SECTION B PART 1 - SERVICE SPECIFICATIONS

Mandatory headings 1 – 5. Mandatory but detail for local determination and agreement.
Optional heading 6. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement.

Service Specification No.	
Service	**Intermediate Support Team (Older Adults & Advanced Care)**
Commissioner Lead	**Blackburn with Darwen CCG on behalf of;** • **East Lancashire CCG** • **Blackburn with Darwen CCG** • **North Lancashire CCG** • **Fylde and Wyre CCG** • **Blackpool CCG** • **Greater Preston CCG** • **Chorley and South Ribble CCG** • **West Lancashire CCG**
Provider Lead	**Lancashire Care (NHS) Foundation Trust**
Period	**2013-14**
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

- NSF for Older People – DH (2000)
- NICE Guidelines (2006)
- NSF for Long Term Conditions – DH (2005)
- National Dementia Strategy – DH (2009)
- Everybody's Business (2005)
- Halfway Home (DH 2009)
- National Dementia Strategy (2010)
- Lancashire Dementia Case for Change (2011)

The Intermediate Support Team (IST) acts as an integral part of the adults secondary mental health service, with connections and impacts on broader areas of acute and older adult health and social care. This service is a distinct intensive community support (eg. capable of visits up to 3 times a day)

The IST functions as a multidisciplinary, adult community based service with the key focus on older adults and those requiring advanced care. The IST services are designed to:

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- Prevent inappropriate admission to mental health inpatient beds
- Facilitate timely discharge from hospital to the client's home.
- Offer specialist mental health expertise to wider health and social care services
- Support long term condition and end of life pathways
- Provide comprehensive, multidisciplinary holistic assessments, resulting in a structured individual care plan that involves intervention to maximise patient's independence for them to resume living at home
- Provide a Gatekeeping function, initially most appropriately for care home cases where an admission is being considered, including Mental Health Act assessments to provide intensive support to care and nursing homes in the care of those with dementia
- Be time limited: on average four weeks

The IST function also involves an integrated care provision approach aimed at independence and recovery by; promotion of positive risk taking, reducing unnecessary levels of risk, and supporting a return home or maintained placement in the least restrictive care home setting.

IS teams will focus on meeting, at critical times, the mental health needs of patients whose mental health conditions are complicated by physical health co-morbidity, by increased physical vulnerability and risk, and by factors relating to later life stage changes. These service users might be have a diagnosis of dementia, may be physically infirm, vulnerable to falls, have sensory impairment, physical health issues and/or co-morbidity, and be taking multiple medications as well as suffering from a mental illness.

Although these broad themes may be apparent as early as someone's 50s they are probably more prevalent in those aged over 75. Using the 'advanced care' approach to community input for functional mental illness, people over 75 may be aptly supported through the IST following admission.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

3. Scope

3.1 Aims and objectives of service

The overall aim of the service is to provide a rapid response to enable intensive short term support to older people diagnosed or presenting with functional or organic mental illness in any setting. The Intermediate Support Team provides a range of care services aiming to:

- Promote faster recovery from illness
- Prevent avoidable deterioration
- Maximise residual skills and independent living
- Avoid unnecessary hospital admission through a gate keeping role
- Enable patients to regain skills and confidence following a period of ill health
- Facilitate timely discharge from in patient care
- Increase resilience of carers
- Avoid inappropriate admissions to care homes and movement between homes
- Provide liaison, education and training for formal / informal carers.
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Where intensive short-term interventions are required to stabilize a situation, beyond what other teams are able to deliver. The IST will work with service users, their families and carers in their own

home and in other community settings. This will include residential and nursing care settings, where the Care Home Liaison Team have identified a need, and supporting more challenging discharges from in-patient settings, including general hospital where the Hospital Liaison Team have identified a need.

The objectives of the IST service are:

- to provide a high-quality facilitative specialist assessment and mental health support
- to ensure that the IST service is readily accessible and meets the range of needs of the local population, including minority groups
- to ensure that older people with mental health problems and their carers have appropriate information that allows them to manage their care more effectively along the pathway and understand how to access other assistance
- to engage people with mental health problems and their carers in decisions about the care options available to them
- to ensure continuity of care across the entire health pathway and integration with other care providers
- to reduce premature admissions or moves to long term care
- To intervene at a stage where risk is still manageable and the situation can be stabilised, where the situation is deteriorating, but not critical.
- to ensure that the service is delivered in a considered, timely and co-ordinated manner for those in acute settings and care facilities

3.2 Service description/care pathway

Intensive Short-term Interventions Intermediate Care/ Home Treatment

- Proactive work to stabilise and reduce risk before it becomes a crisis
- Maximise residual skills and independent living
- Promote faster recovery from illness
- Prevent avoidable deterioration / relapse
- Prevent escalation to crisis
- Prevent early admission to long-term care
- Support discharge from mental health wards where the discharge is complex or there is a history of readmission
- Support discharge planning from acute hospital where there is an identified possibility to avoid admission to residential care
- Maximize independence, choice and control
- Address whole needs
- Reduce long term dependency

Crisis Management

- Support CMHT, through involvement at the earliest instance, where it is identified a person requires intensive support in order to prevent further relapse
- Out of CMHT operational hours, accept referrals where it is identified that a person requires intensive support in order to prevent further relapse by a team with specialist skills in assessing and addressing the needs of people with dementia or advanced care needs

Triage (telephone) and Gatekeeping (face to face)

- Gatekeeping provides a face to face assessment where an admission is imminent in community settings and in general hospital, in order to consider the potential for an IST intervention to divert from admission if possible or to bed-find where this is not possible. In

some cases, such as some Mental Health Act assessments, where a delay would be unacceptable, as a minimum, detailed discussion would be undertaken by telephone.

Interventions will be undertaken in the following areas:

- Provision of therapeutic activity, lifestyle or wellbeing related activity tasks (largely working with staff to continue this).
- Supervision, advice or role modelling regarding management techniques (demonstrating approaches to existing domiciliary care services and residential/nursing homes staff in what ever their duties involve)
- Providing education and demonstrating approaches with informal carers
- Care planning including comprehensive Risk Assessments and Management
- Psychological support to service user and carer.
- Symptom monitoring.
- Short term therapeutic interventions (e.g. Cognitive Behaviour Therapy, Solution Focused Brief Therapy)
- Use of Assistive Technology to aid risk assessment and management.

Days/ hours of operation

The IST will provide a seven day per week service whereby they are able to visit or provide telephone support over extended hours (8am – 8pm)

Referral processes

Referrals will be accepted within the IST throughout in hours and extended hours. Response time will be dependent on clinical need, but in general

- Gatekeeping within 4 hours
- Urgent within 24 hours
- Where the referral is more routine or planned, contact will be made within 24 hours and assessment started within 5 days or as agreed with the referrer, service user and/or carers.

On referral the following information will be reviewed:

- Risk assessment
- History of mental health
- Presenting problem
- Intermediate care need
- Carer input

Team acceptance Guidelines

- Referrals and non-gatekeeping referrals should be accompanied by any assessments available and/or accessible relevant information.
- Service users should be informed that the referral is being made and, as far as possible, will have agreed to this referral.
- The referrer and GP will be informed by letter that the case has been accepted by the Intermediate Support Team.
- Agreement will be reached with the referring agency regarding care coordination.
- In terms of individuals with adult advance care needs, it is clinically appropriate to assess need rather than by chronological age since ‘normal’ aging evolves with each generation.

Management of the referral

IST will collate referral information in order to stimulate all information required for the referred person and the response required will be dependant on setting and response requested by the referrer.

Lancashire will implement the whole service approach to the IST care delivery. The comprehensive assessment and support with an identified IST qualified clinician will be undertaken for all accepted patients by IST services.

Intermediate support will in most cases be conducted face to face and be integral to determining the

individual offer of support to the service user/carer/provider. Service users will be encouraged to have accompaniment by a carer at an initial assessment. Where the carer is unable to be present, conversations with the carer may take place separately. Where appropriate, involvement of advocacy services will be encouraged.

Care pathways

Transfer of care from other services to IST (CMHT/Long term conditions team/Social services)

- In some circumstances it may be more appropriate to remain involved due to the rapport / relationship with the service user/ carer.
- There may be occasions that IST will Care coordinate patients until another health or social care worker is identified.
- The IST will ensure ongoing involvement from relevant professionals as part of their intervention and discharge planning.
- Involvement from IST ought not be simply to provide a diagnosis
- Where it is apparent the service user's needs are complex and relate predominantly to the individual's mental health, the case may be taken over comprehensively by the IST but use complementary provider resources such as a rehab unit.

Urgent cases not open to Mental Health

- IST will be contacted with a view to a joint visit. If time limited, intensive interventions have the potential to resolve the crisis, IST will take on management of Home Treatment

Interface with residential Intermediate Care

- IST will working in partnership with residential Intermediate Care services for people who have dementia, as appropriate, and provide appropriate interface with step up / step-down and other interim residential services for people with significant problems associated primarily with dementia

Interface with Approved Mental Health Practitioners (AMHP)

- In most cases, gatekeeping assessments will be initiated by the referrer or the AMHP as part of the initial assessment process, prior to a Mental Health Act (S13) assessment being undertaken. This has the potential to reduce the number of S13 assessments undertaken, by diverting from admission at an earlier point.

Interface with Community Health

- IST will work in close partnership with Community Health staff to address the physical health issues of Service Users undergoing intermediate care and Home Treatment interventions
- IST will work collaboratively with Community Matrons where Home Treatment interventions have the potential to prevent an admission to residential care or hospital

Interface with General Practice

- IST will inform the GP when a case is referred/accepted within 24 hours
- IST will work closely with the GP to ensure any physical health issues are addressed promptly
- IST will provide a letter to the GP at discharge, informing them of progress, outcomes and of any on-going care plans

Interface with General Hospitals

- IST will work with in-patients in acute hospitals, where Mental Health services have identified complex discharge needs which could be supported by IST, particularly where there is the potential for a return home with this support

Interface with Mental Health In-patient units

- Where IST have undertaken a gatekeeping assessment but an admission is unavoidable, IST will identify a bed and inform the ward and the Discharge Liaison practitioner of the admission
- Discharges will be supported seven days a week and all admissions will be screened within 24 hours and monitored throughout to identify the potential for early discharge and Home

Treatment, even when the person may remain symptomatic.

- IST will include a Discharge Liaison Practitioner role, focused on the in-patient units. This role will assist inpatient staff to track and structure various aspects of the discharge process facilitating timely discharge.

Interface with Crisis Resolution and Home Treatment (CRHTT) & out of hours teams

- CRHTT and IST will offer advice and support to each other, where needed, and may work jointly on some cases
- The CRHTT duty worker will collaborate on gatekeeping for people with Dementia or Advanced Care
- Out of IST extended hours, CRHTT and the local authority out of hours services be involved to determine admission assessments. Where the person has identified Advanced Care needs, CRHTT will follow any existing contingency plans, if the person is not admitted, and will transfer responsibility to IST as soon as possible

Discharge process

Discharge might be considered through multi-disciplinary review at the point when the case becomes less intense and the aims of IST's input are reviewed or when :-

- The individuals problems have improved, stabilised, resolved or at an acceptable level to the patient, referrer and carer.
- Where a more appropriate service for care has been identified and can be safely transferred to or continued by other agencies.
- If the service user is admitted to hospital (re-referral for discharge may later be initiated).
- When appropriate continued input from Mental Health services is assured
- Local authority or shared care intervention may satisfy the needs

Any discharges will only take place, following a CPA review and agreement, regarding any ongoing care plan.

The person's GP, referrer and all other parties involved will be informed of the outcomes of the teams' interventions when the person is discharged from the team.

3.3 Population covered

This service is to be delivered across the Lancashire area from within PCT 'footprints'.
This is contingent with the Transition plan.

3.4 Any acceptance and exclusion criteria

- People who reside within the local catchment area and within the LCFT boundary

AND

Treatment at Home:

- People who have a diagnosis of dementia, or may not have a diagnosis but are presenting in a way that indicates they may have dementia
- People who have a diagnosis of functional/psychological mental health needs which meet the criteria for Advanced Care and would best be met within older adult mental health services, or are presenting in a way that suggests they may be experiencing functional/psychological mental health problems.)

AND

- Will benefit from a time limited intensive period of treatment

OR

Gatekeeping Assessment:

- People who have a diagnosis of dementia, or may not have a diagnosis but are presenting in a way that indicates they are likely to have dementia
- People who have a diagnosis of functional/psychological mental health needs which would best be met within older adult mental health services, or are presenting in a way that suggests they may be experiencing functional/psychological mental health (Advanced

Care).

The person referred will likely be in one of the following situations:-

- Potential to require admission to a mental health admission ward, and would benefit from multi disciplinary, short term, intensive input from older adult mental health services to prevent the admission:
- The person is currently on an acute hospital or mental health ward and requires support to facilitate the discharge, in collaboration with care co-ordinator where necessary. This may also involve patients whose care may be considered delayed.
- Where a person who is not an in-patient is to be placed in a care home and is very likely to present with challenging behaviour that will need intensive support, training and handover to the care home to be successful.
- The person requires short term, intensive support to return them to their home environment
- The person resides in the community (whatever setting) and has experienced a recent deterioration in their mental health or where the carer's situation requires a timely response to be able to stabilise the situation.
- Where a person displays behaviour that challenges with connections to care providers, such that the care agency or care home need intensive support to continue a sustainable care package, stabilise the situation and prevent unnecessary moves. In the case of a care home, IST will support Care Home Liaison in the delivery of intensive interventions.
- The person is undergoing a re-ablement care package or receiving domiciliary rehabilitation and is presenting with mental health issues which require short term, intensive input from a mental health service to prevent premature admission to care or MH ward.
- People in Long Term Care (any registration) who are strongly indicating they wish to return to community living (e.g. sheltered or own home) and who may be able to do so given specialist mental health assessment and intensive support.

The IST will be accessible to all, regardless of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex or sexual orientation, and deal sensitively with all service users and potential service users and their family/friends and advocates. It should design systems and processes for assessment and support that are sensitive to the needs of different user groups (for example LD or where English is not the first language).

Eligibility

The complexity and heterogeneity of symptoms for dementia and advanced care makes it difficult to provide a list of referral criteria; instead support from the IST will be a clinical decision based on the possibility of their benefiting from the support and advice of a specialist intermediate mental health service. This will be on the basis of presenting symptoms, a review of past and collateral history from an informant, exclusion of other acute medical reasons such as delirium by physical examination and investigations.

IST will offer support in any intervals prior to investigation results.

In a needs lead service, service users who may meet an advance care category form a naturally separate grouping which will allow them IST access facilitating the efficient use of trained resources separate to other specialisms of dementia care and general adult psychiatry. This aims to minimise age discrimination against the elderly as they compete for, and are marginalised in, services that focus on younger individuals with different illness and risk profiles.

3.5 Interdependencies with other services

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

4.2 Applicable standards set out in Guidance and/or issued by a competent body

4.3 Applicable local standards

This service should adhere to all relevant standards, guidelines and local formulary. The service should notify commissioners should any benchmarking against these standards identify gaps in commissioned services.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

The Provider's Premises are located at:
At appropriate sites throughout the LCFT footprint, associated with the transition plan.

7. Individual Service User Placement

[Insert details including price where appropriate of Individual Service User Placement]