

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	05/MHLD/0010
Service	Assertive Outreach team
Commissioner Lead	Mental Health & Learning Disability CCP
Provider Lead	tbc
Period	April 2014 – March 2016
Date of Review	To be agreed

1. Population Needs																	
1.1	National/local context and evidence base																
	<ul style="list-style-type: none"> • NSF-MH, • New Horizons • MHA 1983 • MCA 2005 • NICE Guidance, evidence based and best practice • Local Joint Strategic needs Assessment • Safeguarding- children and adults • Mental Health and well-being agenda 																
2. Outcomes																	
2.1	<u>NHS Outcomes Framework Domains & Indicators</u>																
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">Domain 1</td> <td style="width: 60%;">Preventing people from dying prematurely</td> <td style="width: 20%; text-align: center;">✓</td> </tr> <tr> <td>Domain 2</td> <td>Enhancing quality of life for people with long-term conditions</td> <td style="text-align: center;">✓</td> </tr> <tr> <td>Domain 3</td> <td>Helping people to recover from episodes of ill-health or following injury</td> <td style="text-align: center;">✓</td> </tr> <tr> <td>Domain 4</td> <td>Ensuring people have a positive experience of care</td> <td style="text-align: center;">✓</td> </tr> <tr> <td>Domain 5</td> <td>Treating and caring for people in safe environment and protecting them from avoidable harm</td> <td style="text-align: center;">✓</td> </tr> </table>	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	✓	
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																
	<p>The overall aims of Assertive Outreach Services are to provide a service to people with a complex, severe and enduring mental health problem who find it difficult to maintain engagement with more traditional mental health services.</p> <p>The overarching objectives of Assertive Outreach Services are to:</p> <ul style="list-style-type: none"> • seek out people and work with them in locations where they feel comfortable; • maintain people within the community wherever possible and to avoid unnecessary hospital admissions; 																

- to promote the recovery of each individual to the maximum level of functioning within their needs of that individual.

3.2 Service description/care pathway

The Assertive Outreach Services will actively seek out people and work with them in locations where they feel comfortable. The service aims to maintain people within the community wherever possible, avoiding unnecessary hospital admissions. The team will actively promote the recovery of each individual to the maximum level of functioning for an individual within their needs.

It is acknowledged that Assertive Outreach Services offers the opportunity to engage effectively with this small group of people and consequently to reduce the numbers of repeat admissions that are required.

Assertive Outreach Services deal specifically with small numbers of people with severe mental health problems and complex needs. They have difficulty in engaging with services and would otherwise require repeated admission to hospital, often under detention.

Assertive Outreach Services are required to be sensitive to age, gender and culture in the following ways:

- the high prevalence of diagnosed psychosis in certain cultural groups emphasises the need for a culturally competent service;
- the needs of different groups should be explored and gender/culturally sensitive services should be provided.

Assertive Outreach Services will provide:

- assessment;
- care co-ordination;
- regular review.

Assessment:

The following are expected to form the assessment process:

- initial multi-disciplinary screening to ensure that the service is appropriate;
- comprehensive multi-disciplinary needs assessment;
- physical health assessment where appropriate;
- comprehensive multi-disciplinary risk assessment;
- use of standard assessment measures to monitor change and identify progress;
- statement of needs and production of care plan;
- all assessments should be culturally competent.

Care Co-ordination:

- each service user will be assigned a care co-ordinator who has overall responsibility for ensuring appropriate assessment, care and review by themselves and others within the team;
- care co-ordinator role is allocated taking into account the individual team members, strength of relationship between individual team member and the service user and the preferences of the user;
- staff know and work with all service users so that continuity of care is provided by the team as a whole;
- written and verbal means of ensuring good communication between team members;
- service user to care co-ordinator ratio should be at a maximum of 14:1

Regular review:

- brief daily meetings where each service user is reviewed, involving a member of the

medical staff, and where risk is reviewed;

- weekly review meetings with the consultant psychiatrist where action is agreed and changes in treatment are discussed with the team as a whole;
- progress and outcomes regularly monitored;
- progress and outcomes regularly monitored, including service user, carers and other important to the service user involved;
- care plan formally reviewed at least six monthly.

Service model

The model for Assertive Outreach Services will be based on a range of interventions as set out below.

Assertive Engagement:

- high priority will be given to providing services and support to service users and carers/ and/or family in the initial stages of engagement;
- focus on strengths and interests of service users and the benefits which contact with the service can bring;
- a persistent approach to engagement, with repeated attempts at contact where necessary. Assertive means tenacious, creative and innovative but not aggressive.

Basics of daily living:

- care plans should address all aspects of daily living, empowering service users and respecting their independence;
- practical support provided by the team should be available, including hands on involvement in shopping, cleaning and budgeting where required. This helps to establish and maintain the relationships with service users;
- daily living skills training to raise independence of service users;
- empowering service users and respecting their independence is crucial;
- the team, on behalf of the service user, may need to be assertive with other services, for example housing, to ensure better living conditions are provided and maintained.

Support for family and/or carers and/or significant others:

- practical support should be provided as needed, with a care plan being produced and regularly reviewed;
- psycho-social education should be available provided to family, carers and significant others;
- behavioural family therapy should be available over extended periods of time as appropriate.

Medication:

- delivery and administration of medication to service users who require intensive monitoring;
- care packages designed to improve co-operation with treatment (concordance);
- the service user should be involved in decision making and monitoring the effects of medication.
- standard side effect monitoring tools should be used regularly by both service users and staff. Careful attention should be made to avoid or reduce side effects as this will promote the maintenance of engagement and concordance

Attention to the physical health of the service user:

- physical health problems, including dietary needs and dental care should be identified and addressed;
- help and encouragement to access health services, including health promotion and screening services should be given;
- the team should provide assistance with keeping appointments with GPs, hospitals and other services.

Prevention of Relapse:

- all service users to have their own 'early warning signs' plan developed in agreement with the service user and their carers. These plans can be effective in reducing severity of relapse as they deal with the signs pertinent to the individual service user;
- the plan should be on file/electronic CPA to be shared with primary care, GP and others as appropriate;
- efforts should be made to identify and reduce the conditions which leave the service user vulnerable to relapse.

Crisis interventions:

- one aim of Assertive Outreach Services is to avoid the use of hospitalisation or restrictive care wherever possible;
- as much treatment as possible should be provided within the community, in or near to the home of the service user and this may require intensive support by the team during a crisis;
- if acute care is thought to be needed there should be a joint assessment by the Assertive Outreach Services, Crisis Response Team and inpatient team so that the least restrictive alternative can be utilised.

Inpatient and respite care:

- if inpatient care is required, the Assertive Outreach Services should maintain contact throughout the admission and be involved in decision making and ensuring that the views of the service user, family or carers are taken into account;
- regular joint, formal reviews should take place to ensure the service users if transferred to a less restrictive environment as soon as clinically appropriate;
- the Assertive Outreach Services should be involved in discharge planning, and in involving all other relevant services, such as Primary Care, Day Services etc. Assertive Outreach Services also to ensure the home environment is ready for the service user's discharge.

Cognitive Behavioural Therapy

- CBT can be of considerable benefit to service users and a range of techniques should be available within the team and used when appropriate.

Social systems interventions:

- intervention should be provided to maintain and expand the service users' social networks and peer contact to reduce social isolation.

Help in accessing local services and educational, training and employment opportunities:

- assessments by Assertive Outreach Services should cover aspirations and opportunities;
- referral to specialist education/occupation services for help with placement should be readily available;
- pathways to education and valued employment can be shown, and help provided to enable service users to achieve this.

Key Components of service delivery will include:

- **Assessment:** Behavioural Assessment; Carer's Assessment; Specialist Mental Health Assessment; CPA Assessment; Assessment of Psychosis
- **Care Planning and Management:** Flexible Person Centred Care; Task Focused Care With Timed Tasks
- **Carer's Support**
- **Early Detection of Depression**
- **Intervention:** Intensive Home Treatment; Employment Support; Management of Mental Health Crisis; Prescribing, Monitoring and Review of Psychotropic Medication; Specialist Behavioural Management; Psychosocial Interventions; Early Intervention in Psychosis
- **Rapid Response**
- **Self Help and Support:** Other: Yes
- **Social Care:** Drop In; Employment / Training; Social Activity

- **Support:** Intensive Support; Domiciliary and Practical Support; Emotional Support; Social Support
- **Therapy:** CBT (Cognitive Behavioural Therapy); Counselling; Individual Psychological Therapy
- **Training:** For Carers; For Primary Care
- **Transport**

Operational Hours

The core hours of service provision are:

- Monday – Friday 9am – 5pm

The service will ensure access to support is available outside the core hours of the service and will have capacity to respond rapidly to changes in need and provide intensive community support seven days a week.

Referral processes

Accepts referrals from:

- Bournemouth and Poole CMHTs, Dorset Forensic Team, Early Intervention Service, Nightingale House Complex Care and Recovery Service
- Assertive Outreach Teams from other areas
- In writing and addressed to team assistant containing information on AOT referral form including risk assessment

Discharge process

The following will shape discharges and transfers

- as long as there is evidence of benefit to the service user, assertive outreach should continue indefinitely;
- if a service user shows a good recovery, transfer to a CMHT could be considered, for less intensive ongoing intervention;
- rapid re-referral must be possible;
- service users/family/carers and primary care should be actively involved in any discharge planning process;
- when the service user moves to her or his home it is the responsibility of the Assertive Outreach Services to ensure that care is transferred effectively and engagement maintained. Contact should continue until engagement with new team is fully established.

3.3 Population Covered

The service will serve the geographical location of Bournemouth, Poole and East Dorset

3.4 Any acceptance and exclusion criteria.

Users who are served by the Assertive Outreach Service are:

- people with a severe and persistent mental disorder (schizophrenia, major affective disorders) associated with a high level of dysfunction as a result of their mental health problems;
- people with a history of high use of inpatient or intensive home based care as demonstrated by:
 - more than two admissions;
 - a period of inpatient care lasting more than six months;
 - a period of home treatment lasting more than twice the usual length of engagement;
 - a history of difficulties for individuals to maintain lasting and consenting contact with service.

The following is a non-exhaustive list of indicators of need and it is acknowledged that users who have multiple and complex needs may well present with more than one of these indicators:

- a history of violence or persistent offending;
- significant risk of persistent self-harm or neglect;
- poor response to previous treatments;
- dual diagnosis of substance misuse and a serious mental illness;
- detained under the MHA (1983) on at least one occasion in the past two years;
- living in unstable accommodation or homeless.

3.5 Interdependence with other services/providers

- Community Mental Health Teams
- Early Intervention in Psychosis Service
- Crisis Resolution and Home Treatment Team
- Rehabilitation Services
- Primary Care
- Acute Mental Health In-patient units
- Dorset Forensic Team
- Day Services
- Employment support services

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

NICE CG178 Psychosis and schizophrenia in adults: treatment and management
NICE CG 82 – Schizophrenia
NICE CG 38 – Bipolar disorder: The management of bipolar disorder in adults, children and adolescents, in primary and secondary care
NICE CG120 – Psychosis with coexisting substance misuse

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