SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	**05/MHLD/0014 v2**
Service	Assessment & Treatment Service St Anns
Commissioner Lead	**Mental Health & Learning Disability CDG**
Provider Lead	Dorset Healthcare University NHS Foundation Trust
Period	April 2016 – March 2017
Date of Review	Included in Acute Care Pathway Review in 2015/16

1. Population Needs

1.1 National/local context and evidence base

- NSF-MH,
- New Horizons
- MHA 1983
- MCA 2005
- NICE Guidance, evidence based and best practice
- Local Joint Strategic needs Assessment
- Safeguarding- children and adults
- Mental Health and well-being agenda

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

- Services provided are consistent with evidence of best practice
- Services are of high quality and are focused on engagement, treatment, and recovery.
- The aim the services is to stabilise people's health needs and enable people to return back to their own home's where they will be supported by Community services in their own familiar surroundings.

3.2 Service description/care pathway

Adult inpatient services offer acute care for people who have mental health needs, and aged 18 years and older, including assessment of need, joint planning and therapeutic treatment. The service is operational 24 hours a day, 365 days per year.

3.2.1 Referrals to the Service

Patients will be referred to AAU following an initial assessment by the Crisis Home / Treatment team or following a Section of the Mental Health Act. Referral to the treatment wards will be via AAU

3.2.2 The Services

The **Acute Assessment Unit** aims to provide a comprehensive assessment, diagnosis and initial treatment service for patients aged 18 years and older whose mental health needs mean that the patient is unable to be managed safely within the community by the Crisis Service. It is a mixed unit and in order to provide safety and dignity for female patients on the ward, there is a female only area including bedrooms, lounge and bathrooms.

The service will focus on providing detailed, multidisciplinary assessments and brief crisis interventions with the aim of enabling the patient to return to the community as soon as is practicable. This will include close liaison with family, carers, CMHTs, Crisis Home Treatment service, GPs, treatment wards and other professionals involved in the patients care so that we can fully understand patients' difficulties and ensure a safe and appropriate return to their community.

The Treatment Wards (Adults under 65: Harbour - Male and Chine- Female and adults over 65 – Alumhurst Ward) are short-to-medium term treatment wards for people of working age adults with a diagnosis of significant mental illness. The focus of care will be ongoing assessment of patients' physical health needs, mental health needs and psychological baseline review, which will inform patients' treatment and recovery plans. The wards provide high quality care for patients who will often have psychotic illnesses or severe mood disorder.

The Treatment Wards work towards the philosophy of the Safewards Model which is being embedded across the wards. The wards work closely with the CMHTs to focus on recovery.

This is currently structured into 67 bedded services across 4 wards:
16: Harbour (Male)
14: Sea View: AAU (Mixed gender)
17: Chine (Female)
20: Alumhurst (Mixed gender)

Alumhurst Ward is a mixed ward for the short to medium term assessment and treatment of service users aged 65 and over suffering from significant and enduring functional mental illness.

The focus of care is on continued assessment and treatment of service user's physical health, mental health needs and psychological baseline review. This will facilitate

discharge home (or to other suitable accommodation) at the earliest, safe and clinically appropriate opportunity. This will also include close liaison with families and carers, CMHT's and the Crisis Home Treatment Service.

3.2.2. Assessment and Care Planning

Assessment and care planning will be in accordance with the Trust's Assessment and Care Planning policy and national definition of the Care Programme Approach (CPA).

Initial assessment will usually be undertaken jointly by two team members on AAU, a member of the medical staff and another qualified staff member.

Physical examinations and appropriate investigations will be done in line with the Trust's Physical Care of Inpatients Policy.

A Risk Assessment will be undertaken in line with the Trust's Clinical Risk Policy. A HoNOS assessment will be completed in line with Trust agreement. Consideration will be given as to whether a breathalyser and use of drug testing will be done. It is expected that this will be undertaken in all patients for whom alcohol is known to be a problem and all patients with psychotic symptoms.

Following assessment a formulation will be drawn up in conjunction with the medical staff. This will include a provisional diagnosis, differential diagnosis, possible aetiology, problem list, initial risk assessment and agreed observation levels.

3.2.3 Interventions

The initial 24-hour care plan will include the following:

a. Observation level
b. Medication
c. Named nurse/nurses
d. Need for further assessment
e. Initial brief psychological interventions
f. Activity programme
g. Further investigations

AAU has a multi-disciplinary meeting attended by the consultant or Section-12 approved doctor at which the initial formulation will be presented and adjusted according to additional information received. Following the first MDT meeting a more detailed care plan, including provisional discharge date/transfer to an appropriate inpatient facility will be agreed.

Occupational therapy and groups are an important component of the assessment process as well as providing structure to the day and being therapeutic. It is thus expected that all patients will engage with occupational therapy if their mental state allows as part of their assessment and treatment package.

The wards will provide a weekly timetable of therapeutic activities. The care plan will be reviewed by the multi-disciplinary team. All patients will be offered daily 1:1 sessions with a member of the ward staff. All patients will have a copy of the wards

weekly OT, therapy and activity timetable which will be discussed with them. Appropriate activities will be incorporated into their care plan.

The wards work closely with families and carers of its patients, and involves their input into care planning. All patients are encouraged to attend community meetings to discuss the running of the ward. All patients will be given a service user experience questionnaire to complete on discharge.

3.2.4 Transfer Process

Patients who require longer than a two week admission will be transferred to one of the treatment wards.

Staff will complete part of the discharge summary to ensure that the treatment ward teams are aware of the assessment and management plan up to the point of transfer.

3.2.5 Discharge process

The ward team will identify whether the Crisis / Home Treatment Team need to be involved prior to discharge so that a referral to their team can be made in advance of the day of discharge.

The ward team will liaise closely with the patients CMHT and, if needed, the Home Treatment Team to ensure that discharge is appropriate and safe. Patients that are subject to S117 will have a discharge planning meeting prior to discharge attended by at least one of their community team.

The patient's diagnosis, risks and care plan on discharge will be included on the discharge summary as appropriate. A copy of the discharge summary will be given to the patient on the day of discharge, identifying 48hr or 7-day follow-up arrangements. All service users will leave hospital with an appointment with a named individual to receive a follow-up. This will be within 7 days of discharge in accordance with the Trust Guidance. This includes who to contact in the event of a Mental Health Crisis.

The discharge summary will be prepared the same day and distributed to the Care Coordinator, Consultant, GP and HTT as appropriate. If the discharge occurs out of hours then a copy of the discharge summary will be made available to the relevant health professionals the day of discharge.

3.3 Population Covered

The service will serve Dorset, Bournemouth and Poole and provide overspill for West Dorset (as required)

3.4 Any acceptance and exclusion criteria.

There will be no exclusions to AAU but inclusion will be subject to appropriate entry to the service based on the care pathway.

No service users meeting the admission criterion will be excluded from admission, alternative placements should be sought for service users from the following groups;

a. Service users with sole diagnosis with an Organic Brain Syndrome

b. Service users for whom the main purpose of admission is detoxification from alcohol and drugs.
c. Service users whose sole diagnosis is that of Learning Disability.
d. Service users whose sole diagnosis is that of Dementia.

3.5 Interdependence with other services/providers

- Community Mental Health Teams
- Early Intervention in Psychosis Service
- Crisis Resolution and Home Treatment Teams
- Assertive Outreach Teams
- Rehabilitation Services
- Primary Care
- Day Services
- Employment support services
- Supported Housing services
- Named patient and S117 department : Dorset CCG
- Learning Disabilities Intensive Support Team

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

NICE CG178 Psychosis and schizophrenia in adults: treatment and management
NICE CG 82 – Schizophrenia
NICE CG 38 – Bipolar disorder: The management of bipolar disorder in adults, children and adolescents, in primary and secondary care
NICE CG120 – Psychosis with coexisting substance misuse

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

Accreditation for Inpatient MH Services (AIMS)
ECT Accreditation Services (ECTAS)

4.3 Applicable local standards

5.

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:
St Ann's Hospital, 69 Haven Road Poole, Dorset, BH13 7LN

7. Individual Service User Placement