SCHEDULE 2 – THE SERVICES

A. Service Specifications

and agreement

Service Specification No.	05/MHLD/0009
Service	Adult Community Mental Health Teams
Commissioner Lead	MH & LD CCP
Provider Lead	tbc
Period	1st April 2014 – 31st March 2016
Date of Review	December 2015

1. Population Needs

1.1 National/local context and evidence base

No health without Mental Health, 2011, Dept of Health
No Health without Mental Health - Delivering Better Mental Health Outcomes, 2011
No health without mental health: implementation framework, 2012
No decision about me, without me, 2012, Dept of Health
The Health and Social Care Act, 2012
Mental Health Act, 2007
A mandate from the Government to NHS England: April 2014 to March 2015, Dept of Health
Bournemouth & Poole Health and Wellbeing Strategy, 2013 - 2016
Joint Health and Wellbeing Strategy for Dorset, 2013 - 2016
Dorset, Bournemouth & Poole Joint Strategic Needs Assessment

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

3. Scope

3.1 Aims and objectives of service

The aims of each Community Mental Health Team are to promote Wellbeing, better Quality of Life and Recovery for people with severe and enduring mental illness and their carers through:

- Providing high quality, evidence based treatment and care for Service Users,
- Providing support that enables each Service User to achieve their individual goals and aspirations,
- Informing Service Users and carers about options for treatment and hence enable treatments to be a partnership guided by Service User choice,
- Providing information and support for Service Users and carers,
- Promoting the needs of individuals with mental health problems and reducing the stigma associated with mental health care.
- Through helping service users to access a range of mainstream services and achieve good quality of life e.g.
  - Housing,
  - Employment or meaningful Occupation,
  - Stable Relationships,
  - Primary Health Care etc.
- Ensuring that service users' family and other individuals who form part of their immediate support network receive the advice and help they need to support the service user and maintain a positive and meaningful relationship with them,
- Promoting holistic care taking account of physical as well as mental good health, ensuring that people physical health needs are identified within recovery care plans with the aim of improving physical wellbeing.
- Ensuring that Service Users and carers are treated with respect and dignity,
- Ensuring that care is offered in accessible locations and in a timely manner,
- Working in an environment that safeguards vulnerable people.

3.2 Service description/care pathway

The service will be provided through an integrated health and social care approach with teams being made up of a multi-disciplinary workforce eg Consultant Psychiatrists, Psychologists, Nurses, Social Workers, Occupational Therapists, Support Time and Recovery (STR) workers.

Referrals can be made via letter, telephone, electronically or faxed directly to the CMHT by the GP, Steps2Wellbeing or any Health or Social Care Professional, including:

- Members of the Primary Care Teams
- Local Authority Staff
- Staff in other Specialist Mental Health Services,
- Steps2Wellbeing
- Multi-Agency Public Protection Agency, (MAPPA)
- Staff from General (Acute) Hospitals (incl psychiatric liaison services)
- Self-referrals in the 12 months following discharge if included in the discharge / Recovery plan
- Staff in Addiction Services
- Self-referral

The core hours of the service will be Monday – Friday 9.00am – 5.00pm.

Each CMHT will ensure practitioners are available between 9.00am – 5.00pm Mon-Fri to respond to emergencies. (outside these hours mental health emergencies will be managed by the Crisis Resolution and Home Treatment Team (CRHT))

All referrals will be responded to in a timely fashion with the following standards applying:

Emergency Referrals will be assessed on the day of referral unless agreed with the referrer to see the following day.
Acutely suicidal or vulnerable service users, and those whose mental health problems may place others at risk

Urgent Referrals will be assessed within 5 working days.
Individuals with significant and distressing mental health problems who have suicidal thoughts or thoughts of harming others but whose clinical presentation is not such to require an immediate same day assessment.

Non-urgent referrals – Assessed within 28 days.
Individuals not meeting the criteria of emergency or urgent referrals

CMHTs will give high priority for assessment where one or more of the following criteria apply:

- Risk of abuse by others/vulnerability,
- Where the Service User poses a risk to others,
- Significant risk to self,
- Impaired ability to function effectively and safely within the community without assistance,
- Behavioural disturbances which may lead to the breakdown of the current social situation.

Assessment

Each service user will receive a comprehensive assessment that will be used to develop appropriate treatment plans.

Assessments will be completed in a variety of settings taking into account risk, timeliness and service user convenience.

All clients requiring assessment will receive a face to face assessment.

Where service users are in contact with other agencies (for example Police, Probation, Children's Services), liaison with those agencies will occur as part of the comprehensive assessment.

Staff will also ensure that carers of the service user are offered a carer's assessment and plan of care in their own right.

Intervention, Therapies and Treatment

The service will work flexibly to engage service users and carers in providing services which are service user focused.

All service users will be allocated a care co-ordinator or lead professional. The Lead Professional/Care Coordinator should work with the Service User/Carer to develop, implement, monitor and review a care plan in accordance with the Assessment and Care Planning Policy.

Care plans will be recovery orientated and incorporate (in accordance with the service user's wishes):

- Identifying hope and aspirations including personal identified goals
- Maintaining friendships and relationships
- Accessing public and leisure facilities
- Having a meaningful occupation (meaningful activity)
- Maintaining healthy lifestyle and wellbeing
- Maintaining and improving physical health

All Service Users should receive a copy of their care plan, clearly identified as such, unless there is a multi-disciplinary team (MDT) decision not to do so in accordance with risk.

CMHT Staff will ensure relevant information about interventions and choice is made available to service users and carers. This will include information on local service user and carer forums. The CMHT may provide specific groups to support carers.

Therapeutic interventions offered/provided to service users and carers may include:
- Group and individual based interventions eg life skills programmes, DBT skills groups, carer's groups
- Individual CBT based interventions eg Motivational Interviewing
- A range psychological therapies as set out within Dorset Healthcare's Register of Approved Therapies
- Medication
- Social interventions including information and advice

Where there is a social care aspect to the care plan the use of direct payments must be considered for both the Service User and carer in accordance with the Local Authorities policies for Direct Payments.

Consideration should be given for the use of Continuing Health Care in line with the Trust Policy.

The CMHT's will work towards individual health care budgets in accordance with current CCG policy.

The provider is expected to work in partnership with Bournemouth Borough Council, Borough of Poole, and Dorset County Council to deliver the service.

The provider will have a clear policy for the transition from CAMHS to mental health adult services.

Discharge

Where possible the decision to discharge a patient should be jointly made by the Care Coordinator/Lead Professional, Service User and Carer. Such decisions should be made in advance of the discharge.

For Service Users on CPA the decision to discharge must be discussed and clearly documented in the Service User Record as part of the multi-disciplinary team meeting. The details of the most senior clinician contributing must also be noted. For Service Users on Standard Care the decision to involve the MDT will be determined by complexity and risk.

The discharge plan should include:
- A diagnosis
- Current and planned future treatment
- Current risk assessment
- Information and advice given to the service user and carer
- Details on how to re-access the service

CMHT's are required to review both existing and new S117 contracts as a statutory requirement of the MHA Code of Practice. Where a service user is subject to S117, consideration should be given to discharging the Service User from S117, at the same time they are discharged from CPA/standard care.

The S117 after-care plan should be regularly reviewed and the ongoing S117 requirement clearly documented. It will be the responsibility of the care co-ordinator (or other officer responsible for its review) to arrange reviews of the plan until it is agreed that it is no longer necessary.
Where a Service User is stable but still on psychotropic medication they need to remain on S117. However, such individuals can be discharged to Primary Care with their S117 review being managed by Social Services and Primary Care.

The minimum review period under CPA is annually, however reviews should also take place following any significant changes to the person's mental health or circumstances e.g. admission to hospital, or dependent on the needs of the individual. Good practice suggests reviews should be held at a minimum of every 6 months.

If there is a continuing need for specialist psychiatric oversight of psychotropic medication the individual should not be discharged and will continue to be regularly reviewed by members of the CMHT.

3.3 Population covered

All individuals registered/temporarily registered with NHS Dorset CCG member practices. Clients who have recently moved into the area and require support from the CMHT will not be prevented from accessing CMHT support. Similarly those individuals who live locally but are not registered with a GP will be able to access CMHT support. Where relevant the CMHT will support the individual to register with their local GP practice.

3.4 Any acceptance and exclusion criteria and thresholds

The service provided by the CMHT's will focus on Service Users with a significant mental disorder who are aged 18 years and over and include individuals with:

- Schizophrenia and psychotic disorders and delusional disorders,
- Affective disorders such as mania, bipolar affective disorder, bipolar depression and severe and complex depression where there is a risk to life or severe self-neglect. In some cases, depression which has not responded to appropriate treatments at a primary care level may be appropriate for assessment and intervention in secondary care,
- Eating disorders (in conjunction with specialist eating disorders service where necessary),
- Organic Mental Disorder where the individual requires specialist input e.g. for behavioural or psychological issues,
- Significant Mental Health problems following childbirth for referral onto Perinatal Services,
- Significant neurotic, stress related and somatoform disorder, such as phobias, anxiety disorder, post-traumatic stress disorder and obsessive-compulsive disorder which have not responded to previous appropriate treatment,
- Personality disorder co-existing with the above diagnoses and/or personality disorder that causes significant distress or risk to the Service User or others and where there may be a benefit from specialist expertise,
- Assessment for adult ADHD and initiation of treatment if appropriate.
- Individuals with autistic spectrum disorders who have a co-morbid severe mental disorder as described above.

3.5 Interdependence with other services/providers

- Primary Care
- Crisis Resolution and Home Treatment Teams (CRHT)
- Intermediate Care Service for Dementia
- Steps to Wellbeing (S2W)
- Community addiction services (both internal and external agencies)
- Employment support agencies
- Perinatal Mental Health service
- Eating Disorder Service
- Intensive Psychological Therapy Service (IPTS)
- 3rd sector
- Recovery Education Centre
- Psychiatric Liaison Service
- CAMHS

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- NICE clinical guideline 178, Psychosis and schizophrenia in adults: treatment and management
- NICE clinical guideline 120, Psychosis with coexisting substance misuse
- NICE clinical guideline 38, Bipolar disorder - The management of bipolar disorder in adults, children and adolescents, in primary and secondary care
- NICE clinical guideline 77, Antisocial personality disorder - Treatment, management and prevention
- NICE clinical guideline 78, Borderline personality disorder - Treatment and management
- NICE clinical guideline 16, The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care
- NICE clinical guideline 133, Self-harm: longer-term management
- NICE clinical guideline 90, The treatment and management of depression in adults

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 Parts [A-D])

5.2 Applicable CQUIN goals (See Schedule 4 Part [E])

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement