Service Specification No.	July 2018 (Version 1)
Service	Adult Mental Health Provision of Psychiatric Intensive Care (PICU) services
Commissioner Lead	Associate Director of Contracting and Commissioning
Provider Lead	
Period	1st April 2019 – 31st March 2021 with an option to extend for a further 12 months
Date of Review	March 2020

1. Population Needs

1.1 National/local context and evidence base

Psychiatric intensive care is for patients who are in an acutely disturbed phase of a serious mental disorder. There is an associated loss of capacity for self-control, with a corresponding increase in risk, which does not allow their safe, therapeutic management and treatment in a less acute or a less secure mental health ward. *(National Minimum Standards for Psychiatric Intensive Care in General Adult Services Updated 2014) The National Association of Psychiatric Intensive Care Units (NAPICU) was established in 1996 to provide guidance on psychiatric intensive care issues in the UK, to overcome variability of practice and terminology where definitions of units are concerned and also to ensure high quality multidisciplinary care.*

The NAPICU standards contain a clear definition of psychiatric intensive care, as distinct from low secure care. Admission to a PICU should be due to a new episode or to an acute exacerbation of the patient's condition which cannot be safely managed in a general adult ward. (In contrast, patients in low secure units may be experiencing chronic behavioural disturbance not necessarily due to an acute clinical presentation.)
The standards also contain the prevalent UK model which is one of an environment physically located within and part of the care pathway for general adult psychiatry and local inpatient mental health services. The physical environment of a PICU is one of its defining aspects. The design of any unit is key to its success and should maximise the primary functions of safety, therapy and security.

Access to a recognised PICU is required for all acute mental health services.

Psychiatric intensive care is delivered by qualified and suitably trained multidisciplinary clinicians according to an agreed philosophy of unit operation underpinned by the principles of therapeutic interventions and dynamic clinically focused risk engagement. Length of stay must be appropriate to clinical need and assessment of risk, but would aim not exceed eight weeks in duration.

Local context:

Derbyshire CCG does not currently commission PICU beds from the NHS Local Mental Health provider.

From the 1st April 2017, Hardwick CCG took responsibility for PICU services under direct

Commissioning and has undertaken an 18-24 month Proof of concept (PoC) with a Regional Provider for the provision of 3 x Male and 1 x Female PICU beds and 1 x Female bed with a boarding NHS provider.

The Proof of concept was undertaken to support the review and redevelopment of the existing specification, care pathway and support engagement with the market to determine a route to market going forward.

Going forwards Commissioners will commission 5 x Male beds and 4 Female beds (1 x Female bed will continue to be Commissioned with a boarding NHS provider – 5 Female in total) as local to Derbyshire as possible on a block contract price, with additional spot purchases preferably delivered by the provider, but sourced by the provider with a third party (as required), for a 2+1yr term (initial 2 years with option to extend up to a maximum of 1 year based on performance), commencing from 1st April 2019.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	✓
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local Defined Outcomes

The NAPICU standards clearly illustrates appropriate service environment, access to external space, visitation facilities, risk management and safety. Commissioners expect any provider to adhere to the NAPICU standards when delivering the service/s.

1. The length of stay will be within the recommended time of a maximum of eight weeks.
2. Patients should have access to specialist practitioners of psychological interventions for a minimum of one day (eight hours) per week per unit.
3. Patients should have access to Occupational Therapists who are able to offer structured and meaningful activity programmes for patients.

4. Patients should have access to a Social worker.

3. Scope

3.1 Aims and objectives of service

- Provide a high level of nursing, medical assessment, care and treatment for those patients who cannot be managed safely on an open ward.
- Provide a safe and therapeutic environment conducive to improvements in mental state and behaviour, aiding recovery and returning patients to the referring area.
- Provide structured, organised, assertive and calm interventions without creating a feeling of oppression.
- Provide a proactive and extensive range of interventions aimed at the resolution of acutely disturbed behaviour and the improvement and stabilisation of mental state.
- Ensure that there is close involvement with the PICU Case Manager, the Patients Care Co-ordinator and Acute Mental Health services as appropriate within Derbyshire.
- Maintain and support regular contact with family (if appropriate).

3.2 Service Description/Care Pathway

Referrals

Referrals will be, as per the Derbyshire CCG and Derbyshire Healthcare Foundation Trust PICU protocol (See Appendix 1).

- Referrals will generally be accepted from other in patient areas and occasionally on a case by case basis from community settings.
- Referral can be made 24 hours per day, 365 days per year
- All referrals will receive an immediate response to requests for assessment, assistance and admission.
- Response rate for referrals should be within 1 hour of receipt of information from referrer.

Assessment

Following an initial assessment to clarify whether or not the person meets the criteria for admission to the service, a comprehensive multi-disciplinary health, psychological, social care risk assessment will take place. The assessment will take into the account the needs of carers and any dependent children and be sensitive to the individual needs of the patient.

Assessment and diagnosis

- There will be regular assessment and recording of mental state examinations and behaviour by appropriately qualified professionals.
- Consultant psychiatrists and other medical staff will ensure the application of medical knowledge and clinical skills against a backdrop of evidence-based practice (Royal College of Psychiatrists, 2010).
- In collaboration with the MDT, the medical team will lead on formulating, devising and reviewing diagnoses. This includes combining biological, occupational, psychological, social and cultural

factors, whilst keeping in mind any associated physical health disorders.
- The provider will source and provide access to Interpretation and Sign language services (as required) to support the patients' needs.

Admission

The decision that a PICU bed is necessary is made by DHCFT and a decision by the provider not to take the referral should be exceptional and will require an exception report to commissioners. The Grounds for admission and or refusal are described below and in the protocol.

- The specific reasons for admission need to be agreed between referrer and assessing team outlining the purpose of admission and high level treatment objectives and the demonstrable clinical rationale for admission.
- Patients will only be admitted if they display a significant risk of aggression, absconding with associated serious risk, suicide or vulnerability (e.g. due to sexual disinhibition or over activity) in the context of a serious mental disorder.
- Admission to a PICU should be due to a new episode or to an acute exacerbation of the patient's condition which cannot be safely managed in a general adult ward. In contrast, patients in low secure units may be experiencing chronic behavioural disturbance not necessarily due to an acute clinical presentation.
- Multidisciplinary management strategies in the referring acute admission unit will need to have not succeeded in containing the presenting problems.
- Management strategies attempted should be outlined clearly in the referral to PICU if referred from another treatment setting within mental health (e.g. acute wards).
- There should be mutual agreement between referrer and admitting unit on the positive therapeutic benefits expected to be gained from the time-limited admission, including a clear rationale for assessment and treatment.
- All patients referred for a PICU bed will have been assessed as requiring access to a PICU by DHCFT PICU Case Manager or covering other manager.

While historical factors will play an important part in assessment, current symptomatology should be the prime consideration in determining whether admission is appropriate.

The service will provide

- A multi-professional approach to treatment, which promotes a socially inclusive model of care. This will include patient involvement reflecting the recovery process and providing, individualised and holistically planned care.
- Assistance to individuals to achieve their optimum levels of independence, functioning and well-being, recognising that each individual has the need and the right to be treated with dignity and respect at all times.
- A multi-disciplinary team committed to the principles of working in a non-judgemental manner with due regard given to individuals' religious beliefs and cultural background.

Overall therapeutic engagement & activity

- Each patient to be invited to meet with a member of suitably qualified staff for one-to-one contact each waking shift.
- All patients to have a daily multidisciplinary review directly involving at least the medical and nursing clinicians.
- All patients to receive an in-depth multidisciplinary review at least once a week, involving the whole

MDT and external professionals, which incorporates the views of carers.

- All patients must have a face to- face review with a consultant at least once a week (NICE, 2012).
- The MDT should obtain details of the family and social circumstances prior to admission.
- Liaison with the patient's care co-ordinator or community mental health team (CMHT) should occur in the first week of admission to a PICU. This should be repeated at regular intervals during the PICU admission.
- Boundary setting interventions should be utilised for the shortest duration possible in a therapeutic manner. This may include contracting, de-escalation, restraint, time-out and seclusion. Developing strategies for understanding the reasons and context for disturbed behaviour should be a core function of the PICU.
- Any interventions engaging disturbed behaviour should pay careful attention to the evidence and national best practice guidance such as "Positive and Proactive care: reducing the need for restrictive interventions" (Department of Health 2014) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf.
- Overall engagement should be underpinned by an emphasis on coping strategies to self-manage acute symptoms where possible.
- Health promotion activities should be available and encouraged, including but not limited to: diet; exercise; substance misuse and smoking cessation.
- Social-skills or life-skills training should be available, incorporating psycho-education, on topics relating to activities of daily living such as interpersonal communication, relationships, coping with stigma and stress management.
- The unit should have access to interpreters, sign language and other communication media as appropriate.
- Following risk assessment, patients should be able to leave the unit to attend activities elsewhere in the building and, with appropriate supports and escorts, to access usable outdoor space every day, where detention status permits.
- Staff with appropriate expertise in social service processes should be actively involved in the provision of social work assessments, Care Programme Approach (CPA) meetings and community care planning.
- A defined activity programme will be available to all patients, with individual and tailored activities where required. This should facilitate meaningful occupational choice during the daytime and also be available at weekends and evenings (College of Occupational Therapists, 2012)
- Professional staff should ensure the assessment of mental health symptomatology including impairment of concentration, perception and orientation.
- There should be provision for specialist functional assessments by a specialist occupational therapist using standardised tools and assessments to aid diagnosis.
- There should be provision for ASD and / or learning disability assessments by a Specialist Psychologist using standardised tools to support the MDT as needed.
- Professional staff should ensure the delivery of psycho-education to deconstruct complex tasks, with the objective of promoting recovery and improved functioning. Arrangements should be in place for appropriately qualified and trained staff to deliver group-work, individual skills sessions and activities of daily living (ADL).
- The PICU MDT should ensure provision of a tailored and bespoke treatment, engagement and activity programme utilising the skills of all members of the MDT. This should have PICU specific consideration including functional, diversional, psycho-educational therapy focusing on the holistic care of acutely disturbed patients.
- Patients should be assisted in the development of coping strategies and trigger-recognition, leading to an overall Wellness Recovery Action Plan (WRAP).
- A range of art therapy and creative media should be available.

Physical health

- Specific expertise will be available to lead on physical healthcare assessment and management.
- Provision should be made for physical health examinations, relevant investigations (including imaging), and the management of any adverse medication effects. This should be overseen by senior medically qualified staff.
- Staff carrying out physical examinations should either be of the same gender, a same-sex chaperone should be present, or the patient should be able to choose the gender of the staff member.
- This involves liaison with medical colleagues in other specialities to ensure parity between physical and mental healthcare outcomes.

Treatment – pharmacological

- The medical team are primarily responsible for the prescribing and monitoring of medications. This includes reviewing adverse effects and dosages to ensure optimal outcome for the patient.
- Polypharmacy and the use of above BNF (British National Formulary) dosages of medications will be avoided as far as possible. When they are used, there will be a clear documented rationale by a specialist psychiatrist or pharmacist and a regular review of practice.
- PICU professional staff will ensure that there is a defined and well understood procedure for recognising and closely monitoring any side effects from prescribed medication.
- The PICU will keep, maintain and update skills required to implement a number of evidence-based, validated side effect assessment scales (either clinically assessed or self-reported).
- The specialist mental health pharmacist working in the PICU will have a good understanding of the general pharmacological management of the acute presentations of mental disorder and acute disturbance.(Please refer also to the Derbyshire Health Care Foundation Trust standards – Appendix 2)
- Any decision to prescribe a medication that is not supported by the DHcFT Pharmacy standards should be discussed with the DHcFT pharmacy Team before being administered (unless in an emergency).
- The specialist mental health pharmacist will work with other professionals in the PICU to ensure a high standard of medicines management.
- Appropriately qualified and senior medical staff will lead ongoing formulation of a pharmacological treatment plan. This will occur with input from patients and the MDT.
- There will be an active review of all prescribed medicines at least once a week in the MDT review meeting with the consultant psychiatrist and other members of the MDT, ensuring that those who need medicines get optimal regimes.
- There will be provision for a specialist mental health pharmacist to visit the unit several times a week and take part in the weekly MDT reviews.
- Many medicines will need to be reviewed on a daily basis, and the pharmacist needs to visit the PICU frequently enough to do this with prescribing colleagues, focusing on their therapeutic as well as adverse effects.
- All prescriptions for medicines will be ‘clinically screened’ by a pharmacist to ensure suitability, safety, and that the relevant legal requirements are followed.
- Provider will have policies and procedure to support the administration of controlled drugs if the patient requires these to be given.
- Pharmacists will assist prescribers with the medicines reconciliation process on admission of the patient to the PICU.
- Where appropriate, pharmacists and prescribers will use therapeutic drug monitoring to safely optimise doses of specific medicines.
- All patients will have access to independent education and advice about medicines, preferably from a specialist mental health pharmacist in the PICU.
- The advice of a specialist pharmacist will be available to other staff regarding the administration and storage of medicines on the unit.

- The input of the specialist mental health pharmacist in the PICU will be required in treatment resistant and challenging cases, to work alongside the MDT and review the prescribing history. Such reviews should lead to individualised pharmacological treatment plans which balance clinical need and risks, whilst enhancing patient choice.
- Mental health nurses in particular will be able to offer patients and carers written and verbal information about their medications (for both their physical health and mental health disorders). This should be delivered in conjunction with medical and pharmacy colleagues in the PICU.
- The PICU medical team have access to a wide range of treatment interventions for the management of acute mental disorder presentation. This includes access to a general medical hospital setting and electroconvulsive therapy (ECT). ECT is given in line with current best practice guidance (e.g. Waite & Easton, 2013; NICE, 2003).

Treatment - Rapid tranquillisation (RT)

- RT can be safely used to control acutely disturbed and/or violent behaviour when other nonpharmacological methods of de-escalation have failed or are inappropriate (NICE, 2005; Department of Health, 2014). All relevant monitoring equipment and medicines to manage any adverse effects should be readily available in the unit (NICE, 2005).
- There should be a robust protocol regarding RT usage which is consistent with national guidance (e.g. NICE, 2005) including relevant physical monitoring of patients.
- Following the use of RT the patient should has physical health monitoring as per NICE Guidance
- The use of RT should be monitored regularly and audited at least annually.

Treatment - Psychological interventions

- Patients will have access to specialist practitioners of psychological interventions for a minimum of one day (eight hours) per week per unit.
- The PICU will have an attached clinical psychologist with expertise in the clinical assessment and treatment of patients presenting with acute mental disorder and associated behavioural disturbance.
- Psychological therapies will be available (both individual and group) to address immediate recovery needs.
- Psychosocial interventions will be available for working with families aimed at education and support.
- The psychologist should engage and empower patients to think psychologically in spite of their acute presentation, and motivate them to engage in medium to longer term psychological therapy where appropriate.
- Psychological techniques (e.g. use of behavioural, psycho-therapeutic techniques) in the care plan for patients in the PICU should be supported by specialist advice.
- Provision should be made for specialised psychological assessment of needs, abilities or behaviour (for example psychometric testing).
- Psychological support should be provided for debrief following serious incidents and in the development of particular interventions involving physical restraint or seclusion.
- Psychological thinking or mindfulness is a core characteristic of the whole PICU team, from interactions around medicines adherence to those around emotional support. Team-based interventions delivered by other professionals, such as nurses, will also focus on reflection and a psychological understanding of the challenges associated with managing acute disturbance (for example, reflective practice groups, case-based

Physical environment

Provider should refer to AIMS PICU standards guidance http://hic-psy.nl/wp-content/uploads/2012/10/Standards-for-PICUs-Accreditation-for-Inpatient-Mental-Healthe-Services-

2010.pdf

Building

- The PICU should be on the ground floor.
- As the PICU is part of a hospital, an entrance to the unit that does not necessitate travelling through the rest of the hospital should be provided and this should be accessed via an Airlock entrance as per NAPICU guidance
- The unit's configuration and its fixtures and fittings should be anti-ligature
- Measures are taken to ensure sight lines are not impeded (e.g. by the use of mirrors)
- Corridors should be wide enough to allow three people to move abreast comfortably.
- There should be access to a quiet room for worship, meditation, reflection and counselling that is available to everyone who attends the unit. Every effort should be made to keep these resources away from the main patient areas and bedrooms.
- The interior of the PICU should be smoke free. This should be achieved through the provision of a designated, safe outdoor smoking environment
- A family visiting room, which is warm, clean and well equipped, should be available outside the main body of the unit.
- The dining area should be big enough to enable the patients to eat in comfort and to promote interaction and engagement between patients and staff.

Garden

- There should be access to an enclosed secure garden, which should be of reasonable size to allow a feeling of some space.
- All garden furniture should be immovable.
- Gardens should only be accessed in the presence of PICU staff on a clear individual risk assessment basis.
- At least a portion of the garden should be sheltered from the elements.

Extra care area

- There should be an extra care area (ECA) within the PICU, that can provide a quiet, low-stimulus space for patients experiencing high levels of arousal during periods of disturbed behaviour and can be used for de-escalation, patient support and management, and treatment in a bespoke space for high intensity intervention.
- The ECA and seclusion facility to be located in an area away from the main patient areas and bedrooms.
- It should be possible to regulate both room temperature and ventilation in the ECA and in any seclusion facility.

Seclusion

- The seclusion room should comply with the standards detailed in the Mental Health Act Code of Practice (Department of Health, 2008).
- The practice of using patient's bedrooms, or other designated rooms, as 'de facto' seclusion must be avoided.
- The seclusion facility should be located in an area away from the main patient areas and bedrooms.
- It should be possible to regulate both room temperature and ventilation in the seclusion facility.
- The seclusion facility should be no less than 15m2.
- The seclusion room door should be of solid core design and robust; of no less than 55mm in thickness and have a viewing panel with no blind spots into the seclusion room.

- The seclusion room door must open outwards.
- It should not be possible to reach any fixtures and fittings (including lighting), even from standing on the bed.
- The bed within the seclusion room should not be moveable and should have padding which cannot be removed, is robust and easily cleaned.

Bedrooms

- Bedroom doors should have a vision panel to allow staff observation into the room; which can be controlled from the outside by staff only.
- It should be possible to open doors both ways in an emergency situation
- Care is required to ensure that sound privacy is not compromised and that the emergency anti-barricade system does not allow a view into the room.
- Patients should be able to lock their rooms both when they are inside the room and on leaving it, to safeguard their property and to increase the feeling of safety, privacy and dignity. However, staff will need the facility to override the lock and the handles should be anti-ligature.

Main entrance

- An airlock design is required for the main entrance, comprising two doors set opposite to each other. Electronic locks should not allow one door to be opened until the other is closed. There should be an emergency override system in case there is a need to get a large number of staff in or out of the unit quickly.
- The main entrance should be located away from the main clinical area so as diminish the extent to which it may represent a focal point for absconding attempts when the entrance is in use.

Care planning

- The Care Programme Approach will be implemented to develop Care Plans that will address all needs identified in the assessment, with details of how they are going to be met.
- Consideration will be given to the needs of carers in relation to the treatment and care of the Patient for whom they care.

Team Approach

All patients admitted to the service will be managed within the Care Programme Approach (CPA). Contact will be retained with the patient care co-ordinator and with DHcFT PICU Case Manger or covering Manager.

Age, Culture & Gender Sensitive Service

The Service will aim to develop a collaborative working partnership with other agencies, offering a holistic approach to care, taking into account the Patients emotional, physical and spiritual needs with no religious indoctrination. Patients will be treated as an individual with dignity and respect and confidentiality is of the utmost importance and will be preserved.

Regular Review

Multi-disciplinary Patient focus review meetings will take place at which

- A member of the medical staff will be involved.
- Clinical and safety Risk will formally be assessed and reviewed on a regular basis.

- Progress and outcomes will be regularly monitored.
- Care Plan will be formally reviewed weekly.
- Patients and family/carer/people important to the Patient will be involved in the review of the care plan. Patient should be offered a copy of their care plan and offered the opportunity to sign it and / or is able to access their Care plan on request.
- A copy of their care plan is giving to their Carer / family if the patient agrees.

Safeguarding

Please note: for out of area providers, your policy should be compliant with Derby and Derbyshire Adult and Children Safeguarding Policy
(Children -
http://derbyshirescbs.proceduresonline.com/docs_library.html, Adults -
http://www.derbysab.org.uk/media/derby-sab/content-assets/documents/DSAB--Policy-and-Procedures-2017---June-2017.pdf)

- Inter-agency protocols are in place for the safeguarding of adults and children
- There are protocols and procedures in place for the confidential reporting of inappropriate ore abusive care
- The patient (and their carer, if patients agrees) is informed of the procedures that would be followed if disclosure of abuse where made and they are reassured they would be taken seriously.
- Staff received up-to-date training and development appropriate to their role to recognised signs and symptoms associated with physical, Sexual, emotional, financial, institutional abuse or self-neglect / neglect by others.
- Procedures must be in place to notify DHcFT staff and commissioners of any safe guarding referrals made.

Transfer back to open ward

- When a patient no longer requires psychiatric intensive care, they will be transferred to the appropriate Hospital service or potentially discharged to the Community.
- A copy of the referral/assessment/transfer documents will be given to the acute ward staff or care coordinator (if discharged directly to the Community) as part of a handover.
- Should an individual be discharged directly to Community, the PICU will have provided 7 days medication to the individual and will have informed the patient GP practice and given a copy of the patient's current medications.
- If the patient agrees, PICU staff will inform family/ careers of discharge, prior to discharge occurring.

Information Management and Technology (IM&T)

System integration will form part of the contract mobilisation. Any provider will be expected to work with DHcFT IT staff, which will develop an appropriate IT Platform that allows PICU providers Read only access to DHcFT individual patients clinical records.

The provider will work with DHcFT to allow Trust staff to access clinical records and for an appropriate process of transfer of clinical information between providers.

3.3 Population Covered

This service will provide access to PICU beds for patients registered with a Derbyshire GP practice, who

are over the age of 18 years.

3.4 Any Acceptance and Exclusion Criteria

Acceptance criteria

Inclusion criteria

- Patients admitted should be aged 18 or over. Patients should not normally be over the age of 65. Any exceptions to this would be expected to be discussed with the PICU Case manager and / or Covering manager.
- Patients should be detained under the appropriate completed assessment/treatment section (not admitted under Section 136) of the MHA 1983.
- Restricted patients (those subject to restrictions under the MHA 1983, via the courts, prisons or Ministry of Justice) should not be accepted unless there is clear pathway or provision to transfer them to a more appropriate clinical environment as warranted by the clinical or risk profile (e.g. a medium secure unit, a low secure unit, a general adult psychiatric inpatient ward or a criminal justice setting) if warranted by their clinical condition.
- Patients with specialist conditions which may not be primarily psychiatric in nature but do have associative symptomatology, clinical or risk profile should not be accepted unless there is clear pathway or provision to quickly transfer them to a more appropriate clinical environment (e.g. Huntington's disease.)
- The admission of young people to an adult ward must meet the age appropriate guidance published by the Department of Health.

Learning Disabilities

- 'Reasonable adjustments' to care for people with learning disabilities should be made and particularly those who present with co-morbid mental illness.
- When people with LD are admitted to acute adult inpatient services there are clear risks that they may be vulnerable, marginalised, and their admission may be prolonged. There are a group of LD patients for whom their involvement with secondary and tertiary inpatient services, and whilst complicated by their LD, is triggered by acute mental illness. Where their level of need meets the necessary criteria, admission to a PICU service will be wholly appropriate. Such admissions should be as brief as possible, this can be helped by appropriate staff awareness training, good liaison between inpatient and community services, up to date health action plans, access to advocacy services and support from community LD assessment and/or treatment services. Support will be particularly relevant for individuals with adaptive or language deficits or an underlying pervasive developmental disorder (NDTi 2012).

Exclusion criteria

- The PICU will not normally accept admissions directly from the community, however, it will be recognised that this might be necessary on occasion and each case will be considered on an individual basis.
- Individuals under the age 18 years will not be admitted to an adult PICU.
- Admission should not occur in the following circumstances:
  a) The patient is assessed as presenting too high an internal or perimeter security risk for a PICU and requires admission to a Low Secure Unit (LSU) or Medium Secure Unit (MSU).
  b) The patient has a primary diagnosis of substance misuse and the primary purpose of admission is solely to prevent access to substances
  c) The patient's behaviour is as a direct result of substance misuse and they are not suffering from an exacerbation of their mental disorder at the time of referral;
  d) The patient has a primary diagnosis of dementia;

e) The patient has a primary diagnosis of Learning Disability (LD) and requires a specialist LD facility;
f) The patient's physical condition is too frail to allow their safe management in a PICU;
g) The patient has a chronic condition which would not benefit from admission to PICU;
h) The patient is restricted (subject to restrictions under the MHA 1983, via the courts, prisons or Ministry of Justice) and has no clear pathway or provision for transfer from the PICU once clinically warranted.
i) The patient has a primary diagnosis is a significant brain injury
j) The patient has a primary diagnosis of personality disorder, no presentation of psychosis or severe mood disorder

3.5 Interdependence with other services/providers

External partners include DHcFT, Local Authorities, Police Force, East Midlands Ambulance Service and Primary Care. NHS England Specialist Commissioning Service, Prison Service, Multi Agency Public Protection Services.

.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The service is delivered in line with national guidance and with locally agreed service model.
The service focuses on providing interventions that are evidence based according to NICE recommendations.

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

Please refer to Appendix 3: Design Guidance for Psychiatric Intensive Care Units 2017 and Appendix 4: NAPICU Standard 2014 for details.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule P4 Parts A-D)

5.2 Applicable CQUIN Goals (See Schedule P4 Part E)

N/A

6. Location of Provider Premises

The Provider's Premises are located at:

Location of the premises to be inserted on contract award.