

# **The Community Mental Health Framework for Adults and Older Adults**

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Prepared by: NHS England and NHS Improvement and the National Collaborating Centre for Mental Health

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Promoting equality and addressing health inequalities are at the heart of NHS England's values.

Throughout the development of the policies and processes cited in this document, we have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

This Framework was commissioned by NHS England in 2017. It has been developed by the National Collaborating Centre for Mental Health (NCCMH) in partnership with a large Expert Reference Group drawn from a range of disciplines and professions across health, social care, the VCSE sector, community groups, and users and carers. The NCCMH also benefited from the contributions of a team of National Advisors, and a service user and carer reference group. A full list of members appears in the fuller implementation guide, which will be published on the Royal College of Psychiatrists' website (<https://www.rcpsych.ac.uk/improving-care/nccmh/>). The NCCMH also drew on expert advice and support from NHS Arm's Length Body policy leads and other stakeholders. NHS England, NHS Improvement and the NCCMH are grateful to all who have contributed to the development of this Framework.

# Contents

<b>1.</b>	<b>Introducing this Framework</b>	<b>2</b>
1.1	A new place-based community mental health model	2
1.2	The importance of community	4
1.3	Addressing inequalities in mental health care	4
1.4	The purpose of this Framework	5
<b>2.</b>	<b>The case for change</b>	<b>7</b>
2.1	Stagnation and fragmentation	7
2.2	Barriers and variation	7
2.3	The Care Programme Approach (CPA)	7
2.4	Improving access to appropriate care	7
2.5	Moving between services	8
<b>3.</b>	<b>This Framework and what it can deliver</b>	<b>9</b>
3.1	The structure of the new Framework	9
3.2	Functions of community mental health services in this Framework	12
3.3	Benefits of this Framework	14
<b>4.</b>	<b>Implementation</b>	<b>15</b>
4.1	Developing a place-based model of community mental health care	15
4.2	Leadership and governance	15
4.3	Infrastructure	17
4.4	Workforce	17
	<b>Annex A: Positive practice examples</b>	<b>19</b>
	<b>Annex B: Complexity of mental health problems within this Framework</b>	<b>20</b>

## 1. Introducing this Framework

### 1.1 A new place-based community mental health model

Community mental health services have long played a crucial yet under-recognised role in the delivery of mental health care, providing vital support to people with mental health problems closer to their homes and communities since the establishment of generic community mental health teams (CMHTs) for adults 30 years ago. However, the model of care is now in need of fundamental transformation and modernisation.

This Framework provides an historic opportunity to address this gap and achieve radical change in the design of community mental health care by moving away from siloed, hard-to-reach services towards joined-up care and whole population approaches, and establishing a revitalised purpose and identity for community mental health services. It supports the development of Primary Care Networks, Integrated Care Systems (ICSs) and personalised care, including how these developments will help to improve care for people with severe mental illnesses.

This is why community mental health services are at the heart of the [NHS Long Term Plan](#).<sup>a</sup> One of its key objectives is to develop “new and integrated models of primary and community mental health care [which] will support adults and older adults with severe mental illnesses”.<sup>d,e</sup> The [NHS Mental Health Implementation Plan 2019/20 – 2023/24](#)<sup>f</sup> describes our overall approach to delivering these models and the

#### Context

The NHS Long Term Plan describes a:

“new community-based offer [that] will include access to psychological therapies, improved physical health care, employment support, personalised and trauma-informed care, medicines management and support for self-harm and coexisting substance use... and proactive work to address racial disparities.”

Local areas will be:

“supported to redesign and reorganise core community mental health teams to move towards a new place-based, multidisciplinary service across health and social care aligned with primary care networks.”

In line with the [Clinically-led Review of NHS Access Standards](#),<sup>b</sup> **four-week waiting times** for adult and older adult CMHTs will be tested with selected local areas, as part of wider testing of these new models in 2019/20 and 2020/21, supported by over £70 million new funding.

In parallel, the [Independent Review of the Mental Health Act](#)<sup>c</sup> has called for “a reinvigoration of our community services”, which is what this Framework and the Long Term Plan seek to deliver.

a <https://www.longtermplan.nhs.uk/>

b <https://www.england.nhs.uk/publication/clinical-review-nhs-access-standards/>

c [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/778897/Modernising\\_the\\_Mental\\_Health\\_Act\\_-\\_increasing\\_choice\\_reducing\\_compulsion.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice_reducing_compulsion.pdf)

d This objective will need to align with the development of community-based “Ageing Well” models of integrated care for older people with frailty and multimorbidity, which were also announced in the Long Term Plan. Please note that this Framework covers adults including older adults with *functional* mental health problems, who may have *coexisting* cognitive issues, or dementia, as well as other coexisting health issues such as frailty or substance use. There is a separate pathway for dementia care. This pathway can be found in the implementation guide for dementia care (<https://www.england.nhs.uk/mental-health/dementia/implementation-guide-and-resource-pack-for-dementia-care/>).

e For more information about providing better care for people with co-occurring mental health and substance use needs, see Public Health England’s Better Care for People with Co-occurring Mental Health, and Alcohol and Drug Use Conditions (<https://www.gov.uk/government/publications/people-with-co-occurring-conditions-commission-and-provide-services>).

f <https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/>

major new Long Term Plan investment over the next 5 years that will support delivery, reaching almost £1 billion<sup>a</sup> extra per year by 2023/24.<sup>b</sup>

This Framework (described in more detail in [Section 3](#)) sets out how the vision for a new place-based community mental health model can be realised, and how we can modernise community mental health services to shift to whole person, whole population health approaches. In particular, we want to drive a renewed focus on people living in their communities with a range of long-term severe mental illnesses, and a new focus on people whose needs are deemed too severe for Improving Access to Psychological Therapies (IAPT) services but not severe enough to meet secondary care “thresholds”, including, for example, eating disorders and [complex mental](#)

*People with mental health problems want to live a good life, and it is the job of mental health services to help them do that.*

Isaac Samuels – Person with Lived Experience

[health difficulties associated with a diagnosis of “personality disorder”](#).<sup>c</sup>

We also want to ensure that the provision of NICE-recommended psychological therapies is seen as critical in ensuring that adults and older adults with severe mental illnesses can access evidence-based care in a timely manner within this new community-based mental health offer, to give them the best chance to get better and to stay well – as service users have so often told us they would like.

## Funding and preparation

In 2019/20, as set out in the [NHS Operational Planning and Contracting Guidance](#),<sup>d</sup>

“Long term Plan funding for mental health will start to flow into clinical commissioning group (CCG) baselines and they must, in association with sustainability and transformation plans (STPs) and ICSs, commission services that deliver improved services set out in the plan such as community mental health teams for people with Severe Mental Illness.”

Additional 2019/20 CCG<sup>e</sup> baseline funding must be used to “stabilise and bolster core adult and older adult community mental health teams and services for people with the most complex needs”. Alongside this, preparatory work needs to be undertaken “for the mobilisation of a new integrated primary and community model”.

The [assurance statements to accompany the Planning Guidance](#)<sup>f</sup> clarify that this preparation “should include strengthening local relationships between primary care, secondary care, local authorities and VCSE services, developing understanding of local need through information and data (such as the NHS England and NHS Benchmarking Network community mental health services stocktake), and early workforce planning”.

Further expectations are set out in the NHS Mental Health Implementation Plan 2019/20 – 2023/24, which confirms that from 2021/22 to 2023/24, all STPs/ICS will receive a fair share of central/transformation funding to develop and deliver new models of integrated primary and community care. This central/transformation funding will be in addition to the continuous uplifts in all CCGs’ baseline funding for adult and older adult community mental health from 2019/20 to 2023/24, rising to a total of almost £1 billion extra funding per year in cash terms by 2023/24.

a In cash terms.

b <https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/>

c <https://www.mind.org.uk/media/21163353/consensus-statement-final.pdf>

d <https://www.england.nhs.uk/wp-content/uploads/2018/12/nhs-operational-planning-and-contracting-guidance.pdf>

e See [Abbreviations](#) for definitions of all abbreviations used in this document.

f <https://www.england.nhs.uk/wp-content/uploads/2019/02/Annex-B-guidance-for-operational-and-activity-plans-assurance-statements-v2.pdf>

Implementing this Framework will break down the current barriers between: (1) mental health and physical health, (2) health, social care, voluntary, community and social enterprise (VCSE) organisations and local communities, and (3) primary and secondary care, to deliver integrated, personalised, place-based and well-coordinated care.

Through the adoption of this Framework, people with mental health problems will be enabled to:

1. **Access mental health care where and when they need it**, and be able to move through the system easily, so that people who need intensive input receive it in the appropriate place, rather than face being discharged to no support
2. **Manage their condition or move towards individualised recovery on their own terms**, surrounded by their families, carers and social networks, and supported in their local community
3. **Contribute to and be participants in the communities** that sustain them, to whatever extent is comfortable to them.

This Framework will support CCG planning as well as the development of the 5-year strategic plans of STPs and ICSs, as outlined in the Long Term Plan, the [NHS Operational Planning and Contracting Guidance](#)<sup>a</sup> and the [NHS Mental Health Implementation Plan 2019/20 – 2023/24](#).<sup>b</sup>

It will enable healthcare providers and commissioners, STPs, ICSs, Primary Care Networks and people who use and have experience of services to work together to deliver a model that **reinvigorates community provision** and fully utilises the resources of the wider community.

For information on how to deliver change in line with this Framework please go to [Section 3](#).

## 1.2 The importance of community

Community, whether it is a geographical location, or a group in which people find or place themselves, provides a context for people's lives.

This Framework locates community mental health services in the centre of the community, as the central pillar of mental health care, allowing all other services in the mental health care system to function more effectively.

Social determinants, availability of services, assets and other resources have a direct bearing on the level of mental health problems in a community. A key aspect of effective mental health care is ensuring that all communities can **maximise the support they provide to people who need it** and therefore address local population needs.

## 1.3 Addressing inequalities in mental health care

This Framework and [related resources](#)<sup>c</sup> will help local systems address inequalities in mental health care. Such inequalities add another layer of disadvantage for particular groups as set out in the Independent Review of the Mental Health Act. There is a strong legal, economic and ethical case for combating these inequalities, and the NHS Long Term Plan has signalled the need for local systems to undertake “proactive work to address racial disparities”. Strengthening relationships with local community groups and the VCSE will support the adoption of more rights-based care based on greater choice and engaging early with communities to address inequalities.

*When improving mental health care, there can be no quality without equality.*

Jacqui Dyer MBE, Black Thrive

a <https://www.england.nhs.uk/wp-content/uploads/2018/12/nhs-operational-planning-and-contracting-guidance.pdf>

b <https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/>

c <https://www.rcpsych.ac.uk/improving-care/nccmh/care-pathways/advancing-mental-health-equality>



Specifically, the Long Term Plan is committed to taking “a more concerted and systematic approach to reducing health inequalities and addressing unwarranted variation in care”. For example, the life expectancy of people with severe mental health problems can be up to 20 years less than the general population. By 2023/24, the NHS Long Term Plan commits that at least 390,000 people with severe mental health problems will have their physical health needs met.

See [Annex A](#) for service-led examples of positive practice in advancing mental health equality.

## 1.4 The purpose of this Framework

### 1.4.1 Local collaboration

In this context, health and social care commissioners will collaborate with all providers on a sustainably-funded partnership basis – that is, without recurrent short-term tendering cycles and complex contract management processes. This will help to make the use of existing resources more efficient, combined with substantial additional Long Term Plan resources directed into community-based services according to agreed local priorities, including greater investment in prevention and early intervention.

### 1.4.2 Meeting people’s needs in the community

People with mental health problems will be supported to live well in their communities, to maximise their individual skills, and to be aware and make use of the resources and assets available to them as they wish. This will help them stay well and enable them to connect with activities that they consider meaningful, which might include work, education and recreation.<sup>a</sup>

In this Framework, close working between professionals in local communities is intended to **eliminate exclusions** based on a person’s diagnosis or level of complexity (see [Annex B](#)) and **avoid unnecessary repeat assessments and referrals**. In the more flexible model envisaged by this Framework, **care will be centred around an individual’s needs** and will be stepped up or down based on need and complexity (see [Annex A](#)), and on the intensity of input and expertise required at a specific time.

This Framework will be applicable to people irrespective of their diagnosis. This includes but is not limited to those with:

- coexisting frailty (likely in older adults)
- coexisting neurodevelopmental conditions
- eating disorders
- common mental health problems, such as anxiety or depression
- [complex mental health difficulties associated with a diagnosis of “personality disorder”<sup>b</sup>](#)
- co-occurring drug or alcohol-use disorders, and other addiction problems, including gambling problems
- severe mental illnesses such as psychosis or bipolar disorder.

As the NHS Long Term Plan makes clear, there is a need for particular attention to be paid to improvements in care for young adults aged 18–25, and older adults. While need rather than age should be the determining factor of where and how people are cared for, staff with particular expertise in caring for people within these age groups should be readily available. Any necessary transitions should be managed carefully and safely with specific support in place for users, carers and families.

a Information and ideas are available in this Rethink Mental Illness report: <https://www.rethink.org/media/2249/building-communities-that-care-report.pdf>

b <https://www.mind.org.uk/media/21163353/consensus-statement-final.pdf>

It is envisaged that instead of sitting in entirely separate teams, dedicated services or functions will “plug into” a new core model through agreed in-reach or liaison arrangements and shared care, providing rapid, evidence-based clinical input when appropriate and specialist clinical expertise when needed, thus helping to **maximise continuity of care**.

Currently, these capacities are mainly located in secondary care teams, whose effectiveness in serving the wider population, beyond a small

number of people with the highest levels of need, is often restricted by resource limitations and commissioning arrangements that lead to lower caseload numbers and an inward-looking approach.

For a full description of this Framework see the [full implementation guidance](#).<sup>a</sup>

### Key aims

People with mental health problems will be enabled as active participants in making positive changes rather than passive recipients of disjointed, inconsistent and episodic care. Delivering good mental health support, care and treatment in the community is underpinned by the following six aims:



1. Promote mental and physical health, and prevent ill health.
2. Treat mental health problems effectively through evidence-based psychological and/or pharmacological approaches that maximise benefits and minimise the likelihood of inflicting harm, and use a collaborative approach that:
  - builds on strengths and supports choice; and
  - is underpinned by a single care plan accessible to all involved in the person’s care.
3. Improve quality of life, including supporting individuals to contribute to and participate in their communities as fully as possible, connect with meaningful activities, and create or fulfil hopes and aspirations in line with their individual wishes.
4. Maximise continuity of care and ensure no “cliff-edge” of lost care and support by moving away from a system based on referrals, arbitrary thresholds, unsupported transitions and discharge to little or no support. Instead, move towards a flexible system that proactively responds to ongoing care needs.
5. Work collaboratively across statutory and non-statutory commissioners and providers within a local health and care system to address health inequalities and social determinants of mental ill health.
6. Build a model of care based on inclusivity, particularly for people with coexisting needs, with the highest levels of complexity and who experience marginalisation.

<sup>a</sup> <https://www.rcpsych.ac.uk/improving-care/nccmh/care-pathways/community-framework>



## 2. The case for change

### 2.1 Stagnation and fragmentation

CMHTs have long taken a central role in the delivery of mental health services, but their development has stagnated over many years. Recent focus has been on specialist teams introduced in response to the National Service Framework or primary care and assessment teams. The creation of these separate specialist teams has, in most places, led to fragmentation and discontinuity of care.

Nonetheless, there are some encouraging developments around the country, with services demonstrating innovative ways of working that result in care that is responsive, cohesive and efficient (see the examples of positive practice in [Annex A](#)). In general, few community mental health services are able to make the most of community resources. In part this is a result of an historical lack of policy focus to help define a clear identity and function along with associated resources. This is now being addressed through this Framework and the Long Term Plan.

### 2.2 Barriers and variation

When multiple services provide care, multiple assessments can be common. This is distressing for the person, increases the chance of drop out, delays treatment and is a poor use of resources. This in turn puts pressure on primary care services as people with legitimate care needs are excluded from mental health teams as they do not fit rigid service specifications or meet often arbitrary thresholds.

### 2.3 The Care Programme Approach (CPA)

The CPA has had a central role in the planning and delivery of secondary care mental health services for almost 30 years. The principles

underlying the CPA are sound and there has been some excellent work over the years in implementing and in improving it. However, from early on, doubts were raised about its utility – principally, that it attempted to unite a model of resource allocation with one of clinical care delivery and planning, and that it created a two-tier system in which a person is either “on” or “off” CPA. Its role has been further complicated by its close association with risk management. A number of attempts have been made to evaluate its impact but have failed to provide convincing evidence for its effectiveness.

The [CQC](#)<sup>a</sup> recently reported that “there is a large variation in the proportion of people on the CPA between trusts, which suggests that there are systematic differences in how trusts individually interpret and apply the CPA policy”, with figures that “ranged across trusts from a low of 3% of respondents on the CPA to a high of 73%” among a sample of service users from different mental health trusts who responded to their annual community mental health survey.

This Framework therefore proposes replacing the CPA for community mental health services, while retaining its sound theoretical principles based on good care coordination and high-quality care planning.

### 2.4 Improving access to appropriate care

Some triage services now manage referrals in secondary care and direct people to specialist teams, but this can make processes more complex. Across the system, some waiting times are increasing, there are long waiting lists for psychological therapies from many secondary care providers, and services lack resources and a single, strategic approach that can improve clinical and cost effectiveness.

a [https://www.cqc.org.uk/sites/default/files/20161115\\_cmh16\\_statistical\\_release.pdf](https://www.cqc.org.uk/sites/default/files/20161115_cmh16_statistical_release.pdf)

If initial support, care and treatment are lacking, people's health can deteriorate (particularly in those with more severe problems) making them likely to go on to require more intensive or acute support. This may increase the pressures on other mental health services, where inpatient and community-based urgent and emergency services face high demand.

Use of the Mental Health Act has risen significantly over the past 10 years, and people in many parts of the country are still placed outside of their home area due to lack of local service capacity. At the same time, over many years, there has been a reduction in services for people who need longer-term care in the community as the focus has shifted to specialist, often time-limited services. NHS England and NHS Improvement have established programmes of work to address these pressures.<sup>a</sup>

Moreover, assessment under the Care Act 2014 can be difficult to access and is often not integrated with other assessments. Not having such an assessment can mean that people cannot access personalised support and housing, advocacy, welfare advice and employment support. This in turn can increase the risk of poorer mental health.

## 2.5 Moving between services

Over 50% of referrals to CMHTs come from sources other than primary care, including

other community or inpatient teams, social care or self-referral. When people's care moves between teams, typically over 20% of them do not reach the new team. This may be due to complicated referral and transition processes, or a lack of the most appropriate support in one place to address multiple needs.

Transitions are a particular issue for young people moving into adult mental health services – a proportion of whom never receive care and support from adult services – and people moving from general adult services to those for older people.

People who have co-occurring drug and/or alcohol-use disorders and mental health needs can also experience discontinuities in their care. This can often be due to a lack of skills or competences, meaning that they can be excluded from drug and alcohol services due to their mental health problems, or excluded from mental health services due to their drug and alcohol problems. This is why this Framework's principle of inclusivity is important; embedding expertise and building skills that provide support for co-occurring drug and/or alcohol-use disorders is a key element of NHS England's Long Term Plan ambition to create "a new community-based offer". People with this expertise should take the lead in establishing formal links and partnerships with statutorily local authority-commissioned drug and alcohol services.

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a NHS England and NHS Improvement have committed to ending the use of out of area placements (OAPs) for adults and older adults requiring non-specialist acute inpatient mental health care by 2021. Over the past year there has been a joint, clinically-led support programme in place to assist local areas with the delivery of this ambition; data on OAPs are reported regularly and locally developed plans and trajectories have been agreed (<https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/out-of-area-placements-oaps>).

NHS England is currently working with NHS Improvement and a number of local systems around the country to develop learning about what good local mental health rehabilitation pathways look like and how to implement them safely and sustainably. This learning will be used to support further local improvements in line with the Long Term Plan. The overarching aim is to ensure that people can be supported in the most appropriate setting for their needs and in their local community where possible. There will also be close alignment with NHS Improvement's Getting It Right First Time (GIRFT) programme, which has a new workstream focused on mental health rehabilitation (<https://gettingitrightfirsttime.co.uk/medical-specialties/mental-health/>).

## 3. This Framework and what it can deliver

### 3.1 The structure of the new Framework

#### 3.1.1 At the local (“neighbourhood”) and wider community level

This Framework sets out a new approach in which place-based and integrated mental health support, care and treatment are situated and provided in the community. This will be for people with any level of mental health need. It will enable **more and higher-quality care to be provided at a local community level** (of 30,000 and 50,000 people, the population of a Primary Care Network’s geographical footprint) by ensuring that care takes place in the context of people’s lives, and supports them to live better within and as part of their communities. It has a strong focus on the needs of people with severe mental health problems, including those who have coexisting physical health problems.

It is likely that economies of scale mean that more targeted, intensive and longer-term **input for people with more complex needs will be provided at the wider community or “place” level** (of around 250,000–500,000 people<sup>a</sup>).

#### 3.1.2 The core community mental health service

This Framework proposes a core community mental health service, which will bring together what is currently provided in primary care for people with less complex as well as complex needs with that provided by secondary care CMHTs and in residential settings (including supported housing and care homes).<sup>b</sup>

It should be built around existing GP practices, neighbourhoods and community hubs – elements that make up the new Primary Care Networks.

The configuration of each team will be determined by each local area, based on its population’s needs (see [Section 4.4](#) on workforce).

The NHS Long Term Plan’s commitment to create **new and integrated models of primary and community mental health care** will see a major expansion in the adult and older adult community mental health workforce. Over time, these models will see a significant proportion of community mental health staff become integrated within primary care, to provide better support to patients and the primary care workforce. This will build on the successful work co-locating some IAPT workers in primary care, and will be led by mental health trusts in partnership with Primary Care Networks.

Primary Care Networks are the fundamental building blocks of ICSs and they will embed mental health care – including for people with the most severe and enduring illnesses – within them.

The overall approach will be tested using targeted central transformation funding over the next 2 years. However, NHS England expects that, as a minimum, all local systems start by using new CCG baseline funding starting from 2019/20 by expanding CMHTs and aligning them with Primary Care Networks. Further expectations are set out in the NHS Mental Health Implementation Plan 2019/20–2023/24.

a This is merely indicative, and the footprint may be greater depending on the nature of the service and local need.

b Mental health support for people in care homes will be provided as part of the national roll-out of the Enhanced Health in Care Homes (EHCH) model. Where appropriate, this will be done through shared-care approaches with relevant community multidisciplinary teams at Primary Care Network-level and/or community mental health services to ensure consistent access to older people’s mental health care. During 2019 and 2020, NHS England will develop a national service specification to support the implementation of a vanguard model for EHCH. Please see chapter 1 of the NHS Long Term Plan and the five-year framework for GP contract reform 2019 (<https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>) for further information on the national roll-out of EHCH.

Each area will need to ensure that they have processes in place that will bring together the different facets of community care and deliver better mental health outcomes for the local population by ensuring that:

- People can have a good-quality **assessment** at whatever point they present
- **Interventions** for mental health problems are readily available and accessible at the location most appropriate to people's needs
- Care can be stepped up where or when more **specialist care** is required, and stepped down, in a flexible manner without the need for cumbersome referrals and repeated assessments
- There are effective links with **community assets** to support and enable people to become more embedded within their community and to use these assets to support their mental health.

At a wider level this will be based on the work of STPs/ICSs and Health and Wellbeing Boards, and informed by the content of local Joint Strategic Needs Assessments. The involvement of service users, families and carers is critical in the **co-design and co-delivery**<sup>a</sup> of new local approaches.

### 3.1.3 Functions of community mental health provision

To effectively address the needs of people with a range of mental health needs, there should

be key functions located in communities, and delivered from within this Framework's place-based and integrated model.

This would promote better outcomes for the individual and provide access to the following:

- advocacy services
- assessment, advice and consultation for mental health problems
- community assets (for example, libraries, leisure and social activities, and faith groups)
- coordination and delivery of care
- effective support, care and treatment for co-occurring drug and alcohol-use disorders
- employment, education, volunteering and training services
- evidence-based interventions for mental health problems, including psychological and pharmacological treatments, and NICE-recommended psychological therapies for people with severe mental illnesses<sup>b</sup>
- help and advice on finances (including benefits)<sup>c</sup>
- high-quality, co-produced, personalised care and support planning<sup>d</sup>
- housing and social care services
- physical health care
- services enabling access to mental health information and online resources
- specific support groups (such as older adult groups, hearing voices groups, or problem-specific support groups, for example for diabetes or depression)

a <https://www.rcpsych.ac.uk/improving-care/nccmh/other-work/coproduction>

b NHS England & NHS Improvement have established a national and regional programme to increase access to psychological therapies for people with psychosis, bipolar disorder and complex mental health difficulties associated with a diagnosis of "personality disorder". This includes supporting the establishment of regional and local clinical leadership and, in partnership with Health Education England, major new investment in training courses for staff working in community mental health services.

c See the *Whose Job is it Anyway report* (2017) (<https://www.moneyandmentalhealth.org/wp-content/uploads/2017/10/Whose-Job-is-it-Anyway-Report-spreads.pdf>) and the Citizens Advice *Putting advice where people need it most* web page (2018) (<https://wearecitizensadvice.org.uk/putting-advice-where-people-need-it-most-de70f7ba70a7>).

d <https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf>



- support that takes into account frailty, mobility issues and sensory impairments, and helps people live independently.

### 3.1.4 Mental health services for people with more complex needs

These services will be part of the same system of care and have close links with local communities, plugging in and providing consultation and advice to the new “core” model, but will have the expertise and capacity to deliver care to people with more complex needs. This should include crisis and inpatient care, where links should be seamless, and specialist residential care or dedicated community eating disorder services. In all care for complex needs, the principle of continuity remains critical. It should also include intensive and assertive support, long term care, and support for those who may be at risk of exclusion from their community, including:

- people leaving the criminal justice system or people with multiple vulnerabilities frequently in contact with the police
- rough sleepers
- socially excluded people
- those with very complex needs, such as people with disabling psychotic disorders or people with disabling complex mental health difficulties associated with a diagnosis of “personality disorder”.

Stepping up people’s care and support to this level, or stepping it down to that provided in the local community, should be straightforward and seamless so that people who use services, their carers and families do not feel and experience any gaps or boundaries.

### 3.1.5 Accessing care

In this Framework, there will be a “no wrong door” approach to accessing care. People with the full range of mental health problems will be able to access support, care and treatment in

a timely manner and from wherever they seek it, whether from their GP, from a community service, through online self-referral, other digital means or another route. People with the highest levels of need and complexity will have a coordinated and assertive community response.

#### Social prescribing

Through [social prescribing](#),<sup>a</sup> the range of support available to people in the community will “widen, diversify and become accessible across the country”, as set out in the Long Term Plan and [NHS England’s Universal Personalised Care publication](#).<sup>b</sup>

#### Individual placement and support (IPS)

The NHS is on track to meet its Five Year Forward View for Mental Health commitment to support up to 20,000 people with severe mental illness to find and retain employment by 2020/21. The NHS Long Term Plan builds on this, so that the NHS will support an additional 35,000 people a year – a total of 55,000 people per year by 2023/24. Based on over 20 years of research, the IPS employment model is internationally recognised as the most effective way to support people with mental health problems to gain and keep paid employment.

#### Physical health care for people with severe mental illness

NHS England has a programme to improve physical health care for people with severe mental illness, including early intervention, to avoid development of preventable disease. Resources and information are available on the [NHS England website](#).<sup>c</sup> The Long Term Plan has a commitment to expand this further and this Framework supports these ambitions by setting out principles of integration between primary and secondary care and mental and physical health care.

a <https://www.england.nhs.uk/personalisedcare/social-prescribing/>

b <https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf>

c <https://www.england.nhs.uk/mental-health/resources/smi/>

People’s support systems would include some or all of what is in the [diagram below](#), with mental health services focusing on delivering any additional support, as well as evidence-based interventions including psychological therapies.

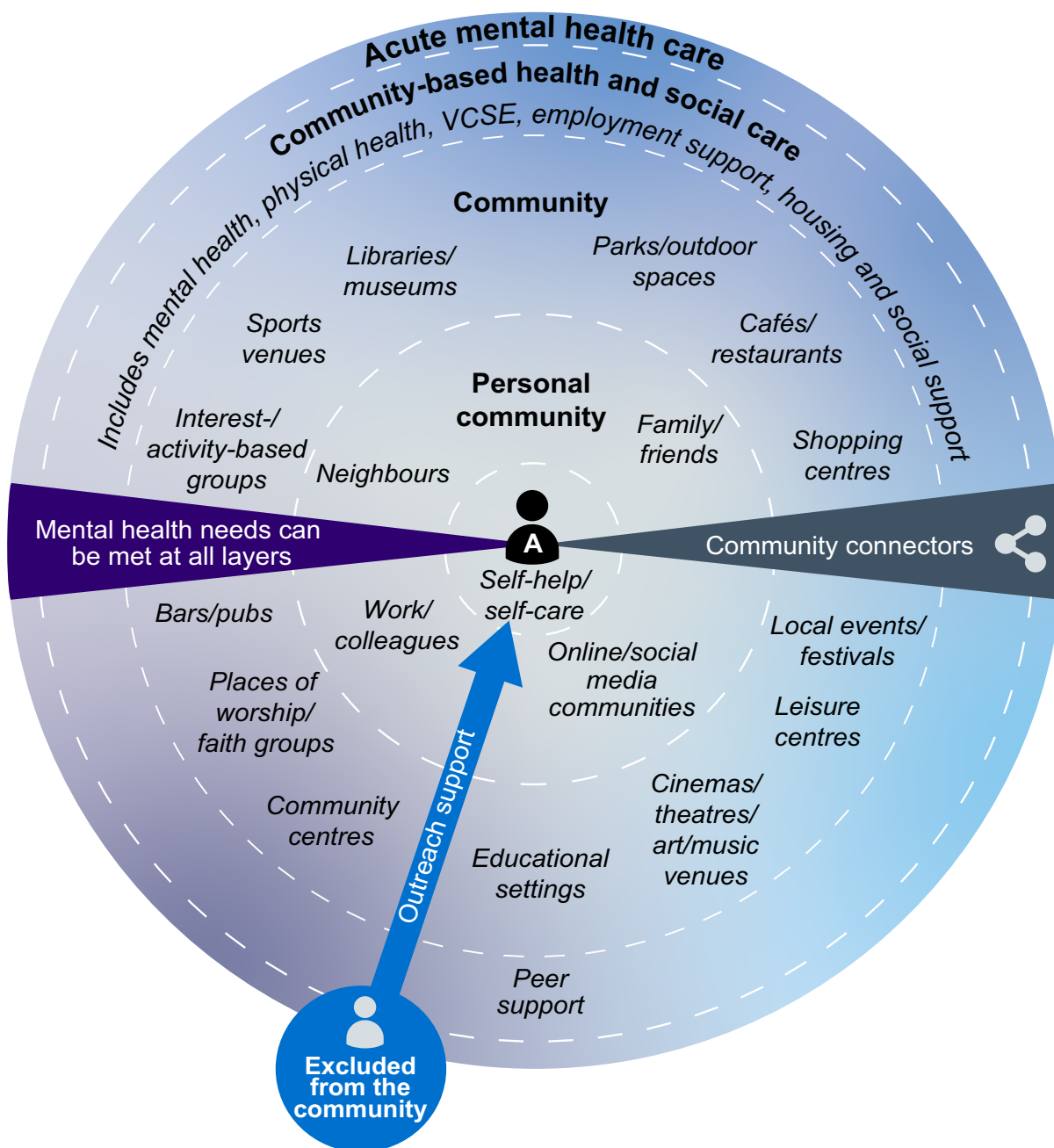
### 3.2 Functions of community mental health services in this Framework

#### 3.2.1 Assessment and interventions

In this Framework, assessment is biopsychosocial and forms part of the

integrated team approach to assessment. Most importantly, assessment is a collaborative process, not only among mental health team members but also with the person and their families, carers and support network. It relies on communication and respect between individuals – especially professionals from different backgrounds and settings – and a mutual understanding about the approach to assessment.

Assessment can be undertaken by different members of the core community mental health service at the point at which a person seeks access, though staff must be suitably qualified





and experienced. It will vary according to the needs of the individual and the complexity of their problem(s). Assessment can be a relatively brief initial contact in which an understanding of the person's current problems and a shared view of an intervention have been developed and agreed with them. The intervention itself may comprise a simple, short advice session that enables the person to obtain help for themselves, or perhaps no further help will be required. Digital technologies, such as mobile applications, may be used.

However, for a significant proportion of people there will be an intervention detailed in an agreed personalised care and support plan, developed mutually (subject to the person's capacity). For people with less complex problems, care plans will be brief and uni-professional, and may set out, for example, a psychological therapy course (for example, dialectical behaviour therapy, or DBT), support to join a community group, help in resolving a difficulty at work, or initiation of a treatment with medication and subsequent follow-up.

For people with more complex problems, the assessment will be more comprehensive, and may require multidisciplinary input (in the case of older adults living with frailty, for example), and interventions are also likely to be multi-professional in nature.

As set out in the **Long Term Plan**, in a place-based integrated service, available interventions should include access to psychological therapies, improved physical health care, employment support, personalised and [trauma-informed care](#),<sup>a</sup> medicines management and support for self-harm and co-occurring drug or alcohol-use disorders.

### 3.2.2 Coordinating and planning care

A key component of this Framework is setting out a method for coordination of care that will replace the CPA and enable high-quality, [personalised care and support planning](#)<sup>b</sup> in line with the [NHS England Comprehensive Model of Personalised Care](#).<sup>c</sup>

Under this Framework, every person who requires support, care and treatment in the community should have a co-produced and personalised care plan that takes into account all of their needs, as well as their rights under the Care Act, and Section 117 of the Mental Health Act when required.

The level of planning and coordination of care will vary, depending on the complexity of their needs. For people with more complex problems, who may require interventions from multiple professionals, one person will have responsibility for coordinating care and treatment. This coordination role can be provided by workers from different professional backgrounds. [The Triangle of Care](#)<sup>d</sup> can facilitate the greater involvement of carers, whose expertise should be central. Adopting improved [whole family approaches as pioneered within social care](#)<sup>e</sup> can increase the effectiveness of planning.

The care plan will include timescales for review, which should be discussed and agreed with the person and those involved in their care at the outset. Digital technologies can be used to maximise the interoperability of plans, and to allow users to manage their care or record advance choices.

This Framework subsumes the important aspects of the CPA for community mental health services, including care planning and care coordination, and reframes them in a system that will work for everyone, will focus on improved outcomes and will deliver place-based integrated mental health care to people

a [https://www.centreformentalhealth.org.uk/sites/default/files/2019-04/CentreforMH\\_EngagingWithComplexity.pdf](https://www.centreformentalhealth.org.uk/sites/default/files/2019-04/CentreforMH_EngagingWithComplexity.pdf)

b <https://www.england.nhs.uk/ourwork/patient-participation/patient-centred/planning/>

c <https://www.england.nhs.uk/personalisedcare/comprehensive-model-of-personalised-care/>

d <https://carers.org/article/triangle-care>

e <https://local.gov.uk/sites/default/files/documents/care-act-and-whole-family-6e1.pdf>

whatever their level of need. This Framework envisages a shift away from risk assessments and ineffective predictive approaches to safety planning and “positive risk taking”, with staff supported by managers and to do so under progressive, partnership clinical governance arrangements.

### 3.2.3 Community connection

This Framework largely builds on existing skills and expertise (see [Section 4.4](#) on workforce); however, a specific “community connector” or “social prescribing link worker” role might need to be created (or the functions of that role carried out by, for example, peer support workers, recovery coaches or care coordinators).

Part of everyone’s role is to work with their community. For example, local authorities have developed community asset-based approaches and the core skills of social workers include identifying and connecting people to their social networks and communities. Community connectors/social prescribing link workers, however, will work closely with the whole spectrum of community services and the local VCSE sector. The key functions of this role are to be familiar with the local resources and assets available in the community, vary the support provided, based on needs, and assess a person’s ability and motivation to engage with certain community activities.

See positive practice examples of community connection in [Annex A](#).

## 3.3 Benefits of this Framework

For people who work in mental health care, the benefits of this Framework are linked to the benefits for service users. There will be less administration and bureaucracy because within an integrated system there will be fewer referrals.

This Framework uses the term **community connector** to describe the role that might otherwise be known as a **social prescribing link worker, wellbeing advisor or care navigator**. While NHS England favours the term “social prescribing link worker”, the title varies, and can be determined locally when these roles are created, but the core elements will remain the same. NHS England has committed to fund the recruitment and training of over 1,000 social prescribing link workers to be in place by the end of 2020/21, rising further by 2023/24.

This integration should result in more time in direct contact with service users, which will comprise joined-up, ongoing, personalised care and support, and access to the right care at the right time for them and for their families and carers, including freeing up time to deliver evidence-based care such as psychological therapies. People with mental health problems will have fewer assessments, will not be required to repeat their histories, and will not fall through the gap between services. Moreover, they will be supported to live as well as possible in their communities.

This Framework will support staff to use their professional judgement, which will increase autonomy, foster innovation and enable partnerships to be built across health and social care. For the primary care workforce, there will also be significant benefits. They will be better supported to care for people with mental health problems, increasing their skills and knowledge, and better able to access expert mental health clinical advice rapidly or even immediately. Their referrals will not be rejected and they will not have to wait for responses from mental health services. Fewer primary care appointments will be needed by people seeking mental health support and there will also be fewer people who attend GP practices frequently with unmet mental health needs.<sup>a</sup>

a <https://www.rcpsych.ac.uk/improving-care/nccmh/care-pathways/community-framework>

## 4. Implementation

Implementing this Framework, which involves triple integration of mental health, physical health and social care, will take time, requiring careful joint working across STP/ICS geographies by providers, commissioners, local authorities, local VCSE organisations, service users and carers, and the local community. Some components are already being implemented in certain areas, though not in a systematic way, so testing of these new models in selected areas will seek to address this.

Implementation will be an iterative process. The new models mentioned in the Long Term Plan, which this Framework describes in more detail, will be tested in those areas in receipt of new NHS England transformation funding in 2019/20 and 2020/21, and the learning will be fed back within regions and across the country. This testing phase is an opportunity for commissioners and service providers to work closely in setting out a vision for better mental health care that all ICSs can bring about. The experiences of service users and carers will be an essential part of the evaluation process.

[The NHS Mental Health Implementation Plan 2019/20–2023/24](https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/)<sup>a</sup> confirms that from 2021/22 to 2023/24, all STPs/ICS will receive a fair share of central/transformation funding to develop and deliver new models of integrated primary and community care; this central/transformation funding will be in addition to the continuous increase in all CCGs' baseline funding from 2019/20 to 2023/24.

Throughout the implementation process, commissioners and providers should ensure that there are protocols in place for maintaining high-quality care and ensuring patient safety.

### 4.1 Developing a place-based model of community mental health care

The King's Fund has published [ten design principles](https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Place-based-systems-of-care-Kings-Fund-Nov-2015_0.pdf)<sup>b</sup> and NHS England has published [guidance on integrated care](https://www.england.nhs.uk/integratedcare/).<sup>c</sup> Using these as guidance, organisations can collaborate to manage the common resources available to them. The Framework proposed here applies the collaborative model to the delivery of community mental health care. In this case, providers include VCSE organisations, the local authority and other providers of social care, as well as statutory primary and secondary healthcare providers.

### 4.2 Leadership and governance

The first and most important step in implementing this Framework will be initiated by a group of leaders with a shared vision, who can drive change and establish strong relationships. The leaders should be experienced clinicians, commissioners, practitioners, managers and people who have used and have experience of services, who can work effectively across organisational and professional boundaries.

Sound clinical governance under this Framework is critical to its successful implementation within systems that promote cross-professional and organisational safety and learning approaches. Agreed governance structures will be required for the effective operation of all services in this Framework, including the development of systems and processes to support the integration of primary care, secondary care mental health, social care, VCSE organisations and housing and community services.

a <https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/>

b [https://www.kingsfund.org.uk/sites/default/files/field/field\\_publication\\_file/Place-based-systems-of-care-Kings-Fund-Nov-2015\\_0.pdf](https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Place-based-systems-of-care-Kings-Fund-Nov-2015_0.pdf)

c <https://www.england.nhs.uk/integratedcare/>

The component bodies of the mental health governance structure will need to establish robust links with, and be overseen by, STPs/ ICSs and develop a joint common vision. They should then agree principles and key outcomes for local systems.

Representation should include:

- CCGs
- local authorities, including:
  - social services
  - drug and alcohol services
  - education
  - housing and employment
  - public health
- mental health services
- physical health services
- primary care, including Primary Care Network representatives
- service users and carers
- VCSE organisations.

These bodies will be responsible for the design, delivery and strategic development of new models of community mental health care. This design will include the implementation of systems for reviewing performance and outcomes at all levels (system, service, individual service user) to enable a focus on the quality of community mental health care provision as well as timely access.

Integration of commissioning processes at the local system level will facilitate collaborative working by providers, leading to improved patient outcomes and experience.

One way of achieving this is through multi-year **alliance contracting**. An overarching contract across organisations means that each member organisation is contractually mandated to achieve the same objectives. Members of the alliance could co-produce a set of shared values and agree a local vision and principles for the community mental health service, which would ensure a focus on priorities (for example, continuity of care and trusted assessments). Local partners agreeing a multi-year alliance contract with in-built flexibility could also help to focus efforts on the quality of care and help smaller VCSE organisations to operate on a surer, sustainable basis.

The Local Government Association and NHS Clinical Commissioners have developed [guidance](#)<sup>a</sup> on how to best achieve integrated commissioning. NHS England has developed [a practical guide](#)<sup>b</sup> on leading large scale change and the Health Foundation has published [a learning report](#)<sup>c</sup> setting out lessons from the new care models programme.

### Support for implementation of this Framework

NHS England will put in place implementation support when testing new models in line with this Framework to ensure that new models operate effectively. Additionally, in 2019/20, NHS England will begin supporting local systems to improve the quality of care planning, working across its mental health and personalised care programmes.

a [https://www.local.gov.uk/sites/default/files/documents/25.70\\_Integrated%20Commissioning%20for%20Better%20Outcomes\\_final.pdf](https://www.local.gov.uk/sites/default/files/documents/25.70_Integrated%20Commissioning%20for%20Better%20Outcomes_final.pdf)

b <https://www.england.nhs.uk/wp-content/uploads/2017/09/practical-guide-large-scale-change-april-2018-smll.pdf>

c <https://www.health.org.uk/sites/default/files/SomeAssemblyRequired.pdf>



### Long Term Plan implementation and resourcing to test the model in 2019/20 and 2020/21

NHS England and NHS Improvement are investing over £70 million new Long Term Plan funding to test new models and 4-week waiting times in the following 12 STPs/ICSs over the next 2 years, covering all 7 NHS regions in England:

- Cambridgeshire and Peterborough
- Cheshire and Merseyside
- Frimley
- Herefordshire and Worcestershire
- Hertfordshire and West Essex
- Humber, Coast and Vale
- Lincolnshire
- North East London
- North West London
- Somerset
- South Yorkshire and Bassetlaw
- Surrey Heartlands

### 4.3 Infrastructure

Systems need to be in place to be able to routinely collect good-quality outcomes data, including people's experience of care. Digital tools, such as an online personal clinical record owned by users, can be used for self-reporting. When introducing outcome measures, consider:

- the rationale (why outcomes are being collected and in what context)
- the opportunity cost (balancing the value of the data against the time taken to collect it)
- whether the measure is at the individual, service or system level.

STPs/ICSs should also consider integrated, system level outcomes and indicators that are meaningful to the range of provider

organisations involved. Evaluation of the first wave of model test sites will provide insights into what activity, experience and outcome measures can be developed and collected, and how. The Long Term Plan includes a commitment to ensuring that IT systems are integrated so that (with people's permission) clinical records can be shared and accessed by the whole multidisciplinary team and other agencies.<sup>a</sup>

For examples of positive practice in infrastructure and data, see [Annex A](#).

### 4.4 Workforce

The full range of staff in multidisciplinary services within each local community should collaborate to deliver effective mental health care. The starting point for this workforce would be staff currently working in secondary care community mental health services. However, to realise the joined-up approach this Framework sets out, these teams would fully integrate their working with other local services, including Primary Care Networks, employment and housing support staff, key VCSE organisations in the area and social support services. Care will be planned and delivered across this wider partnership.

While this list is not exhaustive, key roles in local place-based, multidisciplinary services could include:

- administrative staff
- clinical psychologists
- mental health nurses
- mental health pharmacists
- occupational therapists
- primary care staff
- psychiatrists
- psychological therapists
- social workers and other local authority workers (for example, housing support workers and debt advisors)

<sup>a</sup> Further information on digital transformation relating to the Long Term Plan can be found in chapter 7 of the [NHS Long Term Plan Implementation Framework \(https://www.longtermplan.nhs.uk/wp-content/uploads/2019/06/long-term-plan-implementation-framework-v1.pdf\)](https://www.longtermplan.nhs.uk/wp-content/uploads/2019/06/long-term-plan-implementation-framework-v1.pdf), and in the [NHS Mental Health Implementation Plan 2019/20–2023/2024 \(https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/\)](https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/).

- support workers
- team managers.

Services should also make full use of newer roles, including:

- community connectors/social prescribing link workers
- paid peer support workers/experts by experience.

Having a collaborative and integrated approach to delivering care also means that skills and competences can be shared across multiple disciplines.

*The perfect mental health service exists – it just isn't all in one place.*

Tony Russell, founder: Positive Practice in Mental Health

### Abbreviations

CCG	Clinical commissioning group
CMHT	Community mental health team
CPA	Care Programme Approach
CQC	Care Quality Commission
EHCH	Enhanced Health in Care Homes
IAPT	Improving Access to Psychological Therapies [primarily for adults with depression and anxiety disorders]
ICS	Integrated Care System
IPS	Individual placement and support
OAP	Out of area placement
STP	Sustainability and Transformation Partnership
VCSE	Voluntary, community and social enterprise



## Annex A: Positive practice examples

### Addressing inequalities in mental health

[Black Thrive<sup>a</sup>](#) – Lambeth, London

[Liverpool Advice on Prescription in Primary Care<sup>b</sup>](#) – Liverpool

[Project Future<sup>c</sup>](#) – Haringey, London

[Psychology in Hostels Project<sup>d</sup>](#) – South London and Maudsley NHS Foundation Trust

[Rainbow Alliance<sup>e</sup>](#) – Leeds and York Partnership NHS Foundation Trust

[SIFA Fireside<sup>f</sup>](#) – Birmingham

### Community connection

[Certitude Lower Road Forensic Service<sup>l</sup>](#) – Lewisham, London

[Community Restart \(Restart Social Inclusion Service\)<sup>m</sup>](#) – Lancashire Care NHS Foundation Trust

[Connecting People Intervention<sup>n</sup>](#) – University of York

[The Pod<sup>o</sup>](#) – Coventry

[Westongrove Partnership \(Care Navigator pilot\)<sup>p</sup>](#) – Aylesbury, Buckinghamshire

### Innovative ways of working

[The Life Rooms<sup>g</sup>](#) – Mersey Care NHS Foundation Trust

[Pathfinder Clinical Service<sup>h</sup>](#) – Pathfinder West Sussex, Sussex Partnership NHS Foundation Trust

[PRISM \(Primary Care Mental Health Service\)<sup>i</sup>](#) – Cambridgeshire and Peterborough NHS Foundation Trust

[St Peter's Medical Centre<sup>j</sup>](#) – Sussex Partnership NHS Foundation Trust

[Westminster Older Adults Integrated Community Mental Health and Home Treatment Team<sup>k</sup>](#) – Central and North West London NHS Foundation Trust

### Infrastructure and data

[Healthlocker<sup>q</sup>](#) – South London and Maudsley NHS Foundation Trust (Global Digital Exemplar)

[PRISM \(Primary Care Mental Health Service\)<sup>i</sup>](#) – Cambridgeshire and Peterborough NHS Foundation Trust

a <https://www.blackthrive.org.uk/>

b <http://www.southliverpoolcab.org.uk/index.php/en/about-us/2012-04-22-07-19-05/advice-on-prescription-project>

c <http://www.mindinharingey.org.uk/project-future.asp#.XPfVXohKiUI>

d <http://positivepracticemhdirectory.org/archive/psychology-hostels-project-lambeth/>

e <https://www.leedsandyorkpft.nhs.uk/get-involved/rainbow-alliance/>

f <https://www.sifafireside.co.uk/>

g <https://liferooms.uk/>

h <https://www.pathfinderwestsussex.org.uk/about-us>

i <https://www.cpft.nhs.uk/Documents/Miscellaneous/Prism%20leaflet%20Feb%202018.pdf>

j <https://www.stpetersmedicalcentre.co.uk/practice-information/>

k <https://www.cnwl.nhs.uk/service/westminster-older-people-community-mental-health-team/>

l <https://www.certitude.london/>

m <https://www.lancashirecare.nhs.uk/Community-Restart>

n <https://connectingpeople.net/>

o <http://www.coventry.gov.uk/thepod>

p <https://www.england.nhs.uk/blog/plotting-the-right-path-with-care-navigators/>

q <https://www.slam.nhs.uk/patients-and-carers/patient-information/healthlocker>

## Annex B: Complexity of mental health problems within this Framework

### Complexity

The term “complexity” is used to capture the different requirements for services that people with mental health problems have, ranging from “less complex” to “complex” and to “more complex”. People may move between levels of complexity as their needs change.

Diagnosis alone does not always give a clear indication of complexity. For example, a person with a psychotic disorder may function very well and need limited help and support in managing their condition, whereas a person with chronic depression and diabetes may have more complex needs that require the support of a specialist multidisciplinary mental health team.

Complexity is cumulative and influenced by the following factors:

- nature, duration and severity of mental health problems (including comorbidity and neurodevelopmental disorders)
- co-occurring drug and alcohol-use disorders
- problems associated with ageing, such as frailty
- nature, duration and severity of coexisting physical health problems
- availability and quality of personal and social support and networks
- associated functional impairment
- effectiveness of current or past treatment and/or support
- services’ ability to engage with people and be accessible.