SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	02/GMS/0193
Service	Weymouth Homelessness Service
Commissioner Lead	Dorset Clinical Commissioning Group
Provider Lead	Dorset HealthCare
Period	September 2016-March 2017
Date of Review	September 2016

1. Population Needs

Background

Homelessness services for people who experience poor mental health including serious mental illness have been varied in terms of capacity and design, and this means that people who are homeless do not always receive the appropriate care and support they require.

In Bournemouth and Poole there is a MH practitioner who works closely with street services across the conurbation. Street services in Bournemouth consist of third sector organisations such as BCHA & CGL, and statutory services including the police and local authority service.

The MH Practitioner accepts referrals and works with the other agencies in order to make sure that people identified as a rough sleeper, and who appear to have a mental health need receive the right intervention based on a thorough assessment and care planning process.

In Weymouth no such service currently exists which means that if a person is homeless in this area they receive a less of a service than if they were living in other urban areas in Dorset especially where they have a health or mental health need.

The development of this service will begin to address some of the disparity of service provision in the areas in Dorset where there are high levels of deprivation and homelessness.

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	
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 a safe environment and protecting them from avoidable harm	

2.2 Local defined outcomes

- Signpost patients to other health and social care services e.g. GP, drug and alcohol, mental health, podiatry and dental services
- To reduce the number of unplanned/emergency admissions to hospital
- To help people engage with primary medical services resulting in improved health outcomes

The expected outcomes that the MH Professionals will deliver are:

- Engagement of homeless people with mental health services, completing assessments to determine the most appropriate care required and onward referral to services where appropriate, including voluntary agencies, social care and drug / alcohol services.
- Reduction in the number of mentally ill homeless people who present in crisis, for example the reduction in the number of presentations to the Emergency Departments, or who come to the attention of the police (e.g. via Sec 136)
- Ensure people who are insecurely housed have access to mental health and general health care
- Improve access to mainstream services for mentally ill homeless people, for example GP and mainstream psychiatric services as appropriate

The expected outcomes that the Nurse Practitioner will deliver are:

- Provision of an assessment service for patients presenting with medical problems in a variety of different venues where homeless people are found. This will include performing physical examinations.
- Clinical decision making on the basis of assessment and to implement a package of care, including prescribing where trained to do so, initiate appropriate tests and make referrals as necessary.
- Monitoring of homeless peoples' general health, and health promotion where appropriate
- Ensure people who are insecurely housed have access to mental health and general health care
- Reduction in the number of homeless mentally ill clients who present at acute hospitals for physical health conditions

3. Scope

3.1 Aims and objectives of service

- To provide a flexible, open, accessible, responsive needs-led assertive mental health / health care service delivered through consistent engagement, assessment and referral on to the most appropriate support or health service as required
- To provide advice and support, including for other agencies working with homeless clients in Weymouth
- To support the aims Dorset's homelessness strategy

3.2 Service description/care pathway

The two Practitioners in Weymouth will be part of a larger homeless network in Dorset.

In Weymouth the network will include:
- The Street Homeless Outreach team (SHOT)
- BCHA
- Soul Food
- The Lantern Project
- YOU

The network will also include various others including charities, churches and statutory services such as the Police, Probation, Community MH Service, CADAS and EDP.

The Practitioners will deliver care in a manner consistent with their respective training, experience, professional code of practice and agency requirements.

The service will employ 1 WTE Band 6 MH Practitioner and 1 WTE Band 6 General Nurse Practitioner with particular knowledge about drug and alcohol misuse.

The Mental Health Practitioner will carry an active case load of up to 15 service users (active is defined as having face to face contact). It is acknowledged that there may be seasonal variations in the level of case load.

The Nurse practitioner will provide an assessment service to the Homeless population in the Weymouth locality.

The Practitioners will be line managed by the Specialist Practitioner. The two practitioners will work from a range of bases in Weymouth according to service and client need.

The service is generally available:

- Monday to Friday 0900-1700hrs

Although these are the formal hours, the service is able to operate flexibly so that the two Practitioners are able to work with clients early in the morning or in the evening whilst the clients are still bedded down or getting ready to do so.

The Service offers an open referral system and anyone can refer to the service. However the main referrers are likely to be homelessness services, GPs and self-referrals.

The service is not an emergency service and referrals will be assessed on the basis of clinical priority and need.

Referrals are made by homeless services and others when they are first seen and sometimes those people will move on again for a time then re appear.

The two practitioners will prioritise contacts with clients based on the level of risk assessed.

3.2 Access to the service and other linked services

Medical responsibility for the service user normally lies with the service user's General Practitioner (GP) and the Practitioner staff will contact the relevant GP and other members of the Primary Care Team when appropriate.

The Practitioners will support vulnerable homeless individuals who meet their criteria to access mainstream primary care or secondary care services where appropriate.

One of the primary roles of the Practitioners is to engage with service users and signpost them to other appropriate services.

3.3 Discharge process

Clients will be discharged from the Practitioner when/if:

- They are permanently accommodated
- They do not have a SMI
- They move away from the locality e.g. If they are reconnected with their home area
- They are unwilling to engage even with assertive outreach approach
- Their support plan has been fully completed

3.4 Training/ Education/ Research activities

Practitioner will offer training and education to all services working within the field of homelessness on signs, symptoms, management and care of those with mental health and physical health problems,

Population Covered

The service is available to people who:

- Are 18 years and over
- Are Rough Sleeping or in insecure tenure e.g. B&B or "sofa surfing"
- Have a mental illness/or there is reason to believe that they have a mental illness (including depression or anxiety).
- Have a personality disorder or personality difficulties
- Have a dual diagnosis e.g. mental illness and addiction problems
- Have a physical health need requiring assessment, diagnosis and treatment
- Have no suitable accommodation

3.3 Any acceptance and exclusion criteria and thresholds

There are no exclusions in relation to referral; the service will accept all referrals.

However following the initial assessment if there is no evidence of Severe Mental Illness or Disorder the case will be closed to the Mental Health Practitioner.

3.3 Interdependence with other services/providers

The Practitioners are employed by Dorset HealthCare but the service will develop partnerships with other services in Dorset for example CADAS, EDP, Soul Food and Dorset County Council to benefit people who come in to contact with the service for example where people might require a joint response to their particular need.

The Practitioners will input in to any new developments for the homeless to ensure that these individuals have the right level of support at the right time.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

- Inclusion Health: Hidden Needs (2014)
- Mental Health Strategy – No health without mental health
- The Housing Act 1996 and The Housing Act 2004
- NICE Guidance, evidence based and best practice
- "Getting Through" Access to mental Health Services for people who are homeless or living in temporary or insecure accommodation- A good practice guide (2008)
- No second night out – vision to end rough sleeping

4.2 Applicable local standards

- Local Joint Strategic needs Assessment
- Safeguarding- children and adults
- Mental Health and well-being agenda
- Homelessness Strategies in place across Dorset

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

6. Location of Provider Premises

The Provider's Premises are located at:

The service will be based at:

Westhaven Hospital
Radipole Lane
Weymouth Dorset
DT4 0QE
Tel: 01305 362060

7. Individual Service User Placement