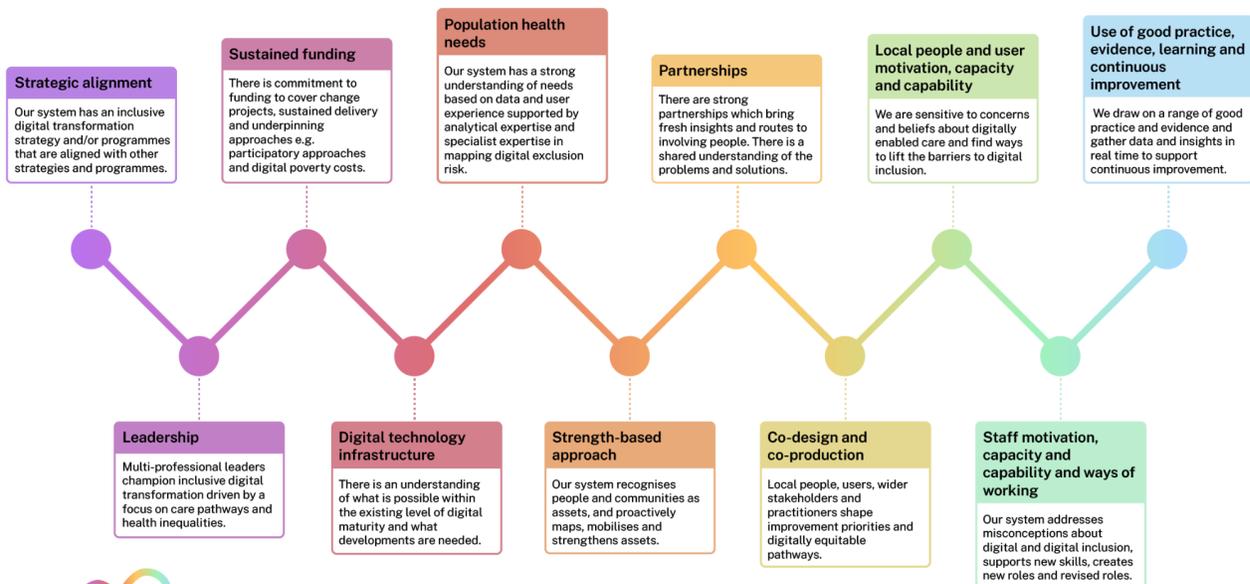
2.3 Interviews

We interviewed stakeholders across ICSs, Clinical Commissioning Groups (CCGs) and NHS/community based providers. We carried out semi structured interviews with the following:

- 13 stakeholders across 4 ICSs
- 5 stakeholders across 2 CCGs
- 8 stakeholders across 8 NHS/community-based providers.

We used the canvas tool in **Figure 2** as well as existing evidence to guide discussion in interviews.

Figure 2. Inclusive Digital Transformation Canvas (enlarge image [here](#))



The purpose of these system level interviews was to understand strategic activity (existing or planned), enablers and barriers to IDT within mental health at all levels and to understand what could be done to lift barriers. These interviews were used to inform the development of case studies of where ICSs/CCGs are currently up to in meeting the components of IDT and also evaluate individual digital inclusion interventions surfaced through conversations with providers.

We also spent time with 9 people living with mental health illness who use/need mental health services and people from their support networks to develop a better understanding of how people experience the digital transformation of services and the barriers and opportunities this may present. In addition to the 9 individual conversations, we had a discussion with a group of 15 young people. These discussions have also allowed us to capture stories from people who use services.

Interviews and discussions took place across August to October 2021. Findings from the interviews are summarised in [Section 3.4](#) and discussed in [Section 4](#) alongside the overall research findings. Interview outputs are also being used to create case studies which will be included in the next version of this report or other outputs from this work (e.g. the Guide) as appropriate.

3. What we found

3.1 Rapid literature review

3.1.1 Overview

In an environment where health inequalities continue to rise²³, the need to ensure that health care and support for people living with a mental health illness is

²³The Health Foundation, 2020. *Health Equity in England: The Marmot Review 10 Years On* [Online] Available at: <https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on> [Accessed 20 October 2021].

accessible across more disadvantaged and seldom heard groups is ever growing in importance.

The Topol Review²⁴ predicted that as healthcare technologies develop, digital inclusion will become more central to accessing mental health care. Digitally enabled care accelerated in response to the pandemic and consequently laid bare the true extent of the digital divide^{25 26}. There are a number of examples which showcase the potential benefits of digital based health interventions for people living with a mental health illness (see Appendix 1 for examples), yet there is limited robust evidence on how to increase engagement and uptake of digital mental health services, both overall and amongst particular disadvantaged and seldom heard groups²⁷.

The link between digital exclusion and health outcomes is now well established based on the literature. Evidence indicates that accelerated digital transformation across mental health provisions in response to Covid-19 exacerbated health inequalities²⁸ and in some cases, worsening mental health illness²⁹. This is partly due to mental health related services being experienced as less accessible by some, due to Covid-19 related factors, particularly where face to face services were

²⁴Health Education England, 2018. *The digital future of mental healthcare and its workforce: a report on a mental health stakeholder engagement to inform the Topol Review* [pdf] Available at: <<https://topol.hee.nhs.uk/wp-content/uploads/HEE-Topol-Review-Mental-health-paper.pdf>> [Accessed 20 October 2021].

²⁵The Health Foundation, 2020. *Learning from lockdown - How can we build a healthier future post-COVID-19?* [Online] Available at: <<https://www.health.org.uk/publications/long-reads/learning-from-lockdown>> [Accessed 20 October 2021].

²⁶For Healthcare Leaders HSI, 2020. *Inclusion crucial for a digital-first health service*. [Online] Available at: <<https://www.hsi.co.uk/technology-and-innovation/inclusion-crucial-for-a-digital-first-health-service/7027443.article>> [Accessed 20 October 2021].

²⁷Cardiff: Public Health Wales NHS Trust, 2020. *Digital technology and health inequalities: a scoping review*. [Online] Available at: <<https://phw.nhs.wales/publications/publications1/digital-technology-and-health-inequalities-a-scoping-review/>> [Accessed 20 October 2021]

²⁸NHS Confederation Mental Health Network, 2020. *Digital inclusion in mental health: a guide to help increase choice and improve access to digital mental health services*. [Online] Available at: <<https://www.nhsconfed.org/publications/digital-inclusion-mental-health>> [Accessed 20 October 2021].

²⁹Doctors of the world, 2020. *A Rapid Needs Assessment of Excluded People in England During the 2020 COVID-19 Pandemic* [pdf] Available at: <<https://www.doctorsoftheworld.org.uk/wp-content/uploads/2020/06/covid-full-rna-report.pdf>> [Accessed 20 October 2021].

restricted³⁰. This led to reports of reduced or even no access to health-based support for some people affected by mental health illness³¹.

3.1.2 Key themes

The themes that came out of the literature review were:

Barriers and risk factors:

- Barriers and risk factors are complex and interrelated and include; affordability, low digital skills/efficacy, lack of awareness, lack of access to devices, data and the internet, trust, concerns around usability or safety, income/poverty, language, literacy, culture and ethnicity, educational attainment, employment status, disability, housing status, cognitive impairment, age, precarious lives, lack of staff skills and capacity.
- It is important to consider the complexity and connections between inequalities and mental health illness and also the exacerbation of inequalities for people living with mental health illness of digital transformation.
- For some people there are barriers related to specific mental health illness, symptoms and treatment, e.g. reduced concentration, hallucinations and paranoid ideas.
- Recognition of the need to upskill staff in tackling digital exclusion for people living with mental health illness

³⁰NHS Confederation Mental Health Network. 2020. *Mental Health Network* [Online] Available at <<https://www.nhsconfed.org/networks-countries/mental-health-network>> [Accessed 20 October 2021].

³¹Rethink, 2020. *Rethink Mental Illness Severe Mental illness and Covid 19 Service support and digital solutions* [pdf] Available at: <<https://www.rethink.org/media/3820/rethink-mental-illness-severe-mental-illness-covid-19-service-support-and-digital-solutions.pdf>> [Accessed 20 October 2021].

- People living with mental health illness are less likely to use the internet to manage their condition (25%) than people with physical health conditions (37%)³²
- There are a number of (local or regional led) digital inclusion schemes running, but exclusion cannot be fixed with a one-off programme or initiative, and needs to be embedded at a system level. Though we are starting to see this coming through local and regional agendas and across ICSs, there is limited robust evidence specifically linked to those with mental health illness.

Digital and inequalities:

- There is some evidence to suggest general benefits to people living with mental health illness of digitally enabled services. Conversely, there is also evidence that in some cases digital services can contribute to worsening of mental health illness
- There is limited evidence of engagement, uptake or work around ensuring digital transformation is inclusive across more disadvantaged and excluded groups
- There is evidence that digital support can also help to overcome barriers for some groups where there is a lack of trust in healthcare professionals or stigma, e.g. some young people from black and ethnic minority groups.

Misconceptions:

- Digital is sometimes perceived as inferior and there is a need to raise awareness of the clinical effectiveness of digital solutions through peer stories and trusted sources

³²Lloyds Bank, 2021. *UK Consumer Digital Index 2021*. [Online] Available at: <<https://www.lloydsbank.com/banking-with-us/whats-happening/consumer-digital-index.html>> [Accessed 20 October 2021].

- There are assumptions made by people who use and deliver services that are untested and not always correct about suitability, quality and barriers both for and against the use of digital, e.g. some young people are digitally excluded (a third of young people struggled to access mental health support during the pandemic).

Solutions:

- The key to understanding issues and solutions is co-design but there is limited evidence of this happening systematically with more disadvantaged and excluded communities living with mental health illness
- Digital inclusion is a complex multi-faceted issue which requires more than a single focus and short-term project, it needs to be tackled at a system level
- The evidence suggests that local, cross-sector based solutions are more likely to be effective due to differences in local context and the importance of relationships and partnership working
- The person centred care agenda extends to IDT, choice and personalised approach to building skills, confidence and motivation are enablers to digital inclusion
- Based on the evidence presented, effective inclusive digital transformation approaches should build in mechanisms to tackle access, technical ability, clinical and attitudinal factors
- Recognition of the value of the voluntary sector and smaller grassroots communities and other trusted touchpoints in reaching more excluded groups.

3.2 Documentary analysis

3.2.1 NHSE/I System Returns

From the review based on NHSE/I System Returns completed between August 2020 and March 2021, some of the key findings were that:

- Most intended and ongoing activities across ICSs focussed on digital exclusion across the whole population rather than actions specific to mental health
- A small number of activities did refer to actions in the context of mental health - for example the implementation of Attend Anywhere and increasing engagement with grassroots communities who work with people living with mental health illness
- A small number of ICSs provided feedback on what they felt was required to ensure inclusive digital transformation could be delivered, including supporting access to a free to use platform/app for remote consultations; quality data on excluded populations; case studies and learning from other ICS areas.

Some examples of generic digital inclusion activities included:

- Supplying the right tech e.g. iPads for virtual family visits in hospital wards and care homes
- Triaging services to identify digital barriers
- Working alongside local councils and VCSE partners to support communities and individuals who are digitally excluded
- Working with VCSEs to design digital skills for inclusion training

- Supporting recruitment of Digital Ambassadors.

IDT across ICSs is, in the main, at early developmental stages, although there are some case studies of good practice. For example:

- Connected Nottinghamshire: Working across Nottingham and Nottinghamshire, the ICS have been running a digital and social inclusion project called 'Get Nottinghamshire Connected', as part of its long-term vision to achieve more accessible digitally enabled care. Through a recent partnership with 'Patients Know Best' to explore the digital needs of the local population the ICS is enabling free digital support and training across libraries and other community venues
- Islington CCG is working with partners to introduce trusted apps into the young person's mental health care infrastructure. They have been using the NHS apps library and building digital champions across 35 local, youth centred, organisations.

3.2.2 Key Lines of Enquiry (KLOEs)

As with the NHSE/I System Returns, ICSs reported on development of digital workstreams, steering groups (including those with representation from people who use/need services), dedicated staff, as well as digital inclusion programmes on track or starting off.

For example:

- East London Health & Care Partnership - have a dedicated mental health analytics support working as part of a mental health multidisciplinary Mental Health Programme Office alongside clinical leads and service managers
- Our Healthier South East London - have a community mental health transformation programme with the aim of providing a blueprint for the

mental health programme board on how service redesign can incorporate user-centred and digitally inclusive approaches into the overall programme.

Collaboration and transformation:

Overall, the KLOE responses suggest there is work being done to ensure ongoing cross-discipline collaboration. In a self-assessment, 55% of ICSs agreed and 40% of ICSs partially agreed that the redesign of mental health pathways involves ongoing cross-discipline collaboration including engagement with digital, clinical, service user and change management expertise, and joint working across health and social care.

There are transformation programmes in place (e.g. community transformation programmes) that involve a range of people including system partners, multi disciplinary teams and those with living experience. Co-design and collaboration with a range of services is being adopted. It is reported that although the work is currently being done, for many ICSs it is in early stages of development with room for improvement.

Designing in a user-centred and digitally inclusive way:

ICSs tended to report that they are aiming for pathways and processes to be co-designed with input from the clinicians and experts by experience. In a self-assessment, 50% of ICSs agreed and 45% of ICSs partially agreed that the redesign of mental health pathways adopt a user-centred and digitally inclusive approach. Some examples given were patient-led feedback programmes, digital working groups and 'digital cafes'. The approach is still maturing and not fully integrated into service redesign and there is further work required system-wide to define this approach across the ICSs. One ICS reported that the design of pathways is typically user-centred around clinicians but not people who use/need services and recognised that this was an area for improvement.

3.2.3 Landscape of IDT in mental health

Data from both the NHSE/I System Returns and KLOEs was analysed with the aim to gather understanding of the current landscape of maturity around IDT in mental health across England. Each ICS area was assessed individually based on data provided with numerical scores plotted against key criteria. When plotting this data, we observed that the maturity assessment followed the diffusion of innovation curve³³ (see also Diffusion of Innovation Theory³⁴ in [Glossary](#)) which describes how people adopt innovation over time and categorises different adopter types based on their speed to adopt a new technology or idea. The five established adopter categories within this theory and their associated proportions (as percentage of a population) are; innovators or pioneers (2.5%), early adopters (13.5%), early majority (34%), late majority (34%) and laggards or latecomers (16%). The theory explores the different behaviours and characteristics of the adopter categories which can be useful to understand when seeking to influence change and the adoption of an innovation or idea.

According to the diffusion of innovation theory, early adopters are the technology enthusiasts and visionaries and the next group, the early majority, are 'pragmatists'. The biggest challenge for innovation adoption is 'crossing the chasm' between these two groups. The theory highlights the importance of creating the conditions where the early adopters can influence the early majority, e.g. showcasing good practice, peer to peer networks etc.

Additionally it is important to acknowledge that each ICS will have a unique set of circumstances, e.g. resources, relationships and historical context. The spread of IDT beyond early adopters will require an understanding of this complexity and

³³Behaviour Change Models, 2019. *Diffusion of Innovation Theory*. [Online] Available at: <https://sphweb.bumc.bu.edu/otlt/mph-modules/sb/behavioralchangetheories/behavioralchangetheories4.html> [Accessed 20 October 2021].

³⁴ Everett.M.R., 1962. *Diffusion of Innovation*. Free Press

recognition that this will involve a change of culture, development of new skills and relationship building.

Of the 42 ICSs in England:

- 6 ICSs (14%) scored most highly in our assessment - these can be seen as our *pioneers and early adopters*
- 28 ICSs (67%) had similar scores in the middle in our assessment - we split these further into an *early majority* (16 ICSs or 38%) and *late majority* (12 ICSs or 29%)
- 8 ICSs (19%) had lower scores in our assessment - these can be seen as our *latecomers*.

These percentage breakdowns roughly mirror those in the diffusion of innovation curve and **Figure 1** provides a visual representation of the ICS areas within the adopter categories.

Figure 1. The current landscape of IDT in mental health in England (each circle on the diagram represents one of the 42 ICS areas)

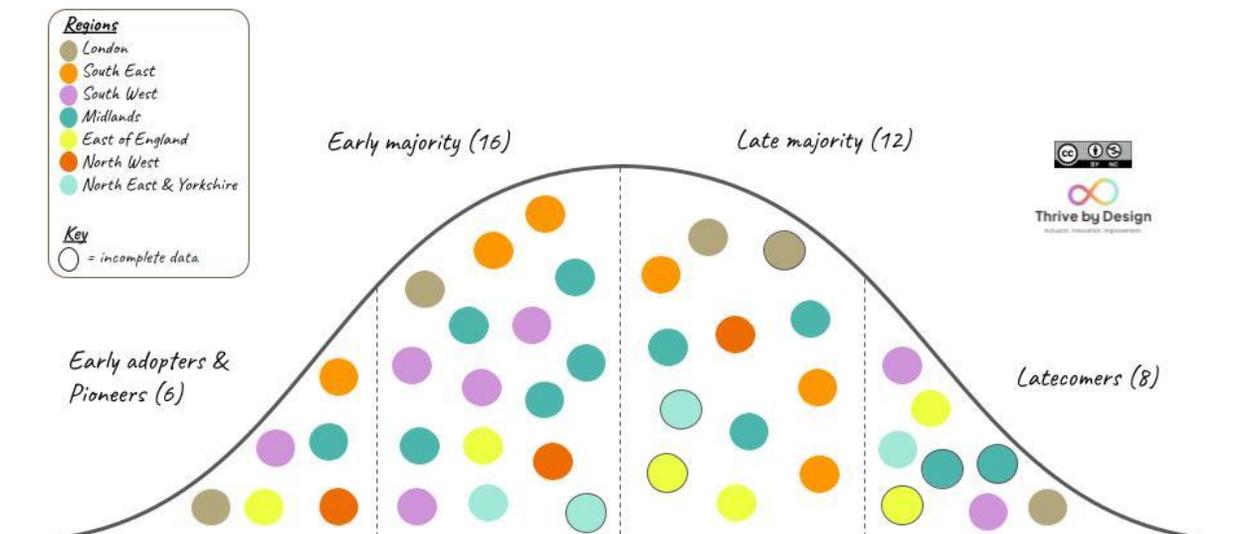


Figure 1 shows us that:

- ICSs across the country are currently at different stages with adopting IDT.
- There are no regional patterns for where ICS areas currently sit in terms of IDT maturity, suggesting that progress depends on ICS leadership not any coordinated regional approach.
- In the *pioneer and early adopter* group, there is representation from 6 of the 7 regions in England. These ICSs will be important for influencing spread of IDT within their regions and more widely.

3.3 Local provider survey

A total of 93 people responded to the survey and around half of all ICS areas were represented. 61% of responses were from 4 ICS areas: West Yorkshire & Harrogate (11%); Greater Manchester (12%); North West London (16%); Birmingham & Solihull (21%).

From the responses to the survey we found the following:

- Digital skills, confidence and motivation of service users were reported as a top barrier to entry for people accessing digital mental health services
- Respondents reported that those who are economically disadvantaged/poverty are less likely to access digitally enabled care
- Enablers to developing digital inclusion activities in mental health include: funding, access to resources, knowledge and awareness on what is available, co-production and collaboration (with users with mental health problems as well as clinicians and developers), staff engagement, user friendly and easy to use solutions and seeing change/impact
- Upskilling staff and service users through awareness around what is available at a local level and national level and staff training would be an enabler. For

service users, there is also a need to educate and train users on what is available and how to access it. These activities also need to be accessible to users (e.g. subtitles and British Sign Language (BSL) information available)

- Barriers to developing digital inclusion activities in mental health include: funding (opportunities to develop the activities), access to resources and equipment, digital poverty (costs for digital access), lack of knowledge and awareness (understanding the needs for different groups) and workforce capacity and capability
- About one third of respondents said that people who use/need services were not being involved (or they were not aware of such involvement) in the development of digital mental health services -where involvement is happening, it tends to be in the form of patient experience surveys, mystery shopping, service user groups, co-production workshops / meetings & discussion forums
- For authentic and meaningful involvement of people who use/need services, funding and direct investment is necessary alongside the right culture, skillset and engagement approach
- 57% of respondents from the survey (4 ICS areas) reported that there are digital inclusion activities happening in their organisations that support people who use their services
- 28% of respondents from the survey (4 ICS areas) provided examples of such activities, such as:
 - **South London & Maudsley NHS FT (August 2021 to Feb 2023)**
Digital Equalities project working with Community Calling (O2) to distribute refurbished phones with a data plan to people who use services and do not have a mobile device. Also employ two digital

mentors to support people who use services to improve their digital literacy and confidence. The aim is to improve accessibility to digital services and remote health care for people

- **Isle of Wight NHS Trust (June 2021 to December 2021)** -leading on a research project recruiting people living with severe mental illness (SMI) who self-report being digitally excluded/low levels of digital literacy to run focus groups to design the content and delivery of support needed to improve levels of digital health literacy in this group of people. This is to understand what support is needed to improve levels of digital health literacy in people living with SMI on the island and how it can be delivered and deliver this support and evaluate it and if positive outcomes incorporate in to care pathways
- **West Berkshire Council** (June 2021 to present) held a digital inclusion workshop with the aim to pull together shared learning and look at barriers and enablers and the work already happening in relation to digital inclusion. It also aims to connect people and share experience and resources to feed into the next phase about mapping activities, identifying the gaps and setting an ICS approach to digital inclusion to help address health inequalities

3.4 Interviews

3.4.1 System level interviews

Digital inclusion activities taking place in mental health within the NHS tend to be patchy, short term, single focus and are generally not embedded at a system level.

There are projects that demonstrate good practice that are driven by passionate people in organisations and places, but challenges arise when needing support of

colleagues from other functions (e.g. procurement or IT) and funding is not long term. Digitally inclusive care is being prioritised across some parts of the system, but not always well linked to mental health services.

Our review of ICSs/CCGs identified different levels of IDT “readiness”, with an overall lack of a systemic approach to tackling digital exclusion. Interventions in the main tend to be at a provider level, with an assessed lack of mechanisms to capture evidence of impact. Though there are some examples of structural and operational actions to set up an infrastructure which can support IDT, these are at early stages of maturity, with uncertainty around whether the approach is the right one. For example, one ICS reported:

“We have done a lot of development at the system level, it sounds good-there are activities planned-but once we do it, it may start to trip up... The ambition is there-but we are not ‘doing it’ yet”

We also discovered that none of the ICSs we spoke to currently has all the mechanisms in place to ensure IDT is embedded across the board. That said, some promising steps are being taken, and there was generally an awareness that ICSs/CCGs needed to do more.

3.4.1 People with living experience

The needs of people with living experience of mental health illness and using various different types of mental health service were considered through a series of semi-structured interviews, group discussions and informal chats.

The outputs from these conversations are intended to give a view of how digital transformation is experienced by those who use/need services, how digital in general plays into the lives of people who use/need services and what problems and opportunities it creates. An overview of some of the insights are provided below.

Personalised is important

- What works for one person, will not work for the next. And what one person needs support with, may change over time.
- Assumptions are often made about what a person can or can't do, or what they want or don't want.
- Often people who are accessing support for their mental health get short term support or intervention for what is often a longer term need or set of needs. The opportunities for digital to support in between intervention or service access are realised, however without guidance from a trusted person who understands an individual's needs this can be overwhelming in terms of where to start.

"The thing that people forget is that I feel like this 365 days a year. So I need help at different times of day. I don't see what digital can do but if it helped in those times then maybe. I need someone to show me."

Digital is not all good or all bad

- Use of digital has pros and cons for many of the individuals we spoke with. For some it is a lifeline for communicating with others, for a release (e.g. gaming) and for doing both practical and enjoyable things (e.g. shopping, listening to music, booking travel). It can also be detrimental for mental wellbeing (e.g. the feeling of always 'being on' or increased anxiety around how something works) or bring other risks (e.g. others taking advantage, or communicating with people who are not a good influence).
- There are many reasons why people may not currently have access to internet, a device or both -and this may be within the person's control or not. For example, loss, theft or pawning of devices, changing views on technology and how I want to use or avoid it at different times, loss of interest, not having

reliable internet connection within housing set up, changing living arrangements.

Things change and that's okay

- Services change and people know and expect that. However it is important for people to understand why things are changing, how it will affect them and what they will need to do. Not being communicated with is the biggest concern when things are changing.
- Being involved in how changes are made is seen as a good thing. However, the majority of the people we spoke with had not been asked or did not know how they would get involved. One person spoke about 'over-volunteering' themselves to things and how this had a negative impact on their wellbeing at the time - longer term commitments can sometimes be more challenging as you don't know how you are going to feel or what else you will have on.
- It is important to consider how people are involved and what will ensure it is going to work for them. Involvement alongside trusted people may be useful (e.g. a family member, peer or part of their support network) and careful consideration should be given to where the work happens, how it happens, language used and how this is done in a meaningful way.

4 Discussion

4.1 Overview

The following sections consider the current landscape unpicking some of the key themes identified from the findings collated through the literature review, documentary analysis, survey and interviews.

4.2 Understanding of assets, needs and gaps in the local population

The mental health charity Mind³⁵ argues that to ensure people who use services are not being excluded from services, it is necessary to ensure that data is collected and monitored so that this can be robustly measured.

Some ICSs (based on interviews and NHSE/I System Returns) are working with partner organisations (e.g. local authorities, Healthwatch, citizen panels) to identify local needs. One such example is from an ICS in North East and Yorkshire, who recently carried out an ICS mental health ‘digital inclusion stocktake’. A few other ICSs reported future plans to understand who is digitally excluded across their area. Others had recruited Digital Inclusion focused officers to help map needs across their respective areas and there are some ICSs and CCGs who are working across a range of grassroots communities to deliver interventions to underserved populations.

Understanding the level of digital exclusion prevalence and factors that can lead to digital exclusion is fairly well established at a national level (see Appendix 1), but the evidence suggests that there is still work to do in collating and analysing the local and granular level of need.

While there was an observed ambition to better capture assessment of local need, most interviewees agreed that they were struggling to identify both who is digitally excluded, and potential partners and opportunities in the local area to tackle this. It was also acknowledged that lack of awareness of what is happening could lead to duplication and missed opportunities to signpost people who may benefit from what

³⁵Mind, 2018. *Digital therapies and mental health support*. [pdf] Available at: <https://www.mind.org.uk/media/6513/briefing-digital-mental-health-support-2018.pdf> [Accessed 20 October 2021].

is on offer. A recent mapping review of ICSs supported these findings, identifying that only just over a third (35%) had carried out a needs analysis³⁶.

This point was also captured by Norfolk and Waverley CCG, who are delivering several digital inclusion activities with grassroot organisations who support underserved communities affected by mental health illness:

“There is no single place where we articulate our strategy, there is lots of good stuff going on—but we need to join the dots, there are lots of groups working well [we need to] address this as a system.”

Where there had been attempts to contact service users, a few interviewees acknowledged that they only collected information via digital methods. The Covid-19 pandemic had also been a barrier, with many ICSs reporting being unable to collect ‘outreach’ survey data for those digitally excluded due to social distancing restrictions.

Even the most well-designed digital mental health services will remain inaccessible without ensuring currently excluded populations are understood³⁷. Isle of Wight NHS Trust carried out a ‘self-audit’ of staff and local mental health charities, which was informed by the guide developed by the NHS Confederation Mental Health Network³⁸. The process was described as particularly valuable due to unpicking some of the assumptions held by staff, such as believing that digital is not suitable for people living with dementia. Though the response rate was assessed as low, the insights were fed back to the team, with the aim of using this information to inform clearer Trust policies around digitally enabled care.

³⁶Thrive by Design, 2020. *Mapping Digital Inclusion Across Health and Care in England*. [Online] Available at: <<https://wearemhabitat.com/blog/mapping-digital-inclusion-across-health-and-care-in-england>> [Accessed 20 October 2021].

³⁷Good Things Foundation, 2019. *Digital Inclusion in Health and Care: Lessons learned from the NHS Widening Digital Participation Programme (2017-2020)*. [Online] Available at: <<https://www.goodthingsfoundation.org/insights/digital-participation-lessons-learned/>> [Accessed 20 October 2021].

³⁸NHS Confederation Mental Health Network, 2020. *Digital inclusion in mental health: a guide to help increase choice and improve access to digital mental health services*. [Online] Available at: <<https://www.nhsconfed.org/publications/digital-inclusion-mental-health>> [Accessed 20 October 2021].

Working in partnership with community organisations where trust has already been built and ‘where people go’ provides an effective route to not only raise awareness of initiatives, but also gain feedback around design³⁹, and may be the only realistic way to work with some excluded groups. For example, homeless populations tend to have a higher prevalence of mental health illness than the general population and research shows this group are more likely to seek help and support with getting online if it’s provided in their own environment and by people they know and trust.⁴⁰

Community engagement was assessed as valuable and important across ICS and CCG interviewees, with many taking steps to work more closely with local councils and VCSE partners to support digitally excluded communities. One CCG valued engaging outside of their existing networks as it helped them to think ‘outside of the box’. All viewed an outward facing approach, working with VCSE/grassroot organisations to support access to the most excluded populations as essential. Good Things Foundation has recently become the first digital inclusion charity to be a part of the VCSE Health and Wellbeing Alliance, this is important as they have identified digital exclusion as a cross-cutting issue needing more attention. Respondents described actions they were taking to target underserved groups through working with schools, organisations and groups who are supporting refugee and migrant, gipsy and traveller communities and carer groups around their mental health and support needs. One example is a provider connected to Calderdale CCG is working alongside an organisation that supports asylum seekers and refugees to inform a more culturally appropriate offer.

³⁹Good Things Foundation, 2019. *Digital Inclusion in Health and Care: Lessons learned from the NHS Widening Digital Participation Programme (2017-2020)*. [pdf] Available at: <https://static1.squarespace.com/static/5a744e79bff20048181ee226/t/5f7f262c3672621a57560b28/1602168376463/Digital++Inclusion+in+Health+and+Care++Lessons+learned+from++the+NHS+Widening+Digital+Participation+Programme+%282017-2020%29++.pdf> [Accessed 20 October 2021].

⁴⁰NHS Digital, 2021. *How we can support digital inclusion*. [Online] Available at: <https://digital.nhs.uk/about-nhs-digital/our-work/digital-inclusion/supporting-digital-inclusion-locally> [Accessed 20 October 2021].

4.3 Building digital capacity and capability across local areas

There are different, cross-sector designed resources available to identify and address digital exclusion, which ICSs, CCGs and providers can be signposted to. These include mapping tools, infrastructure related (e.g., free WIFI), digital champion schemes, interactive platforms, national guidance, and training platforms. Of note is a digital inclusion resource developed by the Mental Health Network, NHS Confederation Mental Health Network⁴¹. A list of these resources can be found in Appendix 1.

Our findings identified that ICS/CCGs recognised the need to better support digital inclusion, with half of the 21 ICSs represented in a 2020 NHSX mapping exercise taking a strategic approach and providing funding to support digital inclusion activity⁴². Examples of activities specific to mental health include implementation of Attend Anywhere and increasing engagement with grassroots communities who work with people living with mental health illness. Other generic examples referred to supplying equipment, triaging services to support digital inclusion, working with Digital Ambassadors. There are also several examples of working across organisations to support digital inclusion, as identified across case studies and the discussion of provider initiatives included in Appendix 1.

While emerging examples of identifying and tackling digital inclusion activities are encouraging and are necessary, we would argue that this does not go far enough to ensure digital transformation is truly inclusive. There was also a sense that this was

⁴¹NHS Confederation Mental Health Network, 2020. *Digital inclusion in mental health: a guide to help increase choice and improve access to digital mental health services*. [Online] Available at: <<https://www.nhsconfed.org/publications/digital-inclusion-mental-health>> [Accessed 20 October 2021].

⁴²Thrive by Design, 2020. *Mapping Digital Inclusion Across Health and Care in England*. [Online] Available at: <<https://wearemhhabitat.com/blog/mapping-digital-inclusion-across-health-and-care-in-england>> [Accessed 20 October 2021].

somewhat partial in scope, not always being coupled with a commitment to identifying local needs, or co-designing solutions.

4.4 Working in partnership to identify solutions

Following on from the previous section, if we are to mitigate the risk of a ‘two-tiered’ system, where the experience of health inequalities is exacerbated due to being excluded from digital options, there is a need to ensure participatory practices are embedded across IDT agendas^{43 44}.

At present, participatory approaches exist, with examples of strategies being informed by consultation with people living with mental health illness. Though in the main, these tend to sit within services or interventions (with examples provided later Appendix 1), rather than being integrated at the ICS/CCG level.

Only a few could be described as close to co-design such as the Surrey County Council and Surrey mental health CCG collaborative. The NHSX mapping survey showed just under a quarter of ICSs (23%) reported that they were co-designing digital services with people who are digitally excluded (some examples of co-design at an intervention level are shared in Appendix 1).

Guidance developed by the NHS Confederation Mental Health Network⁴⁵ stresses that co-produced approaches are central to ensuring digital transformation is inclusive for people living with mental health illness. They suggest that this can be achieved through ensuring a diverse group of people who use services are involved (as is happening in some cases and identifying and upskilling potential digital leads to support the process, including upskilling staff).

⁴³Cardiff: Public Health Wales NHS Trust (2020) Digital technology and health inequalities: a scoping review. [Online] Available at: <https://phw.nhs.wales/publications/publications1/digital-technology-and-health-inequalities-a-scoping-review/> [Accessed 20 October 2021].

⁴⁴Rethink Mental Illness (2020) Webinar: "Thinking Differently - a 'first steps' guide to transforming community mental health care". [Online] Available at: <https://www.youtube.com/watch?v=LkFr1hxnBss&t=2396s> [Accessed 20 October 2021]

⁴⁵NHS Confederation Mental Health Network, 2020. *Digital inclusion in mental health: a guide to help increase choice and improve access to digital mental health services*. [Online] Available at: <https://www.nhsconfed.org/publications/digital-inclusion-mental-health> [Accessed 20 October 2021].

For interviewees, the most important element of setting up meaningful participation was working closely with a range of clinical and community groups, particularly those which incorporate co-design.

It was not generally viewed as necessary to set up communication specifically around digitally enabled care, but rather, to work with groups living with mental health illness and focus on the ways in which digital can support their care pathways. Isle of Wight NHS Trust who is carrying out a project on digital exclusion across populations impacted by severe mental illness (SMI) described working with a Lived Experience Lead based at their trust. The lead is linking across digital and non-digital transformation activities to identify what actions have been taken to ensure service design is inclusive. Another provider referred to digital as “the easy part” and that what was more important was building longevity through building meaningful collaborations.

Some co-design examples that were identified include:

- Cheshire & Merseyside ICT providers -13 partnership agencies across voluntary sector, NHS and schools agreed to co-design a centralised referral system –also co-designed elements of a Child and Adolescent Mental Health Services (CAMHS) service –which went live on mental health week
- Islington CCG: Digital Health Lab -Islington CCG is working with partners to introduce trusted Apps into the young person mental health care infrastructure. They have been using the NHS apps library and building digital champions across 35 local, youth centred, organisations
- Surrey County Council and Surrey mental health CCG collaborative have set up a Community Connections Surrey to bridge the gap between primary and secondary care mental health through working with independent user-led mental health network and service providers, to involve people who use their services (National Collaborating Centre for mental health, 2019).

From the survey results 34% of respondents reported that they don't know if people are involved in the development of digital mental health services or that they are not involved at all. There is a need for there to be funding to provide resources to do 'co-production' properly, a direct investment for co-production purposes only and a cultural change for it to be a part of the developmental process.

"We try and work collaboratively, but this isn't yet at a level where its 'business as usual' or indeed meaningful" -survey respondent

The data from the KLOEs documentary analysis suggests that 95% of ICSs are doing co-design in a structured way which is a significant difference from the research we have conducted. This could be due to:

- 1) The person (or people) who completed the KLOEs are privy to localised inclusive co-design however it isn't well known across the ICS so others tell a different story
- 2) The power dynamics of completing a KLOE for NHSE/I means that ICSs are seeking to influence and highlight their successes rather than highlight areas for improvement.
- 3) Different understanding of co-design approaches

There is a need to ensure that co-design is authentic and does not become a tick box exercise. Thrive by Design have been using co-design as an approach to digital transformation for a number of years and work to the following set of principles which help to mitigate against the inappropriate use of the term co-design. These are:

1. Design with people, not for them: The whole premise of co-design is including those who will be affected by decisions. They are the experts in their lives and know their world better than anyone else.

2. Go where the people are: Conversations are more open and honest when people feel comfortable and safe. Spend time where they spend time. Don't ask them to come to a formal building as it shifts the power dynamic. Consider your local community spaces

3. Relationships not transactions: Health is a very emotive subject. People's relationships with professionals, peers, digital tools and their environment are unique to them and must be taken into account

4. Work in the open: Share your learning. Share your work. Be transparent in your design decisions. Have the confidence to tell people why something has worked and why something hasn't. It will help others

5. Understand underlying behaviour: Look beyond immediate causes to understand the many different factors underlying behaviour: personal and social, cultural and economic. Be conscious of the assumptions that you might make. We look beyond those that others might have made.

6. Do it now: We learn so much more by trying things. Get it out there and see what works and what doesn't. This will unearth things that you will have never considered before and make things better.

4.5 Building capability through strategies and leadership

ICSs agreed that IDT requires leadership and a clear message that this is a priority at the system level, with interviewees referencing focused work streams and ensuring it is on the agenda at board level. A few had nominated 'Health Inequalities Executive leads' and NHS partners. In the North East and Yorkshire, ICSs are looking to set up a community of practice for quality improvement approaches to reducing inequalities in mental health trusts. Norfolk and Waverley CCG are

incorporating findings from research which explored user perspectives around searching for mental health information into a forthcoming digital strategy.

There was an observed difference in priority and approach to IDT based on whether or not an ICS was perceived to have buy-in at leadership levels. For example, an ICS which perceived that it was not prioritising inclusive digital care referred to a lack of time, incompatible IT systems and that it is not on anyone's 'to do list'. There were similar observations in NHS provider organisations where initiatives and projects seemed to be driven by people in services who have spotted the need for interventions and not necessarily supported across the whole organisation.

There were references to the link between the commitment of Chief Clinical Information Officers (CCIO) to IDT and the level of maturity of the ICS both in terms of digital and IDT. One positive example was an ICS who was more mature in its IDT approach who referred to a CCIO who is cascading a digital champion model amongst staff and had been instrumental in recruiting a Chief Nursing Informatics Officer (CNIO):

“We made a conscious effort that they were going to ensure it was about clinical engagement, about clinical change—different to other CCIOs—[where] some become executive info or systems people”

This also refers to the importance of factoring in someone from a clinical background to drive the agenda across the workforce.

Some felt that one of the things holding back a more systemic adoption of IDT was the need for a “push” at a national leadership level, with some referencing the Electronic Patient Record (EPR) agenda. Most referenced the need to work toward digitally inclusive care, but did not feel there was the same push to incorporate co-design. One interviewee expressed concern that without IDT being escalated, progress made during the pandemic will be lost once business as usual resumes.

Ray et al. (2020)⁴⁶ point out that ensuring digital health transformation is inclusive may feel daunting, particularly where accelerated measures have been put in place during the pandemic.

4.6 Developing a digitally enabled mental health workforce

While a system level approach was viewed as essential to embed IDT, often it is dedicated individuals championing the agenda, in the case of one ICS it was felt that whilst the inclusive agenda was being pushed through by "passionate individuals", this had not been sufficient for systems to take notice.

Existing mental health professional frameworks could benefit from embedding digital more explicitly. The research shows that most do not touch on co-producing health care or give more than a passing reference to digital. If digital is referred to, it is sometimes assessed as an 'optional skill'⁴⁷.

The local provider survey results showed that 44% of people said that digital skills, confidence and motivation of staff were a barrier to people accessing digital mental health services and staff engagement was a factor in developing digital inclusion activities in mental health.

Staff competency and cultural hurdles (e.g. around digital not being their 'thing') was a key theme across the fieldwork. One of the most frequently reported barriers to IDT and digitally enabled care was a lack of skills, confidence, and motivation of staff.

⁴⁶The BMJ Opinion, 2020. *Offline and left behind: how digital exclusion has impacted health during the covid-19 pandemic* [Online] Available at <<https://blogs.bmj.com/bmj/2020/07/03/offline-and-left-behind-how-digital-exclusion-has-impacted-health-during-the-covid-19-pandemic/>> [Accessed 20 October 2021].

⁴⁷Health Education England, 2020. *The Digital Readiness Programme*. [Online] Available at: <<https://www.hee.nhs.uk/our-work/digital-readiness>> [Accessed 20 October 2021].

Interviewees reported that once participants (and staff) are reassured that trying out digitally enabled care will not remove future choice, they are more willing to try it out (which supports the evidence base, see Appendix 1). Most interviewees identified a need to support and upskill existing staff so that they felt confident both using, and signposting digital resources:

“If culture or digital confidence or education with staff is not at a certain level—it is difficult for them to encourage inclusion with patients” (ICS Clinician)

Staff provided feedback on the kinds of training and support that they feel is needed. Though Information Communication Technology (ICT) related skills are undoubtedly important, interviewees were also keen to explore a more informal, personalised training that targets specific needs. Peer-led training and digital champion models were viewed by some as more effective for staff. One provider referred to low staff uptake of more formal training, and that peer models were identified as more popular than mandatory ICT based training through asking staff about their preferences.

As well as a more targeted approach, being more flexible around ways to engage staff in specific research projects was also happening, with one ICS successfully engaging staff through adapting the format of meetings:

“We have changed our methodology to embrace [digitally engaged staff]—so rather than dragging clinicians to board meetings once a month—if we are doing a project, we have 30 min sprint groups—everyone comes in if ... able to join for half an hour rather than using a traditional project structure. It has enabled them to engage and start conversations externally”

An interviewee with relatively well-developed IDT workstreams viewed that before true inclusivity can be factored into design, these should have input from mental

health staff across the board, and not just CCIOs or those who have an interest in IDT and digital inclusion, which tends to be what currently happens.

Respondents also referred to the need to:

- Develop tailored job roles and responsibilities amongst existing staff, with CCIOs, CNIOs, 'digital nurses', 'digital champions' and 'digital inclusion officers' all referred to
- Providing additional resources for existing staff (e.g. one CCG secured additional resources for admin staff so they could spend more time working with patients to access digital).

Unsurprisingly, the perceived impact of individuals tended to reflect the seniority of that staff member, with CCIOs viewed as having the ability to not only make a tangible impact, but also to ensure that IDT is included as part of their role, and that they have an interest in developing this area and driving it forward.

“Digital inclusion in mental health is multi-leveled and multi-faceted. There needs to be better planning for how services might use digital resources in their routine practice, better training and awareness of the platforms that work and are safe depending on the context of treatment, increase staff confidence about using digital resources routinely through training and ongoing support with the processes. Increase reach and accessibility of those resources for individuals with disadvantages. Encourage open feedback and communication of what works and what doesn't”-Survey respondent

4.7 Engaging clinical and non-clinical staff

For IDT to become a reality, some referred to the importance of focusing on co-design with staff including clinicians, with one CCG emphasising the need to ensure engagement across multiple backgrounds in mental health, including Psychosis, Crisis, Anxiety, Personality Disorders, and Learning Disability and Autism

(LDA). An observed perception across respondents was that there is a tendency to frame the discussion around access to patients:

“Digital inclusion is not just patients and carers—it is the workforce—at every level”-ICS

Regarding digital transformation agendas more broadly, a few referred to this traditionally being led by people from an ICT background, which was assessed as the wrong approach where discussed. For a few, ensuring a staff-led IDT approach was necessary to change belief systems amongst some clinicians that IDT is a ‘digital problem’ and not relevant to their role:

“Digital doesn’t mean IT—it should be a complete workflow—including culture and transformation for staff—accessibility for patients. I feel frustrated as digital isn’t a server—it is a whole transformation—tech is just the enabler—shouldn’t be the driver to improve inclusivity”-ICS

It can also increase confidence that they do not need to become ‘digital experts’, as one clinician involved in running a digital inclusion initiative put it:

“I am a clinician first—I don’t need to know the cogs and wheels”

Bringing clinicians on board also provides an opportunity to unpick some of the assumptions that digital is less appropriate for particular mental health conditions. Research evidence around offering remote consultations to people living with a mental health illness bears out this concern, with some professionals assuming it was less suitable, despite evidence which shows it can be beneficial (see Appendix 1). Assumptions about suitability of digital or an individual’s ability to access digital were highlighted in the discussions we had with people with living experience of mental health illness.

4.8 Access to opportunities for investment and development

While respondents unsurprisingly referred to an overall lack of investment there was also discussion that existing resourcing is not fit for purpose to support the long-term approach needed to apply IDT across systems. Comments referred to short term funding models, time limited funding calls, and a tendency to focus on individual initiatives that are not linked across the patch, as a clinician based at one ICS explains:

“We need to connect better –link the mental health system together from a digital point of view with [the overall] digital programme. At the moment it is Trust led – operationally driven, it needs to link at ICS level”

One CCIO viewed that the long term planning required to embed IDT requires a guaranteed revenue stream, rather than the current capital funding model. The CCIO pointed out that it is less about buying equipment and software, and more about the provision of training and support across the life of the software:

“We applied for a NHSE/I capital grant –which we received at the beginning of this year so we could buy the hardware. The only way to get money centrally is through capital allocation –which isn’t very helpful when looking to fund posts”

One CCG suggested that while mental health services have access to funding, its intended use is not always clearly defined, meaning that with funding pressures across the wider system, it is necessary for leaders to make the case for investment in IDT.

Most ICSs/CCGs agreed that opportunities to resource IDT ambitions tended to be easier if actions have already taken place to incorporate IDT, a good example of this was provided by Cheshire & Merseyside ICS:

“We are a GDE (Global Digital Exemplar) and our CCIO is a board member –it helps accelerate things... we also focus on deprivation and inclusivity at board level... Bidding for funding works for us, but we are technically advanced, we have already got foundations in place... trusts that are not digitally enabled.. .they don’t have a CCIO who can fill in the application with two days to do it –they don’t have the person with the allocated time.”

In light of this, recent moves to ‘level up’ funding, which will favour trusts who haven’t been part of earlier initiatives such as GDE and Fast Followers, was welcomed.

Evidence e.g. Good Things Foundation⁴⁸ emphasised the need for ICSs/CCGs to invest in setting up systems which support collaboration with the wider community. There are examples of where this is starting to happen, an ICS reported via NHSE/ System Returns that they are identifying funding streams, including Big Lottery or government grants, to help support IDT, as well as funding VSCE and public sector partnerships to carry out digital inclusion activities, with some focused on specific groups (such as older people). In another case a Trust is now providing small pots of transformation money to smaller charities:

“We are supporting a project to consider who is digitally excluded in the perinatal community... we have funded 12 organisations in the community –providing small grants of £10 to 15k”

⁴⁸Good Things Foundation, 2019. *Digital Inclusion in Health and Care: Lessons learned from the NHS Widening Digital Participation Programme (2017-2020)*. [Online] Available at: <<https://www.goodthingsfoundation.org/insights/digital-participation-lessons-learned/>> [Accessed 20 October 2021].

The survey indicated that digital inclusion activities seem to have recently started between 2020 and 2021, Sustained change requires sustained funding. Funding is often short term and for ‘pilots.’ Once this finishes there is an assumption that activities will be ‘sustainable.’ But this is rarely the case. There is also a greater risk where digital inclusion activities have emerged due to the pandemic and ‘emergency responses’.

Based on discussions that some providers may not know where to begin to ensure they provide digitally enabled care, a good place can be to identify a need and try out something small. A Post-traumatic stress disorder (PTSD) clinic based at Camden and Islington initially set up a small tablet lending scheme, through identifying that their patients needed access to digitally enabled care during the pandemic. Through delivering this, the trust built up confidence to expand and work with [AbilityNet](#) and other partners to expand the service. Being enabled to develop a ‘proof of principle’ around the benefits of targeting digitally excluded populations was reported as instrumental to being provided with resources to employ a digital inclusion officer.

4.9 Learning and sharing

We explored if ICSs/CCGs who have more proactively prioritised digitally enabled health and care amid Covid-19, were capturing and sharing learning to support improvement at the ICS/CCG and further afield. Most reported that information sharing more generally had improved during the pandemic, with reference to a range of avenues opening up through which learning can be shared. An example provided by one CCIO included: an ICS level digital group, ICS level CCIO group, regional level CCIO groups, and a WhatsApp group connecting every CCIO group in the country. Whilst the meetings were initially set in place to respond to Covid-19

related needs, these have expanded to include discussions around digitally enabled care, with most hoping that these groups will continue beyond the restrictions.

Yet despite these developments, a systematic approach is lacking, with evidence sharing tending to be more informal and ad hoc – generally across neighbouring ICS. A few referenced using the FutureNHS Platform for information, though feedback was mixed, suggesting that a consultation on how this platform might look moving forward would be useful. Understanding the power of informal networks and a known place for finding and sharing ideas, insights and good practice was also highlighted as important.

5 Recommendations

Based on evidence and insight surfaced through this discovery process, a set of recommendations are provided that we believe will enable the system as a whole and at a local level to work towards a more inclusive approach to the digital transformation of mental health pathways and services.

Whilst this report is focused on mental health, digital exclusion is a complex system issue, and therefore, some of the recommendations relate to the wider context in terms of the wider determinants of health and health inequalities and cutting across different clinical pathways.

5.1 For national organisations

- 1. Long term revenue funding models** - The majority of digital funding programmes are supported through capital funding models. Yet IDT is more suited to a guaranteed longer term revenue stream. Embedding IDT is less about buying equipment and software, and more about the provision of data collection and analysis, partnership building, training, and support to achieve meaningful and sustainable change. A levelling up focus to support areas that have most need, or have previously not participated in initiatives such as GDE may be useful.
- 2. Clear, directive policy with supporting, comprehensive guidance & tools which place inclusion at the centre of digital transformation and holds national and local health and care systems to account** - This means leadership and clear policy direction moving inclusion into the digital and health inequalities mainstream. It also means development and deployment of accompanying tools/guides, which ensure that every health and care

system takes an IDT approach, for example a framework through which ICSs can self assess, track and review progress. The process of development and the marketing and communications strategy is as important as the end product.

3. Better evaluation methods:

- a. Evaluate emerging good practice - the lack of evidence can limit future work. There is a need for better evaluation methods by those who deliver and use services.
- b. To support the diffusion of innovation, there is a need to focus on enabling pioneers to evaluate the impact of their work and share their knowledge and insights with other interested ICSs (e.g. through action learning sets, mentoring, coaching, networks, playbooks). This should include work happening across as well as within regions.

4. Build local leadership understanding and buy-in - There is a need to specifically target local leaders from ICSs and providers to raise awareness and encourage engagement in this agenda. Exploring opportunities for a co-ordinated regional approach could also help in ensuring local leaders have support networks in place across the region they work in.

5. Improve the Digital Brand - Explore how to engage people who deliver and who use services in understanding the benefits of using digital to improve the quality, efficiency and accessibility of services.

6. Better and consistent data collection locally and at a national scale - there isn't enough quality and quantity of data on those digitally excluded. Better access to data to help ICSs, local authorities, national bodies to assess the real picture (as opposed to the risk picture) will help to understand whether

digital exclusion is actually widening health inequalities or worsening health outcomes.

5.2 For integrated care systems and local providers

- 1. Carry out a needs analysis for service users, staff and voluntary organisations delivering those services** - Understanding the nuanced needs of groups and individuals allows us to challenge our assumptions about barriers to inclusion. Needs change across time, geography and community so this must be a continual process of assessment to review how stakeholders needs change over time.
- 2. Start from where you are and start small** - Whilst it is vital to take the time to understand the context and needs, it is also important to value existing strengths and assets and go where the energy is, set shared goals, start small and take iterative steps in the right direction.
- 3. Co-design with key stakeholders** - Co-designing means working with people who have a stake in the service and/or the problem to be solved. This involves people who need services (including people more often excluded), their families, clinicians and commissioners. Co-design approaches can be implemented in a variety of different ways but importantly should address power imbalances that might already exist between stakeholders and aim to build common purpose, trust and understanding. This leads to a better end result and means that the people involved feel a sense of ownership, who may in turn champion and engage their peers.
- 4. Build the skills, confidence and motivation of the mental health workforce** - Ensure professional frameworks and training supports staff to understand digital health technology, digital inclusion and IDT as a key priority and that

they embrace it. The research indicated a preference for peer-led, informal and personalised models.

- 5. Develop specific job roles and/or objectives within job roles** - Either create targeted job roles or better still, make tackling inequalities and inclusive digital transformation everyone's job. Formalising and giving people responsibility gives agency and permission to drive and deliver change and fosters new ways of working.
- 6. Build in mechanisms to support robust and inclusive feedback and service evaluation** - Understanding the needs of people who use the service, ensuring the design is flexible, accessible and personalised and that quality improvement mechanisms are built in to ensure ongoing communication and feedback.
- 7. Frame IDT within the wider health inequality agenda** - There is a direct relationship between digital exclusion and health inequalities. The latter is a high priority for integrated care systems. For both these reasons it is important to make the connection and frame IDT within the health inequalities agenda.
- 8. Secure regional and local leadership 'buy-in'** - Securing leadership 'buy-in' helps secure permission to dedicate time and resources to support IDT and increases the chances of wider and longer term developments.
- 9. Develop an understanding of the complexity of barriers and factors related to digital exclusion** - Digital exclusion is a complex issue that is compounded by socio-economic circumstance, health inequalities and mental health illness. Understanding the context of exclusion paves the way for a more impactful solution.

- 10. Work with trusted touchpoints to engage with people whose voices are seldom heard and who are more disadvantaged by the constructs of society and our current health and care systems** - Work in partnership with (and fund) community organisations where trust has already been built to engage with people who might not otherwise have their insights and needs heard. These communities (e.g. people who are homeless, refugees and asylum seekers and gypsy and traveller communities) are more likely to have a higher prevalence of mental health illness and health inequalities.
- 11. Acknowledge the responsibility the health and care system has for supporting the digital inclusion of people in communities** - As an ICS, there is a need to work together to identify funding for partnership with and digital inclusion delivery by those trusted touchpoints in the VCSE.
- 12. Ensure informed choice is factored in at every stage of a pathway** - Lack of choice for people who use and deliver services may disempower, diminish self efficacy and contribute to a reticence in using digital technology. Services need to be blended, offering real choice. Staff must also be supported to understand preferences and how to mitigate barriers to enable this.

6 Conclusion

This discovery has revealed a mixed picture of IDT across the country and across integrated care systems, yet it appears the case for digital exclusion as a priority for health and care systems is arguably won.

Delving into the detail, the research showed the complexity of barriers and factors in the context of mental health. Lack of trust, lack of available private space and expectations that a digital service is not as good quality as a face to face service are some of the barriers which were particularly emphasised in mental health alongside some of the general barriers such as lack of digital access, skills, confidence and motivation. The relationship between mental health, inequalities and digital is a complex one and it is important not to make assumptions about digital exclusion and either people who use or deliver services.

Language, policy and practice is still emergent and there is considerable more work to do at a national and integrated care system level to embed inclusive digital transformation into how we do things around here.

The research highlighted that much of the existing activity is focused on individual and often short term funded digital inclusion activities or projects. The research also highlighted a pattern of current adoption of inclusive digital transformation which correlates very closely to the well known diffusion of innovation meaning we do have innovators and early adopter integrated care systems who are well advanced in aspects of inclusive digital transformation in mental health. This is a good starting point as given the right conditions, the early mainstream will be influenced by these pioneers.

Key to further progress will be ensuring leaders are engaged and championing the agenda, improving data analysis, effective monitoring and evaluation mechanisms,

and cross-sector partnership working. Two key enablers which really stood out were co-designing in partnership with people who are seldom heard and digitally excluded and long term revenue funding.

It was possible to draw out a clear set of recommendations from this discovery both for national policymakers and integrated care systems and providers which it is hoped will enable the health and care system to travel forward along the journey of inclusive digital transformation.

There is a long way to go to ensuring we do not compound pre-existing inequalities with the digital transformation of mental health services but there is energy for change, pockets of good practice and a wide open window of opportunity in the formalisation of integrated care systems to make inclusive digital transformation how we do things around here in the mental health context.

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