1 Population Needs

1.1 Local Needs

Bristol has a population of 428,100 making it the largest city in the South West of England and the 7th Largest city in England. It is one of England’s 8 ‘Core cities’, meaning it is one of the eight largest city economies outside London. The population is expected to grow to 460,800 by 2020.

Bristol has a unique population which brings with it a diverse range of challenges.

- Some wards of Bristol are amongst the most deprived in the country. A few are among the most affluent.
- 14% of the population of Bristol live in the areas that make up the most deprived 10% of the whole of England.
- 25% of the population live in areas that make up the most deprived 20% of England.

The map below shows the deprivation indices by ward for Bristol.
16% of Bristol’s population belongs to a black or minority ethnic group, including a large immigrant Somali population. These groups often have difficulty accessing mental health services and need a targeted approach to meeting their needs.

The map below shows the location in the City of Bristol of high proportions of BME community members.
There are more people under 16 living in Bristol than people over 65, meaning that Bristol has a younger growth profile than England as a whole.

Bristol has a significant number of people who have complex needs and/or chaotic lives and find it difficult to self-manage or remain fully engaged with mental health services without focused pro-active support.

Bristol has a homeless health service, several walk-in GP services and a range of drug and alcohol services.

Bristol has significantly worse rates of depression than England as a whole, at 14%.

Bristol has high rates of emergency hospital admission due to self-harm (275 in 2011/12)

Bristol has significantly higher numbers of people misusing drugs and alcohol when compared to the rest of England.

The Office of National Statistics (ONS) estimate that around 7,500 people per year access NHS specialist mental health services in Bristol.

As well as NHS mental health services, Bristol has a thriving third sector offering support and services (both commissioned and not) to meet a range of needs. Some examples relevant to Bristol Mental Health include:

- Mental Health Crisis Houses
- Supported housing for people with mental health needs
- Support to maintain wellbeing and retain tenancies
• Recovery education
• Peer support and user led groups
• Experience-related support, for example for people who have been raped, people who have experienced domestic violence
• Specific condition-related support groups
• Local telephone helplines and promotion of national helplines
• Counseling and psychological therapies
• Advocacy

The needs of people in crisis

Bristol Clinical Commissioning Group (CCG) is presently procuring through open competition a new comprehensive 24/7 Crisis service that will include a single point of access and triage, rapid assessment and comprehensive intensive home treatment for people experiencing an acute mental health crisis. This service will be implemented from October 2014 and will become the mental health emergency service for Bristol and will overcome the problems that exist with the present crisis service.

As well as a mental health emergency service, broad consultation with the people of Bristol identified a need for a place of sanctuary, where people experiencing distress can receive support to help them stabilise themselves and to prevent deterioration into a mental health crisis and ensure their safety and wellbeing. This specification aims to innovatively and practically meet the need for a place of sanctuary.

1.2 National/local context and evidence base

The following documents have informed the development of this service specification:


Modernising Mental Health Services in Bristol, Stakeholder Engagement Report, NHS Bristol, 3rd October, 2011

Modernising Adult Mental Health Services in Bristol, Consultation Feedback and Analysis, Bristol Clinical Commissioning Group, November 2012

Modernising adult mental health services in Bristol, Service Specification Feedback Report, Bristol Clinical Commissioning Group, March 2013

Bristol Self-Harm Surveillance Register Annual Report, Carroll R., Gunnell D., University of Bristol, 2012

This annual report describes data on self-harm patients collected in 2012 at the Bristol Royal Infirmary. It shows the peak time for attendances at the Emergency Department, are between 10pm and midnight, almost a fifth (19.2%) of all presentations occurred within these 3 hours of the day.
The Impact of a Mental Health Crisis Respite upon Clients’ Symptom Distress,
Rosen, J., O’Connell, M., Community Mental Health Journal, DOI 10.1007/s10597-012-9523-0, 21 July 2012
This study examined clients who were admitted to a mental health respite programme in the first 3 months of 2011 in order to identify the ability of the program to reduce symptom distress and to explore related psychosocial factors. Participants were provided with self-report questionnaires that include measurements of demographics, mental health status, symptom severity and programme satisfaction. Results indicate a significant improvement is symptom distress, mental health confidence and self-esteem from admission to discharge. No change was detected in largely external measurements.

Missing Link Annual Report 2011-2012, Evaluation of Link House, pages 8 – 11, Missing Link, 5 Queen Square, Bristol BS1 4JQ
This evaluation of Link House, the Women’s Crisis House in Bristol, used both quantitative and qualitative data from service users and mental health professionals. The evaluation concluded that Link House has been able to respond effectively to women experiencing a mental health crisis and has made a significant improvement to the mental health care pathway. The data shows that the service has been very successful in preventing hospital admission and in facilitation early discharge. The cost of a Crisis House bed in less than half the cost of a hospital bed.

This paper evaluates the contribution to suicide prevention made by an innovative project, Maytree, a respite center for the suicidal. Maytree offers a distinctive brief period of sanctuary for four nights for suicidal people; within this limited time it aims to provide opportunities through talking, reflecting, and relaxing for reducing the intense feelings that lead to suicidal behavior. The focus of this paper is on evaluating the first 3 years of Maytree’s operation, exploring how Maytree works, and its effects on the people who stay there as “guests.” This shows that Maytree reaches people who are at significant risk of suicide. Guests report both short term relief and longer term benefits.

Guests experiences of Maytree during and after their stay, Briggs S., Linford H., Harvey A., University of East London and Tavistock Clinic, UK, October 2012. www.maytree.co.uk
This project aimed to assess how guests experienced their stay at Maytree and how guests believed Maytree impacted on their experiences after the stay. There was a key focus on whether guests experience a reduction in their levels of suicidality during and after the stay. The project employed qualitative methods, studying case notes of a sample of 50 consecutive guests and undertaking semi structured interviews with 12 ex guests. The small ample size is recognized as a limitation of this study and the in-depth detailed data and rigorous qualitative analysis are noted as strengths.
The study found that a large majority of guests reported reduced suicidal levels during the stay, and the sample interviewed 4-9 months after the stay reported that they were less
suicidal. For a small proportion of guests no reduction in suicidal levels was reported. The clearest finding was that for a significant number of guests the stay was felt to be transformational. This is understood to mean that Maytree had a significant and powerful impact which led guests reappraising their lives.

The three research projects described above are based on self-reported data with no control groups, so needs to be viewed with that in mind.


This report summarises a full Social Return on Investment (SROI) analysis prepared for Leeds Survivor Led Crisis Service (LSLCS). The report considers retrospectively the value that LSLCS has achieved using activity data from 2010 and funding for the financial year 2010/11. The evaluation states that there is £5.17 benefit per £1 invested in the LSLCS. This is a summary report, the full report includes a Sensitivity Analysis, which analyses the impact of varying all of the significant assumptions used to calculate this figure. From this they recommend that a range of between £4.00 and £7.00 per £1 invested is used to describe the SROI for LSLCS.


bmj.com

This is a systematic review of randomized controlled trials and other comparative studies of involving users in the delivery or evaluation of mental health services. Five randomized controlled trials and seven comparative studies were identified. The process of service delivery of employees who were or who had been users of mental health services differed from that of employees who had not. Users spent longer in supervision, in face to face contact with clients or doing outreach work and they spent less time on telephone or office work. Employees who were or who had been users had a higher turnover rate and had less distinct professional boundaries.

Employing users in or alongside case management services did not have any detrimental effect on clients in terms of symptoms, functioning or quality of life; they had fewer reported life problems and improved social functioning. In some studies, clients of employees who were or had been users went for longer until hospital admission and fewer clients needed to be admitted to hospital or stay in hospital was shorter, although time in hospital was not significantly different in all studies.


This study examined the evidence from controlled studies for the effectiveness of consumer-led mental health services. A total of 29 eligible studies were appraised all in high income countries. Overall consumer-led services reported equally positive outcomes for their clients as traditional services, particularly for practical outcomes such as employment or living arrangements and in reducing hospitalisations and thus the cost of services. Involving consumers in service delivery appears to provide employment
opportunities and be beneficial overall for the consumer-staff members and the service.

This report is based on a review of the literature on Peer Support in Mental Health Services by the University of Nottingham and consultations with service users about peer support. The report describes the benefits of peer support work by promoting hope and belief in the possibility of recovery, empowerment and increased self-esteem, self-efficacy and self-management of difficulties, social inclusion, engagement and increased social networks. It makes recommendations for greater peer support in service user groups, and for peer support that involves the employment of service users as paid providers of services.

**No Health without Mental Health 2011**, a cross-government mental health strategy for people of all ages.HM Government

**No Health without Mental Health Implementation Framework, 2012**

**Guidance for commissioners of acute care – inpatients, crisis and home treatment, May 2013**, Joint Commissioning Panel for Mental Health

**The NHS Plan**, Department of Health, 2000

At the moment the only option in many areas is to admit people with an acute mental illness to hospital. Crisis resolution teams respond quickly to people in crisis, providing assessment and treatment wherever they are:

- A total of 335 teams will be established over the next three years
- By 2004, all people in contact with specialist mental health services will be able to access crisis resolution services at any time. The teams will treat around 100,000 people a year who would otherwise have to be admitted to hospital, including black and South Asian patients for whom this type of service has been shown to be particularly beneficial. Pressure on acute inpatient units will be reduced by 30% and there will generally be no out of area admissions which are not clinically indicated

**Listening to Experience, an independent inquiry into Acute and Crisis mental health care**, MIND, 2011
http://www.mind.org.uk/assets/0001/5921/Listening_to_experience_web.pdf

Summary of recommendations:

For commissioners and local health boards:

- Review how far acute services are meeting local people’s requirements, and consult
with black and minority ethnic communities in this process

- Set clear standards for values-based services in the procurement or planning process and hold providers to account using measures that include patient/carer satisfaction
- Expand the range of options to meet different needs; for example, crisis houses, host families and services provided by people with experience of mental health problems, and self-referral options

For provider organisations:

- Consider ‘inpatients’ as ‘guests’ as well as recipients of care
- Review the standards of hospitality that are being offered and ask the guests for their feedback
- Commit to working without violence and reappraise control and restraint methods, in particular ending face-down hold.
2 Scope

2.1 Aims

This specification refers to the crisis sanctuary highlighted in red in the service map below.

This service aims to meet the needs of people experiencing acute emotional distress associated with a mental health problem (which may or may not have been given a formal diagnosis) The Bristol Sanctuary aims to provide a safe, welcoming and comfortable place for people in emotional distress and for those seeking to prevent the onset of a crisis. The Sanctuary will also be a place for someone who has a relationship with someone in crisis.

The Sanctuary will provide a holistic, non-judgmental, non-directive, empathic and respectful service. The Provider will need to ensure this is also true for service users who are from Black and Minority Ethnic communities, are refugees, asylum seekers or economic migrants, are Lesbian, Gay, Bisexual or Transgender and who have learning difficulties and long term health conditions.

If users of the Sanctuary want information about other services available, the staff and volunteers at the Sanctuary will be able to provide this. To be able to do this well, they will build links with other services and be aware of what other support is available. They will also need to support the service user to access these other services.

The Sanctuary will work in partnership with other statutory and third sector service providers. It will be available for those who already use other mental health services and for those who have not used any services before. The Sanctuary may be used as an
The Sanctuary will provide peer support from staff and volunteers, some of whom will have lived experience.

Bristol is made up of many different groups, traditions and cultures so the Sanctuary will be sensitive to the different cultural needs, language and communication needs, physical and sensory access needs, religion and belief, gender needs and the needs of different age groups. It will be a safe and respectful place for everyone.

The Sanctuary will be person centered and provide support to individuals to recognize and develop their own strategies for crisis prevention and management. It will be a place where people can utilize their own experience to assist themselves and others through the sharing of problems, alternatives and solutions.

The sanctuary will provide a nurturing and supportive workplace, which demonstrates a valuing of staff (paid and voluntary) and supports their personal and professional development.

The sanctuary will help build capacity within the city of Bristol to provide additional support for people in emotional distress or pre crisis.

### 2.2 Objectives

The objectives of the Bristol Sanctuary service are:

1. To provide a place of sanctuary for people experiencing acute emotional distress
2. To offer an inclusive service for everyone who is experiencing emotional distress and for those who have a relationship with someone in crisis
3. To reduce the risk of harm to people
4. To support people with the self-management of their mental health problems. Each individual has their own experience of emotional distress or crisis and the causes and impact of the emotional distress and crisis will be different for each person. The service will aim to provide the right kind of attention and support so people can find their own solutions.
5. To work sensitively and appropriately with people at risk and people with complex needs
6. To minimise the need for people to be admitted to hospital by providing support to avert the escalation of the individual’s emotional distress or crisis.
7. To provide a service for adults of any age on the basis of need

### 2.3 Service description

The service will provide a place of sanctuary that is safe, comfortable and welcoming. There will be one to one support available, opportunities for people to socialize, share food, offer and receive support, including peer support. There will also be quiet spaces for
people who want to be alone.

The Sanctuary will provide a service out of hours so there is no duplication with other services.

The service will be based in the community and will work very closely with the Crisis Houses, the Bristol Crisis Service and the Community Assessment and Recovery Service.

The service will also work closely and co-operatively with the following organisations who regularly encounter people in emotional distress:

1. GPs and their practice teams, including GP out of hours services
2. The Police Service
3. The Ambulance Service
4. A&E
5. Social Care
6. Housing
7. The voluntary sector
8. Children’s Social Care and Integrated family support teams
9. Assertive Engagement Service
11. Religious groups
12. Services for the homeless at the Compass Centre
13. Organisations working with people experiencing domestic violence
14. The local community

The provider may want to investigate closer involvement of external expertise, such as health, social care, housing so this expertise can be provided to service users and staff.

The Sanctuary will link closely with housing and homeless services to be able to support people whose accommodation is under threat or who are homeless, to ensure they have somewhere to go with the Sanctuary closes.

2.3.1 A Place of Sanctuary

The Bristol Sanctuary will be a place that people can go, out of hours, which feels safe, homely, comfortable and welcoming. While at the sanctuary people will be able to relax. They can choose what they want to do. What is on offer will include: one to one support from a support worker; complimentary therapies; information about other services available; the opportunity to cook and share food; a relaxing space in which to talk to others, read, play board games etc.

The Sanctuary will also provide a quiet space for those people who want to be alone.

The Sanctuary will be positioned in a place well served by public transport, in a residential area, which is reasonably quiet and calm, discreet, close to the city centre and in a neutral location that isn’t socially loaded. There needs to be good parking available for staff and people who want to visit the Sanctuary. The building must be accessible to everyone, including those with a physical impairment.

The Bristol Sanctuary will work closely with the local telephone and text helplines including
Mindline, the Samaritans, the CRUSE helpline, Womenkind helpline and the self-harm text & email service TESS.

The Bristol Sanctuary will work closely with the Wellbeing Therapy providers to ensure peer led group works are available, particularly those relating to crisis management.

2.4 Patient Involvement

- The Sanctuary will involve the people who use the service at all levels of the organisation and in all aspects of its development, including training and recruitment.
- Real time feedback will be sought and used to develop the service to ensure it meets the changing needs of the service users.
- Other feedback will also be sought including the possible inclusion of an independent evaluation of the service

2.5 Days/hours of operation

The preferred operating hours for the Bristol Sanctuary are Friday, Saturday, Sunday and Monday, 7pm to 2am. This is based on the experiences of Leeds and Corby Crisis Sanctuaries and on the Bristol self-harm surveillance register. The later shows that the peak time for attendances at the Emergency Department at the BRI in 2012 was 10pm to midnight. Almost a fifth (19.2%) of all presentations occurred within these three hours of the day. We do not have local frequency data on which day of the week most suicides occur, however, Leeds do have that data, and it shows that most suicides in Leeds occur on a Monday. The Leeds Survivor Led Crisis Service experience their greatest demand on a Monday night.

Once operational, the provider of the Bristol Sanctuary will be encouraged to review the operating hours and test other options, such as opening during the day time at weekends.

2.6 Client Group

The Bristol Sanctuary will be for young people and adults over the age of 16.

Legal and confidentiality issues will need to be agreed for people who are aged 16/17 in line with appropriate safeguarding procedures. There will also need to be very close links with the Children and Adolescent Mental Health Services (CAMHS) and other Adult Mental Health Services where appropriate, in addition to Children’s Social Care and the Local Authority’s First Response and Early Help Teams. Applicable to all other Adult Mental Health Services re-procured within this package, is the following agreement:-

The services will treat clients between 16 and 18 years on the basis that they can be most appropriately treated by the adult service and prefer this to being treated by the CAMH service according to the 16/17 pathways.

Both the Children and Adolescent Mental Health Service (CAMHS) and Adult Mental Health Services (AMHS) are funded to work with 16 and 17 year olds. While CAMHS is likely to be the service with primary responsibility, flexibility is to be maintained so that the need of the individual patient is the focus in deciding appropriate packages of provision. All CAMHS and AMHS services will adhere to the transition protocol.

Policies and procedures will be in place to ensure the safeguarding of any children who
may be brought to the crisis sanctuary by an adult in crisis. This will be actively discouraged.

2.7 Accessing the service
The Bristol Sanctuary will be for people who are emotionally distressed or are seeking to prevent the onset of a crisis.

People will choose to come to the Bristol Sanctuary themselves, other agencies can encourage people to visit but not tell them to go there.

There will be open access if a person is visiting the centre for the first time. On subsequent visits people will be encouraged to telephone first.

Those people who are unable to travel to and from the place of Sanctuary on their own, will be offered access to a free transport service.

The provider will be expected to promote the service to men as they are less likely to access services but have higher rates of suicide than women.

Reasonable adjustments will be made to the service so it is accessible to people with Autistic Spectrum presentations and people with personality disorder diagnoses and other dual/multiple needs. Reasonable adjustments, such as access to translation services will also be put in place for people whose first language is not English.

The provider will be expected to promote the service to different groups of potential service users, their families and potential referral agencies, particularly from minority and marginalised communities.

2.8 Information Sharing
To enable the effective collaborative working of all providers and organisations within Bristol’s mental health care system, an agreed set of information about people who use the Bristol sanctuary will be entered into a shared information management system.

The provider will use the information management system provided by the system leader and will provide appropriate information and reporting through the system for contract monitoring purposes.

Information on service user experience shall where possible be collected in real time so it can be used to improve service user experience of the service.

2.9 Population covered
The service will cover people whose address is within the Bristol Clinical Commissioning Group area.

This restriction will be explained to people from outside the area who walk in to the Bristol Sanctuary so they understand why they are not able to use the service. They will be told about other services that are available to them.

2.10 Any acceptance and exclusion criteria
The Sanctuary will be as inclusive as possible, to meet the needs of young people and
adults experiencing emotional crisis or in the pre-crisis or post-crisis phase of their mental illness through psychological and peer support and a place to be.

The Sanctuary is not a clinical service and will not have medical or nursing staff on site, therefore it will be unable to provide to people experiencing an acute mental health crisis who will be referred instead to the Bristol Mental Health Crisis Service where their needs can be safely and effectively met by the right professionals.

The Sanctuary will work closely with the Mental Health Crisis Service Single Point of Access and the Crisis Houses, so that people who are experiencing an acute mental health crisis can get the support they need quickly.

The Sanctuary intends to be inclusive with reasonable adjustments where necessary. As a result a previous history of substance misuse or violence and aggression will not be sufficient grounds for the automatic refusal of access to the Bristol Sanctuary, all requests to use the service should be carefully evaluated on their own merits. However, any individual who is so intoxicated, or under the influence of drugs at the time of presentation, in a way that makes them a danger to themselves and/or to others will not be given access to the Sanctuary but will be appropriately referred and, in the case of young people under the age of 18, this will be in line with current safeguarding procedures and the agreed 16/17 pathway.

2.11 Interdependencies with other services

The provider of the Bristol Sanctuary will be expected to have close and effective working relationships with a wide range of services and agencies, including Emergency Departments Liaison Psychiatry, the Crisis Houses, the Community Access Support Service and the organisations they are supporting, the Community Assessment and Recovery Service, the Specialist Dementia Wellbeing Service, the Assertive Engagement Service, the CAMH service, the Bristol Level 1 Wellbeing Therapies provider, GPs, Out of Hours and Emergency Services, Health and Social Care locality teams, Community Development Workers, Children's Social Care and Integrated Family Support teams and relevant community & 3rd sector organisations, such as those working with homeless people.

The service provider will need to work closely with the Emergency Departments to ensure that people in mental health distress, not requiring physical treatment, are encouraged and supported to use the Bristol Sanctuary and other services. Particular attention will need to be given to training and support of Emergency Departments front-line staff.

Clear policies and procedures will be shared with other services defining the use of the Bristol Sanctuary, how it can be accessed and by whom and specifically who the service is not for. This will enable other services to appropriately refer, including using the Crisis single point of access if they are unsure.

The provider will be expected to sit on the Bristol Mental Health Provider Forum and Bristol’s Safeguarding Children’s Board and to participate in any other working groups associated with the development and working of the new mental health system.

There is an expectation on the provider to engage with a wide range of stakeholders to help identify potential for service improvements.
2.12 Staffing
The service will be delivered by a mixture of paid and voluntary staff. There will be support workers able to offer one to one support and other staff who can ‘socialise’ with people in the sanctuary and make sure the house is comfortable and is working well.

Specialist 16 – 25 workers employed within the Bristol Mental Health Assessment & Recovery Service will be utilized to support young people, ensuring that staffing provision and support for this age group is appropriate.

Staff must have the right attitude and skills to ensure they can listen, connect with people, be non-judgmental and support people to develop their own strategies for crisis management and prevention.

All staff and volunteers will be supported with regular supervision, training, away days, peer support and a reflective practice group. Volunteers and staff will be encouraged and supported to progress within the organisation.

Volunteers should supplement the service. The service shouldn’t rely too heavily on volunteers so that if there are no volunteers available, the service should still be able to operate.

The Sanctuary will operate a social model and a psychologically informed environment. There will be no medical or clinical staffing.

At least 25% of the staff and volunteers will have lived experience.

Staff will be appropriately trained so they are aware of the needs of people with Autism. They will also need training in conflict management and resolution.

There is an aspiration for the staff to represent the communities they serve and for all staff to have received training in valuing diversity.

2.13 Lean Design
Services will be designed according to lean principles, minimising waste and ensuring effective delivery and value for money. Duplication and non-value added activities will be identified and designed out of services. The provider will demonstrate a culture of continuous improvement.

2.14 Risk management
The service will have procedures in place to manage risk in relation to changing mental health conditions of people accessing the service.

There will also be procedures in place to manage the risk of groups with a particular protected characteristic not accessing the service or receiving an inappropriate service, for example, due to lack of sensitivity around issues such as language, culture, religion, sexual orientation and disability.

The service will work with other providers to support them in the management and care of individuals with long term mental health interventions that minimise risk.
2.15 Quality Assurance
The provider will take responsibility for establishing a properly documented quality assurance system ensuring service quality. This quality assurance system will have equality and diversity principles built into it. This quality assurance system and outcomes will be shared with the commissioner upon request.

The provider will co-operate with any quality assurance reviews requested by the commissioner. Reviews will require full cooperation, access to patient records and service provider records. This might also include taking part in user led commissioning evaluation and monitoring exercises.

2.16 Freedom of Information requests
Any information that providers submit to Bristol CCG can have a Freedom of Information request made. Any information the provider holds on behalf of Bristol CCG can be subject to Freedom of Information request. Providers must provide Bristol CCG with and information which falls under this definition. The provider can comment on whether any information should

2.17 Research, audit and evaluation

2.17.1 Research
The Provider will work collaboratively with the System Leader and Commissioners to ensure:

- Access to best available evidence
- Promotion of participation in research, audit and evaluation

The Provider is required to have systems and processes in place to ensure that people are given the opportunity to take part in high quality research, audit and evaluation studies. Examples of such systems and processes could include:

- Adopt an ‘opt-out’ policy in which people with mental health needs and family/carers are informed that research is a routine part of the philosophy of the Bristol Mental Health Model and that they may be contacted about opportunities to join research unless they explicitly request not to be contacted
- Have a system in place such as a ‘consent for approach register’ to keep a record of people who are willing to be offered research opportunities, together with relevant demographic details and their diagnosis
- Have job descriptions and plans that make reference to Provider’s commitment to promoting people’s recruitment in to research studies and the view that it is a positive intervention
- Inform existing and new employees at induction of the Provider’s commitment to contributing to the evidence base, a culture of innovation and improvement, and how employees can contribute
- Ensure access to appropriate research-relevant training
Facilitate opportunities for people with mental health needs and family/carers to inform and participate in the research portfolio. For example, research opportunities for people with mental health needs and family/carers should be clearly presented in clinical areas using posters and leaflets or other media, and in Provider communication strategies.

Design opportunities which anticipate and overcome any barriers to research associated with the protected characteristics – eg language, learning difficulty, physical impairment, etc.

The Provider should understand that research, audit and evaluation does not only concern medical trials, but can include social and non-pharmacological interventions.

All research, audit and evaluation should provide evidence of service user involvement in design and implementation and co-production.

The Provider should make a statement on research activities undertaken in their annual Quality Account and should include a statement of the number of and profile of people recruited and the number of studies they host.

**2.17.2 Evaluation**

The Provider will agree with the Commissioner the level of service evaluation required to be undertaken, which may include service user led commissioning evaluation.

In most cases the Provider will be required to perform at least one full evaluation of the service within twelve months of operation, and thereafter at least every 18 months, other monitoring and audit activities may be required more frequently in agreement with the Commissioner.

The full evaluation should use appropriate data to assess whether the service is delivering the objectives as set out in the service specification and is providing value for money while also evaluating the processes involved in running the service. An evaluation plan should be developed in conjunction with the Provider’s service delivery plan and clearly state the choice of performance measures that will be collected. The full evaluation should include an Equality Impact Assessment of the service in relation to the public sector Equality Duty (Equality Act 2010). This should include an analysis of the equality and diversity-related information and data gathered by the Provider. It should also include a review of the service response to issues raised by any Equality Impact Assessment carried out prior to award of contract.

This plan should then be agreed with the Commissioner and service users and be funded from the overall value of the contract. It is expected the plan will collect a mixture of quantitative, qualitative and process data (where appropriate), and data might include as a minimum:

- Performance measures such as the number and profile of people using the service, to see if there is equity of access for the diverse Bristol population (relating to age, gender, race, religion, disability, sexual orientation, geographical location etc.)
- Patient satisfaction interviews, surveys, complaints and compliments (disaggregated to highlight any adverse impacts on particular social groups)
- Staff interviews (disaggregated to highlight any adverse impacts on particular social
groups)
• DemQal or other measures appropriate for assessing clinical and cost effectiveness
• Surveys, interviews, focus groups and workshops with stakeholders to assess the number who are encouraging people they encounter in serious emotional distress to use the Bristol Sanctuary
• Person reported outcome measures and Quality of Life measures to assess the impact of the Sanctuary on the persons ongoing mental health journey (disaggregated to highlight any adverse impacts on particular social groups)

The service evaluation is expected to inform the ongoing development of the service. As a result of the evaluation parts of the service may cease, change or increase. The Provider is encouraged to constantly reflect best practice in the service and has the flexibility to try new interventions and to cease out of date ones.

The service will work closely with external academic bodies, to influence the current curriculum of training and post registration continued professional development, to ensure that the workforce are able to deliver the requirements of the service

2.18 Information Management & Technology
Within Bristol Mental Health Services the focus of the IM&T systems will be on continuity of patient care across services and not on organisational boundaries. In order to support the requirement for joined up care the System Leader will provide the following as part of Lot 1 within the procurement:

• The core clinical information system
• The system wide reporting solution
• Configuration and support associated with these core systems

The core systems will be used by

• Community Mental Health Services including:
  a) Assessment and Recovery Service
  b) Early Interventions in Psychosis Service
  c) Crisis Service Single Point of Access Crisis Assessment and Intensive Home Treatment Service
  d) Complex Psychological Interventions Service
  e) System Leader

• Community Rehabilitation Services
• Primary Care Dementia Wellbeing Service
• Employment Services
• Assertive Engagement Service
• Inpatient Services, including 136
• Bristol Sanctuary
• Women and Men’s Crisis Houses

The provider must work with the System Leader to share and document business
processes and to work together to effectively implement the shared clinical record and reporting solution. The provider must contribute to developing a collaborative, problem solving culture for implementing and maintaining a shared IT approach.

At a high level, the provider is responsible for the provision of:

- Local hardware and infrastructure
- Non-clinical business applications such as email, finance, HR and file servers
- Telephony

2.18.1 Electronic Patient Record (EPR) System

The provider must use the EPR system provided by the System Leader to ensure there is a single patient record across the whole Bristol mental health system.

To enable the effective collaborative working of all providers and organisations within Bristol’s mental health system, all patient information is to be entered into the EPR system in real time, i.e. during the consultation with the patient.

All records are to be kept on the EPR system and all written communication between practitioners and or services is to be kept within the system.

This should ensure that everybody who may come into contact with a particular patient has access to up to date accurate and complete information at all times.

The provider must support the System Leader to put in place a system which captures medication information that can be shared across relevant providers.

The provider must ensure they make staff available to be trained on how to use the core EPR system.

2.18.2 Reporting

The provider will be able to generate their own reports from the core reporting solution that will be made available by the System Leader. The provider must ensure they make staff available to be trained on how to generate reports from the system.

Through the core reporting solution, the provider will be responsible for:

- Their own minimum data set return to the Department of Health
- KPI reporting to the Commissioner
- All other statutory returns
- Ensuring their own data quality

The System Leader will have specific responsibilities for generating system wide reports which include data from some or all of the providers across the system. This information will be used to help identify problems and produce evidence based response to
performance issues. The provider will work with the system leader to improve data quality and consistency across the system.

Information on patient experience shall where possible be collected in real time and provided to clinical teams so that it can be used to improve patient experience of the service during the course of their episode of care, rather than gathered at the end and reflected in future practice.

2.18.3 Wider Information Sharing

Wider information sharing across the patient pathway is at the heart of safe and effective care. Information must be available to staff at the point of care to support clinical decision making.

The System Leader will be responsible for enabling information sharing between the core EPR solution and other systems agreed with the Commissioner.

Connecting Care is the flagship systems integration/clinical portal project in Bristol, North Somerset and South Gloucestershire and active stakeholders include; CCGs, GPs, social care, acute hospitals, community providers, the ambulance service. It is expected that the provider will be committed to Connecting Care as the method for sharing data between stakeholder organisations.

Where electronic data sharing is not in place, the provider must work with other providers and the System Leader to ensure information is shared appropriately. This could include:

- Recording interventions in the GP clinical record
- Ensuring that Social Services are updated with relevant information such as services being delivered and any change to place of residence as a consequence of health service delivery

2.18.4 Hardware and Infrastructure

The providers must ensure they have appropriate hardware, infrastructure and telephony in place to allow them to access relevant clinical and non-clinical IT systems. This will include the EPR and reporting solutions provided by the System Leader and any other applications that the provider requires in order to deliver the specified service, for example email, finance systems, HR systems, file-servers.

The System Leader will provide a warranted environment specification in relation to the core EPR and reporting solutions, which the provider must adhere to.

All hardware and infrastructure should have a high level of resilience to ensure that services can be delivered to the agreed service and quality levels. Disaster recovery processes and business continuity plans must be in place.

2.18.5 System Maintenance and Support

The System Leader will manage the maintenance and support associated with the core EPR and reporting solutions, including the provision of a helpdesk.

The provider must ensure that they have robust and appropriate maintenance and support
arrangements (including disaster recovery and business continuity) in place for:

- The hardware and infrastructure that they will use to access the core systems
- Any other clinical or non-clinical systems that will be used to deliver the specified services
- Telephony

3. Applicable Service Standards

3.1 Applicable national standards eg NICE, Royal College

NICE Quality Standards (QS14) for Patient and Carer Experience to be upheld throughout the Bristol Crisis Service.

The service should apply standards from NICE Guidelines (CG 25) about managing violence in Emergency Departments. This guidance is currently being updated.

Staff should be trained to recognise alcohol misuse and alcohol dependence. Appropriate protocols and care pathways should be put in place for the safe management of these individuals. Care should be taken to protect other people from inappropriate exposure to challenging or unpleasant behaviours (NICE CG115).

Staff should be trained and the service should have systems in place to recognise and respond appropriately to individuals with psychosis and co-existing substance misuse as per NICE guideline (CG 120).

People with borderline personality disorder should not be excluded from any health or social care service because of their diagnosis or because they have self-harmed. Staff should be supported on an on-going basis and appropriately trained to understand and work with individuals with a borderline personality disorder (KUF training or equivalent). The service should have in place appropriate protocols and pathways linked to and agreed with other agencies, for the safe and appropriate management of individuals assessed as having a border line personality disorder (NICE CG78).

The service should have in place a clear protocol and pathway, linked to and agreed with other agencies, for the safe and appropriate management of individuals assessed as having an anti-social personality disorder (NICE CG 77).

NICE Guidance (CG16) for the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care should be implemented.

Assessment of needs:

- All people who have self-harmed should be offered an assessment of needs, which should be comprehensive and include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment.
- Referral to alcohol or substance misuse nurses if any alcohol or substances were used in the self-harm incident
Assessment of risk:

- All people who have self-harmed should be assessed for risk: this assessment should include identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide, and identification of the key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent.

Liaison with CAMHS Deliberate Self Harm Team and Out of Hours Emergency Psychiatry

The service will work collaboratively with the Hospital CAMHS (Deliberate Self Harm Team) regarding presentations of 16/17 year old who have self-harmed or need urgent mental health assessments. There is an agreed Out of Hours Emergency Psychiatry Pathway for use with young people up until they are 18.

Mental Health Crisis

The provider will be expected to provide services compliant with NICE Guideline 136 which describes the expected standards of patient experience in mental health services and in managing mental health crisis section 1.5 of the guideline would apply.

4. Key Service Outcomes

All providers are expected to collect and share required information from the services that contributes to the national mental health minimum dataset. Some of the outcomes outlined in this section refer to the same data but are mentioned here with a focus on Bristol Mental Health outcomes. Where the same data is required for more than one purpose it will only need to be collected once.

4.1 All agencies who encounter people in serious emotional distress encourage them to attend the Bristol Sanctuary
  a. Baseline number of referrals by GP area.
  b. Satisfaction of referring services, e.g. Police, Ambulance, A&E, Local helplines, crisis service, Organisations working with people who are deaf, blind, on the autism spectrum, having learning difficulties etc.
  c. Reduced numbers of people in emotional distress being held in a police cell as a place of safety
  d. Reduced numbers of people in emotional distress with no physical health needs being seen in A&E

4.2 The service will ensure equity of access to services for the diverse Bristol population
  a. Consistent recording of demographic & nature of incident information
  b. Equality and diversity data collection and analysis that leads to service changes to improve access to services
  c. Evidence of reasonable adjustments to service delivery to meet the needs of people with learning disabilities and autism by using experience based methodologies
  d. Evidence of service delivery and collaborative working with specialist agencies
and service providers to meet the needs of marginalised groups, such as men, people who self harm, black and minority ethnic communities, people with physical impairment etc.

e. Evidence of engagement with other services to promote appropriate sign posting and referrals.

f. Evidence of marketing, communication campaigns and search engine optimisation to raise awareness and attendance

4.3 People using the Bristol Sanctuary and their families or carers are satisfied with the service and feel that they are treated with empathy, dignity and respect

a. Feedback from service users and carers on how satisfied people are with the service they have received (disaggregated to highlight any adverse impacts on particular social groups)

b. Service user outcomes feedback (disaggregated to highlight any adverse impacts on particular social groups)

4.4 In line with Transitions Strategy Improve Access for 16-25, particularly vulnerable young adults.

a. No. of 16 - 25 year olds receiving crisis sanctuary services - reported quarterly

b. No. of new 16-25 year olds receiving crisis sanctuary services - reported quarterly

c. Increase the number of 16-25 year olds receiving a service by 10% from baseline in year 2

d. All data collected for other outcomes will be reportable for the 16-25 year old age range specifically

4.5 The rights and welfare of children are safeguarded at all times

a. Progress on action plan to improve Safeguarding Children Audit score as agreed with commissioner

b. Number and percentage of staff trained in the Bristol Safeguarding Children Board's Protocol for Joint Working across Adult Mental Health and Children's Services.

c. Number of children whose welfare has been identified to be at risk and risk addressed in the previous month.

5. Location of Provider Premises

The service will need to operate from a location that enables a timely and efficient response to the needs of patients and that ensure staff working out of hours are safe and secure.

The commissioner reserves the right to visit premises and to gain assurance that the quality of the environment is suitable for the service. This will include the accessibility of the premises, so as not to exclude potential employees and service users with particular impairments.
Parents' mental health problems are a major factor in impacting on outcomes for children and child safeguarding situations, and a major factor in the development of poor mental health in the next generation.

**Adherence to Bristol Clinical Commissioning Group’s Safeguarding Children Standards**

The provider will adhere to the Bristol CCG's Standards for Safeguarding children (see separate document), including:

- Having an up to date safeguarding policy and procedure, including how to respond to disclosures of historic allegations of abuse and how to supervise and manage visits from celebrities and volunteers.
- An active training plan for staff, as outlined in the Standards, but also particularly ensuring that all clinical and managerial staff receive training in the Bristol Safeguarding Children Board's Protocol for Joint Working across Adult Mental Health and Children's Services.
- The service will ensure that staff comply with local policies and procedures relating to safeguarding and they have undertaken training appropriate for their professional role.
- A safe recruitment policy and procedure, and all staff in contact with patients having a full DBS check.
- Systems for reporting and dealing with safeguarding concerns about members of staff.
- Understanding of and cooperation with the Information Sharing Protocol.
- Cooperation in completion of reports for serious case reviews, and implementation of action plans arising from safeguarding reviews.
- The service will ensure that staff comply with local policies and procedures relating to safeguarding and they have undertaken training appropriate for their professional role.
- Provision of safeguarding supervision for all staff in line with the current guidance on ‘working together to safeguard children’
- The Provider must have clear guidance for staff on who to contact for advice, support, guidance and supervision around safeguarding children.
- The Provider will be expected to engage in any inspection of safeguarding procedures as required. These inspectors require access to practitioners, case records and tracking outcomes for Parents of children, young adults and looked after children. There is generally only 2 days notice for these types of inspections.

The Commissioner may audit the providers safeguarding practice through documentation and face to face interviews with staff.

**Assessment of Caring Responsibilities**

The Provider will ensure they undertake a parenting/carers assessment on any client who has a caring responsibility. If safeguarding concerns are identified the Provider must liaise with ‘First Response’\(^1\) or a Safeguarding Lead in their service to access further support.

**Think Family**

A think family approach and the ‘think family toolkit’ for working with troubled families should be incorporated into training courses, including awareness of the impact of adult mental health.

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\(^{1}\) First Response is one number (0117 903 6444) that anyone in Bristol can telephone if they are worried about a child or young person. First response have information and guidance, they can refer to the Early Help team for support or can do a safeguarding referral to a social work team.

Young Carers
In families where a parent has mental health needs, children and young people often take on caring roles. They need information about mental health. The training needs of young carers will be considered in planning training for carers. If the Provider identifies a young carer they must assess their needs to see if ‘First Response’ or early help is needed and make a referral as appropriate.

Perinatal mental health
In recognition of the detrimental impact of very early poor parent-child relationships, and the desirability of preventing the next generation of mental ill health, the provider will liaise with maternity services and CAMHS to create a coordinated effective approach to perinatal mental health which treats the parent's mental health needs in conjunction with the relationship between parent and child, in line with recent guidance from Royal College Of Psychiatrists. (http://www.rcpsych.ac.uk/pdf/perinatal_web.pdf). The Provider must also assess for any safeguarding concerns and make a referral to First Response’ for child protection or early help as appropriate.

Adherence to Bristol Clinical Commissioning Group's Safeguarding Adult’s Standards.
The provider will adhere to the Bristol Policy for Safeguarding Adults (see separate document), including

- An up to date safeguarding policy and relevant procedures
- An active training plan for staff, ensuring that all clinical and managerial staff receive training in Adult Safeguarding and the Mental capacity Act
- A safe recruitment policy and procedure, and all staff in contact with service users having a full DBS check.
- Systems for reporting and dealing with safeguarding concerns about members of staff
- Understanding of and cooperation with the Information Sharing Protocol
- Cooperation in completion of reports for serious case reviews, and implementation of action plans arising from safeguarding reviews
- If during the course of treatment disclosers of domestic violence /abuse are made, practitioners should follow safeguarding adults and children procedures.