

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No:	Appendix 1 to Medium and Low Secure (Adults) specifications C02/S/a and C02/S/b
Service	Access Assessment Medium Secure Mental Health Services (Adults) C02/S/a Low Secure Mental Health Services (Adults) C02/S/b
Commissioner Lead	<i>For local completion</i>
Provider Lead	<i>For local completion</i>

1. Scope
<p>1.1 Prescribed Specialised Service</p> <p>This appendix covers the provision of access assessments for adult medium and low secure services as described in main specification</p> <p>1.2 Description</p> <p>An access assessment is the clinical assessment and formulation of the mental health and risk management needs of an individual. It is used to inform decisions about the most appropriate inpatient placement for the person in terms of their care and treatment needs and the level of security required.</p> <p>1.3 How the Service is Differentiated from Services Falling within the Responsibilities of Other Commissioners</p> <p>Reference main specification</p>

2. Care Pathway and Clinical Dependencies

2.1 Care Pathway

2.1.1 The access assessment service makes decisions in consideration of the whole care pathway for that person and consideration of alternative pathways to admission to secure care, e.g., and particularly the offender personality disorder pathway or community sentencing options.

2.1.2 The access assessment service is a crucial part of the care pathway and its function is to:

- Determine if admission to secure care is necessary and consideration of alternatives to admission
- Identify the appropriate level of security required and least restrictive environment
- Articulate treatment needs including the need for a specialist service if required
- Inform decisions about the readiness of patients within the secure care pathway to move between levels of security e.g. stepping down from high to medium or from medium to low secure services.

2.1.3 The access assessment service will inform decisions about the need for treatment in secure conditions. It will support patients being placed in the least restrictive environment, given their identified risks and individual care needs, whilst ensuring public protection.

The access assessment service will focus on four key questions:

- i. Should the person be admitted to secure inpatient services?
- ii. What level of security does the patient require?
- iii. How urgent is the admission?
- iv. What are the initial assessment/treatment needs?

2.1.4 The access assessment service will not always provide an assessment for admission to a specific hospital/service, however on occasions an admission assessment may be conducted at the same time by the same team.

2.1.5 Patients will have the opportunity to be engaged with the service in the process and the outcome will be shared with them.

2.1.6 The access assessment service will have the clinical skills/experience and authority to make decisions and recommendations, The service will ensure that respective assessments are conducted by the most clinically appropriate individual or team members.

2.1.7 The service will make sure that the assessment is conducted within a structured framework which will include using recognised risk assessment tools, e.g.

- The Security Needs Assessment Profile S.N.A.P. Manual Version 4.1 Collins M, Davies Dr. S & Ashwell C (2007)
- Dangerousness Understanding, Recovery and Urgency Manual (The DUNDRUM QUARTET) V1.0.21 Kennedy H, O'Neill C, Flynn G & Gill P (2010)
- HCR20 HCRv3
- EPS
- SVR-20
- RSVP

2.1.8 Access assessment services will provide for identified geographical hub areas. The service may be responsible for specific levels of security, gender and/or diagnostic groups.

2.1.9 The Service will ensure that access assessments are not be undertaken for patients with a diagnosed learning disability and/or autistic spectrum disorder who may require secure care, **until** a 'pre-admission' Care and Treatment Review (CTR) has been undertaken by the individual's originating Clinical Commissioning Group (CCG) to determine if hospital admission is required, or if an alternative setting is considered more appropriate to meet their needs. The service will be aware that there are however some occasions where it is appropriate for an access assessment to be undertaken first without a pre-admission CTR taking place, e.g. prisoner transfers or patients requiring urgent treatment.

2.1.10 Response Times

The services will be responsible for meeting set timescales and prioritizing referrals based on clinical need.

Due to the varying nature of referrals for access assessments different responses may be required and these will need to be delivered within appropriate timescales based on clinical need.

The access assessment service will communicate using secure communication channels, to provide an efficient and secure means of sharing confidential clinical information.

The timescales that the service will work to are described below:

- i. Urgent referrals

- Urgent referrals may require an emergency response.
- Initial verbal response regarding appropriateness of referral should be given within 24 hours of receipt or sooner if nature of the referral dictates this, based on clinical judgement.
- The urgency of the referral is determined by the receiving clinical team and should be informed by discussion with the referrer which should be undertaken as a priority.
- Assessment should take place within 24 hrs ordinarily
- Outcome verbally notified to referrer within 24 hrs of assessment
- Initial report 'brief' 24 hrs post assessment
- Final written report within 7 days of seeing patient

ii. Routine referrals

- Initial verbal response regarding appropriateness of referral to be given within 14 working days
- A proposed time frame in which the assessment will be conducted discussed and agreed with the referrer
- The access assessing clinician will inform the referrer of who is undertaking the assessment and ask that they make individual aware of assessment, prior to visit.
- A multi-disciplinary assessment will take place within 20 working days of all necessary information being available to referrer
- Formal written access assessment report to be shared with the referrer within 10 working days of the assessment taking place.

The service will take into consideration the following:

iii. Prison Transfers

In general, prisoners requiring transfer to secure inpatient services should be managed under the process and timescales set out within the Good Practice Procedure Guide for the Transfer and Remission of Adult Prisoners under s47 and s48 of the MHA (DH 2011)

This Good Practice Guidance states that the timescales for transfer of prisoners who are acutely mentally ill to secure care is 14 days from the assessment, which identifies that the criterion for detention under the MHA is met. The access assessment service will adhere to this guidance.

iv. Ministry of Justice (MoJ) Restrictions and Community Treatment Order (CTO) Recalls

Where a person, subject to a MoJ restriction or CTO has been discharged from a secure service and then relapses, their current clinical team may consider that they require admission to hospital. The person would not be automatically admitted to secure care. The access assessment service will be required to undertake an assessment to ensure that an admission

into secure services is appropriate and the least restrictive environment has been explored first.

2.1.11 Ensuring Quality and Consistency

The access assessment service will work in collaboration with the NHS England Mental Health Case Manager.

The service will accept that NHS England reserves the right to appraise or seek clarity about decisions made during the access assessment process. NHS England will do this via the processes described below.

i. Dispute Resolution

On rare occasions, the referring clinical team may not agree with the outcome of, and recommendations made, by the access assessment service (e.g. the access assessment may state that an admission to secure care is not in the best interests of the individual). In such circumstances, the access assessment service will instigate a clinician to clinician discussion regarding the differences of opinion.

If the respective clinicians are unable to agree an outcome, the referral, clinical information and recommendations made by the access assessment service are reviewed by the Mental Health Commissioner and Mental Health Case Manager involved in the referral, to establish the reasons for the dispute. The access assessment service then provides additional information, which will include information about the patient's current presentation and behaviour, outcomes of recent assessments of the patient and referrals made to other services.

The Mental Health Case Manager will attend the patient's CPA or other professionals meeting to assist with the decision.

Following the above procedure, a decision will be made by the respective NHS England Specialised Commissioning Mental Health Team that the access assessment provided by the service should stand or that the case should go forward into arbitration.

Recalls to hospital under the MHA are sometimes required as a matter of urgency, in these cases decisions can be made outside the dispute procedure so as not to delay the recall to hospital, a decision will be made by the access assessor based on the urgency of the case in question. If required a review can take place in accordance to the process described retrospectively.

ii. Arbitration Process

If the Dispute Resolution process set out above fails to resolve the

difference of opinion, an arbitration process will commence - the outcome of which determines the final outcome in the case.

This process involves NHS England seeking advice from a Forensic Consultant Psychiatrist unconnected to the referrer or access assessment service.

The advising Forensic Consultant Psychiatrist will review all the relevant clinical information including the access assessment service's report and will form a view on the suitability of the recommendations made. Their view and subsequent recommendations will be shared with the respective NHS England Mental Health Lead and Case Manager.

In providing advice, the independent Consultant will clearly state the rationale for their decision. The independent Consultant's recommendation will be final. If the final recommendation is for the patient to be admitted to medium or low secure services, NHS England notifies the appropriate secure service. Should the service not be able to admit, an alternative placement is sought.

2.1.12 Referrals for Access Assessment

The access assessment service will only accept a referral from a consultant psychiatrist or their delegated clinician, who has assessed the patient in their current setting (e.g. the local mental health unit or community setting) and who considers there is a clinical need for secure care.

In terms of addressing conflict of interest the service will be clear that a report prepared for court is not an access assessment but could, as with other available information, form a useful part of the information considered in carrying out the access assessment.

The service will work with referrers to ensure that all relevant clinical and other supporting information (e.g. risk assessments, CPA reports, MHRT reports) is provided at the time of the referral to the access assessment service.

The access assessment service will ensure that information required from the referrer for the purpose of an access assessment, as a minimum, should include:

- Name including any aliases
- Date of birth
- NHS number
- GP
- Last address
- Name and contact details of local care coordinator

- Responsible CCG
- Responsible Local Authority
- Current placement and admission date
- Diagnosis
- MHA section or other detention order
- Reason for referral/ presenting problem
- Relevant clinical and risk history including offending
- Timescales of note e.g. EDR (expected date of release)
- MAPPA level
- Clear recommendation on the least restrictive care option being sought (i.e. recommended security level) and rationale
- Suggested care and treatment plan (including initial thoughts on intended outcome from the secure admission/ discharge destination from secure care)
- For patients with an LD and/or ASD diagnosis, a copy of their pre-admission CTR where this has taken place prior to admission.

2.1.13 Exceptional circumstances

In exceptional circumstances there may be overwhelming evidence of need within the referral documentation, a face-to-face access assessment may not be required. The access assessment service will make this judgement based on the individual circumstances and may decide to make their recommendations based on a 'paper' review of the clinical information and further telephone consultation with the referrer.

2.2 Interdependence with other Services

See main specification.

3. Population Covered and Population Needs

3.1 Population Covered By This Specification

See main specification

3.2 Population Needs

See main specification

3.3 Expected Significant Future Demographic Changes

None

3.4 Evidence Base

4. Outcomes and Applicable Quality Standards

4.1 Quality Statement – Aim of Service

The overall **aim** is to ensure consistency in approach for the access assessment process. The assessments will be timely and facilitate the appropriate and efficient admission of patients to secure care; taking into account the entire care pathway, the individual needs of the patient and considering potential alternatives to admission to secure care.

4.2 **Outcomes and Indicators** as main specification

4.3 Commissioned providers are required to participate in annual quality assurance and collect and submit data to support the assessment of compliance with the service specification as set out in Schedule 4A-C

4.4 Applicable CQUIN goals are set out in Schedule 4D

5. Applicable Service Standards

5.1 **Applicable Obligatory National Standards**

As main specification

5.2 **Other Applicable National Standards to be met by Commissioned Providers**

As main specification

5.3 **Other Applicable Local Standards**

Reference local or regional protocols

6. Designated Providers (if applicable)

Not applicable

7. Abbreviation and Acronyms Explained

As main specification

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