Appendix 1

Community Mental Health Services Cardiff and Vale University Health Board

June 4

2018

Community Health Council Briefing

Version. 2

1. Summary of the proposed service change

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.

The aim is for the work to be managed in phases – initially using the opportunity of the availability of a locality based accommodation in Barry Hospital as a future Health and Well Being Hub for the Vale locality to establish a Locality Vale Community Mental Health Service in order to practically ease accommodation problems, referral duty pressures and progress the integrated management and leadership structure across the locality. Crucially, these proposed changes are the enabler to allowing CMHT practitioners to spend more time on care and treatment of patients on their caseloads. The Mental Health Clinical Board and its partners aim to radically change the experience of its services users based on the following principles:

Increase ⇧	Reduce ⇩
Availability: 24/7 services	Waiting: seeing people sooner
Help and advice from a range of people and mental health services	Need for people to attend A&E to see a mental health professional when appropriate
Communication and joined up working between mental health services and organisations	Confusion when trying to get help during a mental health crisis
Services based around service users and not buildings or paperwork	Inconsistency and duplication in referral and admission processes
Support from people with a lived experience of mental health	Reliance on people to access peer and specialist support alone
Drop in facilities and friendlier environments for people in distress	Overall stigma and assumptions around mental health service users
Care as close to home and within the community as possible	Need for people to visit A&E as a last refuge for support and treatment
Expert staff available for longer hours in our hospitals	Need for police involvement unless absolutely necessary

Care focussed on supporting recovery and helping people to be more resilient in the future	Care focussed purely on treating or managing the symptoms of mental illness
Opportunities for social inclusion including employment, education and housing support	Leaving people to navigate their social needs alone as they do not come under the 'health' remit

The next phase of the work will explore and 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. The proposals are complementary to the Shaping Our Future Well Being strategy and Together for Mental Health delivery plan.

2. Describe the patients who use the current service

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%. This population growth is set to rise further with
A projected Population in 2021 –of 520,500

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.

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.

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.
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.

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

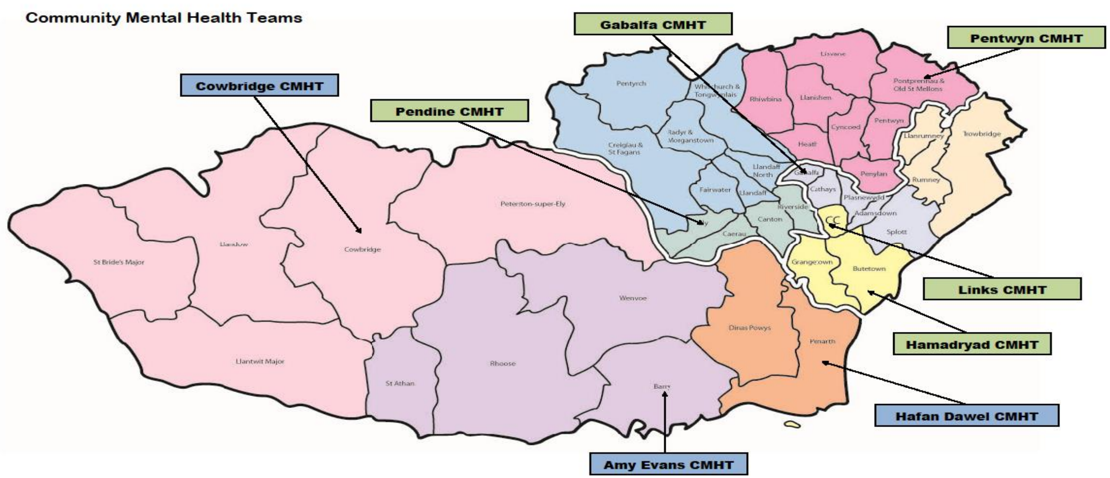
Suicide rates in Wales are higher than in England but lower than in Scotland and Northern Ireland. During the period 2002-2015, European age-standardised rates (EASRs) (aged 10+) in Cardiff and Vale ranged from 12.1 per 100,000 in the Vale of Glamorgan to 13.1 per 100,000 in Cardiff, similar to the Wales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

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 if the current service model remains the same.

3. **Are there any specific equality groups who receive the current service?**
   Please see attached EQIA

4. **What is the current service provision and how is it delivered**



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 the Local Authorities. 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). These are intended to support CMHTs to focus on those most in need to allow the CMHTs to focus on those with the most complex needs. In addition over the last few years, the traditional role of CMHTs has changed with the introduction of Crisis Resolution and Home Treatment Teams (CRHTTs), and other specialist teams which has impacted on the way CMHTs 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'*

5. Why does the service need to change?

Messages from Research

The National Survey of people using Community Mental Health Services 2014[1] and the Kings Fund Lessons from Mental Health[2] make clear observations in relation to Community Mental health Services. In that they should:

- Provide a simple vertical integration of the whole range of mental health care from in-patient provision to universal community services.
- Provide rapid access to Psychological therapies.
- Have capacity to intervene early and manage illness within the wider context of achieving a fulfilling life.
- Have a system where patients are given in increasing role in self-determination and the patient/professional relationship is valued.
- Have clear links to specialist and universal services and employment.

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[1] CQC 2014. National Summary of the Results for the 2014 Community Mental Health Survey

[2] Gilburt & Pech (2014) Service Transformation - Lessons from Mental Health

- Have improving relationships with GPs.
- Have a skill mix of staff where the ‘right staff are doing the right job’.
- Have a focus on social inclusion.

6. What comments have you received from patients/carers about the current service?

See attached – in terms on feedback on current services and questions raised regarding the proposed way forward.

What options have you considered in terms of changing these services to meet (5) and (6) above

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 Serious Mental Illness (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. All under an integrated leadership and management model
4. **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, Increasing Access to Psychological Therapies (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.

7. **What are the changes that you propose to make to the service? Options Appraisal and Preferred Option**

Options Appraisal - Summary

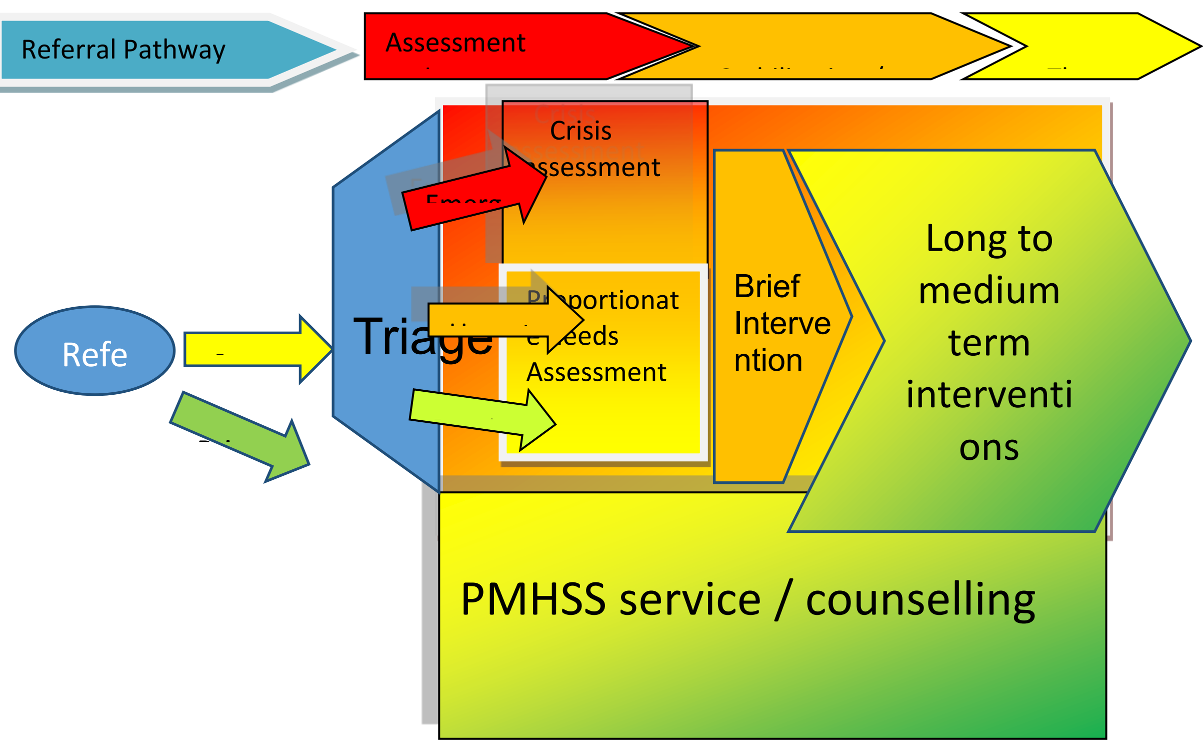
Option	Advantages	Disadvantages
1. **Do nothing**.	Minimal Change	See case for change in section 5
2. **Move existing services to locality team bases with minimal re-modelling of services**.	Potential for Reduced Management costs. Financial savings from release of Avon House. Single Integrated Manager to cohesive leadership to the whole service to ensure equity of service provision and service user experience across the Vale. Clear linear management structure. Clear distinction of Professional Lead responsibilities. Improved communication associated with co-location Amy Evans Centre not currently suitable for increased number of staff and will require capital expenditure to improve working environment.	A Vale Locality community service base will require one main base with potential to offer satellite clinics in Western Vale office. Service users from east and West Vale are more likely to have to travel further for out-patients appointment No change to clinical model with continues long waits etc.
3. **Locality Model for all Community Services**.	Potential for Reduced Management costs. Financial savings from release of Avon House. Single Integrated Manager to cohesive leadership to the whole service to ensure equity of service provision and service user experience across the Vale. Clear linear management structure. Clear distinction of Professional Lead responsibilities. Improved communication associated with co-location Amy Evans Centre not currently suitable for increased number of staff and will require capital	'A Vale Locality community service base will require one main base with potential to offer satellite clinics in Western Vale office. Service users from east and West Vale are more likely to have to travel further for out-patients appointment – this would be mitigated by the availability of neighbourhood clinic

	expenditure to improve working environment. A specific permanent Access/Duty Team with responsibility for delivering all duty functions as described in Single Integrated Manager to cohesive leadership to the whole service to ensure equity of service provision and service user experience across the Vale. Clinical benefit of co-location with reduced waits, matching need to capacity and skills and access to PTs the Flowchart. Right people in the right jobs'. Elimination of the conflicting challenges of duty and case work for all staff. Staff have opportunity to develop improved assessment and liaison skills. Identified resource to offer short term interventions to promote wellbeing and prevent need for secondary mental health care. Improved liaison with GP Clusters and 3rd sector organisations in Tier 1. Improved response to Crisis interventions	services in the Eastern and Western Vale areas.
4. Adopt a functional community team model such as the North East London Foundation Trust model.	A specific permanent Recovery Team with responsibility for all recovery/treatment functions. Professionals can focus on longer term evidence based intervention and outcomes. Opportunity to specialise staff on Early Interventions, Social Inclusion; family and care support etc. Improved links to In-patient services in Tier 2, 3, and 4. Improved liaison with GP Clusters and 3rd sector organisations in Tier 1.	Evidence that Service users fall through the cracks in services. Scale of change with low evidence base potentially too disruptive. Lose generic case management responsibility of Community locality services, currently cherished by service users.

Preferred Option 3.

A program of work commenced in January 2018, sponsored by the Mental Health Clinical Board which considers broadly the future service model for community services. As part of that work, in the summer/autumn of 2018 the capital planning department in C&V UHB is able to deliver accommodation for the amalgamated Vale community services. The Community Services program of work will oversee the timely delivery of the co-location of the 3 Vale teams into Barry Hospital, the establishment of an integrated locality management structure and the merging of relevant team processes to ease duty pressures and release practitioners time to spend on care and treatment of service user on their caseloads.

This will be part of a broader and ongoing program of work to develop community services more generally. There are currently only indicative timescales built into these changes – with a proposed implementation period of September to December 2018 to explore and devolve all potential locality based mental health services into the vale locality community service model whilst retaining access to a base in Cowbridge & Penarth to allow delivery of some services in these neighbourhoods. The vision for the model as seen below:



Mental Health Services within Cardiff and Vale UHB have received an investment from Welsh Government to develop a new facility in Barry Hospital. The facility is being developed to allow the establishment of a single CMHT base for the Vale of Glamorgan. The new base will enable a locality model for community mental health services to be progressed. It is recommended that:

- All team members are relocated to a single base in Barry Hospital at a point in the Autumn of 2018.

- The collocated team base is, managed and led by a single integrated, if temporary, team structure implemented at the same time as the collocation. A permanent management and leadership model will be agreed and implemented following a period of 3-6 months when the extent of the locality arrangements are agreed.

- Relevant team functions and processes are merged to release clinicians' time for caseload management work between September and December 2018.

- A second phase Organisational Change Policy process will commence in early to mid 2019 to restructure the clinical and management community leadership across Cardiff and Vale.

All of the above changes will impact on staff location and working practices. For staff with substantive contracts a period of consultation will commence at an appropriate point. This consultation will be managed in the context of the Organisational Change Policy for NHS Wales. This OCP process will be overseen and supported by a wider program of work to modernize the community services more broadly

8. How Will the Change be Managed

A full Project Steering Group (PSG) has been established in the MHCB with sponsorship of the CB's Director of Operations and a full time senior clinician as a project lead. The program of work is following a full UHB change program with the appropriate engagement and evaluation of impact. An implementation plan has been written and is available for scrutiny. The project lead is responsible for ensuring delivery of the overall improvement project which will encompass three working groups:

- Organisational Change Process/ Communication and Engagement
- Engagement with stakeholders – see attached
- Accommodation/Relocation
- Service Redesign - Clinical Models/ Pathways/Processes

The PSG will oversee, steer, monitor progress to ensure delivery of the project against an agreed work plan, targets and milestones, ensuring these supports and promote the delivery of improvement to integrated mental health services for working age adults in the community.

It will provide escalation support for the work streams in operational best practice, decision making and ensure all key stakeholders are engaged and that the project is aligned to supporting the organisation's strategic direction and operational priorities and provide support in facilitating and embedding change.

9. Have discussions taken place with Stakeholders, including Local Authority and Third Sector?

YES – See attached

10. Workforce

The UHB and the Local Authority services for the Vale locality will work in partnership with their respective organizational staff change processes to achieve the following:

- All team members are relocated to a single base in Barry Hospital at a point in the Autumn of 2018.
- The locality mental health community team base is managed and led by a single integrated, if temporary, team structure implemented at the same time as the collocation. A permanent management and leadership model being agreed and implemented following a period of 3-6 months when the extent of the locality re-modeling is agreed.
- Relevant team functions and processes are merged to release clinician's time for caseload management work between September and December 2018.
- A second phase OCP process will commence in early to mid 2019 to restructure the clinical and management community leadership across Cardiff and Vale.

11. Finance

The program of work is broadly cost neutral in terms of staff resources. The efficiencies related to the collocation of the teams is offset in the short term (initial 3 to 6 months) by the cost of the project manager and temporary locality management and leadership structure. The demand into services remains the same and efficiencies will be offset in the longer term by cost neutrally managing increases in demand.

Accommodation refurbishment costs and the cost associated with sustaining locality based clinics in the Eastern and Western Vale neighbourhoods are drawn from ICF funding for the refurbishment of Barry Hospital and the savings from being released from lease arrangements for the neighbourhood clinics. This is of course all NHS funding of a sort and again is broadly cost neutral.