

LOCAL SERVICES DIVISION

ADULT MENTAL HEALTH DIRECTORATE

COMMUNITY SERVICES STRATEGY

EXECUTIVE SUMMARY

The Adult Mental Health Clinical Strategy details the development of a service re-design / transformation Programme for 2014-2016 which includes the closure of acute admission wards to facilitate the development of enhanced crisis resolution and home treatment services; the closure of in-patient rehabilitation units to facilitate the development of community rehabilitation services; a focus on early intervention; the development of psychological therapies across community services and the development of family intervention services

This paper describes the second stage of the service re-design programme which requires a review of all existing community mental health services across the adult mental health directorate to ensure service models and pathways are meeting the needs of the population and service and commissioning requirements.

The JOSC are asked to support the Trust in its wish to engage and consult on changes.

STRATEGIC DRIVERS FOR REVIEW

SERVICE REVIEW: CLINICAL PATHWAYS

Working towards Mental Health National Tariff (PbR) has been mandated since April 2011. The trust has introduced clustering and has been developing cluster pathways for the last two years. The redesign of community services needs to ensure that all services can deliver the required national tariff care pathways.

ISSUES IN CURRENT SERVICE DELIVERY

There are a number of issues in the current service delivery model which need to be addressed, namely:

- **Waiting times:** Ideally all services would aim to see patients within 2 weeks of referral
- **Over complication of services:** multiple service teams can appear complicated and confusing for referrers and patients.
- **Repetition of assessment:** patients are often assessed by numerous services before a service is offered. This means that patients have to tell their story several times and leads to feelings of hopelessness, e.g. no-one can help me. It leads to the patient being seen as a problem rather than the service being able to meet their need

- **Debates between teams:** time and energy can be taken up debating which team the patient fits into. This is frustrating and can result in poor relationships between teams.
- **Duplication of service:** a number of service teams share common cluster groups which can lead to lack of clarity regarding pathways
- **Lack of equity of service:** Young people with psychosis receive an intensive service from EIP. This is not equitable for older patients who present with psychosis.
- **Outpatients:** medical time taken up with large out-patient clinics. Teams work more effectively with consultants embedded within the leadership of the team. A full review of medical Out-patient clinics needs to be undertaken
- **Pathway of discharge to Primary Care:** There is not a clear pathway for referral back to primary care
- **Size of County South CMHTs:** the county south CMHTs have very small numbers of community staff and this makes service delivery difficult

Any service redesign will aim to identify solutions to the issues identified.

FINANCIAL CONSIDERATIONS

Whilst this redesign scheme does not identify any immediate cost savings, the Trust must ensure that services are clinically and cost effective and that service changes are sustainable in a competitive market.

THE COMMUNITY SERVICES RE-DESIGN PROGRAMME

The Community Service Re-design Programme is being managed in two parts. The first part focuses on the development of the enhanced models for provision of community crisis resolution and home treatment services. This approach has been implemented with the closure of the acute admission wards at the QMC.

The second part is a review of all existing community mental health services in Nottingham City and Nottinghamshire County South and North. The AMH Community Mental Health services have been delivered along traditional models for many years, for example, Community Mental Health Team's and NSF (National Service Framework) services, Early Intervention in Psychosis and Assertive Outreach.

New service models for the delivery of community mental health care and treatment (such as the FACT model which is being delivered in Newark) have been introduced in recent years. This review will consider the benefits and disadvantages of the existing community teams, examine any problems with systems and structures within the teams that may impact on service delivery.

Expected outcomes of the review: The implementation of this review will deliver improved efficiencies in service delivery, and new ways of working (e.g. new ways of working for medical staff and increased use of non-medical prescribers and nurse led clinics).

COMMUNITY SERVICES REVIEW: CITY AND COUNTY AMH

COMMUNITY SERVICES REVIEW:

The AMH community services for Nottingham City, Nottinghamshire County South and Nottinghamshire County North have been established for many years. Some teams have retained traditional models of service delivery such as locality Community Mental Health Teams and services that were developed out of the National Service Framework policy implementation guidance such as Early Intervention in Psychosis, Assertive Outreach and Crisis Resolution and Home Treatment.

Over the last 3-5 years a significant number of changes have been made to services as a result of health and social care strategic drivers, policy and economic requirements. Although many traditional services have been retained these are operating to different models and pathways across the city and county areas in part due to the needs of the local population and following previous organisational change processes. This has led to a complex range of services and system of service delivery.

SERVICE REVIEW: TERMS OF REFERENCE

A project work-stream has overseen the second stage of the community services review. This has coordinated a series of focus groups, consulted different professional groups across the community mental health services and reviewed the following information and issues:

- Team Caseload's
- Individual care co-ordination caseloads
- Caseload management: productivity/activity review
- Patterns of Referrals to teams
- National Tariff Cluster patterns
- National Tariff Cluster Pathways
- Patient Pathways through services
- Patterns of community activity
- Team Functions
- Operational protocols and policies
- Staffing structures across teams
- Multi-disciplinary working
 - Roles of professionals
- Structure and Delivery of services
 - Medical out-patient services
 - Nurse led clinics
 - Non-medical prescribing
- Delivery of evidence based practices
- Interfaces between teams/services
- Training needs and Core competencies of staff
- Estates suitability

SERVICES REVIEW: EXPECTED OUTCOMES

Expected outcomes of the community services review:

- Review the current community mental health structures and models of delivery.
- Review the staffing structures and professional grades of staff required in community services.
- Review the training and professional development required within community mental health services to deliver new ways of working.
- Examine the most up to date evidence based practices for the effective delivery of Community Mental Health care.
- Ensure the pathways of care developed in community mental health services support the service re-design programme for the closure of acute mental health and in-patient rehabilitation beds and the development of enhanced crisis resolution and home treatment services.
- Consider the developments and interventions required to enable new ways of working in community services
 - Early intervention
 - Nurse led clinics
 - Non-medical prescriber roles
 - Evidenced based psychological interventions
 - Multi-disciplinary Team working
- Identify the models of delivery and pathways of care required across Community Mental Health Services in Nottingham City and Nottinghamshire County south and north areas
- Make recommendations for any changes required to teams and services to ensure the most effective and efficient delivery of care and treatment to service users
- Detail the routes of access for initial referrals from Primary Care Services.
- Ensure value for money within the financial budget identified for community services

OPTION APPRAISAL

An option appraisal for configuration of existing community teams was communicated to teams and services city, county south and county north areas.

NOTTINGHAM CITY COMMUNITY SERVICES

Secondary mental health services for Nottingham City are accessed through referral to the Single Point of Access team at Highbury Hospital and cover the Nottingham city CCG catchment area. Referrals are processed at allocation meetings which operate twice weekly. The Front line services such as CATS, Recovery, Early Intervention in Psychosis and Deaf Services are accessed via this process. Other services; Assertive Outreach and Community Rehabilitation are tertiary and are accessed via internal referral. City Community Services are located at the Stonebridge Centre; Highbury Hospital and Marlow House.

NOTTINGHAM COUNTY COMMUNITY SERVICES

County South Community Services

Secondary mental health services for Nottinghamshire County South are accessed through referral to the Single Point of Access for each of the following areas/teams. The Front line services such as Community Mental Health Teams, Early Intervention in Psychosis and Deaf Services are accessed via this process. All other services are tertiary; Assertive Outreach and Community Rehabilitation are accessed via internal referral. County South Community Services are located at Manor Road (Gedling); the Hope Centre Beeston (Broxtowe and Hucknall); Musters road West Bridgford Rushcliffe); Highbury Hospital (county south EIP).

County North Community Services

Secondary mental health services for Nottinghamshire County North are accessed through referral to the Single Point of Access for each of the following areas/teams. The Front line services such as Community Mental Health Teams, Early Intervention in Psychosis and Deaf Services are accessed via this process. All other services are tertiary services and are accessed via internal referral. The County North teams are located at Northgate Newark; Millfields Mansfield; Bassetlaw District Hospital.

ADDITIONAL COMMUNITY SERVICES

Social inclusion and Well-being

This service covers Nottingham city and county south areas and provides specialist occupational therapy; employment and volunteering specialists working to an IPS model (individual placement support).

Deaf Services

This service provides specialist community mental health services to Nottingham city and Nottinghamshire county north and south patients who are deaf or deafened.

Carer Support Service

This service provides support services to carers' of patients receiving services from Nottingham city community services.

Psychological Services service

- Step 4 Psychological Health (city)
- Psychotherapy
- Specialist Depression Service
- Mindfulness Service
- Bipolar disorder service
- DBT

CURRENT SERVICES / MODELS OF DELIVERY

CATS

The City CATs service was created at the request of the City CCG to provide a single point of access to all city services. The service provides assessment and treatment to patients with high levels of non-psychotic illness and disability. The service was originally created as an integrated health and social care team. The service receives a high volume of referrals and undertakes a screening/triage function of all referrals from city GP's. The service requires some adjustment to ensure that patients are seen in a timely manner and have time limited interventions. The services has seen an increasing caseload of people referred with ADHD; these client are managed by medical staff within the team whilst waiting for ADHD specialist diagnostic assessment which is currently up to a year, this is due to prescribing of controlled medication.

Early Intervention in Psychosis

The Nottingham City and Nottinghamshire County South Early Intervention teams are managed as one service by one team manager. The city team works to a North and South geographical model to serve the two Nottingham Universities. The City and south county teams are city focused to fit with a student population who use city based services.

The EIP service is focused on shortening the course and decreasing the severity of the initial episode, thereby minimising the many complications that can arise from untreated psychosis. This is essentially;

- The early detection and treatment of psychosis within a bio psychosocial framework.
- The provision of treatment, and psychological intervention during the 'critical' early phase focussing on strengths, hope and recovery.

The service works to the broad parameters of the National Service framework EIP policy implementation guidance.

The target group for early intervention is 14 – 35 years of age.

- The Adult Mental Health (AMH) EIP teams work with 18 – 35 year olds.
- This is Cluster 10 within HoNOS PbR.
- Head 2 Head, Child and Adolescent Mental Health Services (CAMHS) provide care for the 14 – 18 year olds.

The Directorate has EIP teams across the city of Nottingham and Nottinghamshire county south and north patches. There is strong evidence base for retaining Early Intervention in Psychosis services in the city. These teams have been able to respond quickly and effectively to patients presenting with high levels of risk and distress. Nottingham City has the highest proportion of patients referred for an EIP service. This is in the main due to the two local universities and a large number of further education colleges in the City. The city EIP service has seen a large increase in referrals over the three years. There is evidence of high rates of early onset psychosis in Nottingham city.

However, the current EIP service does not operate to full National policy implementation guidance and requires amendment. For example; patients over 35 do not have access to specialist EIP services as per NICE guidance. Capacity pressures across services have also led to difficulty with clients transitioning to other services resulting in clients staying in the service the recommended three years.

City Recovery

The City Recovery team was created in 2010 from existing three city CMHT teams. The Recovery Service is a secondary care mental health service. The team provides assessment, treatment and recovery based interventions for service users with mental health diagnosis, who require longer term contact with services. Longer term is defined as more than one year. This multi-disciplinary service is committed to providing an appropriate range of treatments and interventions, for a range of cluster pathways which promote mental health and social inclusion and reduce discrimination for people with severe and persistent mental health problems. There is also a collaborative working approach with statutory services, voluntary services and the private sector. The underpinning philosophy of the service is recovery orientated, to promote independence, autonomy and choice for service users. Emphasis is placed on community based assessment and care, working in partnership to promote social inclusion.

The team takes referrals for any new clients of age 18-64 with severe and complex mental health problems across a range of PBR cluster groups. The team will continue to work with existing clients who are 65 plus who continue to experience mental health difficulties and the service is able to meet their needs. Clients under the care of the City Recovery Service will be supported either under the Care Programme Approach (CPA) care pathway or the care pathway process. Clients on either pathway will have a care coordinator who is responsible for coordinating appropriate assessment, care planning and reviews. Care -coordinators will be a member of the multi-disciplinary team. The Recovery team receives referrals from all other city services and therefore has a large caseload.

Assertive Outreach City

Assertive Outreach Services aim to provide a comprehensive and flexible client centred service for people and their families experiencing severe and enduring mental health problems who historically have struggled to engage with mental health services.

The service provides an intensive multi-disciplinary community based approach to the delivery of care for people with severe and enduring mental health problems. In both City and County teams social care staff and social care services will be delivered outside of the immediate team. In seeking to maximize the value of a whole team approach, all staff take a shared responsibility for the care of all service users and service users are viewed as active participants in the direction of their care.

Successful outcomes for Assertive Outreach Teams are based upon the establishment of collaborative partnerships which support the development of trust and the opportunity for therapeutic risk taking. Assertive Outreach teams should offer a wide range of evidence-based interventions including practical support as well as frequently reviewed access to medication. Service users who take a positive decision to manage their mental health will be

supported to explore how they may be able to achieve their goals in a planned way whilst continuing to utilise the support the team can provide in enhancing their social circumstances. Target group:

- Adults identified as suffering from a severe and enduring mental illness who have a primary diagnosis of psychosis or bi-polar disorder and are aged between 18 and 65 years at the point of referral.
- Receiving services or in need of services equivalent to the CPA Care Pathway of the Care Programme Approach (CPA).
- Evidence of difficulty in maintaining lasting and consenting contact with traditional statutory services, and lack of meaningful engagement with services.
- Service users will typically have multiple complex needs, including a number of the following:
 - Posing significant risks to self or others including self-neglect.
 - Poor response to previous treatment.
 - Dual diagnosis of substance misuse and serious mental illness.
 - Unstable accommodation or homelessness.
 - Non-concordance with treatment/care plan.
 - Must meet criteria for Clusters 16 or 17.

The City Assertive Outreach service operates as two city teams. It does not meet full policy implementation guidance. It currently operates seven day working. As above pathways are not clear into and out of this team and it requires change.

Community Rehabilitation

The service is for people who fit the criteria for intensive community rehabilitation from the psychosis clusters 12 and 13. The expected duration of treatment/intervention will be a maximum of 2 years with the aim to try to move people through the system within 12-18 months. Clients may live independently, communally, with carers', some will be supported in community based rehabilitation units or 24-hour supported accommodation, with additional support provided by SDS packages and or personal health budgets.

The service will provide in-reach to inpatient acute admission wards for early identification of clients appropriate for a community rehabilitation pathway to support effective and timely discharge and pathways through inpatient services. The service will provide in-reach to the inpatient rehabilitation units in Nottinghamshire, including locked rehabilitation to ensure discharge packages are proactive and a continuity of therapeutic relationship is provided, promoting timely discharge and transition through services.

The service will offer an alternative to an inpatient rehabilitation admission via a community rehabilitation package with the emphasis on maintaining people in the community as a first priority. Exit from the service will follow a successful period of rehabilitation moving towards discharge to primary care or if assessed as requiring social care support, service users will be referred to social care or other community mental health services and third sector agencies.

The Community Rehabilitation service was created in 2013 from the closure of in-patient rehabilitation units. Their remit is to provide community rehabilitation and as an alternative to an in-patient rehabilitation placement.

Community Mental Health Teams (County South and County North)

No service specification exists for the traditional community mental health services. These have been in place in Nottingham city and Nottinghamshire county areas for over thirty years and have developed different models across south and north areas. The community mental health teams are multi-disciplinary community based working in partnership with other agencies providing specialist assessment and treatment, risk assessment and risk management of patients with moderate to severe mental health problems. Community mental health teams have developed a range of evidence based interventions supporting clients across the broad range of national tariff cluster groups.

Newark FACT

The creation of the Fact model for Newark and Sherwood merged the existing individual teams (Assertive Outreach, Early Intervention in Psychosis, Community Mental Health Team, Crisis Resolution and Home Treatment Team and Medical Outpatients) into one Flexible Assertive Community Treatment (FACT) Team, which will offer interventions based on cluster led Care Pathways.

These Pathways are offered to Service Users whose needs are assessed and identified to be best met by the identified pathway, outcome measures inform both the Service User and clinician when their objectives have been achieved or another Pathway of care becomes appropriate.

All staff work across Pathways and a Service User can receive interventions from more than one Pathway at any given time. The Service actively seeks to match Service User need against staff skills.

DEVELOPMENT OF EVIDENCE BASED INTERVENTIONS

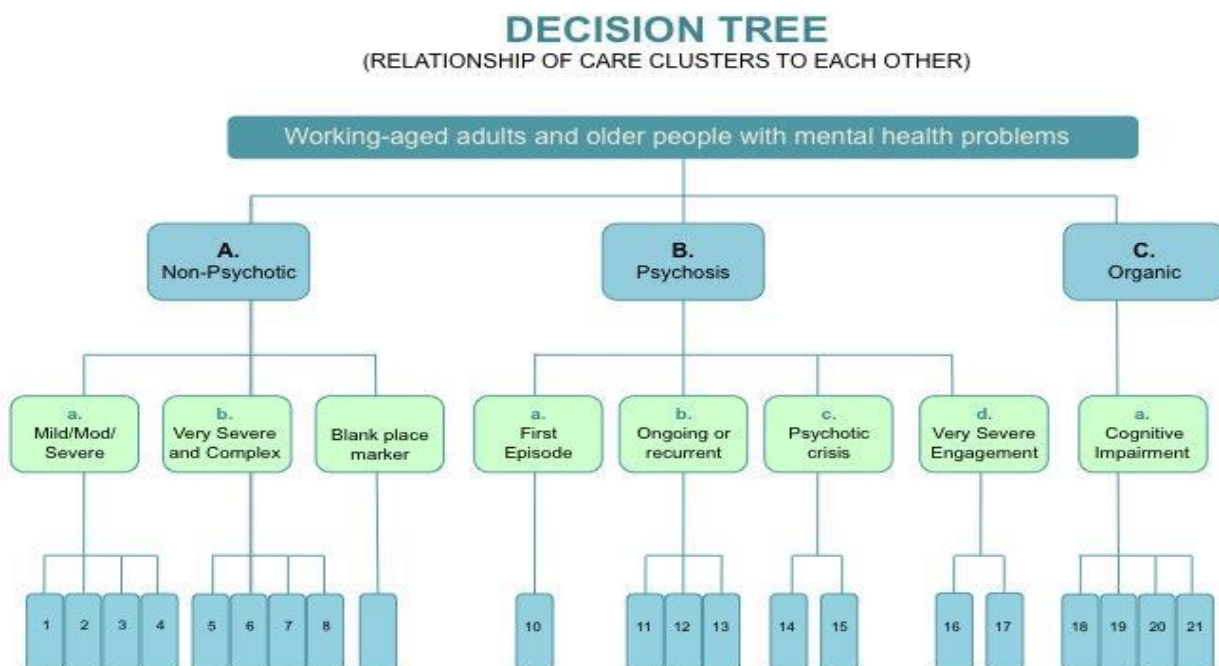
The adult mental health clinical strategy details the strategic intentions of the directorate in the development of evidenced based interventions as follows:

- Development of Cluster 1-3 care pathways, within IAPT and primary care, contact with secondary care advisory only.
- Development of cluster 4 care pathway, jointly with IAPT/primary care. Ensure cluster 4 within secondary care have access to appropriate psychological interventions.
- Development of care pathways for clusters 5-7, ensuring provision of intensive CBT as recommended by NICE, ensuring access to specialised prescribing in line with NICE and Maudsley guidelines. Development of rTMS service and support research in this area.
- For cluster 6, includes development of specialised depression service to provide second opinions, local specialist expertise and influence prescribing. In addition to

attract external funding through tertiary referrals for consideration of specialised treatments not routinely available, including rMTS, psychosurgery.

- For development of cluster 7, joint working with primary care and social care to ensure appropriate social care package and monitoring in place, and SDS. Thereby reducing contact with secondary care, freeing up resource to provide psychological and prescribing interventions.
- Provision of a community care pathway, including DBT, for cluster 8 service users, to reduce acute inpatient bed use and readmissions.
- Care pathway development for clusters 10-17. Includes development of specialised bipolar service, to enable specialised psychological interventions. Ensure financial and clinical benefits of EIP, AO are preserved, but design services to meet geographical need as efficiently as possible, this includes development of FACT teams for geographically dispersed areas.
- Joint working with primary care to develop cluster 11 pathway, reduce use of routine follow up in secondary care, but enabling prompt, easy access to secondary care for those in relapse/transitioning to clusters 13, 14, 15.
- Development of nursing clinics for psychosocial intervention in clusters 7, 11 and 12, when secondary care input is still required.
- Community re-provision for some long term users of residential inpatient care, but maintaining some provision in this area.
- Change in threshold for transition from acute inpatient care to residential rehabilitation wards, to enable acute bed reduction and enable those requiring a longer period of inpatient care to receive it in a therapeutically appropriate environment.
- Development of crisis house to support acute in-patient bed reduction.
- Development of enhanced community crisis and home treatment service as an alternative to inpatient care, to enable the reduction of inpatient bed numbers

National Tariff Cluster Pathways



The strategic outcomes expected from the implementation of the clinical strategy are:

- Improved clinical outcomes as evidenced by greater cluster transition probabilities.
- Improved access to effective interventions
- Better service user experience of working in partnership with services to achieve personal goals
- Reduced need for inpatient care

Over the last two years the directorate has developed a range of specialist evidence based treatments which have been delivered in community mental health teams, in specialist clinics, nurse led clinics, seeing individuals and groups for;

- Distress tolerance
- Specialist Depression Treatment
- Specialist Bipolar Disorder Treatment
- Dialectic Behavioral Therapy
- Cognitive Behavioral Therapy
- Mindfulness
- Interpersonal Therapy
- Recovery focused groups

OTHER PROFESSIONAL INTERVENTIONS

Occupational Therapy provision

Occupational therapy is a profession concerned with promoting health and wellbeing through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by enabling people to do things that will enhance their ability to participate or by modifying their environment to better support participation.

The aims and philosophy of occupational therapy (OT) are:

- To maximise occupational participation.
- To assess and treat individuals, using purposeful and meaningful activities to maximise their level of function and independence in everyday life.
- To assess and treat individuals to enable occupational participation, performance and skills in the areas of self-care, domestic tasks, work/education & leisure.
- To endeavor to utilise service user's strengths and values when working towards a joint treatment plan
- Motivation, confidence, interests, roles, routines, communication skills, problem-solving, motor skills, social and physical environment are the main parts of OT assessments.

OT is highly valued across the directorate and is reflected in the numbers of referrals. Referrals to OT have increased since the introduction of social care self-directed support packages have been introduced as clients require functional assessments of need.

Psychology provision

The role of the Psychologist may be broken down into five key areas:

- Direct clinical work
- Indirect clinical work / working with the whole team
- Research and evaluation
- Training and supervision
- Organisational

PROPOSALS FOR SERVICE CHANGE

WHAT WILL THE SERVICE CHANGE DELIVER

The scale of the transformational change programme in adult mental health with the closure of a number of in-patient admission beds and the development of an enhanced crisis resolution and home treatment services has the potential for high levels of risk. The review and development of the non-crisis related community services aims to mitigate potential risks within this service change through ensuring community services remain robust and of benefit. In addition to this objective, these proposals will have the following benefits:

- Improve accessibility to the services from the point of referral
- Improve timeliness of assessment to treatment waiting
- Minimise transitions between different services for the service user
- Simplify structures for referrers and service users to minimise confusion and improve clarity of roles and options
- Offer more fully multidisciplinary services
- Reduce team size improving cohesiveness consistency and cross service relationships
- Improve discharge pathways to primary care and the ability to re-enter services should this be necessary

OPTION APPRAISAL

An option appraisal for configuration of exiting community teams has been undertaken seeking the views of teams across Nottingham city, county south and county north areas.

Evidence for Change:

There is strong evidence base regarding EIP although there is currently debate regarding the delivery of this from a specialised team versus a pathway model, e.g. FACT. Reviews of other city based services external to Nottingham have shown that when specialised EIP services are not available there can be an impact on early recognition and diagnosis of psychosis. The guiding principles of EIP – prompt assessment and treatment, intensive support when required, services which relate to age and interests, access to psychology, support to undertake education and employment, embodying hope for the future, invest now to save later – apply to all patient groups and therefore should be embedded in all teams.

Michael West et al (2012) researched what makes a good team work and concluded that the following principles make a good and effective team:

- Clear goals for the team
- Clear leadership
- Clarity of roles within the team
- Appropriately trained staff with positive values and attitudes
- Time for reflection
- Effective team meetings, including development time
- Medical staff embedded in the team as part of clinical leadership
- Good relationships with other teams

These principles align with the principles of Early Intervention in Psychosis and if applied to all teams would assist teams to be more effective.

Following a review by the Directorate management teams three options are being considered as follows:

Model One: Locality based Generic Community Mental Health Team Model

- **City:** Locality Based Mental Health Team (incorporating the specialty functions of EIP, AO, City Recovery and CRT pathways) provided by 4 teams across the City offering services on a geographical basis. Separate assessment service maintained
- **County South:** Service for CRT and EIP to be separated from the existing City services and repatriated to local management structures, creating 3 locality based MHT for county south (incorporating EIP, AO, CRT and CMHT) covering Broxtowe and Hucknall, Gedling, and Rushcliffe
- **County North:** 3 Locality based MHT for County North (incorporating EIP, AO, CRT if in existence, and CMHT) covering Mansfield and Ashfield, Bassetlaw, and Newark and Sherwood. (Newark and Sherwood incorporating CRHT also as FACT Model)

Model Two: Enhanced Community Rehabilitation Team/Early Intervention in Psychosis model with generic Community Mental Health Teams

- **City:** CRT AND EIP to merge, providing a focused service for first onset psychosis and those within cluster 13. Age barrier for referral to service removed (EIP age limit currently 35) and time limit for involvement with service increased (current time limit for involvement with EIP 3 years) 3 teams covering the City offering the service to specified localities. In addition 3 locality based MHT (including AO and City Recovery) for other cluster groups. Separate assessment service maintained
- **County South:** CRT and EIP to merge, providing a focused service for first onset psychosis and those within cluster 13. Age barrier for referral to service removed

- (EIP age limit currently 35) and time limit for involvement with service increased (current time limit for involvement with EIP 3 years). One service for county south. In addition 3 locality based MHT (including AO and CMHT) for other cluster groups. 1 in Broxtowe and Hucknall, 1 in Gedling, and 1 in Rushcliffe. Assessments will be undertaken by the mental health teams
- **County North:** CRT and EIP to merge, providing a focused service for first onset psychosis and those within cluster 13 Age barrier for referral to service removed (EIP age limit currently 35) and time limit for involvement with service increased (current time limit for involvement with EIP 3 years). One service covering Mansfield, Ashfield and Bassetlaw. Newark to remain separate as current FACT model only just in place and funded. In addition separate locality based community MHT for Mansfield and Ashfield, and Bassetlaw. Newark to retain FACT service. Assessments will be undertaken by the mental health teams. Assessments will be undertaken by the mental health teams

Model Three: Cluster Pathways Model

- Pathways based services split along psychosis/ non-psychosis cluster pathways
- **City:** Split between psychosis and non-psychosis by identified cluster. Retain separate assessment Service. The team structure would incorporate AO, CRT, EIP and Recovery. Staffing for each team dependent on needs identified and cluster distribution staffing model to allow staff to be based in teams in which skills and experience could be best utilized
- **County South:** Pathways based services, split between psychosis and non-psychosis by identified cluster. The team structure would incorporate AO, CRT, EIP and CMHT. Staffing for each team dependent on needs identified and cluster distribution. Staffing model to allow staff to be based in teams in which skills and experience could be best utilised. Continued locality based services for Rushcliffe, Gedling, and Broxtowe and Hucknall.
- **County North:** Pathways based services. Split between psychosis and non-psychosis by identified cluster. Referrals would be via SPA Services incorporated into this model would be AO, EIP, CMHT, and Group services. Staffing for each team would be dependent on needs identified and cluster distribution staffing model to allow staff to be based in teams in which skills and experience could be best utilized. Continued locality based services. Services to continue to be locality facing in Bassetlaw and Mansfield and Ashfield. No change to Newark services

NEXT STEPS

The next steps arising from this proposal are as follows:

Engagement of Stakeholders

The Directorate will be co-ordinating a range of engagement events with stakeholders across the geographical areas of Nottingham City, Nottinghamshire South County and Nottinghamshire North County to seek views on the current provision and possible re-design of community mental health services to secondary care clients.

- Service user and carers - using existing service user and carer groups and meetings and undertaking focus groups.
- Public engagement events.
- Engagement of protected characteristic groups and other groups who have not traditionally engaged in consultation processes.
- Statutory Partner agencies, such as social care, the police, primary care.
- Non statutory partner agencies
- Staff groups within Adult Mental Health
- Key staff groups within the trust

RECOMMENDATIONS

The Committee is asked to support the following recommendations:

- A programme of engagement events with service users and other stakeholders in relation to a review of existing community services provided by Nottinghamshire Healthcare NHS Foundation Trust Adult Mental Health services.
- The re-design of community mental health services across Nottingham City and Nottinghamshire County South and County North areas.

Adult Mental Health Directorate
May 2015