CareQuality Commission

Good 🟢

Bradford District Care Trust

Community-based crisis services

Quality Report

Bradford District Care Trust
New Mill
Victoria Road
Saltaire
Shipley
West Yorkshire
BD18 3LD
Tel: 01274 228300
Website: www.bdct.nhs.uk

Date of inspection visit: 17-19 June and 1 July 2014
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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
BDCT Headquarters, New MIll	TADHQ	Intensive home treatment team	BD20 6TA
BDCT Headquarters, New MIll	TADHQ	Intensive home treatment team	BD9 6DP
BDCT Headquarters, New MIll	TADHQ	A&E liaison at Bradford Royal Infirmary	BD9 6RJ
BDCT Headquarters, New MIll	TADHQ	A&E liaison at Airedale General Hospital	BD20 6TA

This report describes our judgement of the quality of care provided within this core service by Bradford District Care Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Where applicable, we have reported on each core service provided by Bradford District Care Trust and these are brought together to inform our overall judgement of Bradford District Care Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for Community-based crisis services	Good ●
Are Community-based crisis services safe?	Good ●
Are Community-based crisis services effective?	Good ●
Are Community-based crisis services caring?	Good ●
Are Community-based crisis services responsive?	Good ●
Are Community-based crisis services well-led?	Good ●

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

Bradford District Care Trust offers a range of crisis and home treatment services including: the intensive home treatment team (IHTT), A&E liaison service and single point of access team.

Crisis and home treatment services were safe. Staff understood and implemented safeguarding procedures well. The team routinely discussed caseloads and any associated risks, and these were also discussed more formally during handovers. IHTT had a traffic light system in operation, whereby staff could determine people's risks and needs quickly and at a glance. New information about risks was communicated effectively. In addition, the use of the RIO electronic records system made sure that key information was shared in real time with other teams involved in a person's care.

People's care and treatment was planned effectively and was recovery-focused. Assessments were comprehensive and took account of people's skills, as well as their areas of need. Care and treatment was also person-centred and people were involved in the development of their care plans. Teams were multidisciplinary and worked well together, and staff received training and supervision for ongoing professional development.

Staff treated people with dignity and respect. Care was delivered with kindness and compassion, and staff made sure that people were involved in all stages of their care,

treatment and support. Staff also listened to people's views and provided information clearly so that people could make informed decisions. The language used by staff was encouraging and demonstrated empathy.

Services were responsive to people's needs and had been developed in consultation with local people. People who used the service knew who to contact for support during the day and at night. Staff responded quickly to changes in need and, when needed, provided more visits. IHTT teams worked closely with community mental health teams and were involved with people before being admitted to hospital, during their stay in hospital and when planning and facilitating discharge back to the community. However, there was a risk that people might not receive the right care at the right time because A&E liaison was not a 24-hour service and IHTT could not provide face-to-face assessments out-of-hours as they only had one member of staff on duty throughout the district after 9pm seven days a week.

Crisis and home treatment services were well-led. Staff felt well supported by their managers and were consulted about the future direction of the trust. Staff and people who used the service were encouraged to get involved with service development. We also saw evidence of learning from incidents and responding to feedback. Staff understood the need for on going improvement of the service and this was achieved by regular audits and monitoring of quality.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Systems for safeguarding and reporting incidents were well established. Staff told us that they received feedback on reported incidents. We also saw that lessons from team, and wider trust, incidents were included in the agenda for monthly team meetings. All teams had access to the RIO electronic records system so staff could highlight any concerns about risk. The service used a red, amber green system to help staff identify risks to people and they used this information to plan their visits.

The personal safety of staff was also protected. Staff working alone 'checked in' with, or received a call from, other members of the team.

We saw on the RIO system that risk assessments and care plans were updated and reviewed.

Good ●

Are services effective?

Records for people under a Community Treatment Order (CTO) were comprehensive. We saw evidence that people were involved in their care and that the orders were reviewed by the multidisciplinary team.

We saw from records that people received a comprehensive assessment by medical and nursing staff on initial contact. Physical health monitoring was also routinely monitored as part of people's care.

People were offered a good range of evidence-based psychological therapies and were regularly asked for feedback on the services. People were complimentary about the teams and valued the service they received. The team manager monitored caseloads and the team's capacity through regular team meetings and monthly supervision. Staff received appropriate inductions, supervision and appraisals.

Good ●

Are services caring?

People told us they were treated with dignity and respect. We found that clinicians were skilled and knowledgeable, and that staff used language that was compassionate, clear and simple. People who used the services had access to appropriate literature and information. Staff also supported people with social and domestic issues, and supported carers.

Good ●

Are services responsive to people's needs?

Services had been developed in consultation with local people. People knew how to access help out-of-hours. Those in need of

Good ●

Summary of findings

urgent assessment out-of-hours were told to use A&E services or contact charitable or third sector services. If people attended A&E they were assessed by the psychiatric liaison team and referred to other services.

We observed teams working well together and saw many examples of good working relationships. Teams would routinely liaise with the crisis team about people they were particularly concerned about. They also made sure that this information was readily available should they receive contact from them out-of-hours.

We found evidence of trust wide learning from complaints and incidents.

Are services well-led?

Good ●

Staff were dedicated and felt well supported by their managers. Some staff told us that they had attended the 'listening into action forum'. They also had access to the minutes of management meetings on the intranet. We saw evidence on the intranet that staff were consulted about the trust's future plans.

The trust's internet was updated as plans changed. Staff had a broad understanding of the changes that had been introduced in the organisation, and people using the service were regularly asked for their comments and opinions about the service.

Staff were up-to-date with mandatory training, which monitored regularly. Staff also used a variety of supervision available to them on a regular basis. Staff were knowledgeable about how to access advocacy services for people.

There was a trust-wide risk register in place to oversee and identify risks to the trust, staff and people using services. We saw that local audits of records were completed for the care programme approach (CPA), which staff said managers were able to monitor electronically.

Summary of findings

Background to the service

Intensive home treatment team (IHTT)

IHTTs offer a 24-hour service, seven days a week for people who are acutely unwell and require significant support. Teams consist of health and social care professionals who aim to provide care and support close to where people live, and to prevent admission to hospital where possible. The teams can support people following admission to hospital and will work with individuals to make sure that their stay in hospital is as short as possible. Where possible, IHTT's will also support people when they are discharged from hospital. The two IHTTs of Bradford District Care Trust cover the city and south and west areas of Bradford, as well as north Bradford, Airedale and Craven.

A&E liaison

The A&E liaison teams are based in the accident and emergency (A&E) departments at Airedale General Hospital and Bradford Royal Infirmary. People are assessed by a psychiatric liaison nurse or other mental health professional, and referred or signposted to a relevant service. Psychiatric liaison nurses are available seven days a week between 9am and 5pm at Airedale General Hospital. A temporary initiative running from Jan 2014 to March 2015 extends provision until 2am seven days a week. Psychiatric liaison nurses are available seven days a week between 7.00am and 3.00am at Bradford Royal Infirmary. At all other times, A&E staff are able to make a referral to other services, where appropriate.

Single point of access team

The team triages all referrals from primary care, GP's primarily to adult, older adult, youth services and addictions. The team screens, records and then triages referrals to the appropriate team using similar criteria for similar services, for example adult community mental health teams.

Our inspection team

Our inspection team was led by:

Chair: Angela Greatley, Chair, The Tavistock and Portman NHS Foundation Trust

Team Leader: Jenny Wilkes, Head of Inspection – Hopsitals Directorate (Mental Health), Care Quality Commission (CQC)

The team included CQC inspectors and a variety of specialists: a social worker, occupational therapists, an independent Mental Health Act advocate and a senior nurse.

Why we carried out this inspection

We inspected this core service as part of our Wave 2 pilot mental health inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We visited the crisis and home treatment services of Bradford District Care Trust on 17, 18 and 19 June 2014. Before visiting, we reviewed a range of information we hold about the core service and asked other

Summary of findings

organisations to share what they knew. We held listening events with people that use services at the Lynfield and Airedale sites and undertook site visits to the team bases. We also carried out an unannounced inspection of the accident and emergency (A&E) liaison service at Bradford Royal Infirmary on 1 July 2014. During the visits we held focus groups with a range of staff, including nurses, doctors and therapists. We observed how people were being supported and reviewed the care and treatment records of people who used the services. We also met and spoke with people who used the services and they shared their views and experiences.

We reviewed and inspected the community services being provided. We visited two intensive home treatment teams (IHTT) and the A&E psychiatric liaison team at Bradford Royal Infirmary. We also visited the 'single point of access team' for mental health. As this team had only been in operation for three months, it was too early for us to provide a rating for this service.

In addition, we visited the IHTT at the Airedale Centre for Mental Health and Lynfield Mount Hospital. Health

What people who use the provider's services say

We held listening events before the inspection and people told us that the support they received from the intensive home treatment team (IHTT) was good. However, some people commented that they sometimes felt they received limited support when they were in crisis. For example, visits from an IHTT member was only for a limited time period, such as 15-minute visits.

People told us that they were involved in the planning and treatment of their care and that they could consent to their care and treatment, as well as discuss and agree treatment options with medical staff. The people we spoke with were very positive about the services they received and described staff as 'professional', 'friendly', 'caring' and, 'compassionate'. We also saw examples of how people and their carers were consulted about their care and treatment and how outcomes of surveys about the services were used to inform staff about the standards of service they provided.

Good practice

- The trust provided on going training for staff in psychological therapy.
- There were non-medical prescribing leads for assessment and treatment.

- Safeguarding practices were safe and staff were knowledgeable about appropriate safeguarding referrals.
- The lone worker policy was followed, which helped to keep staff safe when visiting in the community.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should continue to work with commissioners of services to make sure appropriate services are available to people 24 hours a day. The A&E psychiatric liaison teams did not operate a 24-hour service, and at Bradford Royal Infirmary there were no separate facilities to assess people in private. The out-of-hours crisis services based at Lynfield Mount and Airedale

Centre for Mental Health only had one person on duty, so were not able to provide face-to-face assessments. This meant people were diverted to A&E departments or third sector providers, such as the Samaritans.

- The trust should continue to liaise with managers of the acute hospitals to secure an appropriate environment for mental health assessments in each A&E department.

Summary of findings

- The trust should continue to make sure that the impact of major service redesign, including the development of the single point of access and administrative hubs, is properly monitored and managed to make sure that the service continues to deliver caring and responsive care.

![Care Quality Commission logo]

Bradford District Care Trust

Community-based crisis services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Intensive Home Treatment Team	Airedale Centre for Mental Health
Intensive Home Treatment Team	Lynfield Mount Hospital
A&E Liaison at Bradford Royal Infirmary	Trust Headquarters
A&E Liaison at Airedale General Hospital	Trust Headquarters

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the provider.

We did not monitor responsibilities under the Mental Health Act 1983 at these locations, however we examined the trust's responsibilities under the Mental Health Act at other locations and we have reported this within the overall trust report.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were also aware of their responsibilities under the Mental Capacity Act (2005) and were able to demonstrate through some of the treatment records reviewed. This was evidence by how they recognised, responded and raised issues about mental capacity.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Systems for safeguarding and reporting incidents were well established. Staff told us that they received feedback on reported incidents. We also saw that lessons from team, and wider trust, incidents were included in the agenda for monthly team meetings. All teams had access to the RIO electronic records system so staff could highlight any concerns about risk. The service used a red, amber green system to help staff identify risks to people and they used this information to plan their visits.

The personal safety of staff was also protected. Staff working alone 'checked in' with, or received a call from, other members of the team.

We saw on the RIO system that risk assessments and care plans were updated and reviewed

Our findings

Track record on safety

Staff were trained in safeguarding vulnerable adults and children. Staff we spoke with were knowledgeable about their responsibilities in regards to the safeguarding process. They described the process for referring any identified potential or actual concerns to the relevant department. The trust policies and procedures were accessible on the trust's own intranet site, but the corporate policies dated from 2012 and had not been reviewed in 2013 as per the policy timescale for revision. Staff gave examples of the type of safeguarding concerns they would report and described the process for completing this. They told us concerns were discussed with line managers where appropriate in the first instance. Safeguarding referrals were made to Bradford City Council. Social workers formed part of the multidisciplinary team and so were able to provide advice and guidance on safeguarding matters.

Staff confirmed that the trust had an on-line reporting system to report and record incidents and near misses. We saw that staff had access to this system via 'password' protected computers. The trust wide evidence provided

showed us that the trust was reporting concerns through the National Reporting and Learning System (NRLS). The levels of reporting were within expectations for a trust of this size.

Learning from incidents and improving safety standards

The trust's serious incident data showed us that trust wide learning from serious incidents had been reviewed by the governance team and shared throughout the trust. Staff confirmed this and reported that the lessons learnt from these incidents had been discussed within their specific team. For example, we saw copies of the trust's online safety alerts. This provided information and guidance for staff to follow. Most members of staff spoken with were aware of the safety alerts and we were told they were discussed at larger team meetings. The evidence reviewed demonstrated the trust had embedded learning from incidents within the organisation.

Staff confirmed they had received risk assessment training and told us that they felt well supported by their line manager following any safety incidents. We saw the use of RIO was outstanding and staff used this system to update risk assessments and risk profiles of people on a daily basis.

Staff told us they used the trust's electronic incident reporting system (EIR) for reporting any incidents, concerns or near misses. Feedback from serious untoward incidents was fed back to the individuals involved and wider trust incidents distributed by email globally. Lessons learnt from incidents relating to the team, and wider across the trust, were included in the agenda for monthly team meetings. Managers told us action plans were developed from investigations and lessons learnt. These were circulated globally, with feedback given to specific teams. Staff told us they were supported and debriefed by their manager following any incidents that occurred when they felt unsafe. Managers were described as supportive.

The psychiatric liaison service team were well aware of the serious incident reporting process and learning outcomes from this. Incidents were reported both through the

Are services safe?
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Bradford District Care Trust and Bradford Royal Infirmary incident reporting systems. Incident reporting and lessons learnt were shared among the three trusts providing and hosting the psychiatric liaison services.

In the 'single point of access' service every person was initially triaged by the call handling staff and then passed to the individual duty workers. Duty workers could then either divert people or tasks to the local community mental health duty teams or refer to individual services. Following the continuous monitoring of the service, following 'teething problems', pathways had been developed and introduced for staff to refer people to other services within the trust. When the service was initially set up we saw the system for processing referrals had been inconsistent and led to a small number of referrals being delayed in reaching services. This was brought to the attention of the trust and CQC during our visit. We looked into the concerns about the service and spoke with the administration and development manager as well as call handling and duty staff. We saw the administration manager had developed guidance for staff and duty officers on managing the systems. We spoke to the development manager and saw that measures to improve the referral system had been put in place. This included an advanced nurse practitioner to support duty officers as well as additional staff to support the primary care staff in the team. We also spoke to staff about the model introduced for the single point of access team. Staff were aware that the development manager was visiting another trust to look at their single point of access service. The aim was to look at and learn from a well-established single point of access service.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse
We saw there was information displayed in the team facilities onsite about the trust's safeguarding adult's policy. We also saw the online safeguarding policy and procedure and patient safeguarding information leaflets. This meant that patients and staff had been given the required guidance in order to support them to raise concerns when these were identified. Agency staff told us they had an induction and this included safeguarding adults and children training. We saw the team used the acute mental health care induction format and this included training and reading the policies and procedures for safeguarding.

Staff were aware of the trust's safeguarding and other polices. They told us that they knew how to raise any safeguarding concerns. This was demonstrated in some of the individual treatment records we reviewed. These showed us that risk assessments had been completed and identified if people were at risk of exploitation or were vulnerable due to their mental health needs. Staff were also aware of their responsibilities under the Mental Capacity Act (2005) and were able to demonstrate, through some of the treatment records reviewed, how they recognised, responded and raised issues about mental capacity.

Staff were aware of the trust's whistleblowing policy and confirmed that they felt able to raise concerns with their direct line manager. We saw direct evidence of staff raising concerns about the referral system for the single point of access team.

We saw that medication was appropriately and securely stored. Medicines management was seen to be effective with audits undertaken by pharmacy. We found there was a suitable medicines management system in place for the receipt, storage, administration and recording of medication. However, on one occasion we saw that medication taken to be delivered to a person that was not at home was left in the vehicle of a staff member and not signed back in and stored securely.

There was a lone working policy and procedure in place. We saw the paper system in place which allowed the facility to highlight where people presented an identified risk to staff safety. We saw 'whereabouts' sheets were completed when were out of office and the duty worker was responsible for ensuring those out had returned safely.

Records management was electronic and used the RIO system. The staff said they had good access to patient information and could record a detailed picture and background of individual risks to staff. We saw that care plans and risk assessments were generally completed within 48 hours of referral to the teams.

Assessing and monitoring safety and risk
We observed handovers and sat in on two team handover meetings during our visit to the teams. These appeared well planned and organised. Each person currently receiving care was discussed, with increased time being given to those who were assessed as having higher risks, including any new referrals for follow up. Appropriate sharing of information to ensure continuity and safety of

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

care was observed. On receipt of a referral people were seen and assessed within 24 to 72 hours. Referrals were accepted by the recently formed single point of access team, community mental health teams, inpatient services, accident and emergency and GP. During our visits to three people using the crisis services we saw staff discussed individual safety plans with people and how they could use these to increase safety as well as to lessen their distress. We saw that staff offered to increase the frequency of visits in response to risk indicators when talking to people about their care. We observed an assessment by IHTT and the family member raised concerns about their relative being allowed to walk out of the A&E department by A&E staff when their relative was a risk to themselves. The concerns were not about the psychiatric liaison team staff but the A&E staff. As a result an urgent referral had been made to the intensive home treatment team. The relative was advised to complain to the relevant trust.

We reviewed six electronic records overall. Safeguarding and abuse issues were considered within the assessment document. We saw that staff joint worked with other agencies and across services to promote safety. Caseloads and capacity were monitored by the team manager through daily and weekly meetings as well as monthly supervision. These sessions included discussion about referrals, discharges and levels of risk, as well as establishing capacity for new referrals.

A&E psychiatric liaison team
The teams based at Bradford Royal and Airedale General Hospitals did not provide a 24-hour service. However, the Airedale site was able to provide this service temporarily due to winter pressure funding until the end of June 2014 and has since been extended to March 2015. The staff on duty at Bradford Royal Infirmary demonstrated that they were able to assess the risk of patients and refer them to other services if necessary. If patients could not be assessed because they were under the influence of drugs or alcohol they had to wait until they could be assessed unless an assessment under the Mental Health Act (MHA) 1983 was required. Staff were able to stay with patients if there was a risk identified. The staff had access to RIO and System 1 so could access information about, or put referrals onto, these systems as well as update them in real time. A system had been put in place that informed the GP by fax of people presenting at A&E. If required the police were informed about individual concerns and carried out a welfare check on the individual.

Understanding and management of foreseeable risks
Electronic records seen showed us that people who had recently been assessed by the single point of access team had an initial risk assessment completed over the telephone to determine which service they would be directed to and the level of risk determined how quickly they could access services. We saw that referrals to IHTT were seen within 24 to 72 hours.

Assessments we reviewed included assessments of the person's physical health needs as well as an assessment of and the risk to themselves or others where appropriate. Evidence was seen of the active involvement of the person in assessing risks for themselves in partnership with staff.

We saw good examples of risk assessments and subsequent care plans linked to those Community Treatment Orders (CTO) reviewed during our inspection.

Are services effective?

Good ●

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

Records for people under a Community Treatment Order (CTO) were comprehensive. We saw evidence that people were involved in their care and that the orders were reviewed by the multidisciplinary team.

We saw from records that people received a comprehensive assessment by medical and nursing staff on initial contact. Physical health monitoring was also routinely monitored as part of people's care.

People were offered a good range of evidence-based psychological therapies and were regularly asked for feedback on the services. People were complimentary about the teams and valued the service they received. The team manager monitored caseloads and the team's capacity through regular team meetings and monthly supervision. Staff received appropriate inductions, supervision and appraisals.

Our findings

Assessment and delivery of care and treatment

We looked at records and saw that care plans were outcome based and reflected progress in achieving aims in a recovery based model of care. Progress notes linked to the care plan in place. Records we were shown were person-centred and demonstrated people's involvement. People told us they were aware of their care plans and they had been involved in their reviews. During our visits to people we saw that they were involved in their assessment and care planning. We also observed staff taking calls from people that used the service. We observed that staff asked people about their care and treatment and used plain language to explain medical terminology and discussed treatment and support options with people.

We saw good evidence of comprehensive assessment by medical and nursing staff on initial contact and they covered all aspects of care as part of a holistic assessment.

We heard that new patients were seen within a four hour assessment target and known patients were seen within 24 hours. Teams offered a good range of evidence based psychological therapy and we heard that psychological services aimed to see patients within ten days of referral. Patients told us that they had benefitted from

psychological therapies and understood the treatment contract about engaging in psychological therapy. One person commented that, "CBT (talking therapy) had helped reduce the anxiety. I'm definitely seeing things are better".

Staff were able to discuss issues around consent and capacity and how to undertake or organise an assessment for people as necessary. Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were part of the mandatory training program.

In the single point of access service every person was initially triaged by the call handling staff and then passed to the individual duty workers. Duty workers could then either divert people or tasks to the local community mental health duty teams or refer to individual services. Assessment was not face-to-face by the single point of access team, but referrals to crisis services were in real time and could be responded to quickly. The duty system in the single point of access team is being changed to duty workers picking up calls from the different geographical areas of Bradford Community trust and completing the assessment on RIO. This means the duty team will deal with all incoming referrals and not just those linked to their respective geographical area. A dedicated duty team is being planned so there is more consistency around the assessment and referral system. RIO also links to System 1 used by primary care, so information can be passed between the systems. Faxed referrals from GPs were scanned and uploaded into the systems so staff could access the referral documents.

The A&E psychiatric liaison team was based in Airedale and Bradford district hospitals. The mental health trust provided the staff. This was not a 24-hour service. The team consisted of band six and seven nurses. There was also on-call medical cover with a doctor able to attend for mental health assessment. Staff were able to show us the recent referrals and assessments completed by the team. We saw that people were assessed as quickly as possible and team endeavoured to see people within the four hour casualty waiting time. Assessment documents demonstrated that staff completed a thorough personal history. This included recent social, family and health information, as well as contributing factors to the crisis. Detailed information was taken about past contact with mental health services and this included any previous psychiatric history. People could

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

not be appropriately assessed until they had the capacity to understand the assessment process. This meant that the assessment process could be delayed due to the influence of alcohol or drug use.

Outcomes for people using services

We saw monthly audit tools had been introduced to monitor case management, health and safety and records which was fed into the trust system. Feedback about performance was shared with managers for their action. Staff reported that whilst this system had increased time spent on administration, it has promoted more regular review of their caseloads and meant that people were being referred on to other teams or discharged where appropriate in consultation with the consultant psychiatrist.

Once people had been assessed in A&E they would be offered on going support via the community mental health teams or discharged with appropriate advice. If it had been determined they were not at risk they could leave A&E providing the relevant referral information and advice had been given to them. For example, if an individual presented under the influence of alcohol they were advised not to drive. Information about charitable and third sector services was provided if people wanted to access non NHS services. If medication was prescribed this was obtained from the pharmacy prior to the person leaving. Assessment and referral information was then faxed to the GP and the electronic systems updated.

Staff, equipment and facilities

Staff told us they were supported to undertake training outside of mandatory training. We saw a robust supervision process in place. Staff received management supervision monthly. Performance issues and caseload capacity were embedded in this process. This included specialist supervision, for Approved Mental Health Professionals (AMHP) and non-medical prescribers. Senior medical staff told us they had regular organised peer group supervision.

Teams we visited had daily or twice daily handover meetings, weekly clinical meeting for case discussion and also a monthly team meeting for more team related issues, which included information sharing. Community staff had alcohol gel available to them as part of the infection control policy when visiting people in the community.

In the single point of access team we saw that the team were provided with cover and recruitment was on going,

with plans to expand the number of call handling staff. The administration manager demonstrated how they were improving the telephone system in use so call handlers were able to hold taking calls until they had completed the administration and recording process. This meant that information was recorded in real time and up-to-date.

The A&E psychiatric liaison team staff told us that training had not been an issue for them and they had to complete their mandatory and role specific training. We saw the electronic recording systems in place to prompt, monitor and track staff training. Training was monitored at both team and service level. Staff demonstrated how they recorded their own learning logs on the electronic staff record (ESR) and how this information was collated and shared with the manager. The team manager told us they had arranged for clinical supervision for the team with band seven or advanced nurse practitioners. The manager confirmed they had managerial supervision with their line manager every six weeks and for team members approximately every eight weeks. Staff told us that informal peer support was available as the manager had an open door policy.

Staff told us that they had received induction and training to prepare them for their role and were supported by their line manager. Each member of staff spoken with told us that they received supervision and annual appraisals from their line manager as required. This meant that staff received the appropriate levels of support from their immediate manager.

Staff confirmed that systems were in place to monitor staff sickness and that they had access to occupational health support. Most staff told us that they felt well supported by their line manager

Multi-disciplinary working

Information on patients subject to the care programme approach (CPA) was shared on the electronic system which both health and social work staff could access. We saw that RIO and System 1 was accessible and used to record all relevant information. For example, if the crisis teams had a concern about risk this was flagged electronically with other teams involved in that persons care. These systems were well used by staff to provide information to and for other teams. We sat in on a multidisciplinary team meeting and saw the different professions worked well together and contributed toward person centred care.

Are services effective?

Good ●

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Staff told us in all the teams we visited that capacity to meet demand was challenging but there was good team support from more senior nurses and managers. In all teams we visited staff described positive relationships with other services. This meant that a multidisciplinary approach to care and treatment was optimal. Multidisciplinary teams were made up of, or had input from, occupational therapists, nurses, social workers and medical staff. A good relationship was reported between the crisis teams and other mental health services.

The A&E psychiatric liaison team said they worked with the intensive home treatment team who were the gatekeepers to inpatient beds. The psychiatric liaison team could refer directly to intensive home treatment, assertive outreach, community mental health, early intervention and psychosis and inpatient beds as well as requesting MHA assessments. This meant that inpatient beds were allocated dependent upon need and the crisis services could support people as an alternative to hospitalisation if appropriate. The team at Bradford Royal Infirmary said that when capacity increased they could get support from the intensive home treatment team's staff.

In the single point of access team we saw that people could not access the site and there was no walk in service. This service opened three months ago. The staff we spoke with were very positive about the service but had found the initial operational period difficult due to the evolving systems and processes within the service. The

development manager told us that the local clinical commissioning group had agreed additional funding to provide a band 7 advanced nurse practitioner to be attached to the service as well as the development lead. This meant that the initial service development issues had been recognised and improved systems put in place to create more fluid multidisciplinary inter-team working.

The development manager said the main concern about multidisciplinary working was that duty workers were not consistently provided so as systems changed staff did not keep pace. Comments from duty workers were that there was no training on the systems prior to the single point of access team being introduced, but said there were improvements being put into place.

Mental Health Act (MHA)
We did not fully monitor responsibilities under the MHA at these locations, however we examined the trust's responsibilities under the MHA at other locations and we have reported this within the overall trust report.

We saw information about the MHA was available in areas that people accessed. We saw this was made available in different languages and an interpreter service was available to people.

Records we looked at for people under a Community Treatment Order (CTO) were comprehensive with evidence of people's involvement and multi-disciplinary review

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary of findings

People told us they were treated with dignity and respect. We found that clinicians were skilled and knowledgeable, and that staff used language that was compassionate, clear and simple. People who used the services had access to appropriate literature and information. Staff also supported people with social and domestic issues, and supported carers.

Our findings

Kindness, dignity and respect

We spoke with three people using services and two carers. They were very complimentary about the care and treatment they received. However, one person told us, "It took them ages for them to get here after I telephoned; it took them at least twenty minutes".

We saw staff were compassionate, warm, friendly, positive and engaging with people. People did not visit the office base and were seen at home. We managed to speak with people who we visited with the intensive home treatment team.

We observed an assessment and reviewed notes. We found that cultural needs were included and staff considered cultural or personal preferences as part of the assessment. There was a good mix of staff from different cultural backgrounds which reflected the ethnic and cultural diversity of the local communities.

The environment of the bay designated for mental health assessment at Bradford Royal Infirmary offered little privacy and dignity as it was curtained on one side with bays either side. It was inappropriate to carry out MHA assessments which occur on a relatively regular basis. People could be cared for in that room for up to eight hours (and beyond) while waiting for a bed or MHA assessment

and it was not appropriate for the reception of people in mental distress. The trust are reliant on the acute hospital for the availability of premises and rooms within the A&E department and we were told that there was no other area that could be utilised on a permanent basis although a private room could be found on request.

People using services involvement

People we spoke with understood about their medication and were happy to talk to staff about side-effects as well as any benefits. People demonstrated an understanding about their mental illness and the role of medication as one part of their holistic treatment.

Staff were clear about how to secure advocacy services for people. If people needed long term support from an advocate staff told us they could refer them to the advocacy service. People told us the social care staff working within teams had supported them to access services and act as advocates when necessary. We saw evidence of appropriate literature and information being routinely provided to people throughout their treatment and we saw that carers were also offered an assessment and provided with information about services available to them and their family members. These were available as necessary in a variety of accessible formats. People told us that written information was available about other services.

Emotional support for care and treatment

We met and spoke with three people and two carers who used the intensive home treatment teams. Staff we met with told us that people's carers were involved in their assessment and care planning, which we saw during our visits to people. In all the care plans we sampled there was evidence that carer's were involved where possible. This was balanced with a person's right to choose who was consulted with about their care and treatment.

The carer of a person using the home treatment team told us, "They have been here for me."

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Good ●

Summary of findings

Services had been developed in consultation with local people. People knew how to access help out-of-hours. Those in need of urgent assessment out-of-hours were told to use A&E services or contact charitable or third sector services. If people attended A&E they were assessed by the psychiatric liaison team and referred to other services.

We observed teams working well together and saw many examples of good working relationships. Teams would routinely liaise with the crisis team about people they were particularly concerned about. They also made sure that this information was readily available should they receive contact from them out-of-hours.

We found evidence of trust wide learning from complaints and incidents.

Our findings

Planning and delivering services

The intensive home treatment team was accessed by referral from general practice via the community mental health team (CMHT) duty system during normal working hours or single point of access. Otherwise, through out-of-hours services, other primary care health professionals, secondary care inpatient, police stations and A&E departments.

The home treatment teams were able to provide telephone support and in a crisis assess people and request assessment under the MHA. Community mental health teams could alert the intensive home treatment and bed management teams of any pending crisis when people accessed a range of services. This meant that appropriate systems to share information with other services were established.

Staff informed us that people needing an inpatient bed had to access this through the intensive home treatment teams.

Right care at the right time

We saw that following referral people were seen by the intensive home treatment team within 4 hours for new patients or 24 hours for known patients. We saw that

people were offered access to psychological therapies within 10 working days and that people were referred to other teams when the 'crisis' phase had passed or as appropriate for further support. People were not kept on the team's caseloads and staff worked within NICE (National Institute for Health and Care Excellence) guidance.

The single point of access team was based at the Airedale and Lynfield Mount hospital sites and offered a telephone referral service for the whole trust to which GPs referred to. There were no medical staff in the team. Call handlers took the initial contact and passed the referral to the duty officers. Duty officers also took referrals from primary care. Duty officers completed the referral process and passed less priority work to the duty teams based in the community mental health teams. The team operated Monday to Friday 8am to 5pm.

A non-medical prescriber assessment was being further developed as part of the service. Crisis teams had non-medical prescriber nurses based with them. We spoke with non-medical prescribing staff and reviewed a treatment plan. Staff told us this role was functioning well.

During the unannounced visit we case tracked some of the recent breaches of the four-hour waiting rule in A&E. We saw that there were at times delays in referring to A&E liaison but this was usually accounted for or reported as the person receiving urgent medical attention, recovering from physical health issues or as intoxicated. The A&E liaison service was as responsive as they could be when normally only one person was on duty. We saw that A&E liaison saw people within short periods of time once they were referred during the core hours of when a service was provided.

However, there were spikes in demand. For example on a morning before the inspection, there were seven people referred to A&E liaison. Some of these referrals related to people who had not been able to access a service due to the gap in provision throughout the night – although some of these referrals were from the wards rather than the A&E. These referrals were prioritised but it still meant that there was a delay in seeing everybody who was referred.

Care Pathway

Staff told us that all members of the team were valued and respected regardless of discipline or level of seniority. We saw how team members worked collaboratively and well

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Good ●

together. Transfer of care between teams was said to be faster as community mental health and assertive outreach staff were located in the same offices in some areas and this helped speed up transfers to these teams. Staff told us that since the case management system was introduced consultant caseloads had been reviewed and reduced. This had created a more fluid system and capacity in the community mental health teams had increased, with waiting times to access these services reduced. Case management monitoring had been introduced into teams so managers could monitor that people were accessing the relevant care pathway and being referred to other services or discharged within appropriate timescales.

Staff were clear about the lines of accountability and who to escalate any concerns to. Staff were able to describe the other services involved in people's care pathways and how the intensive home treatment and A&E services worked with other services.

The intensive home treatment teams were involved with people prior to their discharge from inpatient wards and with people requiring intensive home treatment follow up. Staff from the respective teams linked into inpatient multi-disciplinary and discharge planning meetings. This meant people's transition back into the community was well coordinated and not unnecessarily delayed.

Within teams initial triage was undertaken with people being referred either by phone or face-to-face to agree upon the immediate plan of care and level of contact. This had a degree of flexibility and was subject to change in consultation with people. This meant teams we visited operated with a degree of flexibility to meet patient needs.

The single point of access and A&E psychiatric liaison staff said they worked toward ensuring the patients care

pathway to other services was smooth. However, these services were not available 24 hours. A&E psychiatric liaison service at Bradford Royal Infirmary and at Airedale General Hospital did not operate 24 hours a day. At Airedale District General Hospital commissioners had extended the opening hours of the service, but this was due to end in March 2015. We spoke with the modern matron and service manager for Airedale and Bradford hospitals. They told us that the psychiatric liaison team was responsive to patients needs and saw patients as soon as was possible. They said the staff from the respective teams would assess patients on inpatient acute medical wards as well as A&E. They said they valued the staff and teams responsiveness and hoped that the teams could increase and offer longer hours so they could respond over a 24-hour period on a permanent basis.

Learning from concerns and complaints

Staff were aware of the trust's complaints policy. Complaints were received directly and passed to the team manager or from the patient advice and liaison service (PALS). Staff told us that complaints were referred to the PALS service and they did not get involved in individual complaints. Advocacy services could also be accessed if patient's required support with making or during a complaint.

Evidence of trust-wide learning from complaints and incidents was demonstrated through the team manager sharing with staff and globally through updates via the trust email and intranet system. This information was included and discussed in monthly team meetings. Staff told us they were not always informed of the outcome of the complaints made at team level.

Are services well-led?

Good 🟢

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

Staff were dedicated and felt well supported by their managers. Some staff told us that they had attended the 'listening into action forum'. They also had access to the minutes of management meetings on the intranet. We saw evidence on the intranet that staff were consulted about the trust's future plans.

The trust's internet was updated as plans changed. Staff had a broad understanding of the changes that had been introduced in the organisation, and people using the service were regularly asked for their comments and opinions about the service.

Staff were up-to-date with mandatory training, which monitored regularly. Staff also used a variety of supervision available to them on a regular basis. Staff were knowledgeable about how to access advocacy services for people.

There was a trust-wide risk register in place to oversee and identify risks to the trust, staff and people using services. We saw that local audits of records were completed for the care programme approach (CPA), which staff said managers were able to monitor electronically.

Our findings

Vision and strategy

Most of the staff we spoke with told us they felt well supported by their managers. They all spoke positively about their role and demonstrated their dedication to providing quality patient care. They told us that team managers and the board engaged with them, provided information and consulted with them in a variety of formats. Key messages about the trust were communicated to team managers by senior management and this was then shared with the team.

We ran a number of focus groups as part of the inspection and spoke to a wide number of staff groups. Staff reported that management at team level was good and they felt supported. However, a number of staff complained that whilst they were aware of the trust's vision and values, they felt disconnected from the process of change and that

issues fed back through the consultation process were not listened to. Team managers commented that they were supported by their managers but they may not appreciate the impact that changes had on staff.

Responsible governance

Staff told us that they felt well supported by their line manager. Staff told us that they received clinical, managerial and group supervision as required. Staff attended monthly team meetings. The trust vision was cascaded through the intranet 'Connect' and update emails. Staff were aware of the 'culture' conversations but not many had participated in them as they said they did not always have the time to do so.

Staff told us team meetings were good for feedback in regard to audits undertaken. The team meeting we observed shared relevant information about people the team were supporting as well as trust business.

We saw evidence of how the trust monitored serious untoward incidents within specific services. For example we saw a report on figures for the last six months on serious untoward incidents and deaths. There was some evidence that the trust was using the incidents as a learning experience. For example, when they had not been given sufficient evidence about people risks or criminal or forensic histories.

In relation to the A&E liaison services, there were limited joint arrangements with the acute trust to consider the quality of clinical care, monitoring of quality and governance arrangements of the A&E liaison services other than the A&E breaches and local quantitative data that the A&E liaison sent to their managers. There were manager to manager meetings taking place. The acute trust monitored information and data on A&E breaches including where the breach was attributable to Bradford District Care Trust including performance within and outside the four-hour breach and performance against any locally agreed targets. This showed that there had been 48 breaches in the last six months attributable to mental health delays which for overall breaches within A&E related to a small proportion.

From April 2014, where the breach was over eight hours there was a root cause analysis undertaken. We were told that there has only been one such incident since April where mental health was concerned. This related to delays in waiting for an out-of-hours mental health assessment.

Are services well-led?

Good ●

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

The two trusts contributed to the root cause analysis which provided a full description of why the breach had occurred but limited detail about what could be done to prevent a reoccurrence.

Monthly monitoring of records were submitted to the governance team by managers. They received reports to monitor their performance. Audits of records we saw were in-depth in regard to outcomes for people contained in care plans and progress notes. Staff attendance on training was monitored by managers and we saw evidence of high attendance rates for staff training. Training data was seen and this was updated and shared with staff. Staff reported that their individual electronic staff records for training were inaccurate at times. We were told by managers that when the system was introduced there was an IT error and that this had now been fixed. At the time of the error information uploaded by staff was not always recorded. Staff reported that sickness and absence was monitored and we saw information from the trust that long term sickness absence was higher for a period of time but was improving.

Leadership and culture

We saw a supportive culture within teams. Staff had a broad understanding of the current and future need of the organisation. We saw that staff were passionate about their work and showed a genuine compassion for people. Staff told us that the chief executive had visited their teams and engaged with staff.

Engagement

People were asked about their views of the service, for example in the use of satisfaction surveys which related specifically to the team that cared for them. These asked them to rate the quality of the staff that supported them. Teams also provided people with surveys about the service they had received and we saw evidence of the results of surveys in staff offices. There was a high satisfaction rate from people using the service. This meant the trust actively sought people's opinion and participation in improving service delivery. Staff were knowledgeable about how to access advocacy services for people.

Performance improvement

Staff understood their aims and objectives in regard to performance and learning. Staff told us they valued the supervision they received and that it was "supportive". We saw that service developments were being monitored for risks, efficacy and with consideration of local needs. We saw that monthly team meetings focussed on team objectives and direction particularly through the implementation of new ways of working as part of the quality audit feedback.