

SCHEDULE 2 – THE SERVICE

Service Specification No.	05/MHLD/0017
Service	Older People's Community Mental Health Teams (Older People's CMHT)
Commissioner Lead	Mental Health and Learning Disability Clinical Commissioning Programme Team
Provider Lead	Dorset Healthcare
Period	1 April 2014 to 31 March 2016
Date of Review	December 2015

1. Population Needs

1.1 National/local context and evidence base

Older people form a larger proportion of the population. Nationally by 2035 the number of people aged 85 and over is projected to be almost 2^{1/2} times larger than in 2010.

Dorset has a higher than national average percentage of its population over 65 years of age who live in both urban and rural areas.

The table below details the demographics for the local population.

Authority	Total Population	Aged 65+	% Aged 65+
Bournemouth Unitary Authority	188,733	33,847	17.9%
Poole Unitary Authority	149,009	32,199	21.6%
Dorset County Council	416,721	112,255	26.9%
Total Dorset	754,463	178,301	23.6%

Source: Office for National Statistics (ONS) 2013 Mid-Year Estimates

Older People's Mental Health services are concerned with the care and treatment of people with complex mixtures of psychological, cognitive, functional, behavioural, physical and social problems usually related to ageing.

Service providers must deliver care through an integrated approach, working in partnership with primary care, social care, third sector agencies and voluntary sectors as appropriate.

Care should be personalised with a focus on early intervention to promote independence and well-being to improve quality of life, prevent escalations of mental illness and provide alternatives to hospital admission.

Relevant policies and guidance documents related to this specification are outlined below:

- 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 Care Act, 2014

- Mental Health Act, 2007
- Mental Capacity Act, 2005
- A mandate from the Government to NHS England: April 2014 to March 2015, Dept of Health
- Living well with dementia: A National Dementia Strategy, Dept of Health 2009
- Bournemouth & Poole Health and Wellbeing Strategy, 2013 - 2016
- Joint Health and Wellbeing Strategy for Dorset, 2013 - 2016
- Dorset, Bournemouth & Poole Joint Strategic Needs Assessment
- Safe, compassionate care for frail older people using an integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders, NHS England South, February 2014
- Guidance for commissioners of older people's mental health services, Joint Commissioning Panel for Mental Health, 2013
- Multi-Agency Safeguarding Adults Policy (pan Dorset) 2013

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 Service providers are required to focus on the domains of the framework.

Adult Social Care Outcomes Framework 2013/14

Domain 1	Enhancing quality of life for people with care and support needs	*
Domain 2	Delaying and reducing the need for care and support	*
Domain 3	Ensuring that people have a positive experience of care and support	*
Domain 4	Safeguarding adults whose circumstances make them vulnerable and protecting from harm	*

2.3 The table sets out desired outcomes for public health and how they will be measured.

Public Health England Outcomes Framework 2013 – 2016

Outcome 1	Increased health expectancy – taking account of health quality as well as length of life
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Outcome 2	Reduced differences in life expectancy and healthy life expectancy between communities		
Domain 1	Domain 2*	Domain 3	Domain 4 *
Improving the wider determinant of health	Health Improvement	Health Protection	Healthcare public health and preventing premature mortality
Objective: Improvement against wider factors that affect health and wellbeing and health inequalities	Objective: People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities	Objective: The population's health is protected from major incidents and other threats, while reducing health inequalities	Objective: Reduced number of people living with preventable ill healthy and people dying prematurely, while reducing the gap between communities

2.3 Local defined outcomes

3. Scope

3.1 Aims and objectives of service

The aim of Older People's CMHTs is to provide a community based service which will promote mental well-being and improved quality of life and recovery for its Service Users.

The service will:

- Provide high quality, evidence based treatment and care for Service Users,
- Provide support that enables each Service User to achieve their individual goals and aspirations,
- Inform Service Users and Carers about options for treatment and hence enable treatments to be a partnership guided by Service User choice,
- Provide information and support for Service Users and Carers,
- Promote the needs of individuals with mental health problems and reducing the stigma associated with mental health care.
- Facilitate and support service users to access a range of mainstream and voluntary services in order to achieve good quality of life e.g.
 - Housing,
 - A meaningful occupation/activities including employment where relevant,
 - Stable relationships,
 - Primary Health Care
 - Memory Support and Advisory Services
 - 3rd sector support agencies e.g. Rethink, Alzhiemers Society, Age UK
- Ensure 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 to maintain a positive and meaningful relationship with them,

- Promote holistic care taking into account physical as well as good mental health,
- Ensuring that people's physical health needs are identified within recovery care plans with the aim of improving physical wellbeing,
- Ensure Service Users and Carers are treated with respect and dignity,
- Ensure care is offered in accessible locations and in line with agreed access standards,
- Provide support in an environment that safeguards vulnerable people.

3.2 Service description/care pathway

Community Mental Health Teams for Older People will consist of multi-disciplinary teams of mental health workers which may include the following ;nurses, social workers, occupational therapists, support workers and psychiatrists. The team will provide assessment, care, treatment and advice for individuals suffering from severe mental disorder and where appropriate their Carers and families.

Referral process

OPCMHT referrals are accepted via letter, telephone, electronically or to a secure fax from the GP or any other health/social care professional, including:

- Members of primary health care teams
- Local authority staff
- Staff in other specialist mental health services
- Primary care mental health teams (including IAPT/Steps to Wellbeing)
- MAPPA/MARAC
- Staff from acute general hospitals
- Addiction services

Self-referrals will be accepted from individuals within 12 months of discharge from the service.

On receipt of a referral, a suitably qualified practitioner will screen to determine the level of priority – emergency, urgent, non-urgent (routine).

Response Times

Clinical priorities are defined as:

- Emergency referrals (to be seen that day – within 24 hours – unless agreed by the referrer that it can wait until the following day.)
Emergency referrals are appropriate for acutely suicidal Service Users and those whose mental health problems may put other individuals at risk.

The referral request will be made by telephone call with any additional clinical information sent via fax as necessary. If a referring doctor wishes to speak to a senior doctor, this can take place on request.

- Urgent referrals (to be seen within 5 working days)
Urgent referrals are appropriate for Service Users 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.

If a referring doctor wishes to speak to a senior doctor, this can take place on request.

- Non- urgent referrals (to be seen within 28 days)
Individuals not meeting the criteria of emergency or urgent referrals

Assessment

Each Service User will receive a comprehensive assessment that will be used to develop appropriate care and treatment plans.

Assessments will be completed in a variety of settings taking into account risk, timeliness and Service User convenience e.g. outpatients and in their own home as deemed appropriate.

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.

Assessments will be completed in accordance with relevant organisational policies e.g. Clinical Risk Policy

Carers

Staff will also ensure that Carers of the Service User are offered a Carer's assessment and plan of care in their own right.

Interventions

OPCMHT staff will work flexibly to engage Service Users and Carers in providing services which are Service User focused.

OPCMHT staff will provide information to Service Users and Carers, including information on resources which may be available to them and information about the local Service User and Carer forums.

All Service Users will be allocated a Care Co-ordinator or Lead Professional as identified under the Care Programme Approach guidelines. The Lead Professional or Care Co-ordinator 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 determined by risk.

Therapeutic interventions offered by the OPCMHT may include medication, psychological therapies (as set out in the Trusts Register of Approved Therapies) and social interventions.

Direct Payments and Individual Budgets:

- 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.
- Consideration should be given for the use of Continuing Health Care.
- The OPCMHTs will work towards individual Health Care Budgets as per relevant CCG policy.

Discharge process

Where possible the decision to discharge a patient should be made jointly by the Care Co-ordinator or Lead Professional, Service User and Carer 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 at a minimum:

- 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.

Section 117

Older People's CMHTs are required to review both existing and new s117 (Mental Health Act, 2007) contracts as a statutory requirement of the Mental Health Act 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 the relevant Local Authority and Primary care.

The minimum review requirement 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, therefore, suggests reviews should be held at a minimum of every 6 months.

3.3 Days/ hours of operation

Each CMHT base will ensure that telephones are staffed between 9.00 and 17.00 hours Monday to Friday (excluding Bank Holidays), with access to clinicians for a rapid response. Managers and team leaders must ensure that telephones are answered by a member of staff during these times; answerphone machines should not be permitted within working hours.

Answerphone machines should be in place out of working hours, with a message stating:

- Times when the CMHT is available,
- The telephone number for the Crisis and Home Treatment Response Team.

Social Services Out of Hours service operates seven days a week 5pm to 8.40am Monday to Thursday and from 4pm Friday to 8.40am Monday.

- The service provides emergency cover and access to essential services outside of the main local office working hours and covers Poole, Bournemouth and Dorset; support telephone number - 01202 657279

3.4 Population Covered

The service will be provided to patients registered with an NHS Dorset CCG general practice. Clients who have recently moved into the area and require support from the OPCMHT will not be prevented from accessing OPCMHT support. Similarly those individuals who live locally but are not registered with a GP will be able to access OPCMHT support. Where relevant the OPCMHT will support the individual to register with their local GP practice.

3.5 Acceptance and exclusion criteria and thresholds

The service will focus on Service Users over 65 years of age. When the needs of an individual aged under 65 years can best be met by the Older People's CMHT they will be accepted. An example would be an individual presenting with early on-set dementia.

All service users will have a significant mental disorder which will include:

- Schizophrenia and psychotic disorders and delusional disorders
- Affective disorders, such as mania, manic depression and moderate / severe depression
- Eating disorders (in conjunction with specialist eating disorders service where necessary)
- Organic mental health disorders
- Significant neurotic, stress related and somaform disorder
- Personality disorder co-existing with the above diagnosis 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

Older People's CMHTs will give priority for assessment where one or more of the following criteria exists:

- Risk of abuse from another party,
- The Service User poses a risk to others,
- Impaired ability to function effectively and safely within the community without assistance,
- Behavioural disturbances which may lead to a breakdown of the current social situation.

3.6 Interdependence with other services/providers

The following agencies directly or indirectly influence the work of the Older People's CMHTs:

- GP and primary health care team
- Borough of Poole
- Bournemouth Borough Council
- Dorset County Council
- Voluntary sector
- Primary Care Psychological Therapies Service (IAPT)
- Psychiatric liaison service in acute hospitals
- Memory Assessment / Memory Advisory Services
- Intermediate Care Dementia Service
- In patient mental health service
- Independent sector care homes
- Safeguarding Adults Services

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
- NICE Quality Standards QS14 (December 2011) – Quality standards for service user experience in adult mental health
- NICE Guidelines CG136 (December 2011) - Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services
- NICE clinical guideline 42 (November 2006) – Supporting people with dementia and their carers in health and social care

- NICE guidelines CG123 (May 2011) - Common mental health disorders: Identification and pathways to care
- NICE quality standards QS53 (February 2014) – Anxiety disorders
- NICE quality standards QS8 (March 2011) – Depression in adults quality standard

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

Employees should work in accordance with their respective professional body's code of conduct and maintain their registration.

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

Services will be offered from a range of venues across Dorset, including the service user's own home, taking into account risk, timeliness and wherever most appropriate for the individual, based on choice and need.

7 Individual Service User Placement