

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	16
Service	Wirral Complex Needs Service Specification
Commissioner Lead	NHS Wirral Clinical Commissioning Group (NHS Wirral CCG)
Provider Lead	CWP
Period	1 st April 2016 – 31 st March 2017
Date of Review	January 2017

1. Population Needs

1.1 National/local context and evidence base

Local Context

NHS Wirral CCG through the Mental Health QIPP Team has identified the development of a Complex Needs Service for patients with a primary diagnosis of ADHD or Personality Disorder, who would benefit from a multi-disciplinary approach to their care due to their presentation and associated risks, as a key priority area. The service will also work with and accept referrals from the Homeless Service due to the high incidence of the conditions within this population.

The current pathways for ADHD and Personality Disorder have been developed independently of each other, with the outcomes of the service pathways being:

- **ADHD:** assessment, diagnosis and pharmacological intervention with basic psychoeducation where appropriate;
- **Personality Disorder:** assessment with limited access to psychological interventions, support is also provided via supervision and consultation to other practitioners.

It is recognised that across each of these conditions there exists co-morbidity and potentially even crossover of diagnosis.

Active case management and risk management within a multi-disciplinary/agency setting is currently not provided as part of the above pathways. Furthermore, there is no access to short-term practical problem solving, which in turn leads to social crisis being routed through a medical pathway.

From an ADHD and Personality Disorder perspective, the experience of services is that a proportion of service users are highly risky and regularly involved in OOH/emergency provision, have high incidents of criminal and substance misuse behaviours often attributed to their ADHD or Personality Disorder and that ADHD patients have very high DNA rates. The current pathways result in a combination of assessment, monitoring and, in the case of Personality Disorder, a therapy arm. However, there is no provision to enable service users into making contact with supporting services to offer practical support, or support with any other co-morbidities.

Poor mental health is a common cause and consequence of homelessness and whilst local data on the mental health needs of homeless people is limited, local hostels are reporting an increasing number of residents presenting with mental health issues, which are particularly difficult to manage in a shared living environment where most residents have complex needs. In the absence of timely assessment and diagnosis, and a lack of adequate therapeutic interventions, poor mental health can also lead to hostel residents being evicted when their behaviour impacts adversely on other residents and/or staff. This may then lead to rough

sleeping and an even greater likelihood of exclusion from health care and support services.

Background to the Complex Needs Service

The Complex Needs service was piloted for 12 months from the 1st October 2013, and during this time 116 patients were assessed by the service, out of which 52 were case managed. Key service outcomes were as follows:

- significant reduction in GP visits
- significant reduction in A&E visits
- significant reduction in GP OOH visits

Improvement in recovery measures such as:

- pervasiveness score
- complexity score
- risk score
- unmanageability score

On this basis it was agreed that the service would continue to be funded, through the Better Care Fund, from 1st April 2015. It was agreed that the existing ADHD, PD and Homeless Outreach functions would be amalgamated into a single service. Where, following triage, it is felt that a client would benefit from an intensive case management approach, they will receive an enhanced level of service as has been trialled through the complex needs service to date – this client group will be referred to as ‘complex needs’. Clients that are not deemed to require an enhanced level of service and case management approach will be triaged into ADHD / PD / Homeless Outreach functions, but within the umbrella of a single service.

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	x
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x

2.2 Local defined outcomes

Expected Outcomes

- Reduction in service utilisation (OOH's services, A&E, GP)
- Reduction in risk behaviours
- Improvement in mental health
- Reduction in substance misuse and associated social harm
- Improvement in Quality of Life Outcome Indicators (employment, relationships, education)
- Social Return on Investment including employment, improved family functioning, improved physical health and reduction in criminal behaviour
- Increased positive service user experience
- Reduction in DNA rates, through increased engagement with the service
- Transfer of care to General Practice/Primary Care Mental Health/CMHT Services/other services as appropriate once patient is stable/once it is clinically appropriate to discharge the patient

- Better transition planning from services for younger people into adulthood

3. Scope

3.1 Aims and objectives of service

Aims

- To bring together expertise and skills of a range of services into a multi-disciplinary/agency team, to provide a case management approach to complex patients, who have a primary diagnosis of ADHD or Personality Disorder, or who are not suitable for either existing primary or secondary care mental health services, as well as maintaining the diagnostic specific pathways for less complex people.
- To improve the pathway and experience of care for those most in need through integration and enhancement of existing pathways, to enable a more efficient use of resources, ensuring that the service user receives the right intervention at the right time in the right place.

Objectives

- To provide a comprehensive assessment to inform a care co-ordinated treatment package if required
- To co-ordinate the care of patients who meet the criteria for the service
- To develop a management plan for each patient
- To relay the management plan to the patient, their family/carer and their General Practitioner
- To agree with the patient short and long term goals
- To support patients with a range of interventions e.g. evidence based psychological therapies, medical interventions, practical support based on need
- To support patients to reach a point at which their condition is sufficiently stable for transfer or joint working with General Practice or CMHT/Primary Care Mental Health/other services as appropriate
- To work with a wide range of stakeholders to ensure that patients and their carers have access to appropriate support to enable better understanding and management of their condition.

3.2 Service description/care pathway

Service Overview

The service will enhance the range of medical and psychological interventions currently available through existing pathways, with an opportunity to introduce practical and social issue resolution approaches within the model.

More specifically, the service will provide:

- Case Management/Care Co-ordination to those with a complex presentation
- Risk Management
- Practical Issue Resolution
- Longer term psychological interventions (individual/group psychological interventions as appropriate)
- Medical management
- Recovery focused interventions
- Assertive Management which will include actively supporting service users to engage with services.

Service Remit/Criteria

The remit of the service is to assess, treat and co-ordinate the care of patients who meet the following criteria for the Wirral Complex Needs Service (please note, not all criteria need to apply):

- Primary diagnosis of ADHD or Personality Disorder,
- Those who are not suitable for either existing primary or secondary care services, for instance, complex patients that have not responded to IAPT therapies
- Case management/care co-ordinated approach required
- Pervasive/chaotic
- Poor levels of engagement with services and low levels of manageability – engaging with, but not able to make best use of conventional psychological therapies (treatment seeking patients)
- High level of service utilisation (i.e. OOH's Services, multiple GP presentations, A&E attendances etc.)
- Complex with co-morbidities (e.g. substance misuse, OCD, mild learning difficulties etc.)
- Significant levels of risk to self or others.

Care Pathway

The care pathway for the Wirral Complex Needs Service will include the existing pathways for ADHD, Personality Disorder and the Homeless Service

The length of medical intervention provided by the service will be in line with NICE clinical guidelines, or shorter than this in line with the patient's medical need. The practical support provided will be flexible to meet the needs of the patient.

All clients will be triaged to determine the appropriate level of intervention, according to their complexity. It is envisaged that, following triage, management of the patient will take one of four routes:

1. complex needs case management, where there is reason to suggest that the patient will benefit from an intensive multi-disciplinary approach, or where previous primary care or secondary care approaches have not worked
2. management of ADHD
3. management of Personality Disorder
4. Homeless Service

Whichever pathway is followed, it is expected that the patient will benefit from the multi-disciplinary approach available through this service if required, having access to the following interventions where appropriate:

- Evidence based one-to-one therapies including CAT, CBT
- Group based therapy and interventions
- Specialist Drug and Alcohol input through joint-working with the provider of drug and alcohol services
- Expert by experience support through the use of peer mentors employed within the service
- Access to practical and social support (e.g. comprehensive social, financial, housing advice) via the use of Recovery Mentors
- Meaningful Social and leisure engagement
- Access to employment and education support
- Indirect Psychological Work delivered by practitioners under the supervision of qualified Psychologists
- Medical Management and advice in relation to medication issues.

The service should adopt a 'treatment readiness' model, taking into account internal and external factors that may affect the service user's ability to engage.

The team must also be available to support advice to referring clinicians, both by e-mail and telephone, on the management of clients both known to, and not known to, the service or CWP.

ADHD

The specific responsibilities of the service in relation to clients referred with ADHD or suspected ADHD will be as follows:

1. Conduct pre-treatment assessments in line with NICE Clinical Guideline 72 namely:
 - A full mental health and social assessment
 - A full physical history and measurement of blood pressure, pulse and weight. Physical assessment to include history of exercise syncope, undue breathlessness, other cardiovascular symptoms, family history of cardiac disease and history of sudden death in young family members.
 - Where appropriate to arrange ECG and liaise with primary care to organise further examinations and investigation of cardio vascular system (or other physical health problems identified).
 - Risk assessment for substance misuse and drug diversion.
2. Provide GP (and referrer, if not GP) with a type written summary of the assessment and advise GP by facsimile on the initiation of treatment in line with NICE clinical guideline 72.
3. Explain to the patient their role in the provision of appropriate and safe treatment, ensuring the patients understand their condition and drug treatment. Encourage patients to contact the Adult ADHD Service with any concerns and encourage them to participate in the monitoring of therapy and assessment of outcomes of treatment.
4. Provide information about the medication to patients, including common side effects, necessary monitoring, and where that monitoring will take place.
5. Advise patients of the rare reports of hepatic disorders providing guidance on suggestive symptoms, and rare reports of suicidal ideation with Atomoxetine and instruct patients as to whom they should report these, should they occur.
6. Advise GPs on titration of doses according to the NICE clinical guideline 72 recommendations for the medication prescribed, by facsimile initially to be followed by type written summary of rationale for dose changes.
7. Monitor blood pressure, pulse and weight during titration period, monitor for side effects and liaise with primary care should any physical or mental health problems arise.
8. Keep the patient informed of the process at all stages to ensure continuity of treatment.
9. Frequency of follow-up to be dependent on the drug used and the speed of titration.
10. Provide timely appointments where patients are receiving prescriptions from their GP and they feel that a prompt assessment or review of their ADHD treatment is required.
11. Provide prompt advice to the patient's GP, either by e-mail or telephone, and give a clear management plan in respect of individual patients, including prescribing advice for when a patient fails to attend either a secondary or primary care appointment.
12. In the event of a missed appointment, the patient should be given a second opportunity to attend. Following a second DNA, the patient will be discharged from the service, and clear advice must be given to the GP as to the patient's ongoing management.

Personality Disorder

Treatment should be in line with the following NICE Clinical Guidelines: Antisocial Personality Disorder (CG77) and Borderline Personality Disorder (CG78).

The service will provide assessment and treatment, training, and consultation utilising established procedures for risk assessment and formulation, understanding complexity of

presenting personality disorder, and amenity to psychological interventions including Cognitive Behavioural Therapy, Dialectical Behavioural Therapy, Cognitive Analytic Therapy and Psychodynamic Psychotherapy. Assessment will include development of agreement on the level of complexity, utilising the Personality Disorder Dimensional Cluster model, and where possible, clients will be signposted to appropriate individual therapy.

The assessment process will include risk formulation, complexity of presentation, degree of harm to others, evidence of repeated self-harm; interpersonal dynamics associated with over-dependence upon and/or conflict with mainstream services; lack of impact on distress from using mainstream services (and/or lack of lasting positive change from repeated episodes of care ('revolving door' clients). Service users accepted in to the service will be offered a choice of treatments and when appropriate should remain under the care of the relevant clinical team.

Service model

The treatment and interventions offered will be mainly group-based. This will include Dialectical Behaviour Therapy, a Therapeutic Community Based Day Programme and a Service User Support group. The core functions of the service will be:

- Undertake assessment and treatment which, when appropriate, is in line with CPA
- Provide consultation, training support and supervision within the organisation and with primary care practitioners
- Develop a clear link with local and regional forensic services
- Establish and maintain the therapeutic alliance with individual service users
- Establish boundaries to manage risk
- Promote reflection in clinical practice
- Establish and maintain therapeutic boundaries with service users
- Set realistic and prioritised goals for service users and the component parts of the service
- Signposting to treatment for specific areas e.g. self-harm, offending behaviour, individual therapy
- Provide appropriate and meaningful information for service users
- Dealing with co morbidity, for example; substance misuse, also eating disorders, depression and anxiety.
- Develop liaison, pathways and links with crisis and home treatment service.
- With additional resources, develop and facilitate networks for service users and families/carers
- Report data requirements that will provide meaningful service evaluation
- Develop a clear pathway mapping out the care that is available and how services can be accessed.
- Develop links and working relationships with 16-19 service and Multi-systemic therapy / Youth Offending Team to address emerging PD issues and with CAMHS to address support needed for parents with difficulties associated with PD

The Service will facilitate and cascade training across all relevant services, and will develop service user participation and engagement at all levels. The training will aim to ensure that all contact with people with PD where a direct therapeutic relationship is provided is informed by a theoretical understanding of the nature of their difficulties and ways to approach these, and by an appropriate and respectful value-base.

Service User Groups Covered

Criteria for triggering the involvement of the specialist PD team will encompass certain client characteristics including:

- A diagnosis of PD or likely to meet the criteria for diagnosis
- A history of repeated self-harm and/or risk to others
- Presenting with a level of personality disturbance that interferes with engagement with main stream mental health services
- Evidence of a lack of lasting change from repeated episodes of care ('revolving door' clients)

- Experiencing personality based difficulties that would benefit from formal group based treatment (DBT, Therapeutic Community Based Day Programme or Service Users Support Group)
- People who may not be 'treatment seeking' or able to benefit from treatment, but for whom clinical consultation will enhance the overall level of care or, at least, prevent deterioration.
- Individuals who meet the above criteria, with a substance misuse problem/learning disability and who can establish their ability to participate in a programme of work.

Clients that are homeless or at risk of homelessness

Clients with complex needs and multiple mental health disorders are often at risk of losing their home or experience homelessness at some point in their lives. As such, the complex needs service will provide outreach mental health provision and support to people deemed to be homeless or at risk of homelessness, both for clients under the complex needs service, but also to any Wirral resident that would benefit from their intervention. This will include:

- Maintaining a referral and care pathway for homeless people with mental health problems
- Providing early mental health assessment
- Making referrals into mental health services via appropriate pathways.
- Providing support to client and hostel staff whilst awaiting full assessment and treatment
- Raise awareness of homelessness within mainstream mental health services
- Collect robust data on the mental health needs of homeless people with mental health problems
- Ensure robust monitoring, review and evaluation of the service and make recommendations for service development if necessary
- The Practitioner will work closely with local mental health services and primary care services, along with drug and alcohol services, to ensure that each homeless individual approaching any of these services can easily access each other's support to ensure a holistic, joined up approach, providing the best opportunity to address the often complex needs of homeless individuals
- For people where English is not the first spoken language or where disability makes communication difficult, the service will ensure people have access to accredited interpretation services.

The service aims to provide support and signposting to Primary and Secondary mental health services for homeless people with mental health problems, who would otherwise find it extremely difficult to access or engage with mainstream services, and has the following responsibilities:

- To make contact on an assertive outreach basis with homeless people who are deemed to have mental health problems, through street and agency outreach
- To make assessments of clinical needs, vulnerability and risk, and support assessments of housing, and social care needs
- To engage and build relationships with complex needs patients and enable them to access services where real or perceived barriers exist
- To work collaboratively with voluntary sector agencies in the homelessness field. To receive individual referrals, or work jointly with them to improve the mental health of service users and their access to housing
- To continuously monitor and evaluate the service provided
- To provide opportunities for research relating to aspects of homelessness and mental health
- To provide regular reports to the CCG, identifying problems experienced by homeless people in accessing mainstream services, highlighting good practice and making recommendations for improvement.
- Offer a liaison, consultation and advisory service about mental health issues to staff in homeless agencies and hostels regarding individual and general client issues
- Raise awareness about mental health issues by providing educational opportunities to staff in the Independent Sector homelessness agencies and contributing to their in house training programmes

- Work collaboratively with a broad spectrum of agencies in the homelessness field both to receive individual referrals, and to work jointly to improve the mental health of service users and their access to housing. This will include attending forums and advisory groups
- Offer support to other homelessness agencies in managing service users with mental health problems with a view to sustaining individuals in accommodation
- Keep its service under review and consult/collaborate with other agencies to ensure the service is well targeted to identify potential service users, assist people effectively and make best use of resources.
The Practitioner will provide an Outreach model of care which will facilitate taking services to the individuals wherever they are rather than requiring them to remember appointments and attend clinics and hospitals.

The Practitioner will undertake regular sessions of outreach both on the street and to homelessness agencies like drop in centres and hostels. These sessions may include the following:-

- Advice/consultancy for staff in those agencies.
- Information exchange e.g. when the outreach worker is trying to locate an individual. This would be in accordance with the confidentiality policy.
- Informal contacts with individual homeless people that may involve offering some general advice and signposting.
- Contacts initiated by hostel staff either because it is the first time they have seen the individual or because they have observed something which makes them suspect that there may be a mental health problem. These contacts are usually informal initially and take place in a public place like a drop in centre or the street. They may be very brief and non-conclusive with little hard information being gleaned. They may however lead the Practitioner to feel that there is enough evidence to seek to develop the engagement to further explore any mental health issues that may exist.
- Taking referrals from staff members or self-referrals. If the person being referred is present an initial 'screening assessment' may take place. Because of the circumstances and environmental factors these 'assessments' may not be complete or conclusive.
- Contact may be made with or information received about a patient from another mental health team.

Referral criteria

To meet the criteria for the complex needs service, service users must either:

- Have a suspected or confirmed Primary diagnosis of ADHD, Personality Disorder, or,
- would benefit from a case management/care co-ordinated approach
- be pervasive/chaotic
- show poor levels of engagement with services and low levels of manageability – engaging with, but not able to make best use of conventional psychological therapies (treatment seeking patients and evidence of attempts of step 4 PCMHT interventions))
- reflect a high level of service utilisation (i.e. OOH's Services, multiple GP presentations, A&E attendances etc.)
- be complex with co-morbidities (e.g. substance misuse, OCD, mild learning difficulties etc.)
- have clear signs of anxiety and depression
- pose significant levels of risk to self or others.

Homeless outreach support will be offered for:

1. An individual for whom there is a suspicion of a mental health issue. This definition does not preclude people with dual diagnosis of either substance abuse or personality disorder as part of their presentation.

AND

2. The individual must be one of the following:
 - A rough sleeper (including squats and derelict buildings) OR
 - A resident of a hostel/night shelter for the homeless OR
 - A new arrival in Wirral with a history of homelessness, which includes those with a

nomadic lifestyle who move from city to city OR

- A person who has a home but is, because of his/her mental health issues, at risk of homelessness. (People in this situation will usually be referred by the Housing Options Team)

Referral Route

- Referrals will be accepted from NHS Wirral CCG GP Practice Teams or from Primary or Secondary mental health services for patients who are not suitable for existing services
- New referrals into the service will be accepted from GP Practice Teams and Primary Care Mental Health only using the Access Team referral form.
The provider is expected to work with the Adult ADHD and Personality Disorder Service Leads to identify patients who would benefit from accessing the Wirral Complex Needs Service. Referrals from these services must also be sent to the Access Team for assessment and triage.
- For referrals for homeless outreach support, there will be an open referral system that encourages and accepts referrals from hostel staff, homeless outreach staff and organisations working with people who are homeless or at risk of homelessness. GP's and Health & Social Care professionals are encouraged to refer to the Practitioner, and clients who are resident in Hostels can self- refer through established clinic slots. Points of access to the service are through face to face contact, telephone, text message, letter or outreach. Admissions to inpatient units of individuals who appear to be homeless but are not known to the Practitioner should, in the first instance, remain under in-patient service protocols. The Practitioner should be informed at the earliest opportunity and be involved in the discharge planning process.

Response Times

Response times for the homeless element of the service will flexible subject to triage of risk and need by the Practitioner. Appointment times will also offer flexibility to encourage the active engagement with the Practitioner by the client group.

For service users who follow the ADHD, Personality Disorder or Complex Needs care pathway referrers will be contacted within two weeks of referral to confirm receipt of referral and an appointment will then be offered. Waiting times will be monitored and it is expected that an appointment will be offered within 18 weeks of referral irrespective of the pathway followed.

Discharge Process

- Service users who are not deemed suitable for acceptance into the service following triage of assessments by the Wirral Complex Needs MDT, or the homelessness practitioner, will be discharged to their GP/referring specialist service or, when appropriate, signposted/referred onto another service. The patient's GP and referrer (if different) must be notified of the outcome
- Service users who have accessed the Wirral Complex Needs Service should be discharged at the point at which they have completed the agreed piece of time-limited work with the Complex Needs Team and when their condition is sufficiently stable for discharge to the patients' GP/specialist service as appropriate. A discharge letter must be sent to the patient's GP and referrer (if appropriate) within 5 working days of date of discharge, which includes a summary clinical management plan outlining requirements/recommendations for ongoing care/management as appropriate
- A clinical risk assessment must be undertaken at the point of discharge from the Wirral Complex Needs Service, to identify the need to involve or discharge the patient to other services, based on need and safeguarding issues

DNA/Cancellations

Where DNAs or cancellations happen, the provider will be expected to:

- Discharge patients back to their own GP/referring specialist service, patients who DNA/cancel 2 consecutive appointments. The patient and referrer should be notified of this decision within 3 working days
- The provider must have a strategy/policy in place outlining the approach to reducing the annual DNA rate.

Education and Training

The provider will be expected to work closely with the commissioners and other stakeholders to provide education and training to GP Practice Teams. As a minimum this will include:

- **Case Reviews/Conferences:** Support to be provided to GP Practice Teams through MDT case conferences for patients who have accessed the service. In the main this will be delivered via telephone consultation. However, the provider must be flexible in meeting the needs of GPs for face-to-face conferences/case reviews as required. The Care Co-ordinator will be the point of call for GPs to keep them abreast of patients accepted by the service
- **Consultation with Primary Care:** This will include regular contact with GPs and practice teams to discuss patients who will not engage, present challenging behaviours and with whom the GP feels unsure as to the best treatment/intervention plan, to prevent the patient from becoming more complex
- **Educational Support to GP Practice Teams:** This will be provided to GP Practice Teams via phone or email (as appropriate) to support the management of ADHD/Personality Disorder patients within primary care. The provider will also develop a Wirral wide education programme, educating GP Practice Teams on the management of complex patients with a primary diagnosis of ADHD or Personality Disorder. The provider will be expected to deliver a minimum of 2 GP educational events per twelve month period.

Working Closely with Services Commissioned by Wirral CCG

The provider will play a key role in supporting patients and their carers to access support that is available in the community and to helping patients and their carers to understand the reason for their referral into the service and any diagnosis and interventions that they receive. Therefore, the provider must engage with other professionals as clinically indicated.

In particular, the provider must ensure that close links are developed with the Wirral CCG Primary Care Mental Health (PCMH) providers. For any patients deemed suitable for the Wirral Complex Care Team, a preliminary discussion between the PCMH provider and Wirral Complex Care Team must take place to assess the client's potential suitability before a direct referral from PCMH is made.

For any patients deemed suitable for discharge into PCMH, the provider must discuss with the relevant PCMH provider the client's potential suitability for PCMH. If the client is deemed suitable, the client's GP should be informed of the referral.

The provider must inform the commissioner of all clients discharged/stepped down to PCMH.

The provider must facilitate joint management of patients under the care of both PCMH and the Wirral Complex Care Team. Joint management will be supported by the Care Co-ordinator.

The provider must also ensure that close links are in place with Adult Social Services and homelessness services, to help address any needs of the client that can be met by Adult Social Services and homelessness services.

Capacity and Demand

Capacity and demand is based upon existing and projected activity within the PD, ADHD, Homeless and Complex Care Teams, also taking into account the patients that would be suitable for discharge into shared care arrangements with the patient's GP. The provider will monitor the capacity and demand of the service on a monthly basis and report to the commissioner any issues relating to the service. An indicative activity plan is outlined in Schedule 2 Part B.

Service Monitoring and Evaluation

Please note the service and contract monitoring requirements for the Wirral Complex Needs Service are detailed in Schedule 2 Part B.

The provider must submit a bi-annual evaluation report of the service outcomes, including the

following

- Levels of satisfaction with the service – feedback from service users, carers, staff, providers included in the model
- Key challenges faced by the service
- Service user interaction with other provider services, following complex needs service intervention – e.g. reduced reduction in GP appointments or A&E attendances
- Complex Needs Service staff development issues
- Interface with other providers
- Feedback on GP training sessions delivered by the service
- Review of Complex Needs Service model to identify efficiencies to be realised, recommended changes to the service model going forward, evidence the benefit of the service to service users (i.e. what would happen if the service was not available to the patient cohort suitable for the Complex Needs Service)
- Social Return on Investment
- Analysis of service data

3.3 Population covered

Wirral Clinical Commissioning Group has responsibility for:

- a) persons who are provided with primary medical services by a member of the group, and
- b) persons who usually reside in the group's area and are not provided with primary medical services by a member of any clinical commissioning group.

3.4 Any acceptance and exclusion criteria and thresholds

Service User Groups Covered

- All adults (18 plus), who are registered with a Wirral GP at the time of referral
- Consideration must be given to those clients who turn 18 within 6 months of referral
- All service users who access the service must have a primary diagnosis of ADHD or Personality Disorder and have been identified as benefitting from a multi-disciplinary approach to their care due to their presentation and associated risks or who are not suitable for either existing primary or secondary care mental health services.

Exclusion Criteria

- Any person aged less than 18 years (aside from those due to turn 18 within 6 months of referral)
- Those who do not meet the referral criteria for the Wirral Complex Needs Service.

3.5 Interdependence with other services/providers

The service will support whole systems relationships and develop agreed protocols and interfaces with:

- NHS Wirral CCG and its Member Practices
- Secondary Care and Community Mental Health Services
- Primary Care Mental Health Services
- Drug and Alcohol Services
- CAMHS, young people's ADHD services, and Local Authority Services concerned with children and young people that are at risk of developing a personality disorder
- Voluntary sector organisations
- Wirral University Teaching Hospital
- Community Health Professionals
- Other services/providers as appropriate

Manage interdependencies with:

- GP Practice Teams
- CMHTs

- Primary Care Mental Health Services
- Wirral Social Services
- Allied Health Professionals
- Carers' groups
- Patient and Public Forums
- Acute Trusts
- Community Hospitals
- Other services/providers as appropriate

Service Launch/Promotion of Service

The provider will be expected to produce service information to be circulated to General Practice, Primary Care Mental Health, Adult ADHD, Personality Disorder, CMHT Services and other services as appropriate to explain the remit of the Wirral Complex Needs Service. The provider may also be expected to present to any of these groups around the service as appropriate.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- NICE CG72 Attention Deficit Hyperactivity Disorder (ADHD)
- NICE CG78 Borderline Personality Disorder: Treatment and Management
- NICE CG77 Antisocial Personality Disorder

The NHS Constitutional Standard of 18 weeks from referral to treatment will apply to this service.

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

4.3 Applicable local standards

4.4 Safeguarding

- On occasions the team will assess and make an appropriate referral to social services if there are any concerns regarding safeguarding children, adults at risk, and other family members.
- Team members will contribute to the delivery of multi-agency safeguarding plans as appropriate
- Staffing structures must be in place to ensure induction of new staff and on-going case and clinical supervision of all staff. This must include safeguarding supervision from an appropriately qualified professional.

Safeguarding training

- The provider safeguarding team will ensure staff receive safeguarding training in accordance with statutory guidance "Safeguarding Children and Young People: roles and competencies for Health Care Staff Intercollegiate Document 2014 + working together to Safeguard Children 2014)" For Adults it is now Safeguarding Adults Roles + Competencies for health Care staff. Intercollegiate Document Feb 2016.
- The provider must ensure the delivery of a comprehensive annual continuing professional development programme for all staff, ensuring within six months of joining:
 - Staff attend multi-agency safeguarding training at the appropriate level, for children and adults.

Applicable Local Standards

- Wirral Safeguarding Children's Board Policies and Procedures
- Wirral Safeguarding Adult Partnership Board Policies and Procedures
- Wirral Children's Partnership Council's Guide to Integrated Working (which includes comprehensive guidance on information sharing)

- Wirral MARAC policy and procedure
- Wirral Domestic Abuse Strategy
- Wirral CCG (2015) Commissioned Services Standards for Safeguarding Children and Adults at risk Policy.

Applicable National Standards

- Working Together to Safeguard Children (DE/DH 2010/2013)
- Children Act 1989 & 2004
- National Service Framework for Children, Young People and Maternity Services (DH 2004)
- Care Act 2014
- Mental Capacity Act & Deprivation of Liberty Safeguards (2005)
- NICE CG89: When to suspect child maltreatment (2009/2013)
- National Prevent strategy
- Female Genital Mutilation Act 2013

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:

The service will be provided in a range of community locations across Wirral. The provider should work with the commissioner to ensure that the service is delivered from a range of accessible locations, in line with commissioner and patient requirements. This is likely to include General Practices, particularly in areas where there is a high prevalence of prospective service users.

The team will have a Central Base located at the Stein Centre, St.Catherine's Hospital, Birkenhead, CH42 0LQ.

Days/Hours of Operation

Monday to Friday 0900 – 1700 (excluding bank holidays), with a view to expanding the hours of service delivery in line with commissioner and patient requirements as appropriate.

7. Individual Service User Placement