Service Specification: Psychiatric Liaison

Version Control Sheet

Version Control:	
Name	**Role**
Lesley Cleworth	Service Delivery Manager, NHS South Cheshire CCG and NHS Vale Royal CCG

Amendment History:			
Version	**Date**	**Author**	**Reason**
1	22/12/15	L Cleworth	
2	31/3/16	C Mills	Standard Sections
3	11/4/16	C Mills	Standard sections Outstanding: Section 2
4	11/5/16	Gill Sidney/C Mills	CWP Comments added, standard sections: change to quality requirements
5	9/8/17	G Dyson	CWP comments incorporated
6	15/01/18	G Dyson	Further CWP comments incorporated

Approval History:		
Date Approved	**Approved By**	**Role**

SCHEDULE 2 – THE SERVICES

A - Service Specification

Service Specification No.	14
Service	Psychiatric Liaison
Commissioner Lead	Jamaila Tausif
Provider Lead	Cheshire and Wirral Partnership NHS Foundation Trust
Period	1st April 2017 – 31st March 2020
Date of Review	January 2019

Executive Summary

Psychiatric Liaison is concerned with the care of people presenting with both mental and physical health symptoms regardless of presumed cause. Psychiatric Liaison 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.

1 Population Needs

1.1 Local Strategic Context

NHS South Cheshire Clinical Commissioning Group (CCG) and NHS Vale Royal CCG cover a total population of 275,490, with 30 GP practices.

The Needs Assessment shows that NHS South Cheshire CCG has a population of 173,000 with 18 GP practices, with registered list sizes ranging from 2,500 to 21,242. The practices cover a geographical area of Cheshire stretching from Audlem in the south to Middlewich in the north.

Around 10.7% of our population across South Cheshire live in areas that are among the 20% most deprived in England. A further 15.6% live in the next most deprived fifth of areas in England.

NHS South Cheshire CCG's geographic area falls entirely within the boundary of Cheshire East Local Authority.

NHS Vale Royal CCG covers a population of 102,490, with 12 GP practices across Winsford, Northwich and surrounding rural areas. Around a third of the NHS Vale Royal CCG population live in local communities that are described as 'deprived'; based on employment, income, living environment and education, skills and training.

NHS Vale Royal CCG falls within Cheshire West and Chester Local Authority boundary.

The percentage of the population (aged 16-74) estimated to have a common mental health problem is as follows:

- NHS South Cheshire CCG – 14.26%- which equates to around 20,000 adults.

- NHS Vale Royal CCG – 14.63%-, which equates to around 12,000 adult

NHS South Cheshire CCG and NHS Vale Royal CCG Strategic Priorities are:

- Transforming Mental Health – recognising that this is a significant area of health need locally with a national focus on parity of esteem
- Transforming Primary Care – developing a systems approach to general practice, using the registered list as the cornerstone, that delivers an outcomes approach to high quality, person centred care
- Transforming Urgent Care – to bring a renewed focus on transforming the current system (some of which will be delivered through the Better Care Fund)
- Integration – the delivery of Integrated Community Teams and the transformation of community services (some of which will be delivered through the Better Care Fund)
- Person Centred Care – with a focus on self-care, self-management and empowering communities and individuals
- NHS Constitution Standards - accountable for improving health outcomes, commissioning high quality care and best use resources

1.2 National Strategic Context

The need for a preventive and recovery focused model of mental health care is well-recognised, but the current model of mental health remains one which prioritises the care of people with severe and enduring mental health, the majority of whom first come into contact with specialised mental health services at a time of crisis.

The Government's strategy for Mental Health is 'No Health without Mental Health' (2007) and calls for a move towards prevention, promotion and earlier intervention in mental health, with a focus upon primary care and primary care psychological therapies. For this to occur it requires change and improvement in primary mental health care to manage increasing mental health need and a significant increase in demand for services.

The Strategy also calls for closer working between providers and commissioners of mental health and physical health given:

- Comorbid depression is associated with a 50–75% increase in health spending among diabetes patients. *Simon G, Katon W, Lin E, et al (2005)*
- People who have suffered a heart attack have a 30% chance of developing depression (Davies et al 2004) and are three times more likely to die of these causes if they also suffer from depression than if they do not *Frasure-Smith N, Lespérance F, Juneau M and Talajic M (1999)*
- It is estimated that up to 51% people suffering with COPD have clinically significant symptoms of depression and/or anxiety disorder; similarly, prevalence of panic disorder is markedly higher in people who have COPD, with up to 67% experiencing panic disorder.
- Between 30% and 45% of patients attending chronic pain clinics are estimated to be clinically depressed and are also likely to have a high degree of health anxiety about their pain.

- The prevalence of post-stroke depression has been estimated to be as high as 61%. Additionally, research has shown that middle-aged men are three times more likely to suffer a stroke if they are depressed (May 2002).
- Two thirds of medical beds in general hospitals are occupied by people aged over 65 and around 30% will have dementia and are more at risk of developing issues such as falls, pressure sores and incontinence (Alzheimer's Society)

Primary care is often the first port of call in times of health care need and the majority of people who come into contact with NHS services as a result of mental illness do so in general practice. For most patients, developing a good relationship with their general practitioner (GP) is central to continuity of care, as this facilitates engagement with and communication across, the whole of primary care. Good engagement and communication allows the GP, and indeed any member of the primary care team, to deliver collaborative care, working with other members of the team and with mental health specialists as needed. A focus of mental health service liaison with Primary Care will be to ensure Choice in Mental Health is promoted and supported.

Given the complexity of some mental health issues which may include the need for risk management and monitoring compliance with treatment programme initiated in secondary care, GPs and other primary care staff will require specialist input from mental health trained staff, such as Therapists (including IAPT practitioners), Psychiatric Nurses etc.

2 Outcomes

2.1 NHS Outcomes Framework Domains & Indicators (NHS OFI): CCG Outcome Indicator Set (COIS) 2015/2016: Transforming Mental Health

Domain 1		**Preventing People from Dying Prematurely**
COIS	NHS OFI	
C1.1	1ai and ii	Reduction in potential years of life lost (PYLL) from causes amenable to mental health
C1.12	N/A	Reducing premature death in people with serious mental illness: People (percentage) with serious mental illness who have received a list of physical checks (In development)
C1.23	N/A	Reducing premature death in people with serious mental illness: Serious mental illness: smoking rates (*percentage of people who are current smokers out of people with serious mental illness identified on GP systems)*
Domain 2		**Enhancing Quality of Life for people with Long Term Conditions**:
COIS	NHS OFI	
C2.1	2.0	Enhancing quality of life for people with long term conditions: Improved health-related quality of life for people with LTCs
C2.2	2.1	Ensuring people feel supported to manage their condition: A greater proportion of people aged 18 and over suffering from a long-term condition feeling supported to manage their condition
C2.9	N/A	Enhancing the quality of life for people with mental illness: Access to community mental health services by people from BME groups (*rates per 100,000 population)*
C2.10	N/A	Enhancing the quality of life for people with mental illness: Access to psychological therapy services by people from BME groups (*rates per 100,000 population)*
C2.11a	N/A	Enhancing the quality of life for people with mental illness: IAPT Reliable Recovery *(In development: percentage of referrals which indicated a reliable recovery following treatment)*
C2.11b	N/A	Enhancing the quality of life for people with mental illness: IAPT Reliable Improvement *(In development)*
C2.11c	N/A	Enhancing the quality of life for people with mental illness: IAPT Reliable Deterioration *(In development)*
C2.13	2.6i	Improving the quality of life for people with dementia: Estimated diagnosis rate for people with dementia *(in development)*
C2.14	N/A	Improving the quality of life for people with dementia: People with dementia prescribed anti-psychotic medication (in development)
C2.15	2.4	Enhancing quality of life for carers: Health related quality of life for carers
C2.16	N/A	Enhancing quality of life for people with a mental health illness: Health related quality of life for people with a long term mental health condition
Domain 3		**Helping People to Recover from Episodes of Ill Health or Following Injury:**
COIS	NHS OFI	Improving recovery from mental health conditions: Alcohol: admissions Improving recovery from mental health conditions: Alcohol: readmissions

		Improving recovery from mental health conditions: Mental Health readmissions within 30 days of discharge (aged 17 and over) Improving recovery from mental health conditions: Percentage of adults in contact with secondary mental health services in paid employment

2.2 Locally defined outcomes

For details of locally defined outcomes, please reference:

Current CWP/CCG contract
Schedule 4 - Quality Requirements
Section C - Local Quality Requirements.

3 Scope

3.1 Aims and objectives of service

The provision and development of Psychiatric Liaison services enable a wide range of support to be provided to people with mental health issues as well as meeting targets, standards and guidelines for the CCG, the Acute and Mental Health Trusts. These include:

- Emergency Department waits.
- Percentage of service users whose transfer of care from hospital was delayed.
- Health improvement in depression and general mental health conditions.
- Equitable care in A&E.
- Suicide and self-harm reduction.
- Improved outcome for service users with long term conditions and mental health co-morbidity
- Management of service users who frequently attend AED or present with somatoform disorders
- Objective 8 of the National Dementia Care Strategy

The service will build on existing service to provision to increase the level of detection and management of people with mental health needs. This will benefit service users in the following ways:

- Provide a range appropriately qualified practitioners to provide assessment and treatment.
- Reduce excess length of stay in hospital associated with co-morbid mental and physical disorder.
- Ensure service users attending A&E. for mental health needs are assessed appropriately in a timely manner to reduce the amount of time spent in A&E department.
- Contribute to the National and Local Suicide Prevention Strategy by taking appropriate action to reduce suicide.
- Reduce risk of self-harm or harm to others by appropriate risk assessment, treatment and management.
- Offer brief psychological intervention to service users who present following an incident of self-harm.
- Offer more appropriate signposting from assessment to other services.
- Improve the experience of service users with dementia in the general hospital setting.

The service will provide the following:

- Specialist mental health, social and risk assessment to service users presenting to A&E departments or receiving care and treatment within the acute trust.
- Signposting and referral to other services; promoting self-help and the provision of service users' information following assessment; brief, time limited psychological intervention and clinical management; support and advice to general hospital staff of service users presenting with the following conditions, where these conditions cause moderate to severe effect on presentation or management of associated physical condition; are moderate/severe in nature; and/or are enduring and unlikely to resolve spontaneously:

- Self-harm
- Physical and mental health co-morbidity
- Adjustment to and behavioural reactions to physical health conditions and treatment
- Somatoform Disorders and 'medically unexplained' symptoms
- Organic mental disorders
- Psychiatric emergencies
- Suicide risk
- Dementia, Delirium and Organic mental disorders

Psychiatric Liaison will encourage the effective engagement of the service user, and engage with carers unless expressly discouraged by the service user.

3.2 Service description/care pathway

3.3 Population covered

For all those age 16 years and above and registered with a GP practice within NHS South Cheshire CCG or NHS Vale Royal CCG or an emergency presentation from outside this catchment area

and

Have a presentation requiring mental health assessment and have been admitted to A&E or are in receipt of treatment within the host hospital trust.

3.4 Acceptance and Exclusion Criteria and Thresholds

People under the age of 16 years of age are not eligible for this service.

3.5 Interdependencies with other services/providers

The psychiatric liaison team, based in Leighton hospital, will liaise with a number of stakeholders, including but not restricted to, the following:

- Community Integrated Teams
- Community Mental Health Teams (Adult and Older People)
- Primary Care Mental Health Teams
- Accident and Emergency Department
- Acute Hospital Trust
- General Practice
- Wellbeing Hub
- Maternity Services
- Drug and Alcohol Services
- Child and Adolescent Mental Health Services
- Learning Disability Services
- Other statutory and non-statutory services
- Carer Support - The service recognises the unique and specialist contribution of carers of people with mental disorder and will seek, with consent, to involve them at all stages of the care pathway.

3.6 Referral Processes and Standards

- Referrals are accepted from A&E or Ward team.
- Emergency referrals made directly to bleep holder and recorded as per local team agreement.
- Urgent referrals are made to team base via telephone
- Routine referrals made to team base via telephone, fax or letter

Criteria for Referral

Emergency*: Seen within 1 hr – as per national guidelines

- High risk self-harm /suicide
- Mental Health act assessment
- Presentation with acute & severe mental illness agitated or disturbed behaviour.
- Self-referral to A&E.

General*: Within 24 Hours – as per national guidelines

- Psychosocial assessment following self-harm.
- Service users where mental health advice required for immediate management decision.

* Response times as set out above only apply to the psychiatric liaison service and not to the out-of-hours service

3.7 Treatment/Services available

- Mental Health act assessment
- Psychosocial assessment following self-harm.
- Service Users where mental health advice required for immediate management decision.
- Support to wards and outpatient clinics

Pathways exist for emergency mental health assessments and integrated care pathways for self-harm.

3.8 Discharge Process

Onward Referrals

Staff will refer on to the appropriate service, for example:

- Acute Inpatient Mental Health Unit Cheshire and Wirral Partnership Trust via referral to the Home Treatment team for people resident within the Trust's footprint or onward referral to the appropriate unit
- Home Treatment Team
- Referral for time limited treatment to Psychiatric Liaison Team
- Referral to the Wellbeing Hub for IAPT or other services offered by the Wellbeing Hub
- Referral back to General practice with appropriate advice

Discharge

- Local protocols will clearly define the process for safely closing an episode of care and managing onward referrals which promotes effective care management of people and their carers across service boundaries
- The referrer will be informed when a service user is discharged.
- General Practitioners will receive a full discharge summary for referred service users within 2 working days of discharge, whilst other non-clinical referrers will receive a discharge report within 7 working days.
- Essential information about the service user's spell of care that supports the GP to continue support and management following discharge from the service will include the following data (audited six-monthly):

  - Date and source of referral to the service
  - Diagnosis
  - Medication (include details of what has been stopped/started and why including any monitoring protocols and quantities of discharge medication)
  - Broad outline of the treatment provided
  - Cluster on entry and exit
  - Early signs of relapse
  - Helpful strategies for maintaining wellbeing
  - Any other support services involved/referred to
  - Copy of most recent risk assessment
  - Any physical health conditions

  Where practical the care team will check, that a named clinician or team has taken over responsibility (particularly important for service users with impaired capacity or who are vulnerable for other reasons)
  These actions will require service user consent
- Written psychosocial assessment will be retained in the service user's case notes and management plan communicated to A&E / ward staff

3.9 Communication and Engagement

The provider is responsible for communication about and marketing of the service, this includes:

- Developing and maintaining a service website
- Production of the service information (e.g. service leaflets) and treatment guides
- Providing information in languages and formats representing the local community
- Promoting / raising awareness of the service locally and widely to ensure equity of access
- General communication and promotion of the service across the Borough
- Proactive engagement with minority/harder to reach communities

4 Applicable Service Standards

4.1 Applicable National Standards (e.g. NICE)

Title	Reference
Anxiety	QS50
Bi-polar	QS 45
Borderline Personality Disorder	CG78
Common Mental illness	CG 123
Common Mental Illness	CG123
Computerised cognitive behaviour therapy for depression and anxiety	NICE Review of Technology Appraisal 51
Dementia	CG42/NG16
Depression	QS8/CG90/1
Depression in Adults with a chronic physical health problem	CG 91
Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults	CG113
Obsessive-Compulsive Disorder	CG 031
Personality Disorder	QS88
Post Natal depression	CG45
Post-traumatic stress disorder (PTSD)	CG26
Psychosis and Schizophrenia	QS80/CG178
Self-harm	QS34
Service User Experience in AMH	QS14, CG136
Social Anxiety Disorder	CG159
Violence & Aggression	NG10

Note: This list is not exhaustive. The provider will be responsive to any changes to National, Regional and local reporting requirements.

4.2 Applicable Guidance/Policy Documents set out/issued by a competent body e.g. Royal Colleges

- No Health without Mental Health (DH, 2011): objective of improving the interaction of mental and physical health to enhance care and reduce costs
- Health and Social Care Act 2012: parity between mental health problems and physical health problems
- NHS Outcomes Framework 2012/13: three improvement areas relating to mental health.
- A Mandate from the Government to NHS England April 2014 to March 2015 (DH, 2013): all acute Trusts should offer Psychiatric Liaison Services from 2014. NICE Guidelines: CG136, CG123, CG82, CG25, QS14 and any other applicable NICE guidelines for the resident population of the service.
- Mental Health Code of Practice

- Joint Commissioning Panel for Mental Health (2012) Guidance for commissioners of liaison mental health services to acute hospitals. Available at www.jcpmh.info
- College of Emergency Medicine Toolkit: Mental Health in the Emergency Department (Feb 2013)
- Any other national standards applicable to the delivery of good care and high quality evidence based treatment in mental health.
- Academy of Medical Royal Colleges (2008) Managing Urgent Mental Health Needs in the Acute Trust: a guide by practitioners for managers and commissioners in England and Wales.
- Academy of Medical Royal Colleges and Royal College of Psychiatrists (2009) No health without mental health: the ALERT summary report. London: Academy of Medical Royal Colleges.
- Any other Codes of practice and good practice guidance applicable to the delivery of good care and high quality evidenced based treatment in mental health.
- Code of Practice: Mental Health Act 1983-revised 2008: (DH, 2008)
- CQC Essential standards of quality and safety: (DH, 2010)
- Good Psychiatric Practice 3rd edition: (RCPsych., 2009)
- Guidance for commissioners of rehabilitation services for people with complex mental health needs (Joint Commissioning Panel for Mental Health, 2012)
- Nursing and Midwifery Code of Conduct: (NMC, 2012)
- Outcome measures recommended for Use in Adult Psychiatry. (Royal College of Psychiatrist, 2011)
- Parsonage M, Fossey M, Tutty C (2012) Psychiatric Liaison in the Modern NHS. London: Centre for Mental Health.
- Parsonage, M. and Fossey, M. (2011) Economic evaluation of a liaison psychiatry service. London: Centre for Mental Health.
- PLAN (Psychiatric Liaison Accreditation Network) CCQI, Royal College of Psychiatrists.
- Service quality and clinical outcomes: an example from mental health rehabilitation services in England. (Killaspy, H et al, 2012 British Journal of Psychiatry)
- Choice In Mental Health Care: Guidance on implementing patients' legal rights to choose the provider and team for their mental health care, NHS England December 2014
- CR183. Liaison psychiatry for every acute hospital: Integrated mental and physical healthcare (Royal College of Psychiatrists, 2013)

Note: This list is not exhaustive. The provider will be responsive to any changes to National, Regional and local reporting requirements.

4.3 Applicable local standards

None that apply to this service.

4.4 Performance Reporting

The provider is required to report to:

- Mental Health and Learning Disability Data Set (MHLDDS)

- The Department of Health via Health & Social Care Information Centre (Omnibus system) monthly
- CCG performance reporting is via contract meetings and is:

  - As per the outcome schedule in Section 2 of this specification and Section 4C of the current contract
  - Additional reporting requirements as per the information schedule within the contract
  - Against each service - defined pathways – monthly (link to activity levels)

The provider's data lead and other staff involved in the production of reports must adhere to information governance protocols and policies.
It is a legal responsibility of the provider to inform service user s how their data will be used and give service users the choice to 'opt-out' from national reporting. Service managers should therefore ensure that system suppliers build in the facility to allow service users to 'opt-out' of the system.

4.5 Performance Information

Any performance and contract monitoring data must be separated into NHS South Cheshire CCG and NHS Vale Royal CCG to meet CCG reporting requirements.

The areas of provider performance requirements can be identified as:

- General activity performance data (as defined in the MHLDDS)
- Performance linked to meeting identified outcomes (see Section 4C of current contract for further details)
- Commissioning for Quality and Innovation Schemes and Service Delivery and Improvement Plans (see Section 5 of this specification for further details)
- Service initiatives and development plans (see Section 5 of this specification for further details)
- Workforce reporting (See section 6 of this specification for further details)

4.6 Choice

The NHS encourages choice – in order that people from other geographical areas outside of the usual catchment zone can choose to have their care provided by a service in another area. This may require liaison on discharge from the local service with a team from another area. Additionally, the service should have pathways and processes in place - across all provision - that actively encourages and supports choice (e.g. choice of appointment days, times or gender of professional).

4.7 Safeguarding

The Service must ensure that policies and procedures relating to safeguarding children and adults are adhered to with advice sought from the Designated & Named Professionals as required.

Staff must have undertaken as a minimum, the required continuing professional development in safeguarding training annually as approved by their appraiser and the service professional lead.

All staff working with children and/or adults must have enhanced Disclosure and Barring Service (DBS) checks.

The Service should also adhere to the safeguarding clause and its references in the main body of the contract.

4.8 Equality of Access

The service should be accessible to a diverse population and should make reasonable adjustments where necessary to ensure that people from protected characteristic groups are treated equitably.

In order to meet Equality and Diversity standards, the service provider is expected to ensure that relevant data is routinely collected and recorded and included in annual reporting.

5 Quality and Service Improvement

5.1 Applicable National Quality Requirements (see also Schedule 4, parts A-D)

The service must ensure that they contribute to the wider patient safety agenda including as is appropriate, but not exclusively, the control of infection agenda (for example, training, audits and root cause analysis investigation of Clostridium Difficile and MRSA Serious Untoward Incidents), and the identification, reporting and investigation of incidents and complaints. Participation in clinical audit and implementation of changes arising from audits should take place, in accordance with the organisation's audit plan. The service should be able to demonstrate learning and improvement across the quality agenda and in response to local and/or national policy guidance.

5.2 Local Quality Requirements

The Provider will:

- Ensure that it produces a proposed annual Service Development and Improvement Plan that demonstrates plans to work toward ensuring that the adult component of the local acute hospital liaison mental health service is able to deliver the 'Core 24' service specification by 2020/21. This will include provision of an on-site 24/7 service. This is dependent on investment being secured, as it is not achievable in the current level of funding.
  By 2016/17 development of the SDIP which include trajectories and milestones with a view to meeting the Core 24 level of provision by 2020/21
- The Provider will work with the CCG to develop an SDIP with a dedicated mental health crisis and liaison response for children and young people presenting to emergency departments, wards and community settings. During 2016/17 the Provider is required to develop a plan including trajectory, milestones, clinical and economic evaluation to enhance the provision of crisis and liaison response for children and young people.
- The Provider will also include in its proposed annual Service Improvement Plan development options for the Service resulting from locally identified needs and/or national and/or local policy guidance and strategy
- The Provider will endeavour to cost its proposed annual Service Improvement Plan within the limits of the agreed budget. Where this is not possible, the Provider will submit a bid to the Commissioner that will be considered in the line with other Commissioning priorities and budget constraints
- The Provider will routinely collect outcome measures in line with the RCPsych standards for adults (FROM-LP). During 2016/17 the Provider will work towards developing systems and processes for capturing and reporting data as required by FROM-LP. Full implementation and data reporting to the CCG will be required from April 2017 onwards

The Provider is responsible for:

- Continually improving the quality of service delivery, for example, in response to audit (undertaking and completing the audit cycle)
- Continually reviewing and being aware of relevant new and emerging guidance and recommendations and take the appropriate steps to assess and improve the service to achieve current best practice

- Ensuring that appropriate professional standards are maintained, updated and validated through clinical supervision and provision of relevant training to support reflective practice and Continuing Professional Development
- Fully co-operating in the review and improvement/re-design of the Service at the request of the Commissioner which will include monitoring and reporting arrangements

5.3 Commissioning for Quality and Innovation (CQUIN) Schemes

CQUIN schemes will be agreed between the provider and the commissioner and will include detailed action plans that reflect milestones and named leads. The provider will be required to submit regular updates on progress as part of scheduled contract and performance meetings.

5.4 Service Delivery and Improvement Plans (SDIPs)

SDIPs will be agreed between the provider and the commissioner and will include milestones and named leads. The provider will be required to submit regular updates on progress as part of scheduled contract and performance meetings.

SDIPS will be required to demonstrate any of the following:

- Recovery plans in year linked to resolving escalated issues identified within contract meetings by either Commissioner or provider e.g. CQUINs/ SDIPs/ activity performance
- Recovery plans and timescales will be agreed through contract performance monitoring meetings
- Service action plans linked to service user feedback, user surveys and involvement to shape service delivery to meet local need including a seven day service
- Service action/ development plans linked to changes in national and local clinical guidance e.g. NICE guidance
- Service action/ development plans linked to responses to risk assessments, Serious Untoward Incidents/Root Cause Analyses
- Service action/ development plans linked to complaints
- Service action/ development plans linked to changes in local workforce
- Service action/ development plans linked to changes in budget allocation i.e. local Cost Improvement Plans

Commissioners will need to be made aware of the potential impact of cost-improvement programmes proposed by providers. Providers will need to show how they will continue to meet the specification along with the impact of any workforce issues and any changes in national and local clinical recommendations.

Any changes to the scope of this service specification will need to be agreed with commissioners. A change request procedure will be aligned to appropriate governance and performance arrangements within the provider and commissioning organisations.

5.5 Service User Involvement

The service will operate an inclusive service that places the service users at the centre of treatment. Service users' views, involvement and personal experiences will define the service. The providers are to adopt the model of 'co-production' whereby services are planned and delivered in mutually beneficial ways that acknowledge and reward local 'lay' experience while continuing to value professional expertise. Service users should be regarded as an asset and encouraged to work alongside professionals i.e. development of user groups if appropriate.

6 Workforce Standards

The provider is to ensure the development and maintenance of a competent workforce, supported by an appropriate training programme, including:

- Operational Workforce standards
- Workforce capacity and configuration recommendations
- Education and training standards

The provider is required to report on achieving these workforce standards to the commissioner on an annual basis, including workforce statistics linked to E&D requirements and standards, staff training compliance, appraisal compliance and professional registration.

Providers will:

- Ensure the workforce has the necessary compassion, values and behaviours to provide person-centred, integrated care and enhance the quality of experience through education, training and regular continuing personal and professional development that instils respect for children/young people and parents/carers
- Anticipate the numbers and capabilities of the workforce needed currently and for the future, ensuring an appropriate skill mix in teams able to deliver a range of recommended evidence-based interventions with a delivery model that best focuses the capacity of the service to the demands of the population
- Ensure the workforce has the knowledge and ability to communicate effectively with other relevant services
- Ensure the workforce is educated to be responsive to changing service models, innovation and new technologies, with knowledge about effective practice and research that promotes adoption and dissemination of better quality service delivery
- Ensure that sufficient staff are educated and trained with the required knowledge and skills within teams. The skill set required in the team may be subject to change according to changes in local needs
- The provider must provide adequate supervision to all clinical practitioners according to best practice and policy
- Ensure that there is compliance with the recommendations of the Francis Report (2013) and in particular the Code of Candour
- Monitor caseloads for staff to ensure safe and effective delivery of services
- Work towards creating a workforce that represents its diverse local community and be able to demonstrate full compliance with Equality and Diversity standards

7 Location of Services

The service is based within Leighton Hospital.

The provider will ensure that no individual is disadvantaged as far as practically possible, due to his/her geographical location.

The service locations and any future changes to these should be mutually agreed between commissioners and providers ensuring that there is an equitable distribution across the clusters based on population needs.

8 Hours of Operation

The service is available from 9am – 6pm, seven days per week.

The provider will ensure that outside of normal opening hours, service users contacting the service in an emergency are directed to alternative sources of support out of hours. In the case of this service, between 6 pm and 9 am a limited service is provided, giving priority to the Accident and Emergency Department by the Out of Hours Practitioner with support from the Psychiatric trainee doctor for verbal advice.

These staff will also attend for a young person under the age of 16 who do not present with DSH or suicidal thoughts but do present with mental disorder, or for more complex presentation via the Consultant Psychiatrist on call (in person or via phone dependent upon their location).

9 Service Line Reporting

Provider to report on cost of service delivery at a speciality level including actual staffing information in support of these costs summarised to grouping of staff, on an annual basis covering financial periods M1-12 example below.

Example of information to be included;

Speciality – (Name of Service)

Cost for delivery of Service £x

Staffing Information – Whole Time Equivalent:

Medical Staff
Qualified Nursing
Unqualified Nursing
Admin