SCHEDULE 2

THE SERVICES

Schedule 2 Part 1: Service Specifications

SERVICE SPECIFICATION

Service Specification No.	**05/MRFH/0018**
Service/ Care pathway/ Cluster	**Organic Inpatient services for Older People**
Commissioner Lead	**CCP for Mental Health & Learning Disability**
Provider Lead	**Dorset Healthcare University NHS Foundation Trust**
Period	**April 2013 to March 2014**
Date of Review	**Year 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**	

1. Purpose

1.1 **National Context**

Nationally it is recognised that the mental health needs of the ageing population are set to increase, and it is predicted that the number of people living with dementia in the United Kingdom (currently 750,000) will double within thirty years.

The National Dementia Strategy (2009), Dementia Quality Standard (2010) and local strategies all identify the following aims for mental health services for older people:

- Early diagnosis and early interventions
- Better care for people at home and in care homes
- Better care in Hospital
- Better support for carers

1.2 Local Context

The proportion of people aged over 65 in Dorset is higher than the national average, and by 2030 it is predicted that 40% of the population in Dorset will be aged over 65 and over.

It is also predicted that 70% of people diagnosed with a mental impairment will have dementia.

1.3 Local Needs

In partnership with stakeholders Dorset HealthCare University NHS Foundation Trust and the Dorset, Bournemouth and Poole PCT Cluster have developed a proposed model of care to meet this growing need. The model aims to provide more intensive support in the community for people with dementia and their carers, enabling them to stay within their normal place of residence, and enabling those involved in their care to better support them.
In order to achieve this aim the balance between inpatient provision and community provision needs to be revised; the Trust needs to move resources from inpatient services to community services.

The Intermediate Care Service for Dementia will provide a vital role in delivering the reconfigured services; the service will work closely with inpatient services in order to support people to both remain in their homes, and return to their homes when it is clinically appropriate for them to do so. It is widely accepted that where possible it is better to care for people with dementia where they live, rather than in hospital. As a result of this, the required capacity of inpatient services will be lower.

2. Service Scope

2.1 Aims and Objectives

The reconfigured inpatient services for older people with organic mental illness will provide assessment, treatment and intensive inpatient care for older people with organic mental illness.

The inpatient services will be accessible to service users in East Dorset with a primary diagnosis of organic mental illness who already access Dorset HealthCare University Foundation Trust services and who are assessed as needing care which can only be provided in an inpatient environment.

The aims of the service are:

- To provide an appropriate number of inpatient services for those who require acute treatment and assessment
- To work closely with the Intermediate Care Service for Dementia to ensure people are not admitted inappropriately to hospital, and are able to leave hospital when it is appropriate to do so
- To provide an appropriate therapeutic environment for older people who require acute care for organic mental illness.

The objectives of the service are to:

- Ensure that inpatient beds are utilised effectively and appropriately to achieve maximum benefit for people with the most complex mental health problems.
- To ensure that general standards of care, hygiene and the environment are of an appropriate standard to minimise the risk to the patient of contracting infection or illness whilst on the ward.
- To provide a service where the patient's cultural, religious and communication needs are met.
- To ensure effective safeguarding procedures are in place to protect vulnerable patients from abuse.
- To provide high quality care through an experienced, competent, supported and trained

workforce.

- To provide advice, information and support to service users and carers to enable them to participate fully in the assessment and in decision making about future care options.
- To provide a range of evidence based treatment options including therapeutic activities to aid the patient's recovery or enhance their quality of life.
- To ensure that all patients will continue to be assessed and have an appropriate plan in place should discharge be appropriate.
- To provide practical and emotional support (including bereavement support) to carers to enable them to sustain a caring relationship.
- To provide a calm, stable and comfortable environment for patients in the later stages of their diagnosis or coming to the end of their life.
- To assist patients and their carers to access the support and information they will need following discharge to support their choices about care arrangements.
- To work in partnership with the Intermediate Care Service for Dementia and other relevant agencies eg. Primary Care, Social Care, Housing and third sector and independent sector providers to ensure smooth and effective admission and discharge processes.
- To provide information and advice to other partners including independent sector nursing homes to assist in the management of the patient's condition following discharge

2.2 Acceptance and Exclusion criteria

Acceptance: Service users with a primary diagnosis of organic mental illness who are currently known to the Intermediate Care Service for Dementia, Community Mental Health service, OPMH In-Reach team or Crisis Team.

Exclusion: Service users with a primary diagnosis of functional mental illness, direct GP referrals, Self referrals

The organic inpatient services will meet the needs of people who require informal admission, and those detained under the Mental Health Act.

2.3 Geographical population served

East Dorset (covering Bournemouth, Poole, Christchurch, East Dorset and Purbeck)

3. Service Delivery

3.1 Location of service

- The inpatient service for older people with organic mental illness will be provided in refurbished facilities at Alderney Hospital in Poole offering a maximum of 48 beds.

3.2 Operational Model

- The reconfigured inpatient service for older people with organic mental illness will provide 24 hour care.

- Continuity of care is an essential ingredient of quality care for older people with mental illness no matter where or for what reason specialist services are involved. Continuity of care should be provided and include the involvement of as few different staff (consistent with the person's needs) as possible.
- There will be a multi-disciplinary team including Consultant Psychiatrists, Registered Mental Health Nurses, Mental Health Support Workers, Occupational Therapy, Physiotherapy, Dietetics and other specialised practitioners.
- The multi-disciplinary team will assess every patient to identify cognitive problems and implement treatment/management programmes which will be recorded and managed via an individual care/treatment plan
- Carers should be made aware of their right to a separate assessment of their needs and given information on how to access this, but if this is declined their views and wishes should be recorded on the patient's assessment.
- Each patient will have regular reviews and re-assessments of their needs, involving the patient (where possible), their carer and/or advocate.
- Inpatient care will be provided as part of a care pathway and will be provided on the basis of the least restrictive option to meet an individual's needs.
- Where discharge to another setting is assessed as being in the patient's best interests then a clear discharge / care plan should be in place outlining the needs above, how they should be met and any management plans to accompany the patient to their next placement. If at all possible contact should be made with the new placement to enable continuity of care through effective communication with the new carers.
- Advanced directives will be employed to implement end of life care plans where appropriate.
- The practice standards and ethos of care should reflect those outlined in DoH policy guidance and recommendations cited in Section 5 below.
- The reconfigured service will comprise four wards; one female assessment and treatment ward, one female ITU, one male assessment and treatment ward, and one male ITU.
- The service will work closely with the Intermediate Care Service for Dementia and Older People Community Mental Health Service to ensure timely and appropriate discharge and to prevent inappropriate admissions.
- The service will work alongside an administrative and operational base for the Intermediate Care Service for Dementia.

3.3 Capacity

- Based on retrospective analysis of existing inpatient cases and planned availability of the Intermediate Care Service for Dementia the estimated bed requirement is set at a maximum of 48.
- It is important to note these figures are a prediction and the service demand will depend on the clinical need of each individual and effective operation of the Intermediate Care Service for Dementia.

3.4 Referral Process

- Admission to the service will be via the Intermediate Care Service for Dementia which will be involved in all admissions and discharges into the organic inpatient services.
- This will ensure people's needs are identified and the appropriate service is provided, eliminating avoidable admissions to hospital.

- Outside the operating hours of the Intermediate Care Service for Dementia, requests for assessment/admission will be accepted from the Crisis Team

3.5 Interdependencies with other agencies

- The organic inpatient service will work closely with other internal Dorset HealthCare services, specifically Older People Community Mental Health service and the Intermediate Care Service for Dementia.
- The team will work closely with the relevant local authority, specifically in relation to mental health act assessments, and social care providers
- The team will also work closely with the third sector in order to signpost patients to appropriate supportive services from which they might benefit.

3.8 Education, Training and Research activities

The service model will comply with best practice and it is the responsibility of the provider to ensure implementation of any best practice evidence based guidance. Services will be assessed against National Clinical Strategies, National Institute for Health & Clinical Excellence (NICE) Guidance, and agreed best practice. Where there is a resource implication a contract variation may be required. The Provider must be registered with and meet approved quality services in line with The Care Quality Commissions regulations and standards (2009)

The provider will be expected to comply with the clinical governance framework for the NHS Dorset Cluster and to function under agreed operational and clinical policies.

Clinical Obligations:

- If Statutory/Professional Registration is required it must be maintained at all times.
- The provider must ensure that each practitioner takes responsibility for maintaining continuous professional development in order to meet requirements of professional registration
- All practitioners must work within the boundaries of professional registration and relevant professional Code of Conduct.
- The provider must demonstrate that systems are in place to ensure that competencies are maintained and skills are up to date. The provider must ensure that sufficient numbers and grades of staff are employed in order to provide an appropriate skill mix and to ensure the service can be consistently delivered in accordance with the service specification.
- All staff will ensure compliance to statutory and legal frameworks implementing service developments in a timely manner as new directives are published

4. Key Service Outcomes

4.1 Intended Outcomes

- Reduction of inappropriate admissions to inpatient services
- Reduction in the number of delayed discharges

- Decreased demand and reduced capacity in Older People organic inpatient services allowing increased capacity within the community
- Redevelopment of existing Older People organic inpatient services to a single centre of excellence offering a focus for information to families/carers as well as appropriate care for late-stage dementia
- Patients have a clear care/treatment plan which identifies their needs and outlines how these are to be managed.
- Patients have their privacy and dignity respected.
- Carers are offered appropriate support and supported to access an assessment of their needs
- Patients at the end of their lives are able to die with dignity.
- Patients and Carers feel they have appropriate information (in accessible formats) to enable them to make informed decisions and take control of their daily living arrangements.
- Patients and Carers feel that their cultural, religious and communication needs were taken into account and addressed.
- Patient and carer comments, complaints or concerns were received positively and acted upon promptly.

5. Applicable Standards

5.1 NICE Clinical Guidance

NICE Clinical Guidance 42 – Dementia (2006) states people with dementia should not be excluded from any services because of their diagnosis, age or co-existing disabilities, such as learning disabilities.

People with dementia who develop non-cognitive symptoms that cause them significant distress or who develop behaviour that challenges should be offered an assessment at an early opportunity to establish the likely factors that may generate, aggravate or improve such behaviour.

The National Dementia Strategy (2009) highlights the need for better care for people in their home. Objective 6: *Improved Community personal support services* identifies the need for a comprehensive community personal support service that includes responsiveness to crisis services, and home support.

5.2 Additional guidelines and policies

Further underpinning evidence is contained in the following guidelines and policies. The recommendations should be incorporated into the protocols, processes and practice on the ward:

- National Service Framework Older People 2001 -DoH
- Forget Me Not - Audit Commission 2000
- A New Ambition for Old Age - 2006 DoH
- Raising Standards, Specialist Services for Older People with Mental Illness- Report of the Faculty of Old Age Psychiatrists 2006
- Living Well with Dementia - National Dementia Strategy 2009 DoH
- Mental Health Act 1983 as amended in 2007
- Mental Capacity Act 2005

- Integrated Services for Older People 2002 - Audit Commission
- Everybody's Business 2005 DoH

6. Baseline Performance Targets – Quality, Performance & Productivity

Indicator	(Baseline establishment)	Method of Measurement	Frequency of monitoring
ACTIVITY AND PERFORMANCE			
Number of admissions	150 (annual)	DHFT monthly service performance report	Monthly
Length of stay (average)	12 weeks	DHFT monthly service performance report & exception report for breaches of target	Monthly
Number of discharges		DHFT monthly service performance report	Monthly
Number of people discharged split by locality		DHFT monthly service performance report	Monthly
QUALITY			
Number of adverse incidents		(see note below)	Annual
Carer and client satisfaction survey undertaken (format to be agreed with commissioner)		Note: Reported via Trust Quality Report	Annual
Each patient to have an active individual care and treatment management plan discussed and agreed with them		(already reported via monthly contract meetings)	
Annual audit of anti-psychotic prescribing and on prescribing of dementia drugs including the level of individual patient reviews		Note: Reported via Trust Quality Report (POMH-UK audit)	Annual
A record of discussions regarding end of life care planning – advance care planning with evidence of liaison with General		Reported via Trust Quality Report	Quarterly

practice			

NB
There is an assumption that the NHS minimum dataset recorded for each patient will be available for further data analysis/investigation as the basis for "standard" reports or individual query. For example it will be possible to identify individual length of stay, delayed discharges by Local Authority of residence, individual duration of delay, reason for delay, discharge destination etc.

7. Prices

Area of Spend	Expected Annual Cost
Reconfigured Acute Services Staffing Budget	£2,766,706
Non-Pay expenditure (Alderney) £100,787 Non-Pay expenditure (King's Park) £19,780 Total Non-Pay expenditure	£120,567
Total Pay and Non-pay costs	£ 2,887,273
Direct overheads (Alderney) £1,807,746 Direct overheads (King's Park) £1,819,212 Total Direct overheads	£3,626,958
Total Service Cost	£ 6,514,231

NB Indirect overheads attributed to Alderney I/P = (additional) £503,029 [budget line elsewhere]