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 proactive 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
• Counselling 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 Implementation Framework, 2012**


**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 alternative to statutory services, or may complement involvement in mainstream services.
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. 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.

Any individual assessed as being a danger to others, intoxicated, or under the influence of drugs 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.

People with Personality Disorders diagnoses and/or other dual/multiple needs will be supported when this is appropriate within the service.

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 Shared Care Protocols

2.14 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.

2.15 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.

2.16 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.

2.17 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

2.18 Research, audit and evaluation
2.18.1 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 – e.g. 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.

2.18.2 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)
- DemQol 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.

2.19 Information Management, Innovation & Technology

The provider will use the Information Management & Technology (IM&T) systems provided by the System Lead Provider (SLP) to underpin and support the Bristol Mental Health services.

The provider must work with the SLP to share and document business processes and to work together to effectively implement a shared system.

The provider must contribute to developing a collaborative, problem solving culture for implementing and maintaining a shared IT approach.

The focus of the IT systems must be on continuity of patient care across services and not on organisational boundaries. It should also include the capability to highlight potentially adverse impacts on particular protected/social groups.

2.19.1 Information Sharing

Providers must support the participation in the Connecting Care project to deliver information sharing with partner organisations that need this information to deliver improved patient care. The providers must support the SLP to co-operate with development of the local Connecting Care portal project managed by SWCSU.

2.19.2 Hardware and Infrastructure

Providers must ensure they have appropriate hardware and infrastructure in place to allow them to access relevant IT systems. This should include but is not limited to:-

- Appropriate Public Sector Network or Public Sector Network for Health connectivity
- Working with the lead provider to ensure access to clinical records to support contemporaneous clinical notes including remote access or mobile working solutions for peripatetic staff
- Agreed Infrastructure links to other specified services (as agreed) and their systems, including Health and Social Care if this becomes necessary as part of agreed joint working processes
- Flexibility and scalability to meet future requirements
- Assured delivery of a timely and secure service to agreed Service Levels, including flexibility and capacity to deal with emergencies
- Resilience to ensure no single point of failure, and ensure delivery to the agreed Service and Quality Levels including disaster and service recovery timescales.
2.19.3 Reporting
The provider will be able to generate their own reports from a shared data warehouse solution. The provider must ensure they make staff available to be trained on how to generate reports from the system.

Each provider will be responsible for their own minimum data set return to the department of health. Each provider will have responsibility for ensuring their own data quality. The system leader will work with all providers to improve data quality and consistency across the system.

The System Leader will have specific responsibilities for generating system wide reports which included 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 must satisfy the statutory reporting requirements and submit minimum dataset(s) to the Health and Social Care Information Centre including all relevant KPI information (to be agreed).

2.19.4 Information Governance
The provider must contribute to and sign up to the information sharing protocols developed by the System Leader.

The provider must comply with all Information Governance (IG) standards, NHS standards for record-keeping, the Data Protection Act, Information Governance toolkit, Caldicott principles and Department of Health standards and the common law duty of confidentiality.¹

The core IG requirements of Mental Health Service providers when acting as a service provider to the NHS are that the provider shall:

- Perform an annual information governance compliance assessment via the NHS IG toolkit. In doing so, shall achieve a minimum of level 2 compliance across all requirements. If unable to meet this level the provider shall agree an action plan to achieve this with the commissioning organisation
- Utilise the ‘Mental Health Trust Version 11 (2013-2014)’ model of the toolkit unless there is a more relevant model that will be agreed with the commissioner.
- In relation to compliance, the following items are specifically required to assure that the self-assessment is robust: The provider must:
  - Ensure they have identified senior individuals to fulfil the roles of Caldicott Guardian and Senior Information Risk Owner. As a default these roles should be with two separate individuals. If the roles are held by one person information supporting the reasoning for them being held by one individual must be given
  - Ensure all mobile devices (including but not limited to laptops, tablets, smartphones and removable media) are encrypted to current NHS standards
  - Ensure they work with the SLP to educate and train staff on the handling of personal data, with a minimum of an annual update and assessment of knowledge
  - Maintain all information storage within the United Kingdom, unless appropriate technical and organisational measures (as defined by principle 8 of the Data Protection Act (1998)) are in place and agreed with the commissioner
  - Have an active risk assessment and management programme to ensure the ongoing security of all information assets and information flows

¹ https://www.igt.hscic.gov.uk/RequirementsList.aspx?tk=41448490811170&lnv=2&cb=864f9c3e-71ce-4145-a50e-ad05a3ac31a8&sViewOrgType=5&sDesc=Mental%20Health%20Trust
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 of 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 then 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 carer on how satisfied people are with the service they have received (disaggregated to highlight any adverse impacts on particular social groups)
b. Patient 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.

6. Think Family & Safeguarding

Parents’ mental health problems are a major factor in impacting on outcomes for children and, at worst, 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:

- An up to date safeguarding policy and procedure
• 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
• A safe recruitment policy and procedure, and all staff in contact with patients having a full CRB 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
• The service will be represented on the local Safeguarding Board. The service will have appropriate practices to assure the safety of children who are visiting wards.

Assessment of Caring Responsibilities
The service will ascertain whether the person receiving care has any caring responsibilities for children or vulnerable adults and whether such persons have appropriate alternative carers in the immediate and short term.

Where this is in doubt, the service will assist the person to arrange alternative family carers, or contact appropriate services to check or arrange, following standard safeguarding procedures from the outset.

Think Family
A think family approach should be incorporated into training courses, including awareness of the impact of adult mental health difficulties on children. [http://www.scie.org.uk/publications/guides/guide30/summary.asp](http://www.scie.org.uk/publications/guides/guide30/summary.asp)

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.

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](http://www.rcpsych.ac.uk/pdf/perinatal_web.pdf))

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 patients having a full CRB 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.