**DRAFT STATEMENT OF REQUIREMENT FOR THE PROVISION OF PSYCHIATRIC AND MENTAL HEALTH INPATIENT AND OUTPATIENT PSYCHOTHERAPY SERVICE PROVISION**

**INTRODUCTION**

1. Defence Medical Services (DMS) has overall responsibility for military healthcare provision. Community mental healthcare is the responsibility of Defence Primary Healthcare (DPHC), covering UK, overseas and Northern Ireland. Military mental health (MH) is occupationally focused and primarily involves the promotion of positive psychological health and wellbeing as well as the treatment of mental illness.
2. This contract will form part of the Defence occupational mental healthcare pathway, supporting Defence Community Mental Health (DCMH) in providing psychotherapy, and in providing appropriate inpatient provision, when required. It will reflect the different thresholds and tolerances for treatment used within Defence which will reflect the different risks to the NHS.
3. A Glossary of Terms throughout this Statement of Requirement (SOR) is at Annex A.

**BACKGROUND**

1. There are 11 DCMH and 7 smaller Mental Health Teams (MHT) in the UK and Cyprus. They are widely dispersed and are managed by DPHC. There are other smaller MH teams or individuals assigned overseas in support of entitled personnel engaged in specific Operations or Training who are also able to refer into this service. A Hub (DCMH) and Spoke (MHT) model of delivery is used with the MHT coming under the larger Hub for governance, clinical assurance and for multi-disciplinary team meetings. To optimise the care pathway and build on the local provision of care, appropriate provision must be made to meet the inpatient mental healthcare and Outpatient Psychotherapy Service (OPS) requirement for Service Personnel (SP) and entitled civilians from overseas bases, at a location that is in close proximity[[1]](#footnote-1) to the patient’s Unit or home address.
2. Defence Mental Healthcare Service (DMHS) are responsible for facilitating a smooth working relationship between Service Authorities (SA) and the provider of inpatient mental health care and will provide a liaison/rehabilitative function in the form of a Service Liaison Officer (SLO) from each of the Hubs, with a Lead SLO (LSLO) appointed to advise and co-ordinate the SLO network and to have an enhanced leadership function with the provider. The strength of this collaboration is vital to the success of the complete care pathway.
3. To support community mental healthcare, Defence also contracts a surge Outpatient Psychotherapy Service (OPS) of a rolling 120 psychotherapy referral sessions as per [Appendix 2](#_OUTPATIENT_PSYCHOTHERAPY_SERVICE) of this requirement.
4. The current UK locations of the DCMH, the approximate populations at risk (PAR) and contact details are at [Annex](#_Annex_A_to) B. Future changes to the structure of DPHC and the Armed Forces may alter mental healthcare delivery locations.

**OVERARCHING REQUIREMENT**

1. The overarching requirement of this contract is to provide supplementary access to mental healthcare for:
   1. An inpatient setting for entitled personnel[[2]](#footnote-2) that is safe, locally based, inpatient services with the ability to provide urgent expert assessment, treatment, stabilisation and return to service or transition to civilian facilities or civilian life. Once discharged from inpatient care entitled personnel will usually have their community care provided by Defence Medical Services (DMS) in one of the Departments of Community Mental Health (DCMH) or smaller Mental Health Teams (MHT). Refer [Appendix 1](#_Appendix_1_–) for detail.
   2. To provide surge provision of a rolling 116 (annual total of no more than 416) new referrals for National Institute for Health and Care Excellence (NICE) approved psychotherapy for all DCMHs and Defence mental health staff and other identified personnel – referred to as the Outpatient Psychotherapy Service (OPS). The range of psychological provision required, to be delivered in conjunction with good communication with the referring DCMH:
2. Delivery of evidence based psychologically informed interventions for a range of presentations (as listed in spec), which will be up to and including stepped care levels 3/4a in complexity.
3. Delivering accredited specialist psychological interventions, that may draw on more than one psychological model, underpinned by theory and evidence based.
4. In some more complex cases, following MDT/therapist discussions, to deliver highly specialist or complex psychological interventions requiring especially high levels of skill, knowledge and experience.
   1. Provision of clinical supervision, as required and requested, to MOD MDT clinicians (including approach specific specialist accredited supervision) is also a requirement of the contract. This will be based on DCMH requirements, and the following methods of supervision are available:
5. Face to face (where appropriate)
6. 1:1 Telephone Supervision
7. Skype/Video Supervision
8. EMDR Group Sessions
   1. The national delivery of the OPS will be reviewed every three months for clinical effectiveness, projection of future requirement and the clinical profile of patients referred. This will inform the on-going level of intervention required at the quarterly contract meetings.
   2. Clinical effectiveness will be monitored via the questionnaires used in the DCMH and OPS:
      1. Patient Health Questionnaire, 9 question version (PHQ-9) – Q9 score must be noted in the relevant box on the PSR.
9. Generalised Anxiety Disorder, 7 question version (GAD-7).
10. Work and Social Adjustment Scale (WSAS).
11. World Health Organisation; Alcohol Use Disorder Identification Test – **10** item version (ALCOHOL AUDIT).
12. PTSD Check List - Civilian Version (PCL-C) / **PCL-5** (all new referrals with effect from 02/12/19).
    1. Refer [Appendix 2](#_OUTPATIENT_PSYCHOTHERAPY_SERVICE) for guidance on processes.
13. **Clinical Governance.** The Contractor shall:
    1. Deliver care in an environment that embraces National Service Frameworks, National Institute for Clinical Excellence (NICE) Clinical guidelines, and other relevant national policies concerning the delivery of care to entitled personnel with mental health problems.
    2. Provide evidence showing that mature Clinical Governance procedures are in place within all clinical facilities. In addition to participating in externally-monitored Quality Assurance programmes, demonstrate a systematic approach to internal clinical audit.

* 1. Undertake a cycle of audit of the clinical aspects of MOD patient care provision to include length of stay, production of timely reports, treatment provision and treatment outcome on an annual basis.
  2. Any issues or adverse reports with regards to Governance/Assurance are to be communicated to the Authority immediately, along with actions being taken to manage/mitigate the report.
  3. The Authority requires preference for admission to be afforded to Host Facilities and/or sub contracted providers of a CQC grading of ‘good’ as a minimum. Where this cannot be achieved the Authority is to be informed immediately in order to review both Service and Patient interest to ensure parity and equity afforded to Service Personnel.
  4. Should CQC grading change during a Patient admission (i.e.: facility placed under ‘special measures’), the Authority is to be notified immediately due the Authority’s duty of care. Where this has occurred there will be a requirement to review the admission dependent upon host facility action plan/risk/mitigations in place. The Contractor shall provide full support during this review.

1. 2004.

**Annexes:**

1. [Glossary](#_Glossary)

B. [Locations and Contact Details of UK-Based Departments of Community Mental Health (DCMH) and Mental Health Teams (MHT)](#_Annex_A_to)

C. [Key Performance Indicators](#_KEY_PERFORMANCE_INDICATORS)

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**Appendices:**

1. [Defence Inpatient Service Provision Requirements](#_Appendix_1_–)
2. [Outpatient Psychotherapy Service to MOD Personnel Requirement](#_OUTPATIENT_PSYCHOTHERAPY_SERVICE)

# Annex A

# **GLOSSARY**

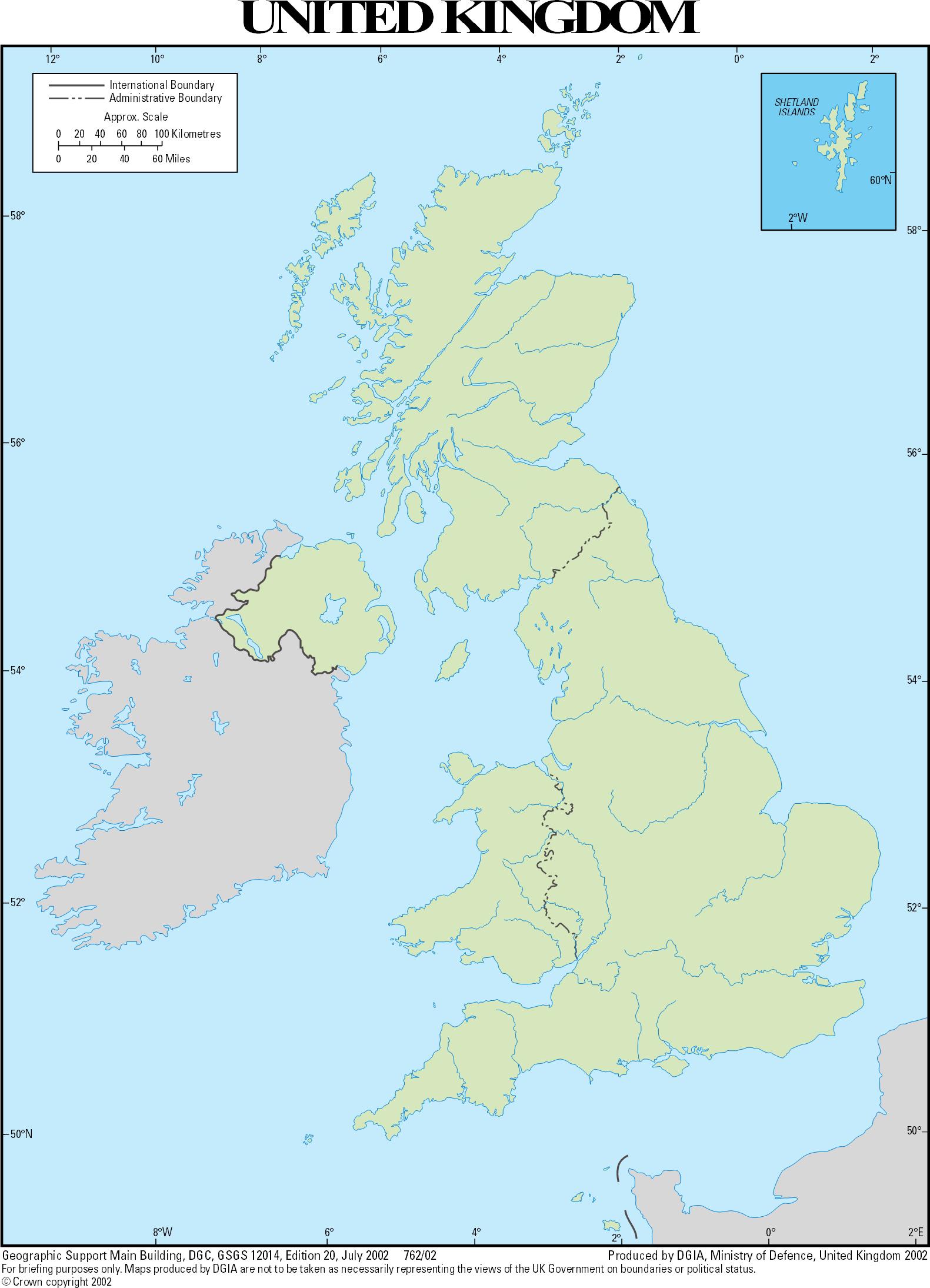
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| [**A**](#_A) | [**B**](#_B) | [**C**](#_C) | [**D**](#_D) | [**E**](#_E) | [**F**](#_F) | [**G**](#_G) | [**H**](#_H) | [**I**](#_I) | [**J**](#_J) |
| [**K**](#_K) | [**L**](#_L) | [**M**](#_M) | [**N**](#_N) | [**O**](#_O) | [**P**](#_P) | [**Q**](#_Q) | [**R**](#_R) | [**S**](#_S) | [**T**](#_T) |
| [**U**](#_U_1) | [**V**](http://cui2-uk.diif.r.mil.uk/r/599/03.%20Support%20the%20Delivery%20of%20DMH/03_04%20Provide%20Commercial%20Activities/Glossary%20Table%20v.1.docx#V) | [**W**](http://cui2-uk.diif.r.mil.uk/r/599/03.%20Support%20the%20Delivery%20of%20DMH/03_04%20Provide%20Commercial%20Activities/Glossary%20Table%20v.1.docx#W) | [**X**](http://cui2-uk.diif.r.mil.uk/r/599/03.%20Support%20the%20Delivery%20of%20DMH/03_04%20Provide%20Commercial%20Activities/Glossary%20Table%20v.1.docx#X) | [**Y**](http://cui2-uk.diif.r.mil.uk/r/599/03.%20Support%20the%20Delivery%20of%20DMH/03_04%20Provide%20Commercial%20Activities/Glossary%20Table%20v.1.docx#Y) | [**Z**](http://cui2-uk.diif.r.mil.uk/r/599/03.%20Support%20the%20Delivery%20of%20DMH/03_04%20Provide%20Commercial%20Activities/Glossary%20Table%20v.1.docx#Z) |  |  |  |  |

|  |  |
| --- | --- |
| **A** |  |
| AC | Authorised Clinicians |
| AF | Armed Forces |
| **B** |  |
| BABCP | British Association for Behavioral and Cognitive Psychotherapies |
| BACP | British Association for Behavioral and Cognitive Practitioners |
| BFG | British Forces Germany |
| **C** |  |
| CBT | Cognitive Behaviour Therapy |
| CL | Clinical Lead |
| CMHN | Community Mental Health Nurse |
| CMP | Civilian Medical Practitioners |
| CPA | Care Programme Approach |
| CQC | Care Quality Commission |
| **D** |  |
| DCMH | Departments of Community Mental Health |
| DDA | Disability Discrimination Act |
| DDO | Deputy Designated Officer |
| DMG | Defence Medical Group |
| DMHS | Defence Mental Health Service |
| DMICP | Defence Medical Information Capability Program |
| DMS | Defence Medical Services |
| DNUS | Detainee Not Under Sentencing |
| DO | Designated Officer |
| DPHC | Defence Primary Healthcare |
| DSH | Deliberate Self-Harm |
| DUS | Detainee Under Sentencing |
| **E** |  |
| ECG | Electrocardiogram |
| ECT | Electroconvulsive Therapy |
| EMDR | Eye Movement Desensitisation and Reprocessing |
| ETA | Estimated Time of Arrival |
| ETD | Estimated Time of Departure |
| **F** |  |
| FMB | Full Medical Board |
| FTRS | Full Time Reserve Service |
| **G** |  |
| GP | General Practitioner |
| **H** |  |
| HLO | Hospital Liaison Officer |
| **I** |  |
| ICD | International Classification of Diseases |
| ISP | Inpatient Service Provision |
| **J** |  |
| JMES | Joint Medical Employability Standard |
| **K** |  |

|  |  |
| --- | --- |
| KPIs | Key Performance Indicators |
| **L** |  |
| LSLO | Lead Service Liaison Officer |
| **M** |  |
| MAPPA | Multi-Agency Public Protection Arrangements |
| MBS | Medical Board of Survey |
| MCTC | Military Corrective Training Centre |
| MDT | Multi-Disciplinary Team |
| MF | Medical Facility |
| MH | Mental Health |
| MHA | Mental Health Act |
| MHT | Mental Health Teams |
| MO | Medical Officer |
| MOD | Ministry of Defence |
| MPS | Military Police Service |
| **N** |  |
| NHS | National Health Service |
| NICE | National Institute for Clinical Excellence |
| **O** |  |
| OPS | Outpatient Psychotherapy Service |
| OSWP | Outside Work Party |
| **P** |  |
| PAR | Populations at risk |
| PRO | Personnel Recovery Officer |
| PRU | Personnel Recovery Unit |
| PSI/R | Patient Safety Incident/Reports |
| PTSD | Post-Traumatic Stress Disorder |
| PUI | Patient Unique Identifier |
| **Q** |  |
| QM’s | Quarter Master |
| **R** |  |
| RAF | Royal Air Force |
| RCDM | Royal Centre for Defence Medicine |
| RN | Registered Nurse |
| RSM | Regimental Sergeant Major |
| **S** |  |
| SA | Service Authorities |
| SE | Safety Events |
| SLO | Service Liaison Officer |
| SMI | Serious Mental Illness |
| SOP | Standing Operating Procedures |
| SOR | Statement of Requirement |
| SP | Service Personnel |
| **T** |  |
| TfCBT | Trauma focused Cognitive Behaviour Therapy |
| U |  |
| URG | Urgent Review Group |
| USO | Unit Standing Orders |
| **V** |  |
| **W** |  |
| **X** |  |
| **Y** |  |
| **Z** |  |
|  |  |

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### Annex B



MHT Wrexham - tbc

DCMH Plymouth

DCMH Portsmouth

DCMH London

DCMH Bulford

MHT St Athan

DCMH Aldershot

DCMH Brize Norton

DCMH Donnington

MHT Preston

MHT NI

DCMH Faslane

MHT Edinburgh

DCMH Leeming

DCMH Digby

DCMH Colchester

MHT Kinloss

**UK-Based DCMH Locations**

**DEPARTMENTS OF COMMUNITY MENTAL HEALTH**

**DCMH ALDERSHOT**

|  |
| --- |
| **ADDRESS** |
| Aldershot Centre for Health  Hospital Hill  Aldershot  GU11 1AY |

**DCMH BRIZE NORTON**

|  |
| --- |
| **ADDRESS** |
| RAF Brize Norton, Carterton,  Oxfordshire  OX18 3LX |

**DCMH BULFORD**

|  |
| --- |
| **ADDRESS** |
| Bengal Rd  Bulford Camp  Salisbury  SP4 9AD |

**DCMH COLCHESTER**

|  |
| --- |
| **ADDRESS** |
| Building CO2, Merville Barracks  Colchester  Essex  CO2 7UT |

**DCMH DIGBY**

|  |
| --- |
| **ADDRESS** |
| RAF DIGBY  Lincoln  Lincolnshire  LN4 3LH |

**DCMH DONNINGTON**

|  |
| --- |
| **ADDRESS** |
| Venning Barracks  Telford  Shropshire  TF2 8JT |

**DCMH FASLANE**

|  |
| --- |
| **ADDRESS** |
| Medical Centre  HMS Neptune  HM Naval Base Clyde  Helensburgh G84 8HL |

**DCMH LEEMING**

|  |
| --- |
| **ADDRESS** |
| Building 20  The Old Medical Centre  RAF Leeming  Northallerton  North Yorkshire DL9 9NJ |

**DCMH PORTSMOUTH**

|  |
| --- |
| **ADDRESS** |
| HM Naval Base  Portsmouth  Hampshire  PO13LT |

**DCMH PLYMOUTH**

|  |
| --- |
| **ADDRESS** |
| 1st Floor Seymour Block HMS Drake  HM Naval Base Devonport  Plymouth PL2 2BG |

**DCMH LONDON**

|  |
| --- |
| **ADDRESS** |
| Station Medical Centre  Woolwich  London  SE18 4BW |

**MENTAL HEALTH TEAMS**

**MHT Edinburgh**

|  |
| --- |
| **ADDRESS** |
| REDFORD BKS  COLINTON ROAD  EDINBURGH  SCOTLAND, EH13 0PP |

**MHT KINLOSS**

|  |
| --- |
| **ADDRESS** |
| RAF Kinloss  Forres  Moray  IV36 3UH, |

**MHT NI**

|  |
| --- |
| **ADDRESS** |
| Thiepval Barracks  BFPO 801 |

**MHT Preston**

|  |
| --- |
| **ADDRESS** |
| Medical Centre  Fulwood Barracks  Preston  Lancashire PR2 8AA |

**MHT ST ATHAN**

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|  |
| --- |
| **ADDRESS** |
| Building 400  Ardour Street  East Camp  MOD St Athan |

**MHT Wrexham -** To be confirmed

### **KEY PERFORMANCE INDICATORS**

| **KPI 1 - Inpatient Admission Criteria – Target 97%** | | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| **ID** | **PARA NO** | **PERFORMANCE INDICATOR** | **ACTION** | | **OUTCOME MEASURE**  **(DELIVERABLE)** | **TARGET** |
| **Inpatient Admission Criteria** | | | | | | | |
| KPI1.1 | Appendix 1, para 3 | The Contractor provides an admission bed for acute entitled personnel in a suitable facility carefully chosen to match clinical need within 4 hours of a request. | The Contractor is to provide a single point of contact with telephone number 24 hours, 7 days a week for Authorised Clinicians and admit acute entitled personnel as required. | | Provide the bed within 4 hours | 100% |
| KPI 1.2 | Appendix 1, para 18.i | The Contractor admits entitled personnel to a hospital, within 2 hours travelling time of their Service unit or their place of residence (if clinically indicated) into a dedicated MOD bed. | Dedicated provision is maintained across the UK in line with the DCMH footprint. | | Provide a bed within 2 hour travelling time as defined by route finder | 95% |
| **KPI 2 - Patient Management – Target 98%** | | | | | | | |
| **ID** | **PARA NO** | **PERFORMANCE INDICATOR** | **ACTION** | | **OUTCOME MEASURE**  **(DELIVERABLE)** | **TARGET** |
| KPI2.1 |  | Initial patient report to be produced and provided to SLO within 72 hours of admission. | Contractor to supply an initial 48-hour report within 72 hours of the initial assessment in the agreed template format to the SLO | | Report received within 72 hours of admission | 100% |
| KPI2.2 | Appendix 1, para 20 | All requests for extended a patient stay beyond the initial 10-day package will be require no later than day 8 of the initial stay. | Contractor to complete extension request form for all stays beyond 10 days and all subsequent 7-day extensions. | | Annex H to be completed and forwarded to the SLO by day 8 of the initial stay | 100% |
| KPI 2.3 | Appendix 2, para 7 | OPS - The contractor receives a referral from the Authority and contacts the patient to agree their 1st appointment date, as part of outpatient treatment, within 10 working days of the referral being received. | Contractor to contact the patient to agree the first outpatient treatment date, within 10 working days of the Authority’s referral - the agreed 1st appointment does not need to be within 10 days. | | Contact with patient to agree 1st appointment date attempted within 10 working days of referral. The contractor to provide confirmation of first contact with the patient via a monthly report. | 95% |
| KPI 2.4 | Appendix 2, para 4 | OPS - All requests to extend patient treatment sessions will need to be requested from the DCMH, giving at least 2 sessions’ notice, in multiples of 6 up to a standard maximum of 30. | Patient agreed sessions should optimally be 1-2 weekly, but negotiable with the patient. Sessional reports should be forwarded to the DCMHs.  Contractor to request agreement from the Authority to provide additional treatment sessions.  Requests, beyond session 16, to be forwarded to DCMH. | | Within 10 working days.  Written requests:  Beyond 18 - by session 16.  Beyond 24 - by session 22. | 100% |
| **KPI 3 - Discharge Requirements – Target 97%** | | | | | | | |
| **ID** | **PARA NO** | **PERFORMANCE INDICATOR** | **ACTION** | | **OUTCOME MEASURE**  **(DELIVERABLE)** | **TARGET** |
| KPI 3.1 | Appendix 1, para 21 | The Contractor will complete inpatient discharge summary template (Annex E) for all entitled personnel provided to the patient on the day of discharge, a copy will be emailed to the authority on the day of discharge. | Using the template at Annex E, the Contractor is to provide an inpatient discharge summary to the patient, the patient’s General Practitioner and DCMH. | | Report Received by the Authority on the day of discharge | 100% |
| KPI 3.2 | Appendix 1, para 21a-e | The Contractor provides a full inpatient discharge report to the Authority via email for all entitled personnel within 5 days of discharge. | Contractor to provide a full typewritten inpatient discharge report; including level of patient risk, ICD 10 diagnosis and code. | | Report received within 5 days of discharge | 95% |
| KPI 3.3 | Appendix 2, para 24 | OPS - A Discharge Summary will be completed at the close of therapy. | Contractor to complete Discharge Summary at close of therapy and forward to DCMH. | | Within five working days of the final session. | 95% |
| KPI3.4 | Appendix 2, para 14-17 | OPS - **DNAs:** In the case of non-attendance, a DNA report to be completed | DNA report should be submitted to appropriate DCMH with reason for DNA/cancellation. Should patient be uncontactable the same working day, contact should be made with DCMH Duty Clinician. | | Same Working Day | 100% |
| **KPI 4 - Clinical Governance – Target 100%** | | | | | | | |
| **ID** | **PARA NO** | **PERFORMANCE INDICATOR** | **ACTION** | **OUTCOME MEASURE**  **(DELIVERABLE)** | | **TARGET** |
| KPI4.1 | Appendix 1, para 28g | Contractor is to inform the Authority of all patient safety events (SE) involving entitled personnel. Red incidents to be reported within 24 hours of the incident. Amber and Green incidents to be reported within 28 days of the incident. | Contractor to provide summary reports in line with the SOR. | Time Frame Measure  SE Report received | | 100% |
| **KPI 5 - Management Information – Target – 97%** | | |  | |  |  | |
| **ID** | **PARA NO** | **PERFORMANCE INDICATOR** | **ACTION** | | **OUTCOME MEASURE**  **(DELIVERABLE)** | **TARGET** |
| KPI 5.1 | Appendix 1, para 28 (d) | * 1. Monthly Inpatient Admission and Discharge Stats via a report to the Authority   2. A daily bed-state of all patients to Lead SLO   3. Anonymised results of patient satisfaction surveys provide quarterly. | Contractor to provide accurate reports (as outlined) to time | | Reports received by the Authority as outlined | 100% |
| KPI5.2 | Appendix 1, para 28 (d) | Outpatient outcome data to be collected each session and quarterly data reports to be submitted. | Contractor to provide OPS quarterly data reports - providing totals for the number of sessions delivered, for all completed cases discharged from the service.  To Include pre and post therapy outcome measures.  To include anonymised results of completed patient satisfaction surveys. | | Reports received by the Authority quarterly, as outlined. | 95% |

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# Appendix 1

**DEFENCE INPATIENT SERVICE PROVISION REQUIREMENTS**

**INTRODUCTION**

* + - 1. Defence requires inpatient service access at a lower criterion than standard NHS admission criteria due to the unique level of risk associated with access to firearms. This requirement articulates the gap between standard NHS admission and Defence admission requirements.

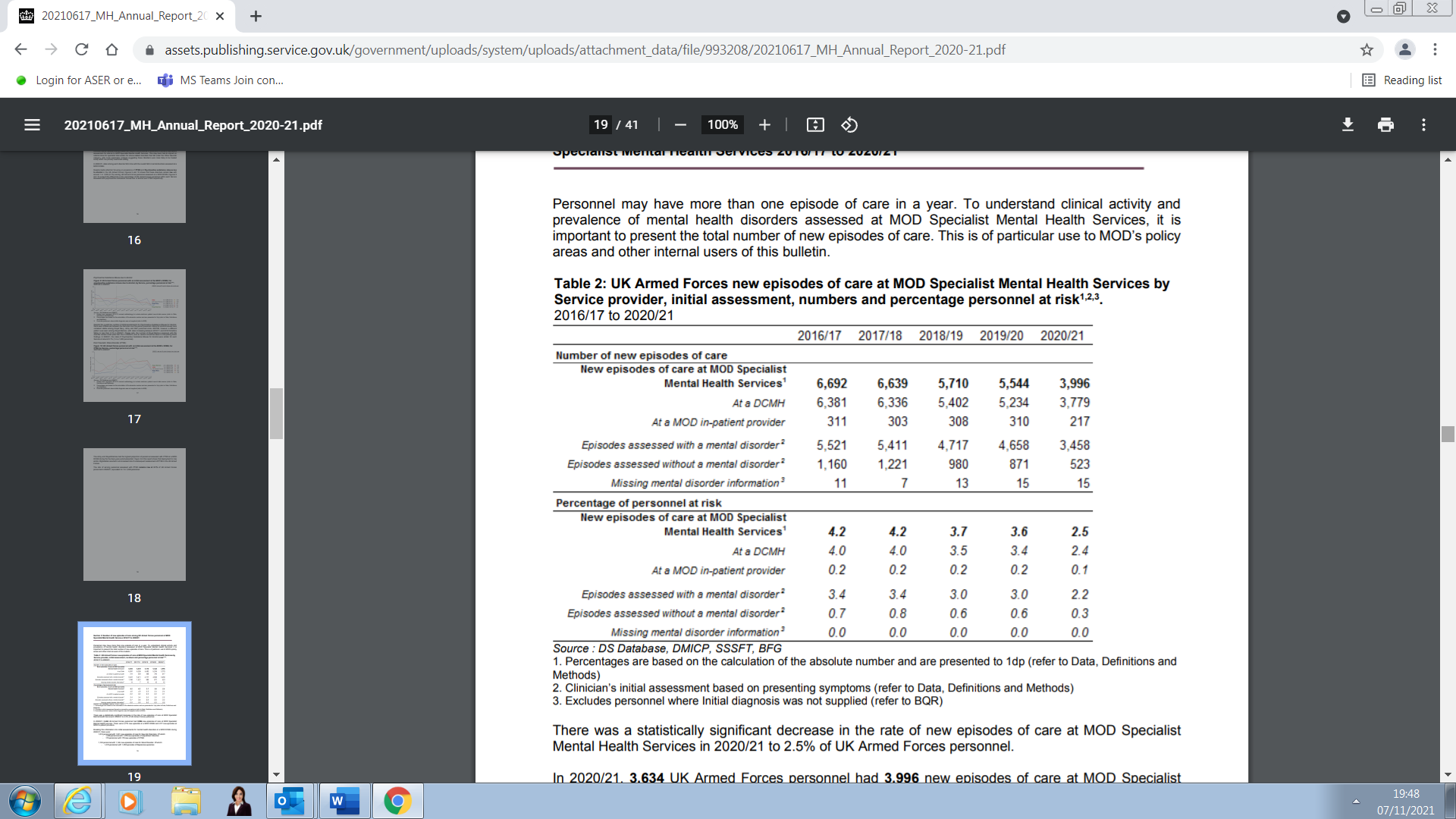
**BACKGROUND**

1. Referral can be made for serving and operational Reserve Royal Navy (RN), Army, and Royal Air Force (RAF) There is a requirement for the provision of a contracted in-patient care for entitled personnel, this includes MOD employed civilians living and working overseas (entitled personnel from overseas are usually aero-medically evacuated to the UK for the provision of this care).
2. An initial admission would be for up to 10 days, with further bed days being requested as clinically appropriate. The 10 day stay/admission is for stabilisation and treatment of personnel and management of risk with the individual then being discharged back to the care of the General Practitioner (GP), Medical Officer (MO) and DCMH. For eligible civilians, the admission would be for 10 days only and any care required after the initial 10 days will be the responsibility of the NHS, arranged by the provider.
3. The number of personnel admitted to the MOD in-patient provider remains low at 0.2% of all Armed Forces personnel in 2020/21 (Table 1). This is despite the trend of increasing numbers of personnel being seen by DMHS for assessment.

Table 1

**UK Armed Forces personnel presenting at MOD Specialist Mental Health Services by Service provider, initial assessment, numbers and percentage population at risk**

**2016/17 – 2020/21**



1. Usually between 5 and 10 patients per year require admission under the Mental Health Act (MHA) (1983 & 2007) to either a general psychiatric facility or to a secure facility. These individuals are usually admitted to the NHS facility following assessment by the local NHS MH team and authorised clinicians (AC). The majority of entitled personnel, however, do not suffer from serious mental illness (SMI) but, in the main, demonstrate depressive-type mood disorders, anxiety related disorders including PTSD, personality disorders and substance misuse difficulties.

**REQUIREMENT**

1. The Authority has a requirement for the provision of high quality occupationally focused care for SP and entitled civilians deemed to require inpatient assessment, stabilisation and treatment. The Contractor will provide a nominated bed within 4 hours of a request; demonstrate a high level of commitment towards evidence-based practice, quality improvement and achieving clinical excellence. Specifically, the Contractor will:
   1. Provide access to services that compliment and reinforce the philosophy and principles of the AF mental health occupationally focused, care pathway.
   2. Provide a service at a location that is as close as possible to the patient’s Department of Community Mental Health or where clinically indicated their home.
   3. Provide facilities for the treatment of entitled personnel that are registered with the Care Quality Commission (CQC)[[3]](#footnote-3) and maintain that registration throughout the period of the contract.
   4. Facilitate the delivery of a safe and effective management of Service personnel, eligible dependants and civilians in liaison with the Service Authorities with the aim of discharging them back to their Medical Officer/DCMH or NHS GP as soon as is safe and practicable to do so.
   5. There may be occasions (< 10 per annum) where an under 18 will require admission. This is where a SP is under the age of 18 or is an eligible dependant from overseas. In these circumstances access to a Child and Adolescent Mental Health Service (CAMHS) bed will be required and may be used. If a SP under the age of 18 is assessed to be safe to be accommodated on the general adult ward, this is acceptable.
   6. SP detained under the Armed Forces Act in the Military Corrective Training Centre (MCTC) may also require admission. Such a patient may be a high risk of absconding but may not require to be sectioned under the MHA. It should be noted that in cases where SP under sentence are referred to Inpatient Service Provision (ISP) for admission, the detainee will be escorted by MCTC trained personnel to maintain detention requirements in accordance with Standing Operating Procedures (SOP), an example of the SOP can be found at [Annex A](#MCTC). Hospital staff are only authorised to detain such entitled personnel if they are sectioned under the Mental Health Act (MHA) (1983/2007).
   7. Where appropriate, an escort may also be provided for those entitled personnel who are in possession of current sensitive/secret information to document what information is disclosed. There may be a requirement for some of the provider’s personnel to have an enhanced security vetting to facilitate assessment and treatment of personnel with highly sensitive information.
   8. Provide inpatient care for escorted detainees, detained under the Armed Forces Act, transferred from Military Corrective Training Centre (MCTC) and provide this care in an environment appropriate to the clinical needs where absconding can be prevented[[4]](#footnote-4). This may require unarmed MCTC security personnel to be located in or around the ward in case of the patient absconding.
   9. Provide inpatient care in an environment appropriate to the clinical needs of entitled personnel with sensitive information, where they can be escorted by a MOD employee if required, and any information shared inappropriately can be contained, the MOD escort can advise relevant parties as necessary.
   10. Support the aeromedical evacuation of psychiatric entitled personnel returned to UK from overseas. The Contractor will not be expected to provide any component of the evacuation chain other than the place of admission. The Authority will provide escorts and transportation.
   11. Where possible, attention should be given to the provision of daily activities appropriate to entitled personnel specifically gym/fitness facilities.
   12. Requests for adhoc services maybe requested, e.g. Standard Inpatient Eating Disorder Service, MRI scans, CT scans.
2. **Referrals.** The Authority will refer entitled personnel to the Contractor using typewritten letter formats including the military referral letter known as the F Med 7 ([Annex B](#_F_Med_7)) that will be sent immediately (within 24 hours) to the Contractor[[5]](#footnote-5). The Contractor shall only admit and assess the following entitled personnel who have been referred by UK, Overseas and Military Operations based Authorised Clinician (AC) for an initial period of **10 days**.
3. Referral can be made for all regular RN, Army and RAF personnel including mobilised Reserve[[6]](#footnote-6) personnel, and eligible civilians. This is expressly for a period up to 10 days only. The responsibility for facilitating the onward medical, domestic and welfare arrangements to support the care needs of dependants or entitled civilians following this 10-day admission will rest with the referring medical unit in liaison with the DCMH closest to the ISP. The SLO will be involved with the discharge organisation in conjunction with the individuals overseas Medical Facility (MF) or NHS GP with who the civilian is registered. If the eligible civilian requires on-going inpatient care, this would be arranged via the Contractor.
4. All referrals will be made initially by telephone and supported in writing by the Authorised Clinician. Authorised Clinicians (AC) are:
   1. Service or MOD employed MH clinicians (including the National on call SLO).
   2. Service Medical Officers (MO) or MOD employed Civilian Medical Practitioners (CMP)[[7]](#footnote-7).
   3. Role 4[[8]](#footnote-8) DMS Secondary Care Consultants.
5. **Liaison between the Authority and the Contractor**. The Contractor will ensure there is close liaison between the nominated hospital(s) and the nominated Service DCMH and will nominate a suitable individual (senior experienced Registered Nurse (RN) (MH) practitioner at Band 6-7) as a Hospital Liaison Officer (ECT), at each hospital to act as a single point of contact. The HLO is expected to be a suitably qualified, senior member of the inpatient unit clinical team and is to be available during normal weekday working hours. Normal weekday working hours are defined as 0800-1700. The purpose of close liaison between the Contractor and the Authority is to ensure that the pathway of care for each patient is fully integrated and that the transfer of entitled personnel between the Authority and Contractor, and vice versa, is as seamless as possible.
6. The SLO will be a military or Service/MOD employed RN (MH) from the nominated DCMH who will act on behalf of the Authority. Where the DCMH SLO is not available due to being on leave, course, duty etc., the DCMH will nominate another SLO for that period.
7. The Authority will appoint a LSLO (the LSLO will be a Band 7 or military equivalent) to coordinate the work of the DCMH SLOs and act as the senior point of contact for the authority and the DCMH SLO when required. The Authority will also have an appointed Designated Officer (DO) who will be the deciding officer along with the LSLO on complex cases and subsequent requests from the Contractor and the Authority.
8. The SLO will be a suitably experienced military or civilian RN (MH), with an extensive knowledge and understanding of Service medical administration and will provide advice and guidance on all matters relating to entitled personnel. They will act as a conduit between the DCMH, the Primary Care Team, Medical Facility, and hospital inpatient unit, the individual’s Unit or Personnel Recovery Unit/Officer (PRU/PRO) and, where appropriate, the Aeromedical Evacuation Team. The primary role of the SLO is to act as the advocate for the Service patient whilst he/she is admitted to a non-military facility.
9. When entitled personnel are admitted, the Contractor will enable the SLO to make regular telephone contact with the Hospital inpatient unit and will, as a minimum:
   1. Visit the entitled person and members of the care team within 72 hours of admission.
   2. Attend relevant ward rounds and case conferences/reviews and must be integral to the discharge and community care planning meetings.
   3. Ensure full participation of the Authority in aftercare or follow-up discussions.
10. The Contractor will have direct access to the LSLO/SLO or their deputies during normal weekday working hours. Normal weekday working hours are defined as 0800-1700 hours.
11. The Authority requires the SLO to be provided with the appropriate level of access to the entitled person and to their individual health record.
12. The Contractor is responsible for ensuring that a weekly liaison meeting shall be held between the HLO and SLO.
13. **Admission Criteria.** The Contractor will:
    1. Provide a single point of contact to an ‘admissions officer/manager’ that can be accessed by Authorised Clinicians 24 hours a day, 7 days a week. This service may be used by clinicians in overseas locations that require Consultant Psychiatrist advice in the management of personnel.
    2. Provide 24 hours, 7 days a week, telephone access to a Duty Consultant Psychiatrist. The purpose of this access is to permit direct discussion on patient admission with a referring AC.
    3. Accept referrals from ACs (as per Para 7).
    4. Provide a place of safety for assessment.
    5. Provide a full psychiatric assessment conducted by a Consultant Psychiatrist.
    6. Provide an admission bed in a suitable facility chosen to match clinical and welfare needs.
    7. Admit acute entitled personnel to a Psychiatric Intensive Care Unit (PICU) when required, 24 hours per day, 7 days per week.
    8. Provide the AC making the admission request with a bed in their preferred location; it is accepted that some flexibility in this criterion is required but where the location of choice is not available the Contractor will be responsible for finding a suitable local alternative from within their bid. The answer “no beds” to a request for admission is **NOT** an option in this contract.
    9. Admit entitled personnel to a hospital within easy reach of their Service unit or their place of residence. Within the UK this facility should be within 2 hours travelling time of the referring DCMH/MHT in the majority of cases. The AC requesting admission will specify the preferred admission location. This will be identified as being close to the Service unit or the patient's home as clinically appropriate. The Authority will be responsible for transporting the patient by road to the specified location.
14. **Admission Category.** The Contractor shall ensure that each patient will be assigned to a specific/named Consultant Psychiatrist who is clinically responsible at all times for the management and delivery of care to that patient. The Contractor will also ensure that the named Consultant Psychiatrist is drawn from a small pool (maximum 3) of their Consultant Psychiatrists in each unit[[9]](#footnote-9). The Contractor will accept entitled personnel:
    1. Requiring inpatient mental health assessment, that the DCMH Clinicians feel cannot be safely undertaken in the community.
    2. Requiring inpatient admission because they need temporary sanctuary/respite from the risk related to experience of mental health problems in a safety critical environment.
    3. Requiring specific treatment that needs inpatient support.
    4. Requiring medically supervised detoxification from alcohol and or other substances when appropriate to do so.
15. **Assessment and Treatment.** Upon receipt of a suitable referral, the Contractor will be required to admit the entitled person for a period of up to **10 DAYS**. On occasions where it is necessary to prolong the admission beyond the initial 10 days, the Contractor’s Consultant Psychiatrist must request an extension of the admission period. This request will be made to the SLO by no later than day 8 of the initial stay. Extensions of the admission period will be for up to 7-day periods[[10]](#footnote-10). Over the course of the inpatient admission, the Contractor will:
    1. Undertake an initial assessment of the mental state of an entitled person within 2 hours of arrival and undertake appropriate stabilisation treatment to achieve an early discharge back to the care of a DCMH or their NHS GP for non-Service personnel.
    2. Undertake, when requested or indicated, appropriate assessment (within 24 hours of admission) and treatment under the provisions of the MHA (1983 & 2007)[[11]](#footnote-11). The Contractor’s Clinicians are to regularly liaise with the SLO and will inform the Authority of any changes to the entitled person’s status under the provisions of the Act. Furthermore, the Contractor will correctly administer the entitled person, subject to the provisions of the Act, in accordance with the Code of Practice and policy and guidance issued by the Mental Health Act Commission[[12]](#footnote-12).
    3. The Contractor will undertake the treatment required to achieve mental state stabilisation via the most appropriate therapeutic strategies in accordance with current evidence-based practice. The Contractor will undertake medically supervised detoxification from alcohol and other substances over a period no longer than 7 days[[13]](#footnote-13).
    4. The Contractor is to provide appropriate drug and psychotherapeutic treatment for all entitled personnel during an inpatient care episode to establish the entitled individual’s stabilisation. All treatments that are begun are to be in liaison with the SLO so that the continuation of treatment beyond discharge can be appropriately managed. To facilitate this, the Contractor is to provide the patient at the point of discharge a discharge summary ([Annex](#_DISCHARGE_NOTIFICATION_AND) C) for the attention of their MO/GP and medication for a further 7 days. A copy of the discharge summary will also be sent to the DCMH and GP electronically.
    5. If treatment beyond the basic requirement for mental state stabilisation is requested or necessary, the Contractor will not undertake any such treatment until the Authority has given authorisation of this request:
       1. Where specific treatment is requested, out with that required for stabilisation, by the Authority, the Contractor will provide an individual itemised price for the work before the Authority decides whether the treatment should proceed.
16. When the Contractor considers that a treatment protocol is required to stabilise the entitled person for discharge, the request is to be made Contractor to the SLO with the relevant pricing. The Authority encourages a collaborative approach to exceptional requests and the SLO, LSLO, DO will decide whether the treatment should proceed.
17. The Contractor will inform the patient that agreement with the Authority is necessary before treatments or assessments that require further funding can proceed, except in emergencies[[14]](#footnote-14).
18. The Authority Consultant Psychiatrist from their DCMH will visit Service personnel[[15]](#footnote-15) after they have been an inpatient for 28 days, primarily to assess occupational prognosis.
    1. The Contractor shall undertake the clinical care of entitled personnel. The Authority may submit suggested treatment protocols though primacy will lie with the consultant in charge of the case. Any additional proposed treatment beyond stabilisation of mental state is to be discussed and agreed by the Authority’s SLO and Consultant, prior to commencement of such treatment.
    2. The Contractor will provide an initial physical examination and arrange all necessary investigations e.g. blood tests, ECG etc. for initial assessment and safe prescription of medications following admission.
    3. If further investigations or assessments are required during the admission, the Contractor will arrange the required investigations/assessments following discussion with the SLO and Consultant. The Contractor will also arrange any liaison assessments with Physicians/surgeons because of physical ill health of entitled personnel; this will be arranged in collaboration with the entitled person’s GP and or primary care MF. In situations where there is a physical crisis/emergency, the Contractor will provide or arrange the required definitive treatment/care. The Authority expects the Contractor’s to liaise with the SLO as soon as is practically possible in these circumstances. The Contractor will arrange for the safe transfer to a suitable facility for entitled personnel who develop any conditions not included in this contract, whenever possible in consultation with the Authority, but always informing the Authority.
    4. If, during an admission, the Contractor’s clinicians feel it is necessary to make the SP subject to the provisions of the MHA (1983 & 2007)[[16]](#footnote-16), the Contractor will make the arrangements to provide the necessary assessment(s) and take the actions required to provide the safe treatment for the patient. If this includes transfer of the patient to a more intensive and/or secure environment, the Contractor will undertake the safe transfer of the patient and inform the SLO.
    5. Very occasionally, for clinical or welfare reasons, it may be appropriate to transfer a patient between the Contractor’s inpatient units. This will be managed on a case by case basis in consultation with the SLO, LSLO, DO and DDO. Where the transfer is for the Contractor's own reasons, the Contractor will be responsible for the arrangement and cost of transferring any patient between its inpatient units. If the transfer is at the request of the Authority, the Authority will pay the cost incurred for the transfer (this will be dependent upon location of the units and mode of transfer), but for all requests a breakdown of costs must be provided before authority is given.
    6. Due to the UK employing a number of Commonwealth and Ghurkha Service personnel there may be the very occasional requirement to provide translation services to assist with full assessment. The Contractor will arrange for the appropriate translation services if required and a pricing schedule needs to be provided for these services.
    7. Whilst under inpatient care the Contractor will provide the following specific assessments if clinically indicated which will attract payment as detailed in the pricing schedule:
19. Forensic psychology assessment.
20. Forensic psychiatric assessment.
    1. During and on completion of inpatient stays the Contractor will be required to undertake patient assessment against outcome measures agreed between the Authority and the Contractor. The Contractor and Authority will work closely together to improve outcome measures during the life of the contract.
21. **Discharge Requirements.** The decision to discharge a Service patient is a collaborative one between the Contractor’s responsible clinicians, the DCMH Consultant Psychiatrist[[17]](#footnote-17) and the SLO and will be conducted in the spirit of the Care Programme Approach (CPA)[[18]](#footnote-18). Given the structure and work patterns of the NHS and Military establishments, entitled personnel will not be discharged on a Friday or at weekends or public holidays except in exceptional, pre-arranged circumstances with the SLO. Once the Consultant in charge of an inpatient has decided that they are medically suitable for discharge, agreement must be obtained from the SLO.
22. **Environment.** It is imperative that the physical and ‘psychological environment’ provided is conducive to the wellbeing and rapid recovery of SP and eligible civilians. The Contractor will give careful consideration as to how they would care for SP alongside their general population, considering potential differences in pathology and associated behaviour between Service and NHS patients.
23. The entitled person must have the ability, if they so wish, to separate themselves from the general civilian population of a ward/unit. Therefore, entitled personnel must be accommodated in single rooms or with other entitled personnel in single-sex areas/accommodation unless dictated otherwise by clinical need.
24. Due to the potential requirement for operational casualties with physical complex trauma requiring admission to the inpatient provision, all areas need to be compliant with the Equality Act 2010. Some may require clinical facilities as there is a potential need to deliver general medical and nursing acute care needs to those with physical injuries (historically less than 5 per annum).

**Appendix 2**

**OUTPATIENT PSYCHOTHERAPY SERVICE FOR MOD PERSONNEL**

1. The Contractor shall provide:
2. All assessed entitled Service personnel with timely access to effective treatment by creating additional capacity external to the Defence Mental Health Services as necessary.
3. Quick access to psychotherapy treatments for Service patients when need exceeds DCMH capacity, either through an increase in referrals or reduction in capacity (e.g., sickness absence, staff churn, operational requirements). The referral process outlined at Annex A to Appendix 2will be used to ensure best outcomes for the patient and effective use of resource for Defence.
4. The Inpatient Service Provider (ISP) will provide High Intensity Therapy from the Improving Access to Psychological provision to provide remote video consultation (RVC) and where requested/required face-to-face therapy close as possible to local DCMHs. This service will be known as the “Outpatient Psychotherapy Service” (OPS).
5. All referrals from the DCMH to provider will be managed via the central bed management team HQ/ Lead SLO.
6. The intervention will be for **12 - 30[[19]](#footnote-19)** one-hour sessions of an evidence-based psychotherapy, which will be identified by the joint Multi-disciplinary Team (MDT) meeting with an OPS clinician in attendance in person, RVC, or by teleconference call. This decision-making process will be informed by the referral documentation sent to the LSLOfrom the DCMH. Although the initial request will be for 12 sessions, this can be extended in blocks of 6 up to a total of 30 (see Fig 1 for criteria).

| **Sessions** | **Session action required** | **Criteria** | **Authorised by** | **Next steps** |
| --- | --- | --- | --- | --- |
| 1 - 12 | n/a | Agreed at joint MDT | Referring DCMH Service Liaison Officer | LSLOreferral process |
| 13 - 18 | By Session 10 | Clinical need | OPS clinician in agreement with the patient | Extension advised on Post Sessional Report |
| 18 | By Session 13 | Occupational assessment | Appointment to be made with DCMH Con Psych | Request made by DCMH Service Liaison Officer |
| 19 - 24 | By Session 16 | Clinical need agreed at MDT. Must be considered by session 16. | DCMH Clinical Lead through MDT. | Extension requested on Post Sessional Report |
| 25 -30 | By Session 21 | Clinical need proposed by MDT for a notes review by DCMH Clinical Lead. Must be considered by session 21. | DCMH Clinical Lead through MDT. | Extension requested on Post Sessional Report |
| 30 - 45 | By Session 15 | 1. When there has been an unavoidable change in therapist  2. If a change in modality is required. This is an active decision made early in the care pathway because the chosen first-line modality is ineffective. | DCMH Clinical Lead through MDT. | Extension requested on Post Sessional Report |

Figure 1. Criteria for extensions to therapy for the OPS.

**Implementation**

1. The outpatient provision must only be used for those patients that have been assessed by the joint MDT or other local equivalent arrangement as suitable for a targeted 12 to 30-session intervention[[20]](#footnote-20) ([Annex A](#_Annex_A_to_1)). The patient’s suitability for psychotherapy must be confirmed by the DCMH Clinical Lead or Key Worker prior to a referral being made to the outpatient provider.
2. Each patient shall be offered 12 sessions of psychotherapy with an opportunity to extend to 18 if clinically indicated up to a maximum of 30[[21]](#footnote-21) (refer [figure 1](#_Figure_1) and [Annex A](#_Annex_A_to_1)). All referrals and extensions must be discussed with the patient, and referral forwarded to the LSLO [[22]](#footnote-22) by the Service Liaison Officer in the DCMH[[23]](#footnote-23) - see [Annex B](#_Annex_B) for covering note and [Annex C](#_Annex_C_to) for the referral template. All extensions to the initial 18[[24]](#footnote-24) will be discussed at the joint MDT or other local equivalent arrangement with oversight by the DCMH Clinical Lead. The Service Liaison Officer [[25]](#footnote-25) and OPS clinician will remain in contact to maintain communications and ensure the DCMH remains up to date. If all parties agree the request for extension is approved, the OPS Clinician will advise the LSLO (via the PSR), the patient, and the Service Liaison Officer (refer Annex B and C). The Service Liaison Officer will maintain a spreadsheet of patient referrals to the OPS for tracking – refer [Annex D](#_Annex_D_1).
3. In cases where, due to complexity, the diagnosis change’s part way through treatment, sessions can be extended by 15 to 45. Changing modality is an active decision made early in the care pathway because the chosen first-line modality is ineffective, therefore the change must be identified by session 15. The 45 sessions number is specific to allow the patient to have a full run of 30 sessions of the new modality if a change is needed (using a multi-modal approach from the outset is a different matter and is normally limited to the usual 30 sessions), or where another modality is introduced to augment the primary modality that has proven effective (e.g., adding EMDR to a pernicious area where TF-CBT has been effective overall).
4. The DCMH Service Liaison Officer must provide an up-to-date full assessment of the individual to the LSLO giving a diagnosis/formulation. The outpatient provision is to be made clear to the patient, so that that they understand what is being offered and what their commitment is and the need to obtain explicit consent from the patient before they are referred to the provision. Consent must be evidenced by the individual signing the consent form at [Annex E](#_Annex_E_to), which is to be scanned onto DMICP once complete and forwarded to the I-MMMAC. The patient retains the right to decline this intervention, but must have the implications explained to them, which are to remain on the waiting list until there is an available DCMH clinician.
5. In putting patients forward for this service consideration should be given to the stability and readiness for therapy, and any co-morbidities. Suitability for RVC should be considered, see guidance at Annex F
6. Therefore, the bi-lateral MDT or other local equivalent arrangement discussions between the DCMH and OPS clinicians are essential to the delivery of this service. In all cases, particularly complex trauma, treatment goals must clear and articulate expected outcomes from the outset, as complete functional and symptomatic recovery may not be achievable even in the maximum number of sessions permitted. Patients likely to be referred for outpatient treatment are likely to have, but are not exclusive to:

1. Depression.
2. Anxiety disorders.
3. Post-Traumatic Stress Disorder (careful consideration needs to be given with regards to appropriateness for 12-30).
4. **For the avoidance of doubt**, the following describes the range of psychological provision required, to be delivered in conjunction with good communication with the referring MDT:
   1. delivery of evidence based psychologically informed interventions for a range of presentations (as listed in spec), which will be up to and including stepped care levels 3/4a in complexity.
   2. delivering accredited specialist psychological interventions, that may draw on more than one psychological model, underpinned by theory and evidence based.
   3. In some more complex cases, following MDT / therapist discussions, to deliver highly specialist or complex psychological interventions requiring especially high levels of skill, knowledge and experience.
5. Provision of clinical supervision, as required and requested, to MOD MDT clinicians (including approach specific specialist accredited supervision) is also a requirement of the contract. This will be based on DCMH requirements, and the following methods of supervision are available:
   1. Face to face (where appropriate)
   2. 1:1 Telephone Supervision
   3. Skype/Video Supervision
   4. EMDR Group Sessions
6. The MOD will review national delivery of the OPS every three months for clinical effectiveness, projection of future requirement and the clinical profile of patients referred. This will inform the on-going level of intervention required at the quarterly contract meetings with the Contractor. However, it is envisaged that there will be regular meetings with the contractor to identify challenges and opportunities for service improvement.
7. Clinical effectiveness will be monitored quarterly via the questionnaires used in the DCMH and OPS:
   1. Patient Health Questionnaire, 9 question version (PHQ-9) – Q9 score must be noted in the relevant box on the PSR.
   2. Generalised Anxiety Disorder, 7 question version (GAD-7)
   3. Work and Social Adjustment Scale (WSAS)
   4. World Health Organisation; Alcohol Use Disorder Identification Test – **10** item version   
      (ALCOHOL AUDIT)
   5. PTSD Check List - Civilian Version (PCL-C) / **PCL-5** (all new referrals with effect from 02/12/19)
8. All governance and assurance associated with the psychotherapy provision will be the responsibility of the Contractor.
9. All referrals are to be forwarded via the referral form at [Annex C](#_Annex_C_1),. These referrals can only be made during working hours 0900 – 1700, Monday to Friday. The contractor will coordinate/organise all invoices.
10. The patient will travel to the provider’s OPS location. However, alternative arrangements can be considered if travel proves not suitable and this has been agreed.
11. A full psychotherapy assessment will be made at the first session to review the information provided by the DCMH and to establish the required treatment modality to be delivered. The completion of OPS minimum data set (GAD-7/PHQ-9 and WASAS) should be completed at every appointment and the full measures (GAD-7/PHQ-9/WASAS/Alcohol Audit 10 and PCL-5) should be completed at the first and final sessions.
12. If a step up or step down in therapeutic intensity is indicated this case is to be undertaken at the advice of the OPS clinician. This will be organised and co-ordinated by the DCMH Service Liaison Officer and OPS clinician delivering the care.
13. Extensions beyond session 18 must be requested at no later than session 16 and must be agreed by the DCMH clinical lead. An occupational assessment will need to have completed by session 18, this should be requested no later than session 13. Extensions beyond session 24 must be requested at no later than session 21 for consideration of the DCMH Clinical Lead. Cost of extension sessions remain the same per session as the original 12. This is done in blocks of 6 up to a maximum of 30 – refer [Figure 1](#_Figure_1).

**Did not attend (DNA) and or breaks in psychotherapy**

1. Where individual attends for 1 session only and then decides that they no longer want to be part of the outpatient provision, the contractor will only charge for the 1 session and will not look to recoup the full cost. If the individual attends for 2 or more sessions and then decides to not attend anymore then the Authority will be charged for the full block of 12 or 6 sessions.
2. On occasion where the 12 sessions are not required, but more than 2 have been accessed, the ISP will invoice for 12 sessions. It is vital to ensure that the individuals being referred to the provision are appropriate and have been adequately prepared. With this assurance, there can be an assumption that the individual being referred will maximise the 12 sessions.
3. If an appointment is missed and there is not more than 48 hours’[[26]](#footnote-26) notice, then that will be counted as a missed appointment and will be counted as part of the overall 12 sessions. If the patient does not make contact prior to the appointment time, the OPS clinician will attempt to contact them to investigate and rebook. If the Contractor are unable to make contact within one hour or by 15:30 hrs (whichever is the sooner) they should contact the DCMH Clinician (not the SLO) to request follow ups. Actions are to be recorded by the OPS clinician on Annex I, for all DNAs.
4. Where the patient has two consecutive DNAs, the LSLO will inform the DCMH who will consider suitability to continue. The SLO will then ensure the patient’s SPOC arranges a case review. Where the patient has three DNAs cumulatively, the case will be raised at the next MDT (or an urgent discussion arranged as necessary) to discuss appropriateness of continued care with the OPS, other options for onward care, and risk. The SLO will advise the LSLO of the decision via the update template at [G](#_Annex_G_to_1).
5. Where there is a break in provision due to unexpected extended staff absence of an allocated OPS clinician, the provider will undertake to ensure clinical notes are sufficiently comprehensive to enable another clinician to continue psychotherapy.
6. There may be instances where for reasons outside the patient’s control, they are unable to participate in active therapy. This may be more apparent where remote consultations are being used. Where this break is expected to change the OPS, therapist will provide check-in phone calls to maintain contact and confirm patient status – these will not count towards their session count. Every fourth check-in call should be a review, the output from which will be sent to the DCMH for a review at the next available MDT to confirm the patient pathway either to be returned to the DCMH or to continue with OPS.
7. Any breaks in therapy require discussion with the DCMH on a case-by-case basis.
8. The risk associated with the individual that is referred to the OPS remains with the DCMH/primary care arrangements until they are taken onto caseload by the ISP/OPS service. Once the individual is seen by the outpatient provision the risk will be shared between the DCMH and the ISP provider. When discharged back to the DCMH, the full risk returns to the DCMH. As a minimum, the following risk management procedures will apply:
   1. If the patient is identified at moderate-high risk by the OSP clinician, they will urgently inform the DCMH Duty Clinician after ensuring that the patient is safe. The DCMH Duty Clinician will arrange crisis care and urgent follow-up at the DCMH if that is indicated.
   2. If needs be in high-risk cases, the OPS clinician, **together with the local DCMH**, will involve the local Crisis and Home Treatment Team and, in exceptional cases, a Mental Health Act assessment may be called.
   3. Safeguarding procedures in relation to children and vulnerable adults lies, as always, with the clinician who identified it, regardless of whether they work in the DCMH or OPS.
   4. The ISP/OPS clinician can contact the DCMH to request that the DCMH make a referral to the ISP contract if this is required to manage the risk. As with all inpatient referrals, consideration of whether the admission is appropriate to the ISP contract or suitable for standard NHS inpatient provision, should be made.

**Reports and Data**

1. Post sessional report (Annex [H](#_Annex_H_to_1)) will be sent to the DCMH Service Liaison Officer within 3 working days of each session (including final session). Any DNA reports (Annex G) must be completed and sent to the DCMH SLO on the day. An additional final report/discharge [Annex I](#_Annex_I_to) report will be produced and sent to the DCMH within 5 working days of the final appointment, detailing the diagnosis, treatment provided and outcome, with recommendations where appropriate.
2. A quarterly data dashboard will be prepared by the CONTRACTOR to show nationally and per DCMH (subject to review/refinement):
   1. Number of referrals made.
   2. Numbers of sessions during the quarter.
   3. Types of intervention used.
   4. Average number of sessions per individual discharged patient (definition to be refined)
   5. Conditions referred.
   6. Number of DNAs.
   7. Number of patients discharged after 1, 2 or 3-11 sessions.
   8. Separate patient satisfaction report, based on questionnaire at [Annex J](#_Annex_J_to), to be supplied quarterly.

32. Annex K has the Outpatient Admission, Discharge & Performance Data Requirements

1. All communication will be via the DCMH Service Liaison Officer and the OPS provider and all referrals and discharges via the I-MMMAC. There will, however, be instances where clinician to clinician contact e.g., DCMH Duty Clinician needs to be made aware in situations such as, but not exclusive to, increased risk or questions relating to care pathways. In these circumstances, contact should be made with the duty clinician, as attempting to make contact with the Service Liaison Officer, who may be out of office, may increase risk in these cases.
2. Details contained within this Guidance are likely to change over time. This will be managed via the Designated Officer for the contract (currently SO1 MH).

Annexes:

[Annex A](#_Annex_A_to_1) - Admission to the ISP Outpatient Psychotherapy Service (ISP OPS) Flowchart

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# **Annex A to Appendix 2**

**ADMISSION TO THE ISP Outpatient Psychotherapy Service (ISP OPS)**

**FLOW** **DIAGRAM FOR OUTPATIENT ACCESS**

The DCMH identifies potential suitable patients and discusses these at MDT or local equivalent arrangement*.*

At session 30, patient is discharged to DCMH and stepped down to Step 2/4 case management only for stabilisation, crisis support and transition arrangements

Final 25 – 30 sessions commence. Onward treatment to be discussed at MDT, patient to be updated by SLO

At session 21 Refer to DCMH Clinical Lead for a notes review for Sessions 25 - 30 to be considered

If agreed as necessary sessions 19 – 24 commence

MDT Considers patient for sessions 19 -24 if necessary

*Referred no later than session 16*

At 13-16th session patient referred to DCMH Con Psych for occupational assessment, outcome to inform MDT discussion.

*DCMH SLO must ensure that this happens in plenty of time to avoid a break in care if it is anticipated that more than 18 sessions will be needed*

If necessary, sessions 13 – 18 commence and DCMH SLO advised by OPS. SLO adds patient to MDT list for discussion for extension/discharge.

ISP OPS accepts the patient and arranges care. The DCMH provides a SPOC (SLO) that case manage all OPS patients from the DCMH to ensure fidelity of the process.

Session 1 – if patient/clinician content to continue then sessions 2-12 commence

If referral not recommended at MDT, patient managed by DCMH

If patient/clinician agree no more sessions needed following session 1 - patient managed internally by DCMH

If patient is fit for duty - discharge back to primary care

If extension not requested or is denied patient managed internally by DCMH

If extension not requested or is denied patient managed internally by DCMH

If patient does not wish to continue or treatment complete - discharge to DCMH to follow MH patient pathway

If patient does not wish to continue or treatment complete - discharge to DCMH

If patient wishes to cease treatment at any point, they will be referred back to DCMH

If referral agreed at MDT, referring DCMH clinician arranges case meeting with patient to explain process and sends referral paperwork to I-MMMAC

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1. In the majority of cases, the location is to be within 2 hours travelling time from the DCMH or Home Address. [↑](#footnote-ref-1)
2. Entitled Personnel are all Regular personnel in the Royal Navy, Army and Royal Air Force and for mobilised Reservists. The contract also provides inpatient provision for dependants and contractors from overseas. This is detailed in [*JSP 770*](http://defenceintranet.diif.r.mil.uk/libraries/library1/DINSJSPS/20150608.1/20150811-JSP%20770%20%20Final%20v11-U.pdf) and is for an initial 10 day admission only. During this admission the individual will either be stabilised and discharged back to their own GP or will be transferred to an NHS bed. [↑](#footnote-ref-2)
3. Or any equivalent UK Nation body and/or superseding or replacing body [↑](#footnote-ref-3)
4. The numbers of MCTC detainees utilising this service is estimated to be less than 5 per annum. [↑](#footnote-ref-4)
5. In cases where patient are being admitted from austere Operational locations, clinicians may not be able to provide and type written (word processed/printed) letter of referral and transmission of the referral letter may be delayed due to the theatre-based communications situation. [↑](#footnote-ref-5)
6. A member of the Reserve who is mobilised on active duty or is on a “Full Commitment” Full Time Reserve Service (FTRS) contract. For those personnel on a “Home Commitment” contract are **NOT** eligible for admission/access to this contract. [↑](#footnote-ref-6)
7. This will include those employed for locum duties or GPs providing out of hours cover through local contract arrangements. [↑](#footnote-ref-7)
8. The function of Role 4 care is defined as ‘…provides the full spectrum of definitive medical care that cannot be deployed to theatre or is too time consuming to be conducted there’. The Royal Centre for Defence Medicine (RCDM) Clinical Unit and the Defence Medical Rehabilitation Centre (DMRC) are now the Role 4 Medical Group. [↑](#footnote-ref-8)
9. The aim here is to improve continuity with regard to relations with SLO, and allow experience with MOD entitled personnel to grow. [↑](#footnote-ref-9)
10. Exceptional treatments such as ECT will be judged on a case-by-case basis and extension periods will be shaped to meet the treatment and care plan. [↑](#footnote-ref-10)
11. And other UK nation equivalents. [↑](#footnote-ref-11)
12. Or other UK nation equivalents. [↑](#footnote-ref-12)
13. Unless the individuals physical condition and or severity of dependence requires this to be exceptionally extended to 10 days. [↑](#footnote-ref-13)
14. These are emergency procedures that are to preserve life or enable diagnostic decisions to be made such as EEG, ECG or other emergency investigations. [↑](#footnote-ref-14)
15. Non Service personnel should be discharged at 10 days. [↑](#footnote-ref-15)
16. And other UK nation equivalents. [↑](#footnote-ref-16)
17. Or other nominated suitable DCMH clinician. [↑](#footnote-ref-17)
18. Multidisciplinary plan with suitable attention paid to risk management and occupational outcome. [↑](#footnote-ref-18)
19. In line with NICE Guideline 123, common mental health problems: identification and pathways to care. [↑](#footnote-ref-19)
20. Can be extended up to a maximum of 30. An additional 12 (to max of 30 sessions) can be authorised as per Fig 1. [↑](#footnote-ref-20)
21. Payments will be made in blocks of 12 or in the case of agreed extensions, blocks of 6 up to max of 30. Clinical lead authorises sessions 19 – 24, DCA authorises sessions 25 - 30. [↑](#footnote-ref-21)
22. All referrals are to be forwarded as Annex B, in the same way as a referral for an inpatient bed to the LSLO at MPFT. These referrals are to be made only after discussion at the joint MDT during working hours 0900 – 1700, Monday to Friday. The LSLO will also organise all invoices. [↑](#footnote-ref-22)
23. This should be discussed and considered at session 10 of the 12 and request made. [↑](#footnote-ref-23)
24. Extensions will be in blocks of 6 sessions. [↑](#footnote-ref-24)
25. The Service Liaison Officer will ensure that the patient’s Key Worker remains appraised. [↑](#footnote-ref-25)
26. 48 Hours or 2 working days [↑](#footnote-ref-26)