Reference: FOI.ICB-2526/171

Subject: AWP Contract for Mental Health Crisis Services 2022/23

I can confirm that the ICB does hold some of the information requested; please see responses below:

QUESTION	RESPONSE
Could you please provide me with a copy of the ICB commissioning contract with AWP for provision of mental health crisis/ intensive services covering Bristol for 2022/2023. Including the hours of the service and place/facilities where crisis services are delivered from.	Crisis and intensive services were commissioned by NHS Bristol CCG (Clinical Commissioning Group) from Avon and Wiltshire Mental Health Partnership (AWP) NHS Trust in 2013. The specification for those services is enclosed. For further information regarding these services as operational in 2022/23, the requester is advised to contact the provider directly, using the following link: https://www.awp.nhs.uk/contact-us/freedom-information

The information provided in this response is accurate as of 9 September 2025 and has been approved for release by David Jarrett, Chief Delivery Officer for NHS Bristol, North Somerset and South Gloucestershire ICB.

Service Specification No.	BMH 03
Service	Bristol Mental Health Crisis Service: Single Point of Access, Crisis Assessment and Intensive Home Treatment Service
Commissioner Lead	Bristol CCG

1 Population Needs

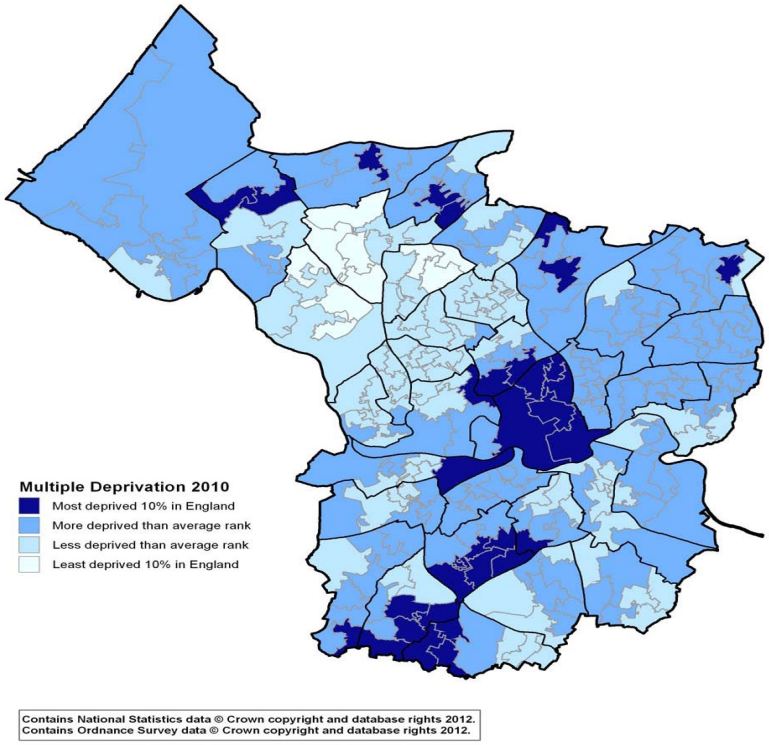
1.1 Local Needs

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.

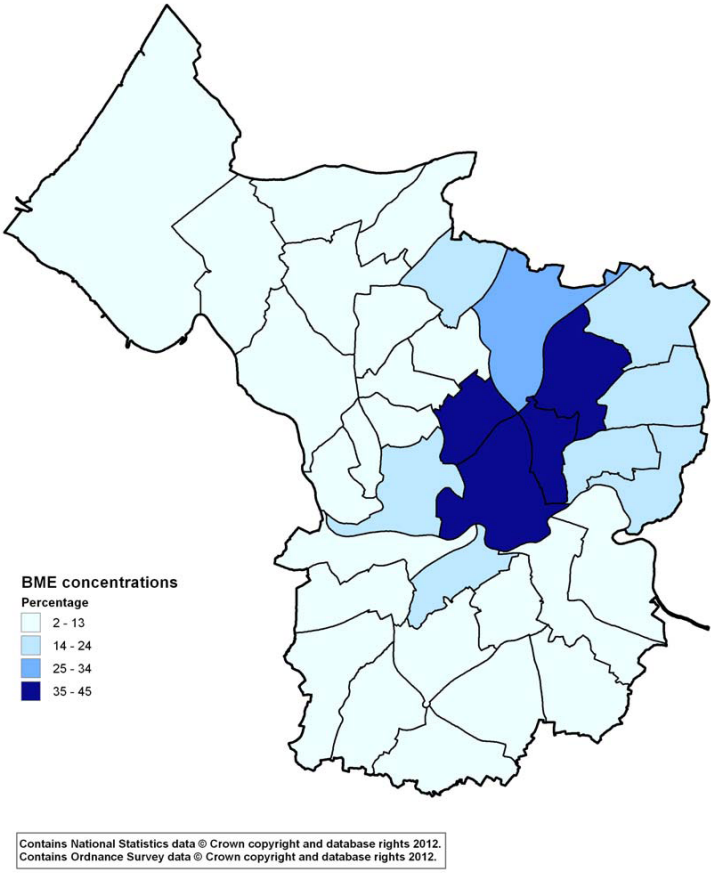
- Some wards of Bristol are amongst the most deprived in the country. A few are among the most affluent.
- 14 % of the population of Bristol live in the areas that make up the most deprived 10% of the whole of England.
- 25% of the population live in areas that make up the most deprived 20% of England.

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 that 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 focussed 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 groups
- Experience-related support, for example for people who have been raped, people who have experienced domestic violence
- Specific condition-related support groups
- Telephone helplines
- Counselling and psychological therapies
- Advocacy

The needs of people in crisis

Bristol's existing Crisis Service is a city-wide service. It is not presently able to fully meet the population's needs, in part due to insufficient resource within the team who cover the entire city. Key issues identified by people with mental health problems, their friends, families or carers and other services that this specification aims to address around unmet needs of the population of Bristol are:

- Crisis response is not fast enough and people feel they are often left too long which can result in an unnecessary distress and sometimes an unnecessary admission
- The current Crisis service is not sufficiently resourced to be able to provide intensive home treatment in a way that makes the patients and their friends, families or carers feel fully supported
- People who have taken alcohol or drugs are often not provided a service, even when they are not incapacitated by their drug or alcohols use
- The ambulance service do not feel able to call on the crisis service for support with patients who have rung 999 in a mental health emergency and consequently transport people to the acute general emergency department even when they have not got an injury or physical health problem
- The Police service feel the crisis service is not sufficiently responsive to their requests for support with people in their care who have mental health needs. This leads to people being taken to a place of safety more often than necessary and to this place of safety being a police cell, which can be a very traumatic experience for a person experiencing a mental health crisis
- There is no service for people experiencing severe mental and emotional distress who do not need an acute mental health crisis response but who absolutely need a response that ensures their safety and wellbeing
- People known to services have poor quality crisis plans that too often they simply say 'call the crisis team'. This has two effects – the crisis team do not know immediately the best way to work with the person experiencing the crisis and what has been agreed with them and the person in crisis or their friends, families or carers do not try any other steps before calling the crisis team
- People who need an urgent assessment but are not experiencing mental health crisis are often passed to the crisis team rather than being assessed promptly by the community recovery team. This absorbs crisis team capacity inappropriately

This specification requires these needs to be met and looks to providers for innovative approaches and practical, fully worked-up plans to achieve this.

1.2 National/local context and evidence base

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

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

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

No Health without Mental Health Implementation Framework, 2012
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216870/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf

Guidance for commissioners of acute care – inpatients, crisis and home treatment, May 2013, Joint Commissioning Panel for Mental Health
http://www.jcpmh.info/wp-content/uploads/jcpmh-acutecare-guide.pdf

The NHS Plan, Department of Health, 2000
www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118522.pdf

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

Crisis Resolution, Sainsbury Centre for Mental Health, 2001

http://www.centreformentalhealth.org.uk/pdfs/crisis_resolution_mh_topics.pdf

Early paper setting out the model for Crisis teams. Useful table differentiating Crisis Team from Assertive Outreach.

Crisis resolution teams and inpatient mental health care in England, North East Public Health Observatory, May 2005
http://www.nepho.org.uk/securefiles/130228_1247//Crisis_Team_Effectiveness_Study_Report_Final.pdf

The conclusions:

- Introduction of crisis resolution teams generally were associated with a modest reduction in the number of admissions but no effect in the number of bed days used. The significant reduction was confined to admissions of older working age adults.
- Introduction of crisis teams providing 24/7 on-call were associated with a substantially greater reduction in admissions overall, including a reduction in admissions for younger working age adults. These teams were also associated with a significant fall in bed usage in older working age adults.
- Detailed analysis of the patterns seen argue strongly that these associations were causal; that is to say it was the introduction of crisis teams which brought about the reductions.

Randomised controlled trial of acute mental health care by a crisis resolution team: the north Islington crisis study, Johnson S. Nolan F. et al., *BMJ,* 331, 15 Sept 2005

http://www.bmj.com/content/331/7517/599

260 residents of the inner London Borough of Islington who were experiencing crises severe enough for hospital admission to be considered.

Interventions: Acute care including a 24 hour crisis resolution team (experimental group), compared with standard care from inpatient services and community mental health teams (control group).

Conclusion: Crisis resolution teams can reduce hospital admissions in mental health crises. They may also increase satisfaction in patients, but this was an equivocal finding.

Crisis resolution/home treatment teams and psychiatric admission rates in England

Glover.G., Arts. G., Babu. K., The British Journal of Psychiatry 189: 441-445, 2006
http://bjp.rcpsych.org/content/189/5/441.short

Background: Introduction of crisis resolution/home treatment teams has been associated with a reduction in hospital admissions in trials. Between 2001 and 2004 there was a rapid expansion in the numbers of these teams in England.

Method: Observational study using routine data covering working age adult patients in 229 of the 303 local health areas in England from 1998/9 to 2003/4.

Results: Admissions fell generally throughout the period, particularly for younger working age adults. Introduction of crisis resolution teams was associated with greater reductions for older working age women (35–64 years); teams always on call were associated with additional reductions for older men and younger women. By the end of the study admissions had fallen by 10% more in the 34 areas with crisis resolution teams in place since 2001, and by 23% more in the 12 of these on call around the clock than in the 130 areas without such teams by 2003/4. Reductions in bed use were smaller. Introduction of assertive outreach teams was not associated with overall reductions in admissions.

Conclusions: Introduction of crisis resolution teams has been associated with reductions in admissions

Helping people through mental health crisis: The role of Crisis Resolution and Home Treatment services, National Audit Office, December 2007

http://www.nao.org.uk/publications/0708/helping_people_through_mental.aspx

Review of operation of Crisis teams:
In recent years Crisis Resolution Home Treatment (CRHT) services have been developed to provide acute care for mental health patients living in the community and experiencing a severe crisis requiring emergency treatment. Previously, such treatment could only have been provided by admitting the patient to an inpatient ward. The introduction of CRHT services was one of the key elements in the 1999 National Service Framework for mental health. The introduction of CRHT teams has been associated with reduced pressure on beds, and the teams are successfully reaching patients who would otherwise probably have needed admission**.** Many teams lack dedicated input from key health and social care professionals, particularly consultant psychiatrists. This can restrict their ability to provide comprehensive, multi-disciplinary care, as well as the extent to which they are integrated and accepted within local mental health services. We found that having a CRHT staff member at the assessment makes it far more likely that the assessment will consider whether CRHT is an appropriate alternative to admission, and increases the chances that the CRHT team will be involved in an early discharge.

Crisis Resolution Teams, Rethink Policy Statement 15, 2009

http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=5&sqi=2&ved=0CFwQFjAE&url=http%3A%2F%2Fwww.rethink.org%2Fdocument.rm%3Fid%3D482&ei=FngvUf2bGa-q0AWslIHwDg&usg=AFQjCNHpHUOvOBehYh2IxwMQh6bj_uKAqQ&sig2=gXjVl_m1aQ7haEJVTTnI3g

The provision of effective crisis resolution services was made a priority by the 1999 National Service Framework for Mental Health. The required number of such services is in place, but there is inconsistency in how well they are resourced. Crisis resolution services providing home treatment can be beneficial for people with mental illness, and Rethink is therefore keen to see greater investment in what is already known to be an effective service model. We support the recommendations made by the National Audit Office for increased investment and greater attention to performance measures based on patient feedback and beneficial outcomes.

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

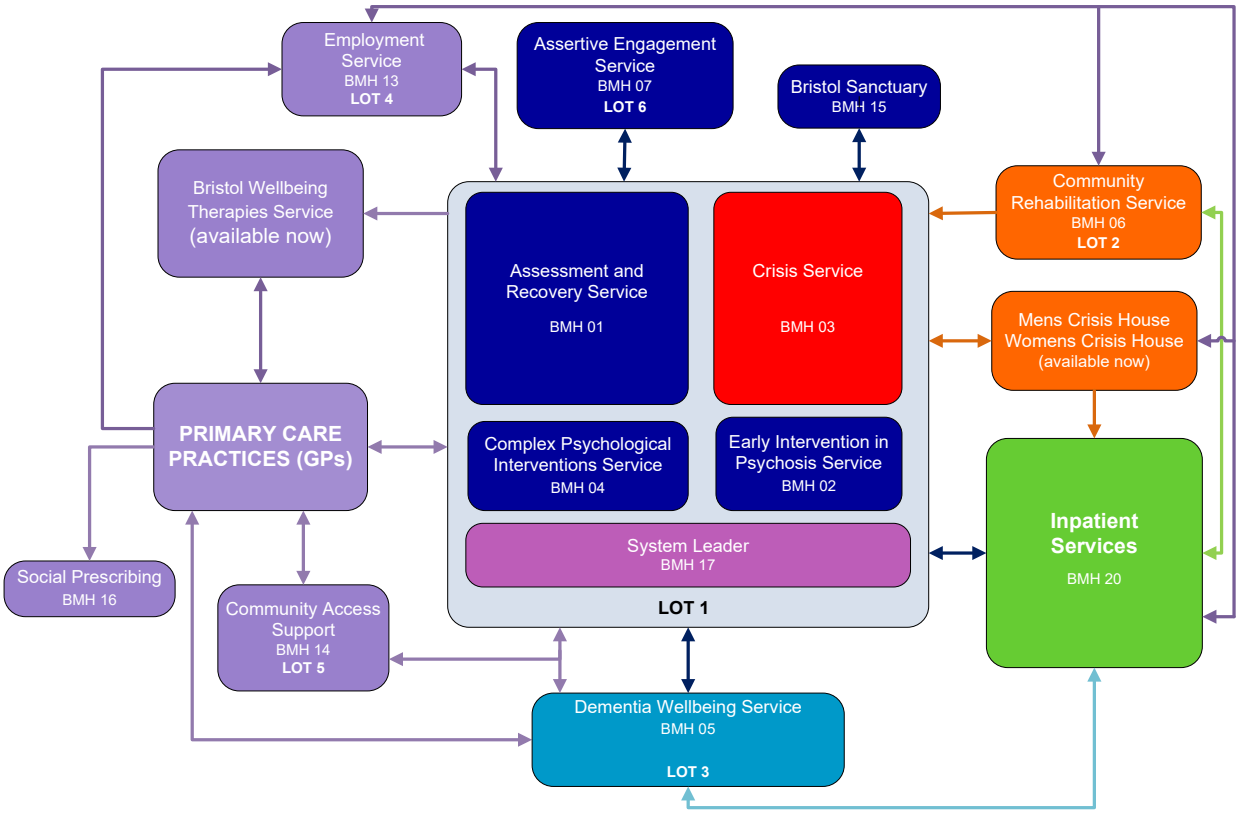
For provider organisations:

- 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 holds

1 Scope

1.1 Aims

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



In the context of this specification, a mental health crisis is when someone is experiencing a period of acute psychological distress, associated with a mental health problem (which may or may not have been given a formal diagnosis). The crisis may be a sudden deterioration of an existing mental health problem or they may be experiencing mental health problems for the first time. They need immediate treatment and/or care and/or support in order to prevent further deterioration in their mental or physical wellbeing.

The Bristol Mental Health Crisis Service aims to keep people who have mental illness well and intervene quickly when needed to minimise distress, minimise deterioration and reduce the risk of harm to people experiencing crisis and their friends, families or carers. The service aims to minimise admissions to hospital and reduce the severity and duration of crisis.

The Bristol Mental Health Crisis Service will work collaboratively with GPs and their teams, the Police, the Ambulance service, the local Accident and Emergency Unit and with the Community Assessment and Recovery Service to address emerging mental health crises pro-actively and promptly to maximise opportunities for de-escalation and rapid recovery and minimise the likelihood of escalation and admission.

The vision for the new Bristol Mental Health Crisis service is to bring together crisis and home treatment functions with a new crisis access and triage point for people in extreme mental and emotional distress, for whom there is currently no ‘emergency service’ other than the Accident and Emergency Department. The crisis service will receive and manage those individuals whose needs

for assessment, safety or treatment cannot be effectively delivered through primary care, or the recovery service.

An innovative model is sought for mental crisis management involving new ways of working, which will retain the specialist expertise necessary to respond effectively to assessments under the Mental Health Act, the treatment and management of individuals with a psychosis induced mental health crisis; and in addition provide appropriate mental health triage, assessment and treatment for people in acute mental and emotional distress.

- Crises should be prevented as far as possible: this places key emphasis on crisis planning and ensuring that there is a graduated provision of support for patients
- Crisis services are based around the needs of patients and not service providers: this includes making access as clear and direct as possible
- Crises are managed in partnership between the patient, their carer/ family where appropriate, and the crisis service. There will be occasions when the patient may be forced to have treatment that they do not want. However, the greater the confidence that the patient has that the service is 'on his/her side' the greater willingness they will have to engage with it. Part of this confidence may be achieved by patients being engaged in the management and delivery of the service
- Individuals, their family and carer's feel supported throughout the episode of crisis
- The patient should be empowered to deal with the crisis rather than an 'expert' external solution being imposed. Patients should be encouraged and supported to become expert in their own condition and how to manage it
- People who are experiencing severe emotional distress should receive a sympathetic response and be pro-actively supported to find help if their needs to not require a formal crisis service response
- The expertise of people with mental health needs and lived experience in dealing with mental distress should be recognised. They should be considered for employment in providing crisis peer support services (after appropriate selection and training)

Services will be provided on the basis that each person using the service is an individual, with their own strengths, needs, life experiences, beliefs, aspirations, friendship and support networks. Therefore to establish an effective therapeutic relationship, services need to be person centred and outcome focused. Assumptions should be avoided as should taking a one size fits all approach when considering how to engage with individuals or how to offer or deliver support. This approach is in addition to consideration of gender, race disability or sexuality and depends on embedding a positive organisational culture. Staff should be supported to ensure they have the appropriate training, attitude and approach towards the people they are working with. The person has to be at the centre of everything the service does rather than the other way around.

1.2 Objectives

The Bristol Mental Health Crisis Service will provide:

- 24/7 contact point Single Point of Access (SPA)
- 24/7 mental health triage and assessment for mental health and emotional crisis
- 24/7 Intensive treatment at home to avoid hospital admission
- Information, training and support to other professional groups, families and the public about the recognition and effective management of a mental health crisis

The objectives of the service are:

a. To offer an inclusive service for everyone who is experiencing mental health or emotional crisis, including those who do not need assessment or treatment by the crisis service
b. To reduce the risk of harm to patients and support their self-management of their mental health problems
c. To minimise the need for patients to be admitted to hospital provide early intervention and support to avert the escalation of the individual's crisis.
d. To treat people experiencing mental health crisis in the least restrictive environment possible
e. To provide round the clock rapid response emergency assessment at home when safe to do so for people experiencing an acute mental health crisis
f. To deliver intensive mental health care at home (home treatment) to enable people to remain in their homes and communities during a mental health crisis, including working closely with the pharmacy service to ensure expert prescribing for individual patients.
g. To provide 24 hour telephone support, advice and signposting to people experiencing severe emotional crisis who do not need a mental health emergency response
h. To manage admissions such that a patient can be admitted without delay when this is the best course of action
i. To identify and address people's social needs, both where the individual qualifies for a formal package of support from social care or housing and where the individual has less intense social needs that affect their mental wellbeing.
j. To pro-actively support discharge from hospital to home, of those people who could be cared for in their own home with an intensive support package from the crisis home treatment service as part of a pathway through to Bristol Mental Health Community Recovery Service
k. To provide crisis services for adults of any age on the basis of need

1.3 Service description

The Bristol Crisis Service will provide a rapid response to people in acute mental health crisis, offering them rapid assessment and immediate intervention and treatment within their home or a community setting and enable the patient to be cared for in the least restrictive environment possible.

They will manage admission to inpatient beds when this is most appropriate course of action for the patient. They will facilitate and support discharge back into the community at the earliest possible stage by providing intensive care at home for people who are well enough to receive this.

The service will be embedded in the community and will work very closely with the Community Assessment and Recovery Service, sharing local knowledge and improving understanding of and relationships with individuals with mental health problems and their friends, families or carers. They will provide comprehensive service 24 hours a day, 7 days a week. The patient and their family or carer(s) will be actively involved in decision about their care and when a pre-agreed crisis plan exists, this will be followed whenever possible.

The service will work closely and co-operatively with the following organisations who regularly encounter people in mental health crisis:

- GPs and their practice teams
- The Police Service
- The Ambulance Service
- A&E
- Social Care
- Housing
- The voluntary sector
- Children's Social Care and Integrated family support teams
- Crisis Houses
- Crisis Sanctuary (once aviliable)
- Assertive Engagement Service

The Crisis Service will be organised and resourced in such a way that it can, effectively and equitably:

a. Ensure that patients are offered as much choice and control over their care as possible

b. Be needs led and not diagnosis driven. It will offer a social as well as medical perspective and be recovery focussed

c. Create a relationship of trust / partnership between the patient and the Crisis service. This trust might be built in a variety of ways, such as encouraging patients to phone/visit crisis services when they do not need them, so they can know what to expect if they should use them

d. Be responsive to requests for advice and appropriate involvement from agencies working with families where adult mental health difficulties are affecting the welfare of children (this will mean either having a high level effect in the short term OR having a long term effect which will impact on outcomes in the future) and be a core part of developing 'total family' systems across the city

e. Assess risk to the welfare of any children or vulnerable and young carers and act to address these. Encourage whole family joint working initiatives between CAMHS and AMHS where both adults and children in a family have mental health difficulties

f. Support the development of up to date crisis plans for all patients by the Community Assessment Service, Specialist Dementia Wellbeing Service, primary care teams and other mental health services within the system

g. Manage mental health crises and emotional distress in a timely and safe manner, most appropriate for the individual patient and their illness and in line with the wishes they have expressed in their crisis plan if they have one.

h. Liaise with appropriate services to ensure that physical health needs are appropriately addressed

i. Respond effectively and promptly to requests from the Police, Ambulance service, Social Care, Crisis Houses, Crisis Sanctuary

j. Work closely with the pharmacy service to ensure expert prescribing for individual patients, regular reviews and ongoing monitoring of individual patients using higher risk medicines

k. Support people of all ages, with a particular requirement to ensure that the needs of older people are appropriately met. This will require clinicians with older age skills and experience

l. Provide services to people who have taken alcohol or drugs

m. Provide services flexibly to meet the needs of people from different ethnic groups

n. Make reasonable adjustments to ensure the service is inclusive for those who experience additional difficulties such as learning disabilities, autism, personality disorders, language problems, deafness, physical disability

o. Where young people up to the age of 18 are using the service they will be supported to maintain their education in line with the Raising Participation Age: http://www.education.gov.uk/childrenandyoungpeople/youngpeople/participation/rpa

1.3.1 Crisis Single Point of Access – telephone triage and support

The Bristol Crisis Service will provide 24 hour a day 7 day a week comprehensive telephone access for all referrers and for patients and their families who are already known to services.

The Bristol Crisis Service will be the first point of contact for the Police Services when they are considering section 136 for an individual.

This telephone service will be staffed by appropriately qualified mental health professionals able to deal with mental health crisis and able to provide initial triage and telephone advice to patients and their friends, families or carers and other professionals, as a first response to the crisis. The single point of access will be sufficiently resourced to be able to deal effectively with the typical call volumes at different times of the day and night, so that calls are always answered in person.

Patients who are already known to Bristol Mental Health services will have a care plan, which will include an up to date crisis plan. The crisis plan will enable them and their nominated person to contact the crisis service directly on a dedicated phone line where identified as part of this plan.

The telephone service will be able to access existing patients agreed crisis plans, follow them and add to them where clinically appropriate, providing feedback to appropriate health care professionals following contact with the service

They will also be able to triage the caller's needs and take action other than initiating a crisis response if this is not appropriate, for example if the individual is experiencing severe emotional crisis, not due to mental illness.

Alternative actions is likely to involve providing telephone advice and any of the following:

- Arranging for an appointment the following day with the Community Assessment & Recovery Service or Specialist Dementia Wellbeing Service
- Signposting to their GP, who also be notified by the service
- Signposting to Bristol Wellbeing Therapies services
- Signposting the most useful Bristol services, including voluntary sector services, for the individual based on their issue.
- Referral to one of the Crisis Houses
- Referral to the Crisis Sanctuary, when this is available.

Information about the call will be recorded in real time and will be flagged up to the relevant teams by the information management system.

- Provide immediate, qualified, telephone triage through a crisis telephone number that is provided to patients and friends, families or carers as part of their crisis plan and which is shared with primary care, the police, the ambulance service, A&E and other individuals and organisations as appropriate

- Provide an individual rapid response to the person experiencing crisis, within timescales agreed with commissioners, of the initial telephone call
- Provide support, signposting and onward referral to other appropriate statutory and voluntary services for people in acute mental and emotional distress who after triage do not require a specialist mental health crisis service

1.3.2 Crisis Assessment

When the Single point of Access agrees with the caller that a crisis response is required they will initiate the response attendance of Crisis Assessment team.

The crisis assessment service will attend the patient quickly, within timescales agreed with the commissioner, where clinically indicated and agreed with the patient and / or their designated representative.

The provider will be expected to work closely with the police service and ambulance service to agree appropriate response time to people in mental health crisis who are being attended to by these services. The service will make the relevant clinical assessment to ensure the least restrictive intervention for those individuals known to mental health services.

The crisis assessment will:

- Use a multidisciplinary and multiagency approach: bringing different perspectives and skills sets to the process of assessment
- Ensure active participation of the person using services and their family, friends and/or carer
- Focus on the strengths, resilience and aspirations of the person using services, their family, friends' and/ or carers' resiliencies and aspirations

As part of the crisis assessment, the needs of any dependents, such as children or elderly relatives will be identified and plans put in place to ensure they are cared for while the client is in crisis.

As part of the crisis assessment the family / carer of the individual in crisis will be assessed and offered support.

The provider is expected to work with commissioners to agree a local delivery model that supported people in crisis 24/7. Where it is not appropriate for the assessment to be carried out in the patient's home setting, the crisis team will have access to a suitable appropriate facility in which the assessment can be carried out.

1.3.3 Supporting Mental Health Act Assessments

The crisis service and the on-call psychiatrist will attend, and provide specialist input to, Mental Health Act assessments when required, either by the crisis service or by partners in the police, ambulance service and social care, or at the S136 suite.

Work closely with local authority Approved Mental Health Practitioners, Avon and Somerset Police to deliver their responsibility as art of a locally agreed protocol for section 136/135.

- Work closely with inpatient services to identify beds for patients who need admission

- Ensure least intervention through timely attendance and assessment for those known to mental health services
- Ensure follow-up takes place for those discharged from S136 who require it

1.3.4 Crisis Interventions

Following crisis assessment the crisis service will make a plan to treat and support the patient. This may include:

- Intensive home treatment
- Referral to a Crisis House
- Admission to an Inpatient Service
- Referral to Crisis Sanctuary (when available)
- Booking an urgent appointment with the Community Mental Health Assessment and Recovery service or Specialist Dementia Wellbeing Service the following day
- Referral to other sources of support and information, such as those provided by voluntary organisations

1.3.5 Crisis Intensive Home Treatment

The Bristol Mental Health Crisis service will provide a mental health intensive care service at home for people in acute mental health crisis for whom this has been assessed as the most appropriate response. The service will flexible to meet the needs of patients in crisis over 24 hours a day and 7 days a week.

This service will provide safe and supportive alternative to hospital admission for individuals experiencing an acute episode of mental illness so that wherever possible people can remain at home, maintain a focus on ordinary living, continue relationships with families and exercise choice and control over the type of help received.

This service will support short lengths of stay and early discharge from inpatient services by providing safe and supportive intensive care at home.

The Crisis Home Treatment Service will:

- Manage mental health crises in a timely and safe manner
- Provide a high standard of treatment and care, primarily within an individual's home environment, providing regular contact and the capacity and competency to work with individuals and those who may care for them within an intensive and therapeutic outcome focused manner
- Reduce patients' vulnerability to crisis and maximise their resilience
- Facilitate and improve the quality/experience of admission to, and discharge from, hospital. Provide a coordinating role around the use of inpatient services, including a 'gate keeping' function to determine appropriateness for admission and identifying opportunities for early discharge with enhanced care packages, in partnership with the other services
- Ensure that physical health, mental health and social care needs are appropriately addressed

- Provide advice on medication, prescribing and monitoring of patients' responses to medication
- Facilitate appropriate interventions in the assessment of substance misuse and strategies for engagement and harm reduction in dual diagnosis
- Ensure carers assessments are undertaken and support identified, including referral of any young carers to appropriate services
- Work in partnership with other agencies to promote the safeguarding and welfare of children and vulnerable adults, and public protection
- Ensure that an appropriate treatment/care and risk management plan is agreed which includes the views of the patient and relevant friends, families or carers, advance directives and discharge planning arrangements
- Provide each patient with an appropriate personal plan and facilitate onward referral and signposting
- Screen people for drug and alcohol misuse problems and refer them for assessment by drug and alcohol services when appropriate
- Assess the risk to welfare of any victim of domestic abuse and make appropriate referrals to address this

1.3.6 Inpatient admissions

The provider will manage the admission and discharge process to inpatient beds, both locally and out of area when necessary. The provider will be expected manage admissions within the Bristol bed base except when clinical reasons require a different solution.

The service will be required to develop and agree an admission protocol in partnership with the inpatient services provider and maintain a good understanding of the bed capacity and the interdependencies with other local providers for access to beds.

The provider is expected to work closely and collaboratively with the inpatient provider to ensure their integration in the Bristol Mental Health system and to support the development and improvement of outcomes and reduced length of stay in inpatient services.

A joint escalation policy will be in place with the inpatient service and commissioners in relation to bed availability and prioritisation and repatriation of out-of-area placements

The provider will be responsible for identifying beds as part of section 12 assessments for Bristol residents.

1.3.7 Information, training and support

The Bristol Crisis Service will educate patients, their families, the public and professionals, about effective and appropriate recognition and management of mental and emotional crisis, including appropriate use of primary care and the Community Assessment and Recovery Service, in addition to the crisis pathway.

Specific organisations that will be the focus of training and support include:

- The Police Service
- The Ambulance Service
- Primary Care GPs and their teams, including GP out of hours services

- Crisis Houses
- Crisis Sanctuary
- Assertive Engagement Service
- Voluntary sector organisations
- Community groups, via the community access support service

This should be part of the wider communication/training plan coordinated by the System Leader

1.3.8 Making Services Accessible

Providers will actively consider how their service will respond to the needs of Bristol's diverse population. This will include complying with relevant equalities legislation and best practice guidance. We will expect the service to make reasonable adjustments to ensure the service is open and accessible to the whole of our population.

Particular reference will be made to needs of people with disabilities, people from black and other ethnic minority communities, people who currently find it difficult to access current services or who are under-represented within those services.

There is a specific expectation that people with a learning disability will not be excluded from the services offered and that reasonable adjustments will be made to ensure an inclusive service delivery model.

The service will be delivered in line with the requirements of the national and local autism strategy to ensure people with autism have access to mainstream public services where ever possible and in doing so will be treated fairly as individuals.

People who are deaf will be enabled to access services through the provision of appropriate support.

People who require help with language, such as interpreting, in order to access services will be provided with appropriate support.

The service will accept service users who are being supported to access this service by the Assertive Engagement service.

1.4 Participation of patients and people with lived experience of mental illness

i. The provider will ensure that people with mental health problems and their friends, families and carers are involved in the planning and delivery of their own care.

ii. The provider will ensure patients of all ages are co-producers in the development and delivery of the service.

iii. The provider will engage in defined service evaluation programmes that include patients in line with Bristol Clinical Commissioning Group's performance review programmes.

iv. Patients will be partners in any future service design, organisation development service reviews and where possible staff recruitment.

v. The provider will attend the Patient Board and will respond with positive actions to address issues raised by patients and their friends, families or carers.

1.5 Days/hours of operation

The Single Point of Access and Triage, Crisis Assessment and Crisis Home Treatment service will all be available all 24 hours a day, 7 days a week services.

The service provider will need to ensure sufficient capacity to maintain safe and effective delivery during the hours of operation.

1.6 Client Group

The overall Crisis service is for adults in acute mental health or emotional crisis. There is no upper age limit for the service. The minimum age to access the service is 16 years.

The service 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 protocols.

The Crisis Service will provide a mental health crisis service for people with dementia. This will be governed by the Dementia Crisis Shared Care Protocol.

The Crisis Intensive Home Treatment element of the service is for those in mental health crisis who have one or more of the following factors:

- Risk factors require urgent/immediate intensive intervention
- Risk factors such as self-harm that can be an indication of increased risk of suicide
- Current support needs significantly greater than those usually required by the patient to remain well within the community
- Significant risk of deterioration with the risk of hospital admission if not addressed
- An intensive period of treatment is needed to stabilise deteriorating mental health of a patient under the care of the Community Mental Health Assessment and Recovery Service

1.7 Referral criteria and sources

The Crisis SPA can be accessed by anybody in mental or emotional distress, a professional caring for them, or anyone concerned about them.

The Crisis Assessment Service can be accessed:

a. Directly by **existing** patients as part of their crisis plan
b. By referral from the Crisis SPA
c. By referral from GP primary care
d. By referral from the out of hours GP service
e. By referral from other mental health services, including the Assertive Engagement Service , Crisis Houses, Crisis Sanctuary (when aviliable)
f. By referral from the Accident and Emergency Liaison Psychiatry Team, in situations where no physical healthcare treatment is required

g. By referral from the Ambulance Service. The service will provide advice to the Ambulance Service in responding to individuals presenting with mental health issues

h. By referral from the Police Service. The service will provide advice to the Police Service in responding to individuals presenting with mental health issues.

i. By referral from 111 service

The Crisis Home Treatment Service will be accessed by through the Crisis Assessment team, or directly by patients if this is identified in their personal crisis plan.

The Crisis Sanctuary facility (once available) will normally be accessed by referral from the Crisis SPA, but will allow walk-in access to appropriate clients.

1.8 Discharge processes

1.8.1 Discharge from Crisis Triage and Assessment

Discharge will involve onward referral or signposting, as appropriate to Crisis Home Treatment Service, Crisis Houses, GP services, Bristol Wellbeing Therapies service, social interventions or other low level interventions, the Assertive Engagement Service, the Recovery Service, and relevant community & 3rd sector organisations.

In the case of signposting, the service provider will not need to provide a discharge summary or crisis plan.

In the case of onward referral, where a mental health assessment has taken place, a discharge summary and crisis plan will be provided to the patient, the referred-to organisation and the patient's GP.

1.8.2 Discharge from Crisis Home Treatment Service:

Each patient will have a discharge summary and an initial or updated crisis plan on discharge.

The patient's GP will be informed of the episode and be sent a copy of the discharge summary and crisis plan on discharge.

Patients will be discharged/transferred from the Crisis Home Treatment Service according to the following policy guidelines:

a. Discharge/step down to another service will be in consultation with the relevant service and the GP where appropriate

b. A plan will be agreed with the patient, wherever possible in advance, and the planned transfer/step down (discharge) date will give adequate time to prepare the patient, carer and any receiving service (where appropriate) for this transition. Where the patient has caring responsibilities for children or vulnerable adults, appropriate liaison will take place to ensure their welfare

c. Discharge plans must include relapse management strategies agreed with the patient/carer where appropriate

d. The patient/carer must be given the opportunity to comment on the service they have received and contribute to service improvement

1.8.3 Relapse prevention and management

- Individualised relapse plans should be agreed with all involved in the person's care and kept on file

- Efforts should be made to identify and reduce stressors, which precipitate relapses
- Individuals accessing the service on subsequent occasions should receive continuity of care, they should not be responded to as 'new clients' on each presentation

1.9 Information Sharing

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

All records are to be kept on the shared information management 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 will use the information management system that will be specified by Bristol CCG and will provide appropriate information and reporting through the system for contract monitoring purposes.

Information on patient experience shall where possible be collected in real time and provided to their clinical team 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.

1.10 Population covered

The service will cover the Bristol Clinical Commissioning Group area. Patients from outside the area who enter crisis while they are in Bristol will be able to access this service but the provider will need to inform commissioners of the numbers and CCG area of those from outside Bristol.

1.11 Any acceptance and exclusion criteria

The service will ensure that people over the age of 16 in mental health crisis get the support and services they need at the right time and in the right place, 24 hours a day, 7 days a week, 365 days a year where one or more of the following apply:

- Risk factors require urgent/immediate intensive intervention
- Current support needs significantly greater than those usually required by the patient to remain well within the community
- Significant risk of deterioration with the risk of hospital admission if not addressed
- An intensive period of treatment is needed to stabilise deteriorating mental health of a patient under the care of a recovery service
- Support, education and advice will be provided for those with mild to moderate needs to support management within primary care.

Any individual assessed as being a danger to others, or who are intoxicated, or under the influence of drugs will be appropriately managed. In addition, people with Personality Disorders diagnoses and/or other dual/multiple needs will need to be appropriately supported within the service.

1.12 Prescribing

The provider will work collaboratively with the Pharmacy Service in Bristol to ensure effective prescribing that meets individual's needs. Prescribing will be within the remit of the BNSSG Joint Formulary and a representative of the provider will attend Joint Formulary meetings.

Where people are starting on higher risk medicines, the provider will ensure appropriate pathology tests are carried out and the results checked an acted upon. This may form part of the shared care protocols to be developed between GP's and providers.

1.13 Interdependencies with other services

The provider will cooperate closely with other services both within and outside mental health to help ensure that patients do not fall into the gap between services.

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

The service provider will need to work closely with the Emergency Department to ensure that patients in mental health distress or crisis, not requiring physical treatment, are diverted into this service in a fast and timely fashion. Particular attention will need to be given to training and support of Emergency Department front-line staff.

A shared care protocol will be in place to ensure a joint care planning approach between the Crisis Home Treatment Service and Community Assessment and Recovery Service, and to ensure that the transition to the Community Assessment and Recovery Service, following the resolution of the crisis episode, is seamless, safe and successful. This will also be put in place manage the transition from Crisis Home Treatment Service and the Specialist Dementia Wellbeing Service.

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

The provider will provide whatever reporting is required to support the Safeguarding Children's and Safeguarding Adults Boards.

The provider will ensure the participation of the clinical case manager in reviews as requested by Social Care or Commissioners. Clinical case managers will be involved in the discussions regarding complex case discharges from hospital to support successful placements and prevent avoidable placement breakdown due to escalation or deterioration in mental health

1.14 Staffing

The service will be delivered by multi-professional teams, working appropriate hours to deliver a pro-active, robust and comprehensive service in line with specifications that meets the needs of the people of Bristol by providing safe and effective care.

Staff will be appropriately trained and qualified to provide safe effective care and registration and safety records will be routinely checked to ensure ongoing compliance.

Over time, the workforce will change to reflect the diversity of the population and to ensure that people with lived experience are embedded at all levels of the organisation.

The culture of the organisation will be such that staff feel comfortable to share their own experience of mental illness without fear of stigma or discrimination. The culture will be patient centred and recovery focused. Staff will be selected on the basis that they aspire to deliver excellent services in a caring way and will be supported to do so.

Staff performance will be evaluated in part based on the feedback received from patients and their families, carers and friends about their experience of care by that individual,

The organisation will have a dedicated lead and/or advisory resource to advise staff on issues relating to the Mental Capacity Act and/ or Deprivation of Liberty Safeguards to support staff in their awareness and competence in complying with the act

2.15 Staff Training and Development

Staff will have access to a range of training and development opportunities to ensure their ongoing development and that they remain up to date with latest best practice. The provider is expected to identify, plan and deliver a tailored training programme for individual staff and this should be regularly updated to reflect new thinking and best practice guidance.

Training will include skills in learning disabilities, autism and working with people with disabilities to ensure these people can be effectively supported by the service. As well as relevant clinical and care management training, staff should also have the opportunity to participate in safeguarding training, cultural awareness training, psychologically informed environments training, reducing stigma training and training from other providers in the system that is agreed to be value added by the provider forum from time to time.

All staff who use it will also be well trained in the single electronic patient record system and in ensuring high quality data, records and reporting.

The provider will maintain accurate data about staff training and share this with the commissioner and other system providers as relevant. The provider will report by exception any non-compliance with mandatory training.

All staff will have an allocated level of safeguarding children training as indicated in the itercollegiate document.
http://www.rcn.org.uk/__data/assets/pdf_file/0004/359482/REVISED_Safeguarding_03_12_10.pdf

The employer should reach 90% compliance across these training levels.

1.15 Shared Care Protocols

As part of service design, the provider will develop shared care protocols in partnership with other services to ensure managed care and transitions between services and a seamless experience for people.

Shared care protocols will identify agreed working practices for how care will be delivered by multiple organisations and who will take responsibility for which elements of that care according to pre-negotiated criteria.

Shared protocols will be regularly reviewed to ensure they remain appropriate and relevant.

1.16 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.

1.17 Risk management

The service will ensure positive risk taking is undertaken at a pace that is appropriate to the individual's needs and abilities, through the use of thorough and regular risk assessment which will include physical, mental and social elements.

The service will have procedures in place to manage risk in relation to changing mental health conditions of people access the service.

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.

A proactive management approach that reduces risk and support patients to remain compliance with agreed personal recovery plans.

Evidence of risk assessment update and review as part of on-going care pathways for people access the service.

1.18 Quality Assurance

The provider will take responsibility for establishing a properly documented quality assurance system ensuring service quality. 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.

1.19 Mental Health Act / Mental Capacity Act / Deprivation of Liberty Safeguards (DOLS)

Treatment and care should take into account person's needs and preferences. People should have the opportunity to make informed decisions about their care and treatment, in partnership with their care professionals.

Professionals should discuss with the person while they have capacity and their family/carer the use of:

- Advance Statements
- Advance Statements to refuse treatment
- Lasting Power of Attorney
- A preferred place of Care Plan (allows people to record decisions about future care choices)

If people do not have the capacity to make decisions, care professionals should follow the Department of Health's advice on consent and the code of practice that accompanies the Mental Capacity Act (2005).

The Provider shall be aware and up to date on advice on capacity decisions and compliance with the Mental Capacity Act (2005) and accessing advocacy services. Where appropriate the Provider shall reinforce the message that a diagnosis of dementia does not mean that a person does not have

capacity. The Provider should support other non-specialist staff where:

- the level of capacity is genuinely unclear, or
- a significant decision is to be made (e.g. a change in relation to the place of residence)

Where the decision is likely to be in relation to a new place of residence, the Provider shall engage with health and social care professionals, the person and their family/carers in a timely manner to ensure this is delivered in a coordinated way.

1.19.1 Deprivation Of Liberty Safeguards

Where services are being provided in hospitals, care homes (including Nursing Homes and Residential Homes) the Mental Capacity Act Deprivation of Liberty Safeguards (MCA DOLS), as part of the Mental Health Act 2007, by the Department of Health in April 2009 must be considered.

The MCA DOLS are in place to prevent deprivations of liberty without proper safeguards including independent consideration and authorisation. Deprivations of liberty in hospitals or care homes, other than under the Mental Health Act, should now follow the MCA DOLS process and all affected patients and residents should benefit from the new safeguards.

1.20 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

1.21 Research and Evaluation

1.21.1 Research

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

- Access to best available evidence
- Promotion of participation in research

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 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

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

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

1.21.2 Evaluation

The Provider will agree with the Commissioner the level of service evaluation required to be undertaken. 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.

This plan should then be agreed with the Commissioner and be funded from the overall value of the contract. The evaluation must be delivered in partnership with an external organisation, to ensure transparency. It is expected the plan will collect a mixture of quantitative, qualitative and process data (where appropriate), and data might include as a minimum:

- Patient satisfaction interviews (minimum of 30), surveys, complaints and compliments
- Staff interviews (minimum 20)
- DemQal or other measures appropriate for assessing clinical and cost effectiveness
- Surveys, interviews, focus groups and workshops with stakeholders
- Person reported outcome measures, Quality of Life measures
- Performance measures such as numbers of people accessing the service, referrals, waiting times, demographics, 'Did Not Attend'

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

1.22 Medical Training

The System Leader will act as the main point of contact for University Medical faculties and the Health Education England. The provider will organise training placements and rotations, throughout

the Bristol Mental Health services, including those provided by other organisations, in line with agreed programmes and parameters.

The provider will work collaboratively with the System Leader and Health Education England to define and implement high quality training and experience for undergraduate and post-graduate medical students and trainees, that meets the requirements of the GMC and Health Education England.

1.23 Information Management & Technology

The IM&T requirements for all Lot 1 services are detailed in the System Leader specification later in this document, therefore refer to section 2.2 of the System leader specification for this information.

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 patients 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. In particular:

Triage:

- All people who have self-harmed should be offered a preliminary psychosocial assessment at triage (or at the initial assessment in primary or community settings) following an act of self-harm. Assessment should determine a person's mental capacity, their willingness to remain for further (psychosocial) assessment, their level of distress and the possible presence of mental illness.

- Consideration should be given to introducing the Australian Mental Health Triage Scale, as it is a comprehensive assessment scale that provides an effective process for rating clinical urgency so that patients are seen in a timely manner.
- If a person who has self-harmed has to wait for treatment, he or she should be offered an environment that is safe, supportive and minimises any distress. For many patients, this may be a separate, quiet room with supervision and regular contact with a named member of staff to ensure safety.

Treatment:

- People who have self-harmed should be offered treatment for the physical consequences of self-harm, regardless of their willingness to accept psychosocial assessment or psychiatric treatment.
- Adequate anaesthesia and/or analgesia should be offered to people who have self-injured throughout the process of suturing or other painful treatments.
- Staff should provide full information about the treatment options, and make all efforts necessary to ensure that someone who has self-harmed can give, and has the opportunity to give, meaningful and informed consent before any and each procedure (for example, taking the person to hospital by ambulance) or treatment is initiated.

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.

When to suspect child maltreatment. NICE clinical guidance CG89 (2009)

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 mental health crisis can obtain immediate advice and support through a telephone service

a. Baseline number of referrals by GP area, from criminal justice and Court Assessment and Referral Service.
b. Satisfaction of referring services, e.g. Police, Ambulance, A&E
c. Reduced numbers of people in mental health crisis being held in a police cell as a place of safety
d. Reduced numbers of people in mental health crisis with no physical health needs being transported to A&E

4.2 People experiencing acute mental health crisis receive rapid response and assessment

a. Time from initial contact to assessment team attending patient
b. Proportion of patients who receive a crisis assessment starting within agreed timescales of contacting services, when an assessment was needed
c. Proportion of patients requiring a move to a place of safety for assessment GP area, age, gender and ethnic group

4.3 People whose crisis assessment recommends crisis home treatment, begin their treatment within agreed timescales

a. Time from completion of assessment to start of treatment

4.4 People whose crisis assessment recommended admission to hospital, are admitted as soon as possible

a. Number of people requiring admission by GP area, age, gender and ethnic group
b. Time from completion of assessment to admission

4.5 People who are admitted to inpatient services and become suitable for home treatment are discharged in a timely way

4.6 Patients and their carers using the crisis access telephone service are satisfied with the service they receive

a. Patient and carer satisfaction scores
b. Patients and their friends, families or carers feel they have been appropriately supported and effectively signposted when they did not need a crisis response
c. Patients and their friends, families or carers feel the service they received met their needs
d. Percentage who felt they were treated with dignity

4.7 Patients receive effective intensive home treatment services at home that result in them recovering their stability and being able to return to the care of Community Assessment and Recovery Service, or their GP.

a. Outcomes of individual interventions
b. Length of time supported by Crisis and Home treatment service
c. Time between crisis episodes (i.e. length of following period of stability)

4.8 Only patients who cannot be managed in a community environment are admitted to hospital through the crisis service.

a. Admissions are considered appropriate by both crisis service and inpatient services
b. No. of admissions by GP area and age, gender and ethnic group
c. No. of admissions that result in discharge to intensive support

4.9 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 data collection based on access to service by condition and co-morbidities, e.g. personality disorder that leads to service changes to improve access to services
d. Evidence of reasonable adjustments to service delivery to meet the needs of people with learning disabilities and autism
e. Evidence of service delivery to meet the needs of marginalised groups
f. Evidence of engagement with other services to address the mental health needs of people with co-morbidities, e.g. substance misuse

4.10 People using mental health services and their families or carers are satisfied with the service and feel that they are treated with empathy, dignity and respect

a. Percentage of current services users with an identified carer
b. Feedback from patients on effectiveness of care and personsal recovery plan in place
c. Patient experience feedback on Bristol mental health community services
d. Patient outcomes feedback
e. Percentage of newly identified friends, families or carers with a carer assessment within 4 week
f. Percentage of friends, families or carers with an assessed need who have a care plan within 4 weeks of assesment

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

a. No. of 16 - 25 year olds receiving crisis services - reported quarterly
b. No. of new 16-25 year olds receiving crisis 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
e. No of 16 – 25 year olds feeling satisfied and supported by the crisis service they receive.

4.12 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, reported monthly.

5. Location of Provider Premises

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

The provider may wish to consider co-locating the Crisis Service and the Community Assessment and Recovery service to strengthen collaborative working and intelligence sharing about patients and their friends, families or carers. The provider may wish to consider providing the Crisis Service in a locality model.

Any location where crisis assessments may be carried out, other than the persons own home should be calm and conducive to minimising the stress around an assessment.

The commissioner reserves the right to visit premises and to gain assurance that the quality of the environment is suitable for the service.

The crisis assessment function will respond to incidents which require attendance on site this may be in a neighbourhood location, in a home, in a community centre or other public or private place.

The home treatment element of the service will mainly be delivered in the patient's home, which may be a hostel or other establishment, the crisis house or other location.

6. Think Family & Safeguarding

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' http://media.education.gov.uk/assets/files/pdf/w/working%20together.pdf
- 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 difficulties on children.
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. 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.

Lead professional for safeguarding issues

The service provider must have a lead professional for safeguarding issues.

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

[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.

- 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.
- Using the Bristol Care Direct number (0117 9222700) as the single point of contact for adults where there are safeguarding concerns