Domain 1: Commissioned or Provided Services	
Service: Intensive Home Treatment Team	
Owner / Dept Lead: Pete Garland (Clinical Manager); Liz Hawrylenko (Bradford IHTT Lead); Faye Pilling (Airedale IHTT Lead); Abi Larvin (EDI)	
Outcome 1A: Patients (service users) have required levels of access to the service	**Score: 2**

Evidence:
The Intensive Home Treatment Team provides an alternative to hospital admission managing risk and crisis. They support service users and their families in an intensive manner at the most acute phase of their journey through mental health services using a flexible and holistic approach, personalised and tailored to the individual. The Intensive Home Treatment Team (IHTT) – comprised of the Bradford and Airedale teams - hold approximately 870 appointments per month supporting adults who are experiencing severe mental illness. The team also works closely with and signposts to partner agencies and other NHS teams.

Referrals are made via an internal referral, such as via Community Mental Health Teams, First Response or the Acute Liaison Psychiatry Service (ALPS). Key to removing barriers to access for crisis services, including IHTT, is the First Response. Traditionally, people in mental health crisis would need to have been referred via their GP, Community Mental Health teams, or other healthcare professionals. However, the First Response phone line is available 24/7 and is open to anyone as self-referral who providing rapid clinical assessment, clinical intervention and sign-posting, alongside continued crisis intervention from IHTT. People experiencing mental health crisis' may be too unwell to seek support themselves, and therefore the service is also available to family and carers. Service users, their families and carers are able to use when required, as often as needed. While improving access, it has also reduced the numbers of people attending A and E, detentions under section 136 and reduced demand on police and ambulance services and has been highlighted as a national case study (Bradford First Response).

The BDCFT communications team have clear communication planning to promote the service both internally and externally, alongside the 111 Mental Health option. This includes cascading information to local partnerships, such as Healthy Minds and the Cellar Trust. Printed materials are also shared with GP surgeries and voluntary partners and the service is regularly promoted

on our social media channels and has a dedicated landing page on the Trust website. The team work in partnership with the Healthy Minds communication team to provide printed materials for the service at key events across the system. Awareness days, such as Time to Talk and World Mental Health Day, are used as opportunities to promote the service via social media and internal channels. The First Response team is also referenced in relevant mental health press releases.

The team recognise that a barrier to accessing IHTT is call volumes for First Response service, which is a key route into IHTT. Approximately 1 in 5 calls result in crisis intervention, with others being signposted to non-crisis services. It is hoped that by providing proactive signposting to non-crisis services alongside First Response communications will reduce the demand on the First Response service from those not in acute crisis, thereby enabling faster response times for First Response, resulting in better access to IHTT for those in crisis. BDCFT are working in partnership across the system to achieve this with Healthy Minds – a VCSE-delivered directory of mental health groups and services within Bradford District and Craven.

Referrals are an even split between male and female service users, however, females are slightly overrepresented within the number of successful appointments, which is in line with anecdotal reports from the IHTT that males may be less likely to engage with mental health services.

Breaking down referrals by ethnicity, the ethnic group of 12% of referrals is unknown. Black and Mixed groups are representative of the overall population, and this remained true when reviewing across ethnic subgroups. However, Asian ethnic groups are underrepresented within referrals (17.9% of referrals, compared with 29.0% of the Bradford and Craven population), Once referred, the number of successful appointments and discharges for Asian and Asian British service users is on par with referral numbers (17.8% of appointments, 18% of discharges). The lower referrals for Asian groups is mostly accounted for by underrepresentation of the Pakistani community (14.4% of referrals, 23.2% of the population).

65% of referrals experience high levels of deprivation (IMD level 1-3). Appointments and discharge numbers on par with referral numbers for those service users experiencing high deprivation. Analysis of the domains of deprivation demonstrated that the majority of the IHTT caseload live in areas which have high levels of crime, lower education levels and the local population experience higher levels of unemployment, health conditions and disabilities.

Religious makeup of the caseload is difficult to assess as religion is not recorded for almost 60% of referrals. The largest religious group are Christian (21.3%), followed by Muslim (10.6%).

Sexual orientation is similarly difficult to assess as sexual orientation is not recorded for 70% of referrals. Of those where sexual orientation is known 92% of referrals report identify as heterosexual with the remaining 8% described themselves as homosexual, gay, lesbian or bisexual.

Staff report that they feel service users have good levels of access and clearly articulate what barriers may prevent particular groups from accessing the service – including language barriers, cultural stigma, being unaware of services or having no fixed abode. Staff members felt that it's important to understand each individual's needs, visit them in their homes and, where appropriate, involve family and carers.

Outcome 1B: Individual patients (service users) health needs are met	**Score: 3**

Evidence:
Service users within IHTT have high acuity conditions and therefore the service focuses on ensuring patients are stabilised, kept safe, signposted and, if safe to do so, able to be treated at home and avoiding admission to hospital. Care planning is personalised to the patient. The team includes nurses, social workers, support workers, advance nurse practitioners, occupational therapists, psychotherapists and a consultant psychiatrist to provide multidisciplinary care for service users. Appointments are predominantly face to face (76.6%), with team members visiting service users in their own homes, with telephone contacts to supplement this. By offering assessment and home treatment as an alternative to hospital admission, this allows for service users to be in familiar surroundings, often with friends and family available to support with recovery. Recognising that suicide risk is high following discharge from inpatient mental health services, the IHTT also support those who are being discharged from hospital. The team use a RAG planner to ensures needs of service users are met. The board includes an overview of the caseload to support planning and what care everyone requires, with service users with the highest acuity being reviewed daily at huddles and receive daily visits.

Criteria for referral into IHTT is that hospital admission criteria are met, however, key to meeting service users' needs is being able to treat service users in their own homes where safe to do so. Analysis of the caseload outcome showed that 15% of caseload are admitted to hospital, demonstrating a reduction in acuity and avoidance of admission for 85% of the caseload. Following IHTT care, service users are referred to CMHT and/or VCSE organisations for ongoing care.

The team also recognise that some individuals may feel more comfortable with VCSE-led support rather than ongoing care via BDCFT. Where appropriate and personalised to the service user, the team refer individuals into these services, such as the Cellar Trust and Safe Spaces. Recognising the importance of VCSE partnerships, the team co-work with Bradford Breathing

Spaces, a mental health service supporting young people. Referrals are also made to appropriate organisations and services which provide additional support, evidencing that the service goes beyond solely meeting people's health needs and recognises the impact of wider social determinants on mental health. This includes signposting to housing support, bereavement services, relationship counselling and charities for specific groups or experiences.

IHTT leadership regularly monitor against key KPIs to ensure the needs of their service users are being met. This includes monitoring whether care plans, risk assessments and MDT review completed for the caseload – which are completed for 99-100% of service users. Care plans are provided to patients via email or post to ensure they are aware of their care plan. The team also audit care plans monthly to ensure quality is maintained. Upon discharge from the service, patients and their GPs receive a copy of a discharge letter, and a crisis plan to ensure they are aware of how to access support should their mental health deteriorate following discharge.

Approximately 8.5% of appointments are with a service user whose main spoken language is not English within their patient record. The team regularly use interpreting services, with 47 appointments in the last 3 months, with just over half of interpreting provision provided by a face-to-face interpreter. The most common interpreting languages accessed were Persian, Urdu, Slovak and Arabic. Input from the team highlighted that having a culturally and ethnically diverse team supports with meeting the needs of our diverse community in Bradford District and Craven, and there are open discussion and ideas shared between the team.

The team also shared that they ensure discharge is appropriately timed and personalised for service users, rather than within specific timescales, to ensure that service users are ready to be discharged, and that appropriate follow up care is in place prior to this. Open conversations within the team, offering training on cultural competency and improving access to interpreting provision, particularly relating to ad-hoc provision, were identified as potential improvements to better meet the needs of our communities.

Outcome 1C: When patients (service users) use the service, they are free from harm	**Score: 2**

Evidence:
As mentioned in section 1B – all service users are risk assessed and crisis plans are co-developed with the service users to ensure they have information to access support if required. The RAG board supports safety by ensuring patients receive the appropriate level of contact and have their care reviewed regularly. Patient leaflets include information for the First Response service within BDCFT which provides a 24/7 phone line and external crisis phone lines are also provided. Staff felt that service users typically have positive experiences of the team.

Incident data and themes are reviewed by the leadership regularly and are discussed with team members at huddles. Over the past year there have been 88 incidents reported across the IHTT, evidencing a learning culture where staff feel safe to report incidents. When broken down by ethnicity, 52% of these incidents related to patients who are white, 22% were ethnically diverse and 26% the ethnicity was not disclosed. The age profile and gender of incidents was consistent with the caseload. The most common cause group for patient safety incidents were relating to self-harming behaviour (33%), access/admission issues (22%) or physical violence and aggression (8%), which is in line with a high acuity caseload. The majority of incidents had no harm impacts (62%), a further 18% resulting in minor harm, 12% moderate and 8% major or catastrophic.

Outcome 1D: Patients (service users) report positive experiences of the service	**Score: 1**

Evidence:
There were a total of 10 complaints and 31 compliments for IHTT between November 2023 to 2024. It is not currently possible to provide demographic breakdowns of complaint data due to system interoperability issues. Team leaders keep local records of complaints and compliments and this is shared with the Patient Experience team who collate these with other feedback. Patient information leaflets include PALS contact details to support feedback.

There were no FFT responses for Airedale or Bradford IHTT between April and September 2024, likely owing to the current method of feedback collection, with paper FFT uptake being low across the trust. The service are considering how to better involve service users and capture additional feedback but are also conscious that feedback collection should be sensitively timed and delivered, given that most service users are in crisis at the time of access. The clinical lead for IHTT is exploring piloting a patient forum for First Response to capture feedback, with potential to expand this model for IHTT in the future.

Following the closure of business of the previous FFT provider, there is work ongoing in the trust to procure and implement digital FFT collection via a new provider which will enable teams across the organisation to collect feedback via QR codes. Data will be available by demographic groups, to identify feedback themes specific to protected characteristics.

Domain 1 – IHTT Overall	**Score: 8**