Mersey Care NHS Foundation Trust

Liaison psychiatry services

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Liaison psychiatry services

Inspected but not rated

We carried out this unannounced focused inspection as part of a national review of urgent and emergency care systems. The Mersey Care NHS Foundation Trust mental health psychiatric liaison teams based at the Royal Liverpool University Hospital and Aintree University Hospital (both part of the Liverpool University Hospitals NHS Foundation Trust) were chosen as part of the review, to examine the impact of psychiatric liaison within an urgent emergency care system, as well as any possible impact on patient safety. This was a focused inspection with emphasis on specific key lines of enquiry within the safe key question, the responsive key question and the well-led key question.

We did not rate this service at this inspection. The previous rating of good remains. We found:

- Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified.
- The service had enough nursing and support staff to keep patients safe. This was supported using bank staff during periods of staff sickness, high footfall of patients, or during business continuity.
- Staff followed infection control guidelines, including handwashing.
- Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.
- The psychiatric liaison team had skilled staff available to assess patients immediately 24 hours a day seven days a week.
- Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.
- The service followed national standards for transfer of patients between places.
- Leaders had the skills, knowledge and experience to perform their roles.
- Staff felt respected, supported and valued.

Is the service safe?

Inspected but not rated

Safe and clean environments

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. The assessment rooms allocated to the liaison teams were inspected and found to be clean and safely

Our findings

furnished. At the Royal Liverpool University Hospital, the liaison team had a four-cubicle area designated The Hub, there was also a small nurse station with computer access. There was also one assessment room located in the area, a Section 136 suite, so designated as the place of safety for those patients detained by the police under Section 136 of the Mental Health Act, and one other small interview room. However, at Aintree University Hospital, the liaison team only had designated access to the Section 136 suite in accident and emergency: any assessment or interview by the mental health liaison team had to take place in any room that was deemed available in the emergency care area. The environment was not the responsibility of Mersey Care NHS Foundation Trust, therefore we shared this information with the team inspecting Liverpool University Hospitals NHS Foundation Trust.

Rooms were risk assessed as to the suitability of purpose and in conjunction with the risk assessment of the patient. Staff at both sites told us that often there were more patients waiting to be seen than available, suitable space to be interviewed. These patients were risk assessed as to suitability to wait in the general accident and emergency area, although staff admitted that after prioritisation of patients based on risk, this could sometimes lead to patients having to wait in an area that may impact on their presentation.

Closed circuit television monitoring was in place at both sites, positioned with privacy in mind. In the Section 136 suite at Aintree, mirrors were also utilised to ensure all parts of the room were in view.

All designated interview rooms had alarms and staff available to respond. Staff did not have personal alarms. There was one alarm for the psychiatric liaison staff who were using The Hub at the Royal Liverpool University Hospital, the staff member on duty in the area carried the alarm. On the Aintree site, the Section 136 suite had an alarm strip fitted around the wall, for emergencies. Staff told us that, in the event of assistance being required, being in and around the accident and emergency areas meant that there were lots of staff. Psychiatric liaison staff praised the security staff at both hospitals. However, when staff at Aintree had to find a room to interview a patient and they had to leave the immediate area of the accident and emergency site, they had to rely on their risk assessment of the patient to decide if they would be safe or not with the patient. They stated they would adhere to the lone worker policy at all times.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations. Patients who were assessed by the psychiatric liaison teams were physically assessed either in accident and emergency or on the admitting ward, to be considered physically fit enough to participate in a mental health assessment.

All areas were clean, well maintained, well-furnished and fit for purpose. The furniture in use at both the Royal Liverpool University Hospital and Aintree University Hospital was of a style suitable for the assessment of patients with a possible mental health condition.

Staff made sure cleaning records were up-to-date and the premises were clean. During the inspection, it was noted that acute hospital staff were ensuring on-going infection and prevention control whilst staff tasked with the cleaning of the accident and emergency care departments were constantly cleaning clinical areas. The psychiatric liaison teams had their own infection prevention and control staff who ensure that current guidance was being followed by their teams. This was audited.

Staff followed infection control guidelines, including handwashing. The psychiatric liaison teams carried out monthly environmental checks that included all the areas used by their staff. The check for 24 February 2022 at the Royal Liverpool University Hospital clearly showed that up to date infection and prevention control information was posted for all staff to see, and that equipment and furniture was checked. The staff conducting the check had noted that the floor and part of the patient area was not clean, and they noted this and liaised with cleaning staff to ensure that it was dealt

with. At Aintree University Hospital the staff used a community infection prevention and control clinical area assurance checklist to ensure that high standards were being maintained, as well as the same checklist in use at the Royal Liverpool University Hospital. The checklist dated 25 February 2022 showed that all checks were complete and found to be in order and noted that all blinds in the areas had been replaced.

Staff made sure equipment was well maintained, clean and in working order. Any equipment used by the psychiatric liaison team was maintained by the site trust, and it was noted that the equipment in The Hub area at the Royal Liverpool University Hospital had up to date maintenance and calibration stickers affixed.

Safe staffing

The service had enough stuff, who received basic training to keep people safe from avoidable harm. The number of patients on the caseload of the mental health crisis teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.

Nursing staff

The service had enough nursing and support staff to keep patients safe. The Royal Liverpool University Hospital psychiatric liaison team was budgeted for 16.2 band six registered staff, at the time of inspection they had 15.8 whole time equivalent staff in place, with a vacancy for another staff member to work a partial contract. Aintree University Hospital psychiatric liaison team were budgeted for the same number of registered staff, however there were only 12.4 whole time equivalent staff in post, with 3.6 whole time vacancies. There were six support workers employed at the Royal Liverpool University Hospital and seven support workers employed at Aintree University Hospital. The urgent care model used by the provider of the psychiatric liaison teams allowed for the mobilisation of staff at times of increased activity, with staff working at a local hospital run by the trust used as a hub of bank staff to cover that increase in activity.

We were told by staff that they would support each other when demand was high; staff who would normally be dealing with patients referred from the ward would assist staff dealing with high numbers of patients referred via accident and emergency access. One staff member stated that there were days when the team felt “overstaffed”, and others when they were clearly struggling due to patient numbers.

The service had low and / or reducing vacancy rates. The vacancy rate at the Royal Liverpool University Hospital was negligible, but there were slightly over three registered nurse vacancies at Aintree University Hospital. Recruitment to the teams was an on-going project. The trust had a policy of over-recruitment to consider future possible shortfall of staff.

The service had low and / or reducing rates of bank and agency nurses. Both sites frequently utilised bank staff to cover shifts. Agency nursing staff were not utilised by the provider. The bank staff rates of use fluctuated due to sickness, increased patient activity and footfall, and business continuity.

The service had low and / or reducing rates of bank and agency nursing assistants. As with trained staff, the service at both sites utilised bank staff to cover for sickness, increased patient activity and footfall, and business continuity.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Bank staff were all familiar with the psychiatric liaison team, due to the nature and skillset required of the posts.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. All staff had been fully inducted by the trust. Handovers were used for each shift to ensure all relevant information was

passed on. In the ward referral office at the Royal Liverpool University Hospital, a whiteboard contained relevant details of patients and referrals, including dates and times of referral. At the site office at Aintree University Hospital, and electronic screen was wall mounted that displayed any referrals that had been made or were in the process of awaiting assessment.

The service had low and / or reducing turnover rates. Staff at both psychiatric liaison teams had experience, with an ongoing programme of recruitment to offset any changes in personnel.

Managers supported staff who needed time off for ill health. Staff we spoke to told us that they felt supported during times of ill health and sickness.

Levels of sickness were low and / or reducing. Due to the prevalence of Covid-19 and the on-going issues related to staffing through sickness issues, as well as typical sickness reasons, the psychiatric liaison team and their leadership team used all avenues available to ensure safe staffing levels.

Managers used a recognised tool to calculate safe staffing levels. In 2021, the urgent care teams went through an organisational change process. The rationale for change was to bring together the 4 urgent care teams under a new integrated 24/7 Urgent Care Service to enhance access and timely response for individuals presenting in crisis across the Local Division. The model had enabled a flexible skilled workforce to mobilise across all urgent care sites which respond to peak activity demands and provide timely, responsive assessments, reviews, and clinical interventions with community settings.

The number and grade of staff matched the provider's staffing plan. The active number of staff in the psychiatric liaison teams were down due to maternity leave and sickness, the staff rota for the week 28 February to 6 March 2022 showed that three band 6 nursing staff were on maternity leave at Aintree University Hospital. The staff rota for the same week at the Royal Liverpool University Hospital showed no staff on maternity leave, and only two health care assistants on extended sick leave. We were told by staff that nature of footfall and demand in accident and emergency was very fluid, and this could lead to staffing problems initially if demand was high, before assistance could arrive. However, the care model allowed for flexible staff deployment to cover for sickness or absence, as well as increased patient footfall. A consultant told us that the relationship between acute and liaison staff was good, and also mentioned staffing generally across the psychiatric liaison teams, outlining that, unlike a ward with a specific number of beds, the patient flow through the teams could vary enormously.

Medical staff

The service had enough medical staff. There was one vacancy for an older person consultant on the Aintree site, however a candidate had been found and was due for interview in May 2022.

Managers could use locums when they needed additional support or to cover staff sickness or absence. There was consultant cover for both Aintree and the Royal Liverpool University Hospital working within the psychiatric liaison team, with several specialist doctors (core trainee and specialist trainee) who assisted with day to day operations within the psychiatric liaison team. There were no locum doctors active within the psychiatric liaison teams.

The service could get support from a psychiatrist quickly when they needed to. There was an on-call system for consultant and specialist registrars out of hours, who could be contacted via the local switchboard.

Our findings

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. The risk assessment tool used by staff was a standard tool that was part of the electronic recording system for patient notes. We reviewed two sets of case notes outlining the patient journey and saw that risk assessments featured in both sets of notes. The risk assessments were comprehensive and up to date. Risks were managed positively, taking not only presentation into account but any previous records held on the particular patient. This level of consideration was evident with both psychiatric liaison teams.

Both psychiatric liaison teams were audited using the case file audit tool framework for the core-24 service, a comprehensive audit tool that took into account risk assessments as well as many other case file requirements, including whether capacity was assessed, or whether a mental state examination was completed. The audit tool for the psychiatric liaison team at the Royal Liverpool University Hospital showed that 100% of the patients seen by staff had risk assessments completed in the month leading to the end of March 2022. At the Aintree site, for the same period, 75% of the patients had risk assessments completed. We were told that sometimes a patient would leave in the middle of an assessment, leading to only a partial completion of documents. If this happened, the referral would remain open in case the patient returned within a reasonable time period, but ultimately if would be closed if the patient did not return. If the patient was deemed at serious risk, staff would take all possible actions to ensure the patient could be traced or checked by relevant agencies

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. From a physical health standpoint, patients were fully assessed by the accident and emergency staff or ward-based nursing staff before any patient was referred to the psychiatric liaison team. The psychiatric liaison team staff monitored patients for any increased agitation or symptoms in their presentation whilst being assessed and treated.

Staff continually monitored patients on waiting lists for changes in their level of risk and responded when risk increased. There were no waiting lists in place at the psychiatric liaison team.

Staff followed clear personal safety protocols, including for lone working. Mersey Care NHS Foundation Trust had a lone-working management policy that outlined the requirements regarding both the trust and the employees with regard to safety protocols. This included dynamic risk assessment that took into account conflict resolution training, situational security (being close to an exit when in a room and whether there was anything that might be used against staff as a weapon), and to utilise any personal equipment they may have (personal alarms). Staff told us that they were careful when having to leave the immediate area of the accident and emergency department, due to limited interview locations. However, the only personal alarms that were available were for the area in and around the Hub at the Royal Liverpool University Hospital. The interview room at Aintree University Hospital had a red alarm strip around the wall of the room, should it be needed. There were no recent records of any incidents that had occurred in areas away from the designated accident and emergency, but incidents had occurred within the department.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Our findings

Staff received training on how to recognise and report abuse, appropriate for their role. Staff told us that they had received safeguarding training as part of their mandatory training package, and in discussion could describe how they could recognise different types of abuse and raise issues if necessary.

Staff kept up to date with their safeguarding training. We saw evidence that safeguarding training was taking place and audited, along with other mandatory training.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. In discussion, staff could describe how they would protect patients from harassment and discrimination, giving examples where necessary.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff told us that they had been trained to identify people at risk of harm, and either contacted or signposted patients to relevant services. This was shown in the outcomes measured and reported during the daily bed flow meetings.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Both psychiatric liaison teams had flow charts that clearly showed how to make a safeguarding referral should one be necessary. In discussion, staff were able to vocally describe actions to take about safeguarding issues.

Staff access to essential information

Staff working for the mental health crisis teams kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. We reviewed the journey of care for two patients, one from an accident and emergency referral, the other from a ward referral. Care notes were comprehensive, well written, and securely stored on the electronic recording system. The recording system itself was relatively easy to use, and relevant staff had access.

When patients transferred to a new team, there were no delays in staff accessing their records. Patient records were electronic, access was not a problem. Staff at the psychiatric liaison teams also kept a file of blank paper copies of relevant assessment and recording forms, in case there was a catastrophic failure of the computer system.

Records were stored securely. The trust had a full and comprehensive information governance policy that outlined all relevant aspects of the secure handling of information by staff and management.

Is the service responsive?

Inspected but not rated

Access and discharge

The mental health crisis service was available 24-hours a day and was easy to access – including through a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff assessed and treated people promptly.

Our findings

The service had clear criteria to describe which patients they would offer services to. Any patient who was deemed to have a mental health problem by the acute staff at either the Aintree or the Royal Liverpool University Hospital accident and emergency departments were referred to the psychiatric liaison teams. The teams would see the patient within one hour of referral (if in accident and emergency), or within 24 hours if a ward referral.

The psychiatric liaison team had skilled staff available to assess patients immediately 24 hours a day seven days a week. The hospital psychiatric liaison teams offered a 24-hour service based at the three A&E departments in Liverpool and Sefton.

Staff saw urgent referrals quickly and non-urgent referrals within the trust target time. We were told by staff that there would be priority given to certain referrals, such as younger people or patients brought in by police under the Mental Health Act. Staff aimed to see all referrals within the trust target time.

The trust set and the service met the target times seeing patients from referral to assessment and assessment to treatment. Key performance indicators for the psychiatric liaison teams showed for one-hour referral times (all contacts) the target was 90%, and Aintree University Hospital psychiatric liaison team for February was running at 95%, with the Royal Liverpool University Hospital running at 94%. For the 24-hour ward referral target (all contacts) of 95%, Aintree University Hospital psychiatric liaison team for February was running 92%, with the Royal Liverpool University Hospital psychiatric team running at 99%, with a target of 95%.

The four hour bio-psycho-social assessment target at both psychiatric liaison teams for February (combined) was running at 64%; however, during the inspection, we saw that patients had left the hospital during the time from first contact to the assessment phase, meaning that the assessment could not take place.

The 24-hour assessment target (combined) for both psychiatric liaison teams was running at 80%.

The team tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. Staff told us that they would engage with any patient who was referred and would act accordingly if the patient had difficulty engaging.

Under the Core 24 service provided by Mersey Care NHS Foundation Trust, there were crisis care lines available to patients to access urgent mental health advice on a 24 hour a day, seven day a week basis. This could include a mental health assessment, signposting to a local psychological therapy service, referral to the trust virtual crisis café, or signposting to a different community service such as housing or financial advice.

Patients had some flexibility and choice in the appointment times available. Due to the nature of the psychiatric liaison team, staff would try to get appointments based on urgency.

Appointments ran on time and staff informed patients when they did not. Key performance indicator data showed that the referral times were being met, and that patients were kept informed when necessary.

Capacity and flow meetings were held every Tuesday, as well as daily bed management meetings. The capacity and flow meetings were held over the computer media system, and the minutes compiled. The minutes for 22 February 2022 showed an increase in referrals for the psychiatric liaison teams across the previous seven days, and discussed issues for escalation, such as difficulties in accessing suitable locations for patients in a timely manner.

Our findings

The daily bed management data was very comprehensive, a spreadsheet accompanied by a short narrative that captured the psychiatric liaison team activity for the previous 24-hour period. On the Aintree University Hospital bed management data for 24th February, the data showed that there were six patients awaiting beds, and the other activity within the accident and emergency department for the psychiatric liaison team showed ten other patients seen, the data showing the different areas where the team saw patients (triage, observation ward and major incidents). The data also included, among other information, the times of referral, first contact, second contact, staff involved in the treatment and the outcome for the patient. The data for the Royal Liverpool University Hospital for the same day showed that there no patients awaiting beds, and that the psychiatric liaison team saw seven patients, with the same categories of information appended.

There was an escalation procedure for bed management outlined in the bed management policy. The escalation procedure was known by senior management.

The service used systems to help them support patients. Psychiatric liaison team staff used the electronic record system to identify patients who were currently or had previously been under the care of a mental health team. This allowed them the opportunity to more directly signpost and react to the needs of patients who attended the accident and emergency department. The teams also had access to an electronic dashboard system that outlined the bed situation and the patient numbers and footfall through the accident and emergency department as they related to mental health patients.

Staff supported patients when they were referred, transferred between services, or needed physical health care. The physical healthcare of patients was directly monitored by the acute trust staff prior to onward referral to the psychiatric liaison teams. The psychiatric liaison teams supported patients once referred.

The services followed national standards for transfer. The integrated care service that included both the acute trust and the trust providing the psychiatric liaison teams followed national standards. There was a contract with a private organisation that allowed for specialist mental health staff to be called upon to assist in the monitoring and transfer of patients to mental health facilities, thereby alleviating some of the pressure of the process on the psychiatric liaison team. Standard operating procedures were in place for each eventuality, considering which section of the Mental Health Act the patient was being detained or transferred under.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

We spoke with senior staff at the psychiatric liaison teams, their knowledge and experience of their role was in depth and relevant. Staff knew of the strategy of the trust and were able to explain the values that under-pinned the work ethic for the teams.

There was an effective framework for monitoring performance of the service, this was shown by the comprehensive information retained and presented daily at meetings and the key performance indicators used to measure the performance against trust and national targets.

Our findings

There were relevant pathways in place for patient groups, such as palliative care, children with mental health problems, and frail and elderly patients.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff told us that they felt supported and valued. One staff member said they would be happier if there was more consideration about staff safety when dealing with a violent patient.

We were told that there were regular team meetings, at Aintree University Hospital these took place every Wednesday afternoon. Staff told us they got regular electronic mails advising them of the support that was available. The trust issued a colleague support pack on induction, outlining the work that had been done for staff wellbeing and mental health, and the strategies that were available for all staff. This included advice on subjects including lifestyle, family and children, financial problems, and had a comprehensive support structure for staff to access when taking the coronavirus restrictions into consideration and the possible effects this could have.

There were opportunities for career development, and staff told us they could raise concerns without fear of reprisal.

There was also a supporting colleagues policy that was aimed at all employees, outlining the trust strategy in the event of a traumatic or stressful event involving staff, the support that was available, the rationale behind it and contact details for unions and relevant staff.

The psychiatric liaison team at Aintree University Hospital had recently been awarded a cash sum by one of the unit teams in the acute trust, for their work in the accident and emergency department. We saw interaction between acute and liaison team staff, and it was clearly professional and effective.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The trust intranet allowed access to all policies and procedures that might be needed to provide the safe care and treatment expected from the psychiatric liaison teams. The electronic note system in place allowed for information on patients currently or previously in treatment, giving staff an important knowledge base on which to treat a referred patient.

We were told that there were effective mechanisms in place to ensure that any possible underperforming by psychiatric liaison staff would be noted and acted upon. The actions included increased supervision, performance management plans, identifying the reasons for possible failure to reach a standard, and putting in place all support that was available. The trust policy on ‘handling concerns about the conduct, performance and health of medical staff’ was followed.

The psychiatric liaison teams had access to the trust risk register, and senior managers could add concerns to that register when required. There were plans and routes in place for access to extra staff should circumstances of high patient footfall require it. On the day of inspection at the Royal Liverpool University Hospital psychiatric liaison team, we saw first-hand staff accessing The Hub at a local hospital for bank staff, and arranging of a taxi paid for by the trust to collect the staff member and bring them directly to the accident and emergency department. The staff member had worked at the service before and was fully briefed as to their role and requirement for the shift.

Our findings

There was a trust risk management strategy and policy that outlined all aspects relating to risk, and this was available on the intranet for staff to access if necessary.

Our findings

Our inspection team

The team that inspected this service comprised one CQC inspector although this was part of a larger system review involving other inspection teams.