A. Sub-Contract Service Specifications

Service Specification No.	PROC.90.005
Service	BSoL Recovery House Service including Staffing
Commissioner Lead	Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT)
Provider Lead	
Period	3 years (plus 2 optional)
Date of Review	2 years from service commencement

1. Population Needs

1.1 Local context

Background

Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) and Birmingham Women's and Children's NHS Foundation Trust Forward Thinking Birmingham are agreeing a multi-agency collaborative to provide short stay environments for individuals experiencing an acute mental health crisis, aged 18+.

Such a facility would provide a viable recovery-based resource for those who may be escalating toward a psychiatric inpatient admission and for those who may be considered for a step-down provision from an acute inpatient bed. It is intended to support those who would benefit from brief biopsychosocial interventions during short term crisis. The crisis would be viewed as "the moment when the typical activities of the service user's day break down".

Commissioners are seeking an organisation that can provide accommodation and a **shared staffing model**.

The Recovery House will be a 24 hours service and needs to be accessible 7 days a week.

The facility must provide a safe environment and support in which service users will receive immediate assistance in identifying the nature of the crisis and how this may be addressed.

This will be achieved by using a model of co-production, solution focused and other brief interventions. The expected duration of a service users stay will be a maximum of 7 nights.

There is substantial evidence that demonstrates Recovery houses support inpatient bed capacity, reduce bed days and improve flow. The Recovery house will be able to feed into this pathway for both service providers, for short term crisis admissions.

National Context and Evidence

Mental Health continues to be a priority both nationally and locally, as outlined within the NHS long term plan, NHSE crisis transformation program and the five year forward plan implementing the mental health forward view.

The development of crisis alternatives, which includes the proposed Recovery house, forms part of the NHSE/I transformational program to increase the capacity and diversity in the local crisis pathway. The intention of this will be to:

- Increase the capacity of community-based crisis services to complement traditional NHS crisis teams.
- Ensure that all areas have a diverse range of different services within an integrated crisis care pathway, that meet a range of different service user needs and preferences for accessing crisis or pre/post crisis support.
- Co-design alternative crisis services that better meet the needs of service users accessing such services and encourage better outcomes for these groups.
- Identify and seek to address local inequalities in access, experience and outcomes of crisis care
- Provide alternative therapeutic treatment options for service users experiencing a crisis impacting on their mental health.
- Support collaboration with local voluntary sector organisations that can support these aims.

National evidence indicates that when key principles of crisis and recovery house models are adopted, recovery outcomes and service user satisfaction have been consistently favourable, demand for psychiatric acute inpatient provisions has reduced and collaborative working has improved.

'***Closing the gap: priorities for essential change in mental health'*** published by the Department of Health sets out to challenge health and social care to transform support and care available to adults with mental health problems. ***'Parity of Esteem'*** has also become a focus in which mental health should be viewed in a similar light to physical health. Some of the key messages from both these documents encourage:

- Person centred services
- Focus on recovery
- Addressing inequalities in access
- Linking with other services

The out of area collaborative devised by NHSE has highlighted a number of successful delivery models. The principles of functioning recovery and crisis and recovery houses have been well established for nearly 2 decades and whilst variations of key delivery arrangements have occurred with the evolution of different models, there is commonality in the delivery outcomes when subsequent research evaluations have occurred.

Research suggests that people with a diagnosis of emotional dis-regulation do not benefit from prolonged / protracted inpatient stay but it is acknowledged that these individuals do have frequent social and emotional crises which may respond to brief crisis intervention which could be supported by a recovery house, where an admission isn't required.

The key differences in functioning of a crisis/recovery house as opposed that of a psychiatric acute inpatient provision were captured in the paper entitled “An evaluation of Wales first crisis house”.

These were:

1. High staff to resident ratio in crisis house offering intensive 24 hour support
2. Therapeutic and homely environment, less stigmatising and stressful for the individual and their family and friends
3. Individualised support and holistic care planning, focused on communication and support
4. Open front door policy, gives everyone the freedom to come and go
5. Support to maintain daily living skills even in crisis
6. Close communication with and support for family and friends and those in crisis
7. Signposting to community services to facilitate on-going recovery

The above will be core principles of the Recovery House

Meiser et al (2006), highlighted women’s crisis houses have provided effective care for a large number of women with significant mental health problems, demonstrating good improvement in symptoms. Similarly Osborn et al (2010) stated that community alternatives were associated with greater service user satisfaction and less negative experiences. The benefits of crisis/recovery houses were also cited by Howard et al (2008) who identified that crisis house models offered a viable alternative to wards for female’s not requiring intensive supervision/observation. Contact with services was also reduced as pathways were simplified.

Ryan et al (2011) evaluated the impact within inner city Liverpool and ascertained that:

1. Community based houses can effectively manage people with moderate to high levels of mental health needs
2. Gate keeping access to crisis house through home treatment provides an additional option to crisis services
3. Community based crisis house can provide an alternative to place of support for people who have a history of hospital admission
4. Effective joint working between statutory services is possible and can deliver innovative services

In evaluating the impact of Crisis House admissions in respect of mental health recovery and achievement of personal goals for people using the service, the benefits of working with the voluntary sector was also further analysed by Larsen & Griffiths (2013).
They concluded that the expansion and further development of alternative third sector alternatives services can benefit health providers and traditional psychiatric inpatient care as they can help to reduce the pressure on standard acute wards through acute admission diversions, early discharge from wards and pre-empting imminent crisis. They can also improve the effectiveness of existing hospital based ward service through allowing them to focus on people with more severe needs, who can benefit most from this environment and clinical treatment focus.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**X**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**X**

Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**X**
Domain 4	**Ensuring people have a positive experience of care**	**X**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**X**

2.2 Local defined outcomes

To develop and provide a therapeutic and recovery focused service to provide short term solution focused interventions to contain and resolve the crisis as a pre-emptive measure or in response to the onset of a crisis. The Service will ensure least restrictive options including a pathway from acute admission wards but also to seek to prevent what may have otherwise resulted in a hospital admission or escalation of the crisis situation.

- To achieve a length of stay within a defined time period
- Reduce the requirement for Out of Area (OOA) placements
- To provide a safe alternative to manage service users in crisis
- Improved self-management of crisis for service users
- To promote better service user outcomes locally.

3. Scope

3.1 Aims and objectives of service

The aim of this Service is to assist service users experiencing a crisis that is impacting on their mental health, to identify the nature of the crisis and supporting the provision of brief solution focused interventions to goal set and develop a shared vision of recovery centred crisis management.

The service would be considered for service users, where it has been clinically assessed that they could be safely managed in an open community-based setting with a wrap-around support package.

The Service will complement the new and existing acute and urgent care pathways across the Birmingham and Solihull (BSOL) Mental Health system for individuals aged 18+.

The objectives of the Service are:

- Providing an increased range of therapeutic and psychological interventions in a safe and supportive environment for those in crisis.
- Provide an improved experience for service users.
- Increase and enhance the alternative crisis options available for clinicians.
- Support service users to build on their strengths and resilience.

- Provide skilled and appropriate interventions according to the service users' needs and mental health requirements.
- Collaborative working with voluntary sector partners to support service user's psycho-social support needs.
- To retain and build links with community services and to maintain continuity of care for service users with existing support networks.
- Adhere to short term admissions, keeping to a fixed boundary to maintain flow and effectively manage length of stay.
- Reducing inpatient admissions and provide a safe alternative where treatment within an acute psychiatric setting is not required.
- Reducing the reliance on OOA admissions where this is not in the best interest of the service user.

3.2 Service description / care pathway

a. Service Description

The Sub-Contractor will work in partnership with BSMHFT and Birmingham Women's and Children's NHS Foundation Trust on behalf of Forward Thinking Birmingham (hereafter referred to as FTB), to provide safe, therapeutic and clinically effective support to adult (18yrs+) service users requiring recovery focused crisis interventions, ensuring that the care and social needs are met to the standards within the remit of the Subcontractor's relevant CQC registration.

The service will be delivered by a single Provider and will operate on preferably a single site (although consideration for 2 sites within close proximity to each other would be considered to ensure a gender specific option) within a 5-mile radius of Birmingham City Centre

The service will need to accommodate a minimum of 10 beds and within this number, we would require the flexibility to offer a female only area of 4 beds (e.g. a particular floor or wing of the house). The rationale for the separate female only area is to ensure we can appropriately support vulnerable females whilst also supporting ethnic and cultural sensitivities of the diverse Birmingham population.

The Service will provide a safe and supportive environment in which service users will receive immediate assistance in identifying the nature of the crisis and how this may be addressed. This will be achieved by using a model of co-production, solution focused and other brief interventions.

The length of admission within the Recovery house will be for a maximum stay of 7 nights. It is essential that these boundaries are kept to for the model to work effectively and allow consistent flow.

In the shared staffing model the day-to-day operational functioning of the Service will be managed by the Recovery house manager(s) employed by the Sub-Contractor.
The clinical activity will be overseen by a registered clinical lead who will work closely with the Sub-Contractor to achieve a range of agreed outcomes.
In the shared staffing model the Sub-Contractor will be required to ensure that the Recovery house is staffed and accessible 24 hours a day, 7 days a week.

In the shared staffing model the Sub-Contractor will be required to support the stabilization of the service user's crisis and facilitate appropriate interventions relating to psychosocial, financial, relationship, accommodation issues impacting on or precipitating the nature of the crisis, in a timely manner.

The Sub-Contractor will be working within their own Safeguarding policy for adults and young people including MCA DOLs, however, there will be an expectation that the Sub-Contractor is fully aware of and committed to engaging with the commissioning services policies and procedures to ensure compliance with the local respective Safeguarding Board requirements as part of this service specification.

Facilities and amenities

- The physical environment should be home-like and non-institutional, with places for privacy and reflection and open areas for social and peer activities.
- All bedrooms will be en-suite and lockable.
- In the shared staffing model the sub-contractor will ensure each room will be provided with bedding, linen and a basic welcome pack with all essentials for maintaining personal hygiene.
- Each room should contain a lockable draw or cupboard for the safe storage of self-administered medication
- Access to communal areas Kitchen, Lounge, dining area which enable the provision of gender specific areas.
- There will a requirement to have sufficient space that can be utilised to facilitate therapeutic sessions, clinical reviews and appointments with relevant professionals.
- The Sub-Contractor will be required to provide food provisions that will encourage and enable 3 meals a day to support service users where the crisis, low motivation or their practical cooking skills may be a barrier to services users preparing meals. Staff employed by the Sub-Contractor will be required to have food hygiene training as part of their local training requirements.
- In the shared staffing model we will require adherence to the safe storage of medication within a community setting as outlined by CQC. Service users will dispense their own medication, where it has been clinically assessed as appropriate to do so. This may be with supervision within the recovery house to ensure adherence in line with the supplied medication guidance.
- The property will be licensed by the local authority in-line with the housing Act 2004 licensed HMO and will conform with the Homes (fitness for Human Habitation) Act 2018

b. Care Pathway - Crisis house interventions
The Sub-Contractor in the Shared Staffing model will be required to:

- Appoint at least 1 registered service manager to oversee the Recovery house/s, ensuring collaborative working with BSMHFT and FTB to achieve the identified goals of the service user's admission.
- Hold patient care and recovery central to all provision providing individualised support and holistic care planning focused on communication and support.
- Supporting people to recognise and use their own skills, resources, and resourcefulness.
- Ensure that service users will be kept updated and involved in the progress of their crisis/recovery support plan.
- Engaging in the co-production and sharing responsibility for developing understanding of difficulties and co-creation of plans to develop safety and well-being
- Maintenance of daily living skills by providing support to those who need prompting or encouragement in personal care, managing their diet and dietary needs etc.

- Support the delivery of a structured therapeutic activity programme.
- Lead the facilitation of crisis interventions related to the services users identified psychosocial support needs.
- Identify ongoing community support or resources to support continued recovery.
- Demonstrate the provision of meeting workforce establishment in relation to level of skill and resource required.
- Provide assurance in relation to quality, safety and continuity of care provided within the service provision.
- Provide least restrictive care in high quality environments that meet the required service specifications as agreed in the Standard Operating Policy (SOP).
- Provide safe admission and discharge care and support arrangements as part of the crisis pathway.
- Maintain contemporaneous record keeping utilising BSMHFT and FTB respective single electronic patient record systems.
- Provide an improved experience for service users experiencing crisis.
- Participate in Recovery House Multi-Disciplinary Team (MDTs) meetings with the commissioning service, to discuss admissions, progress of crisis interventions and discharges.
- Comply with announced and unannounced Quality Assurance visits that will be undertaken by the Head Provider

Referrals in the Shared Staffing model

Referrals into the Service will be gate kept by the allocated clinical teams and screened by a senior clinician with involvement of the Sub-Contractor to assess suitability of the referral with consideration of the client group at the time. The referral process will include a co-produced crisis house support plan, between the service users and referrer, outlining the support needs and expectations of the admission. Referrals can be made 24/7 but agreements around arrival times will be jointly agreed which are in line with the best interest of the service user needs whilst balancing the needs of those already in the house

Clinical in reach in the Shared staffing model:

Both BSMHFT and FTB will provide additional clinical in reach and clinical staffing resources to support the successful Sub-Contractor and the crisis interventions available to service users accessing the Service. A brief overview of the clinical model has been provided below:

The clinical team will work closely with the Sub-Contractor to meet the needs of the service users admitted to the Service. In addition to the registered clinical lead, clinical input will be provided by the following who will work collaboratively with service users and the Sub-Contractor to reduce or resolve the crisis and facilitate discharge planning. The clinical team will comprise of:

- A Consultant Psychiatrist will be responsible for the medical input for service users' within the crisis house for the respective mental health services.
- Registered crisis pathway nurses facilitating and providing nursing led crisis interventions and 24/7 clinical input. One crisis pathway nurse will be available per shift.
- The clinical team will also provide support to the Sub-contractor with the delivery of a daily activity programme, they will lead and provide governance for the psychologically informed interventions.

There will be a 24/7 escalation process regarding clinical concerns which will be identified and escalated by the clinician based within the Recovery house.

3.3 Population covered

Individuals aged 18 years and over who are registered with BSOL GP practices.

3.4 Any acceptance and exclusion criteria and thresholds

Admissions criteria to Recovery House

The Service is intended to provide a step up or step down facility. Step down from inpatients may be considered for those requiring focused and supportive psychological interventions to support and enhance their discharge planning arrangements from an inpatient unit, where it has deemed clinically appropriate. Step up would be for those where the crisis would be viewed as "the moment when the typical activities of the service user's day breakdown" and this is impacting on their mental health, but not requiring an inpatient admission.

Users of the Service can have several admissions throughout the year to support crisis, prevent escalation as evidence indicates that for some service users, this can help to avoid hospital admission, where hospital treatment isn't required.

Service users will be required to sign a Recovery house agreement as part of the admission process centred around keeping themselves and others safe and engaging with the Recovery house team to achieve their expected outcomes.

Access to the Service will be available 24/7 and should not be a barrier to admission out of usual working hours.

The admission threshold outlines the Recovery House key remit in providing safe, effective and appropriate interventions. Before submitting a referral, the referring team will confirm that:

- Service users accessing the Service have capacity to consent to admission, adhere to the recovery house admission agreement and engage with the supportive crisis interventions available.
- Safe resolution and management of the crisis is assessed to be achievable within a defined period of time (maximum 7 nights) where the primary need for admission is in relation to an acute mental health concern and not a primary social care need.
- Treatment and interventions required within the crisis house will not include restraint or restrictive practices. Service users are required to agree to work with staff to maintain their safety and that of others.
- Service users haven't been deemed to be at high risk of suicide due to current suicidal intent or plans, following clinical assessment. Where the potential risk of self harm has been identified, safe management plans will be developed and supported by the psychology team.
- Where a service user has a dual diagnosis, their mental health support needs will be the primary reason for referral. Use of drugs or alcohol on site will not be permitted.
- Where known forensic history has been identified, associated risk has been considered and assessed on a case-by-case basis, where admission is deemed a safe and appropriate option.

- Service users have an address. Where housing concerns are present, this cannot be the primary reason for admission.

Exclusions:

- Service users with sole drug or alcohol issues will not be admitted solely for a detox.
- Recent history of significant violence and presentation of significant risk, which exceeds the thresholds of safe management within the crisis house.
- Service users with a significant current forensic history involving violence to others.
- Services users with a history of sexual offences.
- History of fire setting subject to risk assessment
- Admissions would not be accepted directly from the police or ambulance services.

The appropriateness of a service users' admission will be reassessed where their presentation or concerns arise that are beyond the threshold of the Service's remit. Following discussion and agreement with the respective clinical team, service users may be asked to leave the Service prematurely under the following circumstances:

- Presents significant risk of violence/aggression.
- Returns to the Recovery house intoxicated or under the influence of illicit substances.
- Uses illicit substances or drinks alcohol on the Recovery house premises.
- Non-concordance with the Recovery house agreement.

Where a service users' clinical presentation deteriorates beyond the threshold of the Recovery house, the process for urgent review and transfer to better accommodate their mental health support needs will be followed through a clear escalation process.

3.5 Interdependence with other services/providers

- Voluntary sector services
- Home Treatment
- Liaison Psychiatry
- General Practitioners and other members of the primary healthcare teams
- Adults Social Care
- Adult mental health services
- Young adult mental health services
- Substance misuse services
- Accident and emergency facilities in emergency departments
- Crisis Café

- Bed Management
- Place of Safety
- Psychiatric Decision Unit
- Urgent Care
- Mental Health Act Assessment
- AMHP Service

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

Borderline personality disorder: recognition and management. Clinical guideline [CG78]

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

Royal College of Psychiatry recognised as a pathway to support people in crisis.

4.3 Applicable local standards

Risk Assessment

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)

5.2 Applicable CQUIN goals (See Schedule 4D)

6. Location of Provider Premises

7. Individual Service User Placement

8. Applicable Personalised Care Requirements

8.1 Applicable requirements, by reference to Schedule 2M where appropriate