**SCHEDULE 2 – THE SERVICES**

1. **Service Specifications**

**Hexagon Landcroft Road**

|  |
| --- |
| **1. Population Needs** |
| **1.1 National/local context and evidence base**   * + 1. One in four people in the UK will suffer a mental health problem in the course of a year, according to The Mental Health Foundation. The cost of mental health problems to the economy in England has recently been estimated at £105 billion, and treatment costs are expected to double in the next twenty years. Mental Health is high on the Government’s agenda, with the Five Year Forward View for Mental Health published in 2016. Mental Health also features strongly in the NHS Long-term Plan published in 2019     2. Mental illness covers a wide range of conditions such as depression, anxiety disorders and obsessive-compulsive disorders, through to more severe conditions like schizophrenia. Southwark’s Joint Strategic Needs Assessment for Mental Health (JSNA-MH) was published in 2017 and outlines important data about the incidence of mental illness: * It is thought one in four people will experience a mental health problem in any given year * It is estimated that £1 in every £8 spent in England on long term conditions is linked to poor mental health * Roughly half of the claims for employment and support allowance (ESA) in Southwark are related to mental health * A wide range of protective and risk factors determine an individual’s risk of mental ill-health   + 1. **Common mental disorders** (CMD) include conditions such as depression and anxiety. Results from the 2014 Adult Psychiatric Morbidity Survey (APMS) show that 1 in 6 adults had a common mental disorder (CMD) in the week prior to the survey, rising to almost in 1 in 5 adults in London. Applying the London prevalence to Southwark would equate to almost 47,600 adults in the borough experiencing a CMD. Population projections suggest this could increase to around 52,000 adults over the next decade   According to the 2014 APMS the prevalence of CMD has increased since the previous survey, mainly driven by rises among women with rates among men broadly stable. Almost 1 in 5 women reported experiencing CMD in the past week, compared to almost 1 in 8 men. The gender gap is particularly pronounced among those aged 16-24. Women are also more likely to have severe symptoms of CMD. Applying results from the latest APMS survey to the Southwark population now suggests that 26,300 women in the borough will have experienced CMD in the last week, compared to 16,400 men.   * + 1. **Severe Mental Illness** (SMI) refers to a range of conditions which include schizophrenia, bipolar affective disorder and depression with psychosis. * 54% of Southwark’s SMI population are male and it most commonly affects people between 30-60 years of age * SMI disproportionately affects people from the Black ethnicity grouping * People with SMI can be affected by a vicious cycle of risk factors including smoking, obesity and socioeconomic deprivation * Due to these vulnerabilities, the SMI cohort represents significant health needs and costs   + 1. **Substance misuse:** Approximately a third of people who access substance misuse services have a mental health problem. Adults who entered treatment at a specialist drug or alcohol misuse service in 2015-16 and received care from a mental health service for reasons other than substance misuse as a proportion of all individuals entering specialist treatment. The proportion of adults in addiction treatment services with a dual diagnosis is higher in Southwark than both regional and national comparators. It is estimated that at least one third of people who access substance misuse services have a mental health problem. While this indicator includes adults within specialist substance misuse services - indicating a high level of need, it does not measure the severity of mental health nor the extent of substance misuse among patients      * + 1. **Mental ill-health represents a significant burden on our local population and the health and care system** * It is estimated that almost 47,600 adults in Southwark are currently experiencing a CMD, this is expected to rise to approximately 52,000 individuals over the next decade * Although less disabling than major psychiatric disorders, the higher prevalence of CMD mean that their cumulative cost to society is greater * All types of CMD are more prevalent in women than among men, and they are also more likely to experience more severe symptoms * Young women were identified as a particularly high-risk group with an estimated 5,600 cases in the borough * Employment and socio-economic status were identified as a substantial risk factor. In Southwark, approximately half of the claims for employment and support allowance (ESA) are related to mental health – with 6,000 cases in February 2016 * There are 3,800 cases of severe mental health disorder in Southwark. More than half of Southwark’s SMI population are male * People with long term physical conditions are two to three times more likely to experience mental health problems - approximately 22,600 people in Southwark   1.1.7 **Prevention of mental ill-health and promotion of mental wellbeing is a key aim of Southwark’s Joint Mental Health and Wellbeing strategy.**  Mental wellbeing is the positive aspect of mental health: promotion of mental wellbeing can contribute to enhanced life expectancy, improved educational and occupational attainment and reduced prevalence and impact of mental illness. Support to develop positive mental health and wellbeing can help to deliver a range of benefits including reduced emotional and behavioral problems in children and adolescents, increased resilience in communities, reduced levels of mental disorder in adulthood, better general health, less use of health services and reduced mortality in healthy people and in those with established illnesses. |
| **2. Outcomes** |
| * 1. **NHS Outcomes Framework Domains & Indicators**  |  |  |  | | --- | --- | --- | | **Domain 1** | **Preventing people from dying prematurely** | **✓** | | **Domain 2** | **Enhancing quality of life for people with long-term conditions** | **✓** | | **Domain 3** | **Helping people to recover from episodes of ill-health or following injury** | **✓** | | **Domain 4** | **Ensuring people have a positive experience of care** | **✓** | | **Domain 5** | **Treating and caring for people in safe environment and protecting them from avoidable harm** | **✓** |  * 1. **Local defined outcomes**      1. The Provider shall aim to achieve the following outcomes:   **Domain One**   * Prevent service users from deteriorating in their mental health   **Domain Two**   * Improvement in the mental wellbeing of service users * Service user’s physical health has been addressed and managed * Increase achievement of personal goals identified in service user’s support and recovery plan   **Domain Three**   * Reduction in unplanned inpatient admissions * Reduction in length of stay of inpatient episodes * Increase in employment of service user’s crisis plan to prevent hospital admission   **Domain Four**   * Increase choice and control in service users lives * Improve service users experience of care and support received from service   **Domain Five**   * Decrease number of serious incidents and safeguarding alerts * Provide successful care for patients requiring mental health support for longer periods |
| **3. Scope** |
| **3.1 Aims and objectives of service**  3.1.1 Theaims of this **low-level** supported living service are to enable service users with mental health needs to live the community and function at an optimal level of independence, with appropriate levels of support. In particular, the Service will meet the needs of individuals who **may be** leaving hospital or residential care services, stepping down **from higher-level supported housing services or people who are no longer able to live in independent accommodation**  A key aim of this service is to support residents with a range of needs to live as independently as possible, developing the skills necessary to move on to independent living. Within this context, the Service will:   * Enable people to recover and develop the capacity to live more independently in their communities * Provide a skilled staff team where support workers are recovery focussed, are operating on the principles of psychologically informed environments and support people to develop their ability to do things for themselves. * Provide appropriate levels of support to minimise the risk of crisis, to be able to provide more intensive support when needed and increase the potential for long term recovery * Provide an environment that facilitates access to employment, training, education and wider community activities * Provide a service culture that empowers people and enables them to increase their confidence, assertiveness and awareness   3.1.2 The following values and principles will underpin all activities undertaken in the delivery of the Service:   * The Service shall promote and encourage choice and be based on promoting independence through support to achieve desired outcomes * Service Users are supported in achieving their full potential * Service Users shall be treated with courtesy, dignity and respect and will be at the centre of all decision-making that impacts on their lives * Personalisation, meeting the needs of individuals in ways that work best with them * Incorporation of the Recovery Approach, summarised by the phrase ‘hope, agency (i.e. control) and opportunity for all’ * The Service shall seek to meet and promote the needs of Service Users from minority groups and from groups with protected characteristics. It will be a fundamental principle of all policies and practices that people are equally valued regardless of factors which include but are not restricted to: gender, age, disabilities, race, ethnic origin, language, gender re-assignment, marital status, religion or sexual orientation * To work with Service Users using a co-productive approach in the planning, development and monitoring of the Service and in establishing good practice, reviewing policy and procedures and maintaining and continuously improving delivery of the Service   3.1.3 The Service will work with Service Users to an agreed support plan which will include targets and goals relating to emotional support, financial management, and connection to the local community. The support plan will be Service User led and also include reference to managing stressful situations, coping with mental health issues, confidence building, developing social networks and supporting good physical health. The Service will link the Service User with other support networks and health services, as appropriate  3.1.4 The support plan must identify and record the Service User’s needs arising from specific ethnic, religious, cultural, gender, sexuality, disability, age or other requirements as determined by the Service User  3.1.5 The Service will work closely with care coordinators, clinicians, and other significant professionals in the care and support of the service user in order to ensure holistic and coordinated support for the individual, which is focused on staying well and supporting good mental and physical health  **3.2 Service description/care pathway**  3.2.3The Service will provide support for up to a maximum of 3 Services Users with enduring mental health needs. The Service will be provided at: 29, Landcroft Road, East Dulwich, SE22 9LG  3.2.4 **A total of 25 hours of support will be provided per week, service residents will also have access to telephone support at night provided by staff at Kirkwood Road**  The Provider must ensure that Service Users are provided with adequate support in order to enable them to continue to live in the community and to reduce the risk of admission to hospital. Support will include monitoring the Service Users’ mental and physical health and general quality of life and will be focused on enabling their recovery and ability to remain living in the community  **Type of service**   * Community services - Mental Health * Supported living   **Specialisms/service**   * Caring for adults aged 18 and over * Mental health conditions   **The Support Plan**  3.2.5 In respect of each Service User the cornerstone for the service standards to be attained and the key requirements to be met will be the Service User’s support plan. The support plan will describe the support the service user requires to enable them to achieve their recovery and support goals. The support plan shall include details of the outcomes the Service User will seek to realise whilst engaged in the Service, and how the Provider will help and support the Service User to achieve them.  3.2.6 The support plan must reflect the personal aspirations and requirements of the Service User and describe the unique service provision arrangements that will be established to address their specific goals and targets. The Provider will review the support plan within twelve weeks of the commencement of the Service. Thereafter the support plan will be regularly reviewed in order to monitor the service user’s progress in a structured way and to ensure that the support plan remains relevant at all times.    **Key Worker**  3.2.7 The Provider will arrange for the appointment of a key worker, for each Service User, who is appropriately trained and experienced in caring for people with mental health care and support needs. The key worker will take primary responsibility for ensuring that the service provided is consistent with support plan requirements. Wherever possible, choice and control will be offered to Service Users in connection with their key worker.  **Rehabilitation**  3.2.8 The Provider will develop intervention strategies in conjunction with other relevant  health and social care agencies that help Service Users to achieve optimum functioning and independence within the context of their mental health needs. There is an expectation that the Provider will become familiar with, and utilise, community assets and capacity to promote recovery for Service Users. The Provider should use a range of methods for delivering the service to maximise coverage and capacity and to meet people’s needs in a personalised way.    **Environment**  3.2.10 The Premises will meet the environmental standards for supported living services and be maintained to a good standard.  3.2.11 Each Service User will be issued with a licence/tenancy agreement to occupy the  shared premises, setting out the terms and conditions of their tenure which will be reflective of the amount of time agreed by Commissioners.  **Staffing**  3.2.12 The Provider must staff the Service with appropriately qualified, trained, knowledgeable and experienced staff with the competencies to ensure that individual outcomes are met, levels of quality are achieved and that the Service remains safe and effective for everyone involved. The diversity and skills of staff should reflect the needs and profile of service users in Southwark.  Staff should be supervised and provided with access to appropriate induction, training, appraisal, supervision and professional development opportunities. The breadth, depth and nature of training should be appropriate to meet the needs of the people supported in the Service. The service should adopt the principles of a psychologically informed environment, ensure that staff are trained in these principles and that the training programme supports the development and implementation of this approach.  The Provider should ensure that staff have key competencies as outlined below:   * Excellent communication / engagement skills * A positive attitude to supporting people with mental health needs * An empathic / non-judgemental approach * Working in person centred ways, using a supportive and empowering approach * Ability to inspire trust and confidence   The Provider should ensure that staff are appropriately trained and have good knowledge and understanding of mental illness, as well as knowledge of specific issues relating to the support and care of people with mental ill health such as:   * Support planning and risk assessment with individuals with mental health problems * An understanding of the range of mental health issues including serious mental illness, personality disorder, common mental disorder * Recovery and outcome-based approaches to support greater independence * Working safely and positively with risk * Understanding substance misuse * Dealing with challenging and aggressive behaviour * Deliberate self-harm * Safeguarding vulnerable adults * Move-on planning   **Health, safety and risk management**  3.2.13 The Provider must ensure that all relevant health and safety requirements are applied as required. This includes (but is not limited to):   * Carrying out suitable and sufficient risk assessments * Ensuring that employees are competent to carry out the work they are engaged in * Monitoring health and safety performance * Reporting any significant incidents to Southwark commissioners in line with the Serious Incident Reporting Procedure as follows:   - Major injury, fatality and significant near miss – by telephone as soon as possible and including Southwark commissioners in relevant areas of health and safety investigation and corrective action  - Minor injury and other violence related incidents (not included above) – report on a quarterly basis (including corrective action)  The Provider must have clear written policies on safety for Service Users and staff as well as periodic training and discussion of current on-going practices. These policies should cover lone working, dealing with aggression and the threat of violence. Risk assessment policies and practices should be reviewed on an on-going basis. The Provider will need to ensure that policies, training and working practice enable all staff to work safely but positively with issues of risk, balancing issues of safety with approaches which allow individuals to make their own choices about how they live their lives.  **Referral processes and sources**  3.2.14 Referrals to the service will be agreed by the Southwark Funding Panel or  Southwark Placements Advisory Panel, which are integrated health and social care panels. The panels will consider the needs of the individual Service User and make a recommendation to refer to the supported living Service, which will be actioned immediately following the panel.  3.2.15 The Provider will assess the Service User’s suitability for a placement at the Service, subject to an ongoing risk assessment. The Provider shall aim to process referrals within five working days, from the date of initial referral  On receipt of a completed application form, written acknowledgement will be provided by the Provider within two working days. At this stage, a request will be made for supporting documentation, e.g. risk assessment, psychiatric report, and social work reports. The documents must be current i.e. written within the last six months and made available within 3 days of receipt of the completed application form.  3.2.16 Once the application form is complete and all additional documentation is provided, where practical an arrangement will be made for an informal visit to the Service. An assessment may be undertaken on the same day as a visit to the service by the Service User or, alternatively, a Service User may be visited at their current address for an assessment. The outcome of the assessment will be communicated to the referrer and other interested parties and if assessed as suitable immediate plans agreed for a move into the service  3.2.17 The referrer will ensure that any necessary processes involving third party approval e.g. Home Office are completed prior to the Service User’s admission  **Referral criteria**  3.2.18 The Service will be expected to support people who have a history of mental illness and who may also have a history of psychiatric admissions. Some referrals may have complex issues which include homelessness, drug use, previous criminal activity – such referrals will have been assessed as suitable to live in a **low support supported housing service**  Referrals to the service may be:   * People who may be at risk of admitted to hospital * People who are being discharged from hospital * People who have a forensic history and are assessed to be suitable for the supported living service * People who have few other support systems in place and are socially isolated * People who because of the consequences of their mental ill health are at increased risk in the community, including self-neglect   3.2.19 There will be a written policy on acceptance and exclusion criteria for referrals which will be agreed with Southwark Council, CCG and Provider of the supported living service  **Move-on from the service**  3.2.20 The support plan shall give details of the goals and targets that the Service User will work to attain before they would be considered ready to move-on from the Service. Regular support plan reviews will be undertaken to monitor the Service User’s progress, and the review meeting will decide, in partnership with the Service User and relevant care/social work staff, when they are ready for consideration for move-on  **Transfer Summaries**  3.2.21 If plans are made to transfer a Service User to another service, the key-worker  (Coordinator of Care) will provide the receiving agency with sufficient documentation to enable a smooth takeover from the client's perspective, minimising delays and the need for repeat interviews. A transfer summary shall set out the issues originally presented, actions taken to resolve them, the current situation, action that needs to be undertaken immediately and actions to be undertaken later.  **Departure planning, aftercare and support**  3.2.22 When the care of a Service User is being transferred to another provider, client  contact will not be terminated until that transfer has been completed to the satisfaction of the client and both the referring and receiving agency  3.3 Population covered  3.3.1 The Service shall be available to residents of the London Borough of Southwark.  3.4 Any acceptance and exclusion criteria and thresholds  3.4.1 Service users shall meet the following eligibility criteria:   * a resident of the London Borough of Southwark; * aged over 18 years; * with an enduring mental health need * able to attain and sustain an acceptable level of self care; * the potential to engage with, and to benefit from, the support provided by the Service; and * willing to participate in a risk management programme   3.4.2 The Service shall be available to any resident of the London Borough of Southwark who satisfies the eligibility criteria.  **Any exclusion criteria**  3.4.3 The following exclusion criteria shall apply to the Service:   * requiring a nursing, **residential care or high-support housing service**; * having a primary presenting issue other than a recognised mental health problem e.g. substance misuse * with a risk or offending history which would mean their behaviour that would put other people at significant or immediate risk (Although this will be considered on a case by case basis so as not to exclude individuals where a referral could be of benefit) * unable to engage with the services; or * a current serious alcohol or drug issue and unwillingness to address it.   3.5 Interdependence with other services/providers  3.5.1 The Provider shall work in a collaborative and co-ordinated way with other providers, (both statutory and independent), of health, welfare, education and employment services and the Care Management Service.  3.5.2 The Service will be delivered in accordance with, and have proper regard to, all relevant and applicable legislation relating to the provision of the Service including (in particular but without limitation) the following:   * The Public Health 1936; * National Assistance Act 1948; * Sexual Offences Act 1956; * Sexual Offences Act 1967; * The Food and Hygiene (General) Regulations Act 1970; * The Chronically Sick and Disabled Persons Act 1970; * The Equal Pay Act 1970; * Misuse of Drugs Act 1971; * Health and Safety at Work Act 1974; * Rehabilitation of Offenders Act 1974; * The Sex Discrimination Act 1975; * The Race Relations Act 1976; * The Mental Health Act 1983 and Guidelines; * The Disabled Persons (Services, Consultation and Representation) 1986; * The Sex Discrimination Act 1986; * The Client Access to Personal Files Act 1987; * N.H.S and Community Care Act 1990 and Guidelines; * The Food Safety Act 1990; * Disability Discrimination Act 1995; * The Carers (Recognition and Services) Act 1995; * The Human Rights Act 1998; * The Data Protection Act 1998; * The Sex Discrimination (Gender Reassignment) Regulations 1999; * The Human Rights Act 2000; * Race Relations (Amendment) Act 2000; * Employment Act 2002; * The Control of Substances Hazardous to Health Regulations 2002; * The Employment Equality (Religion or Belief) Regulations 2003; * The Employment Equality (Sexual Orientation) Regulations 2003; * Equality Act 2006; and * Mental Health Act 2007 (when implemented on 3 November 2008).   3.5.3 In particular (but without limitation) all aspects of the Service must meet current English and EU Legislation as the same may be amended or re-enacted from time to time.  **Safeguarding**  3.5.4 The Service will provide a sufficient number of appropriately experienced and qualified staff in accordance with the requirements of the specification. All staff will be appropriately trained to undertake the tasks to which they are appointed. The Provider will have adequate contingency plans to cover staff sickness and annual leave in order to avoid disruption to any element of the Service.  3.5.5 The Service Provider must carry out checks, at the appropriate disclosure level, with the Criminal Records Bureau, on all staff employed, sub-contracted or otherwise, engaged to work on the provision of this Service. For the avoidance of doubt, any persons regularly involved in caring for, training, supervising or being in sole charge of vulnerable adults under this contract must have an enhanced CRB check carried out. No personnel shall be permanently employed by the Service Provider to carry out these services prior to a satisfactory check being obtained but personnel may be used on this contract on a provisional basis pending CRB checks, following compliance with the SOVA Scheme and providing that the Service Provider ensures that the appropriate safeguards are put in place.  3.5.6 The Service Provider shall familiarise themselves and adhere to the London Multi-Agency Policy and Procedures (updated August 2016) and the Statement of Government Policy on Adult Safeguarding |
| **4. Applicable Service Standards** |
| **4.1 Applicable national standards (eg NICE)**  N/A  **4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)**  The Provider shall satisfy at all times the CQC registration standards for supported living for people with a mental health need.  **4.3 Applicable local standards**  **Days/Hours of Operation**  4.3.1 As an accommodation-based service, support will be available every day of the year.  **Service User Feedback**  4.3.2 The Provider will ensure that system for consulting Service Users and their friends, relatives and informal carers (the “Relevant People”) and for monitoring Service User satisfaction are developed and implemented. Details of the systems must be made available to the Commissioner, on request, for consideration and approval.  4.3.3 Service User involvement will be promoted at all times, both formally and informally throughout the Service. The Provider will ensure that a formal mechanism for user involvement and user consultation is in place with regard to the overall operation of the Service and any service developments.  4.3.4 The Provider will ensure that a customer satisfaction survey of Service Users is completed annually.    **Complaints**  4.3.5 Service Users and their Relevant People must have access to a clearly defined, written complaints procedure which must be implemented by the Provider to the satisfaction of the Commissioner. The procedure must include provision for a written record to be made of all complaints and of any action taken. Details of written records of complaints will be available to the Commissioner upon request. A copy of the complaints’ procedure must be given to Service Users on commencement of the Service.  4.3.6 The Provider will make available to Service Users and their Carers details of the Commissioner’s complaints procedure and how it may be used.  **Protection of Service Users**  4.3.7 The Commissioner will be notified as soon as possible of any emergencies, serious incident, illness, injury, or death relating to any Service User, or to any Service User being placed at risk because of the behaviour of another.  4.3.8 The Commissioner has an open policy on information it holds concerning Service Users in its care in accordance with the Access to Personal Files Act 1987. The Provider must comply with this approach to information held in relation to the Service Users.  4.3.9 The Provider shall treat as confidential and shall not disclose to any person, other than a person authorised by the Trust, any information concerning the identity, medical condition or treatment of a Service User. |
| **5. Applicable quality requirements and CQUIN goals** |
| * 1. **Applicable Quality Requirements (See Schedule 4A-C)**   2. **Applicable CQUIN goals (See Schedule 4D)** |
| **6. Location of Provider Premises** |
| **The Provider’s Premises are located at:**  29 Landcroft Road, East Dulwich, SE22 9LG |
| **7. Individual Service User Placement** |
| N/A |