REPORT TO:	**Health and Social Care Scrutiny Sub Committee 18th October 2016**
AGENDA ITEM:	**8**
SUBJECT:	**Decommissioning Foxley Lane Women's Unit**
LEAD OFFICER:	**Paula Swann, Chief Officer CCG**
CABINET MEMBER:	**N/A**
PERSON LEADING AT SCRUTINY COMMITTEE MEETING:	**Paula Swann, Chief Officer, Croydon CCG Stephen Warren, Head of Commissioning, Croydon CCG**
ORIGIN OF ITEM:	
BRIEF FOR THE COMMITTEE:	To discuss and comment on any areas of concern and/or any further information required.
CORPORATE PRIORITY/POLICY CONTEXT:	

1. EXECUTIVE SUMMARY

1.1 The Croydon Integrated Mental Health Strategy for adults 2014-2019 identified significant local challenges around 'a system that was imbalanced' with a significant number of people in secondary care who could be better managed in community and primary care and an over reliance on inpatient provision. A key outcome from the report was to reset community and primary care as the main setting for supporting people with mental health problems through delivering increased resources available in the community.

1.2 There was agreement amongst stakeholders that greater investment in preventative, early intervention and crisis services should be welcomed and it was generally agreed that moves to divert people away from inpatient services are entirely appropriate.

1.3 During the last two years Croydon CCG has worked in collaboration with the South London & Maudsley NHS Foundation Trust (SLAM) and invested significantly in community care; extending care co-ordinators and the home treatment service (HTT) as well as psychiatric liaison and crisis care to effectively support people out of hospital and prevent avoidable admissions.

1.4 During 2015/16 Croydon saw an increase in people requiring formal inpatient care, which has led to a mental health cost pressure. QIPP savings have been identified to enable both the CCG and SLAM to be able to deliver commitments to improve mental health services within the financial envelope available.

1.5 As part of Croydon CCG's Mental Health QIPP Savings, the Foxley Lane Women's Service has been identified as a QIPP scheme for the service to be decommissioned and provided within a community/primary care setting in alignment with the mental health strategy.

2 BACKGROUND

2.1 Foxley Lane is an eight bed women's inpatient unit for informal[1] patients who are not detained under the Mental Health Act.[2]. It is proposed that the care provided in this unit be provided in the home and in the community by a range of community-based services for people in crisis including the expanded and developed Home Treatment Team and Psychiatric Liaison Services, with the case for change set out in this paper.

3 SERVICE INFORMATION

3.1 The women's service at Foxley Lane has formed part of the acute care pathway for acute inpatient services since October 2010. The team offer a service for women, aged 16-65, with an ongoing mental illness and are who are experiencing a mental health crisis. The service is run by women for women on a day-to-day basis and has a male consultant who visits the unit for clinical review meetings. It was initially set up as a dedicated crisis facility for women in Croydon. However, data on bed use demonstrates it is not functioning in this manner currently. Comparable services are not provided in any other of the four boroughs that SLaM serves.

3.2 Foxley Lane provides assessment, treatment and care to people who are in a position to recognise the signs of their own deteriorating mental illness and are able to request the service themselves. Service users are screened prior to admission to ensure that they are willing to take part in the assessment and treatment process.

3.3 Foxley Lane is not classed as respite provision. Admissions to Foxley Lane are typically complex and multi-factorial and would not meet the threshold for a mainstream respite episode. The most comparable service is the Drayton Park Women's Crisis House (Camden and Islington). No other SLAM facility operates as a dedicated crisis service.

3.4 Since its opening, service developments (notably the development of HTT and the learning obtained from triage wards) have allowed the trust to develop new models of care to support patients in crisis in the community.

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1 Informal patients are patients who have voluntarily agreed to be admitted and who have not been sectioned under the Mental Health Act.

2 Part of the conditions of use of the residential property are that there should not be formally detained patients admitted to the service.

4 SERVICE PERFORMANCE

4.1 Activity

Admissions

On average there are currently 2-3 direct admissions per month to the service and 2-3 transfers from other wards per month. The transfers from other wards are principally from the Gresham, triage, overspill, and private overspill wards.

The graph below shows the admissions from April 2014 until May 2016.

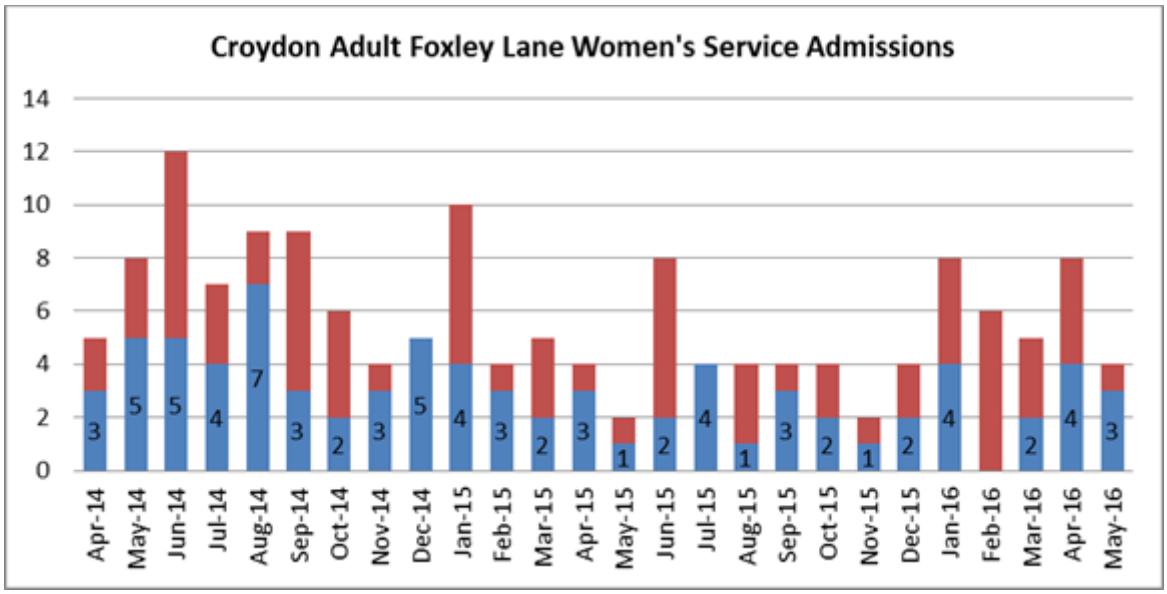

Figure 1: Foxley Lane admissions (Blue: direct admissions, red: transfers).

During 2014/15 there was an average of 7 admissions per month, during 2015/16 there was an average of 4.6 admissions per month and during April and May of 2016/17 there was an average of 6 admissions per month. Table 1 below provides further details.

Table 1: Foxley Lane Admissions

Admissions	Annual total	Direct	Transfers	Monthly ave.
2014/15	84	46	38	7
2015/16	55	25	30	4.6
2016/17	n/a	n/a	n/a	6*

*monthly average for 2016/17 is for April and May only.

Readmissions

Over the last 12 months, there were no readmissions within 28 or 90 days.

Bed Occupancy Levels

Over the last 12 months, the bed occupancy level averaged at 90% excluding leave (94% including leave)[3]. The bed occupancy level of the unit is currently (June 2016) 95% excluding leave (99% including leave)[4]. An average bed occupancy rate of 85% (excluding leave) is considered optimal by the Royal College of Psychiatrists.[5]

Length of stay

The average length of stay for direct admissions (who also complete their stay) at Foxley Lane is 35.9 days and total average length of stay for those transferred into and then discharged from Foxley Lane is 42 days. The average length of stay for adult inpatient services in SLaM for 2015/16 was 43 days. For 2016/17 it was 57 days in April and 45 days in May. Given that Foxley lane is female only (normally associated with shorter length of stay) and accepts only informal patients this is substantially higher than might be expected. The increased length of stay for patients transferred from another ward is also concerning. However it is consistent with other evidence that transferring patients between wards during an admission increases length of stay unless for clear clinical need (e.g. PICU admission).

Patient experience

Overall, according to recent (2016) patient experience (PEDIC) survey results, Foxley Lane patients responded very positively regarding the ward and their care.

4.2 Diagnoses and Demographics of Foxley Lane patients

The women who use the service are mainly diagnosed with:

- mood affective disorders e.g. Bipolar (38%)
- schizophrenia, schizotypal and delusional disorders (24%)
- disorders of adult personality and behaviour (21%).

This compares to other inpatient wards (e.g. Gresham 1 female acute) in which the women are mainly diagnosed with Schizophrenia.

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3 Occupied bed days over the last 12 months excluding leave 2,642 and including leave 2748.

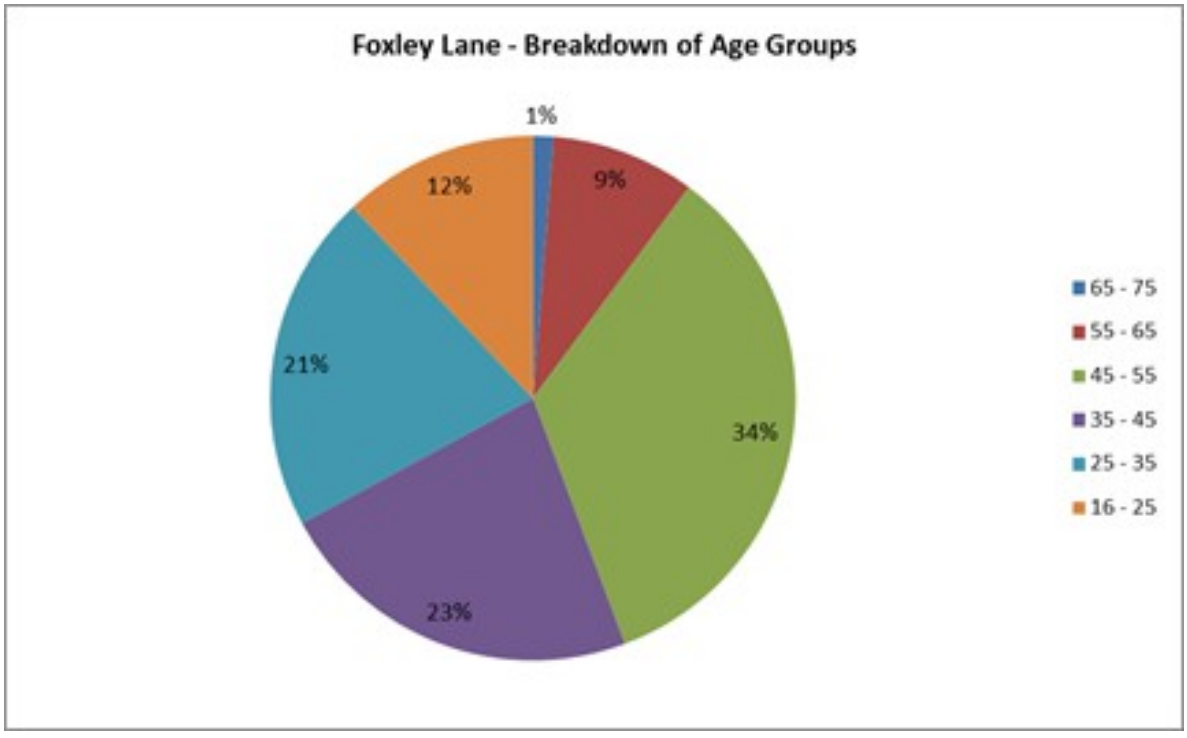
4 Informal patients may have permission to leave the ward for a night or longer to, for example, spend time at home with family as they move towards discharge. Occupied bed days including leave means these nights are counted as occupied. Figures excluding leave mean they only include patients who were physically on the ward (normally calculated at midnight, i.e. patients who were in a bed at midnight on that day).

5 Royal College of Psychiatrists. *Looking Ahead – Future Development of UK MentalHealth Services: Recommendations from a Royal College of Psychiatrists' Enquiry* (Occasional Paper OP75). Royal College of Psychiatrists, 2010.

The service is used by women from a broad range of ethnicities. The largest group using the service is White British (54%). The table illustrates ethnicity in more detail.

Ethnicity	Number	Percent
Asian Other	5	3%
Black African	10	6%
Black Caribbean	6	4%
Black Other	19	12%
Chinese	1	1%
Indian/British Indian	3	2%
Mixed Other	4	3%
Other Ethnic Groups	3	2%
Pakistani/British Pakistani	7	4%
White & Asian	1	1%
White & Black Caribbean	1	1%
White British	85	54%
White Irish	3	2%
White Other	10	6%
Grand Total	**158**	100%

The service is used by women from a wide age range (16-75 years). The biggest age group using the service are aged 45-55 years (34%). Over 75% are aged 25-65 years. The graph below illustrates the age range in more detail.



4.3 Staffing

The unit has 18 staff (13.3 WTE) and a part time ward manager. There is also a visiting consultant. Further staff information is provided in the table below.

Band	**WTE**
Band 2 Unqualified Nursing	4.76
Band 3 Unqualified Nursing	1.00
Band 3 Administration	0.70
Band 5 Qualified Nursing	3.08
Band 6 Qualified Nursing	3.20
Band 7 Qualified Nursing	0.60
Total	**13.34**

Note: This excludes medical staffing

The lower staff grades in this unit and the informal nature of the admissions demonstrate the lower level of need compared to the staffing in the main acute wards.

SLaM would expect to be able to accommodate most Foxley Lane staff within current vacancies in the Acute Clinical Academic Group (CAG). It may be difficult to accommodate the high number of Foxley Lane staff working part time. SLaM would follow the job protection policy throughout.

5 PROPOSAL

5.1 Foxley Lane is no longer able to function as it was initially developed. The data presented demonstrate it is unable to focus on management of crisis admissions and its length of stay is significantly longer than other acute female wards.

5.2 A number of interventions have been developed over the past 6 years that would expect to provide high quality care for this client group. These include the introduction of a new enhanced home treatment service. Home Treatment is available to both men and women of all ages and the access criteria is based on acuity and ability to be treated at home. A proportion of the client group currently admitted to Foley Lane could, it is believed, have their care managed at home by a range of community based services including the expanded and developed Home Treatment Team.

5.3 New models of inpatient care are also better able to manage crisis admissions. Although much of the learning for these developments have come from triage wards there is consistent data that such an approach can be equally successfully used on acute wards for example in Southwark. It is a way of working and not a specific ward type that is important. The learning from triage wards (that regular review and care reduce length of stay for brief crisis admission, and that transfers of care between wards without a clear clinical imperative inevitably increase length of stay) can provide an alternative model of care for those patients who cannot be safely managed at home for brief periods.

5.4 Finally, it is recognised that admissions need to be managed as a system to ensure close working between inpatient and community staff. The acute Care CAG is introducing a new senior management role (Borough Head of Pathway) who will work to ensure the system is operating effectively. Experience within LSL is that inpatient bed management is much easier to achieve if admissions beds are concentrated on a single site. Foxley Lane contributes to the situation currently in Croydon whereby admission beds are dispersed through SLAM and in private overspill.

5.5 Croydon operates a similar model of adult acute care to the other boroughs in which SLAM works. There are however, differences in resourcing reflected in provision for non-crisis community services in the four boroughs. It is expected that the changes discussed above will reduce the need for private overspill bed use. Croydon currently is impeded in operational delivery by its relatively low number of inpatient beds on the Bethlem site. The Acute CAG is currently exploring how this may be rectified. There is widespread acceptance that inpatient care should be provided as close to home as possible and for as short a time as needed. Implementing more robust crisis community services is expected to help deliver this.

5.6 Croydon Home Treatment Team (HTT) is a multi-disciplinary team consisting of both health and social Care staff and provides support for people who are experiencing a crisis and can be supported at home. The HTT operates 7 days a week from 8am until 10pm and provides a rapid response following referral. It provides intensive support in the early stages of a crisis, including social care interventions and actively involves the service user, family and carers.

5.7 The HTT provides a community based treatment service in the community as an alternative to treatment in hospital and the average length of treatment is around 21-28 days. See Appendix 1 for the full HTT service specification.

5.8 There are also Promoting Recovery and MAP treatment services for known service users alongside a range of services for women with personality difficulties (e.g. Touchstone Personality Disorder Service), whilst East and West Assessment and Liaison community services assess people who are new to services. The Borough head of pathway will work with medical leads to ensure active collaboration between these community services and inpatients wards.

5.9 The existing team structures, in particular HTT, are more robust now than when Foxley Lane initially opened and therefore the proposal is to provide better community-based care for the current service users. Croydon HTT currently has 33 WTE staff. Post October the 1st 2016 this will change to 31.8 WTE staff locally with the remaining 1.2 WTE staff going into the central hub (Acute Referral Centre) of 11.5 WTE staff, which will create the 24 hour triage function. The triage function replaces the need for referral forms to be completed. This triage function is expected to release more time for face to face assessments and thus avoid instances where the service is only accepting urgent and emergency admissions. This is expected to further enhance the AMH model principles of supporting care in the community.

5.10 The HTT has also developed a strategy with colleagues in community personality disorder services to strengthen the pathway at the point of crisis for this cohort of users. Specifically under development was the notion of joint assessments and 'up skilling' of HTT staff to enable greater management of patients whose presentations are often complex and with greater risk to self. This process is now embedded as standard practice in the team. Croydon HTT has recently gained Home Treatment Accreditation (HTAS) to up skill the staff team.

5.11 Personality disorder training is seen as the next step in what will be ongoing development for staff. The Personality disorder training assessment upskilling of HTT staff will take place in September.

5.12 The HTT currently operates from 8am until 10pm. From the 1st of October, the service will offer 24 hour gatekeeping. This will enable the service to ensure the least restrictive option of treatment is offered to patients presenting in crisis.

5.13 The HTT is expected to be fully expanded and developed by October.

5.14 The HTT will be providing a fully NICE compliant service once the development is completed in October.

5.15 In addition, there will be communication with existing MAP, Promoting Recovery and Primary Care community services to ensure least restrictive care provision as appropriate.

5.16 The majority of the (Foxley Lane) cohort of patients is expected to benefit from having a greater proportion of their acute crisis managed in their home and local community. Appropriate arrangements will also need to be made for the cohort of patients who are homeless and or require specialist placements.

5.17 In summary, the benefits of the clinical case for change is an enhanced current pathway for female service users in Croydon, avoiding a lengthy inpatient admission and better outcomes for the service and the patient. Patients will have 24/7 access to home treatment which provides care in the least restrictive environment, has enhanced clinical outcomes and shorter acute episodes.

6 FINANCIAL IMPLICATIONS

Savings expected to be achieved for the CCG based on the proposal to close Foxley Lane by redeploying the current staff are outlined in the table below. There are currently no savings allocated from the estate.

Table 2: Savings

Savings	**2016/17**	**2017/18**
Staffing	£138k (to be validated by SLaM and subject to closure date)	576k
Total savings	**£138k** (to be validated by	**576k**

	SLaM and subject to closure date)	

The cost of a bed in Foxley Lane is £295 per OBD compared to an Acute OBD price of £342. The average length of stay for Foxley Lane is 36 days for direct admissions (£10,620) and 42 days for patients transferred in to the service (£12,390). The episode price for Home Treatment Team is £2,431.

7 POTENTIAL RISK

7.1 Potential risks have been outlined as follows with mitigations:

Potential Risk	**Mitigation**
Patient Safety: None identified – patients will continue to be cared for in the least restrictive safest environment.	n/a
Clinical Effectiveness: Potential for some patients to be admitted to an acute overspill bed. This will have an impact on Clinical Effectiveness for that individual if compared to admission to Foxley Lane.	Develop and strengthen the Home Treatment Team (HTT) and provide care in the local community as a model of best practice. In addition, there will be communication with existing MAP, Promoting Recovery and Primary Care community services to ensure least restrictive care provision as appropriate.
Patient experience will be impacted if the individual needs care and treatment away from their support network and family.	Undertake patient engagement to understand the benefits of this service.
Risk of the reduction in beds impacting the remaining Croydon acute wards (e.g. Triage, Gresham 1 and Gresham 2) i.e. increased length of stays and bed occupancy levels. This could also potentially affect private overspill figures. More specifically there is likely to be an issue with a large cohort of patients who are homeless and or require specialist placements.	Develop and strengthen the Home Treatment Team (HTT) to manage patients in the community effectively as described above.
Risk of savings not being achieved due to cost of patients remaining fully or	Other mental health savings schemes proposed to cover any potential gap in

Potential Risk	Mitigation
partially within the inpatient system (OBDs) (e.g. if assessment and liaison service assessed them as requiring inpatient services).	savings.
Risk of slippage in achieving savings due to potential extent of consultation required.	Other mental health savings schemes proposed to cover any potential gap in savings.
Risk of strain on other pathways due to disinvestment in those services e.g. Sun and Touchstone, Promoting Recovery Team etc.	CCG and SLaM will monitor and respond accordingly.
Risk of strain on Home Treatment Team (HTT).	The CCG and SLaM will monitor any impact accordingly.

8 CONCLUSION AND RECOMMENDATION

8.1 Based on the case presented in this report it is recommended that Foxley Lane is decommissioned and that the service is provided as outlined as part of a community based model of care which has been designed to optimise outcomes and value for money.

8.2 The community model will promote equity of access, in that care will be delivered as close to where patients live as possible as well as ensuring equity of outcome for men as well as women.

8.3 Extensive engagement took place across partners and stakeholders including patients and public in the development of the Integrated Mental Health Strategy and the proposed models of care in the community. This has continued with the steering groups overseeing the implementation of the model.

8.4 Given this, it is proposed that engagement for this proposal is undertaken over an eight week period, which will include community meetings, key stakeholders, information and survey, work with key interested groups and users.

8.5 The use of the building itself will be considered as a part of the review of estates that is currently underway within SLaM in support of providing high quality services from high quality estates within Croydon.

8.6 The Overview and Scrutiny Committee is asked:

- To note that the CCG will proceed with engagement around the closure of the Foxley Lane Unit.

- To discuss and comment on any areas of concern and/or any further information required.
- To note the enagagement plan attached at Appendix B

9 EQUALITIES IMPACT

An Equalities Impact Assessment was undertaken as part of the development of the Integrated Mental Health Strategy. A specific equality impact assessment will be undertaken in relation to the segment of the population using Foxley Lane.

10 ENVIRONMENTAL IMPACT

Not Applicable.

Contact Officer: Paula Swann

Chief Officer, CCG

Appendix 1 – Home Treatment Team 2015-16 Service Specification

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	
Service	Adult Mental Health (AMH) - Home Treatment
Commissioner Lead	NHS Croydon (CCG) and NHS Southwark (CCG)
Provider Lead	South London and Maudsley NHS Foundation Trust (SLaM)
Period	2015-2016
Date of Review	19 February 2015

1. Population Needs

1.1 National/local context and evidence base

National Context

"No Health without Mental Health", is the Department of Health's National Strategy for delivering mental health outcomes for people of all ages, including children and adolescents, adults of working age and older adults.

The following six shared objectives were set:

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a positive experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination

It is estimated that nationally, at least 1 in 4 people will experience a mental health problem at some point in their life and 1 in 6 adults has a mental health problem at any one time. People with severe mental illnesses die on average 20 years earlier than the general population. Having mental health problems can be distressing to individuals, their families, friends and carers, and affects their local communities. It may also impact on all areas of people's lives. People with mental health problems often have fewer qualifications, find it harder to both obtain and stay in work, have lower incomes, are more likely to be homeless or insecurely housed, and are more likely to live in areas of high social deprivation.

Southwark and Croydon Context

A Home Treatment Team (HTT) is responsive to the needs of patients known to adult mental health teams. The service is provided in peoples' homes and offers an alternative to inpatient care. Research conducted in the UK indicates that the majority of patients with serious mental illness who are experiencing acute difficulties and their carers prefer community-based treatment as an alternative to hospital admission.

The Home Treatment service is a multi- disciplinary team providing a community based treatment service in the community as an alternative to treatment in hospital. The team gate keeps admissions into the boroughs inpatient services. The team works closely with inpatient services to facilitate an early discharge as soon as possible. The team assess in a variety of locations including the persons' home, A+E and CMHTs. The average length of treatment is around 21-28 days. The service offers a wide range of interventions based on the needs of each individual client and actively seeks the involvement of carers and other professionals involved in the persons care.

The service will adhere to the following principles of care:

- 7 days a week service 8am-10pm
- Rapid response following referral

- Intensive intervention and support in the early stages of the crisis, including anynecessary social care interventions
- Active involvement of the service user, family and carers
- Assertive approach to engagement
- Time-limited intervention with sufficient flexibility to respond to differing needs
- Learning from the crisis
- Facilitate early discharge from acute inpatient wards
- Develop collaborative partnership working arrangement with other services to enable credible alternatives to admission.

There has been much written in a policy context which evidences the effectiveness of Home Treatment Teams for working age adults. The main context being the Mental Health Policy Implementation Guide (DH 2001), which builds upon the National Service Framework for Mental Health and the delivery of the NHS Plan (DH 2000), and provides an implementation guide on the development of Crisis Resolution / Home Treatment Teams.

The clinical evidence for Home Treatment Teams is further promoted by the Sainsbury Centre and National Institute of Mental Health in England (NIMHE). This supports and builds upon the policy context and includes:

- Enhanced clinical outcomes
- Shorter acute episodes
- Less use of hospital admissions
- Reduces bed days
- Greater levels of therapeutic cooperation
- Preferred by users and carers
- Targeted and effective use of resources
- Provides care in the least restrictive environment
- Reduces the trauma of admission
- Reduces stigma
- Maintains the social system
- Shift of power
- More family/carer involvement

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 or 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 aim of the Home Treatment Service is to provide a short term community based treatment and care package aimed at facilitating recovery at home for people in crisis who would otherwise require inpatient care.

Objectives of the service are to:

- Be the treatment of choice for mental health crisis.
- Ensure that clients who could be treated outside hospital are.

- Facilitate early discharge of people receiving inpatient treatment.
- Perform a gate keeping function to control access to adult mental health inpatient beds.

The team consists of both health and social care staff.

Goals: Working with each individual service user, the service will:

- Ensure that the crisis in mental state is resolved
- Ensure that the service user has an agreed crisis plan that gives clear arrangements for any future crisis
- Ensure that the service user is referred on to the appropriate healthcare team.

3.2 Service description/care pathway

All referrals to this service must be made by secondary care mental health professionals. Direct referrals are not accepted from primary care or secondary physical health care staff. All referrals must be made in line with agreed protocols.

Interventions that may be provided

The service will provide the following range of interventions. These will be provided to individual clients as clinically appropriate:

- Comprehensive mental state assessment
- Physical health assessment
- Risk Assessment
- Care Planning, including working with the service user's family and carers
- A designated named worker, who will co-ordinate care to an individual patient
- As much support at home as required to treat the service user at home
- Medication
- Medication review
- Clozapine titration
- Assistance with benefits
- Assistance with housing
- Assistance with arranging child care
- Child Risk Assessment
- Ongoing education and support to family and carers
- Education about the crisis and the service user's illness
- Problem solving therapies
- Stress management therapies
- Brief Supportive Counselling
- Interventions aimed at maintaining and improving social networks
- Relapse prevention plans that identify early warning signs that are shared with the relevant primary and secondary care professionals
- Crisis planning, to ensure that the service user and their family/carers are aware of who and how to call for help
- Effective links with Inpatient services
- Joint discharge planning with the service user and their family to ensure that all service users are discharged to an appropriate service at the end of home treatment.

The service operates from 8 am – 10 pm 7 days per week. Outside of these hours, patients in crisis can be assessed for Home Treatment by the PLNs in A&E, who can accept a patient on behalf of Home Treatment teams. All interventions will be offered in line with the CPA policy, and recorded on the Electronic Patient Journey computer system.

Referral processes

All referrals to this service must be made by secondary care mental health professionals (including PLNs in the Emergency Departments). Direct referrals are not routinely accepted

from primary care and not from secondary physical health care staff. All referrals must be made in line with agreed protocols.

Discharge process

The service user will be considered "ready for discharge" when:

- The acute crisis in mental state has been resolved
- The service has identified the appropriate service to which to discharge the service user and has (in line with the relevant referral protocol) referred the service user to this service or, when the service has arranged and attended a handover meeting between the service and the community mental health team that has ongoing responsibility for the service user's care
- An agreed crisis plan is in place.

Once these criteria are met, the service user will be discharged from the home treatment service.

The Trust will not continue to provide a home treatment service for service users when the above issues have been resolved, but other issues (eg housing) have not yet been resolved. The Home Treatment service will be responsible for passing service users to the receiving service (whether primary or secondary care) clearly setting out the progress that has been made up to the point of transfer and the actions outstanding.

3.3 Population covered

The service is for people aged over 18 with an acute psychiatric crisis of such severity that, without the involvement of the Home Treatment Team, hospital treatment would be necessary.

Geographical population served

This service is provided primarily for service users registered with a GP from Croydon and Southwark CCGs. Funding for patients accessing this service will be charged according to the rules detailed in the "Who Pays' guidance August 2013 version.

3.4 Any acceptance and exclusion criteria and thresholds

The service is not for people with:

- No mental health problem
- Mild anxiety disorders
- Primary diagnosis of alcohol or other substance misuse without a co-morbid mental health problem
- Brain damage or other organic disorders, including dementia
- Learning Disabilities without a co-existing mental health problem
- Neurodevelopment or autistic spectrum disorders without a co-morbid mental health problem
- Exclusive diagnosis of personality disorder
- Recent history of minor self-harm, but not suffering from a psychotic illness or severe depressive illness.
- Crisis related solely to relationship issues.

3.5 Interdependence with other services/providers

This service specification links to those for:

- Adult Inpatient Service
- Community Mental Health Teams
- Early Intervention – Community Service
- Forensic Services

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

RCP Home Treatment Accreditation Standards.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

4.3 Applicable local standards

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:
Tamworth Road - Croydon
5 Windsor Walk - Southwark

7. Individual Service User Placement