GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Case for Change 2017

2017

This document sets out proposals to further improve integrated mental health services for working age adults in the community, consisting of the community mental health teams, crisis teams and specialist teams within a whole community system including the primary care mental health services and non-statutory services

Proposed Developments for Community Mental Health Services

Contents

1. Summary

This document sets out proposals to further improve integrated mental health services for working age adults in the community, consisting of the community mental health teams, crisis teams and specialist teams within a whole community system including the primary care mental health services and non-statutory services.

The proposals have been shaped by previous engagement with partners and stakeholders, including patients, carers and staff following concerns raised by these stakeholders that the Community Mental Health Teams (CMHTs) were facing particular challenges including:

'excessive referral demands'
'low core caseload contact time with patients'
'were a catch all service'
'were working in mostly poor environments'
'have difficulty in delivering psychological therapies'
'suffering reductions in LA staff who are unable to deliver statutory work'
'working to a lack of vision for community services'
'slow progress with modernizing professional roles'

This document is being used as a case for change to enable stakeholders and agencies to test service model options against a set of clinical, professional and operational aspirations based on the service users experience and needs.

This will inform the next stage of the engagement process, in conjunction with the UHB and Community Health Council to agree how we test this and develop an implementation plan based on an EQIA.

To date strategic parameters advised by the UHB and council relate to it being complementary to the Shaping Our Future and Well Being Strategy and Together for Mental Health delivery plan.

The next stage will be to collaborate with stakeholders, including the Community Health Council and other partners to agree the next steps of engagement.

2. Purpose of the Document

This document sets out some specific service improvements that the UHB and its partners would like to make to community mental health services for working age adults in secondary care. This is in order to address concerns over poor accommodation, increasing demand, the impact that has on professional and statutory roles and the delivery of psychological interventions. Improving these aspects of the service will crucially support changes that will help us to continue to work towards our home first vision for the services whilst providing a therapeutic, high quality and safe service. The catalyst for this review relates to previous concerns raised by community staff, service users and carers around these issues, benchmarking of community performance and activity and feedback from GPs.

To inform and support this work, in 2015 we have already sought the views of the patients, carers, staff and the wider community in describing what success looks like and what service model options are available to us in achieving this success.

We now want to test back what we have heard, share our response to the issues raised and discuss the proposed way forward for a whole system in primary and secondary care and our partners. We are committed to working with our communities and partners to improve health outcomes for everyone, delivering outcomes that matter to people, and would like to thank everyone who has contributed so far and people who contribute to this next phase of engagement. As the UHB takes the next steps we are also looking forward to working with partners and stakeholders to further progress our services.

3. The University Health Board

Cardiff and the Vale University Health Board is one of the largest NHS organisations in the UK, providing healthcare services for the 475,000 people living in Cardiff and the Vale of Glamorgan. Working with many professional groups, we promote healthy lifestyles whilst planning and providing healthcare in people's homes, community facilities and hospitals. In addition to considering the needs of the local population, the UHB also provides specialist care to the people of South Wales, Wales and for some services, the wider UK.

Our mission, Caring for People; Keeping People Well is why we exist as a health board and our vision is that a person's chance of leading a healthy life is the same wherever they live and whoever they are.

In making this vision a reality, we have been working with staff and people who use our services and partner organisations to shape our strategic direction. At its heart our strategy, **Shaping Our Future Wellbeing**, has the desire to achieve joined up care based on the 'home first' idea, avoiding harm, waste and variation, empowering people and delivering outcomes that matter to them.

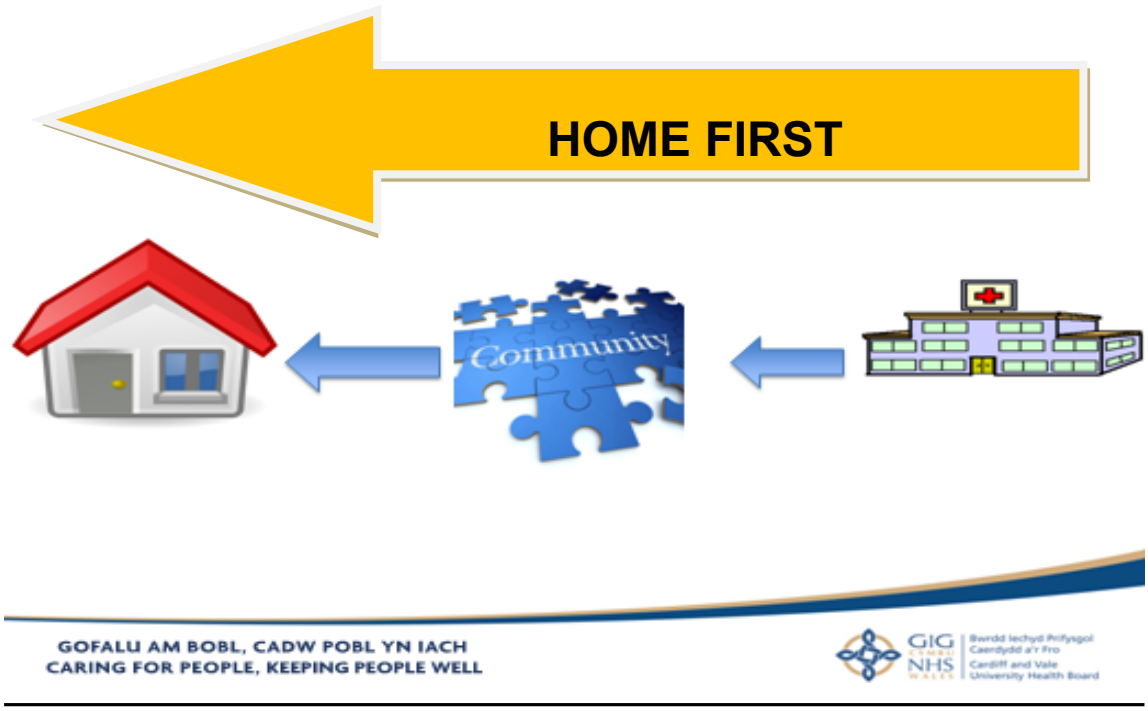
4. What are Mental Health Community Services

Mental well-being has been defined by the World Health Organisation as: 'A state whereby individuals recognise their abilities, are able to cope with the normal stresses of life, work productively and fruitfully, and make a contribution to their communities'. The **'Together for Mental Health'** national strategic plan is designed to ensure that people will be resilient in life and to life changes, will be prevented from developing a mental illness and where a mental illness has developed, to promote recovery. It has an all ages, life course approach, and includes both prevention and treatment elements. Therefore the strategy focuses on the needs of people with and without a mental health diagnosis. It acknowledges the roles that primary care, the statutory and third sector play in promoting well-being for service users and carers.

In 2010 the Welsh Government issued the Interim Policy Implementation Guidance and Standards for Delivering Community Mental Health Services. This guidance sets out a tiered model of mental health care and places Community Mental Health Teams (CMHTs) at the heart of secondary mental health care in Wales. It states that CMHTS:

- Receive referrals (at present mainly from primary care)
- Undertake screening assessments
- Offer a range of more specialist assessments and interventions and deliver a constructive discharge

Subsequently in 2012 Mental Health (Wales) Measure 2010 was implemented. The Measure provides primary legislation and regulation on the provision of Local Primary Mental Health Support Services, Part 1, and the coordination of care and treatment for relevant patients receiving secondary mental health services in Wales, Part 2. Part 2 of the Measure places recovery and a holistic approach to care and treatment planning at the forefront of delivering secondary mental health care.



5. Our Population in Cardiff and Vale

Size

The population of Cardiff and Vale of Glamorgan is growing rapidly. Currently, around 484,800 people live in this area and between 2005 and 2015, the number of people increased by 9.2%, more than twice the Wales average of 4.4%. The number of people aged over 85 years has increased by almost 35% between 2005 and 2014[1]. This population growth is set to rise further with the largest increase (10.4%) in population was seen in Cardiff which increased from around 320,000 in 2005 to 350,000 in 2014

Projected Population 2021 - Under 16 - 99,100 / 16 – 64 - 336,200 / 65 – 84 - 72,400 / 85+ - 12,800

[1] Office of National Statistics (ONS) mid-year population estimates (MYEs), 2005 and 2015

Total - 520,500

Age and Gender
The city of Cardiff has a skewed population compared to the Vale of Glamorgan because of the large numbers of students and disproportionately fewer older people. In 2014, approximately 18.4% of Cardiff's population was aged 15-24. As a higher proportion of mental disorders develop between the ages of 14 to 20, Cardiff has greater incidence of mental illness. In contrast a fifth of the Vale's population was aged 65+ in 2014, with its greater proportion of older people, the population of the Vale is likely to comprise a higher overall percentage of people with dementia than Cardiff.

Ethnicity
The proportion of people from the black and ethnic minority (BME) community[2] in the Vale of Glamorgan is 4% and is similar to the Wales average at 6%. In Cardiff, however, the proportion stands at 16%[3].
Research shows that the incidence of psychosis is higher in the African Caribbean and Black African populations[4].

Educational Attainment
The percentage of Year 11 school leavers who were known to be not in education, employment or training (NEET) in 2015 in Wales was 2.8%, ranging from 1.7% in the Vale of Glamorgan to 4.5% in Cardiff[5].
In general, people with a psychotic illness have fewer qualifications and are more likely to have left school before the age of 16 with no qualifications, compared to other groups.

Unemployment
In 2010,the percentage of people who were claiming one or more employment related benefits in Wales was 14.7%, whereas in Cardiff and the Vale, it was slightly less at 12.2% and 11.9% respectively. Mental health conditions are the primary reason for those claiming health-related benefits[6]. More recent data for the year ending 30th June 2016 suggests 4.4% of Vale of Glamorgan residents and 5.2% of Cardiff residents are classed as unemployed.

Housing and Homelessness
The number of households in Cardiff who were deemed to be eligible, unintentionally homeless and in priority need was 820 in 2014/15. In the Vale of Glamorgan this was

[2] BME defined as all non-white ethnic groups aggregated from KS201EW table (ONS, Census 2011)

[3]Office of National Statistics (ONS) Census 2011, KS201EW.

[4] Morgan et al, First episode psychosis and ethnicity: initial findings from the AESOP study, World Psychiatry, 2006, 5:1, 40-46.

[5] Careers Wales Pupil Destinations from Schools in Wales, 2015

[6] ONS and DWP data from Public Health Wales Observatory, Nov 2009 to August 2010

235[7]. Of these households, 50 had a member who was vulnerable due to a mental illness, learning disability or learning difficulty. Statistically, you are more likely to have a mental health condition if you are homeless: 43% of those accessing homelessness projects in England were suffering from a mental illness.

Diagnosis of Mental Illness

According to the GP registers in Cardiff and the Vale as at March 2016, there were 4,372 people with a diagnosis of a serious mental illness.

There were also 2,947 people with a diagnosis of dementia. However, according to the Alzheimer's Society 2014 report, GP data represents only a fraction of people with dementia in the community[8]; therefore under-diagnosis is an issue, despite Cardiff and Vale having the best detection rate in Wales.

Deprivation

Deprivation is associated with poorer mental health outcomes and those with a poorer level of income are more likely to have a common mental illness. Deprivation in the Vale of Glamorgan is largely clustered around Barry and 6.4% of the Vale areas fall into the 10% most deprived in Wales. In contrast, areas of deprivation in Cardiff are mainly in the southern arc of the city and 15.8% of Cardiff's areas fall into the 10% most deprived in Wales[9]. Cardiff includes some of the least deprived areas of Wales (e.g. in Cyncoed) and some of the most deprived (e.g. in Splot), which partly explains the large gap in healthy life expectancy in males (24.4 years) within the local authority.

Prevalence

According to the Welsh Health Survey 2014-15, 13% (age-standardised) of adults in Wales reported currently being treated for a mental illness, the prevalence was 14% and 11% for Cardiff and Vale respectively[10].

This is likely to be an underestimate of the people who have a mental illness as surveys suggest that in England 16% of people have a common mental illness.

In terms of a diagnosis of a serious mental illness (schizophrenia, bipolar disorder and other psychoses), there are 4,372 people on primary care registers with these conditions, which is 0.9% of the total GP list size[11].

A prediction tool, PsyMaptic has calculated that, in Cardiff and the Vale, we would expect to find 61 new cases of psychosis per annum, between the ages of 16-64[12].

In Cardiff the number of persons age 30 and over predicted to have dementia in 2016 was 3,677 rising to 5,242 in 2030. In the Vale of Glamorgan, the number of persons

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[7] Info base Cymru, 2013/14. Available from: http://www.infobasecymru.net/IAS/themes/housing/tabular?viewId=26&geoId=1&subsetId=

[8] Alzheimer's Society, http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=1666

[9] This is taken from the results of the Welsh Index of Multiple Deprivation 2011.

[10] WHS, 2014-15, WG. http://gov.wales/docs/statistics/2016/160622-welsh-health-survey-2015-health-status-illnesses-other-conditions-en.xls (Table A2)

[11] Quality and Outcomes Framework, June 2016, WG https://www.gpcontract.co.uk/browse/262/Dementia/16

[12] Psymaptic, http://www.psymaptic.org/prediction/psychosis-incidence-map/

age 30 and over predicted to have dementia in 2016 was 1,867 in 2013 rising to 2,905 in 2030[13].
In 2016, there are 2,947 people with a diagnosis of dementia on GP registers in Cardiff and Vale. When adjusted to take account of the age structure of the population in 2013, the dementia rate is 2.9 per 1,000 people, compared to 2.7 per 1,000 people for Wales as a whole[14]

Service usage
Benchmarking data shows that the Adult Community Mental Health Team caseload per 10,000 weighted populations is 147 within Cardiff and Vale, which is similar to NHS Benchmarking data of 140. Within this service, there are 252 contacts per whole time equivalent, compared to 240 across the UK.
The numbers of admissions per 100,000 populations are 245 in Cardiff and Vale, compared to 234 across UK benchmarking data. Bed occupancy in Cardiff and Vale is 115%, whereas across the UK it is 91% on average.

Suicide
Suicide rates in Wales are higher than in England but lower than in Scotland and Northern Ireland[15]. During the period 2002-2015, European age-standardised rates (EASRs) (aged 10+) in Cardiff and Vale ranged from 12.1 per 100,000 in the Vale of Glamorgan to 13.1 per 100,000 in Cardiff, similar to the Wales rate of 12 per 100,000 persons[16]

[13] Daffodil Projections, Welsh Government, 2016

[14] Produced by Public Health Wales Observatory, using Audit+ (NWIS).

[15] Using data produced by Public Health Wales Observatory, taken from ONS, GROS & NISRA

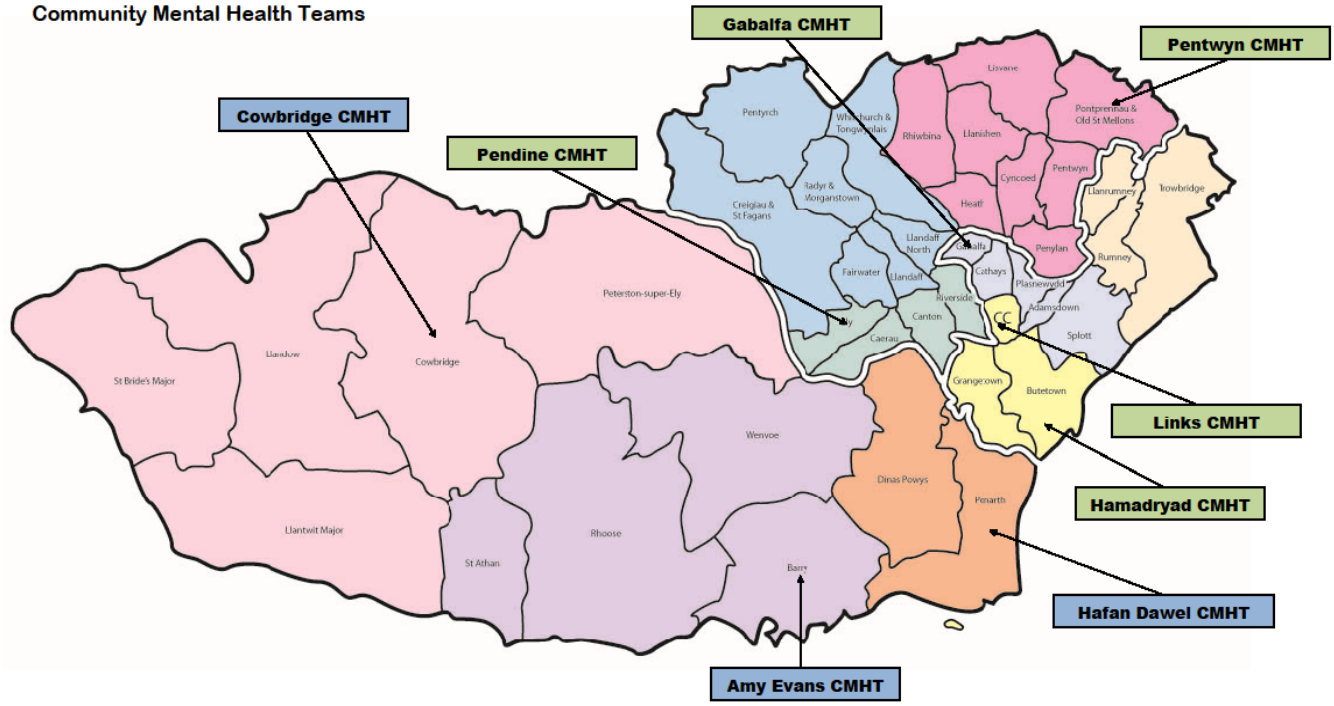
[16] Figures produced by Public Health Wales Observatory, using PHM & MYE (ONS)

Concluding Comments

It is clear from the population information that Cardiff and Vale offers a diversity of challenges related to growth, ethnic mix, morbidity, risk and homeless which are unique challenges collectively. The mental health clinical board is aware that these additional factors challenge the sustainability of services is the current service model remains the same.

6. Cardiff and Vale Community Mental Health Services

In Cardiff and Vale Mental Health adult mental health Community services are delivered out of 8 community mental health teams, five in Cardiff and three in the Vale



Each CMHT has developed a process of referral management, that although has consistencies across the neighbourhood footprint, is also based on local interpretation, resource and practice. Each CMHT has developed local relationships with GP practices in the area. The 8 CMHT neighbourhood boundaries are currently not aligned to localities, clusters or Local Authority boundaries.

These Multi disciplinary and multi agency teams began to be developed three decades ago and moved the health and social care support of the majority of people with a serious mental illness into these community settings, acting as the cornerstone of mental health services. These local teams enabled people to be cared for and treated

closer to or at home. All 8 teams provide a range of referral responses from routine within 28 days to the EU equivalent of emergency response times within 4 hours of a GP request. All emergency and urgent requests are responded to in person by the CMHT duty workers. The teams work to Welsh government guidelines for Community Mental Health Teams.

The teams provide caseload care and support for up to 3,500 people across Cardiff and Vale at any one time and deal with up to 600 referrals per month between them.

CMHTs in Cardiff and Vale are jointly operated by the UHB and Local Authority. To their clients on caseloads they offer a specialist MDT service including community based outpatients and psychological interventions as part of a whole system in conjunction with in-patients, crisis and home treatment teams, liaison services and a range of specialist community teams such as peri-natal, assertive outreach, borderline personality disorder, forensic, rehabilitation and eating disorders.

Within Cardiff & Vale the modernization agenda has had an impact on the operation of CMHTs in particular the development of Primary Mental Health Support Services (PMHSS) and the Mental Health Measure (MHM) which are intended to support CMHTs to focus on those most in need allow the CMHTs to focus on those with the most complex needs. In addition over the last few year CMHTs have had much of their traditional roles eroded with the introduction of Crisis Resolution and Home Treatment Teams (CRHTTs), and other specialist teams which has impacted on the way they work.

CMHT staff also describe how the nature of the mental illnesses are becoming more complex and diverse such as dual diagnosis, neuro-developmental disorders and personality disorder with the interpretation of secondary care responsibility becomes more diverse as a consequence. This has been a challenge to services. All teams have an appointed Integrated Manager in post whose responsibility includes *'overall responsibility for the integrated pathway and service user experience through the CMHT from referral to discharge'*

7. Progress Towards The Mental Health Strategy

- CrisisTeams – Two 24 hour admission avoidance teams currently the largest in Wales
- Use of PARIS – All of mental health service users on PARIS with collaborative use with the Local Authority in Community Adult services
- Referral Response – Best practice referral standards in Wales with all emergency and urgent referrals a clinician to clinician discussion. All breaches of referrals times for emergency and urgent referrals require same day reporting.
- Part1 Services – Developing primary care mental health services including PMHSS are currently receiving double the referrals of the rest of the service combined. This preventative service will be added too by emerging mental health specialist roles in GP practices
- Integration – Although 'light touch' integration, the teams have sustained integrated arrangements for a number of years

- Specialist Teams – including Borderline Personality Disorder, Assertive Outreach, Eating Disorder Services, First Episode Psychosis, Autistic Spectrum Disorder Service and other specialist community services have been developed in support of CMHTs. Their impact on CMHT work will be greatly affected by the future community service model

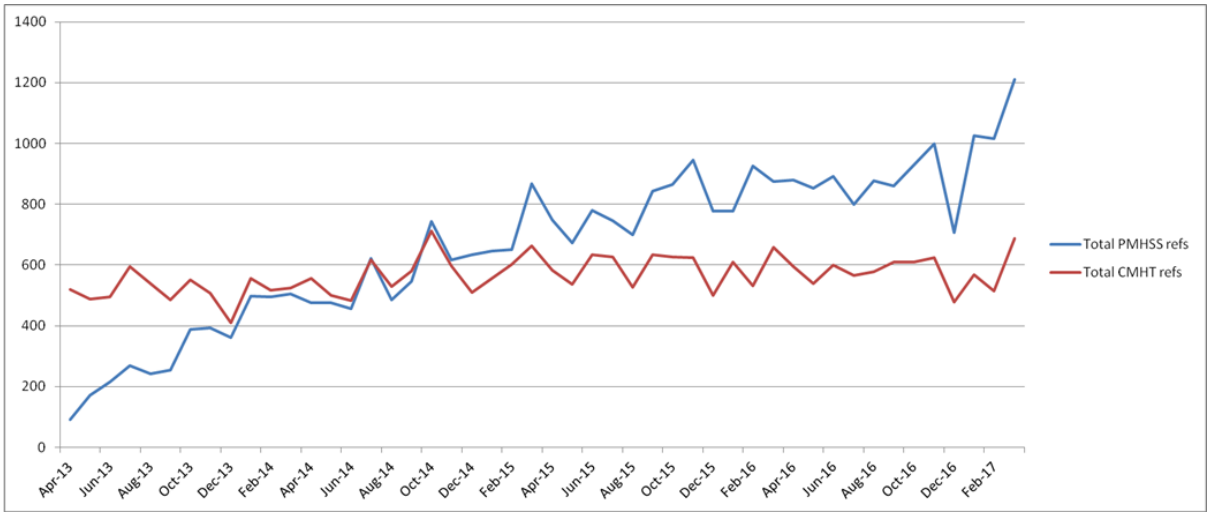
8. Why Further Change?

During the IMPT period 15/16 the Adult Mental Health Directorate approached the MHCB seeking support in a number of areas related to CMHT practice which were confirmed through national benchmarking feedback and an extensive internal engagement exercise in 2015/6 to all community stakeholders over 10 events. This exercise was led by the Clinical Board. The following challenges were identified for the sustainability and quality of Community Mental Health Services:

❖ *Increasing Demand & Reducing Resources*

Figure 4 shows the pattern of referrals into CMHTs alongside Part 1 referrals

Figure 1.



Within the context of these increasing referral numbers from GPs an analysis of referrals was undertaken at the time which showed:

- There had been little or no impact on referrals following the introduction of PMHSS services – this was a national picture – in fact 17.3% of referrals were redirected to LPMHSS following screening
- 68% of referrals are not accepted into CMHT for ongoing care
- GP's are the main source of referral
- There was little change in classification of referral pre screening (GP) and post screening (CMHT)

Staff Feedback at the time

- There have been social workers lost to the teams, depleting core team numbers and adding pressure to duty rota commitments with a typical CPN or social worker spending less than 50% of their time with service users on their caseloads. This is a conservative estimate with this role varying widely from CMHT to CMHT.
- The assessment process is inefficient and over burdensome with paperwork
- The assessment focus takes up a great deal of CMHT time and resources leading to delays in assessment outcome and reduced capacity for longer term recovery interventions

❖ ***Clinical Contact time & Psychological Interventions***

UK benchmarking confirms the challenges described above with Cardiff and Vale touching the lower quartile performance of contact time with service users.

Work is underway to assess the number of service users who receive prescribed psychological interventions by an appropriate professional in a timely way. This work is ongoing but the benchmarking results reflect CMHT psychology support to be amongst the lowest in Wales which is emerging from the analysis

❖ ***Operational Variation***

The arrangement of eight separate CMHTs creates duplication in the management and function of the teams and necessitates a multitude of lines of communication. It is suggested that this increases the opportunity for errors, duplication and inequality of service provision across Cardiff and the Vale. The current arrangement demands a great deal of administration and management time which impacts on the time and resource available for evidence based recovery interventions. Each team has adopted own practices, resulting in varying patient experience.

❖ ***Weakened integrated management arrangements***

The Staff structure responsible for the management and delivery of the CMHTs includes an Integrated Manager being responsible for their nominated team. When the current arrangements were implemented, due to the pace required, the posts are a relatively low grade/band in the team requiring persuasion to manage rather than seniority. This current arrangement is unsatisfactory. It is notable that there is very little opportunity for working across the teams as patients are allocated to a single team according to the location of their GP. Staff comment at the time included:

- Lack of clarification of the roles and responsibilities within the team, leaving teams feeling ‘fragmented’

❖ **Limited Development of New Ways of Working**

During the 2015 engagement period and since, regular feedback from service users relate to them requesting to be seen by the highest qualified health specialist when they are in most need and conversely a range of disciplines and agencies during recovery to reflect their social and well-being needs. Together with the limited availability of a psychological model of care in specialist services the current service model and configuration is reflective of these concerns.

❖ **Impact of Specialist teams**

Specialist Teams have proliferated within the mental health service model due to the diversity of complex care needing support. These teams include forensic, addictions, neuropsychiatry, borderline personality disorder, Assertive Outreach, Eating Disorder Services, First Episode Psychosis, Autistic Spectrum Disorder Service and other specialist community services have been developed in support of CMHTs. Their impact on CMHT work will be greatly affected by the future community service model. This again is an example of where core CMHT work has been eroded and diverted into specialist services. The reported impact on CMHTs is that what was intended to ease the pressure on caseloads for these specialist problems, although these new teams support a small number of complex patients, they teams have raised expectations on services. CMHTs feel they are now expected to deliver complex care plans for those service users with these specialist needs who do not meet the criteria of the specialist teams.

- **Accommodation review**

Half of the eight CMHT bases have health and safety concerns, with repeated governance risks raised by the UHB and Local Authority CMHT staff and managers. Although efforts are being made to alleviate the greatest areas of concern the current accommodation is not sustainable, with immediate concerns in the mid Vale and two teams in Cardiff. Hopefully this will align with the SOFWB intentions to develop locality based services, including accommodation and co-locate clinically allied services.

- **Catch all service**

Feedback that boundaries are being blurred between primary and secondary care mental health services and there are representations that the Mental Health services need to reclaim the specialist service agenda for CMHTs and become a mental illness service compared to a mental health and well-being service in primary care.

- **Outpatients**

The UHB has currently set a challenge to its clinical boards to consider the out-patient model and the value of it being on a general hospital site ans well as reviewing its value in terms of outcomes for service users, particularly out-patient follow up arrangements. In mental health outpatients moved off hospital sites decades previously but the model exists in CMHTs

- **General Feedback from 2014/5 engagement**

94 service users and carers responded to a survey

- Feedback of CMHT's was generally positive with 33% of respondents praising the work they do
- Many respondents felt that they were not listened to
- 13% of people said that services were not accessible when they needed them and that the definition of 'crisis' was too narrow
- Families responded highlighting a need for a point of contact within services, especially within the CMHT
- Families also stated that there should be clearer processes and information for accessing crisis support out of hours

Staff feedback not covered above

- Valued multi-disciplinary working and undertaking joint assessments

- Suggestion that assessments and emergency interventions should be carried out by a separate team so CMHTs can have more time to focus on recovery
- Use of an end of day meeting to discuss assessments was useful where it existed

9. What Does Success Look Like

The Joint Commissioning Panel for Mental Health (JCMHP) issued guidance for commissioners of community specialist mental health services in May 2013. The JCPMH is a collaboration co chaired by the Royal College of General Practice and the Royal College of Psychiatrists. Of note the guidance states that :

'There is currently no standard model for the commissioning and provision of community mental health care services' but states that there should be consideration of five key issues :

- Core Purpose
- Service Overview
- Service Components
- Service Standards
- Service Outcomes

The Joint Commissioning Mental Health Panel states that there is no single or 'optimum' model of community specialist mental health services. *'The CMHT will be based on a generalist MDT that provides assessment and treatment interventions that are compatible with current evidence-based guidance, to a defined catchment population'.* In order to continue to shift the balance of care towards home, and to optimise how the community services do this, and in the absence of clear model direction from national policy, services are left to considering local arrangements and benchmarking to consider options for change.

In doing this in Cardiff and Vale, there are a number of objectives and service principles against which any options for change will be measured. These include the following areas against which any options for improvement will be measured through further engagement:

Does the Option:

- Address environmental concerns including limited group rooms , therapy areas, toilets and meeting rooms, DDA compliance across all facilities & reduce overcrowding for staff and patients
- Reduce demand and improve conversion rates from assessment into caseloads
- Reduce multiple assessments for scheduled care, i.e. ADHD & unscheduled care
- Provide needs based assessment that meets WG targets for waiting times and reduces duplication. Support an assessment format that is based on needs of the client and support the Social Services Health and Wellbeing Act assessment requirements.

- Enable the care and treatment of critical masses of patients allowing development of specialist clinics with medical support, i.e. physical health monitoring, ERG groups
- Improve benchmarking results regarding contact times and staffing norms in community services
- Progress the New Ways of Working agenda for professional groups
- Complement the Shaping our Future and Well Being strategy such as locality working & improved access to partner and 3rd sector agencies via the Health and Wellbeing Hub
- Complement the all Wales Together or Mental Health Strategy delivery plan
- Simplify referral pathways for GPs
- Support the increased delivery of Psychological Therapies as per 26 week soon to be Tier 1 WG target
- Increase access and speed to care and treatment for people with serious mental illnesses
- Increase access for 'Hard to Reach' groups based on ethnicity, gender and other protected characteristics.
- Improve benchmarked areas of quality and safety towards upper quartile performance for UK standards
- Support and strengthen integration
- Ensure delivery of home first principles – Care within the patients home and reasonable travelling distances.

10. What Service Models Exist To Achieve That Success

Options to be considered:

1. **Do nothing**. Retain all eight CMHT bases

2. **Move existing services to locality team bases with minimal remodelling of services**. Realign GP practices to locality model, no significant changes to working patterns. All clinicians to manage a mixed caseload of new assessments and SMI. Development of a psychological therapies hub to improve access to psychological interventions. Centralize duty systems per locality to optimise professional's time.

3. **Locality Model for all Community Services**. For all community services including CMHTs, CRHTTs & all Specialist Teams to devolve to and operate out of a central locality team base with a central point of access to all services. Separate assessment, intervention and recovery pathways. Develop Psychological Therapies hub

4. **Locality model for community services, split between inpatient and community services.** Splitting inpatient and community responsibilities for the medical workforce. For all community services including CMHTs, CRHTTs & all Specialist Teams to devolve to and operate out of a central locality team base with a central point of access to all services. Segregation of assessment and long term condition management. Development of a psychological therapies hub to improve access to psychological interventions.

5. **Adopt a functional community team model such as the North East London Foundation Trust model.** Three localities. Functional split between inpatient and community services. Sector split of community services – Assessment and brief intervention team, IAPT service, Community Recovery Team managing patients with long term needs, Crisis and Home Treatment services to mirror locality structure.

The options described above are only intended to capture possible service models for the purpose of an options appraisal.

11. Next Steps/Recommendations

The review and development of a whole system such as community mental health service maybe the most complex change faced by the Mental Health Clinical Board and its partners to date, involving multiple professionals, agencies and team bases all with specific challenges and priorities requiring resolution or improvement.

This review has to negotiate short term problems such as accommodation and the demands on professionals of duty work, to longer term sustainability issues of practice and professional development, matching the clinical model to need, and team integration.

It is a priority to present this to SLG for partners to initially agree the account of the challenges, what is the vision for success and what are the range of options available, against which to appraise that vision.

Following this agreement the MHCB recommends that the next step of this review is to be a neutral process where our multi agency partners critically assess each option against criteria deemed important to the services and the organisation. When a agreements are reached in terms of accommodation, service models, integration and governance arrangements, a refreshed implementation team is established with appropriate leadership and extended terms of reference to develop and implementation plan beyond the current plan which seeks to resolves more short terms challenges such as the assessment pathway.