Definitions

Term	Definition
Bidder	The organisation making a formal offer for the Framework
Care Coordinator	A mental health professional (nurse, occupational therapist or social worker) allocated to the care coordination of a person requiring mental health support, usually facilitated through the CPA process
Care Plan	Is a plan of care for all patients who are provided care under the CPA framework; it provides information of day to day mental and physical health needs along with social care needs. The care plan will also provide contingency and crisis care plans.
Care Programme Approach	Provides a framework for all people who are entitled to mental health care to ensure all required services are provided and followed up in the form of a care plan.
Contracting Authority	As defined in Section 2 (Definitions) of the Public Contracts Regulations 2015.
Crisis Resolution and Home Treatment Team	Provide short term intensive home treatment for people experiencing acute mental health crisis.
Essential	Where used in relation to Non-NHS beds, the placement must be requested as a last resort with all other options explored and eliminated by the placing CCG or NHS Trust
Green Light Tool Kit	Published by Department of Health in 2004, updated in 2013 to ensure people with Autism and/or Learning Disability are provided fair access to mental health services and receive effective interventions to meet their needs.
Home Team	The local mental health team to include Care Coordinator and CRHT, who ordinarily provide mental health intervention, treatment and support to a Patient.
Keyworker	For the purpose of this specification, the keyworker will be the patient's main point of contact within the provider service and coordinate and liaise with the community services local to the patient's home.
LOT(s)	Relates to the number of categories the requirements of the framework have been divided into.
Out of Area Placement	Also referred to as non-NHS, is a placement to which a patient is transferred which is considered to be out of their usual family or social network, and away from their mental health Care Coordinator and services are located.
Patient	Also referred to as individuals, people, persons and users within the text of the document refers to those who are or may be receiving assessment, intervention and treatment of their mental health illness.
Participating Authorities	Also referred to as Trusts and CCGs within the text of the document; will be contracting non-NHS beds through the agreed framework

Providers	Also referred to within the text as Non-NHS, who will provide facilities in line with the service specification.
Red2Green Bed Days	Provides a SAFER monitoring system for patient journeys and assurance that delays in intervention, treatment and discharge are being managed effectively.
Service	Relates to the specific criteria required from Providers of a service as set out to meet the requirements of each awarded LOT

Glossary

BNF	British National Formulary
CCGs	Clinical Commissioning Groups
CJA (2003)	Criminal Justice Act (2003)
CPA	Care Programme Approach
CQC	Care Quality Commission
CRHT	Crisis Resolution & Home Treatment Team
CRU	Community rehabilitation Unit
GMC	General Medical Council
HCA	Health Care Assistant
HCPC	Health & Care Professional Council
KSF	Knowledge & Skills Framework
MHA (1983)	Mental Health Act (1983)
MDT	Multidisciplinary Team
NICE	National Institute of Clinical Excellence
NMC	Nursing & Midwifery Council
OAP	Out of Area Placement
RCGP	Registered Council of General Practitioners
SLA	Service Level Agreement

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Framework Agreement for the Provision of Supplementary Mental Health Placements to Support NHS Capacity Requirements

Schedule A SPECIFICATION

Chapter 1 – General specification

This Chapter should be read by **all Bidders** as it covers the provision of Acute Mental Health Inpatient services, Psychiatric Intensive Care, High Dependency and Unlocked Rehabilitation for Adults.

1.1 Background:

Significant evidence has highlighted the high percentages of non-NHS beds used by NHS Foundation Trusts, Mental Health Trusts and **CCGs** across England to support the mental health needs of people where the NHS does not have bed capacity, or in some cases, the services to support specific mental health needs. There is also substantial data of Patients being transferred to **OAPs** which often impact on the patient not having the availability of being supported by their usual health and social network, with poor integration of services and discharge planning, and a loss of carers and family involvement. The impact reported has at times been of Patients requiring rapid readmission to a mental health inpatient service, and in worse case the patient taking their own life.

Following calls for NHS mental health services to respond to the rising concerns connected with the use of non-NHS placements the NHS Procurement Hubs for the East, North and South of England and London are implementing a single-priced framework for non-NHS placements Essentially required by **CCGs** and Trusts which is envisaged to stabilise the competitive market.

In order to meet the Mental Health National Agenda set to eliminate the use of Inappropriate Out of Area Placements in Mental Health by the end of March 2021, the Framework will focus on all referrals for non-NHS beds to be an Essential requirement in order to meet patient need and will be as close to the Patients home team as possible.

1.2 Service Aims

In order to support the framework the expectation of non-NHS bed Providers is to:

- Support the NHS in the delivery of high quality treatment that is safe and effective in **CQC** certified facilities.
- Provide a responsive, flexible, reliable service to the Participating Authorities which can meet the requirements in a prompt manner
- Facilitate the safety and treatment of Patients in an environment which is appropriate to their needs
- Provide the relevant therapies and support to Patients to ensure their well-being and progress along their pathway
- Provide appropriate reporting of services provided

- Work closely with Participating Authorities to foster a positive working relationship with the goal of maximising the effectiveness of appropriate evidence based care.
- Ensure The Five Year Forward Plan and The Long Term Plan for Mental Health are being promoted.

The aims of this specification are to ensure that the Service delivery represents the CQC Domains:

- **Safe** – the services offered must protect patients from abuse and avoidable harm
- **Effective** – the care, treatment and support being provided will achieve good outcomes, assisting with maintaining quality of life based on best available evidence.
- **Caring** – patients will be treated with compassion, kindness, dignity and respect.
- **Responsive** – Services will be organised to meet patient need
- **Well-Led** – leadership, management and governance will ensure they provide high quality care based on individual need. There will be encouragement in learning and innovation, with promotion of a fair and open culture.

In addition the Service will represent:

Excellence – comply with relevant regulation standards to include **NICE** guidance, along with all other national and local guidelines.

Value for Money – the services offered must be affordable, and represent value for money for the NHS.

1.3 National Standards

All services provided must be registered with the relevant regulator and have a minimum of **GOOD** rating with the CQC, adhering in all instances to relevant legislation, standards, recommendations and best practice as issued by the following:

- **NICE**
- Any relevant professional body, e.g. **GMC**, **NMC**, **RCGP**, **HCPC,** etc.
- Following any audit from regulated bodies and adverse incident reporting
- National guidance, policies and procedures which relate to service provision

All Patients are owed certainty from the service providing care that all legal duties are being followed by Providers and include:

- Human Rights Act (1998)
- Equality Act (2010)
- Mental Health Act (1983)
- Mental Capacity Act (2005)
- Health & Social Care Act (2012)

All outcomes are to be demonstrated by means of evidence based practice methods to assess on-going needs and reflect progress made. The following rating scales are examples of tools that may be used to evidence progress and presented at each **CPA** review:

- Health of the Nation Outcome Scales (HONOS)
- Functional Analysis of Care Environments assessment tool (FACE)
- Patient reported outcome measure satisfaction tools (PROM) (e.g. DIALOG/DIALOG +)
- Social and Occupational Functioning Scale (SOFAS)

Other validated measures may also be appropriate to supplement the above and as outcome measures during admission and following discharge:

The achievement of the outcomes detailed above is paramount to service delivery, and the recovery approach is to be implemented for all patient's and reviewed regularly to assess recovery progress.

1.4. Service Specification:

1.4.1 Referral:

All referrals for a Non-NHS bed **will** be made following total exploration of alternative options usually available to the CCG or NHS Trust and **will** be considered Essential to meet the Patient's need.

Referrals **will** be for NHS registered patients only.

All referrals **will** be made through and accepted from the appropriate channels, which may be locally determined i.e. Local Crisis Home Treatment Team, Local Care Coordinator.

Where the provider is unable to provide admission, the Service **will** provide practical advice to other applicable services in the management of people with complex needs, co-morbid conditions and treatment resistance.

1.4.2 Admission:

Detained Patients under the **MHA (1983) will** have their Rights provided both in writing and verbally on admission to a unit. A patient's capacity to consent to admission and on-going decision making will be assessed upon admission and regularly throughout. Where capacity is assessed as being absent then a best interest's decision will be made and recorded as such.

The Service **will** explain to the Patient the purpose of their admission with an agreed care plan and expected length of stay.

1.4.3 Assessment:

The Service **will** provide a prompt assessment of mental health needs, not repeating assessments already carried out in the community.

The Service **will** follow the Red2Green Bed Day process as implemented by NHS Improvement, and where Red Bed Days are identified, the Service **will** provide a clear

explanation to the patient and their home mental health Care Coordinator what is causing the Red Day(s) and how this will be addressed to ensure a positive patient journey.

1.4.4 Treatment:

All interventions and treatment(s) **will** commence without delay, taking account of any pre-existing or occurring co-morbid conditions.

The Service **will** provide high levels of therapeutic care underpinned by evidence-based practice in keeping with recognised best practice where this is published or is custom and practice. This will include a comprehensive assessment of the needs of the individual in order to devise an individualised treatment programme that will address social, physical, intellectual and mental health needs within a specific and measurable care plan, regularly collated and reviewed through the **CPA** framework.

Increased levels of observation levels **will** not be continued where it is considered to no longer be (or is seen to be non) therapeutic, and **will** be discontinued at the earliest opportunity. All increased levels **will** be notified to the commissioning Trust and monitored. Patient and healthcare staff engagement **will** be meaningful and positive, with evidence provided to support requirement for continued observation level.

The Service **will** demonstrate improvements in patient symptoms, risk, social inclusion and independent living skills which will be achieved through the preparing of and moving on of Patients to suitable community or step-down living.

1.4.5 Medication and Intervention:

Where medication is used as part of therapy this **will** be offered within a concordant framework, within **BNF** limits and existing national guidance in relation to prescribing for mental health illnesses. Any prescribing outside of these boundaries must only occur with a clear and transparent explanation of the reasons for such prescribing and with clear communication back to the responsible community mental health team. Regular medication reviews **will** be arranged and documented; these reviews **will** include use of 'as required' (PRN) medications along with incidence of the use of rapid tranquilisation (RT). Where PRN or RT is used Provider policy and procedures for reporting must be adhered to. Prescribing of mood stabiliser and antipsychotic medications producing side effects that require regular monitoring, **will** be carried out in accordance with NICE guidelines to ensure physical health monitoring is carried out at the specified time periods.

The Service **will** promote recovery and social inclusion through the provision of therapeutic, occupational and recreational activities, and community links with continuous daily risk assessment/risk management within a therapeutic environment. A care pathway **will** be identified from the date of admission to services and include patients in all aspects of decision-making.

1.4.6 Home Team/Local Authority:

The Service **will** ensure communication and liaison as required for the care of the patient, is effective with all routes for the maintenance of this being identified.

The Service **will** allow freedom for the patient's home CCG and mental health service to access facilities at all times. The sharing of information and records **will** be provided upon request.

Discharge **will** be arranged with the local home team and **will** ensure the patients local authority are kept informed of patient's whereabouts and transfers.

1.4.7 Mental Health Act (1983), Capacity and Consent:

For all patients whose capacity to consent to admission and treatment is assessed as being absent, a Deprivation of Liberty Safeguarding will be arranged in order to ensure those patients are protected where their liberty may be deprived through restricting or restraining practice.

Where leave is to be arranged, conditions of leave (i.e. Section 17 for patients detained under MHA 1983) **will** be set out and recorded in the patient's notes with clear arrangements to include period of leave and any limitations to geographical area to be visited or accessed. A risk assessment and plan **will** be completed prior to any leave arrangements being recorded. A lone working policy for staff escorting Patients on leave **will** be available and adhered to.

1.4.8 Environment and Safety:

The maintenance of a safe and sound environment for all **will** be paramount, with levels of observation imposed on a patient being of minimal restriction and of therapeutic purpose for the level of observation.

Safe and suitable storage of medication **will** be ensured at all times with suitable additional storage of controlled medications made available. Appropriate recording of medication prescribing and administration **will** be maintained at all times, which **will** follow a robust medication and prescribing policy in accordance with NICE guidance. Where drug errors exist, relevant reporting protocol **will** be adhered to.

The safety of all Patients, staff and visitors to the environment **will** be upheld, with all incidents reported and documented as per protocol.

Where required, safeguarding alerts **will** be completed and appropriate and necessary action **will** be carried out to promote safety and wellbeing of all, as well as the person(s) affected. The individuals care co-ordinator or responsible community mental health team **will** be notified of such alerts.
Facilities **will** be inclusive for all, and where required, environments are adaptable to the needs of the individual (e.g., where mobility or sensory disabilities may be an issue)

1.4.9 Equality & Diversity:

Service delivery **will** take account of all protected characteristics of patient's equality, diversity and inclusion through policies and practices to include but not limited to, patient's gender, cultural, religious and spiritual preferences. This **will** ensure that an individualised, person centred approach is adopted when planning all aspects of care and care provision.

Patient's relatives and carers, where appropriate and consent is given, **will** have an active role in the development of care plans. There **will** be a demonstrable commitment to working together in an environment that promotes empowerment of the care team, patients, relatives and carers, with all parties seeking to communicate openly and honestly in sharing their views.

The Service provided **will** be 'fair, personalised, effective and safe'.

1.4.10 Provider Monitoring:

The Provider **will** ensure that clinical audit is an integral part of service culture and provision in order to monitor service responsiveness to the various aspects of care in line with national guidance.

The Provider **will** ensure effective monitoring of clinical care with high quality systems for clinical record keeping and the collection of relevant information. All record keeping **will** comply with the requirements of the Provider and any associated Royal College or other professional group's guidance.

1.5 Protection of Patients

1.5.1 Safeguarding Protocol:

The Service Provider will follow locally agreed procedures for the detection and response to suspected harm to a vulnerable adult in line with the Care Act 2014: Safeguarding Adults.

Service Provider staff must at all times be mindful of the possibility of vulnerable adult abuse situations and must have an awareness of how such situations may present themselves and be prevented.

All staff involved in caring for Service Users must be aware of the laws and guidance protecting Service Users.

Any improper conduct against a Service User by staff, visitors, volunteers or other Service Users must be recorded and reported within twenty-four (24) hours to the Responsible Commissioner, any other Commissioner who has a Service User placed at the Home, the relevant Local Authority and the police where appropriate. The ten types of abuse considered to be reportable, and may be classed as a criminal offence are:

- Physical abuse
- Domestic violence or abuse
- Psychological or emotional abuse
- Sexual abuse
- Financial or material abuse
- Modern slavery
- Discriminatory abuse
- Organisational or institutional abuse
- Neglect or acts of omission
- Self-neglect

1.5.2 Patient Possessions:

Service Providers will have procedures in place for protecting and securing Patient's possessions at all times.

On admission into the Service, the Patient in conjunction with the admitting staff member will complete a written inventory of the patient's monies, valuables and any other property they may be admitted with. The inventory will be signed and dated by the Patient and staff, along with a representative as appropriate. A copy of this will be kept in the Patient's records.

The Service provider will ensure that all financial transactions undertaken by the Service provider on the Patient's behalf are properly recorded and witnessed. Any additions/removals of a Patient's possessions must also be recorded. The Service provider will make these records available for the local Home Team upon request.

Service provider staff must not be involved in the borrowing of Patient's monies or the lending of valuables.

The Service provider will provide the local Home Team with evidence of their written procedures for dealing with Patient's possessions and investigations of allegations of theft.

1.5.3 Patient Monies

The Service provider will recognise and respect the Patient's right to confidentially conduct their own financial affairs, unless the Patient does not wish or lacks the capacity, to do so.

If the Patient is not managing their own finances and they are not being managed through a Power of Attorney or an appointed Court of Protection Deputy, then the Service provider, following discussion and agreement by the Local Authority, may in exceptional circumstances apply to the Court of Protection to obtain responsibility for the administration of the Patient's money. The service provider will also inform the Home Team of the agreement made.

The Service provider and all employees will not accept any Power of Attorney or Court of Protection appointment in respect of any Patient without first notifying and obtaining pre-authorisation from the Local Authority in writing.

In some circumstances, it may be appropriate for the Service provider to become the agent or even appointee of the Patient's benefit.

If the Service provider is responsible for the Patient's monies then the Service provider must ensure that monies are not pooled across Patients and that the Patient's personal expenses allowance is administered properly and kept safely. Proper records will be maintained to demonstrate this.

The Patient's personal monies must never be banked in the Service provider's bank account.

Under no circumstances will the Service provider use the Patient's money to meet fees payable under this care specification. However a Patient will be expected to pay for the following items from their own finances, but which are not limited to:

- Cigarettes and tobacco;
- Newspapers and magazines, where specifically ordered by the Patient;
- Clothing and other similar personal items;
- Personal specific travel incurred at the Patient's specific request (excluding travel that is connected with the Patient's care needs
- Specific hairdressing which is not provided by the Service
- Opticians;
- Legal advice;
- Holidays;
- Social activities (outside of those provided by the Service provider)
- Toiletries;
- Chiropody;
- Computers.

1.5.4 Patient Valuables

The Service provider will be liable for any loss or damage (not caused by the Patient) to clothes or other valuables recorded or receipted as being brought into the Service. Any theft of, or damage to, Patient's items must be covered by the Service's public liability insurance.

Unless the Responsible Commissioner and Service provider otherwise agree in writing, the Service provider will not require and will ensure that no other person will require, any Patient to sign any document whatsoever containing any waiver of the Service provider's liability to the Patient.

1.6 Relationship skills should include the ability to:

- Work collaboratively so as to empower people, using recovery and person-centred approaches
- Use creative and flexible approaches to motivating people who have negative symptoms and cognitive problems

- Promote hope and maintain enthusiasm and therapeutic optimism, even when progress is slow

1.7 Clinical skills should include the ability to:

- Work with individuals and carers to assess strengths, functional impairments, disabilities and barriers as part of a comprehensive assessment
- Work with individuals to identify their personal recovery goals and to agree an approach to attaining them
- Will ensure the MDT collaborates with the patient and their carers to develop care plans to include:
    - An agreed intervention strategy for both physical and mental health.
    - Will have measurable goals and outcomes
    - Strategies for self-management
    - Advanced directives or statements of Patient wishes
    - Crisis and contingency plans
- Planned review dates and clear discharge plan
- Help individuals develop or regain skills, often through a series of small steps
- Provide psycho-education and relapse prevention work which is tailored to the person's cognitive level
- Use cognitive-behavioural therapy for psychosis, adapted where necessary for people who have cognitive impairment
- Use individually tailored behavioural approaches, where indicated
- Prescribe and monitor medication for mental illness
- Monitor physical health and advise on how to stay healthy
- Work in a motivational way with co-existing substance misuse problems

1.8 Liaison and advisory skills should include the ability to:

- Give advice and support to carers and professional colleagues
- Give advice on modifying environments or support to enable people to access social, vocational and educational roles
- Work in partnership with users, carers and services and facilitate support networks
- Work with a range of agencies to assess local need, develop services and monitor complex care packages
- Develop patient pathways
- Liaise closely with commissioners and relevant services to ensure a seamless continuity of care provision and support upon transfer from Provider services

It must be noted that points 1.6 – 1.8 (inclusive) represent a minimum list of skills which may be supported by additional skills provided by individual services, and therefore it should not be considered that this is an exhaustive list.

1.9 Multidisciplinary Team:

The **MDT** will primarily consist of Medical, Occupational Therapy, Nursing, Psychology and non-qualified **HCA** or support workers, who will have specialist skills to support Patients with non-pharmacological as well as pharmacological interventions and treatment. The staff ratio to patient and staff skill mix will be appropriate to treat and care for all Patients mental and physical health needs

All mental health practitioners' clinical practice and competencies will be monitored in line with their relevant regulatory body, with registration maintained via (as applicable) Revalidation or Audit processes. Continuous development will be linked through the **KSF** or other competency based outline for each role, and further monitored and managed through annual reviews as part of the **KSF** and Personal Development framework.

1.10 Physical environment and procedural requirements

Accommodation should be as close to where a person's usual carer and or family network is, along with their community mental health team. The accommodation available should meet the needs of those admitted to the facility, ensuring choice within the least restrictive environment as possible. It should be of a high quality and well maintained, providing a feeling of safety and security for Patients, taking into account having safe access to an outside space for fresh air.

The Service should provide a smokefree environment following the NHS smokefree policy in promoting a smokefree environment, along with providing advice and treatment or intervention for a person admitted to the Service who is dependent on smoking.

The accommodation should meet all health and safety requirements, including a signing-in book, elimination of or identification and management of ligature points and fire safety, with all staff, Patients and visitors entering via a dedicated entrance being monitored and controlled by reception staff.

The Service should promote independence for all Patients with sufficient flexibility to allow people to move on to higher support as required, or lower support at a time when they are ready. This would also include the possibility of patient's having escorted/unescorted leave when part of a consistent coherent care plan aimed at incrementally reintroducing the patient to normal living and subsequently leading towards discharge. Arrangements for leave should be continually monitored as part of a therapeutic care plan to include risk management.

Risk assessments and safety planning should be done individually with Patients and regularly reviewed with an attitude to minimising avoidable, unwarranted risk whilst also taking into account the need to promote as normal a living environment as possible. Where risk assessments advise, ad-hoc and/or regular searches for illicit or restricted substances to include alcohol, should take place in line with agreed local protocol. All direct care staff are to be trained in basic breakaway techniques and basic risk management including de-escalation techniques and minimisation of violence and aggression training with scheduled updates provided. A fitting alarm system will be installed and used with appropriate training and maintenance of the system. Any incidence of restrictive practice must be reported as per MHSDS version 4|Defintions and Reporting for Restrictive Interventions from 1 April 2019

Visiting times will be clearly arranged in policy for all to adhere to. Such policies will provide a consistent philosophy in assisting Patients to stabilise and recover from presenting mental states. Where visits of children are arranged, individual planning with appropriate approval and supervision will be required in order to manage specific risk indications.

1.11 Accessibility/acceptability

The Provider will meet the needs for all patients regardless of age, gender, culture and disabilities, ensuring that packages of care are delivered effectively with any necessary reasonable adjustments to ensure equality of access.

SLA's will be agreed by Providers of Services with local General Practitioner Practices and Acute Trusts to ensure patients physical health, along with mental health needs are being fully met where they are placed out of their ordinary place of residence.

1.12 Integrated Care pathway

Anticipated outcomes of following an integrated care pathway for mental health Patients ensures that all services required to compliment care needs are joined up, providing a seamless juncture between health and social care to be supported by services in the voluntary sector.

It is essential that Patients subject to the **CPA** process continue to be supported by their mental health care co-ordinator, thus ensuring that during the duration of the placement they continue to maintain links with the responsible multi-disciplinary team to facilitate a seamless continuity of care during transfer to the community. Compliance with Section 117 aftercare arrangements will be essential.

The Provider will have responsibility in ensuring all required primary and secondary care services are included in patient care plans, with contingency and crisis plans and discharge summaries to be completed and provided to the patient and relevant others following discharge from their service.

Where a patient has physical health care needs requiring intervention or investigation the Provider will ensure that either relevant referrals are completed as appropriate or a robust handover is provided to the Patients key worker/Care Coordinator in order for the required follow up to be maintained.

Providers of services will be expected to liaise with social providers to ensure integrated social needs are met and maintained for Patients transferring to a community setting.

1.13 Relevant Clinical Networks

Providers are encouraged to make appropriate links with clinical networks and research teams/organisations to ensure standards and quality are improved.

1.14 Pathways

Please see annexe 1

1.15 Workforce and Training

The Provider will ensure that the staff mix is responsive to delivering a successful recovery model. Staff will be appropriately qualified to deliver the service requirements. The Provider will need to ensure that staff maintain registrations (where appropriate) and continue to undertake clinical supervision and mandatory training, such as, but not exclusively, in manual handling, breakaway, control and restraint. Evidence of this should be available to the Trust commissioning the placement upon request.

Staffing levels will be a matter for management and commissioners to agree within minimum standards. Where there are pressures for additional resources this should be considered with the proviso that existing staff are deployed in the most effective way which includes ensuring that ward establishments, skill mix and the availability of support staff are as closely aligned as they can be with workload. Professional judgement, patient dependency and activity analysis should all be used to arrive at the appropriate level for a given unit. Dialogue between managers, nurses and other clinicians is required, with involvement of the patient actively considered.

1.16 Geographic coverage/boundaries

In order to facilitate the use of this agreement for Participating Organisations, the requirement is being separated into, but not awarded into, the following geographical locations, based on the NHS England team areas:

- North Regional Team: www.england.nhs.uk/north/
- Midlands and East Regional Team: www.england.nhs.uk/mids-east/
- London Regional Team: www.england.nhs.uk/london/
- South East Regional Team: www.england.nhs.uk/south-east
- South West Regional Team: www.england.nhs.uk/south/

It is anticipated that a key consideration when making a placement will be that the patient is as close to their residential home/family contacts as is possible, unless there are clinical or other personal reasons why this is not a desirable requirement.

1.17 Days/Hours of operation

The Service will be fully operational and supported by an appropriate staffing level and skill mix, 24 hours a day, 7 days a week.

1.18 Referral route

The Service will receive referrals of NHS registered Patients.

There is an expectation that the Service will accept Patients whose movements are restricted by the Courts or Ministry of Justice, i.e. those who are detained under Section 37, 41, 48 and 49 of the **MHA** (1983). It is not expected that admissions will be solely restricted to Patients who fall within this part of the legal framework, as there will also be expectation for patients who are detained under Section 2, 3 or 4 of the **MHA** (1983) to be accepted.

Staff should work within regulatory guidance from their professional/regulatory body and in accordance with the **MHA** (1983) and the **CJA** (2003).

1.19 Discharge Criteria and Planning:

The Service will not discharge/transfer a patient if this would not be in accordance with effective care co-ordination and in particular if this would put the public or the Patient safety, health or wellbeing at risk. The Service will use all reasonable endeavours to avoid circumstances whereby discharges are likely to lead to emergency re-admissions to care or in-patient services. If a Service is repeatedly discharging Patients in breach of this requirement, then action will be taken to review efficiency and safety of the provision of care. An action plan will be drafted to ensure this is remedied. If the action plan is not accepted or the Provider does not participate fully in the process, then the Contracting Authority reserves the right to cease the contractual agreement with the Provider due to these concerns.

All discharge/transfers of a patient from the Provider's facility will be agreed at a CPA review meeting with all appropriate health care professionals, carers and the patients input and agreement. Prior to discharge, the service shall fully assess the patient's health and social care needs and assess if the patient's care plan addresses them. The Service, in liaison with external agencies, e.g. CRHT, Care Coordinator, Contracting Authority, Mental Health Review Tribunal, will ascertain requirements for Patients needing aftercare and/or supervision. Where a patient has been subject to a MHA (1983) section and S117 Aftercare applied, agreed aftercare and/or supervision will be coordinated with the Social Services Department and the patient's local community mental health team to ensure that appropriate aftercare arrangements are in place. Where aftercare is required, then the responsible commissioners as appropriate must be consulted to ensure that aftercare can be provided locally, and to ensure the provision offers a cost effective service. When aftercare is not required, then consideration will be given to removing the Section 117 entitlement to aftercare provision. If this is done, then the placing community mental health team and commissioners of services will be informed of this decision and action.
In readiness of discharge, the Service will ensure that its clinical teams work jointly with the patient's home area mental health services and local authority to ensure the appropriate management and transfer of the patient. In order to facilitate ongoing liaison with the patient and community services, a key worker will be appointed for each patient. The keyworker will also be active in assisting with applications for benefits and also advise Mental Health Review Tribunals of the patient's social circumstances.

Prior to discharge the Service shall provide, where applicable, a copy of the Section 117 Aftercare review minutes and care plan to:

- the patient

- the referring clinician/Care Coordinator as applicable
- the patient's GP
- the consultant who will be providing the patient's aftercare
- the patient's local authority/social worker as applicable

The Service shall ensure that arrangements for discharge from in-patient care are carried out in a manner which is consistent with the requirements of effective care co-ordination in liaison with the local community team. The Service shall specifically ensure that all Patients discharged from in-patient care into the community are followed up within seven days of discharge by a community visit, or telephone call, or other appropriate method, with the exception of Patients identified as being at an increased risk of suicidal ideation who will be provided a discharge follow-up within 48 hours. For patients being transferred to another provider, a review plan set out in the Patients care plan will include an up-to-date risk assessment, along with any occupational therapy, psychologist reports and assessments that will enable the receiving provider to arrange effective care and avoid duplication of assessments.

Appropriate self-assessment questionnaires should be made available to Patients to complete in order to provide feedback on their mental health and wellbeing and the service delivery. Carers will also be given the opportunity to provide feedback at the completion of the care package to inform service delivery and carer support offered and/or provided. All feedback acquired will be made available to the Home Team upon request.

1.20 Patient Transportation

It may be required in some instances, for the Provider in consultation with the Care Coordinator, to arrange transport for accepted Patients into their service. At such times the Provider will ensure that Patient dignity is upheld at all times and that the most appropriate transportation is organised after a risk assessment.

1.21 Key Performance Indicators

It is expected for all Service providers to report on Key Performance Indicators which they may set for themselves or may have in agreement with contracting Trusts. All reports are to be made available upon request by Contracting Authorities without delay.

The following are considered representative examples of KPIs that may be set to evidence delivery of service, patient satisfaction and compliance with national frameworks:

- Reports on Patient Safety Incidents, Safe Staffing levels and Safeguarding alerts.
- Length of stay, delayed discharge and readmission target setting
- Mandatory training and personal development reviews for staff, along with professional registration compliance.
- Patient Satisfaction Outcomes and Carer Surveys

1.22 Specification LOTs

The before mentioned requirements are to be provided under a number of LOTs for both male and female services, and is expected to provide a comprehensive solution to NHS Trusts and commissioners.

Bidders are advised that this specification represents requirements which apply to all contract engagements made under this framework agreement. Where there are specific requirements to NHS Trusts, Providers will be notified of them as part of their own contract award procedures.

This requirement is to be awarded as eight overarching LOTs:

LOT One: Mental Health Male Acute In-Patient Service
LOT Two: Mental Health Female Acute In-Patient Service
LOT Three: Mental Health Male Psychiatric Intensive Care Service
LOT Four: Mental Health Female Psychiatric Intensive Care Service
LOT Five: Mental Health Male High Dependency Rehabilitation Service
LOT Six: Mental Health Female High Dependency Rehabilitation Service
LOT Seven: Mental Health Female Community Rehabilitation Service
LOT Eight: Mental Health Male Community Rehabilitation Service

Bidders must note that Lots One, Two, Three and Four are being awarded for an initial framework agreement term to 31st March 2021. There will be an option to extend these agreements to 31st October 2023.

The framework agreements for Lots Five, Six, Seven and Eight shall be for a period of four years, to 31st October 2023.

Bidders are advised that they may bid for one or more LOTs, but must note that submissions for each LOT will be evaluated separately and as such, Bidders are advised that each offer for each LOT must be open for acceptance onto the framework agreement as a stand-alone offer.

Acceptance of offer onto one LOT does not guarantee acceptance onto any or all other LOTs. For ease of reading through this specification it has been separated into chapters which relate to corresponding LOTs. As it is anticipated that the services provided will be universal for Female and Male admissions these LOTs have been grouped to the specific service within the appropriate chapter rather than replicated by gender. Bidders are required to meet the general specification as outlined in this Chapter 1 in addition to the requirements for the specific LOTs being bid for as outlined in the chapters below:

Chapter 2	LOTs 1 and 2	
Chapter 3	LOTs 3 and 4	
Chapter 4	LOTs 5, 6, 7 and 8	

In order to facilitate the use of this agreement for Participating Organisations, the requirement is being separated into, but not awarded into, the following geographical locations, based on the NHS England team areas:

- North Regional Team: www.england.nhs.uk/north/

- Midlands and East Regional Team: www.england.nhs.uk/mids-east/
- London Regional Team: www.england.nhs.uk/london/
- South East Regional Team: www.england.nhs.uk/south-east
- South West Regional Team: www.england.nhs.uk/south/

1.23 Price Increases

In order to reflect changes which may influence the costs you incur during the delivery of this service, your attention is drawn to 4.59 – 4.71.2 of the attached Master ITT document.
Price increases within this framework agreement will only be accepted in accordance with the protocol detailed.

1.24 Bed Availability Tool

It is anticipated that during the life of this framework agreement, an electronic Bed Availability Tool will be developed to offer commissioners and other users of the services provided under the Framework, 'real time' information regarding placement availability. With the use of such a tool it is forecast that commissioners and Trusts using non-NHS beds will be able to identify the closet beds that meet their service requirements, which in turn will reduce risk of Patients being placed at a distance from their local network, and save booker time in making enquiries about beds that are not available.

Should this tool be developed and rolled out for usage, it will be expected that all Providers who sign up to the framework, will engage with, and utilise the functionality of the Bed Availability Tool to ensure accuracy of 'real time' information at all times.

Face to face or Webinar training on the use of the system will be provided at such a time as the tool is made available for use.

1.25 Universal Electronic Recording System

It is expected over time for all Service providers to use an ERS that is compatible with that/those used by NHS mental health Trusts and CCG's in order for a collaborative record keeping system to be employed in order for the patient pathway to become fully aligned.

1.26 Step Down of Care

Where Patients are placed into the Service at a high level of care (for example, 1-1, 24 hour observations) the Contracting Authority requires that this care is reviewed as appropriate when reviewed against the requirements of the patient as their condition improves. Contracting Authorities must be notified of step down in care, and the costs for the placement and care of that patient will be amended accordingly.

1.27 Notification of Alternative Capacity

Where a Provider to the framework agreement has multiple premises from which services to this framework agreement are provided, the Provider should notify the responsible Contracting Authority as soon as a more suitable clinically appropriate placement become available at a location closer to a current patient's home.

The Contracting Authority will then determine, based on factors including Patient and clinical requirements, whether the Patient should be relocated to premises closer to their home locality and the Provider shall assist and facilitate the Contracting Authority with any information they may need to inform this decision/relocation.

1.28 NHS Digital Mental Health Dataset

It is a requirement that all NHS funded patients within a mental health service are included within the NHS Digital Mental Health Dataset (https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set) As such, all providers to the framework agreement must complete and submit this information in accordance with the requirements of the Dataset.

1.29 Compliance with Mental Health National Agenda and Policy

As previously highlighted it is with utmost importance that all NHS Mental Health provided services remain compliant with the Mental Health National Agenda, and therefore all **CCGs** and NHS Trusts will ensure all requests for placement into a Non-NHS bed will be made as an Essential referral and will be to the nearest Non-NHS bed available to a Patient's Home Team thus ensuring OAPs are kept to a minimum where absolutely required in practice.

With continuous developments in mental health policy and procedures it is expected for all Service providers to keep abreast of occurring changes and to update their practice and standards in order to maintain compliance with the specification of the Single-Priced Framework for Non-NHS Essentially Required Beds.

Chapter 2 - Acute Mental Health Inpatient for Adults

This Chapter should be read by Bidders applying for **LOT's one and/or two** to satisfy themselves that they meet the requirements as set out below

The duration of the Framework Agreement for Lots One and Two is for the period to 31st March 2021. An optional extension to 31st October 2023 may be awarded subject to the need being confirmed as required.

2.1 Background:

Lord Crisp (2015), provided evidence in his commissioned report, that NHS acute mental health inpatient beds have reduced from around 150,000 as of 1955 to around 22,300 by 2012, with a 39 percent bed reduction being noted from 1998 to 2012. Possibly in response to this and due to a lack of community services available to Patients in crisis, there was a reported steep increase in the requirement for NHS trusts and **CCGs** supporting people with mental health needs to acquire non-NHS mental health in **OAPs**. Such demand has impacted on the financial state of NHS mental health services as well as on the patient experience.

2.2 Introduction

The primary function of an Acute Inpatient facility is to provide 24 hour care for people whose presenting crisis in mental health has not responded to interventions and treatment attempted by their local mental health services. A referral to an Acute mental health facility will have been considered by the local Crisis Resolution Home Treatment Team as the most appropriate course of action following all other intervention and treatment options being exhausted.

It is important for people requiring such specialist care to be provided an admission that is purposeful, following an integrated care pathway and being as open and transparent as possible. The Service should be local to their usual support network along with their mental and primary health services in order to maintain and build positive relationships for the person admitted.

Acute Mental Health Services are subject to quality standards and providing a core process of personalised assessment, intervention, review and forward planning which will incorporate both the physical and mental wellbeing of the person requiring acute inpatient admission.

In order to minimise risk of admissions becoming non-therapeutic and increasing possibility of institutionalisation, admission lengths will not be delayed past clinical need, with length of stay expected to have median rate no higher than national acute MH admission median (30 days). Any admission becoming longer than the national guidelines of 60 days must have a review of the reasons why discharge has not been possible involving local services, commissioners and the provider. Clear care and discharge planning will be put in place from the commencement of all admissions, and length of stay will be based on **MDT** assessments and a robust treatment plan. All admissions will be subject to the Red2Green Bed Days protocol, with accountability to the patient's local mental health service when Red days occur.

All patients will be informed on admission the purpose of their admission with expected length of stay and their care plan to be written with them. Where Red days occur or any delays in discharge plans, these will also be discussed with the patient with reasons why and how they are will be addressed.
Throughout a patients admission the CRHT will maintain daily contact with the ward to ensure the agreed treatment plan is on track and to review the patient for intervention and treatment response, along with monitoring of stability for possibility of an earlier discharge to the community than that care planned.

All acute inpatient facilities will provide a safe and homely environment which fosters stability and security. The MDT should include health and allied care professionals, as well as non-qualified **HCAs** who are able to provide specific therapies, approaches and assessments for patient's, along with a range of psychosocial interventions. These may include interventions such as cognitive behavioural therapy, motivational interviewing, cognitive function assessments, and behavioural analysis amongst others. Where possible, interventions should involve self-management strategies, and guidance to support physical health, such as exercise, smoking cessation and dietary advice. In addition, the **MDT** will work with patient's families and carers to promote understanding and reduce stress associated with the care of a person presenting with a mental illness.

More specifically, Occupational Therapists are required to identify specific problems that the patient may have with more complex living skills, assisting in care planning to address these needs. **HCAs** have a key role in helping patient's gain or regain their confidence in managing their own self-care, keeping their living space clean and doing their own laundry etc. Promotion of independence must be paramount in service delivery, and is to be supported via intensive therapeutic activity designed with the individual patient's needs in mind.

Providers are expected to develop an overview of the changing needs of local patient's and establish systems for close working with housing providers and commissioners to plan suitable facilities that meet these needs. Strong links with user and carer organisations, leisure facilities, employment services and other local services will be developed in order to encourage local links and involvement in local facilities.

All staff should deliver their specialist interventions within the collaborative framework of the recovery approach.

2.3 Aims of the services provided

The aim of this service is to provide assessment (as required), intervention and treatment to people whose mental health has not responded to intervention and treatment in the community with all efforts of the local CRHT being exhausted. The focus of the service will be to successfully intervene and treat a person presenting in an acute phase of a mental health illness. All referrals will be received and accepted from the local CRHT.

2.4 Service specification:

2.4.1 Referral:

The Service **will** accept admissions in consultation with CRHT only.

Reason for admission **will** be clearly explained with evidence of what assessment, interventions and treatment(s) have been attempted whilst the patient was in the community.

All patients **will** have been or **will** be referred for a Care and Treatment Review to be arranged by the patients local CCG within two weeks of admission where admission has not been planned following a completed **CTR**.

2.4.2 Admission:

Clear plans **will** be agreed with the referring CRHT which **will** be the patients care plan for admission

All admissions **will** be agreed and limited to stabilising a person's mental state, with the expectation for on-going treatment and interventions to be continued in the local community.

2.4.3 Assessment:

The Service **will** ensure that all patients diagnosed with autism and/or a learning disability are provided fair access to mental health services with effective interventions in accordance with the Green Light Tool Kit.

The implementation of a care plan **will** commence the Patient's trajectory of recovery, enabling them to move towards a less intensive service.

2.4.4 Treatment:

The Service **will** provide every Patient with a written care plan which **will** reflect their individual needs and **will** identify individual needs of Patients via the use of appropriate risk and other assessments

The Service **will** take a strengths, needs and aspirations approach to care planning.

Care plans **will** be developed that meet individual Patient's' health and social care needs; these **will** be regularly evaluated and reformulated to reflect changing requirements

Treatment programmes **will** be personalised to reflect the needs of the individual

Discharge planning **will** take place from admission with the focus of reducing length of stay to a minimum.

Mental health and physical well-being **will** be promoted, with limiting historical risks being identified and monitored.

The Patient **will** be prepared for a return to the community setting in a manner which is appropriate to their individual degree of social skills and risk factors

2.4.5 Medication and Interventions:

The Service **will** aim pharmacological treatments at symptom and risk reduction, focussing on the impact of negative symptoms and the promotion of positive risk taking within a safe environment.

The Service **will** also ensure non-pharmacological interventions focus on the development of insight into symptoms and negative behaviours, to support the patient to be able to work towards an optimal quality of life, gain independence and make appropriate decisions.

The Service **will** effectively reconcile the need for a therapeutic approach and environment with the need for physical and recreational activity supported.

Care **will** be delivered through a wide range of therapies and interventions which are to be tailored to meet individual needs

Meaningful and developmental activities **will** be offered to all Patient's with active encouragement for them to take part.

2.4.6 Home Team/Local Authority:

The Service **will** allow freedom for the patients home CRHT and Care Coordinator to access facilities at all times.

The sharing of information and records **will** be provided upon request.

The local CRHT and/or care coordinator **will** lead on care being provide and ensure timely discharges are complied with.

Providers **will** work in a close and co-ordinated way with both core community and acute services to provide the highest possible quality of care throughout the Service, both within the geographical area of the Service and in the placing community; the objective must be to ensure the smooth continuity of the service provision when the Patient is transferred back to the referring Trust.

The funding Trust **will** be regularly updated and informed of the Patient's situation and progress via the Care Coordinator.

2.4.7 Mental Health Act (1983), Capacity and Consent:

It is expected that the Service **will** accept people referred who are informal as well as those who are detained under the MHA (1983).

Support for the provision of independent advocacy (to include Independent Mental Health Advocacy (IMHA)) and other appropriate voluntary input **will** be provided

2.4.8 Environment & Safety:

An aesthetically pleasing environment and surroundings **will** be provided

Patients **will** have sufficient space and storage for the duration of their admission to the facilities, allowing for personal effects to be brought into the environment that are considered to be suitable and within the risk tolerance of the unit.

2.4.9 Equality and Diversity:

The Service **will** provide a comprehensive person-centred assessment of needs and risk, to include family and carers views. The Service **will** actively work to help the person build on their strengths and work towards their aspirations.

Patients and their carers **will** be involved in individual care planning decisions, and regular reviews of care planning and the progress the Patient has made

Social inclusion and equality **will** be promoted by ensuring the Patient has personal choice through involvement and empowerment

Vocational and educational opportunities **will** be encouraged to promote engagement and integration

2.4.10 Co-Existing Problems:

The Service **will** have the capacity to support Patients who have co-existing substance misuse problems.

2.5 Outcome Targets

It is anticipated that a target length of stay will be no longer than 30 days from onset of admission, with discharge planning commencing upon admission to the Service and will remain the focus of the Patient stay. Where a patient is nearing the national 60 day bed threshold, reviews will be stepped up to weekly intensive reviewing with explicate reasoning for any delays in discharge.

Length of stay will be discussed and agreed with the Patient, with continuous discharge plans discussed on a regular basis and any delays to the planned discharge being discussed with the patient as required.

The Red2Green Bed Days monitoring process will be applied to ensure the patients care plan and objectives of admission are being kept at the centre of the admission at all times. Where Red days are identified a clear explanation of why they exist along with how they will be addressed are to be provided to the patients home mental health services.

All persons admitted will be discharged at a clinically appropriate time, and not allowed to remain in a constrained environment past clinical need. The Service will actively work with the local CRHT, Care Coordinator and patient to reduce risk of the person becoming institutionalised regardless of their length of admission. All patients will be discharged to their Home Team.

A safe and homely space will be provided for people admitted for assessment during an acute state of mental illness. All Patients are to receive person-centred, individualised packages of care, utilising a recovery approach via a therapeutic pathway. All staff are to promote positive risk taking in order to encourage personal recovery and development.

Independence and social integration are to be provided via appropriate activities both in the clinical setting and community as applicable. Symptom reduction and reduction in negative behaviours are to be sought in order that the individual can achieve optimal quality of life.

Patients are to be made to feel involved and empowered to contribute to service development by providing opportunity to share ideas and initiatives to managers and leaders of the service.

Promotion of multi-disciplinary and multi-agency liaison is to be encouraged for input into service delivery.

Services should adopt an integrated care approach to recovery from mental illness and associated behavioural issues by enhancing skills and promoting independence and autonomy in order to give Patient's real opportunities for the future that may lead to successful community living with appropriate support.

2.6 Physical environment and procedural requirements

The principles underpinning the approach to the provision of accommodation should be as follows:

- An acute inpatient facility will aim to provide a high standard of humane treatment and care in a safe and therapeutic setting.
- The Service should promote independence with a variety of facilities on offer for Patients to access, both on and off site. Upon review, this could form part of a patient's personalised care plan with the overall goal being to promote independence, promote access to the local community and amenities, and encourage Patient's to engage in normal life activities that would be beneficial to their recovery programme. This could involve shopping, cooking, attendance at the gym, college or attending the library - dependent on Patient choice and what facilities are on offer.

2.7 Referral criteria & sources

Referral for admission will be considered only once all other measures to intervene or treat a person's presenting mental health crisis have been exhausted. When making a referral for admission the referring CRHT and Service provider will set a robust plan for the purpose of the admission to include assessments required along with intervention and treatment to be provided.

The following patient profile is to be met as acceptance criteria:-

- All Patients will be 18 years and over
- Presenting in an mental health state that has not responded to intervention and treatment provided by CRHT
- Requires assessment, intervention and/or treatment that could only be provided in a hospital setting

In circumstances where there is an offending history, Providers will:-

- Explore the relationship between the mental disorder and offending and/or challenging behaviour.
- Develop treatment interventions designed to optimise the effectiveness of treatment and

minimise the possibility of future offending behaviours, and/or address challenging behaviours.

2.7.1 Exclusion Criteria

Referrals other than from the patients home CRHT will not be considered for admission. The following categories of persons would not generally be considered suitable for admission:

- People under the age of 18.
- People who have not been provided assessment, intervention and/or treatment from their local CRHT.
- People who require a more intensive degree of intervention than is provided by Acute inpatient mental health services.
- Sexual offenders without an underlying mental illness or other health need for which the service is primarily designed.
- People whose primary diagnosis is brain injury or dementia.

2.7.2 Response time and prioritisation

It is expected that the Provider will be able to offer a response time of 4 hours to admit a patient. It is also expected that given the nature of these placements, a more urgent response time may be required, with Providers being required to have appropriate systems in place to both receive and prioritise placements in accordance with the requirements of the contracting service and Patient in terms of their health and wellbeing. Where an admission has not occurred within 12 hours of the admission request, escalation of the process will be carried out.

Chapter 3 - Mental Health Psychiatric Intensive Care Services for adults

This Chapter should be read by Bidders applying for **LOT's 3 and / or 4** to satisfy themselves that they meet the requirements as set out below

The duration of the Framework Agreement for Lots Three and Four is for the period to 31st March 2021. An optional extension to 31st October 2023 may be awarded subject to the need being confirmed as required.

3.1 Background:

Following a history of shortages within the mental health sector of NHS Psychiatric Intensive Care beds, efforts have been made to reduce the inequality across these beds, however it is known that there continues to be a national shortage of this type of bed with a high dependence on non-NHS psychiatric intensive care units.

3.2 Introduction

The primary function of a psychiatric intensive care unit (**PICU**) is to provide high intensity nursing and medical care to Patients whose illness cannot be safely or easily managed on an acute ward.
It is expected that Patients requiring a **PICU** are likely to:

- Display an acute behavioural disturbance with an associated loss of capacity for self-control that seriously compromises physical and/or psychological wellbeing of themselves and/or others.
- Be presenting with a risk of aggression, suicide and/or serious self-harm
- Be at risk of increased vulnerability which may be related to sexual disinhibition or over-activity in the context of mental disorder

Psychiatric intensive care is a specialist inpatient mental health service which specifically addresses acute needs of Patients. The aim of the service is to provide rapid assessment and stabilisation of a person's mental disorder through active engagement and treatment.
The **PICU** will be a small highly staffed, specialist environment with additional measures aimed to manage clinical acuity and risk presented by a Patient. A comprehensive, cohesive multi-disciplinary team with a shared vision and the capacity and capability to engage effectively with highly disturbed Patients, will provide a range of therapeutic interventions and clinical treatments within the agreed model of care required of a **PICU** service.
Staffing capacity should be sufficient to deliver the care and treatment model and maintain a safe environment at all times. Staff mix and ratios should be flexible enough to meet changing levels of risk. It is expected for **PICU** teams to have skills within the team and facilities to assess and appropriately manage co-morbid conditions of both physical and mental health.
Admission to such units may be required as a result of an emergency following assessment of a Patient in the community requiring more intensive assessment and treatment, however **PICU**'s should be able to arrange facility for planned admissions, negotiated with the referring **MDT** in order to identify specific treatment needs and goals to be attained. Such referrals will be anticipated as being required as part of a longer admission to mental health inpatient

services when it has been considered that higher intensive assessment and intervention are required. The emphasis of admission is on intensive psychological, psychosocial and pharmacological treatment, combined with a range of measures to minimise risk, disturbance and vulnerability to the Patient.

Referrals for a **PICU** placement will be made by an appropriate **MDT, with input from the local CRHT**, with clear objectives of the admission, treatment plan and goals set out. A clear plan is to be agreed between the referring team, the **PICU** and where applicable the Patient being referred. It is expected that treatment plans will have a positive impact upon the Patient and will justify the reason for referral to the **PICU**.

All **PICU's** will provide a safe and homely environment which fosters stability and security, for the period of time required for treatment to be successfully administered to reduce exacerbated behaviour.

Where possible it is considered good practice for a **PICU** service to carry out an assessment of needs following receipt of a referral in order to complete an agreed treatment plan and length of stay. At times when admission to a **PICU** is considered not to be appropriate or in the Patients best interests, then advice and management of presenting behaviour or mental health symptoms are to be provided to the referring service.

3.3 Aims of the services provided

The aim of this service is to deliver effective psychiatric intensive care to Patients whose needs cannot be met by less intensive mainstream adult mental health services. The focus of the service is to provide a high staff ratio to Patient service to support those people presenting with acutely challenging behaviours which may put themselves or others at risk of harm or increased vulnerability. It may be that the person being referred may or may not have been previously known to mental health services and may or may not have an assessed diagnosis of mental health illness. It is expected that people being referred for intensive care treatment will be detained under the **MHA** (1983) due to the nature of a **PICU** and the constraints of the unit, however patients who require admission on an informal status will not automatically be excluded.

The Service will demonstrate improvements in patient symptoms and arrange transfer to the referring Adult Acute ward at the earliest opportunity following the provision of services that are fair, personalised, effective and safe.

3.4 Service specification:

3.4.1 Referral:

The Service **will** have in place a dynamic referral system that ensures understanding from referrers of the acceptable referral criteria into the service.

The Service **will** reflect a psychiatric emergency service being able to respond to all referrals within 24-hours of the referral being made

3.4.2 Admission:

Admissions **will** be as short as clinically possible, not usually exceeding six – eight weeks.

Discharge planning **will** take place from admission with the focus on length of stay being a minimum period of time.

Patients **will** not remain in a PICU past the benefits of a **PICU** being exhausted

3.4.3 Assessment:

Assessments **will** be carried out as a matter of urgency upon receiving a referral.

Will provide a service that is available 24/7 and provides a safe environment in which rapid assessment and intensive management of behaviour and mental health symptoms **will** be coordinated via an integrated care pathway.

The Service **will** provide a comprehensive person-centred assessment of needs and risk, to include family and carer.

3.4.4 Treatment:

Treatment **will** focus on having a direct impact on reducing short and medium term clinical risk

Will be recovery goal orientated, providing regular progress reviews to the referring mental health team.

Individual needs **will** be identified via the use of appropriate risk and other assessments.

Care plans **will** be developed that meet individual Patient's health and social care needs; these **will** be regularly evaluated and reformulated to reflect changing requirements, with Patients and their carers being involved in individual care planning decisions, regular reviews of care planning and the progress the patient has made.

Mental health and physical wellbeing **will** be promoted, with limiting historical risks being identified and monitored

3.4.5 Medication and Interventions:

Will be delivered through a range of therapies and interventions which are tailored to meet individual needs

3.4.6 Home Team/Local Authority:

The Service **will** provide multi-disciplinary and multi-agency liaison to promote input into service delivery, working in a close and co-ordinated way with both core community and acute services.

The highest possible quality of care **will** be delivered throughout, both within the geographical area of the service and in the placing community.

The objective must be to ensure the smooth continuity of the service provision when the Patient is transferred back to the referring Trust, with the Patient being prepared for an appropriate transfer and effective links being maintained with them.

Links with the Patient's home mental health care co-ordinator to include the CRHT and commissioner **will** be maintained, and the placing Trust **will** be regularly updated and informed of the Patient's situation and progress.

The Patient's mental health home team **will** take the lead on the patients discharge pathway and ensure discharge is to their local community.

3.4.7 Mental Health Act (1983), Capacity and Consent:

It is expected that the Service **will** accept people referred who are informal as well as those who are detained under the MHA (1983).

Support for the provision of independent advocacy to include Independent Mental Health Advocacy (IMHA) and other appropriate voluntary input **will** be provided.

3.4.8 Equality and Diversity:

Social inclusion and equality **will** be promoted by ensuring the Patient has personal choice through involvement and empowerment, and reflected in treatment programmes which **will** be personalised to reflect the needs of the individual.

3.5 Outcome Targets

The target length of admission is expected not to exceed six – eight weeks, with all Patients being transferred to a less intensive mental health service at the earliest possible opportunity as clinically appropriate.

All Patients are to receive person-centred, individualised packages of care to meet needs of exacerbated behaviour and mental health disorder.

All Patients are to be actively encouraged and empowered to be involved in the planning of their treatment plan and progress reviews.

Challenging behaviour and symptom reducing interventions are to be sought in order for the individual to achieve optimal quality of life.

3.6 Physical environment and procedural requirements

Where de-escalation, restraint or seclusion techniques are used to manage escalating behaviours, they should be employed for the shortage periods of time possible. The development of strategies to understand reasons and what context a Patient may present in a manner that requires more intrusive intervention should be a core function of the **PICU**. It is encouraged for a quiet area of the unit to be dedicated to the use of de-escalation providing a safe space for Patients to go to for this specific purpose. All risk assessments will include the likelihood of need for de-escalation, restraint and/or seclusion to be administered and recorded in the Patients care plan to reflect the risk assessment. All incidents of de-escalation, restraint and seclusion will be recorded in the patients notes and be auditable. Training based on national guidance will be made available to all staff regardless of profession or if qualified or not, to ensure safe administration of de-escalation, restraint and seclusion. All seclusion periods will have regular reviews carried out by an appropriate psychiatrist and senior mental health team. Where de-escalation, restraint or seclusion have been

administered to manage a Patients presenting behaviour, a prompt de-briefing to all affected will be arranged.

3.7 Workforce and Training

Mandatory training for staff engaged in Psychiatric Intensive Care of Patients will include the prevention and management of violence and aggression, which should incorporate de-escalation techniques and the use of control and restraint procedures.

3.8 Referral route

The service will receive referrals of NHS registered Patients. Whilst referrals are expected to be received from acute in-patient, low secure, medium secure and other rehabilitation services, as well as from the justice service, they should always have been agreed with the local CRHT.

3.9 Referral criteria & sources

It is expected that due to the restrictive nature of a **PICU** that all Patients being referred to the Service will usually be detained under a Section of the **MHA** (1983). All staff should work within regulatory guidance from their professional/regulatory body and in accordance with the **MHA** 1983 and the **CJA** 2003.

The following criteria will also be expected to be met for acceptance to a **PICU**:-

- Aged 18 years and over, but generally under the age of 65 years.
- Requiring assessment and treatment for behaviour difficulties which are compromising mental and physical health.
- Presenting with risk that cannot be safely assessed or treated in an open acute inpatient facility.
- Such risks will include:
    - Significant risk of aggression and associated violence to self, others and property
    - An increased risk of persistent absconding
    - Risk of suicidality or vulnerability which may increase risk to self of sexual violation.

3.9.1 Exclusion Criteria

Although each referral should be considered individually on its merits, the following categories of persons would not generally be considered suitable for admission:

- People under the age of 18.
- People who have a primary diagnosis of substance misuse, intoxication or a known dependence.
- Where it is known that the persons behaviour is a direct result of substance misuse with no exacerbation of mental disorder at the time of the referral.
- Diagnosis of dementia
- Diagnosis of a learning disability

- Diagnosis of a significant brain injury
- Where the patient is too frail to allow safe management in a **PICU**

3.9.2 Response time and prioritisation

It is expected that the Provider will deliver an emergency psychiatric service, being able to accept a suitable referral to their Service within 24 hours of a referral being made. Where possible, Providers should carry out an assessment of needs prior to admission to establish an agreed care plan with the referring team and where applicable with the referred patient.

Chapter 4 - Mental Health High Dependency Rehabilitation and Community Rehab Unit Services for Adults

This Chapter should be read by Bidders applying for **LOTs 5, 6, 7 and/or 8** to satisfy themselves that they meet the requirement as set out below

4.1 Background:

Mental Health Rehabilitation Inpatient services work with individuals presenting with complex psychosis whose needs cannot be met by general adult mental health services. The **CQC** raises concern that despite rehabilitation services being an essential element to providing a comprehensive mental health system, there are high numbers of rehabilitation beds used that are a long distance from the patients home, and for significant periods of time. There are reports of patients, in some instances being placed out of area for the majority of their adult life, creating broadening barriers to reconnecting to their local care community and networks. There are also examples of Patients being placed or remaining in restrictive care environments that are no longer therapeutically required to meet the patient needs, resulting in the event of independent living being impeded, whilst promoting risk of institutionalised reliance on restrictive mental health services.

In addition to the effect **OAPs** have upon the Patient, these services are a financial burden to the NHS with **OAPs** costing 65 percent more than similar services in the patient's local area. With the need for the NHS to put limits on monies that are being spent in areas of the NHS that are not being monitored as closely as others, there has been an emphasise put on the repatriation of Patient to local areas and to ensure the commissioning of rehabilitation placements is more effective both for the patient and for the NHS budget.

4.2 Introduction

4.2.1 High Dependency Rehabilitation Inpatient Services are available for people who have severe mental health symptoms associated with (multiply) complex comorbidities, a significant risk history and ongoing challenging behaviours. It is expected that most people will be detained under the MHA (1983) on admission.

The focus on the rehabilitation Service will be to achieve maximum engagement from patients is order to optimise benefits from medication and increase opportunities to reduce challenging behaviours. The Service will also be expected to use psychological interventions to assist in a patients recovery goals with support to (re)engage with families and their local community, and where applicable, repatriate to local areas from out of area placements.

A range of hospital and community-based units will support Patients in their recovery. It is expected that most Patients will have a target length of stay of no longer than 12 months. It is anticipated that some Patients will require a much shorter stay with expectation for Service Providers to be able to accommodate this, and to ensure transfer to a less dependent environment for the patient is carried out at the earliest opportunity. There should not be an assumption that a placement is likely to meet needs of a Patient indefinitely.

It must be noted that if a Patient placed into this Service was to present with symptomology consistent with an acute mental health episode, the Patient will require in-patient treatment in an Acute or Psychiatric Intensive Care Unit (**PICU**) in order to treat the nature of their mental disorder.

All rehabilitation units will provide a safe and homely environment which fosters stability and security, avoids institutionalisation and offers the Patient an experience that will be free from abuse or exploitation from others.

4.2.2 Community Rehabilitation Units provide services for people who are unable to be transferred directly from High Dependency Units to Supported Community Accommodation due to on-gong complex needs requiring on-going rehabilitation.

Where a **CRU** is registered as a ward, patients can be accepted who are detained under the mental health act (1983), otherwise for **CRU's** that are not registered as a ward patients may be admitted subject to a Community Treatment Order or Section 41 Community Order of the mental health act (1983).

The focus of a **CRU** will be to facilitate further recovery of patients requiring on-going rehabilitation services, which will be achieved through medication management to include self-medication, the engagement with psychological interventions, along with gaining of independent living skills achieved in the living and community environments.

A **CRU** will be expected to be 'Open' units staffed 24 hours per day and will provide a length of stay for one to two years in order to achieve recovery for patients to step-down to supported living accommodation.

Key to the service is a multi-disciplinary team to comprise of specialist medical, occupational, nursing, psychology staff and non-qualified support workers, who will provide expertise to the complex and diverse treatment needs of Patients referred for rehabilitation. The team will provide a range of psychosocial and psychological interventions and therapies and will explore complex medication regimes often required by Patients admitted to rehabilitation services. Where possible, interventions should involve self-management strategies, and guidance to support physical health, such as exercise, smoking cessation and dietary advice. The team will also work with the families and carers of Patients to promote understanding and reduce stress related to caring for people with mental illnesses.

In addition, Occupational Therapists are required to identify specific problems that the Patient may have with more complex living skills, and assisting in care planning to address these needs. Support workers also have a key role in helping Patients gain or regain their confidence in managing their own self-care, keeping their living space clean and doing their own laundry etc.

It is expected for referrals to be acted upon promptly with assessments being carried out at an earliest opportunity. Where a referral is not considered appropriate, practical advice to be offered to the referrer for the management of people with complex needs, co-morbid conditions and treatment resistance. Providers are expected to develop an overview of the

changing needs of local Patients and establish systems for close working with housing providers and commissioners to plan suitable facilities that meet these needs. Strong links with user and carer organisations, leisure facilities, employment services and other local services will be developed in order to encourage local links and involvement in local facilities. All staff should deliver their specialist interventions within the collaborative framework of the recovery approach.

4.3 Aims of Services Provided

The aim of this service is to deliver effective rehabilitation and recovery to Patients whose needs cannot be met by less intensive mainstream adult mental health services. The service will focus on those Patients with severe and complex mental health problems or with a dual diagnosis of mental health and learning disability, with mental health being the primary diagnosis. There will also be an assumption that those referred are high users of in-patient and community services. Patients with a continuing mental health care need and Patients with challenging behaviour will also be placed within this service. The services provided must be 'fair, personalised, effective and safe'.

The Service must demonstrate improvements in Patient symptoms, social inclusion and dependent/independent living skills, with reduced associated clinical risk. Demonstration of such will be achieved by the preparing for and moving Patients to lower supported accommodation in the community, which may or may not be independent living.

Reviews of a patients on-going care and treatment needs will be completed within one month of admission, three months following admission and then at least once annually to ensure all needs are being met and delivered timely and appropriately. All reviews will be carried out in accordance with the patients Home Team being available to attend, and documentation of the reviews provided in a timely manner following a review meeting.

4.4 Service specification

4.4.1 Referral:

All referrals **will** be for NHS patients

All referrals **will** be made by the patient's local mental health team or mental health inpatient service.

4.4.2 Admission:

Will provide a step down service for Patients who are unable to return home or into the community following a secure or acute mental health inpatient admission

4.4.3 Assessment:

The Service **will** provide specialist assessment, treatment and interventions through a dynamic **MDT**.

4.4.4 Treatment:

Will provide a whole system approach to recovery in order to maximise a Patient's quality of life and social inclusion.

All Patients **will** be encouraged to use and build skills, promoting independence and autonomy in order to give hope for the future, providing opportunity for collaborative relationships with Patients in order to identify and work towards personalised goals.

The Service **will** have the capacity to support Patients who have co-existing substance misuse problems

4.4.5 Home Team/Local Authority:

Links with the Patient's care co-ordinator and Responsible Medical Officer/Responsible Clinician and commissioner **will** be maintained.

4.4.6 Environment & Safety:

Patients **will** live in an aesthetically pleasing environment and surroundings and have sufficient space and storage for their current and accumulated personal effects.

Where a Patient has brought with them significant items of property e.g. furniture and other personal effects, an inventory of **all** items will be made, signed and dated by the Patient and recording staff member and kept in the Patient's record. Any changes/additions to the property kept by the Patient must be updated appropriately.

4.5 Outcome Targets

The target length of stay is expected to be 12 to 18 months with expectation for step down to a lower level of need environment, ideally to independent/supported living placement to be facilitated upon discharge. It is anticipated that symptom reduction and reduction in negative behaviours will be achieved during this type of placement and will assist the individual to achieve optimal quality of life.

All Patients are to receive person-centred, individualised packages of care, utilising a recovery approach and a PROM for example, DIALOG or DIALOG Plus. Independence and social integration via educational and vocational activities within the local community are to be promoted. A recovery approach is to be implemented for all Patients and reviewed regularly (at least every 6 months) to assess recovery progress.

Patients are to be actively encouraged to be the leaders of their own care, and to contribute to service development by considering their ideas and initiatives

4.6 Physical environment and procedural requirements

The Service should promote independence, with a variety of facilities on offer for Patients to access, both on and off site. Upon review, this could form part of the Patients personalised care plan, with the overall goal being to promote independence, access to the local

community and amenities and encourage service users to engage in normal life activities that would be beneficial to their recovery programme. This could involve shopping, cooking, attendance at the gym, college or attending the library - dependent on service user choice and what facilities are on offer.

There should be sufficient flexibility to allow people to move on to higher or lower support at a time when they are ready. This would also include the possibility of Patients having escorted/unescorted leave when part of a consistent coherent care plan aimed at incrementally reintroducing the Patient to normal living and subsequently, leading towards discharge. Arrangements for leave should be continually monitored as part of risk management.

Where it is considered appropriate for a Patient to self-administer medication, an assessment of the Patient's capacity to be involved in the process will be carried out and documented to state the outcome. This will be carried out by an appropriate member of the **MDT**.

Safe storage of medication being self-administered by a Patient will be ensured at all times. The following medications will be considered as not appropriate for Patients to self-administer in a ward/rehab unit environment:

- All controlled medications
- Injectable medications unless to be self-administered following discharge to independent/low supported living; i.e. insulin
- All medications that are prescribed on a sliding scale dose or on a variable regime, which require careful monitoring by a qualified member of the **MDT**.

Where a Patient is self-administering medication, relevant documentation is to be completed and kept up to date to ensure accuracy of record keeping and safety are maintained. On-going assessments are to be undertaken to ensure continued appropriateness of self-administering of medication and feasibility to the ward/rehab environment.

4.7 Integrated Care Partnerships & Relationships

Rehabilitation services need to know their local communities well in order to build strong links for Patient's recovery pathway. Such community services will include, support groups, vocational services, clubs, educational facilities, leisure facilities, community police, etc.

Strong links with the communities from which Patients come will be required to be established, to include housing providers (local authorities and registered social landlords) in those areas, so that Patients needs for reintegration can be met upon discharge from the service.

It is essential that the Providers take adequate responsibility to ensure all Patients within their care have access to primary healthcare services whether inside their facilities or off-site. It is expected that the Provider will have good liaison with the local GP Practice to ensure registration of Patients onto their patient list. It is the responsibility of the Provider to ensure

that GPs have full risk assessment and supporting documentation from the moment of the individual's registration.

Where a Patient is placed out of area to their usual GP, they will be registered as a temporary patient with the GP practice nearest to their placement. This will ensure the Patient is returned to their originating Local Authority and Mental Health Home Team without complication of being registered out of area. The Service will be required to ensure Service Level Agreements are made and continued with local General Practitioner Practices and the local Acute Trusts in order to meet all physical health needs of admitted Patients.

Patient's will be expected to visit their registered GP surgery as required, unless clinically unable to.

In addition Patients will be provided information and access to all other primary healthcare services available, to include dental and ophthalmic services.

Appropriate age and gender specific screening in line with Department of Health guidance will be made available to all Patients along with physical health screening checks to be carried out on an annual basis. Where required referrals will be made to appropriate primary and secondary health care clinics, with assistance provided as required, to ensure Patients attend appointments.

Rehabilitation services require a wide range of skills and expertise. Team members will need to share relationship, clinical, liaison and advocacy skills as well as possessing specialist skills in particular areas.

4.8 Referral route

The service will receive referrals of NHS registered Patients, of which may be received from community mental health teams, acute in-patient, low secure, medium secure and other rehabilitation services.

4.8.1 Referral criteria & sources

Patients referred for this type of service will match the profile set out below:-

- Aged 18 years and over
- Requiring assessment and/or treatment for a severe and complex mental health problem with associated risk of:
    - Aggression and violence towards people and property, time related i.e. not currently presenting but evidence of this in the past.
    - Absconding - usually periodic or persistent but the consequences of the absconding are not serious enough to warrant continued treatment in low security.
    - Sexually problematic behaviour (not related to particular offence category).
    - Significant and complex needs that require intensive rehabilitation services.

- Presenting with such challenging behaviour that can or may not be managed safely in other environments.
- There are significant risks in relation to mental disorder or short-term risk/symptoms requiring stabilisation.
- There have been multiple attempts at treatment within transitional services or the Patient is assessed as not being able to make progress within local community or other mental health services.

In circumstances where there is an offending history, Providers will:-

- Explore the relationship between the mental disorder and offending and/or challenging behaviour.
- Develop treatment interventions designed to optimise the effectiveness of treatment and minimise the possibility of future offending behaviours, and/or address challenging behaviours.

4.8.2 Exclusion Criteria

Although each referral should be considered individually on its merits, the following categories of persons would not generally be considered suitable for admission:

- People under the age of 18.
- People who require a lesser or greater degree of intensive rehabilitation and/or security than is provided by these services.
- Sexual offenders without an underlying mental illness/learning disability or other health need for which the service is primarily designed.
- Primary diagnosis of autism, brain injury or dementia.

4.8.3 Response time and prioritisation

It is expected that the Provider will be able to offer a response time to requests for information regarding placements that meets the requirements of the Contracting Authority.

Given the nature of these placements, it is to be expected that often an urgent response is required, and Providers will be required to have appropriate systems in place to both receive and prioritise placements in accordance with the requirements of the Contracting Authority and patient in terms of their health and wellbeing.