**SCHEDULE 2 OF NHS STANDARD CONTRACT – THE SERVICES**

1. **Service Specification**

**2019 /21**

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| **Service Specification No.** | V4.0 |
| **Service** | **Veterans’ Whole Criminal Justice Pathway “Pathfinder”** |
| **Commissioner Lead** | NHS England |
| **Service Provider Lead** | Nottinghamshire Healthcare NHS Foundation Trust |
| **Period** | 01/07/2019 – 30/12/2021 |
| **Date of Review** | 26/06/2019 |

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| **1. Population needs** |
| * 1. **Purpose**   The purpose of the Veterans Whole Care Pathway “Pathfinder” is to provide a whole CJS pathway service for serving and ex-serving UK (veterans) who are about to enter the Criminal Justice process or have been arrested and or convicted and sentenced to a period of imprisonment.  This service is being designed to be proactive at the first point of contact which could even be before a person is suspected of a crime. It is designed to pick up the individual and from that time onwards perform as a care co-ordination service right through to the time that person is deemed to no longer need this specialist support, typically 9 months. If the first time the veteran comes into contact is at the point of arrest the service will work alongside the NHSE commissioned Liaison and Diversion scheme to support the veteran through the criminal justice process. If the veteran is subsequently convicted at court the service will pick them up as part of a community order or follow them into prison where a mentoring service will be available to support their rehabilitation until they are released when the service will again pick them up to assist with their resettlement.  **1.2 The Needs of armed forces veterans**  Whilst the overwhelming majority of veterans make a successful transition to civilian life, a small proportion will experience problems and may have a range of vulnerabilities including drug and alcohol misuse and mental health problems. Within this group, there will be veterans who require assistance with employment, housing, socialisation or other interventions to integrate back into normal way of life, including help with family relationships and adjustment back into society.  Veterans may have experienced traumatic events as a result of military service or as a result of experiences before and after serving. Furthermore, post-traumatic stress (PTSD) for veterans is often as a result of multiple events. In addition, veterans are more likely to present with a wide range of other mental or physical health difficulties, as well as multi-trauma Post Traumatic Stress (PTS) of more severe levels than that of civilian counter parts. A Trauma informed approach to this service would be beneficial.  There are separate specialist services for those with complex mental health conditions including the Veterans’ Mental Health Transition, Intervention and Liaison Service (VMH TIL) that offers support to serving personnel approaching discharge from the military and veterans. Similar to the Veteran’s Mental Health Complex Treatment Service, the VMH TIL service focuses on those with complex needs and ensures those with less complex needs are assisted to find appropriate local services.  The presenting needs of veterans have been comprehensively studied and the findings indicate the most common mental health problems in them include:   * Adjustment disorders * Alcohol misuse * Anxiety / panic disorders * Depressive disorders * Personality disorders * Post-traumatic stress disorder * Substance misuse   The review of the pathway also identifies that veterans experience higher levels of social and welfare problems that should be addressed. Addressing these factors has proved to be effective in reducing the need for some treatments and improving the effect of others. Important social and welfare areas include:   * Employment * Finances * Housing * Relationships   The military culture and needs of the armed forces frequently require serving personnel to demonstrate a strong ‘can do’ and ‘get on with it’ attitude. This attitude, along with the stigma towards seeking help for example with mental health, prevalence of a traditional masculine culture and individual pride, can increase the barriers to veterans seeking early help. This could include a lack of confidence in traditional services e.g. primary care services. This can also result in veterans presenting frequently at a point of crisis in their lives. |
| **2. Outcomes** |
| **2.1 NHS Outcomes Framework**  The provision of good holistic support including early identification of crisis will deliver improved outcomes across all five domains.  Table 1   |  |  |  | | --- | --- | --- | | Domain 1 | Preventing people from dying prematurely | x | | Domain 2 | Enhancing the quality of life for people with long term conditions | x | | Domain 3 | Helping people to recover from episodes of ill health following injury | x | | Domain 4 | Ensuring people have a positive experience of care | x | | Domain 5 | Treating and caring for people in a safe environment and protecting them from avoidable harm | x |   **2.2 Outcomes for armed forces veterans**  Agreed service user outcomes will not only show a general effectiveness of engagement with services but include indicators that demonstrate not only symptom reduction but also those indicators that focus on a wider social, mental health and wellbeing perspective.  **2.2.1 Health and wellbeing**  Improved patient experiences are required and each service user who is managed within the service will have a co-produced person-centred co-ordination and care plan addressing health, wellbeing and social functioning.  Access to a co-produced care plan will indicate the actions the service user/carer/family and other providers will take to help prevent relapse and reoffending.  Access to a co-produced contingency plan will indicate the actions agencies and organisations that are supporting veterans will take to help prevent relapse and reoffending and maintain support engagement.  Where appropriate, and with the right consent, family and carers can be included in planning and assessing the needs and objectives with the veteran.  **2.2.2 Experience**  All joint providers will co-ordinate the care and collate nationally required patient experience information to inform service and quality improvements. Indicators as agreed with NHS England Health & Justice team will cover the following aspects:   * Respect for patient-centred values, preferences, and expressed needs * Coordination and integration of care * Information, communication and education/training * Physical and emotional comfort * Welcoming the involvement of family and friends * Access to timely support and interventions * Development of Peer to Peer support as part of the journey (Veteran 2 Veteran) for those untrusting of the civilian world.   Any Patient Reportable Experience Measures required in addition to those detailed in the national data set will be agreed between the commissioner and provider of the service. Agreed measures will be detailed in the Quality Schedules within the Contract.  **2.3 Service outcomes**  Full details of the service outcomes will be detailed in the contract including schedules 4 and 6.  The service should deliver:   * Increased speed of access to interventions from all locations within the agreed pathfinder footprint * Comprehensive assessments that accurately reflect personal, social and physical needs * Support for veterans to access services required to address their specific needs. * Timely access to specialised detoxification services in collaboration with local service providers. * Increasing numbers of individuals successfully engaged, mentored and referred to third party intervention provider * Improved experience reported by veterans. * Support to gain housing or employment where identified. * Co-produced crisis and contingency plans with the service user/their family and other providers. Crisis plans will detail actions the veteran and their family will undertake. The contingency plan will detail the actions providers will take to prevent relapse and maintain engagement. * Evaluation of the effectiveness of the service through systematic and comprehensive collection of pre and post treatment outcomes on 100% of patients treated which includes those where there was an intention to treat but did not complete treatment. * The use of online and digital interventions must adhere to clinical practice standards and information governance regulations. * Provision of training, expert advice and support to local services (across the different sectors).   **2.4 National Guidance**  If national guidance changes, providers will be expected to comply as required.  **2.5 Performance Reporting**  Providers will be expected to work with commissioners and other providers in the other regions to agree service user centred Key Performance Indicators.  A non-exhaustive list of key performance indicators includes metrics on:   * Total service users identified * Total number of accepted referrals * Number of appointments (Attendances) per service user broken down by intervention / professional / service provider * Total number of completed patient pathways * Percentage of first appointments kept on referral to mainstream services. * Percentage of first appointments kept on referral to voluntary and other support services. * Percentage of follow-up appointments kept. * Percentage of individuals who complete a course of treatment or are discharged by service provider. * Desistance rates between re-offending incidents. * Information sharing protocols in place. * Service user satisfaction audit. * No of Veterans leaving prison with a Mentor * Number of veterans leaving prison and found accommodation. * Number of veterans leaving prison and found employment. * Number of veterans linked into training or education   **2.6 Reporting**  Providers will be required to submit initially monthly and then quarterly reports to NHS England following an agreed format. |
| **3. Scope** |
| **3.1 Primary Objective**  The primary objective of the service is to provide a joined up, whole care pathway for veterans who have served in UK armed forces within the Criminal Justice System. This includes those on the fringes of criminal behaviour and those exiting prison having served their sentence.  This pathfinder and the national strategies that support it are for veterans who have served in UK forces. We would like to establish the likely unmet need for non-UK (foreign)  Veterans even though they are not covered by this pathfinder. Any form of help or advice provided to criminal justice agencies to refer these non-UK veterans will sit outside of this pathfinder. Mainstream services remain available to them.  The service will focus on those veterans who have any form of vulnerability that may impact on their social inclusion, social standing or criminality. For those who are already part of the CJS the objective will be to support them post CJ decision or sentence by the court. This will include mentoring and support to reintegrate into society and address such challenges as housing, employment, desistance and ultimately to contribute to reducing reoffending.  **3.2 Interventions**  The interventions must be available at any point of their criminal justice journey. That includes pre-criminal behaviour, through any policing custody or investigation process, through the courts and during or exiting any prison sentence. The intervention must be flexible and targeted to the needs of the individual taking due cognisance of any CJS process.  **3.3 Access to service**  Those veterans requiring access to the service can come from a variety of referral forms.  They could be self-referral, referral by concerned parties, friends, family, third sector bodies including charities. They can also be made by statutory bodies including police, solicitors, courts, NHS England and prisons to name a few.  Service providers are encouraged, with the appropriate consent, to include families in their support work for veterans.  **3.4 Care Coordination**  The service must provide a “Care Coordination” function. There must be an ability for all bodies working in partnership to work across a common IT platform with unique identifiers. This will support a continuity of care with relevant shared information and ensure the service user cannot be “lost in the system”.    Two of the critical functions of care coordination are:   * Establishing and sustaining a professional relationship with the veteran and significant others based on regular contact. * Coordinating, monitoring and recording assessment, planning, delivery and review of care including risks.   **3.5 Population covered**  The service is for UK Veterans (serving or ex-serving) who are vulnerable and involved, or likely to be involved, in the criminal justice system.  NHS England do not discriminate and are proud to show equity of care for all so the provider is expected to show the same considerations regardless of race, sexual orientation, disability or offending background.  Not being registered with a GP practice will not be a bar to accessing services and indeed the provider will be expected to support the veteran to hold current registration with a GP.  A veteran for the purpose of this pathfinder is classified as a person who has served in the UK armed forces for one day or more (regular or reservist). [Veteran status](https://www.gov.uk/apply-medal-or-veterans-badge) may also apply to those who have served as Merchant Navy personnel who have served in an operational theatre supporting the Royal Navy. It does not currently apply to non-UK veterans although any work to identify this unmet need would be encouraged.  For those veterans who present with higher risks there are other NHSE commissioned services that can be referred into such as the Veterans Mental Health Complex Treatment Service (CTS) Transition, Intervention and Liaison service (TILs).  These services will provide interventions in collaboration with the relevant secondary mental health provider(s). The service will therefore target resources at those who are hard to engage, exhibit poor coping styles, have poor impulse control and/or have high risk behaviours.  **3.5.1 Geographical location of services**  The Pathfinder locations have been pre-selected as Nottingham and Lincolnshire based on the skills, experience and standing of current provision and their desire and ability to work together for the benefit of the service user.  **3.5.2 Families**  Interventions which indirectly support veterans should be provided to family members where it can be shown to have a direct positive impact on help and improving outcomes of the veteran.  **3.5.3 Population not covered**  For the duration of the pathfinder this service will be restricted to Nottinghamshire and Lincolnshire with some licence to the providers where there are common sense cross-overs, such as 10 miles into adjoining Counties, including court and prison boundaries.  The provider is to encourage registration with a GP practice.  **3.5.4 Veteran Population**  It is widely recognised that the majority of service leavers do well. Those veterans who do not, may have multiple overlapping health and social problems (such as unstable housing, unemployment, violence, substance misuse and deliberate self-harm). Early Service Leavers (who served for less than four years) are more likely to do less well after leaving the service although their mental health problem is less likely to be operationally attributable.  A previous review identified that service personnel and veterans are now seeking help earlier from Defence Medial Services (DMS), NHS providers and service charities. The workload of DMS, charities and the NHS is expected to increase.  Regular serving personnel show an increased risk of alcohol misuse after deployment, but deployed reservists and regulars who have seen combat, report higher rates of probable PTSD after deployment.  The Annual population survey: UK armed forces veterans residing in Great Britain 2015 (revised October 2016), identifies that younger veterans report higher levels of depression and mental illness than older veterans.  The needs of veterans who have protected characteristics which differ from the main veteran population should always be considered. Review of existing evidence identified that: female veterans have experienced more childhood trauma and military sexual trauma than male counterparts; that Gay Lesbian Bi-Sexual and Transgender (LGBT) veterans maybe at a higher risk of suicide. Whilst the review did not identify any published evidence regarding the specific mental health needs of UK BME Veterans, services should be culturally capable and able to address the diverse needs of a multi-cultural population through effective and appropriate forms of assessment and interventions. Consequently, the commissioned service will need to adapt as further evidence is published to ensure it meets the needs of each individual.  This table illustrates historic referrals to previously NHS funded veterans’ mental health services.    **3.6 Links and Interdependencies with other services**  The best outcomes for veterans with mental health problems will occur where providers across sectors (e.g. residential care, employment services, criminal justice (Including Liaison and Diversion), health and justice services and well-being services) can work and provide services collaboratively.    Liaison with the veteran’s GP will help inform any assessment and interventions provided. If the veteran is transferred to another service or discharged from treatment, the GP must be kept informed at all times. |
| **4. Service model** |
| **4.1 Referral**  There will be many points of referral to the Pathfinder. They can be self-referrals or referrals from many other sources including but not limited to family & friends, social environments e.g. pubs, clubs, churches and statutory bodies such as police, courts, solicitors, prisons and courts.  The provider must maintain a close working relationship with NHSE commissioned Liaison and Diversions services that operate mainly from police stations and courts but will also see voluntary interview suspects in other locations  This service will need effective communication and transparent decision making processes with good record keeping processes.  **4.3 Assessment**  There should be a common assessment framework for all providers linked to the Pathfinder.  Having use of a common IT platform will ensure that this is easier to achieve.  The assessments must be carried out with consent by suitably trained and experienced workers subject to agreed recruitment standards.  **4.4 Help Seeking**  When a veteran does not attend appointments, proactive and determined efforts need to be made to assist help seeking/and engagement with interventions and treatment. There will be effective use of care coordination and workers within the team to promote help seeking with engagement and stabilisation interventions.  Where contact is lost, the service will make an individual assessment of risks and inform/escalate to the appropriate service/agency.  **4.5 Responsiveness**  The service will contact the veteran ASAP but usually within 48 hours of referral to offer an initial appointment, followed by the offer of an appointment within ten working days from receipt of the referral.  **4.6 Interventions**  The interventions with each service user will be bespoke and suitable for their unique circumstances. Each intervention must contribute to the overall aims and objectives as set out in the operating model.  **4.6.1 Delivery model**  Services must be able to provide a range of interventions to meet the needs and safety of veterans. The service will therefore provide a comprehensive range of interventions such as those referred to below:  Alcohol:  The service will provide referrals to interventions that promote less harmful drinking, and reduce alcohol as a means of self-medicating psychological difficulties.  Substance Misuse and Addictions:  The service will provide referrals to appropriate interventions to address any substance misuse and other addictions for example gambling.  Family interventions:  Subject to agreement with the service user interventions which indirectly support the veteran will be provided to spouses/family members where it has been shown to have a direct positive impact on veterans.  Where a carers’ assessment has not been completed by a service earlier in the pathway, then an assessment must be offered.  Medication:  The service will support the veteran through GP appointments to ensure they can access required prescribed medications.  Reintegration/reconnection:  Often overlooked, this third stage is essential for maintaining recovery. This should include the use of support workers, occupational therapy, employment services, secondary mainstream services and community providers.  Physical health and long term conditions:  In collaboration with the veteran, the service will ensure the patient’s GP is informed of any new or changing physical health needs so that an assessment of that need can be completed.  **4.7 Care Planning**  In collaboration with the veteran and care coordinator, the care plan will be updated.  Care plans should be developed to capture the range of interventions in a format that describes what interventions will be provided to support the veteran.  Where the service user has relocated outside of the geographical boundary of the pathfinder service and has registered with a GP practice in England in another area, the service care coordinator will be responsible for safely transferring the veteran to a new service.  **4.8 The Team**  The provision of a culturally sensitive service is an essential component. Whilst members of the team do not have to have served in the military themselves, each member of the team will have a well-informed understanding of how the military works, and the language used to secure the confidence of the veteran.  To deliver the range of interventions, a multi-professional suitably trained and supervised team will be required and include the necessary range of professionals to provide a safe and effective service.  Peer support/recovery workers will play an important role with the veteran in establishing trust, assisting and providing stabilisation and reconnection interventions.  Team members should have access to regular supervision appropriate to the demands of an individual’s caseload and identified needs.  **4.9 Training, education and knowledge**  Depending on the individual role staff will have the relevant qualifications, experience, training and competencies to deliver this service specification effectively.  Providers will need to have a robust workforce plan that can demonstrate an adequate skills base is available to fulfil the intervention requirements detailed in this specification.  Professional standards for the supervision of team members must be adhered to.  Staff will be supported to engage with continued professional development.  **4.10 Consent**  Service providers must publish, maintain and operate a consent to treatment and share information policies that are consistent with good practice and comply with the law.  All staff should follow the guidance detailed in the: [Consensus Statement on Information Sharing and Suicide Prevention.](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/271792/Consensus_statement_on_information_sharing.pdf) https://www.nspa.org.uk/wp-content/uploads/2018/05/Consensus\_statement\_on\_information\_sharing.pdf  **4.11 Communications mediums**  After initial face to face appointments, the decision to utilise IT and other electronic means of communication, for example Skype and text, can be used where assessed as being beneficial. This should be with consent and where information governance arrangements can be fulfilled.  **4.13 Hours of Service**  The service is expected to offer core office hours (agreed with the commissioner) where the provider will need to have staff available for service user interaction.  Services should be available between the hours of 8am – 8pm Mon-Friday and 8am to 2pm on Saturdays which sits outside of traditional working shift pattern of Mon-Fri 9-5. This can be reviewed when services have been established for a period of time and will only be changed with the consent of the commissioner. A message handling service outside of these hours should be utilised.  The provider should have in place working arrangements to cover staff absences, such as sickness and holidays.  Veterans will have access to information which sets out clearly how to contact the service in hours and leave messages out of core hours.  **4.14 Communications**  Providers will develop and implement a communications plan that promotes their service and its availability and enlightens potential service users for the reasons for the service, where it operates and the relationships between the veteran’s service and statutory bodies within the criminal justice system.  This should include the route that can be taken to be referred into it.  **4.15 Collaboration**  The range of interventions needed will require effective cross boundary working by providers and pull on the strengths of a variety of providers from different sectors. Collaborating partners will be able to ensure timely access to appropriate interventions including but not limited to drug and alcohol interventions. |
| **5. Applicable service standards** |
| **5.1 Service Standards**  5.2 Although the individual services and providers may have their own individual service standards the partnership should develop their own ReGroup cross service document.      **5.2 Relevant legislation guidance**  The service provider will operate according to relevant legislation and guidance, with particular reference to:  •      [Mental Health Act 1983 (amended 2007)](http://www.legislation.gov.uk/ukpga/1983/20/pdfs/ukpga_19830020_en.pdf) and [Code of Practice](https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983)  •      [Mental Capacity Act 2005](http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf)  •      [Equality Act 2010](http://www.legislation.gov.uk/ukpga/2010/15/contents)  •      [Safeguarding Adults – the role of health services](https://www.gov.uk/government/publications/safeguarding-adults-the-role-of-health-services)  •      [Care Act 2014](http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted" \t "_blank)  •      [Working Together To Safeguard Children 2015](https://www.gov.uk/government/publications/working-together-to-safeguard-children--2)   * [PREVENT Guidance](https://www.gov.uk/government/publications/prevent-duty-guidance) * [NICHE Guidance Post Traumatic Stress](https://www.nice.org.uk/guidance/cg26) * [NICHE Guidance Common Mental Health Problems](https://www.nice.org.uk/guidance/cg123/chapter/1-Guidance)   Please note that the list above is not exhaustive.    **5.3 Key Documents**  The provider must give consideration to the following key documents:   * [Next Steps on the NHS Five Year Forward View](https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/). * [Five Year Forward View for Mental Health](https://www.england.nhs.uk/mental-health/taskforce/imp/) * [Mental Health Crisis Care Concordat 2014](https://deref-mail.com/mail/client/UvlozaqJyzk/dereferrer/?redirectUrl=https%3A%2F%2Fwww.gov.uk%2Fgovernment%2Fuploads%2Fsystem%2Fuploads%2Fattachment_data%2Ffile%2F281242%2F36353_Mental_Health_Crisis_accessible.pdf) * [The Armed Forces Covenant](https://www.gov.uk/government/publications/the-armed-forces-covenant).   **5.4 Regulator**  The service providers will need to ensure that where relevant or legally required they register with the [Care Quality Commission](https://deref-mail.com/mail/client/rfHZohGBb58/dereferrer/?redirectUrl=http%3A%2F%2Fwww.cqc.org.uk%2F).   * 1. **Associated Documents** * [Annual population survey: UK armed forces veterans residing in Great Britain 2015](https://www.gov.uk/government/statistics/annual-population-survey-uk-armed-forces-veterans-residing-in-great-britain-2015) * [UK service personnel medical discharges: financial year 2015/16](https://www.gov.uk/government/statistics/uk-service-personnel-medical-discharges-financial-year-201516) * [The Mental Health of UK Armed Forces (2014)](https://www.kcl.ac.uk/kcmhr/publications/Reports/Files/mentalhealthsummary.pdf) |
| **6. Applicable quality requirements and CQUIN goals** |
| **6.1 National Requirement**  National quality requirements are detailed in the [guidance and contract documents](https://www.england.nhs.uk/nhs-standard-contract/17-18/) detailed by NHS England.  Quality reporting – TBA [input Sched 4]  Information reporting – TBA [input Sched 6]  **6.2 CQUINS**  To be agreed annually with the provider if applicable  **6.3 Data recording should include:**  Mental health data set should be recorded  **6.4 Health and social care outcomes frameworks**  The [health and social care outcomes frameworks](https://www.gov.uk/government/collections/health-and-social-care-outcomes-frameworks) are an interrelated architecture of indicators to guide the setting of quality requirements. These are mapped to suggested key performance indicators (KPIs) in [this guidance document](http://www.england.nhs.uk/wp-content/uploads/2014/12/outcms-indctrs-map.pdf).  **6.5 Feedback**  Service providers must ensure that processes are in place to regularly capture, monitor and act on feedback and experience of service users and their families and carers. It is expected that this will be reported on to demonstrate how service users’ views and those of their families and carers have helped to inform delivery of the service.  **6.6 Service Evaluation**  Service providers will work with the commissioner and their partners to support a service evaluation and respond constructively to key findings. |
| **7. Location of service provider premises** |
| **7.1 Service environments**  Services will be provided in environments which are conducive to the effective delivery of care which:   * offer confidentiality * provide support close to home (this may also be in the home following assessment, such as for those who are housebound or have prohibitive mobility issues) * have a hub and spoke model utilising a range of community settings * be accessible by public transport * can accommodate the provision of individual or where relevant group interventions * use electronic record keeping * be accessible and compliant with regulations and laws including:   + The Equalities Act   + Disability Discrimination Act * provide access to interpreters e.g. British Sign Language |