Service Specification No.	A01
Service	Acute Inpatient Service
Commissioner Lead	Joanne Marsh, Senior Locality Commissioning Manager, CCG
Provider Lead	Rachael Birks, Associate Director Acute and Urgent Care
Period	1st April 2022 – 31st March 2023
Date of Review	As required

1. Population Needs

1.1. National/local context and evidence base

It is estimated that about 66,000 people in the over 18 population are registered with GPs in the two Clinical Commissioning Groups for which this service is provided (NHS North Staffordshire and NHS Stoke on Trent) would have a common mental health problem such as anxiety, depression or OCD. These conditions can have mild, moderate or severe impact on someone's ability to function.

This service is intended to help meet the needs of people with more severe level of these problems, which is estimated as being about 5,000 people in the local population.

It is also estimated that about 1,600 people in the local population would have a more severe mental health problem such as psychosis, and this service would also be expected to meet their needs.

The levels of need described above are based on national prevalence rates – because of the recognised impact of deprivation and poverty on the prevalence of mental health problems – both for common and more severe problems, it is probable that the actual levels of local need are higher but the exact impact on local needs cannot be estimated at this time.

No health without mental health. A cross government mental health outcomes strategy for people of all ages (2011)

The five year forward view for mental health (February 2016). This report form the independent mental health taskforce for NHS England sets out a strategy for delivering mental health care with specific recommendations to be met by 2021.

2. Outcomes

2.1. NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**ü**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**ü**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**ü**
Domain 4	**Ensuring people have a positive experience of care**	**ü**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**ü**

2.2. Local defined outcomes

- In all cases admission to hospital is appropriate in order to meet needs that cannot be addressed in community settings

- In all cases discharge from hospital is timely and well managed.

- Lengths of hospital admissions are reduced through early facilitated discharge supported by the Acute Home treatment team and/or the persons care team

- The number of repeat hospital admissions are reduced as individuals are supported via more flexible options which meet their needs enabling them to maintain relationships and social contacts.

- The support provided to all service users admitted to an in-patient setting will be co-ordinated via the Care Programme Approach.

3. Scope

3.1. Aims and objectives of service

Inpatient wards continue to be an essential element in the acute mental health pathway. Treatment at home is not always realistic or desirable, especially when a service user's level of risk to self or others is such not to allow long periods of time without supervision or where the home environment is exacerbating a patient's crisis.

The service's aims are:

- To provide a prompt response to individuals experiencing a crisis or other acute mental health difficulties
- To provide intensive support to service users in an inpatient setting
- To ensure that service users are referred for hospital admission only when there is a clearly identified clinical need, where the severity of that need, risk or complexity is such that alternatives would not be sufficient to meet their needs or provide a required level of safety
- To work with the AMHP service in relation to service users who need to be formally assessed and detained under the Mental Health Act
- Care plans will be designed to manage and reduce positive mental health symptoms and;
    - Will address physical health needs resulting in the reduction of inequalities in health care.
    - Will reduce the need for services by promoting self-advocacy, enabling service users to move to less intensive service interventions or away from secondary care.
    - Will detail the role of carers and they will be active participants in the reviewing process. Will detail the responsibilities of partner agencies and they will be active participants in the reviewing process.
- To provide psychiatric hospital based treatment for service users experiencing mental health difficulties either in crisis or acute distress and ensure that they are in inpatient care for the minimum time necessary, maintaining the service user's role in the community, and that they are

returned to treatment in the least restrictive environment as close to home and as soon as is clinically possible

- Ensure patients who meet the criteria for an Independent Mental Health Advocate (IMHA) are offered and referred to the service within the statutory guidelines.
- To facilitate early discharge by early involvement in discharge planning, consulting with inpatient multi-disciplinary teams, service users and carers, care co-ordinators and CMHT's
- To support service user's prompt and appropriate return to their community, ensuring that a services users discharge from an inpatient resource is properly planned and co-ordinated with the service user.
- To ensure access to therapy and social inclusion programmes appropriate to their needs, this will be reflected in care plans.

3.2. Service description/care pathway

The inpatient service comprises of three wards which offer inpatient care for adults with acute mental illness, providing structured, supportive, short term, individualised care for those who are in an acute phase of a mental disorder.

- **Ward 1** – A 14 bedded mixed sex ward which offers a greater level of intensive care, safety and security for individuals suffering from an acute mental health problem with associated risks that cannot be managed on an open acute ward but does not require psychiatric intensive care (PICU) provision.
- **Ward 2** – A 22 bedded male ward
- **Ward 3** – A 22 bedded female ward.

Electro Convulsive Therapy (ECT) is one of the therapeutic treatment options offered to Adult Inpatients in wards 1, 2 and 3, where assessed to be appropriate.

3.3. Population covered

The service is for adults who are registered with a general practitioner within the Clinical Commissioning Group (CCG) areas of NHS North Staffordshire and NHS Stoke-on-Trent. For people who are not registered with a GP, the service will be provided but support given to enable the person to register.

3.4. Any acceptance and exclusion criteria and thresholds

3.4.1. Acceptance Criteria for Wards 1, 2 and 3

To be eligible for the service people must meet the following acceptance criteria:

- Be 18 years old or over
- Be in an acute phase of a mental health disorder
- Require assessment and/or treatment which cannot be provided within a community setting

Admission will be in response to a new episode or an acute exacerbation of the patient's condition.

In addition to this, Ward 1 will take Patients displaying the following behaviours:

- An enhanced risk of aggression
- Absconding with an associated serious risk
- Suicide or vulnerability in the context of a serious mental disorder.

3.4.2. Exclusion Criteria for Wards 1, 2 and 3

The following patients should not be admitted to acute care wards:

- The inpatient service is not considered appropriate for children and young people aged under 18.
- Primary diagnosis of substance misuse, dementia, learning disability;
- Patients intoxicated with alcohol or substances;
- Patient's physical condition is too frail to allow safe management within the acute wards.

Where service users require the following:

- Sustained periods of special observation in relation to violence and aggression that require 1 to 1 nursing observation i.e. in excess of 24 hours and where there is no indication from the MDT that this will de-escalate within the next 24-48 hours, and;
- Where the service user demonstrates planned intent with immediate risks that cannot be managed in the physical environment of Ward 1 consideration will be given to referring the service user to a PICU.

Where agreement has been reached with Commissioners to transfer a patient to a PICU the Provider will facilitate transfer back to the most relevant provision i.e. Home Treatment, CMHT, inpatient etc. in a timely manner when the patient no longer needs secure containment.

3.4.3. Acuity Levels for Wards 1, 2 and 3

The Department of Health (1999) practice guidelines which identified 3 levels of enhanced observation. In line with these guidelines NSCHT's Policy and Procedure for the Safe and Supportive Observation and Engagement of Patients at Risk (Policy 1.35) identifies four levels of nursing observations:

General Observation (Level 1): This is the minimum acceptable level of observation. Under this level of observation, nursing staff make regular checks on the whereabouts and well-being of all patients. In practice this is implemented by a minimum of hourly contact with all patients on the ward. This is in line with statutory Health & Safety regulations.

Close Intermittent Observation (Level 2): This level of observation is appropriate when patients are potentially, but not immediately, at risk. A designated nurse is assigned to monitor the patient's whereabouts and circumstances at regular, intermittent periods (generally 10 – 15-minute intervals). In practice this level supports the management of risks associated with harm to self and others, or poor physical health.

Constant Visual Observation (Level 3): Continuous visual observation is required when the patient demonstrates vulnerability but without clear intent or plan and is assessed as being at risk of serious harm to themselves or others at any time. In practice this level supports the management of risks associated with serious harm to self and others or significantly poor physical health that requires constant nursing attention.

Special Observation (Level 4): Special observations are applied when a patient demonstrates immediate / imminent risk of suicide or seriously harming themselves or others. This results in the need for the patient to be nursed in close proximity and requires nurses to give due regard to safety, privacy, dignity, gender and environmental dangers. A designated nurse is physically present by the patient's side 24 hours per day and never leaves the patient for any reason unless relieved by another designated nurse. There may be occasions when more than one nurse is required to support this level of observation due to the level of risk presented by the patient.

Within the current recommended safe staffing levels, for the Acute Wards 1, 2, 3 **either of** the following levels of observations (i.e. either Level 2 column, Level 3 column or Level 2&1 column) are able to be provided:

Obs Level	Level 2	Level 3	Level 2 & 3
Ward 1	**2**	**1**	**1 Level 2 & 1 Level 3**
Ward 2	**2**	**1**	**1 Level 2 & 1 Level 3**
Ward 3	**2**	**1**	**1 Level 2 & 1 Level 3**

3.5. Interdependence with other services/providers

The service works closely with the Access and Acute Home Treatment team to gate keep and manage admissions to hospital and facilitate early discharge to ensure that the patient is managed in the least restrictive environment.

The service works with GPs and Primary care services to ensure support is provided post discharge.

The service works closely with the bed-based Rehabilitation Units at Florence House and Summers View to ensure discharge of patients with longer term rehabilitation needs requiring a specialist inpatient service.

The service works with partner agencies such as housing providers, housing support providers, substance misuse services and others to ensure that admission to inpatient care and discharge is managed in ways that enable service users to maintain accommodation and other appropriate support.

4. Applicable Service Standards

4.1. Applicable national standards (e.g., NICE)

- All service users discharged from hospital will receive a 'face to face', telephone or digital contact by exception in line with the Directorate SOP on post discharge follow up with their care team within 7 days of discharge.
- The percentage of admissions gate kept by the Home Treatment Team will meet the standard set out in national guidance

4.2. Applicable standards set out in Guidance and/or issued by a competent body (e.g., Royal Colleges)

- AIMS accreditation – Acute standards

4.3. Applicable local standards

- The number / percentage of readmissions within 30 days following discharge is below the level specified in performance management targets.

5. Applicable quality requirements and CQUIN goals

5.1. Applicable Quality Requirements

See Schedule 4

5.2. Applicable CQUIN goals

See Schedule 3

6. Location of Provider Premises

The Provider's Premises are located at:

Harplands Hospital, Hilton Road, Stoke-on-Trent

Service Specification No.	**A02**
Service	Mental Health Rehabilitation Services
Commissioner Lead	Denise Dyke, Commissioning Manager
Provider Lead	Fiona Platt, Service Line Manager, North Staffordshire Combined Healthcare Trust Ben Boyd, Associate Director Specialist Services, North Staffordshire Combined Healthcare Trust
Period	2022/2023
Date of Review	October 2022

1. Population Needs

1.1 National/local context and evidence base

A mental health rehabilitation service provides specialist assessment, treatment, interventions and support to enable the recovery of people whose complex needs cannot be met by general adult mental health services.

These services aim to work with people to help them acquire or regain the skills and confidence to live successfully in the community. They focus on addressing and minimising the symptoms and functional impairment that people may have, with an emphasis on achieving as much individual autonomy and independence as possible[1].

National Context

The prevalence of severe mental illness is estimated to be about 1 in 100 people, equating to 550,000 people in England. About 75% have a diagnosis of psychosis, around 10% have bipolar disorder, and the remaining 15% have other diagnoses such as neurodevelopmental disorders, and severe depression. Around 20% of people newly diagnosed with a severe mental illness will go on to develop particularly complex problems and need mental health rehabilitation[2]. People with other mental health disorders whose functioning is significantly affected by their illness or disorder may also need mental health rehabilitation.

[1] Guidance for commissioners of rehabilitation services for people with complex mental health needs. Joint Commissioning Panel for Mental Health. November 2016

[2] Guidance for commissioners of rehabilitation services for people with complex mental health needs. Joint Commissioning Panel for Mental Health. November 2016

Over 80% of people who are referred for mental health rehabilitation have a primary diagnosis of schizophrenia, schizoaffective disorder or other psychosis, around 8% have bipolar affective disorder, and the remaining 11% have other diagnoses. Around two-thirds are male. Although people who need mental health rehabilitation have varied primary diagnoses, a common feature is the complex problems they experience, which have a severe, negative impact on their day-to-day functioning, including managing everyday activities and social, interpersonal and occupational functioning. These problems make it impossible for people to be discharged from acute mental health inpatient care back to the community.

Rehabilitation is essential to address these complex problems. For the vast majority of people, mental health rehabilitation leads to successful and sustained discharge from hospital and a meaningful, rewarding community life.

There have been a plethora are recent reports concerning people with serve mental illness and the local services that support their rehabilitation and recovery. In recent years, there has been a focus on Early Intention in Psychosis with resources for new services being made available. This has had a positive effect and outcomes on people who suffer from psychosis but there is a small number of people who will relapse and require longer-term support.

As part of the NHS Long Term Plan[3], the Community Mental Health Framework[4] clearly states the need for those with serious mental illness and rehabilitation needs, require specialist rehabilitation input. The CQC reports in 2020[5] and in 2018[6] highlight the need for local Rehabilitation services to reduce and avoid Out of Area treatment for this vulnerable cohort, as well as flagging the importance of staff having the right skillset to provide active rehabilitation, rather than maintain the clinical status quo with patients. The Getting it Right First Time (GIRFT[7]) Mental Health Rehabilitation work stream has also brought mental health rehabilitation to the forefront and states the need for community rehabilitation teams.

Recent NICE guidance[8] that focuses on mental health rehabilitation also highlights the important of good mental health rehabilitation services and states that such services for people with complex psychosis should:

• be embedded in a local comprehensive mental healthcare service

• provide a recovery-orientated approach that has a shared ethos and agreed goals, a sense of hope and optimism, and aims to reduce stigma

[3] The NHS Long Term Plan. January 2019
[4] NHS Mental Health Implementation Plan 2019/20 – 2023/24. July 2019.
[5] Mental health rehabilitation inpatient services – 2019 update. CQC. October 2020.
[6] Briefing – Mental health rehabilitation inpatient services. CQC. March 2018
[7] GIRFT is a national NHS development programme delivered in partnership with the Royal National Orthopaedic Hospital NHS Trust and NHS Improvement.
[8] NICE guidance 181 Rehabilitation for adults with complex psychosis. August 2020

• deliver individualised, person-centered care through collaboration and shared decision making with service users and their carers involved

The joint report from Rethink Mental Illness and the Royal College of Psychiatrists, *In sight and in mind*[9] explains that there is good evidence that when local mental health rehabilitation services are provided, they are able to support the majority of people with the most severe, long-term mental health conditions, enabling them to enjoy a good quality of life in the community.

The reports highlights a number of recommendations that includes if patients require rehabilitation mental health treatment in the community, that they should be supported by local specialist rehabilitation services in each CCG footprint, as part of the implementation of the NHS Long Term Plan. This will ensure that effective recovery-based care is available to proactively support people to progress from in-patient to community-based rehabilitation settings as soon as they are able.

NHS Long Term Plan[10], also identified that gap in health inequalities was a significant contributor in early mortality for patients with severe mental illness. Also according to the Independent Mental Health Taskforce to the NHS in England (2016), people with severe mental health illnesses tend to die 15-20 years earlier than those without.

Local Context

Getting It Right First Time (GIRFT) have supported North Staffordshire Combined Health Care (NSCHT) with a workshop on Rehabilitation services in August 2020 following their review and presentation of local data. The key discussions were:

- Building clear links between rehab services and services users placed out of area
- Benefits of developing a specialist community Rehab team
- Potential need for more intensive NHS beds or supported tenancies
- Physical health needs within the Rehab population

The *Together we're better Five Year Delivery Plan 2019/20 –2023/24 for Staffordshire and Stoke-on-Trent* (Final submission – January 2020) details the plans for improved access to community mental health and to reduce health inequalities.

[9] In sight and in mind: Making good on the promise of mental health rehabilitation. Rethink Mental Illness and the Royal College of Psychiatrists. February 2020.
[10] The NHS Long Term Plan. January 2019

Stoke-on-Trent and North Staffordshire have some of the highest rates for Mental health admission to hospitals (patients aged 18) in the North Midlands:

Area	Admission rate per 100,000 population (19/20 Q2 snap shot PHE Fingertips)[11]
North Staffordshire	**379**
Stoke-on-Trent	**760**
England	**277**

In addition the prevalence of people who are registered at a GP practice with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses is grater in Stoke – on-Trent and North Staffordshire compared to the Staffordshire Sustainability and Transformation Partnership (STP) footprint:

Area	People who are registered at a GP practice with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses (QOF 19/20)[12]	Prevalence
NS	**1748**	**0.8%**
SOT	**2743**	**0.93**
Staffordshire STP	***Data not available***	**0.76**
England	***Data not available***	**0.93**

Staffordshire Health and Wellbeing Strategy 2018-2023 identified that out of every 100 people in Staffordshire 19 have long-term illness or disability (nearly 1 in every 5 people). Out of every 100 people in Staffordshire 9, live in one of the 20% most deprived areas nationally (nearly 1 in every 10 people).

Stoke-on-Trent is characterised by high levels of deprivation and is currently ranked the 14th most deprived local authority (out of 326) in England, with life expectancy for both men and women being lower than the national average.

With the high mental health prevalence and the high levels of deprivation, it is imperative that the population of Stoke-on-Trent and North Staffordshire have a good, high quality mental health rehabilitation pathway to reduce the health inequalities that is seen by this cohort of patients and improve the outcomes for them and their families.

[11] https://fingertips.phe.org.uk/
[12] https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/general-practice-data-hub/quality-outcomes-framework-qof

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term conditions	x
Domain 3	Helping people to recover from episodes of ill-health or following injury	x
Domain 4	Ensuring people have a positive experience of care	x

2.2 Locally Defined Outcomes

The expected outcomes are as follows:

- Improved physical health, mental health and social outcomes of patients presenting with chronic and complex mental illness.
- Service Users shall receive timely access to specialist evidenced-based assessment, diagnosis and relevant treatment/interventions and support to manage their mental health and wellbeing so as to maintain their independence and ability to live at home.
- Service Users will have a structured patient-centred journey, which includes the treatment, interventions and support to manage their mental health and wellbeing, hence promoting their independence, increasing their social functioning and inclusion and ultimately their quality of life.
- Greater planning for wellbeing, including clear pathways into services, positive problem solving, promotion of self-advocacy, maintenance and crisis planning.
- Development of and review of care plans that are co-produced with the Service Users and their family/carer to promote inclusion and participation.

- Formal hospital admissions under the Mental Health Act will be reduced by working with Service Users and their family/carer, through early detection in deterioration of service users mental health presentation and through the development of effective contingency/crisis plans

- Increased early identification of people requiring rehabilitation services so that they can be treated in the least restrictive environment possible.
- Improved Service User's satisfaction with the support they receive when they are in rehabilitation services.
- Care, treatment and support is provided in the least restrictive setting.
- Improved skilled workforce to meet the demand of the local population of people who require mental health rehabilitation.
- Reduction in the Length of Stay in bed based service.
- More patients are accessing the treatment and support they need, as Service Users will be able to move through the system seamlessly, ensuring fewer delays.

- Carers are provided with advice, information and support that helps them maintain their caring role and their own wellbeing.

- Discharge from community beds are coordinated and planned in a timely manner.

- A range of recovery based outcome tools will be used to demonstrate effectiveness of the service delivered, including both clinical tools and patient oriented tools (e.g. STAR).

For Service Users supported in the community expected outcomes will be as above* and include:

- First contact after allocation will be made with the service user within 24 hours, either face to face or by telephone to make formal arrangements for an assessment to commence.

- Assessments will be completed within 28 days from first contact.

3. Scope

3.1 Aims and objectives of service

The Mental Health Rehabilitation and Recovery Service aims to support those Service Users with long term mental health problems, many of whom may find independent living challenging. This may include those who are moving from an institutional environment on a pathway toward more independent living or service users in the wider community under the care of the Community Mental Health Teams who may need more time and support to help them move forwards on the journey of recovery.

The Service is part of comprehensive mental health rehabilitation care pathway that has an emphasis on recovery and enabling people to access the type of rehabilitation service that best meets their needs at any stage of their illness that is close to their home and family and has strong links with the wider community.

Rehabilitation Services provide a comprehensive, flexible service for rehabilitation and recovery. Providing a pathway through services to move in a dynamic process to provide maximum independent community living within the governance of CPA. These services are provided in a range of settings which meet the needs of people with mental health needs who require support to enable and enhance their personal recovery. These services are delivered in various settings that include community inpatient units, and patient's home settings and are intrinsically linked to wider community services provided by NSCHT and in partnership with other providers.

The key aims of the Mental Health Rehabilitation and Recovery Service are:

- To provide Service Users with the most appropriate, high quality, evidence based and timely treatment and interventions in the least restrictive setting in order to aid recovery.

- To promote a positive and optimistic environment so that long-term recovery is able to thrive.

- To help people with severe and enduring mental illness to achieve and maintain stability of their mental health and to gain (or regain) the skills and confidence for successful community living

- To meet Service User's clinical needs by providing specialist rehabilitation interventions

- To reduce the need for hospital admissions and increasing stability in the lives of service users and their carers/family.

- To improve Service User's social and everyday functioning and autonomy by enabling self-management skills.

- To adopt a recovery based approach that instils hope and empowers people

- To enable Service User's to access the community assets that can enhance their social networks and social inclusion

- To facilitate Service User's to progress along the rehabilitation care pathway, from higher to lower supported settings

The objectives for this service is to provide a range of community-based therapeutic services that:

- Meet national good practice guidelines for the treatment of mental ill health with a focus on individuals' rehabilitation needs;
- Are delivered by a workforce that is knowledgeable, skilled and competent;
- Are delivered in a number of innovative and ever evolving ways so as to ensure the continuity of provision;
- Offer flexible, responsive and proactive services that are of a consistently high standard and quality;
- Maintain 10 of the community inpatient beds for Service Users who, because of vulnerability or high risk, cannot be assessed in their home or need repatriation back into the area;
- Maintain 8 of the community beds for Service Users who, require additional support for their mental health that cannot be provided in the community or need repatriation back into the area;
- Delivers a rehabilitation and recovery model with the focus on providing people with the tools to attain independence and self-determination;

- Develops and implements personalised evidence-based rehabilitation plans with service users and their carers, with measurable outcomes that indicate gains in quality of life, social inclusion, competence, independence and self-determination, rather than focussing on reduction of symptoms or behaviour;
- Works in partnership with other providers of services to enable people to access universal services such as housing and employment;
- Supports the vital role of carers and ensures their access to an independent assessment of their needs;
- Provides advice and support to Service Users, families and carers;
- Establishes a detailed understanding of all local resources relevant to support of individuals with mental health rehabilitation issues and promote effective interagency working:
- Recognise that not everyone returns to the same level of independence they had before their illness and may require supported accommodation (such as residential care, supported housing or floating outreach) in the long term.

The key values and principles of the service are:

- Partnership working
- Service User and Carer involvement
- Effective Communication and Information Exchange
- Use evidence based practice
- Maximise Recovery, independence, autonomy and social inclusion
- Provision of intensive interventions in conjunction with the Community Mental Health Teams
- Providing reactive and supportive interventions based on service user need
- Ensuring seamless transition between the different functions of the service.
- The Service endeavours to follow the Providers values in providing a compassionate, accessible, responsible and excellent service.

3.2 Service description/care pathway

The Service is part of a comprehensive mental health rehabilitation and recovery care pathway that shall include a number of different elements that aim to meet the needs of the population at the different stages of their recovery journey. This is to ensure that Service Users are always in the least restrictive environment possible but have access to the appropriate support and interventions that they require. The Service shall provide an integrated, community based approach, to facilitate

a smooth transition from an inpatient setting to the community, as well as working with Service Users in the community to reach their own optimum level of self-care. The elements are the service ae:

- One community rehabilitation unit, registered as a ward, Summers View
- One maintained community rehabilitation unit, Hilda Johnson House (previously know as Florence House).
- A Community Team which shall provide support for people who reside in their own accommodation, supported tenancies and residential facilities as well as facilitating repatriation for people placed out of area.

Summers View

Summers View shall provide 10 beds and facilitate a rehabilitation and recovery service for people with ongoing and complex psychiatric needs who require specialist community inpatient psychiatric nursing care. The expected length of stay at Summers View is up to 2 years. Summers View shall :

- be registered as a ward and able to admit people who are detained under the Mental Health Act
- be available to both male and females clients.
- operates over a 24/7 period
- admit people who are stepping down from acute beds or those stepping down from low secure and locked rehabilitation services
- work towards becoming AIMS (Royal College of Psychiatrist) accredited

The service will offer the opportunity to monitor and maintain the Service User's mental health whilst addressing and support social inclusion and supported integration into the community. Service User's using this service are subject to care co-ordination and the team maintains close working relationships with other community based services to enable an integrated approach to ongoing assessment which enables and facilitates the patients move into appropriate accommodation at the optimum time in relation to their recovery plan.

Hilda Johnson House

Hilda Johnson House shall provide 8 beds as part of the Rehabilitation and Recovery Service, for Service User's that have ongoing but less complex needs then those patients in Summers View. It shall provide an option for individuals to move onto a less restrictive environment, mimicking independent living in the community, as part of their Recovery. The expected length of stay is up to 12 months. Hilda Johnson House shall :

- Be available to both male and females clients.

- nursing support operated over a 24/7 period
- admit Service User's who have un-met mental health needs are stepping down from acute beds, Summer View or those stepping down from low secure and locked rehabilitation services

Each Service User is encouraged to live as independently as possible, with the support of staff to increase their skills to prepare for living in the community This greater independence allows patients to access to a range opportunities (educational, leisure, vocational, therapeutic and employment) and developing skills in daily living, budgeting. Alongside mental health monitoring, medication administration, interventions and advice, psycho education and OT assessments.

Community Rehabilitation Team

The Community Mental Health Rehabilitation Team shall be based at Hilda Johnson House and offer clinical support to the Service Users there as needed, but also offer support peripatetically to Service Users in the community across North Staffordshire and Stoke on Trent.

The Community Mental Health Rehabilitation Team shall provide a designated care co-ordinator for each Service User but shall operate with a shared team caseload approach where staff share their knowledge of clients and expertise and support each other to provide appropriate interventions.

This element shall operate over a 7 day week, including evenings and weekends. It is expected that Service Users on community team caseload will require multiple contacts every week. If less is required then discharge should be considered.

The Community Mental Health Rehabilitation Team shall collaborate and work with supported accommodation services. Staff should make the majority of contacts with the Service User in their home rather than at the team base. Team staff should work closely with the support staff at the Service User's supported accommodation to ensure clients' care plans are tailored to their needs and clarify which staff are responsible for providing specific treatments and support

In addition the Community Mental Health Rehabilitation Team shall hold care management responsibility for locally CCG funded clients with complex needs who are currently receiving inpatient rehabilitation or living in highly supported accommodation outside the local area, to ensure proactive reviews to facilitate their move to a suitable local service wherever possible at the earliest opportunity (previously the Recovery and Repatriation Team).

Staffing

There will be a mixed skill set across the Mental Health Rehabilitation and Recovery Service in line with NICE Guidance that includes the following:

- Consultant psychiatrist with a
- Specialty doctor (to support improved access to Physical Healthcare)

- Registered Mental Health nurses
- Psychologists
- Occupational therapists
- Repatriation nurses
- Repatriation social workers
- Support Workers
- Team Manager
- Administration support
- Service Manager

All Service Users in any of the elements of the Service will have access to the above staff, depending on need.

All staff shall support the Service User to progress through the rehabilitation pathway:

- The team should increase the intensity of treatment and support during periods of relapse.
- The team should provide ongoing contact and support during periods of inpatient care and enable discharge as soon as possible.
- The team should adjust care plans to enable the person to gain the skills and confidence to manage in more independent accommodation

Appendix 1 details the service model and care pathway for the Mental Health Rehabilitation and

Recovery Service and highlights differences and similarities between the three elements of the Service.

Referrals

Referral are accepted from a number of sources via healthcare professional (acute wards/secure placements/early intervention for psychosis services/Community Mental Health Teams (CMHT)). Referrals from Social Care shall be via NSCHT CMHT.

There shall be a single common referral form for all the elements of the rehabilitation pathway. This will be into Summers Views in the first instance. Weekly joint rehabilitation MDT meetings will

review the referrals received. If it is decided that a referrals is not appropriate for rehabilitation services, then MDT will offer advice / signposting/discussion with the refer, as appropriate

Referrals will be considered for those Service Users who have:

- Severe and enduring mental health difficulties associated with a high level of need.
- People with complex psychosis as soon as it is identified that they have treatment-resistant symptoms of psychosis and impairments affecting their social and everyday functioning
- Dual diagnosis including psychoses with secondary alcohol or substance use
- Repeated episodes of illness with multiple hospital admissions
- Independent living difficulties whilst receiving significant community support
- Are currently placed out of area for mental health rehabilitation
- The Service can work with patients under Mental Health Act 1983 –this includes working with service users on Section 17 Leave and Community Treatment Orders

Admissions and Care Planning

The Service shall conduct a comprehensive biopsychosocial needs assessment by a multidisciplinary team within 4 weeks of the Service User entering the rehabilitation service. This shall include a number of aspects that encompass, primary and coexisting mental health problems, psychotic history, medication, physical health, social needs, cognitive function and shall be in line with the NICE clinical guidance(NG-181),

The results of this comprehensive assessment shall inform treatment and care planning. The care plan should:

- Be developed collaboratively with the Service User
- Cover the areas of need identified during assessment, including both mental and physical health.
- Include the Service User's personal recovery goals
- Clarify actions and responsibilities for staff, the Service User themselves and their family or carers (where relevant).
- Be reviewed at least every 3 months at a multidisciplinary care review meeting attended by the Service User and all those involved in their care, including family/carers if the Service User wishes, and updated according to changes in the Patient's needs.
- Include a detailed crisis and contingency arrangements including details of who to contact.

The Service shall ensure the above is done in an accessible manner. The care plan shall include both staff-rated and Service User-rated measurements of the Service Users' progress into their care plan reviews, so that their support can be adjusted if needed.

Interventions

The Service should cultivate a therapeutic structured, safe and secure environment and demonstrating compassionate care towards Service Users, as these are the most powerful interventions that can be used. It shall instill hope with Service User's and work towards a more independent lifestyle and develop and maintain continuity of individual therapeutic relationships wherever possible.

The Service shall provide specialist rehabilitation interventions that shall include both psychiatry and psychological approaches and be in-line NICE Guidelines, especially those for Mental Health Rehabilitation, Psychosis & Schizophrenia, Self-Harm, Bipolar Disorder, Personality Disorders, Autism and Depression to direct treatments, medication and interventions.

All Service elements shall provide access to psychological therapies including individual cognitive behavioural therapy (CBT) and family intervention for Psychosis. Additional psychological interventions should also be considered, especially for people who are not ready to engage in CBT.

Treatment and interventions should be provided to Service User's in accordance with their care plan. As well as appropriate medication and psychiatry and psychological approaches, these should focus on a range of tailored interventions to assist people to gain skills for more independent living, such as:

- activities of daily living skills (self-care, cooking, cleaning, shopping, budgeting)
- interpersonal functioning and social skills
- vocational rehabilitation (leisure, education and work)
- physical health promotion (diet, weight, exercise, sleep, oral health, health monitoring, accessing health services, cessation programmes for smoking and substance misuse)
- self-management of medication

Promotion and management/self-management of physical health shall be a key aspects of the Service and this shall be reflected in the staff mix of the Service. Consideration, on-going review and interventions for a patients physical health need shall be in-line with NICE guidance.

The community team should include a suitably qualified team member to lead on physical health who can liaise with Service User's GPs about their physical healthcare and conduct routine physical health checks. This person should also ensure that Service User's physical health care plans are tailored to their specific needs and include routine monitoring and screening for physical health issues, health promotion and monitoring of side effects from medication

Staff in all elements of the Mental Health Rehabilitation Service should discuss at regular intervals with Service User's whether, and how, they want their family or carers to be involved in their care. Staff should have training in the skills needed to negotiate and work with families and carers, and in managing issues relating to information sharing and confidentiality. Staff should provide families and carers information about local carer support services and offer a carer assessment where indicated. Consideration of how to ensure regular contact and visits between Service Users and their carers/families/close friends, as well as the care teams responsible for their community care, is essential. This forms a key part of service users' recovery and maintenance of hope.

Transfer and Discharge Process

Efficient collaborative working between the elements Mental Health Rehabilitation and Recovery Service is essential to providing effective and safe discharge pathways for these individuals with highly complex needs. There should be seamless transfers of care for patients, moving to the least restrictive option as soon as is clinically possible.

The care co-ordinator should liaise with the relevant service when the person is ready to be discharged from the team to ensure a smooth transition. It is imperative that social care colleagues are involved in discharge plans at the earliest of stages, so there is a full MDT approach to discharge, especially back into the community or local area.

The care coordinator should make referrals to appropriate supported accommodation when the person is ready to move to more independent accommodation and support them through the process of assessment and move-on, including graduated leave where appropriate.

The discharge process will follow the CPA Policy and Guidelines. Service Users will be discharged back to CHMTs promptly when their mental health needs have been met and they have 'recovered' to a degree that makes this possible. This will ensure capacity for new referrals.

- Discharge is subject to care planning within the Care Co-ordination process
- A discharge plan will be agreed with the patient and documented in the patient records
- The discharge planning will be recorded at the patients Care Program Approach meeting and co-ordinated by a named Care Co-ordinator
- Access to support services should the need to re-refer will be clearly defined

3.3 Population covered

The service is for people (aged 18 years and over) who are registered with a general practitioner within the North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups. For people who are not registered with a GP, the service will be open to people for whom the above CCGs are recognised as being responsible commissioners.

People referred may fit the following criteria (this list is not exhaustive and referral should be considers on a case by case basis);

- Those with problems with organising and planning daily life - finding it hard to plan and actually carry out what they mean to do.
- They have symptoms of mental illness, such as hearing voices that are distressing or make it difficult to communicate with other people.
- Those being exploited or abused by others.
- Behave in ways that other people find difficult or threatening - this can lead to contact with the police or courts.
- Make harmful use of alcohol and non-prescribed ("street") drugs.
- Have difficulties because:
    - Medication just doesn't work well enough for them.
    - Illness affects their concentration, motivating and ability to organise themselves.
- Suffer from depression and anxiety.
- Struggle to manage everyday activities - like self-care, budgeting, and shopping, cooking, managing money.
- The stigma of mental illness can be an added burden. It may be particularly difficult to find work, have a reasonable income, or to be included by other people. They may have to cope not only with a difficult mental illness, but also with the attitudes of other people.
- Severe and persistent mental health need and currently receiving mental health services. This may be associated with significant disability, predominantly psychoses such as schizophrenia and bipolar disorder. Often requiring skilled or intensive treatments (e.g. Clozaril therapy)
- Longer-term disorders of lesser severity but which are characterised by significant social impairment, requiring proactive follow up.
- There should be an identified potential for positive change and for a move to more independent living.
- Must be willing to participate in a programme based on recovery principles and approaches
- Complex problems of case management, as a result of significant and enduring mental health needs, such as those presented by people requiring interventions under the Mental Health Act 1983, often working in conjunction with Community Mental Health Teams

3.4 Any acceptance and exclusion criteria

Appendix 1 provides further details on the acceptance and exclusion criteria for the various elements of the Service.

The Service does not support people who are under 18 years of age and people whose primary diagnosis is that of substance misuse.

The Service supports Service Users with complex mental health needs and more specifically:

- are receiving care from early intervention for psychosis services and developing problems that are likely to require mental health rehabilitation services now or in the near future
- With complex mental health needs whose needs include support with establishing stability in their mental health, gaining confidence in social skills and practical daily living tasks.
- With mental health needs who require a period of inpatient or community nursing support as part of their recovery plan in order to return to community living.
- With mental health needs whose living situation is contributing to their mental ill health and would benefit from community support or accommodation linked to specialist psychiatric and psychological care
- Usually after a few years of mental health problems - and a number of hospital admissions. However, it can sometimes be helpful if they are trying to get over a first episode of illness.
- If they can't be discharged from an acute ward, but are unlikely to get any better there (lack accommodation cannot be the only reason for admission into Hilda Johnson House).
- If they are moving to a placement with less support and supervision. This can happen if leaving a forensic or secure service, or if moving from residential care to a more independent home in the community.
- If they might benefit from the structured environment and intensive therapeutic programmes that are available in a rehabilitation environment.

Exclusion criteria for the Services are:

- Those whose mental health is in an acute phase which would prevent them from engaging in a rehabilitation plan
- Those who are in crisis for whom the crisis pathway will be deemed most appropriate

- Those who at the point of assessment are deemed as (as a result of their presenting complex condition /challenging behaviour) not having the current capability or potential to engage in the rehabilitation process at that time.
- Those whose only requirement is accommodation is this is reason for a delayed transfer of care

3.5 Interdependencies with other services

There shall be a co-ordinated approach between other services within NSCHT, such as:

- Crisis Care Centre
- Community Mental health Teams
- Early Intervention in Psychosis
- Community Assessment, Stabilisation and Treatment Team (CASTT)
- CAMHS for young people who are approaching eighteen years of age,
- Mental Health Liaison/ High Volume Users Team for those people who attend A&E frequently and for whom rehabilitation may be suitable
- MAPPA

There shall also be a coordinated approach between other mental health services outside of the Provider/ NSCHT:

- Secure Services
- Community forensic teams at MPFT
- Independent provider of in-patient rehabilitation services
- Local Authorities and their social care team
- Voluntary community and social enterprise (VCSE) organisations, especially those located in the Northern Staffordshire and Stoke-on-Trent location.

Given the poor health inequalities of people with serve mental illness, the Service shall work closely with other key stakeholder services that provide physical care for this cohort of patients in a coordinated and integrated way. Especially ensuring that Service Users receive their Annual Physical Health Check for patients with SMI.

The Service shall also look to develop closer working practices and pathways with those services and organisations that focus on other aspects of a person life than can have an impact on their mental health, such as social care, housing, benefits, education and work and the voluntary sector (both for voluntary experience and to access peer support networks).

It is imperative that the development of individually tailored patient pathways uses an interdisciplinary approach within the specialist team, support for service users to access other services, and support for other service providers to work with people with severe mental illness. The whole systems approach is inclusive of carers and family members and plans will include consideration of home circumstances and referral to other services where appropriate.

In addition these service shall be an integral part of the wider Community Mental Health Transformation programme and that aims to improve access into services for people with SMI.

These interdependences are vital so that that preventative and alternative community based strategies for this population are constantly improving, so as to meet their needs and achieve the best outcomes and reduce the high health inequities traditional seen by people with SMI.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

- NICE CG181 - Rehabilitation for adults with complex psychosis
- NICE CG178 - Psychosis and schizophrenia in adults: prevention and management
- NICE CG58 - Coexisting severe mental illness and substance misuse: community health and social care services
- NICE CG136- Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services
- NICE NG185 - Bipolar disorder: assessment and management

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- Royal College of Psychiatrists

https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/rehabilitation-services

- Joint Commissioning Panel for Mental Health – Rehabilitation Services for people with complex mental health needs (2016)

https://www.jcpmh.info/wp-content/uploads/jcpmh-rehab-guide.pdf

- Getting it Right First Time, Mental Health Work stream

https://www.gettingitrightfirsttime.co.uk/medical-specialties/mental-health/

4.3 Applicable local standards

5. Quality

5.1 Applicable Quality Requirements (See Schedule 4)

Summers View to work towards becoming fully AIMS accredited (Royal College of Psychiatry AIMS Rehab Standards for Inpatient Mental Health Rehabilitation Services).

5.2 Applicable CQUIN goals (See Schedule 3)

6. Location of Provider Premises

The Provider's Premises are located at:

Summers View

Furlong Road
Tunstall
ST6 5UD

Hilda Johnson House and the Community Rehabilitation Team

Hilda Johnson House
Sutherland Centre
Belgrave Road
Stoke-on-Trent
ST3 4LR

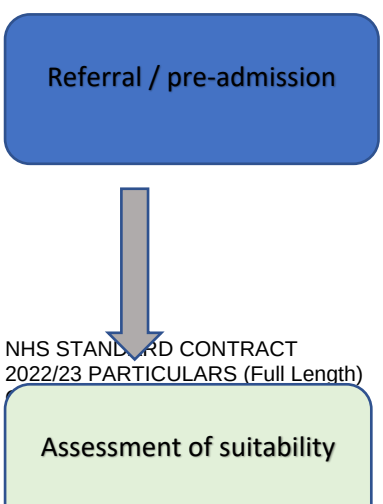
7. Individual Service User Placement

Not applicable.

8. Applicable Personalised Care Requirements

Applicable requirements, by reference to Schedule 2M where appropriate

Appendix 1 - Mental Health Rehabilitation Service Model and Care Pathway



Summary of Admission Criteria

- Severe and enduring mental health difficulties associated with a high level of need and complexity
- Organic conditions/ABI/LD/ASD/substance misuse not primary diagnosis
- Clear clinical and rehabilitation needs and goals and willingness / ability to engage with rehabilitation
- 18 years plus
- Male or female
- Under Care Programme Approach

Referral / pre-admission process

Summers View	Hilda Johnson House	Community Team
Referral are accepted from a number of sources via healthcare professional (acute wards/secure placements/early intervention for psychosis services/CHMTs). Referrals from Social Care shall be via NSCHT CMHT. **There is a single common referral form for all the elements of the rehabilitation pathway. This will be into Summers Views in the first instance.**		

Weekly joint rehabilitation MDT meetings will review the referrals received. If it is decided that a referrals is not appropriate for rehabilitation services, then MDT will offer advice / signposting/discussion with the refer, as appropriate

- **Aged 18+.**
- **Under Care Programme Approach.**
- **Severe and enduring mental health difficulties associated with a high level of need.**
- **People with complex psychosis as soon as it is identified that they have treatment-resistant symptoms of psychosis and impairments affecting their social and everyday functioning**
- **Dual diagnosis including psychoses with secondary alcohol or substance use**
- **Repeated episodes of illness with multiple hospital admissions**
- **Independent living difficulties whilst receiving significant community support**
- **Are currently placed out of area for rehabilitation**
- **Patients detained under Mental Health Act 1983 (includes working with service users on Section 17 Leave and Community Treatment Orders)**
- **Learning Disability and/or Autism are not a barrier to admission but not as primary diagnoses.**
- **Acquired Brain Injury or Organic Degenerative conditions cannot be the primary diagnosis.**

Must have clear clinical and rehabilitation goals that are achievable within 24 months **Detentions under the MHA are accepted (including s37/41)** **Must not present a current/acute significant risk of self-harm or violence.** **Are not in their acute phase of their illness** **Risk to others has been assessed** **Have complex mental health problems that severely affect their social and everyday functioning, which means they need a period of clinical support and rehabilitation within an inpatient setting.**	**Must have clear clinical and rehabilitation goals that are achievable within 12 months** **Must not present a current significant risk of self-harm or violence.** **Patients who are voluntary (informal) or those subject to a community order (for example, a community treatment order, guardianship, or conditionally discharged Section 37/41)** **Risk to others has been assessed** **Have complex mental health problems that severely affect their social and everyday functioning, which means they need a period of clinical support and rehabilitation, and have** • **recently been discharged from in patient ward/unit** • **are living in the community and their mental health is showing signs of deterioration over and above what social care should provide** **Not having accommodation in the community is not a reason for admission, there must be mental health needs that require a period of further rehabilitation, over and above what social care should provide.**	**Must have clear clinical and rehabilitation goals that are achievable within 12 months.** **Have complex mental health problems that severely affect their social and everyday functioning, which means they need a period of clinical support and rehabilitation, and have** • **recently been discharged from in patient ward/unit** • **are living in the community and their mental health is showing signs of deterioration over and above what social care should provide** **Patient is currently in a CCG funded out of area rehabilitation placement.**

Assessment of suitability

<table>
<tr><th>Summers View</th><th>Hilda Johnson House</th><th>Community Team</th></tr>
<tr><td colspan="3">The MDT will assess referrals once a week at rehabilitation MDT meeting.

What are the time frames for the assessment to be started and completed? Assessment of suitability will commence within 7 days of accepting referral and be completed within 28 days. This reflects that these services are not to meet an urgent/acute patient need.

The patient shall be reviewed/assessed by a rehab team member.

If there is no capacity within services at the time of referral, then the patient shall be added to a waiting list.

If not suitable then sign-posting advice provided in the assessment report. If a referral is not suitable then the MDT will discuss with the referrer the reasons why and if appropriate provide sign-posting/advise of other support/services that would be more suitable.</td></tr>
<tr><td>Service users who, because of complexity, vulnerability or high risk, cannot be assessed/treated in their home or need repatriation back into the area</td><td>Service users who require additional support and treatment but do not have the complexity, vulnerability or high risk that warrant admission into Summers View

Require repatriation back into the area and health and wellbeing support to reintegrate back into the local area.

Have complex mental health problems that severely affect their social and everyday functioning, which means they need a period of rehabilitation, and have</td><td>Have complex mental health problems that severely affect their social and everyday functioning, which means they need a period of rehabilitation, and have
recently been discharged from in patient ward/unit
are living in the community and their mental health is showing signs of deterioration over and above what social care can provide
Require repatriation back into the area and health and wellbeing support to reintegrate back into the local area.</td></tr>
</table>

	• **recently been discharged from in patient ward/unit** • **are under CPA** • **are living in the community and their mental health is showing signs of deterioration over and above what social care can provide**	**The rehabilitation needs can be meet by a community / at home service, although this might ultimately require a 'step up' to a higher level of support**

Admission into Service & Care Planning

<table>
<tr><th>Summers View</th><th>Hilda Johnson House</th><th>Community Team</th></tr>
<tr><td colspan="3">

Within 4 weeks of admission in the Service, a comprehensive biopsychosocial needs assessment by a multidisciplinary team shall be conducted. This shall include a number of aspects that encompass,

- **primary and coexisting mental health problems,**
- **psychotic history,**
- **medication,**
- **physical health,**
- **social needs,**
- **cognitive function**

and shall be in line with the NICE clinical guidance(NG-181)

The resulting care plan should be produced in collaboration with patients and their carers/families and be easily accessible. It should also clarify actions and responsibilities for staff, the patient themselves and their family/carers (where relevant).

Both clinical and service user-rated evidenced outcome measures to monitor the patient's progress to be utilised.

Patients' progress and care plans should be reviewed with them at multidisciplinary care review meetings at least:

- **every month in the inpatient rehabilitation service and in Hilda Johnson House**
- **Every 6 months in the community.**

</td></tr>
<tr><td>Patient's physical health needs should be reviewed within the first 24 hours of admission

Potential discharge date and potential accommodation on discharge agreed by MDT</td><td>Potential discharge date and potential accommodation on discharge agreed by MDT within 6 weeks of admission and to be reviewed at every 3 months as a minimum.

If applicable, CPA reviews to be held every 3 months and</td><td>Potential discharge agreed by MDT within 6 weeks of admission into service and to be reviewed monthly

For those patients who are in an out of area placement, CPA reviews to be held every 6 months, plus additional Project</td></tr>
</table>

within 6 weeks of admission and to be reviewed at each quarterly CPA. **CPA reviews to be held every 3 months (as a minimum) and to include all of the above assessments plus proposed discharge date and proposed accommodation on discharge/transfer** **Specialist assessments that may be required (ASD/ADHA/SALT)**	**to include all of the above assessments plus proposed discharge date and proposed accommodation on discharge/transfer.**	**86 led reviews in the interim (so that placements are essentially reviewed every 3 months).** **These reviews should include a focus on proposed discharge date and proposed accommodation on discharge/transfer.**

Interventions

Summers View	**Hilda Johnson House**	**Community Team**
The Service should cultivate a therapeutic structured, safe and secure environment and demonstrating compassionate care towards service users, as these are the most powerful interventions that can be used. **Instil hope with patients and work towards a more independent lifestyle.** **Develop and maintain continuity of individual therapeutic relationships wherever possible** **Follow NICE Guidelines, especially those for Mental Health Rehabilitation, Psychosis & Schizophrenia, Self-Harm, Bipolar Disorder, Personality Disorders, Autism and Depression to direct treatments, medication and interventions.** **Psychological therapies including individual cognitive behavioural therapy (CBT) and family intervention for Psychosis. Additional psychological interventions should also be considered, especially for people who are not ready to engage in CBT.** **Help patients find meaningful occupations (including work, leisure or education) and build support networks using voluntary, health, social care and mainstream resources** **Help patients to gain skills to manage both their everyday activities and their mental health, including moving towards self-management of medication.** **Encourage positive risk-taking.** **Promotion and management of physical health. Consider annual ECGs for everyone with complex psychosis in rehabilitation services.**		

Support to access peer support networks and social networks **Monitor outcomes and progress by both clinical and person centred outcome tools.**		
Every patient has a 7 day personalised therapeutic/recreational timetable of activities to promote social inclusion, which the team encourages them to engage with	**Exposed to greater control and responsibility for their living environment compared to Summers View.** **Every patient has a 7 day personalised therapeutic/recreational timetable of activities to promote social inclusion, which the team encourages them to engage with** **WRAP booklets.**	**For people in out of area placements agreeing the necessary steps to help the person progress in their recovery so they can transfer to an appropriate placement/home/supported living (this may or may not be in the local Northern Staffordshire area) at the earliest opportunity.**

Discharge /Transfer

Summers View	**Hilda Johnson House**	**Community Team**
Transfers between rehabilitation services (typically looking to stepping down) to be reviewed at the weekly Rehab MDT meeting. **If required, patients will be transferred to other services at NSCHT for example PICU/acute wards/CMHTs.** **Discharge to independent accommodation, supported living situations and if required residential or nursing care, planning for such discharges to be made in partnership with the relevant Social Work service and a request for a Care Act assessment.** **Prior to discharge, need to consider those services and organisations that focus on other aspects of a person life than can have an impact on their mental health** • **Primary care** • **Voluntary sector support** • **Peer support networks** • **Social care** • **S117 aftercare**		

• **MAPPA** • **Forensic community services at MPFT** • **Housing associations** **Ensure there are robust crisis and contingency arrangements, including details of who to contact**		
Discharge and accommodation should be central to every ward round and CPA. Discussion around future accommodation needs and proposed discharge date must be recorded at each CPA. Any sustained difficulties around locating appropriate accommodation must be escalated in an appropriate and timely manner. **Patients discharged from inpatient care have their care plan or interim discharge summary sent to everyone identified in the plan as involved in their ongoing care within 24 hours of discharge.** **Provide specific transition support to patients when their care is being transferred to another care team** **A discharge summary is sent within a week to the patient's GP and others concerned with persons consent, including why the patient was admitted and how their condition has changed, diagnosis, medication and formulation.** **Discharge CPA/117 meeting to be arranged with at least two months' notice with clear discharge plan agreed by community care co-ordinator and MDT. Need for CTO or Guardianship, community RC, level of community support,**	**Any sustained difficulties around locating appropriate accommodation must be escalated in an appropriate and timely manner.** **Provide specific transition support to patients when moving into community living support and social care and agree responsibilities for each service provider and a review timetable.**	**Provide specific transition support to patients when moving into community living support and social care and agree responsibilities for each service provider and a review timetable.**

housing provider and funding arrangements must be agreed by all stakeholders.		

Service Specification No.	A03
Service	Acute Home Treatment Team
Commissioner Lead	Nicola Bucknall, Commissioning Manager – North Division, CCG
Provider Lead	Rachael Birks, Associate Director, Acute and Urgent Care Directorate
Period	1st April 2022 – 31st March 2023
Date of Review	**See 22/23 SDIP**

1. Population Needs

1.1 National/local context and evidence base

Mental wellbeing is referred to feeling good and functioning well. The Joint commissioning Panel for Mental Health states "The concept of feeling good incorporates not only the positive emotions of happiness and contentment, but also such emotions as interest, engagement, confidence and affection. The concept of functioning effectively (in a psychological sense) involves the development of one's life, having a sense of purpose such as working towards valued goals, and experiencing positive relationships".

Nationally the *Mental Health Taskforce Strategy of 2016* which forms the backbone of the government`s Mental Health Five Year Forward View 2016 sets six overarching objectives, aimed at improving the mental health and wellbeing of the whole population and improving outcomes for service Users. This strategy also highlights the needs for patient choice and expanding the role of caring for patients in the community as well as ensuing that services are commissioned that understand and can meet the needs of local people if possible within the comfort of their home.

Separately, the number of people affected by mental health problems is increasing. Mental illness is now the leading cause of disability in the UK, whilst stress, anxiety and depression were the leading cause of lost work days in 2017/18 according to a Health and Safety Executive study conducted in 2018. Some 17.6% of the adult population broken down as (21.0% of women and 11.9% of men) have a common mental health problem being anxiety or depression. Within the UK, it is estimated that 1 in 4 people will experience a diagnosable mental health problem throughout their lifetime. As mental health problems are extremely common, the implications are diverse and widespread across the country. According to the Mental Health Foundation, mental illness is also the leading cause of sickness in the UK, with 70 million workdays lost every year at a financial cost of around £105 billion per annum. At the end of October 2017, there were almost 1 million people accessing adult mental health services through the NHS.

The NHS in its 10 year plan released in January 2019, also identified that gap in health inequalities was a significant contributor in early mortality for patients with severe mental illness. Also according to the Independent Mental Health Taskforce to the NHS in England (2016), people with severe mental health illnesses tend to die 15-20 years earlier than those without.

The Five Year Forward View for NHS England (2016) identified key areas for development and committed to developing and implementing mental health care pathways, including maximum waiting times for treatment by 20/2021. The NHS 10 year plan is aimed at working towards enabling further service expansion and faster access to community and crisis mental health services for both adults and particularly children and young people of which Home Treatments are an integral part. In addition,

Primary Care networks will from 2020/21 work towards assessing their local population by risk of unwarranted health outcomes and, working with local community services, make support available to people where it is most needed including mental health away from hospital unless there is need. Home Treatment Teams are expected to forge links and be at the forefront of these primary care networks for patients in the community with a mental health illness. Based on their individual needs and choices, people identified as having the greatest risks and needs will be offered targeted support for both their physical and mental health needs under home treatment where qualifying.

1.2 Background; Home Treatment Teams

Home Treatment Teams were introduced throughout England as part of a transformation of the community mental healthcare system. They aim to assess all patients being considered for acute hospital admission, to offer intensive home treatment rather than hospital admission if feasible, and to facilitate early discharge from hospital (Department of Health 2001). Key features include 24-hour availability and intensive contact in the community, with visits twice daily if needed and easy access to prescribing for the patient. The original Mental Health Policy Implementation Guide (Department of Health 2001) suggests that Home Treatment Teams should be available for adults of working age from the age of 18 and also for people with learning disabilities. The introduction of Home Treatment Teams throughout England was mandated by the NHS Plan (Department of Health 2000)

1.3 Local context

Stoke on Trent has some of the lowest levels of wellbeing in the country. Data from the Office of National Statistics shows for both life satisfaction and for feeling if the things people do in their life is worthwhile, Stoke-on-Trent has the lowest averages in the country. In terms of feeling happy, Stoke-on-Trent is in the bottom five in the country whilst North Staffordshire does not fare much higher.

North Staffordshire and Stoke-on-Trent neighbourhoods have historically experienced, and continue to experience, significantly higher levels of poverty and deprivation than the rest of England, with over half of the population living in the most deprived areas of the country. At least 30% of the neighbourhoods in Stoke on Trent are overall in the most deprived rankings nationally. Overall, Stoke on Trent is the 13th most deprived area in the country, according to the Index of Multiple Deprivation 2015. 48 of its local authority districts are in the most 10% deprived neighbourhoods nationally. Overall North Staffordshire including Staffordshire Moorlands sits 7th out 10 in the decile of the most deprived areas nationally, with 1 being the most deprived and 10 the least deprived. This, coupled with the current economic downturn, makes it likely that there will be a larger adverse consequential impact on mental health and wellbeing for the people of North Staffordshire and Stoke-on-Trent than in other localities nationally. Therefore the Home Treatment service is a crucial contributor to plans to improve and then maintain levels of mental health and wellbeing in the two boroughs, since these are significant factors that need to be addressed to enable wider improvements in both health and wellbeing.

Low or lack of income known as (income deprivation) combined with a lack of employment, (employment deprivation) are also significant factors in high levels of mental ill health. Stoke on Trent for example is the 18th most income and employment deprived local authority in the country. The Stoke-on-Trent Joint Strategic Needs Assessment (JSAN) also reveals that due to the level of deprivation in the City is likely that the prevalence rates of mental ill health will continue being greater than the rest of England.

Using the Quality Outcomes Framework (QOF) report for 2018, prevalence for depression has gone up for Stoke on Trent to 14% up from 12.5% the previous year and for North Staffordshire up to 13% from previously being at 11.5%. Mental health prevalence now stands at over 0.99% overall compared to the England average of 0.92% in both Stoke on Trent and North Staffordshire. It is with this regard that

Home Treatment Teams are vital in ensuring people are treated within the community and home settings to enable hospitals and acute care to deal only with emergencies or those who genuinely need real time admission.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**x**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**x**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**x**
Domain 4	**Ensuring people have a positive experience of care**	**x**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**x**

2.2 Locally defined outcomes

The key service outcomes for the service are:

- To offer intensive home treatment as an alternative to an acute inpatient admission. The main purpose of the service is to support patients to stay at home rather than going into hospital if possible
- The service will be available 24 hours a day, 7 days a week and will be accessible and appropriate to all those who may need it.
- Specifically, the service must promote equality for those protected by the Equality Act 2010.
- The service should offer treatment at home and should help patients continue with their day-to-day activities, including education, work, volunteering, caring for family members and leisure activities.
- Increased availability of psychiatric in-patient resources for those service users who require that level of support.
- On leaving care, individuals should have a discharge care plan that will enable them to continue to recover in a less intensive setting. At a minimum this will include:

i) how to access future help

ii)relapse indicators

iii) self-help measures

iv) and advice to their families/carers.

- To be easily accessible from a single point of access for patients in Stoke on Trent and North Staffordshire.
- To treat individuals experiencing acute mental health difficulties in the least restrictive environment with minimum of disruption to their lives.
- The service is provided in a range of settings offering an alternative to inpatient care and will be supported by Community Mental Health Teams and other specialist Community Teams.
- Reduce psychiatric hospital admissions, as individuals are supported via more flexible options which meet their needs enabling them to maintain relationships and social contacts whilst receiving intensive support at home
- To contact GPs/practices within 24 hours when someone is admitted acutely/seen by the Home Treatment Team and that they are again inform GPs/practices within 24 hours when someone is discharged with a current diagnosis and with list of their current medication (more detailed discharge summaries can follow later)
- Reduction in admissions to psychiatric hospital following requests for assessments under the Mental Health Act through the provision of less restrictive resources for Approved Mental Health Professionals co-coordinating assessments.
- To achieve at least 95% success rate monthly, being the percentage of successful inpatient admissions that the service has gate kept
- Reduce incidents of poly pharmacy due to the participation of primary health practitioners in Care Plans, Risk Management Plans, Relapse Prevention Plans, and Crisis Intervention Plans and reviewing process.
- Reduce un-planned/self-discharge as service users are supported and encouraged to actively engage with services.
- Seamless transitions for service users facilitated by robust links between the service and Community Mental Health and Social Care Teams.
- Improved satisfaction for service users and carers as a result of increased choice, least restrictive response to their needs and their active participation in service interventions.
- Team/ staff development of specialist skills and competence in safe assessment and management of acute crisis in the community.
- The welfare of children deemed at risk is addressed and referrals are made to the appropriate sources to meet the needs of children affected by their carer's mental health issues.
- The service ensures that the welfare of vulnerable adults is addressed and referrals made to the appropriate sources to meet individuals needs and risks.
- Improve accesses to the service supporting those with poor levels of mental wellbeing from the comfort of their home where possible.
- Improve speed of access to other services working with the Home Treatment Team.
- Increase proportion of people who make significant improvements or recovery at home

- Improved emotional wellbeing of service users who come into contact with the service
- Provide aftercare to patients leaving hospital to stop re-admissions.
- Empower service users to achieve:
    - Increased mental health awareness
    - Increased mental wellbeing
    - Improved physical wellbeing and health practices
    - Increased social inclusion and achievement of personal goals

3. Scope

3.1 Aims and objectives of service

The service shall help deliver health outcomes in a number of priority areas, in general these range from prevention and ensuring that there are appropriate early interventions; through to helping service users self-care. With specific regard to this service, it is anticipated that the outcomes shall be focused on ensuring that there are appropriate early interventions available to service users as well as promoting self-care and mental wellbeing to avoid acute hospital admissions.

- To provide a prompt response to individuals in the community experiencing a crisis or other acute mental health difficulties
- To achieve at least 95% success rate monthly, being the percentage of successful inpatient admissions that have been gate kept by the service (Home Treatment Team)
- To provide intensive support to service users with in their own homes or in other accommodation
- The service shall deliver a high quality, patient centred service that enables people to improve and maintain their well-being, thereby reducing the need for hospital admissions and over reliance on specialist services.
- To ensure that service users are referred for hospital admission only when there is a clearly identified clinical need, where the severity of that need, risk or complexity is such that alternatives would not be sufficient to meet their needs or provide a required level of safety at home.
- To work with the AMHP service in relation to service users who need to be formally assessed under the Mental Health Act
- To provide an alternative to psychiatric hospital based treatment for service users experiencing mental health difficulties either in crisis or acute distress and ensure that they are treated in the least restrictive environment as close to home as clinically possible.
- Where service users are admitted to hospital the service will facilitate early discharge by early involvement in discharge planning, consulting with inpatient multi-disciplinary teams, service users and carers, care co-ordinators and CMHT's.

- Increased mental health awareness and mental wellbeing of service users
- Improved physical wellbeing and health practices of service users
- Increased social inclusion and achievement of personal goals of service users

The service will be part of the Healthy Minds Network in Stoke on Trent. The Healthy Minds Network is a network of organisations that provide an integrated and complementary range of mental health services that are primary care and community based, for common mental health disorders. The service provider shall work in a collaborative way with all members of the network ensuring the service user experiences seamless and timely access to services through efficient referral and supported signposting pathways within the Network

Details about the Healthy Minds Network can be accessed at http://healthy-minds.org.uk/

3.2 Service description/care pathway

Hours of Operation

The service will operate 24 hours a day, 7 days per week, and 365 days per year.

The service shall be accessible, flexible and innovative in addressing the needs of the individuals accessing the service and shall offer resources and interventions in line with relevant mental health legislation, NICE guidance and current evidence based best practice.

The service shall:

- Ensure that there is appropriate referral and signposting support to access community based and voluntary sector mental health services where the course/home treatment is not sufficient/appropriate to meet the mental health needs of the individual concerned
- Ensure that the best outcome is achieved for service users accessing the service, collating and demonstrating outcomes as required.
- Help provide/sign post to information on self-help opportunities to improve resilience and wellbeing.

3.3 Referral and Assessment

Referrals are to be made from either:

- The Access Team as part of that team's Crisis Response/Inpatient Gate Keeping function.
- Acute Adult Inpatient Wards supporting timely discharge of patients.
- Community Mental Health Teams who identify people in the community who are escalating towards crisis where interventions by the Acute Home Treatment Team will prevent admission to an acute ward.
- GPs via the Access Team

- Self-referrals via the mental health access telephone number/111 service into the Access Service which will then triage appropriate referrals.

Referrals shall be accepted by telephone, fax, email or face to face and all referrals shall be processed via the Access Team.

The Access team shall validate referrals to determine whether the service is appropriate for the person referred and inform the service user of other possible services where not.

3.4 Population covered

The service is for adults who are registered with a general practitioner within the Clinical Commissioning Group (CCG) areas of NHS North Staffordshire and NHS Stoke-on-Trent. For people who are not registered with a GP, the service will be provided but support given to enable the person to register.

The service shall be accessible to all members of the community in line with the Equality Act 2010 and the Public Sector Equality Duty derived from that legislation. The service shall demonstrate equality of access for all groups of people identified in legislation as having protected characteristics.

3.5 Any acceptance and exclusion criteria and thresholds

The Home Treatment service is intended to meet the needs of service users experiencing mental health difficulties either in crisis or acute distress where those needs could best be met through the provision of intensive support in their own home or other non- hospital setting.

The service is not appropriate for service users whose needs are so severe that they could only be met by hospital admission, and it is also not appropriate for service users experiencing only mild or moderate mental health difficulties. There is no formal threshold for identifying those who would not benefit from the service, it will be judged on a case by case basis. The service is not usually appropriate for service users with a primary diagnosis of dementia or other organic mental health condition.

The service does not provide support for young people under the age of 18 but will make effort to help those about to reach their 18th birthday and or transitioning from the children and young people`s service who are near their 18th birthday.

3.6 Interdependence with other services/providers

The service has a key relationship with a number of other services notably :

- The Access Team (relationships described above)
- Acute Inpatient Services – both on arranging admission and facilitating discharge

- Community Mental Health Teams – coordinating support and managing crises for people known to services
- AMHP Service (commissioned by Local Authorities) for assessment and decision making in relation to the Mental Health Act
- Specialist Teams – coordinating support and managing crises for people known to services.
- As part of the Healthy Minds Network, it is imperative that the service forms collaborative relationships with organisations within this network to maximise efficiency and improve integrated working. The service shall facilitate referring / supported signposting of service users within the network ensuring they receive seamless and timely support.
- The service shall build strong working relationships with key service providers such as mental health and substance misuse services as well as GPs, primary care services, support agencies and the voluntary sector.

3.7 Self –Help Resources

Below is an outline of some of the self-help services available and list of mental health services is attached below which the service might find useful when dealing with some groups of patients brought to their attention.

This list and attachment is not exhaustive and the links are correct at the time of writing.

Community Services (Tier 1&2)

Abuse

Women's Aid

Tel: (0808) 2000 247.

Offering help for women experiencing domestic violence. For further information and details of the nearest safe place to stay, visit the Women's Aid website.

Savana

The Dudson Centre, Hanley, Stoke on Trent, ST1 5DD. Tel: (01782) 221000 - (24 hour answerphone). Savana

Savana offers support and information to anyone who has encountered or experienced any form of sexual assault or violence at some point in their lives.

Survivors UK

Helpline: 0845 122 1201 open 7pm - 9.30pm Mon & Tues, 12pm - 2.30pm Thurs. Survivors UK

Offering information and support for men (over 18) who have experienced childhood sexual abuse or adult sexual assault/rape.

Karma Nirvana

Tel: 0800 599 9247. Monday - Friday 9.30am - 5.00pm. Karma Nirvana

Karma Nirvana is a registered Charity that supports victims and survivors of forced marriage and honour based abuse.

Rape Crisis

Tel: 0808 802 9999 open 12 - 2.30pm and 7 - 9.30pm. Rape Crisis

Rape Crisis is a registered charity and is the national umbrella organisation for a network of independent member Rape Crisis Centres, which provide crisis and longer term support. For information and contact details for local centres, phone or visit their website.

Advice and Information

Citizens Advice Bureau

Offering advice and information on a wide range of issues. Visit the CAB national website for more information and details of your nearest branch and contact details.

Alcohol

ADSIS - Alcohol & Drug Service in Staffordshire

ADSIS HQ, 2 Hargreaves Court, Staffs Technology Park, Beaconside, Stafford. Tel: (01785) 224771. Monday - Friday 8.30am - 4.30pm (4.00pm on Fridays). Tel: (01782) 662585 for North Staffordshire. ADSIS

Offering advice, support and information to anyone affected by their own or someone else's drinking and/or drug use.

Aquarius

Balwant House, Havelock Place, Stoke-on-Trent, ST1 4PR. Tel: 01782 283113 Email: stoke-on-trent@aquarius.org.uk. 9.00pm – 5.30pm Monday to Friday, out of hours there is an answerphone. Aquarius

Aquarius offers a free confidential service to anyone with or affected by someone else's alcohol, drugs or gambling problems.

Alcoholics Anonymous

Tel: 0845 7697555. Alcoholics Anonymous

Helping people with alcohol problems.

Bereavement

The Dove Service

The Dudson Centre, Hope Street, Hanley, Stoke on Trent. Tel: (01782) 683155. The Dove Service

'Providing support and counselling to those struggling with bereavement, life-changing illness and loss.' There are services for all age groups.

Cruse Bereavement Care

Tel: 0844 477 9400 helpline@cruse.org.uk or southstaffordshire@cruse.org.uk South Staffordshire branch: Tel 01543 433479.

Cruse Bereavement Care

Offering information, and support to anyone affected by bereavement.

Crime

Victim Support

Victim Support North Staffordshire, Winton House, Stoke Road, Shelton ST4 2RW. Tel: 01782 843908. Victim Support

Victim Support Mid-Staffordshire, The Haling Dene Centre, Penkridge, Staffordshire ST19 5DT. Tel: 01785 715666.

Offers support and information for victims of crime.

Drugs

ADSIS - Alcohol & Drug Service in Staffordshire

ADSIS HQ, 2 Hargreaves Court, Staffs Technology Park, Beaconside, Stafford. ST18 0WN Tel: (01785) 224771. For North Staffordshire Tel: (01782) 662585. ADSIS

Offering advice, support and information to anyone affected by their own or someone else's drinking and/or drug use.

Frank - a national drug helpline

Tel: (0800) 776600. Talk to Frank

24-hour advice and help. This can be offered in a variety of different languages.

Release

Tel: (0845) 4500215. (11am - 1pm and 2pm - 4pm Monday to Friday). Release

Helpline offering information on all aspects of drugs and drug-taking including legal advice.

CRi

Hope Street, Hanley, Stoke on Trent. Tel: (01782) 219777. CRi

CRi is a national charity providing information and support in relation to substance misuse.

Eating Disorders

BEAT

Wensum House, 103 Prince of Wales Road, Norwich, NR1 1DW.

Youthline (up to and including 18 years old)

Tel: 0845 634 7650. Text line 07786 201820. Email address, fyp@b-eat.co.uk

Helpline (19 years old and over)

Tel: 0845 634 1414. Email address help@b-eat.co.uk

For further information, visit the BEAT website.

Information and help on all aspects of eating disorders, including Anorexia Nervosa, binge eating disorder and related eating disorders.

Men Get Eating Disorders Too

mengetedstoo.co.uk

This Charitable orgainsation aims to raise awareness of eating disorders in men.

Emotional/psychological

Anxiety UK

Tel: 08444 775774 (helpline), open Mon-Fri 9.30am-5.30pm. Anxiety UK

Offering information and support to anyone affected by anxiety.

British Association for Counselling and Psychotherapy

Tel: 01455 883300. For further information visit the BACP website.

Offering information and counselling in the UK through its members.

Changes

Tel: 01782 413101. Office is open Monday - Friday 9.00am - 5.00pm, groups meet at various times. Changes

Changes is a mental health charity that provides a recovery service for people in mental distress, based on users attending weekly mutual-help groups and following a 12 step recovery programme.

North Staffs Mind

83 Marsh Street, Hanley, Stoke on Trent, Staffs. ST1 5HN. Tel: (01782) 262100. Monday to Thursday 9.00am to 8.00pm, Fri 9.00am to 5.00pm.

Helping people with any kind of mental distress. Mind

Mind (National website)

http://www.mind.org.uk/

OCD Action

Tel: 0845 390 6232. Email: support@ocdaction.org.uk OCD Action

Offering advice and support to anyone affected by Obsessive-Compulsive Disorder (OCD). They also offer support groups in the West Midlands, including Newcastle under Lyme. Visit their web pages for details.

OCD UK

Tel: 0845 120 3778. Email: support@ocduk.org OCD UK

Offering advice, support and information to anyone affected by Obsessive-Compulsive Disorder (OCD).

Papyrus

HOPELineUK Tel: 0800 068 4141 or email: pat@papyrus-uk.org or text: 07786 209697 Papyrus

Open Monday – Friday from 10am – 5pm and 7pm – 10pm, and 2pm – 5pm on weekends.

Papyrus - HopelineUK - offers support and advice to young people (under 35) having suicidal thoughts or anyone concerned about a young person.

Rethink

Offering information about mental wellbeing difficulties and support that is available.

Rethink website

Safe Spaces Network

Tel: 01782 811815 Email:info@brighter-futures.org.uk Brighter Futures

The Safe Spaces Network offers a safe space to people in mental distress or crisis for whom a hospital admission is neither wanted nor needed.

Sane

First Floor Cityside House, 40 Adler Street, London E1 1EE. Helpline open 365 days a year. Tel: 08457 678000, 6pm - 11pm daily. Sane

Offering support and information concerning all types of mental illness to both sufferers and carers.

Staffordshire Mental Health Helpline

Tel: 0808 800 2234 Helpline open: 7pm - 2am Monday to Friday, 2pm - 2am Weekends.

Calls are free from landlines and major mobile networks.

Offering support to anyone with a mental health difficulty. Staffordshire Mental Health Helpline

Staffordshire Mental Health information

Providing information and details of a range of mental health services and projects across Staffordshire where you can get help and advice.

The Calm Zone

The Calm Zone

Support for young men aged 15-25.

Self-injury Support

The Self-injury support website has lots of information about self-harm and also provides information on support groups and helplines throughout the Country.

The Echo Group is based in Stoke on Trent and provides support and information for people (male and female) who have experienced self harm aged 18 and above. They provide a group and drop-in session. For further information contact the Echo Group on 01782 683192.

For further information about the Echo Group and other support, visit Brighter Futures and Self injury support website

The Muslim Youth Helpline

Tel: 0808 808 2008 Monday - Friday 6pm - 12am, Saturday - Sunday 12pm - 12am.

The Muslim Youth Helpline (MYH) is a registered charity which provides pioneering faith and culturally sensitive services to Muslim youth in the UK. It is aimed at 16-25 year olds. They provide a free and confidential counselling service available nationally via the telephone, email, internet and a face to face befriending service in the Greater London area. The service uses male and female volunteers trained in basic counselling skills to respond to client enquiries. MYH also runs an interactive peer support site.

The Samaritans

24 hour phoneline: (08457) 909090. email: jo@samaritans.org Samaritans

- 15 Chapel Lane, Burslem, Stoke on Trent ST6 2AB. Tel: (01782) 213555
- Stafford Old Meeting Hall, Garden Street, Stafford ST17 4DD Tel: (01785) 243333
- 27 Fountain Street, Leek, Staffordshire ST13 6AS. Tel: 01538 384100

Offering emotional support to anyone who is suicidal or despairing.

Visyon

Tel: 01260 290000

Visyon aims to provide emotional support for 11 to 25 year olds in and around the Congleton Borough. The service does provide support to people in Staffordshire whenever possible.

Anxiety UK (formerly National Phobics Society)

- Monday to Friday: 9.15 am to 9.00 pm: tel: 08444 775 774; 0161 227 9898; email: info@anxietyuk.org.uk
- A national registered charity formed 30 years ago by a sufferer of agoraphobia for those affected by anxiety disorders.

Depression Alliance
Helpline: 0845 123 23 20; information@depressionalliance.org

- Information, support and understanding for people who suffer with depression, and for relatives who want to help. Self-help groups, information, and raising awareness for depression.

Gambling

GamCare

Tel: 0808 8020133. 8am – 12 midnight, 7 days a week. Gamcare

GamCare provides support, information and advice to anyone suffering through a gambling problem. Talk live online to one of their trained Advisors or call their helpline and speak to a trained Advisor for counselling support, information and advice.

Gender London Lesbian & Gay Switchboard

PO Box 7324, London, N1 9QS. Tel: 0300 3300630 (10am - 11pm every day). London Lesbian & Gay Switchboard

Offering information and a support network.

Stonewall

Tower Building, York Road, London SE1 7NX. Tel: 0800 0502020 Mon - Fri 9.30am - 5.30pm. Stonewall

Campaigning for equality and justice for lesbians, gay men and bisexuals.

Piccadilly Centre (NHS)

Stoke on Trent. Tel: 0300 1230970 Mon – Friday 9.00am to 5.00pm. Piccadilly Centre/Gaylife

Gender Matters

Wolverhampton. Tel: 01902 744424. Email: info@gender-matters.org.uk Gender Matters

Offering advice and support to trans people and promoting equality.

HIV/AIDS

Staffordshire Buddies

PO Box 474, Hanley, SOT, ST1 3HX. Email: ask@staffordshirebuddies.co.uk Tel: (01782) 201251. Mon-Friday 9.00am – 5.00pm. Staffordshire Buddies

Offering advice and emotional support for people with HIV or AIDS.

Terrance Higgins Trust Helpline

Tel: 0808 8021221 Mon-Friday 10.00am to 8.00pm. Terence Higgins Trust

Offering information on all aspects of HIV and AIDS.

Parenting

Gingerbread

Rothesay Court, Furnace Road, Longton, ST3 4LY. Tel: 01782 344740 9.00am – 5.00pm Mon to Friday. Email: admin.assistant@gingerbreadcentre.co.uk. Gingerbread

Offering support and advice to single parents.

Family Information Service

Tel: 0800 0151120 or 01782 232200. Monday to Thursday: 8.45am - 5.00pm, Friday: 8.45am - 4.30pm. Email: fis@stoke.gov.uk Family Information Service

An answerphone is in operation during out of office hours.

Parents in Mind

http://www.nsmind.org.uk/parentsupport/index.htm

Parents in Mind Team on 01782 683136

Pregnancy

Health Centres

Coalport Building, Staffordshire University, Leek Road, Stoke on Trent ST4 2YJ Tel: 0300 123 1765.
Beaconside Health Centre Weston Road, Stafford ST18 0AB. Tel: (01785) 353570.
There are GPs and nurses available at both sites. The nurses and GPs can offer advice and support on a variety of issues including pregnancy and contraception.

Student Health Centre Stoke Beaconside Health Centre Stafford

Relationships

Family Mediation Service (South Staffordshire)

19 Victoria Road, Tamworth. Tel: 01827 314020. Monday - Friday 9.00am - 5.30pm

Family Mediation Services offer mediation to divorced, divorcing or separating parents to help them resolve disputes or potential disputes, particularly about their children, but including other issues such as financial or property. Legal Aid may be available to pay for mediation. The Family Mediation Service is a national organisation.

Relate

North Staffordshire: The Dudson Centre, Hope Street, Hanley, Stoke on Trent, ST1 5DD. Tel: 01782 683050. Relate

Stafford: The Mediation Centre, 7 - 8 St Mary's Grove, Stafford ST16 2AT. Tel: 01785 273133.

Counselling for people experiencing relationship difficulties.

Karma Nirvana

Tel: 0800 599 9247. Monday - Friday 9.30am - 5.00pm. Karma Nirvana

Karma Nirvana is a registered Charity that supports victims and survivors of forced marriage and honour based abuse.

The Forced Marriage Unit

Tel: 020 7008 0151 Monday to Friday, 9.00am to 5.00pm. Out of hours Tel: 020 7008 1500 (ask for the Global Response Centre) or phone the Police on 999. Email fmu@fco.gov.uk.

Forced Marriage Unit

If you are worried you might be forced into marriage or are worried about a friend or relative, then confidential advice and guidance is available from the Foreign and Commonwealth Office Victims of Forced Marriage Unit via their website.

Domestic Abuse & Arch

Need info re links/numbers from Karen.

Hospital Services (Tier 2&3)

The Access Team

The Access Team is a single point of contact and access for all North Staffordshire Combined Healthcare NHS Trust services.

The Access Team incorporates all former Single Point of Access teams and the Crisis Resolution Home Treatment Team.

The Access Team:

- operates 8am to 8pm Monday – Friday and 9am to 5pm at weekends (with crisis cover available outside of these hours)
- covers adult and older people's mental health services, learning disabilities, child and adolescent services
- cover the whole of Stoke-on-Trent and North Staffordshire

This service now provides the following:

- Teams of qualified Health and Social Care Staff who work together to provide an assessment, advice and sign posting service to support recovery and promote well-being
- The team will talk to individuals and/or referrers and assist them in getting the support they may need and access to the right services
- Support for people with mental health problems who are experiencing severe difficulties when the stability of their mental health has been interrupted by crisis
- provides short term crisis intervention and/or home treatment to people to reduce the likelihood of them
- works to enable earlier discharge from inpatient care and ensures that all admissions are appropriate and that where possible, the person does not become admitted.

Referral Route

The Team operates an open referral system, which means if you are concerned about your mental health or someone you care for you can contact the team direct.

They also take referrals from other professional groups for example General Practitioners, Heath Visitors, A&E and Police.

Contact Details

0300 123 0907

3.8 Workforce/Staffing and model of operation

Home-based treatment is a clear alternative to hospital admission (i.e. without the service the individual will be admitted). The following will form part of the service:

- A minimum of two professionally qualified and trained case workers will be available at all times. These staff will hold a recognised medical, nursing, social work, occupational therapy, or psychology

qualification with a level of skill and knowledge appropriate for the assessment and subsequent engagement with service users and their carers/family members.

- The team will have access to a senior psychiatrist 24 hours a day to undertake assessments where the level of need indicates this is appropriate
- In addition, the service will employ additional staff to provide relevant support to service user's and carers/family members under the appropriate clinical, professional and management supervision of one or more of the above like a named care worker to coordinate
- Daily team meetings as necessary where senior team members including medical staff present to discuss progress and risk, and to provide supervision with medical reviews as part of initial assessment
- A range of evidence-based interventions, including psychoeducation for patients and carers and training for staff in problem solving, supporting families and social networks during crises and simple crisis intervention principles – brief interventions (including brief cognitive therapy, brief focused therapy, brief interpersonal therapy, brief interventions for alcohol misuse, medication adherence interventions and relapse prevention) should either be delivered by the team or readily available from partner services on referral from the team
- Prescription of medication as necessary – access to prescribers 24 hours per day
- Discharge planning and seamless transfer to ongoing intervention, including face-to-face handover meetings at the point of discharge
- Provides assessment and short term treatment in the community for people who might otherwise need admission to an acute psychiatric unit
- Offers support to those who have been in hospital and are ready for early discharge
- Assessment will normally be in the individual's home or at an NHS unit.
- While the service user is receiving support from the Home Treatment Team, they and their carers can contact the team 24 hours / seven days week
- The team will provide intensive support and care during a crisis, according to an agreed plan of care
- The care plan will include the location where the team will meet the patient, how often the visits will happen, interventions needed, contact details for the CRHTT, medication/treatment information, needs of families/carers
- Treatment is home based to keep disruption to everyday life to a minimum
- The Provider shall have sufficient and skilled staffing to provide care safely and to deliver the outcomes required by Service users who access the Service as outlined in this specification.
- The staff shall undertake appropriate training to ensure that they are kept up to date with best practice and training shall be developed in line with new policy, guidance and best practice.
- The service Provider shall appoint a clear and identifiable Service Lead who shall have highly developed and respected skills to ensure the success of the Service and who shall be accountable for the delivery of the identified outcomes.

- All staff working in the service shall demonstrate a thorough knowledge and understanding of local resources and pathway relevant to the needs of the people who are accessing the Service.
- There shall be adequate arrangements to provide appropriate levels of supervision and support to staff involved in delivering Home treatment services. This shall cover issues related to case management as well as other relevant issues. These arrangements shall be consistent with identified good practice.

3.9 Interdependence with other services/providers

The service forms part of a spectrum of services commissioned by Stoke-on-Trent CCG to address the mental health needs of its population. It is specifically responsible for responding to people with mental health problems, and in doing so, to work in partnership with other services responding to the needs of this group of people.

The Provider shall also develop relationships with non-health care related services, such as social care and educational services. A sequential interdependency exists both within the Provider's various services and externally with other statutory and voluntary sector provider services.

3.10 Step down/ Step up beds at Hillcrest, Summers View and Florence Houses

The two CCGs and Brighter Futures identified 4 flats at Hillcrest that should be used as step down beds for service users coming from mental health rehabilitation services provided at Summers View and Florence houses or as step up beds for services users not qualifying to go into Summers View (18 bed mental health rehabilitation unit) or Florence House (10 bed mental health rehabilitation unit) but cannot be kept in the Community, at home or any other facility. Hillcrest is owned by Brighter Futures and provides a mix of 13 supported living flats and additional space for day opportunities. It is staffed by both Brighter Future staff who provide supported living support and NSCHT staff who support day opportunities. Summers View and Florence Houses are mental health rehabilitation services commissioned by the CCG through NSCHT.

The staff support the people using the 4 flats at Hillcrest who will also be able to access the day support available at the facility during day time. NSCHT identified that existing staff at Hillcrest could not provide the support the envisaged cohort of people in the 4 flats required at night and therefore an additional members of staff from the Home Treatment Team support the flats overnight as part of the Acute Home Treatment pathway and NSCHT Hillcrest establishment.

Management of the 4 beds at Hillcrest as well as those at Summers View and Florence Houses will be facilitated by the Home Treatment Team who have existing function as gate keepers for acute beds. The Home Treatment Team currently also actively work as in reach to the inpatient wards to facilitate early discharge. The cohort of people using the step down/step up beds are expected to be the same people with whom home treatment would ordinarily support within their home environment. The average stay in the Hillcrest flats will be between 4 to 14 days. No access to the Hillcrest flats will be available where a permanent residency is not in place. Support will also be made available from the existing Acute Home Treatment Team when required.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The service shall comply with relevant national standards of best practice in mental health provisions and make onward referrals as appropriate to assess need. The standards can be accessed at https://www.nice.org.uk/guidance/qs14

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

The service shall comply with relevant Royal College of Psychiatrists standards of best practice in mental health provisions and make onward referrals as appropriate to assess need. The standards can be accessed at https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/ccqi-resources/ccqi-resources-core-standards-for-community-based-mental-health-services.pdf?sfvrsn=eee5269a_2

4.3 Applicable local standards and key performance indicators.

1. To be involved in specifically gate keeping access to beds at Summers View, Florence House and Hillcrest Houses.
2. The Provider shall ensure appropriate policy is in place in line with current health and safety and risk management guidance together with appropriate mechanisms to record, audit and monitor feedback on service provision and actions taken to resolve issues.
3. The Provider shall work in accordance with their Adult Safeguarding Policy and procedures. The Provider shall ensure that they have an up to date adult safe guarding protection policy and ensure that all staff receive training relating Adult Protection, safeguarding and vulnerable people.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4)

5.2 Applicable CQUIN goals (See Schedule 3)

6. Location of Provider Premises

The Provider`s Premises are located at:

Harplands Hospital, Hilton Road, Stoke on Trent.

The service will be available with 24-hour cover, 7 days per week.

Service Specification No.	A04
Service	Access Service (including Crisis Resolution)
Commissioner Lead	Nicola Bucknall, Commissioning Manager – North Division, CCG
Provider Lead	Rachael Birks, Associate Director, Acute and Urgent Care Directorate
Period	1st April 2022 – 31st March 2023
Date of Review	**See 22/23 SDIP**

1. Population Needs

1.3 National/local context and evidence base

It is estimated that about 66,000 people in the over 16 population registered with GPs in the two Clinical Commissioning Groups for which this service is provided (NHS North Staffordshire and NHS Stoke on Trent) would have a common mental health problem such as anxiety, depression or OCD. These conditions can have mild, moderate or severe impact on someone's ability to function.

This service is intended to help meet the needs of people with more severe level of these problems, which is estimated as being about 5,000 people in the local population.

It is also estimated that about 1,600 people in the local population would have a more severe mental health problem such as psychosis, and this service would also be expected to meet their needs.

The levels of need described above are based on national prevalence rates – because of the recognised impact of deprivation and poverty on the prevalence of mental health problems – both for common and more severe problems, it is probable that the actual levels of local need are higher but the exact impact on local needs cannot be estimated at this time.

Stoke-on-Trent has historically experienced, and continues to experience, significantly higher levels of poverty and deprivation then the rest of England, with over half of the population living in the most deprived areas of the country. This coupled with the current economic downturn, is likely to have a larger consequential adverse impact on mental health and wellbeing for the people in Stoke on Trent than in other localities.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**Y**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**Y**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**Y**
Domain 4	**Ensuring people have a positive experience of care**	**Y**

Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**Y**

2.2 Local defined outcomes

The expected outcomes are as follows:

- Ensure there is equal access to Mental Health Services for all. To act as gatekeepers toward the Acute Home Treatment Team (including resolution).
- Ensure enhanced access to mental health services.
- All people referred to Access will undergo a mental health assessment by a qualified mental health practitioner.
- To provide a single point of contact for mental health referrals.

3. Scope

3.1 Aims and objectives of service

The aims/objectives of the Access Service are:

- To provide a single point of contact for mental health referrals.
- To provide prompt and expert assessment of needs for people referred to the service.
- To maintain service user contact and increase engagement and concordance
- To contribute to a reduction in overall hospital admissions
- To reduce the amount of compulsory admissions
- To provide practical support, whilst also being innovative, creative and pro-active
- To maximise the appropriate use of health, social services, and voluntary and community facilities including work, housing, leisure and educational opportunities.
- To provide multi-disciplinary team approach to support the users in the community.
- Provide advice and support to service users, families and carers.
- Establish a detailed understanding of all local resources relevant to support of individuals with mental health issues and promote effective interagency working.
- Provide a culturally competent service, including ready access to interpreter services for minority languages and British Sign language.
- Gain a detailed understanding of the local population, its mental health needs and priorities, and provide a service that is sensitive to this and religious and gender needs.

- Provide support and advice to primary care through collaborative working.
- Reduce the stigma associated with mental health care
- Establish effective liaison with local Community Mental Health and Social Care Teams, Primary Care Team members, Acute Care, Early Intervention teams and other referring and onward referring agents to establish processes to manage complex cases.

The core principles of the service are:

- Everyone is entitled to an assessment
- Customer Care is essential in engagement
- Referrers and the referred should not be passed around the system
- A flexible response is required
- The service provides a clear understanding of who does what for the referrers and service users
- Communication between teams, to the service user and referrers is at the core of the service
- Ensure patients are not assessed repeatedly, unnecessarily
- There are clear time scales for response in line with Emergency, Urgent and Routine
- The service is integrated with Social Care and Health

3.2 Service description/care pathway

The Access Service will assist anyone referred to Access and arrange the right care for urgent and non-urgent referrals. It will offer an immediate response by telephone or face-to- face, if required, sign-posting, further assessment, if required, and a crisis response from if that level of service is required.

Referral Processes

Referrals are accepted from any source.

Referral Routes

Referrals can be received via the following methods:

- Telephone
- Self-Presentation (Walk-in)
- Paper Referrals

- Electronic systems (i.e. email)

Hours of operation

The Access Team will be operational 24 hours a day seven days a week including Bank Holidays.

Response Times

There are three categories of referral with response times as appropriate:

Emergency: any referral that appears to be potentially life threatening in nature or of sufficient severity that it may place the referred person in immediate danger to themselves or others. It is expected that these types of referrals will receive an immediate response. Mental Health Act assessments may also fall within this category which would require liaison with the AMHP service.

Urgent: any referral that appears to require an urgent response due to the nature of the needs presented, which is non-life threatening in nature, and does not place the referred person in immediate danger to themselves or others. These types of referrals should be responded to within a maximum of 4 hours.

Routine/Moderate: any referral that, following a level of assessment (screening) by a Senior Qualified Mental Health Practitioner, appears to be non-urgent/acute in nature but which may require advice, signposting or further assessment/professional support to explore a range of options that may meet assessed needs. Initial response should be within 24 hours. Need should be resolved at first contact wherever possible.

Interventions

Assessment

All referrals receive an Initial Screening Assessment and where the need indicates, a further Comprehensive Assessment.

Care planning and short term support

Where the referred person has mental health needs but onward referral to specialist mental health services is not appropriate, support is offered by the Access Team to resolve urgent or short-term issues. In these circumstances, the Care Program Approach is used to facilitate care co-ordination.

Referral to Specialist Mental Health Services

Where the assessment process indicates that the referred person has needs that should be met through the provision of secondary or specialist mental health services, then the person is referred on to the relevant service to receive treatment and support.

Referral and Signposting to other Mental Health Services

Where the assessment indicates that the person referred does not have needs that should be met through specialist mental health services, they will be either referred or signposted (depending on the relationship between services) to appropriate non-specialist mental health services

Workforce

The Access Team comprises of:

- Social work professionals
- Community Psychiatric Nurse
- Support Time Recovery Worker
- Occupational Therapist
- Access to input from psychologists
- Access to dedicated psychiatrist sessions

3.3 Population covered

Those registered with GPs within Stoke on Trent Clinical Commissioning Group and North Staffordshire Clinical Commissioning Group.

If the patient is not registered with a GP the service will working with the patient towards registration and access to the service.

3.4 Any acceptance and exclusion criteria and thresholds

This service is for 18 years and above patients with mental health, learning disability needs The service needs to support choice for 16/17 year olds who may be better placed accessing an adult service. Service needs to support transition from children and young people as per the transition policy.

No other exclusions apply.

3.5 Interdependence with other services/providers

The Access Team work closely with other mental health providers within North Staffordshire Combined Healthcare Trust and outside organisations, including voluntary sector organisations.

This service also links with the Section 75 agreement with the Local Authority.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.3 Applicable Quality Requirements (See Schedule 4)

5.4 Applicable CQUIN goals (See Schedule 3)

6. Location of Provider Premises

The Provider's Premises are located at:

Access Team, Hope Centre, Hanley, Stoke-on-Trent, Staffordshire, ST1 2DA

Service Specification No.	A05
Service	Adult Community Mental Health Team
Commissioner Lead	Nicola Bucknall, Commissioning Manager – North Division, CCG
Provider Lead	Jane Munton-Davies, Associate Director, Stoke Community Mental Health Services Josey Povey, Associate Director, North Staffordshire Community Directorate
Period	01 April 2022 – 31 March 2023
Date of Review	As Required

1. Population Needs

National/local context and evidence base

- The Recovery-based model of care
- "No Health Without Mental Health" – national mental health strategy
- 'Mental Health is Everybody's Business' Staffordshire and Stoke on Trent Mental Health Strategy
- 2014 Care Act

2. Outcomes

2.1 <u>NHS Outcomes Framework Domains & Indicators</u>

Domain 1	**Preventing people from dying prematurely**	**Y**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**Y**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**Y**
Domain 4	**Ensuring people have a positive experience of care**	**Y**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**Y**

2.2 Local defined outcomes

- Reduction in acute in-patient admissions
- People supported to access groups, activities, employment and universal services
- Service user's progress measured through the use of outcome tools (WAP Plans, Recovery Stars etc.)

3. Scope

3.1 Aims and objectives of service

Adult Community Mental Health and Social Care Teams will support and provide opportunities for service users to maximise their potential and support their wellbeing and recovery including consideration of the responsibilities set out in the 2014 Care Act. This is demonstrated in the aims and objectives of the teams which are:

Aims

i. Recognise and promote the personal dignity of service users, carers and their families

ii. Provide effective, evidence-based treatments to reduce and shorten distress and suffering.

iii. Work collaboratively with functional teams to ensure people are supported in the community.

iv. Provide services provided via the multidisciplinary team.

v. Ensure the care is delivered in the least restrictive and disruptive manner possible.

vi. Assist service users and carers in accessing support, both to reduce distress but also to maximise personal development and fulfilment.

vii. Provide advice and support to service users, families and carers.

viii. Establish a detailed understanding of all local resources relevant to support individuals with mental health issues and promote effective interagency working.

ix. Provide a culturally competent service, including ready access to interpreter services for

x. minority languages and British Sign language.

xi. Demonstrate a detailed understanding of the local population, and provide accessible, locally based services that recognize and support diversity and deliver service parity to both urban and rural areas.

xii. Provide support and advice to Primary Care through collaborative working.

xiii. Establish effective liaison with Primary Care.

xiv. Protect service users and carers from abuse or neglect and recognize and respond appropriately to adult protection and clinical protection issues and act within clearly defined policy and procedures.

xv. Recognising risk and being proactive within defined risk management tools. For limiting self-harm and harm to others.

xvi. Staff will operate within a system that promotes inclusion in all aspects of service delivery.

Objectives

i. providing a range of structured, evidence based psychological and therapeutic interventions via care pathways

ii. providing accessible, locally based services

iii. maximise individual choice and promoting independence and recovery realizing the individual's contribution to society

iv. ensure the physical health, mental health and emotional well-being of service users is met

v. offering flexible, responsive and proactive services that are of a consistently high standard and quality

vi. providing a supportive environment for people with long-term mental health problems and for those who are acutely ill

vii. offering a range of evidence based interventions on both an individual and group basis in accordance with the appropriate care pathway

viii. promoting Service user and carer choice and involvement in all aspects of planning and service development

ix. working collaboratively with private voluntary sector partners.

x. promoting meaningful activity, employment and 'lifelong learning' to improve social and economic well-being.

xi. promoting social inclusion by developing opportunities for service users to participate in mainstream services in integrated community setting

Expected Outcomes for Service Users

- All service users will have an individual care plan based on a needs assessment and an allocated care co-ordinator working to the principles of CPA.

- The need for hospital admissions will be reduced through early detection and providers working with service users and carers to develop effective relapse prevention plans.

- A well trained workforce working with service users and carers promoting recovery models.

- Care plans will be formulated to promote service users recovery, discharge and transition into primary services.

- Care plans will detail the reasons for the use of medication and provide comprehensive information of there use to service users and inform them of other treatments and interventions in exploring ways to manage and treat mental health symptoms.

- Care plans will address physical health needs resulting in the reduction of inequalities in health care.

- Care plans will reduce the need for services by promoting self advocacy, enabling service users to move to less intensive service interventions or away from Secondary Care.

- Service users will be aware of and be able to access services including use of the Staffordshire Cares website: www.staffordshirecares.info

- Service users and carers will actively engage in assessments and reviews required to meet

- NHS Continuing Healthcare Criteria and Community Care assessment.

- Service users will be enabled to access or maintain vocational and educational activities and suitable accommodation appropriate to their needs, this will be reflected in care plans and where appropriate vocational/educational and accommodate providers will be active participants in care teams

- Care plans will reflect service users hobbies and interests improving activities of daily living and social functioning

- HONOS assessment will be applied.

- Carers and families will be assisted in gaining knowledge with regard to service user's mental health diagnosis and who to contact should a crisis arise.

- Providers will ensure that the welfare of children deemed at risk is addressed and referrals are made to the appropriate sources to meet the needs of children affected by their carer's mental health issues.

- Service users will be active participants in their care process determining interventions and contact with provider services.

- Care Plans will detail the role of carers, including their entitlement to a carers assessment, and they will be active participants in the reviewing process.

- Care plans will detail the responsibilities of partner agencies and they will be active participants in the reviewing process.

- Care co-ordinators will review care plans on an on-going basis by liaising with service users and others involved in the delivery of services and support.

- All Service users receiving support from specialist mental health services will be given the opportunity to engage in a documented review of their care plan, at minimum, every six months.

- If a service user does not engage in their documented review the Care Co-ordinator/Lead Professional will record the reasons why the service user did not engage.

- The outcomes of reviews will be communicated to all relevant parties and records will be amended to reflect their content.

- Outcomes for Service Users are central to the content of this service specification.

3.2 Service description/care pathway

This service specification includes a range of services provided by the CMHT to people who are recovering from or living with mental health problems.

There are two, geographically based CMHTs currently delivered from four resource centres covering North Staffordshire and Stoke on Trent.

Services are configured around an Access Service, Community CPN Service and other functional and/or Specialist Services provided by North Staffordshire Combined Healthcare.

CHMTs are multidisciplinary teams and include staff from the following disciplines:

- Mental Health Nursing
- Occupational Therapists
- Social Workers
- Approved Mental Health Professionals
- Input from Medical Staff
- Psychologists
- Administrative Support Staff

Community Mental Health and Social Care interventions should be sensitive to the different needs of the local population, ensuring equity of access and service delivery for all potential service users.

Operational accountability on a day to day basis will be to the Senior Team Leader who in turn reports to the Joint Head of Service.

All staff will be accountable for their professional conduct within the frameworks set down by their relevant professional body.

<u>Payment by Results (PBR) Care Clusters</u>

Service users will follow a pathway through services in accordance with their needs. Interventions along pathways will be provided by a skilled, multi-disciplinary workforce.

Each service user supported by a CHMT will be allocated to a Care Cluster, according to the nature and severity of their condition. Each care cluster has a range of recommended interventions or support services that may be offered to the service user. Some of these interventions will be generally delivered by CHMTs.

Care Clusters that the CHMTs will work with on a regular basis include:

Acute non psychotic (high severity)

This group will be severely depressed and/or anxious and/or other. They will not present with hallucinations or delusions but may have some unreasonable beliefs. They may often be at high risk for suicide and they may present child protection and engagement issues.

Non-psychotic chaotic & challenging disorder

This group will have a wide range of symptoms and chaotic and challenging lifestyles. They are characterised by moderate to severe repeat deliberate self-harm and chaotic, over dependent engagement with services.

First episode psychosis

This group will be presenting to the service for the first or second time with mild to moderate psychotic symptoms. They may also have depressed mood and/or anxiety or other behaviours. Drinking or drug-taking may be present but will not be a major problem. There may be some impairment of role functioning especially around relationships.

Chronic severe mental illness group (High symptoms)

This group will have a history of psychiatric symptoms and be in receipt of ongoing support from the service, i.e. intensive home support or residential accommodation. They will present with moderate psychotic symptoms and some neurosis and are likely to have poor role functioning.

Severe psychotic episode

This group will generally have been known to the service for a long period of time. They will be experiencing an acute psychotic episode with severe symptoms that cause severe disruption to role functioning. They may present a risk to others or be vulnerable themselves.

Severe depression

This group will be suffering from an acute episode of moderate to severe depressive symptoms. Hallucinations and delusions may be present. It is likely that this group will present a risk of suicide and have disruption in many areas of their lives.

Dual diagnosis

This group has chronic, moderate to severe psychotic symptoms with unstable, chaotic lifestyles and drug or alcohol abuse. They may present a risk to others and engage poorly with services. Role functioning is often globally impaired.

This group also represents individuals with mental health and learning disability. The 'Green Light for Mental Health' is a framework and self audit toolkit for improving mental health support services for people with learning disabilities. The teams use the checklist to establish what services are in place and working well for people with mental health and learning disability needs forms the basis of the subsequent action planning process.

Referrals

Referrals will be made and screened via the Access Service for potential service users from both North Staffordshire and Stoke on Trent.

The Access Service will screen referrals, ensuring that there is sufficient information on which to base a decision for acceptance or non-acceptance. The Access Service will also determine, with the referrer, the urgency of the response required and so determine whether the referral will be treated as an urgent or routine referral.

Response Times

Local response times are to ensure that a first appointment is offered within 6 weeks of the receipt of a referral.

New referrals received from Acute In-patient Services will be allocated a Care Co-ordinator within 7 days.

Appointments for new referrals will be prioritised on urgency.

All service users discharged from acute in-patient care will receive follow up from the relevant CMHT within 7 days of their discharge, or within 48 hours in cases with an identified risk.

Self-Care

The aim of the service is to improve the quality of services and clinical outcomes for people affected by mental ill health following the principles of the Recovery Model. The service aims to assist service users in developing self management techniques which maximise their resilience and reduce their vulnerability to mental illness.

Promotion of Recovery and Education for Service Users and Their Carers

The CMHT will work with service users in ways which assist them in developing self management techniques which maximise their strengths

The CMHT will supply resources that promote self management, such as Wellness Action Plans (WAP) or Making My Wishes Known for advance decisions.

Service users and their carers/family members will be given an explanation of their condition and advice about all management options which will be discussed with service users and carers during the CPA process.

Service User Participation

The CMHT will work with service users in ways which foster partnerships, including:

- Views on location of services
- Service user participation groups
- Work with the local Patient Advice and Liaison Service
- Service user surveys
- Local complaints processes and annual review
- Promoting self-care including Expert Patient Programmes

Combined Healthcare will make arrangements to carry out service user and carer/family member surveys in relation to the service and will co-operate with such surveys that may be carried out by the Commissioner.

Combined Healthcare will have regard to any Department of Health guidance relating to satisfaction surveys and will be expected to demonstrate evidence of having used survey results to make improvements in service delivery.

Information

Service users and their carers/family members shall be provided with the following information as a minimum:

- A description of the service, range of interventions provided and what to expect
- The name and contact details of their Care Co-ordinator/Lead Professional and other relevant members of the team
- Contact details for out of hours advice and help
- A Care Plan via the CPA process which includes a safety Plan, Relapse Prevention Plan and Crisis Intervention Plan
- Comprehensive information about medication
- A Discharge Summary including information on how to re-refer in the event of a relapse
- How to express views on the service.

3.3 Population covered

The CMHTs provide specialist secondary mental health and social care services for adults aged 18+ who are registered with either a Stoke on Trent or North Staffordshire GP.

3.4 Any acceptance and exclusion criteria and thresholds

The service excludes people whose primary diagnosis is catered for by an existing specialist team. These include Children's and Adolescent Mental Health Services, Substance Misuse services, Neuropsychiatry, Learning Disabilities and where identified needs can be met through other existing services.

Social Care services offered by the CMHT will be subject to the application of Fair Access to Care Services criteria (FACS) currently in operation by either Staffordshire County Council or Stoke on Trent City Council. Social Care will also be delivered taking account of the 2014 Care Act.

The service will not generally work with people who are aged under 18 years.

3.5 Interdependence with other services/providers

The CMHT will ensure that they establish good and effective working relationships with other teams and agencies to achieve socially inclusive outcomes for service users. This will include, but not be exclusive, to Primary Care, including IAPT, police, housing and employment services.

Adult Community Mental Health and Social Care services will be provided through close collaboration with Care Co-ordinators to deliver a holistic, recovery focused care plan for service users.

Internally, the CMHT will work closely with other teams operated by North Staffordshire Combined Healthcare including:

- Access Service
- Assertive Outreach Services
- Early Intervention Services
- Inpatient Services
- Outpatient and Day Services
- Criminal Justice Mental Health Service
- Urgent and Emergency Mental Health Liaison Service
- Psychology Service

The operation of the service will be organised to promote and facilitate social inclusion and greater independence utilising established close links with local community based resources.

The service will work closely with partners providing education/employment support and opportunities for people with mental health problems.

The CMHT will have regular interface with functional teams, inpatient services and specialist services to discuss referrals, maintain positive relationships and support effective two way communication between all areas of mental health services.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE) **4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)** **4.3 Applicable local standards**
5. Applicable quality requirements and CQUIN goals
5.5 Applicable Quality Requirements (See Schedule 4) **5.6 Applicable CQUIN goals (See Schedule 3)**

Service Specification No.	A06
Service	Assertive Outreach Team
Commissioner Lead	Nicola Bucknall, Commissioning Manager – North Division, CCG
Provider Lead	Josey Povey, Associate Director, North Staffordshire Community Directorate
Period	1st April 2022 - 31st March 2023
Date of Review	As Required

1. Population Needs

National/local context and evidence base

It is estimated that about 1,600 people in the local population would have a more severe mental health problem such as psychosis, and this service would be expected to meet the needs of those at the more complex and severe level.

The levels of need described above are based on national prevalence rates – because of the recognised impact of deprivation and poverty on the prevalence of mental health problems – both for common and more severe problems, it is probable that the actual

levels of local need are higher but the exact impact on local needs cannot be estimated at this time.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	

2.2 Local defined outcomes

- Service users remain engaged with relevant services
- Incidences of hospital admission are reduced
- Service users retain existing accommodation and are supported to access settled accommodation
- Aspects of service users lives that are not directly linked to their mental health needs (for example substance use) are better managed
- Recovery is supported

3. Scope

3.1 Aims and objectives of service

Assertive Outreach Teams were set up, following guidance from the Department of Health in 2002, to work as a dedicated service aiming to engage with and provide intensive support to individuals with severe and enduring mental health problems who have difficulty engaging with mainstream secondary care mental health services.

Since 2015 the team and its operating principals have been embedded into Community Mental Health Teams.

The Service works with service users who experience symptoms of psychosis and who find it difficult to engage with mainstream community mental health services. This may be because, for example, they are homeless, have drug and alcohol difficulties, have been involved with the criminal justice system or have complex difficulties.

The main aims and objectives of the service are to;

- Develop meaningful engagement with service users, provide evidence-based interventions and promote recovery
- Increase stability within the service users life, facilitate personal growth and provide
- opportunities for personal fulfilment
- Provide a service that is sensitive and responsive to service users' cultural, religious and gender needs

- Support the service user and his/her family/carers for sustained periods
- Promote effective interagency working
- Ensure effective risk assessment and management

The longer term aim of the service is to develop a relationship between the service user and mental health services and for the outreach workers to develop a flexible, and needs focused approach that enables the delivery of a health and social care package that fits each individual's need.

3.2 Service description/care pathway

Service users referred to the Service will usually have had a history of admissions to hospital, possibly having been detained under the Mental Health Act, and have often encountered problems with medication / treatments.

The service operates 365 days per year, weekends and bank holidays the hours of operation are 09.00 – 17.00 hrs, all remaining days are 08.00 – 20.00 hrs.

Referral to the Service is made by a service user's care coordinator on the basis that the service user would benefit from the Service's approach.

The Service is made up of a community based team of community psychiatric nurses and support time and recovery workers who provide support, mental health monitoring, medication administration and monitoring, and psycho education for service users. Social needs such as finance, housing, employment and education will also be addressed.

3.3 Population covered

The service is for people who are registered with a general practitioner within the Clinical Commissioning Group (CCG) areas of NHS North Staffordshire and NHS Stoke-on-Trent. For people who are not registered with a GP, the service will be provided but support given to enable the person to register.

3.4 Any acceptance and exclusion criteria and thresholds

The service is appropriate for service users aged 18 and over whose primary issue is psychosis and who are having difficulty engaging with mainstream community mental health services. It is seen as appropriate for service users with severe and enduring mental health needs who also have more complex needs.

The service is not seen as appropriate for service users with a forensic history where this outweighs their mental health needs. Service users with certain types of personality disorders may not benefit from the service but will not routinely be excluded.

3.5 Interdependence with other services/providers

It also works closely with the Early Intervention in Psychosis Service, focusing on those service users less willing to engage.

The service works closely with the Criminal Justice Mental Health team, and with Community MH Teams and Inpatient services.

Partnerships directly with the police is also necessary, as the Service works with complex individuals with multiple needs and presentations.

The service has close working relationships with substance misuse services commissioned by the respective Local Authorities for those service users with Dual Diagnosis, and with services offering housing related support.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

http://guidance.nice.org.uk/CG82 (Currently being updated)

http://www.nice.org.uk/CG38

http://www.nice.org.uk/CG120

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals
5.7 Applicable Quality Requirements (See Schedule 4) **5.8 Applicable CQUIN goals (See Schedule 3)**
6. Location of Provider Premises
The Provider's Premises are located at: Community Mental Health Teams

Service Specification No.	A07
Service	Early Intervention in Psychosis Team
Commissioner Lead	Joanne Marsh, Senior Locality Commissioning Manager, CCG
Provider Lead	Josey Povey, Associate Director North Staffordshire Community Mental Health Services
Period	1st April 2022 - 31st March 2023
Date of Review	**See 22/23 SDIP**

1. Population Needs

1.1 National/local context and evidence base

The term 'psychosis' covers a range of mental illnesses, the most common of which is schizophrenia. The mean age of onset of psychotic symptoms is 22 years for women and 19 years for men, with 80 per cent of first episodes occurring between the ages 16 and 30 years. Psychosis is estimated to affect 3.4 per cent of the population over a lifetime.

Psychosis and psychotic disorders can be extremely debilitating. A long duration of untreated psychosis is associated with poorer personal recovery, increased service use and poorer economic outcomes in both the short and long-term. People who do not access effective treatment quickly are far more likely to experience poor physical health, lower levels of social functioning and poorer occupational and educational outcomes.

- In the UK, only 8% of people with schizophrenia are in work, despite many more being willing and able to work.
- People with severe and prolonged mental illness (diagnoses that usually involve psychosis, such as schizophrenia and bipolar disorder) are at risk of dying on average 15 to 20 years earlier than other people. Two thirds of these premature deaths are from avoidable physical illnesses, including heart disease and cancer, many caused by smoking. This is one of the greatest health inequalities in England. People with psychosis are three times more likely to attend A&E with an urgent physical health need and almost five times more likely to be admitted as an emergency
- If untreated or poorly treated, psychosis can become a long-term condition with high levels of relapse, high rates of inpatient admission, increased detentions under the Mental Health Act 1983 and high rates of comorbid physical health conditions.

The model for Early Intervention in Psychosis (EIP) services was set by NHS England in the Implementing the Early Intervention in Psychosis Access and Waiting Time Standard Guide of

2016. This was an evolvement from the National Service Framework Policy Implementation Guide produced over fifteen years ago (in 2003) around EIP. The purpose and intention of both guides being of reducing the impact of psychosis on younger adults and reducing the longer-term costs of supporting them by intervening at the earliest point.

The guide estimated that the incidence of first episode psychosis in England is 31.7 per 100,000 population and specialist Early Intervention teams were commissioned to meet local need in each area for the 14-35 age group defined in the guidance based on this estimate.

The independent Mental Health Taskforce, which published its report in February 2016, highlighted the need to improve access to high-quality care for all including the introduction of the access and waiting time standard for early intervention in psychosis (EIP) services heralding the start of a new approach to deliver this improved access and embed standards akin to those for physical health.

The new EIP standards set out in the guide are not just a new approach for mental health but became a clear national priority for the NHS. Delivering the new EIP standards is one of the

1.2 Local Context

It is currently estimated that there would be between 26 and 49 new cases of first episode psychosis in Stoke-on-Trent, and between 13 and 42 in North Staffordshire (Figures from Psymaptic.org) making a total of between 39 and 91. The actual estimated figure would be 64 new cases per year being 40 in Stoke on Trent and 24 in North Staffordshire.

It is estimated that in Stoke on Trent and North Staffordshire there are over 1,200 people will experience a psychotic disorder in a 12 month period and about 2,000 people with probable psychosis. It is likely that there would be approximately 240 referrals for EIP of which estimates suggest there are likely to be about 64 people experiencing their first episode of psychosis across Stoke on Trent, Newcastle Under Lyme and Staffordshire Moorlands.

The incidence rate for first episode psychosis has been estimated to be significantly higher for Stoke-on-Trent than for North Staffordshire because of the higher levels of deprivation, different mix of ethnic groups in the population and its relatively “urban” nature compared with the rest of North Staffordshire.

From April 2016 the criteria for the service was extended to include all those experiencing a first episode of psychosis and those classed At Risk Mental State (ARMS), and the service has been expected to achieve access and waiting time targets as part of the Parity of Esteem agenda (NHS Five Year Forward View) national targets.

2. Outcomes

2.1 <u>NHS Outcomes Framework Domains & Indicators</u>

Domain 1	**Preventing people from dying prematurely**	**X**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**X**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**X**
Domain 4	**Ensuring people have a positive experience of care**	**X**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**X**

2.2 Local defined outcomes

- A reduction in the duration of untreated psychosis to a median of three months and 80 per cent maximum of six months
- To meet caseload targets against the national requirements

3. Scope

3.1 Aims and objectives of service

The Early Intervention (EI) Service is a specialist service supporting individuals experiencing a first episode of psychosis. People who experience psychosis can and do recover. The time from onset of psychosis to the provision of evidence-based treatment has a significant influence on long-term outcomes. The sooner treatment is started the better the outcome and the lower the overall cost of care.

The core aims of Early intervention is psychosis are to

- To provide a service to individuals and their families who are experiencing a first episode of psychosis, embracing diagnostic uncertainty, with an emphasis on managing At Risk Mental States (ARMS) and psychotic symptoms/experiences rather than diagnosis
- Reduce the duration of untreated psychosis, including support for people with an at-risk mental state, and for some, prevent transition to psychosis
- Produce effective outcomes in terms of recovery and relapse rates
- To work with the expectation that people can recover from psychosis, attaining ordinary lives and stay well.
- To work within a bio-psycho-social approach that is delivered intensively and sensitively during the three years following a first episode of psychosis and for

intervention and treatment to be provided in the least restrictive and stigmatising environments, that emphases choice and promotes recovery

- To detect psychosis quickly, intervene early and emphasise the need for social as well as symptomatic recovery.
- An approach with an emphasis upon developing meaningful and sustained engagement based on an assertive outreach principle – in which failure to engage should not automatically lead to case closure
- To improve professional and lay awareness of the need and benefits of early assessment and intervention of psychosis, to help reduce the ignorance, fear and stigma associated with psychosis
- To provide a service to individuals and their families with an emphasis on managing psychotic symptoms/experiences rather than diagnosis
- To allow early identification and preventive interventions reduce the length of time young people remain undiagnosed and not receiving appropriate interventions and treatment and to emphasise the need for social as well as symptomatic recovery.
- To provide sustained and intensive evidence based interventions, particularly in the early phase of a person's psychosis.
- To work with the expectation that people can recover from psychosis, attaining ordinary lives and stay well.
- To provide treatment and support intensively and sensitively during the three years following a first episode of psychosis and for these to be provided in the least restrictive and stigmatising environment
- To provide a service which is young person and family orientated and culture, age and gender sensitive.
- To use an assertive outreach principle to develop meaningful and sustained engagement –failure to engage should not automatically lead to case closure
- To increase stability in the lives of people, facilitate development and provide opportunity for personal fulfilment by emphasising normal social roles and people's development needs, particularly in education and achieving employment
- To provide a user centred service integrating CAMHS and adult mental health services and working in partnership with primary care, education, social services, youth and other services.

3.2 Service description/care pathway

The majority of people accessing EIP are likely to be under the cluster 10 First episode of psychosis; however it is accepted that there will at times be people on care cluster 14 psychotic crisis. Below is a summary, based on NICE guidelines, of the key components of a high-quality EIP service:

- Assessment through single point of access a readily accessed point of contact by a practitioner competent in recognising first episode psychosis
- Staff who build up trust and confidence
- Provision of good information to help them to understand psychosis and treatment options
- A care coordinator who will support them throughout their time in the service, including helping them with self-management skills, social care issues such as housing or debt management, and relapse prevention work
- A choice of psychological and pharmacological interventions
- Support, information and advice for families and carers, including carers' assessments where required
- Facilitate and signpost to support with employment, training and / or education
- Regular physical health checks as appropriate , monitoring and appropriate treatment, with support and / or education
- Regular monitoring of risk
- Routine monitoring of other coexisting conditions, including depression, anxiety and substance misuse, particularly in the early phases of treatment
- A crisis plan and prompt service response to help them to manage when in crisis.

The service will work to raise awareness of psychotic symptoms/education and support early case detection by developing an understanding amongst professionals and others of how psychosis can develop during adolescence and early adulthood, working with partners in: adult mental health; Child and Adolescent Mental Health Services (CAMHS); education;

primary care; youth services; the 3rd sector; social services; criminal justice liaison;

children's services; A&E, etc. It should provide training and guidance for GPs and other key agencies on the importance of early detection and how to refer people with potential psychosis.

3.3 Referral Criteria and Accessibility

Referrals are accepted from all sources including self / family and a range of agencies across all sectors. The service will operate a single point of access given the tight turnaround times with regards to eligible patients starting a NICE approved package of care within 2 weeks of referral.

All referrals will be triaged to ensure that they potentially meet the criteria for the service. This initial screening will in most cases be completed within 24 hours and with an aim to

provide treatment within 2 weeks of referral. At least 53% of all referrals for a first episode of psychosis should start NICE recommended package within two weeks.

Carers (including young carers) will be identified in assessment. For service users with caring responsibilities appropriate support, contingency and crisis plans will be put in place for the service user as a Carer and for the person/s they care for.

Where other mental health services such as CMHTs or CAMHS have been involved with an individual prior to referral, these services will continue to be involved and continue to act as the Care Co-ordinator/Lead Professional until the assessment has been completed and a decision reached as to whether they are suitable for the service.

Service users who are not found to be psychotic or who are otherwise not appropriate for the service following assessment will be referred onto the most appropriate services to meet their needs.

Following assessment and acceptance by the service, the service will offer a number of interventions in line with recommended NICE and other guidelines. A care coordinator will be appointed and a care plan agreed.

3.4 Assessment, Signposting, Interventions and Care Planning

The service Provider shall ensure:

- A service user-centred, multidisciplinary assessment coordinated by a qualified member of the team (the assessment may include use of 'specialist assessment tools' such as HONOS plus and GAS)
- Sufficient time shall be allowed to develop a relationship and let symptoms stabilise
- Assessment to identify appropriateness/need for a 'psychosis' service
- Capacity to adopt a 'watch and wait' brief when diagnosis uncertain
- Assessment to include: physical health assessment as routine and psychiatric history; mental state examination; risk assessment – including suicide risk; social functioning and resource assessment; psychological assessment; occupational assessment; family/support assessment; service user's aspirations and understanding; contribution from people important to the service user
- Assessment for first episode psychosis should be completed by a competent and qualified professional.
- The service shall work proactively to engage people experiencing first episode psychosis because it is often those who do not engage with services immediately who are most in need of support.

- Service users who are not found to be psychotic or inappropriate for the Early Intervention Service following assessment will be referred onto the most appropriate pathway to meet their needs, this may include referring back to the originating referrer, a copy of the assessment shall be sent.
- Follow CPA guidelines: provide care plans and regular review.
- For under 16's where CPA is not compulsory the guiding principles shall be adopted to support consistent practice and co-coordinated management of care for each service user. This shall also support a sensitive transition across the child/adult interface.
- Family/carers/significant others shall be routinely involved in the process of service user engagement, assessment and treatment.
- Where required organise for a carer's assessment to be undertaken

Being a NICE concordant adherent EIP service, the service will offer and deliver the following interventions

- Family interventions, Medication (where appropriate)
- Cognitive Behaviour Therapy for Psychosis (Psychological therapies)
- Education and employment support using the Individual Placement Support model (i.e., Enable)
- Physical Health Assessments
- Wellbeing Support (healthy eating, physical activity, smoking cessation)
- Carer focused education and support
- Relapse prevention / Crisis Planning / Wellness Recovery Action Planning
- Psychological therapies
- Engagement with the world of work, education and training
- Support with housing and accommodation
- Support with Co-Morbidity/Dual Diagnosis
- Support with maintaining physical health and wellbeing
- Consultation and liaison

The service will follow CPA guidelines and provide regular review of care plans. For under 16s (where CPA is not compulsory) the guiding principles will be adopted to support consistent practice and co-coordinated management of care for each service user. This will also support a sensitive transition across the child/adult interface. Family/carers/significant others will be routinely involved in the process of service user engagement, assessment and treatment. The

service will use of assertive outreach model of engagement - a failure to engage should not lead to case closure. This may involve working closely with the Assertive Outreach Service.

3.5 EIP Clock Rules

The clock for the two-week pathway starts when a referral has been flagged as 'suspected first episode psychosis' or is recognised as such upon receipt be it at access point or any of the service points in the pathway. Referrals would usually be made either to a central triage point ('single point of access') or direct to an EIP service. Referrals may come from any source and may be internal (for example from a children and young people's mental health service, a CMHT, an inpatient ward, prison or forensic mental health services) or external (for example from a GP, carer, school or self-referral).

The clock starts regardless of referral source, the age of the person being referred or comorbidities such as learning disabilities, substance misuse, personality disorder or autism. The only exemptions from these arrangements will be referrals of people who are experiencing psychotic symptoms with a confirmed organic cause, for example, brain diseases such as Huntington's and Parkinson's disease, HIV or syphilis, dementia, or brain tumours or cysts.

Non-attendance or cancellations will not stop or pause the clock for the national access and waiting time standard.

Treatment will be deemed to have commenced when the person:

- **has had an initial assessment; AND**
- **has been accepted on to the caseload of an EIP service capable of providing a full package of NICE-recommended care; AND has been allocated to and engaged with by an EIP care coordinator**

3.6 Discharge/ Length of Stay

The majority of cases will have up to a 3-year model of involvement, given the high risk of relapse and the significant risk of suicide in the first few years of a psychotic illness. Service users may be considered for earlier discharge from the Service where their needs and the predicted risk of relapse and /or suicide indicate this would be appropriate.

Retention of service users within the service may be appropriate – for example if engagement and stabilisation were problematical early in the course of illness, in cases with CAMHS involvement, or where discharge at point of transition may be seen as further undermining stability, if the service's caseload capacity allows. Service users who have been seen by the

service with minimal evidence of psychosis but where psychosis has not developed will normally be discharged after six months**.**

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Retention of service users within the service may be appropriate – for example if engagement and stabilisation were problematical early in the course of illness, in cases with CAMHS involvement, or where discharge at point of transition may be seen as further undermining stability, if the service's caseload capacity allows. Service users who have been seen by the service with minimal evidence of psychosis but where psychosis has not developed will normally be discharged after six months.

3.7 Discharge/Signposting

- Prior to discharge, all service users shall be supported to integrate within the community.
- All service users shall have a Relapse plan that supports them after discharge to include how to manage their condition, how to manage any recurrence of the condition and where and when to access services if required in the future. It shall focus on developing mental health resilience.
- All service users shall be encouraged and signposted to complete a Wellness Recovery Action Plan (WRAP)
- When a service user no longer requires further intervention, they shall be signposted to local community support services and provided with self-help material
- To improve access and support to maintain people in work or support them to return to work.
- Support them into education or training and where appropriate support people to find meaningful activity including volunteering and community support
- The Five ways to wellbeing shall be embedded within all aspects of delivery

The following discharge possibilities will be considered:

- If stable and well, discharge to Primary Care
- If well, but there are some concerns about the ability of primary care to care for the person, continue support via outpatient contact and consider shared care or support to primary care.

- If continuing symptoms persist, refer for ongoing care from the relevant Community Mental Health Team
- If unstable and fulfilling criteria for outreach refer to the Outreach Teams

Prior to discharge the Care Plan will be reviewed and all involved agencies/individuals will be consulted and updated regards to any unmet need and/or risk. A comprehensive discharge plan will be provided, indicating current treatment and procedures for re-referral to the team (provided it is within the 3-year period of when they first had contact with the team).

3.8 Population Covered

- The service is for people who meet the acceptance criteria and are registered with a general practitioner within the Clinical Commissioning Group (CCG) areas of NHS North Staffordshire and NHS Stoke-on-Trent. For people who are not registered with a GP, the service will be provided but support given to enable the person to register.
- The service shall ensure its services are accessible and also actively promotes services to hard to reach groups with a specific emphasis on improving accessibility and service usage for vulnerable communities.

Hours of Operation.

The service shall operate 24 hours a day, 7 days a week. It is expected the service will have core hours (9am-5pm) and will provide out of hours opportunities for patients on an individual basis 24 hours a day, 7 days a week.

3.9 Acceptance, Exclusion Criteria and Thresholds

The service is available to individuals who are experiencing symptoms of psychosis for the first time. Where there is a strong suspicion they may be developing psychosis the team may offer a period of extended assessment until this is confirmed. In all cases the duration of untreated psychosis (DUP) should be less than 3 years.

Exclusion criteria :

This service would not generally be appropriate for people who do not specifically meet the acceptance criteria. If, following initial assessment, there is ambiguity about the appropriateness of service intervention the service will provide support until the ambiguity is resolved from an EI perspective and EIP clock rules will remain until the ambiguity is resolved.

- The service is not usually suitable for people aged less than 14 years old. However, where appropriate, individuals under the age of 14 years experiencing positive psychotic symptoms and those who are strongly suspected of having such symptoms and are high risk MAY be offered a service.

- Where there is evidence of protracted DUP longer than 3 years it is unlikely that the individual would benefit from an early intervention approach. The decision to offer a service will be taken on a case by case basis.

3.10 Interdependence with other Services/Providers

The service will have interdependence with inpatient services - to ensure age appropriate, least restrictive/stigmatized settings, e.g. alternatives to hospital care such as crisis accommodation and if hospitalisation is required, age, gender and culture appropriate accommodation is arranged.

There will also be interdependence with Adult Acute Inpatient and CAMHS Specialised Commissioning (Tier 4) where inpatient admission required for under 16 year olds

Local CAMHS services – referral from, co-operation with and discharge to and/or transition planning

Interlinks with adult CMHTs – referral from, co-operation with and discharge to where required Assertive Outreach – where difficulty in getting engagement

Access Team – referrals

Substance Misuse services – for those service users with Dual Diagnosis / Comorbidity GPs and Primary Care – education, referral, discharge and shared care

The service will also work with statutory agencies such as Local Authority Services, Health

Services, Police, and independent, private and voluntary agencies which provide Mental Health Services/Children Services or services not specific to mental health but who may be involved in early identification and which can also help promote social inclusion.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

https://www.nice.org.uk/guidance/cg155

http://www.nice.org.uk/guidance/qs102

https://www.nice.org.uk/guidance/cg178

http://www.nice.org.uk/guidance/qs80

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/early-intervention-in-psychosis-teams-(eipn)/epin-standards-first-edition.pdf?sfvrsn=fd9b4a0f_2

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.9 Applicable Quality Requirements (See Schedule 4)

5.10 Applicable CQUIN goals (See CQUIN Schedule)

6. Location of Provider Premises

The Provider's Premises are located at:

Early Intervention Service
The Hope Centre

Upper Huntbatch Street
Hanley

Stoke on Trent

Staffordshire
ST1 2BX

Service Specification No.	A08
Service	Criminal Justice Mental Health Team (CJMHT)
Commissioner Lead	Joanne Marsh, Senior Locality Commissioning Manager, CCG
Provider Lead	Josey Povey, Associate Director North Staffordshire Community Mental Health Services
Period	1 April 2022 – 31 March 2023
Date of Review	As required

1. Population Needs

1.4 National/local context and evidence base

The Criminal Justice Mental Health Team is a multi-agency mental health team set up to work within criminal justice settings in order to support addressing the needs of individuals with multiple complex vulnerabilities including health and social care needs.

The CJMH Team service is intended to help meet the needs of those with mental health problems who are in contact or have a history of contact with the criminal justice system.

Although crime is rarely committed as a direct result of mental ill-health, there is strong evidence which shows that offenders have complex and wide-ranging needs, including homelessness, drug and alcohol dependency, literacy and numeracy problems and mental health issues. Offenders are a highly marginalised and socially excluded group and evidence suggests that up to 60% of the prison population for example have a mental health need with more than one in ten prisoners having a severe mental illness.

Furthermore, custody can exacerbate an individual's mental ill health, heighten vulnerability and increase the risk of self-harm and suicide.

2. Outcomes

2.1 <u>NHS Outcomes Framework Domains & Indicators</u>

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	

Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	

2.2 Local defined outcomes

The Criminal Justice Mental Health Team provides an innovative screening service available at several points within the criminal justice system. This allows early detection and assessment of offenders with mental health problems to ensure appropriate and effective.

The team's primary role is to provide liaison between mental health and criminal justice services to ensure an individual's needs are understood and taken into consideration as well as supporting diversion for those with needs to appropriate services to address identified needs and reduce potential for re-offending.

The team work with individuals from court offering screening assessment, referrals, signposting and short-term support to address identified needs, support communication with criminal justice agencies and aid engagement with appropriate services.

2.3 Key Principles

- embrace vulnerability as a starting point for recovery, growth and change.
- focus on building people's own resilience and resources. Seeing the whole person rather than a collection of discrete problems to solve.
- have a thorough knowledge of how to apply clinical and psychological practice within Criminal Justice settings.
- continually adapt to changing environments, learning from the people who need the service being at the heart of everything delivered.
- build effective partnerships that will stand the test of time. Partnerships that change lives for the better.
- give people choices when choice seems impossible.

2.4 Outcomes

The CJMHT will be expected to deliver the following outcomes;

- Early identification of mental health need at the point of arrest

- Appropriate liaison with mental health service providers
- Appropriate diversion of those most in need (though balancing that need with protection of the public)
- Advice to the police and court throughout the criminal justice process
- Demonstrate improved long-term outcomes, both in improving the mental health of this population and reducing re-offending rates
- Gather data to assess cost effectiveness of the service across the criminal just system
- Proactive screening
- Re-engage people with services who may need to
- Help reduce re-offending behaviour
- Take referrals from a wide range of professionals within the criminal justice system, health and social care, the voluntary sector, and from mental health services
- Help the police where appropriate make a fully informed risk assessment of any individual assessed by the team
- Help with advice and information to probation officers
- Direct involvement and input to multi-agency public protection arrangements
- Provide advice in pursuing court reports

3. Scope

3.1 Aims and objectives of service

It is widely acknowledged that people with a mental illness have a much more difficult task getting the right treatment once in prison, either on remand or serving a sentence, which is why it is vital they are effectively screened at the earliest opportunity after

The service, working in partnership with commissioners and Criminal Justice Agencies, will support the local implementation of the Bradley Report. The primary aim and objective will be to support offenders to cease or return to offending behaviour and liaise with Criminal Justice Agencies with a view to diverting offenders from the Criminal Justice System whilst maintaining the balance between the individual's mental health needs and protecting the public. Specifically this will be achieved by;

- identifying whether an individual is on a Care Programme Approach, is suffering severe mental illness or needs to be assessed under the Mental Health Act

- providing mental health screening, assessment, referral and liaison for offenders.
- provide ongoing support if the individual ultimately goes to court, passing on relevant information to the court-based team member. Subsequently, oral and written evidence can then be given to the court regarding the mental health of the person to help determine the best criminal justice/ mental health
- offer flexible referral criteria to maximise engagement for a client group that is hard to reach.
- provide neutral information for the court services about an individual's mental health, our team is able to help inform timely decisions about the correct report requirement and reduce the number of people with mental health problems who are in prison unnecessarily. Crucially, the service has the potential impact of helping to reduce re-offending
- ensure robust risk assessment and management of offenders with mental health problems.
- support other teams within NSCHC in managing service users who may have a

history of or are presenting with offending behaviour.

- ensure offenders with mental health needs have equal access to health and social care support.
- ensure effective communication exists between NSCHC and Criminal Justice Agencies.
- the team will act as a conduit for the formal exchange of information between different parts of the criminal justice system, health service and social care service.
- the team is expected to have forged strong links with the police, courts and probation service to ensure we are best placed to meet the needs of the people we
- work in partnership with Criminal Justice Agencies and 3rd sector providers to

ensure the health and social care needs of offenders with mental health needs are met.

3.2 Service description/care pathway

The service will offer a range of interventions and support from the multi-disciplinary team including:

- mental health assessments.
- time limited, intensive co working with other teams in NSCHT, (normally post prison release).
- clinical risk management advice.
- the single point of contact for NSCHT in MAPPA.
- support for offenders with a mental health need in Court.

- improved communication between criminal justice agencies and health and social care agencies
- diversion of users from the criminal justice system into an appropriate place
- referral to other health and social care providers
- reduce re-offending through enhanced risk management including liaison with MAPPA and expertise in the use of structured risk assessment tools.
- intensive, time limited co-working; to enhance transition arrangements (e.g. on release from prison)

The primary objective of the service is to facilitate the earliest possible diversion of offenders with mental disorders from the criminal justice system and provide good signposting to appropriate local health and social care services. The team aims to provide the best and most effective service by addressing the wider range of problems associated with people who have some degree of mental disturbance and warrant a range of care, support and, in some cases, treatment.

3.3 Population covered

The service is for people who are registered with a general practitioner within the Clinical Commissioning Group (CCG) areas of NHS North Staffordshire and NHS Stoke-on-Trent. For people who are not registered with a GP, the service will be provided but support given to enable the person to register.

3.4 Any acceptance and exclusion criteria and thresholds

Referral criteria

The service is aimed squarely at those

- who come into contact with the criminal justice system because they have committed, or are suspected of committing, a criminal offence and:
- who may be acutely or chronically mentally ill
- who have neuroses, behavioural and/or personality disorders
- who have a mental health problem as a function of alcohol and/or substance misuse
- who are suspected of falling into one or other of these groups

- who are recognised as having a degree of mental disturbance, even if this is not sufficiently severe to come within the MHA criteria
- have a history of self-harm/risk of self-harm s have a history of contact with mental health services
- considered the circumstances of their offence is unusual
- considered their behaviour in custody has been unusual
- whom criminal justice staff have concerns about their mental health
- people known to mental health services

Referrals will be accepted from these services:

- Police
- Court staff
- Magistrates
- Probation service
- Solicitors
- Defence advocates
- Crown prosecutors
- Custody services
- Health professional
- Social Care professional

The service will be provided for people aged 18 years and above who have mental health problems and are engaged or have been engaged with the Criminal Justice System.

Referrals will be taken from health professionals and criminal justice agencies and will be allocated for assessment within 7 working days.

The team operates Monday to Friday from 9 to 5.

It excludes those with a diagnosis of alcohol and substance misuse only.

3.5 Hours of Operation

9am-5pm – Monday to Friday.

The team will also have a daily presence in the North Staffordshire Justice Centre (Monday to Friday), and avail weekly clinics within local probation offices, probation approved premises and community rehabilitation companies.

3.6 Interdependence with other services/providers

Critical relationships for the CJMHT will be with Criminal Justice Agencies such as Staffordshire Police, Staffordshire and West Midlands Probation Trust and H.M. Court Services. Equally key relationships need to be maintained with Adult Community MH Services at North Staffs Combined Healthcare and MH Prison In-Reach Teams located in HM Prisons.

The service will also link with NHS England who provide the Liaison and Diversion service from the Northern Area Custody facility in Etruria.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

Mental health of adults in contact with the criminal justice system

https://www.nice.org.uk/guidance/ng66

https://www.nice.org.uk/guidance/qs163

https://pathways.nice.org.uk/pathways/health-of-people-in-the-criminal-justice-system

Mental Health Treatment Requirements (for guidance and information only)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/391162/Mental_Health_Treatment_Requirement_-_A_Guide_to_Integrated_Delivery.pdf

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

Centre for mental health briefing 2018: Probation services and mental health

https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/briefing45_probation.pdf

Reforming women justice report 2011.

http://www.prisonreformtrust.org.uk/Portals/0/Documents/Women%27s%20Justice%20Taskforce%20Report.pdf

Prison reform trust evaluation.

file:///C:/Users/manhco/Downloads/Responding-to-the-needs-of-women-in-the-criminal-justice-system-evaluation-January-2018.pdf

The Bradley Report (2009)

Breaking the Cycle (2011)

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.11 Applicable Quality Requirements (See Schedule 4)

5.12 Applicable CQUIN goals (See Schedule 3)

6. Location of Provider Premises

The Provider's Premises are located at:

The Hope Centre

Upper Huntbach Street

Hanley

Stoke on Trent

Service Specification No.	A09
Service	Parent and Baby Day Service (inc. Perinatal Wave 2)
Commissioner Lead	Joanne Marsh, Senior Locality Commissioning Manager – North Division, CCG
Provider Lead	Jane Munton-Davies, Associate Director, Stoke Community Mental Health Services
Period	1st April 2022 – 31st March 2023
Date of Review	**See 22/23 SDIP**

1. Population Needs

National/local context and evidence base

The Confidential Enquiry into Maternal Deaths (2004) found that psychiatric disorders are the leading cause of maternal death in the UK, with over half of these deaths being due to suicide. Depression is the mental disorder associated with the greatest number of suicides, and the majority of suicides in pregnant and postnatal women (about 60%) occur in the 6 weeks before delivery and the 12 weeks after delivery.

Although suicide is the most common cause of death in the perinatal period and women with severe mental illnesses have high rates of suicide postnatally, the rates of suicide for women in the antenatal and postnatal periods are lower than that for the whole female population.

It is not possible to estimate the likely numbers in the population experiencing severe common mental health problems – either depression or anxiety, since the prevalence rates are linked to the number of deliveries rather than the female population as a whole.

Psychosis linked to birth is reported to occur in between 1 or 2 per 1,000 deliveries, but there is evidence that many are pre-existing conditions exacerbated by childbirth, so it is not possible to estimate the numbers likely to be affected.

2. Outcomes

2.1 <u>NHS Outcomes Framework Domains & Indicators</u>

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	

2.2 Local defined outcomes

3. Scope

3.1 Aims and objectives of service

The Parent & Baby Day Service specialises in the early detection, assessment & treatment of mental health problems associated with pregnancy and the first year of child birth.

The service also assists in the management of pre-existing mental health difficulties through the antenatal and postnatal period.

3.2 Service description/care pathway

The service is available to mothers for preconceptions advice and following a confirmed pregnancy and up to 12 months after birth. It offers a range of support and psychological treatments to assist in the service user's recovery. The service also offers support to the parent's family and carers.

<u>Referral</u>

Referrals are accepted from:

- Maternity services e.g. Midwives, Obstetricians

- Primary care services e.g. GP, Health Visitor
- Community Mental Health Teams
- Specialist mental health services
- Social Services

Referrals are usually made directly to the service on standard Parent and Baby Day Service forms. Referrals in letter format may be accepted. No telephone or self-referrals will be accepted.

Advice regarding criteria for referral can be obtained from the duty professional nurse at the Parent and Baby Day Service between 8.30 am and 4.30 pm Monday to Friday or the Nurse-in-Charge 8.30 am to 4.30 pm at weekends.

Where the patient requires hospital admission, professionals may contact the Parent and Baby Day Service for support/advice.

Response Times

All referrals will be processed within 3 working days of receipt and a decision made as to appropriateness for the Service. If the referral is accepted then an initial assessment appointment will be arranged. If the referral is not appropriate, the referrer will be informed and where appropriate an alternative course of action will be suggested. A service user will be offered an appointment within two weeks of acceptance to the service. Depending upon the circumstances they may be seen sooner, priorities are determined by the level of urgency. The service does not operate as a crisis response team.

Following assessment, a care plan will be agreed.

Interventions

The following interventions are offered:

- Medical reviews with Consultant Psychiatrist.
- Assessment and treatment
- 1:1 support.
- Anxiety management group.
- Relaxation group.

- Self-esteem group.
- Couple work.
- Relationship play.
- Nursery support.
- Baby massage.
- Coffee morning.
- Triple P Parenting programme.

Discharge

Once a service user has completed their treatment they are usually discharged back to the care of their GP.

Should a service user need more input from secondary mental health services the service user will be referred to their nearest CMHT.

After discharge some service users are referred to services in the voluntary sector for support.

If a service user fails to engage with the service they will receive a letter asking them to make contact with the service to discuss their care. Should they not reply then they are discharged from the service as it is assumed they no longer require our service. The original referrer would be informed.

Staffing

The service is made up of:

- Unit Manager
- Psychology
- CPN's/ nurses/ Care Co-ordinator
- Health Care Support Worker/Nursery Nurse
- Administration Support
- Consultant Psychiatrist
- Occupational therapist

- Peer support workers

3.3 Population covered

The service is for adults (aged 16 or over) who are registered with a general practitioner within the Clinical Commissioning Group (CCG) areas of NHS North Staffordshire and NHS Stoke-on-Trent. For people who are not registered with a GP, the service will be provided but support given to enable the person to register.

3.4 Any acceptance and exclusion criteria and thresholds

Acceptance Criteria:

Preconception

Preconception counselling can be made available but only for women with existing severe and enduring mental health difficulties and those who have had a previous puerperal psychosis.

Antenatal

Referrals will be accepted for women following a confirmed pregnancy that are experiencing a moderate to severe depression. Where the delivery date is imminent it may be advisable to delay referral until after the baby's birth. Additional positive indicators for referral are:

- Family history of bi-polar illness
- History of schizophrenia
- Previous puerperal psychosis
- Previous depression resulting in hospital admission
- Pathological anxiety related to childbirth

Postnatal

Referrals will be considered for women in the postnatal period with babies less than 12 months of age experiencing moderate to severe mental health difficulties.

Additional indicators for referral would be:

- Severe depression following childbirth
- Puerperal psychosis or manic episode
- Anxiety related to childbirth/infant
- Attachment disorder
- Existing severe mental health difficulties where professionals wish to seek specialist advice or co-work
- Child Protection issues but only where the mother has significant mental health problems (see note on exclusions below)

As women within the service will only be seen until the baby is 12 months of age, where referral is made where the baby is at 10/11 months treatment options will be limited though assessment/ signposting can be offered if appropriate.

Exclusion Criteria

The service will not generally be appropriate in the following circumstances:

- If a baby is subject to child protection proceedings which may result in the baby not being reunited with its mother then we are unable to offer a care package to the mother.
- Mild to moderate depression
- Following miscarriage, stillbirth or termination of pregnancy
- Mental health problems related to specific factors which require specialist intervention but are unrelated to pregnancy/childbirth

3.5 Interdependence with other services/providers

The service works closely with the Brockington Mother and Baby Unit at Stafford to which a woman could be admitted with her baby if appropriate.

The service works with the Acute Home Treatment team where the mother is experiencing a mental health crisis

The service works closely with Community Mental Health services for those mothers requiring continuing support from secondary care post discharge

The service works closely with Primary Care and GPs to ensure appropriate support continues to be provided post discharge
4. Applicable Service Standards
4.1 Applicable national standards (eg NICE) http://guidance.nice.org.uk/CG45/NICEGuidance/pdf/English **4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)** **4.3 Applicable local standards**
5. Applicable quality requirements and CQUIN goals
5.13 Applicable Quality Requirements (See Schedule 4) **5.14 Applicable CQUIN goals (See Schedule 3)**
6. Location of Provider Premises
Parent & Baby Day Unit, Broad Street, Hanley, Stoke-on-Trent, Staffordshire, ST1 4EQ

Service Specification No.	A10
Service	Community Triage
Commissioner Lead	Nicola Bucknall, Commissioning Manager – North Locality
Provider Lead	Rachael Birks, Associate Director Acute and Urgent Care
Period	1st April 2022 – 31st March 2023
Date of Review	As required

1. Population Needs

National/local context and evidence base

Crisis and acute mental health services are a crucial part of mental health care, helping people when they are most unwell and vulnerable (MIND, 2012). Staffordshire Police respond to a large number of calls from members of the public whom the police identify as being in emotional distress / mental crisis. In the majority of cases, Staffordshire Police are the first or only agency to engage with the individual at the place of the incident.

A report by Staffordshire's Police and Crime Commissioner identified, during a two-month period, 911 police incidents recorded as "Mental Health" across Staffordshire. Of these, 855 related to "concern for safety" and 56 related to "mental health". The table below breaks down these incidents across Staffordshire and Stoke-on-Trent.

Concern for Safety	**Number of Incidents**	**Mental Health**	**Number of Incidents**
North Staffordshire	**182**	**North Staffordshire**	**9**
Stoke-on-Trent	**304**	**Stoke-on-Trent**	**16**
South Staffordshire	**369**	**South Staffordshire**	**31**
Total	**855**	**Total**	**56**

The volume of incidents appears to be impacting on the number of people detained under Section 136 of the Mental Health Act particularly in North Staffordshire/Stoke-on-Trent. The comparatively higher number of Section 136 detentions has led to increased numbers of individuals being held in police custody due to a shortage of health based Places of Safety. This is a trend that is mirrored nationally. (House of Commons Health Select Committee 2013).

Emerging services across England are offering alternatives to police forces in terms of frontline support and safe places to divert people to. Examples of these include;

- First Response Street Triage Team – Middlesbrough
- The Sanctuary – Moss Side, Manchester

Interventions offered by these services are underpinned by evidence from a report by MIND

"Listening to Experience" which showed that individuals wanted care, safety, someone to listen and something to do as opposed to a medically dominant response. Many people preferred more peer support from people who have themselves experienced mental health problems.

Further evidence to support this type of intervention for mental health problems includes:

- 'No Health without Mental Health' (DOH 2011).
- Quality Standard for Service User Experience in Adult Mental Health (NICE 2011)
- Joint Commissioning Panel for Mental Health RCP, Acute Care Guidance
- Independent Commission on Mental Health and Policing Report (2013)
- Mental Health Crisis Care: Commissioning Excellence (MIND 2012)
- Post-legislative scrutiny of the Mental Health Act 2007, House of Commons Health Select Committee, 2013
- 'A Criminal Use of Police Cells?'- (HMIC, HMIP, CQC, HIW 2013)
- Mental Health Crisis Concordat (HMG 2014)

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	☐
Domain 2	**Enhancing quality of life for people with long-term conditions**	☐
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	☐
Domain 4	**Ensuring people have a positive experience of care**	☐
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	☐

2.2 Local defined outcomes

The expected outcomes from the service are as follows;

- Reduction in the amount of police time spent inappropriately managing people in emotional distress / mental crisis.
- Reduction in the amount of ambulance personnel time spent inappropriately managing people in emotional distress / mental crisis.
- Reduction in the number of people detained under Section 136 of the Mental Health Act.
- Reduction in the number of people detained under Section 136 of the Mental Health Act managed in police custody.
- Improved understanding by service commissioners of the needs of people in emotional distress / mental crisis.
- Increased levels of police skills and knowledge to manage people in emotional distress / mental crisis.
- Improved pathways to alternative services that can support people in emotional distress / mental crisis.
- Reduction in repeat episodes of emotional distress / mental crisis
- Reduction in A&E attendances resulting from reducing repeat episodes of emotional distress / mental crisis.
- A high level of satisfaction from service users.

3. Scope

3.1 Aims and objectives of service

- To provide a dedicated resource for use by Staffordshire police officers that will enable a multi- agency approach across health, social and police services for individuals in emotional distress / mental crisis.
- To ensure a timely assessment of an individual's emotional distress / mental crisis when in contact with the police in a community setting.
- To create a safe and appropriate pathway for people dealt with by the police where the Mental Health Act is not applicable.

3.2 Service description/care pathway

From 1st April 2015 it has been agreed that the operational hours for the service will be available from 4pm to 2am 365 days per year. This is a reduction in operational hours of 2 hours per day. This will enable the team, consisting of three experienced mental health professional to be available and benefit from mandatory training and additional provider specific training. It also allows Staffordshire Police to allocate an officer for the full shift period and expand the provision for more officers to work with the team.

Additionally, a Support Time Recovery Worker, (STR), will be available during weekdays for individuals referred by the mental health professionals to support social care issues.

The basis of the service is a Community Triage Team will;

- Provide a dedicated response to Staffordshire Police Officers;
- Provide an immediate response by telephone or face-to-face;
- Be located in Hanley Fire Station;
- Provide the following interventions;

    - Assessment - All referrals receive an Initial Screening Assessment over the telephone by the mental health practitioner and where the need indicates, a further face-to-face Comprehensive Assessment of need.

    - Care planning and short term support - Where the referred person has identified needs but onward referral to specialist mental health services is not appropriate, support is offered to resolve urgent or short-term issues and will be provided by the STR for a fixed period not exceeding 14 days.
    - Referral to Specialist Mental Health Services - Where the assessment process indicates that the referred person has needs that should be met through the provision of secondary or specialist mental health services, then the mental health practitioner will refer the individual on to the relevant service to receive on-going treatment and support.
    - Referral to Section 136 Suite - Where the assessment process indicates that the referred person requires a Section 136 to be applied, they should be referred to the Section 136 Suite at the Harplands Hospital as per the Staffordshire-wide Section 136 Policy.

- Referral and Signposting to other Services - Where the assessment indicates that the person referred does not have needs that should be met through specialist mental health services, they will be either referred or signposted to the appropriate services.

- Work closely with other providers within Northern Staffordshire and outside organisations, including voluntary sector organisations depending on the need of the individual.

3.3 Population covered

People aged 16 and above who;

- come into contact with Staffordshire Policing Teams covering Newcastle, Staffordshire Moorlands and Stoke-on-Trent; and
- are in emotional distress / mental crisis; and
- require an immediate assessment of need so that their care can be quickly and safely managed by the most appropriate agency.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- NICE Guidelines and Quality Standards
- CQC – The Essential Standards

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

4.3 Applicable local standards

- Mental Health and Wellbeing: A Joint Strategy for Stoke-on-Trent 2011-15
- Joint Commissioning Strategy for Services for Adults (18-64 years) with Mental Health Needs in Staffordshire 2008-2012 (Staffordshire Joint Commissioning Unit 2008).
- Local Key Performance Indicators
- Acute Standard Operational Procedures

- Trust Policies and Guidelines
- Trust Vision, Values and Strategic Goals
- Back to Essentials

- People using the service and their families or carers, feel they are treated with dignity and respect and the support they receive is sensitive to the circumstances of each individual including cultural sensitivity.
- People in emotional distress / mental crisis are assessed and supported to promote their best health and wellbeing outcomes and are enabled to access support and information which helps them to manage their needs.
- Timely intervention and reablement mean that people and their carers will be less dependent on statutory and emergency services.
- People using the service feel actively involved in their assessment and supported in managing their emotional distress /mental crisis.
- When people present with emotional distress / mental crisis, the support they receive takes
- place at the point of crisis or distress and is responded to at the point of referral.
- People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.
- A well trained workforce is enabled to work with people with complex needs who will work
- with service users and carers promoting recovery models.
- People using the service are asked about their experience of support and this is used to monitor and improve the service.

5. Applicable quality requirements and CQUIN goals

5.15 Applicable Quality Requirements (See Schedule 4)

5.16 Applicable CQUIN goals (See Schedule 3)

6. Location of Provider Premises

Not applicable

Service Specification No.	A12
Service	Autism Assessment Service (Non LD)
Commissioner Lead	Denise Dyke, Commissioning & Service Redesign Manager, CCG
Provider Lead	Jane Munton-Davies, Associate Director, Community Mental Health Teams – Stoke
Period	1st April 2022 – 31st March 2023
Date of Review	As required

1. Population Needs

1.1 National/local context and evidence base

The term autism describes qualitative differences and impairments in reciprocal social interaction and social communication, combined with restricted interests and rigid and repetitive behaviours, often with a lifelong impact. In addition to these features, people with autism frequently experience a range of cognitive, learning, language, medical, emotional and behavioural problems. These can include a need for routine and difficulty understanding other people, including their intentions, feelings and perspectives. Approximately 50% of people with autism have an intellectual disability (IQ below 70), and around 70% of people with autism also meet diagnostic criteria for at least 1 other (often unrecognised) physical or mental health problem, such as sleep problems, eating problems, epilepsy, anxiety, depression, problems with attention, dyspraxia, motor coordination problems, sensory sensitivities, self-injurious behaviour and other behaviour that challenges (sometimes aggressive). These problems can substantially affect the person's quality of life, and that of their families or carers, and lead to social vulnerability. The clinical picture of autism is variable because of differences in the severity of autism itself, the presence of coexisting conditions and the differing levels of cognitive ability, which can range from profound intellectual disability in some people to average or above average intellectual ability in others. The provision of services for people with autism is varied across England and Wales. The Autism Act (2009) requires each local authority area to develop a local autism strategy for the provision of health and social care services for people with autism (aged 14 years and older).

Nationally, the UK has a prevalence rate of just over 1% of the population who can be said to be on the Autistic Spectrum. National prevalence studies (Baird et al 2006, Baron-Cohen 2009) put the adult prevalence rate for Autism at just over 1% of the population. Therefore, for the Stoke on Trent and North Staffordshire CCG's area this equates to an estimated population of 4,700 people with Autism

The national strategy for autism, "Fulfilling and Rewarding Lives" was updated in April 2014 in the "Think Autism" document published by the Department of Health. The services covered by this specification are in line with the contents of national strategies.

The word "spectrum" is used because the characteristics of the condition vary from one person to another and there are varying degrees of impact on the individual.

The three main areas of difficulty experienced by all people with autism are:

- Social communication, particularly using and understanding facial expressions, tone of voice and abstract language
- Social interaction – recognising or understanding other people's emotions and feelings and expressing their own
- Social imagination – understanding and predicting other people's behaviour, making sense of abstract ideas and imagining solutions beyond their own perspective

Individuals struggle in different ways depending on how the condition affects them. Many people with an ASC may also experience some form of sensory sensitivity or under-sensitivity to sounds, touch, taste, light or colours and often prefer to have a fixed routine.

'All adults with autism are able to live fulfilling and rewarding lives within a society that accepts and understands them. They can get a diagnosis and access support if they need it, and they can depend on mainstream public services to treat them fairly as individuals, helping them make the most of their talents.' Fulfilling and Rewarding Lives (Department of Health, 2010)

1.2 Local strategic context

Locally this service will respond to concerns raised by service user and carer groups about their ability to access diagnostic services for ASD.

The service will be a local diagnostic service for adults who may have Asperger's Syndrome or a high-functioning autism condition and for whom no current pathway exists within adult learning disability or mental health services in Stoke on Trent and North Staffordshire.

The service will provide a timely diagnosis in respect of individuals who may present with conditions that would place them on the Autism Spectrum which will help the individual, families, friends, partners, carers, professionals and colleagues to better understand and manage their needs and behaviour

The service will be a locally managed diagnostic service that incorporates best clinical practice with respect to adults with ASD

The service will provide advice regarding ongoing support post diagnosis

The service will build on previous recommendations made in the Staffordshire and Stoke on Trent Adults Autism Strategy 2013 – 2016

NICE Clinical Guideline 51, Autism: recognition, referral, diagnosis and management of adults on the autistic spectrum was issued in January 2014. The guideline recommends the establishment of a multi- disciplinary team for adults with autism including clinical psychologists, nurses, occupational therapists, psychiatrists, social workers, speech and language therapists and support staff.

This specialist team should have a key role in the co-ordination of:

- Specialist diagnostic and assessment services,
- Specialist care and interventions
- Advice and training to other health and social care professionals
- Support in accessing and maintaining contact with housing, educational and employment services
- Support to families, partners and carers where appropriate

The services will have an open door ethos and will develop and support mainstream services to ensure they are autism friendly and accessible by people living with autism whatever they needs. The service will be asset based- building on what a person can do and not on deficits. The service will be truly person centered by supporting people to have the time they need to understand any issues they have; by building on what they like and are good at to support them in the world they wish to inhabit.

The Service will work with families and carers of people referred to it to ensure that they fully understand issues linked to ASC. Families and carers will be offered or signposted to support in their own right where appropriate

2. Outcomes

2.1 <u>NHS Outcomes Framework Domains & Indicators</u>

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	Y
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	Y
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	Y

2.2 Local defined outcomes

This specialist team will have a key role in the co-ordination of:

- Specialist diagnostic and assessment services,
- Specialist care and interventions
- Advice and training to other health and social care professionals
- Support in accessing and maintaining contact with housing, educational and employment services
- Support to families, partners and carers where appropriate.

3. Scope

3.1 Aims and objectives of service

Aim

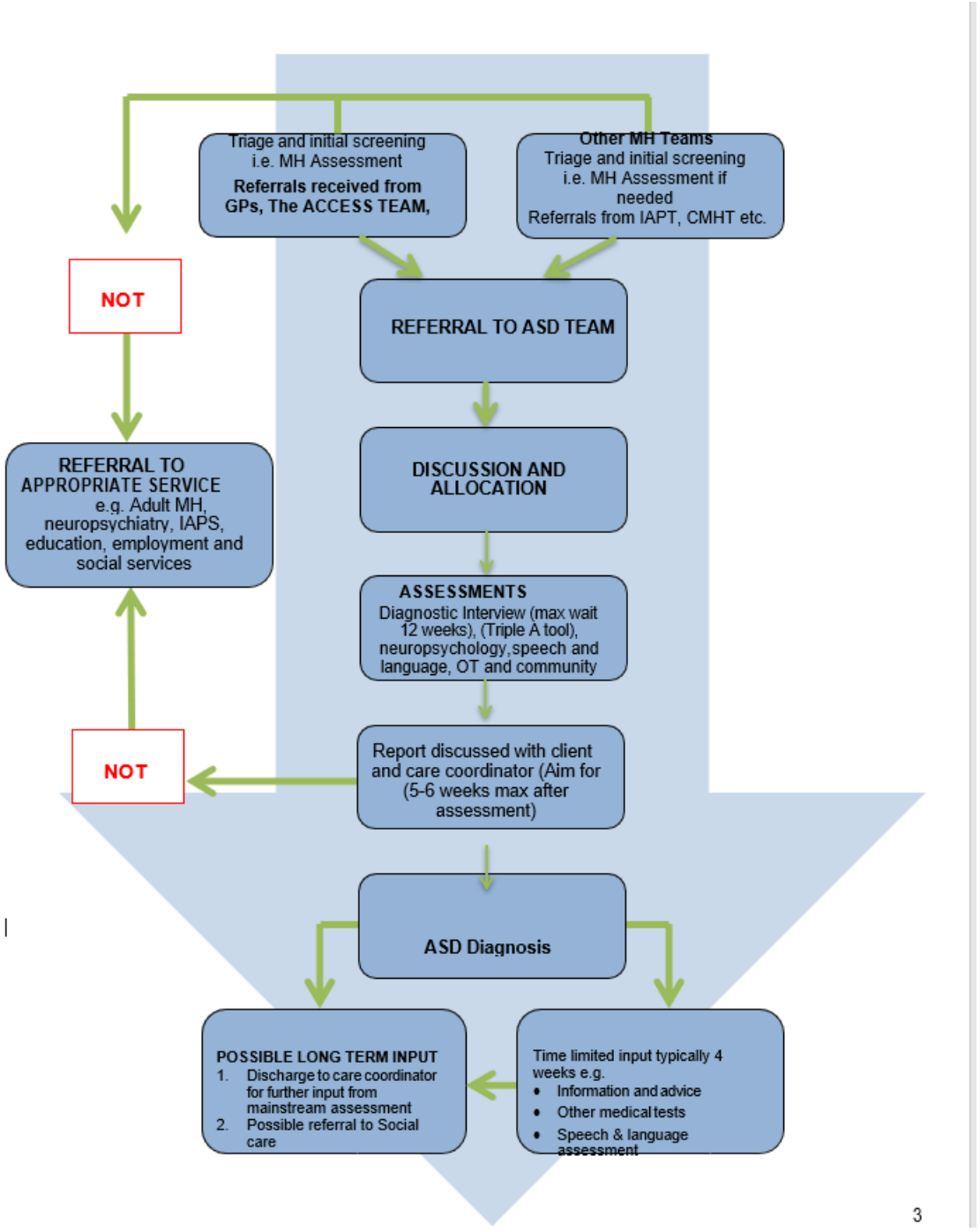
To provide an assessment and diagnostic service to adults with a suspected Autistic Spectrum Disorder (ASD) in Stoke on Trent and North Staffordshire.

Objectives

- To enable adults with a suspected ASD and who do not have a diagnosed learning disability to obtain a timely formal diagnosis of their condition
- To assist health and social care professionals in other services to work with people who have an ASD and require on-going support
- To signpost people with ASD to other agencies and sources of support as appropriate

- To act as a knowledge hub on ASD for the local health and social care economy

3.2 Service description/care pathway



The service specification takes account of the Autism Act 2009 and subsequent national guidance including, Fulfilling and Rewarding Lives, 2010; Think Autism. Fulfilling and Rewarding Lives, the strategy for adults with autism in England: an update, April 2014; Autism – National Institute for Health and Care Excellence, January 2014), that set out clear expectations for health and social care services to enable people with autistic spectrum conditions to live fulfilling lives.

People with Aspergers Syndrome however usually criteria fall outside the eligibility for Adult Learning Disability Services (and would typically not want to use such services). Equally, Adult Mental Health services have also traditionally excluded people with ASD from their eligibility criteria. Consequently people with ASD have often 'fallen through the net' and experience additional problems with depression, anxiety and social exclusion.

There is currently no cure and no specific treatment for Asperger's Syndrome. However, as understanding of the condition improves and services continue to develop, people with Asperger's Syndrome have more opportunity than ever of reaching their full potential. There are many approaches, therapies and interventions, which can improve an individual's quality of life, as outlined in the NICE guidance.

Some people see a formal diagnosis as an unhelpful label; however, for many a diagnosis:

- Helps the individual, families, friends, partners, carers, professionals and colleagues to better understand and manage their needs and behaviour
- Is the key needed to open the door to specialised support,

The ASD Assessment Service will provide assessment and diagnostic capacity and some elements of short term interventions to support people diagnosed with an Autistic Spectrum Disorder.

Short term interventions will be tailored to the needs of individual patients, but may include:

- Neuropsychological assessment
- Sensory assessment
- Speech and language assessment
- Assessment of challenging behaviour
- Facilitation of other medical tests as required
- Advice on the 3 core features of ASD (Social interaction, communication and repetitive behaviour)

The service will aim to complete 95% of assessments for those eligible within 12 weeks of receiving a referral for an individual. The standard is not measured at 100% given that there is an element of recognition some service users might not engage.

Longer term support will be provided by generic services which may be provided by Combined Healthcare or by other agencies such as Social Care with support and advice provided by the ASD Assessment Service as required.

The ASD Assessment Service will also provide advice and support to colleagues supporting people with an ASD who have other co-morbid conditions. Support may include:

- Early identification of crisis triggers
- Advice on crisis and contingency planning
- Advice on prescribing and medicines management
- Advice for families, partners and carers
- Advice on adaptations to physical environments
- Signposting to existing support such as employment support

3.3 Population covered

The service will cover people over the age of 18 registered with a Stoke on Trent or a North Staffordshire General Practitioner.

17 year olds who have been receiving a therapeutic service from the CYP ASD service will be referred directly to the adult service if they need therapeutic input past their 18th birthday.

3.4 Any acceptance and exclusion criteria and thresholds

The services will NOT generally work with:

- People aged under 18
- People registered with a GP outside of Stoke on Trent or North Staffordshire
- People who have a learning disability (who are catered for by existing learning disability services)
- People who after use of an initial screening tool by secondary care, a mental health professional, or a registered GP or and are judged to be in need of an additional diagnosis or referred in by third sector organisations.

The service is to be provided in such a way that ensures:

- Relevant and timely diagnosis is made of an individual
- An option for future management and support of individuals is identified in line with the National Strategy for Autism and NICE guidelines (CG6142, Adults with Autism).

3.5 Interdependence with other services/providers

The ASD Assessment Service will need to work alongside a range of other services and agencies to provide advice and support to colleagues to enable other teams and services to work effectively with people who have a diagnosed ASD.

These will include:

- Generic mental health teams in Combined Healthcare
- Improving Access to Psychological Services (IAPT) services
- Social Care Teams, including Independent Futures
- Independent Sector agencies

The service will be responsible for internal pathways and/or protocols for referrals to other services both for clients who have been diagnosed with an ASD and for those clients who have been assessed as NOT having an ASD.

Referrals from General Practitioners, other linked services and Community Mental Health teams will come via a single point of entry. The relationship between the provider and primary care is therefore key to ensure robust pathways and appropriate access to diagnosis. The service is also expected to develop a robust pathway with the relevant Local Authorities for onward referrals and support for clients and their families where appropriate

3.6 Accessibility / Acceptability

People with autism or who suspect they have autism may have certain characteristics which present them with challenges in the way they communicate with others and their ability to be in situations that require some degree of social interaction.

The service provider is therefore expected to ensure that they provide:

- appropriate and accessible information to individuals about their service

- appropriate and accessible information about timescales for diagnosis
- a suitable accessible environment for individuals if the diagnosis is to take place in a clinical or other environment away from the person's home
- clear information to people about what will and may happen post diagnosis

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

NICE guidance on Autism

https://www.nice.org.uk/guidance/qs51/resources/autism-pdf-2098722137029

The Adult Social Care Outcomes Framework 2014–15 (Department of Health, November 2012)

https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-2014-to-2015

NHS Outcomes Framework 2014–15

https://www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/autism-and-asperger's-syndrome-information-for-parents-carers-and-anyone-who-works-with-young-people

4.3 Applicable local standards

It is expected that the service provider(s) will ensure appropriate policies are in place in line with current health and safety and risk management guidance together with appropriate mechanisms for recording, auditing and monitoring feedback on service provision and actions taken to resolve issues.

Safeguarding

When the team is involved in assessing people with a suspected Autistic Spectrum Disorder they must consider whether there are any safeguarding concerns relating to the service user or other people in the environment. Where there is concern for the safety of the service user or others then it is the responsibility of the professional identifying the concern to notify the appropriate authority. This includes escalating concerns about the safety or appropriateness of an individual's placement with immediate effect.

The service team should ensure that at the point safeguarding issues emerge they are referred in line with local safeguarding policies and procedures. This is the responsibility of the professional leading the assessment and should be clearly communicated to other partners. For example if the assessment clearly identifies that the adult being supported by Team is at risk or a carer for another adult or a parent or lives in a household with children and that these carer/ children may be at risk because of the adult/ parental behaviour, then the responsibility to refer rests with the worker who identified this issue and a copy of the written referral retained in the service user's record. The service team should follow local procedures making reference to referral processes to ensure that the correct local safeguarding process is adhered to for the protection of adults and children. The Provider will ensure that all staff receive training relating to Adult Protection, the Mental Capacity Act and Deprivation of Liberty Safeguards on a multi-agency basis.

5. Applicable quality requirements and CQUIN goals

5.17 Applicable Quality Requirements (See Schedule 4)

5.18 Applicable CQUIN goals (See Schedule 3)

Service Specification No.	A13
Service	Urgent and Emergency Liaison Mental Health Services **(all age)**
Commissioner Lead	Nicola Bucknall, Commissioning Manager – North Locality
Provider Lead	Rachael Birks, Associate Director Acute and Urgent Care
Period	1 April 2022 – 31 March 2023
Date of Review	As required

1. Population Needs

National/local context and evidence base

1.1. Proper funding for mental health crisis care and its full integration within NHS urgent and emergency care was one of the commitments made in the Five Year Forward View for Mental Health.

1.2. Improving liaison mental health provision has been a long-standing goal for the NHS; in April 2016, as part of the CCG Improvement and Assessment Framework 2016/17, CCGs were also asked to agree plans and funding for a core 24 (24 hours, 7 days a week) mental health liaison service by 2020/21.

1.3.

Liaison psychiatry, also known as Psychological Medicine, is the medical specialty concerned with the care of people presenting with both mental and physical health symptoms regardless of presumed cause. The specialty employs the bio-psychosocial model being concerned with the inter-relationship between the physiology, psychology and sociology of human ill health.

Liaison psychiatry services are designed to operate away from traditional mental health settings, in the main in acute care hospital emergency departments and wards, and medical and surgical outpatients.

Liaison psychiatry teams are multidisciplinary, clinically led by a consultant liaison psychiatrist who will have higher specialty training in general adult psychiatry with sub specialty endorsement in liaison psychiatry. Many liaison psychiatrists will also have higher specialty training in general medicine or general practice.

Liaison psychiatrists as well as being in a position to diagnose and prescribe can also formulate and deliver brief psychotherapeutic interventions most commonly cognitive behavioural therapy or psychodynamic interpersonal therapy.

Whilst the national guidelines focus largely on the front end of the urgent care pathway liaison teams provide vital support, treatment and care planning for complex patients on general wards with both physical and mental health comorbidities.

The multidisciplinary liaison psychiatry team will typically include specialist mental health nurses, clinical psychologists, occupational therapist and social workers. As this is an all age service expertise and skills in assessing and treating children and young people will also be an integral part of the service skill mix.

Physical and mental health is inextricably intertwined. Long-term conditions (LTCs), such as diabetes, are associated with high rates of mental illness. Some 70% of NHS spend goes on the treatment of LTCs, a great deal of which currently involves treatment in acute hospitals.

The mental health needs of a patient in a physical health care setting often remain undiagnosed and therefore untreated. To optimise the physical health care of patients, it is essential that their mental health and wellbeing are addressed at the same time.

Mental disorder accounts for around five per cent of A&E attendances, 25% of primary care attendances, 30% of acute inpatient bed occupancy and 30% of acute readmissions self-harm accounts for between 150,000 and 170,000 A&E attendances per year in England.

Medically Unexplained Symptoms (MUS) may account for up to 50% of acute hospital outpatient activity.

13–20% of all hospital admissions and up to 30% of hospital admissions via A&E at weekends are related to alcohol.

One quarter of all patients admitted to hospital with a physical illness also have a mental health condition that, in most cases, is not treated while the patient is in hospital.

Most patients who frequently re-attend A&E departments do so because of an untreated mental health problem.

Two thirds of NHS beds are occupied by older people, up to 60% of whom have or will develop a mental disorder during their admission.

Rates of emergency hospital admissions (all ages) for intentional self-harm have increased in Stoke-on-Trent since 2010/11

The 2016/17 local emergency admissions rate for self-harm in Stoke-on-Trent was ranked the 4th highest in England (out of 148 areas)

Local data shows that the number of admissions for CYP (across North Staffordshire and Stoke-on-Trent) presenting with self-harm and other mental health needs, has increased on average 6% each year over the last 4 years; with a total rise of 34% from 2014/15

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely** **Reducing premature death in people with serious mental illness**	**ü**
Domain 2	**Enhancing quality of life for people with long-term conditions** **Ensuring that people feel supported to manage their condition** **Enhancing quality of life for people with mental illness**	**ü**
Domain 3	**Helping people to recover from episodes of ill-health or following injury** **Improving outcomes from planned treatments** **Improving outcomes from injuries and trauma**	**ü**
Domain 4	**Ensuring people have a positive experience of care** **Friends and Family Test**	**ü**

	Improving peoples experience of out-patient care **Improving access to primary care services** **Improving experiences of healthcare for people with mental illness**	
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm** **Patient Safety Incidents Reported** **Reducing the incidence of avoidable harm**	**ü**

2.2 Local defined outcomes

Mental Health Liaison Service will realise the following key objectives:

- Good service user experience and care outcomes
- Improved access to mental health care for a population with high morbidity (self-harm, depression, dementia)
- Will support the 4 hour A&E target by providing a timely and appropriate response to emergency and urgent referrals related to mental health, dementia and addiction
- Reduced re-admissions and lengths of stay for people with mental illness
- Improve the access of adults & CYPs who self-harm to community-based support services & to reduce the number of NEL for reasons associated with self-harm
- Support the reduction of LOS and DTOCs (delayed transfers of care) particularly for older adults with dementia
- Reduced risk of mental health related adverse events in the acute hospital
- Enhance knowledge and skills of acute hospital clinicians

- Support the acute trust to be compliant with legal requirements under the mental health act (2007) and mental capacity act (2005)

3. Scope

3.1 Aims and objectives of service

The overall aim of the Urgent and Emergency Liaison Psychiatry Service is to support identification and improve treatment and care of hospital patients of any age, within the University Hospital of North Midlands (UHNM) Royal Stoke site, experiencing mental health disorders, including the target groups of Dementia, Delirium or Depression, substance misuse (Drug and Alcohol) issues and self-harm; and to provide mental health in-reach support to the North Staffordshire NHS Community Hospitals

- To provide Emergency Departments and Acute Care Hospital Inpatient units with rapid access to specialist mental health assessment 24/7
- To provide effective mental health interventions in Emergency Departments and Acute Care Hospital Inpatient Wards to optimise the time the patient spends in these environments aimed at reducing length of stay
- To provide liaison with community services for mental health (including those for children and young people), addictions, housing, care support and primary care to accelerate the onward care of people into a community setting
- To provide education and advice to general hospital staff in the recognition and management of common mental health presentations including depression and anxiety, self-harm, alcohol and addictions, personality and eating disorders, psychosis, delirium and dementia
- To provide advice and support to hospital staff in respect of the safe operation of the mental health act and complex capacity assessments
- Support hospital services to adhere to NICE guidance criteria for managing mental health and psychological conditions and those co-morbid with long-term conditions by developing joint protocols and working practices
- Improve pathways from UHNM (Royal Stoke site) and the North Staffordshire NHS Community Hospitals, to appropriate mental health services for children and young people, older adults, drug and alcohol services, learning disability services and other appropriate follow-on support services

- Improve dialogue and information transfer between acute, community and primary care services around treatment planning and on-going care management.

3.2 Service description/care pathway

Partnership working

The service will develop joint governance arrangements with UHNM – to monitor quality, patient safety, make service improvements, Service representatives will attend relevant UHNM operational team meetings, provide training both ad hoc and via a formal programme.

The service will develop data sharing agreements so that relevant care / risk plans can be shared where this is in the best interests of the patient and staff supporting the persons care.

In addition to direct clinical work with patients the service will provide liaison and training for staff at UHNM (Royal Stoke site) and the North Staffordshire NHS Community Hospitals intended to reduce stigma associated with mental illness (including dementia, memory problems and confusional states) alcohol and drug misuse, improve identification, increase psychological mindedness and increase the ability of staff to manage and care for patients with a range of mental health, behaviour symptoms, alcohol and drug misuse conditions, including children and young people.

The service model will offer mental health assessment, treatment, supervision and training intended to build mental health skills and capacity amongst general staff at UHNM (Royal Stoke site) and the North Staffordshire NHS Community Hospitals. A formal, rolling plan of education will be agreed with the Chief Nurse in UHNM and will be tailored to Directorates training needs

The mental health liaison service will work closely with neighbouring mental health trusts ensuring that appropriate clinical information sharing processes and clear clinical pathways are in place to enable continuing support for the patient.

Service

The Mental Health Liaison Service will provide a multi-professional psychiatric liaison service to UHNM (Royal Stoke site) and North Staffordshire NHS Community Hospitals. There will be one point of access and this will be communicated to all clinical areas. The team will receive

electronic referrals from the UHNM clinical referral system. In cases of emergency the team will also accept telephone requests.

Mental Health Liaison team will provide access to mental health assessment, brief interventions and treatment, onward referral and liaison with staff at UHNM (Royal Stoke site) and North Staffordshire NHS Community Hospitals.

The Mental Health Liaison Service will be provided to any patient (all age) who presents with or who are thought to have an underlying mental health need, and specifically those in the target groups of Dementia, Delirium or Depression, and those with alcohol or substance misuse issues or self-harm.

The Mental Health Liaison Service will be fully integrated into the acute setting at UHNM (Royal Stoke site) and provide an in-reach service to the North Staffordshire NHS Community Hospitals, working closely with clinicians in the acute and community hospital settings to ensure that patients' needs are met holistically balancing physical, social and psychological needs of the individual and their carer/s.

The service will operate in line with relevant Mental Health Legislation, NICE Clinical Guidelines and current evidenced best practice:

Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults – Guidance - **Referred to as EBTP standards throughout this specification**

Triage and response times

All referrals will be triaged and a decision made whether the referral is considered emergency, urgent or routine

In the case of an emergency referral (which may occur both in Emergency departments and on wards) the service will review the patient face to face within 1 hour as per the EBTP standards

Urgent referrals will be clinically triaged (not face to face) within 1 hour, receive a full assessment and have a developed care plan within 24 hours. The referrer will be notified of likely response time as this will be dependent on risks identified in the clinical triage.

Emergency, urgent and routine referral criteria will be clearly defined (in line with guidance) and communicated to UHNM staff

The following definitions are taken from NHS England's guidance on urgent and emergency mental health liaison and apply equally to urgent and emergency community response.

Emergency: An unexpected, time-critical situation that may threaten the life, long-term health, or safety of an individual or others, and requires an immediate response.

For example, patients who are actively suicidal, attempting to self-harm, risk of harm to others, refusing lifesaving treatment, patients trying to abscond who have not yet been assessed

Urgent: situations that require a face-to-face response, are serious, where an individual may require timely advice, attention or treatment, but it is not immediately life-threatening.

For example, patients requiring assessment (without immediate risk), possible diagnosis of mental illness, patients requiring input /changes to a management plan,

Routine: where an urgent or emergency face to face response is not required, for example where telephone advice is sufficient, or the person is signposted to another service.

For example, planned follow up of patients already assessed, telephone advice for patients scored as low risk on the referral proforma, advice on local services to signpost to

As part of the triage process patient records, including mental health notes on Lorenzo, UHNM I-portal, will be reviewed and information sourced from children's social services where relevant,

Assessments should not be delayed because the patient is receiving medical care. Each case should be considered following triage / further discussion with the referring clinician.

If a patient cannot engage in the process due to serious medical concerns, effects of medical treatment, levels of consciousness, severe intoxication, the assessment should be delayed and the EBTP 'clock stopped'. The mental health liaison team should remain updated about the patient's condition and assess as soon as possible.

The liaison psychiatry team will support the ED department to meet the 4-hour clock targets and this will be taken into consideration at the point of clinical triage.

The MHLT will also support short stay portals turnaround times e.g. AMRA, CDU so that where possible and clinically appropriate admissions are avoided.

Assessment and Intervention / treatment

Children's referrals will come from Children's ED and inpatient areas, These assessments are more complex and in depth, and often include multiple discussions with other agencies. Contact with social services is made to ensure all background knowledge is available to the assessing practitioner regarding social issues. Should the patient require admission, then appropriate forms should be completed and liaised with NHS England. If a MHA is required then a discussion needs to be had to ensure a CAMHS consultant can complete the assessment where possible.

The mental health liaison team will facilitate and coordinate the process for any patient requiring a Mental Health Act assessment. linking in with Section 12 approved doctors, MHA teams, AMHPs

Patients brought to A&E under S136 of the Mental Health Act will be accepted by the mental health liaison team within 1 hour unless safety concerns are identified and the Police are required to remain on site. (see annex 2 of this specification)

For all patients:

- Any known current risks and relevant risk management plans will be shared with UHNM staff

- Following assessment a care plan will be agreed with the patient and staff at UHNM (Royal Stoke site), and clearly documented in the UHNM medical notes.

Where appropriate the Mental Health Liaison Team will provide ongoing support during the admission and these arrangements will be clearly documented in the management plan and communicated to ward staff

- Support the decision and process to transfer patients to a more appropriate inpatient setting

When CYP require access to a mental health in-patient bed but there is a delay >4 hrs, they are looked after in a suitable paediatric facility with appropriate in-patient facilities, regular CAMHS review, trained registered mental health nurses and paediatric nursing support.

The treatment plan will depend on the assessed need and may include the following

- The provision of information and advice to patients/service users including harm reduction
- The provision of information and advice to ward staff at UHNM (Royal Stoke site) and the North Staffordshire NHS Community Hospitals
- Brief interventions at UHNM (Royal Stoke site), particularly for older people, drug and alcohol issues
- Support on-going care by providing treatment and liaison during an in-patient stay at either UHNM (Royal Stoke site) or one of the North Staffordshire NHS Community Hospitals Information about onward referral or follow up post discharge

The service will make direct referrals to services in the community including Access Team, Community Mental Health Teams, Home Treatment Teams, Community Drug and Alcohol Services, IAPT Services, Learning Disability Services, CAMHS, Memory Services, Reablement and Intermediate Care Services, Voluntary and Independent Care Sector Provider Organisations etc.

Liaise with OOA community services for OOA patients to ensure appropriate support on discharge

The service will contact the patient's community keyworker (if already known to mental health services) so that the persons care plan and risks can be updated and appropriately managed. For children and young people, this would be the relevant children and young people mental health service.

Organise a follow up appointment with the relevant community services depending on risk and inform the patient before discharge from UHNM

The mental health liaison team will support arrangement of transfers of patients requiring mental health inpatient beds, tier4 CAMHS beds.

Transport arrangements (e.g., Rapid and Secure) is the responsibility of the ward / department the patient is on

See pathway and response times in Annex 1 below

Enable data, record and information sharing across mental health services, general hospitals, primary care and other health and social care services to ensure:

- Rapid, appropriate and safe treatment
- Timely and effective community-based follow-up
- That patient up-to-date histories and preferences are known.

Days/Hours of Operation

- The Urgent and Emergency Liaison Psychiatry service will operate 7 days a week
- The service will operate 24 hours a day
- Community Hospital cover is Monday-Friday 8am – 4pm excluding Bank Holidays

Referral Criteria

The Mental Health Liaison service will accept and prioritise referrals for all patients (all age) presenting with

- Mental Health problems
- Dementia, Delirium or Depression
- Substance (Drug and Alcohol) misuse (OOA in the absence of alcohol liaison services)

Service Response Times

Emergency referral response times (A&E, portals or wards)

- The liaison mental health team should **respond to a referral within one hour**. A response consists of a review to decide on the type of assessment needed and arranging appropriate resources for the assessment

- Within four hours of arriving in an ED or being referred from a ward it is recommended that the person should:
    - *have received a full biopsychosocial assessment if appropriate, and*
    - *have an urgent and emergency mental health care plan in place, and*
    - *as a minimum, be en route to their next location if geographically different, or*
    - *have been accepted and scheduled for follow-up care by a responding service, or*
    - *have been discharged because the crisis has resolved*

OR

    - *have started a Mental Health Act assessment.*

•

Urgent referral response times

An urgent referral would usually be received from a ward in a general hospital, and relate to an emergent or deteriorating mental health problem that is not considered a crisis requiring an emergency response. The majority of urgent referrals are likely to be for older adults or children and the response should be carried out by staff with training in working with these groups

- The mental health liaison team should respond to the referrer within one hour of receiving a referral from a general hospital ward to ascertain its urgency, the type of assessment needed, and resources required for the assessment

- The urgent mental health liaison assessment should be completed within 24 hours of receiving a referral.

- Within 24 hours of presenting with a suspected urgent mental health problem on a general hospital ward it is recommended that a person should:

    - *have received a full biopsychosocial assessment, and*
    - *have an urgent and emergency mental health care plan in place, and*
    - *at a minimum, be enroute to their next location if geographically different, or*
    - *have been accepted and scheduled for a follow-up appointment by a responding service, or*
    - *have been provided advice or signposted, where appropriate.*

If at any point the person's mental health deteriorates, or it is deemed they require an emergency response, including a Mental Health Act assessment, the emergency pathway should be followed.

Discharge Process

- The Mental Health Liaison Team will provide mental health time limited assessment/interventions based on assessed clinical need.

- Patients/Service Users will be discharged from the mental health liaison service based on sound clinical judgement and completion of assessment / intervention

- Urgent and Emergency Liaison Psychiatry will **directly refer** patients as appropriate to other services to support follow on care

- For patients already known to mental health / addiction services, both verbal and written contact, will be made with the patients care coordinator / keyworker.

- Where patients require **immediate** follow up due to clinical risk i.e. acute home treatment team appointments will be made and communicated with the patient prior to discharge

- Where risks are low patients will be signposted / encouraged to self-present at community resource centres if already in contact with CMHT

- Mental Health Liaison Service will ensure timely communication with GP's, Primary Care and other services to support continuity of follow-on care.

- The Mental Health Liaison Service will ensure patient and carer information is available and pathways are in place to a range of services to include: advice and support services, i.e. Dementia Advisors, Carers Association, Self-Harm Clinics, Drug and Alcohol Support services, CAMHS self -help options including support groups, AA, voluntary and independent sector support services

Care Pathways

The service referral / access pathways to support this specification can be found in **Annex 1,**

The service will work with UHNM to co-develop care pathways and joint operational policies for the treatment / management of commonly presenting mental health presentations

The service will work to locally agreed S136 / MHA assessment pathways

Workforce

- The Mental Health Liaison Service will be supported by business and administrative support enabling effective communication and information exchange with surrounding agencies.
- The provider shall have sufficient and skilled staffing to provide care, clinical need and safety to deliver the outcomes required by patients who access the service as outlined in this service specification
- As well as the Core set of consultants (Including expertise in self-harm, older people and addictions) and nurses, liaison psychiatry teams should be a multidisciplinary workforce (e.g. the service may include, social workers, occupational therapists, STR workers, drug and alcohol workers, CAMHS and learning disability nurses)The service should be responsive and the skill mix should reflect the demands of the service
- The Mental Health Liaison Service should have access to professional expertise in psychological therapies.

- The Mental Health Liaison Service should have strong links with Health Psychology and the locally commissioned High Volume User Service which supports frequent attenders to ED
- The staff will undertake appropriate training to ensure they have specific competencies relevant to the speciality of liaison psychiatry as recognised by the Royal College of Psychiatry, Royal College of nursing.
- Staff will be up to-date with best practice and training will be developed in line with any new relevant policy and guidance

3.3 Population covered

This service is for all people of any age attending UHNM that present with mental health needs as described in the criteria above

The service will assess and treat patients regardless of their GP registration, address or immigration status., this includes looked after children from other authorities.

3.4 Any acceptance and exclusion criteria and thresholds

- The Mental Health Liaison Service will provide a:
- mental health service to patients of any age presenting to A&E or on inpatient wards at UHNM (Royal Stoke site)
- a mental health in-reach service to patients within the North Staffordshire NHS Community Hospitals

Exclusions

- Those patients with capacity who refuse to be assessed by the service are excluded however attempts to engage them with mental health services should be made using the appropriate legislation

3.5 Interdependence with other services/providers

The Mental Health Liaison service will forge strong working relationships and develop joint pathways with the hospital-based alcohol liaison team and high volume users team.

Direct referral pathways to the following services (as a minimum) will be put in place:

- Memory Services
- ACCESS / Home Treatment Teams
- Drug and alcohol services
- CAMHS
- Neuropsychiatry

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

- Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults – Guidance, November 2016 NHS England, the National Collaborating Centre for Mental Health and the National Institute for Health and Care Excellence

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- Framework for Routine Outcome Measurement in Liaison Psychiatry (FROM-LP), Faculty of Liaison Psychiatry, Royal College of Psychiatrists, May 2015

- Quality Standards for Liaison Psychiatry Services, Fourth Edition 2014, Royal College of Psychiatrists

- Facing the Future: Standards for children in emergency care settings, June 2018, Royal College of Paediatrics and Child Health

- NICE Guideline Self-Harm 2011, https://pathways.nice.org.uk/pathways/self-harm

4.3 Applicable local standards

- 'Mental Health is Everybody's Business' pan Staffordshire Mental Health Strategy (2015)
- Crisis Care Concordat Implementation Plan

5. Applicable quality requirements and CQUIN goals

See Schedule 4 and Schedule 3.

6. Location of Provider Premises

The Mental Health Liaison Service Team will be based on site at UHNM (Royal Stoke) and provide an in-reach service to North Staffordshire NHS Community Hospitals.

Royal Stoke University Hospital, University Hospitals of North Midlands NHS Trust,

Newcastle Road, Stoke-on-Trent, Staffordshire, ST4 6QG

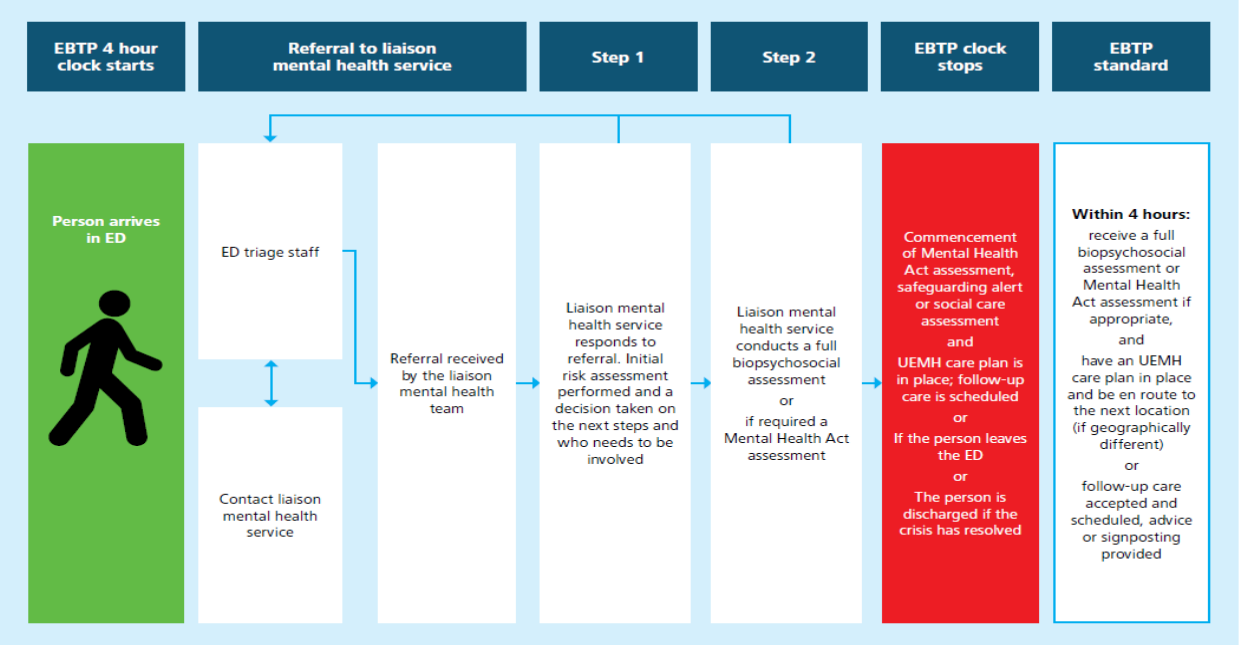
Annex 1

Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults – Guidance Version number: 1 https://www.england.nhs.uk/wp-content/uploads/2016/11/lmhs-guidance.pdf

First published: November 2016

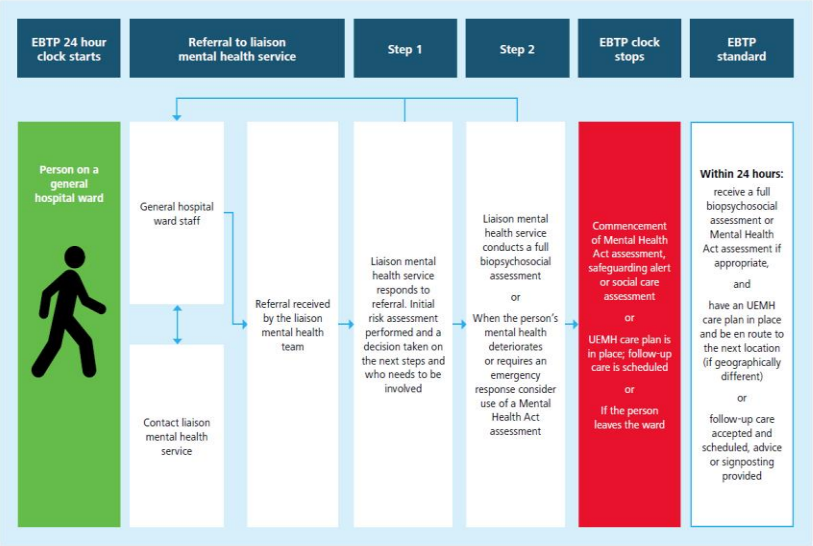
Prepared by: NHS England, the National Collaborating Centre for Mental Health and the National Institute for Health and Care Excellence Classification: OFFICIAL

Figure 1: Summary of the pathway for an emergency response from liaison mental health services



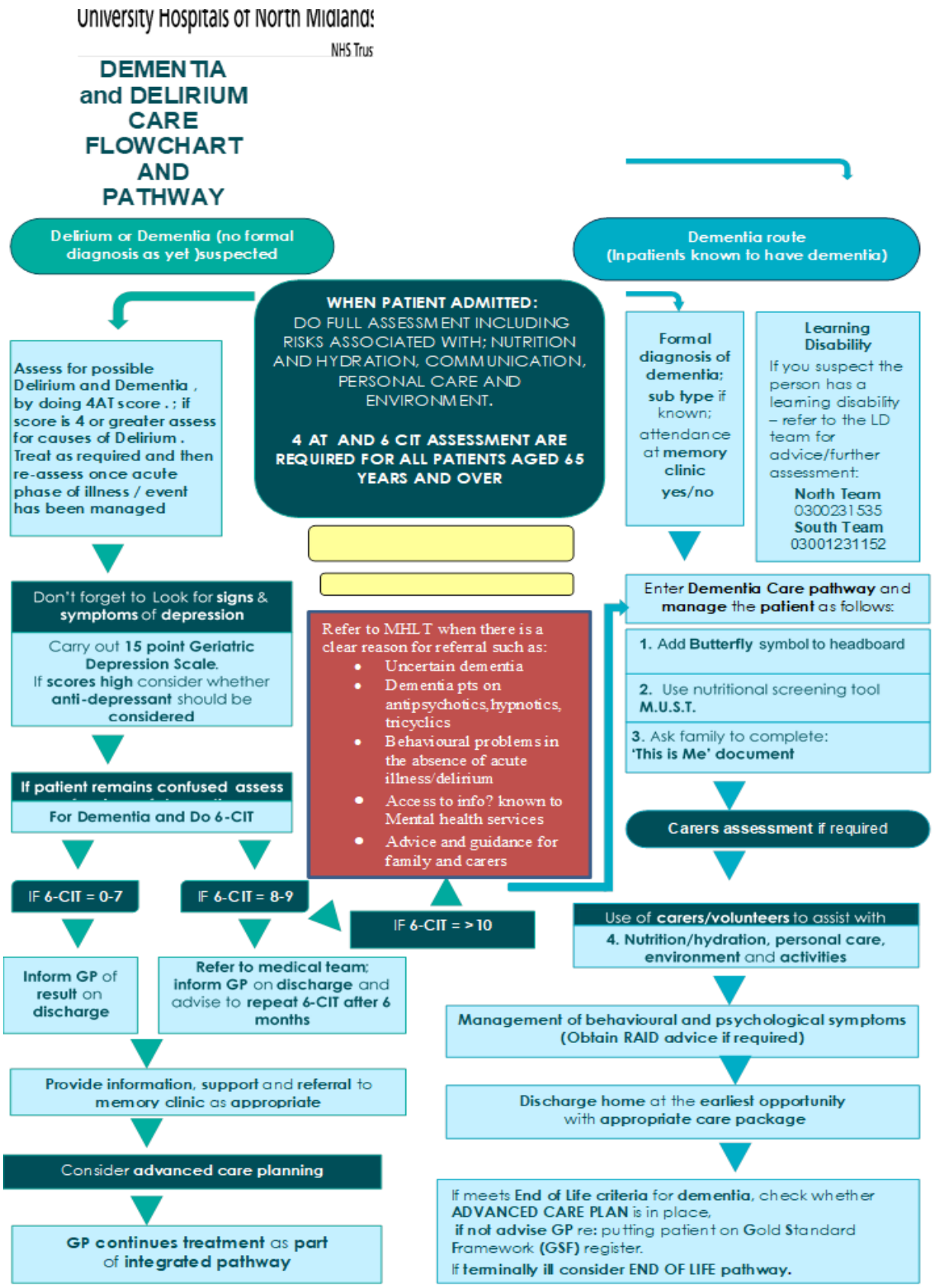
Key: UEMH = urgent and emergency mental health

Figure 2: Summary of the pathway for an urgent response from liaison mental health services



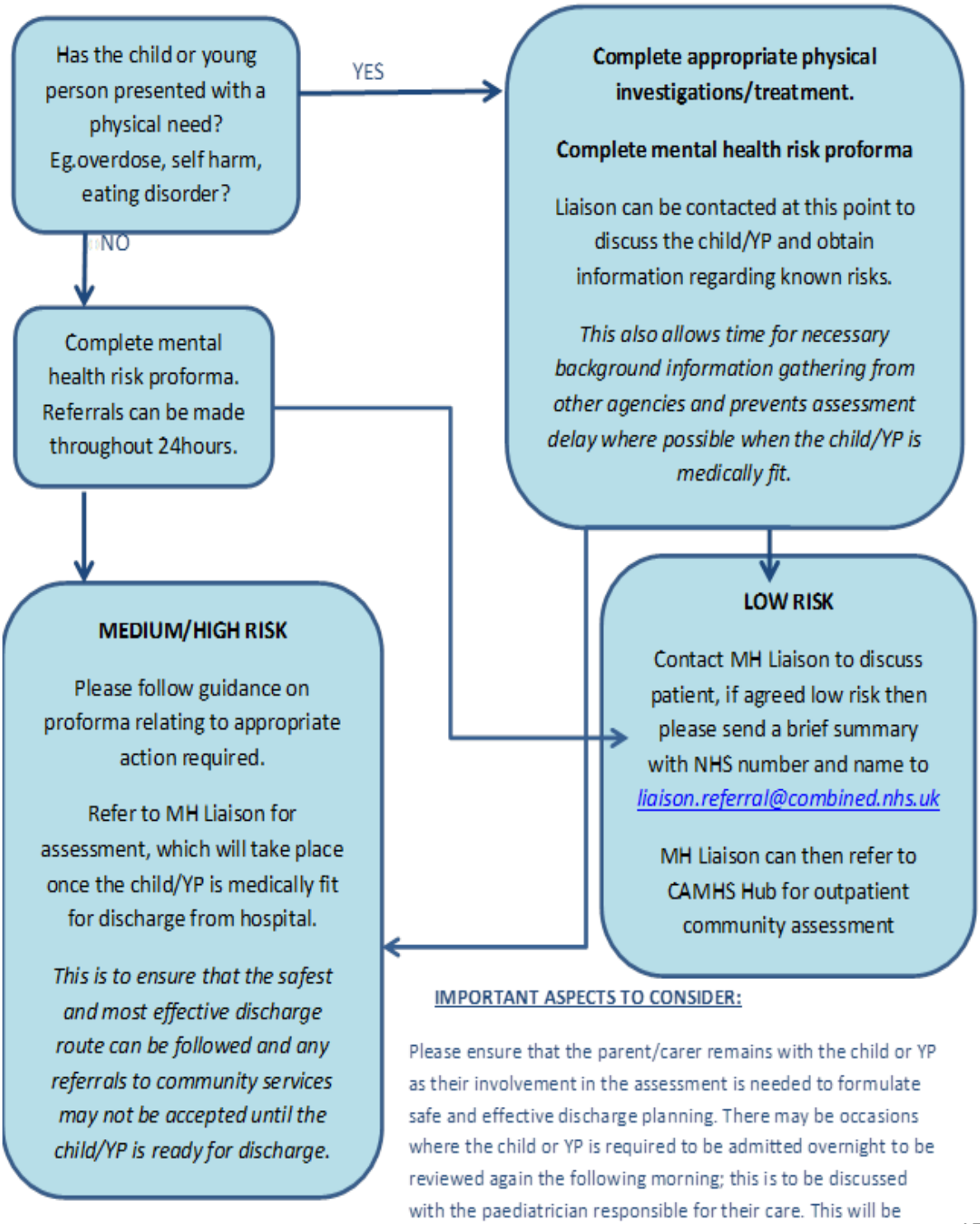
Key: UEMH = urgent and emergency mental health

Annex 2 - Care Pathways



Children and Young Person Referral Pathway for Mental Health Liaison Team from A&E.

PATHWAYS FOR CED MEDICS AND NURSING TEAM.

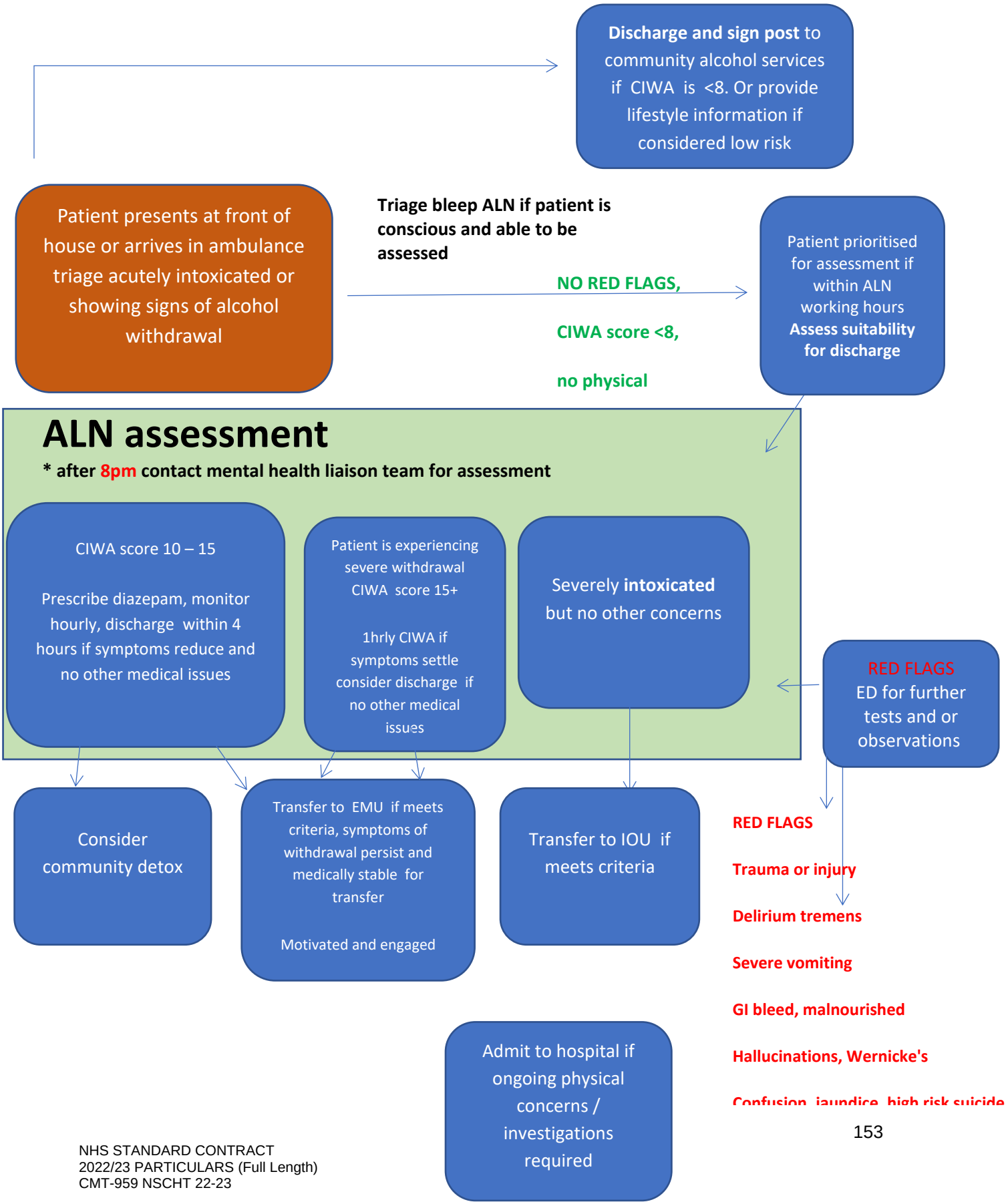


IMPORTANT ASPECTS TO CONSIDER:

Please ensure that the parent/carer remains with the child or YP as their involvement in the assessment is needed to formulate safe and effective discharge planning. There may be occasions where the child or YP is required to be admitted overnight to be reviewed again the following morning; this is to be discussed with the paediatrician responsible for their care. This will be avoided where possible but is sometimes a necessary part of ensuring that all relevant agencies are contacted and involved.

FOR SUPPORT, INFORMATION OR FURTHER GUIDANCE PLEASE CONTACT THE TEAM ON 679159 OR 07860593935 REFERRALS AND ADVICE CAN BE MADE THROUGHOUT 24HOURS.

Alcohol intoxication and alcohol acute withdrawal pathway



Service Specification No.	A14
Service	Cancer Psychology
Commissioner Lead	Joanne Marsh – Senior Locality Commissioner
Provider Lead	Fiona Platt, Associate Director, Specialist Services
Period	01/04/2022 – 31/03/2023
Date of Review	As required

1. Population Needs

National/local context and evidence base

Many people affected by cancer suffer from psychological distress as a direct result of a cancer diagnosis.

The psychological effects of a cancer diagnosis are often felt long after treatment has finished. Many of these issues are identified too late to prevent costly interventions and unnecessary use of health services. With timely, effective support many psychological problems can be dealt with in a more cost-effective manner or avoided altogether.

Providing appropriate and timely psychological and emotional support services can save money for health and social care providers and also benefit the wider community in terms of enabling cancer patients to feel well enough to return to work as well as community and social activities.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	**X**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**X**
Domain 4	**Ensuring people have a positive experience of care**	

Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	

2.2 Local defined outcomes

- Improve patient experience
- Providing appropriate and timely psychological and emotional support services
- Enable cancer patients to experience a more positive life experience.

3. Scope

3.1 Aims and objectives of service

Aim

To improve access to levels three and four psychological therapies for people with cancer as outlined by the National Institute for Clinical Excellence [NICE] Improving Outcomes guidance.

The service shall be holistic in its approach, person and family centred, promoting people's emotional and psychological well-being and offer patient choice.

Objectives

- Provide specialist psychological assessment and intervention to cancer patients and carers
- Increase the quality of the experience of psychological care for cancer patients
- Support health professionals in the North Staffordshire Cancer Centre and in primary care in the psychological management of patients with cancer and their carers by providing education, training, consultancy, support and input to teams and service development
- Improve access to psychological support for adults with cancer

3.2 Service description/care pathway

3.2.1 Service Description

The service shall provide specialist psychological, formulation and intervention for cancer patients. The service will deliver high-intensity, evidence based treatment to cancer

patients with moderate to severe psychological difficulties. This service shall deliver levels 3-4 care, as defined by" Commissioning stepped care for people with common mental health disorders, 2011" that is integrated with existing cancer services and MDTs.

The service will be delivered by a stepped care model of healthcare delivery which has been extensively used to structure and deliver mental health services. A 'stratified approach' to stepped care shall be utilised, whereby patients are assessed appropriately in order to receive the level of care that meets their immediate needs, ensuring patients step up and step down the care pathway when required.

The service shall provide assessment and intervention for patients who are struggling with:

- Coping with diagnosis, engaging in and managing cancer treatment
- Signs of depression, for example: withdrawal, hopelessness, and anger;
- Anxiety, including Post Traumatic Stress Disorder following surgery/treatment, anticipatory nausea, specific medical phobias
- Managing the demands of home, work and family life while caring for themselves;
- Adjustment to loss and change in physical functioning, appearance; self-esteem and sense of self; sexual functioning and intimacy;
- Relationship problems as a consequence of illness
- Adjustment to loss and change in life roles and aspirations;
- Coping with future uncertainty and survivorship anxiety
- A sense of uncertainty about the future and life expectancy
- Poor prognosis/survival rates
- People approaching the end stage of life who are demonstrating moderate to severe symptoms of depression and anxiety

This is not an exhaustive list of difficulties that cancer patients may experience.

3.2.2 Accessibility/acceptability

Patients can be referred by a single point of access by any health professional or self-referral if they are under the care of a cancer service consultant or clinical nurse specialist, if they require psychological assessment and intervention.

Exclusions

- People with expectable and manageable short-term (transient) distress;
- Patients with pre-existing and on-going addictions.
- Patients currently receiving treatment for a psychiatric disorder.
- Patients with psychological problems that are not related to their cancer.
- Patients demonstrating significant anti-social, violent or criminal behaviour;
- People below the age of 18
- Referrals for family or carers of patients affected by cancer.

3.2.3 Response time and prioritisation

Once a referral has been received into the service, contact shall be made with the patient within 48 hours and patients will be offered an appointment.

Non-urgent referrals will be seen within 28 days. Urgent referrals will be seen within 7 days.

The criteria for an urgent referral is:

- Palliative patients who are experiencing significant psychological distress
- Patients at risk of non-compliance with treatment due to psychological distress
- Patients whose psychological distress or cognitive problems are placing them at risk of a breakdown in their support network; or patients with a limited support network

3.2.4. Days/Hours of Operation

The service will be available 5 days a week, Monday to Friday. Core opening times will be between 8.30am and 4.30pm although evening clinics may be developed if required.

3.3 Population covered

Referrals will be accepted for patients above 18 years of age who are registered with a North Staffordshire or Stoke-on-Trent GP.

3.4 Environment

The service will be provided in a safe and non-threatening environment. Care will be delivered by trained practitioners with a core set of skills and competencies to provide care

to this client group. The service will be physically integrated with core cancer provision, with effective communication with primary care and other community support services. In addition, the service will develop community provision, in close consultation with commissioners and service users.

3.5 Interdependence with other services/providers

The provider will ensure integration of the service with all partner organisations working together in a co-ordinated and integrated way, in particularly other North Staffordshire-delivered mental health services, GPs and Cancer Services and MDTs at University Hospital North Staffordshire NHS Trust.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- NICE Improving Outcomes Guidance for Psychological Therapies
- Cancer Plan
- Palliative Care Guidance
- End of Life Strategy 2008
- The NHS Cancer Plan
- Cancer Peer Review Process
- NHS Standards for Better Health (DoH, 2004 – updated July 2006): please refer to the Core Assessment Framework document
- Our Health Our Care Our Say: a New Direction for Community Services (Dept. of Health, Jan2006)
- Commissioning stepped care for people with common mental health disorders, 2011.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (see Schedule 4)

5.2 Applicable CQUIN goals (See Schedule 3)

6. Location of Provider Premises

The Provider's Premises are located at:

The Provider's Premises are located at: UHNM in addition the service will develop community provision

Service Specification No.	A15
Service	Mental Health and Vascular Wellbeing Team (MHVW)
Commissioner Lead	Jo Marsh, Senior Commissioning Manager Jane Barnes, Locality Commissioning Manager
Provider Lead	Jane Munton-Davies, Associate Director, Stoke Community Mental Health Services
Period	1st September 2022 – 31st March 2023
Date of Review	As required

1. Population Needs

1.1. National/local context and evidence base

Dementia is a term used to describe a group of symptoms that may include memory loss, difficulties with thinking, problem solving or language, and often changes in mood, perception or behaviour. Alzheimer's disease is the most common type of dementia, with other types of dementia including vascular dementia, dementia with Lewy bodies and frontotemporal dementia. Dementia is not a part of ageing there are at least 42,000 younger people (under the age of 65) in the UK who have dementia.

It is estimated that there are around 850,000 people in the UK with dementia. However, because of longer life expectancy this number is expected to double by 2035. It is estimated that dementia costs the English economy approximately £26 billion every year and is set to increase.

Mild cognitive impairment (MCI) a pre dementia condition associated with vascular disease is the single identifiable risk factor for dementia apart from age and the only one currently treatable (Bowler 2005). Providing interventions for MCI patients heralds better outcomes which could forestall or delay the progression to dementia (Nice/ Scie 2007).

MCI is acknowledged as a high risk condition for developing dementia. The prevalence rate of MCI is 3%; approximately 1.5 million people in the UK are estimated to have MCI, few people are referred on to specialist services.

The potential for conversion from MCI to dementia represents the opportunity for services to alter the dementia trajectory. A five year delay in diagnosis can provide a reduced prevalence rate by 44% in the next fifty years.

There are very few upstream service models addressing this need in the UK, leaving patients in unsuitable and costly care pathways. There is a pressing need for a service redesign model to have a formal MCI register and able to provide support and advice for patients on self-management, coping mechanisms and clear systems for monitoring and follow up is warranted. Working across primary and secondary care boundaries with all stakeholders involved in dementia pathways. West Midlands Strategic Network (WMSCN) are currently working on producing guidance on an MCI pathway.

Local context

The Mental Health and Vascular Wellbeing Team (MHVW) has extensive experience in applying best practice in ensuring timely diagnosis of MCI and providing safe and effective non-pharmacological interventions for patients with the condition living in North Staffordshire and Stoke-on-Trent.

The service works with primary care to provide an early detection system for patients and to provide support.

2. Outcomes

2.1. NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	

2.2. Local defined outcomes

- Detection and early diagnosis of MCI/early dementia
- Timely therapeutic interventions
- Access to psycho education, life skills and support groups and programmes
- Training for professionals to raise awareness of the significance of MCI.

3. Scope

3.1. Aims and objectives of service

The aim of the service is to:

- Support early detection of VCI/MCI (pre-symptomatic dementia) through screening and assessment of people aged 40+, presenting in primary care with significant mental health problems, in order to ensure appropriate and effective treatment.
- To ensure equality & inclusion by bridging the gap between the National Dementia Strategy & IAPT pathway to ensure quality of interventions are effective in responding to information processing difficulties reflected in this cohort.

The MHVW team's objectives are:

1. Help patients manage their physical wellbeing and mental health
2. Find new ways of working effectively and efficiently with clients
3. Facilitate self-care and independence
4. Put preventative interventions in place to delay onset of dementia in at risk clients
5. Provide psychological therapies to people who may otherwise struggle to access them
6. Help individuals live well with mild cognitive impairment
7. Improve mental wellbeing for client group
8. Provide safe quality patient care

Outcomes for patients with MCI and vascular risk factors:

1. Improved understanding of condition and enable self-management of MCI and vascular risk;
2. Increased compliance with treatment interventions;

3. Patients and carers able to continue in employment;
4. Reduction in GP appointments amongst patients attending in relation to MCI and/or vascular risk factors;
5. Increase in wellbeing;
6. Consistently positive patient experience.

Systems outcomes:

1. Clinical and non-clinical resources optimised for patient benefit;
2. High quality interventions implemented based on best evidence for patients with MCI and vascular risk factors;
3. Improved, usable clinical pathways in place, driven by patients and clinicians;

3.2. Service description/care pathway

The MHVW applies best practice ensuring that potential MCI is identified earlier within primary care and improving the consistency and quality of care for people living with the condition in the city of Stoke-on-Trent.

<u>Supporting Healthcare Professionals</u>

- Integrated care pathway.
- Assessing patients presenting with subjective memory concerns in primary care and liaising with local memory clinics.
- Reducing patient attendance at memory clinics by 1 - 2 appointments per patient referred.
- Supporting patients with prevascular dementia post diagnosis.

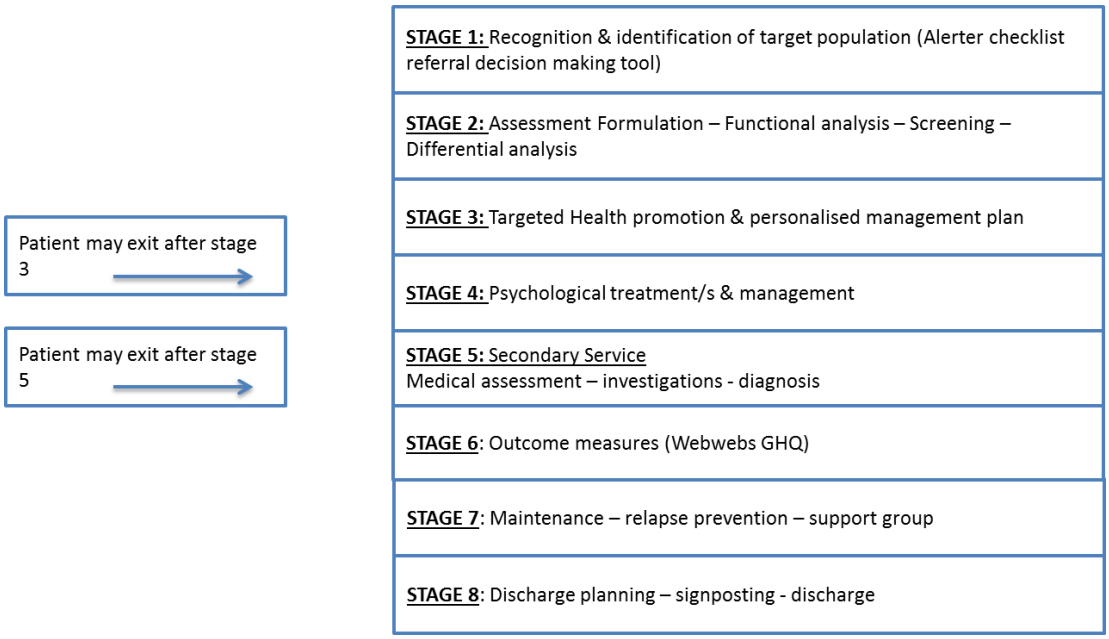
<u>Supporting people with MCI</u>

To develop a better understanding of their condition and enable self-management dependent on clinical view.

Psychological therapies with adaptations for treatment of comorbid mood disorder, management techniques and family session to enable adjustment and improved self – care management with their condition.

- Formal testing cognition
- Monitoring and follow up.

Service Pathway



Service Location and Delivery

North Staffordshire Combined Healthcare NHS Trust will retain overall responsibility for the delivery of the service. Sessions will be held in primary care and local mental health facilities.

Days/hours of operation

The service operates 5 days per week Monday to Friday 8.30 – 5 pm but is flexible to accommodate patient's needs.

Referrals

An Alerter checklist referrer decision making tool has been developed to be completed for all referrals to the service.

Referral Source

Referrals will be accepted from the following:

Pre diagnosis (patient identified with subjective memory concern):

- GP's/Primary Care Services/Primary Care Network (PCN's)
- IAPT
- Access Team

Post diagnosis (patient diagnosed with MCI/pre-dementia)

- Memory clinic
- GP

Service Response Times

Referrals are through a single point of access and are triaged on receipt.

Discharge Process

Patients will be discharged from the service on four different pathways dependent on the outcome of tests and following NICE guidelines

1. Interventions/assessment completed with information processing difficulties discounted – patient is stepped down to IAPT services.
2. Consultant makes diagnosis of Alzheimer's dementia or mixed dementia – refer to memory service pathway.
3. Consultant makes a diagnosis of vascular dementia – refer to memory clinic pathway.
4. Patient has received and completed all interventions. Mental health is stable and no longer requires further 1:1 input. Patients will exit the service with option to attend the support group. Contact details will be provided for future advice or reassessment.

Workforce

The provider shall have sufficient and skilled staffing to provide care, clinical need and safety to deliver the outcomes required by patients who access the service as outlined in this service specification. The staff will undertake appropriate training to ensure they are kept up to-date with best practice and training.

Clinical and General Supervision

The service provider will ensure that appropriate arrangements are in place to provide sufficient levels of supervision and support to staff. These arrangements will need to be consistent with identified best practice across the range of specialties within the team.

3.3. Population covered

The service will be provided to people of any age who are registered with a North Staffordshire or Stoke-on-Trent GP or who live within North Staffordshire and Stoke on Trent,

3.4. Any acceptance and exclusion criteria and thresholds

Acceptance into the Service is via completion of the Alerter check list.

3.5. Interdependence with other services/providers

The key relationships:

- General Practitioners, Primary Care, PCN's
- IAPT services
- Memory Clinic

4. Applicable Service Standards

4.1. Applicable national standards (eg NICE)

The Service shall ensure that it adheres to relevant national standards of best practice in dementia care, to the most recent NICE guidance and other reliable sources of evidence, for example:

- DOH 2006, NICE Clinical Guideline 42 Supporting People with Dementia and their Carers in Health and Social Care
- The word Dementia Council's report 2014/15 recommendation 9 priority area Risk reduction
- NICE Quality Standard 30 on supporting people to live well with dementia (QS30).
- NICE Dementia Pathway

5. Applicable quality requirements and CQUIN goals
5.1. **Applicable Quality Requirements** See Schedule 4 5.2. **Applicable CQUIN goals** See Schedule 3
6. Location of Provider Premises
NSCHT Headquarters and Harplands Hospital

Service Specification No.	A16
Service	High Volume User Service
Commissioner Lead	Nicola Bucknall, Commissioning Manager – North Division, CCG
Provider Lead	Rachael Birks Associate Director Acute and Urgent Care
Period	1st April 2022 – 31st March 2023
Date of Review	As Required

1. Population Needs

National / Local Context and Evidence Base

The findings of Mandelberg *et al* (2000)[13] show that a small number of patients make frequent attendances to emergency departments and account for a disproportionate amount of the total Accident and Emergency (A&E) workload.

In Northern Staffordshire, there is only one main acute Provider and therefore these patients have a high impact on the wait times and flow of the A&E department and ultimately the health system as a whole. These patients attend A&E due to a combination of physical, psychological and social factors[14] therefore they require a Multi-Disciplinary Team (MDT) approach to tackle their complex and diverse issues.

Patients will attend A&E for a number of reasons but may attend unnecessarily if there is a failure elsewhere in the health or social care system and often A&E becomes the 'default position'.

2. Outcomes

[13] Mandelberg J, Kuhn R, Kohn M (2000) Epidemiologic analysis of an urban, public emergency department's frequent users. *Academic emergency Medicine*. 7, 6, 637-646

[14] Genell Abdren K, Rosenqvist U (1987) Heavy users of an emergency department: a two year follow-up study. Social Sciences Medicine. 25, 7, 825-831

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**ü**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**ü**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**ü**
Domain 4	**Ensuring people have a positive experience of care**	**ü**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**ü**

2.2 Local defined outcomes

Priority 1	**Better and More: A community focussed model of care**	**ü**
Priority 2	**Improved care and outcomes for people with LTC's**	**ü**
Priority 3	**Use patient experience to improve quality of care**	**ü**
Priority 4	**Deliver 'Must Do's'**	**ü**

3. Scope

3.1 Aims and Objectives of Service

The key aim of the service is to reduce the number of unplanned attendances to secondary care by facilitating and coordinating multidisciplinary support and intensive, time-limited interventions to patients who frequently attend A&E.

The Provider shall be required to contribute to the following outcomes:

- Reduce avoidable A&E attendances by; 30 %
- Reduce overall hospital admissions including alcohol related admissions
- Reduce readmission rates
- Reduce avoidable 999 calls;

- Improve patient experience and outcomes utilising an holistic approach to care.

3.2 Service Description/Care Pathway

- The service will ensure the coordination of care and the provision of an assertive outreach approach to vulnerable groups of patients, who typically disengage with mainstream services and / or have a disproportionate use of emergency services (acute hospital and ambulance services).

- The patient groups likely to benefit from this approach are:
    - People with complex mental health needs
    - People who have been in hospital many times and have often used crisis services,
    - People who are disengaging with mainstream mental health services, or have multiple and complex needs such as:
        - serious self-harming **and/ or**
        - drug or alcohol use and mental illness i.e. dual diagnosis **and /or**
        - unstable accommodation or are homeless

- The service however is not restricted to patients known to mental health services and will be accessible to anyone meeting the service criteria below.

- The service shall work with other health and social care professionals to ensure a single personalised care and risk management plan is developed. This shall be circulated to all Provider organisations involved in the patients care, for uploading to relevant clinical systems. The plan should have a clear review date so that information is relevant and up-to-date.

- Care plans should be established to progress patients onto an appropriate destination/specialist service at the earliest opportunity to prevent further avoidable acute attendances or admissions.

- The frequency and the number of contacts with the HVU team shall be patient specific, determined by complexity and level of patient engagement, with the aim of becoming less frequent and care being handed to the most appropriate professional(s) to meet their needs on an ongoing basis.

- Facilitate and improve access to and appropriate onward referral of patients into primary, secondary and tertiary services, informing referring clinicians of the need to urgently onward refer; Where possible the service will set up direct referral pathways with other services in agreement with Commissioners

- Advocate and provide expert advice to local multi-agency partnerships addressing the needs of individuals' living chaotic lifestyles and those as risk of social exclusion

- Have appropriate senior level support and escalation processes across a number of organisations to ensure that appropriate care and treatment is in place and services are able to respond quickly.

- The Trust will develop data collection systems for the purposes of monitoring quality, performance / outcomes for Commissioners and to inform the development of services.

- Where deficits or gaps in commissioned services across the health economy are identified the service will establish a process by which to escalate to Commissioners

- The service will utilise technology and innovative approaches to maintain engagement with patients

The service model shall comprise the following elements:

<u>Information and Consent</u>

All patients shall receive education and information about the service on initial contact. This information shall include a service leaflet and information in relation to consent and data sharing with other relevant professionals / organisations

<u>Identification</u>

The Provider shall identify and prioritise the people who attended each A&E most frequently during the previous financial year (this is likely to be people who have attended A&E a minimum of 8 times in that period).

Typically patients appropriate for support from the HVU team will be identified by data reports from the acute hospital trust. There will be some capacity in the team to accept newly emerging frequent attenders of hospital services in year. A process for identification / standard operating procedure (SOP) will be formally agreed with senior clinical and managerial staff in UHNM.

The Provider shall identify and manage patients with complex needs who are high volume users of emergency / urgent care services. These patients will typically have multiple complex needs often with mental health needs (which may or may not be formally diagnosed), substance misuse, multi-morbidities, medically unexplained symptoms, homeless, or vulnerably housed, have poor physical health and or social deprivation.

Initial Review

The Provider shall collect information from multiple sources to establish current services open to and emergency care usage (e.g. WMAS, 111, A&E, crisis teams).

Assessment and care planning

- Undertake holistic assessment of patients' needs and understand the reasons for repeated presentation to A&E / emergency services
- Provide targeted assessments for mental health; social care, safeguarding as appropriate
- Undertake a risk assessment and develop a robust risk management plan that clearly sets out what to do in a crisis
- Agree follow up / review appointments with the patient This will be in a place convenient and comfortable to the patient (e.g. home, community venue/ public place), taking into account the safety of both the patient and HVU staff
- Where patients are already known to the mental health trust the patients usual care coordinator will be included in the development of the care plan. Frequency of contact with the service user should be increased if it is felt that this will minimise crisis and prevent unnecessary attendances to A&E
- Where patients are not known to other relevant services, consideration should be given to making urgent referrals particularly if this will alleviate the number of presentations to A&E

Case Conference Meeting

Multi-Disciplinary Team conferences involving primary care, social care, and psychiatric teams can be useful. Information sharing and discussion of trigger points for attendance can identify issues that community teams can help with.

Specialists such as chronic pain services and drug and alcohol teams may also be helpful to involve.

Consideration should be given to inviting the patient and or carers to a case conference where possible.

The focus of some MDT may be purely to manage risk and requires involvement of police, ambulances and Emergency Mental Health services.

Discharge Process

In accordance with the care pathway, patients shall be discharged back to the care of their own GP / usual keyworker (where already known to healthcare services e.g. mental health care coordinator, substance misuse keyworker, community matron) wherever possible once the agreed management plan has been implemented and change in behaviour with regards to emergency service usage is observed.

It is expected that the service will work with the patients on a time limited basis but this will be determined by need.

In all cases, a summary of care provided, treatment and any details of onward referrals shall be sent to the patients' GP in line with Trust policy

3.3 Population Covered

The service shall be available to all patients aged 18 years or above within the boundaries of Northern Staffordshire regardless of whether they are registered with a GP or not.

3.4 Any Acceptance and Exclusion Criteria and Thresholds

Whilst it is acknowledged that many patients who frequently attend have a mental health diagnosis this service is not limited to patients in contact with mental health services.

Patients will not be excluded on this basis and any underlying / undiagnosed mental health should be explored where appropriate

Inclusion Criteria

- Patients accepted to this service should only be assessed where they are current High Volume Users of A&E or WMAS, or where they have been identified as being at risk of repeated hospitalisation using a statistically robust stratification model. Whilst there is no national definition of frequent attender they will usually be patients who have / are likely to attend 8+ times in 1 year.

Exclusion Criteria

- Patients attending hospital regularly for planned care / admissions (e.g. chemotherapy, dialysis)
- Patients who do not consent;
- Patients under the age of 18 years.

3.5 Interdependence with other Services/Providers

The service shall operate in conjunction with the following, non-exhaustive list of related services;

- University Hospital North Midlands (UHNM)
- Stoke and North Staffordshire GP's (including Out of Hours and Walk-in-Centres)
- West Midlands Ambulance Service (WMAS)
- Staffordshire & Stoke-On-Trent partnership Trust (SSOTP) – Community Health Services
- North Staffordshire Combined Healthcare NHS Trust (NSCHT)
- High Intensity Patient Service
- Integrated Local Care Teams (ILCT's)
- Voluntary Sector
- Police
- Social Services
- Specialist Drug and Alcohol Services (Public Health)
- Stoke on Trent City Council
- Newcastle Borough Council

4. Applicable Service Standards

4.1 Applicable National Standards (e.g. NICE)

NICE: Coexisting severe mental illness and substance misuse: community health and social care services (NG58): https://www.nice.org.uk/guidance/ng58

Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services (CG136): https://www.nice.org.uk/guidance/cg136

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

Case management - What it is and how it can best be implemented, Kings Fund, November 2011: https://www.kingsfund.org.uk/sites/files/kf/Case-Management-paper-The-Kings-Fund-Paper-November-2011_0.pdf

Frequent Attenders in the Emergency Department The Royal College of Emergency Medicine Best Practice Guideline, August 2017

4.3 Applicable Local Standards

North Staffordshire Combined Healthcare Trust Policies:

- *Discharge and transfer policy*
- *Risk management policy*
- *Effective Care planning policy*

5. Applicable Quality Requirements and CQUIN Goals

5.1 Applicable Quality Requirements See Schedule 4

5.2 Applicable CQUIN Goals See Schedule 3

6. Location of Provider Premises

The service will operate Monday to Friday between the hours of 9.00 and 17.00.

The service shall be based at Harplands Hospital, Hilton Rd, Stoke-on-Trent ST4 6TH.

The post holder(s) will be fully mobile with the Provider being encouraged to undertake assessments anywhere within the boundaries of Northern Staffordshire Health Economy.

Service Specification No.	A18
Service	Psychiatric Intensive Care Unit - PICU

Commissioner Lead	Joanne Marsh, Senior Locality Commissioning Manager, CCG
Provider Lead	Rachael Birks, Associate Director Acute and Urgent Care
Period	1st April 2022 – 31st March 2023
Date of Review	As Required

1. Population Needs

1.1 National/local context and evidence base

Policy context

- Department of Health, 2002 "National Service Framework Policy Implementation Guidance".
- Department of Health 2008, Mental Health Act 1983 Code of Practice
- Department of Health, 2005 "The Mental Capacity Act". DoH
- No health without mental health. A cross government mental health outcomes strategy for people of all ages (2011)
- Closing the Gap: Priorities for Essential Change in Mental Health (Feb 2014)
- Mental Health Crisis Care Concordat (Feb 2014)
- Five Year Forward View for Mental Health (Feb 2016)

Local strategic context

- Staffordshire and Stoke on Trent Adult Mental Health Strategy 'Mental Health is everybody's business' 2014-2019
- Staffordshire Strategic Needs Assessment – Working Together for Better Health 2012
- 'Together were Better' Staffordshire Sustainability Transformation Plan (2016)
- Psychiatric Intensive Care Unit – Commissioner Proposal (May 2017)

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely;	
Domain 2	Enhancing quality of life for people with long-term conditions;	
Domain 3	Helping people to recover from episodes of ill health or following injury;	X
Domain 4	Ensuring that people have a positive experience of care; and	
Domain 5	Treating and caring for people in a safe environment; and protecting them from avoidable harm.	X

2.2 Locally Defined Outcomes

Expected Outcomes for Service Users

- Service Users will be treated closer to home.
- The support provided to all service users admitted to an in-patient setting will be co-ordinated via the Care Programme Approach.
- Lengths of PICU admissions will be reduced through prompt, comprehensive assessments and multi-disciplinary working relative to identified needs.
- The length of stay in PICU is not expected to exceed 6 weeks with the average stay for patients below this.
- Providers will support a well-trained workforce enabled to work with people with complex needs who will work with service users and carers promoting recovery models.
- Care plans will address physical health needs as well as mental health needs resulting in the reduction of inequalities in health care.
- Care plans will reduce the need for services by promoting self-advocacy, enabling service users to move to less intensive service interventions or away from secondary care.
- Service users will be discharged to accommodation appropriate to their needs, and where required accommodation providers will be active participants of care teams
- Service users will access vocational and educational activities appropriate to their needs, this will be reflected in care plans and where appropriate vocational/educational providers will be active participants in care teams
- Health of the Nation Outcome Scales (HONOS) assessment will be applied at the reviews of service interventions.

- Interventions will include assisting carers and families to gain knowledge with regard to service user's mental health diagnosis and who to contact should a crisis arise.
- Service users will be active participants in their care process determining interventions and contact with provider services, where their wishes are overridden clear rationale for the reasons will be recorded.
- Care Plans will detail the role of carers and they will be active participants in the reviewing process.
- Care plans will detail the responsibilities of partner agencies and they will be active participants in the reviewing process.

3. Scope

3.1 Aims and objectives of service

Overview of service

The PICU will provide an intensive care environment that provides assessment, treatment and care for those service users who are assessed to require a brief stay and intensive care within a locked environment due to the risks associated with their psychiatric presentation.

Typically, service users requiring admission to PICU will;

- Display acute behavioural disturbance that seriously compromises their physical and/or psychological wellbeing of themselves and/or others.
- Be at notable risk of aggression, suicide and/or serious self-harm.
- Be at risk of increased vulnerability because of sexual disinhibition or over-activity in the context of mental disorder.
- Have co-morbid conditions derived of disorder of both physical and mental health.

Informal patients may also be accepted if agreement with the service user is reached and it is deemed clinically appropriate

The unit also aims to provide specialist support to onsite adult acute inpatient wards where requested in meeting the needs of service users whose presentation may include risk to self or others.

Aims and objectives of service

The emphasis is on intensive treatment combined with a range of physical, procedural and relational security measures that will help to reduce risk, disturbance and vulnerability. The care and treatment needs of patients requiring PICU will not be able to be managed safely in the patient's usual ward setting regardless of the level of security provided. In some cases, patients may be admitted straight to PICU.

Following treatment in PICU, patients are likely to continue to receive inpatient treatment by step down to onsite adult acute inpatient wards.

3.2 Service description/care pathway

Model of Care

The primary function of PICU is the rapid assessment and intensive management of acute mental illness and behavioural disturbance within an integrated care pathway.

This will be delivered by a multi-disciplinary staffed unit providing short periods of intensive treatment for adults requiring rapid assessment and stabilisation before or during a longer period of inpatient care. Staffing levels and skill mix modelled using the National Association of Psychiatric Intensive Care Units (NAPCICU) standards and guidance and will include a dedicated ward manager, psychiatrist, occupational therapist, psychologist, nursing staff and activity workers.

Patients will present increased vulnerability, posing a level of risk that means they are unable to be safely managed in a ward setting. The treatment provided in PICU will have a direct impact on reducing risk. If restrictive interventions are required for the safety of the patient and/or other patients these will be in line with the Department of Health's Positive and Safe Initiative and the least restrictive option used.

The multi-disciplinary team will take an active, treatment-focussed approach aimed at rapid stabilisation, crisis resolution and risk reduction, and prevention of relapse and promotion of recovery.

PICU should be available for newly admitted patients and patients already being treated within inpatient services who require rapid assessment and stabilisation.

The nature of PICU services means that processes for referral, assessment, admission and discharge should be dynamic.

Effective links should be maintained with the referring service to support on-going treatment and transfer back. PICU staff should work collaboratively with health, criminal justice and social care agencies to support effective pathways.

The service should operate within the principles of 'nothing about me without me' placing the patient at the centre of their care and supporting patient choice within the unit where this is clinically appropriate.

The service should actively encourage patients to engage with and participate in formulating, and the ongoing review of, a multidisciplinary therapeutic evidence-based programme appropriate to their individual needs.

All therapeutic interventions and treatments should comply with the relevant NICE and professional association guidance and patients should receive information about medication and its side effects.

Pathway



Psychiatric intensive care services require a comprehensive, cohesive multi- disciplinary team with a shared vision and with the capacity and capability required to meet the complex needs of patients.

The service should have an identified lead consultant for psychiatric intensive care. The core multi-disciplinary team should include medical, nursing, social work, pharmacy, psychology and occupational therapy.

PICU services require a staff group with the capacity and capability to engage effectively with highly disturbed patients and provide a range of multi-disciplinary therapeutic interventions and clinical treatments within the agreed model of care. Staffing capacity should be sufficient to deliver the care and treatment model and maintain a safe environment at all times. Staff mix and ratios should be flexible enough to meet changing levels of risk.

Response times

Referrals should be accepted 24 hours a day 7 days a week and assessments should be completed within 6 hours of referral or in some cases where 136 or MHA 83 assessments have been undertaken the response is immediate.

Where an assessment either in an adult acute inpatient ward or in the community indicates the need for PICU this should be made without delay.

Admission to PICU following assessment should be immediate.

If there is no capacity within the Provider's services, an Out of Area PICU placement should be sourced.

Discharge process

- The discharge process will commence within 72 hours of admission. A 72 hour discharge planning meeting within Care Programme Approach philosophies will occur and will have a focus on the underpinning risk assessment
- In most cases, on discharge from the unit, the service user will be transferred to a less secure environment.
- Where discharge from the unit occurs, a package of treatment and care and the discharge risk assessment will be agreed with the appropriate multi-disciplinary team responsible for the aftercare and a 48 hour or 7 day discharge follow-up plan put in place.
- All discharge planning will occur with service user and care involvement and agreement

3.3 Population covered

Those registered with GPs within Stoke on Trent Clinical Commissioning Group and North Staffordshire Clinical Commissioning Group boundaries.

If the patient is not registered with a GP, the service will work with the patient towards registration and access to the service.

3.4 Any acceptance and exclusion criteria

Days/ hours of operation

The Units are operational 24 hours a day 365 days a year.

Referral processes

Will generally be made from onsite adult acute inpatient wards.

Emergency admissions through the gate-keeping function of the Crisis Resolution Team will also be accepted if the criteria for admission to PICU are met.

The PICU will provide mixed sex accommodation.

Exclusion criteria

- Individuals who do not meet the criteria for alternative to hospital admission
- Individuals with dementia
- Individuals under the age of 18 will be admitted based on clinical need

3.5 Interdependencies with other services

The Acute In-patient wards will work closely with the PICU, as will the community mental health and social care teams (CMHT), Access Team, (Crisis Resolution & Home Treatment), Assertive Outreach, Early Intervention services and Liaison Psychiatry Teams. There is also collaborative working with the Police, Ambulance service and A+ E departments. There are close working arrangements with the Forensic, Learning Disability, Perinatal and substance misuse services. Key interdependency with Staffordshire & Stoke on Trent Partnership Trust; Acute and General Hospitals, and primary care.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- CG 1 Schizophrenia
- CG38 Bipolar Disorder
- TA043 Schizophrenia – AtyPICUal Antipsychotics
- Self-harm (CG16)
- Post-traumatic stress disorder (PTSD) (CG26)
- Obsessive compulsive disorder (OCD) and body dysmorphic disorder (BDD) (CG31)

- Depression and anxiety - computerised cognitive behavioural therapy (CCBT) (TA97)
- Antisocial personality disorder (CG77)
- Borderline personality disorder (BPD) (CG78)
- Anxiety (CG113)
- Mild-moderate to severe depression (NICE CG023)
- Mild – moderate to severe anxiety disorders – generalised anxiety disorder (GAD), panic disorder (NICE CG022)
- Phobias (NICE CG022)
- Obsessive Compulsive Disorder (NICE CG 031)
- Eating Disorder (NICE CG009)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

AIMS – PICU.

https://www.rcpsych.ac.uk/pdf/Standards%20for%20Inpatient%20Wards%20-%20Working%20Age%20Adults%20-%20Fourth%20Edition.pdf

Guidance for commissioners: service provision for Section 136 of the Mental Health Act 1983, Royal College of Psychiatrists, April 2013

https://www.rcpsych.ac.uk/pdf/PS02_2013.pdf

CR159. Standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales), Royal College of Psychiatrists, July 2011

https://www.rcpsych.ac.uk/files/pdfversion/CR159x.pdf

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4)

5.2 Applicable CQUIN goals (See Schedule 3)

6. Location of Provider Premises
Harplands Hospital, Hilton Road, Stoke-on-Trent.

Service Specification No.	A21
Service	Adult Eating Disorders Services – Outpatient/Community
Commissioner Lead	Nicola Bucknall
Provider Lead	Sam Mortimer
Period	01 April 2022 – 31 March 2023
Date of Review	As required

1. Population Needs

1.5 National/local context and evidence base

This service specification is consistent with national best practice and operational frameworks using the following policy guidance;

- *MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa October 2010*
- *Guidance for commissioners of eating disorder services;*
- *http://www.jcpmh.info/wp-content/uploads/jcpmh-eatingdisorders-guide.pdf*
- *Eating Disorder (NICE CG69) Revised May 2017*

Eating disorders (ED) are severe mental illnesses with serious psychological, physical and social consequences. They are characterised by a preoccupation with food and/or weight and body shape and harmful eating habits.

The three most common ED are anorexia nervosa (AN), bulimia nervosa (BN) and binge eating disorder (BED)

.

Anorexia nervosa (AN) has the highest mortality amongst all psychiatric disorders.

There is a critical window for intervention for people with ED. Recovery is less likely if an ED has remained untreated for more than 3-5 years. Early identification and intervention with access to effective stepped care pathways is of paramount importance to improve clinical outcome and increase cost-effectiveness.

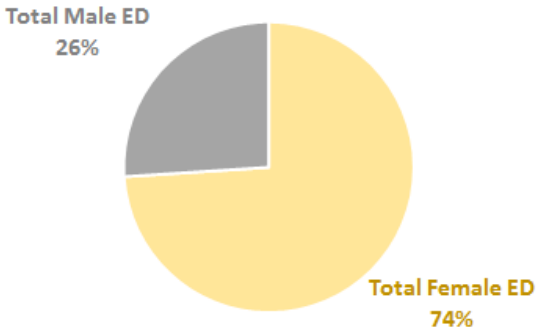
Local strategic context

New care models will see the creation of regional hubs to manage and monitor access to specialist eating disorder inpatient beds. These will be supported by community eating disorder services which will aim to reduce length of stay and out of area placements.

North Staffordshire and Stoke-on-Trent CCGs have identified that there is a gap in services for adults either transitioning from CAMHS services or for adults newly diagnosed with an eating disorder. This has led to admissions to acute hospitals which are unable to fully meet the needs of this patient group or to prolonged and costly OOA placements with limited / no support on discharge.

The new care models for specialist eating disorders will see a shift in resource over time from inpatient to community care.

Estimated Eating Disorder Prevalence in North Staffs & Stoke on Trent Female / Male 18+



Female ED	% of Total	2016	2017	2018	2019	2020	2021	2022	2023	2024
Anorexia	75%	263	263	264	264	263	263	262	262	263
Bulimia	70%	1,496	1,497	1,497	1,496	1,493	1,489	1,486	1,485	1,48
EDNOS	75%	4,308	4,320	4,326	4,330	4,326	4,320	4,316	4,315	4,31
Total Female ED	**74%**	**6,066**	**6,080**	**6,087**	**6,090**	**6,082**	**6,072**	**6,065**	**6,062**	**6,06**

Male ED	% of Total	2016	2017	2018	2019	2020	2021	2022	2023	2024
Anorexia	25%	88	89	89	89	89	89	89	89	89
Bulimia	30%	636	638	641	643	645	647	649	651	653
EDNOS	25%	1,411	1,416	1,421	1,422	1,422	1,421	1,420	1,421	1,42
Total Male ED	**26%**	**2,135**	**2,143**	**2,151**	**2,154**	**2,156**	**2,157**	**2,158**	**2,161**	**2,16**

https://www.beateatingdisorders.org.uk/how-many-people-eating-disorder-uk

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**ü**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**ü**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	**ü**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	

2.2 Local defined outcomes

- Ensure no gap between children's and adult services.
- Promote early identification and specialist treatment
- Promote early intervention through education and seamless pathways
- Improve care and recovery rates
- Provision of NICE compliant interventions

Expected patient outcomes include:

- Weight restoration
- Establishing regular and balanced eating patterns
- Stable biochemistry
- Identifying and exploring underlying emotional problems
- Improved psychological functioning

3. Scope

3.1 Aims and objectives of service

The service aims to promote recovery and or promote optimum functioning and quality of life for those individuals whose illness runs a chronic course.

This specialist service provides treatment using a Bio/psycho/social model which is evidence based. Treatment does not only focus on weight and eating but also on the associated / under pinning, psychological issues. Medical monitoring and physical risk management are also an integral part of the treatment.

Psychological models include Cognitive Behavioural Therapy – Enhanced (CBT-E), Cognitive Analytical Therapy (CAT), Psycho-dynamic Psychotherapy, Systemic Family therapy and Interpersonal Therapy (IPT).

The evidence base suggests that the delivery of treatment for most will be through time limited sessions of CBT-E. A number however will require more intensive treatment over a longer period of time, whilst admission avoidance is paramount, for some people due to their complexity, an admission to a specialist eating disorder unit for intensive treatment will be unavoidable.

The aims of treatment are to:

- Establish regular healthy eating patterns
- For the patient to cease compensatory behaviours
- Restore / maintain a healthy weight range
- Manage/improve physical health
- To understand underlying psychological issues and facilitate positive change in these areas

Individuals with less complex presentations will receive care from the locality CMHT. When working with individuals who have more complex presentations and associated co morbidities, there will be close joint working with the Community Mental Health Team (CMHT), ensuring effective liaison and a shared plan of risk management. It will be clear who is Care Coordinator for the patient.

3.2 Service description/care pathway

This specialist service provides a comprehensive assessment and evidence based treatment for those people with a diagnosable eating disorder including Anorexia Nervosa, Bulimia Nervosa, EDNOS and Binge Eating Disorder.

The service will comprise a team of mental health professionals with training in the assessment, risk management and treatment of individuals with eating disorders. The team will be multidisciplinary and will include doctors, nurses, dietician and practitioners with the skills and competencies to deliver NICE approved psychological therapies.

Specialist services for ED work closely with general mental health services for both children and adults, primary care, voluntary sector organisations, and physical healthcare specialists.

The service will provide an agile locality based service model that will work into the existing community teams and primary care, providing education, early intervention and ongoing therapeutic support within localities, offering assessment and intervention for complex eating disorders to include CBT -e, Psychodynamic therapy and guided self-help.

The specialist service will provide psychological time limited interventions with an expectation that once stability has been achieved the service user will, on a needs led basis either be discharged or be supported by generic community mental health teams.

Practitioners within generic community mental health teams will be trained to deliver manualised CBT-e to those individuals with less complex ED presentations and will where deemed clinically appropriate be responsible for the maintenance of underpinning psychological issues.

A community ED service will provide the following:

• Comprehensive psychiatric assessment to include ED psychopathology and identify comorbid mental health and physical conditions. Diagnosis should be discussed with patient, carer and referrer.

• Risk assessment, both psychiatric and physical. This will include organising relevant investigations (e.g. blood tests, ECG, bone densitometry). Clear arrangements should be made with a patient's GP agreeing responsibility for ongoing physical health monitoring.

• Advice and education to the referrer and other teams including when to refer to CEDS.

• A patient-centred, non-judgemental approach utilising motivational interviewing in order to maximise engagement of patients where ambivalence or denial of the difficult aspects of ED are known to influence patients experience of care and outcomes.

• High quality evidence-based psychological therapies for BN and BED (guided self-help-BN/BED; Cognitive Behavioural Therapy CBT-BN, CBT-BED). In the absence of a strong evidence base for specific psychological therapies for AN, services should be able to provide a range of psychological therapies in line with best practice (e.g. SSCM, CBT, Cognitive Analytic Therapy, psychodynamic psychotherapy). Family-focused psychological interventions should also be widely available.

• Intensive community treatment for patients whose condition is deteriorating or not progressing.

• Collaboration with carers/family with careful consideration of patient confidentiality. Carers' needs assessment should be offered, and appropriate advice and support available in addition to family-based interventions such as carers' support groups and family therapy delivered both to individual families and multi-family therapy.

• Nutritional counselling and psychoeducation with the aim of restoring healthy, balanced eating.

<u>Assessment</u>

Comprehensive assessment includes a detailed account of the patient's history, their current mental health, eating disorder symptomatology and physical health incorporating ECG examination and routine blood chemistry. Bone scans will be requested where clinically indicated. Outcome measures are completed at assessment.

A physical health review is undertaken by a specialist with ED knowledge and takes place as part of the initial assessment. The review includes but is not limited to:

- Medical complications of an eating disorder;

- Details of past medical history;

- Current physical health medication, including side effects and compliance with medication regime;

- Lifestyle factors.

The service should have the capacity to provide the following as part of the physical health assessment and ongoing review:

- Height and weight;

- Blood pressure and pulse;

- Skin and mouth condition;

- Squat (SUSS) test;

- ECG;

- Blood test.

Care Planning

Programmes are based on a plan of care devised in collaboration with the patient and where appropriate their carers'. Associated professionals are informed of the care plan and invited to collaborate as necessary. Patients are treated within the care co-ordination system and are regularly reviewed.

Patients have a documented risk assessment and management plan which is co-produced and shared where necessary with relevant agencies

The service will have clear processes around managing risk and safety as well as unattended appointments (including clear follow-up protocols to engage a person and prevent inappropriate discharge)

Treatment and Care

The service recognises the multi-casual aetiology of eating disorders and aims to offer integrated multidisciplinary assessment and treatment.

The service offers various types of treatment options, therapeutic treatments, medical monitoring, dietetic advice and support and advice for carers.

Patients are offered an intensive programme, which does not only focus on weight and eating, but also acknowledges the need to understand the underlying psychological aspects of the disorder. Individual therapy and a variety of group treatments offer our patients an opportunity for exploration of wider issues which include body image, anxiety management and assertiveness training.

Out-patient Treatment Options include:

- Evidence based, focal psychological therapies- CBT-E, IPT, CAT, Systemic Therapy
- Individual Psychotherapy
- Psycho-education
- Dietary analysis and education - The use of micronutrient supplements is recommended in outpatient weight restoration.
- Medical monitoring - A CED service must be equipped to conduct a full medical assessment, including blood tests and ECGs, and receive same-day results to facilitate same-day clinical decision-making.
- The service has the capacity to provide at least weekly blood tests and physical health reviews from an eating disorder specialist for patients at high risk, as defined by MaRSiPAN (Management of Really Sick Patients with Anorexia Nervosa).
- Support for carers
- Relapse prevention

<u>Diagnostic Criteria</u>

- Individuals with eating disorders that significantly affect their physical health and/or their mental and social functioning.

- Moderate/severe eating disorders with high clinical risk.

- A diagnosis of Anorexia Nervosa, regardless of severity as there is little evidence for the treatment of this disorder in primary care. Most patients with Anorexia Nervosa should be managed on an outpatient basis with psychological treatment provided by a service competent in the treatment and assessment of physical risk

- Severe and enduring eating disorders with complex needs requiring continuing care from multiple agencies e.g. drug and alcohol, community mental health, social care.

- Discharged from inpatient treatment should receive psychological/ psychiatric treatment for at least 12 months post- hospitalisation.

- Rapidly losing weight, such as more than 1 kg a week for 1 month or whom are consistently losing weight but over a longer period of time e.g.<0.5kg a week over 3 months.

- Bingeing and/or vomiting/ and or laxatives use/ and or compulsive exercise at least 5 times a week, for 3 months or more.

- Eating disorder and co-morbid depression, and or are at risk of self-harm or suicide
  .
- Failure to respond to evidence based psychological therapies e.g. online CBT-e for mild Bulimia, Binge Eating Disorder, Atypical Eating Disorder or Other Specified Eating Disorder

Response Times

Response times are determined by clinical need/urgency, urgent referrals will be discussed within 5 working day and prioritized for assessment.

Response times are determined by clinical need/urgency and all referrals will be screened. Accepted referrals will then receive treatment within 11 weeks. Priority will be given based on clinical need (those patients who are transferring from CAMH's services, have an early onset of their eating disorder with short illness duration, are pregnant or have type 1 diabetes and those patients with a BMI of less than 14 with rapid weight loss).

Patients who are discharged from hospital to the care of the community team are followed up within 48 hours of discharge

Discharge Process

In general, discharge will be a process agreed through collaborative discharge planning In some circumstances referrals to other services may be considered.

Once a date has been agreed for discharge, the following should be considered;

1. Any long term follow up plan to be communicated to the patient in terms of how it will be arranged and when it is likely to be carried out. The patient will be asked to complete outcome and satisfaction questionnaires. The data collected will be collated. The satisfaction questionnaires will be inputted onto The Meridian System and used to generate reports. The outcome measures are scored and compared with the measures at assessment.

2. The SU will be supported by the community generic mental health team on discharge from the ED SERVICE if the need is clinically appropriate

3. In cases were the patient is unable to effectively engage in treatment and the physical risks are low then the GP will be asked to take responsibility for monitoring and risk assessment. In some circumstances referrals to other services may be considered.

4. All professionals involved in the patient's care will be informed of the discharge and the care plan. Where the patient is involved with other agencies/services, a detailed summary of the treatment and relapse plan will be sent to them.

5. The patient's GP will be notified of discharge from the service.

Skill Mix

The service has a full multidisciplinary team to deliver NICE concordant care.

3.3 Population covered

Patients over the age of 18 registered with a GP within North Staffordshire and Stoke on Trent CCGs.

When working with university students, the local and home service should work together to ensure seamless continuity of care both in and outside of term time.

3.4 Any acceptance and exclusion criteria and thresholds

The service provides a person centered needs led out-patient/community service for adult patients, both male and female who are predominately aged 18 and over, who suffer with an eating disorder.

However transitional protocols from Childrens ED service will determine the most appropriate team to deliver the required care based on need and not led by age

Inclusion criteria

- Individuals with eating disorders that significantly affect their physical health and/or their mental and social functioning
- Referrals for people with diabetes or pregnant women are accepted into the service with a lower threshold of eating disorder severity

- Moderate/severe eating disorders with high clinical risk.
- A diagnosis of Anorexia Nervosa, regardless of severity as there is little evidence for the treatment of this disorder in primary care.
- Severe and enduring eating disorders with complex needs requiring continuing care from multiple agencies e.g. drug and alcohol, community mental health, social care.
- Individuals discharged from inpatient treatment should receive psychological/ psychiatric treatment for at least 12 months post- hospitalisation.
- Rapidly losing weight, such as more than 1 kg a week for 1 month or whom are consistently losing weight but over a longer period of time e.g.<0.5kg a week over 3 months.
- Bingeing and/or vomiting/ and or laxatives use/ and or compulsive exercise at least 5 times a week, for 3 months or more.
- Eating disorder and co-morbid depression, and or are at risk of self-harm or suicide
- Failure to respond to evidence based psychological therapies e.g. online CBT-e for mild Bulimia, Binge Eating Disorder, Atypical Eating Disorder or Other Specified Eating Disorder

<u>Exclusion Criteria</u>

- Mild eating disorders which do not cause significant distress, considerable physical risk or impairment in the service user's social, occupational and other important areas of functioning. These individuals would be most appropriately referred to initially try online guided CBT-e and supported by generic community mental health teams.

- Loss of appetite, psychogenic disturbance of appetite or other conditions that involve significant weight loss but which are due to physical illness or other psychiatric conditions such as anxiety disorder.

- Morbid obesity (i.e. in the absence of an additional diagnosis of an eating disorder such as Binge Eating Disorder or Bulimia Nervosa).

    - Primary substance misuse
    - Weight loss due to primary depression
    - Weight loss due to organic disease
    - Obesity in the absence of binge eating disorder

- Abnormal eating patterns due to psychosis / learning difficulties
- Specific food phobias

Days / Hours of Operation

The service is predominantly a 9 am-5 pm service, operating Monday to Friday **However this will be developed through a staged approach over next 3 years to support intensive home support and out of hours support to prevent admissions to specialist care**

Referral Process

Referrals will be accepted through a single point of access and will be accepted from General Practitioners and other healthcare professionals with General Practitioner approval.

All referrals are screened by senior clinicians. A decision will then be made as to both the appropriateness of the referral and, if accepted, the degree of urgency, based on clinical needs generally relating to BMI, rate of weight loss or instability of blood chemistry.

Local referral pathways and protocols assist in the referral process and in treatment planning.

Referral criteria includes the following features;

- Rapid and / or sustained weight loss
- Deliberate, poor nutritional intake
- Objective binge eating
- Use of compensatory behaviours in order to avoid weight gain i.e. self-induced vomiting, laxative abuse, diuretic abuse and excessive exercising
- Body image disturbance / distortion
- Drive for thinness
- Morbid fear of fatness
- Persistent failure to meet appropriate nutritional /energy needs / significant nutritional deficiency

3.5 Interdependence with other services/providers

- NHSE commissioned Eating Disorders Inpatient provision

- CMHT – will provide support for people with Eating Disorders

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- Eating Disorder (NICE CG009)
- Eating Disorders Quality Standard (QS175)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

- Management of really sick patients with Anorexia Nervosa Oct 2014 Royal College of Physicians (MARSIPAN).

- Guidance for commissioners of eating disorder services; Joint Commissioning Panel for Mental Health http://www.jcpmh.info/wp-content/uploads/jcpmh-eatingdisorders-guide.pdf

- CCQI Quality Standards for Adult Community Eating Disorder Services, First Edition, May 2019, Royal College of Psychiatrists

https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/eating-disorders-qed/qed-community-standards---first-edition.pdf?sfvrsn=63c956ba_2

- Adult eating disorders: community, inpatient and intensive day patient care - Guidance for commissioners and providers, National Collaborating Centre for Mental Health, August 2019
- Transition from children's to adults' services (2016) NICE quality standard 140.

4.3 Applicable local standards

- Inpatient case conference / referral process / protocol
- Risk assessment and management
- CPA policy
- Local transition protocol from CYP to adult services

5. Applicable quality requirements and CQUIN goals

5.19 Applicable Quality Requirements (See Schedule 4)

- Standardised measures should be used to measure outcome (e.g. Eating Disorder Examination Questionnaire, EDE-Q; CORE; HONOS; Clinical Impact Assessment Questionnaire, CIA) recovery outcomes (e.g. returning to work/college).

- Patient satisfaction with services should also be evaluated.

- A clinical audit of compliance with NICE quality standards will be undertaken in the first year of service delivery
    - Statement 1 People with suspected eating disorders who are referred to an eating disorder service start assessment and treatment within 4 weeks for children and young people or a locally agreed timeframe for adults.
    - Statement 2 People with eating disorders have a discussion with a healthcare professional about their options for psychological treatment.
    - Statement 3 People with binge eating disorder participate in a guided self-help programme as first-line psychological treatment.
    - Statement 5 People with eating disorders who are being supported by more than one service have a care plan that explains how the services will work together.
    - Statement 6 People with eating disorders who are moving between services have their risks assessed.

Quality network for eating disorders (QED)

This is an initiative of the College Centre for Quality Improvement. A quality assurance framework has been developed to provide a set of both core and specific standards.

The standards can be found at:
www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation/eatingdisorderservices/qed.aspx

5.20 Applicable CQUIN goals (See Schedule 3)

6. Location of Provider Premises

The Provider's Premises are located at: within the locality premises of the Trust with a HUB available in the North and the City for team and MDT meetings

Service Specification Number	**A22**
Service Name	**Personality Disorder and Complex Relational Needs pathway including Community Assessment, Stabilisation and Treatment Team (CASTT).**
Population and/or geography to be served	**The Pathway is for:** • **People (aged 18 years and over) who are registered with a general practitioner within the North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups (CCG). For people who are not registered with a GP, the service will be open to people for whom the above CCGs are recognised as being responsible commissioners.** • **Those patients with emotional regulation difficulties including trauma. While some service users may have a diagnosis if personality disorder (PD), the Pathway/CASTT Service shall not be diagnostically driven. The care and support offered should not be determined by whether somebody has a diagnosis or not but whether their needs can be met by the treatment programmes offered in the pathway and their presenting needs.** • **Patients with other comorbidities (such as mild Learning Disability, or neurodiversity) will not be excluded from the service. Each referral shall be considered on a case-by-case basis. Wherever possible reasonable adjustments will be made.** • **For those patients in CAMHS (Children and Adolescent Mental Health Services) are approaching 18 years of age.** **Criteria to access the specialist service, CASTT:** • **Do not have to have a formal diagnosis of PD to access service but will have severe levels of self-harm, suicidality and hopelessness.** • **Show significant instability of** o **interpersonal relationships,** o **self-image** o **mood** • **Have impulsive behaviour**

	• **Must have some commitment to live and a willingness to engage and reduce self-harm behaviours/suicidality.** • **Must be accessing a Community Mental Health Team (CMHT) in order that lower intensity evidence-based treatments for complex emotional needs/personality disorder have firstly been considered/pursued.**
Service aims and desired outcomes	**The Pathway aims to support those patients with emotional regulation and significant instability of interpersonal relationships, self-image and mood, and impulsive behaviour, by providing a consistent, NICE complaint, well-managed and effective service offer.** **The following objectives are considered key to delivering an effective service for the people of Stoke-on-Trent and North Staffordshire:** • **Create a trusting, positive and optimistic environment that instils hope and empowers people long-term recovery and people are able to thrive.** • **Meet national good practice guidelines for the timely assessment and treatment of emotional regulation difficulties including trauma and/or a diagnosis of PD.** • **Patients are offered psychological therapies appropriate to their clinical needs in terms of type, duration and intensity of therapy.** • **Are delivered by a workforce that is knowledgeable, skilled and competent.** • **The workforce who are supporting people emotional regulation difficulties/PD have an agreed level and frequency of supervision.** • **Services are delivered in a number of innovative and ever evolving ways so as to ensure the continuity of provision** • **Offer flexible, responsive and proactive services that are of a consistently high standard and quality.** • **Personalised co-produced evidence-based structured and phased care plans are developed and implemented with patients and their families/carers before services change or are withdrawn** • **Personalised and co-produced crisis plans are developed with patients and their families/carers and other services that may be required.** • **Works in partnership with other providers of services**

	• **Provides advice and support to patients, families and carers.** • **Demonstrate a thorough knowledge and understanding understanding of all local resources relevant to support of individuals emotional regulation difficulties/PD and promote effective interagency working.** • **Provide advice, support and training to other services who come into contact with people with emotional regulation difficulties/PD.** **The expected outcomes are as follows:** • **To improve the identification of people with PD, who may otherwise go unrecognised and un-treated.** • **Patients receive timely access to evidenced-based NICE complaint assessment, diagnosis and relevant treatment/interventions and support to manage their mental health and emotional regulation difficulties so as to maintain settled and stable lifestyles in the community.** • **Patients will have a structured patient-centred journey, which includes the treatment, interventions and support to manage their emotions and mental health, hence promoting hopefulness and self-determination, increasing their social functioning and inclusion and ultimately their quality of life.** • **Greater patient care planning, including clear pathways into/out of services, positive problem solving, promotion of self-advocacy, maintenance and crisis planning.** • **Formal hospital admissions under the Mental Health Act will be reduced by working with patients and their family/carer, through early detection in deterioration of patient's mental health and emotional presentation and through the development of effective contingency/crisis plans.** • **A reduction in attendance at A&E.**

	• **Patients have improved and stable behaviour patterns – reduced impulsive behaviours such as suicidal, self-harming, aggressive behaviours.** • **Improved Service User's satisfaction with the support they receive.** • **The stigma associated with PD is reduced, though education and training** • **Improved skilled workforce to meet the demand of the local population of with emotional regulation difficulties and trauma.** **A range of recovery-based outcome tools will be used to demonstrate effectiveness of the service delivered. Improved quality of life, better relationships, reduced use of high-support and crisis services, and entry into education and employment are important outcomes to measure.**
Service description and location(s) from which it will be delivered	**Service Description and Pathway** **This Service/Pathway is for people who require treatment for emotional regulation difficulties and complex relational needs. The Pathway, including the CASTT Service, should offer a seamless and integrated stepped care approach that includes a Structured Clinical Management focus which aims to empower service users by reducing stigma and enhancing their skills to manage daily life.** **The delivery of interventions within the Pathway shall fall into 3 clear cohorts within 3 symptom domains: Impulsivity, Affective Instability and Interpersonal Conflicts.** • **Cohort 1 – Many service users diagnosed with a Personality Disorder or emotional regulation difficulties can be well supported by the Community Mental Health Teams using single modality evidence-based treatment approaches as recognised in the NHS Long Term Plan. This cohort shall be managed within the Community Mental Health Teams and may be offered evidence-based psychological interventions depending on clinical formulation and presentation (Service Specification A5).** • **Cohort 2- More structured and intensive multi-modal interventions will be required for a time limited period due to the presence of life-threatening behaviours.**

- **Cohort 3 - Specialist psychological therapy in a multi-modal format is required due to comorbidity and complexity of presentation.**

As the evidence suggests that the delivery of interventions to services users within cohorts 2 and 3 should be provided through a specialist team, separate from the Community Mental Health Team but as part of a stepped care approach, these cohorts shall be the focus of CASTT.

In addition, as the ARRS (Additional Roles Reimbursement Scheme) practitioners' roles develop, it is anticipated that patients can be supported in primary care with supervision/support/guidance to the ARRS practitioners from the CASTT team.

There shall be a supportive approach with case management and advocacy support. It is imperative that the Pathway and CASTT develop an optimistic and trusting relationship with patients, with consistent care and an environment of respect and hope. It is also imperative that a holistic approach is taken, and all aspects of the patient's life are considered.

Where appropriate, with consent of the patient, encourage family or carers to be involved.

The Pathway and CASTT shall be delivered in a flexible, blended approach of both face to face and on-line appointments and group work.

Figure 1 provides an overview of the stepped care provision across NSCHT services for adults with complex emotional and relational needs or a diagnosis of Personality Disorder.

Referral

Referrals into CASTT are accepted from one of the Adult Mental Health or Older Adult CMHTs, as the expectation shall be that a lower level of intervention shall have been tried in the CMHT's prior to a referral to CASTT. Referrals into the Pathway and CASST service shall be triaged and assessed in a timely manner and in line with national standards and best practice.

	The Service should ensure that it is accessible to all, whilst remaining adherent to the specified models of treatment and evidence base. **Diagnosis** **The CMHTs will provide a diagnostic assessment of PD, when appropriate. CMHT and CASTT services shall work in conjunction with one another, and lower levels of trauma informed interventions explored via the CMHT with CASTT input into the MDT discussions.** **Interventions and Treatment** **CASTT shall provide a Structured Clinical Management (SCM) or Mentalisation Based Therapy (MBT) standardised programme of intervention that is in line with NICE guidance.** **The relevant programme will be described to the service user at the outset during an assessment of commitment and engagement. Through a defined treatment programme from assessment, to engagement, to treatment and then discharge, usually occurring on a weekly basis the programmes will be focused on exploration and elaboration of treatment targets and goals. For all treatments it is necessary for both patient and practitioner to hold a shared focus which prioritises a commitment to life. Development of collaborative treatment plans, risk and crisis management plans are an integral part of the interventions delivered within CASTT. There shall be assertive follow-up if appointments are missed.** **The principles of CASTT shall be:** • **Provision of a dedicated 1:1 practitioner who is also responsible for the delivery of one or more of the internal weekly group programmes running within CASTT. There should be flexibility within the practitioner's caseload to cover sickness and absence and to support vacancies where needed, to attend weekly MDT within a designated locality, to cover telephone coaching duties, to engage in regular interface with wider system colleagues and to support the delivery of CASTT team functions including MDT and weekly team supervision. It is**

proposed that at full capacity, practitioners should hold a caseload of 12 plus the duties described above to ensure that the expected consistency of the service can be maintained.

- **An emphasis on a consistent approach to supporting an understanding of diagnosis that is more aligned with psychological formulation should be maintained. The formulation process should involve carers and family wherever possible/ appropriate.**
- **Structured group interventions will run throughout the course of treatment.**
- **Clear discharge planning from the outset, with an emphasis on building resourcefulness and resources.**
- **Focus on psychological interventions and away from pharmacotherapy.**
- **Effective and shared crisis planning with sign up from other agencies. The other Services within the Provider should also be part of crisis planning.**
- **Rapid response to referral and re-referral.**

There are for main phases of the intervention programme:

- **6-8 week assessment period (to consider whether the person feels able to commit to life and to engage with the interventions that are offered by CASTT)**
- **A stabilisation period of up to 12 weeks**
- **A treatment phase of between 6 and 12 months**
- **A focussed discharge planning phase of 3 to 6 months**

The treatment phase shall consist of one individual appointment per week and one group per week, as per SCM and MBT guidance. Wherever possible, the broad times of weekly treatment shall be consistent.

The group treatment phase within SCM shall consist of modules aligned to the key symptom domains including impulsivity, affective instability and interpersonal conflict. There is to be a cycle of groups that are on-going at all times. Each group will consist of 6 – 8 week modules, meeting once a week and will be facilitated by at least two clinicians based within CASTT. Group size is anticipated to be between 6 – 10 people for online working. Week 1 of each of

	the group interventions shall be a nodal point, allowing for service users to join/ re-join as needed. **In addition to SCM and where clinically indicated for those patients who have a high degree of complexity, CASTT will be equipped to offer a specialist psychological treatment known as Mentalization Based Treatment (MBT). This treatment is matched in intensity to SCM (both group and individual therapy delivered through a team of practitioners), but it involves the application of specialist psychotherapeutic techniques and therefore requires an increased level of psychological skill and capability on the part of the facilitators. MBT delivery is thus proposed to be acceptable for a smaller proportion of clients with higher levels of complexity and comorbidity. MBT is delivered by a team of practitioners most often comprising of psychologists, psychotherapists and some generalist practitioners with a suitable skill set and experience who can work under the supervision of psychological professionals.** **Transfer and Discharge** **It is imperative that CASTT and CMHTs carefully manage endings of treatment and support transitions into other teams/services. Such changes should be discussed carefully beforehand with patients (and their family or carers if appropriate) and should be structured and phased.** **The psychological interventions provided by CASTT should be time limited in nature, with an expectation that once stability has been achieved the patient will, on a needs led basis be stepped down to less intensive provisions.** **For those patients who disengage from the treatment programme, CASTT shall look to use therapeutic discharge to help with this whereby the "easy off, easy on approach", should be taken. This means that service users can return to the programme after a period of reflection if they hold a willingness to engage and a commitment to live. Clinical judgement and decision making through team consideration shall inform discharge processes from CASTT using the weekly team supervision forum embedded within both SCM and MBT treatment models. This process intends to ensure that the most helpful approach to discharge planning is taken. Some patients may not be discharged from NSCHT completely and may be transferred back to the CMHTs, where they will receive support following psychologically informed principles whilst preparing to return to CASTT should this be appropriate.**

	Operational location and access **CASTT will be based on a hub and spoke model, be agile and locality based. It will work in collaboration with whilst functioning independently of the existing community mental health teams within a stepped care approach supporting therapeutic intervention within localities. Online methods have been found to be of value for this patient group and will be considered where appropriate in order to meet client and service need.** **CASTT shall be operational 5 days per week during office hours. Support outside of these hours will be through Crisis Care and Home Treatment Team provision through collaborative care planning.** **Training and consultation across the Provider Trust** **All Provider clinical staff shall receive bespoke training in the underpinning culture, values and understanding of trauma informed care and the skill set to support this.** **As the service develops, CASTT shall develop training for adult community mental health team practitioners in SCM so that they are able support less complex presentations. This will ensure that patients receive a seamless and integrated stepped care approach to their care between CASTT and the community mental health team, where appropriate.** **All training programmes shall be designed and delivered through a variety of methods, aimed at improving awareness and understanding.** **Staff with the suitable competencies within CASTT shall be trained in Mentalization Based Treatment (MBT). These competencies will be aligned with the Roth and Pilling framework outlined within the NHS Long Term Plan. As MBT is known as a specialist treatment for personality disorder, it is expected that clinicians will have a background in the delivery of psychological treatments for complex problems and will have training and expertise in psychological formulation from a broad range of perspectives. For clinicians who hold qualifications and job plans aligned with the psychological professions, training in and delivery of MBT should be a mandatory component of their role. For generalist practitioners this should be considered on an**

	individual basis within the context of the clinician's competencies, experience and skill set. Due to the level of skill in psychological therapy required to deliver MBT, training in this intervention should be optional rather than mandatory for generalist practitioners. **The staff in urgent/crisis care will need to be familiar with SCM principles and be competent to deliver crisis interventions aligned with these approaches.** **In line with the original NSCHT business case, the workforce of CASTT shall be based on the staffing complement submitted in the business case (June 2020).** **Interdependencies and Partnership working** **Given that Personality Disorder is often comorbid with depression, anxiety, eating disorders, post-traumatic stress disorder, alcohol and drug misuse, and bipolar disorder, where feasible CASTT should engage in regular interface arrangements with colleagues across the wider system. This should ensure that there is inter-service working and look to develop systems of communication and information sharing among different services.** **Services CASTT may interface with within NSCHT are:** • **Crisis Care Centre** • **Home Treatment Team** • **Mental Health Liaison/ High Volume Users Team for those people who attend A&E frequently.** • **Mental Health Rehabilitation Services** • **Learning Disability Services for those with a mild Learning Disability.** • **ARRS (Additional Roles Reimbursement Scheme) practitioners.** • **CAMHS to develop local protocols to govern arrangements for the transition of young people from CAMHS to adult services.** **Given that personality difficulties and disorders are complex conditions which affect many groups of people in society, and which give rise to wide-ranging problems and needs (people with PD may present with a range of physical, mental health and social problems), CASTT and the community mental health**

	teams should maintain close working practices, collaboration and pathways for this cohort of patients with other services and organisations such as • **Primary care and ensuring that clear lines of communication between primary care are established and maintained.** • **Voluntary community and social enterprise (VCSE) organisations, especially those located in the Northern Staffordshire and Stoke-on-Trent location, where support from the VSCE may be beneficial to the service user.** • **Substance misuse services.** • **Education and employment support services/organisations that has been identified in their care plan.** • **The criminal justice system and police.** **National guidance** **The Service shall ensure that NICE Guidance is adhered to, which includes but is not limited to:** • **NICE QS88-Personality disorders: borderline and antisocial** • **NICE CG136- Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services** • **NICE CG16 – Self Harm** • **NICE CG78 - Borderline personality disorder: recognition and management**

<u>Figure 1:</u> Stepped care provision across NSCHT services for adults with complex emotional and relational needs or a diagnosis of Personality Disorder.
Referral into CASTT[1] is via the CMHTs[2] so that there is a stepped care approach to treatment.

<table>
<tr><td rowspan="5">
Increasing level of support required.

Increasing presentation of risk and complexity in the three system domains of:
1. Impulsivity
2. Affective instability
3. Interpersonal conflict.</td><td>Crisis Care Centre & Home Treatment</td><td>• For Out of Hours Support and Crisis/urgent situations.
• The staff in urgent care will need to be familiar with the model and be competent to deliver crisis interventions aligned to the principles of SCM[3] and trauma-informed care.</td></tr>
<tr><td rowspan="2">CASTT psychological treatment programmes.</td><td>• Cohort 3: highest complexity and high resource.
• Should be offered intervention with specialist CASTT team.
• Likely to access urgent care services frequently.
• May benefit from MBT[4].</td></tr>
<tr><td>• Cohort 2: individuals with functional impairments but less comorbidity/complexity.
• SCM cohort within CASTT Service.
• These service users may use urgent care services.</td></tr>
<tr><td rowspan="2">CMHTs:
Cohort 1

Trauma-informed approach adopted within CMHTs.</td><td>• Aligned to 3 symptom domains but do not require multi-modal treatment approach offered through CASTT.
• Managed by CMHT and offered single modality evidence-based treatments delivered by specialist practitioners (usually psychological professions or team practitioners delivering evidence-based treatments for PD). Such treatments (when available) might be Cognitive Analytic Therapy, Schema Focused Therapy, Group Interpersonal Therapy or Transference Focused Psychotherapy as recommended in the Long Term Plan.</td></tr>
<tr><td>• Individuals with problems aligned to at least one of the 3 symptom domains.
• Lower intensity interventions will be available for this cohort in the form of a DBT[5]-informed coping skills programme within the CMHT.</td></tr>
</table>

[1] Community Assessment, Stabilisation and Treatment Team (CASTT), [2] Community Mental Health Teams (CMHT), [3] Structured Clinical Management (SCM), [4] Mentalization Based Therapy (MBT), [5] Dialectical Behaviour Therapy (DBT)

Service Specification No.	B01
Service	Older Adults In-patient provision – Assessment and Complex Needs
Commissioner Lead	Jane Barnes, Locality Commissioning Manager, North Division, CCG
Provider Lead	Rachael Birks, Associate Director Acute and Urgent Care
Period	1st April 2022 - 31st March 2023
Date of Review	Review in year with a view to updating and brining all older people service specifications into one pathway service specification.

1. Population Needs

National/local context and evidence base

According to national prevalence data there are a approximately 5,998 people living with dementia across Staffordshire Moorlands, Newcastle Under Lyme and Stoke on Trent. It is readily acknowledged that the number of older people in our population is growing, with a corresponding increase in the number of those at risk of dementia expected to rise to 1 in 14 people over the age of 65 and 1 in 6 people over the age of 80. Furthermore as the aging population continues to rise so will the inevitable demand on health and social care services. Improving the quality and efficiency of current mental health services to achieve the best outcomes for patients is therefore considered a priority; and is recognised as a key component in a number of national policy and guidance documents. With keen reference made to developing and providing mental health services that are devoid of barriers, supportive of all ages, of the highest quality and delivered in line with current evidenced best practice as demonstrated in the following:

- **DOH, 2001 The National Service Framework for Older People, Department of Health London**
- **DOH 2005, Everybody's Business, Integrated Mental Health Services for Older Adults: A service development guide, Department of Health, London**
- **DOH 2005, Mental Capacity Act, Department of Health, London**
- **DOH 2006, NICE Clinical Guideline 42 Supporting People with Dementia and their Carers in Health and Social Care**
- **DOH 2009, Living Well with Dementia, A National Strategy, Department of Health, London**
- **DOH 2011, No Health without Mental Health: A cross government mental health outcomes strategy for all ages, Department of Health, London**

In addition the NHS new operating framework Everyone counts: Planning for Patients 2013/14 sends out a clear message regarding the importance of providing services that enhance the

quality of life for people with long term conditions, especially dementia, and ensuring that people with mental ill health have an improved and positive experience of community mental health care.

Additional National Guidelines/Policies

A. **Refocusing the Care Programme Approach DOH 2008**
B. **Dignity In Care DH 2006**
C. **Our NHS Our Future NHS Next Stage Review DH 2007**
D. **Everybody's Business DH 2005**
E. **National Dementia Strategy DH 2009**
F. **National Service Framework – Mental Health DH 1999**
G. **Standards for Better Health Annual Health Check CQC**
H. **Safety, Privacy Dignity in Mental Health Units DH 2000**
I. **NICE Guidance/SCIE guidelines**
J. **Dept of Health Code of Practice MHA 83(07)**
K. **Mental Capacity Act 2005**
L. **National Service Framework for Older People DH 2001**
M. **MHA 1983 (07)**
N. **A New Ambition for Old Age – Next Steps in Implementing the NSF for**
O. **Older People DH 2006**
P. **Opportunity Age: Meeting the Challenge of age in the 21st Century DH**
Q. **2005**
R. **Carers policy DH 2009**
S. **Safeguarding Legislation – Safeguarding Vulnerable Groups DH 2006**
T. **Everyone counts: Planning for Patients 2013/14**

In addition, as demonstrated throughout policy and guidance documents significant emphasis is placed on adopting a 'whole systems' approach t o service delivery in order to achieve 'best quality' care for older adults experiencing significant mental ill health.

Local context

In line with the national picture the local health economy has a rapidly expanding population of older adults and in order to meet the diverse needs of the resident population local mental

health services are currently undergoing considerable change and transformation to include: extensive community service re-development and centralisation of inpatient services. This service modernisation approach supports improved access and delivery of more effective care within the community and inpatient service areas that are specifically designed for older adults with high level acute/complex mental health needs.

The impetus to ensure delivery of safe, effective, clinically appropriate inpatient care services for older adults remains a key priority for commissioners as evidenced within local health care policy

2. Outcomes

It is anticipated that the following key outcomes will be realised for older adults with acute or complex functional or organic mental illness who have received inpatient care:

A. **The patient received timely and appropriate access to specialist inpatient care based on individual assessed clinical need**

B. **Each patient received a holistic multi-disciplinary assessment and an individual program of treatment/interventions/rehabilitation supportive of mental and physical health, psychological and emotional needs, social, cultural spiritual and communication needs**

C. **Each patient had an individual care plan developed using a person centred approach considerate of individual choice and preferences to support equality and diversity of need**

D. **Evidenced based clinical treatment and interventions have been used to support patient recovery**

E. **Patient and carer's are involved in all aspects of decision making and the care planning process**

F. **Carers are offered an assessment in their own right**

G. **Inpatient care is delivered in the least restrictive environment**

H. **Patient and carers are provided with relevant advice, information and support to promote their on-going health and wellbeing**

I. **Discharge planning is appropriate, timely and compliant with CPA Policy where indicated**

J. **Discharge plans are comprehensive, identify the patients on-going needs and how these will be met**

K. **Carers needs are incorporated into the discharge plan**

L. **Information and contact details are made available to patients and carers regarding their on-going community support services**

M. **Effective pathways with Community Mental Health Services and a range of other community care providers are in place to facilitate discharge**

N. **GP's and Community support services are in place to provide follow on care at the point of discharge**

3. Scope

3.1 Aims and objectives of service

Improving the quality and efficiency of current services to achieve the best outcomes for patients is a key component of the national strategy, No Health Without Mental Health. Where emphasis is placed on the need to ensure that when inpatient care is required, services are effective, well managed and unnecessary long stays are avoided. Inpatient service providers should adopt a whole systems approach and work jointly with community services to support avoidable admissions where possible, and where admission takes place to ensure a smooth seamless transition back to the community at the point of hospital discharge. Admission should be based on clinical need, to the most appropriate place and least restrictive environment where all aspects of the older adults psychiatric, emotional, social, spiritual and cultural wellbeing can be met.

The overall aim of the inpatient service for older adults is: to provide comprehensive assessment, treatment and rehabilitation for those people who have been clinically assessed as suffering from an acute or complex functional or organic mental illness, that is of such intensity or complexity that the person cannot safely receive assessment or be treated at home or within a community setting

<u>Service Objectives</u>

It is expected that the inpatient service for older adults with acute exacerbation of their dementia or mental illness will deliver specialist mental health care in the least restrictive environment, and provide:

A. **Rapid access to specialist inpatient mental health care for older adults with high level acute/complex/enduring mental health needs**

B. **Specialist support delivered through multi-disciplinary assessment, treatment and rehabilitation within a safe therapeutic environment**

C. **Prompt multi-disciplinary holistic assessment that supports the older persons mental health, psychological, social and physical needs**

D. **An all-inclusive service that is considerate of the older persons cultural, spiritual and communication needs**

E. **Recognise and be sensitive to the individual preferences and choices of older people with acute/complex/enduring mental health problems and adopt an approach that supports equality and diversity of need**

F. **Deliver a range of evidenced based treatment/interventions that are time limited, appropriate to the assessed needs of the individual, ensuring that inappropriate and unnecessary treatments are avoided**

G. **Adopt a person-centred approach to care through the development of individual care plans that focus on recovery and inclusion whilst encouraging patient / carer involvement**

H. **Provide a range of time limited clinical interventions and treatment to support active rehabilitation and recovery, inclusive of developing/promoting patient self-management skills and personal coping strategies**

I. **At all times provide care in line with evidenced best practice and current mental health legislation to include: NICE Clinical Guidelines, Mental Health Act 1983 (amended 2007), Mental Capacity Act 2005, CPA Policy etc.**

J. **Where required support holistic assessments in line with the NHS Continuing Healthcare Criteria.**

K. **Deliver a service that actively promotes recovery and longer term independence to positively reduce the likelihood of premature admission to long term care facilities**

L. **Provide relevant advice, information and support to promote the on-going health and wellbeing of the patient and their carer**

M. **Promote patient and carer involvement in all aspects of decision making and future planning whilst showing due regard for their individual choice and preferences**

N. **Develop effective pathways with Community Mental Health Services and a range of other community care providers to facilitate a smooth transition from inpatient care to community care**

O. **Ensure appropriate planning for the safe discharge of those older adults who have recovered sufficiently to no longer require specialist inpatient mental health care, ensuring compliance with CPA Policy for those with complex/enduring mental health needs**

3.2 Service description/care pathway

3.2.1 Service Description

The inpatient service for older adults with acute exacerbation of dementia or mental illness will be provided at the Harplands Hospital, where multi-disciplinary assessment, treatment and rehabilitation will be delivered

Assessment/treatment interventions will be provided in the least restrictive environment paying due regard for the safety of the individual and that of other patients

The service will Engage the use of IMCA's and other advocacy support to assist patients in the decision making process regarding their care and future planning

A wide range of evidenced based treatment/therapy options will be facilitated that are relevant to assessed clinical need, considerate of individual social circumstance and supportive of family dynamics

Opportunity for specialist rehabilitation will be explored and delivered to support complexity of need whilst working toward positive outcomes in the form of improved independence and wellbeing

The service will be supported by highly skilled and competent staff from ac ross a range of disciplines who can demonstrate expertise in the provision of specialist mental health, medical, nursing and therapy services

All assessment/interventions will be in line with evidenced best practice and compliant with relevant mental health legislation and quality standards including the Mental Health Act 1983 (amended 2007), Mental Capacity Act 2005, CPA Policy, NICE Guidance, Stoke on Trent and North Staffordshire Adult Safeguarding policy and procedure etc.

Access to other specialist assessment deemed relevant to effective service delivery will be available to include, psychology, speech and language therapy, medicines management, dietetics, podiatry etc.

The service will provide targeted carer support and advice and facilitate carer assessment where accepted whilst recognising and noting carers needs, opinions and aspirations within the overall patient assessment.

The service will, at the most opportune moment plan for the safe discharge of those older adults who have recovered sufficiently to no longer require specialist inpatient mental health care, ensuring compliance with relevant policy and practice

The service will ensure discharge planning is inclusive of patient, carer, community mental health services and other relevant agencies to facilitate the smooth transfer to the persons home or service within the community.

The inpatient service for older adults will work with the relevant clinical networks and evidence based screening programmes and tools appropriate to acute or complex functional or organic mental health conditions.

3.2.2 Service Model

The inpatient service model will support a multi-professional whole systems holistic approach to care, providing assessment, treatment and supportive rehabilitation in line with evidenced best practice.

The inpatient service will be sufficiently staffed to safely support the needs of older adults with acute or complex functional or organic mental illness

The staff working in the inpatient service for older adults with acute or complex functional or organic mental illness will be appropriately trained and have the necessary clinical and managerial skills to effectively carry out their role, it is expected that this will include: Psychiatrist, Psychologist, Nurses, Physiotherapist, Occupational Therapist, Social Worker, Support workers, Administrative staff and ancillary support services etc.

Whilst the service will ensure appropriate levels of security, service provision will be

provided in the least restrictive environment possible, length of stay will be time limited based on individual clinical need, with onward referral to appropriate mainstream/community care services on completion of the patient/service user assessment/treatment program

The inpatient service for older adults will develop, work with and maintain relationships with other agencies/organisations to support effective and efficient service delivery to achieve the best possible patient outcomes

It is anticipated that the inpatient service will work to the principles of t he Health of the Nation Outcome Scale (HONOS) and utilise the Yorkshire Care Pathways.

1.2.2 Referral process

The inpatient service provider will ensure the process for referral is communicated to all relevant agencies across the local economy. In addition the service provider will establish and maintain an up to date web based information page to support accessibility

Days/Hours of Operation

The inpatient service for older adults experiencing acute or complex functional or organic mental illness will be provided 24 hours a day over 365 days a year

Referral Criteria

The inpatient service will be provided to people aged 65 and over, who have been clinically assessed as experiencing acute or complex functional or organic mental illness that warrants inpatient psychiatric care.

Where legally required appropriate documentation will be completed in line with the Mental Health Act 1983 (amended 2007)

Referral Source

Referrals to the inpatient service for older adults with acute or complex functional or organic mental illness will be accepted from:

Older Peoples Mental Health and Adult Mental Health Single Point of Access

Out of Hours On Call Psychiatrist

Referral Route

The service provider will establish clear pathways to support accessibility to inpatient services for older adults with acute or complex functional or organic mental illness, to include:

A Single Point of Access

Out of Hours On Call Psychiatrist

Clear links to Access and Crisis Resolution service

Pathway information for all agencies referring into the service

Service Response Times

To support clinical need and patient/service user safety it is expected that the service provider will ensure an immediate response

Discharge Process

The staff working in the inpatient service will be responsible for ensuring appropriate planning for the safe discharge of older adults who have recovered sufficiently to no longer require inpatient psychiatric care and where their assessed needs can be more appropriately met by other relevant services. It is expected that staff working in the inpatient service will initiate discharge at the earliest opportunity and where the following criteria have been met:

- **The agreed inpatient assessment/intervention/therapy/rehabilitation program has been completed**
- **The multi-professional/disciplinary team agrees that inpatient care is no longer required and this has been discussed with the patient/service user and/or carer**
- **A needs appropriate discharge/care plan has been developed by the care coordinator in conjunction with the patient/service user/carer/ and Primary/Community Care/Social Care services**
- **Risk assessments have been completed and risk management plans identified as part of the discharge/care plan**
- **A support package has been commissioned to meet the on-going needs of the patient/service user/carer and is in place**
- **In line with CPA Policy a planned handover of care to the appropriate services has taken place including arrangements for follow up contact.**

The staff working in the inpatient service will ensure:

- **A discharge summary/letter will be provided to the GP with an outline of assessment/treatment/interventions and arrangements for on-going care management and support**
- **Will record in the discharge entry in the patient/service user record, the HONOS elements of MHCT**

- **Will provide patient/service user and carer with information on support services available to include: advice and support services, i.e. Dementia Advisors, Carers Association, Voluntary and Independent sector support services**
- **Will provide advice and information in an appropriate format relevant to the needs of the patient/service user/carer**

1.2.3 Service Location and Delivery

North Staffordshire Combined Healthcare NHS Trust will retain overall responsibility for the provision of safe inpatient services for older adults with acute or complex functional or organic mental illness.

The inpatient service will be delivered at The Harplands Hospital, in gender appropriate accommodation, that affords dignity and respect for older adults experiencing acute or complex functional or organic mental illness

1.2.4 Workforce

- **The inpatient service provider shall have sufficient and skilled staffing to provide care, clinical need and safety to deliver the outcomes required by patients/service users who access the service as outlined in this service specification**
- **All staff working in the inpatient service for older adults will have their training/development needs assessed on an annual basis and will be supported to undertake appropriate training to ensure they are kept up to-date**
- **Training will be inclusive of and developed in line with new policy and guidance and best practice**
- **All staff working in the inpatient service for older adults will have current DBS clearance**
- **All staff working in the inpatient service for older adults will maintain compliance with mandatory training requirements**

1.2.5 Clinical Supervision

The service provider will ensure that appropriate arrangements are in place to provide sufficient levels of supervision and support to staff working in the inpatient service for older adults who are involved in the delivery of assessment and clinical/therapeutic interventions.

These arrangements will need to be consistent with identified best practice across the range of specialties within the inpatient team. It is expected that direct links with a Consultant Psychiatrist will be in place to support patient review and ensure patient safety.

1.2.6 General Supervision

The service provider will ensure arrangements are in place to provide appropriate levels of supervision to all staff working in the inpatient service for older adults. These arrangements will need to be consistent with identified best practice and inclusive of managerial supervision where appropriate.

1.2.7 Qualifications & Competencies

- **All professionally qualified staff working within the inpatient older adults service will have active registration with the appropriate professional body**
- **Support workers working in the inpatient service for older adults will have received relevant training commensurate with their role and responsibilities**
- **All staff working in the inpatient service for older adults will have extensive experience of assessment, planning, treatment /intervention and evaluation of care across a range of acute and complex functional or organic mental health conditions**
- **All staff working in the inpatient service for older adults will demonstrate a thorough knowledge and understanding of local resources and pathways relevant to the needs of older people with acute or complex functional or organic mental illness and promote effective interagency working**
- **All staff working in the inpatient service for older adults will work in line with current Best Practice Guidance, CPA Policy and comply with all relevant legislation to include: The Mental Health Act 1983 (amended 2007), The Mental Capacity Act 2005 etc.**

1.2.8 Sub-contractors

Any formal agreement between North Staffordshire Combined Healthcare NHS Trust and other providers should be clearly stated and not undertaken without agreement from commissioners.

1.2.9 Care Pathways

It is expected that the inpatient service provider will work to the Health of the Nation Outcomes Scale (HONOS) and Yorkshire Care Pathways

A.3 Population covered

The inpatient service for older adults experiencing acute or complex functional or organic mental illness will be provided to:

- **People aged 65 and over who are residents of the City of Stoke on Trent or North Staffordshire**
- **People aged 65 and over who are registered with a Stoke on Trent or North Staffordshire GP**

A.4 Any acceptance and exclusion criteria and thresholds

- **The inpatient service for older adults will be provided to people aged 65 years and over who are experiencing acute or complex functional or organic mental illness**
- **The inpatient service for older adults will be provided to people aged 65 years and over who are residents of the City of Stoke on Trent or North Staffordshire**
- **The inpatient service for older adults will be provided to people aged 65 years and over who are registered with a Stoke on Trent or North Staffordshire GP**

Exclusions

The inpatient service will not be provided to older adults who do not have acute or complex functional or organic mental illness

A. **The inpatient service will exclude people under the age of 65 years**
B. **The inpatient service for older adults will not be provided to people aged 65 and over who are non-residents of the City of Stoke on Trent or North Staffordshire**
C. **The inpatient service for older adults will not be provided to people aged 65 and over who are not registered with a Stoke on Trent or North Staffordshire GP**

3.5 Interdependence with other services/providers

The key relationships for the service will be with GP's and Primary Care Services, University Hospital North Staffordshire, North Staffordshire NHS Community Hospitals, Community Mental Health Teams and Mental Health Services, Drug and Alcohol Services, Social Care Services and other relevant statutory, voluntary and independent sector service providers

It is expected that clear pathways and lines of communication will be established with and across a wide range of provider agencies/organisation to support a truly holistic 'whole systems' approach to deliver positive patient outcomes

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

Refer to DOH 2006, NICE Clinical Guideline 42 Supporting People with Dementia and their Carers in Health and Social Care

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

The inpatient service will comply with relevant national standards of best practice in mental health care and current legislation in mental health inclusive of: appropriate and relevant NICE Clinical Guidance, Mental Health Act 1983 (Amended 2007), Mental Capacity Act 2005, CPA Policy and Practice etc.

4.3 Applicable local standards

It is expected that the service provider will ensure appropriate policy is in place in line with current health and safety and risk management guidance together with appropriate mechanisms for recording, auditing and monitoring feedback on service provision and actions taken to resolve issues.

Safeguarding

All staff working in the inpatient service involved in assessing older adults with acute or complex functional or organic mental illness must consider whether there are any safe guarding concerns relating to the patient/service user. Where there is concern for the safety of the patient/service user then it is the responsibility of the professional identifying the concern to notify the appropriate authority.

All staff working in the inpatient service for older adults with acute or complex functional or organic mental illness, should ensure that at the point safeguarding issues emerge they are referred in line with local safeguarding policies and procedures. This is the responsibility of the professional leading the assessment and should be clearly communicated to other partners. For example if the mental health assessment clearly identifies that the adult being treated is at risk or is a carer for another adult or a parent or lives in a household with children and that these children may be at risk because of the adult/ parental behaviour the responsibility to refer rests with the worker who identified this issue and a copy of the written referral retained in the patient/service user record.

All staff working in the inpatient service for older adults should familiarise themselves with, and follow local safeguarding procedures to ensure that the correct process is adhered to for the protection of adults and children.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4)

5.2 Applicable CQUIN goals (See Schedule 3)

6. Location of Provider Premises

Harplands Hospital, Hilton Road, Harpfields

Service Specification No.	B02 (including B10) – See 22/23 SDIP
Service	Care Home Liaison Team - Older Person's Mental Health Services and Care Home Physiotherapy
Commissioner Lead	Jane Barnes, Locality Commissioning Manager
Provider Lead	Jane Munton-Davies, Associate Director, Stoke Community Mental Health Services
Period	01 April 2022 – 31 March 2023
Date of Review	**See 22/23 SDIP**

1. Population Needs

1.1 National/local context and evidence base

Nationally nearly 416,000 people reside in care homes in the UK, 4% of those are 65 and over rising to 16% of those aged 85 or more. Their health and social care needs are complex; the majority have a disability, many have dementia, and collectively have high rates of both necessary and avoidable admissions to hospital.

The care home population is increasing due to the growing number of older people needing care and support, as well as improving survival rates from trauma and other severe physical conditions and disabilities.

It is well evidenced that residents in care homes have poorer access to healthcare services which is reactive and patchy compared with the general population despite the fact that they are among the sickest patients and have the most complex needs**.**

Research and best practice guidance shows that for high quality care; care should be proactive and delivered by a multidisciplinary service.

Care home residents are likely to be frailer and have medical conditions including dementia or have sensory impairments that increase the risk of falling. In care homes the rate of falls is almost three times higher than that of older people living in the community.

1.2 Local strategic context

The CCG's are working on a number of initiatives to enable care closer to home. The CCG's have developed a Care Home Strategy describing how the "Framework for Enhanced Health in Care Homes" published by NHS England in 2016 will be implemented and built

upon. These services fit with the majority of the priorities described in the Strategy and one of the key priorities is to ensure equity of access to healthcare service. This includes the development of pathways which will enable care home residents to access responsive specialist support in their normal place of residence. The vision for the Strategy is 'that care home residents have access to safe, good quality care in an environment most appropriate to their needs'.

For some time a care home physiotherapist service has been available to maximize resident's functional ability, independence and quality of life. Whilst there is a separate reporting line the service specification is included in this service specification.

Appendix 1 also details the additional support provided to care homes through the Outreach Track and Triage Role which commenced as a winter pressures project but is now part of the offer to care homes all year round.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	**ü**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**ü**
Domain 4	**Ensuring people have a positive experience of care**	**ü**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**ü**

2.2 Local defined outcomes

- Reduced number of admissions to hospital (acute or mental health hospital) from care homes
- Patients treated in the least dependent setting possible
- Reduction in antipsychotic use within care homes
- Earlier identification of dementia and increase in formal diagnosis.
- Improve access to falls prevention services
- To reduce number of calls to ambulance services for falls.

3. Scope

3.1 Aims and objectives of service

The aim of the CHLT is to provide integrated assessment, care planning, psychiatric and psychological treatment and care coordination for Adults aged 65 years and older experiencing functional or organic mental health problems in care settings. This shall involve working with service users and home care staff in nursing and residential homes.

- Assessment of complex challenging behaviour and significant mental health needs.
- Initial assessment of patients with a suspected dementia, with onward referral to appropriate services for diagnosis and management.
- Giving advice on the management of people with complex challenging behaviours and prescribing of appropriate medication when necessary.
- Review of patients prescribed antipsychotics to ensure that medication prescribed is clinically effective and still required. Antipsychotics should be reviewed every 3 months (NICE guidance). Reviews will only take place for patients open to the team.
- Prescribing treatment and care planning for people with complex and enduring mental health problems.
- Delivering a seamless and integrated service that is flexible, holistic and responsive to the needs of the individual and their carers.
- Promotes recovery and social inclusion.
- Provides education and support to care home staff
- Promote and assist in effective discharges from North Staffordshire Combined Healthcare Trust inpatient facilities and preparation for Care Home placement for the older person, their family and staff.
- Work with the Outreach Track and Triage Service commissioned to provide assertive outreach – 24 hour care homes. (Appendix 1).
- Work with the Care home Physiotherapy service who will:-
    - Ensure referred residents have a clear management plan in place
    - Provide education to the care home workforce on fall prevention strategies and initiatives.
    - Ensure that post hospital discharge pathways are in place for those residents who would benefit from further therapy intervention.

The objectives of the CLHT service are to:

Provide high quality care through:

- Staff qualified and experienced with the appropriate skills, knowledge and training to offer a high standard of service to service users, carers and other professionals.
- Prompt and expert assessment diagnosis and care planning of service users referred to the team with functional or organic mental health problems.
- Person centred planning within the CPA/ SAP framework.
- Provide effective evidence based treatments to reduce and shorten distress and suffering and promote recovery.
- Provide ongoing support, and therapeutic interventions to ensure quality of life is improved and to enable the least restrictive care possible.
- Planning to reduce the likelihood and impact of crisis and respond in a timely and appropriate manner.
- Ensure that the service is delivered in the least restrictive and disruptive way possible.
- Stabilise and improve social functioning to enable the service user to remain living in the care home.
- Refer on to other specialist services as appropriate e.g. Rehabilitation, Intermediate Care.

Promote recovery and inclusion through:

- Providing support, advice and information to service users and carers to help them cope with and manage their condition.
- Ensuring that inappropriate or unnecessary treatments are avoided.
- Establishing a detailed understanding of the relevant resources available to support older people with mental health problems and their carers.
- Ensuring that the service is culturally appropriate taking account of cultural, religious and communication needs.
- Providing on-going advice, support, education and guidance to Social Care, and other statutory, voluntary and independent sector providers.
- Providing effective liaison with local Primary Care teams, and other referring agencies to shape referrals in order to manage complex cases.
- Working collaboratively within a whole system approach to ensure that the service user experiences a seamless journey.

Expected Outcomes

Service User and Carer Experience

- Services users/Care Homes receive a prompt and timely response to the referral. First contact after allocation to be made within 24 hours (in line with good practice standards).
- The need for hospital admission is reduced or prevented.
- The assessment process is completed within 4 weeks using CPA.
- Service users receive a comprehensive person centred assessment of their needs and have a clear treatment and care plan in place which they have participated in and agreed. This includes a risk assessment and risk management plan that is clearly recorded on the care plan and service users file.
- Service users and carers have their cultural, religious and communication needs addressed in the assessment process.
- Service users and carers are empowered to participate fully in the assessment and feel their views and wishes have been taken into account and these are reflected in the assessment, treatment and care plan.
- Service users have achieved optimum level of functioning and are enabled to continue living in the place of their choice.
- The service user's symptoms and distress are controlled through an effective, evidence based treatment plan including on-going therapeutic interventions which is recovery focused.
- Service users and carers are given information and advice to help them make informed decisions about the care options available.
- Carers are signposted to the appropriate provider for a separate assessment and are supported to express their views and wishes.
- Positive feedback from patients and carers of their experience with the service.
- Service users and carers have access to information about the resources available to assist them in the future and how to access them.
- Patient and carer comments, complaints or concerns are received positively and acted upon promptly.
- Complaints to the service are minimal.
- Discharge from the team is timely and appropriate when clinical needs are met.

3.2 Service description/care pathway

The key areas for delivery are:

- assessment

- care planning

- interventions

- advice, education and support for service users and formal and informal carers

The Care Home Liaison Team performs functions for two groups of people:

1. People with a functional mental illness such as depression and psychotic illness.
2. People with Dementia, including Alzheimer's, Vascular and Lewy Body

The main function of the team is to provide an integrated, whole systems, person-centred assessment, treatment, care planning, and on-going management and information service, to older adults and their carers living in nursing or residential care.

The service is made up of a multi-disciplinary team who work in collaboration with a consultant psychiatrist and the wider Older People's Community Mental Health team to provide an effective and comprehensive service in line with the current guidance (***NICE guidelines and Everybody's Business)***

The Care Home Liaison Team (CHLT)

Good practice suggests that the CHLT should be made up of staff that are qualified and experienced and trained to an appropriate level to work with people with complex needs. The team may be integrated with single line management or multi-disciplinary, but working within common processes and protocols that ensure that service users receive a seamless, flexible, holistic and responsive service.

The CHLT shall include the following:

- Consultant Psychiatrist.
- Community Mental Health Nurses
- A single point of entry to the team for people making referrals.

The CHLT will work with the Care home Physiotherapy service which will:-

- Respond to referrals from all care homes in Northern Staffordshire for the purpose of assessment, rehabilitation and treatment. Urgent referrals will be seen within 2 working days.
- Triage as to determine the best response to the request eg GP/Pharmacy liaison.
- A range of rehabilitation will be provided with varying levels of intensity. Patients will be proactively managed to regain confidence, regain/maintain mobility and promote independence.
- Implement the agreed therapy management plan, which will include any potential risks.
- Prompt commencement of active physiotherapy as soon as appropriate.
- Re–assess and update the therapy management plans as necessary.
- Work alongside carers and provide guidance on the management plan with an expectation that they will support daily therapy where appropriate.
- Where necessary attend MDT meetings within care homes.
- Ensure appropriate communication and recording within the care home setting to ensure flow of information eg sharing care plans. The care home physiotherapist will also ensure that the GP is also informed of any significant therapeutic interventions or changes to management plans.
- Work within the home to reduce the number of falls, supporting proactive falls risks.
- Provide falls prevention training for targeted homes.
- Contribute to assessments.
- Ensure that the patient's equipment is safe to use at assessment.
- Order equipment on a loan basis for the purposes of short term use. Equipment costs for long term management of patients' needs, will not be covered by this service, except for walking aids and any aids that contribute to reducing falls.
- The care home physiotherapist will have a stock of low cost consumables (ie ferrules).
- The care home physiotherapist should follow any equipment policies set by the community equipment provider or commissioners.
- The physiotherapist will not be responsible for checking all residents equipment on a routine basis, however, where issues are identified by care home staff the physiotherapist will ensure safe clinic care for the residents.

Assessment

The assessment will be an holistic assessment with team members drawing on the expertise of other professionals, services users and carers. Access to specialist assessments from other disciplines for example: speech and language, pharmacy should be available as and when required.

If following the assessment it is identified that the persons needs fall outside the remit of the CHLT, the service user shall be referred to the appropriate agency that are best placed to meet the needs identified. Similarly if a person is assessed as requiring other services, e.g. Intermediate Care a referral shall be made to the appropriate team.

The care plan will be devised in conjunction with the service user and carer, from the outcome of the assessment process which has identified the service user and carer needs and will consider risks and how these shall be managed. It shall also include unmet needs and the outcomes expected from the care plan including any views and wishes of the service user and carer. (If appropriate there may be a separate care plan for the carer) The care plan shall be drawn up by the care coordinator but in collaboration with the wider OPMH team, primary and community services. For people with complex needs, a crisis and contingency plan shall also be developed engaging care home staff in its actions.

Treatment/interventions

A range of evidence based treatments in line with NICE guidelines shall be available to service users and they shall not be excluded from particular treatments on the basis of age, or dependency.

Service Users shall have an individual treatment /intervention plan.

Review

The CHLT shall hold regular on-going reviews of service users to monitor progress and outcomes of the care and treatment plan. The review shall consider whether the on-going involvement of CHLT is appropriate or whether on-going support could be appropriately provided through mainstream services. This shall enable the team to manage caseloads and ensure effective use of resources. Reviews shall be in line with CPA where this is applied and shall be at least annual. It is expected that the CHLT shall not be involved longer than 6-8 weeks with a review occurring before discharge.

3.3 Population covered

The Care Home Liaison Team and physiotherapist service shall provide a service to:

- People with dementia and those aged 65 and over with dementia or a mental health condition impacting on cognition, emotions and behaviour who are

residents of Stoke on Trent or North Staffordshire and who are living in a care or residential home.

- People with dementia and those aged 65 and over with dementia or a mental health condition impacting on cognition, emotions and behaviour who are registered with a Stoke on Trent or North Staffordshire GP and who are living in a care or residential home.

3.4 Any acceptance and exclusion criteria and thresholds

- The Care Home Liaison Team shall be provided to people with dementia or those aged 65 and over with dementia or a mental health condition impacting on cognition, emotions and behaviour who are residents of Stoke on Trent or North Staffordshire and who are living in a care or residential home.

- The Care Home Liaison Team shall be provided to people with dementia or for those aged 65 and over with dementia with a mental health condition impacting on cognition, emotions and behaviour who are registered with a Stoke on Trent or North Staffordshire GP and who are living in a care or residential home.

- The care home physiotherapist service will accept referrals for the following reasons which will be prioritised on clinical risk and need. For urgent cases residents will be assessed within 2 working days of referral:-

- Falls risks
- Reduced mobility
- Rehabilitation following hospital discharge/continuation of therapy plan
- Musculoskeletal injuries
- Chronic or acute respiratory problems that would benefit from physiotherapy intervention.
- Equipment relate disuse – identification of new need or advice on how to use newly prescribed equipment.

Exclusions

- The Care Home Liaison Team shall not provide a service to people under the age of 65 years who do not have dementia/ dementia type illness and who are not living in a care or residential home.
- The Care Home Liaison Team shall not provide a service to non-residents of the City of Stoke on Trent or North Staffordshire
- The Care Home Liaison Team shall not provide a service to people who are not registered with a Stoke on Trent or North Staffordshire GP.
- Care home physiotherapist service – residents who do not consent to assessment and treatment. Residents requiring specialist physiotherapy.

Referral processes

Referrals are to a single point of access for the team and are accepted from all residential and nursing homes in the locality.

Response times

Referral response time is based on clinical triage and the most appropriate professional will respond within 2 weeks. If deemed appropriate, the care home shall be contacted directly by telephone and an appointment made for an initial assessment to take place at a mutually convenient time. However urgent referrals shall be met in a timely manner.

3.5 CHLT Interdependence with other services/providers

The Care Home Liaison Team shall support a multidisciplinary holistic approach to service provision, develop and maintain close working relationships with a wide range of partner agencies across statutory, voluntary and independent sector organisations.

The key relationships for the service shall be with residential and nursing homes and their care teams, CMHT's, Care Home Physiotherapist Service, In-patient mental health units, MHLT, Psychiatrists, GP's and Primary Care Services, North Staffordshire and Stoke on Trent Social Care Departments and North Staffordshire Combined Healthcare NHS Trust.

The care home physiotherapist service will establish and maintain working relations with the following:

- CCG care home pharmacist
- Hospital based therapy and discharge teams
- Intermediate care teams/ANP providing rapid response to care homes
- Mental health services working directly with care homes.

- GPs and practice matrons
- Social workers
- Specialist falls service
- Palliative care teams.

Training/ Education/ Research activities

The CHLT shall provide training and education to residential and nursing home staff around good dementia care, emerging new evidence/policy and treatments/ interventions that alleviate BPSD symptoms.

Workforce

- The service provider shall have sufficient and skilled staffing to provide care, clinical need and safety to deliver the outcomes required by patients/service users who access the service as outlined in this service specification.
- Staff working in the Care Home Liaison Team shall have their training /development needs assessed on an annual basis and shall be supported to undertake appropriate training to ensure they are kept up to-date.
- Training shall be inclusive of and developed in line with new policy and guidance and best practice.
- All staff working in the Care Home Liaison Team shall have current CRB clearance
- All staff working in the Care Home Liaison Team shall maintain compliance with mandatory training requirements.

Qualifications and Competences

- All professionally qualified staff working within the Care Home Liaison Team shall have active registration with the appropriate professional body
- Support workers shall have received relevant training commensurate with their role and responsibilities
- All staff working in the Care Home Liaison Team shall have extensive experience of assessment, planning, treatment /intervention and evaluation of care across a wide range of mental health conditions including dementia and complex enduring/severe mental health problems
- All staff working in the Care Home Liaison Team shall demonstrate a thorough knowledge and understanding of local resources and pathways relevant to the needs of people with dementia and those with complex/enduring/severe mental health problems and promote effective interagency working

- The Care Home Liaison Team shall work in line with current Best Practice Guidance, CPA Policy and comply with all relevant legislation to include: The Mental Health Act 1983 (amended 2007), The Mental Capacity Act 2005 etc.

Clinical Supervision

The service provider shall ensure that appropriate arrangements are in place to provide sufficient levels of supervision and support to staff involved in the delivery of assessment and clinical interventions. These arrangements shall be consistent with identified best practice across the range of specialities within the team.

It is expected that direct links with a Consultant Psychiatrist shall be in place to support patient review and ensure patient safety.

General Supervision

The service provider shall ensure arrangements are in place to provide appropriate levels of supervision to all members of the Care Home Liaison Team. These arrangements shall be consistent with identified best practice.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

NICE Guideline ngG97 Dementia: assessment, management and support for people living with dementia and their carers.20/06/18

NICE Guideline cg90 Depression in adults: recognition and management

NICE Guideline cg91 Depression in adults with a chronic physical health problem: recognition and management – 28/10/09

The Care Home Liaison Team shall comply with relevant national standards of best practice in dementia and mental health care and current legislation in dementia and mental health inclusive of appropriate and relevant NICE Clinical Guidance, CPA Policy and Practice and other applicable guidelines to include.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

Dementia: support in health and social care, NICE quality standard (QS1) – June 2010

Mental wellbeing of older people in care homes, NICE quality standard (QS50) December 2013

Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease, NICE technology appraisal guidance (TA217) March 2011.

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.21 Applicable quality requirements (See Schedule 4)

5.22 Applicable CQUIN goals (See Schedule 3)

6. Location of Provider Premises

The Provider's Premises are located at:

North Staffordshire Combined Healthcare NHS Trust

Harplands Hospital,

Hilton Road,

Stoke on Trent

Days/ hours of operation /Location of service

This service is currently based at Bradwell Hospital and Marrow House.

Days/ hours of operation

The service shall be available during normal working hours (9 am to 5 pm) Monday to Friday with arrangements for contact outside these hours where required, recognising these will be exceptional.

North Staffordshire Combined Healthcare NHS Trust shall retain overall responsibility for the delivery of service and appropriate location of the Care Home Liaison and the Care Home Physiotherapist Service.

Appendix 1

Outreach Track and Triage role

The aim of the service is to provide specialised support for patients with dementia/suspected dementia to either return to their own home or to access further assessment in CCG funded assessment beds. It supports "home first" principles under the 'Discharge to Assess' model and is an enhancement and refocus of the existing Outreach service.

The model of support consists of a team of mental health practitioners, Occupational Therapist and minimal medical cover to provide a robust and timely response to patients being discharged from The Royal Stoke University Hospital (RSUH).

The original Outreach service currently supports admission avoidance for older adults with a primary mental health need and early supported discharge from the Harplands. It operates between 8am and 8pm 7 days a week.

The Outreach service will provide a practitioner to the RSUH on a daily basis to support assessment of patients identified as discharge ready, this will provide a seamless link to both Mental Health Liaison team (MHLT), inpatients facilities and the Community Mental Health Teams (CMHT).

Overall aim:

To provide specialist mental health input to avoid unnecessary admissions and support early discharge to both home (in co-ordination with Home First) and enable efficient flow through the CCG funded assessment beds.

Objectives:

- Identify the most appropriate CCH assessment placement from RSUH for the patient's level of physical and mental health need.
- Provide specialist advice and care planning guidance to minimise any negative impact of environmental transition for older patients with dementia.
- Discharge home to be the primary option of support where returning home is safe and appropriate for the patient (this to be assessed by Home First).
- Joint working with Track and Triage to support discharges to CCG funded assessment beds.
- Attendance at weekly Nursing EMI CCG Multi-disciplinary team meetings (MDTM's).
- Advice and guidance around 1:1 staffing recommendations and review of 1:1 support.

Outreach Track and Triage Pathways

Outreach Track and Triage support

The Outreach Track and Triage service will work with the RSUH Track and Triage team to identify patients in emergency portals, short stay wards and other wards at RSUH that could be suitable for early supported discharge home (if not already identified by Home First Team).

Outreach CCG assessment beds

Outreach will support CCG assessment bed placements to develop appropriate care plans and review psychiatric medication as required through MDTM's and referrals from the CCG hub.

Outreach will work with wider agencies across the health economy to facilitate flow through mental health support systems once a patient is placed in a CCG assessment bed.

Exceptions

- The service offers a specialist advisory role and does not co-ordinate DST's. Specialist advice will be provided to support the process.
- The service is not intended to provide additional staffing capacity for CCG beds or to act as 1:1 support. The team will review 1:1 arrangements and make recommendations around appropriate care planning to manage risks.

Timeliness of response

Outreach will provide a daily visible attendance for assessments within the RSUH and will have the ability to act immediately if discharge from Royal Stoke is viable.

Service Specification No.	B04
Service	Memory Service
Commissioner Lead	North Division CCG's Jo Marsh, Senior Commissioning Manager Jane Barnes, Locality Commissioning Manager
Provider Lead	North Staffordshire Combined Healthcare Trust Jane Munton-Davies, Associate Director Rachael Birks, Service Manager
Period	1st April 2022 – 31st March 2023
Date of Review	As required

1. Population Needs

National/local context and evidence base

National Context

Dementia is a term used to describe a group of symptoms that may include memory loss, difficulties with thinking, problem solving or language, and often changes in mood, perception or behaviour. Alzheimer's disease is the most common type of dementia, with other types of dementia including vascular dementia, dementia with Lewy bodies and frontotemporal dementia. Dementia is not a part of ageing there are at least 42,000 younger people (under the age of 65) in the UK who have dementia.

It is estimated that there are around 850,000 people in the UK with dementia. However, because of longer life expectancy this number is expected to double by 2035. It is estimated that dementia costs the English economy approximately £26 billion every year and is set to increase.

The National Dementia Strategy (DH 2009) highlights the scale of the challenge that dementia presents to society. The Prime Minister's challenge 2020, which was building on the progress from the first Challenge issued in 2012, aims to make England the best country in the world for dementia care, support, research and awareness.

NHS England's Transformational Framework – the Well Pathway for Dementia follows a patient's pathway through dementia and discusses diagnosing patients well, supporting patients well, living well and dying well with dementia.

By 2020, there are National plans to establish an evidence based treatment pathway for dementia. The pathway will have two strands, the first of which is a standard that recommends that by 2020, 85% of people with suspected dementia who are referred to a memory assessment service receive a diagnosis and start treatment within 6 weeks of referral (starting treatment means that the person has met with a named care co-ordinator

and that an initial care plan of NICE-recommended treatment for dementia has been agreed).

The second pathway standard recommends that a person living with dementia receives NICE-recommended support for a minimum of a year (support means that the initial care plan, is reviewed by the named care co-ordinator as the person's needs dictate, but at least once within 12 months of it first being agreed. Revisions should be jointly developed and agreed with the person living with dementia, and, if applicable, their carer). This is clarified in the Implementation guide and resource pack for dementia care which details the care co-ordinators role and also the NHS England Dementia: Good Care Planning guide.

The CCG Improvement and Assessment Framework (IAF) contains the following indicators that the CCG's are assessed against.

- Estimated diagnosis rate for people with dementia
- Dementia care planning and post-diagnostic support

Local context

The local Joint Stoke-on-Trent Dementia Strategy – "Living well with Dementia: Stoke-on-Trent Joint Dementia Strategy 2015-2019 (currently being refreshed) was written by Stoke-on-Trent CCG and Stoke-on-Trent City Council. The Council facilitated a large consultation exercise with the residents of Stoke-on-Trent and it outlines the priorities that came out of the consultation.

- Priority 1 – Spread the message of living well – improve professional and public awareness of dementia
- Priority 2 – Timely diagnosis and support – for people to receive a diagnosis in the right way, at the right time, with access to the right support
- Priority 3 – Enable people to live well with dementia – access to high quality, personalised support for both the person with dementia and their carers'.

Dementia prevalence is rising locally; subsequently the number of people requiring post diagnosis support is increasing. The table details the current predicted dementia prevalence rates for as at November 2019 across Northern Staffordshire.

	North Staffordshire	Stoke-on-Trent	Total
Dementia prevalence Nov 19	**3,087**	**3,161**	**6,248**
Dementia Diagnosis %age	**74.8%**	**88.7%**	**81.8%**

Diagnosis numbers Nov 19	**2,309**	**2,803**	**5,112**
MCI Diagnosis Q2	**517**	**505**	**1,022**
Care Planning Nov 19	**66%**	**65%**	

The North Staffordshire Carers Association was funded in 2015-17 to carry out a pilot amongst dementia carers. The evaluation of the project highlights gaps in service especially around being able to provide individual support to carers when it is required either:

- Following diagnosis to enable carers to receive the support they require with finances, coping with caring, signposting to support that is available, etc
- During times of escalation of symptoms when the support for carers needs to be revised.

From the pilot, it was agreed that separate patient and carer pathways were required to identify the support available and identify gaps.

It is felt across Northern Staffordshire that there should never be a "dementia crisis" if patients and carers are supported well. Improvements to support patients and carers have been made:

- 2015/16 with the introduction of the Dementia Primary Care Liaison Team providing support in the community for stable patients.
- The Memory Support Service/Dementia Connect provided by the Alzheimer's Society commenced from June 2019. Strong links have been established with the memory clinic to ensure that all newly diagnosed patients are electronically referred directly to this service.
- Memory clinic have developed a pathway from MCI diagnosis through to end of life.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	**ü**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	**ü**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	

2.2 Local defined outcomes

It is anticipated that the Memory Assessment & Diagnostic Service will deliver the following key outcomes for the people of Stoke on Trent and North Staffordshire

- An increase in the number of people with dementia receiving early assessment/care in their own home or a community setting
- Increase in the proportion of people with dementia receiving a diagnosis while they are in the mild stages of the illness
- More people with dementia supported to remain in their own home for longer
- People with dementia and carers feel supported from diagnosis to end of life
- A reduction in the number of avoidable admissions to acute psychiatric inpatient care
- A reduction in inappropriate / crisis admissions in Acute Trust and community beds

Service outcomes are as follows:

- an increase in the proportion of people with dementia receiving a formal diagnosis compared with the local predicted prevalence (NICE quality standard 2 – see page 13 in this guide)
- an increase in the proportion of people with dementia receiving a diagnosis when they are in the mild stages of the illness (NICE quality standards 1, 3, 4)
- an increase in the number of patients and carers who have a positive experience of health care services
- reduced risk of crises later in the course of the illness.

3. Scope

3.1 Aims and objectives of service

The aim of the memory service is to deliver early assessment and diagnosis and initial management of patients with dementia. It will provide all patients who fulfil the referral criteria with a person-centred service, which empowers people with dementia and their carers to make informed decisions about care and which helps maximise quality of life. The service should work closely with the community mental health team and help reduce the risk of crises later in the illness and enable the patient to be cared for at home for as long as possible while this is the preferred place of care.

The objectives of the service are:

- to promote and facilitate early identification and referral and encourage eligible patients to attend assessment.
- to provide a high-quality accurate diagnosis of dementia that is communicated in a person-centred way to both the person with dementia and their carers and which meets the individual needs of the person with dementia and their carers.
- to provide diagnosis early in the disease.
- to ensure that the service is readily accessible and meets the range of needs of the local population, including minority groups
- to ensure that people with dementia and their carers have appropriate information that allows them to manage their care more effectively along the pathway and understand how to access other assistance such as electronic referral to the memory support service and referral for Carers Assessments.
- to engage people with dementia and their carers in decisions about the care options available to them, including the development of personal care plans.
- to ensure continuity of care across the pathway and integration with other care providers.
- to ensure that the service is delivered in a considered, timely and co-ordinated manner.
- to provide opportunities for people with dementia to be included in research studies.
- Provide clinics and appointments in community settings when possible.
- Work alongside primary care colleagues to increase confidence and skills in managing this patient group

The memory service will work as a specialist service as part of a wider Older People's Community Mental Health team in order to provide a holistic assessment and continuation of care within the community.

Specialist dementia services support people during particular phases of their illness, including at diagnosis, during a stay in an acute general hospital, or when they are experiencing behavioural or psychosocial problems that require expertise beyond that normally provided by the primary care team.

Service description/care pathway

3.1.1 Service description/care pathway – Appendix 1 is a visual representation of the pathway)

The memory service might be delivered in a number of different settings, including in the community, in GPs' surgeries, in clinics or in patients' own homes. The service is for people with mild to moderate dementia whose dementia has not been diagnosed. Those at all stages of severity with complex mental health needs or risk may need direct referral to the OP CMHT.

The service will provide high quality assessment, diagnosis and early intervention services for people with mild to moderate dementia (care clusters 18 and 19). Patients with more complex needs will be seen and supported via the CMHT, on an exceptional basis (care clusters 20 and 21)

The service will develop and maintain positive relationships with a variety of partner agencies (e.g. older peoples social care, voluntary sector) across the local economy that is supportive of an holistic, whole systems approach to care.

The service will at all times, operate in line with relevant Mental Health Legislation, CPA Policy, NICE Clinical Guidelines and current evidenced best practice.

The basic patient pathway is detailed in Appendix 1 on page 10 of this service specification.

The Memory service will deliver an effective and efficient community based 'needs led service' inclusive of the following key elements[15].

[15] DoH Service specification for dementia: memory service for early diagnosis and intervention (2011)

Manage referral and arrange assessment

- The memory service via the CMHT Duty system shall contact patients and carers in person or by telephone within 3 operational days of receipt of referral. The patient shall be offered a memory assessment (initial offer).
- The memory service (via the CMHT) shall send patients who cannot successfully be contacted after 2 attempts and within 8 operational days, an offer of an assessment date in writing. If the offer is not accepted, or the patient cannot be contacted within 3 attempts, the patient shall be referred on to GP- and the GP willl be asked to discuss reasons for non-attendance with the patient and undertake a review for a possible re-referral in 6 months.
- The memory service shall follow NICE/SCIE guidelines on sharing information with patients and their families.
- In consultation with the patient, and where appropriate the carer, the service shall determine whether the patient is willing and/or ready to attend an assessment.
- Where the patient is ready and willing, they shall be offered an assessment date that is within 10 operational days of successful contact.(i.e the initial appointment should be within 2 weeks of the referral having been received, the only exceptions to meeting this timeframe will be patient choice)
- Patients shall be encouraged to be accompanied by a carer at the initial assessment and only in extreme circumstances where the carer is unable to attend shall the first assessment with the carer take place separately via telephone (patients to provide consent when possible).
- Patients with a learning disability or suspected learning disability to be appropriately supported throughout the assessment and diagnosis process, utilising the relevant internal expertise.

The patients will then be informed of the Memory Support Service which is available to patients, carers and families and is an integral part of the memory service pathway. With the patient's and carer's permission an electronic referral will be made to the Memory Support Service.

The memory service will also facilitate onward referral and signposting to enable patient/service user to access a range of community services, including GP and Primary care services, Social Care, housing, employment, voluntary and independent sector organisations

The memory service will provide advice and support to GP's and Primary care services to promote clinical liaison and quality care management of older people with dementia and or complex/enduring mental health problems.

The target for the memory service is to maintain a “four appointment” approach, using an appropriate skill mix of staff from within the memory service, however medication reviews to be carried out on a needs led basis.

Using the West Midlands Mental health Care Clusters (August 2010) the service will be aimed at support people in the following care clusters:

- 18: Cognitive Impairment (Low need)
- 19: Cognitive Impairment or Dementia Complicated (Moderate need)
- Patients with severe and complex needs will be seen on an exceptional basis (care clusters 20 and 21)

3.1.2 Service Location and Delivery

North Staffordshire Combined Healthcare NHS Trust will retain overall responsibility for the delivery of service and where possible will ensure that memory assessment services are located within a designated community setting* central to their respective catchment areas and / or are delivered in patients normal place of residence (where this is deemed clinically necessary)

**Commissioners will work with the Provider and Primary Care to improve access to services and provide care closer to home*

3.1.3 Days/hours of operation

The memory assessment and diagnostic service will ensure appropriate and flexible access according to the needs of the service. The service will look towards providing the service over extended hours/weekends following consultation with stakeholders and with the support of Commissioners.

3.1.4 Referral processes

Referral Criteria

The Memory Service will ensure the process for referral is communicated to all partner agencies across the local economy. In addition the Memory Service will establish and maintain an up to date web based information page, accessible to the public, providing information on the function of the memory service and highlighting the referral process to the memory assessment service:

- Referrals to the service will be made via a designated Access Points
- Referrals will be triaged and prioritised based on urgency of clinical need
- Referrals will be allocated on a daily basis as they are received by the Team Manager/ Duty Worker
- Clients unable to attend a clinic will be offered a home visit if appropriate.
- The service will establish clear pathways to mainstream and other specialist mental health services
- The referrer will be informed of the outcome of the referral to include:

Acceptance of the referral

Signposting/onward referral to alternative service appropriate to the service user needs

Referral Source

Referrals will be accepted from the following:

- GP's and Primary Care Services
- Mental Health Liaison service supporting the University Hospital North Staffordshire and the Community Hospitals
- North Staffordshire and Stoke on Trent Social Care Departments
- North Staffordshire and Stoke-on-Trent Intermediate Care Teams
- North Staffordshire Combined Healthcare NHS Trust
- Independent sector providers
- People referring themselves, though it will be made explicit that contact will be made with the relevant GP before action is taken

Referral Route

- The memory service will set up a Single Point of Access for all referrals into the service
- The memory service will prioritise referrals based on clinical need and urgency.
- The service will establish clear links with on call Psychiatrist, Access and Crisis Teams

- All Patients/Service Users will be assessed by a competent mental health practitioner.

There will be agreed access points for all referrals. There will be a service referral form; however the memory service will accept telephone/fax/written referrals to increase accessibility The referral must include:-

- Medical History
- Medication

3.1.5 Service Response Times

To support best practice and ensure efficient and effective service delivery to meet the needs of patients/service users, carers and referrer's it is envisaged the following elements will be incorporated into the service:

The CMHT will operate a triage system to prioritise referrals and work within a set of pre-determined response times to include:

- Same day response for emergency referrals – response within 4 hours Monday to Friday
- Within 72 hours for urgent referrals
- Within 2 weeks for routine referrals

3.1.6 Discharge Process

The memory service will be responsible for ensuring appropriate planning for the safe discharge of those older people who, based on their level of need, no longer require specialist mental health services and where their assessed needs can be more appropriately met by other relevant services.

The memory service will initiate discharge where the following criteria have been met:

- The agreed interventions/therapy has been completed and patient is stable
- There is agreement that the person should be discharged, following discussion with the patient/service user and/or carer
- A needs appropriate discharge plan is in place
- A support package has been commissioned to meet the onward needs of the patient/service user and/or carer

- Post discharge support with the relevant agency has been agreed and is available and an agreed date has been set for discharge between all parties including patient/service user and/or carer
- A referral to the memory support service has been made with consent from the patient/service user.
- Patients diagnosed with Mild cognitive impairment to be discharged back to their GP. Follow up to be carried out in primary care in order to identify any potential decline, in which case the patient will be re-referred back into the memory service.

Follow-up

The memory service will:

- Where a diagnosis of dementia is made, the memory service will provide a discharge letter and care plan to the patient's GP within 7 days of the diagnosis being shared with the patient.
- Provide a timely referral back to the relevant GP with a summary outline of assessment/interventions and arrangements for on-going support
- Will record in the discharge entry in the patient/service user record, the HONOS elements of MHCT (care clusters)
- The service will provide patient/service user and carer with information on support services available to include: advice and support services, and refer i.e. Dementia Advisors, Carers Association
- Ensure pathways are in place to a range of GP and Primary care, voluntary and independent sector support services
- (As part of the wider CMHT) provide advice and information in an appropriate format to meet the needs of the individual

3.1.7 Care Pathways

Care planning should be in line with national guidance NHS England Dementia:Good Care Planning document.

3.1.8 Workforce

Clinical Supervision

The service provider will ensure that appropriate arrangements are in place to provide sufficient levels of supervision and support to staff involved in the delivery of assessment and clinical interventions.

General Supervision

The service provider will ensure arrangements are in place to provide appropriate levels of supervision to all members of the team.

3.2 Population covered

The memory service will be provided to:

- People of any age who are residents of the City of Stoke on Trent or North Staffordshire
- People of any age who are registered with a Stoke on Trent or North Staffordshire GP

3.3 Any acceptance and exclusion criteria and thresholds

Exclusions

- The Memory Service will not be provided to patients who are non-residents of the City of Stoke on Trent or North Staffordshire except where extra contractual arrangements are in place and agreed by commissioners

3.4 Interdependence with other services/providers

The key relationships for the service will be with

- GP's and Primary Care Services,
- Memory Support Service.
- University Hospital North Staffordshire,
- Community Hospitals,
- North Staffordshire and Stoke on Trent Social Care Departments and
- North Staffordshire Combined Healthcare NHS Trust.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- DOH 2006, NICE Clinical Guideline 42 Supporting People with Dementia and their Carers in Health and Social Care
- National Institute for Clinical Excellence (2001) Guidance on the use of Donepezil, Rivastigmine and Galantamine for the Treatment of Alzheimer's Disease. No 19. London: NICE
- NICE Quality Standard 30 on supporting people to live well with dementia (QS30).
- NICE Dementia Pathway

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

- NHSE – Implementation guide and resource pack for dementia care
- NHSE – Dementia: Good Care Planning
- NHSE – Transformation Framework – The Well Pathway for Dementia

4.3 Applicable local standards

Stoke on Trent best practice in the clinical management of Dementia in general practice, 2011

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements

See Schedule 4

5.2 Applicable CQUIN goals

See Schedule 3

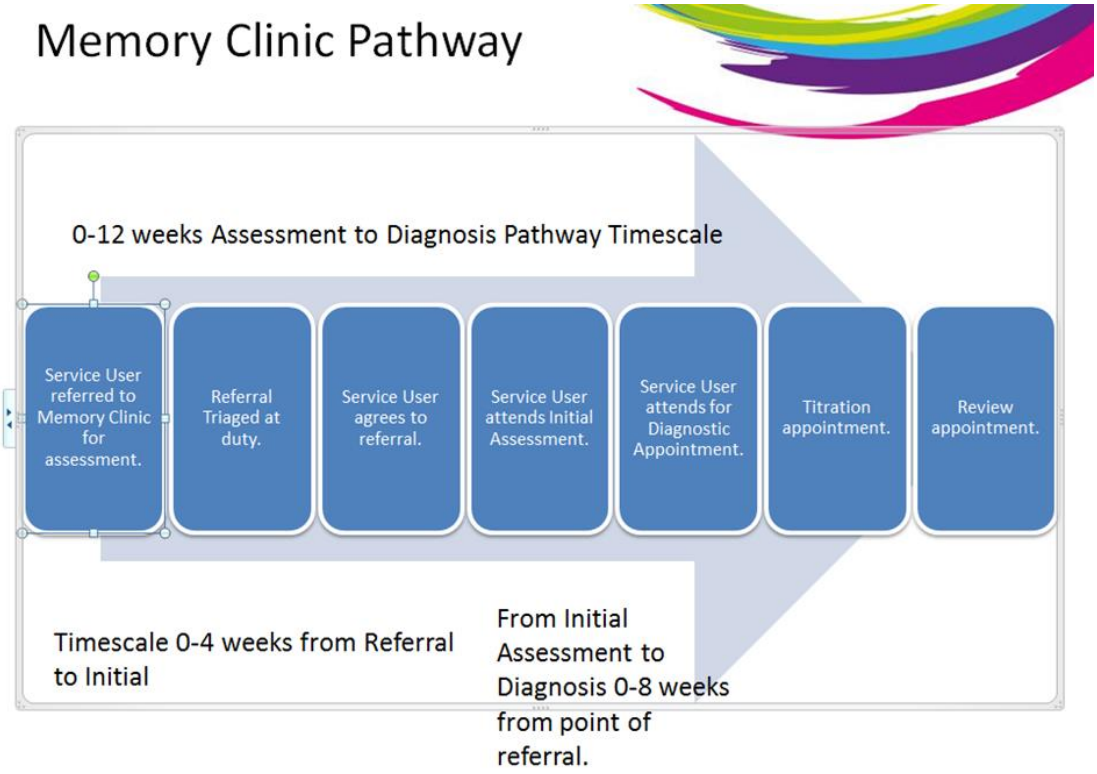
6. Location of Provider Premises

The Provider's Premises are located at:

North Staffordshire Combined Healthcare NHS Trust will retain overall responsibility for the delivery of service and where possible will ensure that memory assessment services are located within a designated community setting* central to their respective catchment areas and / or are delivered in patients normal place of residence (where this is deemed clinically necessary)

**Commissioners will work with the Provider and Primary Care to improve access to services and provide care closer to home*

Appendix 1:



Service Specification No.	B06
Service	Older People's Community Mental Health Teams
Commissioner Lead	Jane Barnes, Locality Commissioning Manager – North Division, CCG
Provider Lead	Jane Munton-Davies, Associate Director, Stoke Community Mental Health Services Josey Povey, Associate Director, North Staffordshire Community Directorate
Period	1st April 2022- 31st March 2023
Date of Review	**See 22/23 SDIP**

1. Population Needs

National/local context and evidence base

National Context

According to national prevalence data there are a approximately 5,998 people living with dementia across Staffordshire Moorlands, Newcastle Under Lyme and Stoke on Trent. It is well recognised that mental health difficulties experienced by older people are common as is the increasing incidence of dementia, and as the aging population continues to rise so will the demand for services. The current national drive to improve outcomes for people with mental health problems is therefore timely in emphasising the need to deliver quality services that will support and maintain the longer term mental health and wellbeing of people. Providing services that are based on need and not age is supportive of equality care, although it is still important to recognise and support the specialist service requirements for older people with mental health problems. (National Dementia Strategy 2009, Everybody's Business, 2005)

As with all services, older people's mental health services need to be accessible, tailored to individual need and preferably where possible and safe, delivered within the individuals home environment or local community setting.

Providing mental health care in this way is the concern of Community Mental Health Teams, who are considered to be the cornerstone of specialist mental health provision

offering assessment, treatment, support and advice to older people and their carers within the home environment or local community setting (Everybody's Business 2005, NICE 2006).

National Guidance clearly promotes the value and effectiveness of delivering specialist mental health services whilst the person remains in their home environment and recognises that this approach is more in keeping with the current expectations and preferred choice of older people to receive care that not only meets their needs, but is also provided at their convenience and outside of the more traditional 'bed based' models of mental health care delivery.

Best practice in mental health care provision is well evidenced and is supported in the following documents:

- **DOH, 2001 The National Service Framework for Older People, Department of Health London**
- **DOH 2003, Mental Health Policy Implementation Guide, Community Mental Health Teams, Department of Health, London**
- **DOH 2005, Everybody's Business, Integrated Mental Health Services for Older Adults: A service development guide, Department of Health, London**
- **DOH 2005, Mental Capacity Act, Department of Health, London**
- **DOH 2006, NICE Clinical Guideline 42 Supporting People with Dementia and their Carers in Health and Social Care**
- **DOH 1983 (amended 2007), Mental Health Act, Department of Health, London**
- **DOH 2009, Living Well with Dementia, A National Strategy, Department of Health, London**
- **DOH 2011, No Health without Mental Health: A cross government mental health outcomes strategy for all ages, Department of Health, London**

In addition the NHS new operating framework Everyone counts: Planning for Patients 2013/14 sends out a clear message regarding the importance of providing services that enhance the quality of life for people with long term conditions, especially dementia, and ensuring that people with mental ill health have an improved and positive experience of community mental health care.

Local Context

In line with the national picture the local health economy has a rapidly expanding population of older people, and as a consequence is currently undergoing a period of significant change across both primary and secondary care services. This is inclusive of a range of initiatives specifically designed to improve and transform the way local mental health care services are delivered. This local drive promotes a model of care which centres on 'care closer to home' and is in keeping with the national impetus to move away from a predominately bed based service model to a more focused and intensive community care based model. Providing services in this way can help to ensure that care is delivered in the least restrictive and disruptive way possible, reduce the stigma associated with mental health care, and by fostering independence through illness within the individual's social context, help to minimise the risk of older people becoming alienated from their local communities. The local emphasis on maintaining and improving independence for older people with dementia and complex/enduring mental health problems remains a key priority for Stoke on Trent and North Staffordshire economy

2. Outcomes

2.1 NHS Outcome Domain Framework Domains and Indicators

Domain 2 - enhancing quality of life for people with long-term conditions

Domain 4 – ensuring people have a positive experience of care

2.1 Local defined outcomes

It is anticipated that the CMHT's will realize the following key outcomes for the people of Stoke on Trent and North Staffordshire

- **An increase in the number of people with dementia and or older adults complex/enduring mental health problems receiving assessment/care in their own home or a community setting**
- **An increase in the number of people with suspected dementia receiving early assessment, diagnosis and appropriate treatment**
- **Antipsychotic prescribed medication regularly reviewed to support appropriate**
- **prescribing and patient/service user safety**
- **More older adults supported to remain in their own home for longer**
- **Improved patient and carer satisfaction**
- **A reduction in the number of crisis intervention**
- **A reduction in number of carer breakdowns**
- **A reduction in the number of avoidable admissions to acute psychiatric inpatient care**

- **A reduction in inappropriate attendance at A&E**
- **A reduction in the number of avoidable admissions to acute general care where the primary need is mental health not physical health**
- **A reduction in delayed transfers of care/discharge from inpatient hospital care attributable to mental health problems**
- **Compliance with CPA Policy through the provision of care-coordination**

3. Scope

3.1 Aims and objectives of service

The CMHT Service will support a multi-disciplinary approach, providing prompt community based mental health assessment, treatment/ intervention and care management for older people with dementia and/or complex/enduring mental health problems. Engaging with a multiplicity of teams/agencies and organisations the service will actively promote 'whole systems' working to ensure patient/service user/carers universal needs are effectively supported within a community setting.

The CMHT Service will deliver mental health assessment/treatment/intervention and care management in line with evidenced best practice and will be expected to seek accreditation with the

Aim: The overall aim of the CMHT is to maintain or improve the independence of older people by providing a responsive specialist community mental health service to those older people with dementia or complex/enduring mental health problems. The service will be provided within the individual's home environment or an appropriate community setting.

The CMHT will provide an integrated multi-professional core service supported by an Outreach Team that operates over 7 days a week

Objectives: The following objectives are considered key to delivering an effective CMHT service for the people of Stoke on Trent and North Staffordshire:

- **Provide a Single Point of Access for referrals into the service**

- **Provide prompt assessment, diagnosis and evidenced based treatment/intervention in the home environment or a community setting for older people with dementia or complex/enduring mental health problems.**

- **Provide interventions that are time limited dependent on the assessed needs of the individual, with referral back to the GP when their condition improves**

- **Provide care co-ordination for older people with complex mental health needs in line with CPA policy.**

To support avoidable admissions to acute psychiatric inpatient care, acute general care where the primary need is mental health not physical health, and support avoidable admissions to long term care, whilst ensuring that inappropriate and unnecessary treatments are avoided

- **Facilitate timely discharge for people who are receiving hospital inpatient care**
- **Recognise and be sensitive to the individual preferences and choices of older people with dementia or complex/enduring mental health problems and adopt an approach that supports equality and diversity of need**

- **Provide on-going care co-ordination for older people being supported by the Outreach Team or admitted to Acute Psychiatric Admission units.**

- **Demonstrate a thorough knowledge and understanding of local resources relevant to older people with dementia or mental health problems and promote effective interagency working.**

- **Carry out initial memory assessment and diagnostic clinics for people suspected to have dementia.**

- **Support smooth transition to Memory Service for people prescribed anti-dementia medication and carry**

out follow up reviews in the community setting as designated

- **Ensure safe discharge where people have recovered sufficiently or their needs are more appropriately met by another agency**

- **Provide advice and support to primary care services to promote clinical liaison and quality care management of older people with dementia and/or complex/enduring mental health problems**

3.2 Service description/care pathway

The CMHT service will provide community based multi-professional mental health assessment/treatment/intervention and care to people who have dementia and for older people (currently defined as age 65) with complex/ enduring mental health problems.

The CMHT service will develop and maintain positive relationships with a variety of partner agencies across the local economy that is supportive of an holistic, whole systems approach to care,

The service will at all times, operate in line with relevant Mental Health Legislation, CPA Policy, NICE Clinical Guidelines and current evidenced best practice.

The CMHT service will deliver an effective and efficient community based 'needs led service' inclusive of the following key elements:

- **Timely identification of dementia or mental health conditions, with early intervention and support to maintain patient/service user and carer independence and overall sense of wellbeing**

- **Prioritisation of 'need' and considered response, based on a range of**

- **pre-determined response times to include Rapid access within 4 hours, Monday to Friday**

- **Comprehensive assessment, treatment/intervention and care management using Care Co-ordination to support the most effective service delivery**

- **Provide targeted carer support and treatment in line with assessed need**

- **Provide a range of time limited clinical interventions and treatment to support active rehabilitation and recovery, inclusive of developing/promoting patient/service user self-management skills and personal coping strategies**

- **Promote full engagement and ownership with the patient/ service user and carer,**

(with service user agreement), in the assessment process and development of the care/treatment plan,

- **Ensure all patient/service users are provided with a copy of their individual care plan**

- **Engage patient/service users and carers (with service user agreement) in the development of discharge plans, wellness plans, and contingency plans for crisis prevention and crisis management**

- **Deliver least restrictive crisis interventions to reduce any negative impact caused by the crisis and develop contingencies to prevent further episodes**

- **Facilitate onward referral and signposting to enable patient/service user to access a range of community services, including GP and Primary care services, Social Care, housing, employment, voluntary and independent sector organisations**

- **Provide advice and support to GP's and Primary care services to promote clinical liaison and quality care management of older people with dementia and or complex/enduring mental health problems**

- **Provide information, advice and support to carers and facilitate referral into other services as appropriate to individual need**

- **Provide information, advice and support to a variety of service providers to sustain effective longer term community provision for patient/service users and carers**

- **Provide information and support around end of life care planning**

3.2.1 Service Model

The service model will support a multi-disciplinary approach and provide for prompt community based mental health assessment, intervention and care management for older people with dementia and/or complex/enduring mental health problems.

The service model will adopt a whole systems approach to care working with and across other agencies/organisations to support effective and efficient service delivery

The service will work to the principles of Health of the Nation Outcome scale (HONOS) and Mental Health Clustering Tool (MHCT)

The service will encompass a number of core disciplines with appropriate levels of clinical skills to ensure patient/service user needs are fully provided for. Where necessary the service will engage with other specialist support deemed relevant to effective service delivery, for example, links to medicines management, psychology and social care may need to be considered if not incorporated into the core service

The service will be expected to impact in a number of areas and deliver a wide range of treatment/interventions, to include:

- **Where appropriate a full multidisciplinary team assessment to support early detection and diagnosis of dementia and or complex/enduring mental health problems.**

- **The formulation of a treatment plan, agreed with the patient/service user, inclusive of regular review and evaluation of care.**
- **The development and delivery of programs of care to support active rehabilitation, recovery and wellbeing**
- **The provision of counselling and support to patient/service user as appropriate to assessed need**
- **Assessment of complexity of need in line with Continuing Healthcare Criteria**
- **Time limited follow up to support compliance with CPA**
- **Targeted carer support, advice and onward referral where appropriate to need**
- **Onward referral to other providers that are able to meet the on-going care and wellbeing needs of the patient/service user/carer**
- **Provide, advice, support , education and training to a range of service providers to include, family and non-professional carers, GP's and Primary Care teams, Social Care teams, Voluntary and Independent Sector care providers**
- **Establish, develop and maintain strong working relationships across all areas including statutory, Voluntary and Independent sector providers**
- **Support crisis reduction through the provision of prompt community assessment, intervention and management**
- **Facilitate timely discharge planning through effective communication with patient/service user/carer, GP's, Primary Care teams and appropriate service providers to support on-going care management**
- **Maintain accurate records of patient/service user assessment, treatment, interventions and on-going care needs inclusive of the HONOS elements of the MHCT at the point of discharge**
- **Support weekly review meetings with the multi-disciplinary team to support best practice, share assessments and provide peer support for the wider team**
- **Comply with Stoke on Trent and North Staffordshire Adult and Children/Families Safeguarding policy and procedure**

3.2.3 Days/ hours of operation

The CMHT core service will operate Monday to Friday 9.00am to 5.00pm, with flexibility as appropriate to the needs of service areas, the core service will be supported by an outreach team which will operate over 7 days per week, between the hours of 8am to 8pm

3.2.4 Referral processes

Referral Criteria

The CMHT will ensure the process for referral is communicated to all partner agencies across the local economy. In addition the CMHT will establish and maintain an up to date web based information page, accessible to the public, providing information on the function of the CMHT and highlighting the referral process

- **Referrals to the service will be made via a designated Single Point of Access**
- **Referrals will be triaged and prioritised based on urgency of clinical need**
- **Referrals will be allocated on a daily basis as they are received by the Team Manager/ Duty Worker**
- **When referred clients prefer not to/ are unable to attend a clinic a home visit will be arranged**
- **The service will establish clear pathways to mainstream and other specialist mental health services**
- **The referrer will be informed of the outcome of the referral to include: Acceptance of the referral**

Signposting/onward referral to alternative service appropriate to the service user

Needs

Referral Source

Referrals will be accepted from the following:

3.2.2 GP's and Primary Care Services

- **Urgent and Emergency Liaison service supporting the University Hospital North Staffordshire and the North Staffordshire NHS Community Hospitals**
- **North Staffordshire and Stoke on Trent Social Care Departments**
- **North Staffordshire Combined Healthcare NHS Trust**

- **Independent sector providers**
- **People referring themselves, though it will be made explicit that contact will be made with the relevant GP before action is taken**

Referral Route

- **The CMHT will set up a Single Point of Access for all referrals into the service**
- **The CMHT will prioritise referrals based on clinical need and urgency.**
- **The CMHT will establish clear links with on call Psychiatrist, Access and CRISIS Teams**
- **All Patients/Service Users will be assessed by a competent mental health practitioner**

There will be a single point of access for all referrals. There will be a service referral form , however the CMHT will accept telephone/fax/bleep referrals to increase accessibility.

3.2.5 Service Response Times

To support best practice and ensure efficient and effective service delivery to meet the needs of patients/service users, carers and referrer's it is envisaged the following elements will be incorporated into the service:

- **The CMHT will operate a triage system to prioritise referrals and work within a set of pre-determined response times to include:**

Same day response for emergency referrals – response within 4 hours Monday to Friday

Within 72 Hours for urgent referrals

Within 2 weeks for routine referrals

3.2.6 Discharge Process

The CMHT will be responsible for ensuring appropriate planning for the safe discharge of those older people who have recovered sufficiently to no longer require specialist mental

health services and where their assessed needs can be more appropriately met by other relevant services.

The CMHT will initiate discharge where the following criteria have been met:

- **The agreed interventions/therapy has been completed**
- **There is agreement by the MDT that the person should be discharged, following discussion with the patient/service user and/or carer**
- **A needs appropriate discharge plan is in place**
- **A support package has been commissioned to meet the onward needs of the patient/service user and/or carer**
- **Post discharge support with the relevant agency has been agreed and is available and an agreed date has been set for discharge between all parties including patient/service user and/or carer**

The CMHT will provide:

- **A discharge summary/letter will be provided to the referrer outlining assessment/intervention and arrangements for on-going support**
- **A timely referral back to the relevant GP with a summary outline of assessment/interventions and arrangements for on-going support Will record in the discharge entry in the patient/service user record, the HONOS elements of MHCT**
- **The CMHT will provide patient/service user and carer with information on support services available to include: advice and support services, i.e. Dementia Advisors, Carers Association**
- **The CMHT will ensure pathways are in place to a range GP and Primary care, voluntary and independent sector support services**
- **The CMHT will provide advice and information in an appropriate format to meet the needs of the individual**

3.2.7 Care Pathways

To support the needs of older people with dementia and/or complex/enduring mental health problems. pathways will be developed that are supportive of best practice, deliver care that is person-centred, tailored to individual needs and considerate of the wider social context in which the individual lives

It is anticipated that pathways will be in line and consistent with the Health of the Nation Outcome Scales (HONOS) and include allocation to cluster specific pathways where appropriate. The CMHT will be expected to have in place demonstrable standards for referral through a care pathway to support service accessibility

3.2.9 Accessibility/Acceptability

- **The service will provide community based mental health assessment/treatment/intervention and care management to patients/service users who have dementia or for those with a mental health difficulty aged 65 years and over**
- **Accept, triage and prioritise referrals based on clinical need and urgency**
- **Formulate care plans including review and evaluation of care inclusive of appropriate risk assessments**
- **Provide appropriate support and family interventions where needed and agreed in the care plan**
- **Provide time limited interventions based on assessed need with onward referral to other more appropriate agencies on completion of treatment/intervention**
- **Develop discharge plans in conjunction with patient/service user, carer (with agreement of patient/service user) and future care providers**
- **Facilitate appropriate aftercare arrangements to sustain independence and overall sense of wellbeing for patient/service user and carer**
- **Provide specialist advice and support to GP's, Primary care colleagues and SSOTP staff around longer term care management of patients/service users mental health needs**
- **Provide specialist advice and guidance to GP colleagues on appropriate prescribing of anti-psychotic medication**
- **Maintain accurate and legible records of all patient/service user c ontacts and interventions using the recognised recording method for North Staffordshire Combined Healthcare NHS Trust**
- **support effective communication with GP's, Primary care and Secondary care services through prompt notification and letters advising of interventions, referrals and follow on support**
- **Work closely with colleagues in Urgent and Emergency Liaison and other liaison type services to support continuity of care for those patients/service users experiencing on-going mental health problems who are leaving hospital servic es and returning to a community setting**

3.3 Population covered

The Community Mental Health Team service will be provided to:

People of any age who are residents of the City of Stoke on Trent or North

Staffordshire

- **People of any age who are registered with a Stoke on Trent or North Staffordshire GP**

3.4 Any acceptance and exclusion criteria and thresholds

- **The service will be provided to people with dementia and complex/enduring mental health problems of any age who are residents of the City of Stoke on Trent and North Staffordshire.**

Exclusions

- **The CMHT service will not be provided to people under the age of 65 years who do not have dementia**

- **The CMHT service will not be provided to people aged 65 and over who are non-residents of the City of Stoke on Trent or North Staffordshire except where extra contractual arrangements are in place and agreed by commissioners**

3.5 Interdependence with other services/providers

The key relationships for the service will be with GP's and Primary Care Services, University Hospital North Staffordshire, North Staffordshire 5 NHS Community Hospitals, North Staffordshire and Stoke on Trent Social Care Departments and North Staffordshire Combined Healthcare NHS Trust. And with independent sector providers who specific ally provide services for people with dementia or older people with enduring/complex mental health difficulties

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

Refer to DOH 2006, NICE Clinical Guideline 42 Supporting People with Dementia and their Carers in Health and Social Care

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)
4.3 Applicable local standards
5. Applicable quality requirements and CQUIN Goals
5.1 Applicable quality requirements (See Schedule 4)
5.2 Applicable CQUIN goals (See Schedule 3)
6. Location of provider premises
Not applicable

Service Specification No.	**B07**
Service	Community Outreach Team – People with dementia and Older Adults.
Commissioner Lead	Jane Barnes, Locality Commissioning Manager – North Division, CCG
Provider Lead	Jane Munton-Davies, Associate Director, Community Mental Health Teams – Stoke
Period	01 April 2022 – 31 March 2023
Date of Review	**See 22/23 SDIP**

1. Population Needs

1.1 National/local context and evidence base

National guidance for older people's mental health services has suggested an effective and efficient mode of delivering services is to provide a community based team that operates 7 days per week to augment care offered by CMHTs, (Everybody's Business 2005, and 10 High Impact Changes for Mental Health 2006). Often these teams replace traditional day hospitals as a means of providing an additional intensity of care that complements the assessment and interventions provided by community teams that operate during office hours only. In common with "Crisis Resolution & Home Treatment Teams" as is found in Adult Mental Health, these teams offer an alternative to hospital admission. A key difference i s that they work with service users already known to services and operate more as crisis prevention and home treatment teams.

The Community based team functions in line with the following national policy and guidance:

- Forget Me Not, Audit Commission, 2000
- DOH, 2001 The National Service Framework for Older People, Department of Health London
- DOH 2002, Mental Health Policy Implementation Guidance for OACMHT's
- DOH 2003, Mental Health Policy Implementation Guide, Community Mental Health Teams, Department of Health, London
- DOH 2005, Everybody's Business, Integrated Mental Health Services for Older Adults: A service development guide, Department of Health, London
- DOH 2005, Mental Capacity Act, Department of Health, London

- DOH 2006, A New Ambition for Old Age
- Raising Standards, Specialist Services for Older People with Mental Illness - Report of the Faculty of Old Age Psychiatrists 2006.
- DOH 2006, NICE Clinical Guideline 42 Supporting People with Dementia and their Carers in Health and Social Care
- DOH 1983 (amended 2007), Mental Health Act, Department of Health, London
- DOH 2008, NHS Next Stage Review: High Quality Care for All
- DOH 2009, Living Well with Dementia, A National Strategy, Department of Health, London
- DOH 2011, No Health without Mental Health: A cross government mental health outcomes strategy for all ages, Department of Health, London

1.2 Local strategic context

In line with the national picture the local health economy is aiming to improve services and deliver mental health care closer to home and in the most effective way. To achieve this for people with dementia and older people (defined as aged 65 and over) with dementia or complex/severe mental health problems a period of protracted support within the home environment is advocated. To support this approach, the development of a Community Outreach Team that augments existing Community Mental Teams, by providing extended support over 7 days is being proposed. Delivering services in this way can help to ensure that care is facilitated in the least restrictive and disruptive way possible, reduce the stigma associated with mental health by caring for the person in their own home, proactively reduce the risk of crisis through preventative management, reduce the potential for carer breakdown and assist in a reduction of avoidable hospital or care home admissions.

2. Outcomes

2.1 <u>NHS Outcomes Framework Domains & Indicators</u>

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	**ü**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	**ü**

Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**ü**

2.2 Local defined outcomes

The Enhanced Community Outreach team will deliver the following key outcomes to people of North Staffordshire and Stoke on Trent:

- Provide a responsive specialist service for people with dementia and people aged 65 and over with dementia or mental health problems.
- Older people with dementia and mental health needs to be supported at home to prevent an admission into an acute setting
- Older people with dementia and mental health needs to be supported at home following discharge from an acute setting
- The service to demonstrate an increase in the number of people being discharged from hospital
- The service to demonstrate a reduction in appropriate admissions to a hospital setting
- The service to demonstrate a reduction inappropriate length of stay in a hospital setting
- The service to support any local NHS Hospital or GP with patients that meet the defined criteria

3. Scope

3.1 Aims and objectives of service

The Community Outreach Team shall operate 7 days a week to deliver specialist care to those people with dementia and older people (currently defined as age 65 and over) with dementia or complex/severe mental health problems.

Working as part of a 'whole system' the Community Outreach team shall offer a level of support and intervention over and beyond that currently provided by other mental health teams. The intensity of care provided will complement day time provision currently in place and assist in reducing avoidable hospital admissions through proactive care management to prevent/reduce episodes of crisis.

Aim The overall aim of the service is to provide the foundation of a responsive specialist service for people with dementia and people aged 65 and over with dementia or mental health problems.

Objectives

- The Community Outreach Team shall augment the care offered by CMHTs, offer an alternative to admission to an acute (UHNM and Mental Health hospital) setting and facilitate discharge if someone has been admitted to Harplands and / or UHNM
- The Community Outreach Team shall provide highly specialist input for anyone with dementia or an older person who has been clinically assessed by another NSCHT Team.
- The Community Outreach Team shall offer frequent or prolonged contacts for people with dementia, people aged 65 and over with dementia or severe mental health problems and their family/carers for a time limited period
- The Community Outreach Team shall review patients care on a regular basis appropriate to clinical need
- The Community Outreach Team shall offer a more intensive approach, as the emphasis on care co-ordination will be placed on CMHTs or other teams allowing the Community Outreach Team to focus on providing face to face contact with people.
- The Community Outreach Team shall work in partnership with other teams within NSCHT and also across the Health and Social Care economy, particularly, Social Care, Primary Care, Care Homes, Harplands hospital, UHNM and Community Hospitals.
- The Community Outreach Team shall support patients subject to CPA
- The Community Outreach Team shall provide interventions and support that promote respect and dignity, and aids recovery through encouraging self-management.
- The Enhanced Community Outreach team shall support GPs in North Staffordshire and Stoke on Trent with any patients that meet the criteria in order to avoid an acute admission or re-admission
- Work in partnership with the Staying at Home Scheme, Care Home Liaison Service, ILCTs and GPs to help prevent any avoidable admissions to acute care

Key service outcomes

It is anticipated that the service shall deliver the following key outcomes:

- An increase in the number of people with dementia and or older people with dementia or complex/severe mental health problems receiving assessment/care in their own home or a community setting
- An increase in the number of people with suspected dementia receiving early assessment, diagnosis and appropriate treatment
- Antipsychotic prescribed medication regularly reviewed to support appropriate

prescribing and patient/service user safety

- More people with dementia and people aged 65 and over with dementia or complex/severe mental health problems supported to remain in their own home for longer
- Improved patient and carer satisfaction
- A reduction in the number of crisis intervention
- A reduction in number of carer breakdowns
- A reduction in the number of avoidable admissions to acute psychiatric inpatient care and acute care (i.e. UHNM)
- A reduction in the average length of stay for people receiving in-patient psychiatric care
- A reduction in inappropriate attendance at A&E (UHNM)
- A reduction in the number of avoidable admissions to acute general care (UHNM) where the primary need is mental health not physical health
- A reduction in the average length of stay for people with dementia and people aged 65 and over with dementia or complex/severe mental health problems, returning home from general hospital in-patient care (UHNM)
- A reduction in delayed transfers of care/discharge from inpatient hospital care attributable to dementia/mental health problems
- Compliance with CPA Policy

3.2 Service description/care pathway

The Community Outreach Team will enhance the care offered by Community Mental Health Teams (CMHT) adopt a multi-disciplinary approach to service delivery providing specialist assessment intervention and treatment for people with dementia and people aged 65 and over with dementia or complex/severe mental health difficulties. The service will deliver specialist care to those who require more intensive support and intervention over and beyond that currently offered by other mental health teams.

The service will provide care within the home environment 7 days per week between the hours of 8am and 8pm, whilst maintaining a clear focus on providing a responsive service to support home treatment, crisis prevention and a viable and safe alternative to hospital or care home admission.

The Community Outreach Team will actively support a 'whole systems' approach to care and fully engage with a multiplicity of teams/agencies and organisations to ensure patient/service user/carers universal needs are effectively supported within a community setting.

The Community Outreach Team will at all times deliver mental health assessment, treatment, intervention and care management in line with evidenced best practice and relevant mental health legislation

The Community Outreach Team will provide supplementary support to the CMHT's in the form of specialist mental health assessment, treatment and intervention to patients/service users who have dementia and those aged 65 years and over who have dementia or a mental health condition impacting on cognition, emotions and behaviour.

The service shall:

- Provide a 7 day service between the hours of 8am and 8pm
- Accept, referrals based on clinical need and urgency made via the Community Mental Health Team
- Formulate care plans including review and evaluation of care inclusive of appropriate risk assessments
- Deliver intensive support/treatment/intervention within the patient/service users home environment
- Provide appropriate support and family interventions where needed and agreed in the care plan
- Provide time limited interventions based on assessed need with onward referral to other more appropriate agencies on completion of treatment/intervention
- Develop discharge plans in conjunction with patient/service user, carer (with agreement of patient/service user) and future care providers
- Facilitate appropriate aftercare arrangements to sustain independence and overall sense of wellbeing for patient/service user and carer
- Provide specialist advice and support to GP's and Primary care colleagues around longer term care management of patients/service users mental health needs

- Provide specialist advice and guidance to GP colleagues on appropriate prescribing of anti-psychotic medication
- Maintain accurate and legible records of all patient/service user contacts and interventions using the recognised recording method for North Staffordshire Combined Healthcare NHS Trust
- support effective communication with GP's, Primary care and Secondary care services through prompt notification and letters advising of interventions, referrals and follow on support
- Work closely with colleagues in CMHT's, Urgent and Emergency Liaison and In-patient services to facilitate and support hospital discharge and continuity of care for those patients/service users experiencing on-going significant and/or severe mental health problems who are able to return home with enhanced home support

Service Model

- The service model shall support a multi-disciplinary approach to care and provide for prompt community based specialist mental health assessment, intervention and care management, for people with dementia and people aged 65 and over with dementia or a mental health condition impacting on cognition, emotions and behaviour .
- The service model shall actively support a whole systems approach to care, working closely with a range of mental health teams and other agencies/organisations to ensure patient/service users' needs are effectively supported within a community setting.
- The service shall be provided within the home environment 7 days per week between the hours of 8am and 8pm, and maintain a clear focus on providing a responsive service to support home treatment, crisis prevention and a viable and safe alternative to hospital or care home admission.
- The service shall work to the principles of Health of the Nation Outcome scale (HONOS) and Mental Health Clustering Tool (MHCT)
- The service shall encompass a number of core disciplines with appropriate levels of clinical skills to ensure patient/service user needs are fully provided for. Where necessary the service will engage with other specialist support deemed relevant to effective service delivery, for example, links to medicines management, psychology and social care may need to be considered if not incorporated into the core service.

- The service shall be expected to impact in a number of areas and deliver a wide range of treatment/interventions to include:

- Early identification of mental health needs and early/prompt intervention to minimise distress for patients/service users/carers to support best clinical outcomes

- To provide community based care that supports evidence based clinical interventions and treatment, active rehabilitation, education and preventative strategies

- To formulate treatment plans inclusive of regular review and evaluation of care

- Plan with the service users and carers to develop discharge plans, wellness plans, crisis prevention and crisis management plans

- Implement crisis interventions that reduce the impact, severity and duration of the crisis and seek solutions to prevent further episodes of crisis

- Facilitate onward referral, signposting and support to access universal services, including housing, employment, social care, etc .

- Facilitate onward referral, signposting and support to access other health services including primary care (GP) services and universal health services

- Provide information, advice and support for carers

- Provide information, advice and support for other service providers

Referral processes Referral Criteria

The Community Outreach Team shall accept referrals for people with dementia, or older people (currently defined as age 65 and over) with dementia or complex/severe mental health difficulties who require more specialist and intensive support/intervention than can be provided by other teams

- Referrals to the Community Outreach Team shall be made via a designated Single Point of Access

- The Community Outreach Team shall advise the referrer of the outcome of the referral to include: Acceptance of the referral, signposting/onward referral to alternative service appropriate to the patient/service user needs

Referral Source

It is expected that referrals to the Community Outreach Team shall be accepted from:

- CMHT's
- Mental Health Day Hospitals
- In-patient Mental Health Units
- Urgent and Emergency Liaison service supporting the University Hospital North Staffordshire and the 5 North Staffordshire NHS Community Hospitals
- North Staffordshire Combined Healthcare NHS Trust Services

Referral Route

- The Community Outreach Team shall triage and prioritise referrals based on urgency of clinical need
- Referrals shall be allocated on a daily basis as they are received by the Team Manager/ Duty Worker
- The Community Outreach Team shall establish clear links with CMHT's, Mental Health Day Hospitals, In-patient mental health units, Urgent and Emergency Liaison Service, on call Psychiatrist, Access, UHNM and CRISIS Teams

It is anticipated there shall be a single point of access for all referrals and there shall be a service referral form, however the Community Outreach Team will accept telephone/fax/bleep referrals to increase accessibility

Service Response Times

To support best practice and ensure efficient and effective service delivery to meet the needs of patients/service users, carers and referrer's it is envisaged the following elements will be incorporated into the service:

- The Community Outreach Team shall operate a triage system to prioritise referrals and work within a set of pre-determined response times to include:

- Urgent referrals to be responded to within 2-4 hours

- **Any Referrals received to facilitate** discharge from any hospital setting (Harplands and UHNM) should be responded to within 24 hours

- **Any Referrals received to avoid admission into a** hospital setting (Harplands and UHNM) should be responded to within 2-4 hours

- **All other referrals to be responded to within 24 hours**
- All Patients/Service Users shall be assessed by a competent mental health practitioner

Discharge Process

The Community Outreach Team shall be responsible for ensuring appropriate planning for the safe discharge of those people who have recovered sufficiently to no longer require specialist enhanced community mental health treatment/intervention and where their assessed needs can be more appropriately met by other relevant services.

It is anticipated that the Community Outreach Team shall initiate discharge from the service where the following criteria have been met:

- The agreed interventions/therapy has been completed
- There is agreement by the MDT that the person should be discharged, following discussion with the patient/service user and/or carer
- A needs appropriate discharge plan is in place
- A support package has been commissioned to meet the onward needs of the patient/service user and/or carer
- Post discharge support with the relevant agency has been agreed and is available and an agreed date has been set for discharge between all parties including patient/service user and/or carer

3.3 Population covered

The Community Outreach Team shall provide a service to:

- People with dementia or a mental health condition impacting on cognition, emotions and behaviour who are residents of the City of Stoke on Trent or North Staffordshire

- People with dementia or a mental health condition impacting on cognition, emotions and behaviour who are registered with a Stoke on Trent or North Staffordshire GP

3.4 Any acceptance and exclusion criteria and thresholds

- The Community Outreach Team service shall be provided to people with dementia or those aged 65 and over with dementia or a mental health condition impacting on cognition, emotions and behaviour who are residents of the City of Stoke on Trent or North Staffordshire

- The Community Outreach Team service shall be provided to people with dementia or for those aged 65 and over with dementia with a mental health condition impacting on cognition, emotions and behaviour who are registered with a Stoke on Trent or North Staffordshire GP

- The Community Outreach Team service will be provided to people with dementia under the age of 65 with dementia or dementia type illness impacting on cognition, emotions and behaviour who are residents of the City of Stoke on Trent or North Staffordshire

- The Community Outreach Team service shall be provided to people with dementia under the age of 65 with dementia or dementia type illness impacting on cognition, emotions and behaviour who are registered with a Stoke on Trent or North Staffordshire GP

Exclusions

- The Community Outreach Team shall not provide a service to people under the age of 65 years who do not have dementia/ dementia type illness

- The Community outreach Team shall not provide a service to non-residents of the City of Stoke on Trent or North Staffordshire

- The Community Outreach Team shall not provide a service to people who are not registered with a Stoke on Trent or North Staffordshire GP

3.5 Interdependence with other services/providers

Whole Systems Relationships

The Community Outreach Team shall support a multidisciplinary holistic approach to service provision, develop and maintain close working relationships with a wide range of partner agencies across statutory, voluntary and independent sector organisations.

Service provision shall be considerate of the individual's home circumstance and family dynamics and will facilitate where appropriate onward referral to other services i.e. Children and Families.

The key relationships for the service shall be with CMHT's, Mental Health Day Hospitals, In-patient mental health units, Urgent and Emergency Liaison, Psychiatrists, GP's and Primary Care Services, North Staffordshire and Stoke on Trent Social Care Departments and North Staffords hire Combined Healthcare NHS Trust

Clinical Networks and Screening Programmes

The service shall work with the relevant clinical networks and evidence based screening programmes and tools for mental health conditions, where they are available.

Workforce

- The service provider shall have sufficient and skilled staffing to provide care, clinical need and safety to deliver the outcomes required by patients/service users who access the service as outlined in this service specification

- Staff working in the Community Outreach Team shall have their training /development needs assessed on an annual basis and will be supported to undertake appropriate training to ensure they are kept up to-date

- Training shall be inclusive of and developed in line with new policy and guidance and best practice

- All staff working in the Community Outreach Team shall have current CRB clearance

- All staff working in the Community Outreach Team shall maintain compliance with mandatory training requirements

Qualifications and Competences

- All professionally qualified staff working within the Community Outreach Team shall have active registration with the appropriate professional body
- Support workers shall have received relevant training commensurate with their role and responsibilities

All staff working in the Community Outreach Team shall have extensive experience of assessment, planning, treatment /intervention and evaluation of care across a wide range of mental health conditions including dementia and complex enduring/severe mental health problems

- All staff working in the Community Outreach Team shall demonstrate a thorough knowledge and understanding of local resources and pathways relevant to the needs of people with dementia and those with complex/enduring/severe mental health problems and promote effective interagency working
- The Community Outreach Team shall work in line with current Best Practice Guidance, CPA Policy and comply with all relevant legislation to include: The Mental Health Act 1983 (amended 2007), The Mental Capacity Act 2005 etc.

Clinical Supervision

The service provider shall ensure that appropriate arrangements are in place to provide sufficient levels of supervision and support to staff involved in the delivery of assessment and clinical interventions. These arrangements will need to be consistent with identified best practice across the range of specialities within the team.

It is expected that direct links with a Consultant Psychiatrist shall be in place to support patient review and ensure patient safety.

General Supervision

- The service provider shall ensure arrangements are in place to provide appropriate levels of supervision to all members of the Community Outreach Team. These arrangements shall be consistent with identified best practice.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The Community Outreach Team service shall comply with relevant national standards of best practice in mental health care and current legislation in mental health inclusive of appropriate and relevant NICE Clinical Guidance, CPA Policy and Practice and other applicable guidelines to include :

- Mental Health Act 1983 (Amended 2007)
- Mental Capacity Act 2005
- NICE 2006, Clinical Guideline 42 Supporting People with Dementia and their Carers in Health and Social Care
- NICE Clinical Guideline CG90/91 Depression
- NICE 2009, Clinical Guideline CG90/91 Depression in Adults with a chronic physical health problem

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

It is expected that the service provider shall ensure appropriate policy is in place in line with current health and safety and risk management guidance together with appropriate mechanisms for recording, auditing and monitoring feedback on service provision and actions taken to resolve issues.

Safeguarding

When the Community Outreach Team are involved in assessing people with dementia and or mental health problems they must consider whether there are any safeguarding concerns relating to the patient/service user. Where there is concern for the safety

of the patient/service user then it is the responsibility of the professional identifying the concern to notify the appropriate authority.

The Community Outreach Team service should ensure that at the point safeguarding issues emerge they are referred in line with local safeguarding policies and procedures. This is the responsibility of the professional leading the assessment and should be clearly communicated to other partners. For example if the mental health assessment clearly identifies that the adult being treated is at risk or is a carer for another adult or a parent or lives in a household with children and that these children may be at risk because of the adult/ parental behaviour the responsibility to refer rests with the worker who identified this issue and a copy of the written referral retained in the patient/service user record.

The Community Outreach Team should follow local procedures making reference to referral processes to ensure that the correct local safeguarding process is adhered to for the protection of adults and children.

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.23 Applicable Quality Requirements (See Schedule 4)

5.24 Applicable CQUIN goals (See Schedule 3)

6. Location of Provider Premises

The Provider's Premises are located at:

North Staffordshire Combined Healthcare NHS Trust Harplands Hospital,

Hilton Road,

Stoke on Trent

Days/ hours of operation

North Staffordshire Combined Healthcare NHS Trust shall retain overall responsibility for the delivery of service and appropriate location of the Community Outreach Team.

The Community Outreach Team shall operate 7 days per week between the hours of 8am and 8pm

Ref.	B09
Service	Dementia Primary Care Liaison Service (DPCLS)
Commissioner Lead	Jane Barnes, Commissioning Manager
Provider Lead	Jane Munton-Davies, Associate Director, Stoke Community Mental Health Service
Period	01 April 2022 to 31 March 2023
Date of Review	February 2022

1. Population Needs

1.1 National/local context and evidence base

Dementia is a term used to describe a group of symptoms that may include memory loss, difficulties with thinking, problem solving or language, and often changes in mood, perception or behavior. Alzheimer's disease is the most common type of dementia, with other types of dementia including vascular dementia, dementia with Lewy bodies and frontotemporal dementia. Dementia is not a part of ageing there are at least 42,000 younger people (under the age of 65) in the UK who have dementia.

It is estimated that there are around 850,000 people in the UK with dementia. However, because of longer life expectancy this number is expected to double by 2035. It is estimated that dementia costs the English economy approximately £26 billion every year and is set to increase.

The National Dementia Strategy (DH 2009) highlights the scale of the challenge that dementia presents to society. The Prime Minister's challenge 2020, which was building on the progress from the first Challenge issued in 2012, aims to make England the best country in the world for dementia care, support, research and awareness.

NHS England's Transformational Framework – the Well Pathway for Dementia follows a patient's pathway through dementia and discusses diagnosing patients well, supporting patients well, living well and dying well with dementia.

By 2020, there are National plans to establish an evidence based treatment pathway for dementia. The pathway will have two strands, the first of which is a standard that recommends that by 2020, 85% of people with suspected dementia who are referred to a memory assessment service receive a diagnosis and start treatment within 6 weeks of referral (starting treatment means that the person has met with a named care co-ordinator and that an initial care plan of NICE-recommended treatment for dementia has been agreed).

The second pathway standard recommends that a person living with dementia receives NICE-recommended support for a minimum of a year (support means that the initial care plan, is reviewed by the named care co-ordinator as the person's needs dictate, but at least once within 12 months of it first being agreed. Revisions should be jointly developed and agreed with the person living with dementia, and, if applicable, their carer). This is clarified in the Implementation guide and resource pack for dementia care which details the care co-ordinators role and also the NHS England Dementia: Good Care Planning guide.

The CCG Improvement and Assessment Framework (IAF) contains the following indicators that the CCG's are assessed against.

- Estimated diagnosis rate for people with dementia
- Dementia care planning and post-diagnostic support

Local context

The local Joint Stoke-on-Trent Dementia Strategy – "Living well with Dementia: Stoke-on-Trent Joint Dementia Strategy 2015-2019 (currently being refreshed) was written by Stoke-on-Trent CCG and Stoke-on-Trent City Council. The Council facilitated a large consultation exercise with the residents of Stoke-on-Trent and it outlines the priorities that came out of the consultation.

- Priority 1 – Spread the message of living well – improve professional and public awareness of dementia
- Priority 2 – Timely diagnosis and support – for people to receive a diagnosis in the right way, at the right time, with access to the right support
- Priority 3 – Enable people to live well with dementia – access to high quality, personalised support for both the person with dementia and their carers'.

Dementia prevalence is rising locally; subsequently the number of people requiring post diagnosis support is increasing. The table details the current predicted dementia prevalence rates for as at June2019 across Northern Staffordshire.

	North Staffordshire	**Stoke-on-Trent**	**Total**
Dementia prevalence Nov 19	**3,087**	**3,161**	**6,248**
Dementia Diagnosis %age	**74.8%**	**88.7%**	**81.8%**
Diagnosis numbers Nov 19	**2,309**	**2,803**	**5,112**
MCI Diagnosis Q2	**517**	**505**	**1,022**
Care Planning Nov 19	**66%**	**65%**	

The North Staffordshire Carers Association was funded in 2015-17 to carry out a pilot amongst dementia carers. The evaluation of the project highlights gaps in service especially around being able to provide individual support to carers when it is required either:-

- Following diagnosis to enable carers to receive the support they require with finances, coping with caring, signposting to support that is available, etc
- During times of escalation of symptoms when the support for carers needs to be revised.

From the pilot, it was agreed that separate patient and carer pathways were required to identify the support available and identify gaps.

It is felt across Northern Staffordshire that there should never be a "dementia crisis" if patients and carers are supported well. Improvements to support patients and carers have been made

- 2015/16 with the introduction of the Dementia Primary Care Liaison Team providing support in the community for stable patients.
- The Memory Support Service/Dementia Connect provided by the Alzheimer's Society commenced from June 2019. Strong links have been established with the memory clinic to ensure that all newly diagnosed patients are electronically referred directly to this service.
- Memory clinic have developed a pathway from MCI diagnosis through to end of life.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	

2.2 Local defined outcomes

It is anticipated that the dementia primary care liaison service will deliver the following key outcomes for the people of Northern Staffordshire.

- Promote prompt referral and earlier diagnosis by raising awareness of the condition amongst primary care clinicians.
- Greater numbers of service users being supported post diagnosis within primary care.
- Integrated working with joined up pathways between primary care, specialist mental health, case management and admission avoidance services/teams through the established pathway from primary care to specialist dementia services within emergency/ urgent timeframes ie immediate to response within one working.
- Improved information and support for families and carers.
- Increased understanding of physical care professionals of identifying and managing the needs of people with dementia.
- Reduced admissions to both acute and specialist hospital based services through improved and responsive community support.

3. Scope

3.1 Aims and objectives of service

There is a local drive to promote a model of care which centres on 'care closer to home' and is in keeping with the national impetus to move away from a predominately bed based/secondary care service model to a more holistic, focused and intensive community care based model. Providing services in this way can help to ensure that care is delivered in the least restrictive and disruptive way possible, reduce the stigma associated with mental health care, and by fostering independence through illness within the individual's social context, help to minimize the risk of older people becoming alienated from their local communities.

The local emphasis on maintaining and improving independence for older people with dementia and complex/enduring mental health problems remains a key priority for the local health economy.

The dementia primary care liaison service will achieve the following aims:-

- Increase awareness and confidence of primary care staff in the management of patients with dementia, educating staff on local services available.
- Provide specialist advice to support primary care staff to deliver high quality stable dementia reviews including medication monitoring in line with NICE guidance.
- Promote living well with dementia and support patients to remain in their normal place of residence as long as possible.
- Integrated working with primary care and community services to ensure that case management of patients with dementia has specialist input where necessary.

Objectives

The continued development of the dementia primary care liaison service will enable the development of four key functions:

- Provide a contact point for GP practices where there are immediate or urgent needs. This will require a timely response, usually within two hours, and will provide advice back to the GP in terms of care management or further referral. If specialist service input is required however, the dementia primary care liaison service will have a direct pathway back to the memory service and CMHT's
- Provide specialist advice (when required) to primary care staff who are carrying out the monitoring of diagnosed patients with stable dementia but requiring regular reviews in accordance with NICE guidance (http://www.nice.org.uk/Guidance/CG42).

- Increase awareness and confidence of primary care staff in the management of patients with dementia, educating staff on local services available.
- Membership and input to NCP's, providing advice and expertise on supporting people with dementia and other co-morbidities and undertaking assessments of peoples dementia needs including undertaking joint assessments where necessary and appropriate to do so.

3.2 Service description/care pathway

DPCLS will provide community based multi-professional mental health assessment/treatment/ intervention to people who have dementia, including support to other professionals and carers/ families.

The service will at all times operate within mental health legislation, CPA policy, NICE clinical guidelines and current evidence based clinical practice.

The service will deliver an effective and efficient community based " needs led service" inclusive of the following key elements:

Primary Care

- Establish and develop excellent working relationships between CPN and primary care.
- Support primary care staff to deliver high quality dementia reviews including medication monitoring (for patients stable symptomatically on medication) and completion of cognitive assessment.
- To support GP surgeries to provide joint clinics with the GP/practice nurse, thus aiming to reduce number of clinical appointments the person with dementia needs to attend.

Governance for the management of stable patients in primary care

Patients who are stable will be managed in primary care being discharged back to their GP. However, if concerns arise around the patient's condition a rapid access pathway back into the memory service will be facilitated by the CPN. The CPN will also have access to the Consultants at NSCHT through sessions purchased by the CCG's

- Proactively engage with and provide advice and support to GP's and primary care services to promote clinical liaison and quality care management of older people with dementia and or complex.
- Provide specialist input to the managed of people with dementia/complex mental health conditions that are identified as regular users of secondary care/acute services (e.g., through mechanisms employed by the practice for the unplanned admissions DES).

- Timely identification of dementia or mental health conditions, with early intervention and support to maintain patient/service user and carer independence and overall sense of wellbeing.
- Provide a range of time limited clinical interventions and treatment to support active rehabilitation and recovery, inclusive of developing/promoting patient/service user self-management skills and personal coping strategies.
- Promote full engagement and ownership with the patient/service user and carer, (with service user agreement), in the assessment process and development of the care/treatment plan.
- Ensure all patient/service users are provided with a copy of their individual care plan.
- Engage patient/service users and carers (with service user agreement) in the development of discharge plans, wellness plans, and contingency plans for crisis prevention and crisis management.
- Deliver least restrictive crisis interventions to reduce any negative impact caused by the crisis and develop contingencies to prevent further episodes.
- Provide information, advice and support to carers and facilitate referral into other services as appropriate to individual need
- Provide information, advice and support to a variety of service providers to sustain effective longer term community provision for a patient/service users and carers.
- Link with dementia advisory services so that patients have access to appropriate advice about benefits, lasting power of attorney, support groups and day opportunities to maintain their independence as long as possible.

Rapid response within primary care setting.

- Provide a contact point for GP practices where there are immediate or urgent needs. This will require a timely response, will provide advice back to the GP in terms of care management or further referral. If specialist service input is required, however, the dementia primary care liaison service will have a direct pathway back to the memory service and community mental health teams.
- Prompt holistic assessment that supports the older person's mental health, psychological, social and physical needs which includes work with community team members as necessary.
- Deliver a range of evidenced based treatment/interventions that are time limited, appropriate to the assessed needs of the individual, ensuring that inappropriate and unnecessary treatments are avoided. Support active rehabilitation and recovery, inclusive of developing/promoting patient self-management skills and personal coping strategies.
- Appropriate access to specialist services on a timely basis i.e. 2 hours with clear protocols with specialist dementia services. Establish pathway from primary care to

specialist dementia services within emergency/urgent timeframes i.e. immediate to 24 hour response.

- Provide a range of time limited clinical interventions and treatment to support active rehabilitation and recovery, inclusive of developing/promoting patient self-management skills and personal coping strategies.
- Link in with the pathways developed with the frail elderly pathway.

Service Location and Delivery

North Staffordshire Combined Healthcare NHS Trust will retain overall responsibility for the delivery of the DPCL service. The service will operate mainly from primary care settings and in care home residences.

Days/hours of operation

The DPCL service will ensure appropriate and flexible access according to the needs of the service, which will be available Monday to Friday 9 - 5.

Referrals

The DPCLS will ensure the process for referral is communicated to all partner agencies across Stoke-on-Trent CCG. The referrals process to the DPCLS:

- The DPCLS will set up for referrals to be made to a CPN within the service.
- Referrals will be triaged and prioritised based on urgency of clinical need.
- The referrer will be informed of the outcome of the referral.

Referral Source

Referrals will be accepted directly from GPs and primary care staff, care home staff, hospital therapy and discharge teams, CCG care home pharmacist and other community health and social care professionals.

Service Response Times

To support best practice and ensure efficient and effective service delivery to meet the needs of patients/service users, carers and referrer's it is envisaged that:-

- GP's/ILCT's/MCP's will speak to a professional within 2 hours (especially if the aim is to avoid admission to acute hospital or a mental health admission). The professional when then address the problems discussed and facilitate/respond to the needs of the patients as appropriate.

- Patients will be stepped up for review within 72 hours for urgent and within 2 weeks for routine review with specialist services.

Discharge Process

This is discharging patients from the memory clinic

The memory service will be responsible for ensuring appropriate planning for the safe discharge of those older people who, based on their level of need, no longer require specialist mental health services and where their assessed needs can be more appropriately met by other relevant services.

The memory service will initiate discharge where the following criteria have been met:

- The agreed interventions/therapy has been completed and patient is stable
- There is agreement by the MDT that the person should be discharged, following discussion with the patient/service user and/or carer
- A needs appropriate discharge plan is in place
- A support package has been commissioned to meet the onward needs of the patient/service user and/or carer
- Post discharge support with the relevant agency has been agreed and is available and an agreed date has been set for discharge between all parties including patient/service user and/or carer
- Patients diagnosed with Mild cognitive impairment to be discharged back to their GP. Follow up to be carried out in primary care in order to identify any potential decline, in which case the patient will be re-referred back into the memory service.

Follow Up

The memory service will:

- Provide a discharge summary/letter to the referrer outlining assessment, intervention and arrangements for on-going support
- Provide a timely referral back to the relevant GP with a summary outline of assessment/interventions and arrangements for on-going support
- Will record in the discharge entry in the patient/service user record, the HONOS elements of MHCT (care clusters)
- The service will provide patient/service user and carer with information on support services available to include advice and support services, i.e. Dementia Advisors, Carers Association
- Ensure pathways are in place to a range of GP and Primary care, voluntary and independent sector support services

- (As part of the wider CMHT) provide advice and information in an appropriate format to meet the needs of the individual.

Follow up in primary care will be facilitated by the DPCLS CPN's and should include:-

- Review of medication
- Assess any changes in the psycho-social circumstances.
- Include the patient's carer in the review in order to assess carer involvement and any needs the carer may have.
- Provide signposting to services as required.
- Inform GP of any areas of concern and refer back to the memory service if required.

Care Pathways

To support the needs of people with dementia, pathways will be developed that are supportive of best practice, deliver care that is person-centered, tailored to individual needs and considerate of the wider social context in which the individual lives.

Workforce

A suitably skilled and qualified full time CPN will be attached to each locality.

Two consultant sessions will be available to provide support to both Dementia Primary Care Liaison teams.

Administrative support will be available to support both teams.

Clinical and General Supervision

The service provider will ensure that appropriate arrangements are in place to provide sufficient levels of supervision and support to staff. These arrangements will need to be consistent with identified best practice across the range of specialties within the team.

3.3 Population covered

The dementia primary care liaison service will be provided to people of any age who are resident of Northern Staffordshire and are registered with a North Staffordshire or Stoke-on-Trent GP.

3.4 Any acceptance and exclusion criteria and thresholds

The Service will provide support to people who have been diagnosed with dementia.

3.5 Interdependence with other services/providers

The key relationship for the Service is with General Practitioners, Integrated Locality Care Teams, and the Service shall work in close partnership with GPs in the City. Each general practice shall have a link worker associated with them so that a strong relationship can be developed between the Service and general practice staff.

A further key relationship is with the North Staffordshire Combined HealthCare NHS Trust memory service in order to facilitate urgent follow up of patients in secondary care who have been identified by GP's as deteriorating and requiring further specialist input into their management. This will ensure that Service Users can be seamlessly stepped up or down between services which are clinically appropriate in a timely and easy manner.

It is imperative that the DPCL Service shall have a key relationship with organisations within the IAPT Network. It is expected that the Service shall facilitate the referring/supported signposting of Service Users within the Network, so that the service the Service User receives is seamless and timely. It is expected that all members of staff shall form close working links with the organisations of the Network to maximise efficiency and improve integrated working.

The Service shall also ensure it has "signposting" relationships with a range of other services that address factors linked to mental health and wellbeing, to services that address physical health needs and services available to the population in general.

Where necessary the Service shall develop shared care arrangements with other relevant services to ensure Service User's needs are fully met and all aspects of their care and treatment coordinated.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The Service shall ensure that it adheres to relevant national standards of best practice in dementia care, to the most recent NICE guidance and other reliable sources of evidence, for example:

- DOH 2006, NICE Clinical Guideline 42 Supporting People with Dementia and their Carers in Health and Social Care
- National Institute for Clinical Excellence (2001) Guidance on the use of Donepezil, Rivastigmine and Galantamine for the Treatment of Alzheimer's Disease. No 19. London: NICE
- NICE Quality Standard 30 on supporting people to live well with dementia (QS30).
- NICE Dementia Pathway

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

Royal College of Nursing https://www.rcn.org.uk/clinical-topics/dementia/professional-resources

Joint Commissioning Panel for Mental Health http://www.jcpmh.info/good-services/dementia-services/

4.3 Applicable local standards

Stoke on Trent Best practice in the clinical management of Dementia in general practice, 2011

5. Applicable quality requirements and CQUIN goals

5.3 Applicable quality requirements (See Schedule 4)

5.4 Applicable CQUIN goals (See Schedule 3)

Service Specification No.	B10 (see SDIP for 22/23)
Service	Care home Physiotherapy
Commissioner Lead	Jane Barnes, Locality Commissioning Manager – North Division, CCG
Provider Lead	Jane Munton-Davies, Associate Director, Stoke Community Mental Health Services
Period	01/04/2022 – 31/03/2023
Date of Review	Review in year with a view to updating and brining all older people service specifications into one pathway service specification (see 22/23 SDIP)

1. Population Needs

National/local context and evidence base:

Nationally, nearly 400,000 people reside in care homes in the UK, almost 20% of those are aged 85 years or over. Their health and social care needs are complex; the majority have some sort of disability, many have dementia, and collectively they have high rates of both necessary and avoidable admissions to hospital.

The care home population is increasing due to the growing number of older people needing care and support, as well as improving survival rates from trauma and other severe physical conditions and disabilities.

It is well evidenced that residents in care homes have poorer access to healthcare services compared with the general population despite the fact that they are among the sickest patients and have the most complex needs (British Geriatric Society, 2011). Bebbington et al (2000) also reports that levels of dependency are rising and that the population in residential homes now resembles that only found in nursing homes a few years ago.

Research and best practice guidance shows that for high quality care; care should be proactive and delivered by multidisciplinary services.

In care homes the rate of falls is almost three times that of older people living in the community. Injury rates are also considerably higher, with 10-20% of institutional falls resulting in a hip fracture, and 30% of people admitted to an acute hospital with a hip fracture coming directly from a care home.

Care home residents are likely to be frailer and have medical conditions such as stroke, Parkinson's Disease or dementia or have sensory impairments that increase the risk of falling

Residents of care homes have increased risks of falls due to:

- Certain medications and more than four types of medications increases the risk of falls
- Limited physical activity decreases muscle strength and affects balance, making falls and injuries more likely

Interventions to reduce falls and fractures in care homes include:

- Providing high-strength vitamin D and calcium supplements
- Staff education, advice and guidance e.g. information on modifiable risk factors and other preventive measures
- Education for residents e.g. information on exercise and fall prevention
- Falls prevention environmental assessments e.g. lighting, furniture height, floor surfaces
- Therapeutic exercise programmes; Individual and group

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	**ü**

Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**ü**
Domain 4	**Ensuring people have a positive experience of care**	**ü**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**ü**

2.2 Local defined outcomes

- To improve access to falls prevention services and quality of care for care home residents

- To reduce number of calls to ambulance services for falls

3. Scope

3.1 Aims and objectives of service

The care home physiotherapist service aims to maximize residents functional ability, independence and quality of life.

The service will:

- Ensure residents at high risk of falling have a clear management plan in place

- Educate the care home workforce on falls prevention strategies and initiatives

- Ensure that post hospital discharge pathways are in place for those residents who would benefit from further therapy intervention

3.2 Service description/care pathway

Physiotherapy will be provided over 5 days per week (Monday to Friday) to residents in care homes across Northern Staffordshire. The role will provide rehabilitation and therapy to all categories of care home residents including nursing, residential, EMI and respite patients (where appropriate).

The CCG will agree areas of priority including support for homes with high attendances to A&E and care homes receiving the GP locally enhanced service.

Following recent discharge from hospital for falls, decreased mobility or trauma and orthopaedic surgery it is important that patients are actively managed by the care home physiotherapist and that a management plan is developed (if not already in place) and implemented to maintain or progress residents to their previous level of functional independence (where physically/medically possible) e.g. walking mobility, transfer ability, exercise stamina and ADL independence.

The Service will liaise with the UHNM therapy teams and community hospitals (where appropriate) and carry out therapy plans agreed on discharge.

The service will be delivered by qualified physiotherapists and physiotherapy technicians (under the guidance of qualified staff).

The physiotherapist will provide the following:

- Respond to referrals from all care homes in Northern Staffordshire for the purposes of assessment, rehabilitation and treatment.

- The Physiotherapist can accept referrals directly from the care home and will use clinical judgement to determine whether GP/ pharmacy liaison is required.

- A range of rehabilitation will be provided with varying levels of intensity. Patients will be proactively managed to regain confidence, regain/maintain mobility and promote independence.

- Re-assess and update the therapy management plan as necessary.

- Urgent referrals will be seen within 2 working days

- Implement the agreed therapy management plan, which will include any potential risks.

- Work alongside carers and provide guidance on the management plan with an expectation that they will support daily therapy where appropriate

- Prompt commencement of active physiotherapy as soon as appropriate.

- Where necessary attend MDT meetings within care homes (dependent on the therapy needs of patients within the Home and local meeting arrangements) to contribute to the joint management of patients.

- Ensure appropriate communication and recording within the home setting to ensure flow of information (e.g. sharing of care plans). The care home physiotherapist will also ensure that the GP is also informed of any significant therapeutic interventions or changes to management plans.

- Work with homes to reduce the number of falls, supporting proactive falls risk assessments

- Provide falls prevention training for targeted homes

- Contribute to SAP assessments

- Support LSI process where appropriate

- During the assessment process ensure that patient equipment is safe to use.

- Order equipment on a loan basis for the purpose of short term use (e.g. following surgery or hospital admission) if this will benefit the patients recovery. Equipment costs for long term management of patients' needs, will not be covered by this service, except for walking aids and any aids that contribute to reducing falls i.e. chair /bed raisers (if deemed appropriate and prescribed by the care home physiotherapist).

- The care home physiotherapist will have a stock of low cost consumables (i.e. ferrules).

- The care home physiotherapist should follow any equipment policies set by the community equipment provider or commissioners.

- The physiotherapist will not be responsible for checking all resident equipment on a routine basis however where issues are identified by care home staff the physiotherapist will ensure safe clinical care for the resident.

3.3 Population covered

All care home residents registered with a North Staffordshire or Stoke-on-Trent GP. For clarity, all categories of care home residents including nursing, residential, EMI and respite patients (where appropriate) are included.

3.4 Any acceptance and exclusion criteria and thresholds

Referrals will be accepted directly from care home staff, hospital therapy and discharge teams, GPs, CCG care home pharmacist and other community health and social care professionals.

Referrals will be accepted for the following reasons and will be prioritized based on clinical risk and need:

- Falls risks

- Reduced mobility

- Rehabilitation following hospital discharge / continuation of therapy plan

- Musculoskeletal injuries

- Chronic or acute respiratory problems that would benefit from physiotherapy intervention

- Equipment related issue – identification of new need or advice on how to use newly prescribed equipment.

For urgent cases residents will be assessed within 2 working days of referral.

Exclusions

Residents (or their advocate) who do not consent to assessment and treatment.

Residents requiring specialist physiotherapy (i.e. specialist neuro or chronic respiratory interventions) that is not within the competencies of the care home physiotherapist

3.5 Interdependence with other services/providers

The care home physiotherapist will establish and maintain working relationships with the following:

- CCG care home pharmacist
- Hospital based therapy and discharge teams
- Intermediate care teams / ANP providing rapid response to care homes
- Mental health services working directly with care homes (e.g. CPNs)
- GPs and Practice matrons
- Social workers
- Specialist Falls Service
- Palliative care teams.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- Falls in older people: assessing risk and prevention, NICE guidelines [CG161]: June 2013

- Falls and fractures: effective interventions in health and social care, Department of Health, 2009

- Falls in older people Quality Standard [QS86] Published date: March 2015, last updated: January 2017

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

- GUIDANCE ON BEST PRACTICE IN CARE HOMES FOR THE PREVENTION & REDUCTION OF FALLS & FRACTURES– for commissioners and providers of services of both social care managed homes and independent sector homes, Department of Health East Midlands, November 2010

- Managing Falls and Fractures in Care Homes for Older People – Good Practice Resource. Revised edition 2016, Care Inspectorate

- Falls and Fracture Prevention, Training Manual, NHS Health Education England, 2016

4.3 Applicable local standards

Staff to have undertaken Safeguarding Awareness of Vulnerable Adults Level 2 training.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements See Schedule 4

5.2 Applicable CQUIN goals See Schedule 3

6. Location of Provider Premises

The service will be delivered in care homes across North Staffordshire and Stoke-on-Trent.

The service will be delivered by North Staffordshire Combined Healthcare Trust.

Service Specification No.	B12
Service	Ward 4 Harplands - EMI Assessment Service
Commissioner Lead	Jane Barnes, Locality Commissioning Manager – North Division
Provider Lead	Rachael Birks, Associate Director Acute and Urgent Care
Period	1st April 2022 – 31st March 2023
Date of Review	As and when required

1. Population Needs

2. Outcomes

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 3	Helping people to recover from episodes of ill-health or following injury
Domain 4	Ensuring people have a positive experience of care
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm

3. Scope

The Older People's Shared Care Service will provide timely assessment and intervention for patients with an organic mental illness, following an acute episode of physical ill health and inpatient stay at the Royal Stoke University Hospital. Admissions will also be considered for the community and local care homes. The overall objective of the service is to support patients to be discharged to the setting of least dependency with a comprehensive and sustainable plan of care.

Patients will typically have an organic illness and ongoing physical health care needs.

Model

The model will be multi-disciplinary with oversight from a Consultant Old Age Psychiatrist and Geriatrician; supported by senior nurses, pharmacists and other Allied Health Professionals (AHP's). Assessments will be completed within 28 days subject to dedicated social work capacity being made available from both City and County social care teams.

A Decision Support Tool (DST) will be completed by onsite nursing staff and submitted to the Continuing Health Care team within 24 hours of completion. This arrangement will be in place pending the implementation of the dedicated DST nurses that have been commissioned through the CCG to support step down flow.

Therapy input will be provided from occupational and physiotherapy and there will be a focus on meaningful activity through a dedicated activity worker.

The Provider will support the timely discharge of patients subject to their being adequate commissioned activity to move on to in the community. This may be the availability of 24 hour care beds or domiciliary care packages.

The provider is not responsible for delays associated with factors external to its control such as the availability of home packages of care, 24 hour care placements and external funding panels. Payment will continue to be made on a daily bed basis, if the provider deems the patient to be fit for discharge but the onward package of care is not in place.

Weekly MDT's and daily reviews will be in place to manage flow and escalation processes.

The ward will operate in line with the SAFER Patient flow bundle and will implement the "Red to Green" programme to ensure that the patient experience is optimised.

Information will be reported into the broader Discharge to Assess dashboard to support accurate and timely capacity review.

Admission/Discharge process

Admission will be secured through the Older Persons Outreach Team inclusive of In-reach from Ward 4/Senior Nurse NSCHT) triage and referral as part of the Discharge to Assess "track and triage process". This will be a collaborative approach with Ward 4 as the receiving provider to ensure that patients are appropriate for the service.

- Community referrals will be admitted directly through direct liaison with the ward.

- Estimated Discharge Date will be set on admission and discharge planning will commence from the point of admission.

1. The in reach team will work closely with UHNM.
2. Urgent and Emergency Mental Health Liaison Service and in reach staff will ensure that there is daily review of Medically Fit for Discharge patients that may be appropriate for step down services including Ward 4.

- There may be times when a bed is not immediately available on Ward 4 and a waiting list is in use. The first on the list is not necessarily the first patient to be admitted. The staff at UHNM and in reach team will make a decision based upon patient need.
- All admissions are pre-arranged and admissions will not be accepted out of hours (5pm – 9am) unless previously agreed by NSCHT Consultant, Advanced Nurse Practitioner (ANP) or senior nurse.

Admission Criteria

Ward 4 accepts patients who meet the following criteria:

- Usually over the age of 65. There are occasions when it may be deemed appropriate and in patients best interest that they come to ward 4 before this age.
- Diagnosis of dementia (Patients with a strong suspicion of dementia will be considered).
- Be medically fit for discharge (MFFD) from UHNM for example has a MEWS less than 4, does not require treatment on a regular basis to maintain adequate respiratory or circulatory function, and is systemically stable.
- The patient will not be from a ward that has an outbreak of infection, and or exposure to a multi resistant organism (MRO) where no results are available.
- The patient will have been identified prior to transfer as a potential admission to Ward 4 to facilitate a streamlined cohesive discharge.
- Have a provisional discharge plan agreed with NSCHT prior to transfer.
- Have had a Continuing Healthcare checklist completed if appropriate
- It is expected that where a patient has been on an acute ward for some time that the assessment process including completion of Single Assessment Process (SAP). Completed SAPs should come to Ward 4 with the patient.

Patients admitted from emergency portals will be accepted without discharge route or associated paperwork once assessed and agreed by NSCHT.

Admissions from the community and care homes will be considered where the patient is not in need of acute physical health care or requiring acute diagnostics.

Exclusion criteria

- The ward does not accept patients from outside of the North Staffordshire or Stoke CCG areas.
- The ward does not accept patients who remain medically unstable as detailed above. Patients who experience **high** levels of Behavioural and Psychological symptoms of Dementia (BPSD). These patients may be more appropriate for a Urgent and Emergency Mental Health Liaison Service referral and consideration for Ward 6. The assessment nurse from NSCHT will identify these patients.

4. Applicable Service Standards

Applicable national standards (e.g., NICE)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

Not applicable

6. Location of Provider Premises

Harplands Hospital.

Hilton Rd,

Stoke-on-Trent

ST4 6TH

Service Specification No.	C02
Service	North Staffordshire Community Learning Disability Team Stoke on Trent Community Learning Disability Team
Commissioner Lead	Denise Dyke, Commissioning & Service Redesign Manager, CCG
Provider Lead	Sharon Parkes, Service Manager - Learning Disabilities and CAMHS IP
Period	1 April 2022 – 31 March 2023
Date of Review	As required

1. Population Needs

1.1 National/local context and evidence base

In England during 2012 there were 1.4 million people identified as having a Learning Disability. Of the 1.4 million, 908,000 were of adult age.

- 22% of these were known to their GP
- 44% were in receipt of Disability Living Allowance (DLA).

Demographic studies indicate that the population of people with learning disabilities is increasing at a rate of 1% per year with an overall growth of 10% by the year 2020. It is also known that people with learning disabilities now have increased life expectancy attributable to innovation and improvements in neonatal, maternal and general healthcare services. The outcome of these improvements is an overall increase in the complexity of healthcare needs.

Studies have identified that approximately 1% of the population have an Autistic Spectrum condition with half of this population also having a learning disability. There are also a number of health issues that are more prevalent amongst people with learning disabilities than the general population and these include; respiratory conditions, epilepsy, coronary heart disease, mental ill health (including dementia), physical impairment with associated risk of postural deformities, problems associated with eating and drinking, communication difficulties and sensory impairments. Although these health problems should be managed within mainstream health services, some individuals will need the input and support of specialist services working in partnership with mainstream health professionals.

In recent years, services for adults with learning disabilities have undergone significant change, with more to come. This change has been driven by national policy guidance, promoting inclusion and

person centred planning, with a strong focus on local, specialist community based services, to reduce the need for out of area placements and to have less reliance on inpatient provision

National policy states that while people with learning disabilities or autism may sometimes need hospital care there are far too many people with learning disabilities or autism staying too long in hospital. There is a consensus that large hospital units are outdated and inappropriate and do not provide the care which people with challenging behaviour need. For the few people who need inpatient care, this should be provided in smaller units and as close to home as possible.

To ensure that people are in the least restrictive environment for their needs and are not in a hospital setting for longer than needed, there is a requirement for an increase in community-based services that can support adults with a learning disability who have complex health needs.

Best practice in future care provision to support people with a learning disability and/or autism is well evidenced and is supported in the following documents:

Transforming Care for People with Learning Disabilities – Next Steps (January 2015) outlined a programme of system wide change to improve care for people with a learning disability and/or autism who display behaviour that challenges including those with a mental health condition.

New Service Model for Commissioners of Health and Social Care services (October 2015).

Care and Treatment Policy and Guidance (October 2015).

Building the Right Support (October 2015). This plan describes the mechanisms for achieving transformation including financial underpinnings and commissioning arrangements.

1.2 Local strategic context

Locally, like the rest of the England, Stoke on Trent and North Staffordshire Clinical Commissioning Groups (CCG) are transforming services for people with learning disabilities and complex health needs, which may include autism, mental health conditions, behaviours that challenge and offending behaviours. The CCGs are ensuring that people with learning disabilities and complex health needs can live locally, remain in their homes and be supported within local community, even if their needs change, preventing the need for people to be admitted to Learning Disability inpatient settings.

This cohort in Stoke-on-Trent and North Staffordshire is an extremely diverse group of people and the support they require will be highly individualised tailored to particular needs, strengths, interests and in some cases risks they pose to others.

In terms of local strategic context, there are number of documents that details the need for less inpatients beds and an increase in community-based services that can support adults with a learning disability who have complex health needs:

NDTi Specialist Health Review Report, 2011. In Autumn 2011 Learning Disability Commissioners in Staffordshire and Stoke-on-Trent commissioned the National Development Team for Inclusion (NDTi) to carry out an independent review of local services for people with a learning disability, complex needs and challenging behaviour.

The NDTi report was published in May 2012 and stated that the local health economy was too reliant on use of bed based NHS services and that resources utilised in this way should be re-invested into community based alternatives. The report made a number of recommendations to modernise and improve the local provision for this group. Although the NDTi report was published prior to the "Winterbourne View" findings, there is significant overlap in the two sets of recommendations.

The NDTi recommended across Stoke and Staffordshire there were:

- At most a 'handful' of assessment and treatment beds, with some possibly being in partnership with neighbouring areas to gain 'critical mass'. No campus style NHS beds.
-

Staffordshire and Stoke-on-Trent Transforming Care Partnership Plan (2016-2019).

This plan details how the CCGs and Local Authorities in Staffordshire and Stoke-on-Trent will deliver and commission services in line with the national service model, so that more people with learning disabilities and/ or autism, with behaviour that challenges – including those with a mental health condition can live in the community, closer to home.

Local Prevalence

The predicted population of people with a moderate or severe learning disability is shown in the Tables One and Two below.

Table One (Figures are based on national prevalence rates applied to the Stoke on Trent's adult population.)

Stoke On Trent	2014	2015	2020	2025	2030
Total Population aged 18-64 predicted to have a moderate or severe learning disability	**857**	**857**	**852**	**850**	**853**
Total Population aged 65 + predicted to have a moderate or severe learning disability	**119**	**121**	**128**	**134**	**147**
Total population aged 18 and over predicted to have a moderate or severe learning disability	**976**	**978**	**980**	**984**	**1000**

PANSI and POPPI websites 2014

By 2020, it is predicted that there will be an overall increase in the number of people with moderate or severe learning disabilities in Stoke-on-Trent. The largest increases will be seen in people aged between 25 and 34 and 55 and 64, with a small increase in the number aged over 75. It is predicted that there will be a decrease in people aged between 18 and 24 and 35 and 54.

There has been an increase in the number of Children in Need with learning disabilities over the last three years by 31%.

Stoke on Trent JSNA 2014

Table Two

North Staffordshire	2014	2015	2020	2025	2030
Total Population aged 18-64 predicted to have a moderate or severe learning disability	**733**	**729**	**716**	**706**	**698**
Total Population aged 65 + predicted to have a moderate or severe learning disability	**136**	**140**	**149**	**156**	**169**
Total population aged 18 and over predicted to have a moderate or severe learning disability	**869**	**869**	**865**	**862**	**867**

PANSI and POPPI websites 2014

The service provides support from specialist health professionals to increase access for people with a learning disability to mainstream health services whilst also maintaining specialist focussed expertise. Geographically, the service supports a "Locality Team" model for the delivery of services whilst attempting to provide equal over-arching access to more specific clinical expertise (e.g. offending behaviour, specific psychotherapies, positive behavioural support, epilepsy and sensory impairments) from shared resources– thereby attempting to ensure that the most appropriate clinical expertise is available to as many people as possible who may need it.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	*x*
Domain 3	Helping people to recover from episodes of ill health or following injury	
Domain 4	Ensuring that people have a positive experience of care	*x*
Domain 5	Treating and caring for people in a safe environment; and protecting them from avoidable harm.	x

2.2 Locally Defined Outcomes

- Improved person-centred care and individualised packages of support for people with learning disabilities and behaviour which challenges services
- Delivery of care in the most appropriate environment and with effective use of resources
- Effective use of expertise and promoting use of multi-disciplinary team working
- All clients will be regularly reviewed within agreed timeframes
- Service is local and promotes equity of access
- To improve health, well-being and social functioning through maximising an individual's quality of life.
- All clients will have an agreed discharge plan to ensure continuity of care on admission
- High quality and effective services are provided in an evidence based framework

3. Scope

3.1 Aims and objectives of service

Aim

The North Staffordshire CLDT's will continue to develop in line with both national and local drivers for change, to fit within a whole systems approach for delivering health and social care to people with a learning disability. The primary strategic goal for Specialist Health Providers is to shift the organisational focus from 'inpatient' services and build on the existing community teams to sustain people with specialist health needs in their local community and wider society. This will be delivered in line with the principles of improving an individual's quality of life adopted by NSCHT and will work within the NHS principles and values outlined in the NHS constitution. These apply to everyone who works for the NHS and everyone who receives a service from the NHS. These include:

- A commitment to smooth transition between services.
- The right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly registered organisation that meets required standards of safety and quality.
- The right to be treated with dignity and respect.
- The commitment to share information including copies of letters.
- The responsibility of patients to treat NHS staff with respect
- The responsibility to keep appointments or cancel within a reasonable time.

Objectives:

- To be the primary point of access for specialist assessment, planning and intervention for people with Learning Disabilities living in North Staffordshire who fulfil the eligibility criteria.
- To support people with learning disabilities to live good quality lifestyles as valued members of society through promotion of rights, independence, choice and inclusion.
- To support access to mainstream health services and provide direct support to people with highly complex needs.
- To work in partnership with the Intensive Support Team (IST), LD inpatient service, other health providers and the local authority to support and maintain people with learning disabilities within their local community wherever possible and reduce the dependence on specialist placements or hospital admissions.

- To maintain a focus on addressing health inequalities and meeting health needs for people with learning disabilities through effective, evidence-based health interventions.
- To utilise person centred thinking and person centred tools and promote high quality, safe, efficient, evidence based practice.
- To be the primary point of access for the Intensive Support Team (IST), for adults with learning disabilities who fulfil the eligibility criteria.
- To raise awareness of learning disability issues and challenge discrimination and stigma with health staff, employers, education, social and community groups and other agencies as necessary.
- To ascertain and assess an individual's potential and aspirations for a vocational role and assist them to work towards an individual plan linking with community facilities to achieve active meaningful roles/lives.
- To build an individualised sensory profile to provide the individual, their carers and support staff with tools to help modulate and process their sensory environment. This will support inclusion, improve an individual's confidence and aid skill development.
- The service will work in close partnership with other organisations to provide an alternative to in-patient care and where required support prompt and timely discharges.
- To deliver expert assessments, effective time limited interventions and reviews for individuals with complex care needs.
- The service will provide an on-going 'maintenance' review for service users who are typically known to have a higher risk of relapse or who may not require regular input but would benefit from less frequent face to face review to ensure that appropriate and safe support mechanisms remain in place.
- The service will provide a specialist health review function for clients who are currently living in community placements and who receive health funding from Stoke-on-Trent CCG or North Staffordshire CCG in regard to their complex needs. These community placements could be either outside the local area or are living locally , within privately provided health placements.

3.2 Service description/care pathway:

The CLDT will:

- Be the primary point of contact for all referrals during core hours and will identify any urgent referrals which meet threshold for the IST.
- Provide holistic and specialist assessment of people with a learning disability who have multiple and complex health needs. Reduce the dependence on specialist services and in doing so develop and promote independence.

- Work in partnership to provide evidenced based, person centred support, deliver improved outcomes, reduce health inequalities and support individuals to continue to live in their chosen setting and local community.
- Where appropriate ensure that individuals have individual, comprehensive support plans and health action plans to enable and promote independence, choice and inclusion.
- Provide accessible support plans; service information and satisfaction questionnaires facilitate person centred care and service development.
- Provide health promotion and education for individuals with complex healthcare needs and their carers and will appropriately signpost referrals to other services when necessary.
- Provide education, support and training to mainstream health professionals, family carers and paid carers and in doing so support individuals with a learning disability to break the existing cycle of discrimination.
- Work closely with CAMHS (LD) services, education providers, local authority, service users and their families to carefully plan and understand the needs of young people moving into adult services.
- Provided a Care Programme Approach Care-coordination role for those patients who are in-patient within North Staffordshire Combined Healthcare NHS Trust (and part of the Transforming Care Cohort), regardless of which in-patient setting there are in.

Review Function

The CLDT shall provide a reviewing function of those patients with a learning disability who live in the community (not in a hospital) and who, due their complex health needs receive health funding from Stoke-on-Trent CCG or North Staffordshire CCG for their placement. This includes those placements both in the local area and outside the local area. This specialist regular (quarterly, half yearly or annually dependent on health needs) health review will include:

- Assessing needs of people, ensuing that they are placed in services which are the least restrictive to meet their needs.
- Assessing if the needs of the patient has changes to when originally placed and if so if a change in placements/support package is required.
- Reviewing the support and care being provided by the provider (both of the community placements and if outside of the area any statutory NHS services that are provided) and determining if these best fit the patient's needs.
- Ensuring that the quality of care is delivered appropriate and competently.
- Outlining the services and support required in order for the person to move back into local services/areas.

Following the review, the CLDT will report their finding and recommendation to the CCG in a timely manner. Every 6 months the CLDT shall meet with the CCG to review and provide report and

feedback on this review function of the CLDT and the number of patients who have received a review in the last 6 months and the plan for the next 6 months.

Stepped Care Model

The CLDT operates a stepped care model where, following receipt of referral, completion of assessment or period of intervention a clients' care may be stepped up to the Learning Disability Intensive Support Team (IST) at the time of greatest need and stepped down to a less complex service such as the CLDT and/or primary care when they are stable.

Multi-disciplinary Team Composition

The CLDT has a single line operational management structure; it is multi-disciplinary and consists of Nurses, Occupational Therapists, Psychologists, Psychiatrists, Physiotherapists, Support Workers and Administration staff.

Team members have a specialist interest and knowledge in dementia, sensory impairment and epilepsy and person centred therapies.

The team work in close partnership with Speech and Language Therapists and Dietician (through service level agreements), Social Workers and Learning Disability Primary Healthcare Facilitators.

The Multi-disciplinary Team Approach:

The Multi-disciplinary Team provide high quality specialist learning disability interventions by using an integrated holistic model. These will be based on the needs of the population be sensitive to the needs of people who experience disadvantage within the area including the needs of the BME population. They will demonstrate the best use of resources, promote enablement and reduce the reliance on implementing a medical model of support a person with a learning disability.

The MDT will also provide specialist advice to Primary Care services and/or third sector organisations.

Health Promotion and Prevention

A fundamental role of the CLDT is to provide health promotion, education and training to people who use the service. Education, support and training primary care colleagues, paid carers and service providers.

The team will actively support and facilitate groups to promote smoking cessation, physical health, and healthy living as part of its core work for any clients who receive a service from the CLDT.

Education, Training and Research

The CLDT produces a training plan each year that details the mandatory and professional development training requirements for the whole team. Team training reflects areas required to deliver the LD strategy and provide high quality locally based health services.

The team consists of practitioners who have a broad range of specialist knowledge and expertise, which they able to demonstrate in practice and can deliver as training to care teams. The framework for service delivery uses a broad range of psychological strategies that combine applied behavioural analysis and person centred values to enhance quality of life and reduce behaviour which challenges.

In addition the team provides specialist skills in a range of areas relating to people with a learning disability and associated issues/conditions.

Research activity is a specific area of expertise and one in which Psychologists are trained. Projects of different types are undertaken via individual clinicians and by supporting trainee psychologists in their Doctoral research as well as audits.

Working in Partnership with Users / Carers and other Professionals

The CLDT has clear links with other specialist learning disability and mental health services to ensure effective collaboration and co-working.

The CLDT operates independently of Social Care Services but works in close collaboration with the learning disability social work team for social care interventions to support a care plan when appropriate.

Although other agencies, including social care may be introduced to support the persons plan, the CLDT will continue to work as the lead professional, where appropriate. In line with this it is imperative that a close working relationship between the two parties is maintained.

The service actively engages with service users, their families and carers in the delivery of care and the development of the service. The actions relating to this are clearly identified in the Team Clinical Governance Plan. Client satisfaction questionnaires are used to evaluate the experience of the service upon discharge.

The CLDT has identified Patient Advice and Liaison Service (PALS) Leads. There is PALS information available and this includes accessible formats for service users and their families.

The CLDT will also work in partnership with a number of other organisations as required, including Carer's groups, other providers and sub-contractors.

Days/ hours of operation

All disciplines within the Staffs CLDT operate between Monday to Friday 9am -5pm, however there is flexibility of working hours in accordance with service needs and some work outside of these hours may be required but only following agreement with the CLDT management team.

Referral Process

Access criteria is based on the Valuing People (2001) definition of learning disability: 'Learning Disability includes the presence of a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence) with a reduced ability to cope independently (impaired social functioning): which started before adulthood with lasting effect on development'

Referrals to the service are usually received through the Single Assessment process (SAP) from:

- Clients
- Family and paid carers
- Health professionals
- Social workers
- Day services

Eligibility Criteria

Access criteria is based on the Valuing People (2001) definition of learning disability: 'Learning Disability includes the presence of a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence) with a reduced ability to cope independently (impaired social functioning): which started before adulthood with lasting effect on development'

To be eligible for the service, people must meet all three of the following criteria, and have:

1. A significant learning disability.
2. Complex health need.
3. Difficulties that are critical and substantial in nature which cannot be met via mainstream services.

Response times

The service operates a duty system as a primary point of access. Referrals are currently reviewed on a daily basis and are allocated on a weekly basis (within 5 working days.)

Any referrals received that are deemed as an emergency are actioned immediately on receipt.

Discharge process

The referral and review process are designed to identify and monitor progress toward specific outcomes (i.e. the changes that should be seen / experienced by the user of the service). Discharge is facilitated on achievement of those outcomes. The service aims to ensure that a maximum time period for achieving outcomes is 6 months from receipt of the referral though recognises that all interventions are built around the individual and some outcomes may take longer to achieve.

Therapeutic engagement is on a collaborative client-centred basis hence, discharge is via negotiation and interaction with the person/people involved: agreement is therefore sought on the accomplishment of the original goals and outcomes. Mutual consent is thus obtained concerning the benefits or otherwise of continued treatment, new goals established and further review dates agreed

On completion of intervention a report is forwarded to the referrer, GP and other professionals involved detailing assessments/intervention outcomes, recommendations and reason for discharge.

Clients will be informed of discharge in an accessible format, providing advice on how to contact the team if any problems arise following discharge.

The team has a clear standard which is linked to a Trust policy for the management and response to DNA's. All DNA are also reviewed by the multi-disciplinary team prior to final closure.

If the person is discharged from the caseload following DNA the team will refer back to the care of the original referrer explaining that if intervention is still required then they must re-refer. The person and their General Practitioner are also informed.

When indicated the service would refer onto the Primary Health Care Facilitator as required.

3.3 Population covered

Service User Groups Covered:

The team provides services for people with a learning disability and:

- Children under 18 years (unless there is a clear Transitional Plan in place that identifies a role from age 17 years and 6 months, each referral will be considered on an individual basis:
- Fall within two broad categories of health needs:
- Health needs relating to 'general' ('physical & mental') health needs. The team supports people where they are, or are at risk of being, denied access to essential healthcare because of the challenges they present to general physical and mental healthcare services.
- Health needs also relate to a person's overall state of wellbeing. Essentially this is where people are in danger of losing their home, or significant aspects of their living circumstances, as a result of the challenges they present to those services supporting them. The team directs services away from 'institutional' responses to such crises as they occur and supports the individual within their everyday surroundings to create and sustain a capable and enabling environment around them.
- For carers and care staff that require formal training
- People with Autistic Spectrum Conditions

Geographical population served

The CLDT provides a service to those residing within the North Staffordshire area, including the City of Stoke on Trent

3.4 Any acceptance and exclusion criteria

Exclusion criteria

The service will only be accessed by adults who must meet all of the following criteria:

Aged 18 years and over or transitional arrangements are in place for those aged 17 years and 6 months from their 18th Birthday.

North Staffordshire Combined Healthcare NHS Trust CLDT's do not currently provide services for people with:

- Specific learning difficulties e.g. dyslexia, dyspraxia
- Asperger's Syndrome or other Autistic Spectrum Conditions where there is not a significant learning disability
- Learning difficulties arising from a sensory impairment

- Acquired brain injury
- Supporting carers to attend appointments or to replace them
- Out of county support without a Service Level Agreement

In addition, CLDT's do not provide:

- Externally commissioned legal reports; including those to inform Child Care Proceedings, or in relation to forensic/offending behaviour.

Note: Where appropriate individual work is undertaken with parents with a learning disability, and the team will contribute to assessments/offer advice to inform other services of parents with learning disabilities needs to maintain a childcare within the home. However, the team does not provide ongoing parenting support to maintain the family.

3.5 Interdependencies with other services

The key relationships will be with service users, carers and families, GPs, Social care teams and healthcare professionals working in North Staffordshire Combined Healthcare NHS Trust.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

NICE (2015) 'Challenging Behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges.' Published 28 May 2015 nice.org.uk/guidance/ng11. National Institute for Health and Care Excellence. London.

Building the Right Support, (October 2015). A national plan to develop community services and close in Service User facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition, available at:

https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4)

The teams operate within NICE guidance and local agreed pathways.

5.2 Applicable CQUIN goals (See Schedule 3)

Physical health monitoring of people with learning disabilities (community)

6. Location of Provider Premises

The North Staffordshire Team (includes Staffordshire Moorlands and Newcastle-under-Lyme) is located at Dragon Square Community Unit, Chesterton, Newcastle –under-Lyme, ST5 7HL.

The Stoke on Trent Team is located at Broom Street, Hanley, Stoke on Trent ST1 2EW

Service provision takes place in a variety of locations from a domiciliary visit to generic clinics within primary care services, however the aim of the service is to promote independence and therefore individuals are encouraged to attend the base where appropriate.

Service Specification No.	C04
Service	Intensive Support Team (IST) for People with Learning Disabilities presenting with complex challenging behaviour
Commissioner Lead	Denise Dyke, Commissioning & Service Redesign Manager, CCG
Provider Lead	Sharon Parkes, Service Manager - Learning Disabilities and CAMHS IP
Period	1 April 2022 – 31 March 2023
Date of Review	As required

1. Population Needs

1.1 National/local context and evidence base

The development of the Intensive Support Team (IST) has been influenced by a number of national guiding frameworks.

Valuing People (DH 2001) states that:

- Specialist staff from the learning disability service will if necessary provide support to crisis resolution/home treatment services or other alternatives to in-patient admission wherever possible
- In their specialist role staff should recognise the importance of enhancing the competence of local services to enable service users to remain in their usual surroundings and save the high costs (both personal and financial) of specialist placements out of the area.

The Mansell Report (2007) "Services for People With Learning Disabilities and Challenging Behaviour or Mental Health Needs" has as its' first stated aims:

Better use of investment is required to achieve two aims:

♦ To develop and expand the capacity of local services for people with Learning

Disabilities, to understand and respond to complex challenging behaviour

♦ To provide specialist services locally which can support good mainstream practice

as well as directly serve the small number of people with the most complex challenging needs.

Transforming Care: A National Response to Winterbourne View Hospital: Final Report states that:

Commissioner need to work with providers of specialist services to ensure that community learning disability teams have the additional intensive support they need to keep people out of hospital - including in crises. The report states that local services should include intensive support services in the community.

Transforming Care for People with Learning Disabilities – Next Steps (January 2015) outlined a programme of system wide change to improve care for people with a learning disability and/or autism who display behaviour that challenges including those with a mental health condition.

New Service Model for Commissioners of Health and Social Care services (October 2015).

Care and Treatment Policy and Guidance (October 2015).

Building the Right Support (October 2015). This plan describes the mechanisms for achieving transformation including financial underpinnings and commissioning arrangements.

Care and Treatment Review: Policy and Guidance (May 2015) sets out the expectations for implementation of Care and Treatment Reviews (CTR's) for people with Learning Disabilities (LD) in England. The aim of a CTR is to bring a person-centred and individualised approach to ensure that treatment support needs of the person with LD and their families are met and barriers to progress are challenged and overcome.

1.2 Local strategic context

Locally, like the rest of the England, Stoke on Trent and North Staffordshire Clinical Commissioning Groups (CCG) are transforming services for people with learning disabilities and complex health needs, which may include autism, mental health conditions, behaviours that challenge and offending behaviours. The CCGs are ensuring that people with learning disabilities and complex health needs can live locally, remain in their homes and be supported within local community, even if their needs change, preventing the need for people to be admitted to Learning Disability inpatient settings.

This cohort in Stoke-on-Trent and North Staffordshire is an extremely diverse group of people and the support they require will be highly individualised tailored to particular needs, strengths, interests and in some cases risks they pose to others.

In terms of local strategic context, there are number of documents that details the need for less inpatients beds and an increase in community-based services that can support adults with a learning disability who have complex health needs:

NDTi Specialist Health Review Report, 2011. In Autumn 2011 Learning Disability Commissioners in Staffordshire and Stoke-on-Trent commissioned the National Development Team for Inclusion (NDTi) to carry out an independent review of local services for people with a learning disability, complex needs and challenging behaviour.

The NDTi report was published in May 2012 and stated that the local health economy was too reliant on use of bed based NHS services and that resources utilised in this way should be re-invested into community based alternatives. The report made a number of recommendations to modernise and improve the local provision for this group. Although the NDTi report was published prior to the "Winterbourne View" findings, there is significant overlap in the two sets of recommendations.

The NDTi recommended across Stoke and Staffordshire there were:

- At most a 'handful' of assessment and treatment beds, with some possibly being in partnership with neighbouring areas to gain 'critical mass'. No campus style NHS beds.

Staffordshire and Stoke-on-Trent Transforming Care Partnership Plan (2016-2019).

This plan details how the CCGs and Local Authorities in Staffordshire and Stoke-on-Trent will deliver and commission services in line with the national service model, so that more people with learning disabilities and/ or autism, with behaviour that challenges – including those with a mental health condition can live in the community, closer to home.

The IST service supports these recommendations and those of the Winterbourne Review report and the Staffordshire and Stoke-on-Trent Transforming Care Partnership Plan to reduce in-patient beds, reduce the risk of long stay in-patients and as far as possible keep people out of hospital.

Appendix 1 sets out in diagrammatic form the Tiers of services available to people with a learning disability across Staffordshire and Stoke on Trent. The IST will be a service fitting into Tier 4 of this diagram, bridging between tier 3 and 4, being a specialist healthcare service.

The tiered service model that includes IST will work holistically to address the needs and aspirations of the person with a learning disability accessing the service for support; alongside those of their carers and families. The model will aim to enable and support the person to resume their activities

of daily living, routines and roles that they are temporarily unable to fulfil due to their current level of need or crisis.

2. Scope

2.1 General Overview

The Intensive Support Team (IST) will operate an extended hours service 7 days per week to offer community based highly specialist assessment, support and interventions to people with complex learning disabilities and behaviour that challenges services and ordinary living, to prevent admissions to hospital, prevent escalation of risk behaviours and to offer support during times of crisis.

The IST support would be for a specific time period based on individual needs identified through robust assessment. IST will work supportively at the earliest opportunity to avoid crisis intervention being required. This will require clear pathways of care and access routes into the service.

IST will be able to respond reactively to crises with the aim of transferring the individual back to the CLDT teams when clinically appropriate. IST will work with carers/families, other professionals and partner agencies /community groups; in order for the person to return to their normal pathway through life when they are able to.

Working as part of a whole learning disability service the IST team will offer specific support and intervention for behavioural and psychological issues, over and beyond that currently provided by the CLDT. The intensity of care provided will assist in preventing avoidable hospital admissions and through proactive care management help to reduce/prevent episodes of crisis. The CLDT also clearly has a role to work with this group of the learning disability population, those with complex challenging behaviour and will refer into IST when a period of more intense intervention and support is required.

2.2 Aims and objectives of service

Aim:

The overall aim of the service is to provide an integrated responsive highly specialist assessment, formulation, treatment and support service for people with learning disabilities and complex behaviour that challenges services, providing support in a range of community settings.

Additionally the IST team will support discharge from in-patient services only for those individuals with on-going complex challenging behaviour including those individuals repatriating back to local services.

Objectives:

- To provide a community based alternative to in-patient admissions
- To maintain individuals in their own home and prevent escalation of need, where-ever possible
- To meaningfully engage people with complex learning disabilities who may require a crisis intervention or intensive support following discharge from an in-patient setting with the aim of minimising increased risks that may occur as a result of and during an unsettling transition period.
- To deliver expert assessments and effective evidence based interventions for a specific time period based on individual identified needs for those individuals with complex challenging behaviour. In order for this to work, there has to be an experienced and flexible workforce that are also able to provide direct care and support to individuals in their usual home environment following completion of assessment and formulation for interventions. This should be based on enablement and positive risk taking approaches and one whereby this is time limited and action /outcome specific.
- To provide effective, evidence based highly specialist health interventions in the community that are part of on-going management and support planning. This will enable specialist health services to intervene in relation to episodes of increased needs and then discharge/ withdraw as appropriate and handover the management to other services, carers etc.
- To promote enablement through the development of a culture where core psychological skills are generic to all staff and places an emphasis on outcomes. This has to be balanced with 'normal' day to day life and must be reflected in the way that the staff providing this response have the value basis as well as the right skills and competencies to deliver for example equal status not the "professional/service gift model"
- To stop preventable admissions to in-patient units, local or otherwise.
- To support prompt and timely discharge from in-patient health services where additional and intensive support is needed over and above the role of the CLDT; with the aim of minimising increased risks that may occur as a result of and during an unsettling transition period; and to focus all support on hospital avoidance in all instances. This will be supported

by promoting the value- base of the service and the right balance of professional, clinical and social behaviours amongst the workforce

- To seek to restore stability within the individual's home environment and provide staff with the resources and skills to manage the person within their normal environment. To support this additional clinical management contracts will be used to ensure that clinical advice and recommendations are adhered to. There will be opportunities to signpost carers and family members to other sources of support as required / appropriate.
- To offer individualised, person centred advice and training to other providers, including non-statutory service providers regarding the individual management of complex needs and /or challenging behaviour
- To utilise the positive behaviour support approach in direct intervention plans and in training staff/ carers and others in this approach.
- Where appropriate to support people to move on from inappropriate settings that have demonstrated that they are unable to meet the complexity of the individuals' current needs. The role of the IST team in this instance is again to aim to minimise the increased risks that may occur as a result of and during an unsettling transition period for those individuals with on-going complex challenging behaviour needs.
- To support the role of the CLDT who will be actively involved in the discharge planning process for people in in-patient settings, when the complexity of the individual is identified to require IST and to work more proactively in this process from the point of admission i.e. plan for discharge on admission and plans remain with the person to aid transition on discharge.
- To develop repatriation pathways where appropriate jointly between health and social care
- To provide advice to commissioners as required

2.2.1 Service description/care pathway

All work within the integrated model of service delivery, including the IST team will be undertaken in collaboration with service users, their family carers and/or external care providers.

The IST service will :

- Undertake appropriate assessments in collaboration with service users, family carers and external care providers across all relevant settings considering individual needs and risks.
- Collaborate on priority needs
- Work within informed consent procedures;

- Provide a 7 day service between the hours of 8am and 8pm and telephone response service from the inpatient assessment & treatment team, between 8pm and 8am, 365 days a year.
- Accept referrals based on clinical need/risk and immediate crisis due to placement breakdown or home situation placed at risk.
- Formulate care plans including review and evaluation of care, inclusive of appropriate risk assessments
- Deliver intensive support/treatment/intervention within the service user's current home environment in the context of completed robust risk assessments.
- Provide appropriate support and family interventions where needed and agreed in the care plan / formulation.
- Provide time limited interventions based on assessed need with onward referral to other more appropriate agencies on completion of treatment/intervention as identified.
- Support the development of discharge plans in conjunction with the service user, carer (with agreement of the service user) and future care providers where intensive or specialist expertise is needed for complex challenging behaviour or complexity of management of the individual.
- Facilitate appropriate aftercare arrangements to sustain independence and overall sense of wellbeing for the service user and carers, which the pathway will highlight as referral back to CLDT.
- Provide additional specialist advice and support along with CLDT, to GP's and primary care colleagues around longer term care management of service user's that have accessed the IST.
- Maintain accurate and legible records of all service user contacts and interventions using the appropriate recognised methods according to provider policy and procedures.
- Provide input via CLDT to support effective communication with GP's, Primary care and Secondary care services through prompt notification and correspondence advising of interventions, referrals and follow on support i.e. ensure that a Health Action plan is fully inclusive of the persons holistic plan
- Work closely with colleagues within other services or tiers of the LD services such as Community Learning Disability Teams (CLDT's), mental health services such as Mental Health Crisis teams, Urgent and Emergency Mental Health Liaison Service, Assertive Outreach Teams and Early Intervention Teams and also In-patient mental health and /or learning disability services and social care teams ; to facilitate and support hospital discharge and continuity of care for those patients/service users experiencing on-going significant and/or complex learning disabilities who are able to return home with enhanced home support
- Outcomes from the IST interventions will be evaluated as appropriate and measured against agreed key performance indicators and additional monitoring tools such as The Health Equality Framework (HEF) as agreed between commissioners and providers.

In summary the IST team will enhance the care offered by the existing CLDT and social care teams. The IST will adopt an integrated and multi-disciplinary approach to service delivery providing highly specialist assessment, formulation, intervention and treatment for people with learning disabilities presenting with complex challenging behaviour.

IST will also provide short term enablement, to prevent admissions to hospital, prevent escalation of risk behaviours and to offer support during times of crisis, and/or supporting discharge from an inpatient admission for those individuals with on-going complex challenging behaviour /needs; with a clear role of the support aiming to minimise increased risks that may occur as a result of and during an unsettling transition period.

The service will deliver a variety of interventions according to individual needs. These may include (although this list is not exhaustive) :

- Assessment of the nature and function of behaviour that challenges i.e. functional analysis and risk assessment.
- Complete behavioural formulation and subsequently development of positive support plans and treatment /intervention care plans.
- All behavioural support plans to be collaboratively generated and agreed by stakeholders.
- A range of psycho–social interventions and psycho-therapeutic interventions where clinically appropriate such as; cognitive behavioural approaches and interventions for example Anxiety management , anger management and emotional regulation Psychiatry
- Allied Health Professions (AHP) assessment and interventions to include Occupational Therapy including sensory integration, and Speech and Language Therapy
- Access to Dietetics and Physiotherapy will be accessed externally to the core staffing of the IST via CLDT routes.
- Advice regarding vocational and meaningful activities
- Practical support to ensure social inclusion
-

There will be a positive behavioural support framework approach to assessment and treatment of challenging behaviours (for example applied behavioural analysis). Positive Behavioural Support is a framework for developing an understanding of an individual's challenging behaviour and for using this understanding to develop effective support. This will lead to the formulation of plans – for the person's intended outcomes and the interventions required to achieve these. Discharge planning will start on the person's acceptance into the service, using a transitional care pathway approach. Care plans will be developed in partnership with service users.

The IST Team will actively support a 'whole systems' approach to care, and fully engage with

Organisations, family carers and individuals to ensure their needs are effectively supported.

The IST Team will deliver assessment, formulation, treatment, intervention and care management in line with evidence based best practice and health legislation.

2.2 Accessibility/Acceptability

- The IST will be accessed by referral via the CLDT route. Triage will then signpost a referral to either CLDT or IST.
- Telephone referrals will be accepted outside of office hours 9-5 or at times of crisis that requires a rapid response by a member of IST.
- IST provides a 7 day service between the hours of 8am and 8pm with a telephone response service between 8pm and 8am, provided by staff from the Mental Health Access Team who will liaise with the LD inpatient assessment and treatment service .
- Referrals will be accepted based on clinical need/risk and immediate crisis due to placement breakdown or home situation placed at risk
- IST will provide time limited interventions based on assessed need with onward referral to other more appropriate agencies on completion of treatment/intervention
- IST will operate a clear eligibility and exclusion criteria for the service (see below).
- IST will provide an equitable service across North Staffordshire and Stoke-on-Trent

2.3 Geographical Boundaries/Population covered

The Intensive Support Team Intensive Support Team will provide a service to:

- People with a learning disability meeting the acceptance criteria aged 18 and over who are resident in Stoke on Trent or North Staffordshire
- People with a learning disability meeting the acceptance criteria aged 18 and over who are registered with a Stoke on Trent North Staffordshire GP
- People with a learning disability meeting the acceptance criteria aged 18 and over who are returning from out of area placements, back to Stoke-on-Trent or the County of

Staffordshire, who the responsible commissioner is Stoke on Trent CCG or North Staffordshire CCG.

2.3.1 Acceptance and exclusion criteria

The service will be accessed by adults meeting all of the following criteria:

- Aged 18 years and over.

For those individuals approaching the transition to adult services i.e. 17 years 6 months of age, each referral will be considered on individual basis.

- The individual have a learning disability based on the Valuing People document's definition :

"Learning Disability includes the presence of a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence) with a reduced ability to cope

independently (impaired social functioning) which started before adulthood with a lasting effect on development"

And

- Shows severely challenging behaviour – *"behaviour of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit or delay access to and use of community facilities" (Emerson et al 2007)* **or** is exhibiting behaviours that in ordinary circumstances may not have been seen before.

Exclusions

- The IST will not normally provide a service to people less than 18 years of age. For those individuals approaching the transition to adult services i.e. 17 years 6 months of age each referral will be considered on individual basis.

- The IST will not support people who are not registered with a GP in North Staffordshire or Stoke on Trent
- The IST will not support service users whose needs could be met by mainstream primary or secondary care services or where the primary need is a mental health issue.
- The IST will not support service users who require long term therapeutic intervention, as this will then be appropriately transferred to / delivered by a Community Learning Disability Team or other services/agencies as appropriate.

People aged 16/17

The IST may, if deemed appropriate by the Team Manager, offer telephone support and advice to staff working with young people aged 16 or 17 who are undergoing a process of transition between Children's and Adult's provision of service. Acceptance to the IST for these individuals would be unsuitable due to the management of risk and legislative requirements should more intense intervention be required in a bed based service, which would be providing a service to over 18's.

Relationships

The Intensive Support Team will be delivered through a multidisciplinary integrated team and maintain close working relationships with a wide range of partner agencies across statutory, voluntary and independent sector organisations.

A Lead Professional will be identified for all service users accepted in to the IST. However the care co-ordination will remain with the referring agent who will maintain a close working relationship with other partner agencies as necessary, including attendance at multi-disciplinary meetings.

Service provision will be considerate of the individuals home circumstance and family dynamics and will facilitate where appropriate onward referral to other services i.e. Children and Families

Joint pathways and protocols will be developed on the way in which the IST, CLDTs and wider partners work together prior to/at the outset of the service becoming operational

2.4.1 Interdependencies with other services

The key relationships for the service will be with CLDTs, learning disability in-patient units (including rehabilitation services), mental health community and inpatient services, Psychiatrists, GPs and Primary Care Teams, Social Care Teams in Staffordshire and Stoke on Trent and local providers e.g. North Staffordshire Combined Healthcare NHS Trust and South Staffordshire and Shropshire Healthcare NHS Foundation Trust.

All key relationships/agencies will make a joint commitment to identify clear roles and responsibilities agreeing any areas of overlap. They will agree and establish a robust communication process.

2.4.2 Clinical Networks and Screening Programmes

The service shall work with relevant clinical networks and evidence based screening programmes where they are available.

2.5 Workforce

The integrated multi-disciplinary team will include the following :

Psychiatry; Nursing; Psychology, Allied Health Professionals which include Social Worker, Speech and Language Therapist and Occupational Therapist; Administration; and support staff in the form of Associate or Assistant Practitioner/ Enablement worker(s).

2.5.1 Qualifications and Competencies

- All staff working within the IST will be required to demonstrate the value base appropriate to working in an enablement/facilitation model rather than a care model; to move to a more proactive and collaborative model in which staff recognise service users as individuals. The recruitment process will therefore utilise values-based methodology to ensure this.
- All staff working in the Intensive Support Team will have extensive experience of assessment, formulation, planning, treatment, providing and facilitating psychological and therapeutic interventions which will include positive behaviour support techniques and expertise in mental health and Autistic Spectrum Disorders They will also have extensive knowledge and ability to deliver a whole systems approach inclusive of personalisation pathways and maintaining a citizen approach

- All staff working within the Intensive Support Team will demonstrate a thorough knowledge and understanding of local resources and pathways relevant to the needs of people with a learning disability particularly those that present a challenge to other services, and promote effective interagency working.

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2.6 Service Model

The service will create a model of care that achieves a realistic balance between change-promoting interventions and acceptance where change is limited demonstrated through the application of the Health Equality Framework and regular evaluation of service outcomes to facilitate learning and improvement of service delivery. The team will operate a stepped care model.

The success of the model depends upon:

- The service being set up to ensure service users, family carers and/or provider agencies are working collaboratively with IST to develop, implement, review and refine the service

- Excellent care co-ordination with the referring agent

- Robust risk management of individuals across settings which advises how the individual can be safely supported in a non-aversive way, whilst simultaneously maximising independence and community inclusion.

- Excellent multi-disciplinary team working and frequent review of individuals

- Identification of clear goals and objectives to meet an individual's needs

- A clearly identified care pathway

- Excellent communication between all IST members

- Robust and committed partnership protocols.

2.6.1 Service Location and Delivery

As a Northern Staffordshire and Stoke-on-Trent wide provider model, the resource will be located alongside and on the same site as inpatient bed based services i.e. Assessment & Treatment service. Teams will need to be located for collaborative working to work with already established CLDT's i.e. North Staffordshire and Stoke-on-Trent teams.

The Intensive Support Team will operate 7 days per week between the hours of 8 am and 8 pm and also offer a telephone response service outside of these hours.

The service will be delivered in a range of locations, dependent on the needs of each individual referred to it.

2.6.2 Referral processes

Referral Criteria

The Intensive Support Team will accept referrals for people with a complex learning disability who present with behaviours that challenge services, who require more specialist and intensive support/intervention than can be provided by other established teams.

Referrals to the Intensive Support Team will be made via the Community Learning Disability Team. The CLDT will triage all urgent and routine referrals to the IST.

Routine referrals here refer to an intensive period of planned assessment and intervention as opposed to crisis intervention i.e. a planned discharge from an in-patient bed for those individuals presenting with on-going complex challenging behaviour needs and associated high risks during the unsettling transition period; in order to avoid failure of the transition.

The IST will advise the referrer of the outcome of their referral to include: acceptance of the referral or signposting/onward referral to alternative services appropriate to the service user's needs.

Referral Source

It is anticipated that referrals to the Intensive Support Team will be accepted from:

- Community Learning Disability Teams
- In-patient learning disability units
- Other NHS services locally
- Social Care Assessment and Care Management Teams
- General Practitioners
- Local Mental Health community and in-patient services
- Carers or self-referral if already known (and requesting new crisis support)

- Police

Referral Route

- During core working hours the duty clinician within the Community Learning Disability Team(s) will triage and prioritise referrals based on urgency of clinical need
- Referrals received outside of core working hours will be directly managed by the IST with liaison continuing with CLDT within the next available core working day, as per the referral pathway
- The CLDT will immediately pass on urgent referrals to the Intensive Support Service.
- Referrals into the IST will be allocated on a daily basis by the Team Manager/Deputy Team Leader

Service Response Times

To support best practice and ensure effective and efficient service delivery to meet the needs of patients/service users, carers and referrers it is envisaged that the following elements will be incorporated into the service:

- The CLDT will operate a triage system to prioritise referrals and work within a set of pre-determined response times to include:

Same day response within 2 hours, for urgent referrals

Within 1 week for referrals to provide a service to service users requiring support to move out of in-patient settings

- All patients/service users will be assessed by a registered practitioner from the IST.

Discharge Process

Discharges will occur through the team adopting a collaborative person centred process with the individual/carer and other relevant agencies/stakeholders. The team will close a case when the

reasons for referral have been resolved and it is considered safe to do so, ideally within the 3 month timeframe. For those individuals with on-going needs at this point in the care pathway, consideration will be given to referral for support from another service depending on clinical needs and risks.

All individuals, carers and advocates, will be fully involved with the discharge planning process as deemed clinically appropriate to their on-going needs/presentation.

The IST Team will be responsible for ensuring appropriate planning for the safe discharge of those people who have recovered sufficiently to no longer require specialist health treatment/intervention and where their assessed needs can be more appropriately met by other relevant services

It is expected that the involvement of the IST in an individual referral should last no longer than 3 months. To assist in achieving this target, each case shall be given a detailed review by the Team every 6 weeks in conjunction with weekly team review meetings.

Following acceptance of a referral to IST and a subsequent period on intervention and support it is anticipated that the IST will initiate discharge from the service where the following criteria have been met:

- The agreed interventions/therapy has been completed
- There is agreement by the MDT that the person should be discharged, following discussion with the patient/service user and/or carer, with clear clinical reasoning.
- An appropriate discharge plan is in place and operational.
- A support package has been commissioned to meet the onward needs of the patient/service user and/or carer
- Post discharge support with the relevant agency has been agreed and is available and an agreed date has been set for discharge between all parties including patient/service user and/or carer
- The individuals' needs cannot be safely managed by the IST team and an admission to an Assessment and Treatment bed based service or mental health community or bed based service is required. This would ideally be identified at the point of referral; the referral would not have been accepted.
- An individual referred to the service refuses to engage with the team and it is not deemed in their best interested to continue with the intervention.
- The level of risk is not sustainable or safe to manage and therefore discharge to a more appropriate service is required.

Providers will report to Commissioners if the service is unable to adhere to the 3 month time scale as part of the contract monitoring. Where this occurs more frequently than anticipated the service operation will be reviewed.

Discharge letters will be sent to the relevant GP practice and all appropriate parties, which are comprehensive and indicate current treatment and relevant information.

3. Applicable Service Standards

3.0 Applicable national standards e.g. NICE, Royal College

The team will work within the relevant NICE guidance and professional standards for governing bodies i.e. RCN, RCSLT, COT, HCPC

NICE (2015) 'Challenging Behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behavior challenges.' Published 28 May 2015 nice.org.uk/guidance/ng11. National Institute for Health and Care Excellence. London.

Building the Right Support, (October 2015). A national plan to develop community services and close in Service User facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition, available at:

https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf

Blue Light Protocol, NHS England, Sept 2015, available at:

https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-blue-light-protocol.pdf

Care and Treatment Review, Policy and Guidance, NHS England, Oct 2015, available at:

https://www.england.nhs.uk/wp-content/uploads/2015/10/ctr-policy-guid.pdf

Local Standards

Service will be delivered in line with the Provider's LEARNING DISABILITIES INTENSIVE SUPPORT SERVICE OPERATIONAL POLICY

4. Key Service Outcomes

It is anticipated the service will deliver the following key outcomes:

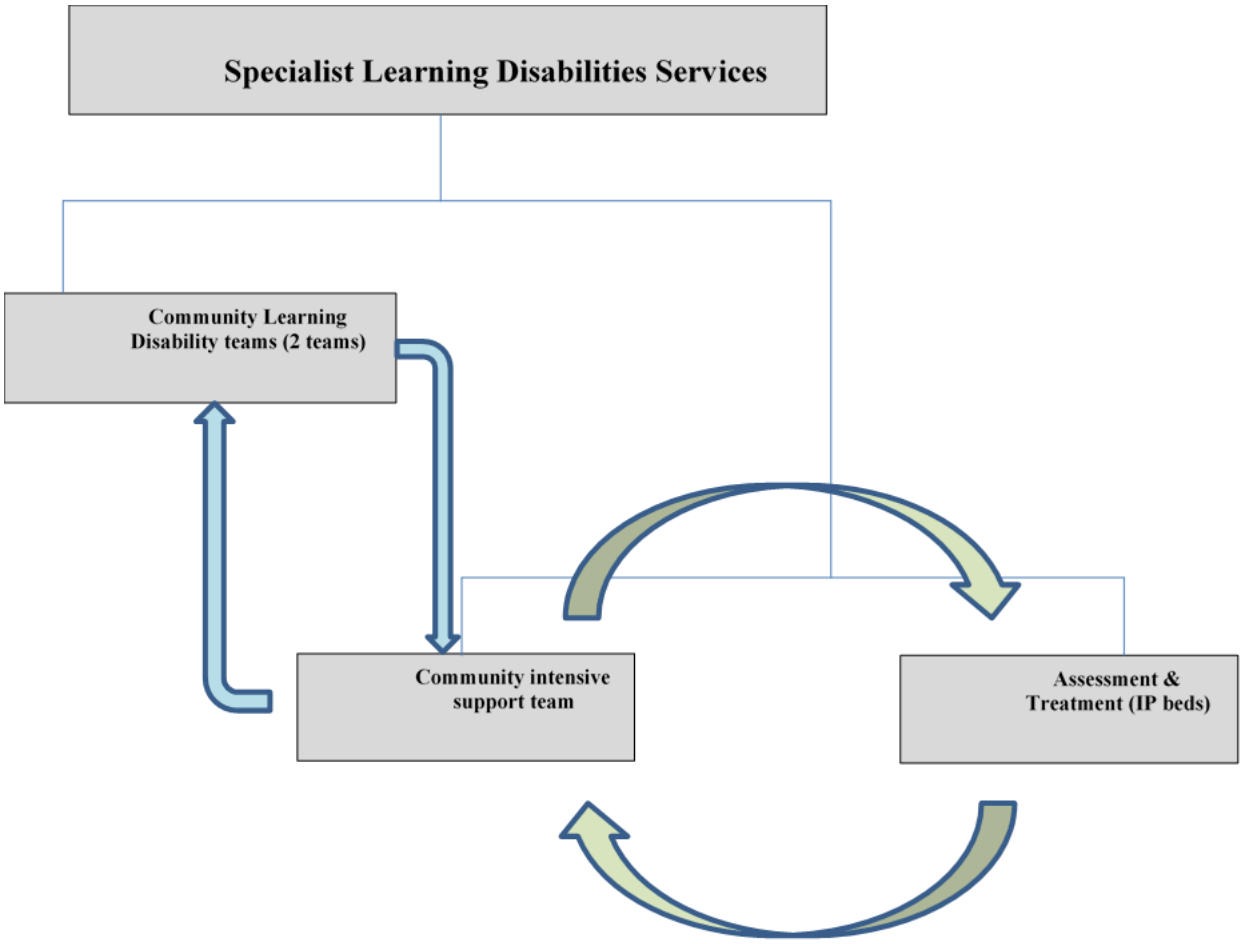
- Reducing frequency and/or severity of behaviours that challenge services and ordinary life for the individual
- Increase in proactive social behaviours, community activity/presence and opportunities
- Immediate response to clients in crises referred from the CLDT
- On acceptance of referral into the service all clients will be allocated a Lead Professional form within the team.
- All clients will be reviewed within agreed timeframes
- All clients will have an agreed discharge plan to ensure continuity of care
- Deliver person-centred care and individualised packages of support for people with challenging behaviour and their families/carers.
- Delivery of care in the most appropriate environment and with effective use of resources
- Access a full multi-disciplinary team, as clinically indicated.
- Prevent disruptive admissions to bed based services, both local and out of area placements, with on-going evaluation and enhancement of the model within resource to include a wider range of options to prevent hospital admission or deterioration in accessing ordinary life opportunities
- Supports the use of bed based provision to a minimum and the risk of people getting 'stuck' in the inpatient setting

5. Location of Provider Premises

The service will be provided by North Staffordshire Combined Healthcare NHS Trust and South Staffordshire and Shropshire Healthcare NHS Foundation Trust on the site of inpatient services.

The service will be provided 7 days per week 8a.m. – 8 p.m. with additional telephone support available outside these hours.

Model of IST pathway

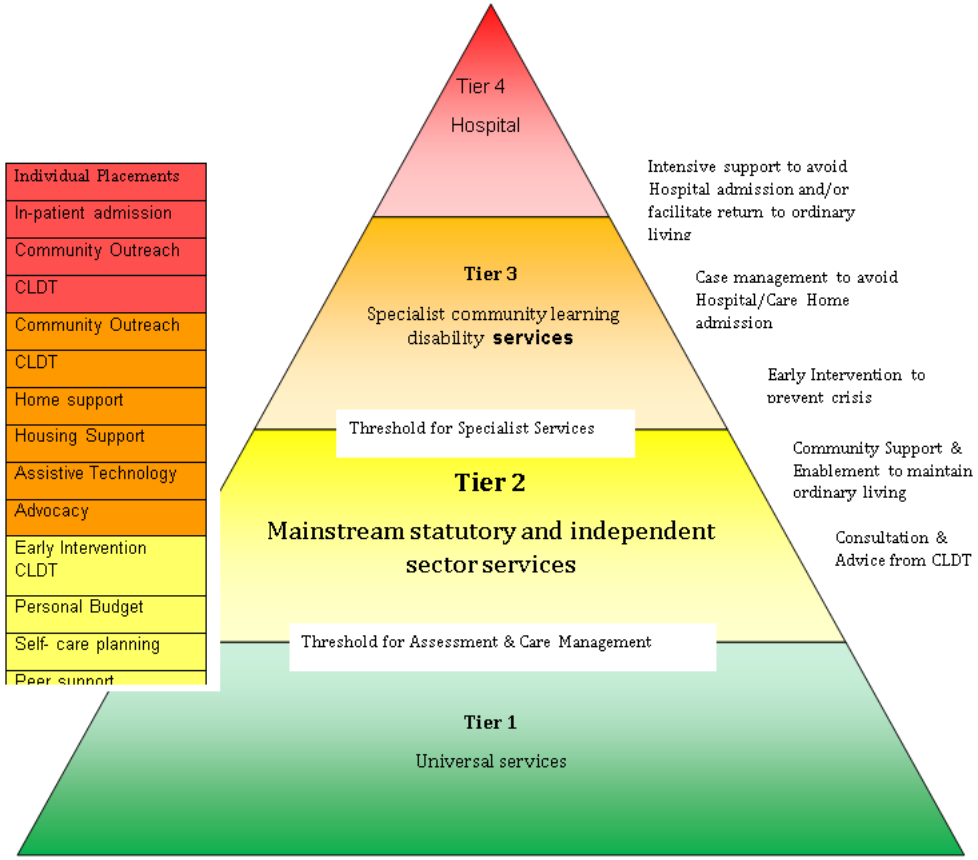


The diagram above represents how an individual may move between and in/out of services. The diagram illustrates how the IST service will sit as part of the Assessment and Treatment services; which has 2 strands - community i.e. IST and in-patient i.e. bed based.

It is anticipated that local providers will have different interpretations of this model and therefore slight variations will exist at the point of delivery and in the associated operational policies.

It is anticipated that local providers will have different interpretations of this model and therefore slight variations will exist at the point of delivery and in the associated operational policies.

Tiers of Service Diagram



Service Specification No.	C05
Service	Learning Disability Inpatient Provision (Assessment and Treatment)
Commissioner Lead	Denise Dyke, CCG Locality Commissioning Manager – North Division
Provider Lead	Jessica Fitzgerald, Service Manager - Learning Disabilities and CAMHS IP
Period	01 April 2022 – 31 March 2023
Date of Review	See 22/23 SDIP

1. Population Needs

1.1. National/local context and evidence base

National Policies provide the following guidance:

- 'People with learning disabilities or autism may sometimes need hospital care but hospitals are not where people should live.'
- 'There are far too many people with learning disabilities or autism staying too long in hospital or residential homes, and even though many are receiving good care in these settings, many should not be there and could lead happier lives elsewhere. This practice must end.'
- 'There is consensus that large hospital units are outdated and inappropriate and do not provide the care which people with challenging behaviour need. It is our clear expectation that commissioners should not place people in large hospitals. There may be a few people who need inpatient care, but this should be provided in smaller units and as close to home as possible. Any new, small specialist hospitals should only be built where JSNAs show a genuine unmet local need for such provision in a way which is consistent with good models of care. Local commissioners should have oversight of the services available in their areas and take the lead in discussing future need and what additional facilities are required.'

Transforming care: A national response to Winterbourne View Hospital: Department of Health Review Final Report - December 2012:

- 'care should be taken to see that any hospital-based treatment is linked with the provision of future community-based resources for the person concerned.'

Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs: Report of a Project Group Prof Mansell 1992:

- 'The appropriate role for psychiatric hospital services for people with learning disabilities lies in short-term, highly focused assessment and treatment of mental illness. This implies a small service offering very specifically, closely defined, time-limited services.'
- 'The role of the National Health Service is: To provide specialist psychiatric assessment and treatment on a short-term basis, but only as part of an integrated pathway of care for the individual that gets them back into the community.'

Services for people with learning disabilities and challenging behaviour or mental health needs, Prof. Mansell Oct 2007

Transforming Care for People with Learning Disabilities – Next Steps (January 2015) outlined a programme of system wide change to improve care for people with a learning disability and/or autism who display behaviour that challenges including those with a mental health condition.

New Service Model for Commissioners of Health and Social Care services (October 2015).

Care and Treatment Policy and Guidance (October 2015).

Building the Right Support (October 2015). This plan describes the mechanisms for achieving transformation including financial underpinnings and commissioning arrangements.

Care and Treatment Review: Policy and Guidance (May 2015) sets out the expectations for implementation of Care and Treatment Reviews (CTR's) for people with Learning Disabilities (LD) in England. The aim of a CTR is to bring a person-centred and individualised approach to ensure that treatment support needs of the person with LD and their families are met and barriers to progress are challenged and overcome.

1.2. Needs of people with Learning Disabilities

In England during 2012 there were 1.4 million people identified as having a Learning Disability. Of the 1.4 million, 908,000 were of adult age.

- 22% of these were known to their GP

- 44% were in receipt of Disability Living Allowance (DLA).

Demographic studies indicate that the population of people with learning disabilities is increasing at a rate of 1% per year with an overall growth of 10% by the year 2020. It is also known that people with learning disabilities now have increased life expectancy attributable to innovation and improvements in neonatal, maternal and general healthcare services. The outcome of these improvements is an overall increase in the complexity of healthcare needs.

Studies have identified that approximately 1% of the population have an Autistic Spectrum condition with half of this population also having a learning disability. There are also a number of health issues that are more prevalent amongst people with learning disabilities than the general population and these include; respiratory conditions, epilepsy, coronary heart disease, mental ill health (including dementia), physical impairment with associated risk of postural deformities, problems associated with eating and drinking, communication difficulties and sensory impairments. Although these health problems should be managed within mainstream health services, some individuals will need the input and support of specialist services working in partnership with mainstream health professionals.

Challenging behaviours (such as aggression, destruction and self-injury) are shown by 10%-15% of people with learning disabilities, with age-specific prevalence peaking between ages 20 and 49. In a recent study self-injurious behaviour was recorded for 27% of individuals (children and adults) with learning disabilities, and the same study reported self-injurious behaviour for between 45% and 93% of people with certain genetic syndromes. In some instances, challenging behaviours may result from pain associated with untreated medical disorders. There are small numbers of people with learning disabilities who, because of the risks of harm to themselves or others:

- are liable to be detained under the Mental Health Act 1983 or Deprivation of Liberty Safeguards
- May be under Ministry of Justice (MoJ) restrictions requiring longer term detention until risk management plans acceptable to the MoJ can be developed.
- require higher levels of physical or relational security than can be achieved in community settings (whilst not meeting the criteria for secure services)
- require assessment and interventions aimed at enhancing skills, reducing risks and developing risk management plans that will support a move to or return to community settings

- require interventions over a longer period than is appropriate for an acute assessment and treatment service.

Such people form an extremely diverse group, including individuals with all levels of learning disability, many different sensory or physical health needs and challenging behaviour.

In addition to learning disabilities they may have a range of needs, such as: mental health problems, autistic spectrum conditions, substance misuse problems, personality disorders, self-harm, a history of offending behaviour and/or challenging behaviour. People may also have sensory impairments and health problems such as unstable epilepsy.

The overall prevalence of challenging behaviours is greater among people with learning disabilities who:

- Have additional impairments of vision or hearing
- Are reported to have periods of disturbed sleep
- Have mental health problems

Health, Inequalities and People with Learning Disabilities in the UK, 2012

1.3. Local Needs Analysis

The predicted population of people with a moderate or severe learning disability is shown in the Tables One and Two below.

Stoke On Trent

Figures are based on national prevalence rates applied to the Stoke on Trent's adult population.

Table One

	2014	2015	2020	2025	2030
Total Population aged 18-64 predicted to have a moderate or severe learning disability	**857**	**857**	**852**	**850**	**853**

Total Population aged 65 + predicted to have a moderate or severe learning disability	**119**	**121**	**128**	**134**	**147**	
Total population aged 18 and over predicted to have a moderate or severe learning disability	**976**	**978**	**980**	**984**	**1000**	

PANSI and POPPI websites 2014

By 2020, it is predicted that there will be an overall increase in the number of people with moderate or severe learning disabilities in Stoke-on-Trent. The largest increases will be seen in people aged between 25 and 34 and 55 and 64, with a small increase in the number aged over 75. It is predicted that there will be a decrease in people aged between 18 and 24 and 35 and 54.

There has been an increase in the number of Children in Need with learning disabilities over the last three years by 31%.

Stoke on Trent JSNA 2014

North Staffordshire

Table Two

	2014	**2015**	**2020**	**2025**	**2030**
Total Population aged 18-64 predicted to have a moderate or severe learning disability	**733**	**729**	**716**	**706**	**689**
Total Population aged 65 + predicted to have a moderate or severe learning disability	**136**	**140**	**149**	**156**	**169**
Total population aged 18 and over predicted to have a moderate or severe learning disability	**869**	**869**	**865**	**862**	**867**

PANSI and POPPI websites 2014

Following analysis of people with learning disabilities who currently require inpatient beds the Services must be able to meet a range of needs which will include: inappropriate sexual behaviour/sexual offending; challenging behaviour – verbal and physical aggressive behaviours; epilepsy; personality Disorder; mental health needs; autistic spectrum disorder; substance misuse; communication needs; conduct disorder; dyspraxia.

1.4. Local Strategic Context

Locally, like the rest of the England, Stoke on Trent and North Staffordshire Clinical Commissioning Groups (CCG) are transforming services for people with learning disabilities and complex health needs, which may include autism, mental health conditions, behaviours that challenge and offending behaviours. The CCGs are ensuring that people with learning disabilities and complex health needs can live locally, remain in their homes and be supported within local community, even if their needs change, preventing the need for people to be admitted to Learning Disability inpatient settings.

This cohort in Stoke-on-Trent and North Staffordshire is an extremely diverse group of people and the support they require will be highly individualised tailored to particular needs, strengths, interests and in some cases risks they pose to others.

In terms of local strategic context, there are number of documents that details the need for less inpatients beds and an increase in community-based services that can support adults with a learning disability who have complex health needs:

NDTi Specialist Health Review Report, 2011. In Autumn 2011 Learning Disability Commissioners in Staffordshire and Stoke-on-Trent commissioned the National Development Team for Inclusion (NDTi) to carry out an independent review of local services for people with a learning disability, complex needs and challenging behaviour.

The NDTi report was published in May 2012 and made a number of recommendations to modernise and improve the local provision for this group. Although the NDTi report was published prior to the "Winterbourne View" findings, there is significant overlap in the two sets of recommendations.

The NDTi recommended across Stoke and Staffordshire there were:

- At most a 'handful' of assessment and treatment beds, with some possibly being in partnership with neighbouring areas to gain 'critical mass'. No campus style NHS beds.
- Assessment and Treatment beds have a clear purpose and linked into local services.

Staffordshire and Stoke-on-Trent Transforming Care Partnership Plan (2016-2019).

This plan details how the CCGs and Local Authorities in Staffordshire and Stoke-on-Trent will deliver and commission services in line with the national service model, so that more people with learning disabilities and/ or autism, with behaviour that challenges – including those with a mental health condition can live in the community, closer to home.

2. Outcomes

2.1. NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	**ü**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**ü**
Domain 4	**Ensuring people have a positive experience of care**	**ü**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**ü**

2.2. Local defined outcomes

- To improve health, well-being and social functioning through maximising an individual's quality of life.
- Improved person-centred care and individualised packages of support for people with learning disabilities and behaviour which challenges services
- Delivery of care in the most appropriate environment and with effective use of resources
- Effective use of expertise and promoting use of multi-disciplinary team working
- All clients will be regularly reviewed within agreed timeframes
- Services provided locally
- Promotion of equity of access

- All clients will have an agreed discharge plan on admission, to ensure continuity of care
- High quality and effective services are provided in an evidence based framework
- People are supported to live in the community, wherever possible
- Prevention of the need for people with learning disabilities to access out of county placements
- Repatriation of people with learning disabilities from out of county placements.

3. Scope

3.1. Aims and objectives of service

Aims

- To support people to move to, or return to, a community setting appropriate to their needs and preferences by reducing barriers (ill health, independence skills, behaviours that challenge or other risks) through specialist assessment, treatment and interventions and prompt discharge planning.
- To focus on enablement, independence and social inclusion.
- To support a person to maintain their independence and have the best quality of life possible in the least restrictive conditions compatible with safeguarding.

Objectives:

The service will:

- provide a comprehensive assessment of each person's challenging behaviours, mental health, physical health, risks, needs and strengths on admission
- assess and stabilise the person following admission
- develop and keep under review an individual person-centred plan (incorporating a health action plan) with agreed outcomes
- maximise the potential of the person to achieve their plan and outcomes through the delivery of treatment, therapeutic interventions, meaningful activities and opportunities
- identify, assess and manage risk to the person, other residents and the public through the use of robust operational and clinical protocols and procedures

- together with partners, deliver support to sustain or begin to build community, family and friend connections with the person's intended home area, in accordance with their preferences and wishes
- prepare and support the person for discharge to a community setting
- Develop independence and social inclusion
- provide access to independent advocacy
- provide adaptive accommodation promoting best, safe practice and reduce likelihood of self-harm
- support the person to make decisions.

3.2. Service description/care pathway

3.2.1. Principles

Key principles:

- Focus on recovery, enablement and independence
- Promotion of social inclusion
- Service user involvement
- Person centred care
- Work together with the service user to achieve person-centred outcomes
- Develop a culture of dignity, compassion, positive human rights and equality where the service user feels valued, respected and has choices
- Provide safe and secure care in a non-institutional home-like physical environment that is the least restrictive possible
- Understands and manage risks to the service user or to others
- Positive behavioural support
- Work in partnership with referrers, community colleagues, health and social care professionals, voluntary and independent sector services to deliver an integrated care pathway with the overall aim of supporting service users to live well and safely in the community
- A valued, skilled workforce
- A multi-disciplinary team
- Provide a range of evidence-based treatment, activities and opportunities

3.2.2. Service Description

The focus of the Inpatient provision will be to provide support for people with learning disabilities, complex health needs and challenging behaviour who cannot be safely managed in the community with a focus on:

1. Preventing people with learning disabilities needing to access inpatient provision out of area.
2. Enabling people currently placed in inpatient provision out of area to be repatriated to the local area
3. People with challenging behaviour (including autism)
4. People stepped down from forensic services

The Unit will provide:

- Six inpatient Assessment and Treatment beds (A&T) beds.

The A&T Unit will focus on short term outcome based interventions working on a discharge pathway to enable people to be supported within the community following their hospital stay.

The Unit will offer a multi-disciplinary approach to clients who are in crisis and are assessed as needing an in-patient admission, whose needs exceed the support that can be provided by the Intensive Support Team (IST). The Unit will provide a range of highly skilled and experienced staff, competent to carry out in-depth assessments and provide detailed treatment plans within a time limited period.

A period of assessment to understand the behaviours which challenge will be followed by the formulation of a plan to maximise the individual's quality of life and offer greater opportunities for future housing/accommodation needs. Outcome based interventions will be based on a sensory integration and positive behavioural support model and provide highly effective strategies through the completion of functional analysis and expert assessment.

Environmental design will provide individual living environments, the flexibility to respond to different needs and preferences with access to quiet places, low stimulation environments and access to safe and secure outdoor space. The accommodation will provide a safe and homely atmosphere that allows for personalised space. The Unit will provide capacity to support males and females.

The Unit will include locked and unlocked facilities for people who require inpatient assessment and treatment and rehabilitation interventions over a period of months (tailored to individual needs) to enable them to move on to the least restrictive possible community settings.

The Unit will enable people from Stoke on Trent and Staffordshire who are currently placed out of the area, who continue to require an inpatient placement, to be able to be repatriated to the area. The Unit will also support people requiring a step up from acute care or community rehabilitation, or a step down from secure settings.

The maximum period of stay will be for 3 months. Appendix 1 provides the times frames and over view of the Service.

The Service will provide:

Comprehensive specialist assessment of a person's challenging behaviours, mental health, physical health, risks, needs and strengths. To include information from the Service User and those who know them, their own goals and preferences, risks to themselves and others, therapeutic needs (including any offending behaviours) and a holistic view of what is needed to help them achieve a good quality of life in the community.

There will be a positive behavioural support framework approach to assessment and treatment of challenging behaviours (for example applied behavioural analysis). Positive Behavioural Support is a framework for developing an understanding of an individual's challenging behaviour and for using this understanding to develop effective support.

This will lead to the formulation of plans – for the person's intended outcomes and the interventions required to achieve these. Discharge planning will start on the person's admission, using a transitional care pathway approach. Care plans will be developed in partnership with service users.

Service users will be involved at all levels, being at the centre of discussions, plans and decisions about their care as well as involved in decision making at organisational levels. Service users will have access to independent advocacy. Information about a person's care, treatment and future planning will be available in an accessible format. Family members and carers will be involved in therapy and planning, as appropriate.

Each person's day will be structured to include access to meaningful activities, education, opportunities, exercise, outside space and health care to promote a healthy lifestyle.

A programme of activities provided will include specialist outcome based interventions, treatments, activities and opportunities that are designed to promote enablement and independence and facilitate individuals to achieve their own person centred goals. Each person will be supported to improve or maintain their general health. Each individual will have the opportunity to be involved in agreeing an activity and therapy programme, relevant to their identified needs, goals and preferences which includes evening and weekend activity. The activity and therapy programme will be a minimum of 30 hours per week unless exceptional circumstances are agreed with the Commissioner for a particular named individual. The Service will provide high quality food and nutrition.

Staffing capacity and skills will match the needs of the patients and the interventions offered; it is expected that, as a minimum, the core team would include learning disability psychiatry, psychology, nursing, social work, speech and language therapy and occupational therapy, with access to other therapists (e.g. arts) as required. Patients will be under the clinical care of the providers Consultant/lead Clinician during their placement. There will be sufficient staffing levels and skill mix to deliver a safe effective service at all times. Staff will receive on-going training, supervision and support.

The services will work towards a care specification for meeting the service users needs and planning for their next placement as they move on from the Unit. The services will work closely with the Community Learning Disability Team (CLDT), where necessary the Intensive Support Team (IST), and the relevant local authority social care services in preparation for discharge. Service Users will access GP's and Primary Care Medical Services, as required.

CPA Meetings will be held involving the multi-disciplinary team (MDT). Care Plans will be reviewed regularly in to assess achievement of outcomes and plan for discharge.

There will be effective governance arrangements and adherence to all regulatory and legislative requirements, including those of the Mental Health Act and Mental Capacity Act.

3.2.3. Eligibility Criteria

Adults with a learning disability, complex health needs and challenging behaviour who cannot be safely managed in the community with support from the CLDT or IST due to an acute breakdown in their healthcare needs, who are:

- Aged 18 years or over
- Registered with a Stoke on Trent or Staffordshire GP

- People with a learning disability meeting the eligibility criteria who are returning from out of area placements (who require an inpatient placement) and originate from Stoke-on-Trent or Staffordshire

AND who are:

- Detained under the Mental Health Act

or

- Whose mental health needs cannot be met within mainstream mental health services

or

- Who require admission for to an LD Inpatient Setting for assessment and treatment

or

- Who are in 'crisis' –and their needs cannot be supported by the IST/CLDT and therefore require in-patient support.

Planned admission shall only occur after a pre-admission Care and Treatment review has taken place. Where an admission took place without an ore-admission Care and Treatment review a posy admission review shall take place within 10 working days of the admission.

3.2.4. Response Times

A Pre-Admission CTR Panel will be arranged by the CCG Lead within 5 working days following receipt of a planned referral.

Any referrals received that are deemed as an emergency (MHA/IST referral) are actioned immediately on receipt. A Blue Light meeting will be arranged by the CCG Lead to discuss any unplanned admissions. For all unplanned admissions a CTR will be completed within 10 days of admission. - See North Staffordshire Combined Healthcare NHS Trust Admission and Discharge Protocol 2015

3.2.5. Discharge Process

Discharge planning will commence on admission. The referral and review process are designed to identify and monitor progress towards specific outcomes as detailed in the Health Equality Framework. Discharge is facilitated on achievement of those outcomes.

The maximum period of stay in Assessment and Treatment is expected to be 3 months.

Under exceptional circumstances if, for clinical reasons, a longer length of stay is deemed to be required, this will need to be approved by the Commissioners.

3.3. Population covered

3.3.1. Service User Groups Covered:

As outlined in 3.2.3 Eligibility Criteria.

3.3.2. Geographical Population Served:

Adults with a learning disability who are registered with a GP in Stoke on Trent and Staffordshire.

Adults with a learning disability meeting the acceptance criteria returning from out of area placements (who require an inpatient placement) and originate from Stoke-on-Trent or Staffordshire.

3.4. Any acceptance and exclusion criteria and thresholds

Exclusion criteria

A service is not provided for:

- Children under 18 years.
- Those whose primary need is not a learning disability

- Where signposting to another service is more appropriate
- Needs that are explicitly social care in nature
- Health needs that should be met within generic primary, secondary and tertiary healthcare services.
- Health needs that could be met in the community
- Individuals who have been risk assessed as requiring higher degree of security
- Individuals whose vulnerability would increase by an in-patient admission.

3.5. Interdependence with other services/providers

The key relationships will be with:

- Service Users
- Carers and families
- Advocates
- GPs
- Social care teams
- Healthcare professionals
- Community Learning Disability team
- Intensive Support Service
- Community health services and primary care
- Mental Health services
- Services for children and young people to enable planning for transition into adulthood
- Housing Providers
- Care Providers
- Forensic commissioners and providers of forensic services

4. Applicable Service Standards

4.1. Applicable national standards (eg NICE)

The teams operate within NICE guidance and local agreed pathways. Especially:

NICE (2015) 'Challenging Behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges.' Published 28 May 2015 nice.org.uk/guidance/ng11. National Institute for Health and Care Excellence. London.

Building the Right Support, (October 2015). A national plan to develop community services and close in Service User facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition, available at:

https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf

Blue Light Protocol, NHS England, Sept 2015, available at:

https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-blue-light-protocol.pdf

Care and Treatment Review, Policy and Guidance, NHS England, Oct 2015, available at:

https://www.england.nhs.uk/wp-content/uploads/2015/10/ctr-policy-guid.pdf

4.2. Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

4.3. Applicable local standards

It is expected that the service provider will ensure appropriate policy is in place in line with current health and safety and risk management guidance together with appropriate mechanisms to record, audit and monitor feedback on service provision and actions taken to resolve issues.

Safeguarding – The provider will work in accordance with the local Staffordshire and Stoke on Trent Adult Safeguarding Policy and procedures.

The provider will ensure that all staff receive training relating to Adult Protection, the Mental Capacity Act and Deprivation of Liberty Safeguards on a multi-agency basis.

5. Applicable quality requirements and CQUIN goals

5.1. Applicable Quality Requirements

See Schedule 4

The teams operate within NICE guidance and local agreed pathways.

The service will be monitored in line with Key Performance Indicators.

5.2. Applicable CQUIN goals

See Schedule 3

6. Location of Provider Premises

6.1. The Provider's Premises are located at:

Assessment & Treatment Unit

Harplands Hospital

Off Hilton Road

Springfields

Stoke-on-Trent

Staffordshire

ST4 6TH

6.2. Days/ hours of operation

24 hours a day, 7 days a week.

7. Appendix 1 – Assessment and Treatment Timeline

PRE ADMISSION	ASSESSMENT		INTERVENTION / TREATMENT						TRANSITION & DISCHARGE	
1-2 weeks	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9-11	Week 12
Pre-Admission CTR meeting led by Commissioners & IST Agree suitability of admission i.e. meet criteria and if not, appropriate signposting or admission avoidance planning with IST. Transfer of information already collated by IST and share all completed assessments with Inpatient team, agree lead nurse and in liaison with the MDT agree and devise supporting assessments required and/or	Admission CPA meeting Overarching Care Plan and 24 hour plan of care, risk assessments if not in place Physical Health Assessments Medication Care Pathway CQUINS e.g. Alcohol/Drug; Patient/Carers; Functional Analysis Completed within week 1 by core group Development of outcomes from functional analysis forming PBS plan followed by weekly		Implement, review and evaluate. Teach and modelling interventions Monitoring specific conditions or needs as identified. Medication reviews weekly.			Mid Inpatient Stay CPA meeting with update from social worker for future placement confirmed. Beginning of transition and discharge planning.	Implement, review and evaluate. Teach and modelling interventions Monitoring specific conditions or needs as identified. Medication reviews weekly.		Finalise discharge pack and wellbeing and recovery plan. Review implementation of transition	Discharge Client Informal face to face discussion with service user/carer/family and obtain feedback. Query section 17 leave for transition/ discharge

proposed intervention plan. **Identification of core team including immediate care group, social worker, occupational therapist, psychologist etc.** **Development of Person Centred Plan and associated outcomes together with person and family/carers**	**MDT review and monitoring.** **Team/Core Group meeting for teaching of intervention plan** **Commence Discharge Plan**							
	CPA with community social worker and IST and/or CLDHT worker.				**CPA with Community Social worker and IST and/or CLDHT worker.**			**CPA with community social worker and IST and/or CLDHT worker.**	

Service Specification No.	C06
Service	Learning Disability Health Facilitation & Acute Liaison Service – Adults (18+)
Commissioner Lead	Denise Dyke, Commissioning & Service Redesign Manager, CCG
Provider Lead	Sharon Parkes, Service Manager - Learning Disabilities and CAMHS IP
Period	01 April 2022 – 31 March 2023
Date of Review	As required

1. Population Needs

1.2 National/local context and evidence base

People with learning disabilities experience greater health needs than others in the population and can also find access to health care very challenging for a number of reasons.

The prevalence data for people with a learning disability in England, based on the Public Health, Improving Health and Lives Learning Disability Observatory, was estimated in 2012 to be 1.14 million. Of these 908,000 are adults (aged 18+) of whom 199,000 (22%) are known to GP's as people with a learning disability.

The following table demonstrates the predictions for the Stoke-on-Trent learning disability population from PANSI (Projecting Adult Needs & Service Information) based on prevalence rates for Stoke-on-Trent for the 18-64 year old population;

	2012	**2014**	**2016**	**2018**	**2020**
People aged 18-24 predicted to have a learning disability	710	712	703	687	656
People aged 25-34 predicted to have a learning disability	867	899	921	941	956
People aged 35-44 predicted to have a learning disability	802	768	750	748	764
People aged 45-54 predicted to have a learning disability	772	788	797	785	759

People aged 55-64 predicted to have a learning disability	637	628	638	659	680
Total population aged 18-64 predicted to have a learning disability	**3,787**	**3,796**	**3,809**	**3,819**	**3,815**

The table below demonstrates the predications from POPPI (Projecting Older People Population Information System) for people aged 65+ in Stoke-on-Trent with a learning disability;

	2012	**2014**	**2016**	**2018**	**2020**
People aged 65-74 predicted to have a learning disability	475	506	520	528	531
People aged 75-84 predicted to have a learning disability	263	266	273	283	300
People aged 85 and over predicted to have a learning disability	93	95	101	105	112
Total population aged 65 and over predicted to have a learning disability	**831**	**867**	**894**	**917**	**943**

Locally in Stoke-on-Trent in 2012/13, 44/44 practices had signed up to the Directly Enhanced Service (DES) for the learning disability annual health check. 1,362 individuals are registered on the learning disability register of which 564 individuals have had a health check completed.

1,362 adults aged 18+ are on the GP learning disability register, this is 29% of the estimated number of adults with learning disabilities in Stoke-on-Trent based on the above prevalence data, this is slightly higher than the 22% known to GP's nationally. This suggests that there is a higher number of people with a learning disability in the city than prevalence data suggests, or that needs of the learning disability population are higher in Stoke-on-Trent than nationally so are more widely recognised.

The number of individuals with a learning disability known to social care based on 2013 data is 2,028; of these 1,775 are 18+ of which 58 are recorded as being 18+ and from an ethnic minority. Of the 1,775, 745 individuals currently access social care services.

The total school age population locally currently stands at 33,000 people. The number of young people receiving assistance in school because of Special Educational Needs (SENs) locally, based on 2013 social

care data, is 6,813. Of these, 6,393 have a primary needs category of moderate learning disabilities, 112 have a primary needs category of severe learning disabilities and 34 have a primary needs category of profound or multiple learning disabilities. Additionally there are 274 young people who have a primary need category of autistic spectrum disorder.

The numbers of young people currently receiving social care services who have or who are going to turn 18 over a four year period is as follows;

Year	Number of Young People
2014/15	30
2015/16	31
2016/17	16
2017/18	23

These figures are slightly higher than in previous years and in line with national projections that younger people are surviving into adulthood with critical, substantial and multiple needs. The following table shows the year on year breakdown of the number of needs young people turning 18 have;

	1 need	2 needs	3 needs	4 needs	5 needs	6 needs	7 needs
2013/14	3	4	1				
2014/15	18	7	3	1	1		

2015/16	17	5	5	1	2	1	
2016/17	9	3	1	2		1	
2017/18	12	3	3	4			1

Health inequalities

People with learning disabilities have poorer health than the general population, much of which is avoidable. These health inequalities often start early in life and result, to an extent, from barriers they face in accessing timely, appropriate and effective health care. The impact of these health inequalities is serious. As well as having a poorer quality of life, people with learning disabilities die at a younger age than their non-disabled peers.

The Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD, published in 2013) found that men with learning disabilities died on average 13 years younger than men in the general population and women 20 years younger. CIPOLD data also showed that people with learning disabilities are three times as likely as people in the general population to have a death classified as potentially avoidable through the provision of good quality healthcare. This suggests that if we improve the quality of healthcare they receive that we can improve their outcomes.

It is widely acknowledged that people with learning disabilities require support to access Primary Healthcare services and in turn service require advice and assistance to be able to support the specific needs of the learning disabled population.

Likewise, it is known that people with a learning disability, do not always received the same standard of care and treatment while accessing acute hospitals as that of the general population. Death by Indifference (Mencap 2012), Healthcare for All (2008) and Six Lives Report (2009) provide evidence of this and support the need for an Acute Learning Disability Liaison Nurse in each hospital.

In addition the Learning Disabilities Mortality Review programme is to be rolled out across England. This will be carried out in the local area and will strive to ensure that reviews of deaths lead to learning which will result in improved health and social care services for people with learning disabilities.

Local provision

To better understand what is needed locally from a Health Facilitation Service, including Acute Liaison, in 2016 a series of workshops, individual focus groups and facilitated discussions were held. These included: regular forums with General Practice staff, Learning Disability Steering Groups and discussion through the LD Partnership Board Health sub-group. The findings from these sessions overwhelmingly highlighted the need for a strategic role which can support and empower mainstream services to undertake holistic planning with the person very much at the centre and making reasonable adjustments as necessary.

There was a clear need to build relationships with hospital, primary and community staff, take on a teaching role; offering advice and support; working strategically to develop pathways and protocols as

well as maximising opportunities for people with a learning disability to benefit from existing pathways and protocols e.g. Urgent and Emergency Mental Health Liaison Service.

The recently launched Nursing, Midwifery and Care Framework 'Leading Change; Adding Value' (NHSE, May 2016) identify the need for skilled Learning Disability Nurses to provide knowledge, guidance and support within primary, community and secondary care services to ensure the right intervention at the right time with the right staff.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**Ö**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**Ö**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	**Ö**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	

2.2 Local defined outcomes

- Reduce the overall health inequalities experienced by people with learning disabilities ensuring they are treated with respect and their right to privacy is upheld.
- Build local capacity in mainstream and specialist health services which assist and support individuals with learning disabilities to access health services, including transition between children's to adult services and improving the availability and quality of accessible information for people with a learning disability and their carers.
- To have a clinical caseload of clients who are facilitated to negotiate the health pathways across the acute, primary and community services. The individual caseload for each Health Facilitation & Acute Liaison Service team member will be based on the individual Quality Outcomes Framework (QOF) register for the Stoke-on-Trent Clinical Commissioning Group (CCG) updated annually.
- Facilitate and support appropriate utilisation of A & E and other acute health care pathways through a case management approach and referral process along with providing a clear strategic focus.

- Support the uptake of GP practices offering annual health checks and health action plans for people with learning disabilities to at least 50% of the total number of adults with learning disability on GP registers.
- Promote better health outcomes and improve access to health education and health promotion activities including national screening, physical activity, weight management and smoking cessation programmes for a person with a learning disability.
- Developing and promoting the use of Health Action Plans and enhancing the information that is contained within them.

3. Scope

3.1 Aims and objectives of service

It is a legal requirement that local health policies do not disadvantage people with learning disabilities. Hence they are required to make `reasonable adjustments` to facilitate fair and equal access to the NHS. People with learning disabilities experience greater health needs than others in the population and can also find access to health care very challenging for a number of reasons.

The Stoke-on-Trent Health Facilitation & Acute Liaison Service shall:

- Provide practical ways to minimise the difficulties described by people with learning disabilities and family carers when accessing a new or different service due to changing needs;
- Provide a clear strategic focus so that health services are able to plan for and provide equal support and health treatment for people with learning disabilities. This will involve the interpretation, collation and triangulation of local data at both a CCG and practice level to inform commissioning decisions and local developments and to target unwarranted variation.

The Provider shall advise on making `reasonable adjustments` to facilitate fair and equal access to the NHS services.

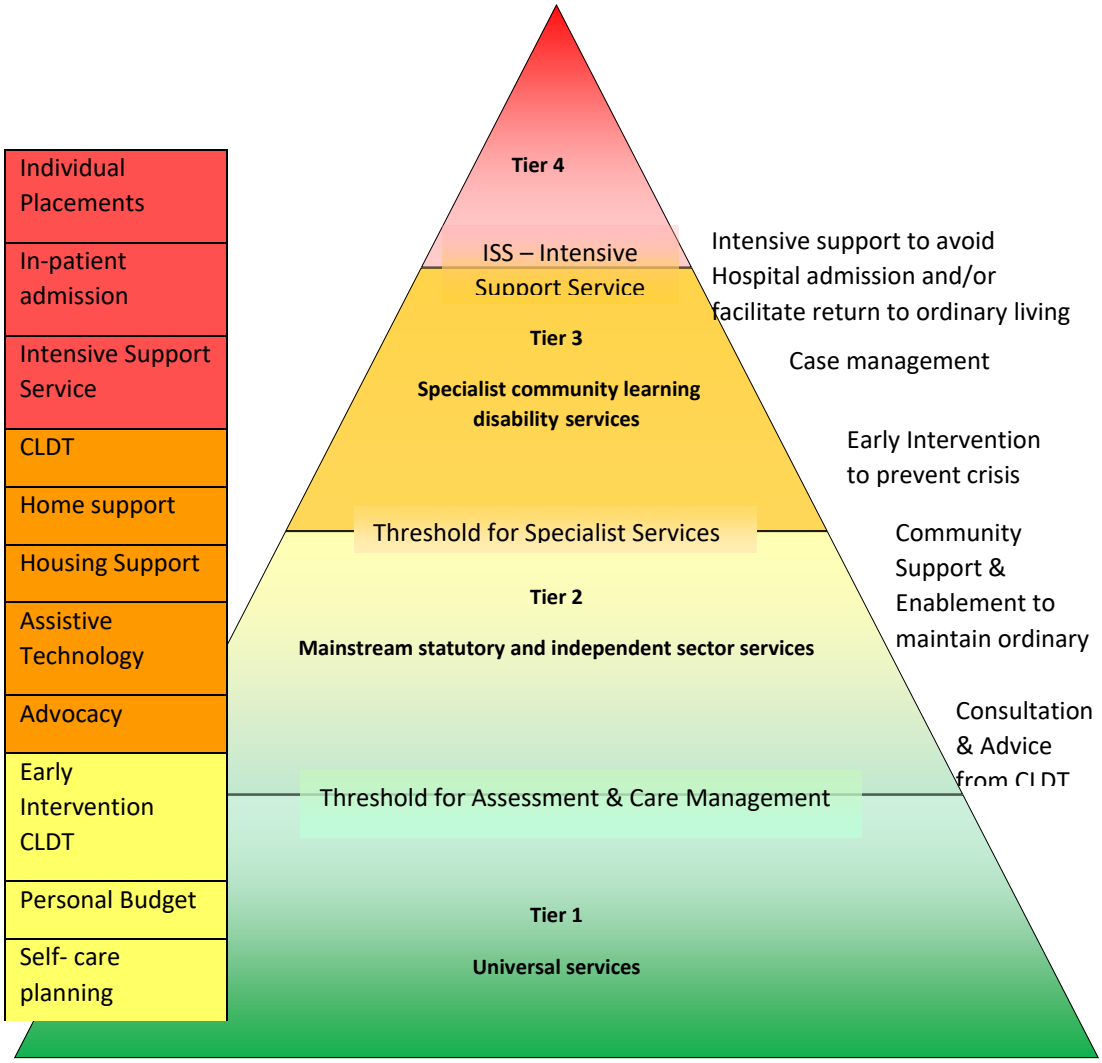
`Reasonable adjustments` include removing physical barriers to access but importantly making whatever alterations are necessary to policies, procedures, staff training and services delivery to ensure that they

work equally well for people with learning disabilities[16]. In addition it includes the use of accessible information in all health services.

The overall aim of the Health Facilitation & Acute Liaison Service is to reduce health inequalities by supporting people with mild, moderate or severe learning disabilities to access mainstream health care and ensure health professionals and organisations gain knowledge and skills in being able to provide primary healthcare that is responsive to their individual needs.

The Learning Disability Health Facilitation & Acute Liaison Service will aim to reduce health inequalities by aligning their services to the Service Development Framework Tiered Service Model;

[16] Hatton et al (2010). Reasonable adjustments for people with learning disabilities in England: A national survey of NHS Trusts. Improving Health and Lives Learning Disabilities Observatory.



The Tiered Service Model provides a framework to help describe what can often be complicated needs across multiple areas of health care, and offers a way of conceptualising and mapping the health needs of people with learning disabilities.

All people with learning disabilities have everyday health needs, just like anyone else. Using this tiered model, services provided at Tier 1 and 2 include primary care and mainstream health services which should be accessible to people with Learning Disabilities.

Mainstream services should be able to make reasonable adjustments to allow this. Although there is a role here in Tier 1 and 2 services for specialist health learning disability, its role here is to support

mainstream services, raise awareness of the needs of people with learning disabilities and to facilitate appropriate access.

Some people with learning disabilities have additional health needs that will require more specialist assessment, treatment, and support from very specialist health services, found at tier 3 and 4.

The Learning Disability Health Facilitation & Acute Liaison Service shall:

Case Management responsibilities for people with learning disability

- To work closely with GP Clinical Commissioning Group and stakeholders to develop and implement a model of case management in primary care which will include risk management approaches.
- To act as a named lead per case that coordinates other professionals and has responsibility for recording progress and following the patient through the pathway where appropriate. This should be in a timed limited manner and should lead to a change in pathway/practice so that learning from cases is disseminated.
- There is a requirement for the Health Facilitation & Acute Liaison Service case manager to liaise regularly with the person's GP and hospital services as relevant.
- To advise the CCG and its services to comply with care quality standards, Care Quality Commission (CQC) inspections and service reviews, Mental Capacity Act (2005) and Equality Act (2010) in relation to their patients with learning disabilities.
- Staff teams in other services need to respond appropriately and work within legal frameworks when working with people with learning disabilities. Improved knowledge and having support and advice to call on will ensure services commissioned by the CCGs are working within the law and are also implementing good practice guidance issued by the department of health. It compliments other services both through links with clinical teams as well as developing strategic links and influencing policy development across the Stoke-on-Trent area.

Strategic responsibilities and longer term sustainability

- To provide clear strategic focus across the CCG area to promote changes in practice that is sustainable and improves outcomes for this cohort of patient.
- To assist with the implementation and development of new pathways
- To have a principle role of identifying barriers to care for people with a learning disability, facilitating new pathways (as well as influencing existing acute pathways)
- Supporting all necessary reasonable adjustments required to ensure safe and effective care delivery to this patient group.

- To interpret, collate and triangulate of local data at both a CCG and practice level to inform commissioning decisions and local developments and to target unwarranted variation.
- To contribute to the commissioning process and to work jointly to ensure existing services and any new service development are able to adequately meet the health needs of people with learning disabilities. The Health Facilitation & Acute Liaison Service is a resource providing support and building links across the CCG, NHS England and the wider health and social care economy including providing advice and support to Prison Health Care Managers, where necessary.

3.2 Service description/care pathway

Stoke-on- Trent Learning Disability Health Facilitation & Acute Liaison Service shall consist of two principal functions:

- Community & Primary Care Health Facilitation
- Acute Liaison Facilitation

Role of Health Facilitation Service

The role of the Health Facilitation Service is summarised as follows:

Advocate

- A credible ambassador for people with a learning disability;
- Fostering equal care through recommending reasonable and achievable adjustments;
- Representing the views of patients and carers to other healthcare professionals ;
- Ensuring recognition of and adherence to specific legislation and sensitive policies such as “do not resuscitate” orders.

Collaborate

- Ensuring a seamless approach between services, sectors and individuals.

Communicate

- Ensuring information flow across healthcare environments, professional groups and between health staff and carers;
- Advising staff on specific communication issues and methods.

Educate

- Formally through induction, updates, Continuous Professional Development programmes and skill development;
- Informally, particularly through opportunistic learning opportunities and role modelling;
- Educating different professional groups if a need is identified;
- Advice and support in Mental Capacity Act and Safeguarding for patients and carers

Mediate

- Building bridges between key individuals, departments, other services and agencies
- Ensuring all individuals understand what is being said and how this will impact on them
- Removing barriers.

Facilitate

- Supporting reasonable and achievable adjustments;
- Enabling access to care through arrangement and adjustment of appointments, pre-hospital preparation, accessible information

Community & Primary Care Health Facilitation

The Community and Primary Health Facilitation service shall ensure that reasonable adjustments are in place to enable people with learning disabilities to access primary care and community services.

Reasonable adjustments can include;

- NHS Annual health checks (AHC)
- Accessible letters and information. Easy-to-read information on Healthy Living/Lifestyles includes smoking cessation, alcohol, exercise, obesity,
- Ensuring Health Action Plans are completed and followed
- Facilitating access and take-up of screening
- Long Term Conditions management including linking with ILCT's
- Accessing Healthcare e.g. Physiotherapy, Acute, Elective, Investigations. e.g. X-ray, diagnostics

The Community and Primary Care Health Facilitation service shall include activity in the following areas.

Identification

The Community & Primary Care Health Facilitation service shall support GP record systems such as the Learning Disability Register and Annual Health Check (AHC) records. This will include:

- Identifying people with a Learning Disability
- Identifying LD patients that are not on the register
- Identifying patients in receipt of an AHC and note their next AHC
- Identifying patients that are not in receipt of a AHC
- Identify patients who have a health action plan
- Identify patients who have not had a health action plan

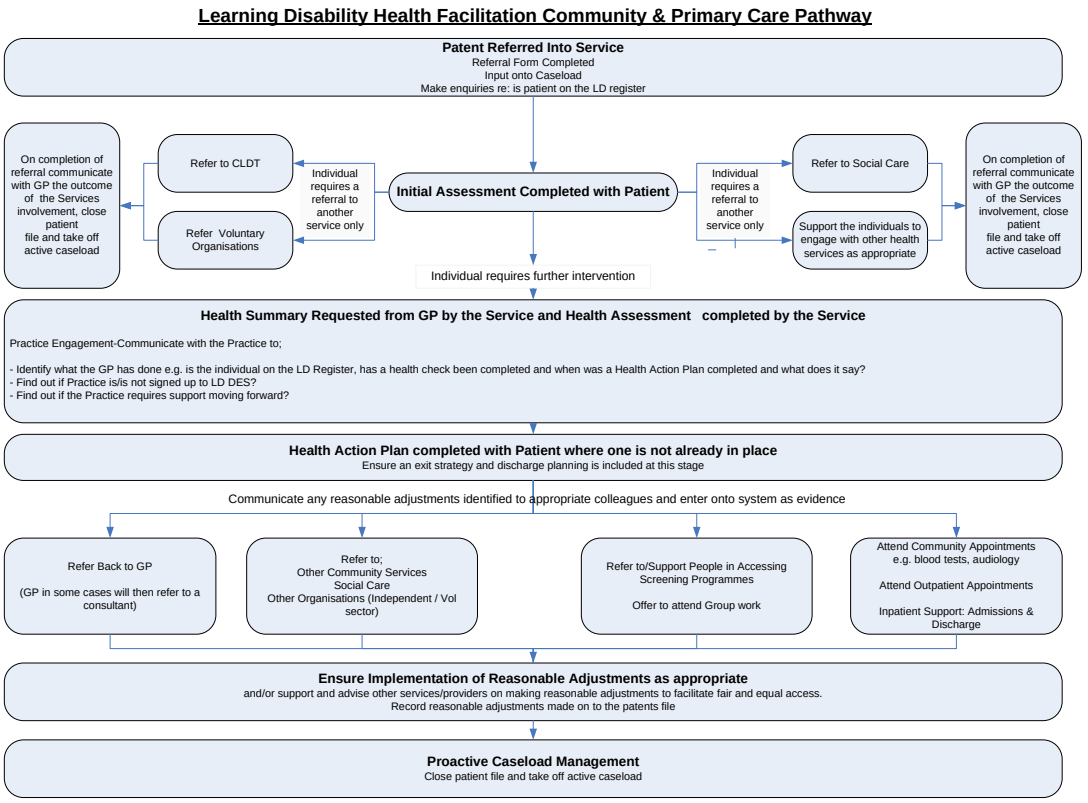
Engage

The Community & Primary Care Health Facilitation service shall support services to make reasonable adjustments in engaging with LD patients. This shall include easy read appointment letters and reminder phone calls or texts, appointments at specific times and/or longer appointments and regular health checks.

This may include where appropriate:

- Engaging with LD patients to attend AHC appointments
- Engaging with LD patients who do not have a AHC
- Engaging with LD patient to attend screening programmes
- Engaging with practices to encourage LD patients to attend screening programmes
- Engaging with LD patients to ensure they have health action plans
- Engaging with practices and ensuring staff have access to easy- read information

Service



The Learning Disability Health Facilitation Service shall:

Community and Primary

- Develop effective and collaborative working with healthcare and multi-agency colleagues, including identifying educational needs and providing specialist and nursing advice, such as mental capacity, mental health act assessment and deprivation of liberties assessments.
- To facilitate the meeting of individual healthcare needs for people with complex needs, liaising with the community learning disability team to co-ordinate support on learning disability referrals who may require help to access generic services.
- To provide support and advice in best interest decisions and consent to the service user, their family/carer, and the professionals involved in decision making about their care. Where appropriate, this function will also be carried out by the Community Learning disability Team.
- Supporting the health needs of people with learning disabilities and their carers within primary care, providing specialist advice, education and intervention and involving other partners where needed and to facilitate open and easy access.
- To actively provide clinical time limited case management for people with mild, moderate or severe learning disabilities in primary care.
- To provide advice and knowledge to the CCG about the effectiveness of the GP practices.
- Identify which practices are delivering the DES and provide additional support where appropriate.

- Identify practices not signed up to the DES and encourage them to sign up to the DES providing a safety net of guidance, support and information.

Across groups

- For team members to coordinate working load across the 3 GP localities of Stoke-on-Trent CCG. Each GP practice shall have a named LD Health Facilitator.
- To actively assist people with learning disabilities known to the service, as well as their carers, health and social care staff when using primary, community and acute services.
- To provide advice regarding safeguarding issues specifically for Learning Disability patients.
- Facilitate the interface between mainstream general hospital services, primary care services and community specialist disability services.
- To be aware there is an unmet need and identify the significant health needs of people with mild, moderate or severe learning disabilities.
- To work with social care and health professionals to overcome barriers to accessing health care and develop joint protocols as required.
- To inform the commissioning and development of local services for people with learning disabilities based on relevant evidence research i.e. demonstrate evidence based practice.
- To work with the CCG Clinical Commissioning Lead on improving systems and identify problems with the recording of learning disability data/information.
- To link with the data quality teams to ensure links to screening programmes are robust and information is recorded and accessible.

Learning Disability Acute Liaison Service

The Acute Liaison Service will support people with mild, moderate and severe learning disability through the admission and discharge pathways in acute care acting to improve quality and access for all individuals with a learning disability.

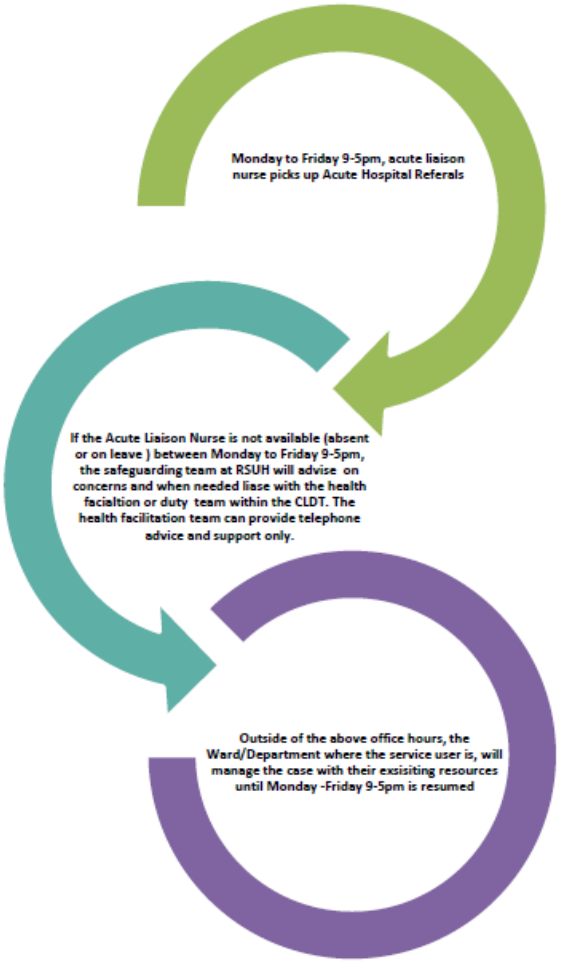
The Learning Disability Acute Liaison Service shall:

- Influence the development and implementation of reasonable adjustments as necessary for people with learning disabilities and advise carers and health and social care staff when using acute hospital services. From time to time and where and appropriate, the Service will be required to actively assist people with learning disabilities in an acute setting in a time limited manner.

- Develop improved partnership working across the health system and work with Royal Stoke University Hospital (RSUH) to improve the quality of care received by individuals with a learning disability in the acute hospital setting. A fundamental part will be to raise the awareness of the health needs of people with a learning disability.
- Scope the development an acute liaison function within A&E including a direct referral pathway process and links with other services.
- Assess and advise accordingly in the acute hospital setting on issues surrounding the individual needs of people with learning disabilities known to the service in relation to:
    - Emergency and pre-admission planning for elective admissions
    - Discharge planning
    - Monitoring of length of stays
    - Access to investigations and diagnostics
- Identify existing / potential barriers in accessing acute services for people with a learning disability and promote initiatives to overcome these barriers.
- Support and enable acute services to make 'reasonable adjustments' within their care delivery for people with learning disabilities.
- Facilitate the meeting of individual healthcare needs for people with complex needs, liaising with the community learning disability team to co-ordinate support on learning disability referrals who may require help to access acute services.
- Raise the profile of the health care needs of people with a learning disability across provision, bridging the gap between acute care areas to enable better communications and access to healthcare.
- Support the Acute hospital with their development and promotion of fair and equal access to acute services including support for people with complex needs who need to access these services.
- Assist acute service provider to identify training needs in relation to learning disabilities and supporting with the development of teaching materials / training packages.
- Provide advice and support to the acute hospital so that they are able to develop support mechanisms for the discharge of routine and urgent admissions from A&E and hospital stays in a timely manner.
- Ensure there is a mechanism in place to identify and flag patients with learning disabilities to the service.
- Support the acute pathways of care ensuring reasonably adjustments are in place to meet individual needs
- Support the provision of readily available and comprehensible information for patients with learning disabilities about treatment options, complaints procedures and appointments.

Reporting Out of Hour Referrals

Acute Liaison Nurse (ALN) out of hours advice flow chart



Most wards and departments are aware the Acute Liaison Nurse Service operates Monday – Friday 9am -5pm (excluding Bank Holidays). This is also on the ALN leaflets and ALN email signature.

The Safeguarding Team at RSUH will share cases with the Acute Liaison Nurse and pick up messages providing support and liaison when the ALN is not available. The Safeguarding team can contact the Health Facilitation or Duty team within the CLDT for telephone support when needed. The CLDT will **not** be able to fully cover the role of the ALN during absence

The Ward or Department will manage the patient using their existing processes and resources - i.e. escalation to the Nurse in Charge/Site Matron. By referring to the Trusts newly revamped Learning Disability Intranet Page for information and resources or by looking at the Iportal System to establish if an LD alert is present for that person and if their Hospital Passport is attached (this will be the case for the most complex patients).

3.3 Population covered

Adults (18+) registered to a GP within the Stoke-on-Trent CCG area with a Learning Disability, including supporting young people in transition to adult services.

3.4 Any acceptance and exclusion criteria and threshold

Open referral system to people with learning disabilities and their carers, health and social care professionals, as well as private care providers and those in the third sector.

Referral criteria & sources

Referrals and requests for support are in respect of adults who have a learning disability and are registered to a Stoke-on-Trent GP.

The expectation is that the acute liaison function of the service will ensure a service is provided to children and young people, if capacity allows, to address any urgent issue/s. Contact with paediatrics would be made by the service to ensure steps are taken to reduce any negative impact on the individual with a learning disability.

The service can provide advice and support for individuals not registered locally in terms of ensuring immediate needs are met, however appropriate liaison with facilitation services out of the local area need to take place at the earliest convenience to ensure information is shared and support from their area of residence can be planned from this point as appropriate.

With regard to individuals registered with a Staffordshire GP (North or South Staffordshire), if an individual with a learning disability were to be referred to the Stoke-on-Trent team, they are to be signposted to the Staffordshire team for intervention.

Exclusion

- Adults without a learning disability (18+ years)
- Children and young people (0-18 years) with or without a learning disability unless a transition plan is in place and it is deemed appropriate for the young person to be in adult services
- If the individual is known to the Community Learning Disability Team (CLDT); work required would remain with the CLDT and the Health Facilitation & Acute Liaison Service would work with the CLDT to identify ways forward on a case by case basis as required. To be eligible for the CLDT service, people must meet all least two of the following criteria, and have:

1. A significant learning disability.

2. Complex health need.

3. Difficulties that are critical and substantial in nature which cannot be met via mainstream services.

The CLDT directs services away from 'institutional' responses to such crises as they occur and supports the individual within their everyday surroundings to create and sustain a capable and enabling environment around them.

3.5 Interdependence with other services/providers

- Learning Disabilities Specialist Health Providers
- Clinical Commissioning Group
- Staffordshire and Carers Hub
- Health and social care teams
- Primary Care Teams
- Commissioners of services
- User/Self advocacy groups
- Carers
- Patient Advice and Liaison Service (PALS)
- Acute Care
- Independent and voluntary organisations
- Prisons across Staffordshire (Stoke-on-Trent currently has no adult prisons however it may be appropriate for work to take place if an individual is being released into the area either from an adult setting or a young offenders institute. NB: the responsibility for prisoners lies with the area the prison is based however local information may be sought and communications to support re-integration and local support mechanisms shared).

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

NICE Quality Standards include:

http://www.nice.org.uk/guidance/qualitystandards/qualitystandards.jsp

Smoking rates in people with a serious mental illness

http://guidance.nice.org.uk/QS43

Self-harm

http://guidance.nice.org.uk/QS34

Patient experience in adult NHS services

Service user experience in adult mental health

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

Equality Standards:

Department of Health (2009), Valuing people Now. A new three year strategy for people with learning disabilities. Making it happen for everyone.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/HealthandSocialCareBill/index.htm

Reasonable adjustments

www.ihal.org.uk/projects/reasonableadjustments

The Health and Social Care Act 2012

www.dh.gov.uk/health/files/2012/06/C2.-Factsheet-Tackling-inequalities-in-healthcare-270412.pdf

The Equality Act (section 149)

www.homeoffice.gov.uk/equalities/equality-act/equality-duty/

5.	Applicable quality requirements and CQUIN goals

5.25 Applicable quality requirements (See Schedule 4)

5.26 Applicable CQUIN goals (See Schedule 3)

6.	Location of Provider Premises

The Provider's Premises are located at:

Services to be delivered across the health and social care economy. It is anticipated that this is a Service that will go to the patient and work in what-ever is the most appropriate environment for the patient, rather than a service where the patient would attends a specific Learning Disability Health Facilitation & Liaison Service clinic, to ensure that the best outcomes are met.

Days/Hours of operation

The service should be accessible between Monday – Friday; 9am – 5pm.

Service Specification No.	D01
Service	Neuropsychiatry Service
Commissioner Lead	Joanne Marsh, Senior Locality Commissioning Manager, CCG
Provider Lead	Fiona Platt, Service Manager – Neuropsychiatry & Adult Mental Health Rehabilitation, Specialist Directorate
Period	1 April 2022 – 31 March 2023
Date of Review	As required

1. Population Needs

1.3 National/local context and evidence base

Neuropsychiatry is recognised as a specialism by the Royal College of Psychiatrists, and increasingly it is understood that 'unrecognised and untreated neuropsychiatric problems cause distress to individuals with various chronic neurological conditions, affecting their quality of life and placing excessive burden on their carers (Agrawal et al, 2008)

Nationally, however, there is only a handful of Neuropsychiatry services provided by the NHS, although there is increasing provision through the independent sector.

Recommendations in the NSF for Long Term Conditions (DH, 2005) emphasise the need to develop comprehensive mental health services for this patient group. However, people with emotional and/or behavioural problems as a consequence of their brain injury or disease typically have problems where specialist psychiatric and psychological skills and expertise are required, which are not routinely provided through general mental health services.

In common with all mental health services, services for people with emotional and/or behavioural problems consequences from their brain injury or disease are required to work through the principles of rehabilitation/recovery. Services need to address both the clinical needs of the service user and also provide referral, signposting and support to access universal services that address the determinants of mental ill health. These include housing, employment, financial issues, and relationship and family issues.

Evidence consistently shows a 40-60% prevalence of mental illness in patients referred to general neurology outpatient clinics. The prevalence of neuropsychiatric and neuropsychological problems in various neurological disorders is reported to be 30-50%.

A ‘stratified care’ approach to treatment is recommended for neuropsychiatric disorders to meet the complexity of their needs:

1.The identification, initial management and signposting to appropriate services is usually undertaken by a neurosciences consultant or mental health specialist;

2. Brief therapy interventions in outpatients by clinical/neuropsychology or occupational therapy for example;

3. Complex care with specialist neurology, neuropsychiatry, clinical/neuropsychology, physiotherapy, occupational therapy and speech therapy

4. Complex care with specialist neurology, neuropsychiatry, clinical/neuropsychology, physiotherapy, occupational therapy and speech therapy providing an interdisciplinary service in inpatient setting.

Additional policy that should be applied to the service is;

- Refocusing the Care Programme Approach DOH (March 2008)
- Department of Health 2008, Mental Health Act 1983 Code of Practice
- Department of Health 2005 ‘The Mental Capacity Act’
- Department of Health 2007 ‘The Mental Health Act as amended from the 1983 Act’
- NHS England, The Long Term Plan, January 2019
- Department of Health 2009 The National Dementia Strategy
- Department of Health 2016 Prime Minister’s Challenge on Dementia 2020 Implementation Plan

Local Context

The specification for Neuropsychiatry Services intends to support the commissioning of good quality neuropsychiatric health services within a wider physical and mental health care system.

Huntington’s Disease

Huntington’s disease (HD) is a genetic neurodegenerative disease with symptoms comprising of motor abnormalities, cognitive impairment, behavioural problems, and psychiatric disorders. The

latter are major constituents of the clinical spectrum of HD and have a substantial impact on daily functioning, constituting the most distressing aspect (for both patient and relatives) and often the reason for hospitalisation. Suicide rates in patients with HD are over four times those of the general population. In the UK it is estimated that 12 people per 100,000[17] with the number of people who have the Huntington's gene and are not yet affected being about twice that of those who have symptoms. It has also been documented that prevalence between 33% and 76% of the main psychiatric syndromes may arise in different phases of HD[18]. From a local audit in 2010, there were 77 HD clients know to local Services.

Progressive Neurological Conditions

Parkinson's disease is a progressive neurodegenerative condition. There is no consistently reliable test that can distinguish Parkinson's disease from other conditions that have a similar clinical presentation. The diagnosis is primarily based on a clinical history and examination. Parkinson's disease is one of the most common neurological conditions. It is estimated to affect up to 160 people per 100,000, with an annual incidence in the UK of 15–20 per 100,000[19]. People with Parkinson's often report anxiety or depression as the most distressing aspect of their condition. At any given time, up to 40% of people with Parkinson's will have significant symptoms of depression and up to 40% of people with Parkinson's will experience significant symptoms of anxiety[20]. It has also been reported that a study that 61% of Parkinson patients have a t least one psychiatric symptom, with the most common being depression (38%) and hallucinations (27%)[21]

Multiple Sclerosis (MS) is the most common cause of neurological disability in young and middle-aged adults. MS is an acquired chronic immune-mediated inflammatory condition of the central nervous system (CNS), affecting both the brain and spinal cord. Public Health England has taken data from GP registers and estimated the prevalence of MS being 190 cases per 100,000 population and incidences of between 8 and 11 new cases diagnosed each year in England per 100,000 population[22]

Recent epidemiological studies have found prevalence rates of psychosis in MS that are two to three times higher than those in the general population. Untreated psychosis in patients with MS can adversely impact on adherence to MS medication, levels of disability, and quality of life[23].

The NHS Right Care Toolkit: Progressive Neurological Conditions (August 2019) provides practical advice and guidance on commissioning and providing services to improve the outcomes of people with Progressive Neurological Conditions. The tool kit states that discussion of emotional, psychological and cognitive needs takes place with individuals with any of these conditions.

[17] https://www.alzheimersresearchuk.org/uk-dri-invests-1-5m-million-huntingtons-disease/ (accessed 4th March 2020)
[18] Ricardo Augusto Paoli *et* all. Neuropsychiatric Burden in Huntington's disease. Brain Sci. **2017**, 7, 67;
[19] Parkinson's disease in adults (NG71)
[20] Mental health matters too. Improving mental health services for people with Parkinson's who experience anxiety and depression (May 2018)
[21] Dag Aarsland *et* al. Range of neuropsychiatric disturbances in patients with Parkinson's disease. *Neurol Neurosurg Psychiatry* 1999;**67**:492–496
[22] Public Health England: Research and analysis Multiple sclerosis: prevalence, incidence and smoking status - data briefing (February 2020). https://www.gov.uk/government/publications/multiple-sclerosis-prevalence-incidence-and-smoking-status/multiple-sclerosis-prevalence-incidence-and-smoking-status-data-briefing (accessed 4th March 2020)
[23] Gilberthorpe TG *et al*. The spectrum of psychosis in multiple sclerosis: a clinical case series. Neuropsychiatric Disease and Treatment 2017:13 303–318

Mental health and cognitive status should be reviewed regularly. Patients should have the options of mental health support available made clear to them, and support from specialist neuropsychiatry or neuropsychology services should be available if required.

Epilepsy

Epilepsy is a central nervous system (neurological) disorder in which brain activity becomes abnormal, causing seizures or periods of unusual behavior, sensations, and sometimes loss of awareness. Incidence in the UK is estimated to be 50 per 100,000 per year and the prevalence of active epilepsy in the UK is estimated to be 5–10 cases per 1000[24].

It is estimated that up to 6% of individuals with epilepsy have a co-morbid psychotic illness and that patients have an almost eight fold increased risk of psychosis[25]. Mood and anxiety disorders are the most frequently reported psychiatric problems with prevalence rates up to 50% in selected populations[26].

Acquired Brain Injury

There were 348,453 UK admissions to hospital with acquired brain injury in 2016-17. That is 531 admissions per 100,000 of the population. On local level, in 2016/20177 as a result of an acquired brain injury there was 1409 and 1131 hospital admission for Stoke-on-Trent and North Staffordshire respectively[27].

Young onset Dementia

Dementia is an overall term for diseases and conditions characterized by a decline in memory, language, problem-solving and other thinking skills that affect a person's ability to perform everyday activities. The term young onset dementia (YOD) refers to dementia that first occurs in a person under age 65.

It is estimated that there are at least 42,000 people with YOD in the UK accounting for approximately 5% of all people with dementia[28]. Assuming constant prevalence, this number is projected to increase to over 50,400 by 2025[29]. The table below shows the local prevalence of Young onset Dementia. The Royal College of Psychiatrists recommends that, where mental health services have responsibility for it, the diagnosis or care of people with YOD should be provided by a dedicated YOD service[30].

[24] NG 137 Epilepsies: diagnosis and management
[25] Clancy et al. The prevalence of psychosis in epilepsy; a systematic review and meta-analysis. BMC Psychiatry 2014, 14:75
[26] Mula M. Neuropsychiatric symptoms in epilepsy: an overview. ACNR 2015;15(5):6-8
[27] https://www.headway.org.uk/about-brain-injury/further-information/statistics/statistics-resources/ (accessed 4th March 2020)
[28] Dementia UK Update. Alzheimer's Society, 2014
[29] College Report CR217 Young-onset dementia in mental health services Recommendations for service provision. October 2018
[30] College Report CR217 Young-onset dementia in mental health services Recommendations for service provision. October 2018

CCG	GP registered population	Prevalence (Dementia) December 2018		
		Recorded prevalence (aged 65 years and over)/%[31]	Crude Recorded Prevalence (aged under 65 years) per 10,000[32]	Dementia (aged under 65 years) as a proportion of total dementia (all ages) per 100[33]
North Staffordshire CCG	218,075	4.48	3.11	2.43
Stoke-on-Trent CCG	290,815	5.23	6.91	6.0
Cannock Chase	133,160	4.33	3.74	3.3
East Staffordshire CCG	141,923	3.92	2.42	2.5
South East Staffordshire and Seisdon peninsular CCG	217,850	3.83	3.85	3.6
Stafford and Surrounds CCG	149,092	3.85	3.04	2.6
Staffordshire STP	1,150,915	4.34	4.23	3.7
England	58,383,266	4.33	3.41	3.6

[31] The percentage of patients (aged 65+) with dementia as recorded on all open and active GP practice disease registershttps://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia (accessed 05.02.2020)
[32] The crude recorded dementia prevalence is the number of people with dementia (aged under 65 years) recorded on GP practice registers, as a proportion of all people (aged under 65 years) registered at each GP practice. https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia (accessed 05.02.2020)
[33] Dementia (aged under 65 years) as a proportion of total dementia (all ages) is the number of people with dementia (aged under 65 years) recorded on GP practice registers, as a proportion of all people with dementia registered at each GP practice. https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia (accessed 05.02.2020)

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**x**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**x**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**x**
Domain 4	**Ensuring people have a positive experience of care**	**x**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**x**

Neuropsychiatric conditions are strongly correlated with the patients' quality of life (Domain 2); patient distress & carer burden (Domain 4); prolonged hospital stays (Domain 4); morbidity and mortality (including from suicide as well as earlier mortality from primary neurological conditions) (Domain 1,3) and for those with highly specialised needs, Inpatient and community specialised neuropsychiatry services may be the only setting where neurological and psychiatric care can be provided because of the complexity of the patients' needs which exclude them from adult mental health services or specialised neurology services (Domain 5)

2.2 Local defined outcomes

The expected outcomes are as follows:

- Service Users shall receive timely access to specialist evidenced-based assessment, diagnosis and relevant treatment

- Service Users will have the treatment, interventions and support to manage their mental health and wellbeing, promoting their independence

- A structured patient-centred journey, that results in Service Users improving the management of their conditions and increasing their social functioning and inclusion

- Hospital admissions will be reduced through early detection and working with Service Users and carers to develop effective contingency plans

- Care plans will address physical health needs resulting in the reduction of inequalities in health care

- Care plans will reduce the need for services by promoting self-advocacy, enabling Service Users to move to less intensive service interventions or away from secondary care

- Development of and review of care plans will be co-ordinated to promote inclusion and participation

- Advice, information and support for carers will be provided that helps them maintain their caring role and their own wellbeing

- Service Users and carers shall indicate satisfaction with their experience of this Service

- To support the commissioning and provision of high quality in-patient and community based Neuropsychiatric services as a part of the wider mental health care system

3. Scope

3.1 Aims and objectives of service

The overall aim of the Service is to provide comprehensive, specialist assessment, treatment and rehabilitation for those people who have a neuropsychiatric condition, that is of such intensity or

complexity that the patients' needs cannot be met in general adult mental health services or neurology services alone.

The aim of the community service provision is to support patients to maintain or improve their independence and have the best quality of life possible in the least restrictive environment and advoiding a hospital admission, by providing a responsive specialist community service.

The aim of the inpatient service provision is to support patients to move to, or return to, a community setting appropriate to their needs and preferences, where their needs are of such intensity or complexity that the person cannot safely receive assessment or be treated at home or within a community setting

The Service will achieve this through the following objectives:

- Providing a range of community-based and inpatient therapeutic Services that meet national good practice guidelines for the assessment, treatment and management of neuropsychiatric conditions, long term conditions and mental ill health.

- Providing flexible, responsive, proactive Services that are of a consistently high standard and quality

- Planning for wellbeing, including clear pathways to services, positive problem solving, maintenance and crisis planning

- Providing a range of structured, evidence based interventions within all Service elements

- Maintaining a number of inpatient beds (15) for service users who because of vulnerability or high risk cannot be assessed or treated in a community setting

- Delivering a rehabilitation/recovery model with the focus on providing Service Users with the tools to attain independence and self-determination

- Developing and implementing personalised evidence-based care plans with Service Users and their carers, with measurable outcomes that indicate gains in quality of

life, social inclusion, competence, independence and self-determination, rather than focussing on reduction of symptoms or behaviour.

- Working in partnership with other providers of services to enable Service Users to access universal services such as housing and employment.

- Services are delivered by a workforce that is knowledgeable, skilled and competent that will establish the service as a National Centre of Excellence actively participating in academic and clinical research and audit

- Providers will support a well trained workforce enabled to work with people with complex needs who will work with service users and carers promoting recovery models

- Supporting the vital role of carers and ensures their access to an independent assessment of their needs.

- Establishing a detailed understanding of all local resources relevant to support of individuals with neuropsychiatric issues and promote effective interagency working

- Providing a culturally competent service, including ready access to interpreter services for minority languages and British Sign language

- Establishing effective liaison with local Primary Care Providers, Adult Mental Health Teams, Older Peoples Mental Health Teams, Neurology, Neurosurgery, Rehabilitation Medicine and other referring agents to establish processes to manage complex cases.

- Providing specialist advice and support to other health teams (both mental and physical health), who have case management responsibility for the patient but where a neuropsychiatric view would benefit the patients outcomes.

3.2 Service description/care pathway

Service Description

The Neuropsychiatry Service shall comprise of both inpatient provision (15 in-patient beds) and community provision. The Service shall deliver a spectrum of evidence based diagnostic assessments, treatment, interventions and support to improve and maintain the mental wellbeing of people with neurological conditions, who require support and treatment for psychiatric and psychological, cognitive and behavioral problems arising from their condition.

The Service shall operate a recovery model of service delivery that is focused on preventing disability and maintaining social role, giving service users and carers more control over interventions and support and focusing on outcomes which fit with their aspirations and inclusion in the ordinary life of their community.

The Service will include the following elements:

- Early identification of neuropsychiatry mental health needs and early intervention.
- Community based services that provide evidence based clinical interventions and treatment, education and preventative strategies
- Planning with Service Users and carers to develop discharge plans, wellness plans, crisis prevention and crisis management plans
- Crisis interventions that reduce the impact, severity and duration of the crisis and seek solutions to prevent further episodes of crisis
- Referral, signposting and support to access universal services, including housing, employment, social care, etc.
- Referral, signposting and support to access other health services including primary care (GP) services and universal health services
- .Advice, information and support for carers will be provided that helps them maintain their caring role and their own wellbeing. Care Plans will detail the role of carers and they will be active participants in the reviewing process. Interventions will include assisting carers and families to gain knowledge with regard to service user's mental health diagnosis and who to contact should a crisis arise. Information, advice and support for other service providers
- Complex assessments and diagnostic pathways of services users presenting with neuropsychiatry conditions.
- Teaching and support to other providers/family carers

- All Inpatient referrals are gate kept by the community team
- Direct referrals for HD patients only
- Time limited interventions with clear deliverables and outcomes agreed with the Service User
- A community provision that shall be delivered in either in the Service Users' own home or other community setting that is as close to home as possible.
- An inpatient service of 15 beds for people who cannot be assessed or treated in the community for reasons of vulnerability or high risk and/or the monitoring and management of those detained under the Mental Health Act
- A focus on the development of capable environments to allow people to remain at home
- Where appropriate for individuals care and support will be provided within the principles defined within Care Programme Approach (CPA). Where CPA is not appropriate we will use the same principles to provide high quality care
- Advice, information and support for the workforce of other agencies working with patients who are accessing the service will be provided. Care plans will detail the responsibilities of partner agencies and they will be active participants in the reviewing process
- First contact after allocation will be made with the service user within 3 working days, either face to face or by telephone or letter to make formal arrangements for an assessment to commence.
- Assessments will be commenced within 4 weeks referral.
- Within 18 weeks from the date of referral into the Neuropsychiatry Service users have either been discharged from services, sign posted to an alternative provider, or received a copy of their care/intervention plan.
- Care plans will reflect service user's hobbies and interests improving activities of daily living and social functioning.
- All service users who, post assessment, require the support of the Neuropsychiatry Service will be allocated a Care Co-ordinator under CPA as appropriate
- All Service users receiving support from specialist neuropsychiatric services will be given the opportunity to engage in a documented review of their care plan, at minimum, every 12 months.
- Service users will engage in assessments and reviews against NHS continuing Healthcare Criteria when their needs indicate this requirement
- Mutli-disciplinary Team, (MDT), care plans will be formulated to promote service users discharge and move into primary services where possible
- MDT care plans will detail the reasons for the use of psychotropic medication and assist service users in exploring alternative ways to manage symptoms

- MDT care plans will address physical health needs resulting in the reduction of inequalities in health care.
- MDT care plans will reduce the need for services by promoting self-advocacy, enabling service users to move to less intensive service interventions or away from secondary care.
- The patient and the carer, if appropriate, will be provided with a care plan, in a format that is accessible to the individual.

Services will be accessible by all members of the community, e.g. through appropriate opening times and location and provision of services for vulnerable and socially excluded groups. These might include interpreting/translation services, and facilities for disabled people.

Providers will ensure that the welfare of children deemed at risk is addressed and referrals are made to the appropriate sources to meet the needs of children affected by their career's health issues.

In any instance where relevant operational standards, cannot be applied then all practitioners and managers involved must exercise their professional judgement in the best interest of the Service Users and make defensible decisions and actions, which will be clearly recorded, giving reasons why this occurred

Staffing

The Service will be delivered through a multidisciplinary team. The Provider will support a well trained workforce enabled to work with people with complex needs who will work with service users and carers promoting recovery models

Within the Community element of the Service, the team shall comprise of

- Community Psychiatric Nurses
- Occupational Therapists
- Support Time & Recovery Workers
- Technician support for Occupational Therapy and Physiotherapy
- Consultant neuropsychiatrists
- Junior Doctors

- Neuropsychology

Within the Inpatient element of the service the team shall comprise of

- *Community Psychiatric Nurses*
- Occupational Therapists
- Technician support for Occupational Therapy and Physiotherapy
- Physiotherapy
- Consultant neuropsychiatrists
- Junior Doctors
- Access to neuropsychology

Practitioners will be skilled and welcoming. Staff will, develop a good understanding of Service Users lives and life situations, in which illness is only one aspect; all clinical and non-clinical staff shall be provided with appropriate accredited training in line with individual competencies, and clinical governance to enable staff to provide accurate, impartial advice and support to service users and carers

Discharge Process

A person will be discharged when:

- The agreed interventions/therapy has been completed
- There is agreement by the MDT that the person should be discharged, following discussion with the patient and/or carer
- A discharge summary/letters are produced and sent to the referrer
- A discharge plan is in place
- A support package has been commissioned where necessary
- Post discharge support has been agreed

Client satisfaction questionnaires are used to evaluate the experience of the service upon discharge

Discharge from the inpatient service will be agreed with the service user, their carers, other service providers, and include:

- 7 day follow up
- Support/care arrangements
- Contingency arrangements in case something goes wrong
- Information about who to contact in a crisis
- Contact details

3.3 Population covered

The service is for people who are registered with a general practitioner within the North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups. For people who are not registered with a GP, the service will be open to people for whom the above CCGs are recognised as being responsible commissioners.

If a person is residing temporarily within the area, but are registered with a GP elsewhere (e.g. a student) discussion will need to take place to determine which service is best placed to meet their needs and a shared care agreement may need to be negotiated by the provider.

3.4 Any acceptance and exclusion criteria and thresholds

The services will be provided to adults aged 18 and over (no upper age limit) who as a result of a brain injury or disease are experiencing negative cognition, emotions and behaviour that require treatment, interventions and support. While there is a diverse range of patients that the Service will accept the 4 largest cohorts of patients that access the service are:

- Huntingdon's Disease – over 18 years

- Memory service – 18 years - 60 years. Those over 60 years will be accepted into the Memory Assessment and Diagnostic Service that is also provided by the Provider. This is due to the differences and complexities in the diagnosis pathways for young onset dementia and the specific personal needs of younger people with dementia and their families. These differences include clinico-pathological variations in the aetiology and presentation of young onset dementia that require specialist knowledge and expertise to diagnose and manage.

- Acquired Brain Injury (ABI) – over 18 years

- Neurological conditions with associated neuropsychiatry need (e.g. Parkinson's, MS, and epilepsy) - 18 years - 65 years. This is a diverse range of patients and acceptance will depend on presenting clinical need and the judgment. There should be a clear rational as to why the patients are being refereed into the Service and there should be expected positive diagnostic and therapeutic benefits on a patients' neuropsychiatry presentation by accessing the Service.

The Service does not support people who are under 18 years of age and people whose primary diagnosis is that of substance misuse.

3.5 Interdependence with other services/providers

Delivering a holistic, problem solving approach to the provision of neuropsychiatry services for people with emotional and/or behavioural problems from their neuropsychiatry diagnosis will require a wide network of relationships with other mental health, primary care and universal services across the statutory, independent and voluntary sectors. The development of individually tailored patient pathways will require an interdisciplinary approach within the specialist team, support for service users to access other services, and support for other service providers to work with people with these conditions. The whole systems approach is inclusive of carers and family members and plans will include consideration of home circumstances and referral to other services where appropriate.

The Service work shall work closely with voluntary sector organisations such as the Huntington's Disease Association and Headway, to receive feedback from patients and their carers so as to continually update service provision.

Key interdependencies will be between clinical networks at University Hospital of North Midlands (UHNM), the Social Care departments of Stoke-on-Trent and North Staffordshire, and North Staffordshire Combined Healthcare NHS Trust Adult, Learning Disability & Older Peoples Mental Health services.

The service shall work with the relevant clinical networks and screening programmes and tools for neurological conditions, where they are available.

A service level agreement is in place for Speech and Language Therapy (HD community and inpatient patients) and Dietetics (inpatients only).

Training/Education/Research Activities

Individual members of the MDT shall be involved in training/education and research in line with their individual job descriptions.

Staff deliver training in many different forms: from macro level of formal teaching & lectures, through to workshops (with groups of staff) and at the micro level of individual skills teaching etc. with service users.

In addition, the Service shall support Nurse Education (via specialist placements) and the training of post graduate Doctoral level trainee Clinical Psychologists, Occupational Therapy students and Medics

Research activity is a specific area of expertise within the Service. Projects of different types are undertaken via individual clinicians and by supporting trainee psychologists in their Doctoral research as well as audits.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

4.3 Applicable local standards

The Provider will ensure that the policies and procedures of the organizations are adhered do and followed:

- Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board
- *Stoke*-on-Trent and *Staffordshire* Local *Safeguarding* Children *Board*

5.	Applicable quality requirements and CQUIN goals

5.27 Applicable Quality Requirements (See Schedule 4)

5.28 Applicable CQUIN goals (See Schedule 3)

6.	Location of Provider Premises

The Provider's Premises are located at:

The Community Services are based at the Bennett Centre Richmond Terrace, Shelton, Stoke-on-Trent ST1 4ND

The Inpatient Services (15beds) shall be provided at Harplands Hospital, Hilton Rd, Stoke-on-Trent ST4 6RR

The Inpatient Unit will operate a 24 hour, year round service.

Community Services will operate 9-5 Monday to Friday.

Out of Hours cover and crisis support will be provided via the Access Team and Acute Home Treatment Team.

Service Specification No.	D02
Service	Clinical Health Psychology / Pain Psychology
Commissioner Lead	Jo Marsh, Senior Commissioning Manager
Provider Lead	Fiona Platt – Interim Associate Director
Period	01 April 22 – 31 March 23
Date of Review	As required

1. Population Needs

1.1 National/local context and evidence base

National Context

People with long-term physical health conditions are two to three times more likely to experience mental health problems, with depression and anxiety disorders being particularly common. Many experience psychological difficulties – for example, in relation to adjusting to their diagnosis, living with symptoms and with the impact on their social role and functioning, or managing side effects.(Kings Fund -10 priorities for integrating physical and mental health- 2016).

The NHS spends at least £1 in every £8 spent on long-term conditions linked to poor mental health and wellbeing with higher levels of anxiety, depression and other mental health problems which in turn reduce people's ability to monitor and manage their physical health (King's Fund, 2012). Having co-morbid physical and mental health difficulties delays recovery from both and significantly impairs quality of life (Joint Commissioning Panel for Health, 2020). Psychological therapy reduces physical healthcare costs by average of 20% (meta-analysis of 91 studies)

Appropriate psychological therapies have been shown to significantly improve quality of life for people with long term conditions (see review Anderson & Ozakinci, 2018), reduce hospital use (e.g. Taylor et al., 2019), improve physical health, reduce distress and mood problems, decrease impact on employment and improve independence as some key examples (NHS Confederation, 2012).

The NHS Long Term Plan(January 2019) has set a number of priorities over the coming years from mental health, including supporting people with long term conditions and including access to psychological therapies and personalised and trauma-informed care.

Mental Health Five Year Forward View: priorities for 2020/21 include the ambition to increase access to evidence-based psychological therapies to reach 25% of need, helping 600,000 more people per year.

Local Context

Staffordshire Health and Wellbeing Strategy 2018-2023 identified that out of every 100 people in Staffordshire 19 have long-term illness or disability (nearly 1 in every 5 people).

Out of every 100 people in Staffordshire 9, live in one of the 20% most deprived areas nationally (nearly 1 in every 10 people).

Stoke-on-Trent is characterised by high levels of deprivation and is currently ranked the 14th most deprived local authority (out of 326) in England, with life expectancy for both men and women being lower than the national average. The prevalence for Long Term Condition is generally higher in Stoke-on-Trent compared to the England average (Stoke-on-Trent Joint Strategic Needs Assessment 2019)

People with long-term conditions and co-morbid mental health problems disproportionately live in deprived areas and have access to fewer resources of all kinds. The interaction between co-morbidities and deprivation makes a significant contribution to generating and maintaining inequalities.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term conditions	x
Domain 3	Helping people to recover from episodes of ill-health or following injury	x
Domain 4	Ensuring people have a positive experience of care	x

2.2 Locally Defined Outcomes

The expected outcomes are as follows:

- Service Users shall receive timely access to specialist evidenced-based assessment, diagnosis and relevant treatment

- Service Users will have the treatment, interventions and support to manage their mental health and wellbeing, promoting their independence

- A structured patient-centred journey, that results in Service Users improving their management of their conditions and increasing their social functioning, inclusion, and quality of life.

- A reduction in presentation within acute health care and primary care settings as Service Users develop effective contingency plans

- Care plans will reduce the need for services by promoting self-advocacy, enabling Service Users to move to less intensive service interventions or away from secondary care

- Development of and review of care plans will be co-ordinated to promote inclusion and participation

- Service Users shall indicate satisfaction with their experience of this Service

A number of clinical outcome measures and clinical tools shall be utilised by the Service to monitor the progress of patinets who access the Service.

3. Scope

3.1 Aims and objectives of service

The overall aim of the Service is to provide timely and responsive psychological service to the people of Stoke-on-Trent and North Staffordshire who are experiencing mental health problems (for example distress, mood or adjustment problem) to a level above primary care therapeutic intervention, that are directly related to living with a diagnosed physical health condition.

Clinical Health Psychology is the branch of psychology that addresses the link between long-term health conditions and psychological distress. By delivering a high quality, patient-centred service, the Service aims to enables people with mental health problems to improve their well-being and functionality, thereby reducing the need to access other mental health and physical health services.

The Service will achieve this through the following objectives:

- Increase the proportion of people who are identified, assessed and receive treatment in accordance with NICE guidance/evidence based psychological care by appropriately qualified clinicians;
- Provide tailored individual care plans describing anticipated treatment and discharge planning;
- Improve the proportion of people who make clinically significant improvements or recover;
- Improve emotional wellbeing, quality of life and functional ability in people with physical health problems;
- Services are delivered by a workforce that is knowledgeable, skilled and competent
- Services are delivered in a number of innovative ways so as to ensure the continuity of provision
- Improve the experience of Service Users and their carers;
- Effective joint working across physical health and mental health teams.

3.2 Service description/care pathway

The Service is for adults with one or more long-term physical health conditions including chronic pain causing or exacerbating distress to a level above primary care level therapeutic intervention. Often patients have complex presentations, suffering with multiple changes in their physical health, which have developed in the context of longstanding mental health difficulties / challenging life events.

There shall be 2 main aspects to the Service that will follow different pathways, depending on a patient's needs:

1. Clinical Health Psychology Pathway(see appendix 1)
2. Pain Psychology Pathway(see appendix 2)

Referrals are accepted for outpatients over the age 18 with psychological difficulties related to their physical health diagnoses that:

- Are unlikely to resolve over time without intervention
- Influence their physical health and can lead to elevated healthcare utilisation
- Interfere with life activities/medical treatment
- Cannot be adequately treated via the IAPT Wellbeing Long Term conditions or standard mental health interventions.

A range of interventions shall be offered, that shall include psychological approaches to managing and adjusting to illness, disability or chronic pain, and interventions for medically caused trauma. These shall be delivered either as group sessions or on an individual basis depending on clinical need. Both group and individual sessions shall be offered in-person or virtually depending on need.

Interventions offered by the Service include one-to-one cognitive behaviour therapy (CBT), acceptance and commitment therapy (ACT), compassion-focused therapy (CFT) and integrative therapy as required.

Pain Psychology Pathway

Group intervention is the primary offer for chronic pain. There are two levels of group:

1. Living Well with Pain is an eight session ACT group intervention for those with complex mental health needs such as trauma, voice hearers and personality disorder diagnosis.
2. Breathworks Mindfulness for Pain group is a six session programme for those with lower levels of complexity who can safely engage with that model.

Referrals shall be accepted from General Practice, IAPT services or internally (step up or across) to North Staffordshire Combined Health Care (NSCHT). Self-referrals and direct referrals from UniUHNM are not accepted.

3.3 Population covered

Clinical Health Psychology Pathway:

The Service is for people (aged 18 years and over) who are registered with a General Practice within the Stoke-on-Trent and North Staffordshire CCG Locality.

Pain Psychology Pathway:

The Service is for people (aged 18 years and over) who are registered with a General Practice within the Stoke-on-Trent CCG Locality. (Note: Patients who are registered with a North Staffordshire GP are able to access the IMPACT service that is provided by Midlands Partnership NHS Foundation Trust (MPFT).

3.4 Any acceptance and exclusion criteria

Acceptance for the Clinical Health Psychology Pathway:

- Psychological distress of a significant and disabling nature directly linked to adjustment / living with LTC
- Motivated, understands the focus of work and remit, commits to attend
- Able to consider psychological perspective to own distress and experience of health
- Any complex mental health needs are well-managed by an appropriate team

Acceptance for the Pain Psychology Pathway:

- Chronic pain is the main feature requiring psychological intervention
- Medical needs regarding pain management are adequately and appropriately managed e.g. diagnosis, prescription of painkillers, provision of medical interventions via pain clinic.

Exclusion criteria for the Service are:

- Inpatients
- Direct referrals from UHNM
- Patients actively undertaking therapy from another service
- Patient awaiting or expecting medical 'cure' for symptoms
- Patients whose presentation is predominantly psychiatric, social or otherwise not primarily related to living with the health condition
- At high risk of suicide / serious harm to self / others or considered in crisis / urgent
- Patients whose primary physical health issue is neurological
- Patients with health anxiety regarding a condition they are not diagnosed with

3.5 Interdependencies with other services

The Service shall work closely with other key stakeholder services that provide physical and mental health care for this cohort of patients in a co-ordinated and integrated way.

In particular, the IAPT Services in Stoke-on-Trent and North Staffordshire, where good referrals pathways already exist to step people up or down as appropriate (including regular referral meetings and/or telephone consultation) shall work in an coordinated way.

There shall be a co-ordinated approach between other services within NSCHT, such as:

- Access Team (to facilitate referrals)
- CAMHS for young people who are approaching eighteen years of age,
- Mental Health Liaison for discharge planning and
- High Volume Users Team.

In addition, consultation shall be provide internally to these above services.

The Service shall also look to develop closer working practices and pathways with those services that focus on the physical care of patients, such as GPs, University Hospitals of Norths Midlands NHS Trust (UHNM) and MPFT.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- Motor neurone disease: assessment and management 2019
- Depression in adults with a chronic physical health problem: recognition and management, 2009
- Type 2 diabetes in adults: management, 2019
- Renal replacement therapy and conservative management, 2018
- Common mental health problems: identification and pathways to care, 2011

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

Royal College of Physicians – Complex reginal pain syndrome in adult – UK guidelines for diagnosis, referral and management in primary and secondary care 2018

https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps02_2015.pdf?sfvrsn=e0e9bbd_4

British Pain Society, Core Standards for Pain Management Services in the UK, 2015

Royal College of Psychiatrists - Providing evidence-based psychological therapies to people with long-term conditions and/or medically unexplained symptoms, 2015

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4)

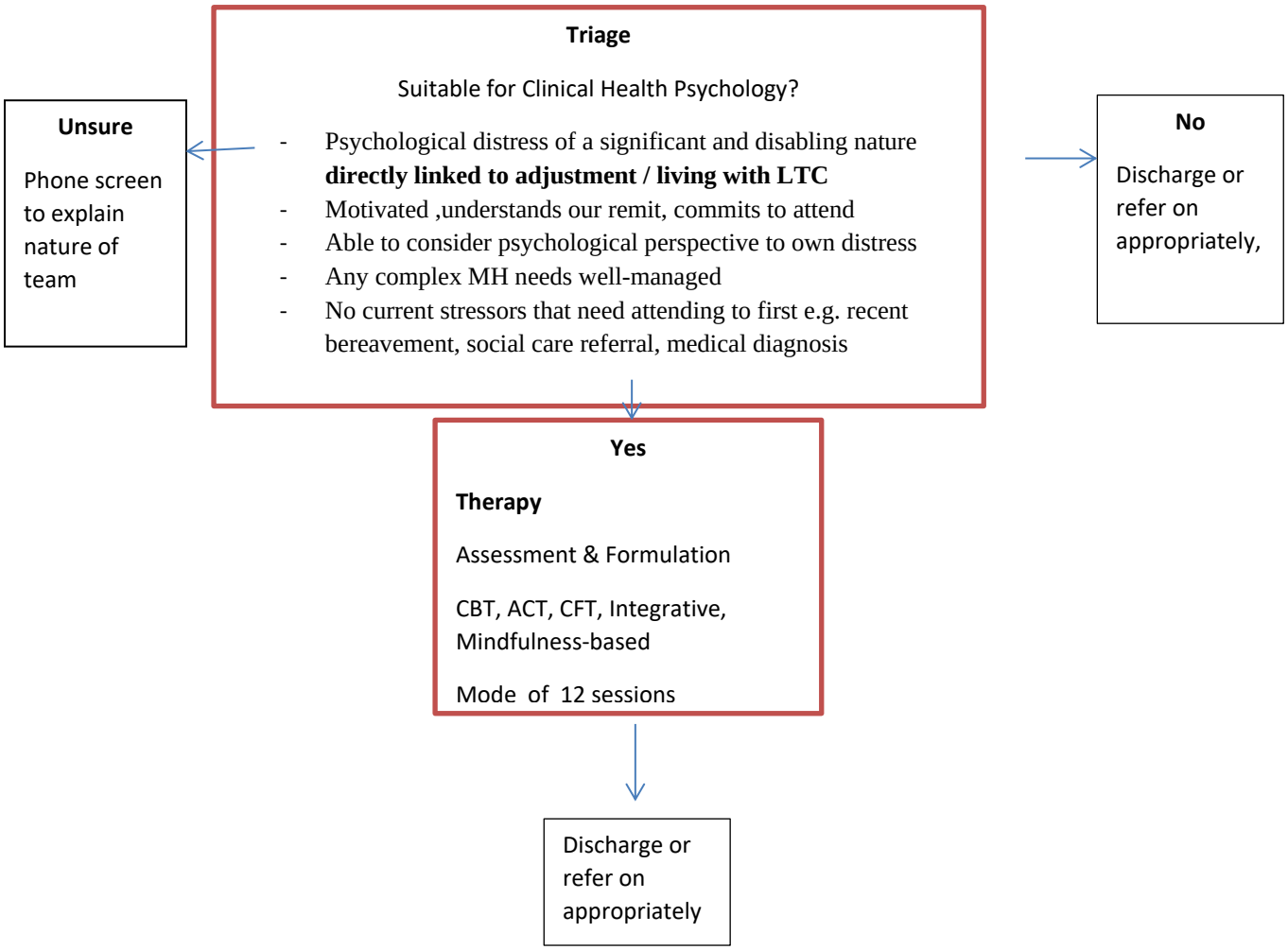
5.2 Applicable CQUIN goals (See Schedule 3)

6. Location of Provider Premises

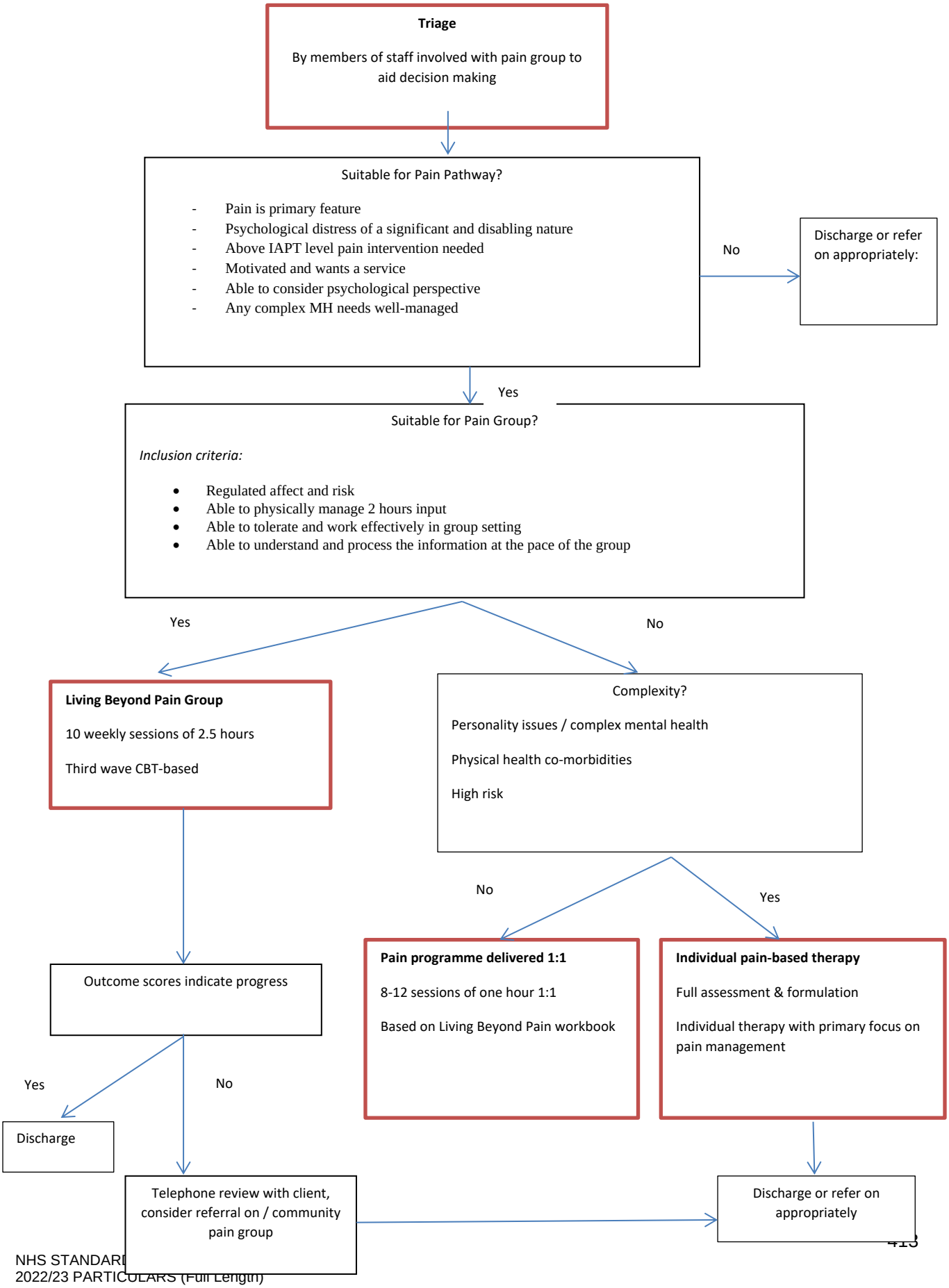
The Provider's Premises are located at:

Bennett Centre, Richmond Terrace, Shelton, Stoke on Trent ST1 4ND

Appendix 1: Long Term Conditions Pathway



Appendix 2: Pain Psychology Pathway



Service Specification No.	E01
Service	Children's Learning Disability Respite Service/Specialist Short Breaks- Dragon Square
Commissioner Lead	Joanne Marsh, Senior Locality Commissioning Manager, CCG
Provider Lead	Sharon Parkes, Service Manager - Learning Disabilities and CAMHS IP
Period	01 April 2022 to 31 March 2023
Date of Review	As required

1. Population Needs

National/local context and evidence base

National

- Transforming services for people with a learning disability and/or autism. Planning Guidance and Support (Dec 2015)
- Every Child Matters (2003)
- Every Disabled Child Matters
- National Service Framework for Children, Young People and Maternity Services 2004 (with particular reference to standard 8)
- Health and Social Care Bill (2012)
- Children and Families Bill Guidance 2013
- Disability Discrimination Act (1995)
- Public Sector Equality Duty (2011)
- The Breaks for Carers of Disabled Children Regulations 2010
- Achieving Equity and Excellence for Children (2010)
- NHS Outcomes Framework 2013 – 2014 (2012)
- Children & Families Bill 2013 (draft)
- Together for Shorter Lives 2013

- Working together to Safeguard Children 2010

Numerous National guidance/publications and research exists which identifies the significant positive impact that short breaks for children with disabilities has upon them and their families. Examples:

- Centre for Excellence and outcomes in CYP services
- Mencap
- Aiming High for Disabled Children : Better Support for Families 2007

Local

- North Staffordshire Combined Healthcare NHS Trust Clinical Quality Strategy 2013-2016
- Stoke on Trent Children and Young People's Strategic Partnership: Children Young People and Families Plan 2013-2016
- Stoke on Trent Short Break Services Statement
- The Staffordshire Children, Young People and Families Plan
- Staffordshire Short Break Services Statement

Evidence Base

Children and Young People with Learning Disabilities

Learning Disability is one of the most common forms of disability and is a lifelong condition with a wide spectrum of need. It can be acquired before, during or soon after birth and affects an individual's ability to learn.

There are no official statistics reporting the population with a learning disability. Various sources have been used to estimate the numbers of people with learning disabilities across Staffordshire and Stoke-on-Trent:

The school census collects data on young people with special educational needs and disability (SEND). Based on the latest data (January 2015):

- 14% of pupils in schools in Staffordshire and Stoke-on-Trent have identified special educational needs (equating to 23,200 pupils).

- 3% of pupils in schools in Staffordshire and Stoke-on-Trent have statements or education, health and care (EHC) plan (equating to 4,800 pupils).
- The numbers of pupils with their primary type of need being a learning disability were: 2,210 (specific), 6,420 (moderate), 670 (severe) and 200 (profound and multiple). The total makes up around 6% of all pupils across Staffordshire and Stoke-on-Trent which is higher than the national average of 5%. Around 1,170 pupils (1.1%) also have autistic spectrum disorder which is similar to the England average (also 1.1%).

In Staffordshire there are:

- 13,079 Children on SEN support
- 2,586 Children in a special school/pupil referral unit
- 316 Other local authority pupils in our special schools
- 3,469 Children with a statement of educational needs
- 350 Children with an education health and care plan and of those we have 135 children in an out of county independent and non -maintained placement which is an 11% increase.
- 199 Children in receipt of Direct Payments with a Learning disability or Autism;
- Children in receipt of Direct Payments with a Learning disability or Autism;

Children in receipt of Direct Payments with a Learning disability or Autism;

Age today	**CYP**
4	**1**
5	**6**
6	**8**
7	**11**
8	**5**
9	**16**
10	**15**
11	**24**
12	**19**
13	**21**
14	**18**

15	**18**	
16	**16**	
17	**19**	

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Local	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	

2.2 Local defined outcomes

Maintenance of the family unit, helps to support family members retain and obtain optimum health themselves, as a result of being provided with a break from their caring role.

3. Scope

3.1 Aims and objectives of service

The service aims to provide planned short break care for children and young people, who have a Severe Learning Disability and additional complex healthcare needs, relating to their nursing/medical needs and/or complex behavioural needs living in Stoke-on-Trent and North Staffordshire, also providing a service to a small number of children and young people who live in South Staffordshire.

This short break aims to meet the family's need for a break from their caring role, which supports the maintenance of the family unit and helps to support family members retain and obtain optimum health themselves.

The Service aims to provide a stimulating, safe and caring environment to meet emotional, developmental, and social needs for the children accessing the service during their short break.

3.2 Service description/care pathway

The service is a 6 bedded residential service which offers planned short break care (overnight stays and day stays), and during the short break stay a range of nursing interventions to meet individually assessed nursing, medical and behavioural needs for children, who have a Severe Learning Disability and additional complex healthcare needs.

Day stays are offered children who also access overnight stays, and to children who are being introduced to the service as part of their assessment and settling into the service.

Children who access this specialist service are usually unable to access other forms of short breaks due to their complex needs.

The service operates over 7 days for 50 weeks per year

If the child lives in Stoke-on-Trent or Staffordshire the referral pathway for the service is part of a multi agency pathway for short breaks and holistic care package co- ordination in each Authority. The multi agency resource panels are an essential aspect of the pathway.

- Once a decision is made to offer a short break contacted will be made with the family within 14 days and a visit arranged to the service.
- The child and family are provided with an information pack about the service
- If the family wish to continue with the process, a series of planned introductory visits are arranged for the child and family, a plan of stays is then agreed with the family and each stay is reviewed with the family, before there is an increase in the level or types of stays.

If children fail to access the service when a planned stay has been arranged the names nurse will contact the family, and/or visit them at home to resolve any difficulties there may be.

Stays are planned for the following year in November, parents are asked for requests for stays at this time, and length and amount of stays are based on individual assessment and

the needs of the child and family. Families receive an annual plan of their planned short breaks in December for the following year.

The service operates a “move on” bed system, which enables emergency admissions to be accommodated.

At the time of transition, 16/17 years or before the transition process is supported and referral made to appropriate adult services following review and assessment, if this is not already in place. Many Children and young people will already have a multi agency transition plan in place which will include the provision of short break care.

This will include an allocated adult Care Social worker of Transitional Social Worker.

Most young people will transition to short break adult care provided by the Local authority, and the referrals for this will be made by the Social Worker. The service at Dragon square will provide information and appropriate support to the young person during the transitional period.

Transport is provided for children accessing Dragon Square, to and from their school each day. This is an integral part of the service, and essential to ensure maintenance of their education, during their short break. Transport is provided by an independent provide through a contract with the Trust. The income comes from the block managed centrally rather than at service level, as part of trust wide transport costs

3.3 Population covered

Short breaks are provided for children and young people who live in Stoke –on-Trent, and North Staffordshire (Newcastle and Moorlands), Registered with a Stoke -on- Trent or North Staffordshire GP; the service also provides a service to a small number of children and young people who live in South Staffordshire. Children can access the service until they reach their 19th Birthday, although most will have made the transition to adult short break services during the year leading to this.

3.4 Any acceptance and exclusion criteria and thresholds

Children and Young people are required to meet the following criteria to access the service.

- Have a Severe Learning Disability and additional complex health care nee ds that require 24 hour registered nursing care whilst they are way from home. These additional needs may include some of the following:
- The need for the administration of frequent rescue medication for Epilepsy
- Complex feeding needs such as NG tube feeding /PEG
- The requirement for CPAP/CNEP/ oxygen therapy
- Complex medical conditions which are difficult to stabilise, such as Type 1 diabetes/kidney disease/heart disease & failure etc.

And/or

- Significant challenging behaviour, related to their severe L earning Disability observed across almost all settings such as severe pica, aggression/violence, self injurious behaviour, faecal smearing. These CYP will usually already be in receipt of specialist therapeutic interventions prior to referral. The behaviour would be of such severity, frequency and duration that therapeutic intervention from registered LD nurses is required to manage this when the child is away from home.

The service does accept children in the pre school years, from the age of 4 although their package of care will be more limited until they reach school age. ie. day stays only.

CYP who meet the criteria for the service will usually be unable to access other forms of short breaks due to their complex needs.

3.5 Interdependence with other services/providers

The service will work in a Team Around the Child approach, with key relationships with social care and education.

Children and Young People accessing the service are reviewed regularly on a multi agency basis and their needs reassessed, to ensure the service is still meeting needs. If the service is assessed as no longer meeting the child's needs referrals will be made to more appropriate services and the service provides transitional support to ensure that any change happens in the most sensitive and appropriate way for the child and the family. A number of professionals are involved in the reviews and care of the children, such as Social Workers, Education, Dietetics, Psychologists, Community LD Nursing, PAMS, and Paediatricians etc. Services are accessed for the CYP during their care as required.

There is close collaboration and liaison particularly with the CAMHS-Disability

service. The senior Nurse/Registered Care Manager for the service also holds a post within the CAMHS-Disability team, and line manages members of this service. Therefore

Occupational Therapists, Community Learning Disability Nurses, Psychologists and Psychiatry are actively involved in the care provided to many of the Children and Young People accessing the service at Dragon Square.

The service shall contribute to EHC assessments for CYP known to the service, this will include providing reports/ information regarding identified health needs and provision required in line with the specified timeframes.

The service shall review EHC draft plans for which they have provided information to quality assure the accuracy of the information included in line with the specified timeframes.

The service shall engage and work in conjunction with the Designated Clinical Officer (DCO) for Special Educational Needs and Disabilities (SEND) to ensure compliance with statutory requirements.

At the time of transition, 16/17 years or before the transition process is supported and referral made to appropriate adult services following review and assessment, if this is not already in place. Many Children and young people will already have a multi agency transition plan in place which will include the provision of short break care. This will include an allocated adult Care Social worker of Transitional Social Worker. Most young people will transition to short break adult care provided by the Local authority, and the referrals for this will be made by the Social Worker. The service at Dragon square will provide information and appropriate support to the young person during the transitional period.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

Nice Guidance:

- Feverish illness in children CG160
- Epilepsies in Children and young people QS27 Diarrhoea and Vomiting in Children CG84 Constipation In CYP CG99
- Vagus Nerve Stimulation for Children and young People Nocturnal enuresis CG111 October 2010
- Autism in children and young people CG128 Sept 2011

- Social and emotional wellbeing PH40 October 2012
- Autism: management of autism in children and young people August 2013-09-13 Challenging behaviour in people with learning disability expected May 2014

5. Applicable quality requirements and CQUIN goals

5.29 Applicable Quality Requirements (See Schedule 4)

5.30 Applicable CQUIN goals (See Schedule 3)

6. Location of Provider Premises

The Provider's Premises are located at:

Bungalow 4/5

Dragon Square Community Unit

Chesterton Newcastle Staffordshire

ST5 7HL

Service Specification No.	E04
Service	Community CAMHS
Commissioner Lead	Joanne Marsh, Senior Locality Commissioning Manager, CCG
Provider Lead	Fiona Platt, Jane Munton-Davies, Josey Povey & Rachael Birks
Period	01/04/2022 - 31/03/2023
Date of Review	**See 22/23 SDIP**

1. Population Needs

1.4 <u>Purpose, introduction and context</u>

The purpose of this document is to specify the provision of Children and Young People's Mental Health Services (CAMHS) in the community. This document will specify the provision of a range of care pathways for children and young people experiencing moderate to severe mental health issues. For Stoke on Trent, this will include an offer for those children and young people from particular vulnerable groups, (including looked after children and young people and young offenders). For both North Staffs and Stoke, priority will also be given to those who have experienced (or who are at risk of) sexual exploitation).

Services for children, young people should place them and their families/carers at the heart of everything they do.

1.5 <u>National/local context and evidence base</u>

There has been universal acknowledgment in policy over the past ten years of the challenges faced by children and young people in developing resilience and psychological wellbeing. For those children and young people with diagnosable mental health problems and their families/carers and the agencies that support them, the challenges are greater. A number of disorders are persistent and will continue into adult life unless properly treated. It is known that 50% of lifetime mental illness (except dementia) begins by the age of 14 and 75% by age 18.

Young people who are not in education, employment or training report particularly low levels of happiness and self-esteem. The Macquarie Youth Index 2014 reported that 40% of jobless young people have faced symptoms of mental health difficulties as a result of being out of work, and one-third of long-term unemployed young people have contemplated suicide. The Healthy Children, Safer Communities

Strategy[34] states that over a third of children and young people in the secure estate for children and young people have a diagnosed mental health disorder.

The mental health of children and young people in the Great Britain survey, last conducted in 2004[35], estimated that:

- 9.6% or nearly 850,000 children and young people aged between 5-16 years have a mental disorder
- 7.7% or nearly 340,000 children aged 5-10 years have a mental disorder
- 11.5% or about 510,000 young people aged between 11-16 years have a mental disorder
- YoungMinds Impact report (2014) identified five key issues that impact on young people's mental health – lack of access to help, sexual pressure, bullying, school stress and unemployment *(http://www.youngminds.org.uk/assets/0001/8154/Impact_Report_2014.pdf)*

Effective evidence based treatments have been identified to improve the life chances of children and young people, and to minimise the impact on the long-term health of the population and economic cost to the public purse.[36]

As children and young people's emotional wellbeing and mental health affect all aspects of their lives, no one service alone will be able to meet their needs. There is a duty of cooperation placed on commissioners and services to work together to the benefit of children and young people.

The Provider shall follow guidance which may impact on CAMHS, for example, *Looked After Children (https://www.nice.org.uk/Guidance/PH28)* NICE and other Guidance.

34 http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/PublicationsandstatisticsPublicationsPolicyAndGuidance/DH_109771

35 Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005). Mental health of children and young people in Great Britain, 2004. A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive. Basingstoke: Palgrave Macmillan http://content.digital.nhs.uk/pubs/mentalhealth04

36 Department of Health, HM Government, 'No Health without Mental Health. A cross governmental strategy for people of all ages', Crown Copyright (2011)
Green et al, Mental Health of children and young people in Great Britain, Office of National Statistics (2004)
Kim-Cohen, J. et al, 'MAOA, maltreatment, and gene–environment interaction predicting children's mental health: new evidence and a meta-analysis', Molecular Psychiatry (2006) v.11, 903–913
The Prince's Trust Macquarie, Youth Index 2014, Prince's Trust (2013)

The Provider shall link with children's partnership arrangements, the duty of cooperation and joint commissioning arrangements for wider children's services.

Children and Young People's Improving Access to Psychological Therapies

CYP IAPT involves transforming mental health services for children and young people and their families/carers. The programme is centred on the principles of offering effective and efficient evidence-based, outcome focussed treatments within a collaborative therapeutic relationship, and with full participation of children, young people and their families and carers in service delivery and design.

These aims are met through a focus on:

- Meaningful participation with children, young people and families/carers embedded within all services and within local, regional and national service planning and development
- A range of high quality treatments delivered by staff trained to expert level in evidence based therapeutic modalities
- Greater accessibility to evidence based interventions for children and young people
- A culture of clinically relevant session by session outcome monitoring embedded within routine practice and used to select, guide and evaluate treatment interventions and support collaborative shared decision-making.

Providers should be aware that carers have an entitlement to information and support in their own right. These are covered in the Care Act (2014) and Children and Families Act (2014). Carers can be caring for a child or young person eligible for CAMHS support or they can themselves be in need of or eligible to use CAMHS services (young adult carers – up to age 25).

What children, young people and families/carers tell us they want from CAMHS and other stakeholders:

Nationally

Consultation with parents and carers about experiences of the children's and young people's Improving Access to Psychological Therapies (IAPT) programme[37], showed these prominent themes:

- Access - long delays in getting to CAMHS, often due to a lack of recognition by health professionals including GPs of the seriousness of the child's problems; coupled with long waits for the service

[37] The involvement of parents and carers in Children and Young People's Mental Health Services, GIFT (2014)

- Family/carer journeys – parents/carers felt frustrated by the need to fight for access for their child and by the lack of consistency in practitioners
- Involvement and support –parent/carers need to be involved and valued in caring for their child but their own needs for support must to recognised too
- Language and information sharing – parents/carers felt frustrated by practitioners inability to use plain words and tendency to patronise. Some parents/carers also felt that judgemental and blaming language was used
- Cultural sensitivity – some practitioners failed to understand the cultural context in which a child was living and to recognise when parents/carers need support to adapt their parenting skills

Locally

The Emotional Wellbeing and Mental Health of children and young people from birth to 18 years Stoke-on-Trent Commissioning Strategy 2015-18 identified that:

Children, young people and adults supporting them want:

- A Single Point of Access (SPA) or hub which is easily accessible to anyone for information, real time professional advice, reassurance and guidance from a mental health practitioner, support in deciding whether a referral to a mental health service is needed and support when there is a crisis.
- More training so that those in contact with children and young people know what to look for and how to provide or find support when there are emerging mental health issues.
- Clearer signposting to available support whilst waiting for appointments.
- Information on the options available and guidance to navigate the range of service provision and pathways available.
- Evidence based interventions that are appropriate, with follow up support as needed. Right service first time.
- Face to face support to be delivered in young people friendly settings and not from clinics or office settings.
- Greater use of technology and access to support on line outside of the school/working day.
- More support from schools, via PHSE and direct interventions on the school premises, in the school day, such as counselling, peer mentors and quiet spaces.
- Short waiting times when access to services is needed.
- Clearer step up/step down as emotional and mental health needs change and fluctuate.
- More early support from non-mental health practitioners and their peers and/or older mentors.
- Increased public awareness of mental health issue generally.

- Not to be stigmatized when seeking and accessing help.

The Emotional Wellbeing and Mental Health of children and young people from birth to 18 years Staffordshire Integrated Commissioning Strategy 2014-18 identified that:

- Engagement has highlighted that it is important to Children, Young People and their Families to be listened to when Emotional Wellbeing and Mental Health difficulties are identified.
- Children and Young people were particularly keen for Emotional Distress not to be dismissed as "naughty" or "typical teenage" behaviour.

It was also highlighted that professionals should be equipped to recognise and respond to Children and Young People in emotional distress. Having quick access and choice about the services offered was also important

Financial cost of children and young people's mental health problems

The costs incurred to the public purse of not treating children and young people early in their lives are considerable and result in an increased cost to the public purse and to wider society.

For example:

- A study[38] estimated additional lifetime costs of around £260,000 per case – or around £5.3bn for a single cohort of children in the UK. These costs include those relating to crime (71%), mental health disorders in adulthood (13%) and differences in lifetime earnings (7%).
- There are clinically proven and cost-effective interventions. Taking conduct disorder as an example, potential life-long savings from each case prevented through early intervention have been estimated at £150,000 for severe conduct problems and £75,000 for moderate conduct problems.[39]
- The costs of providing safe and effective interventions associated with supporting children and young people in the community with crisis support or outreach can be considerably less than those associated with inpatient care.
- In 2012/13, it was estimated the total NHS expenditure on dedicated children's mental health services was £0.70bn.

The impact of mental health disorders extends beyond the use of public services and incorporates the impact of antisocial behaviour and crime on communities etc. Taking this wider societal viewpoint, it has

[38] Friedli L, Parsonage M (2007). Mental Health Promotion: Building an Economic Case. Northern Ireland Association for Mental Health.

[39] Friedli, L. & Parsonage, M. 'Mental Health Promotion: Building an Economic Case Northern Ireland Association for Mental Health, NIAMH (2007)

been estimated that the overall lifetime costs associated with a moderate behavioural problem amount to £85,000 per child and with a severe behavioural problem £260,000 per child[40].

Caring for a child or young person with mental health issues has a negative impact on the physical and mental health of the carer. Carers save the public purse a significant amount of money. Whilst there is no information on carers of children and young people, Carers UK have shown that carers save the UK economy £132 billion per year and the damaging effect caring has on health:

http://www.carersuk.org/news-and-campaigns/press-releases/facts-and-figures

The national vision[41] is for everyone who works with children, young people and their families/carers to be:

- ambitious for every child and young person to achieve goals that are meaningful and achievable for them
- excellent in their practice and able to deliver the best evidenced care with integrity and openness
- committed to partnership and integrated working with children, young people, families and their fellow professionals
- are respected and valued as professionals
- promote equality, diversity and inclusion and reduce inequalities
- practicing with cultural sensitivity and awareness

1.6 Sources of Information and Support

The Staffordshire and Stoke on Trent CAMHS Transformation Plan can be found at:

http://www.northstaffsccg.nhs.uk/search/Text%20Content/staffordshire-and-stoke-on-trent-local-transformation-plan-for-child-and-adolescent-mental-health-services-published--3361

Summary of local CAMHS Needs Assessment 2014 – Stoke on Trent

It is important to review the existing sources of needs assessment and analyse data in order for us to look at how this may inform future priorities, outcomes and commissioning intentions. There is a

[40] Parsonage M, Khan L, Saunders A (2014). Building a better future: the lifetime costs of childhood behavioural problems and the benefits of early intervention. London: Centre for Mental Health
[41] Future in Mind, Department of Health (2015)

comprehensive CAMHS Needs Assessment that accompanies this strategy and upon which the strategy is based.

As well as national prevalence data, it includes activity data for 2012/13 for all CAMH services (delivered by local health and Third Sector providers) including services not commissioned though joint commissioning arrangements. This means we have comprehensive overview of current service use as well as anticipated need. The following is a summary of key points. Please refer to the Needs Assessment for full information, evidence, assessment and rationale for conclusions.

The Needs Assessment identifies that approximately 10,994 young people aged 5-16 would have a mental health issue, when applying prevalence rates across the 4-Tier model of CAMHS. A further 1770 16-19 year olds would have a recognisable neurotic disorder giving a total of approximately 12,764 when allowing for some double counting of 16 year olds an inclusion of 19 year olds.

The CAMHS Needs Assessment can be found at:

http://webapps.stoke.gov.uk/JSNA/Default.aspx

Summary of local CAMHS Needs Assessment – North Staffordshire

Staffordshire has identified CAMHS "Hotspots" based on 2012 data which takes into account multiple factors to identify areas of greatest need. 5 LSOAs in Newcastle are identified in the top 10%. These are Chesterton (2), Holditch, Knutton and Silverdale and Silverdale and Parksite. In Staffordshire Moorlands there 3 areas in the top 10%: Biddulph East (2) and Cheadle NE.

Data relating to Local Authority Districts highlights that the level of need for Emotional Wellbeing and Mental Health interventions may vary at District and Ward level. This data is based on a formula using factors that are known to increase the incidence of mental health difficulties amongst children and young people, such as poverty, special educational needs, school attendance, youth offending and children involved with social services.

The JSNA Needs Assessment can be found at https://www.staffordshirepartnership.org.uk/Health-and-Wellbeing-Board/Staffordshire-E-JSNA-2013-FINAL.pdf

2 Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

It is expected that commissioners will work with managers and clinicians to develop an outcomes framework model of delivery, in line with IAPT principles and to include routine outcomes monitoring and reporting to the National mental health services Data Set.

The provision of good CAMHS will support improved outcomes across all five domains.

Domain 1	**Preventing people from dying prematurely**	**ü**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**ü**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**ü**
Domain 4	**Ensuring people have a positive experience of care**	**ü**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**ü**

For domain 1: Suicide prevention, response to CYP presenting in crisis, A&E liaison

For domain 2: Recovery models, support networks, parent/carer support and interventions

For domain 3: Preventions and access to early help and treatment/interventions at the earliest stage

For domain 4: Embed CYP IAPT principles of improving access (including self-referral) to evidence based, outcome and goals focused care in collaboration with children, young people and their families and carers.

For domain 5: Ensuring age appropriate safe places / places of safety

2.2 Public Health Outcomes Framework

Domain 1	**Improving the wider determinants of health**	**ü**
Domain 2	**Health Improvement**	**ü**
Domain 4	**Healthcare, public health and preventing premature mortality**	**ü**

For all three domains:

a) understand health inequalities, deprivation and poverty and how it relates to CYP MH

b) consider how children and young people and parents/carers are empowered and skilled to support self-management and recovery

2.3 Local defined outcomes

These can be found in the Staffordshire and Stoke on Trent CAMHS Local Transformation Plan.

For Stoke-on-Trent:

- **Outcome 1:** Children and young people are emotionally resilient. The children and young people's workforce has the skills to recognise and support children and young people, referring as necessary to additional support when they become unwell and providing support when in recovery. Children and young people and their parents/carers have access to information, guidance and advice to maintain good emotional wellbeing

- **Outcome 2:** Children and young people and their families are able to access a range of community, school based, and online support in a timely manner, preventing escalation to specialist service provision.

- **Outcome 3:** Children and Young People who become emotionally and mentally unwell are supported to manage their conditions and recover quickly. Those requiring on going mental health service provision into adulthood are supported effectively

- **Outcome 4:** Children and Young People have access to community support that can reduce the length of stay in a Tier 4 placement and/or reduce the need for a Tier 4 placement. Those who cannot return home are supported via a multi- disciplinary approach to ensure their needs are met.

- **Outcome 5:** Vulnerable groups of children and young people are able to access support quickly and supported to manage their conditions enabling quick recovery. Those who need ongoing support after their 18th birthday get it.

- **Outcome 6:** Services offer high quality, evidence based pathways that can show they make a difference.

For Staffordshire:

- **Outcome 1:** More children and young people accessing emotional wellbeing advice, support and signposting from universal services, schools and colleges.

- **Outcome 2:** More children and young people are supported to maintain good emotional wellbeing, difficulties are noticed earlier and appropriate services are available.

- **Outcome 3:** Reduction in lifelong distress as a result of poor mental health.

- **Outcome 4:** Children and young people can access age appropriate Tier 4 placements close to their home Children and Young People are supported within the community wherever possible.

- **Outcome 5:** Efficient care pathways for vulnerable groups of children and young people to allow quicker access to support.

- **Outcome 6:** Efficient care pathways for young people who need emotional wellbeing and mental health support beyond the age of 18.

2.4 Local Area Strategic Outcomes

Locally defined outcomes can help drive up quality improvements and help achieve the desired outcomes for children, young people and their families/carers. The local outcomes have been developed with children, young people and parents/carers and are agreed by partners and receive support from partnership bodies.

Local Transformation Plans for Children and Young People's Mental Health and Wellbeing (LTP) published in late 2015 are to be refreshed annually and as a minimum demonstrate how funding announced and released from the Spring 2015 budget will be used to improve the quality of care, increase workforce and number of children and young people who can receive effective care when they need it and improve waiting times. They should cover the full spectrum of service provision and address the needs of all children and young people including the most vulnerable. They include existing improvement initiatives such as the Crisis Care Concordat (http://www.crisiscareconcordat.org.uk/) as well as plans to achieve key objectives:

- Build workforce capacity and capability
- Roll-out the Children and Young People's Improving Access to Psychological Therapies programmes (CYP IAPT)
- Develop evidence based community Eating Disorder services for children and young people
- Improve perinatal care
- Bring other relevant agencies/services (education, social care, voluntary sector and NHS providers) and local children and young people's mental health services together around the needs of the individual child through a joint mental health training programme

They have been developed with local Health and Wellbeing Boards and are driven by the local Health and Wellbeing Board's Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy. They include specific deliverables for which additional funding has been allocated in particular Eating Disorder Services for children and young people.

Stoke-on-Trent children, young people and families Plan 2016-20:

- ***Priority – Improve emotional wellbeing and mental health***

Our aim is for all children and young people to be emotionally healthy and resilient and that they, and their parents/carers, have access to information, guidance and advice to maintain good emotional wellbeing – ensuring that where they need help with mental health issues they are supported to manage their conditions.

- ***Priority - Make a positive difference to children and young people through parenting***

Our aim is for all parents (by parent we mean prospective parents; fathers as well as mothers; non-resident parents; foster parents; those with parental responsibility and others with care of a child such as grandparents) to be confident and knowledgeable, possessing the skills they need to nurture and encourage their children. As a result, all children will be able to thrive, flourish and be able to successfully manage their behaviour, forming strong attachments and positive relationships within their immediate family circle as well as the wider community. Children will be curious about the world around them and ready to learn and achieve well.

Staffordshire Children, young people and Families Strategic Partnership Strategy:

The Staffordshire Strategy is currently being refreshed. The existing strategy has emotional wellbeing throughout the other priorities rather than identified separately:

- ***The Best Start in Life: Pregnancy and Early Years***

This includes support throughout pregnancy to age five through childcare, pre-school education, physical and emotional health,

- ***Thriving Families: Parenting, Good Lifestyle Choices, Health and Prosperity***

Families will help build resilience in young people and promote and support positive emotional wellbeing.

3. Scope

3.1. Aims and objectives of service

The provider shall:

3.1.1. Work with children, young people, young adults and families/carers in co-designing and reviewing care pathways.

3.1.2. Work with all relevant agencies to ensure that services for children and young people with mental health problems are coordinated and address their individual needs, providing a holistic approach.

3.1.3. Ensure that children, young people and their families/carers are treated with compassion, respect and dignity, without stigma or judgment.

3.1.4. Ensure that children and young people's physical health, social, educational and cultural needs are considered alongside their mental health needs.

3.1.5. Ensure that children and young people who access the service receive treatment in a timely manner.

3.1.6. Provide a range of evidence based (NICE approved) treatment interventions to ensure that children and young people's needs can be met.

3.1.7. Ensure that children and young people's needs are considered in the whole and access to supplementary therapies and support are available

3.1.8. Ensure that provision can provide care in response to an emergency or crisis; 24/7 provision. For the purpose of this service specification, 24/7 provision is defined as a service delivered by the CAMHS service during the core hours of Monday – Friday, 9am to 5pm. Outside of these hours, responses to an emergency or crisis shall be provided by the Access Team or the Urgent and Emergency Liaison Mental Health Service for Patients aged 0-18.

3.1.9. Provide initial and follow-up assessments that are written and shared with the child, young person and/or parent/carer.

3.1.10. Seek and use feedback in a range of settings, including the use of regular outcome monitoring in therapy, feedback regarding service delivery, and complaints.

3.1.11. Ensure that children, young people and their families/carers are offered a choice of interventions that are evidence based and appropriate to their needs. Provide information at all stages of the pathway about interventions or treatment options to support children, young people and families/carers to make informed decisions about

their care. This must be appropriate to their competence and capacity; information needs to be clear, easy to understand and jargon free.

3.1.12. Ensure the impact of adverse childhood experiences, including trauma, abuse or neglect in the lives of children and young people is properly considered when identifying appropriate interventions

3.1.13. Ensure that any additional vulnerability or inequality suffered by children and young people (e.g. learning disability, autistic spectrum conditions, victim of child sexual exploitation) is properly considered when identifying appropriate interventions

3.1.14. Agree the aim and goal of interventions with the child/young person or family/carer, monitor the changes to agreed and shared goals as well as symptoms, and amend therapeutic interactions as a result of these changes, to deliver the best possible outcome

3.1.15. Provide written information to the child/young person and family/carer about the care plan and how to access services (both routinely and in a crisis); this information needs to be clear, easy to understand and jargon free

3.1.16. Provide information about how the services commissioned will increase opportunities for social value and social capital in line with the Social Value Act 2012

3.1.17. Work collaboratively with other agencies in the health and social care and education systems to ensure regular case reviews to ensure effective progress through the care pathway.

3.1.18. Ensure that best use is made of technology to support, facilitate and improve delivery of evidenced based treatment.

3.1.19. Ensure that there is a formal route for referring children/young people to highly specialist mental health services (e.g. inpatient services, specialist outpatient services).

3.1.20. Ensure that good relationships are maintained with relevant agencies in health, social care and education (including statutory, voluntary and third sector organisations) to aid referral into the service and ongoing support and treatment. This includes using whatever locally agreed systems there are to support joint agency working (e.g., Early

Help Assessment (EHA) Team Around the Family), meeting statutory safeguarding guidance and providing clear protocols on information sharing, with children and young people being asked for consent regarding information sharing with other agencies (rather than a blanket decision not to share health information with such agencies).

3.1.21. Ensure that clear communication pathways and information sharing mechanisms are in place so that children, young people and, where appropriate, their families/carers experience a smooth journey through the care pathway.

3.1.22. Ensure Routine Outcome Measures, Patient Reported Outcome Measures are used to inform individual care plans and wider service improvements (http://www.iapt.nhs.uk/silo/files/rom-dec11-03.pdf)

3.2. Service description/care pathway

3.2.1. Autistic Spectrum Disorder (ASD)

Introduction

Indications from recent studies show that figures cannot be precisely estimated, but according to the National Autistic Society it appears that a prevalence rate of around 1 in 100 is a best estimate for children and young people under the age of 16. If applied to the population of Stoke-on-Trent, there are approximately 48, 964 under 16's (2012 mid-year estimates); therefore the estimated number of children and young people with ASD in 2015 will be around 490. ASD affects males more than females and numbers appear to be rising.

The pathway covers the 0-18 age range and offers an assessment and diagnostic service to children and young people presenting with suspected ASD. A limited package of support is offered to families if a child receives a diagnosis of ASD.

A number of new assessments/screening assessments will be carried out each year and a case load of ongoing support to a small number of families may be carried forward from year to year. All families are offered the opportunity to attend support groups and themed sessions on aspects of living with a child with ASD, with the aim of supporting the behavioural and emotional development of the child, this includes families who have received a diagnosis elsewhere.

Outcomes are based on parents/carers accessing the follow up support that is offered (group support, 1-1 support). Not all families will choose to access this support. If the child is found to also have a learning disability, a referral to the CAMHS Learning Disability Team will be made if appropriate.

Assessment tools include the Autism Diagnostic Interview (ADI-R) and the Autism Diagnostic Observation Schedule (ADOS) and the Development, Dimensional and Diagnostic Interview (3di)

Awareness training materials are based on recognised ASD scholars e.g. Baron-Cohen, Attwood, Wing.

Interventions are based on systemic, CBT, behavioural and developmental approaches in psychological therapy.

The service is based on the National Autism Plan for Children and NICE guidance and adheres to national and professional guidance regarding clinical governance, data protection & safeguarding and to the Providers' own policies and procedures as appropriate.

The service will:

- Complete a full assessment
- Provide families with a detailed summary report; this report is circulated to professionals working with the child as appropriate and with the agreement of the family
- Make referrals on to other relevant services where appropriate.

If a diagnosis of ASD is given, the service will:

- Provide access to one to one and/or group support (ASD WISE groups) appropriate to the age of the child:
    - ASD Wise – 3 group sessions
    - ASD Wise Up! – 3 group sessions

- Provide a package of ongoing one to one intervention support to families who require further support in relation to their child's ASD diagnosis, behaviour/psychological needs, or communication needs. A range of interventions/therapies will be offered to address issues including behaviour, fussy eating, anxiety, and depression. The intervention plan will be agreed with parents with measurable outcomes to include: improvement in behaviour of the child and improved family relationships.

- Access to post diagnosis support will be given to those families who received a diagnosis from a recognized professional (see pathway diagram).

- Treatment duration will be based on clinical assessment and will be negotiated on a case-by-case basis with the child and parent/carer while also incorporating best practice models regarding the duration of intervention/treatment.

- Families are able to telephone the service for one-off advice and support.

- The service will provide ASD awareness training sessions to relevant staff groups involved with children and young people.

The pathway can be accessed by professionals identified in the care pathway who will have carried out an initial assessment investigating each area of the "Triad of Impairment" i.e. difficulties in communication, difficulties in social interaction and rigid, repetitive and obsessive behaviour. Clear referral criteria will be issued to referrers to aid accurate referrals.

Children who already have a written diagnosis and are referred to the hub will be offered initial assessments to identify current concerns and allocation to the relevant care pathway. Where appropriate the service will liaise with other professionals (including school, Educational Psychology, Social Care) to gather relevant information. Following on from this assessment a plan will be agreed with the family. This may involve offering psychological interventions to the family such as ASD awareness groups, parenting advice, additional speech therapy sessions and therapeutic input for psychological problems associated with ASD. Where appropriate families may be referred to other services. ASD specialists will work in close liaison with other specialists within the overall Community CAMHS pathways to ensure children and young people do not fall between provision and particularly in circumstances whereby a child or young person is presenting with co-morbid complex mental health problems.

Response time and prioritisation

Children accepted for ASD diagnostic assessment will begin assessment within 18 weeks. Families wishing to join the Wise groups the next available session, subject to places being available.

Priority will be given to:

- Children in care
- Children undergoing the statutory EHC Plan process
- Children and young people known to Families Matter (Stoke) and Building Resilient Families (Staffordshire).

Discharge criteria and exit planning

At the completion of the diagnostic assessment the service will meet with parents/carers to inform them of the results of the assessment.

If a child/young person receives a diagnosis of ASD the family will:

- Receive copy of the assessment report
- Receive a pack of information
- Parents/carers will be invited to the next ASD Wise group.
- Receive one to one family/child intervention where need is identified. Clear outcomes/goal will be identified and the family discharged after the outcomes/goals are achieved
- Inform families how they can contact Community CAMHS should the need arise.
- Add the family to the e- newsletter distribution list (upon consent)

If a child/young person does not receive a diagnosis of ASD they will be discharged. A discharge letter and copy of the assessment report shall be sent to the parent/carer and a copy of the report will be sent to the referrer.

Interdependencies

The service also works closely with the Community Paediatricians, Speech and Language Therapy Services, the Educational Psychology Service, the Special Educational Needs and Disability Team and the Early Years Quality and Intervention Teams and school staff (education welfare officers and SENCO's).

Speech and Language therapy for the pre-school age children is provided by Staffordshire and Stoke-on-Trent NHS Trust under separate commissioning arrangements and will work as an integrated part of the team.

ASD Pathway, North Staffs/Stoke:

Autism Spectrum Disorder Assessment Pathway

HUB decide if referral is appropriate – is there sufficient information? Could developmental delay account for difficulties? Are universal services involved? Is the child over 2 years? ASD team will provide support as required

Referrals forwarded to community teams. All young people and families are seen for a face to face appointment with CAMHS clinician

If ASD is considered clinician completes the ASD screening pack, update the care plan etc…. This is likely to take at least two appointments. Pack includes:

- **Parents**: CAST questionnaire, parental information questionnaire, AQ – 10 (Adolescent version), ROMS (T1) + Sheffield questionnaire
- **Child**: All about me! booklet
- **School**: school ASD questionnaire
- **Clinician**: HONOSCA

Please refer to the NICE guidance www.nice.org.uk/guidance/cg128 for more information on recognition, referral and diagnosis of ASD in childhood.

ASD screen pack indicates difficulties associated with ASD.

CAMHS ASD team can provide support on whether or not to refer to the team. Meeting are every Wednesday 9-10.30 at Dragon Square

ASD screen does not indicate further assessment necessary – feedback outcome to family and review care plan

Option 1: The information indicates ASD and clinician completes assessment within CAMHS team

Option 2: The information indicates ASD and clinician opts to refer into CAMHS ASD team. Complete the ASD pathway referral form which indicates reason's for requesting assessment from the team.

Option 2: Young people who are accepted as appropriate by the ASD team will be placed on the wait list letter sent to the family and referrer.

Both options 1 & 2: ASD assessment completed and outcome feedback to parents/carers. T2 ROMS sent (Sheffield and satisfaction with services) along with a summary report. If the child is diagnosed with an ASD parents are given a copy of the ASD information pack and offered a place on the ASD Wise/ASD Wise UP! Group. Please contact Alex Sutton to put a child on the group waiting list.

Child does not meet the criteria for a diagnosis of an ASD – feedback to family outcome to family and review care plan

Parents either attend ASD Wise/Wise Up! or opt to not attend.

Young person is discharged from CAMHS ASD

3.2.2. CAMHS Learning Disability

Evidence base

Emerson and Hatton (2007) reported that over one in three children and adolescents with a learning disability have a diagnosable psychiatric disorder and are six times more likely to have a diagnosable psychiatric disorder than their peers who do not have a learning disability. The increased risk of having a mental health problem cuts across all types of psychiatric disorders such that children with a learning disability are: 33 times more likely to have an ASD, 8 times more likely to have ADHD, 6 times more likely to have a conduct disorder, 4 times more likely to have an emotional disorder and 1.7 times more likely to have a depressive disorder.

Stoke on Trent

Due to the different definitions of disabilities which exist between services, there is considerable overlap between the children with disabilities population, the Special Educational Needs (SEN) population and the child population accessing acute services and palliative care. Data is collected by local authorities on children with special educational needs, but this does not reflect the spectrum of disability and is only a weak measure for severity.

Learning Disability is one of the most common forms of disability and is a lifelong condition with a wide spectrum of need. It can be acquired before, during or soon after birth and affects an individual's ability to learn.

There are no official statistics reporting the population with a learning disability. Various sources have been used to estimate the numbers of people with learning disabilities across Staffordshire and Stoke-on-Trent.

The school census collects data on young people with special educational needs and disability (SEND). Based on the latest data (January 2015):

- 14% of pupils in schools in Staffordshire and Stoke-on-Trent have identified special educational needs (equating to 23,200 pupils).
- 3% of pupils in schools in Staffordshire and Stoke-on-Trent have statements or education, health and care (EHC) plan (equating to 4,800 pupils).
- The numbers of pupils with their primary type of need being a learning disability were: 2,210 (specific), 6,420 (moderate), 670 (severe) and 200 (profound and multiple). The total makes up around 6% of all pupils across Staffordshire and Stoke-on-Trent which is higher than the national average of 5%. Around 1,170 pupils (1.1%) also have autistic spectrum disorder which is similar to the England average (also 1.1%).

In Staffordshire there are:

- 13,079 Children on SEN support
- 2,586 Children in a special school/pupil referral unit
- 316 Other local authority pupils in our special schools
- 3,469 Children with a statement of educational needs
- 350 Children with an education health and care plan and of those we have 135 children in an out of county independent and non-maintained placement which is an 11% increase.
- 199 Children in receipt of Direct Payments with a Learning disability or Autism;

Children in receipt of Direct Payments with a Learning disability or Autism;

Age Today	Children/YP
4	1
5	6
6	8
7	11
8	5
9	16
10	15
11	24
12	19
13	21
14	18
15	18
16	16
17	19

Aims and objectives of the pathway

The overall aim of the Complex Learning disability pathway is to provide a highly specialist Occupational Therapy, psychological, nursing and behavioural service at CAMHS Tiers 2 and 3 to children and young people with a physical and/or learning disability and their parents/carers living in North Staffordshire and Stoke on Trent.

The multi-professional team aims to help individuals and families to better understand and manage the difficulties they are experiencing by providing highly specialist assessments, information, advice, evidence-based interventions and support. In addition, the service seeks to promote a preventative and early intervention approach to improve children and young peoples' wellbeing.

Pathway Description

The Complex LD pathway will provide specialist, community based assessments and a variety of treatments / therapeutic help to clients and their carers where children and young people with disabilities are experiencing mild to severe problems of behaviour, emotional and mental health. This will be aimed at pre-school aged children with a significant developmental delay and young people with a mild to severe learning disability up to the age of 18 years, working within the wider community CAMHS pathways to ensure needs are met.

Children and young people referred to the pathway present with complex and diverse needs with may necessitate the involvement of several professional from the service. Children and young people with a mild learning difficulty and low level mental health issues will be referred to an alternative Tier 2 service. It is expected that the service will support 300 live complex cases at any one time (i.e. receiving at least one intervention in a 3 month period).

The pathway comprises Clinical Psychologists, a Psychological Therapist, Children's Community Learning Disability Nurses, an Occupational Therapist and input from psychiatry.

The pathway will work with children and young people who present with a range of difficulties including:

- Challenging behaviour
- Low mood / depression
- Eating and diet
- Self-care skills
- Fears and phobias
- Obsessions and compulsions
- Self-injurious behaviour
- Autistic Spectrum Disorder
- Toileting
- Socialisation
- Anxiety
- Anger management

- Independence skills
- Bereavement, loss or adjustment issues
- Sleep

Acceptance and exclusion criteria

The pathway accepts referrals from any professional currently involved with a child/young person who meets one or more of the following criteria:

- For very young children - evidence of significant global developmental delay (i.e., functioning at 70% or more below the level expected for their chronological age)

- For older children – evidence/formal diagnosis of a learning disability (this may take the form of a cognitive assessment or collective evidence which indicates that the young person is functioning at a level significantly behind their peers in most areas)

- Child/young person attends a Special School.

Staff will work across the whole service offer to ensure children and young people do not fall between pathways.

Staff will contribute to Education, Health and Care plans for children with SEND.

The pathway will, where appropriate support children and young people who are stepping up and down from other CAMHS services

Transitions and interfaces

- There is to be a planned arrangement and programme for transition of care from child to adult services for young people with enduring mental health problems. Transition planning to commence on referral or at least 6 months prior to transition, however it is reasonable to assume it may commence earlier with more long term conditions.

- Service users have a named key worker/lead professional/care coordinator to facilitate transition

- Processes in place between the service and Adult Mental Health Service to ensure smooth transition between services. Pathway in place to include support provided by partner organisations such as voluntary sector.

- Protocols to take into account the maturity of the young person and allow for flexibility and scope for choice

- Protocols take account of policies and guidance from Local Children's Safeguarding Boards (LSCB) and vulnerable adults policy

NB. Protocol to be agreed by commissioners

3.2.3. Vulnerable Children and Young People (Stoke on Trent)

The locally agreed care pathway(s) is/are:

- Continuity of care for those young people already accessing the specific YOS and LAC provision and those children and young people who are being sexually exploited, or at risk of sexual exploitation.

- LAC/YOS/CSE are screened by Social Worker or YOS health service and assessed as requiring a CAMHS T3 service.

- Referral made via central referral hub.

- Treatment as per the appropriate Care pathway (see Schedule 2, section 3.4).

The term 'children in care/looked after' refers to any child or young person for whom the authority has, or shares, parental responsibility, or for whom the authority provides care and accommodation on behalf of their parent.

This will be a CAMHS tier 3 service, providing:

- Direct therapeutic intervention to children and young people who are in the care system or open to the youth offending team

- The provision of consultation, support and training to Foster Carers.

NB. Young people who fall into both categories should only be reported once.

Referral criteria, source and route

An initial screening/discussion will take place within the social care/YOS teams as to whether a referral to the service is required.

i. Where a child/ young person scores 17 or higher on the SDQ (Strength and Difficulties Questionnaire), this is an automatic trigger for a referral into the hub by Social Care/YOS. The Provider will ensure a consultation is made with the child's social workers and/or Foster Carers and a care plan with measurable outcomes and goals will be developed to meet the child's immediate and long term emotional and mental health needs. The provider will offer a range of suitable evidence based and where possible, NICE (National Institute of Clinical Excellence) approved, interventions to the child and/or Foster Carers/small group home staff to improve the mental health of the child. The outcomes/goals the service is working to improve will be clearly recorded in the child's case file/care plan. The service will facilitate any referrals required for ASD assessments etc. provided by the Service Provider and will retain responsibility for continuing to meet the mental health needs of the child where clinically appropriate during such assessments. In most cases, it is not expected that intervention ceases pending further assessment, unless this puts the child at risk. A parallel process can be adopted when it is safe to do so.

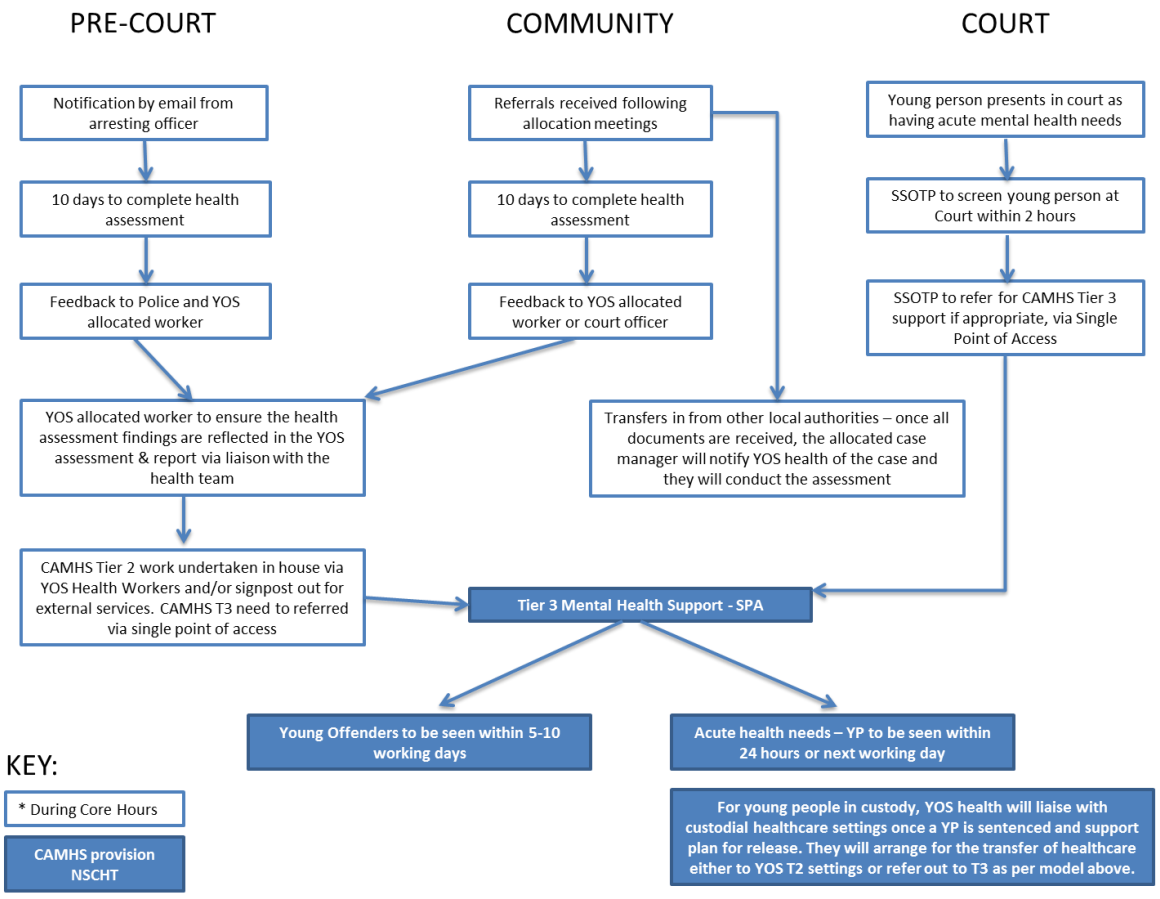
ii. for LAC, where a foster care, small group home or education (school) placement is at risk of breakdown, the service will assess the child/young person's mental health and where appropriate working with other services, ensure a care plan is developed to meet the child's immediate and long term emotional and mental health needs. The provider will identify the outcomes/goals it is working to improve and will be measured against these via the care plan.

iii. When an urgent request is made by social care or a young person previously known to the provider, the hub will assess the immediate needs and risk and where appropriate working with others, ensure a care plan is developed to meet the child's immediate needs. The provider will identify the outcomes/goals it is working to improve and will be measured against these via the care plan. The provider will notify the relevant Social Worker if a child/young person self refers, whether or not the service accepts the referral.

iv. When a child is to be placed outside of the city, the provider will conduct and/or support the development of a mental health assessment and where necessary, develop a care plan prior to them being placed outside of the city, regardless of whether the child is known to the service or not. Where there is a Statement of Education Needs, the SEN team and Education Psychology will lead the assessment process.

v. When a child is already accessing a care pathway and moves into the care system, the child's Social Worker will work with that service and a referral to the Hub will only be made if the needs and not the status of the child dictate

Health process for YOS young people:



Care pathways for LAC

The provider will provide assessment of children and young people who are referred via the child's Social Worker, the Foster Carer's Social Worker or a CAMHS Social Worker and where there is an SDQ score of 17 or more and offer psychological interventions where appropriate, to those children and young people who are accepted into the service to improve emotional well-being and mental health and reduce incidences of poor/challenging behaviour.

The provider will also work with Foster Carers and professionals linked to the child/young person as appropriate, including delivering consultations and training in order to improve the mental health and emotional well-being of children in care. This will include LINE training and the Foster Attachment Forum for those who have completed LINE training.

The Provider will:

- Accept referrals for children and young people aged up to 18 years old where there is a reasonable description that suggests that the child/young person may have an emotional wellbeing or mental health problem

- Stoke on Trent Local Authority area. An SDQ score of 17 or above for Looked after children will ensure priority access.

- Accept referrals from Youth Offending team, LAC social care teams, services working with children and young people who are being, or at risk of being sexually exploited.

- In cases where referrals are found to be inappropriate, with consent, refer or signpost the child/young person and their family/carers to other services.

- Provide information to support court reports on those young people accessing/having accessed the service (YOS)

- Provide intervention in non-clinical settings as appropriate to meet the needs of the young person

- Offer a range of flexible appointments, outside of the usual working day (9am – 5pm) and on Saturdays, to be agreed on a case by case basis.

- For Looked after children and young people, provide 60 hours of training per annum. Training for Foster Carers and Carers may cover the following topics or other topics by negotiation:

- LINE training for foster carers
- How to play therapeutically
- Self-harm
- Raising children's self esteem
- Shame and rage – handling extreme behaviour from children who have experienced early adversity
- Managing sexually harmful behaviours.

- Support the Foster Attachment Forum.

- Provide locally available, age- and developmentally appropriate, co-produced information for children/young people, parents/carers and referrers about the services provided and how they are accessed.

- Support the Early Help Assessment, Education, Health and Care Planning and other statutory and local protocols.

- Support and ensure inter-agency working.

- Support and ensure discharge or transition planning.

- Ensure that the referrer is clear as to whether the service has accepted the referral and, if not, in line with agreed information-sharing protocols, provide the rationale for this and written suggestions to what the services will do.

- Have contact within the CAMHS Hub so that those thinking about referring can have a discussion prior to the referral.

- Gather the agreed range of information at the point of referral and upon discharge

- Implement clear transition processed to support the transfer to an adult mental health service where appropriate of children and young people nearing their 18th birthday.

- Offer ad-hoc, professional one-off support/consultations to Social Workers, Foster Carers and Tier two CAMH providers working with children in care.

- Offer a range of interventions, including direct work with children and young people and support to Foster Carer's and specific training inputs to key professionals. Direct work/contact with children and young people and their carers should take priority over training delivery on an expected 95% /5% split.

- If there is a clear need for a referral into the service this will be facilitated by a Social Worker who will act as a link between the service and Foster Carer/small group home. Education staff, including the Virtual School will also be able to access the service via the Social Care Teams.

Exclusion criteria

Children and young people may not be eligible for the service provided by NSCHCT on the basis of:

- Age over 18 years old

- Children in court proceedings where intervention is not advised under Home Office guidelines

- Can access care pathways without additional flexibilities and enhancements

Response time and prioritisation

Priority will be given to the following:

- Children and young people scoring 17 or higher in the SDQ

- Children and young people whose foster and/or education placement is at risk of breakdown due to the child/young person's behaviour.

- Children and young people who are in care of the LA who have been admitted to the paediatric ward due to self-harm/deliberate overdose/attempted suicide, following an assessment by the Intensive Outreach Team or the hospitals own mental health workers. It is the responsibility of the Intensive outreach team (or equivalent) or Social Worker to make this referral.

It is expected that the time from referral to Initial Appointment will be 2 weeks and from initial appointment to intervention beginning to be 2 weeks. The provider will ensure there are adequate initial appointments every week for social care to utilise and will work with social care/YO to review demand.

Initial assessment

The outcome of the assessment should be recorded in the service user's note and be passed on to any other service involved in the care of the service user with the informed consent of the young person and/or parent/carer.

Provider will:

- See crisis/emergency referrals within the same working day.
- See urgent referrals within 5 working days.
- For routine referrals carry out initial assessment within 10 working days after receipt of referral.
- Provide the agreed intervention within 4 weeks of the initial assessment.
- Assure that the member of staff undertaking the initial assessment is appropriately trained and experienced to undertake assessment, to identify strengths and difficulties including identification of mental health disorders, supported by formulation or diagnosis where appropriate.
- Work in collaboration with the child/young person and, where possible, the parents/carers on the decision to refer for further assessment and/or treatment or to discharge and/or signpost, based on the combined assessment of their needs and risk.
- Any planning for children and young people with severe educational needs should take account of and be part of the child or young person's statement/Education Health and Care plan.

To include:

- Following referral from a Social Worker, an initial consultation with the professional network around the child (to include the carer/s, Virtual School, Educational Psychology) which will contribute to the assessment of a child's needs. This may be an intervention in itself; or may lead to signposting elsewhere; or to further assessment and/ or to ongoing therapy

- a consultation when a child is being considered for an out of area placement

- a contact to contribute to a psychological assessment of a child's needs

- family work with child and carer: includes systemic family therapy and attachment therapy and other evidence based therapies as necessary to meet the needs of the child

- individual evidence based therapy: includes play therapy, art therapy, music therapy and cognitive approaches, solution based therapy (list not exhaustive)

- school intervention, may include observation, implementation of care plan within school programme, advice to teaching and support staff, liaison with Virtual School and Education Psychology

- Whole system intervention to meet the needs of the child, for example, support to Social Workers/small group home staff

- Referral for psychiatric evaluation if assessment suggests this is required

- Support when a child steps up/down the CAMHS 4-Tier model.

Does Not Attend (DNA) /Re-engagement policy

When a service user does not attend, a risk assessment should be made and acted upon. The provider should not close a case without informing the referrer that the service user has not attended. The provider should make explicit re-engagement policies available to referrers, children/young people and parents/carers.

The provider will not automatically discharge the young person as per its usual policy without a discussion with the referrer.

Discharge

A child will be discharged when all the outcomes/goals have been achieved or progress is sufficient to enable the child's needs to be met by a tier 1 or tier 2 service or if a child has been escalated to Tier 4 CAMHS.

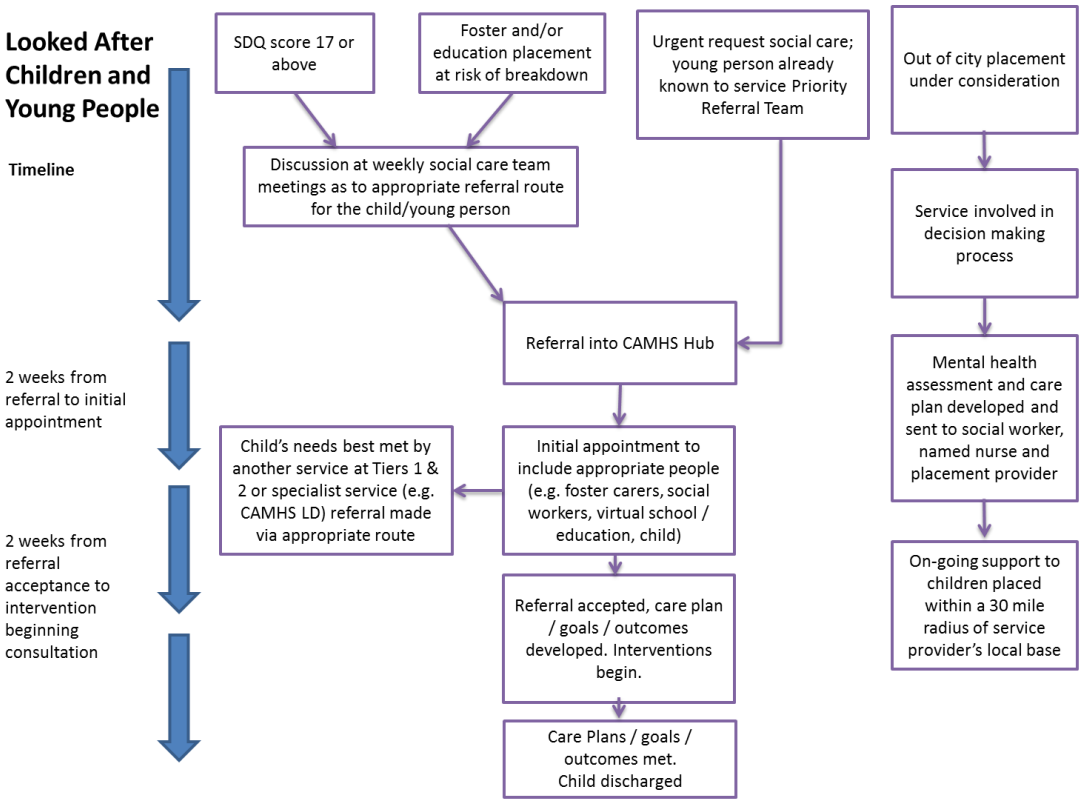
Clear transition planning to ensure there are no gaps in meeting the emotional needs of such children will take place between pathways to ensure children and young people do not fall out of provision if status changes.

If a child is to be placed for adoption, the service will negotiate with the adoption service which service is best placed to meet the child's needs.

Reporting

Where a child is both LAC and YO, they should only be counted once.

The Provider will keep a record of the numbers of all other LAC and YO's accessing provision for the first time who do not require enhanced access and make this available to the commissioner as per the reporting requirements in the contract.



3.3. Legal and Regulatory Framework

Providers shall consider the use of Independent Advocacy Services to support children and young people to gain access to information, to fully explore and understand their options, and to make their views and wishes known.

3.4. Mental Health and Wellbeing Care Pathway

Intervention must be goals focused, evidence informed and outcomes focused.

Access to early help

It is important that the provider considers the holistic needs of the child/young person and where appropriate delivers a wide range of support which may include access to therapies and therapeutic activities.

This support will include:

- Work to become 'therapy ready'
- Alternative and family support and building resilience
- Self-help support including the use of online and technology based support materials; especially whilst waiting for formal treatment to commence
- Parenting interventions
- Brief psychological interventions (including group work and counselling)

Assessment of mental health need

The Provider will:

- Triage CYP with mental health needs via the CAMHS hub and provide access to a mental health professional for advice and support or a referral if appropriate; including access to urgent help

- If, after triage, a full assessment is required the assessment is undertaken by someone experienced to do so quickly, in a person-centred, goal focused manner that is active and collaborative, and such that enables a formulation or diagnosis where appropriate and options for help to be decided upon.

- Ensure information from other mental health assessments is accessed e.g. CHAT (Comprehensive Health Assessment Tool) used by community Youth Justice services and children's secure estate, or a summary health record when leaving the secure estate for children and young people

- Ensure that the rationale for formulation and any associated diagnosis, evidence considered and decisions made will be fully documented. This will be shared with the child/young person and parent/carer in writing as appropriate. Ensure that initial and continuous care planning involves all members of the team providing care, the child/young person and their parents/carers.

- Develop a risk management plan in collaboration with the child/young person and their parents/carers.

- Ensure that informed consent issues around both sharing of information within the family and with other agencies and around treatment are clearly explained and documented.

- Provide a choice of evidence based, NICE approved, care/interventions that will prevent unnecessary admission to an inpatient bed and promote safe discharge and recovery.

- Ensure that legal rights for individuals with regard to choice of mental health provider are implemented. See https://www.england.nhs.uk/mentalhealth/parity/choice/ for guidance

- Ensure any cross-charging arrangements for cross-boundary children/young people are included.

- Contribute to other parts of agreed multi-agency care pathways.

The Care Act (2014) and Children and Families Act (2014) state that any young carers and young adult carers should be offered a Carers Assessment – where relevant this assessment should be taken into account.

When working with a child or young person this needs to be done within the family context and support to other family members should be signposted where needed.

Access to treatment

The provider will deliver a range of evidence based therapeutic and preventative services to children and young people, which may include the following (this list is not exhaustive) and any future relevant CYP mental health wellbeing approved NICE Therapies:

- Cognitive behavioural therapy
- Systemic therapy/family therapy
- Psychodynamic psychotherapy
- Counselling
- Other evidence-based psychological therapies
- Antenatal e.g. social baby
- Evidence based parenting programmes
- Pharmacological
- Psychosocial
- Behavioural Therapy
- Interpersonal psychotherapy for adolescents (IPT-A)

As a guide, it is expected that interventions will be offered to younger children (to age 11) via parenting interventions at Tier 2 (and direct work with the child as appropriate) and Tier 3 interventions offered as direct interventions with the young people over the age of 11 depending on level of maturity.

Young people aged 5+ experiencing mild to moderate mental health/emotional issues (except those with neurological development problems) should be referred from the CAMHS Hub to an appropriate Tier 2 service.

Young people aged 17 should be given the choice at the point of referral of accessing the service or an adult mental health service.

The service will support transition of young people nearing their 18th birthday, as per NSCHCT Transition Process.

The overarching principle of all interventions is to deliver effective, evidence based interventions tailored to meet the individual needs of CYP and their families.

Some services delivered by the service are of fixed duration, for example, Group Triple P is a manualised intervention fixed at 8 sessions, plus pre and post-test assessment.

The service will support the step up, step down and step between services model in conjunction with other CAMHS providers/services in the area.

The care pathways will be accessible via the CAMHS Hub (except for Staffordshire YOS).

The CAMHS hub will:

- Provide a referral and advice line to offer information and support to colleagues working in universal and targeted services in the context of emotional, developmental, environmental and social factors to children/young people experiencing emotional wellbeing and mental health problems.

- Provide a referral and advice line so that those thinking about making a referral can have a discussion

- Provide a referral and advice line to offer information, advice and support to children and young people, their parents and carers

- Triage referrals, referring or signposting to other services when need can be met within universal services at the least restrictive route

- For those triaged as requiring an intervention by a mental health professional, refer to the appropriate care pathway including those offered for mild to moderate issues

- For those who are deemed in need of an emergency appointment, arrange for the child/ young person to be seen that Operational Day. Such appointments may be at the hub, at community clinic, or where the child/ young person is presenting.

The pathways provided by the service are:

- **Attachment, Trauma and psychosis** - This pathway will include assessment, diagnosis and evidence based interventions for children and young people experiencing childhood abuse, neglect and trauma and attachment disorders and include specific services for Looked after Children. This pathway will also include an element of differential diagnosis of psychosis and will work with the Early Intervention Service where required.

- **Behaviour and development** - This pathway will include assessment diagnosis and evidence based interventions for childhood development and behavioural difficulties including concerns regarding autism spectrum disorder (and atypical ASD), attention deficit hyperactivity disorder and conduct disorder. (See Schedule 2A, clause 3.2.1 for detail of ASD assessment process)

- **Complex learning disability** - This pathway provides a range of person-centred health services for children and young people aged 0-18 years that have a significant development delay or moderate/severe learning disability. These children and young people will present with significant intellectual impairment and significant difficulties in adaptive functioning (see Schedule 2A, clause 3.2.2 CAMHS Learning Disability).

- **Eating disorders** - See separate specification for this service.

- **Emotional difficulties** - This pathway will include assessment diagnosis and evidence based interventions for children and young people experiencing emotional difficulties including anxiety, depression and obsessive compulsive disorders at a complex level. It is anticipated that provision of highly targeted treatments of relative fixed duration will be a clear feature of this pathway in line with NICE guidance.

- **Crisis and urgent response** - The service will offer emergency and urgent responses to those in acute distress, presenting with self-harm and suicidal intentions and/or where there is a change in risk profile and where risk is likely to be reduced through an emergency and urgent response. This will include offering a mental health assessment to all admissions to the paediatric ward for self-harm, intentional or unintentional overdose/poisoning by the next or when the child/young person is deemed fit. For the purpose of this service specification, 24/7 provision is defined as a service delivered by the CAMHS service during the core hours of Monday – Friday, 9am to 5pm. Outside of these hours, responses to an emergency or crisis shall be provided by the Access Team or the Urgent and Emergency Liaison Mental Health Service for Patients aged 0-18.

- **Youth Offending (Staffordshire)** - The service will second a full time Band 7 CPN to the North Staffordshire Youth Offending Team in accordance with the memorandum of agreement. Direct

interventions for children known to the Staffordshire Youth Offending Service are available through a separately commissioned service.

- **Youth Offending (Stoke-on-Trent; see Schedule 2A, clause 3.2.2 Vulnerable Children and Young People (Stoke on Trent)** - The service will offer priority access and enhanced interventions such as outreach appointments, appointments of longer duration, more flexibility around DNA's for those young people referred by Stoke-on-Trent Youth Offending service.

- **Looked after children (Stoke-on-Trent; see Schedule 2A, clause 3.2.2 Vulnerable Children and Young People)** - The service will offer priority access for Looked after Children and flexible interventions such as outreach. The service will deliver training (such as LINE) and provide structured support to foster carers in agreement with the Strategic Manager for Looked after Children at the Local Authority.

- **Access to treatment with extensive support** - The provider will deliver evidence based therapeutic services for those who have long-term mental health needs and/or additional vulnerabilities that require longer treatment.

3.5. Population covered

This service shall support children and young people living, or registered with a GP within the boundaries of North Staffordshire CCG or Stoke on Trent CCG.

3.6. Any acceptance and exclusion criteria and thresholds

Acceptance Criteria

The Provider shall accept all referrals meeting the following criteria:

- Family issues – where this is having an adverse effect and the child or young person is showing signs of developing a mental health problem or disorder
- Moderate to severe behavioural disorders
- Child behaviour problems (sleep, feeding, tantrums) once physical causes have been considered and the behaviour falls outside what might be considered to be within the range of normal behaviour when using assessment tools.
- Conduct disorders

- Anxiety, depression, stress and or other mood disorders, e.g. low self-esteem
- Adjustment reactions
- Simple phobias

Additionally, many young people will present with moderate and severe mental health problems that are causing significant impairments in their day-to-day lives. These may be acute presentations. *NB: Presentations that could be described as emerging personality disorder will probably be accepted under mood disorder, suicidal ideation and self-harm. For example:*

- Self-harm – where this is mild to moderate
- Bereavement
- Bullying
- Anger management issues
- Relationship problems
- Emotional and behavioural disorders (moderate to severe)
- Conduct disorder and oppositional defiant disorder
- Hyperkinetic disorders
- Psychosis
- Obsessive-compulsive disorder
- Eating disorders
- Self-harm
- Suicidal ideation
- Dual diagnosis – including comorbid substance misuse
- Neuropsychiatric conditions (e.g. attention deficit hyperactivity disorder - ADHD),
- Attachment disorders
- Post-traumatic stress disorders
- Development disorders
- Significant mental health problems where there is comorbidity with learning disabilities or comorbid physical and mental health problems
- Mood disorders
- Somatising disorders.

The Provider will:

- Facilitate and review self-referrals from young people and parents/carers

- Accept referrals for children and young people aged up to 18 (and to 25 for SEND) where there is a reasonable description that suggests that the child/young person may have an emotional wellbeing or mental health problem from Stoke on Trent and North Staffordshire CCG area or returning to home area following a placement in a secure setting or inpatient unit.

- Accept referrals from Sexual Assault Referral Centre (SARC), YOS Liaison and Diversion service, secure settings for Children and Young People, including self-referral.

- In cases where referrals are found to be inappropriate, with consent, refer or signpost the child/young person and their family/carers to other services.

- Support the Early Help Assessment and local protocols.

- Support the Education, Health and Care assessment and care planning process for those children and young people with SEND.

- Support and ensure inter-agency working.

- Support and ensure discharge or transition planning.

- If the service concludes that the needs of child/young people or family/carer are better met by other agencies. It will signpost and refer accordingly.

- Ensure that the referrer is clear as to whether the service has accepted the referral and, if not, in line with agreed information-sharing protocols, provide the rationale for this and written suggestions to what the services will do: for example, whether the service will refer on or signpost or expect the referrer to do so.

- Gather the agreed range of information at the point of referral

Exclusion Criteria

Inappropriate/incomplete referrals/ non qualifying children will not been seen by the service and will be referred back to the person/service making the referral with a clear explanation as to further information required.

The service (at its own discretion) shall also have the right to exclude a young person/family from the service whose behaviour:

- Breaches accepted rules and standards
- Poses a serious risk to the staff, other children and young people and families and the general public

All attempts will be made to work with the child and their families however, if the above applies the service will:

- Work pro-actively to re-engage the Child/family who has been excluded
- Refer each excluded Child/family to other appropriate related services

The service has clear acceptance criteria that are available to referrers, children/young people, their parents/carers and other agencies/services.

The provider will ensure those with Dual diagnosis – including comorbid drug and alcohol use are managed jointly where appropriate with local drug and alcohol teams, they should not be refused a service until such issues are resolved.

Children and young people may not be eligible for the service provided by NSCHT on the basis of:

- Age (over 18 except for SEND)
- The referred problem may be best treated in an existing alternative service
- Where a more clinically appropriate service has been commissioned from an alternative provider (other specialised community service or in patient service, or children with severe disabilities)
- Court assessments, unless specifically contracted.

3.7. For services that are required to undertake a full mental health assessment

The outcome of the assessment should be recorded in the child or young person's notes and be passed on to any other service involved in the care of the child or young person with their informed consent of and/or their parent/carer.

The provider will:

- See crisis/emergency referrals (those where there is immediate risk to self or others) the same day or within 24 hours. For the purpose of this service specification, 24/7 provision is defined as a service delivered by the CAMHS service during the core hours of Monday – Friday, 9am to 5pm. Outside of these hours, responses to an emergency or crisis shall be provided by the Access Team or the Urgent and Emergency Liaison Mental Health Service for Patients aged 0-18.

- See urgent referrals high level of risk within five Operational Days.

- Assure that the member of staff undertaking the full mental health assessment is appropriately trained and experienced to undertake assessment, to identify strengths and difficulties including identification of mental health disorders, supported by formulation or diagnosis where appropriate, and to identify any risks.

- Work in collaboration with the child/young person and, where possible, the parents/carers on the decision to refer for further assessment and/or treatment or to discharge and/or signpost, based on the combined assessment of their needs and risk.

If a mental health need is identified:

The Provider will:

- See crisis/emergency referrals (those where there is immediate risk to self or others) the same day or within 24 hours. For the purpose of this service specification, 24/7 provision is defined as a service delivered by the CAMHS service during the core hours of Monday – Friday, 9am to 5pm. Outside of these hours, responses to an emergency or crisis shall be provided by the Access Team or the Urgent and Emergency Liaison Mental Health Service for Patients aged 0-18.

- Work in collaboration with the child/young person and, where possible, the parents/carers throughout treatment through to discharge/ transition of care based on the combined assessment of their needs and risk.

3.8. Continuing Care and Assessment

Providers will:

- Ensure that care plans (following the Care Programme Approach [CPA], where applicable) are in place for all people receiving support for mental health problems. These plans should be coordinated across agencies, teams and or disciplines, be clearly written, identify the key coordinator and be developed in collaboration with children/young people and families /carers where possible. A copy should be given to the service user, parent/carer (if appropriate) and other agencies such as the GP.

- Ensure that the care plan includes appropriate risk management and crisis planning.

- Review the care plan with the child or young person and their family/carer (if appropriate), including the goals of treatment, and revise the care plan at agreed intervals. The dates for review should be set out in writing and depend on the nature of the problem – many problems should be reviewed every three months but others may require a more or less frequent review. Where a significant change has taken place, or when there is a change in the care management plan, review should be carried out as soon as is practical.

- Select treatment options in consideration of:
    - Age-appropriate best practice/evidence-based psychological intervention
    - Pharmacological and psychosocial interventions
    - Environmental and occupational/educational interventions or provision
    - The availability of a psycho educational website online prevention packages with access to other face to face support available and mechanisms for any deterioration to be detected and acted upon whilst waiting
    - Engagement, flexibility and choice.

Any planning for children and young people with severe educational needs should take account of and be part of the child or young person's statement/Education Health and Care plan.

3.9. Does Not Attend (DNA) / Re-engagement Policy

The risks and causes of children or young people not attending for appointments are particularly acute for mental health services. Children, young people or their family/carers who do not attend appointments should not be discharged from services. Instead, their reasons for not attending should be actively followed up and they should be offered further support to help them to engage as needed.

The provider must have a robust plan in place to act when a child or young person does not attend. In each case, a risk assessment should be made and acted upon. The service should have explicit procedures in place to ensure that the child, young person and family/carer are contacted following a DNA and that all appropriate measures are taken to:

- Ensure attendance at any future appointments

- Ensure the safety of the child or young person, including notification of other people involved in their care if appropriate

The service should have clear re-engagement policies and make these available to referrers, children/young people and family/carers.

The provider will maintain good relationships with relevant agencies in health, social services education, youth Justice and, where appropriate and with consent, will share information about non-attendance, to mitigate against the risks inherent in the fact that children and young people are often dependent on others to access care.

3.10. Care Transition Protocols

Transitioning out of CAMHS is a period of high anxiety for the children, young people and their parents/carers and therefore it is vital that transitions are managed smoothly and in partnership with all parties, including the child or young person and parent/carer.

Groups needing particularly robust transition processes include:

- Looked after children and young people
- Young people who are LGBTQ, in particular those undergoing gender reassignment
- Care leavers moving to independent living
- Children or young people entering or leaving inpatient care
- Young people entering or leaving the secure estate

- Children and young people with learning disabilities or autistic spectrum condition
- Unaccompanied asylum-seeking children or young people
- Children and young people with caring responsibilities
- Those not in education, employment or training (NEET).

The service must have protocols in place to ensure that transitions between 'sending' services (CAMHS) and 'receiving' services (AMHS, other related services or relevant to the child or young person's mental health needs, or primary care) are robust. Services must work together with the child or young person and, where appropriate, parents/carers to plan in advance for transition. The needs of the whole family should be taken into account. If a family member is identified that needs advice, support or help then they should be directed to another service or meet the need where appropriate.

As a minimum, a child or young person leaving CAMHS should have:

- A meeting to prepare for transition, at least six months before transitioning or, for those who are less than six months from transition age on joining CAMHS, at least one month before transition. The meeting should include:
    - The child or young person;
    - The appropriate key worker from the sending service;
    - Where applicable, a dedicated point of contact for transition from the receiving service; and
    - Where appropriate and the young person agrees, the young person's parent(s)/carer(s).

Where a face to face meeting is not practicable, for example when a young person is moving out of area, this can be done remotely, for example via a video conference.

- A complete transition plan at least 6 months prior to transitioning, signed off by:
    - The sending service;
    - Where applicable, the receiving service;
    - The child or young person;
    - Where appropriate, and where consent is given, the young person's parent(s)/carer(s).

The transition plan must include personal transition goals, jointly agreed with the child or young person. For those entering CAMHS less than 6 months before their date of transition, these requirements must be fulfilled on entry into CAMHS and no later than one month before transition.

- A named and contactable transition key worker, at least 6 months prior to transition, in the sending service or, where transitioning into AMHS or other relevant services, at the receiving service. This key worker must be known to the child or young person and their contact details shared with them. For those entering CAMHS less than 6 months before their date of transition, these requirements must be fulfilled on entry into CAMHS and no later than one month before transition.

- Those leaving CYP MH services who will not transition to a another service, but back to primary care, should have a discharge plan that has been developed and shared with the child or young person and shared with primary care. This plan should ensure that the child or young person and, where appropriate, parents/carers can support self-management where possible to maintain their wellbeing, and will know what to do if they become unwell.

- Follow up after the transition, ordinarily conducted by the receiving service and within six months, to ensure appropriate interventions are in place and transition goals have been met.

Service Transition Protocols should ensure that:

- Children and young people are involved in the process throughout and properly prepared for transition out of CAMHS;

- Children and young people have continuity of care wherever possible;

- Any risks or safeguarding concerns are clearly considered and documented;

- Joint-agency transition planning takes place, as detailed above.

3.11. <u>Accessibility</u>

Providers will:

- Provide written assessments, care plans, etc. that are easy to understand and jargon free; any technical terms in these assessments/care plans should be defined. Consideration will have to be given to ensuring that those with particular communication needs, e.g. hearing/sight impairment, speakers of other languages, have access to information in a suitable format.

- Ensure that the service is accessible and provided in an appropriate setting that creates a safe physical environment. This will take into account issues such as stigma and, where appropriate, gang violence.

- Use venues to deliver treatments that are fully accessible in terms of mobility and other impairments and that have good access to public transport and parking.

- Ensure that services have age-appropriate physical settings. If located alongside services for adults then there should be a separate entrance and waiting area for children, young people and their families/carers.

- Ensure services are available to all children and young people without regard to gender, sexuality, religion, ethnicity, social, or cultural determinants. However, where it is deemed clinically appropriate, alternative services may be established that meet the specific needs of one or more groups within a community. Such services will enhance rather than detract from the existing provision.

- Offer children, young people and parents/carers age and developmentally appropriate, co-produced information for children/young people, parents/carers and referrers about the services provided and how they are accessed and about their care.

3.12. Interdependence with other services/providers

The Provider should ensure they have excellent links with services regularly used by young people, families and carers:

- Schools and academies FE colleges and other education providers
- General Practice
- Children centres and early years settings (nurseries)
- Early Help provider

- Health visitors
- Other mental health services (adult, specialist, forensic)
- Voluntary sector providers
- Independent providers
- Inpatient or paediatric services
- Youth services
- Safe guarding – children and adults (Local Safeguarding Children Board)
- Local authorities
- Emergency departments
- Community child health
- Youth justice system – including youth offending teams, Liaison and Diversion services, Children and Young People's Secure Estate
- Substance Misuse services
- Sexual Assault Referral Centres (SARCs)
- Job centres and careers advice
- Local independent providers.
- Local Mental Health Trust's.

4. Applicable Service Standards

4.1 Applicable national standards and guidance (eg NICE)

This specification links to the following NICE Quality Standards. *Please note that the list is not exhaustive.*

NICE quality standards relating to mental health and emotional wellbeing of children and young people:

NICE Quality Standard/ Guideline number	Title and link	Published	Review	Age range

QS31	Health and wellbeing of looked-after children and young people	April 2013	Apr 2018	0–18
QS34	Self-harm	June 2013	June 2018	Children and young people from 8 and adult
QS39	Attention deficit hyperactivity disorder	July 2013	July 2018	Children and young people from 3 and adult
CG28	Depression in children and young people	Sept 2005	Dec 2015	<18
QS48	Depression in children and young people	Sept 2013	Sept 2018	5–18
QS51	Autism	Jan 2014	Jan 2019	Lifespan
CG 128	Autism diagnosis in children and young people	Sept 2011	Nov 2014	<18
QS53	Anxiety disorders	Feb 2014	Feb 2019	Lifespan
PH 4	Interventions to reduce substance misuse among vulnerable young people	March 2007		< 25
QS59	Antisocial behaviour and conduct disorders in children and young people: pathway	April 2014	April 2019	< 18
CG 158	Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management	March 2013		<18
CG9	Eating disorders	January 2004	Tbc 2017	Children and young people from 8 and adults
CG78	Borderline personality disorder	January 2009	January 2015	Adults and young people (<18)
CG 155	Psychosis and schizophrenia in children and young people	January 2013		< 18

Evidence based treatment pathways

Over the next five years, NHS England will be working with Arm's Length Body (ALB) partners to develop **evidence-based treatment pathways** and the supporting infrastructure required to enable their implementation. Each of the pathways will be designed to span the journey from 'referral to treatment and recovery' including start of NICE concordant treatment. Below are the published and pending

publications relating to meeting the mental health needs of children and young people that the Provider will need to be aware of and implement in practice.

Already published:

- Early intervention in psychosis – the standard is targeted at people aged 14-65. https://www.england.nhs.uk/mentalhealth/adults/cmhs/#eip
- Community services for eating disorders in children and young people (this will be extended during 2016/17 to include in-patient and day patient services within the pathway) https://www.england.nhs.uk/mentalhealth/cyp/eating-disorders/

Planned for 2016/17:

- Generic children and young people's mental health – to be published 2017
- Perinatal mental health
- Urgent and emergency mental health care for children and young people (including 'blue light' mental health response - all ages)
- Acute mental health care

Planned for 2017/18 and 2018/19:

- Self-harm

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

The Provider shall adhere to the following standards/guidance as a minimum (this list is not exhaustive):

- Quality Network for Community CAMHS Standards (QNCC) - found at: http://www.rcpsych.ac.uk/quality/qualityandaccreditation/childandadolescent/communitycamhsqncc/ourstandards.aspx

- Quality Network for Inpatient CAMHS Standards (QNIC) - found at: http://www.rcpsych.ac.uk/PDF/QNIC%20Standards%202013.pdf

- Youth Wellbeing Directory and ACE-V Quality Standards - found at: http://www.youthwellbeing.co.uk/

- Child Outcome Research Consortium (CORC) - found at: http://www.corc.uk.net/

- Choice and Partnership Approach (CAPA) - found at: http://www.capa.co.uk/

- THRIVE Framework - found at: http://www.annafreud.org/service-improvement/service-improvement-resources/thrive/

- Implementing the Five Year Forward View for Mental Health - https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

- Delivering the Forward View: NHS Shared Planning Guidance 2016/17 - 2020/21: https://www.england.nhs.uk/publications/plan-guid-1617/

- The Five Year Forward View for Mental Health - https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

- Future in Mind (2015) - https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people

- Achieving Better Access to Mental health Services by 2020 - https://www.gov.uk/government/publications/mental-health-services-achieving-better-access-by-2020

- No Health without Mental Health. Department of Health (2011) - https://www.gov.uk/government/publications/no-health-without-mental-health-a-cross-government-mental-health-outcomes-strategy-for-people-of-all-ages-a-call-to-action

- Talking Therapies, a 4-year plan. Department of Health (2011) - https://www.gov.uk/government/publications/talking-therapies-a-4-year-plan-of-action

- Closing the Gap. Department of Health (2014) - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

- NHS and Social Care Act (2011) - https://www.gov.uk/government/publications/health-and-social-care-bill-2011-combined-impact-assessments

- Children and Families Act (2014) - http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted

- Mandate to Health Education England - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/310170/DH_HEE_Mandate.pdf

- Chief Medical Officer's Annual Report on State of Public Health (2014) - https://www.gov.uk/government/news/chief-medical-officer-publishes-annual-report-on-state-of-the-publics-health

- Behaviour and Discipline in Schools, Department of Education (2014) - https://www.gov.uk/government/publications/behaviour-and-discipline-in-schools

- Public Services (Social Value) Act 2012: https://www.gov.uk/government/publications/public-services-social-value-act-2012-1-year-on

- Five Year Forward View : http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

- Forward View into action: Planning for 2015/16 guidance: http://www.england.nhs.uk/ourwork/forward-view/

- Personal Health Budgets : https://www.england.nhs.uk/healthbudgets/understanding/mental-health/

- Choice of Provider Initiative : http://www.england.nhs.uk/wp-content/uploads/2014/05/guid-choice-prov-health.pdf

- Health and Social Care Advisory Service (2008) 'Turning what young people say into what services do Quality Standards for children and young people's participation in CAMHS': http://www.chimat.org.uk/resource/item.aspx?RID=67265

- "Delivering With and Delivering Well"[42] was developed by young people, commissioners and providers to integrate the principles of the CYP IAPT programme into existing quality assurance and accreditation frameworks: http://www.england.nhs.uk/wp-content/uploads/2014/12/delvr-with-delvrng-well.pdf

- Guide to Using Outcomes and Feedback Tools with Children, Young People and Families Formerly known as COOP (Children and Young Peoples' Improving Access to Psychological Therapies Outcomes Oriented Practice) and gives guidance on how to use outcome and feedback measures for children and young people with mental health issues and their families: http://www.ucl.ac.uk/ebpu/docs/publication_files/Guide_COOP_Book010414.pdf

- Mental Health Act 1983 (amended 2007): http://www.legislation.gov.uk/ukpga/2007/12/contents

- Mental Capacity Act 2005: http://www.legislation.gov.uk/ukpga/2005/9/contents

- Children Act 2004: http://www.legislation.gov.uk/ukpga/2004/31/contents

- Equality Act 2010: http://www.legislation.gov.uk/uksi/2012/2992/contents/made

- Care Act 2014: http://www.legislation.gov.uk/ukpga/2014/23/contents

- The Human Medicines Regulations 2012: http://www.legislation.gov.uk/uksi/2012/1916/contents/made

- Public Services (Social Value) Act 2012: http://www.legislation.gov.uk/ukpga/2012/3/contents

- 'Working together to safeguard children 2015': https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

- Promoting the health of looked after children : https://www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-looked-after-children--2

[42] CYP IAPT Values and Standards Subgroup - CYP IAPT National Service Development Group, CAMHS Press (2014)

- NHS Choice of Provider initiative: http://www.england.nhs.uk/wp-content/uploads/2014/05/guid-choice-prov-health.pdf

4.3 Applicable local standards

4.3.1 The provider will meet the local outcomes detailed in Schedule 2A, clause 2.3.

4.3.2 Standards for children and young people and parents'/carers' participation:

It is important that children and young people and their family/carers are involved at every level of service provision. This includes on an individual treatment level where we know it improves outcomes when children, young people and their family/carers are involved in shared decision making on their own treatment, setting goals that have a meaning for them, and using their feedback to guide their treatment.

It is also essential to involve children and young people, family/carers and others that come into contact with children and young people regularly such as schools, in the development and improvement of services.

Children, young people's and family/carers feedback, when combined with other outcome metrics, is an important part of service monitoring and effective ways to capture feedback from children and young people and their families/carers should also be considered.

Providers will ensure that all service developments and/or redesigns are undertaken using co-production with children and young people and their families/carers as well as all other relevant agencies.

All services must include children, young people, families and carers when designing and monitoring services. The Provider shall adhere to the principles set out in the Department of Health (2011) Quality Criteria for young people friendly health services ('You're Welcome') sets out principles to improve the suitability of health services for young people. https://www.gov.uk/government/publications/quality-criteria-for-young-people-friendly-health-services

5. Applicable quality requirements and CQUIN goals

Applicable Quality Requirements

See Schedule 4

Applicable CQUIN goals

See Schedule 3

Feedback and Outcome Tools

Providers should use the tools that best facilitate continuous quality improvement in their clinical practice to ensure quality requirements are meaningful both in tracking progress and for day-to-day clinical work and collaborative practice.

6. Location of Provider Premises

The Provider's Premises are located at:

The Provider will offer a range of locations that meet the needs of children/young people and their parents/carers and provide a choice of venue, for example, children's centres, clinics, drop-in sessions in other services and CAMHS providers.

Service Specification No.	E05
Service	CAMHS – Eating Disorder
Commissioner Lead	Joanne Marsh, Senior Locality Commissioning Manager, CCG
Provider Lead	Josey Povey, Associate Director North Staffordshire Community Mental Health Services
Period	1st April 2022 – 31st March 2023
Date of Review	**See 22/23 SDIP**

1. Population Needs

1.1. National/local context and evidence base

There has been universal acknowledgment in policy over the past ten years of the challenges faced by children and young people in developing resilience and psychological wellbeing. For those children and young people with diagnosable mental health problems and their parents/carers and the agencies that support them, the challenges are greater. A number of disorders are persistent and will continue into adult life unless properly treated. It is known that 50% of lifetime mental illness (except dementia) begins by the age of 14 and 75% by age 18. Young people who are not in education, employment or training report particularly low levels of happiness and self-esteem. The Macquarie Youth Index 2014 reported that 40% of jobless young people have faced symptoms of mental illness as a result of being out of work, and one-third of long-term unemployed young people have contemplated suicide. At the same time, effective treatments have been identified to improve the life chances of children and young people, and to minimise the impact on the long-term health of the population and economic cost to the public purse.

In the Autumn Statement 2014 the Government released £30m additional recurrent funds to transform Child and Adolescent Mental Health Services (CAMHS), a proportion of these funds have been allocated to deliver evidence-based Community Eating Disorder Services for Children and Young People (CEDS-CYP).

The pan Staffordshire Local Transformation Plan sets out the overarching principles and ambitions (NHS England; Department of Health, 2015). The Access and Waiting Time Standard for Children and Young People (NHS England; National Collaborating Centre for Mental Health, 2015) provides guidance on establishing and maintaining a community eating disorder service for children and young people. The guidance recommends that the service should have a minimum of 50 referrals per year and cover a minimum population of 500,000 (all age).

The service will cover the population of North Staffordshire and Stoke on Trent CCG's.

The agreed service model will address the requirements of the Access and Waiting Time Standard which intends to:

- Improve the quality of eating disorder services
- Provide new enhanced community assessment and treatment service
- Ensure staff are adequately trained and supervised in evidence-based treatment and effective service delivery
- Ensure best use of inpatient beds

As children and young people's emotional wellbeing and mental health affect all aspects of their lives, no one service alone will be able to meet their needs. There is a duty of cooperation placed on commissioners and services to work together to the benefit of children and young people.

The multi-faceted nature of CYPMH will require a whole system multi-agency approach to commissioning based on the needs of the local population. Changes in one agency or one part of the system can affect demand and delivery in another. This interdependency can create risks if not properly considered but also brings with it the possibility of agencies working together to meet the needs of the populations they serve and to achieve wider system efficiencies. Services should work together in integrated ways around needs of the population to ensure good communication and transitions.

This specification should therefore be linked to other specifications within the local area. For example (this is not an exhaustive list):

- Public Health
- Health Education
- CYPMHS inpatient services
- Health and Justice
- Health Visiting
- School Nursing
- Community Child Health
- Acute Paediatrics
- Accident and Emergency Services
- Perinatal Mental Health Services

- Youth Services
- Support services in schools
- Social care including residential care
- Adult Mental Health services
- Workforce planning and education of staff.

It is important that children and young people, wherever they first seek support or present with difficulties, are supported by professionals to receive appropriate help and support as soon as possible. This specification details delivery of local integrated, whole system, multi-agency care to ensure access to effective, holistic evidence-based interventions.

Financial cost of child and adolescent mental health problems

The costs incurred to the public purse of not treating children and young people early in their lives are considerable. For example:

- Mental health problems in children and young people are associated with excess costs estimated at between £11,030 and £59,130 annually per child. These costs fall to a variety of agencies (e.g. education, social services and youth justice) and also include the direct costs to the family of the child's illness. [43]
- There are clinically proven and cost-effective interventions. Taking conduct disorder as an example, potential life-long savings from each case prevented through early intervention have been estimated at £150,000 for severe conduct problems and £75,000 for moderate conduct problems.[44]
- The costs of providing safe and effective interventions associated with supporting children and young people in the community with crisis support or outreach can be considerably less than those associated with inpatient care.

Prevalence Data:

Location	Number Children 13-18	An. Ner. (Swanson Prevalence) (13-18) .3%	Bulimia (Swanson Prevalence) (13-18) .9%	Binge Eating (Swanson Prevalence) (13-18) 1.6%	Number Young People 15-24	An. Ner. (Hoek Study Prevalence) (15-24) .3%	Bulimia (Hoek Study Prevalence) (15-

[43] Department of Health, HM Government, No health without mental health: A cross- Government mental health outcomes strategy or people of all ages. Supporting document - The economic case for improving efficiency and quality in mental health, Crown Copyright (2011)
[44] Friedli, L. & Parsonage, M. 'Mental Health Promotion: Building an Economic Case Northern Ireland Association for Mental Health, NIAMH (2007)

							24) 1.0%
Stoke on Trent	17288.0	51.9	155.6	276.6	34436.0	103.3	344.4
Staffs Moorlands	6796.0	20.4	61.2	108.7	10286.0	30.9	102.9
Newcastle-under-Lyme	8682.0	26.0	78.1	138.9	18572.0	55.7	185.7
Total North Staffs	32766.0	98.3	294.9	524.3	63294.0	189.9	632.9

Prevalence Data North Staffordshire and Stoke on Trent:

Location	2014/15 Activity **	Projected 15/16 full year	Estimated Prevalence	Projected GAP	% met need
Stoke	14 **	58	484	426	**12**
North Staffs	15 **	66	433	367	**15**
Total	29 **	124	917	793	**13**

**** The Central Referral Hub was only in operation for the last 2 quarters of 2014/15 and therefore collated referrals were not recorded.**

The data indicates that at the present time, between 3% and 9% of children and young people with an eating disorder may be in treatment and/or known to services, of these cases the largest proportion of CYP accessing services had a diagnosis of Anorexia Nervosa. The data does not take into account atypical eating disorders and/or other eating distress, which forms part of the CAMHS caseload. The estimated prevalence of Binge Eating Disorder is 1.6% in 13-18 year olds, the lowest numbers of CYP accessing CAMHS services were those with a diagnosis of binge eating disorder.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**ü**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**ü**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**ü**
Domain 4	**Ensuring people have a positive experience of care**	**ü**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**ü**

2.2 Local defined outcomes

- 90% of CYP referred for assessment or treatment of an eating disorder will access NICE concordant treatment within 1 week for urgent cases and 4 weeks for routine cases (increasing to 95% compliance by 2020).
- Referrals will be screened by the end of the next Operational Day to assess urgency, telephone contact may be made with the CYP or parent / carer to clarify risk
- CYP deemed to be at high risk (and requiring urgent medical assessment) will be seen within 24 hours
- Urgent cases will receive a full clinical assessment (including risk assessment) within 5 Operational Days of referral
- Routine cases will receive a full clinical assessment (including risk assessment) within 4 weeks of referral.
- The service will support early facilitated discharge where clinically indicated to reduce the length of stay for young people admitted to Tier 4 in-patient services. The service will support an overall reduction in the number of Tier 4 in-patient bed nights of 10%.

3. Scope

3.1. Aims and objectives of service

The Children and Young People's Mental Health and Wellbeing Taskforce developed five key themes as part of Future in Mind:

- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers

- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

It calls on all those involved in supporting children and young people to work together to:

- Place the emphasis on building resilience, promoting good mental health, prevention and early intervention
- Simplify structures and improve access
- Deliver a clear joined up approach
- Harness the power of information
- Sustain a culture of continuous evidence-based service improvement; and
- Make the right investments

The provider shall:

- Work with children, young people, young adults and families/carers in co-designing and reviewing care pathways.
- Work with all relevant agencies to ensure that services for children and young people with mental health problems are coordinated and address their individual needs, providing a holistic approach.
- Ensure that children, young people and their families/carers are treated with compassion, respect and dignity, without stigma or judgment.
- Ensure that children and young people's physical health, social, educational and cultural needs are considered alongside their mental health needs.
- Ensure that children and young people who access the service receive treatment in a timely manner.
- Provide a range of evidence based (NICE approved) treatment interventions to ensure that children and young people's needs can be met.
- Ensure that children and young people's needs are considered in the whole and access to supplementary therapies and support are available
- Ensure that protocols are in place between the provider and the provider(s) of emergency or out-of-hours care, should support or consultation be required urgently
- Provide initial and follow-up assessments that are written and shared with the child, young person and/or parent/carer.
- Seek and use feedback in a range of settings, including the use of regular outcome monitoring in therapy, feedback regarding service delivery, and complaints.

- Ensure that children, young people and their families/carers are offered a choice of interventions that are evidence based and appropriate to their needs. Provide information at all stages of the pathway about interventions or treatment options to support children, young people and families/carers to make informed decisions about their care. This must be appropriate to their competence and capacity; information needs to be clear, easy to understand and jargon free.
- Ensure the impact of adverse childhood experiences, including trauma, abuse or neglect in the lives of children and young people is properly considered when identifying appropriate interventions
- Ensure that any additional vulnerability or inequality suffered by children and young people (e.g. learning disability, autistic spectrum conditions, victim of child sexual exploitation) is properly considered when identifying appropriate interventions
- Agree the aim and goal of interventions with the child/young person or family/carer, monitor the changes to agreed and shared goals as well as symptoms, and amend therapeutic interactions as a result of these changes, to deliver the best possible outcome
- Provide written information to the child/young person and family/carer about the care plan and how to access services (both routinely and in a crisis); this information needs to be clear, easy to understand and jargon free
- Provide information about how the services commissioned will increase opportunities for social value and social capital in line with the Social Value Act 2012
- Work collaboratively with other agencies in the health and social care and education systems to ensure regular case reviews to ensure effective progress through the care pathway.
- Ensure that best use is made of technology to support, facilitate and improve delivery of evidenced based treatment.
- Ensure that there is a formal route for referring children/young people to highly specialist mental health services (e.g. inpatient services, specialist outpatient services).
- Ensure that good relationships are maintained with relevant agencies in health, social care and education (including statutory, voluntary and third sector organisations) to aid referral into the service and ongoing support and treatment. This includes using whatever locally agreed systems there are to support joint agency working (e.g., Early Help Assessment (EHA) Team Around the Family), meeting statutory safeguarding guidance and providing clear protocols on information sharing, with children and young people being asked for consent regarding information sharing with other agencies (rather than a blanket decision not to share health information with such agencies).
- Ensure that clear communication pathways and information sharing mechanisms are in place so that children, young people and, where appropriate, their families/carers experience a smooth journey through the care pathway.
- Ensure Routine Outcome Measures, Patient Reported Outcome Measures are used to inform individual care plans and wider service improvements.
- Have clear reporting processes and standards, for example, as set out by the MHSDS, Youth Wellbeing Directory, QNCC and CORC .

3.2. Service description/care pathway

The service will provide:

- A multidisciplinary team supporting the individual and family to ensure best outcomes
- therapists with specific training and understanding of Eating Disorders to provide evidence based interventions, working closely with Dieticians and Paediatric Consultants to ensure both physical and mental health needs are addressed
- Access to service will be via the CAMHS Central Referral Hub
- The team will be located with Tier 3 Community CAMHS and will share resources and skill base to provide integrated service provision to this group of patients

3.3. Access and Waiting Time Standards

Access

The service will be compliant with the following access and waiting time standards:

- Provide CEDS for CYP aged 8 to 18 years
- Initially available Monday – Friday 9am-5pm. The Trust's operational policy is to reflect some flexibility where clinically relevant.
- Provide direct access to services through self-referral and/or referral from GPs and other professionals / workers. YP will be encouraged to self-refer
- Accept referrals from GPs, generic CAMHS, paediatric services, other healthcare settings, schools, colleges and non-healthcare workers (e.g., sports coaches, dance teachers)
- CYP under 16 will need a parent / responsible adult present at the initial contact. YP over 16 may be seen alone, although family involvement will be encouraged.

- Professionals / workers will encourage CYP and parents / carers to seek assessment with their GP, to rule out other physical health concerns. Where this is declined, they will be referred directly to the service. However, the CYP and parent / carers must be informed before contact with the service is made.

- Referrals will be via Central Referral Hub.

- The service will provide clear advice and guidance upon how to contact / access the service, including information online.

Waiting Times

The service will be delivered in line with the following waiting times;

- CYP referred for assessment or treatment of an eating disorder will access NICE concordat treatment within 1 week for urgent cases and 4 weeks for routine cases (90% compliance to be achieved, increasing to 95% compliance by 2020).

- Referrals will be screened by the end of the next Operational Day to assess urgency, telephone contact may be made with the CYP or parent / carer to clarify risk (e.g. physical, psychiatric, safeguarding and/or other risks)

- CYP deemed to be at high risk (and requiring urgent medical assessment) will be seen within 24 hours during Operational Days and by the Access Team outside of Monday – Friday, 9am – 5pm. dependent on the presentation location.

- Urgent cases will receive a full clinical assessment (including risk assessment) and commence treatment within 2 weeks of referral. Urgent treatments will be within one week after assessment.

- Routine cases will receive a full clinical assessment (including risk assessment) and commence treatment within 4 weeks of referral. If the child has not been seen by their GP they will be directed to their GP for consultation, to rule out other physical health concerns, with the next 2 Operational Days, if the GP does not see the CYP the referral will be treated as urgent.

3.4. Multi-agency Liaison / Education

The service will provide education, guidance and advice to primary care (GPs, school nurses), education (school and colleges), social care services (local support teams, safeguarding and secondary care services (acute paediatric services). Including:

- Consultation and advice on the appropriateness of referral
- Advice on accessing the services and/or initiating a referral
- 4 sessions per year providing training and education on early identification of eating disorders

The service will provide a Paediatric Liaison service, in accordance with Junior MARSIPAN guidelines (Royal College of Psychiatrists, 2012).

The expectation under the Paediatric Liaison Service is for a lead psychiatrist to be identified and to develop protocols with UHNM. Extracts from MARSIPAN guidance, relevant to this service, have been listed below:

- A lead consultant paediatrician and a lead consultant psychiatrist should be identified to coordinate care for Junior MARSIPAN patients and build working partnerships and develop protocols to support admission, including protocols for transition for young people 16–18 years of age.

- The decision to apply the Mental Health Act 1983 should be considered from the outset in a Junior MARSIPAN patient refusing treatment. If both the child and the parent refuse treatment, local safeguarding procedures should be followed and the Children Act 2004 (for patients up to age 18) used if necessary. An identified CAMHS consultant with a special interest in eating disorders should provide a second opinion in cases where there is a disagreement or uncertainty.

- When the location of SEDBs is identified, commissioners should put together a Junior MARSIPAN group (child and adolescent psychiatrist, paediatrician, paediatric dietician, paediatric and psychiatric/eating disorders nurses) to act as a focus for skill development/dissemination and advice when a child is admitted to a paediatric bed, which is located in a hospital able to admit such patients.

- The Junior MARSIPAN team should have explicit links with tier 4 CAMHS eating disorders services, who will work in conjunction with tier 3 CAMHS. One or two hospitals should be identified within each strategic health authority area (average population in England per area: 5 million) so that patients can be transferred if required.

- Clinicians and managers from paediatric and adult medical wards and CAMHS services likely to see young patients with anorexia nervosa should develop protocols in advance of situations of risk developing.

- Children and young people admitted to a paediatric ward should have the full and ongoing support of a consultant psychiatrist, who should form a partnership with the paediatrician. Input from trainees is welcome but must be backed by involvement of the consultant psychiatrist and regular contact between the two consultants. It is essential that psychiatrists providing support in this way be fully conversant with severe eating disorders and their management through specific training and experience or can be supported to achieve this. This should lead to the development of a shared care approach.

- To facilitate these arrangements, the following practices are recommended:
    - *production of guidelines on medical management of severely unwell young patients with an eating disorder aimed primarily at junior medical staff*
    - *a guide for nursing and medical staff on supporting patients and families*
    - *regular staff meetings to ensure a consistent approach and minimise the risk of splitting (such as playing off some staff against others by the patient).*

- For each individual admission a set of measures are recommended:
    - a regular multidisciplinary team meeting, usually weekly or more frequently if required, until discharge; senior paediatric, psychiatric and nursing staff – or those that can make decisions – should be present, together with someone with dietetic expertise and other individuals as required; input from trainees is welcomed as appropriate, but they must be adequately supported by senior colleagues
    - the role of this meeting should include reviewing progress with parents, the review of future care plans and conveying these to the young person as appropriate
    - a record of the meeting should be prepared and circulated to all, including the young person and the family; discharge planning should be included in the agenda of the multidisciplinary team meeting when appropriate
    - a nursing care plan which addresses the specifics of patient care for children and young people with an eating disorder should be formulated.

3.5. Clinical Pathways - Assessment

The locally agreed care pathway is detailed below. Initial assessment for an eating disorder will incorporate:

- the type and duration of the eating disorder
- an understanding of the mainlining factors of the disorder and any protective factors
- the physical, psychological and social consequences of the disorder
- the presence and severity of coexisting mental and physical health problems
- current medical risk and whether inpatient stabilisation is needed
- current psychiatric risk (to include significant self-harm) and whether inpatient stabilisation is needed
- whether the child or young person has already receive any NICE-concordance treatment for eating disorders
- the strengths, resilience and capacity of the family to manage treatment in the community
- the level of motivation for the child or young person and their family or carers to engage in treatment, including hidden feelings or despair and hopelessness
- the degree of confidence on the part of their child or young person that they will be able to make use of treatment

3.6. Treatment

Evidence based treatments will be concordat with NICE guidance (NICE, 2004) and include:

- CBT and enhanced CBT (CBT-E)

- Family Interventions and formalised family therapy

- Guided self-helps for bulimia nervosa

- Pharmacology interventions (as second-line interventions only, in accordance with NICE guidance)

At all stages patient choice will be embedded in assessment, care and treatment.

The service will maintain oversight of care from the point of referral, through treatment (in all settings), during post-treatment monitoring and is managing risk and relapse. The CEDS-CYP will be the lead service for co-ordinating treatment even if not directly involved in providing all aspects of treatment.

Where eating disorder is confirmed as the primary presenting problem the CEDS-CYP will manage common co-existing mental health problems such as depression and anxiety. Where the eating disorder co-exists with another mental health problems associated with risk, care will be shared between CAMHS and the CEDS-CYP.

The locally agreed care pathways will be developed by the provider. This care pathway should include consultation and liaison with other professionals.

3.7. Population covered

The service will cover the population registered with North Staffordshire or Stoke on Trent CCG GPs.

3.8. Any acceptance and exclusion criteria and thresholds

<u>Acceptance Criteria</u>

Providers will:

Accept referrals for children and young people aged 8-18 where there is a reasonable description that suggests that the child/young person may have an eating disorder from children or young people registered with GP in North Staffordshire / Stoke on Trent.

- Accept referrals from GPs, generic CAMHS workers, paediatric services other healthcare settings, schools, colleges and non-healthcare workers (e.g. sports coaches, dance teachers). CYP under the age of 16 will need a parent / responsible adult to be present at the initial contact. Young people over the age of 16 may be seen alone, although family involvement will be encouraged,
- In cases where referrals are found to be inappropriate, with consent, refer or signpost the child/young person and their family/carers to other services.
- Provide locally available, age- and developmentally appropriate, co-produced information for children/young people, parents/carers and referrers about the services provided and how they are accessed.
- Support the Early Help Assessment/Common Assessment Framework and local protocols.
- Support and ensure inter-agency working.
- Support and ensure discharge or transition planning.
- If the service concludes that the needs of child/young people or parents are better met by other agencies. It will signpost CYP, families or professionals to that service, referrals will be sent directly where consent is received.
- Ensure that the referrer is clear as to whether the service has accepted the referral and, if not, in line with agreed information-sharing protocols, provide the rationale for this and written suggestions to what the services will do, for example referral onto other appropriate services.
- Provide advice to those thinking about referring can have a discussion prior to the referral.
- Gather the agreed range of information at the point of referral

<u>Exclusion Criteria</u>

Children and young people may *not* be eligible for the service on the basis of:

- Aged below 8 years of age or over 18 years of age
- The referred problem may be best treated in an alternative service e.g. generic CAMHS.
- Where a more clinically appropriate service has been commissioned from an alternative provider
- Children in court proceedings where intervention is not advised under Home Office guidelines
- Court assessments, unless specifically contracted

- Where the service is not commissioned to include the clinical presentation e.g. other mental health problems, eating difficulties

3.9. Initial Assessment

Initial assessment for an eating disorder will incorporate:

- the type and duration of the eating disorder
- an understanding of the mainlining factors of the disorder and any protective factors
- the physical, psychological and social consequences of the disorder
- the presence and severity of coexisting mental and physical health problems
- current medical risk and whether inpatient stabilisation is needed
- current psychiatric risk (to include significant self-harm) and whether inpatient stabilisation is needed
- whether the child or young person has already receive any NIC-concordance treatment for eating disorders
- the strengths, resilience and capacity of the family to manage treatment in the community
- the level of motivation for the child or young person and their family or carers to engage in treatment, including hidden feelings or despair and hopelessness
- the degree of confidence on the part of their child or young person that they will be able to make use of treatment

The outcome of the assessment should be recorded in the service user's note and be passed on to any other service involved in the care of the service user with the informed consent of the young person and/or parent/carer**.**

3.10. Continuing Care and Assessment

Providers will:

- Ensure that care plans (following the Care Programme Approach [CPA], where transitioning to adult services or discharged from Tier 4 inpatient services) are in place for all people receiving support for mental health problems. These plans should be coordinated across agencies, teams and or disciplines, be clearly written, identify the key coordinator and be developed in

collaboration with children/young people and parents/carers where possible. A copy should be given to the service user, parent/carer (if appropriate) and other agencies such as the GP.

- Ensure that the care plan includes appropriate risk management and crisis planning.

- Review the care plan with the service user and parent/carer (if appropriate), including the goals of treatment, and revise the care plan at agreed intervals. The dates for review should be set out in writing and depend on the nature of the problem – many problems should be reviewed every three months but others may require a less frequent review. Where a significant change has taken place, or when there is a change in the care management plan, review should be carried out as soon as is practical.

- Select treatment options in consideration of:
    - Age-appropriate best practice/evidence-based psychological intervention
    - Pharmacological and psychosocial interventions
    - Environmental and occupational/educational interventions or provision
    - The availability of a multimedia prevention package whilst on waiting list
    - Engagement, flexibility and choice.

Any planning for children and young people with severe educational needs should take account of and be part of the child or young person's statement/Education Health and Care plan.

3.11. Does Not Attend (DNA) / Re-engagement Policy

When a service user does not attend, a risk assessment should be made and acted upon. A service should not close a case without informing the referrer that the service user has not attended. The service should make explicit re-engagement policies available to referrers, children/young people and parents/carers.

3.12. Care Transition Protocols

The service will have protocols in place to ensure that transitions between services are robust and that, wherever possible, services work together with the service user and parents/carers to plan in advance for transition (this is especially critical in the transfer from between CAMHS and CEDS-CYP and to the adult ED team and primary care or other services, e.g. voluntary/third sector). As a minimum, children/young people leaving CAMHS should have:

- A written and agreed care plan detailing what service they will receive post-transition
- At least one face-to-face meeting with their key worker and the key worker from the service to which they will move for further care
- Follow up after the transition, to ensure appropriate interventions are in place. As per the requirements of CQUIN Indicator 5, 'Transitions out of Children and Young People's Mental Health Services', Post-Transition Experience component of CQUIN, to be assessed via a User Survey / Questionnaire. Data to be submitted to Commissioners on a quarterly basis, as per the CQUIN requirements.
- A written and agreed plan, if no further interventions or treatment are planned, so that the young person and, where appropriate, parents/carer knows what to do if they become unwell
- A specific protocol for those going to primary care.

Service Transition Protocols should ensure that:

- Children and young people will have continuity of care
- Any risks or safeguarding concerns are clearly considered and documented
- Arrangements for transition planning take place.

Groups needing particularly robust transition processes include:

- Looked after children
- Care leavers moving to independent living
- Young people entering or leaving inpatient care
- Young people entering or leaving prison
- Young offenders
- Children and young people with learning disabilities
- Unaccompanied asylum-seeking minors
- Children and young people with caring responsibilities
- Those not in education, employment or training (NEET).

3.13. Activity

The service will assess and treat a minimum of 50 referrals per year (including existing cases transferring to the new service). Capacity and demand will be kept under review in line with usual contract review arrangements.

3.14. Information Governance and Accountability

The provider will comply with all relevant legislation and guidance to record information, in particular to comply with Data Protection acts, and comply with requirements to keep records for an appropriate period

3.15. Interdependence with other services/providers

Providers should ensure they have excellent links with services regularly used by young people:

- General Practice
- Schools and academies FE colleges and other education providers
- Children centres and early years settings (nurseries)
- Early Help provider
- Health visitors
- Other mental health services (adult, specialist, forensic)
- Voluntary sector providers
- Independent providers
- Inpatient or other highly specialist services
- Youth services
- Safe guarding – children and adults (Local Safeguarding Children's Board)
- Local authorities
- Acute sector hospitals
- Emergency departments
- Community child health
- Criminal justice system – including young offenders services
- Addiction services
- Job centres and careers advice
- Local independent providers

4. Applicable Service Standards

a. Applicable national standards (e.g. NICE)

The Provider shall adhere to NICE Clinical Guidance (CG9), Eating disorders in over 8s: management (2004): https://www.nice.org.uk/guidance/cg9/

This specification links to the following NICE Quality Standards and will be reviewed upon the publication of further guidance.

Please note that the list below is not exhaustive.

NICE quality standards relating to mental health and emotional wellbeing of children and young people:

NICE Quality Standard / Guidelines number	Title and link	Published	Review	Age range
QS31	Health and wellbeing of looked-after children and young people	April 2013	Apr 2018	0–18
QS34	Self-harm	June 2013	June 2018	Children and young people from 8 and adult
QS39	Attention deficit hyperactivity disorder	July 2013	July 2018	Children and young people from 3 and adult
CG28	Depression in children and young people	Sept 2005	Dec 2015	<18
QS48	Depression in children and young people	Sept 2013	Sept 2018	5–18

QS51	Autism	Jan 2014	Jan 2019	Lifespan
CG 128	Autism diagnosis in children and young people	Sept 2011	Nov 2014	<18
QS53	Anxiety disorders	Feb 2014	Feb 2019	Lifespan
PH 4	Interventions to reduce substance misuse among vulnerable young people	March 2007		< 25
QS59	Antisocial behaviour and conduct disorders in children and young people: pathway	April 2014	April 2019	< 18
CG 158	Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management	March 2013		<18
CG78	Borderline personality disorder	January 2009	January 2015	Adults and young people (<18)
CG 155	Psychosis and schizophrenia in children and young people	January 2013		< 18

b. Standards for Children and Young People's and Parents' Participation

All services must include their clients when designing and monitoring services. The list below is not exhaustive

- Department of Health (2011) Quality Criteria for young people friendly health services ('You're Welcome') sets out principles to help commissioners and service providers to improve the suitability of NHS and non-NHS health services for young people.
- National Youth Agency (2006) Hear by Right. Standards for young people's participation (not specifically mental health) (purchase price).
- Health and Social Care Advisory Service (2008), Turning what young people say into what services do. Quality Standards for children and young people's participation in CAMHS

http://www.chimat.org.uk/resource/item.aspx?RID=67265 is based on the Hear by Right standards above and adapted specifically for CAMHS.

- "Delivering With and Delivering Well"[45] was developed by young people, commissioners and providers to integrate the principles of the CYP IAPT programme into existing quality assurance and accreditation frameworks.

c. Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

- Quality Network for Community CAMHS Standards
- Quality Network for Inpatient CAMHS Standards
- Youth Wellbeing Directory and ACE-V Quality Standards http://www.youngminds.org.uk/training_services/training_and_consultancy/for_commissioners/ace-value
- Child Outcome Research Consortium (CORC)
- Choice and Partnership Approach (CAPA)

Associated policy documents:

- No Health without Mental Health. Department of Health (2011)
- Talking Therapies, a 4-year plan. Department of Health (2011)
- Closing the Gap. Department of Health (2014) https://www.gov.uk/government/publications/mental-health-priorities-for-change
- NHS and Social Care Act (2011)
- Children and Families Bill (2013)
- Mandate to Health Education England
- Chief Medical Officer's Annual Report on State of Public Health (2014)
- Behaviour and Discipline in Schools, Department of Education (2014)
- Public Services (Social Value) Act 2012
- Achieving Better Access to Mental health Services by 2020
- Five Year Forward View

[45] CYP IAPT Values and Standards Subgroup - CYP IAPT National Service Development Group, CAMHS Press (2014)

d. Applicable local standards

The service will support early facilitated discharge where clinically indicated to reduce the length of stay for young people admitted to Tier 4 in-patient services. The service will support them to be repatriated home, integrate into their local community and to engage with local support networks. A reduction in average length of stay from 82 to 77 days to be supported.

The service will support an overall reduction in the number of Tier 4 in-patient bed nights of 10%.

2. Applicable quality requirements and CQUIN goals

a. Applicable Quality Requirements (See Schedule 4)

The service will be a member of the QNCC-ED.

http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/childandadolescent/communitycamhsqncc/qncc-ed/joiningqncc-ed1.aspx

b. Data recording must include

All services providing NHS-funded CAMHS must be locally collecting and using CAMHS Minimum Dataset which has been approved by the Information Standards Board for Health and Social Care (ISB) as an information standard for the NHS in England.

Data recording should include:

- Agreed assessment measures
- Whether the individual is currently being seen by any other local services, including in schools or academies.

c. Applicable CQUIN goals (See Schedule 3)

6. Location of Provider Premises

The Provider will offer a range of locations that meet the needs of children/young people and their parents/carers and provide a choice of venue, for example, children's centres, clinics, drop-in sessions in other services and CAMHS providers.

Service Name	**Child and Young Person's Intensive Support Hub (ISH) Service**
Service Specification Number	**E06**
Population and/or geography to be served	**The Child and Young Person's Intensive Support Hub (ISH) Service is for:** • **Children and young people (CYP) aged between 12 and 18 years who are registered with a general practitioner within the North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups. For people who are not registered with a GP, the service will be open to people for whom the above CCGs are recognised as being responsible commissioners. Children under 12 years of age will be seen by the Crisis Centre.** • **CYP with moderate and severe mental health problems that are causing significant impairments in their day-to-day lives. These may be acute presentations.** • **CYP who have reached a point where admission to a CYP mental health bed is being considered.** • **CYP who are experiencing a substantial decline in their mental health where community teams have worked to prevent admission, however risks have increased and further support is required to jointly work with the CYP ISH, to assist in hospital admission.** • **CYP who require community support in assisting in shortening the inpatient stay by facilitating early discharge and support back to the community.** • **A deterioration in a CYP presentation due to Learning Disabilities and/or Autism. In such circumstance the ISH will work with the Learning Disability Services within the Provider to assess the CYP needs and determine which service is best placed to meet these needs.** • **CYP with substance misuse issues will not be excluded from the services. Each referral shall be considered on a case-by-case basis.**
Service aims and desired outcomes	**The aim of the Child and Young Person's Crisis and Intensive Support Pathway, which includes a number of different service components, is to meet the ambition of the NHS Long Term Plan for Northern Staffordshire where there is 24/7 crisis provision for CYP that combines crisis assessment, brief response and intensive home treatment functions. These components, include the Crisis Care Centre, Mental Health Liaison team and the Intensive Support Hub.**

	The specific aim of the ISH is to be an alternative psychiatric hospital-based treatment and provide intensive support to CYP within an appropriate community setting. **The following objectives are considered key to delivering an effective service for the CYP of Stoke on Trent and North Staffordshire:** • **All CYP experiencing a mental health crisis will be able to access a prompt, comprehensive assessment of their needs conducted by trained staff in an age-appropriate manner in a suitable setting 24 hours a day, seven days a week via urgent and emergency provision (Crisis Care Centre and Mental Health Liaison).** • **Addressing the inequalities in access, by breaking down barriers between services and address where there is currently inappropriate care for the CYP most at need.** • **Care should seek to avoid inpatient admissions and provide high quality alternatives to admission.** • **CYP are treated in their own home or preferred environment.** • **There is an offer of bespoke and tailor-made support and care for those CYP who require more intensive support.** • **NICE complaint, well-managed, needs led and effective pathways and service offer.** • **All commissioned services together provide a 'whole system' approach, delivered within the ethos of partnership working, to ensure the right care, at the right time in the right place.** • **The ability to respond in a timely, flexible and creative way to the challenges that young people with a high level of mental health needs present.** **The expected outcomes are as follows:** • **Care, treatment and support is provided in the least restrictive setting, with improve access to intensive community-based care.** • **Improved skilled workforce to meet the demand of the local population of people who require intensive support.** • **Reduction in admissions into CAMHS in-patient services.** • **Timely transition and discharge of CYP from CAMHS in-patient services with a reduction in the Length of Stay.** • **Enhanced and more flexible engagement with CYP and families.**

	• **Higher satisfaction levels with CAMHS services from CYP and families.** • **Reduction in A&E attendance, including repeat attendances for CYP in mental health crisis.** • **Reduction in admissions/OBD on general paediatric wards for CYP in mental health crisis who attend to an acute healthcare setting.** • **Reduction in costs of in-patient admissions, including out of area placements.** • **Reduction in appropriate use of adult facilities such as the section 136 suite for CYP.** **A range of outcome tools will be used to demonstrate effectiveness of the service delivered, including both clinical tools, patient/family-oriented tools and tools that provide an assessment of functioning such as:** ◦ **Parent/Child versions of Kid screen-10** ◦ **Family functioning - Score-15** ◦ **SDQ impact scores**
Service description and location(s) from which it will be delivered	**This service template is intended as a working document which is responsive to change and therefore the service needs to remain flexible in order to adapt to change and new strategic direction. The service described for children and young people will place them and their parents/carers at the heart of everything they do.** **The CYP ISH Service supports the ambition set out in the NHS Long Term Plan for crisis and intensive CAMHS care in Northern Staffordshire (Figure 1). It will bridge hospital and community services to deliver a dynamic CAMHS system that builds upon and develops local and sub-regional capacity and capability. It forms part of the CYP crisis and intensive support pathway in Northern Staffordshire, that is comprised of the following components:** 1. **Crisis, that is provided via** • **All Age Access Team, based at Crisis Care Centre, that is operational 24/7 and provides referral management, triage, assessment and signposting.)** • **All Age Mental Health Liaison Team based at Royal Stoke Hospital.** 2. **Home intervention and outreach team (including brief response), that is provided via** • **Intensive Support Hub (ISH)**

3. Gatekeeping CAMHS in-patient beds, that is provided via

- **Darwin Centre**

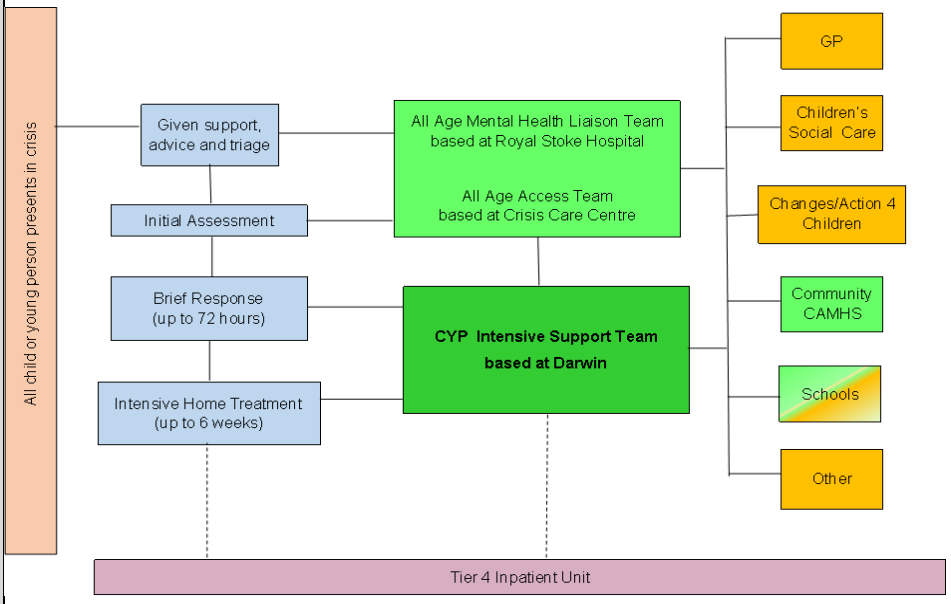
Figure 1:Nationally defined intervention level

1. Support, advice and triage	• May sufficiently address concerns. • Sign post to a more appropriate organization. • Identify any possible mental health problems and whether the child or young person requires a timely face-to-face crisis assessment with a specialist mental health professional. • Based on joined up, local services with clearly defined pathways,
2. Crisis assessment	• When a more detailed biopsychosocial assessment is needed, then this should be completed face to face by professionals trained and experienced in working with children and young people. • It should take place within an appropriate setting for the CYP. • The CYP, and where appropriate their family, carer or support network, should be involved in the decision-making process. • The CYP should be given a choice in who they are seen and assessed by and then supported by the same professional to ensure continuity and avoid repetition.
3. Brief response	• If required following assessment, CYP will also receive brief follow-on interventions over a number of days which may take place in a clinic or in a community setting, including their home.
4 4. Intensive Home Treatment (IHT)	• For some this may include, home treatment or intensive community support, admission avoidance and/or step-down care. • An alternative to CYP who might otherwise require inpatient care, and/or interventions that exceed the normal capability of a generic children and young people's mental health community team.

	• Available outside traditional working hours and capable of offering frequent support contacts - at least three times per week up to multiple occasions per day in the person's home or an appropriate community setting. • Usually up to 6 weeks in duration.

Figure 2 describes the operating model for the Child and Young Person's Crisis/Intensive Support services in Northern Staffordshire.

Figure 2: Child and Young Person's Crisis and Intensive Support Services Operating Model at North Staffordshire Combined NHS Healthcare Trust.



CYP Intensive Support Hub (ISH)

The ISH service is based around the Thrive[46] element of 'getting risk support', where those CYP known to services are for example, are not finding core CAMHS efficient, easy to access/use, or the evidence base interventions are not working for them, which is leading to a deterioration in their mental health and crisis and requires a different level and type of support. The CYP may not be known to CAMHS prior to referral. The key themes of delivery of care and support from the ISH are:

[46] The THRIVE Elaborated (2015) model offers a set of principles for multiagency integrated solutions to respond to the mental health needs of local populations. Unlike other models, it makes a clear distinction between mental health treatment and mental health support

	• **Strongly weighted on clinical discussion and supporting reflective practice across the system to support referrers to offer the young person and family the help or support they need right now.** • **Shared decision making with the young person and their family to facilitate improved outcomes and/or reduce the likelihood of further crises.** • **Pragmatically driven and flexible approach, location and attendees to meet the needs of young people and families.** • **Providing CYP and their family or carer receive evidence based, effective intensive support focused on a short-term model of care.** • **Provide an alternative to psychiatric hospital-based treatment for CYP.** **To enable patients to be involved in decisions about their care and treatment it is important that they are engaged in the whole process including the planning, evaluation and review. It is also important that they are provided with information, which is relevant, up to date and in a format they can understand.** • **The ISH is operational 8am-8pm, 7 days a week.** • **For out of hours, children will be seen by the All Age Crisis Care Centre** **Referrals** **Referrals into the ISH will be accepted from a number of sources, including community CAMHS teams, all age mental health liaison team, Crisis Care Centre (including section 136 suite), CYP mental health in-patient unit, mental health support teams within schools.** **The CYP will have been assessed within 24 hours face to face, of the ISH Service receiving the referral.** **Each patient referred to the CYP ISH caseload will have a named practitioner allocated to them.** **In the case of a CYP with a Learning Disability, the ISH team will liaise with the Learning Disability Services (for example, the Intensive Support Team and the Transforming Care Partnership team) to jointly assess the needs of the patient and establish the correct care and treatment based on presenting needs. Where appropriate a Care and Education Treatment Review (CETR) may be required.**

Intensive support offer

Interventions plans will be completed following the initial 72-hour assessment period should a CYP be identified as requiring ongoing intensive home treatment.

A true person-centered intervention plan should be written using the CYP's own words and encourage the empowerment of the individual to take control of their care in a structured and clear way. It should be done collaboratively with the young person and family as a framework to facilitate inpatient discharge and/or engagement in interventions. A clear intervention plan should:

- **Identify needs including safety.**
- **Identify strengths and aspirations.**
- **Helps to prioritise care and treatment.**
- **Ensure continuity of care.**
- **Knowing who is doing what/when/how**

Intervention should be reviewed upon each contact and a minimum standard following 7 days of initial completion.

Intensive support/intervention in the form of home treatment shall be provided to individuals within their own homes or in another suitable accommodation to help and support to resolve the current situation. Intensive community support should include daily contact if required.

The interventions provided should be tailored and bespoke and have a greater focus on improving functioning, reducing risk and enhancing engagement with services rather longer-term recovery.

In addition, the ISH Team shall offer:

- **"Bolted on" support to existing CAMHS/LD/LAC care package within CAMHS to offer intensive support in the community to focus understanding/case formulation and supporting young people/families implement interventions.**
- **Short-term evidence-based interventions that offer a higher level of frequency/intensity than community CAMHS/LD/LAC services can provide, such as**
    - **PBS alongside sensory profiling & care planning**
    - **Intensive parenting interventions (DBT informed training/Non-Violent Resistant training)**

	CAMHS In-patient support **The CYP ISH will work closely with gatekeeping component within the Darwin Centre (or other inpatient 4 provision) for all CYP in Northern Staffordshire who require admission to an inpatient mental health bed.** **Young People will be admitted to hospital only when there is a clearly identified clinical or risk management need for psychiatric in-patient care with a clear plan of what needs to change in order for discharge to occur. Where admission does occur, then there shall be an in-reach review by the ISH Team within at least 72-hours of admission.** **The ISH will provide comprehensive support for those young people who have been admitted to CAMHS inpatient facility to facilitate discharge and ensure the intensive community support is available to reduce length of stay in hospital. The ISH shall be part of the inpatient review process and assess, whether the reasons for admission still exist and what needs to happen in order for discharge. This will include developing care plans and safety plans collaboratively with the young person and family as a framework to facilitate inpatient discharge and/or engagement in interventions offered across CAMHS/multi-agencies.** **Transfer out of ISH** **Once a CYP has increased functioning and where safe and appropriate, other services that provide 'getting more help' (under the Thrive Model) can move to support the person and their family (such as core CAMHS or the mental health support teams within schools).** **It is anticipated that the ISH team will support the CYP for up to 15 weeks, but this shall be determined on a case-by-case basis.** **The ISH Service will have protocols in place to ensure that transitions between services are robust and that, wherever possible, services work together with the service user and parents/carers to plan in advance for transition.** **Workforce** **The ISH service will be multi-disciplinary in form and as per the original NSCHT business case the workforce will be based on the staffing detailed in the business case.** **However, given the workforce challenges, the Provider shall be expected to be innovative and creative in creating a team that meets the needs of the patients while still adhering to best practice/NICE Guidance. Hence, at times an alternative skill mix roles should be considered to provide greater flexibility, resilience and variety.**

	There will be a minimum of one professionally qualified and trained staff available at all times. The Service will have access to a psychiatrist 24 hours a day to undertake assessments where the level of need indicates this is appropriate. **Staff should be specifically trained in issues of consent and capacity, the use of current mental health legislation and the use of childcare laws, as they apply to this group of patients. Staff should also be trained in and be aware of local safeguarding policies and procedures.** **Interdependences** **In order to fulfil core functions CYP ISH requires a whole systems approach to working. As part of the Staffordshire and Stoke-on-Trent Integrated Care System CAMHS transformation, the Thrive model should be the basis for service provision in the future.** **Liaison with colleagues within other teams across the Provider is crucial to multi-disciplinary working and furthermore essential to providing a seamless and collaborative plan of care for the CYP and their families.** **There should also be effective partnership working and systems of communication and protocols for information sharing among different agencies that are relevant to CYP and their families/carers. Such as:** • **The wider community and social support networks, including Voluntary, Community and Social Enterprises** • **Primary, secondary and independent services** • **Education** • **Social Care** • **Police** • **Catch 22 (Missing and Child Sexual Exploitation Services)** • **Substance misuse services** **National guidance** **The Service shall ensure that NICE Guidance/quality standards are adhered to, which includes but is not limited to:** • **QS53 - Anxiety Disorders** • **CG123 -Common mental health problems: identification and pathways to care** • **QS34-Self harm**

	• **CG53 - Transition between inpatient mental health setting and community or care team home settings** • **NG134 - Depression in children and young people: identification and management**

Service Specification No.	F02
Service	Intoxication Observation Unit
Commissioner Lead	Nicola Bucknall, Commissioning Manager – North Division, CCG
Provider Lead	Fiona Platt, Associate Director, Specialist Services
Period	1st April 2022 – 31st March 2023
Date of Review	As required

1. Population Needs

2.5 National Context and Evidence Base

Alcohol-related harm is a long-standing problem that is placing increasing demands on the NHS. At a time when unprecedented efficiencies need to be made by the NHS and local authorities, preventative action must be taken seriously.

Alcohol is the most common cause for liver disease in England and accounts for over a third of liver disease deaths. The more someone drinks over the lower-risk guideline, the higher their risk of developing liver disease. The UK is one of the few European countries where alcohol consumption has risen in the last 50 years.

There were 1.1 million estimated admissions related to alcohol consumption in 2015/16. This is 4% more than 2014/15. This represents 7.0% of all hospital admissions which is similar to 2014/15 and 2013/14.[47]

In 2015, there were 6,813 deaths which were related to the consumption of alcohol. This is 1.4% of all deaths. Over the last decade alcohol related deaths have risen by 10% at a time when outcomes from other conditions are improving.

[47] Statistics on Alcohol England, May 2017, NHS Digital

Alcohol dependence affects 9% of men and 4% of women in England and over 24% of the English population (33% of men and 16% of women) consume alcohol in a way that is potentially or actually harmful to their health or well-being.

Comorbid mental health disorders commonly include depression, anxiety disorders and drug misuse, some of which may remit with abstinence from alcohol but others may persist and need specific treatment. Physical comorbidities are common, including gastrointestinal disorders (in particular liver disease) and neurological and cardiovascular disease. In some people these comorbidities may remit on stopping or reducing alcohol consumption, but many experience long-term consequences of alcohol misuse that may significantly shorten their life.(e.g. alcohol related brain damage, chronic liver disease).

Of the 1 million people aged between 16 and 65 who are alcohol dependent in England, only about 6% per year receive treatment. Reasons for this include the often long period between developing alcohol dependence and seeking help, and the limited availability of specialist alcohol treatment services in some parts of England. Additionally, alcohol misuse is under-identified by health and social care professionals, leading to missed opportunities to provide effective interventions.

Local Context

North Staffs

- For all three measures of alcohol-related hospital admissions, the rate in Newcastle is statistically significantly higher than the national average – see http://fingertipsreports.phe.org.uk/local-alcohol-profiles/e07000195.pdf for more information
- Conversely, for two of the three indicators in Staffordshire Moorlands the rates are significantly better than the national average – see http://fingertipsreports.phe.org.uk/local-alcohol-profiles/e07000198.pdf
- The alcohol-specific mortality rate in Newcastle is significantly above the national rate, although in the Moorlands the rate is similar to the national average.
- In both Newcastle and the Moorlands the rates of alcohol-related road traffic accidents are significantly above the national average.
- Levels of alcohol-related benefit claimants are statistically higher than the national average in Newcastle but significantly lower in the Moorlands.

Stoke-on-Trent

- Stoke-on-Trent City Councils 2016 Lifestyle survey revealed that 44% of people are potentially drinking alcohol at increasing and higher risk levels. There are estimated to be almost 15,000 young people living with a parent who is a binge drinker and almost 3,000 living with a dependent drinker.

- More than 40,000 Stoke-on-Trent residents are drinking at levels which increase their vulnerability to related harm, (LAPE, 2015)
- Stoke-on-Trent experiences some of the highest numbers of people dying as a direct and indirect result of alcohol misuse (LAPE, 2015) and is the leading cause of premature death
- It costs an estimated £13m per year in relation to hospital resource alone
- The rates for alcohol related crime, including violence and sexual offences, ranks the city within the worst 24 authorities (of 326); with violent crime placing the city the 7th worst (LAPE, 2015)
- In 2015, 21% of residents surveyed referenced alcohol misuse as a contributing factor to feeling unsafe (*Feeling the Difference Survey*, 2015).

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**ü**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**ü**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**ü**
Domain 4	**Ensuring people have a positive experience of care**	**ü**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**ü**

2.2 Local Defined Outcomes

Collective outcomes

The inpatient unit forms part of the wider interdependent network of interventions that form the North Staffordshire drug and alcohol treatment system. The fundamental collective goal of the treatment system is to:

Improve the lives of individuals, families and communities affected by problematic drug and alcohol use

Specifically, the treatment system should collectively achieve a range of outcomes, including:

For communities;

- Reduced offending
- Reduced fear of crime
- Reduced use of public resources (benefit claims etc.)
- Reduction in health costs, reduction in avoidable hospital admissions

For families;

- Improved parenting
- Improved family responsibilities

For individuals;

- Reduce drug / alcohol use
- Improved physical health
- Improved mental health/ well-being/ quality of life
- Improved social situation – education/ employment/ accommodation

Service Specific Outcomes

While contributing directly and/or indirectly to the collective outcomes, the specific outcomes to be delivered by IOU are:

- Assist patients' withdrawal from acute alcohol intoxication in a safe and therapeutic environment
- Prepare patient appropriately for subsequent interventions and community packages of care where appropriate.
- Support the reduction of presentations to secondary care by working closely and in collaboration with community services and the voluntary sector

-

3. Scope

3.1 Aims and Objectives of Service

Aims

- To reduce alcohol-related A&E attendances to the acute trust (including re-attendances)
- To improve the flow of alcohol-related admissions through and out of the acute hospital
- To improve patient outcomes and to deliver more cost effective, co-ordinated care

Objectives

- Provide an alternative and appropriate / safe environment for alcohol intoxicated individuals (instead of A&E)
- To provide safely managed care for alcohol intoxicated patients until they are well enough to return home.
- Using specialist knowledge of wider community alcohol support services ensure that patients are signposted to the correct service so that they receive further support as necessary

3.2 Service Description/Care Pathway

The IOU unit has 2 beds which will be used to monitor and assess patients who are intoxicated

Referrals

- Patients who are intoxicated (alcohol) and meet the transfer criteria (appendix 1 and 2) shall be diverted from the A&E to Harplands Hospital, thereby enabling flow through A&E. The facility shall include a range of staff from community treatment services to enable appropriate patients to be engaged in specialist services and thereby deterring re-presentations at A&E.

- Patients will be identified by the lead medic and a local proforma (Appendix 1) will be completed. Following a telephone call with IOU staff to ensure clinical suitability, the patient will be transferred.

- IOU staff will also proactively attend A&E /CDU to support and assist in the identification of appropriate clients who have the potential to move to IOU.

- The service shall also accept direct referrals from the West Midlands Ambulance Service as per the transfer criteria below (Appendix 1)
- A telephone conversation must take place between the clinician on scene and the IOU, to discuss the patients presenting condition and whether conveyance to the unit would be appropriate.

- If these criteria are met the referrer shall telephone the Nurse in charge at Edward Myers to arrange transfer. The referrer shall complete the IOU Proforma and transfer with the patient.

Operating Hours

The unit will accept referrals 24/7, 365 days a year

Assessment, treatment and interventions

- **Undertake observations as level of intoxication falls**
- **Complete assessment focusing on alcohol history**
- **Develop discharge plan with aim to engage with other agencies as needed**

This service is delivered by Health Care Support workers, however governance arrangements are in place for senior nursing /medical support should it be required.

Staff will have appropriate training and competencies to monitor patients' physical health observations.

For all people who misuse alcohol, carry out a motivational intervention as part of the initial assessment. The intervention should contain the key elements of motivational interviewing including:

- helping people to recognise problems or potential problems related to their drinking
- helping to resolve ambivalence and encourage positive change and belief in the ability to change
- adopting a persuasive and supportive rather than an argumentative and confrontational position.

For all people who misuse alcohol, interventions to promote abstinence or moderate drinking as appropriate and prevent relapse, in community-based settings will be offered. i.e. the IOU will make onward referrals to community based teams

Consider offering interventions (by referring to community services) to promote abstinence and prevent relapse as part of an intensive structured community-based intervention for people with moderate and severe alcohol dependence who have:

- very limited social support (for example, they are living alone or have very little contact with family or friends) **or**
- complex physical or psychiatric comorbidities **or**
- not responded to initial community-based interventions

Where the patient is already known to community alcohol teams the service will contact keyworkers and facilitate follow up appointments. Where possible this will be confirmed prior to discharge.

For those patients presenting to IOU on a frequent basis[48] a case conference will be initiated. IOU will notify relevant organisations involved in the patients care and the lead organisation will be determined (usually community service). In the event that the patient is not actively engaged in any other health service, IOU staff will take the lead.

Discharge

[48] Frequent attenders are defined as presenting to the service (or likely to attend) more than 12 times a year. For e.g. a patient presenting 5 times in a 3 month period should be discussed amongst the team and a case conference will be considered if the patients risks are escalating and repeated presentation to secondary care (IOU or A&E) is highly likely

Patients will be discharged from the unit once IOU staff have determined the patient is safe based on physical presentation.

Patients who become seriously physically unwell will be transferred back to UHNM and discharged from the IOU.

If patients are discharged outside of normal office hours and onward referrals are necessary (and patients consent), IOU will make contact with the patient within 48 hours so that follow up arrangements with community services can be made and confirmed.

For people with alcohol dependence who are homeless the service will establish links with homeless organisations / charities and where appropriate establish safe pathways of care.

Patients will be offered an appointment with community alcohol services or signposted to other appropriate services as per the guidance below:

Alcohol dependence can be categorised as mild, moderate and severe. People with mild dependence (those scoring 15 or less on the Severity of Alcohol Dependence Questionnaire; SADQ) usually do not need assisted alcohol withdrawal.

People with moderate dependence (with a SADQ score of between 15 and 30) usually need assisted alcohol withdrawal, which can typically be managed in a community setting unless there are other risks.

People who are severely alcohol dependent (with a SADQ score of more than 30) will need assisted alcohol withdrawal, typically in an inpatient or residential setting.

Any patient categorised as moderate or severe will be referred to the community (if consenting) and will be commenced on the relevant treatment pathway (as above)

3.3 Population covered

This service will be available to patients who are:

- Eligible patients presenting to Royal Stoke A&E (regardless of CCG / GP registered with)
- Patients conveyed by WMAS from geographical locations within the boundaries of North Staffordshire and Stoke-on-Trent

3.4 Any acceptance and exclusion criteria and thresholds

Inclusion Criteria

- Patients over the age of 18, presenting to A&E (Royal Stoke) or WMAS.

Exclusion criteria

See Appendix 1 and 2 for further detail

- Serious head injuries
- Patients presenting with acute psychiatric conditions (e.g. acute psychosis, high risk suicidal thoughts)
- Direct referrals will not be accepted from the Police.

3.5 Interdependence with other Services/Providers

- University Hospital of North Midlands (UHNM)
- West Midlands Ambulance Service (WsMAS)
- Harplands inpatient wards / mental health teams
- Community alcohol services

4. Applicable Service Standards

4.1 Applicable National Standards (eg NICE)

Alcohol-use disorders: diagnosis and management Quality standard [QS11] Published date August 2011

NICE (2011) National Clinical Practice Guideline Number 115: DIAGNOSIS, ASSESSMENT AND MANAGEMENT OF HARMFUL DRINKING AND ALCOHOL DEPENDENCE

NICE (2010) Clinical Guideline 100: ALCOHOL USE DISORDERS: DIAGNOSIS AND CLINICAL MANAGEMENT OF ALCOHOL-RELATED PHYSICAL COMPLICATIONS

NICE (2008) National Clinical Practice Guideline Number 51: Psycho-social interventions

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

Guidance from the Royal Pharmaceutical Society of Great Britain on the safe and secure handling of medicines.

4.3 Applicable Local Standards

N/A

5. Applicable Quality Requirements and CQUIN Goals

5.31 Applicable quality requirements (See Schedule 4)

5.32 Applicable CQUIN goals (See Schedule 3)

6. Location of Provider Premises

6.1 The Provider's Premises are located at:

Edward Myers Unit, Harplands Hospital, Hilton Road, Harpfields, Stoke on Trent, ST4 6TH

Appendix 1:

Proforma to Assess for Suitability for Transfer to the

Alcohol Intoxication Observation Unit (from WMAS)

The Alcohol Intoxication Observation Unit (IOU) at the Edward Myers Unit, Harplands Hospital has been designed to allow patients who are intoxicated and are suitable for direct transfer from WMAS to be admitted for observation and further assessment in relation to their alcohol use. **Any patient intoxicated with alcohol, age 18 or above, and registered with a GP from Stoke-on-Trent or North Staffs areas (old PCT areas) should be considered for transfer using the following guidelines:**

Patient Name: **Patient Address:**			**A&E No:**
		Yes/No	**Comments**
1	Has the patient presented with alcohol intoxication and no other acute health problems requiring clinical intervention?		**If intervention is required then take to UHNS as normal; A&E team can reassess suitability for IOU**
2	Has a head injury (even a minor head injury) been excluded clinically?		**No patient with a head injury should be directly referred by WMAS to the IOU without first being seen and assessed in ED**
3.	Following clinical examination no obvious signs of self harm were observed or reported		**If evidence of self-harm then take to UHNS as normal; A&E team can reassess suitability for IOU**
IF YES TO ONE OF THE ABOVE PATIENT MAY BE SUITABLE FOR TRANSFER;			

PLEASE CHECK OBSERVATIONS BELOW			
Assessment	Score	Standard	**Yes/No**
GCS		Is GCS ≥ 13?	
Systolic BP		Is Systolic BP ≥90 and <180?	
Pulse		Is Pulse ≤120 and ≥50?	
BM		Is BM ≥3.5?	
Temp		Is Temp ≥35 and ≤38?	

IF <u>YES TO ALL OF THE ABOVE OBSERVATIONS</u> PATIENT IS SUITABLE FOR TRANSFER

Following the assessment guideline above (name)

_____ is medically fit for transfer to intoxication observation unit (IOU):

Signed…….. Date……..
Time……

Name…….. Grade…….
Technician/Paramedic

If these criteria are met please **ring the Edward Myers Unit** (01782 441715) and speak to the Nurse in charge to arrange transfer.

If there are any questions then please contact the Emergency Middle Grade or Consultant on 01782 674466 at A&E

Appendix 2

Proforma to Assess for Suitability for Transfer

to the Alcohol Intoxication Observation Unit

The Alcohol Intoxication Observation Unit (IOU) at the Edward Myers Unit, Harplands Hospital has been designed to allow patients who are intoxicated but no longer in need of A&E services for other conditions to be transferred there for observation and further assessment in relation to their alcohol use. **Any patient intoxicated with alcohol, age 18 or above, and registered with GP from Stoke-on-Trent or North Staffs areas (old PCT areas) should be considered for transfer using the following guidelines;**

Patient Name;	**A&E No;**

		Yes/No	**Comments**
1	Has the patient presented with alcohol intoxication and no other acute health problems requiring intervention?		
2.	Has the patient presented with alcohol intoxication and also taken an overdose of other substances which do not need any further medical intervention?		**Attach Toxbase information if available**
3	Has patient presented with alcohol intoxication and also a minor head injury which after full assessment by middle grade or above requires no further medical intervention?		
4.	Has patient presented with alcohol intoxication and also threatened self-harm?		

IF YES TO ONE OF THE ABOVE PATIENT MAY BE SUITABLE FOR TRANSFER;

PLEASE CHECK OBSERVATIONS BELOW

Assessment	Score	Standard	**Yes/No**
GCS		Is GCS ≥ 13?	
Systolic BP		Is Systolic BP ≥90?	
Pulse		Is Pulse ≤120 and ≥50?	
BM		Is BM ≥3.5?	
Temp		Is Temp ≥35 and ≤38?	

IF YES TO ALL OF THE ABOVE PATIENT IS SUITABLE FOR TRANSFER

Following the assessment guideline above (name) _____ is medically fit for transfer to intoxication observation unit (IOU);

Signed…… Date…….. Time……

Name…… Grade……. (**Only to be signed by middle grade or above**)

If these criteria are met please **ring the Edward Myers Unit** (01782 – 441715) and speak to the Nurse in charge to arrange transfer. **Arrange Ambulance** transport and transfer patient with **this form** and **copy of A&E records**.

Service Specification No.	F03
Service	Individual Placement and Support (IPS)
Commissioner Lead	Nicola Bromage, Senior Strategic Lead, Strategic Commissioning Team, CCG
Provider Lead	Josey Povey, Associate Director, North Staffordshire Community Directorate
Period	01/04/2022 – 31/03/2023
Date of Review	As required

1. Population Needs

2.6 National/local context and evidence base

NHS England has distributed funding to support the expansion of IPS in three targeted waves where Staffordshire Integrated Care System (ICS) was successful:

- Commencing 2018/19: Wave 1: Expansion at pace within an STP area that already have established IPS services;
- Commending 2019/20: Wave 2: Increasing provision in STP areas that do not have any IPS service provision.
- Commending 2020/21: Wave 3 Additional funding to expand IPS provision

The County of Staffordshire, including Stoke on Trent, comprises of a mixture of rural and urban areas. We have one Unitary Authority (Stoke on Trent); a County Council which has 8 District / Borough Councils and 6 Clinical Commissioning Groups. The current configuration of services reflects an integrated approach with mental health service providers to ensure access to IPS for all those under their care. There is a large geographical area to cover which the joint ownership of the shared model between North Staffordshire Combined Healthcare NHS Trust (NSCHT) and the Midlands Partnership NHS Foundation Trust (MPFT) ensures an open referral into the service with IPS staff being an essential partner of the multi-disciplinary teams.

Stoke on Trent CCG;

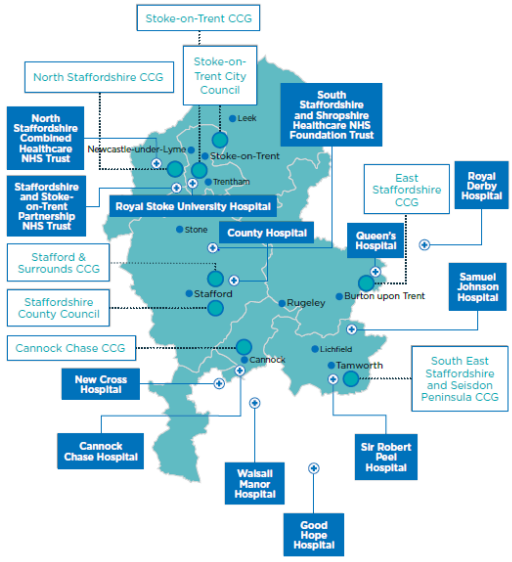
North Staffordshire CCG;

Stafford and Surrounds CCG;

Cannock Chase CCG

East Staffordshire CCG

South East Staffs and Seisdon Peninsula CCG



1.2. People Securing Paid Employment

70-90% of people with mental health issues would like to work, but only 37% are in paid employment. For people with severe mental illness, it's just 8%. Compared with traditional support, IPS has been proven in numerous studies to help more people with severe mental illness back into work more quickly. On average, people receiving IPS keep their jobs longer, earn more, and spend less time in hospital.

Evidence from the performance of IPS service in Staffordshire and Stoke on

Trent suggests that between 30% and 40% of those individuals engaged with the service will go on to secure paid employment.

Work is good for mental health, and poor mental health can be the reason for people becoming unemployed. Evidence suggests that being out of work for long periods is generally bad for your health, resulting in: more consultations; higher use of medication and higher hospital admission rates than for the average population. However, people with a mental illness find it hard to access the workplace, and the workplace itself can be stressful and impact on the wellbeing of individuals.

Employment not only has economic benefits, but it also gives people a sense of self-worth: the longer someone is out of work the harder it is to re-join the job market – early intervention applies equally to treatment and care services for mental illness as to prevention.

Targeted employment support for people recovering from mental illness assists recovery and reduces the demand for care services.

For those with mental health problems, being employed can be an important step to recovery, improving self-esteem and confidence and reducing psychological distress.

Employment is therefore vital for maintaining good mental health and promoting recovery from mental health problems. Work is often part of treatment and getting back to work is part of the recovery process.

Evidence shows strongly positive cost/benefit of IPS:

- Supporting an individual into work generates savings on out-of-work / means-tested benefits, tax credits, and tax receipts
- Additional savings likely to accrue to health service; IPS reduces health service use: fewer days in hospital, reduced rates of readmission (Hoffman, 2014)
- Significant saving if someone with severe mental illness does not relapse
- Economic studies estimate £1.59 saving for every £1 spent (Van Stolk, 2014)

1.3. Existing provision

The Step On service delivers IPS within the Staffordshire Integrated Care System and is fully integrated within the community mental health provision delivered through NSCHT and MPFT.

The Step On team has been operational since March 2013 when they were part of the

Improve project across the West Midlands. This project saw a number of teams through

a development process supported by 'Enable' and the Centre for Mental Health to deliver Individual Placement and Support (IPS) with fidelity to the IPS model; Step On had their first fidelity review in September 2013 and became a centre of excellence which has subsequently been maintained at each independent review.

All current and newly recruited employment specialists shall receive the required training from the centre for mental health to ensure fidelity to the model; this would include, "Doing What Works - Implementing a successful IPS service", Engaging with Employers and Motivational Interviewing.

The 'Step On' service would have, at its centre, the necessity to provide fidelity to the core principles of IPS. Having had the experience of starting a team from the beginning to delivering a service that has been assessed as having exemplary fidelity; IPS only works when the model is implemented fully.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	**ü**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**ü**
Domain 4	**Ensuring people have a positive experience of care**	**ü**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	

2.2 National/Local defined outcomes

Individuals with complex mental health conditions to gain employment and remain in employment in line with the aims of the Five Year Forward view which states that by 2020/21, each year up to 29,000 more people living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies for common mental health problems and expanding access to Individual Placement and Support (IPS).

The Long Term Plan (2019) has set out a vision of recovery that has IPS securely at the centre of health, wellbeing and personal recovery in mental health services. The plan states:-

'Through increasing access to IPS, the NHS will support an additional 35,000 people with severe mental illnesses where this is a personal goal to find and retain employment by 2023/24, a total of 55,000 people per year. This investment will support people to get back into or gain access to employment. It will improve outcomes and recovery for people, meaning they spend less time in hospital and live healthier, happier lives. By 2028/29, we aim to extend this to 50% of the eligible population to benefit up to 115,000 people.'

The Staffordshire ICS has a trajectory that supports the national target as follows:-

	Trajectory 2020/21	Trajectory 2021/2022	Trajectory 2022/2023	Trajectory 2023/2024
Engagements	520	640	881	1103

3. Scope

3.1 Aims and objectives of service

To support service users in achieving and maintaining paid employment, building on an individual's recovery and aspirations for the future.

IPS is an approach which uses a 'place and train' model based on the following 8 evidence based principles:

1. Eligibility is based on individual choice – no exclusions
2. Employment support is integrated with treatment
3. Competitive employment is the goal
4. Rapid job search (within 4 weeks)
5. Job finding, and all assistance, is individualised
6. Employers approached with the needs of individuals in mind
7. Follow-along (in work) supports are continuous
8. Financial planning is provided

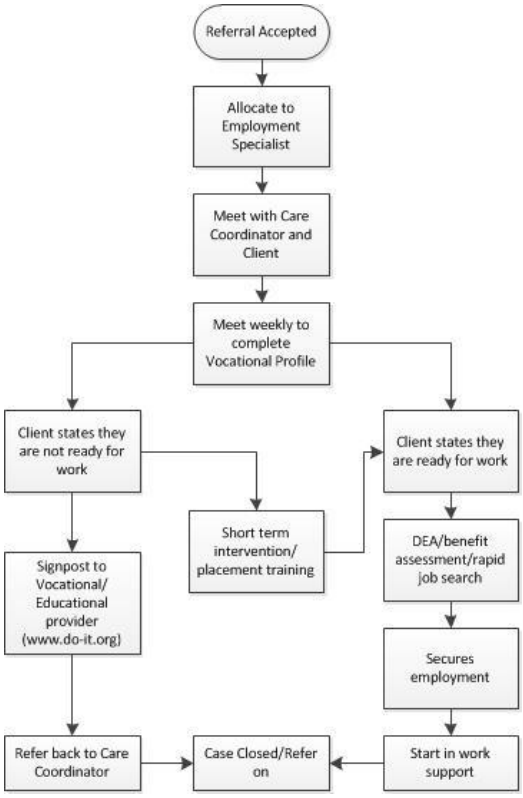
IPS service should be available to all who wish to work and would wish to expand the provision to target specific groups, to open up pathways and increase life chances.

The aim would be to work within services to understand the needs of service users accessing community mental health services and increase opportunity and access to IPS.

The recruitment process will be inclusive with the addition of peer workers to help engage and widen participation for under-represented groups.

The team facilitate a quarterly Vocational Forum over MS Teams which covers the North Staffs and Stoke on Trent and south Stafford localities.

3.2 Service description/care pathway

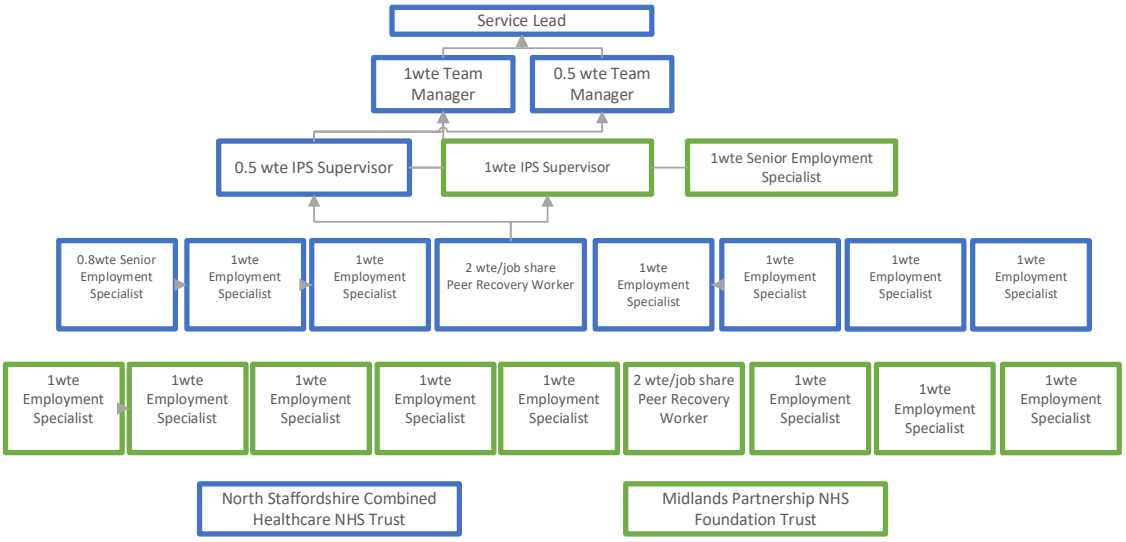


IPS is an evidence based “place then train” model, meaning specialists help service users get a job as quickly as possible, and then support them for an extended period to sustain their employment. It operates with low caseloads (20 people), allowing specialists to provide intensive, individualised support.

The service would expect that the average duration from referral to employment would be between 4 and 5 months, noting that the majority of employment outcomes are achieved within the first 6 months of intervention.

3.3. Staffing Model

Staffing is fundamental to successfully increasing access to IPS and needs to involve, swift recruitment, skilled staff, IPS competencies and appropriate support and supervision.



3.4. Vocational Peer Support Workers

The service will also include the establishment of specialist vocational peer support workers. It is the intention to recruit individuals from a diverse range of backgrounds such as BAME and LGBTQ.

The Peer Support role will work in a fully integrated way based in secondary care clinical mental health teams to provide high quality peer support and to promote user involvement, user empowerment and self-management among people with mental health needs. It is intended the vocational peer support workers will be part of a wider Pan Staffordshire peer support network, linking in for example with Peer workers in the Criminal Justice teams and established Peer workers in MPFT's pathways. It is expected average caseload per whole time equivalent will be 16 individuals alongside group work capacity.

3.5. Staff training and supervision

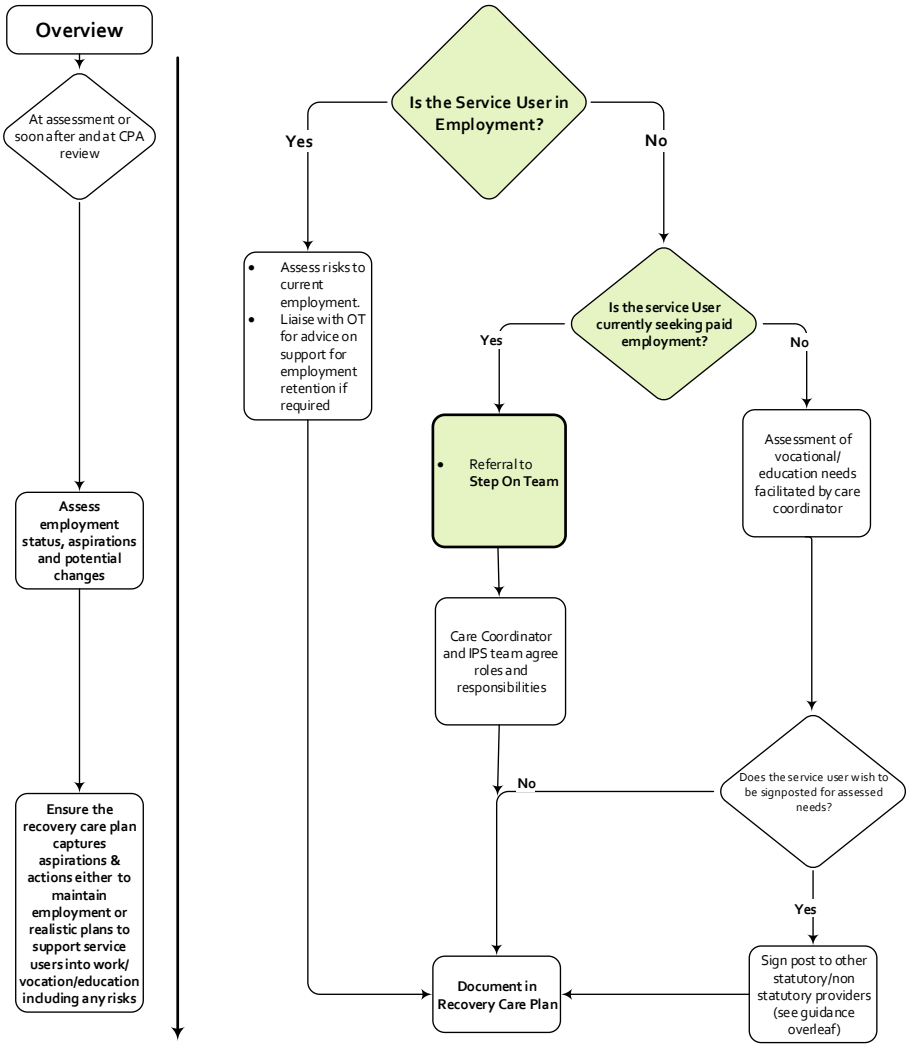
The mental health trusts are invested in ensuring service users have access to IPS services. The new model employs staff as part of the trust who will sit within the CMHT they are working with, use the same electronic patient record, attend the team meetings and feedback their outcomes to support them and to raise understanding.

The staffing identifies both the need to embed workers within teams but also the need for the development of the team along IPS core principles. All staff recruited will receive accredited training through the Centre for Mental Health including the core IPS training, employer engagement training and Motivational Interviewing training. The key to any service that wants to embed evidenced based practice is not just the training but the level of specialist supervision. As skills are acquired they can soon become rusty without constant use and the appropriate level of supervision.

The oversight and management of the existing centre of excellence in NSCHT will ensure that there are clear pathways from the point of referral into services to understand people's vocational status and to appropriately refer into IPS services.

3.6. Integrated Service User Employment Pathway:

Integrated Service User Employment Pathway



The pathway will be shared and reviewed within teams to ensure they are sensitised to vocational issues and the support available to service users.

When a person is accepted the Employment Specialist will have an early joint meeting with the service user and care coordinator leading to a full vocational assessment. This will identify personal strengths, skills including job preferences and any potential work barriers.

The Employment Specialist will support the service user to build an up to date Curriculum Vitae (CV) that will then be uploaded to a Government Gateway account on the Universal Job match site. Following this the worker will complete a rapid job search and begin employer engagement with potential referral into partnership agencies if needed.

There will be on-going support with completing applications, contacting employers to search for potential vacancies with interview skills and techniques coaching. This prepares people to enter the workplace and to foster belief in themselves allowing them to explore different ways of tackling the interview process.

The Employment Specialist actively supports the service user to prepare for work which can include flexible working, the access to work scheme and supports strategies to maintain mental wellbeing whilst in the work place e.g. Wellness Recovery Action Plan (WRAP).

When the individual starts paid employment the worker will maintain regular contact through mutually agreed means thus ensuring the person has effective coping strategies to manage potential workplace stress.

3.7. Workforce Development:

All employment specialists will receive the core training as mentioned. The existing service will provide shadowing and mentoring to new staff to develop the employment specialist to understand all the IPS core principles and how this translates into practice.

The peer workers will be potentially recruited through Step On and be open to existing services with the the team looking to identify those with the skills and motivation to develop as a peer. The team have strong links with Changes a local mental health charity that has existing peer workers who also will be eligible to apply. South Staffordshire has an existing peer worker pathway and development opportunities that the peer worker will be involved and supported through.

The peer workers will have access to Health Education England (HEE) funded training that would provide a framework to enable them to helpfully use their recovery journey to support others and also maintain their health and wellbeing.

3.8. Population covered

Individuals registered with a GP located within the boundaries of Staffordshire Integrated care system. The service will be accessible through NSCHT and MPFT referral pathways.

3.9. Any acceptance and exclusion criteria and thresholds

The referral criteria that is operated across all providers is that any person who expresses a wish or desire to secure paid employment and is in contact with secondary care mental health services is eligible to use the service. The individual must be willing to work. This will initially be tested by their clinician, since employment should be part of the service user's recovery plan.

However, their willingness may also be tested by the IPS team if they feel a clinician has "pushed" an individual to their services. This criteria is the only exclusion criteria embedded in the IPS core principles.

As long as the person is actively engaged in the service and wants to secure paid employment they can access the service as long as they require. This is to ensure there is no 'cherry picking' of service users and the services continue to work with a range of individuals including those who are furthest away from the job market as a result of long periods of 'worklessness' or criminal convictions or legal restrictions placed on them. IPS services operate a "zero exclusion" policy, which means they do not reject service users based on the severity of their condition, their skills, employment history, or any other criteria other than willingness to work.

3.10. Interdependence with other services/providers

The service model embeds services within clinical teams, a core requirement of the IPS model but also an existing challenge to services. The staff will be employed through the mental health trusts (NSCHT & MPFT) with staff in MPFT being supervised by Team Managers based in NSCHT Step On service to ensure that the developing services have fidelity to the model.

The whole Step On service including staff in NSCHT and MPFT will have regular meetings with Job Centre Plus (JCP) and have close links with local businesses. This specific involvement increases the opportunities and helps service users' transition through JCP and into the work arena.

Staffordshire and Stoke on Trent ICS recognises the importance of working with employers and businesses to reduce the stigma associated with poor mental health.

The IPS pathway ensures people are accessing the right support for their needs and aspirations at the right time allowing for flexibility between the services depending on where they are with paid employment goals. This is demonstrated in the 'Integrated Service User Employment Pathway' in Section 3.6 where vocational aspirations are assessed and service users are directed appropriately based on their needs. It is recognised that volunteering can be an important step towards employment. Both MH trusts have active volunteer programmes that support service users to develop their potential and skills for employment; resources such as www.doit.org provide a wide range of local opportunities prior to service users entering the IPS pathway.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

NICE recommends mental health services to provide IPS to their users.

Rehabilitation for adults with complex psychosis

Number: NG181 **Date issued:** August 2020

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

Not applicable

4.3 Applicable local standards

Not applicable

5. Applicable quality requirements and CQUIN goals

5.33 Applicable Quality Requirements (See Schedule 4)

To adhere to service quality requirements, IPS services are governed by fidelity reviews. The aim of the reviews is to support services to implement IPS effectively, avoid fidelity drift, increase job outcomes, and support a culture of continuous improvement. External fidelity

reviews are conducted every 2 years, facilitated by IPS Grow (hosted by Social Finance) and there is a requirement that internal fidelity reviews are completed annually. IPS Grow will lead and coordinate the external reviews, which will be delivered in partnership with the IPS Grow consortium partners, Social Finance and the Centre for Mental Health.

IPS fidelity reviews have an important role in:

- Supporting services to implement high fidelity IPS, but also help experienced services avoid fidelity drift.
- Support quality improvement and increased job outcomes in line with national benchmarks.
- Enables services to understand what they are doing well, and create a culture of continuous improvement.
- Enables follow up technical assistance to be targeted.
- Ensures effective accountability for all stakeholders.

The Step On team have participated in 3 external fidelity review's since being established, in which each review has demonstrated the service's ability to deliver 'exemplar' fidelity to the IPS model. Exemplar fidelity is achieved when IPS services score above 115 out of 125.

Exemplary Score	115-125
Good Fidelity	100-114
Fair Fidelity	74-99
Not supported employment	73 and below

In 2019, the most recent external review was conducted, whereby the service achieved a fidelity score of 116,. This was followed by an internal review in January 2021. The Step On team are in the process of organising the next external fidelity review, which is required to take place in Q3 of 2022-23.

5.34 Applicable CQUIN goals (See Schedule 3)

6. Location of Provider Premises

The Provider's Premises are located at:

The service is embedded within CMHT's and community pathways across the ICS.

Service Specification No.	F04
Service	Specialist Alcohol Liaison and Complex Needs team (CHAT)
Commissioner Lead	Nicola Bucknall, Commissioning Manager, North Staffordshire and Stoke-on-Trent CCGs
Provider Lead	Lisa Nagington, Senior Service Manager, North Staffordshire Combined Healthcare
Period	1st January 2022 – March 31st 2023
Date of Review	As required

1. Population Needs

1.3 National/local context and evidence base

Alcohol-related harm is a long-standing problem that is placing increasing demands on the NHS. At a time when unprecedented efficiencies need to be made by the NHS and local authorities, preventative action must be taken seriously.

Alcohol is the most common cause for liver disease in England and accounts for over a third of liver disease deaths. The more someone drinks over the lower-risk guideline, the higher their risk of developing liver disease. The UK is one of the few European countries where alcohol consumption has risen in the last 50 years.

There were 1.1 million estimated admissions related to alcohol consumption in 2015/16. This is 4% more than 2014/15. This represents 7.0% of all hospital admissions which is similar to 2014/15 and 2013/14.[49]

In 2017/18 there were 338,000 estimated admissions where the **main reason for admission** to hospital was attributable to alcohol (narrow measure).This is **15% higher** than 2007/08

There were 1.2 million estimated admissions where the **primary reason for hospital admission or a secondary diagnosis was linked to alcohol**, which is 3% higher than 2016/17 (broad measure)[3].This represents 7.2% of all hospital admissions. 83% were over the age of 45. When looking at diagnosis **52% of admissions were for CVD, 17% were for mental and behavioural disorders due to alcohol**

In England in 2017, there were 5,843 alcohol-specific deaths. **The number of deaths is 6% higher than 2016 and an increase of 16% on 2007.**

Comorbid mental health disorders commonly include depression, anxiety disorders and drug misuse, some of which may remit with abstinence from alcohol but others may persist and

[49] Statistics on Alcohol England, May 2017, NHS Digital

need specific treatment. Physical comorbidities are common, including gastrointestinal disorders (in particular liver disease) and neurological and cardiovascular disease. In some people these comorbidities may remit on stopping or reducing alcohol consumption, but many experience long-term consequences of alcohol misuse that may significantly shorten their life.

Of the 1 million people aged between 16 and 65 who are alcohol dependent in England, only about 6% per year receive treatment. Reasons for this include the often long period between developing alcohol dependence and seeking help, and the limited availability of specialist alcohol treatment services in some parts of England. Additionally, alcohol misuse is under-identified by health and social care professionals, leading to missed opportunities to provide effective interventions.

Local context

In Stoke-on-Trent:

- It is estimated that nearly one third (31.7%) of adults (aged 18 and over) were drinking more than 14 units of alcohol per week, compared with 25.7% nationally. Adults were also more likely to binge drink.
- In 2017 over 40% of adults (aged 18 and over) were drinking at levels of increasing or higher risk, which equates to around 80,000 people.
- There were an estimated 3,864 dependent drinkers in Stoke-on-Trent in need of specialist treatment.
- Deaths from alcohol reflect the effects of chronic heavy drinking and are most likely to be found in higher risk drinkers and dependent drinkers. Mortality rates from alcohol-specific causes, chronic liver disease and alcohol-related causes were all significantly higher locally compared with England.

Nearly one quarter of alcohol users who started treatment in Stoke-on-Trent had a dual alcohol/mental health diagnosis, which is slightly higher than the national average of 21%.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**ü**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**ü**

Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**ü**
Domain 4	**Ensuring people have a positive experience of care**	**ü**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**ü**

2.2 Local defined outcomes

The fundamental goal of the service is to improve the lives of people affected by alcohol; in so doing, the interventions are expected to contribute to a range of broad strategic outcomes, including:

Public Health outcome framework indicators

- 2.15 Drug and Alcohol treatment completions and drug deaths
- 2.16 Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison
- 2.18 Alcohol-related admissions to hospital
- 4.03 Mortality rate from causes considered preventable
- 4.10 Suicide rate

Adult social care outcomes framework

- Enhancing the quality of life for people with care and support needs
- Ensuring that people have a positive experience of care
- Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

Others

- Improve physical and mental health
- Facilitate timely discharge from hospital and continue detox in the community where clinically safe to do so
- Reducing alcohol related deaths
- Improved Public Protection
- Improved parenting / reduced child neglect and abuse

3. Scope

3.1 Aims and objectives of service

- The aim of the service is to improve the lives of people affected by alcohol, their families and local communities.

- To reduce the risks associated with alcohol and to promote change.

- Maintain people safely in the community and reduce avoidable, frequent and costly attendances to hospital for reasons related to alcohol use.

- To work in partnership with other agencies to improve the health and social welfare of service users frequently using secondary care health services, by offering intensive case management, assertive outreach, fast track access pathways and an enhanced recovery support offer

3.2 Service description/care pathway

General principles

The provider will develop evidence based but innovative interventions that are responsive to changing patterns of alcohol use.

The range and ethos of the Services provided should represent an appropriate balance between harm reduction and more recovery oriented approaches.

Deliver a straight-forward pathway that is easy for people to access and navigate and that clearly demonstrates an achievable alternative to the culture of addiction.

Recognize how alcohol problems not only affect individuals but also impact on their families and communities, providers will enable people to take responsibility for addressing their holistic needs and to build the personal strengths needed to maintain strong and sustainable recoveries from alcohol problems.

Specialist Alcohol Liaison and Complex Needs Team (CHAT)

- Through formal pathways, working relationships and regular joint meetings with the Royal Stoke alcohol liaison nurses, identify appropriate service users for the service. They will typically include:
    - Service users presenting to hospital with alcohol dependency as highlighted by AUDIT screening tools, short AUDIT tool 7+, full AUDIT tool 20+
    - Frequent attenders to A&E for reasons related to alcohol use. Reasons for presentation to A&E may include falls, minor injuries, maxillofacial injuries, upper gastrointestinal haemorrhage, acute intoxication, overdose.
    - General Ward service users with co-existing diabetes, cardiovascular disease, chronic pancreatitis
    - Service users who require planned surgery but need detox / support to reduce their alcohol intake
- Liaise with GPs and case managers within other services (e.g. Edward Myers Unit, Intoxication Observation Unit, Harplands Hospital, Mental health liaison Team, High Volume Users Service) to identify Clients most at risk of relapse or readmission.
- All clients identified as:
    - Frequent attenders to hospital **AND / OR**
    - Having complex multiple physical / mental health needs **OR**
    - Having difficulty engaging with general community addiction services

Will be case managed for a time limited period until the service users risks are minimised / managed (see criteria below**). Step down to other services in the pathway is expected within 3 months but will be determined by need / clinical risk.**

- Provide **rapid access pathways** for community detox supported by wrap around pre-detox (where possible) and enhanced post-detox care.
- Enable safe transfer of care for patients presenting to emergency portals that are suitable for community detox. Provide clinical management of patients over a 7 - 10 day period to ensure safe withdrawal of alcohol. **Patients referred from ED must receive a face to face contact within 24 hours.**

- Similarly there may be people in the community either identified by GPs or by community services that are **attempting to detox themselves and are at risk of dangerously withdrawing** this may require immediate support from CHAT to reduce risk of hospitilisation. The person should be assertively managed and engaged in wider community services before discharge from the CHAT service.
- Provide assertive outreach to clients on the caseload to maintain engagement in services in the community.
- The service should be innovative for particularly hard to reach groups (e.g. homeless) and make reasonable adaptations, whilst maintaining safety, to meet the needs of the person. Links with local hostels and charitable organizations should be developed.
- Make every attempt to engage clients in treatment and proactively contact clients in a variety of ways should they DNA
- Use validated screening and outcome tools e.g. FAST, AUDIT, SADQ and CIWA.to determine the most appropriate treatment pathway and evidence impact of interventions
- Deliver brief interventions, extended brief interventions and care planned interventions, supported by co-ordination of care in the community and active review/follow up.
- Facilitate **fast track access** to inpatient detox /rehab beds as clinically indicated
- Clinical monitoring and management of clients undergoing community detox such as:
    - Pulse, blood pressure monitoring
    - Physical examination (particularly respiratory and abdominal)
    - Taking bloods
    - Measure breath alcohol levels
    - Administration of medication
    - Prescribe medication where appropriate and in line with clinical competencies and local protocols Review clients 7 days post detox to check physical symptoms
- Assess clients risk where appropriate for alcohol related brain injury using tools such as Addenbrooks Cognitive examination (ACE) and Montreal Cognitive Assessment (MoCA) and refer to neuropsychiatry where specialist assessment is indicated
- Deliver motivational and psychosocial interventions focusing on a strength based
- Practitioners will also initiate and take part in multidisciplinary team meetings to ensure co-ordinated care, particularly for those clients that are presenting multiple times to A&E and / or IOU

- Introduce Clients to recovery communities and mutual aid.
- Support the service users holistic needs and using a care coordinator approach, facilitate multiagency working across a range of sectors, case manage until risk complexity has reduced / stabilised
- Services must respond (either through direct service provision of engagement in partner services) to more than physical and/or psychological dependence by addressing issues that contributed to the development of alcohol problems (such as trauma or bereavement) as well as helping people develop the skills required to build sustainable recovery.

Fast Track access to treatment

The service will establish a process whereby patients who are frequent users of hospital services or have complex needs that puts them at risk of frequent hospitalisation; will **as part of an urgent care pathway** be given priority access to the range of treatment options offered by the community drug and alcohol service (including access to inpatient detox, rehabilitation, recovery services).

Priority will be based on clinical needs / risks and be determined following an MDT discussion. This will include professionals from other organisations as required.

A standard operating procedure will be developed which describes the process and priority criteria.

Referred cases will be reviewed and allocated on a daily basis for optimum priority risk management.

Staff will carry small caseloads and move patients appropriately through the treatment system so that there is never a waiting list and cases can be seen within agreed timeframes.

- Entry into service - Referrals responded to within 24 hours from any referral source (emergency portals, GP, IOU beds, Ambulance service, hospital wards, either face to face or by telephone

- Cases where detox was completed in hospital will have a home visit within 24 hours of discharge to discuss post detox support options –

- If this support is accepted cases will be managed by support workers who will facilitate appropriate post detox support including psycho social interventions, workshops,, social activities, mutual aid including AA.
- If the offer is declined and support is not accepted cases will be discussed at a weekly management meeting and appropriate next steps agreed

- Patients referred for continued detox will be seen within 24 hours of hospital discharge to enable medically supported early discharge.

- For cases requiring a detox commencement, comprehensive nurse assessment will take place includes physical health assessment, risk assessment, social circumstances assessment, facilitate bloods where appropriate

- Detox commencement will take place within a timeframe agreed with the service user and will be dependent on clinical risks but will commence no later than 48hours from referral

- Home visits will take place for the duration of the detox and service users will will have a post detox 7 day review and then be supported to access post detox support.

- For cases where the physical complexities deem the case to be too high risk for a home detox, referral is made to EMU in patient facility and discussed at the weekly referral meeting for prioritisation.
- MDT will take place weekly for team discussion, risk management, detox update, step up and step down cases. Every new CHAT case is discussed to ensure that every individual is receiving the optimum and appropriate care matched to their needs and to allow for new referrals being received by the team.

Enhanced Recovery

<u>Harm reduction approaches</u>

Harm reduction is a key component of the Services for all applicable service users, but particularly for people drinking heavily and may form part of both structured and open access Services. A number of core Services must be delivered:

- Self- help and information packs including where to access additional non-alcohol related support in line with asset based community development
- Education and harm reduction preventative initiatives in line with government safe drinking levels
- Open access advice/ information (telephone or 1-1)
- Healthcare assessments and support for health problems
- Open access support for hard to reach groups (homelessness drop ins)

Providers are also expected to deliver other harm reduction Services, potentially including but not limited to:

- Brief/ short term interventions
- Complementary therapies

<u>Proactive re/engagement activities</u>

Proactive Services will be required to identify and engage people (particularly priority groups), A number of engagement activities must be delivered:

- Liaison with health and social care services (acute/mental health, social services etc.) in order to maintain engagement, including dual diagnosis with physical and mental health problems and promote early supported discharges from acute hospitals, where appropriate

- Liaison with criminal justice agencies (including (but not limited to) the police, probation, courts and prisons) to ensure that opportunities to engage offenders into specialist Services are maximised and people do not disengage with Services as they move through the criminal justice system, in particular those sentenced to an ATR.

- Where other priority demands on the service allow, the Providers should have approaches (possibly including outreach initiatives, including working with rough sleepers teams) in place to proactively engage other priority and hard to reach groups

The Providers are strongly encouraged to consider additional approaches and not be limited to these core engagement activities.

Stabilisation/ retention interventions

Structured Services will be required that maintain stability and retain people while identifying needs/ strengths and facilitate behavioural changes. A number of approaches must be delivered:

- Care co-ordination/ case management (varying intensity depending on need/ complexity)
- Fast track step up and step down between; high complexity, medium intensity need
- Support adherence to and facilitate access to pharmacological Services and medications–
- Strength based psycho-social interventions delivered on a 1-1 basis and in workshop formats
- Peer support including mutual aid facilitation/programmes (such as SMART and/or 12-step facilitation)

It is anticipated that the provider will deliver additional Services, possibly including but not limited to:

- Use of apps
- Self-help initiatives including work books and mapping exercises

Progressive Services

Services are required that enable people to progressively achieve their goals, reduce problems and increase strengths, these are likely to include:

- Community detoxification (for alcohol)
- Abstinence-oriented approaches
- Education about safe drinking levels

The service will be expected to support service users holistic needs which may include:

- Referral to and engagement with supported housing and emergency provision for homeless
- Social/ diversionary activities including walking groups, art workshops, First Aid courses
- Fast access to IPS (Individual placement support into employment)
- Complementary therapies
- Social isolation reduction initiatives including gardening, art workshops
- Emotional wellbeing programmes and initiatives
- Access to other commissioned health initiatives (e.g. smoking cessation and healthy weight)

Consolidation Services

Services must be provided that help people consolidate progress made in earlier Services (including following achieving initial abstinence and/or discharge from residential rehabilitation), including (without limitation):

- Providers must facilitate the development of safe and sustainable recovery communities, although these communities must be 'owned' and led by their members (AA, SMART recovery)

- Facilitate access to pharmacological interventions (e.g. Acamprosate)

It is anticipated that a range of other Services may be made available to these service users and possibly including:

- Extended case monitoring
- Social enterprises; and
- Volunteering opportunities.

3.3 Population covered

People who are residents of Stoke-on-Trent will be eligible for the services outlined in this specification.

The service will target dependent drinkers with complex needs (see criteria below).

3.4 Any acceptance and exclusion criteria and thresholds

Eligibility criteria

- The eligibility criteria should be inclusive; to ensure people can access the Services at the point of need and allow resources to be targeted in accordance with needs and strengths; those in greatest need will have access to the most enhanced level of Service provision.
- Services are to be provided for adults aged 18
- Service users referred to the specialist alcohol liaison and complex needs team will:
    - Be frequent users (or at high risk) of multiple emergency services i.e. ambulance, A&E, IOU, Harplands, crisis teams – 'frequent attenders' **AND**
    - Typically have an AUDIT score of ≥20
    - require increased support for co-existing complex physical health needs (e.g. chronic liver disease, end of life) or dual diagnosis and who require a coordinated case management approach
    - require Increased support to remain engaged in services and who require an assertive management approach (e.g. require home visits, greater number of contacts to remain engaged)
- The service will also support people requiring community detox **as part of a ED / hospital discharge pathway** the aim being to either avoid hospital admission or reduce length of stay.
    - Service users with a CIWA score between 10-15 will be considered for community detox

Exclusions for community detox

- Medical red flags such as; trauma or injury, Delirium tremens, Severe vomiting, GI bleed, malnourished, hallucinations, Wernicke's Confusion, jaundice , high risk suicide, seizures

Operating Hours

The CHAT service will operate a 7 day service, Monday – Sunday, 9am – 5pm (operating times will be regularly reviewed and agreed based on local demand data) - new referrals will be accepted over 7 days.

3.5 Interdependence with other services/providers

There are a number of existing specialist alcohol interventions that will operate alongside this Contract. The provider will need to ensure that they have procedures and protocols in place to ensure a smooth referral pathway to other local services.

A summary of these interventions is provided below:

- Recovery champions – there is a peer-led organisation comprised mainly of people who have successfully exited rehabilitation and are now abstinent; they work alongside other existing services and peer mentor groups to promote and provide highly visible examples of positive recovery.

- 12 steps fellowship – there are a considerable number of Alcoholics Anonymous (AA) meetings running each week across the county.

- Medically managed detoxification – there is a hospital-based inpatient drug and alcohol medically managed detoxification services available to Stoke-on-Trent residents – The Edward Myers Unit located in Stoke-on-Trent.

- Intoxication Observation Unit

- Harplands Hospital

- Mental health Liaison Team

- High Volume Users Service

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The Provider will need to ensure their Service delivery model adheres, as a minimum, to the guidance and protocols included in the Contract, including (but not limited to:

- Department of Health (2002) Mental Health policy implementation guide. Dual Diagnosis good practice guide.
- HM Government (2013) Working together to safeguard children: a guide to inter-agency working to safeguard children and promote the welfare of children.
- NICE (2012) Hepatitis B and C: ways to promote and offer testing (PH 43).
- NICE (2011) National Clinical Practice Guideline Number 115: DIAGNOSIS, ASSESSMENT AND MANAGEMENT OF HARMFUL DRINKING AND ALCOHOL DEPENDENCE
- NICE (2011) Alcohol dependence and harmful alcohol use (QS11).
- NICE (2011) Psychosis with co-existing substance misuse (CG 120)
- NICE (2010) Pregnancy and complex social factors (CG 110)
- NICE (2010) Alcohol use disorders: preventing harmful drinking (PH24).
- NICE (2010) Clinical Guideline 100: ALCOHOL USE DISORDERS: DIAGNOSIS AND CLINICAL MANAGEMENT OF ALCOHOL-RELATED PHYSICAL COMPLICATIONS.
- NICE (2008) National Clinical Practice Guideline Number 51: Psycho-social interventions
- NTA (2008) Good practice in harm reduction.
- NTA (2006) Review of the effectiveness of treatment for alcohol problems

In addition, new guidance documents are periodically published and as such the provider is expected to keep abreast of these and implement where necessary following discussion with Commissioners

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

- RCGP (2012) Delivering quality care for drug and alcohol users: the roles and competencies for doctors. A guide for commissioners, providers and clinicians.
- Alcohol Concern/ Drugscope (1999) Quality standards for drug and alcohol services.
- British National Formulary (BNF) good prescribing practice guidance.

4.3 Applicable local standards

- Staffordshire Hidden Harm Strategy
- Staffordshire and Stoke-on-Trent Adult Safeguarding Inter-agency Adult Protection Procedures
- Alcohol Treatment Requirements (ATR) policy

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4)

5.2 Applicable CQUIN goals (See Schedule 3)

6. Location of Provider Premises

The Provider's Premises are located at:

The service will be delivered in people's homes, community / public venues however staff will be based at:

Edward Myers Unit

Harplands Hospital

Hilton Road

Stoke-on-Trent

Staffs

ST4 6RR

Ref	G02
Service	Mental & Physical Health Checks (MPHC)
Commissioner Lead	Kevin Day – Portfolio Manager MH
Provider Lead	General Practice & North Staffordshire Combined Healthcare NHS Trust
Agreement Period	1st April 2023 – 31st March 2024
Date of Review	**24/25**

1. Population Needs

1.1 National/local context and evidence base

1.1.1 Compared to the general population, individuals with Severe Mental Illness (such as schizophrenia or bipolar disorder):

- Face a shorter life expectancy by an average of 15–20 years.
- Are three times more likely to smoke.
- Are at double the risk of obesity and diabetes, three times the risk of hypertension and metabolic syndrome, and five times the risk of dyslipidemia (imbalance of lipids in the bloodstream).

1.1.2 In Staffordshire and Stoke on Trent we have approximately 8200 people registered with GP practices experiencing a severe mental illness. Approximately 1200 are open to secondary mental health services in South Staffordshire and 2100 open to services in North Staffordshire and Stoke on Trent. These patients will either:

- Have their physical health and mental health monitored entirely in primary care.
- Have their physical health and mental health monitored in secondary mental health services.
- Have their physical health and mental health monitored in a mixture of both primary care and mental health services, sometimes duplicated and sometimes without clarity of responsibility.
- Not always be receiving a physical or mental health review.

1.1.3 As a health system we need to commission a model that ensures everyone receives an annual physical and mental health review, with no ambiguity of who is doing what and when

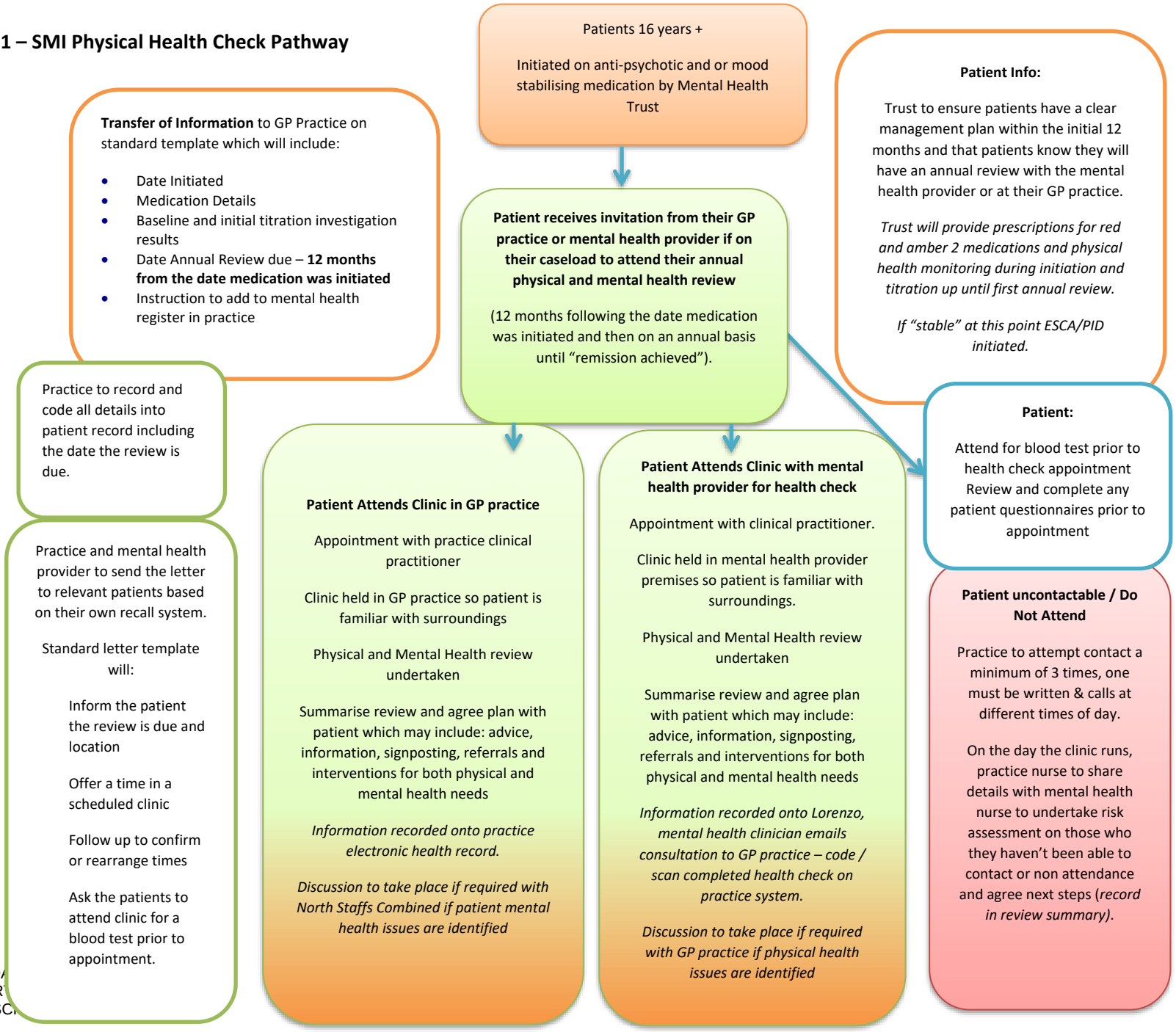
1.1.4 As per Quality Outcomes Framework (QOF) Guidance, the SMI register includes all patients with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy. QOF Guidance documents contain detail on when clinicians should consider excluding patients from the SMI register because their illness is in remission. Where a patient is recorded as being 'in remission' they remain on the register (in case their condition relapses at a later date) but they are excluded from the reporting requirements.

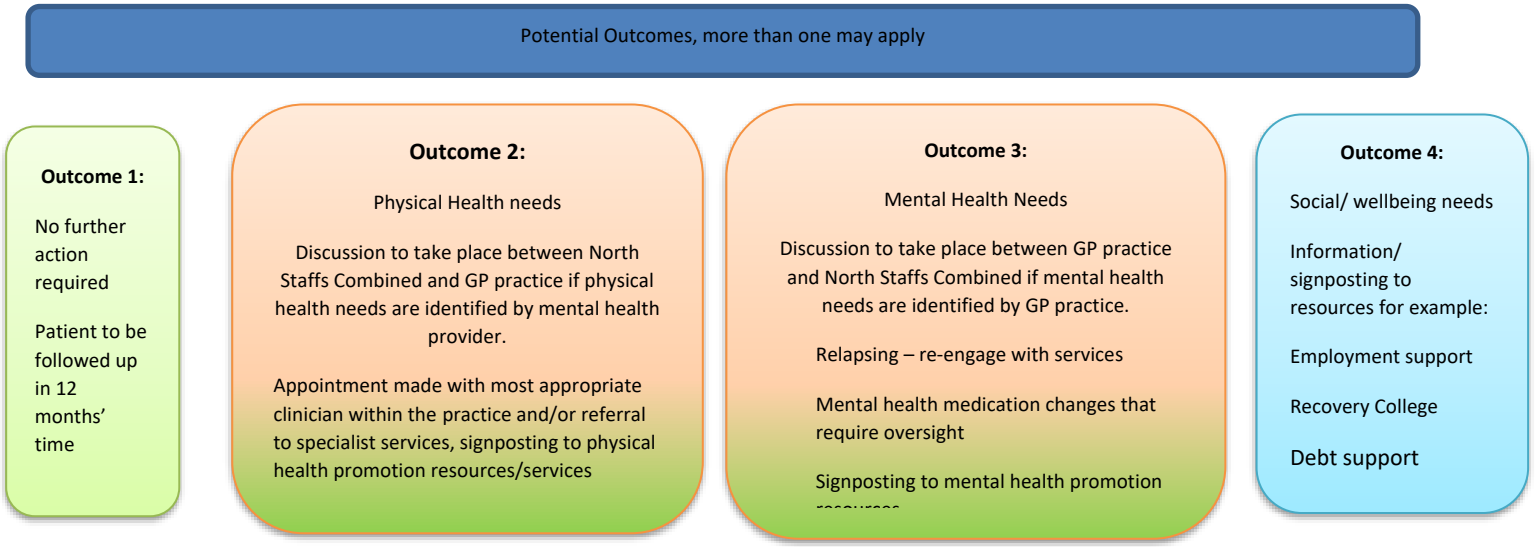
2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

2.2 Local defined outcomes

Appendix 1 – SMI Physical Health Check Pathway




Potential Outcomes, more than one may apply
Outcome 1:
No further action required
Patient to be followed up in 12 months' time
Outcome 2:
Physical Health needs
Discussion to take place between North Staffs Combined and GP practice if physical health needs are identified by mental health provider.
Appointment made with most appropriate clinician within the practice and/or referral to specialist services, signposting to physical health promotion resources/services
Outcome 3:
Mental Health Needs
Discussion to take place between GP practice and North Staffs Combined if mental health needs are identified by GP practice.
Relapsing – re-engage with services
Mental health medication changes that require oversight
Signposting to mental health promotion
Outcome 4:
Social/ wellbeing needs
Information/ signposting to resources for example:
Employment support
Recovery College
Debt support

Appendix 2

Physical Health Checks Input - Table 1	1.2.1 Patients on Mental Health Register (Not Coded as In Remission)
	1.4.1. BMI Recorded
	1.4.2. Blood Pressure Recorded
	1.4.3. Cholesterol or QRISK Recorded
	1.4.4. Blood Glucose or HbA1c Recorded
	1.4.5. Alcohol Consumption Recorded
	1.4.6. Smoking Status Recorded
	1.2.2. Patients With ALL 6 Supporting Measures Completed
Physical Health Checks Input - Table 2	1.6.1. Nutritional Status or Diet and Level of Physical Activity Recorded
	1.6.2. Use of Illicit Substance/Non-Prescribed Drugs Recorded
	1.6.3. Medicines Reconciliation or Review Recorded
Follow-Up Interventions input - Table 1	1.8.a. Patients With BMI 25+
	1.8.1. Patients With BMI 25+ offered Weight Management
	1.8.b. Blood Pressure Above Systolic 140mmHg OR Diastolic 90mmHg
	1.8.2. Patients With BP >140/90 Offered Lifestyle Intervention
	1.8.3. Patients With BP >140/90 Offered Pharmacological Intervention
	1.8.c. Patients With HbA1c 42-47mmol/mol OR FPG 5.5-6.9 mmol/L
	1.8.4. Patients With High-Risk/Prediabetic HbA1c or FBG Offered Intervention
	1.8.d. Patients With HbA1c 48+ mmol/mol OR FPG 7+ mmol/L
	1.8.5. Patients With Diabetic Range HbA1c or FBG Offered Diabetic Intervention
	1.8.e. Patients With A Record of Alcohol Misuse or High Alcohol Consumption
	1.8.6. Patients With A Record of Alcohol Misuse Offered Intervention
	1.8.f. Patients Identified As Current Smokers
	1.8.7. Current Smokers Offered Smoking Cessation or Nicotine Replacement Therapy
	1.8.g. Patients With A Record of Substance Misuse

	1.8.8. Patients With A Record of Substance Misuse Offered Intervention
	1.8.9. Patients Offered Lifestyle Interventions
	1.8.10. Patients Prescribed Statins
Cancer Screening Input - Table 1	1.10.1 Access To National Screening – Eligible For Cervical Cancer Screening
	3.4.1. Patients Receiving A Cervical Smear In Last 60m
	1.10.2 Access To National Screening – Eligible For Breast Cancer Screening
	3.4.2. Patients Receiving Breast Screening In Last 36m
	1.10.3 Access To National Screening – Eligible For Bowel Cancer Screening
	3.4.3. Patients Receiving Bowel Cancer Screening In Last 24m

Appendix 3 – Activity Details

2022/2023	Indicative number of health checks delivered			SMI Register (patients eligible for assessments 100%)			%
	North Staffordshire	Stoke-on-Trent	Total	North Staffordshire	Stoke-on-Trent	Total	
Q1	650	1018	1668	1626	2544	4170	40%
Q2	734	1148	1881	1630	2551	4181	45%
Q3	899	1406	2305	1634	2557	4191	55%
Q4	1100	1721	2822	1638	2563	4202	67%

Appendix i – Court Report Template

Delivering an effective response to people with mental health, substance misuse, learning disabilities needs and wider vulnerabilities in the criminal justice system

Liaison and Diversion Court Report

Name		**D.O.B**	

Brief history and current presentation of mental health, learning disabilities, substance misuse / alcohol issues and any other vulnerabilities
Are there current or relevant previous concerns regarding vulnerability? If yes, detail the history of compliance with services, any perceived links between presentation and offending, and explain how the current concerns are being managed?

Risk of suicide and self-harm
Are there current or relevant previous concerns of suicide and/or self-harming? If yes, how are the current concerns being managed?
Risk of harm to others
Indicate both the level of risk of violence and/or psychological harm and how this would impact on possible court remand and sentencing decisions
Accommodation and support
Identify any specific needs, available referral pathways and how they can be supported to engage with services to meet those needs including alternative accommodation where appropriate

Understanding of criminal justice system and ability to engage with court process
Are their concerns regarding their level of understanding of the criminal justice system and ability to engage in the court process? If yes, what reasonable adjustments are recommended to facilitate effective engagement?
Information to support remand and sentencing decisions
Indicate how you have arrived at any recommendations, history of compliance and an assessment of current likelihood of compliance with services, and care plan (reflecting community and custody settings as appropriate)

Report writer	

Contact number	
Date	