SCHEDULE 2 OF NHS STANDARD CONTRACT – THE SERVICES

A. Service Specification

In confidence – commercially sensitive

2017 /18

Service Specification No.	1
Service	**Veterans' Mental Health Intensive Service**
Commissioner Lead	NHS England
Service Provider Lead	
Period	1/04/2018 – 31/03/2021
Date of Review	

1. Population needs

1.1 Purpose

The purpose of the Veterans Mental Health Intensive Service (VMH IS) is to provide an enhanced service for veterans who have attributable complex mental health problems many of whom will have experienced trauma, which has not been resolved earlier in the care/support pathway. Veterans will have been assessed by the Veterans' Mental Health Transition, Intervention and Liaison Service (VMH TIL) and identified as requiring a period of intensive and proactive interventions. Assessment will indicate that the veteran has not responded to interventions earlier in the pathway; the veteran needs more intensive/assertive package of interventions; or the veteran may have been excluded from other primary or secondary mental health services.

1.2 The Needs of armed forces veterans

Whilst the overwhelming majority of veterans make a successful transition to civilian life, a small proportion experience mental health problems. Within this group, there are veterans who require intensive treatment programmes, where earlier interventions have not brought about an improvement in their health and wellbeing.

Veterans may have experienced traumatic events as a result of military service or as a result of experiences before and after serving. Furthermore, post-traumatic stress (PTSD) for veterans is often as a result of multiple events. In addition, veterans are more likely to present with a wide range of other mental or physical health difficulties, as well as multi-trauma Post Traumatic Stress (PTS) of more severe levels than that of civilian counter parts.

Ensuring those veterans with mental health problems leaving the armed forces are identified and assisted to transition to NHS commissioned care has been identified as a priority to maximise the benefits of interventions and prevent relapse. On 1 April 2017, NHS England launched the Veterans' Mental Health Transition, Intervention and Liaison Service (VMH TIL) that offers support to serving personnel approaching discharge from the military and veterans. Similar to the Veteran's Mental Health Intensive Service, the VMH TIL service focuses on those with complex needs and ensures those with less complex needs are assisted to find appropriate local services.

A review of the pathway has identified that a number of veterans may require a period

of intensive interventions that they can access locally in a timely manner whilst ensuring effective coordination between stabilising interventions and the commencement of trauma focused interventions.

The presenting needs of veterans have been comprehensively studied and the findings indicate the most common mental health problems in them include:

- Adjustment disorders
- Alcohol misuse
- Anxiety / panic disorders
- Depressive disorders
- Personality disorders
- Post traumatic stress disorder
- Substance misuse

The review of the pathway also identify that veterans experience higher levels of social and welfare problems that should be addressed. Addressing these factors has proved to be effective in reducing the need for some treatments and improving the effect of others. Important social and welfare areas include:

- Employment
- Finances
- Housing
- Relationships

Veterans with mental health problems have reported that information on accessing services is unclear and finding the correct route into services can take time. The Armed Forces Covenant aims to ensure that veterans are not disadvantaged as a result of their time in the military. Services should seek to address any known disadvantages, which should include the provision of mental health services that are culturally sensitive, the military language and culture are understood, and the specific needs of veterans are responded to, such as trauma as a result of military conflict.

The military culture and needs of the armed forces frequently require serving personnel to demonstrate a strong ‘can do’ and ‘get on with it’ attitude. This attitude, along with the stigma towards mental health, prevalence of a traditional masculine culture and individual pride, can increase the barriers to veterans seeking early help for example poor trust in MH services and poor access to primary care services. This can also result in veterans presenting frequently at a point of crisis in their lives.

2. Outcomes

2.1 NHS Outcomes Framework

The provision of good mental health will support improved outcomes across all five domains.

Table 1

Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing the quality of life for people with long term conditions	x
Domain 3	Helping people to recover from episodes of ill health following injury	x
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm	x

2.2 Outcomes for armed forces veterans

Agreed patient outcomes will not only include indicators that demonstrate clinical improvement / symptom reduction but also those indicators that focus on a wider social, mental health and wellbeing perspective.

2.2.1 Health and wellbeing

Improved patient reportable recovery outcomes indicators (biopsychosocial) are required and each patient who is managed within the service will have a co-produced person centred care plan addressing health, wellbeing and social functioning.

Access to a co-produced crisis plan (including mental health crisis teams where appropriate) will indicate the actions the service user/carer/family and other providers will take to help prevent relapse.

Access to a co-produced contingency plan (including mental health crisis teams where appropriate) will indicate the actions agencies and organisations that are supporting veterans will take to help prevent relapse and in response to a disengagement and periods of crisis.

Where appropriate family and carers will be included in planning and assessing the needs and objectives with the veteran.

2.2.2 Experience

Providers will collate nationally required patient experience information to inform service and quality improvements. Indicators as agreed by the National Quality Board cover the following aspects:

- Respect for patient-centred values, preferences, and expressed needs
- Coordination and integration of care
- Information, communication and education
- Physical comfort
- Emotional support
- Welcoming the involvement of family and friends
- Transition and continuity

- Access to timely care

Any Patient Reportable Experience Measures required in addition to those detailed in the national data set will be agreed between the commissioner and provider of the service. Agreed measures will be detailed in the Quality Schedules within the Contract.

2.3 Service outcomes

Full details of the service outcomes will be detailed in the contract including schedules 4 and 6.

The service should deliver:

- Increased speed of access to interventions from all locations within the regional footprint
- Comprehensive clinical assessments that accurately reflect psychological, social and physical needs
- Support for veterans to access services for any physical needs/long term conditions.
- Timely access to specialised detoxification services in collaboration with local service providers.
- Increasing numbers of individuals successfully engaged and treated
- Improved experience reported by veterans.
- National Benchmark minimum standards for IAPT that are met or exceeded (for relevant steps).
- Co-produced crisis and contingency plans with the service user/their family and other providers. Crisis plans will detail actions the veteran and their family will undertake. The contingency plan will detail the actions providers will take to prevent relapse and maintain engagement.
- Evaluation of the effectiveness of the service through systematic and comprehensive collection of pre and post treatment outcomes on 100% of patients treated which includes those where there was an intention to treat but did not complete treatment.
- The use of online and digital interventions must adhere to clinical practice standards and information governance regulations.
- Provision of training, expert advice and support to local services (across the different sectors).

2.4 National Guidance

If national guidance changes, providers will be expected to comply as required.

2.5 Performance Reporting

Providers will be expected to work with commissioners and other providers in the other regions to agree patient centred Key Performance Indicators.

2.6 Reporting

Providers will be required to submit monthly and quarterly reports to NHS England following an agreed format.

3. Scope

3.1 Primary Objective

The primary objective of the service is to provide an enhanced service for veterans who have complex mental health problems that are attributable to military service, which have not been resolved earlier in the care/support pathway who have been assessed by the Veterans' Mental Health Transition, Intervention and Liaison Service (VMH TIL) and require a period of intensive and proactive interventions. The service will focus on those veterans who have complex mental health problems including post-traumatic stress disorder (PTSD). Assessment will indicate that the veteran has not responded to interventions earlier in the pathway; the veteran needs more intensive/assertive package of interventions; or the veteran may have been excluded from other primary or secondary mental health services.

3.2 Interventions

The Veterans' Mental Health Intensive Service (VMH IS) will therefore focus on veterans who will benefit from the intensive provision of a range of mental health and social interventions. These may include (but are not limited to) substance misuse, occupational therapy, physical health, employment, accommodation, relationships, financial and trauma focused therapy.

3.3 Access to service

Those veterans requiring an intensive programme of interventions will be identified via an assessment undertaken by the VMH TIL service, which will also have confirmed the military service of the veteran.

3.4 Care Coordination

Care Coordination will normally rest with the VMH IS service. Where appropriate, care coordination should remain with the existing care coordinator to promote continuity of care.

The two critical function of care coordination are:

- Establishing and sustaining a professional relationship with the veteran and significant others based on regular contact.
- Coordinating, monitoring and recording assessment, planning, delivery and review of care including risks.

Interventions will normally be provided for a period of up to 32 weeks.

3.5 Population covered

The service is for Veterans who are registered with a GP practice located in England or not registered with any practice but would be eligible to be registered with a GP practice located in England.

A veteran is classified as a person who has served in the UK armed forces for one day or more (regular or reservist). Veteran status may also apply to those who have served in the Merchant Navy.

For those veterans who present with higher risks, the VMH IS will provide interventions in collaboration with the relevant secondary mental health provider(s). The service will therefore target resources at those who are hard to engage, exhibit poor coping styles, have poor impulse control and/or have high risk behaviours.

Veterans who have a moderate and severe impairment of cognitive functioning, such as dementia, or who have a moderate or severe impairment due to autistic spectrum disorders or learning disabilities, must be referred to the relevant specialist services where appropriate. This could include those who may need the services of forensic and neuropsychological assessments. The VMH IS will continue to provide interventions where assessed as appropriate to do so.

The pathway review identified that some veterans are often excluded by other agencies and charities due to 'unacceptable behaviour, abusive language, violent conduct and being under the influence of alcohol or drugs'. Following assessment or on identifying any risks, the service will proactively seek to engage with these veterans, utilising the military understanding within the team and peer workers to support patient engagement.

3.5.1 Geographical location of services

Based on data in the Annual population survey: UK armed forces veterans residing in Great Britain 2016, the distribution of veterans' living in England is not evenly spread. Resources will be distributed across four services in England that best reflect where veterans live in the following regions.

Table 2

Region	Population of veterans
North	29.9% (648000)
Midlands and East	29.6% (642000)
South East and London	16.2% (352000)
South West	24.4% (529000)

3.5.2 Families

Interventions which indirectly support veterans will be provided to family members where it has been shown to have a direct positive impact on help seeking and therapeutic outcomes of the veteran, such as psycho-educational interventions. Those interventions that address the needs of the family will not normally be provided by the service, for example systemic family therapy. The VMH IS will support access to local commissioned services that provide family interventions.

The service will ensure carers assessments are completed and facilitate access to appropriate support. The VMH-IS will support young carers access local support.

3.5.3 Population not covered

The provider is to encourage registration with a GP practice.

Veterans not covered are those who refuse or have refused all reasonable effort to register with an English GP practice; either prior to acceptance into the service or as a condition of being accepted into the service. In the absence of capacity, the best interests of veterans who are eligible to register with a GP practice, but who have not registered, should be assessed to identify if a service is to be provided/not going to be provided and that assessment should be recorded.

3.5.4 Veteran Population

It is widely recognised that the majority of service leavers do well. Those veterans who do not, may have multiple overlapping health and social problems (such as unstable housing, unemployment, violence, substance misuse and deliberate self-harm). Early Service Leavers (who served for less than four years) are more likely to do less well after leaving the service although their mental health problem is less likely to be operationally attributable.

The review identified that service personnel and veterans are now seeking help earlier from Defence Medial Services (DMS), NHS providers and service charities. The workload of DMS, charities and the NHS is expected to increase.

Regular serving personnel show an increased risk of alcohol misuse after deployment, but deployed reservists and regulars who have seen combat, report higher rates of probable PTSD after deployment.

The Annual population survey: UK armed forces veterans residing in Great Britain 2015 (revised October 2016), identifies that younger veterans report higher levels of depression and mental illness than older veterans.

The needs of veteran who have protected characteristic which differ from the main veteran population should always be considered. Review of existing evidence identified that: female veterans have experienced more childhood trauma and military sexual trauma than male counterparts; that Gay Lesbian Bi-Sexual and Transgender (LGBT) veterans maybe at a higher risk of suicide. Whilst the review did not identify any published evidence regarding the specific mental health needs of UK BME Veterans, services should be culturally capable and able to address the diverse needs of a multi-cultural population through effective and appropriate forms of assessment and interventions. Consequently, the commissioned service will need to adapt as further evidence is published to ensure it meets the needs of each individual.

Table 3 indicates the predicted growth of MOD medical discharges.

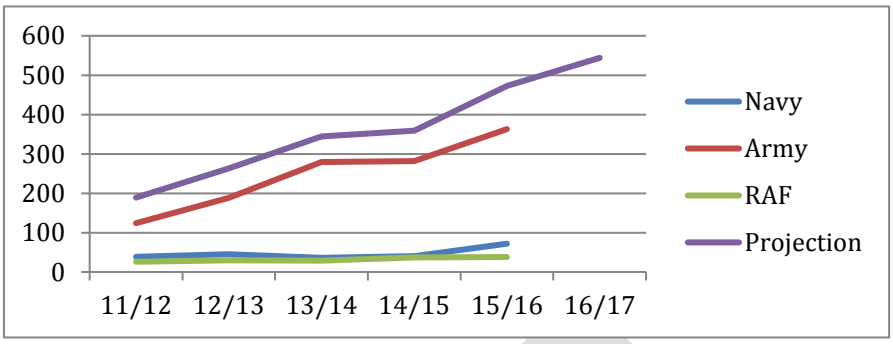
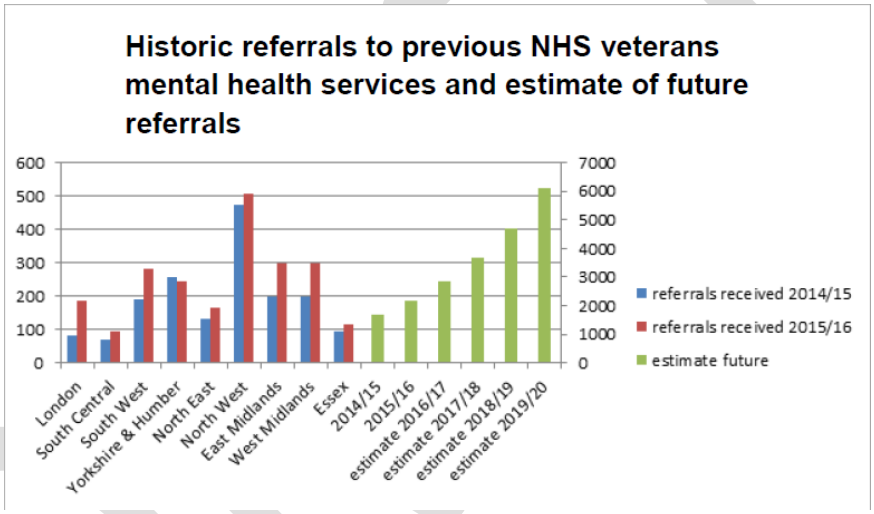


Table 4 illustrates historic referrals to previously NHS funded veterans' mental health services.



3.6 Links and Interdependencies with other services

The best outcomes for veterans with mental health problems will occur where providers across sectors (eg residential care, employment services, criminal justice, health and justice services and well-being services) can work and provide services collaboratively. The VMH IS will therefore work with providers from different sectors, and develop effective working relationships with identified leads and champions in local authorities, police, local authorities, health and justice and probation services.

Where necessary, the VMH IS will have in place shared care arrangements with relevant services, including secondary mental health, such as crisis teams, alcohol and substance misuse and pain management services.

Liaison with the veteran's GP will help inform any assessment and interventions provided. If the veteran is transferred to another service or discharged from treatment, the GP will be kept informed at all times.

The VMH IS provider will collaborate with health and justice services to ensure

continuity of care in and out of custody/detention.

VMH-IS provider will develop effective working relationships with identified leads and champions in Local Authorities, Police, Health and Justice and Probation services.

Service users, including veterans, who have complex needs often encounter difficulties moving between providers and/or teams as they transition care. Providers will have developed and adopted effective dispute resolution processes to ensure safe and effective transfers of care where teams do not agree.

4. Service model

4.1 VMH IS pathway

The VMH IS is a component of a pathway of interventions for veterans with mental health problems. This service is for those veterans who have complex mental health problems, many of whom will have experienced trauma where a period of intensive interventions is needed or where interventions/recovery earlier in the pathway have not brought about a sustained improvement.

The VMH IS will complement existing pathways that exist across local health and social care services.

Step up to this intensive service should ensure that the care pathway:

- provides the least intrusive and effective intervention first
- details criteria for where a more intensive programme is needed to bring about an improvement in health and wellbeing
- supports decision making based on comprehensive assessment and not on a single criteria
- is time limited to ensure a constant focus and flow toward recovery and reintegration
- provides a programme which includes stabilisation, trauma treatment and reintegration that would not normally exceed 32 weeks

4.2 Referral

The single point of referral to the VMH IS will be from one of the VMH TIL services. This will ensure that the veteran's military service has been confirmed and any interventions earlier in the pathway have been considered.

VMH TIL service providers will make a referral by phone and email where services are not co-located.

This service will need effective communication and decision making processes with the VMH TIL service to ensure timely responses are provided to clinicians in secondary mental health services.

VMH TIL service providers, VMH IS providers and commissioners will agree a

universal referral data set for use across the country.

4.3 Assessment

The assessment will be based on a comprehensive clinical assessment undertaken by an experienced clinician, informed by completion of a range of relevant evidence based tools for example but not limited to MINI, PHQ9 and GAD7. A decision to refer to the VMH IS would be based on an up to date risk assessment, including safeguarding considerations, for example safeguarding children, safeguarding adults, domestic violence, *Prevent*, MAPPA and any offending history.

The veteran will not normally be required to undertake a second full reassessment following assessment by a VHM-TIL service to gain access to this service.

Should the service need to access the veteran's armed forces service and medical records this will not delay access to assessment and treatment.

4.3.1 Occupational therapy

The service will undertake a comprehensive occupational therapy assessment which will be completed to inform and develop occupational and vocational interventions, which will be delivered as part of the agreed care plan.

4.4 Help Seeking

When a veteran does not attend appointments, proactive and determined efforts need to be made to assist help seeking/and engagement with interventions and treatment. There will be effective use of care coordination and workers within the team to promote help seeking with engagement and stabilisation interventions.

Where contact is lost, the service will make an individual assessment of risks and inform/escalate to the appropriate service/agency. Staff will be able to follow agreed and robust Did Not Attend (DNA) procedures. Re-engagement with the service should be facilitated.

Where required, the VMH IS will advocate for the needs and wellbeing of the veteran with providers across health justice and social care pathways.

4.5 Responsiveness

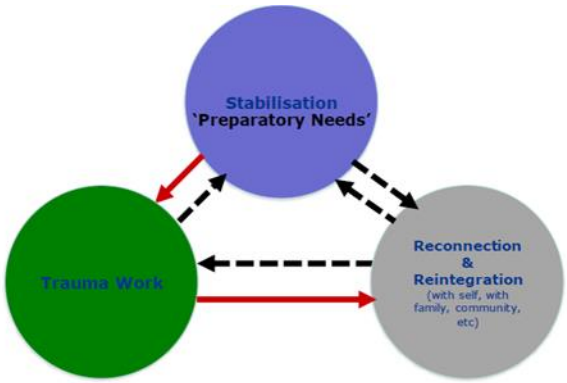
The service will contact the veteran within three working days of referral to offer an initial appointment, followed by the offer of an appointment within ten working days from receipt of the referral.

If demand exceeds capacity, the commissioner should be alerted to any extended waiting period (greater than 21 days).

4.6 Interventions

The service provider will deliver evidenced based mental health care including psychological therapies. Therapeutic interventions are to follow best practice and evidence based approaches such as those published by NICE (National Institute for Health and Care Excellence).

As the majority of veterans accepted into this service are likely to have experienced post-traumatic stress as a result of complex trauma, services and interventions will primarily be arranged on the principles described in the phasic model of care (Herman 1992).



This service will focus on those veterans in need of more intensive and assertive interventions that may be provided over a longer duration. The service will therefore address mental health needs normally identified at Step 3 (NICE CG123). Interventions will need to be place based on an individual assessment of need.

This group of veterans may have presented with severe intense depression and or anxiety and or other disorders where needs become more complex. The service will proactively support veterans who are on the VMH IS caseload when the veteran needs to access crisis or acute care in secondary services.

Where this model (see 4.5.1) is not appropriate for an individual, the service will provide interventions that promote recovery and reduce risk based on the principles of good care planning and in line with the guidance on the Care Programme Approach and appropriate interventions for each registered professional.

4.6.1 Phasic model

Stabilisation

Evidence identified that services must be able to provide a range of stabilisation interventions to meet the needs and safety of veterans. The service will therefore provide a comprehensive range of interventions, including psycho-educational, mood regulation, medication, anger management and grounding techniques. Services will provide specific interventions to address the following key areas:

Alcohol:

The service will provide interventions that promote less harmful drinking,

and reduce alcohol as a means of self-medicating psychological difficulties, including motivational and psycho-educational.

Where the service will not directly be responsible for the provision of any detoxification intervention, the VMH IS must be able to work with the veteran and the relevant local provider to ensure appropriate interventions can be provided during detoxification.

Substance Misuse and Addictions:

The service will provide appropriate interventions to address any substance misuse and other addictions for example gambling.

Family interventions:

Interventions which indirectly support the veteran will be provided to spouses/family members where it has been shown to have a direct positive impact on help seeking and therapeutic outcomes of the veteran for example psychoeducational interventions.

Where a carers' assessment has not been completed by a service earlier in the pathway, then an assessment must be offered.

Medication:

The service will ensure that the veteran can access required prescribed medications. Where VMH IS team members have the relevant expertise and are prescribing medications, the service should ensure all standards are met including those where medications are prescribed offline.

Trauma focused therapy:

Interventions that are supported in NICE Guidance CG26 will be provided. Where mental health has not improved or an alternative intervention is being considered, only interventions with a sound theoretical background can be utilised or which are being tested as part of a well-constructed and ethically approved trial should be provided.

Reintegration/reconnection:

Often overlooked, this third stage is essential for maintaining recovery. This should include the use of support workers, occupational therapy, employment services, secondary mainstream services and community providers. Access to additional sessions with the therapist should be available during the recovery period to help prevent relapse.

Physical health and long term conditions:

In collaboration with the veteran, the service will ensure the patient's GP is informed of any new or changing physical health needs so that an

assessment of that need can be completed.

Collaboration with secondary care professionals who are providing care to the veteran in general health services (for example clinicians involved in treating Traumatic Brain Injury, long term respiratory, dermatology, diabetes, heart disease, chronic pain and musculoskeletal conditions) is vital to ensure that mental health interventions and treatments are met across the pathway in an integrated, responsive and timely manner.

Admission:

Veterans have reported the need to receive care and treatment in environments and from staff that have an understanding (clinically and culturally) of their specific needs. The provider will need to be able to demonstrate a flexible approach to the delivery of care in order to best meet the needs of those veterans who have complex needs and/or higher risks.

For Veterans receiving treatment from VMH IS admitted as a psychiatric emergency into secondary care services. The VMH IS will work with secondary care services to provide appropriate interventions where a veteran's needs and risks require acute crisis care including inpatient environments.

Process and agreements need to be in place to ensure that care is seamless and, addresses immediate clinical needs and risks. The VMH IS will work with secondary care providers to facilitate early discharge with follow up.

4.7 Care Planning

In collaboration with the veteran and care coordinator, the care plan will be updated (or developed if initial referral to a VMH TIL service results in an immediate referral to the VMH IS).

Care plans should be developed to capture the range of psychosocial and physical health interventions in a format that describes what interventions will be provided to support the veteran.

Where the patient has relocated outside of the geographical boundary of the service and has registered with a GP practice in England in another area, the service care coordinator will be responsible for safely transferring the veteran to the new service.

4.8 The Team

The provision of a culturally sensitive service is an essential component. Whilst members of the team do not have to have served in the military themselves, each member of the team will have a well-informed understanding of how the military works, and the language used to secure the confidence of the veteran.

To deliver the range of interventions, a multi-professional suitably trained and supervised team will be required and include the necessary range of registered professionals to provide a safe and effective service.

Peer support/recovery workers will play an important role with the veteran in establishing trust, assisting and providing stabilisation and reconnection interventions.

To ensure a professional occupational therapy assessment is completed, the team will include regular and timely access to a registered occupational therapist.

The service will also ensure regular and timely access to a psychiatrist and where more appropriate, to a non-medical prescriber. The psychiatrist will provide expertise in relation to: medication; assessment of medically unexplained symptoms; sleep disorders; physical manifestation of mental health disorders, complex risk assessment and management; occupational risk management, in addition to the diagnostic function of MH disorder.

Team members should have access to clinical supervision appropriate to the demands of an individual's caseload and identified needs.

4.9 Training, education and knowledge

Staff will have the relevant clinical qualifications, experience, training and competencies to deliver this service specification effectively.

The service will provide placements for students from a variety of professional groups, for example psychology, nursing, psychiatry and allied health professionals.

Providers will need to have a robust workforce plan that can demonstrate an adequate skills base is available to fulfil the intervention requirements detailed in this specification.

Professional standards for the supervision of team members must be adhered to.

Staff will be supported to engage with continued professional development.

4.10 Consent

Service providers must publish, maintain and operate a consent to treatment and share information policies that are consistent with good practice and comply with the law.

The VMH IS should follow the guidance detailed in the: Consensus Statement on Information Sharing and Suicide Prevention.

4.11 Transitions in Care

The VMH IS must use its best efforts through transfers and discharges from care policies to ensure the effective handover of care between providers/GPs. Before a patient is transferred to another service and/or before a patient is discharged, the service provider must liaise as appropriate with the care coordinator and any third party

provider. Using the relevant legal framework, identified risks and needs should be shared with the appropriate partner agencies or authorities.

4.12 Telemedicine

After initial face to face appointments, the decision to utilise telemedicine and other electronic means of communication, for example Skype and text, can be used where assessed as being beneficial. This should be with consent and where information governance arrangements can be fulfilled.

4.13 Hours of Service

As community mental health services move towards a seven day service, veterans will be given flexibility to be seen in the evening and Saturday mornings where this facility is available. The service will have the ability to provide interventions out of normal hours for short periods of time, so as to provide an intensive programme of interventions that meets the needs of the veteran when required.

The provider should have in place working arrangements to cover staff absences, such as sickness and holidays.

Veterans will have access to information which sets out clearly how to contact the service in hours and out of hours in an emergency. The crisis plan will detail arrangements for how the veteran can contact appropriate services.

4.14 Communications

Providers will develop and implement a communications plan that ensures that VMH TIL services, providers of other dedicated mental health services for veterans, service charities and other key stakeholder organisations working with and supporting veterans are aware of the VMH IS, what the eligibility criteria is and how to refer in to it.

The VMH IS will collaborate across the four regional footprints to deliver these plans, providing consistent and integrated communications that provide clear and coherent information on the service, including accessing it via the VMH TIL service which is the single point of entry.

4.15 Collaboration

The range of interventions needed will require effective cross boundary working by providers and pull on the strengths of a variety of providers from different sectors. Collaborating partners will be able to ensure timely access to appropriate alcohol interventions including detoxification.

5. Applicable service standards

5.1 Service Standards

Where the National Institute for Health and Care Excellence (NICE) have produced relevant guidance and pathways these should be followed including guidance on

patients with dual diagnosis; the assessment and treatment of patients with PTS and common mental health problems: identification and pathways to care.

5.2 Relevant legislation guidance

The service provider will operate according to relevant legislation and guidance, with particular reference to:

- Mental Health Act 1983 (amended 2007) and Code of Practice
- Mental Capacity Act 2005
- Equality Act 2010
- Safeguarding Adults – the role of health services
- Care Act 2014
- Working Together To Safeguard Children 2015
- PREVENT Guidance
- NICHE Guidance Post Traumatic Stress
- NICHE Guidance Common Mental Health Problems

Please note that the list above is not exhaustive.

5.3 Key Documents

The provider must give consideration to the following key documents:

- Next Steps on the NHS Five Year Forward View.
- Five Year Forward View for Mental Health
- Mental Health Crisis Care Concordat 2014
- The Armed Forces Covenant.

5.4 Regulator

The service provider will be registered with the Care Quality Commission.

5.5 Associated Documents

- Annual population survey: UK armed forces veterans residing in Great Britain 2015
- UK service personnel medical discharges: financial year 2015/16
- The Mental Health of UK Armed Forces (2014)

6. Applicable quality requirements and CQUIN goals

6.1 National Requirement

National quality requirements are detailed in the guidance and contract documents detailed by NHS England.

Quality reporting – TBA [input Sched 4]
Information reporting – TBA [input Sched 6]

6.2 CQUINS

To be agreed annually with the provider

6.3 Data recording should include:

Mental health data set should be recorded

6.4 Health and social care outcomes frameworks

The health and social care outcomes frameworks are an interrelated architecture of indicators to guide the setting of quality requirements. These are mapped to suggested key performance indicators (KPIs) in this guidance document.

6.5 Feedback

Service providers must ensure that processes are in place to regularly capture, monitor and act on feedback and experience of service users and their families and carers. It is expected that this will be reported on to demonstrate how service users' views and those of their families and carers have helped to inform delivery of the service.

6.6 Service Evaluation

Service providers will work with the commissioner and their partners to undertake a service evaluation and respond constructively to key findings.

7. Location of service provider premises

7.1 Service environments

Services will be provided in environments which are conducive to the effective delivery of care which:

- offer confidentiality
- provide care close to home (this may also be in the home following assessment, such as for those who are housebound or have prohibitive mobility issues)
- have a hub and spoke model utilising a range of community settings
- be accessible by public transport
- can accommodate the provision of individual or group interventions
- provide access electronic health records
- offer office accommodation
- be accessible and compliant with regulations and laws including:
    - The Equalities Act
    - Disability Discrimination Act
- provide access to interpreters e.g. British Sign Language