Oxfordshire and Buckinghamshire Mental Health NHS
NHS Foundation Trust

Proposal for A/OA Organisational Change Paper

September 2010

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1 Executive Summary

This paper has been prepared to inform staff of changes that the Oxfordshire Adult and Older Adult Directorate will make to its Community Services. The paper details these changes to management, community team structures and medical support to in-patient wards.

The paper details the areas of change and the new structures to be implemented to achieve the proposed model of care. It identifies the savings that will be realised through these changes and also the risks and opportunities that these changes will present. The model described draws on over 40 years of clinical and research evidence for Community Mental Health provision.

The objective for the service is the delivery of high quality effective patient centred mental health care to the adult population of Oxfordshire. This will be achieved by basing service organisation on patient need and ensuring that the service model delivers:

- Simplicity of patient pathways with the removal of artificial barriers
- Accessibility
- Continuity of care
- Robust teams with the skills to meet the majority of patient needs from within the team, thus avoiding multiple onward referrals
- Clarity of clinical responsibility
- Clinical Leadership

- Optimal utilisation of resource
- Management locally and corporately which support the delivery of optimal care and reduce the burden of bureaucracy

2 Background

The Adult and Older Adult Directorate employs approximately 1000 staff (725.5w.t.e.) and provides a wide range of services. The Directorate is integrated with Oxfordshire Social & Community Services through a Section 75 agreement.
Services for adults include: In-patient, community mental health services (CMHT), early intervention in psychosis (EIS) and assertive engagement (AOR). Services for older adults include: inpatient, specialist support to day care centres, community care, intermediate care (AES), liaison into general hospitals including a self harm service, memory clinics and in-reach into residential and nursing homes. Both care groups have crisis support and treatment provided from the same team (CRHT).

The pressure on in-patient wards, with reduction in bed numbers and increased severity of conditions presented by patients, instructs that there needs to be more support to these teams. The current model of increasing numbers of community teams admitting into the ward causes relationships between the ward and community teams to be more fragmented, blurs responsibility and has high logistical problems for the wards to serve all these teams.

This document proposes that we need to bridge the dilemma of maintaining continuity of care with developing a model of clinical leadership to the ward teams. By reinstating the CMHT as the core service to deliver treatments in the community this model reduces the numbers of teams interfacing with the wards and also creates a lead medical role to support and develop the ward team.

The current model has many small single consultant teams which makes it vulnerable to reductions in service due to sickness, vacancies and also less responsive to peaks in demand. This proposal allows the development of patch based CMHT's that can be sub-divided into robust operational teams, maintaining clear leadership and accountability with more effective cross-cover and development of wider skill sets across the patch.

3 Financial Drivers for Change

- Over the next 4 years OBMH is required to deliver Cash Releasing Efficiency Savings and provide a small surplus against any borrowing for capital developments. The impact of this on services is the need to have increased efficiency and productivity.

- In previous years the savings required by the Adult and Older Adult Directorate have been met by reductions in management costs and by reducing the in-patient bed stock. It is planned to further reduce management costs, however we are not in a position to further reduce our beds at this time.

- The current income budget of the Directorate is approximately £42m. The savings to be achieved are £5.3 million over the next 4 years. This document sets out how this will be achieved by reducing management and staffing costs.

4 Proposal for Service Change

- The proposal is to reduce community costs by £3.4m, Central Management by £250k and over time to realise savings from reviewing the number of

community bases we have in partnership with Community Health Oxfordshire (CHO). Any shortfall in savings is to be met by reductions in overheads and any other efficiency that can be realised over the 4 years.

- From April 2011 OBMH will be merging with Community Health Oxfordshire. We will work together to ensure that we use our joint estate in the most efficient way. This may assist in realising further estate savings.

- We will retain the Crisis and Home Treatment Team (CRHT), Bridge-building, the Prison In-reach Team, the Assessment and Enablement Team (AES) and our contribution to the Single Point of Assessment Rehabilitation and Care service (SPARC). This recognises the specialist competencies contained in these services which are both relevant for the most vulnerable and needy service users and difficult to provide in a more generalist team.

- We will restructure our Community Mental Health Teams (CMHT's) to achieve the savings required. This restructuring will involve an overall reduction in clinical and administrative staff. With the level of vacancies within the Directorate the proposal is to reduce the number of budgeted posts wherever possible in the first year to allow for a longer period of consolidation of the new model rather than further large changes year on year. The changes will include merging the existing single modular teams into a smaller number of larger teams which retain a locality connection. These changes will afford the retention of a range of shared resources and capabilities within the community service.

- We will also be introducing "hot-desking" and reducing administrative costs through more services sharing the same premises and other initiatives to maximise the efficiency of the buildings we use. This is expected to achieve a minimum of £1m reduction in service costs over time. Most of these

savings will be related to a review of community bases and will be subject to a separate proposal and consultation.

- We will reduce the number of administrative support staff by Adult and Older Adult Services operating out of the same premises and sharing the administrative resource. In addition we will be to implementing the new electronic notes system (RIO) and exploring other opportunities for technology to assist clinical staff to efficiently and directly enter and access case information.

- Savings will have to be realised from increasing the clinical contact time of clinical staff and therefore managing with fewer posts. This will be achieved through increased clinics with resultant decrease in the number of home visits, excepting when these home visits are clinically indicated. It is important to emphasise that home visits will still be necessary for some service users who are unable to attend clinics for various reasons. Also by focussing on agreeing thresholds for access to services with primary care partners. It is expected that the number of clinical contacts will increase from an average of 700 contacts per annum to 840 per annum. In the future the currency for provision of care will be based on outcomes and not on numbers.

5 How the proposal will affect operation of clinical services and posts

At previous Adult and Older Adult Senior Staff Away Days we have discussed the variance between teams in thresholds for access to our community services. The proposal is to begin to use the framework of the Health of the Nation Payments by Results (HoNOSPbR) to cluster patient groups and identify the clinical inputs to meet their care needs. From this work we will identify the core elements and

services that the new community teams will provide. This work commenced at the Adult and Older Adult Management Away Days in April 2010 where clinical and management staff began to identify and agree the core clusters that our community services should work within. In delivering the new model of service we will be clearer about these thresholds for accessing our services and make sure these are more consistent across the county.

We will review the operational practices of our community teams to minimise the amount of resource tied up within community premises. This will include utilising capacity in bases fully, increasing the number of clinic contacts, planning visits to minimise non-patient contact time, use of technology to reduce the administrative support requirements.

We are proposing that the new community teams will continue their existing remit of the care and treatment of those with functional conditions (Adults of Working Age) and functional and organic conditions (Older Adults). In addition the teams will carry the currently separate functions of Assertive Outreach, Early Intervention in Psychosis, as well as the general CMHT functions.

For Older Adults the Day Service teams, which are managed within the CMHT's, will be fully absorbed into the new community teams, with the expectation that the function of group work and support to day centres continues from within the CMHT. Memory Clinics will also remain a function of the new CMHT.

To achieve the required savings we will have to work to a set of agreed principles which will allow and require more efficient and effective use of resources. This may involve some or all of:

- more closely delineated packages of care for finite periods with regular formal assessment of changing needs,
- greater role definition within teams,
- more effective working with families,

- standardised and authoritative assessments to gate keep entry to the service using qualified staff
- reduction in reliance upon routine follow-up care, and the review of policies dictating such practice
- targeting of home visiting by teams for those where it is clinically indicated or who are unable to attend clinics,
- reviewing all cases where there has been no contact with the care co-ordinator or RC in the previous 3 months
- routine use of audit to examine and change practice
- promotion of clinical research and innovation

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There are 725.5wte budgeted posts across the adult and Older Adult Directorate. The proposed changes will equate to a reduction of approximately 47wte budgeted posts (including management reductions) within the Directorate. This will be achieved through vacancy management and thus staff may need to move from their current localities. It is important, however, that this is done with the least amount of change and therefore for the patient as little impact as possible. Many of the current Ward vacancies are being managed by the use of NHS bank staff; therefore it expected that bank usage will reduce significantly with the implementation of the new model and that the majority of the reductions of posts will be made in the first year.

5.1 Premises Savings

Adult and Older adult services currently operate out of 12 community bases (in addition to the main hospital sites at the Warneford, Churchill, Littlemore and the Horton):

Base	Location	Services
Townlands	Henley	Adult and Older Adult
Wykeham Park	Thame	Older Adult
Charter House	Thame	Adult, CAMHS, SCAS

Mereland Road	Didcot	Adult
Ridgeway	Didcot	Older Adult
Abingdon Mental Health Centre	Abingdon	Adult and Older Adult, SCAS
Nuffield Centre	Witney	Adult and Older Adult, SCAS
Julier Centre	Bicester	Adult, SCAS, Prison In reach
Elms	Banbury	Adult
Fiennes	Banbury	Older Adult
Rectory Centre	Oxford	Adult, SCAS, Vol Sector
Manzil Way	Oxford	Older Adult, Complex Needs

In addition to the above there are CAMHS bases in Abingdon, Witney and Banbury. We also have adult community staff based in 3 areas of the Warneford Hospital.

CHO operate out of 9 community hospital bases, many situated in the same market towns as OBMH community bases.

It is proposed to work towards a reduction in the number of bases, with co-location of CHO, adult, older adult, CAMHS and Specialist Adult services wherever practicable possible. A review of the bases will be undertaken and potentials for shared bases explored and this will be consulted on separately in the future. Over the next three years it is envisaged that this will produce a premises saving of between £1m - £1.8m.

It is accepted that there may be some increase in staff travel costs, to allow for this non-pay budgets have been left at the same levels prior to the proposed decrease in staffing, which gives added headroom for this cost pressure.

Summary:
At the April 2010 Adult and Older Adult Senior Staff Away Days there was discussion about the possibilities of base reductions, particularly following the

joining of OBMH and CHO in April 2011. Therefore it is planned to intensively review the all community bases to assess the potential to share single bases where possible.

5.2 Central Management Savings

- In excess of a £250k reduction in central management costs will be achieved.

Central Management

Staff Type	Band	WTE	Total Cost - standard point
Nurse Consultant	8b	2.00	£130,000
PDL	8a	0.50	£24,551
OT	8a	0.51	£27,087
OT	7	0.40	£17,174
Admin	4	1.00	£25,565
Total Pay		**4.41**	**£224,377**
Non-Pay			**£30,000**

The nurse consultant roles have been vacant for 6 months with one nurse consultant successfully taking up the post of Deputy Director of Nursing and the other taking a leading role in the implementation of the productive ward. Two of the service managers are also lead nurses and therefore will maintain nursing leadership across the directorate. In addition the directorate now has two modern matrons in post for one year whilst the ward managers undergo a training programme with the aim of each ward having their own modern matron.

The two OT posts sit within the management cost centre and it is believed that the functions of the posts could be undertaken within the band 7 posts across the directorate therefore the band 7 posts become either practice development nurses,

Senior Practitioners or OT lead posts. This will ensure equity across the service and that all professions have leadership at this level.

5.3 Community Team Savings

- It is proposed to restructure community services from the existing model of the small modular team with access to separate modernisation teams, to larger community teams with the skills to meet the need of service users. The teams will be expected to work to a team model of service provision.

In year one the Early Intervention Service will reduce to one band 7, 8 Care Coordinators and 1 band 5 carer support worker. The management of the Early Intervention team will sit with the city west CMHT manager and the consultant input will be from the service user's sector consultant.

In year one the city Assertive Outreach Team will reduce to one band 7, 5 Care Coordinators and 4 Support, Time and Recovery (STR). The management of the team will sit with the city east CMHT manager and the consultant input will be from the appropriate city consultant for the service user.

Both, the city Assertive Outreach Team and the Early Intervention Team would be reviewed after one year to look at the further integration of the functions into the CMHT's.

- Each team across adults and older adults will have a care coordinator who takes a lead role supporting carers

- For Adult and Older Adult Services this will be reconfiguring the existing small geographically scattered teams to larger Community Mental Health Teams (CMHT). This will achieve a saving on pay costs of approx £2m.

- The CMHT will have a primary focus on the treatment of organic and functional conditions with patterns of both acute mental health symptoms and more enduring and severe mental illness, including the capacity to intervene early in psychosis and to work with difficult to engage patients.

- There will be dedicated time of 1wte for each of the 4 adult admission wards. There will be 0.5wte dedicated time for each of the 3 older adult admission wards. The Intensive Care Unit will continue to have 0.7wte Consultant time.

- We are aware that there is a PCT development group that is defining what a comprehensive memory service would be composed of. It is anticipated that a request will be made for funding of this new service. The dementia strategy is clear that the diagnostic service for dementia and assessment of challenging behaviour remains a specialist secondary care function. The older adult CMHTs would continue to undertake the functions of memory clinics which will continue to develop in conjunction with the implementation of the Dementia Strategy.

- Crisis Resolution and Home Treatment (CRHT) service will be maintained as at present. The within hours urgent response service will be carried out predominately by the CMHT. During afternoon hours there will be shared working between the CMHT and the CRHT teams. Out of hours the CRHT will provide an urgent response and home treatment based service, with increased home visits throughout the night-time period. We will continue to offer the 7 Day Crisis Day Centre in Oxford and the 5 Day Elms Day Centre in Banbury.

- The proposed model is consistent with Oxfordshire PCT's Stepped Care Pathway, with the Mental Health Community Service concentrating on specialist diagnostics, acute crisis and enduring mental health problems.

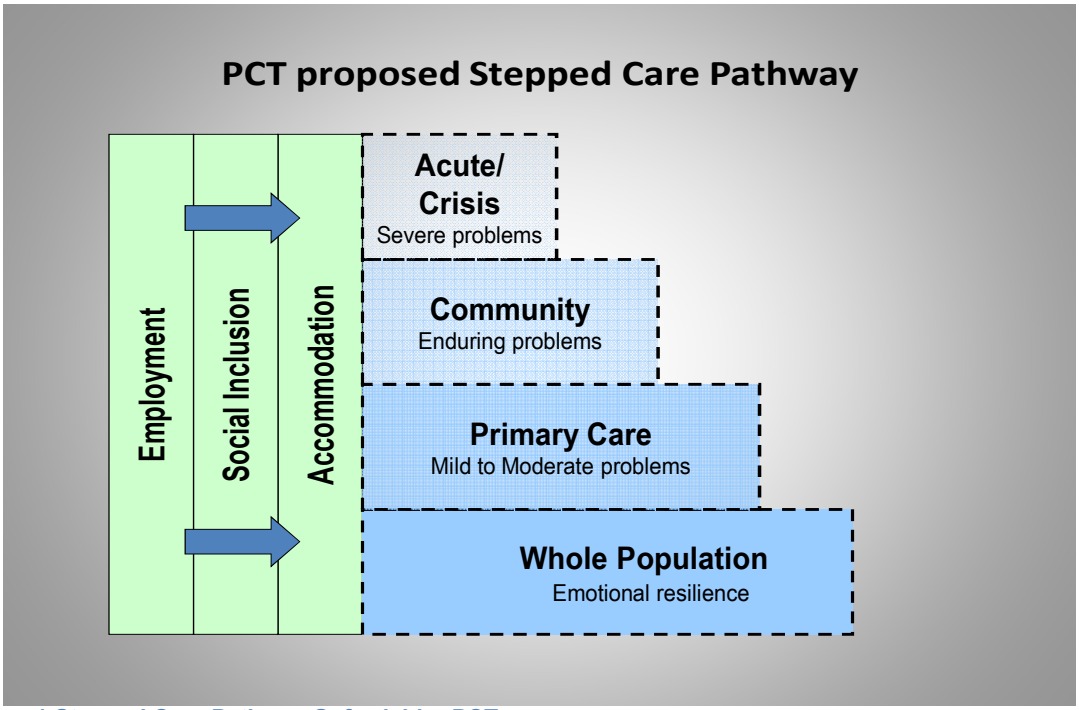

Figure 1 Stepped Care Pathway Oxfordshire PCT

- In terms of reviewing the proposed models effectiveness, we will be examining data re-activity and morbidity which will become available as we continue to collect HoNOS data and relate it to HoNOSPbR

5.4 The Community Mental Health Team Model (CMHT)

The CMHT will maintain the integrity of multi-disciplinary team working and as such will comprise medical, nursing, social work and occupational therapy as core professions. At present there are psychology staff who are managed as part of the specialist adult directorate, but they remain core members of the community teams which they are co-located with.

The CMHT will have a clinical management structure with a Clinical Team Manager and two senior clinical staff from either: Nursing, Social Work or

Occupational Therapy professions. These staff, with the consultant psychiatrists will form the senior clinical leadership group for each CMHT. In addition the Specialist Directorate Senior Psychology staff who are currently based with the CMHT's will be invited to be part of this senior clinical leadership group. Staff will be grouped to maintain links with primary care teams and to ensure that team functioning is optimised.

To enable the CMHT's to function effectively they will require access to clinical space in each of the main market towns across Oxfordshire. The teams will also need good access to clinical information, currently all community staff are using blackberry devices and we are exploring new technologies for mobile working.

5.5 CMHT Core functions

The CMHT will have the core functions of providing specialist mental health care assessment and treatment. The teams will a have clear operational policy which will detail: the thresholds for access to the service, the services offered, the model of care, the roles and responsibilities of team members and how the patient pathway/ journey is expected to be clinically managed. The policy will be developed by the teams and clinicians during the implementation phase of the changes.

The fundamental requirement of the CMHT is to provide individualised care based on diagnosis and patient need. The model of care must support continuity and be clear about the services being offered to the patient.

The larger teams will allow for greater sharing of skills. Having a wider skill mix of staff will allow for tasks to be carried out by those at the appropriate skill level, such as STR workers working on practical tasks with patients.

The CMHT operational policy must include how the team will manage the mental health needs in their patch, be clear about who is responsible for delivery of care and that the team is operating within the best evidence-based practice framework.

5.6 Adult Community Model

The proposal is to create larger teams that meet the functions of the CMHT, AOR and EIS with an initial move to a smaller EIS and AOR.

Across the Adult Services (within Adult and Older Adult Directorate) there are 490 wte staff posts. The proposed model for community services is a reduction of approximately 26wte posts.

Each new Community Mental Health Team (CMHT) will have a Clinical Manager and two Senior Practitioner/ Senior CPN posts. There will also be an increase in unregistered staff to provide more practical support to patients, freeing up qualified staff to undertake therapeutic interventions. All adult CMHT teams will have 3wte Consultant Psychiatrists with 1wte providing the senior medical input for inpatients from the teams catchment area. The operational model for the teams will ensure that key principles of effective patient centred care are delivered.

The proposal is to realign from the existing 17 modular CMHT's (and the countywide Early Intervention team as well as the Assertive Outreach teams) to have 5 locality focused teams (full GP practice figures shown in Appendix 1):

- North (Banbury and Bicester: Adult 18-64 population 104,056)
- City (Oxford West and Kidlington: Adult 18-64 population 72,769)
- City (Oxford East: Adult population 77,440)
- South East (Wallingford, Thame, Henley, Didcot, Wantage and Grove: Adult population 116,914*)
- South West (Abingdon, Witney and Faringdon: Adult population 100,002)
- *Thame data contains all population not only those under Oxfordshire PCT*

5.6.1 CMHT Team Structures Adult County

5.6.1.1 South East Adult

Didcot, Thame and Henley

Position	Number of Posts (wte)
Consultants	3
Speciality Doctors	1
Team Manager	1
Senior Practitioner/PDL	2
Band 6	12

Band 5	1
Band 4 MHP	0
Band 3 STR	3
A&C Band 6	
A&C Band 5	1.5
A&C Band 4	5

5.6.1.2South West Adult

Witney, Abingdon and Faringdon

Position	Number of Posts (wte)
Consultants	3
Speciality Doctors	1
Team Manager	1
Senior Practitioner/PDL	2
Band 6	12
Band 5	1
Band 4 MHP	0
Band 3 STR	3
A&C Band 6	
A&C Band 5	1.5
A&C Band 4	5

5.6.1.3North

Adults North

Position	Number of Posts (wte)
Consultants	3
Speciality Doctors	1
Team Manager	1
Senior Practitioner/PDL	2
Band 6	12 (12 plus 1 Liaison)
Band 5	1
Band 3 STR	3
A&C Band 5	1.5
A&C Band 4	5

5.6.1.4City

City Teams - East and West

Position	Number of Posts (wte)
Consultant	6
Speciality Doctor	2
Team Manager	2
Senior Practitioner/PDL	4
Band 6	22
Band 5	2
Band 3 STR	6
A&C Band 5	1.5
A&C Band 4	10

**Care Co-ordinator is the central function in planning the delivery of service and is a post that is usually filled by a professional from either: Nursing, Social Work or Occupational Therapy. The carers support worker will be a care coordinator with a lead role in carers support.*
***STR Workers will be Band 4 if undertaking MHP training.*

5.6.1.5EIS & AOR Staffing

Position	Early Intervention Team	Assertive Outreach Team
Senior Practitioner/PDL	1	1
Band 6	8	5
Band 5	1	
Band 3 STR		4

5.6.2 Consultant input into the adult wards

The Adult services have five in-patient units, four of which are acute admission (20-21 beds) and one is the psychiatric intensive care unit (PICU) which has 15 beds and serves Oxfordshire, Buckinghamshire and Milton Keynes. Two of the four acute admission units are for male patients and two are for female patients. The city sector bed usage is approximately two of the wards (42 beds), with the rest of the county bed usage being two wards.

The consultant and nursing groups within adults have discussed the options for consultant time on the wards and have agreed the following proposal:

The City Wards (two wards) each will have the equivalent of a whole time consultant made up from two post holders working half-time on each of the two wards. This means each of the city wards will have two consultants working into it.

In the county there are three CMHT's each of which will provide dedicated in-patient consultant cover. This will be met by two consultants in each CMHT providing 3-4 programmed activities (PA's) into a ward. This means each of the county wards will have three consultants working into it.

The PICU has in place a dedicated consultant working 0.7wte in the Ward.

There will be a recorded timetable of consultant time into the wards and a clear expectation of cross-cover being in place to cover any absences. Three months after implementation there will be a review of the effectiveness of these arrangements.

5.6.3 Adult Summary

This proposal delivers some of the required savings. The core function of the CMHT is to provide care, treatment and recovery to patients with significant need and with severe and enduring mental illness, from early intervention in psychosis, severe depression, bipolar conditions, schizophrenia and resistant OCD.

In addition, the proposal includes dedicated consultant time (equivalent to 1 wte per ward) for each of the 4 admission wards.

5.7 Older Adult Community Model

Older Adults will move from the current four locality model to a three locality team model. The proposed model includes:

2.8 wte Consultant Psychiatrists in the South
2.6wte Consultant Psychiatrists in the City
2.4 wte Consultant Psychiatrists in the North

Each area has 0.5wte Consultants (within the stated wte above) per in-patient unit.

There are 235.5wte budgeted posts across the Older Adult part of the Directorate. The proposed model represents a reduction of approximately 11wte staff from those currently in post. There are vacant posts across the Older Adult care group. A detailed breakdown of the existing and proposed posts is shown in Appendix 4. This proposal represents £984k reduction in pay and non-pay.

The structure of each of the proposed Community Mental Health Team (CMHT) locality teams are shown in the following table:

5.7.1 Older Adult Staffing by team

North, City, South

Position	Posts Per Team (wte)
Consultants	2.4 North, 2.6 City, 2.8 South
Team Manager	1
Senior Practitioner/PDL	2
Band 6	12
Band 5	1
Band 4 MHP	
Band 3 STR	3
A&C Band 5	1.5
A&C Band 4	3

**Care Co-ordinator is the central function in planning the delivery of service and is a post that is usually filled by a professional from either: Nursing, Social Work or Occupational Therapy. The carers support worker will be a care coordinator with a lead role in carers support*
***Band 4 if undertaking MHP training*

5.7.2 Consultant input into the older adult wards

The Older Adult consultant and nursing groups have agreed that each of the three wards will have 0.5 wte dedicated consultant input. The expectation is that cross cover will be in place to ensure each ward has cover throughout the year.

5.7.3 Older Adult Summary

This proposal delivers some of the required savings. The AES service will continue to operate countywide and this year will include mental health intermediate care beds. As with the adult CMHT's, the core functions are to provide care, treatment and recovery to patients with severe and enduring mental illness, in the context of presentations of functional or organic conditions. The teams will continue to provide groupwork, inreach to nursing homes and memory clinics. Each of the three in-patient wards will have 0.5wte of dedicated consultant time.

6 Adult and Older Adult: numbers of posts affected

- This represents a net reduction of 47.04wte of community budgeted posts within the Directorate
- This reduces the number of posts across the Directorate, from 725.5wte to 678.46wte

- Vacancies are currently being held in preparation for the proposed changes, with essential cover being provided through the use of NHS Bank staff
- The number of posts being reduced outnumbers the posts vacant, one to ones will provide an opportunity to discuss all options and ensure suitable alternative employment is considered, if appropriate

Risks and Opportunities Impact Assessment

6.1 Risks

RISK	IMPACTS	ACTIONS TO REDUCE RISK
Reduction in Quality of service through staff changes	Patient and carer dissatisfaction with the service. Commissioners dissatisfied and not supporting the new service model.	Patient satisfaction measures to be introduced to review how the new service is being perceived. Also this model is consistent with the approach in the Buckinghamshire arm of OBMH and there are higher levels of patient satisfaction with services there and no increase in patient non attendance rates for their centralised clinic model.
Delay in approval leading to delay in implementation	Financial savings target not met. Staff feeling unsettled and uncertain of their future.	Vacancies being held to offset delays. Staff made aware of the direction of service change through regular directorate away days.
Potential negative impact on staff from them perceiving an increase in their workload	Poorer staff retention and reduction in staff satisfaction with their role.	Increase in productivity to be realised through better use of central clinic model reducing time spent on travelling. Work with commissioners to agree a better quality currency based on clinical outcomes rather than numbers of patients seen – this should be realised through HoNOSPbR patient clustering.
Reorganisation leads to reduction in service capacity due to expected productivity	Poorer service response, patients waiting for care. Referrers dissatisfied with the service.	Staff will be engaged in delivering the changes to ensure that they assist in minimising any reduction in capacity. Productivity gain is set at a realistic

gains not being met, to compensate for the reduction in personnel	Commissioners dissatisfied with the service.	level of increasing contacts to 4.5 per wte per day over a 41 week year.
Unable to release savings in premises due to lease terms or suitable alternative clinical space	Risk of up to £1m of the savings to be achieved.	Proposal assumes that these savings can be realised with CHO over a three year period to ensure delivery.
Central Management Savings not realised	£250k identified for savings, posts already identified and savings ready to be delivered.	Posts already identified and it is likely more than £250k will be achieved.
Stakeholder disquiet about changes in thresholds for access to services	Primary care and services such as IAPT will be expected to treat more cases rather than routinely refer to specialist secondary care. Patients are likely to be discharged more quickly from secondary care services.	Clear criteria for access to services published. Service specifications agreed with commissioners.

6.2 SWOT Analysis

Strengths	Weaknesses
Larger teams are more robust. Better cross cover from having larger teams Centralised clinics allow more patients to be seen than seeing everyone at home with the additional travelling time for clinicians from d.v.'s. The CMHT structure allows for greater contribution from all professional groups into the clinical management of the team. Model is already tested as to its effectiveness in that it mirrors the approach in OBMH A&OA Buckinghamshire services.	Teams that are too large may be difficult to manage. Patients will be expected to travel to appointments when they are able to do so. Possible reduction in the quality of service with less clinical resource available. Complexity of the community bases in terms of leases, ownership and suitable replacements may delay some of the implementation of this element of change. There may be some issues with having access to good clinic space in all areas of the county.
Opportunities	**Threats**
More support for multidisciplinary working within larger CMHT's. Changes mean that teams will have to review the thresholds for access to the teams which gives the opportunity to agree common criteria for access across the teams than is currently the case.	Decreased patient satisfaction leading to poorer patient survey returns and possible patient withdrawal from care.

To increase the productivity of community staff. To work with colleagues in CHO to realise more shared working and operating out of each others community bases.	

7 Summary

The Adult and Older Adult Community Services will be delivered from fewer, larger CMHT's. The CMHT's will form the core element of the specialist mental health care pathway. To work effectively the CMHT's will work across the community and acute care pathway, including provision of specialist support and advice to the integrated CHO/OBMH teams (figure 2 below).

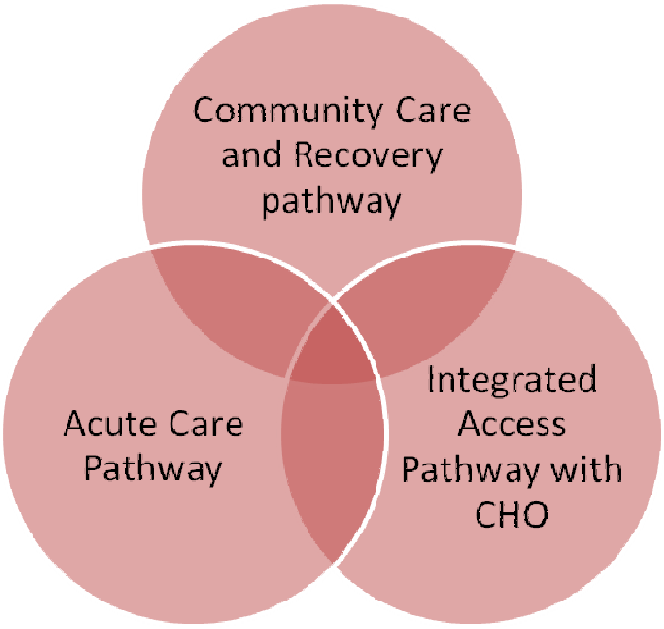

Figure 2 Integrated Pathways

Our services will work more closely with Community Health partners. Bed management will use the Acute and Older Adults Care Pathways model of practice which will afford better bed gate-keeping.
Care inputs and outputs will be based on Patient Clusters and patient and carers will contribute to assessing the effectiveness of services will better developed clinical outcome measures.