SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	
Service	Mental Health Rehabilitation
Commissioner Lead	Rosie Penlington, Commissioning Project Manager, Integrated Commissioning Service.
Provider Lead	Julie Leigh, Head of Recovery and Planned Care Mental Health, Solent NHS Trust
Period	September 2019 onwards
Date of Review	September 2021

1. Population Needs

1.1. National/local context and evidence base

Mental health rehabilitation services provide specialist care to people with complex problems who have not recovered adequately from an acute episode of illness to return home.

Rehabilitation is "a whole systems approach to recovery from mental illness that maximises an individual's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future and leads to successful community living through appropriate support."[1]

Despite the investment in community mental health services in recent decades, there remains a group of service users with very complex needs who require specialist inpatient and community rehabilitation. The cost of services that provide for this group of patients is between 25 and 50% of the total national mental health budget in England.[2]

People in receipt of rehabilitation services are a low volume, high need, high cost group with complex problems that complicate their recovery. These include treatment resistance, which occurs in up to 30% of people with schizophrenia, cognitive impairment, pervasive negative symptoms, poor social functioning and challenging behaviours.

There is good evidence that rehabilitation services are effective. Around two-thirds of people supported by rehabilitation services progress to successful community living within 18 months of admission to an inpatient rehabilitation unit, two-thirds sustain this over five years without requiring further hospital admissions, and around 10% achieve independent living within this period. People receiving support from rehabilitation services are eight times more likely to achieve/ sustain community living, compared to those supported by generic community mental health services.

NICE are developing national guidance for *rehabilitation in adults with complex psychosis and severe mental health conditions* which is expected to be published in June 2020[2].

[1 & 2] Joint Commissioning Panel for Mental Health - Guidance for commissioners of rehabilitation services for people with complex mental health needs

[2] https://www.nice.org.uk/guidance/indevelopment/gid-ng10092

2. Scope

2.1. Aims and objectives of service

The service will provide a community based mental health intensive rehabilitation service delivered in service users home environments, and the partnership provision of rehabilitation supported living accommodation. Rehabilitation will be available following admission to an acute MH hospital, and also as a step-up function from the community to prevent the need for admission.

Rehabilitation is “A whole system approach to recovery from mental ill health which maximizes an individual’s quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future and which leads to successful community living through appropriate support.” *(Killaspy et al, 2005)*

2.2. Service description/care pathway

The service will provide intensive, time-limited outreach rehabilitation in the home environment or supported living rehab accommodation. Rehabilitation plans will be formulated by a multi-disciplinary team including Psychology, Occupational therapy, Nursing, Social worker, Peer worker and support workers and delivered by the team.

The service will ensure it reflects best practice as per the NICE guidance for *rehabilitation in adults with complex psychosis and severe mental health conditions* which is expected to be published in June 2020.

Medical input will be pulled from existing community psychiatry.

Care pathway

Rehab plans will be developed with service users and carers using Dialog model and delivered across the team via home visits.

The service duration & intensity will be determined by service users needs and the progress against rehab plans, this can extend up to 2 years (following the Sheffield model) or multiple visits a day.

Rehabilitation may include support with :

- Ability to scale support up or down considering mental state, risks, ability, rehabilitation goals and recovery capital.
- Build or improve ability to manage ADLs such as Self Care, Shopping, cooking; laundry
- Build confidence
- Community / Social Integration.
- Medication administration and Concordance
- Understanding of illness and illness management.
- Relapse prevention.
- Improvement of mental and physical condition.
- Maintain safety and manage risk.
- Opportunity to look beyond survival but build hope
- Psychological Interventions such as Anxiety Management, Distress Tolerance; Motivational Interviewing; Behavioural Activation; CBT etc.
- Structured activities to encourage lasting community engagement.
- Link with Social and leisure groups, recovery focussed psychosocial groups.

- Confidence building and promoting hope, often we hold the hope until Patient is able to gain enough self-belief to garner their own hope and identify their strengths.
- Support in managing harmful habits such as harmful alcohol use and illicit drug.
- Good quality, safe housing with right level of support.
- Support and recovery plan to include, family, carers, partners, friends. (Open Dialog)
- Tenancy support with finances, rent, bills, benefits.
- Involvement with peer recovery groups.
- Opportunity to learn new skills, regain lost skills.
- Opportunity to stay in job, maintain job.

Active rehab - if service users are deemed to have no rehab potential or fail to engage in rehab plans / activities they will be discharged from the service back to community teams and encouraged to come back under specific circumstances.

Regular reviews of progress against rehab plans will be held.

Service users will be discharged from service when their rehab goals have been met or if no continued progress is being made/no further rehab potential is identified. This will be an MDT decision with patient and carer involvement.

The service will manage a caseload of up to 18 service users across the team.

Hours of operation will be from 8am- 8pm Monday to Friday depending on patient need. Service users will be supported to develop plans for weekend activities - based on recovery models and social inclusion the service will enable service users to access community assets and build community resilience, rather than become reliant on statutory services. If there is a clear clinical need for support over the weekend the service will flex accordingly.

Rehab accommodation offer

A new partnership arrangement with Two Saints will provide 8 supported living beds with a specific focus on rehab. Housing benefit will cover accommodation costs, and Two Saints support staff will supplement the work of the community rehab team by implementing rehabilitation plans in a suitable rehab environment.

The community rehab team will develop rehab plans and provide in-reach support to the accommodation, and follow the individual in to the community as required

2.3. Referrals

Referrals will be accepted in line with the acceptance criteria below from two distinct pathways:

- **Discharge from acute**
  Wards can make referrals to the service whilst the service user is still an inpatient to request in-reach to begin to develop their rehabilitation plans. Home Treatment Team can also refer to the service following completion of a 3 day follow up visit if it then becomes apparent that a patient would benefit from rehabilitation.
- **Step up element**
- Recovery Teams can refer service users for step-up rehab when their mental health is deteriorating. These referrals will be received from Intensive Case Management, and the rehab service will proactively link with ICM to review whether service users receiving intensive support over a period of time have rehab potential.

Referrals will be made via SystmOne.

2.4. Response times and prioritisation

The Team will aim to be responsive to need and aim to assess potential rehabilitation needs within two weeks, full assessments will be undertaken in a planned and timely way dependent on need.
Prioritisation will be given to those in the Acute wards to enable earliest discharge.

2.5. Population covered

The service covers Adults aged 18 + with a diagnosis of severe and enduring mental illness who are registered with a Portsmouth GP.

2.6. Any acceptance and exclusion criteria

Acceptance criteria: Adults aged 18 + with a diagnosis of severe and enduring mental illness who are registered with a Portsmouth GP and able to identify rehabilitation goals and are willing to engage with the support on offer.

Exclusion criteria: Forensic cases who are not ready to return to the community or require more specialised service, e.g. those high risk to others.

2.7. Interdependencies with other services

The service forms part of the community secondary care offer for mental health and sits alongside Community Recovery Teams, the Intensive Case Management function and Crisis Response and Home Treatment Teams.

Interdependencies include:

- Acute Mental Health Wards
- Adult Social Care
- Housing Providers
- Forensic services
- Primary Care

3. Key Service Outcomes

3.1. Reporting Schedule

The provider and commissioner will meet at quarterly intervals to review demand, activity levels and outcomes with a focus on ensuring demand is appropriately managed and resourced, within high quality services.

3.1.1 Diagnostic Service

Key Performance Indicators	Planned activity
Number of service users receiving rehab services	-
Rehab team caseload	18
Number of service users supported to remain in community setting	-
Number of service users accessing Two Saints Rehab Supported Living	8
Demonstrable improvements being made to patient Dialog scores	+
Further service KPIs are in development	

Related measures - Information Requirements
The length of stay in acute MH beds and occupancy rates will be reviewed
The number and type of ECR placements which will be monitored regularly

4. Location of Provider Premises

The service will be based in St Mary's community health campus and operate from service users' homes (the definition of a home covers a service users usual place of residence and may include residential provision or supported living).

The service will also provide dedicated in-reach to the rehabilitation supported living accommodation hosted by Two Saints.