NCL Mental Health Services Strategic Review: Core offer report

September 2021

Contents

Introduction and purpose of this report

Introduction

Before the formation of the NCL CCG, services were commissioned by each of the 5 legacy CCGs in isolation, leading to **substantial variation in the way services are commissioned and delivered across NCL**. The NCL Mental Health Services Strategic Review seeks to create a **sustainable and affordable model** across NCL that **addresses inequalities, spreads good practice** and **improves outcomes** for residents.

This review brings together **stakeholders from mental health services, primary care, acute care, social care and community health services** to develop the interfaces and collaborative working across pathways. A **review of community health services** is running in parallel, with integrated workstreams.

The review comprises of four elements: understanding the **current baseline**, co-development of an **outcomes framework**, co-development of a **'core offer' for mental health services** and co-development of a **transition plan**. Subsequently, further work will take place to deliver transformation over the short to medium term.

Purpose of this report

This report contains the **outputs from the development of the core offer for mental health services.** The core offer was developed through an iterative engagement process through workshops, small working groups, one-on-ones and written feedback and input. The purpose of the report is to present the NCL-wide core offer for mental health services across Children and Young People, Young Adults, Working-Age Adults and Older People. The core offer is intended to be **aspirational** and to reflect a **consistent** offer that **any resident of NCL can expect to access**, whichever borough they reside in. For each care function of the core offer, a specification is shown that aims to describe broad criteria for **delivery of a consistent and equitable offer across NCL.** Select pen portraits have been used to **highlight example pathways through the core offer.**

Aim, objectives and scope for the community and mental health services review

Aim

The aim of the reviews is to have a **consistent and equitable core offer for our population** that is delivered at a neighborhood/PCN level based on identified local needs and that is fully integrated into the wider health and care system ensuring outcomes are optimised as well as ensuring our services are sustainable in line with our financial strategy and workforce plans.

Objectives:

- Provision of a core & consistent offer that is delivered locally based on identified needs and that addresses inequalities and inequities of access and health outcomes
- Provision of community and mental health services that optimises the delivery of care across NHS Primary, Secondary, Tertiary services and the wider system with Local Authority and Voluntary & Charitable Sector (VCS) partners and services
- Moves us closer to the national aspirations around the delivery of care Out of Hospital where clinically appropriate and ensuring it is as accessible as possible
- Ensure we deliver on national Must Dos for community and mental health services

In Scope
All **NHS funded community services** (meaning Adult and Children and Young People services delivered outside of a hospital setting and not part of an Acute Spell) delivered by both NHS Community and Acute Providers. All **NHS funded mental health services** (including Perinatal, Children and Young People, Adults and Older Adults and People with a Learning Disability).
All NHS funded community services delivered by Private and other Providers (Voluntary and Charitable Sector, etc). This includes **community services delivered by Primary Care** partners that are not part of a Primary Care Core Contract, Locally Commissioned Service/Directed Enhanced Service or similar arrangement.
The scope also includes services such as Discharge (Integrated Discharge Teams), End of Life Care, **services for people with Long Term Conditions where these are funded by the NHS** and delivered outside an acute episode of care.

Approach to development of the core offer for mental health services

Baselining work

A case for change for mental health services across NCL was developed based on:

- Baseline analysis of data
- As-is service mapping
- Stakeholder interviews

Initial design

- Aligned on population focused approach and pen portraits for initial design discussions
- Collated national requirements
- Deep dive workshops as initial input on offer including existing best practice

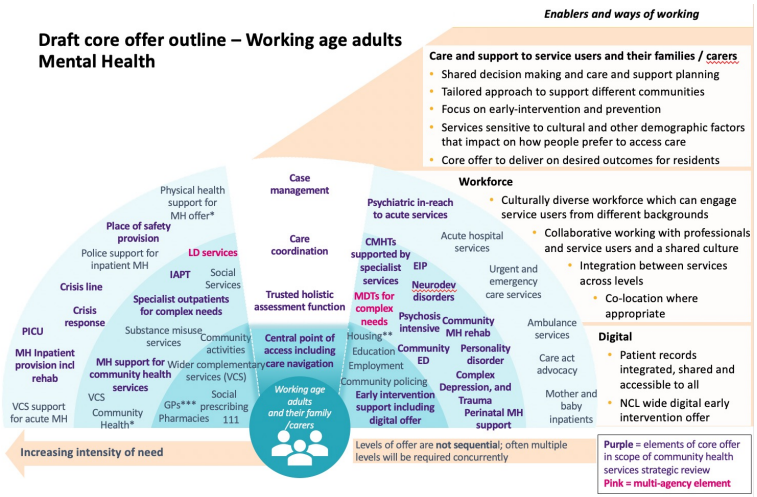
Development of the outline core offer

- Collated initial design inputs
- Developed initial draft, setting out the care functions of the core offer for different age cohorts
- Included critical links to wider services
- Design workshop 2 and 3

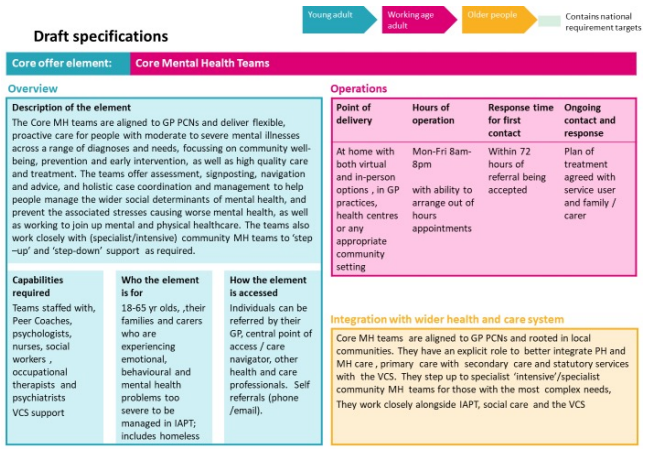
Iterated core offer and developed specifications

- Collated feedback from design workshops 2 and 3
- Iterated core offer based on feedback
- Further developed offer alongside commissioners and providers

Through this process, a core offer outline was developed for different age segments of the population and specifications were drafted for each care function of the core offer



Example core offer outline showing all services



Example specification for single service

The purpose of the core offer is to set out a commitment to the support the NCL population can expect to have access to, regardless of their borough of residence

Purpose of the core offer

The purpose of the core offer is to address the inconsistency of service provision across NCL by setting out a commitment to the NCL population of the support they can expect to have access to regardless of their borough of residence.

The core offer will provide clarity to the population, clinicians and professionals in the system on what support is available, when it is available and how to access it.

The core offer is:

- A description of care functions and services that should be available across NCL for different age segments of the population and how these care functions integrate with the wider health and care system
- In particular, the core offer provides a brief specification for each care function that describes:
  - What the care function is and what it aims to deliver
  - Operating hours and any out of hours provision
  - Response times for first contact with service user and ongoing contact (in line with national requirements)
  - Who the care function is for and how the care function is accessed
  - Links/ integration with other services and agencies
  - Workforce capabilities required
  - Point of delivery (e.g. in person, virtual)

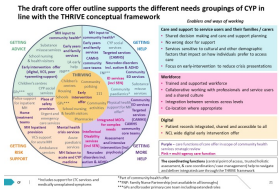
The core offer is not:

- A detailed specification for how providers should deliver care
- A description of how providers should organise workforce, facilities etc. in order to deliver the core offer

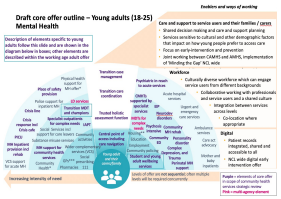
Contents

A core offer has been developed for different age segments of the population and consists of core offer outlines, coordinating functions and specifications for services

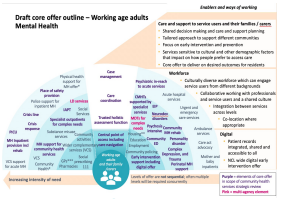
Core offer outlines provide a summary of care functions and services that are part of the core offer for the below age segments. The outlines also show complementary care functions that should be linked in with the core offer and a set of enablers.



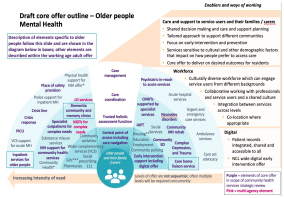
Children and young people



Young adults

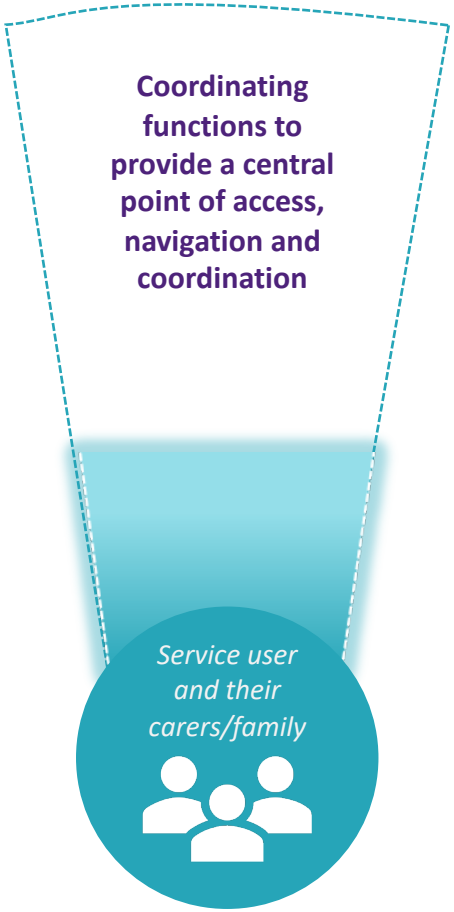


Working age adults

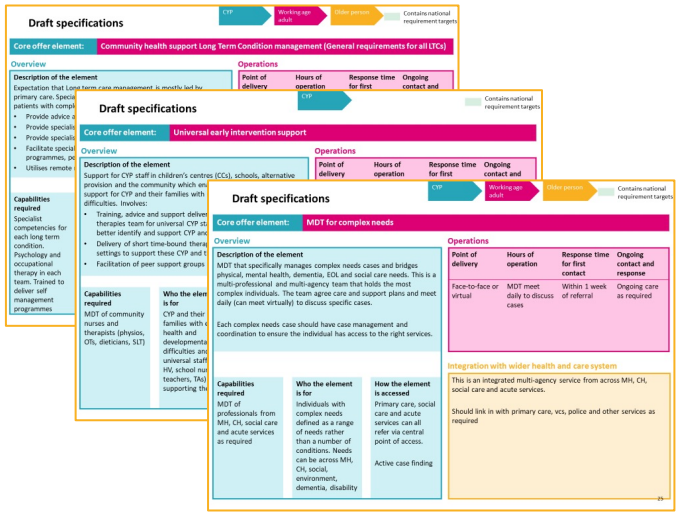


Older people

Each outline also contains a set of **coordinating functions** that are described in further detail in a following section and encompass a central point of access, care coordination and case management.



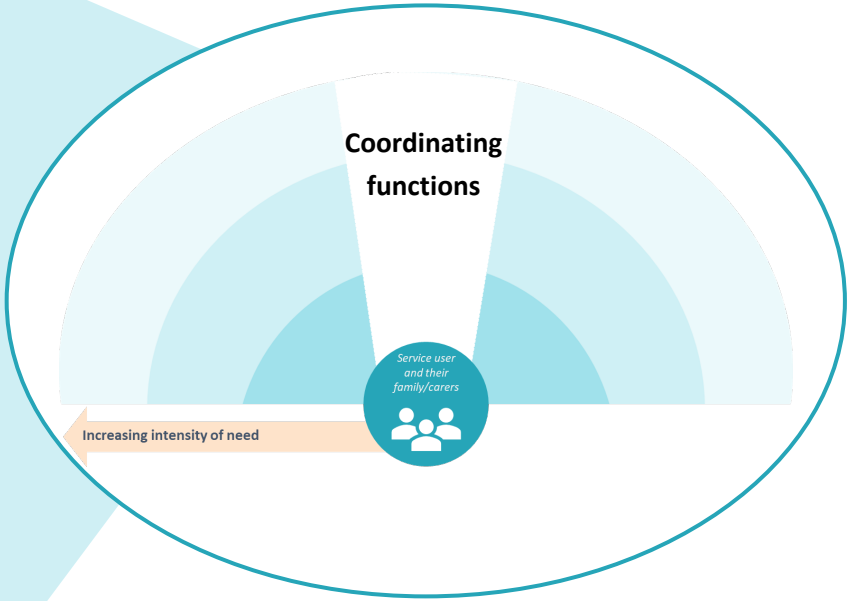
Following each core offer outline, in-scope care functions are further detailed in a set of **specifications**. These provide a description of the care function and lay out access criteria, hours of operation, capabilities required, where the care function should be delivered, waiting times and how the care function should link in with the wider health and care system.



The core offer outlines summarise the care functions that should be delivered by mental health services with the service user at the heart of the design

Core offer care functions

- Each of the core offer outlines provides a **summary of key care functions** of mental health services that should be part of a core offer for age segments of the population
- The care functions are arranged across layers with the **service user and their family / carer at the centre of the offer**
- The further away from the service user, the more intensive the need that the core offer care function provides for
- **Movement between the layers is not necessarily sequential**. Care **delivery can be fluid** and should be delivered where is best for the service user and **as close to home as possible**
- care functions of the core offer that are in scope of the mental health services strategic review are shown in **purple and bolded**. The other care functions are shown to highlight how services should be integrated across and within the layers
- A set of **coordinating functions run across the layers** helping to coordinate, integrate and navigate care for service users



Enablers and ways of working

- Alongside the core offer outlines, key enablers and ways of working are called out in three areas; care and support to service users and their families / carers, workforce and digital
- These enablers will be further examined and expanded upon through transition and implementation planning

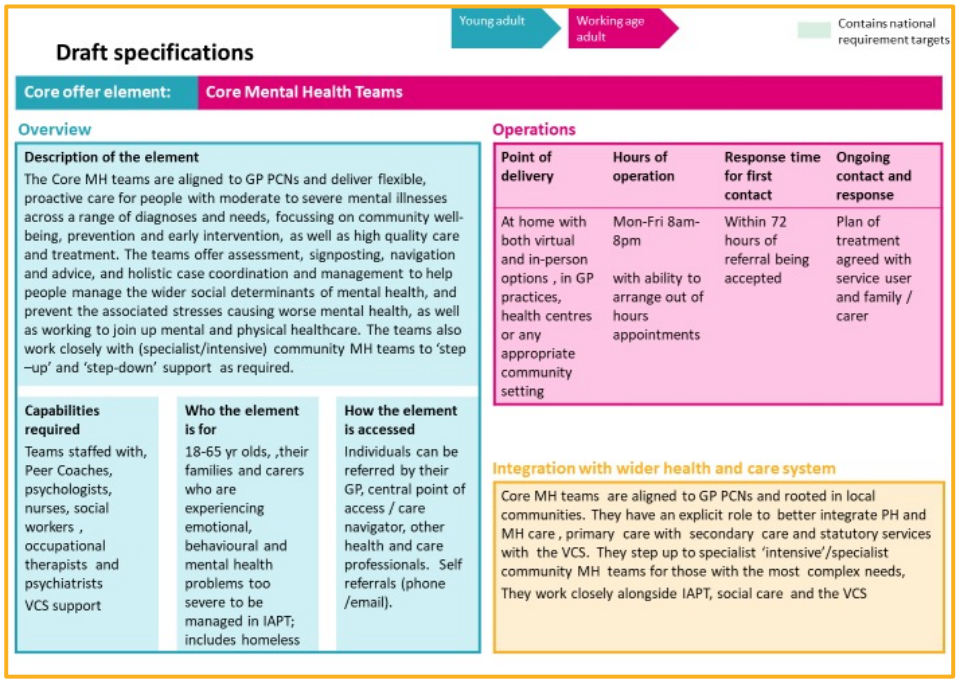
Care and support to service users and their families / carers

Workforce

Digital

Specifications for each care function of the core offer follow the outlines. A description of the coordinating functions is in a separate sectio

Specifications for each care function of the core offer provide an overview of what the care function is and the minimum requirements for its delivery NCL-wide



Draft specifications

Young adult | Working age adult | Contains national requirement targets

Core offer element: Core Mental Health Teams

Overview

Description of the element

The Core MH teams are aligned to GP PCNs and deliver flexible, proactive care for people with moderate to severe mental illnesses across a range of diagnoses and needs, focussing on community well-being, prevention and early intervention, as well as high quality care and treatment. The teams offer assessment, signposting, navigation and advice, and holistic case coordination and management to help people manage the wider social determinants of mental health, and prevent the associated stresses causing worse mental health, as well as working to join up mental and physical healthcare. The teams also work closely with (specialist/intensive) community MH teams to 'step –up' and 'step-down' support as required.

Capabilities required	Who the element is for	How the element is accessed
Teams staffed with, Peer Coaches, psychologists, nurses, social workers , occupational therapists and psychiatrists VCS support	18-65 yr olds, ,their families and carers who are experiencing emotional, behavioural and mental health problems too severe to be managed in IAPT; includes homeless	Individuals can be referred by their GP, central point of access / care navigator, other health and care professionals. Self referrals (phone /email).

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At home with both virtual and in-person options , in GP practices, health centres or any appropriate community setting	Mon-Fri 8am-8pm with ability to arrange out of hours appointments	Within 72 hours of referral being accepted	Plan of treatment agreed with service user and family / carer

Integration with wider health and care system

Core MH teams are aligned to GP PCNs and rooted in local communities. They have an explicit role to better integrate PH and MH care , primary care with secondary care and statutory services with the VCS. They step up to specialist 'intensive'/specialist community MH teams for those with the most complex needs, They work closely alongside IAPT, social care and the VCS

- The aim of the specifications is to **provide a level of consistency and equality of access across NCL**
- The specifications **do not detail how providers should deliver the service**, but rather describe minimum standard requirements around:
  - Where the care function should be delivered
  - When the care function should operate
  - Waiting times for first and ongoing contact
  - Thresholds for service user access
  - Capabilities of the workforce
  - How service users can access the care function
- The specifications also provide an overall description of the care function and how it should link in with the wider health and care system
- It should be recognised that there will **be differences in the scale of provision at a local level**, to align with variation in need at a local level and to integrate with local models of care delivery (e.g., Through PCNs), but these minimum standards described in the specifications remain consistent across NCL

Digital is a fundamental enabler to the delivery of the core offer

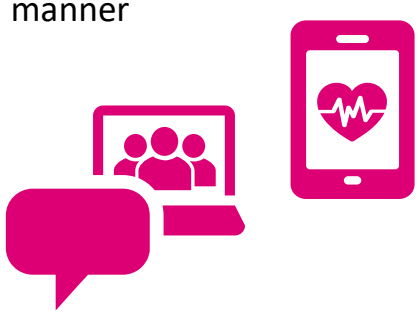
A digital element forms part of the core offer and is integrated throughout the specifications. This could include:

Digital self-help, support and advice services for service users

- NCL wide digital early intervention offer
- Advice, sign-posting, and self-help information for service users, their family / carers and other professionals
- Digital care and support planning to enable individuals to identify goals that matter to them

Virtual services and technology to help patients manage their conditions

- Option to have consultations and triage virtually, building on capabilities implemented during COVID
- Virtual MDTs and staff meetings to increase efficiency
- Technology-enabled solutions (including remote monitoring) that help patients better manage their conditions and receive support when needed in a timely manner



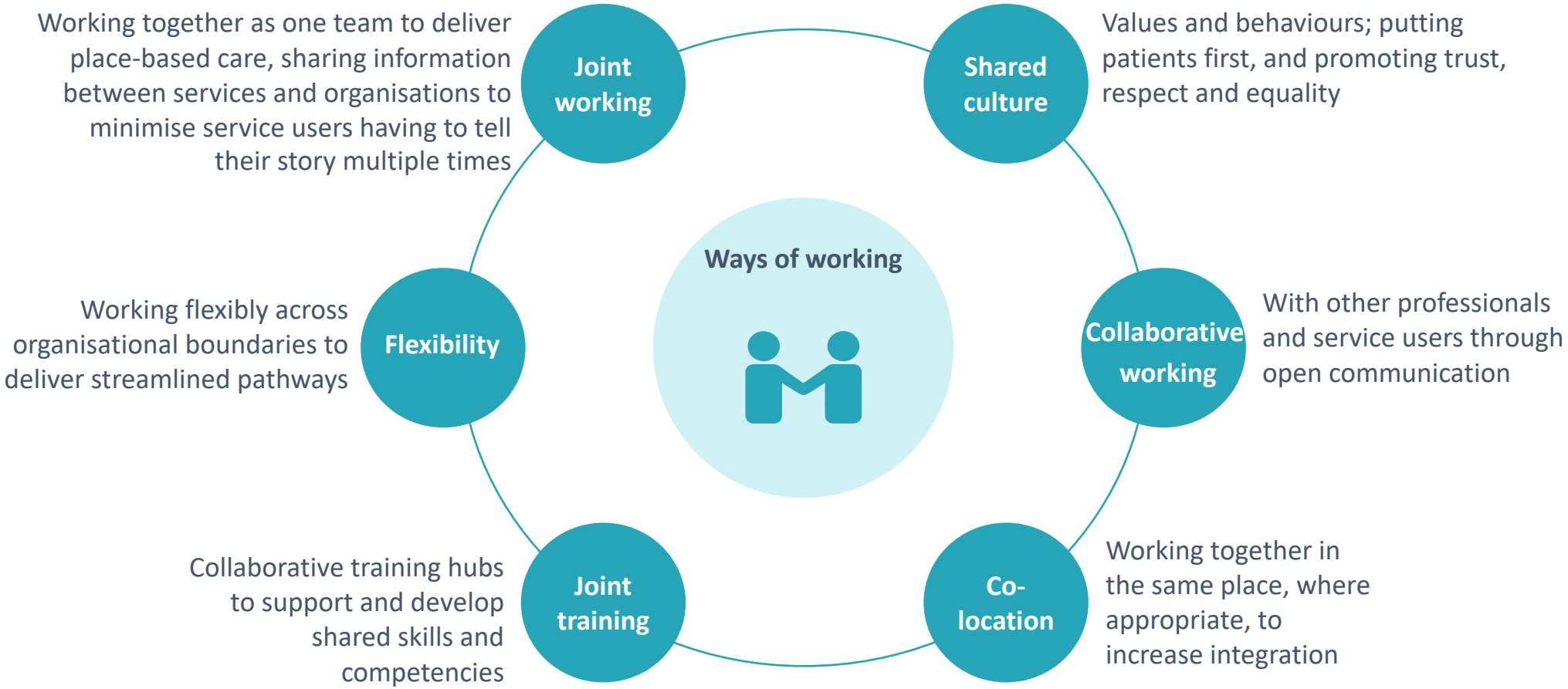
Shared care records and interoperable systems

- Patient records that are integrated, and shared between services and organisations
- Accessible to service users and the appropriate professionals in a timely manner to enable informed individual care planning
- Common structures around digital data across providers

Further work will be required at implementation planning stage to develop the plans to deliver digital transformation to support the core offer. This could be supported by the development of a digital workstream to support the Community and Mental Health Strategic Reviews.

Integrated ways of working across community health, mental health and other agencies will be central to implementation of the core offer

Workforce transformation to support delivery of the core offer could include:

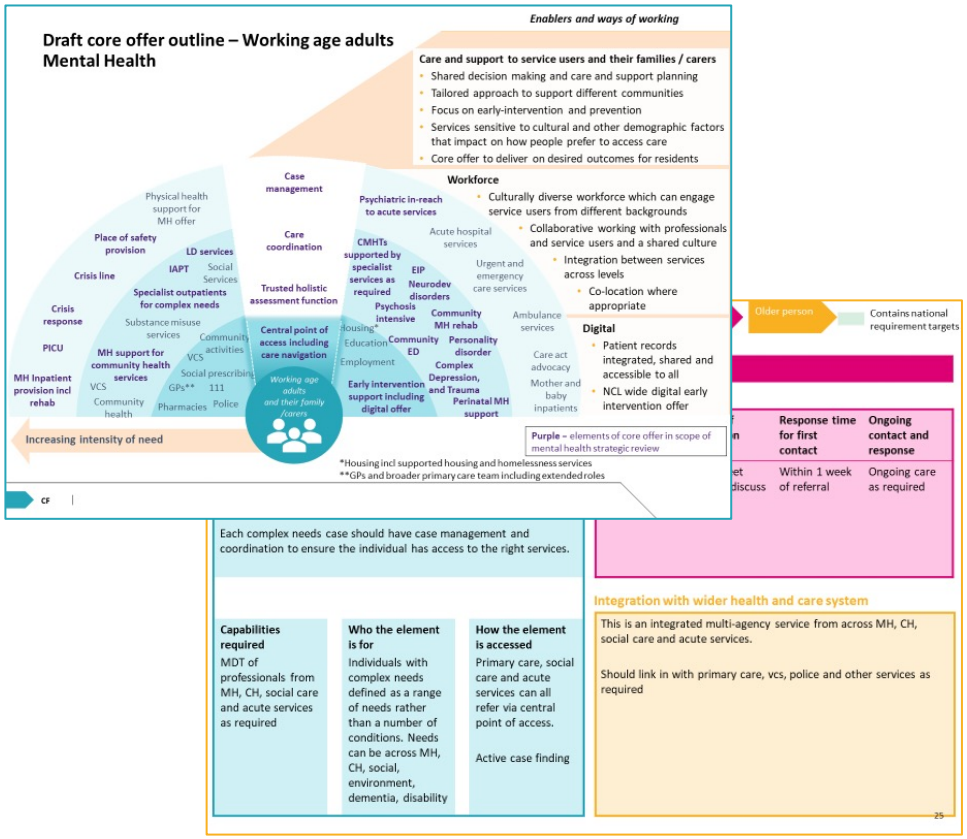


Further work will be required at implementation planning stage to develop the plans for workforce transformation to support the core offer.

The core offer is aligned to other programmes focused on transforming mental health services in NCL

- Development of the core offer for mental health services has **not been done in isolation**, with co-production with other programmes of work that are related to the mental health services transformation
- The purpose of this review is to **bring together is aspiration for NCL-wide Mental Health and Community Health Services into one place**
- This **supports ongoing areas of work** that are looking at specific aspects and services, for example:
  - Community transformation programme
  - CYP models of care
  - Crisis programme
  - IAPT
  - Mental health inpatient programme
- These and other areas of related work will be further **progressed in response to the strategic level core offer**

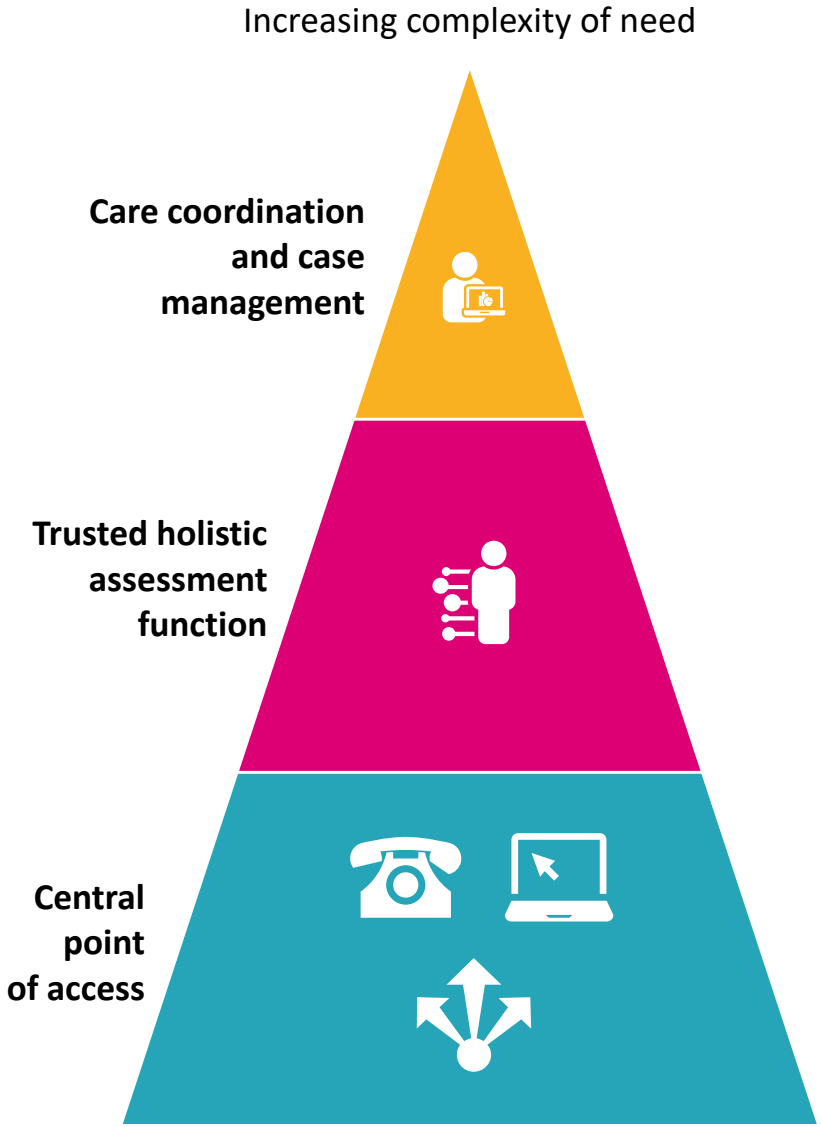
The core offer will be taken forward to feed into an impact assessment and planning for transition



- The core offer outlines, coordinating functions and specifications that have been developed are intended to be carried forward into:
  - An impact assessment which will be a comparison of the core offer against current provision across several domains including access and finance
  - A transition plan that will cover:
    - The level of delivery of different care functions of the offer i.e. PCN, place, ICS
    - Requirements for enablers to deliver at PCN, place and ICS level
    - Roadmap for transition
    - Recommendations for commissioning
- The core offer will not prescribe to providers how they should deliver against the requirements or how providers should organise themselves to deliver the offer

Contents

A set of coordinating functions act to support, integrate and navigate care for service users across the layers of the core offer



- Service users with complex needs are allocated a clinical **case manager**. This individual leads the development of a **holistic care plan and its delivery**
- Care coordinators support this through **organising MDT meetings** and supporting service users and their families and carers to **navigate health and care appointments**

- Service users have **a single up front holistic assessment of their health needs, functioning, living environment & preferences**
- This is conducted by a senior professional with trusted assessor competencies who has the trust of the full MDT
- Service users and their families and carers **only have to tell their story once**

- Central point of contact at borough or NCL level for initial referrals and contacts with local community and MH health services
- Provides telephone and/or email hub which **directs referrals or queries to the right individual or service**
- Accessed by any health/care professionals, by service users and families / carers
- Administrators have access to directory of local services and assets and are able to **help service users and professionals navigate the wider available support**

Further detail around the coordinating functions

Function	Access	Purpose	Components	Capabilities	Care functions supported
Central point of access (including care navigation)	Health and care professionals referring patients to mental health services or seeking advice and guidance Service users and their carers and families self referring	Acts as a single point of contact at a borough or NCL level for initial referrals and contacts with local mental health services The main purpose of the central point of access is to move people seamlessly through services Services also have the ability to move service users to another service (e.g. where a service identifies a patient need that can be covered by another core offer care function)	Telephone and/or email hub which can direct referrals or queries to the right individual or service. Borough level Care navigators help people making contact to understand what MH and community health services and wider health and care and VCS services are available and would be most appropriate	Administrators with clear standard operating procedures Non-clinical care navigators who have a directory of services and excellent working knowledge of available services and assets within the borough. Central point of access needs to be the most responsive with the ability to provide crisis assessment and request crisis response (if required) in a timely manner.	All care functions of mental health offer

Further detail around the coordinating functions

Function	Access	Purpose	Components	Capabilities	Care functions supported
Trusted holistic assessment function	Service users with complex health and care needs	Ensure that service users with complex health and care needs can have a single up front assessment of their health and care needs to enable an initial holistic care plan to be co-developed. Ensures that service users and their families and carers don't have to keep telling the same story	Senior professionals within mental health services working with service users with complex needs are able to deliver holistic assessments which are trusted by professionals from other services Important to note that subsequent assessments likely to be necessary to refine diagnosis and/or support further development of treatment plans	Capability to assess the different health and care needs of service users and for this assessment to be trusted by other members of the MDT involved in the service user's care	Management of service users with complex health and care needs

Further detail around the coordinating functions

Function	Access	Purpose	Components	Capabilities	Care functions supported
Care coordination	Service users with complex health and care needs who require the support of multiple mental health services	Ensure that the multiple services and individuals involved in the care of a service user with complex needs are aware of what each are doing and are able to deliver holistic joined up care	Support the administration of MDT meetings and discussions Support service users and their families and carers to navigate appointments and to understand the role of each	Administrators who are able to support both service users and their families and liaise with different professional stakeholders	MDTs for service users with complex needs
Case management	Service users with complex health and care needs who require the support of multiple mental health services	Support service users with complex health and care needs to have joined up holistic care	Lead the co-development of holistic care plans for service users with health and care needs Accountable for ensuring that different services and professionals are supporting the delivery of this plan	Senior health of care professional who is allocated to patients. Can be from any professional health and care background but must be able to provide trusted holistic assessments	Service users with complex health and care needs

Contents

CYP

The draft core offer outline supports the different needs groupings of CYP in line with the THRIVE conceptual framework

Enablers and ways of working

Care and support to service users and their families / carers

- Shared decision making and care and support planning
- No wrong door for support
- Services sensitive to cultural and other demographic factors that impact on how individuals prefer to access care
- Focus on early-intervention to reduce crisis presentations

Workforce

- Trained and supported workforce
- Collaborative working with professionals and service users and a shared culture
- Integration between services across levels
- Co-location where appropriate

Digital

- Patient records integrated, shared and accessible to all
- NCL wide digital early intervention offer

Purple = care functions of core offer in scope of community health services strategic review
Pink = multi-agency care function

The coordinating functions (central point of access, trusted holistic assessment, & care coordination / case management) help to navigate and deliver integrated care through the THRIVE framework

^Includes support for LTC services and medically unexplained symptoms

*Part of community health offer
**FNP: Family Nurse Partnership (not available in all boroughs)
***GPs and broader primary care team including extended roles

The principles of the THRIVE framework should be applied throughout the implementation of the CYP core offer

1. **Common language:** using the five needs-based groupings across NCL (thriving, getting advice and sign posting, getting help, getting more help, getting risk support)
2. **Needs-led:** approach led by meeting need rather than diagnosis or severity. Being explicit about the plan of care and everyone's role within the plan
3. **Shared decision making:** this process is core to giving young people, children and their parents a voice and empowering them to take part in their care decisions.
4. **Partnership Working: e**ffective cross-sector working, with shared responsibility, accountability and mutual respect based on the five needs-based groupings
5. **Proactive Prevention and Promotion:** helping to enable the whole community to support mental health and wellbeing. Proactively working with the most vulnerable groups.
6. **Outcome-Informed:** Clarity and transparency from outset about children and young people's goals, measurement of progress movement and action plans
7. **Reducing Stigma:** Ensuring mental health and wellbeing is everyone's business
8. **Accessibility:** advice, help and risk support available in a timely way for the child, young person or family, where they are and in their community.

Source: http://implementingthrive.org/about-us/i-thrive-principles/

Contains national requirement targets

Draft specifications

Core offer care function: **CYP Early intervention and prevention offer**

Overview

Description of the care function

A locally tailored but consistent approach to 'Getting Advice and 'Getting Help' that uses community-based services including VCS, schools, Children's Centres and youth centres to identify and address need early and prevent MH concerns escalating. The model includes:

- Online counselling and peer support
- Advice and support for parents and self-help resources for CYP
- Mental health in Schools Teams supporting whole school approaches
- A 'universal offer' of training and support for health, education and care staff
- VCS and LA provided community based emotional health and wellbeing programmes including those incorporating arts, sports etc.
- Personalised approaches such as personal budgets, social prescribing etc.
- A CAMHS liaison and in-reach function into every school
- Tailored ways to address inequalities including those related to deprivation, ethnicity, gender, sexuality, disability and any other factor

Capabilities required

Digital offer. MH in schools team. VCS and LA wellbeing progs. CAMHS and MH (VCS and NHS), psychologists, psychiatrists, family therapists, child psychotherapists. Peer workers.

Who the care function is for

All CYP. Support for CYP and their families with early emotional and behavioural concerns

How the function is accessed

Self referral where appropriate. Through MH in school teams, school and social workers, primary care. Through central point of access

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Schools (inc alt provision), children's centres, community, online	24/7 for online; 9am-5pm for range of offer with some out of hours provision where appropriate	Immediate access to some support; up to four weeks for 1-1 counselling or other support	As required

Integration with wider health and care system

- Offered through a network of integrated health, education and care services. Offer ensures that all professionals working with CYP and their families with early mental health difficulties are able to identify and support these CYP and are able to support them to access effective early mental health support
- The care functions of the early intervention offer are all linked in with the CAMHS core community mental health teams so that if CYP need getting help or more help support this can be promptly accessed
- Key interdependency with safeguarding and social care.
- Services will be integrated with community services for CYP such as SALT, OT, social workers, school councillors, health visiting, public health.

CYP

Contains national requirement targets

Draft specifications

Core offer care function: **CAMHS community core teams**

Overview

Description of the care function

Holistic assessment of referred CYP with emotional and behavioural difficulties and co-development of plan based on THRIVE principles and following NICE guidance (QS48) & QNCC standards

- Intake, clinical assessment and triage undertaken quickly to identify needs early
- Advice, guidance and support for CYP, their families and other professionals working with CYP.
- Delivery of a range of best practice therapeutic and psychiatric interventions focused on achieving individualised outcomes for the child and family
- Participation in range of MDTs regarding how to support child and family and identify and manage risks and/or concerns.
- Integrated with schools and other settings where possible
- Step down and step up where needed from/to crisis services

Capabilities required

Teams staffed with psychologists, psychiatrists, family therapists, child psychotherapists, social workers, nursing, SLT and/or OT, CYP IAPT trainees. Peer workers.

Who the care function is for

CYP (up to 18 years), their families, parents and carers who are experiencing emotional, behavioural and mental health problems.

How the function is accessed

Individuals can be referred by GP, mental health in schools team, social workers and any other professional via central point of access. Also accepts self referrals

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinic setting in person and virtual delivery. Home and school based visits as required	40 hour week with provision of some evening and weekend sessions Out of hours provided by crisis team	Severe depression + high risk suicide = 24 hr Severe depression + low risk suicide = 2 weeks *(NICE QS48)* Routine referral: within 4 weeks *(LTP goal)*	Plan of care agreed with child and family / carer Urgent; 7day follow up Routine: max 6 week follow up *(NICE QS48).*

Integration with wider health and care system

- Part of a network of integrated health, education and care services. Teams must provide support to early intervention offer, primary care and complex care MDTs. Must link up with other CAMHS teams including Mental health in schools teams as well as schools, LA social care, Early Help, youth, youth offending, VCS providers and others.
- Key interdependency with safeguarding and social care.
- Services will be integrated with community services for CYP such as SALT, OT, school councillors, health visiting, public health.

Contains national requirement targets

Draft specifications

Core offer care function: **Targeted Services**

Overview

Description of the care function

CAMHs provide integrated support into CYP LAC, social care, Youth, youth offending and Early Help teams. CYP receive holistic assessments in conjunction with the care practitioners and plans are co-developed in line with THRIVE principles.

- CYP and their families are provided with therapeutic time bound multiagency and multidisciplinary interventions
- CAMHS contribute to the planning and implementation of risk reduction and management interventions

To include the development of integrated social care, Early Help and CYP MH intake assessment and triage models that identify the most appropriate NHS or VCS services, teams or preventative interventions to support CYP.

Capabilities required

Teams staffed with psychologists, family therapists, child psychotherapists, nurses, social workers and child and adolescent psychiatrists, CYP IAPT trainees. MHST, peer workers

Who the care function is for

CYP and their families with mental health difficulties under the care of social care and/or YOT and/or subject to a care plan.

How the function is accessed

Locality LA teams are able to access support directly and promptly via integrated support

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Locality community settings, families homes, schools and virtually	40 hour week with provision of some evening and weekend sessions	Bespoke to the needs of the child (4 weeks routine)	As required

Integration with wider health and care system

Team links with core community CAMHS teams, specialist teams and crisis provision. Out of hours crisis plans must be readily accessible to social care, CYP, families and the CAMHs crisis team.

Ensuring consistency of provision especially for LAC who may move between boroughs.

Team contributes to Team around Child meetings, complex care MDTs and other network meetings.

Key interdependency with Local Authority provision.

CYP

Contains national requirement targets

Draft specifications

Core offer care function: **CYP community, intensive home and inpatient eating disorder service**

Overview

Description of the care function

Provides holistic assessment and co-production of care plans for CYP and families following NICE guidance (NG69):

Community – early identification and support:

- Specialist trained staff embedded within community CAMHS teams
- Provide advice, interventions for ARFID etc and other complex EDs
- Support and training to other MH and wider community services
- Liaison and MDT care planning for lower risk YP, with EDIS, acutes, primary care and others

EDIS – supporting YP with higher levels of need, helping avoid admissions

- Individualised approach bespoke to family delivered by an MDT in home, hospital or clinic as appropriate
- Includes MDT support for day or short-term acute admissions
- Step down from inpatient units
- Network co-ordination, liaison, risk identification and management

Inpatient units – intensive inpatient work built on evidence-based practice

Capabilities required

MDT able to deliver specialist ED interventions; psychiatrists, psychologists, nurses, dietetics, paediatrics, psychological therapists and peer workers

Who the care function is for

CYP aged 17 or under who have a suspected or confirmed eating disorder diagnosis. Service also open for advice, consultation and support

How the function is accessed

Individuals can be referred through their GP, central point of access / care navigator, school, college, other health professionals.

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Informed by initial assessment. Community clinic, in schools, At home with both virtual and in-person options	EDIS 7 days a week 8am to 8pm Community delivery 40 hour week.	*LTP target*: urgent within 1 week and routine within 4 weeks. *NCL target* for urgent : within 5 days and emergencies within 24 hrs	Bespoke plan of care agreed with child and family / carer. *Follow NICE guidance NG69 for follow-up therapy (full details in appendix)*

Integration with wider health and care system

Part of a network of integrated health, education and care services: MDT from ED service should link with GP, any MDT for complex needs children, CYP specialist learning disability, autism and ADHD pathways, social care, schools and school nursing, A+E and acute wards, community paediatrics, MH inpatient care and community mental health teams, acute inpatient, Crisis services

Key interdependency with safeguarding and social care.

CYP

Contains national requirement targets

Draft specifications

Core offer care function: **Early years service and family services**

Overview

Description of the care function

NHS and voluntary sector teams working with children's centres, health visitors, nurseries, midwifery, perinatal mental health and other local services to carry out child and whole family assessments and co-develop intervention plans across the THRIVE framework and following NICE guidelines (PH40, PH12, PH20, QS128, QS31) include:

- Providing training and support to families and professionals including health visiting, parent infant psychotherapy and other Early Years teams around children's emotional and behavioural development and family relationship issues.
- Advice, liaison and training for assessment, triage and delivery of interventions for families needing additional support and provision of family drop-ins
- Contribute to MDT planning across CAMHS, LA services, Primary and secondary care, perinatal and adult mental health services

Capabilities required

Specialist child psychiatrists / psychiatric nurses, family therapists, psychologists, psychotherapists and other CAMHS and adult MH clinicians, parent peer workers

Who the care function is for

Children under 5 years where there is concern about attachment or behaviour or emotional development or family emotional wellbeing or MH

How the function is accessed

Referral can be through GP, midwife, health visitor, early years setting or other services working with the family.

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
In community setting, at home, in a children's centre or virtually	40 hour week with provision of some evening and weekend sessions	Triage within 24 hrs. Urgent; 7day follow up Routine: 6 week follow up.	Follow up 2 weeks after initial appointment

Integration with wider health and care system

Part of a network of integrated health, education and care services: Early years and family services integrated at locality level with early years settings, midwives, health visitors, CAMHS teams, child social services, perinatal services and PCNs primary care practitioners.

CYP and young adult

Contains national requirement targets

Draft specifications

Core offer care function: **Adolescent assessment and intensive interventions including psychosis**

Overview

Description of the care function

Intensive support services operating across the 'Getting More Help' and 'Risk Support' THRIVE domains. For young people and families, aged 11–18, who need extra support to help manage complex and severe mental health presentations. Should follow NICE guidelines (CG155, QS102) and include:

- In reach into secondary care to facilitate discharge to the community
- In reach into inpatient bed management function (Tier 4) to facilitate early discharge
- MDT care planning with Community, Liaison, other specialist MH teams and social care to support admissions avoidance
- Intensive short to medium term interventions for complex and severe MH presentations with high levels of risk.
- EIS model for psychosis – delivered either through standalone EIS teams or through AOTs.

Capabilities required

Child and and adolescent psychologists and psychiatrists, psychotherapy, mental health nursing and family therapy , youth peer workers

Who the care function is for

CYP (11-18) presenting with a range of severe MH concerns eg Psychosis, Bipolar disorder, severe Depression etc

How the function is accessed

In A+E and on hospital wards, referrals from other CAMHS teams, social care, youth services, primary care

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
In A+E, acute hospital wards, inpatient bed management function (Tier 4), community	40 hour week including some evening and weekend sessions	2 weeks (*NICE CG155, QS102)*	Bespoke to needs of the individual

Integration with wider health and care system

Part of a network of integrated health, education and care services: Link with A+E, acute physical health wards, community MH teams inpatient mental health wards, bed management systems, crisis and home treatment teams and primary care, social care, schools and colleges, youth services, youth offending services. Will also need to link with police and place of safety.

Key interdependency with physical health services through PCN Primary Care Practitioners and Community Services.

Contains national requirement targets

Draft specifications

Core offer care function: CYP specialist intellectual disability, autism and ADHD pathways

Overview

Description of the care function

Provision of specialist services to support CYP with intellecutual disabilities, and their families/carers in line with NICE guidance (QS142 and QS51). An MDT of psychologists, psychiatrists, ID nurses, SLT, physios, occupational therapists, dieticians and social workers provide:

- Help, support and advice to families/carers and professionals
- Co-production of care plans and developing services
- Assessment and care management
- Multi-disciplinary neurodevelopmental and/or cognitive assessments including through Child Development Teams for early years
- Liaison and joint working/integration with school, SEND and CYP Disability Social Care teams as well as community health services
- Pre and post diagnostic parenting and psychoeducational support
- Bespoke needs-led psychiatry, psychology, psychotherapy and family therapy
- Challenging behaviour support including Positive Behaviour Support models
- Keyworking and co-ordination function, including MHA care coordination
- Admissions and residential placement avoidance MDT planning eg CETRS
- Therapeutic and Physical health support including postural management
- Dietician support and support for PEG feeding
- Transitions planning with adults' services, including period of transition between services to ensure information is fully handed over

Capabilities required

Integrated teams; psychologists, family therapists, child psychotherapists, social workers and child and adolescent psychiatrists, CYP IAPT trainees, nurse, community paediatrician, SLT, OT, Physio, dietician, health lead for mental capacity. Peer workers.

Who the care function is for

Children, young people (up to 25 years), their families, parents and carers who are have suspected or diagnosed neurodevelopmental concerns and/or intellectual disability concerns.

How the function is accessed

CYP referred via central point of access and also from core CYP mental health teams who ask for specialist opinion and input. GPs, school staff, other MH teams, social care

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinic setting in person and virtual delivery. Home and school based visits as required	40 hour week including some evening and weekend sessions	Within 4 weeks for intellectual disability Within 3 months for autism diagnostic assessment *(NICE QS51)*	Plan of care agreed with child and family / carer Annual health check including review of MH *(NICE QS142)*

Integration with wider health and care system

Part of a network of integrated health, education and care services: Work in an integrated model with CYP community core physical and mental health teams, CYP Disability Services, any MDT for complex needs children, schools, colleges, social care, youth workers, community paediatrics, and MH inpatient care as well as any other specialist MH teams (e.g. CYP eating disorders) and the VCS. Work with primary care specifically regarding regular medication reviews e.g. for ADHD. Integrated with Child Development Teams for early years. Primary care liaison within CYP intellectual disability team to coordinate annual health checks for 14-18 year olds and subsequent health action planning

CYP | Working age adult | Older person | Contains national requirement targets

Draft specifications

Core offer care function: **Integrated MDT for complex needs**

Overview

Description of the care function

MDT that specifically manages complex needs cases and bridges physical, mental health, learning and intellectual disabilities and social care needs over the life span. This is a multi-professional and multi-agency team that holds the most complex individuals. The team agree care and support plans and meet daily (can meet virtually) to discuss specific cases.

Each complex needs case should have case management and coordination to ensure the individual has access to the right services, including education and employment support.

Capabilities required

MDT of professionals from MH, CH, social care and acute services as required

Who the care function is for

Individuals with complex needs defined as a range of needs rather than a number of conditions. Needs can be across MH, CH, social, environment, dementia, disability

How the function is accessed

Primary care, social care and acute services can all refer via central point of access.

Active case finding

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Face-to-face or virtual	MDT meet daily to discuss cases	Within 1 week of referral	Ongoing care as required

Integration with wider health and care system

- This is an integrated multi-agency service from across MH, CH, social care and acute services.
- Should link in with primary care, vcs, police and other services as required
- Key interdependency with physical health services through PCN Primary Care Practitioners and Community Services.
- Key interdependency with safeguarding and social care.

CYP and young adult

Contains national requirement targets

Draft specifications

Core offer care function: CYP mental health crisis services

Overview

Description of the care function

Provides in and out of hours advice, support and short term interventions to CYP and their families presenting in MH crisis.

Crisis line: 24/7 telephone support. Urgent mental health helplines for people of all ages provided across NCL. Able to triage mental health calls and navigate callers and their families to the right source of support.

Crisis hubs: Crisis support delivered by a flexible workforce most suited to the need of the presentation: Staff navigate young people's needs and link with local services and/or offer intensive support if required, delivering immediate risk management for CYP in MH crisis

OOH NCL Crisis Service: In and outreach crisis input to acute and CS, including face to face assessments and short term interventions in A&Es and hubs.

Psychiatry OOH: Psychiatry on call provision

Capabilities required

Teams staffed with psychologists, family therapists, psychotherapists and psychiatrists, nurses, social workers, CYP IAPT trainees, specialist crisis enabled including trauma and DBT, peer workers

Who the care function is for

CYP in crisis up to age 18 yrs and support for families, carers and support for professionals

How the function is accessed

Crisis line – Self / parent / carer/ friend referral

Others - Referral from crisis line, A+E, liaison service.

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Where CYP present - Hospital, hubs, face-to-face and virtual and telephone support. Education, social care setting	Crisis line: 24 / 7 (*LTP)* Crisis hubs: 9am-12am 7 days a week OOH Crisis 24/7 OOH Psychiatry: 24/7	1 hr emergency 4 hrs urgent 24 hrs routine (crisis response)	Assessment, risk management and care planning and liaison with other services within 1 week, ongoing crisis line support

Integration with wider health and care system

Part of a network of integrated health, education and care services: Service should link with GP, any MDT for complex needs, social care including accommodation providers, A+E and hospital, community nursing teams, inpatient bed management function (Tier 4), MH inpatient care and community mental health teams, education, police, youth services and other youth specialist teams.

Crisis response links directly to psychiatric in-reach.

Key interdependency with physical health services through PCN Primary Care Practitioners and Community Services.

Key interdependent with safeguarding and social care.

CYP and young adult

Contains national requirement targets

Draft specifications

Core offer care function: **Multidisciplinary mental health liaison to acute A+E and CYP medicine**

Overview

Description of the care function

Timely multidisciplinary mental health assessment for CYP presenting to A+E, on acute wards & paediatric clinics with various mental health and psychosocial presentations, both primary acute mental health disorders and psychological, emotional and behavioural difficulties associated with physical health. Includes mental health liaison and/or community mental health team assessments to support facilitation of timely acute discharges and ongoing paediatric care (Examples include support for parents of medically unwell neonates, care of those with life-limiting conditions or complex medically unexplained symptoms). Mental health input also built into CYP community health multidisciplinary Long term condition teams (e.g. weight management, diabetes and epilepsy)

Capabilities required

Psychologists, psychiatrists, psychotherapists, mental health nurses, family therapists, play specialists/activity coordinators, occupational therapists, social workers, peer workers

Who the care function is for

CYP mental health presentations in A+E, on wards and out-patient clinics in each acute site

How the function is accessed

Available for telephone advice /support and in-person assessments, care planning and treatment in A+E, on wards, day care and out-patient clinics.

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
In A+E, acute hospital wards, MDT discussions, community bedded rehab, out-patient clinics	24 / 7 for emergency & urgent presentations. 9-5 Mon-Fri for non-urgent.	According to national NHSE target for liaison care – 1 hr response to emergency referrals and 24 hr response to urgent inpatient ward referrals	Up to twice daily review as required with 2hr response for escalations. Weekly – monthly for non-urgent.

Integration with wider health and care system

Part of a network of integrated health, education and care services. Multidisciplinary mental health input (in-reach or 'in-house') should link with A+E, acute physical health wards, inpatient mental health wards, crisis and home treatment teams, paediatric clinics and primary care. Will also need to link with police, social care teams and place of safety.

Mental Health Liaison teams should link directly to crisis response teams, paediatric teams, community CAMHS & primary care.

CYP and young adult

Contains national requirement targets

Draft specifications

Core offer care function: **CYP MH Home treatment and Inpatient provision**

Overview

Description of the care function

Home Treatment Teams: Aimed at supporting CYP with severe mental illness otherwise requiring inpatient admission, in their homes. Provides home-based intensive 1:1 support. Includes in reach to inpatient bed management function (Tier 4) to facilitate early discharge. To minimise hospital admissions and shorten length of stay, keeping families together wherever possible. To include specialist treatment such as DBT and MBT.

Inpatient: Short and medium care for voluntary and MHA CYP admissions. Provision of safety and 24/7 therapeutic support, linking with community care planning. A detailed care plan and assessment are co-produced with the service user and their family / carers. Physical health needs of CYP are also managed with support of physical health in-reach provision

Capabilities required

The team includes psychiatrists, nurses, health care assistants, occupational therapists, psychologists, social workers, peer workers

Who the care function is for

Mental health patients with crises requiring informal or MHA admissions

How the function is accessed

Home Treatment Teams: Via referral from other CAMHS teams or inpatient units

Inpatient: Either voluntary or MHA admissions

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Homes (plus some other clinic or non-clinical locations as appropriate/ CYP Inpatient unit	Inpatient: 24 / 7 (*LTP)* HTTs: To include evenings and weekends	Emergency referrals respond within 4 hours, admission within 24 hrs; Urgent transfer referrals within 48 hrs; Routine referrals within 1 week (*LTP targets)*	Length of stay dependent on progress Daily MDT review and daily therapeutic 1-1 and group input

Integration with wider health and care system

Part of a network of integrated health, education and care services. Home Treatment Teams and Inpatient MH teams should link with GP, Crisis, AOT and Community teams, acutes, social care, youth services, Team around the child meetings and wider network meeting and regional provision if required.

Young adults (18-25)

Draft core offer outline – Young adults (18-25) Mental Health

Description of care functions specific to young adults follow this slide and are shown in the diagram below in boxes; other care functions are described within the working age adult offer

Care and support to service users and their families / carers

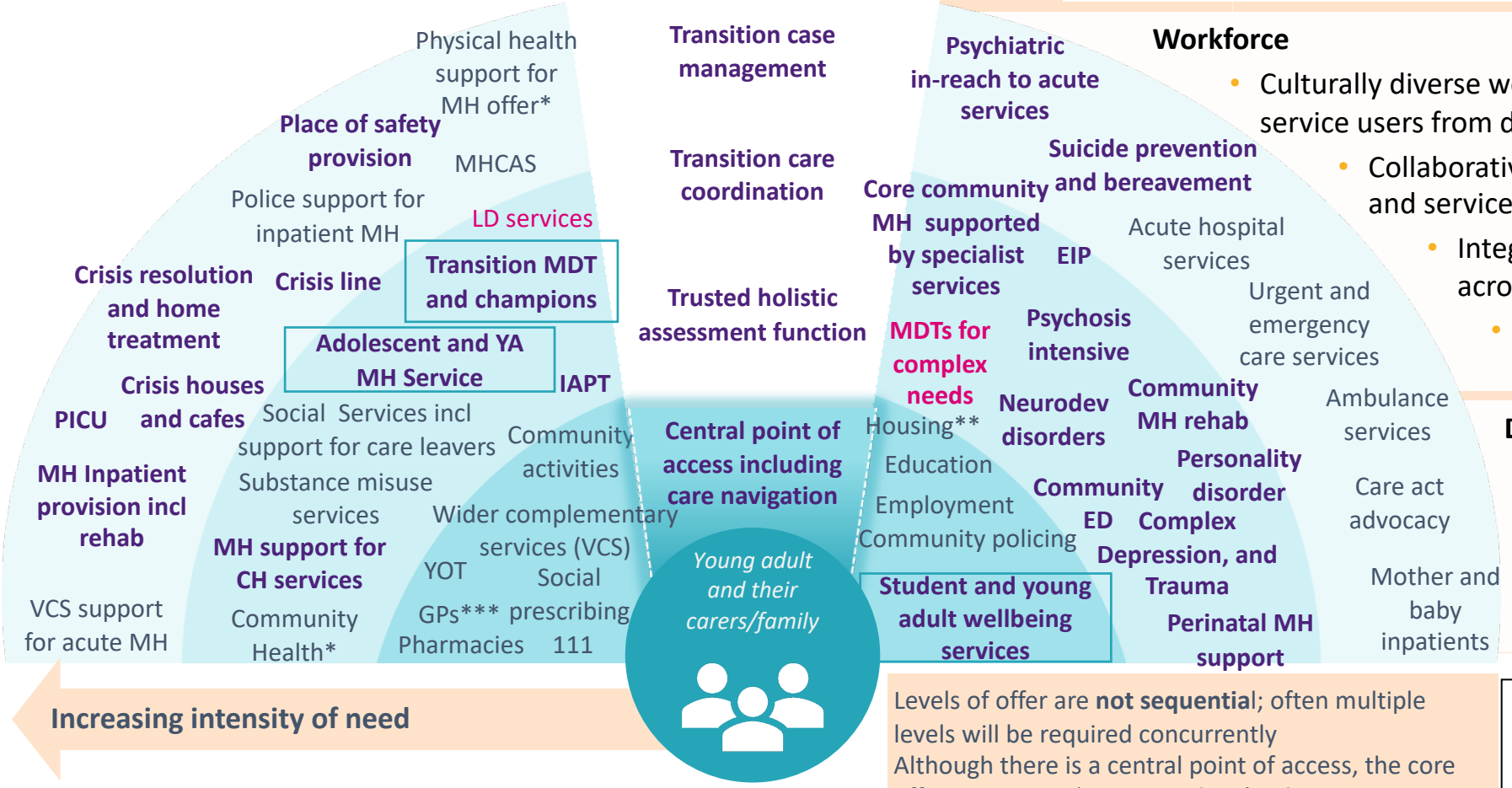
- Shared decision making and care and support planning
- Services sensitive to cultural and other demographic factors that impact on how young people prefer to access care
- Focus on early-intervention and prevention
- CAMHS and AMHS adapt to meet 18-25 needs
- Implementation of 'Minding the Gap' NCL wide and THRIVE

Workforce

- Culturally diverse workforce which can engage service users from different backgrounds
- Collaborative working with professionals and service users and a shared culture
- Integration between services across levels
- Co-location where appropriate

Digital

- Patient records integrated, shared and accessible to all
- NCL wide digital early intervention offer



Increasing intensity of need

Levels of offer are **not sequential**; often multiple levels will be required concurrently
Although there is a central point of access, the core offer operates a 'no wrong door' policy

Purple = care functions of core offer in scope of community health services strategic review
Pink = multi-agency function

*Part of community health offer
**Housing incl supported housing and homelessness services
***GPs and broader primary care team including extended roles

The principles of the THRIVE framework should be applied throughout the implementation of the young adult's core offer

1. **Common language:** using the five needs-based groupings across NCL (thriving, getting advice and sign posting, getting help, getting more help, getting risk support)
2. **Needs-led:** approach led by meeting need rather than diagnosis or severity. Being explicit about the plan of care and everyone's role within the plan
3. **Shared decision making:** this process is core to giving young people, children and their parents a voice and empowering them to take part in their care decisions.
4. **Partnership Working: e**ffective cross-sector working, with shared responsibility, accountability and mutual respect based on the five needs-based groupings
5. **Proactive Prevention and Promotion:** helping to enable the whole community to support mental health and wellbeing. Proactively working with the most vulnerable groups.
6. **Outcome-Informed:** Clarity and transparency from outset about children and young people's goals, measurement of progress movement and action plans
7. **Reducing Stigma:** Ensuring mental health and wellbeing is everyone's business
8. **Accessibility:** advice, help and risk support available in a timely way for the child, young person or family, where they are and in their community.

Source: http://implementingthrive.org/about-us/i-thrive-principles/

Young adult

Contains national requirement targets

Draft specifications

Core offer care function: **Student and young adult wellbeing support**

Overview

Description of the care function

Consistent wellbeing and counselling support available for young adults and students in community and online - full range of services from getting advice through to getting help and risk support:

- Online counselling, peer support and self-help resources
- Training for primary care, university health professionals and employers so that they can support young adults
- VCS or LA provided locality based wellbeing hubs that provide mentoring, peer and coaching support for young adults with early mental health difficulties
- University provided counselling and student support
- Substance misuse support (LA provided)

Capabilities required

NCL wide evidence based digital offer

Locality based young adult wellbeing hubs

Trainers to deliver training for primary care, educational and social care professionals

Who the care function is for

Support for young adults and their families with early emotional and behavioural difficulties

How the function is accessed

Self referral and walk in; anonymous digital access; through primary care, student health hubs, transition service; can also be accessed through central point of access

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Locality wellbeing hubs, online, face-to-face	24/7 for online; 9am-5pm for range of offer with some out of hours provision where appropriate	Immediate access to some support; up to four weeks for 1-1 counselling or other support	As required with links to other services (e.g. IAPT) for further support

Integration with wider health and care system

- Offer ensures that all professionals working with young adults with early mental health difficulties are able to identify and support them and are able to support them to access effective early mental health support
- The care functions of the early intervention offer are all linked in with the CYP and adults core community mental health teams so that if young adults need more specialist support this can be promptly accessed (e.g. IAPT, MH core teams)
- Links in with adult safeguarding

Young adult

Contains national requirement targets

Draft specifications

Core offer care function: **Adolescent and Young Adult Mental Health Service***

Overview

Description of the care function

Offer in line with LTP ambitions (to extend current service models to create a comprehensive offer for 0-25 year olds) and covers:

- Provision of specialist time bound support by a skilled multidisciplinary team, including clinical psychology, psychiatry, psychotherapy, family therapy and social work, offering a range of range of assessments and interventions using multimodal and multidisciplinary approaches. Treatment may be delivered individually or in groups.
- Working to support people to have positive outcomes to enable them to step down from services / prevent need for ongoing or high intensity adult treatment
- Planning and implementation of transition from CYP to adult MH services in line with NICE guidance (QS140, NG43)

Capabilities required

Integrated multi-agency pathways with teams including; psychologists, family therapists, child psychotherapists, social workers and child and adolescent psychiatrists, CYP IAPT trainees, E by E

Who the care function is for

Young people between the ages of 14 and 25 who;

- Require transition from any CYP MH service to an adult pathway
- Are in youth justice, are LAC and may also have SEND / NDD

How the function is accessed

Individuals can be referred through their GP, college, university, other health and social care professionals or by self referral; can also be accessed through central point of access

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinic, with both virtual and in-person options Digital offer to support engagement	Mon-Fri 8am-6pm with ability to arrange out of hours appointments.	Within 4 weeks	Plan of care agreed with young person and family / carer if applicable, bespoke to needs of the young person based on their goals

Integration with wider health and care system

- Part of a network of integrated health, education and care services. Link with GP, schools and colleges, social and community services, youth workers, MH inpatient care
- Links with adult safeguarding.
- Support for parents with mental health needs

**Potential care function for later-phase implementation*

Young adult

Contains national requirement targets

Draft specifications

Core offer care function: Transition MDT (case discussion) and transitions champions

Overview

Description of the care function

- Support to facilitate care planning for young people transitioning from CAMHS and non-statutory services to adult mental health services
- Fortnightly case discussions with senior representatives from CAMHs, adult mental health and non-statutory young people's services. Suitable AMHS care pathways are identified and referrers are linked up with the relevant services
- Additionally a transitions champion is based within a specific adult team and provides direct clinical support to young people during the transition phase and supports other professionals in working in a developmentally-attuned way.
- People will be supported through the transition MDT to the level appropriate to their needs
- Should meet NICE guideline standards (QS140, NG43)

Capabilities required

Appropriately trained transition champions,

psychologists, family therapists, child psychotherapists, social workers and child and adolescent psychiatrists

Who the care function is for

Young adults between 17-24 years old known who have come to the attention of CAMHS, AMHS or non-statutory providers and where a clear care pathway is not easily identified

How the function is accessed

Professionals working with young people can book case discussions; the transitions champion is accessed via the transitions case discussion forum

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Team meets in various locations across NCL or virtually	Meetings at least fortnightly, 1.5 hours	Cases discussed within 4 weeks	Referrers are promptly linked up with relevant AMHS services; prioritisation of young people for assessment and allocation within AMHS

Integration with wider health and care system

The case discussion forum has representatives from CAMHs, statutory and non-statutory adult mental health services, social care, housing, education and non-statutory young people's services.

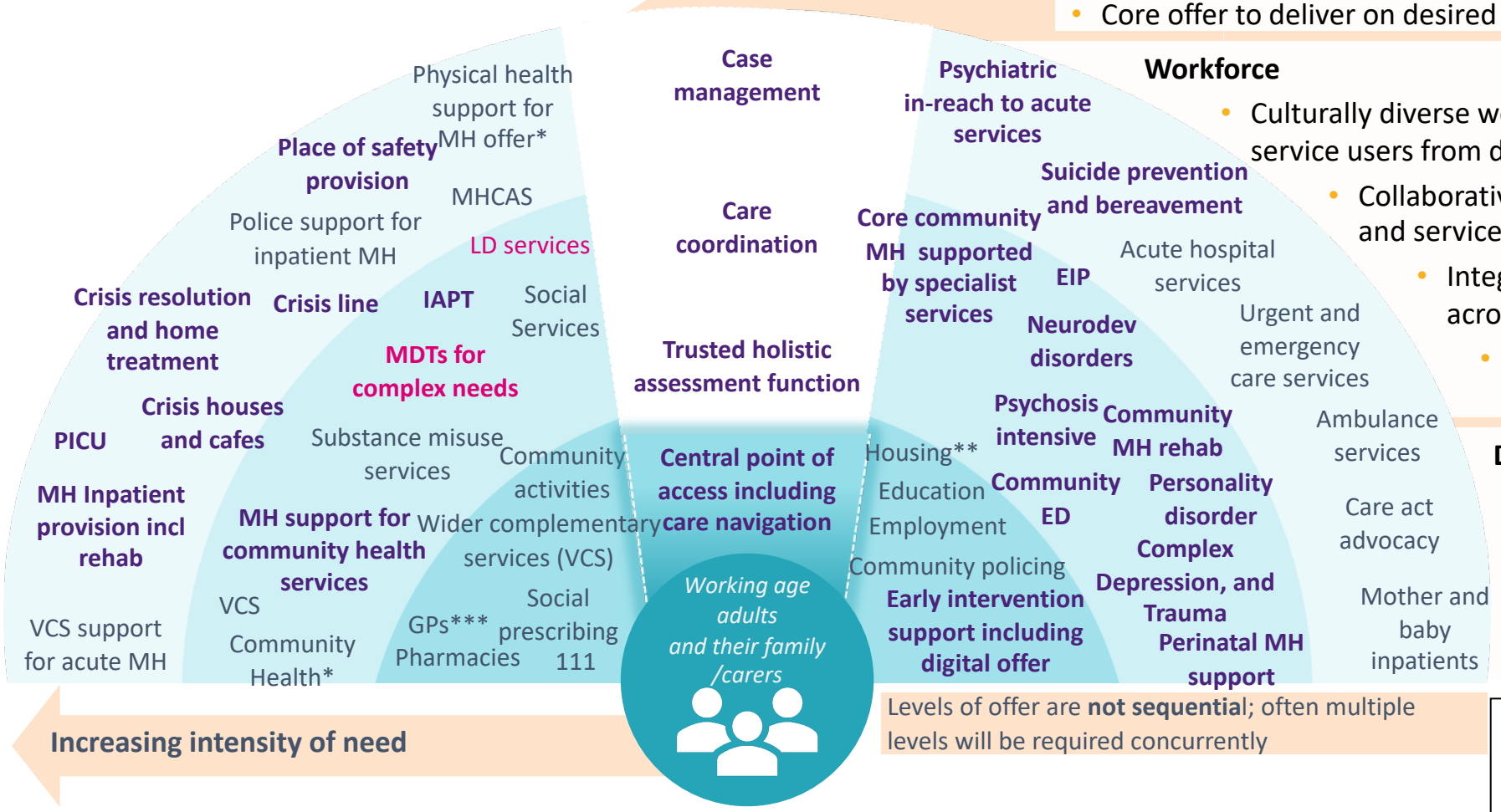
The transitions champion is fully embedded in a secondary care adult mental health service.

Working-age adults

Draft core offer outline – Working age adults Mental Health

Care and support to service users and their families / carers

- Shared decision making and care and support planning
- Tailored approach to support different communities
- Focus on early-intervention and prevention
- Services sensitive to cultural and other demographic factors that impact on how people prefer to access care
- Core offer to deliver on desired outcomes for residents



Increasing intensity of need

Levels of offer are **not sequential**; often multiple levels will be required concurrently

Workforce

- Culturally diverse workforce which can engage service users from different backgrounds
- Collaborative working with professionals and service users and a shared culture
- Integration between services across levels
- Co-location where appropriate

Digital

- Patient records integrated, shared and accessible to all
- NCL wide digital early intervention offer

Purple = care functions of core offer in scope of community health services strategic review
Pink = multi-agency function

*Part of community health offer
**Housing incl supported housing and homelessness services
***GPs and broader primary care team including extended roles

Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: **Early intervention support including digital**

Overview

Description of the care function

Consistent wellbeing support available for adults in community and online; helps to ensure that adults have ”no wrong door”

- Online peer support, counselling and self help resources
- Training for primary care, and employers so that they can support adults with mental health
- VCS or LA provided locality based wellbeing activities that provide peer support and resilience building activities for adults from different communities and cultures

Capabilities required

NCL wide evidence based digital offer

Locality based adult wellbeing hubs

Trainers to deliver training for primary care and employers

Who the care function is for

Support for working age and older peoples and their carers with early mental health difficulties

How the function is accessed

Self referral and walk in

Anonymous digital access

Through primary care, and employers

Can also be accessed through central point of access

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Locality wellbeing hubs, online	24/7 for online; 9am-5pm for range of offer with some out of hours provision where appropriate	Immediate access to some support; up to four weeks for 1-1 counselling or other support	As required

Integration with wider health and care system

- Offer ensures that all professionals working with adults and older peoples with early mental health difficulties are able to identify them and are able to support them to access effective early mental health support
- The care functions of the early intervention offer are all linked in with core community mental health teams so that if adults need more specialist support this can be promptly accessed

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: **Core Community Mental Health**

Overview

Description of the care function

The Core MH teams are aligned to PCNs and deliver flexible, proactive care for young adults through to older adults with moderate to severe mental illnesses across a range of diagnoses and needs in line with NICE guidance QS8, QS53 and:

- focusing on community well-being, prevention and early intervention, as well as high quality care and intervention
- the teams offer trusted holistic assessment and consultation, signposting, navigation and advice, and holistic case coordination and management to help people manage the wider social determinants of mental health, and prevent the associated stresses causing worse mental health
- work to join up mental and physical healthcare
- the teams also work closely with (specialist/intensive e.g. ED, EIP, PD) community MH teams to 'step-up' and 'step-down' support as required.

Capabilities required

Teams staffed with, Peer Coaches, psychologists, nurses, social workers, occupational therapists and psychiatrists

VCS support and EbyEs

Who the care function is for

Adults approaching 18 & older, their families and carers, experiencing emotional, behavioural and MH problems too severe to be managed in IAPT; includes homeless

How the function is accessed

Individuals can be referred by their GP, central point of access / care navigator, other health and care professionals. Self referrals (phone /email).

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At home with both virtual and in-person options , in GP practices, health centres or any appropriate community setting	Mon-Fri 8am-8pm with ability to arrange out of hours appointments	4 week wait standard of referral to commence intervention (*LTP ambition, being testing currently)*	Plan of intervention agreed with service user and family / carer including the use of DIALOG+

Integration with wider health and care system

Core MH teams are aligned to GP PCNs and rooted in local communities. They have an explicit role to better integrate PH and MH care , primary care with secondary care and statutory services with the VCS. They step up to specialist 'intensive'/specialist community MH teams for those with the most complex needs,

They work closely alongside IAPT, social care and the VCS

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: **IAPT (Improving access to psychological therapies)**

Overview

Description of the care function

Holistic assessment and subsequent delivery of NICE approved therapeutic interventions including CBT for depression, anxiety and other common mental health disorders

Available both face to face and virtually available in a variety of languages . Includes offering NICE-recommended psychological interventions for people with LTCs and integration with physical health services. Service users are supported to access ongoing support from local community mental health if required

Capabilities required

Psychological therapists and psychological wellbeing practitioners trained to deliver the range of IAPT/NICE approved psychological interventions for adults with common mental health problems

Who the care function is for

Adults over 16 presenting with common mental health problems and wanting focused psychological interventions.

Exclusions: individuals with complex / severe mental illness or who are a risk to themselves /others

How the function is accessed

People can self refer through website or can be referred by primary care, social workers and other health and care professionals

or through website

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Face-to-face in IAPT locations or virtual or over the phone and GP practices, community venues.	Mon-Fri 8am-8pm with out of hours arrangements	*LTP target*: access within 6 weeks (75% of people referred to IAPT services should start treatment within 6 weeks of referral and 95% within 18 weeks)	Follow up within 2 weeks

Integration with wider health and care system

IAPT service is linked with primary care, local community mental health teams, community health long term condition services and a wide range of community support organisations.

IAPT services are co-located with primary care and community hubs / networks and reduce stigma by being in everyday health settings.

IAPT services can prescribe different kinds of mindfulness and wellbeing apps, for example Headspace

Young adult | Working age adult

Contains national requirement targets

Draft specifications

Core offer care function: Early Intervention Psychosis

Overview

Description of the care function

Early Intervention in Psychosis is a service dedicated to the assessment and management of people who have presented to specialist mental health services with a first episode of psychosis.

The service should deliver a NICE recommended package of care (CG178) to:

- Help to prevent the full-onset of illness for persons in a high-risk state; and
- Improve long-term outcomes for those who have already had a first episode of psychosis.
- Deliver At Risk Mental States provision as per NICE guidance
- Meet NCAP standards

Capabilities required

Psychiatrists, occupational therapists, psychologists, nurses, social workers, welfare rights advisors and support workers, pharmacists, peer coaches and EbyEs.

Who the care function is for

Individuals between 14-64 years experiencing early psychotic symptoms with no established diagnosis and period is not considered drug-induced

How the function is accessed

Individuals can be referred through their GP or central point of access / care navigator

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
EIP practices across NCL. Appointments face-to-face. If service user unable to leave home, initial appointments can be virtual	Mon-Fri 8am-8pm with ability to arrange out of hours appointments	National target: access within 2 weeks *(LTP)* NCL target: initial assessment within 5 working days	8-week comprehensive assessment then if accepted, 3 years' worth of treatment or signposting to appropriate service

Integration with wider health and care system

Key interdependency with physical health services through PCN Primary Care Practitioners and Community Physical Health Services.

Named individual coordinating assessment to link to GP, central point of access and care navigator. For service users with complex needs, named individual should also link with care coordinator / case manager and any acute services (e.g. psychiatric in-reach, MH inpatients and physical health in-reach) and social care.

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: **Psychosis intensive function**

Overview

Description of the care function

Psychosis Intensive Teams offer community treatment and support to people with severe psychotic illness with very complex needs who require specialist MDT support beyond which CMHT can provide. This includes provision of clozapine clinics and depot clinics and bespoke assertive outreach for these service users and their carers.
The psychosis intensive function should deliver care in accordance with NICE guidance QS95, QS80 and CG178; Adults with psychosis or schizophrenia are offered cognitive behavioural therapy for psychosis, family intervention, antipsychotic medication, supported employment programmes, comprehensive physical health assessments, healthy living support

Capabilities required

Teams staffed with psychiatrists, occupational therapists, psychologists, nurses, social workers, welfare rights advisors and support workers, with support from pharmacists. Peer Coaches and EbyEs.

Who the care function is for

Adults (18 years or over) their families, parents and carers with severe psychotic illness who require additional support beyond which their CMHT can provide

How the function is accessed

Referred by CMHT

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At community team bases, at home and with both virtual and in-person options. The approach includes assertive outreach	Mon-Fri 8am-8pm with ability to arrange out of hours appointments.	Within 4 weeks	Plan of intervention agreed with service user and family / carer *LTP:* people with a SEMI should receive an annual physical health check

Integration with wider health and care system

Intensive Psychosis community teams should link with GP, Core Teams, adult social care, and mental health inpatient care as well as any other specialist MH teams and the VCS

Works closely alongside community rehabilitation team and substance missuse. Depot is offered as part of primary care offer when individuals have stabilised with shared Care protocol. This is part of offering ongoing recovery treatment in a normalised setting

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: Personality disorder function

Overview

Description of the care function

Provision of specialist support for service users with personality disorders who could benefit from intensive interventions in line with NICE guidance QS88, CG77, CG78:

- A range of psychosocial interventions to meet the needs of this diverse group, offered in a stepped care approach.
- The pathway for this group would typically include locality-based community mental health teams (Core teams), MDT for Complex Emotional Needs (PD and Psychotherapy services)
- These therapies can be delivered individually or in group settings making use of digital offers where possible
- The list of therapies and diversity of the offer should reflect the diversity of need as well as the diversity in the population with a focus on providing evidence-based interventions where available
- The pathway should focus on ensuring an accessible and responsive whole population approach that addresses gaps in services and improves outcomes
- Provision of consultation, advice and training to core teams and other parts of the system as required

Capabilities required

Clinical Psychology, Psychiatry, Social Workers, Nurse, Psychotherapists, OT and EbyE able to deliver specialist PD interventions. Refer to NICE quality spec and related capabilities

Who the care function is for

Adults with severe personality disorder (EUPD, NPD and ASPD) for time bound specialist support.

Support for carers and family

How the function is accessed

Referrals from core mental health teams as well as referrals from other teams (crisis pathway, inpatients and other intensive teams)

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At home with both virtual and in-person options Or In PD services across NCL	Mon-Fri 8am-8pm with ability to arrange out of hours appointments.	Within 4 weeks	Plan of intervention agreed with service user at set intervals *LTP:* people with a SEMI should receive an annual physical health check

Integration with wider health and care system

MDT from PD service should link with GP and CMHT, any MDT for complex needs, social care including accommodation providers, A+E and the police as required

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: **Neurodevelopmental diagnostic and treatment service including autism and ADHD**

Overview

Description of the care function

NICE * adherent Integrated specialist assessment, diagnosis, treatment and provision of therapeutic interventions/support, including CBT, for adults with autism and ADHD. Additional support will include employment and vocational support.

* Autism spectrum disorder in adults: diagnosis and management Clinical guideline [CG142], and quality standard [QS51] and Attention deficit hyperactivity disorder: diagnosis and management NICE guideline [NG87]

Capabilities required

Teams staffed with suitably trained and experienced psychiatrists , nurses, non-medical prescribers occupational therapists, psychologists, and EbyEs

Who the care function is for

Adults with diagnosed or query neurodevelopment disorders who do not have a severe global intellectual disability

How the function is accessed

Can be referred via the core MH teams and specialist MH services, GPs, Social Workers or central point of access

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinic setting in person and virtual delivery. Home based visits as required	9-5 Monday to Friday Out of hours provided by crisis team	Within 4 Weeks of referral	Plan of intervention agreed with service user and family / carer

Integration with wider health and care system

Work alongside Core MH teams, LD services, neuro-rehab, sheltered housing, VCS, social care and primary care.

Key interdependency with physical health services through PCN Primary Care Practitioners and Community Physical Health Services. Develop their awareness and competencies in working with people who have NDD.

Key interdependency with physical health services through PCN Primary Care Practitioners and Community Physical Health Services.

Young adult | Working age adult

Contains national requirement targets

Draft specifications

Core offer care function: Adult community eating disorder services

Overview

Description of the care function

The adult ED service provides specialist assessment and treatment to adults who have an eating disorder in line with NICE guidance (NG69, QS175).

A day programme is also available via an intensive therapeutic group programme.

They work alongside the patient's core mental health team where co-existing other mental health conditions are present
They also offer consultation, advice and support to other organisations including primary care and Community Mental Health Recovery Services and to families and carers of service users

Capabilities required

MDT able to deliver specialist community eating disorder interventions; should include psychiatrists, psychologists, nurses, a dietician, occupational therapist and psychological therapists

Who the care function is for

Adults aged 18 or over who have a suspected or confirmed eating disorder diagnosis.

Service also open for advice, consultation and support

How the function is accessed

Individuals can be referred through their GP, central point of access / care navigator, CMHT, college, university, other health professionals. Self referrals from adult their families or carers (phone or email).

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At home with both virtual and in-person options	Mon-Fri 8am-6pm with ability to arrange out of hours appointments. Intensive day programme Mon-Fri 10am-3:30pm	Urgent referrals within 1 week and routine referrals within 4 weeks	Plan of intervention agreed with service user, usually covers 1 year of treatment *LTP:* Intensive day patient treatment: 4-5 times per week

Integration with wider health and care system

MDT from ED service should link with GP, any MDT for complex needs, social care, A+E, community nursing teams, MH inpatient care and community mental health teams

Key interdependency with physical health services through PCN Primary Care Practitioners and Community Physical Health Services.

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: Community MH rehabilitation

Overview

Description of the care function

Multidisciplinary community team with specialist rehabilitation skills working in line with NICE guidance (NG181):

- Care co-ordinate people with complex psychosis living in supported accommodation.
- Work closely with supported accommodation staff to tailor people's care plans to their needs and clarify which staff are responsible for providing different components of treatment and support.
- Facilitate the person's progression through the rehabilitation pathway by providing flexible personalised support taking account of wider determinants, and enabling the person to gain independent living skills, vocational skills, and confidence to manage in more independent accommodation and participate in the wider community.

Capabilities required

Rehabilitation psychiatrists, nurses, health care assistants, occupational therapists, social workers, AMHPs, Psychologists and Peer Workers, Dual diagnosis workers

Who the care function is for

People with complex psychosis living in 24 hour supported accommodation or their own homes / other settings, based on need.

How the function is accessed

Transferred to team from other community teams if eligible (complex psychosis and living in 24 hour supported accommodation).

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At home (usually supported accomm-odation). Face-to-face	Mon-Fri 9am-5pm with weekend support to access community	At transfer meeting	6 monthly MDT care reviews and 2-4 weekly visits from care co-ordinator

Integration with wider health and care system

Community MH rehab teams should link with GP, inpatient rehabilitation teams and social care including accommodation providers, Dual Diagnosis Workers, A+E, and the police as necessary. They will work closely alongside the VCS and employment support services who can often provide wider support.

Community Rehab should inreach to Acute MH settings to support discharges to reduce LOS/DTOC.

Young adult | Working age adult

Contains national requirement targets

Draft specifications

Core offer care function: Perinatal service

Overview

Description of the care function

The perinatal MH team works with pregnant and postnatal women with moderate to severe mental health needs who have been referred for specialist input. The team carries out holistic assessment and provides timebound therapeutic interventions in line with NICE guidance (CG192, QS115). This includes providing advice and support to promote self management.

Works alongside health visitors, midwives and adult and CYP social care to manage both risk to mother and baby. Work with women for longer, up until 24 months postnatally and extended work with fathers and partners.

Capabilities required

Perinatal psychiatrists, clinical nurse specialists, clinical psychologist, OT

Who the care function is for

Pre, peri or postnatal women with moderately to severe mental health needs

How the function is accessed

Referral by GP, core MH teams, midwives, obstetrics team, health visitors

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Outpatient clinics in maternity centres, service user's home, virtual	Mon-Fri 9am-5pm with out of hours arrangements	Assess for treatment within 2 weeks of referral and provide psychological interventions within 1 month of initial assessment (*NICE CG192, QS115)*	Follow up for up to 24 months postnatal *(LTP)*

Integration with wider health and care system

Perinatal services should be linked with GPs, midwives, health visitors, mother and baby units, physical health in-reach, core MH teams, specialist MH teams

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: **Complex Depression, Anxiety and Trauma**

Overview

Description of the care function

Provision of specialist time bound support for service users referred from their core mental health team, IAPT or GP who require more intensive and complex interventions for their depression, anxiety or trauma then cannot be provided by IAPT. Treatment may involve evidence based psychological therapies (e.g. CBT, EMDR) delivered individually or in groups, medication reviews and provision of other bio-psychosocial interventions including psychotherapy and cranial stimulation. Individually tailored therapeutic interventions which may span several years. Other types of help include information and advice about mental health conditions, explanations about medication and support to help with employment or education. Provide advice and support to other agencies around trauma informed care and support. Delivered in line with NICE guidelines (NG116, CG90)

Capabilities required

Psychiatric nurses and psychiatrists, clinical psychologists, EbyEs

Who the care function is for

Adults (over 18) with complex depression, anxiety and / or trauma where the individual would benefit from extra support over IAPT

How the function is accessed

Referral through GP, psychological therapies, core MH teams and social care professionals

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Service clinic face-to-face or virtual; Hospital day case setting for ECT	Mon-Fri 8am-6pm with out of hours arrangements	Within 2 weeks of referral	As agreed in treatment plan

Integration with wider health and care system

The service should work closely with general practitioner, core MH teams, IAPT services, specialist mental health teams, MH inpatients

Work closely with VCS and other statutory / non-statutory partners recognising diversity of trauma and wider determinants

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: **Electroconvulsive Therapy (ECT)**

Overview

Description of the care function

ECT remains a safe and effective treatment for patients with the most severe and life-threatening depressive illness where alternative therapies have not worked or rapid treatment is needed to maintain safety. Treatment is offered to inpatients and a small number of outpatients, some of whom are receiving maintenance treatment.

ECT is delivered on twice a week, in a dedicated Suite with new, state of the art equipment and a multidisciplinary and multispecialty clinical team.

NICE guidance on the use of electroconvulsive therapy should be followed (TA59)

Capabilities required

ECT Nurse, Lead Psychiatrist for ECT,

Consultant Anaesthetist,

Operating Department Practitioner

Who the care function is for

Primarily, inpatients with severe affective disorders where drug and psychological therapies ineffective.

Small number of people with schizoaffective disorder or catatonia.

How the function is accessed

Standard referral process to cover treatment eligibility, fitness for anaesthetic and consent/MHA considerations.

Lead Nurse and Psychiatrist by email and telephone.

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
ECT Suite	10-12 Twice a week	Within 24 hours	Until recommended course of ECT is completed

Integration with wider health and care system

The service should work closely with general practitioner, core MH teams, IAPT services, specialist mental health teams, MH inpatients

Work closely with VCS and other statutory / non-statutory partners recognising wider determinants.

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: **NCL mental health crisis line**

Overview

Description of the care function

Urgent mental health helplines for people of all ages provided across NCL. Able to triage mental health calls and navigate callers and their families and carers to the right source of support. For callers known to mental health services, responder will be able to ensure an appropriate and timely response from the CYP or adult local crisis team or community teams. For unknown callers, will be able to carry out clinical risk assessment and direct to liaison and crisis response if urgent or to book in for review with their community mental health or CYP mental health team if less urgent.

Capabilities required

Staffed by both adult and CYP mental health practitioners who can assess severity of presentation and triage appropriately

Has access to directory of available in and out of hours support and access

Who the care function is for

People experiencing a mental health crisis

How the function is accessed

Self / parent / carer/ friend referral by phone

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Phone	24 / 7 (*Nice guideline CG136)*	95% of calls answered in 60s (THINK 111 call response times)	N/A

Integration with wider health and care system

Should be integrated with MH community teams and crisis response.

Have access to integrated care record with crisis plans

Link with 111

Link to core mental health teams, primary care and cyp and adult social care emergency teams

Have direct booking functionality into primary care and MH teams

CYP and young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: **Place of safety provision**

Overview

Description of the care function

Place of safety is a staffed section 136 suite with psychiatric assessment and care provision. They also provide police liaison and diversion provision as well as MHA assessment provision. The team supports service users whilst they undergo assessment and help them to feel safe in the Place of Safety. The teams works together with service users, their family / carers, doctors and Approved Mental Health Professionals (AMHPs) to facilitate efficient assessments and to minimise the length of time people are detained in the suite. Delivered in line with NICE guidance (QS14)

Capabilities required

Psychiatric nurses, AMHPs, psychiatrists, S12 doctors, Peer workers

Who the care function is for

Adult 18+ yrs old identified in the borough by Police Officers who require urgent mental health assessment under s136/135 MHA

How the function is accessed

MHA, S135, S136

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Health based place of safety suite in ICS	24 hours	On patient arrival	Work has to be concluded within 12 hours

Integration with wider health and care system

Place of safety should be integrated with police, MH inpatients, primary care, social care, physical health in-reach (emergency departments), MH core teams, other specialist MH teams

Key interdependency with physical health services through PCN Primary Care Practitioners and Community Physical Health Services.

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: **Crisis houses and crisis cafes**

Overview

Description of the care function

In line with the LTP:

Crisis Houses serve as a safe alternative to hospital admission and support discharge from inpatient settings, they provide trauma informed support and treatment to resolve current crises. Admissions are for short-term intensive care and support.

Crisis cafes are welcoming places where people can go instead of A&E or other urgent services, adults can self present when a crisis escalates.

Capabilities required

Integrated team of VCS, Peer workers, EbyEs, with access to mental health professionals, social care

Who the care function is for

Crisis houses: adults who are in crisis who require 24-hour intensive support in a residential setting.

Crisis cafes: adults and their carers in acute mental health distress or mental health crisis who need a safe, supportive space to manage the crisis.

How the function is accessed

Referral can be through Core MH teams, GP, single point of access, place of safety, liaison or by inpatient wards.

Self-referral

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At home, face-to-face	Crisis Houses: 24/7 Crisis Cafes: Mon-Sun times TBC	On presentation	MDT daily review in crisis houses. Therapeutic support whilst present. Length of stay maximum of 2 weeks

Integration with wider health and care system

Service should link with GP, any MDT for complex needs, social care including accommodation providers, A+E, MH inpatient care and community mental health teams, social care, substance misuse services, police.

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: **Crisis resolution and home treatment**

Overview

Description of the care function

Mental health team offering short-term intensive care and support for those experiencing mental health crisis. Crisis Resolution and Home Treatment Teams (CRHTs) are based in the community and provide a safe and effective, home-based mental health assessment and treatment service in order to reduce the need for inpatient care.

CRHT should meet CORE fidelity and be delivered in line with NICE guidance (QS14)

Capabilities required

Integrated team of mental health professionals and social care

Who the care function is for

Adults with a mental health crisis where community care is viewed as viable and safe alternative to inpatient care

How the function is accessed

Referral can be through CMHT, GP, single point of access, place of safety, liaison or by inpatient wards.

Self-referral

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At home, face-to-face. Location based on need	Accessible 24 / 7 (LTP)	4 hrs for emergency referral and within 24 hours for urgent referrals in community mental health crisis services *(LTP)*	MDT daily review, home based assessment and therapeutic support up to twice daily

Integration with wider health and care system

Service should link with GP, any MDT for complex needs, social care including accommodation providers, A+E, MH inpatient care and community mental health teams, police.

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: **Psychiatric in-reach (liaison) to acute A+E and acute wards**

Overview

Description of the care function

Timely psychiatric assessment for adults presenting to A+E and on acute wards with acute mental health presentations. Includes support for community intermediate care

Includes psychiatric liaison and/or community mental health team assessments to support facilitation of timely acute discharges

Mental health input also built into adult community health Long term condition teams (e.g. weight management, diabetes and epilepsy)

Meet the CORE24 and PLAN accreditation standards

Capabilities required

Liaison Nurses, Adult and Old Age Psychiatrists, Psychologists. Peer support workers

Who the care function is for

Adult mental health presentations in A+E and on wards in each acute site

How the function is accessed

In A+E and on hospital wards

Available for telephone advice and support as well as in person assessments and care planning

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
In A+E, acute hospital wards, acute MDT discussions (e.g. D2A), community bedded rehab	24 / 7 (*CORE 24)*	1 hr for emergency department; 24 hrs for medical ward (*LTP targets currently being tested)*	4 hourly reviews in ED and as required on medical wards 12 sessions of follow up post self-harm

Integration with wider health and care system

Psychiatric in-reach should link with ED (inc HIU group), acute physical health wards, alcohol and substance misuse services, inpatient mental health wards, crisis and home treatment teams, perinatal mental health services, and primary care, as well as voluntary. Will also need to link with police and place of safety.

Psychiatric in-reach links directly to crisis response teams

Duplicative with psychiatric liaison & CRHT

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer element: **Mental Health Crisis Assessment Service (MHCAS) – alternative to ED**

Overview

Description of the element

Emergency psychiatric assessments delivered in a bespoke mental health setting outside of A+E. Delivers therapeutic emergency assessments (response time 1 hour) as A+E diversion and via attendance at front door by LAS, Police and walk-ins.

Diverts majority of presentations from ED to MCHAS for therapeutic intervention and crisis de-escalation.

Meets the relevant CORE24 and PLAN accreditation standards

Capabilities required

Adult and old age liaison Nurses, support workers, psychiatrists, social workers and peer coaches (peer support workers)

Who the element is for

Emergency adult mental health presentations

How the element is accessed

By transfer from A+E (A+E diversion), walk ins and direct conveyance by LAS and Police

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Bespoke facility	24 / 7	1 hr	4 hourly reviews in MHCAS department

Integration with wider health and care system

Close working with EDs, MH liaison teams, crisis teams and inpatient mental health wards.

Regular meetings with LAS and police across NCL.

Young adult | Working age adult

Contains national requirement targets

Draft specifications

Core offer care function: MH inpatient rehabilitation

Overview

Description of the care function

Inpatient rehabilitation for people with complex psychosis in line with NICE guidance QS14, NG53 – includes high dependency inpatient rehabilitation units, longer term high dependency inpatient rehabilitation unit and community rehabilitation units for voluntary and MHA admissions. Provision of 24/7 specialist rehabilitation, linking with community care planning.

A detailed care plan and assessment are co-produced with the service user and their family/carers

Capabilities required

Team includes psychiatrists, nurses, health care assistants, OT, Psychologists, Arts therapists, Activity Workers, Dual Diagnosis workers, Peer support workers. Bed management team. Formalised discharge teams.

Who the care function is for

People with severe treatment resistant psychosis with functional impairments. Co-existing physical health and mental health conditions are commonly present.

How the function is accessed

Majority of referrals from acute wards (80%) and forensic inpatient mental health services (20%).

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Inpatient rehabilitation wards and community rehabilitation units	24 / 7 (*NICE QS14)*	Assessment for eligibility within 2 weeks of referral.	Length of stay on average, 1 year for high dependency unit, 1-3 years for longer term high dependency unit and 2 years for community rehab unit.

Integration with wider health and care system

Close links with community rehabilitation team, social care, other community teams and physical health colleagues including GPs who ensure appropriate physical health care and facilitate move-on to next step in rehab pathway (from higher to lower supported settings).

In reach from community and crisis teams.

Young adult | Working age adult

Contains national requirement targets

Draft specifications

Core offer care function: MH inpatient services

Overview

Description of the care function

Inpatient short and medium care for voluntary and MHA admissions. Provision of safety and 247 therapeutic support, linking with community care planning. Inpatient care for forensic patients requiring secure 24/7 input.

A detailed care plan and assessment are co-produced with the service user and their family / carers

Inpatient care including comprehensive assessments in mental and physical health and treatment including the provision of ECT.

Meet AIMs accreditation standards

Capabilities required

Team includes psychiatrists, nurses, HC assistants, OT, Psychologists, Arts therapists, Activity Workers, Dual Diagnosis workers, Peer support workers. Bed management team. Formalised discharge teams. MHA administration.

Who the care function is for

Adults in crises needing informal or MHA admissions. Too severe to be managed in IAPT or the core CMHTs.

How the function is accessed

Crisis and Liaison Teams gatekeep all admissions

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Inpatient ward	24 / 7	Acute Beds available to CMHT same day and A+E within 4 hrs;	LOS dependent on progress Daily MDT review and daily therapeutic 1-1 and group input 48 hr follow-up*

*48 hr follow-up based on NCISH toolkit 2021

Integration with wider health and care system

Inpatient services should link with core mental health team, GP, any MDT for complex needs, social care including accommodation providers, A+E and flow from acute medical wards, VCS, substance misuse and police. Integration into wider health and care system for community and crisis. Provision of equipment for safe admission. Key interdependencies with Local Authorities; e.g. Care Act assessments, reviews, SGA enquires and with physical health services through PCN Primary Care Practitioners and Community Physical Health Services. Access to physiotherapy, SALT, tissue viability, incontinence, podiatry, spirituality in-reach.

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: PICU

Overview

Description of the care function

Specialist wards that provide secure inpatient mental health care, assessment and comprehensive treatment to individuals who are experiencing the most acutely disturbed phase of a serious mental disorder. Outreach support to other wards.

Inpatient care including comprehensive assessments in mental and physical health.

To meet NAPICU standards.

Capabilities required

The team includes psychiatrists, nurses, health care assistants, OT, Psychologists, Arts therapists, Activity Workers, Dual Diagnosis workers, Peer support workers. Bed management team. Formalised discharge teams. In reach from community and crisis teams.

Who the care function is for

Patients with very high level of risk to themselves or others

How the function is accessed

Only people detained under the MHA can be admitted through hospital or community.

Forensic and Prison population specific pathways

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Inpatient ward	24 / 7	Within 1 hours	Length of stay dependent on progress *(NAPICU guidance: 7-22 days)* Daily MDT review and daily therapeutic 1-1 and group input

Integration with wider health and care system

PICU services should link with core mental health team, GP, any MDT for complex needs, social care including accommodation providers, A+E, VCS, substance misuse and police.

Integration into wider health and care system for community and crisis. Provision of equipment for safe admission.

Key interdependency with physical health services through PCN Primary Care Practitioners and Community Physical Health Services. Access to physiotherapy, SALT, tissue viability, incontinence, podiatry, spirituality inreach.

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: Physical health checks for SEMI

Overview

Description of the care function

All MH services will support people with SMI to receive their annual physical health screening, to access appropriate physical health care and to offer preventative support to reduce risk factors for long term conditions. A population health approach and shared information systems such as HIE and HealtheIntent will enable Core MH teams to collaborate with primary care to increase the take up of full physical health checks in the SMI population (including severe depression and personality disorders). People with SMI are at higher risk of poor physical health compared with the general patient population. Physical health checks should be carried out at least 1/ year. Screening should be linked to clear and accessible physical health care interventions to reduce the excess in long term conditions and the mortality gap for people with SMI.

Capabilities required

Perform and interpret annual physical health check: BP, HR, Diabetes, Lipids, ECG, Weight, Alcohol. Provide preventative interventions to reduce risk factors in this population.

Who the care function is for

Adults over 18 with a diagnosis of a Severe and Enduring Mental Illness (on GP registers)

How the function is accessed

Self / parent / carer/ friend referral by phone, GP

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Primary or secondary care sites	8-6 Mon-Fri with some flexibility to meet needs of patients	*LTP target*: 60% of people with SEMI should have a full physical health check once / 12 months	Regular yearly review or more as required

Integration with wider health and care system

Should be directly integrated with primary care. Work alongside core mental health teams

Links in with all mental health services for people with SMI or LD.

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: Suicide prevention and bereavement*

Overview

Description of the care function

Specialist suicide crisis services to provide brief therapeutic intervention and support in the community for people experiencing a suicidal crisis (in line with NICE guidance NG105) who may otherwise not access/be eligible for MH care. Proactive flexible compassion-based approach focussed on continuity of care. **Safe from Suicide Services** within MH organisations to provide intensive community input for those with recurrent self-harm or at high risk of suicide. **Specific support services for those affected and bereaved by suicide or other unexpected death. Specific 1/1 and group provision required for:**

- Families, friends, young people.
- Organisations such as schools/universities (in-reach), targeted training for key staff, including non-MH staff
- Healthcare staff such as first responders, GPs, ED & MH staff.

Awareness raising & training provision - to create Suicide Safer Organisations, reduce stigma and reduce barriers to help-seeking to prevent suicide; enhanced suicide-specific assessment, intervention and safety planning skills among professionals at different levels. **Safe from Suicide Team providing** oversight and guidance, responsible for MH organisation and inter-organisation service delivery and training, learning from incidents, support across teams, review of protocols (e.g., on transition from A&E, hospital, prison) and competency.

Capabilities required

Psychological therapists, Counsellors, Group therapists, Peer workers, Psychiatrists, Suicide bereavement liaison and support counsellor, suicide prevention trainers, Community risk specialists.

Who the care function is for

People with, and at risk of, suicidality

People impacted by suicide or other unexpected deaths

Organisations in the wider community, including non healthcare

How the function is accessed

In community settings, within MH trusts, in people's homes, within organisations impacted by suicide (eg schools).

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community settings, within MH Trusts, people's homes, organisations.	Suicide prevention services – 24/7 Support after Suicide – 9-9pm 7	Based on need	Based on need

Integration with wider health and care system

Provision of support for schools and other organisations would be best delivered as in-reach, co-designed and co-delivered with leadership teams within the institutions. Specialist suicide crisis service will need to interface with other MH, NHS and local authority services such as housing. Safe from Suicide services should be integrated within MH provider organisations and have close links with other services for those with complex needs.

Given that multifactorial nature of suicide, it is essential that prevention approaches are designed, developed and overseen by a collaborative partnership including community partners, commercial partners, public health, mental health and those with lived experience. Support after suicide for MH trusts should be integrated within the organisation.

**Potential care function for later-phase implementation*

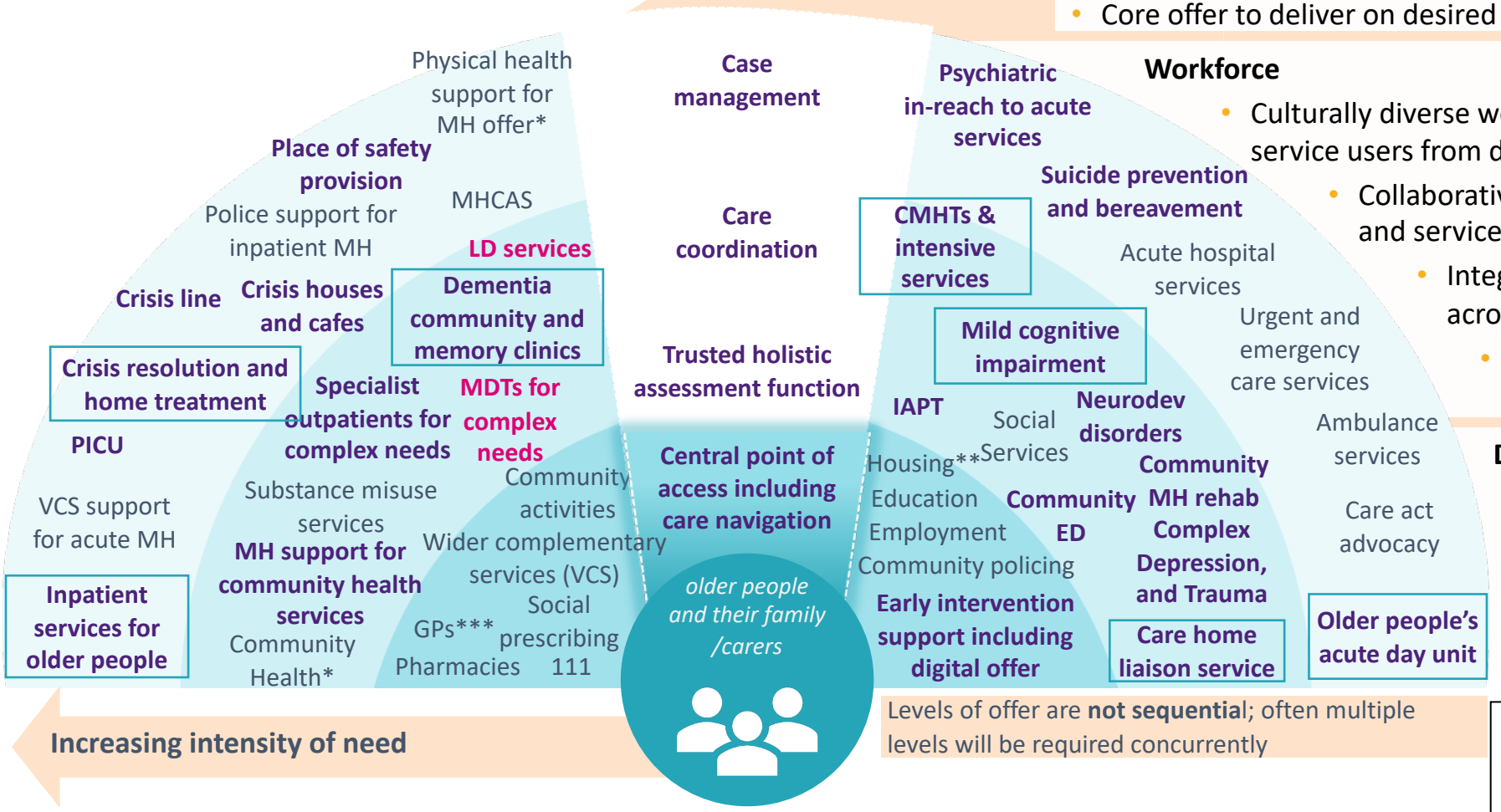
Older people

Draft core offer outline – Older people Mental Health

Description of care functions specific to older people follow this slide and are shown in the diagram below in boxes; other care functions are described within the working age adult offer

Care and support to service users and their families / carers

- Shared decision making and care and support planning
- Tailored approach to support different communities
- Focus on early-intervention and prevention
- Services sensitive to cultural and other demographic factors that impact on how people prefer to access care
- Core offer to deliver on desired outcomes for residents



Workforce

- Culturally diverse workforce which can engage service users from different backgrounds
- Collaborative working with professionals and service users and a shared culture
- Integration between services across levels
- Co-location where appropriate

Digital

- Patient records integrated, shared and accessible to all
- NCL wide digital early intervention offer

Increasing intensity of need

Levels of offer are **not sequential**; often multiple levels will be required concurrently

Purple = care functions of core offer in scope of community health services strategic review
Pink = multi-agency function

*Part of community health offer
**Housing incl supported housing and homelessness services
***GPs and broader primary care team including extended roles

Older people

Contains national requirement targets

Draft specifications

Core offer care function: **CMHT / Intensive Services for Older People**

Overview

Description of the care function

Older people's mental health and dementia assessment, treatment and care management for patients living in the community, whose needs are too intensive to be met within a core team. Supporting patients with earlier discharge from hospital and/or to move to appropriate ongoing care.

This service works closely with the Core MH teams aligned to PCNs to 'step –up' and 'step-down' support as required. In order to deliver flexible, proactive care for people with moderate to severe mental illnesses to provide high quality care and interventions.

Capabilities required

Older people psychiatrists, psychologists, mental health nurse, social work occupational therapy

Who the care function is for

Older adults' and those experiencing age related frailty, with mental illness and/or dementia whose needs are too great to be met in a Core Team or Memory Service

How the function is accessed

Individuals can be referred by the Core MH Team, GP, ASC or other secondary mental health service or carer/self referral

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At home, in clinic, hospital or community	Monday Friday 09.00 to 17.00	Assessment within 4 weeks of referral *(LTP ambition being tested currently)*	Treatment, Care Coordination, onward referral, Social Care Assessment

Integration with wider health and care system

Will work alongside inpatient services and in close liaison with with Core Teams and Crisis/Home Treatment Teams. Will work closely with ASC, Physical Health Services and GPs, housing services, carers and voluntary sector.

Older people

Contains national requirement targets

Draft specifications

Core offer care function: **Dementia community and memory clinics**

Overview

Description of the care function

Specialist service that provides **both** holistic assessment and diagnosis and also treatment of people suspected of developing dementia, including young onset dementia in line with NICE guidance (NG97). Patients diagnosed with dementia will be reviewed regularly to monitor the progression of the condition and to offer therapeutic support, psychological interventions advice and signposting.

Service also provides advice and support to both the service user and their family/carer, advice and support to access local and national support services, and liaison and feedback to their GP

Capabilities required

Team consisting of nurse, independent nurse prescriber, occupational therapist, adult social worker, consultant psychiatrists, psychologists, peer support workers

Who the care function is for

Adults with a history of symptoms associated with Dementia or with a formal diagnosis of dementia

How the function is accessed

Individuals can be referred through their GP, primary and secondary MH or community teams or other specialist services.

Families / carers can also refer to this service

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At home or in memory clinic. Face to face appointments	Mon-Fri 9am-5pm with ability to arrange out of hours appointments	Referral to diagnosis within 6 weeks	Treatment and support plan developed with service user and nominated individual (family, friend, or carer)

Integration with wider health and care system

Dementia community and memory teams should link with primary care, acute medicine for the elderly teams, adult social care, CMHTs, enhanced care in nursing homes teams and MDTs for people with complex needs

Should support and work alongside acute psychiatric in-reach into hospital care (liaison) and IDTs (Integrated discharged teams) to support safe discharges

Older people

Contains national requirement targets

Draft specifications

Core offer care function: **Mild cognitive impairment***

Overview

Description of the care function

Specialist service that provides assessment and diagnosis as well as:

- Regular follow-up to monitor possible progression of cognitive deficit.
- If symptoms deteriorate, service users should be referred to the dementia and memory clinic for specialist assessment and management.
- Active engagement with primary care to manage any other physical conditions (MCI is more likely to progress to dementia if the person has a poorly controlled heart condition or diabetes, or has strokes)

Capabilities required

Team consisting of nurse, independent nurse prescriber, occupational therapist, adult social worker, consultant psychiatrists, psychologists, peer support workers

Who the care function is for

Adults with minor problems with cognition that do not fulfil the diagnostic criteria for dementia.

How the function is accessed

Individuals can be referred through their GP, primary and secondary MH or community teams or other specialist services.

Families / carers can also refer to this service

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At home or in memory clinic. Face to face appointments	Mon-Fri 9am-5pm	Referral to assessment within 2 weeks	Support plan developed with service user and nominated individual (family, friend, or carer)

Integration with wider health and care system

Mild cognitive impairment service should link with dementia and memory clinics, primary care, acute medicine for the elderly teams, adult social care, CMHTs, enhanced care in nursing homes teams and MDTs for people with complex needs

Should support and work alongside acute psychiatric in-reach into hospital care (liaison) and IDTs (Integrated discharged teams) to support safe discharges

**Potential care function for later-phase implementation*

Draft specifications

Core offer care function: **Care home liaison support**

Overview

Description of the care function

Older people's mental health and dementia input to local primary care led enhanced health in care home teams (EHCH) and in line with NICE guidance (NG32, PH16, QS159, QS50). Provide support for care home residents with known mental health conditions and dementia and for residents with new presentations

Provide mental health assessments, support development of treatment plans and link to local older people's CMHT as required

Provide training and support to care home staff and other members of EHCH team as required

Capabilities required

Older people psychiatrists, psychologists, mental health nurse and occupational therapy

Who the care function is for

Care home residents for diagnosis and treatment of known or suspected complex mental health conditions including dementia.

Care home staff - Supporting staff to provide care

How the function is accessed

As part of enhanced health in care homes teams which each support a number of care homes

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Care homes, virtual, EHCH MDTs	Mon-Fri 9-5 Crisis resolution and home treatment teams to pick up outside of working hours	Same day response for urgent reviews, otherwise 1 week	Treatment and support plan developed with service user and nominated individual (family, friend, or carer) ongoing contact with staff

Integration with wider health and care system

As part of Enhanced health in care home teams, work alongside primary care, community health and social care. Provide link between EHCH and the servicer's users older people's CMHT as required. Important to have access to IAPT services, primary care mental health services.

Draft specifications

Core offer care function: **Older Adults Crisis resolution and home treatment***

Overview

Description of the care function

Mental health team offering short-term intensive care and support for older adults (aged 70 years and above OR under care of an older adult community team OR have a diagnosis of dementia) experiencing mental health crisis. Crisis Resolution and Home Treatment Teams (CRHTs) are based in the community and provide a safe and effective, home-based mental health assessment and treatment service in order to reduce the need for inpatient care.

Working with and supporting carers to manage with confidence.

Advice and guidance to care homes and other providers.

Meets Core fidelity and NICE guidelines (QS14).

Capabilities required

Integrated team of nurses, a consultant Psychiatrist, psychiatry trainee, Assistant Practitioner and Occupational Therapist.

Who the care function is for

Older adults with a mental health crisis where community care is viewed as viable and safe alternative to inpatient care or I order to facilitate discharge from hospital

How the function is accessed

Referral can be through CMHT, Social Worker, GP, single point of access, MHCAS, place of safety, liaison or by inpatient wards or self referral.

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At home, face-to-face, location based on need	Mon-Fri 8am-7pm. Weekends/ bank holidays 8am-4pm	4 hours and 24 hours	MDT daily review, home based assessment and therapeutic support up to twice daily

Integration with wider health and care system

Service should link with GP, any MDT for complex needs, social care including accommodation providers, A+E and liaison, MH inpatient care, acute medical inpatient care, community mental health teams, memory services, care home liaison teams, other trust teams and services, police.

**Potential care function for later-phase implementation*

Older people

Contains national requirement targets

Draft specifications

Core offer care function: **Inpatient services for older people**

Overview

Description of the care function

Inpatient short and medium care for voluntary and MHA admissions. Provision of safety and 247 therapeutic support, linking with community care planning. Inpatient care for forensic patients requiring secure 24/7 input. A detailed care plan and assessment are co-produced with the service user and their family / carers

Inpatient care for dementia patients including comprehensive assessments in mental and physical health; particularly in cognition, delirium, pain, continence and nutritional needs and treatment including the provision of ECT.

Capabilities required

The team includes older people psychiatrists, nurses, health care assistants, OT, Psychologists, Arts therapists, Activity Workers, Dual Diagnosis workers, Peer support workers. Bed management team. Formalised discharge teams. MHA admin

Who the care function is for

Older people with needs related to ageing in crises (including dementia) needing informal or MHA admissions.

Too severe to be managed in community.

How the function is accessed

Crisis and Liaison Teams gatekeep all admissions

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Inpatient ward	24 / 7	Acute Beds available to CMHT same day and A+E within 4 hrs;	Length of stay dependent on progress Daily MDT review and daily therapeutic 1-1 and group input

Integration with wider health and care system

Inpatient services for older people should link with core mental health team, GP, dementia community and memory clinics, any MDT for complex needs, social care including accommodation providers and care homes, A+E and flow from acute medical wards, VCS, substance misuse and police. Integration into wider health and care system for community and crisis. Provision of equipment for safe admission. Key interdependencies with Local Authorities; e.g. Care Act assessments, reviews, SGA enquires and with physical health services through PCN Primary Care Practitioners and Community Physical Health Services. Access to physiotherapy, SALT, tissue viability, incontinence, podiatry, spirituality inreach.

In reach from community and crisis teams.

Older people

Contains national requirement targets

Draft specifications

Core offer care function: **Older People Acute Day Unit***

Overview

Description of the care function

An Older adult Day unit which provides a period of time-limited, recovery goal orientated treatment for up to 6 months for older adults with functional mental health diagnoses. The service supports older adults in mental health crisis as an alternative to hospital admission, or to facilitate discharge from hospital. This service offers highly skilled holistic treatment by a very experienced multidisciplinary team offering a tailored care plan to address the needs of the individual, to include psychological therapy, art therapy and a variety of activities and groups. Care is overseen by a Consultant Psychiatrist and involves close liaison with other teams and services, GPs and patient families.

Capabilities required

Team consisting of nurses, occupational therapist, psychologist, art therapist, consultant psychiatrist and trainee doctors.

Who the care function is for

Older adults in mental health crisis as an alternative to hospital admission, or to facilitate a discharge from hospital.

How the function is accessed

Referral can be through CMHT, liaison teams, inpatient wards or other trust teams.

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At the Day unit, home assessments and outreach work t home, face-to-face	Monday-Friday 9am-5pm	Assessment offered within 7 days of referral	MDT regular review. Therapeutic support whilst present. Length of stay maximum of 6 months

Integration with wider health and care system

Service should link with should link with primary care, acute medicine for the elderly teams, adult social care, older people's CMHTs and MDTs for people with complex needs

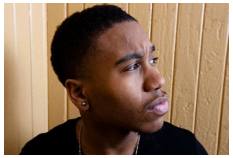
Should support and work alongside acute psychiatric in-reach into hospital care (liaison) and IDTs (Integrated discharged teams) to support safe discharges.

**Potential care function for later-phase implementation*

Contents

Pen portraits

Increasing holistic needs

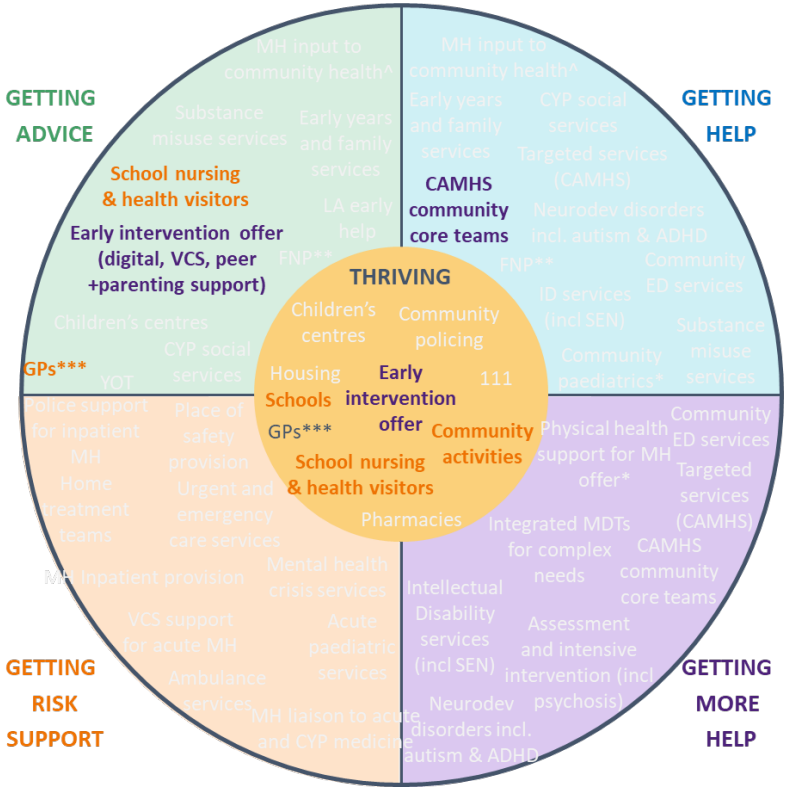
 Children & Young People	**1. Freya** is a white 14-year-old teenager whose academic performance at school has been deteriorating and appears withdrawn and tired in class. She has stopped playing in the band she was formerly a member of. She lives in cramped accommodation with not much money at home, her parents are separating, and she is being bullied at school.	**2. Patrick** is a 7-year-old Black Caribbean boy. He has a diagnosis of autism and also suffers from anxiety. He suffers from language and cognitive impairment and attends a special school. He is cared for by his parents who have two other children. His father has had to give up work to provide the additional support required for Patrick.	**3. Jack** is a British Asian 8-year-old with cerebral palsy. He walks with the support of walking sticks and leg braces. He has difficulties talking and swallowing. He also suffers from moderate learning difficulties and attends a special school. He has regular admissions to hospital suffering from pneumonia. He also has significant hearing loss. His single mother suffers from periodic episodes of depression. They receive support from their extended family.
 Working age adult	**4. Asha** is a British Asian 22-year-old and has suffered from ADHD since primary school. She lives with her family in Archway and is studying economics part-time at London Met university. Her ADHD impacts her performance at university. She has struggled to maintain a job because of her impulsiveness.	**5. Daniel** is a Black 48-year-old man and lives in Tottenham. He suffers from schizophrenia and has been in and out of mental health inpatient facilities including PICU since he was 17. He lives in supported accommodation and is unemployed. His two brothers and mother are supportive but cannot contact him when in crisis. He usually turns up in A&E when he is in crisis. He has asthma but does not reliably take his medication.	**6. Melissa** is a 55-year-old Black woman from Kentish Town with poorly controlled Type I diabetes, and chronic diabetic foot ulcers. These frequently become infected, and she requires hospital admission for treatment of sepsis. She suffers from chronic back pain, is obese and has episodes of depression. She has an opioid addiction. She frequently has to have time off work. She lives with her partner.
 Older people	**7. Vera** is 70, white, lives alone in Bounds Green and is in hospital having fallen over and fractured her hip. She is isolated and lonely. While in hospital, she is very anxious and tells staff that the night team have been stealing her possessions. The ward physio does not feel that she can safely be discharged home because of her poor mobility and her previous history of falls.	**8. Paul** is 72, recently widowed, lives in Edgeware and is Black Caribbean. He has high blood pressure and is now partially sighted. His son noticed he has lost interest in activities and is withdrawn, confused and finds it hard to engage in conversation and he has been getting lost. Paul does not think there is a problem and declines any help.	**9. Yasmiin** is 87, from Somalia and a long-term resident of Camden but now lives in a Care Home in East Barnet nearer to her family. She has mild dementia, breast cancer, heart failure and is thought to be in last 6 months of her life. She has had four hospital admissions in the last six months with breathlessness related to her heart failure.

Example pathway: Teenager with early mental health difficulties

Freya is a white 14-year-old teenager whose academic performance at school has been deteriorating and appears withdrawn and tired in class. She has stopped playing in the band she was formerly a member of. She lives in cramped accommodation with not much money at home, her parents are separating, and she is being bullied at school.

Purple = care functions accessed in the example pathway that are part of the scope of the core offers (community and MH)

Orange = other functions that are accessed in the example pathway but are out of scope of the core offers



What care will look like through the core offer

Freya's school tutor (who has received training under the universal mental health offer) is concerned and has a 1-1 catchup with Freya and asks the local mental health in schools team to see her via the central point of access. The school tutor also provides support with the bullying in line with the school's whole school approach. Freya is seen within two weeks by a mental health in schools practitioner, has a full holistic assessment and is diagnosed with mild anxiety and depression. She is signposted (THRIVE getting advice) to some self-help materials and information re sleep hygiene and anxiety management. She is encouraged to engage with the NCL online digital mental health counselling and peer support offer. Freya's parents are both engaged with group based parenting support. She is also encouraged to sign up to a local resilience building music activity based at local youth club run by the VCS. Freya's mood and anxiety improve and her grades start to improve. Her GP is kept updated via the digital integrated care record.

Subsequently however, her mood does worsen, she starts withdrawing again from activities she previously enjoyed and reports not being able to get to sleep at night. She reports this to the school nurse when having a routine vaccination. The school nurse gets in touch with the mental health in schools practitioner who reviews Freya again. She assesses that Freya's anxiety and depression has worsened and arranges for Freya to be reviewed together with her parents by the core CAMHS community team within two weeks. They co-produce a treatment plan with Freya and her parents together with the school mental health practitioner. This involves a course of cognitive behavioural therapy alongside the ongoing digital support and the support for her parents. Freya's mood improves and she is able to return to her normal level of functioning.

Example pathway: Child with autism and cognitive impairment

Patrick is a 7-year-old Black Caribbean boy. He has a diagnosis of autism and also suffers from ADHD. He suffers from language and cognitive impairment and attends a special school. He is cared for by his parents who have two other children who do not have Autistic Spectrum Disorder.

Purple = care functions accessed in the example pathway that are part of the scope of the core offers (community and MH)

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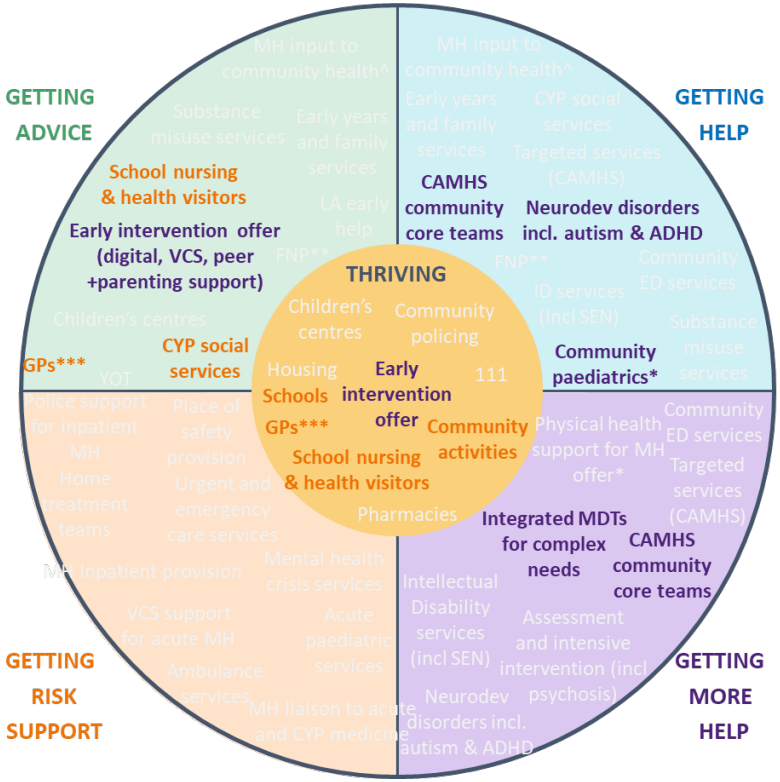


What care will look like through the core offer

Patrick's care is case managed by the neurodevelopmental diagnostic and treatment service and a joint care plan has been developed. His care is regularly reviewed at an MDT involving his parents, his teachers, early help social worker, community paediatrics and members of the neurodevelopmental team. All professionals utilise a digital shared care record which primary care and social care also have access to.

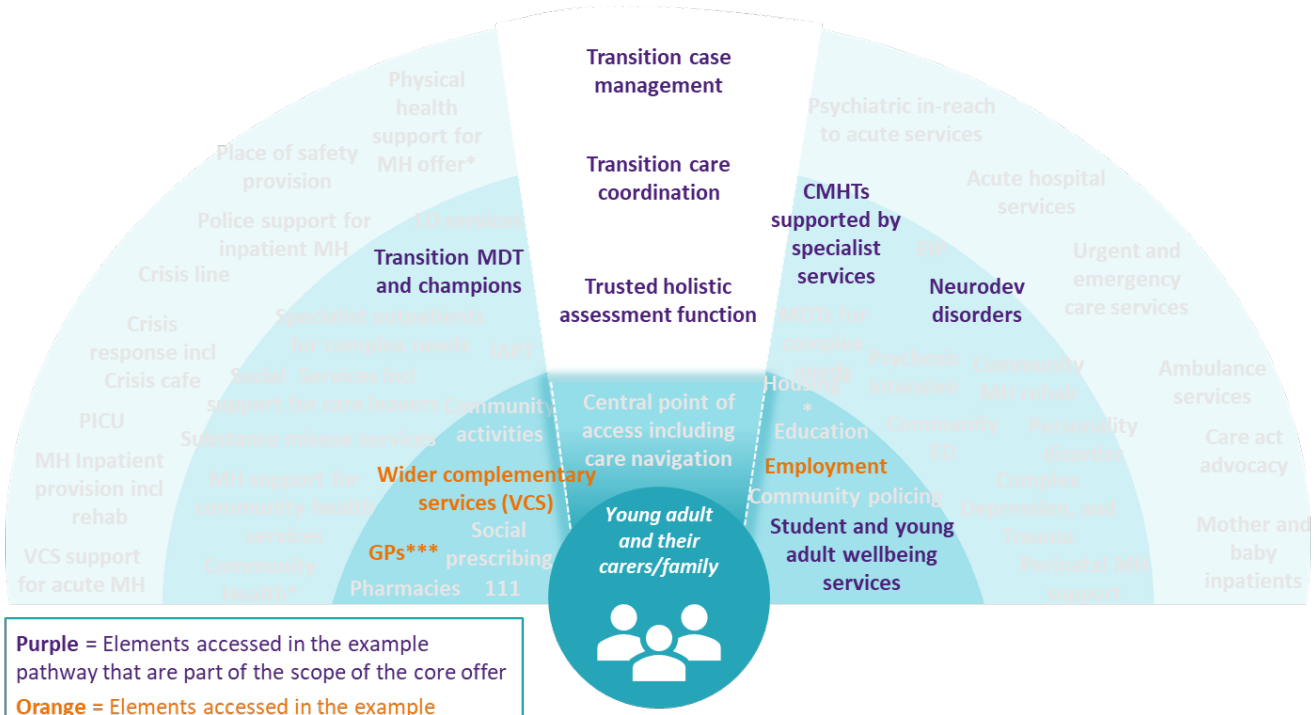
Patrick and his parents are supported to navigate the support available to them. His parents have a number they can contact to get in touch with his case manager during normal hours and an out of hours crisis plan. Teachers and support staff at the school also receive regular training in how to support management of autism. This includes how to best support his education.

Therapeutic support includes delivery of played based and behavioural support in conjunction with training and support for parents and teachers.

He has regular reviews by a child and adolescent psychiatrist, this was how his anxiety was originally diagnosed. His anxiety is managed through a mix of therapy and medication. His parents are supported by CYP social care early help who have arranged for episodes of respite care (short breaks). Regular holistic reviews include assessment of the emotional and practical support requirements for parents and siblings.

Example pathway: Young adult with mental health needs

Asha is a British Asian 22-year-old and has suffered from ADHD since primary school. She lives with her family in Archway and is studying economics parttime at London Met university. Her ADHD impacts her performance at university. She has struggled to maintain a job because of her impulsiveness.



Purple = Elements accessed in the example pathway that are part of the scope of the core offer

Orange = Elements accessed in the example pathway that are out of the scope of the core offer

What care will look like through the core offer

Asha's care is case managed by the local adult core mental health team with the support of a transition clinician from the CAMHs neurodevelopmental team. Her transition from being supported by CAMHs to the adult team was smooth because of regular discussions by the transition MDT. She has a regular review for her ADHD and has the support of an occupational therapist who supports her with both studying and provides vocational support

She accesses a local young adult wellbeing hub in Holloway through which she joins a peer support group and vocational training courses. She also accesses online self help resources through the NCL digital offer

When she sees her GP practice nurse for a contraceptive checkup, she asks how Asha is getting on, as she has access to Asha's integrated digital care record.

Example pathway: Working age adult with severe and enduring mental illness

Daniel is a Black 48-year-old man and lives in Tottenham. He suffers from schizophrenia and has been in and out of mental health facilities since he was 17.

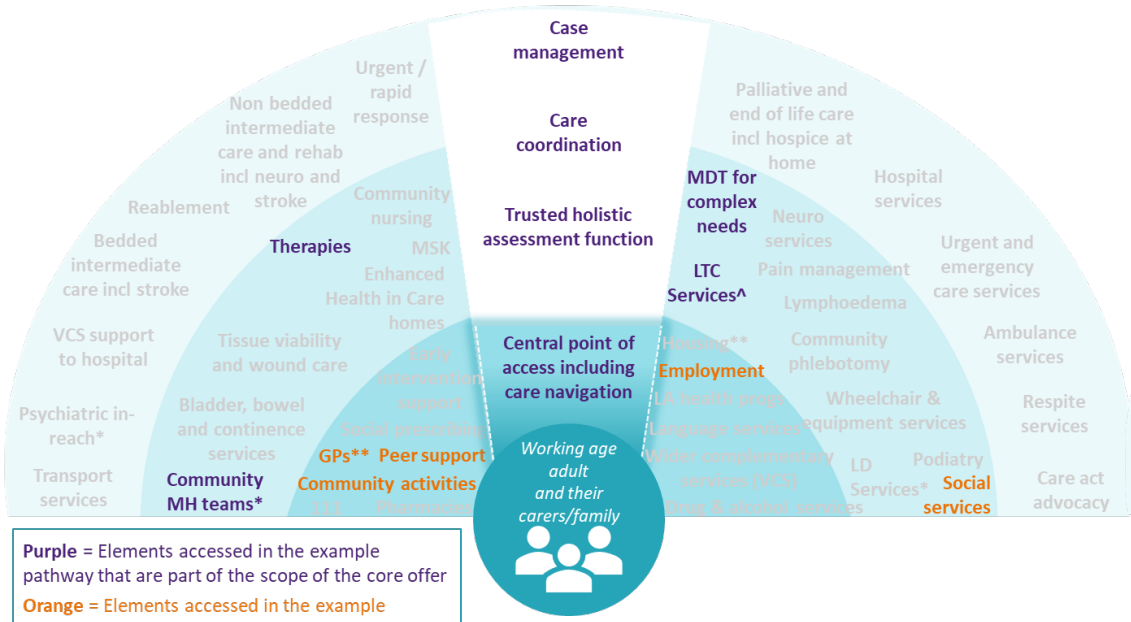
Daniel lives in supported accommodation and is unemployed. His two brothers and mother are supportive but cannot contact him when in crisis. He usually turns up in A&E when he is in crisis.

He has asthma but does not reliably take his medication.

What care will look like through the core offer

Daniel's care is coordinated by his core mental health team, where he has a case manager. Daniel, his family and other health and care professionals can contact his case manager with any queries about his care. He regularly receives his antipsychotic depot injection. The core team regularly reviews Daniel's mental state and gets input from his wider team including his social worker, housing worker and specialist mental health teams as required. He is supported by an occupational therapist regarding his home functioning and is currently being supported to attend an adult learning course. He has just completed a period of intensive support with the community rehabilitation team following his previous mental health admission. This has enabled him to move successfully into his current supported accommodation and to start the course. He is supported to attend a peer support group at the local mosque of which he is a member. Fortnightly reviews with Daniel mean that deteriorations in his mental health state can be quickly picked up and the Crisis home treatment team can provide support to avoid Daniel reporting in crisis to A+E or the place of safety. When the Imam at his mosque becomes concerned about his deteriorating mental health, he is able to contact the crisis line who is aware of Daniel's crisis plan and arranges for an urgent Home treatment team review together with his case manager. He has a yearly full physical health check from the community nurse embedded in the core team. He is supported by his case manager to attend regular reviews with the respiratory nurse who comes to see him at his supported accommodation alongside his case manager. The respiratory nurse is able to access and contribute to Daniel's shared care record.

Community health offer



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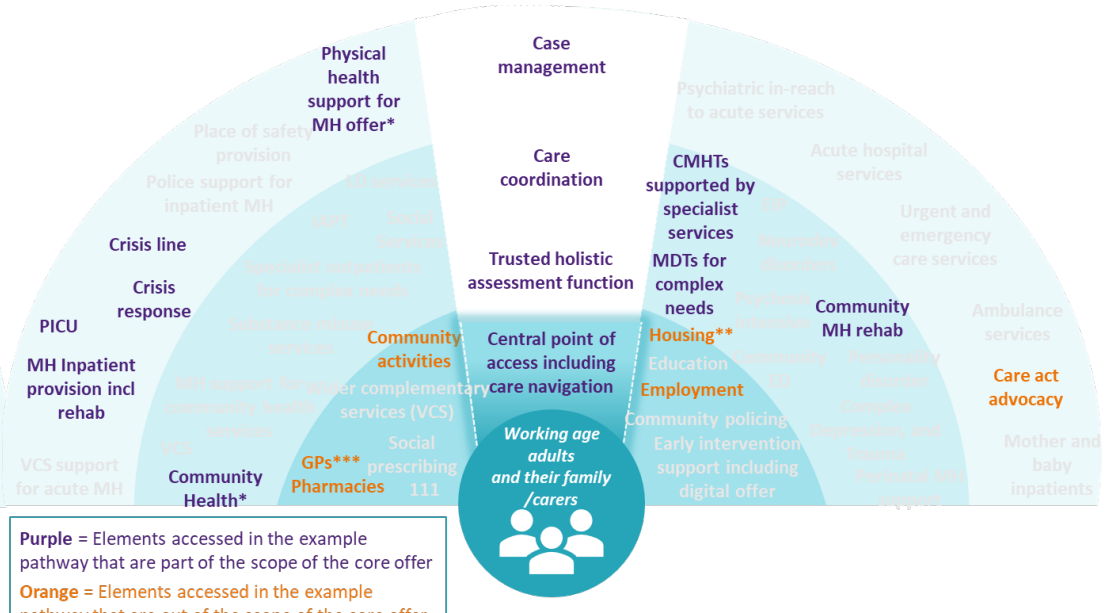
Mental health offer



Purple = Elements accessed in the example pathway that are part of the scope of the core offer

Orange = Elements accessed in the example pathway that are out of the scope of the core offer

Example pathway: Older adult with likely dementia

Paul is 72, recently widowed, lives in Edgware and is Black Caribbean. He has high blood pressure and now partially sighted.

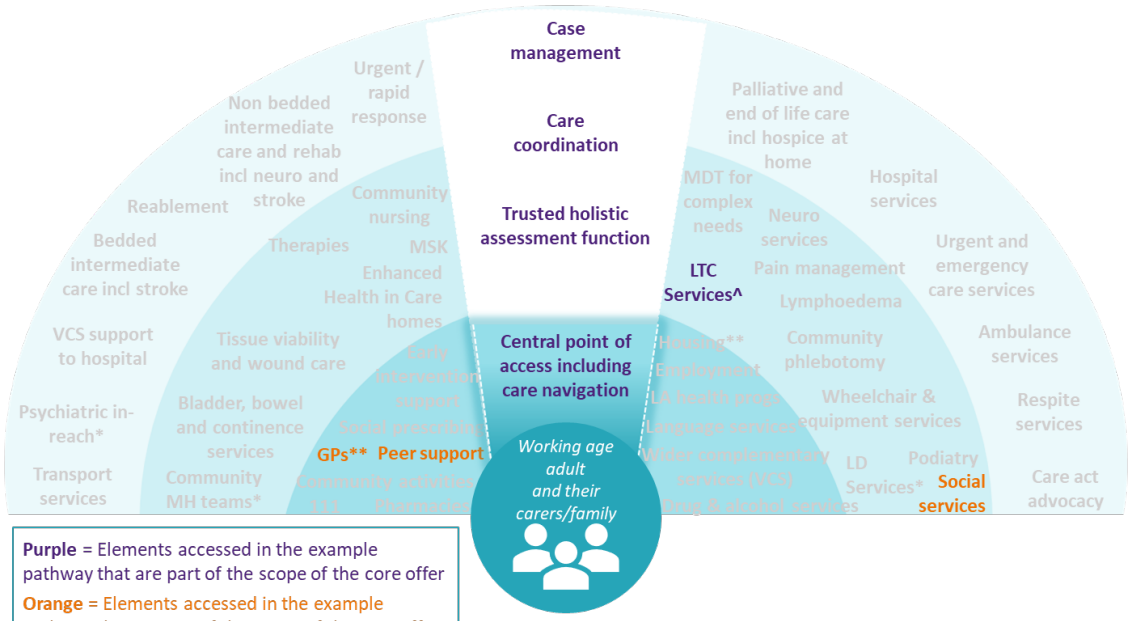
His son noticed he has lost interest in activities and is withdrawn, confused and finds it hard to engage in conversation and he has been getting lost.

Paul does not think there is a problem and declines any help.

What care will look like through the core offer

The GP carries out an initial mental health assessment having received specialist training and support from the memory clinic and contacts the central point of access. This arranges for Paul to have an assessment at the local memory clinic with an older adult psychiatrist or geriatrician. Both Paul and his son's ideas, concerns and expectations are considered and a full assessment of Paul's social and living arrangements is made. The memory clinic MDT reviews the results in conjunction with the assessment and a mild-moderate dementia diagnosis is made. A holistic care plan is developed with input from Paul (as appropriate), his son, and from a social worker linked to the team who assesses the home circumstances and level of risk. Paul is allocated a case manager who acts as a point of contact for Paul, the family and any professionals and supports Paul and his family to understand the condition and make shared decisions, which prioritise Paul's preferences where appropriate, and to access local support groups (e.g. peer support). The case manager gets input from community cardiovascular team to develop a care plan and supports Paul to have a review of his sight at the optician. Paul is encouraged to join local wellbeing activities of his preference and to take part in cognitive rehabilitation therapy and stimulation therapy. Paul agrees with some encouragement from his son to start taking some dementia medication on the advice of the Memory clinic. Paul has three monthly reviews with the Memory clinic and a monthly review with his case manager. A package of care is arranged to support Paul to manage safely at home alongside support from his son. A social worker regularly reviews how Paul and his son are getting on with the potential to increase the level of carer support and/or provide respite care if required.

Community health offer



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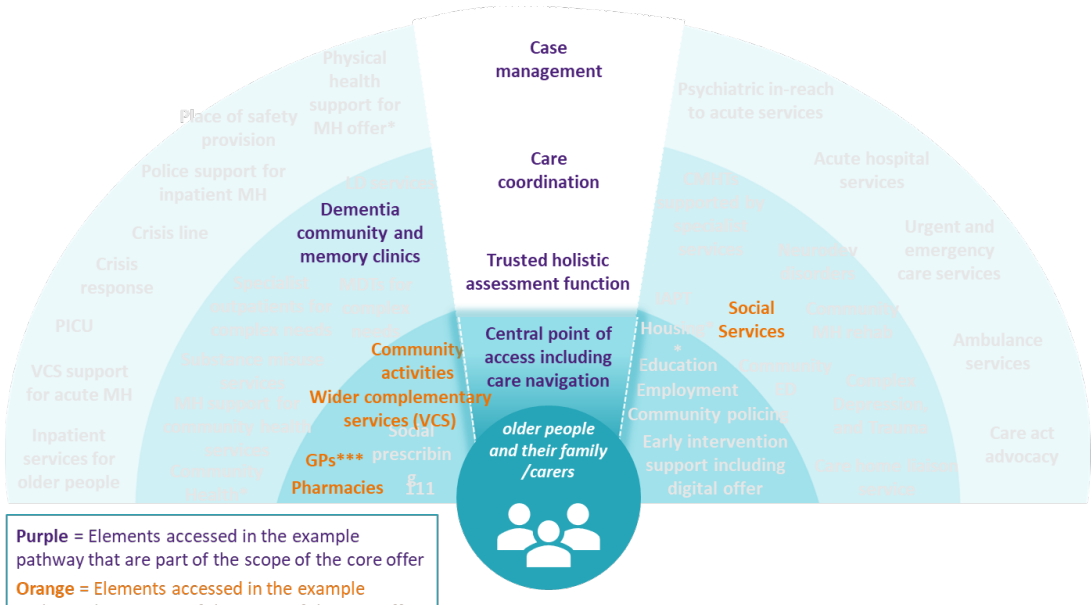
Orange = Elements accessed in the example pathway that are out of the scope of the core offer

Mental health offer



Purple = Elements accessed in the example pathway that are part of the scope of the core offer

Orange = Elements accessed in the example pathway that are out of the scope of the core offer