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NHS Wales Health Collaborative

Adult Community Mental Health Services in Wales

Our vision for the future

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Contents

Introduction

The Welsh Government's T*ogether for Mental Health Delivery Plan 2019-2022 (T4MH)*[1] sets out the following action:

To work with partners to articulate what we want services to look like by setting a common set of values, reviewing models, learning from the evidence of the transformation fund, and producing guidance for Wales.

The purpose of this guidance is to describe what we want adult community services in Wales to look like, learning from good practice and working across all sectors to coproduce a common set of values, standards, and actions to realise this vision across Wales. It has been 10 years since the launch of the *Together for Mental Health strategy*[2] and community mental health service interim guidance publication, as well as a decade since the introduction of the *Mental Health (Wales) Measure*[3]. It is timely to look forwards to the next 10 years as we move to modernise our community mental health services.

Engagement:

In undertaking this work, a number of phased engagement activities took place to coproduce the guidance. This began with extensive conversations and workshops with multiple stakeholders through a six-month literature and engagement review in 2021[4].

The literature and engagement review identified key focus areas and defined our set of values and principles.

Following initial engagement activities, we formulated draft standards based on what we had heard. We then tested these with frontline staff, through a series of virtual workshops across each region in Wales. There were 114 staff participants in the virtual sessions across community services including teams in primary and secondary care, older persons and crisis services. An online survey of frontline staff received an additional 121 responses.

Key questions considered through this review include:

1. What does good look like?
2. What is the core offer across community mental health services (CMHS)?
3. How do we ensure that the workforce has the necessary expertise, guidance, knowledge and skills, and that staff are appropriately supported to deliver effective care and treatments based on research and evidence?
4. What are the areas where we should focus service development? How do we implement cycles of continuous improvement across services?

Overview

This adult community mental health services guidance includes the following elements:

- A graphic illustration of what services would look like in Wales for CMHS
- A set of values and principles
- Descriptions of the functions of CMHS and what will be delivered
- Working towards developing a model for adult CMHS.

A separate engagement **report** details the work undertaken. There will also be work to develop an implementation plan, and to further shape the model of service going forward.

Our vision

To move from a system that is far too complex and difficult to navigate towards a more straightforward, accessible, and streamlined service, with no artificial barriers to accessing support.

For people to be able to access a range of appropriate supports close to home in a timely manner, and based on need.

To improve the consistency and quality of mental health services across Wales, and to enable staff to spend more time supporting people.

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Values and principles

Compassion, dignity and respect
Person-centred care
Prevention and wellbeing
Access and equality
Coproduction
Choice and respect
Quality and consistency
Outcomes-focus
Leadership and innovation

Values and principles

Compassion, dignity and respect

Consultation and engagement exercises highlight the unique relationship that staff in community mental health services develop with service users as essential to effective care.

The Health Education Improvement Wales workforce plan conference that took place in October 2020 drew this out, recognising that whatever service(s) are involved with a patient, the relationship that is built up between a key worker and that person/family may be the most important working factor[5]. The consultation also highlighted that there is a need to do more to recruit staff to work in the mental health field and to see it as an attractive profession. 39% of staff surveyed do not feel valued, and 40% do not feel supported.

The importance of incentives, supervision, and caring for the wellbeing of staff is a critical aspect of supporting the therapeutic relationship. It is challenging to care for others when staff do not feel cared for themselves at work. The impact of Coronavirus on staff wellbeing has been profound and an area that will require dedicated focus over the coming months and years. More should be done to create the conditions which foster compassionate care and strong relationships.

Person-centred care

The joint review of *Community Mental Health Teams (CMHTs)* [6] by Care Inspectorate Wales and Health Inspectorate Wales found that services require further focus and development to ensure service users have choice, which was not always the case. In a paper produced by the *Mental Health and Wellbeing forum* [7] survey respondents and focus group participants expressed concern that people had to 'fit in' with what was available, rather than respecting their individual needs and goals. Detail on what 'choice' should look like is articulated in the *National Mental Health and Wellbeing Forum's Dignity pledge* [8], which cites a need for "the right and freedom for people to make their own life choices, such as: their goals, who is involved in their care, which treatments they choose, freedom from restriction of access to basic needs, (such as activity), and choice of how they work towards their goals as part of the therapeutic relationship.

- People should be empowered, encouraged and enabled to do things for themselves and to make their own decisions.
- Support should be built around the individual and their needs and wishes.

Prevention and wellbeing – focus on keeping people well

Since the inception of the *Together for Mental Health strategy* [2] in 2012, there has been an increased focus on prevention and wellbeing – promoting activities that address the causes of mental ill health early. The Healthy and Active theme in *Prosperity for All* [9] describes a move away from treatment to focus on prevention. *The Social Service and Wellbeing Act* [10] and *a Healthier Wales* [11] also advocate health improvement and early intervention approaches.

The impact of adverse childhood experiences (ACES) and trauma-informed approaches have resulted in a range of new training and professional development courses and initiatives in Wales, though there remains some confusion as to what these terms mean, with different definitions and inconsistency in approach.

Areas for further consideration include:

- Testing models of care supporting greater integration with the third sector and care closer to home (such as hub or sanctuary models)
- Improving communication and awareness of resources for the public, GPs and other referrers, to better coordinate access to a range of care.

Access and equality – no wrong door

Recent literature describes a community mental health system in which help is available at the right time and place, to match the right care with level of need.

The OECD mental health performance framework [12] sets out the components of accessible services, stating that they should:

- Be evidence-based
- Be developed close to the community
- Be provided in a timely manner
- Account for and respect the unique needs of vulnerable groups
- Ensure continuity of care
- Deliver improvement of individual's condition
- Be safe.

Prudent health care principles [13] emphasize the need to "care for those with the greatest health need first, making the most effective use of all skills and resources."

Access and equality – no wrong door *(continued)*

The Race Equality Action Plan for Wales [14] notes that 'There remains variation in how individuals access and engage with the available health services, leading to differences in health outcomes'. Our engagement identified that those who speak languages other than English or who have sensory needs often struggle to receive support from mental health services in accessible way or face unacceptable delays in accessing care. Practices such as requiring response to letters written in English to receive an appointment can lead to exclusion. In addition, stakeholders including staff expressed that they do not have access to training and development around practicing in a culturally competent way. While there has been some progress in implementing the *Diverse Cymru Cultural Competency workplace certification scheme* [15] there is more work to be done to ensure our community mental health services are delivered equally to all members of the public.

Coproduction

One of the high-level outcomes of the *Together for Mental Health Strategy* [2] is that "Individuals have a better experience of the support and treatment they receive and have an increased feeling of input and control over related decisions".

Prosperity for All [8] describes a vision for Wales in which people are United and Connected - "communities prosper where people can participate fully and play an active role in shaping their local environment, influencing the decisions which affect them".

This concept is echoed in the *Social Services and Wellbeing Act*, which states partnership and co-operation drives service delivery[10]. *Prudent health care* identifies that to "achieve health and well-being with the public, patients and professions as equal partners through co-production"[13].

The Mental Health and Wellbeing Forum have produced guidance on Best Practice in Service User and Carer Engagement[16] Once published, this will help mental health services to work towards more consistent and inclusive service development, review and delivery, with coproduction at the centre, and adoption of the principle 'nothing about us without us'.

Choice and respect

The Duty to Review highlights that services should "promote empowerment and choice and support recovery"[2]. A review of *CMHTs* in 2018[15] found that services require further focus and development to ensure service users have choice.

More detail on what 'choice' should look like is articulated in the national mental health and wellbeing forum's *Dignity Pledge* [8], which cites a need for the right and freedom for people to make their own life choices, such as: their goals, who is involved in their care, which treatments they choose, freedom from restriction of access to basic needs, (such as activity), and choice of how they work towards their goals as part of the therapeutic relationship.

A core principle of the S*ocial Services and Wellbeing Act (SSWBA)* is 'voice and control'[16] - putting the individual and their needs, at the centre of their care, and giving them a voice in, and control overreaching the outcomes that help them achieve well-being.

Quality and consistency

Priority area six in the *T4MH delivery plan* is 'Improving Quality and Service Transformation'[14]. Actions include improving access through primary care (6.1i), annual audits of care and treatment plan (CTP) (6.1ii), Defining what good looks like (6.1iii), implementing improvements from CMHT and CTP audits (6.1iv) and auditing secure inpatient provision (6.1v). Also, in the plan is a focus on regular audit of Early intervention in Psychosis services by auditing against Royal College of Psychiatry (RcPsych) standards (6.4i).

Whilst there is a heavy focus on checking in on progress in these actions through audit mechanisms, there is less attention on how the various standards will be achieved. One of the core messages coming from consultation and engagement was the need to develop leadership capacity to drive forward quality improvement initiatives.

Research indicates that quality improvement initiatives are more successful if frontline staff are supported by facilitators who have capability in quality improvement methods, approaches, tools and techniques. (However, building the organisation's capability for quality improvement is also important, and this should be part of the organisation's overall quality improvement strategy.

Outcomes-focus

Many recent documents speak to the importance of evidence-based care. Mental health care is lagging behind its physical counterparts in the use of data and outcomes measures to assess the effectiveness of services. A need to embed the use of outcomes measures in community mental health services is frequently cited amongst recent publications[2,12,13,9].

There is a need to coordinate national programmes and data flows to achieve a more coherent system of measures that tells the story of how CMHS are doing. Stakeholders express that Wales continues to rely too heavily on performance measures such as wait times and numbers of people accessing services, as opposed to measures that focus on outcomes and quality. There are a lack of levers and incentives that support performance based funding models, and a lack of data is collected to help understand how services are doing.

Recent changes to benchmarking processes are leading to a more responsive data flow. The National Collaborative Commissioning Unit (NCCU) roll out of capacity and demand tools are assisting health boards to predict and manage services in a more agile way.

Wales is in the process of developing a live suicide surveillance system, enabling public and voluntary services to be more responsive to those recently bereaved.

An important programme of work to roll out outcomes-focused practice across mental health services is underway, led by Improvement Cymru[17]. This involves training staff in every mental health team in Wales to implement the use of outcome measurement tools that capture service user experience, goals and recovery throughout their time of receiving services. However, the success of this work will ultimately be dependent on the capacity of those trained to take work forward in their teams.

Leadership and innovation

One of the most frequently cited themes that came out of 'what good looks like' engagement was a need to strengthen leadership across mental health services. The adoption of a culture of continuous learning and improvement would support more consistent development of people and services, ultimately impacting on positive service user outcomes. This is echoed by policy documents such as 'ambitious and learning' in *Prosperity for All* [9], which describes creative, highly skilled and adaptable people, so our education from the earliest age will be the foundation for a lifetime of learning and achievement.

Leadership is one of the seven themes in the **National Workforce Plan for Mental Health**. Several actions set out ambitions to support community mental health services in building strong leaders.

Guidance and standards

These standards have been developed following the findings of the engagement and literature review undertaken throughout 2021.

The standards have been tested with frontline staff and will be consulted on widely before they are published. Standards have been cross-referenced with the Royal College of Psychiatry *Community Mental Health Standards* [19] and informed by the *World Health Organisation Guidance on Community Mental Health Services* [20].

1.0 Referral

Standards: 'No wrong door'

1.1 The public, GPs and other referrers have clear information about how to access support

1.2 I am able to access a range of community supports without a referral

1.3 I am offered an appointment with the right service without delay based on my level of need

1.4 When I need to access different services, I do not have to retell my story each time

RCPsych Community Mental Health Standards: *1.1 – 4.2, 10.1, 10.2, 10.3, 15*

Where we are now

- Multiple referral points and confusion for GPs
- Unclear referral pathways between teams
- Lack of flexibility and complicated admin processes
- Disjointed services and lack of communication across sectors
- Access problems: lack of culturally appropriate supports.

Where we are going

- Community hubs and drop-in support – accessed via self-referral or signposting.
- Clear and easy information in public domain
- Single point of access for adult CMHS – with a skilled team at the front door to ensure each person gets to the right place and 24/7 support in a crisis
- Better management of capacity and demand
- Able to re-book appointments that were missed.

How we get there: Single point of access

Those who already operate a single point of access model say the following works best for setting up the 'team at the front door':

- Skilled staff from a variety of backgrounds and teams (MDT) including third sector/ community staff
- Staff at the front door undertaking the assessment rather than just triaging
- Simple, clearly articulated criteria for interventions/supports to be offered
- 24/7 access in a crisis
- Having a process to discuss contested referrals.

2.0 Assessment

Standards: Person-centred care

2.1 'I am asked questions about what matters to me'

2.2 'The assessment is accessible and focuses on finding what works to help me be safe and well'

2.3 'I am asked how my support network should be involved and they are included in the conversation'

2.4 There will be no additional delays based on language, additional learning, or sensory needs

RCPsych Community Mental Health Standards: *3, 11, 12.2, 12.3, 16*

Where we are now

- Telling story many times
- Risk assessments that do not focus on safety planning
- Lack of crisis/relapse planning
- Shortage of Approved Mental Health Professionals/Section 12 doctors for Mental Health Act assessments
- Mental Health Measure[3] unintended consequences of limiting assessors for Part I
- Lack of involvement of carers/family in the process
- Staff having to complete multiple forms/ admin burden.

Where we are going

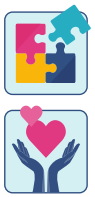
- Implementation of simple once for Wales assessment/CTP forms (brief and complex) to replace multiple variations (already agreed on an all-Wales basis)
- Staff will use outcome tools to inform assessment and establish baseline measures
- Risk assessment will be based on safety planning using new model
- Assessments will be portable across teams and can be updated as needs evolve
- Joint assessments where there is complex need i.e., substance misuse/learning disability etc.

How we get there: One assessment that moves with the person

Stakeholders spoke about the possibility of having a flexible and portable assessment that could travel with the person throughout their journey. Improvements to accessing records are also needed to avoid repeated stories.

Having the right expertise in the room is crucial, including for those with complex needs.

3.0 Care planning



Standards: Coproduction and Person-centred care

3.1 'My care plan explains how we will know when I am getting better and no longer need support'

3.2 'I am given information about appropriate supports, and given a choice which to try'

3.3 'All the teams involved in my care are included in my care plan'

3.4 'Goals are centred around all the areas in my life, not just my mental health'

3.5 'My care plan is reviewed regularly and updated with my progress'

RCPsych Standards: *5.5, 5.6, 13*

Where we are now

- Service goals rather than personal goals
- Varying quality of documentation – lack of MDT input, not a 'live document'
- Staff - admin heavy
- Where non-symptom management information is included, staff tend to focus on work or education
- Physical health care is often absent in care plans
- Care plans tend to focus on the role of the NHS team rather than the entire care network/other agencies.

Where we are going

- Goals will be clearly articulated and SMART so that we can measure progress
- The care plan should match with identified strengths and needs from assessment
- The care plan should set out all the different agencies involved in care and their roles as well as family/carer roles, not just what the NHS team is doing
- MDT should be involved in developing plan, rather than just care coordinator's responsibility.

How we get there: Multi-disciplinary team approaches

Stakeholders expressed the need to include a range of people in the care planning process, most importantly the service user but also involved family/friends.

Stakeholders expressed that this has become a 'task' often undertaken by just one member of staff, but would be better informed by the whole of the MDT to best use the skills and expertise of all team members.

Better Links Across Services

- Care planning would be greatly improved if able to access supports across services more easily
- There is a need to reduce fragmentation and better connect services with one another.

Simplify commissioning processes for care packages

- Improve clarity of process across health and social care
- Introduce more agile financial management processes
- Reduce challenges and accept clinical judgement
- Reduce administrative burden on clinicians.

4.0 Care coordination

Standards: Compassion, dignity and respect and Outcomes-focus

4.1 'My care coordinator takes the time to get to know me as a person and we work together on care planning'

4.2 'We use outcome measures to track progress and work towards goals'

4.3 'All people involved in my team can reach my care coordinator if they have concerns, and are included in reviews'

RCPsych Standards: *5.1, 5.2, 5.3,8, 13.5, 14*

Where we are now

- Lack of communication between agencies
- Understanding about what other teams offer and how to access it is a major challenge
- We do not often use outcomes measures to track progress
- People are being signposted but not offered support or information about how to access
- Discharge from CMHT when accessing another service (and re-referral when done)
- Non-health supporter services are not included in discussions and reviews
- Some staff report falling into a routine of 'wellbeing checks' without clear directed purpose to visits in line with goals and interventions.

Where we are going

- The most important thing is the therapeutic relationship and consistency in coordinator
- The care coordinator supports regular communication between agencies, and includes them in reviews
- The care coordinator monitors progress using recognised outcomes tools and supports the person towards step down/ discharge as they improve
- Anyone involved in person's care can contact the care coordinator to discuss any concerns/provide updates
- Outcomes measures are used to track progress
- To facilitate appropriate transitions/ handover between service areas
- To be able to use the CTP as a 'passport' which is portable as you move around the system.

How we get there: Seeing the bigger picture

- Greater connections between teams
- Having a clear view on what we offer
- Ensuring the whole multidisciplinary team supports coordination
- Ensuring the person closest to supporting the service user care coordinates (breaking down boundaries to this)
- Exploring new roles such as the value of peer support.

5.0 Interventions

Standards: Choice and respect, and Quality and consistency

5.1 I can expect to access similar care, regardless of where I am in Wales

5.2 Staff receive appropriate training and development to deliver a range of therapeutic interventions

5.3 Staff are knowledgeable about supports and services in the local area that may be helpful

5.4 I have choice in the care that I receive

RCPsych Standards: *6.1, 6.2, 7, 10.4, 10.5*

Where we are now

- Staff unable to list interventions across teams
- Variation in the 'offer' across Wales, and within health boards and clear gaps in provision (such as psychological therapies)
- Unclear access criteria
- Staff lack confidence to offer culturally appropriate interventions
- Variable access to training and coverage to attend/use skills after training due to pressures
- Limited access to psychology/long wait lists
- Limited accommodation and care options/ disconnect between health and social care in some areas
- Not being able to 'prescribe' interventions as the care coordinator. Having to re-start from assessment
- CMHTs reporting 'holding' people while they are on wait lists for many months/years, without any interventions while awaiting therapy.

Where we are going

- To create one 'menu of services', accessible by all CMH services and teams – with full time resource to maintain it in each region – eliminating the ideas of '1.5 patients'
- To agree what should comprise our 'core offer' in Wales across the 8 domains in the CTP
- To facilitate drop-in clinics/hubs/resource centres at neighbourhood level
- Increased capacity to deliver psychological interventions
- Testing new roles
- For staff to have constant opportunities to develop on a range of subjects/skills
- For staff to have opportunities to develop greater cultural competence/ unconscious bias.

How we get there: Creating a menu of support

- By having a clear and shared understanding about which interventions we offer across Wales or 'core offer' that services sign up to. Staff also need to understand the referral criteria and how to make appropriate referrals. Frameworks would help to manualise things
- By strengthening relationships with social care and the voluntary sector, and more strategic use of 'social prescribing' models
- Enabling clinical staff to deliver interventions and reducing focus on monitoring alone as the key activity – to maximise capacity for interventions by reducing administrative tasks
- Moving towards a more manualised approach to interventions. Evidence in research / service evaluation illustrates greater fidelity to the model ensures better outcomes for patients, both clinical and in personal lives. The further away from a model teams went, the more positive outcomes decreased
- By having experts who we can call on for advice for people with complex needs.

6.0 Discharge

Standards: Staying well

6.1 'I have a clear plan that indicates when I will be discharged'

6.2 'We use outcome measures to track progress and work towards goals'

6.3 'I have a plan about what to do if I become unwell'

RCPsych Standards: *5.4, 9, 12.1*

Where we are now

- Discharge goals are not set from the start
- Risk aversion concern about liability
- Section 117 issues
- No clear step-down policies
- Lack of 'flow' or case reviews
- Anxiety from patients and staff.

Where we are going

- Goals are set from start and progress tracked using outcomes measures
- Client is involved in discharge planning
- Supports are offered to promote ongoing wellbeing
- Relapse plan in place and person knows how to re-access care if needed.

How we get there: Measuring progress and normalising endings

- Developing clear discharge guidance – making it easier to 'step down'
- Building in discharge goals from start of care planning process
- Using outcome measures regularly to track progress towards goals and to normalise the conversation
- Having a regular slot in MDTs to talk about discharges (not just new referrals)
- Using relapse prevention approaches.

Creating the conditions for change

RCPsych Standards: *17, 18, 19, 20, 21, 23, 24*

Where we are now

- Trust between colleagues/teams can be a challenge
- Decisions often feel 'top down' or at team level without support or investment
- Some teams feel very supported while others do not
- The estate is extremely poor in many community teams, making an unwelcome unsafe environment for people accessing support
- Coverage of shifts to undertake training is variable
- A perceived general reduction in administrative staff to support office functioning.

Where we are going

- A shift from focusing on targets to focusing on quality
- Removing artificial barriers between teams with equal access to supports
- A focus on staff wellbeing
- Access to the right tools to do the job (good Wi-Fi, fit for purpose IT, mobile working solutions)
- A focus on MDT working rather than care coordinator being solely responsible for individual care plans
- Access to regular supervision.

How we get there

- This guidance was signed off by the mental health network board adult subgroup for sign off in May 2022
- A number of proposed actions were identified during the production of these standards
- We will work with stakeholders including service users and carers to coproduce a costed action plan for phased delivery over the next ten years (June-August 2022)
- Delivery will start from September 2022.

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