Care Quality Commission

Lancashire & South Cumbria 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 our national review of urgent and emergency care centres, to support improvement in patient experience and the quality of care received when accessing services and pathways across urgent and emergency care.

We inspected the mental health liaison services in the emergency departments based at the following locations, all part of the Lancashire and South Cumbria NHS Foundation Trust:

- Royal Lancaster Infirmary
- Furness General Hospital
- Blackpool Victoria Hospital
- Royal Preston Hospital

We looked at the impact of mental health liaison within an urgent emergency care centre, 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 domain, the responsive domain and the well-led domain.

We did not rate this service at this inspection. The previous rating of inadequate remains.

We found:

- The service provided safe care. There were enough skilled and experienced nurses and doctors. However, the provider had carried out a safer staffing review that acknowledged the different staffing needs in the new model of mental health urgent assessment centres and were implementing the review recommendations.
- Staff assessed and managed risk well. They reviewed patients' risk regularly and they responded appropriately when risk changed.
- Patients had access to a range of services to meet their needs. There were good relationships with other teams and external organisations to ensure needs were met.
- Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed.
- Staff felt respected, supported and valued. Managers ensured staff received supervision, appraisal and training.

However:

- The standard operating procedure did not correspond with practice in relation to the clock starting for 12-hour breaches
- The rotas in use did not provide oversight of all shifts at each location so that the provider could understand whether they are meeting the safe staffing establishment.

Our findings

What people who use the service say

We were unable to speak to people using the service at the time we inspected. However, we requested feedback from patient surveys carried out by the provider.

Comments were mainly positive, ranging between 96% and 100% at the locations we inspected.

They included:

‘Straight to the point and made welcome in a calm and friendly manner.’

‘I was very impressed by the kind, attentive and empathetic approach evidenced upon my arrival to Avondale. The staff had plenty of time to talk with me and give relevant support.’

‘It was my first appointment and I felt very nervous about it but upon meeting staff I instantly felt relaxed calm and at ease.’

‘First time receiving proper help and everything I needed to say was said and listened to.’

A carer commented ‘Patient feels hopeful after speaking to staff and has changed his life.’

Is the service safe?

Inspected but not rated

Safe and clean environments

We did not inspect the environment as it was the responsibility of another trust; however, we have commented on the areas we saw.

At the Royal Lancaster Infirmary, there was a mental health assessment suite attached to the emergency department. This formed a separate area of the department. It provided privacy for assessment of patients who presented with mental health needs. If a patient needed to remain in the emergency department, there was a designated cubicle close to the nursing station where the patient could be observed.

At Furness General Hospital, Blackpool Victoria Hospital and Royal Preston Hospital, the mental health assessment suites were in a separate unit a short distance away from the emergency department. All provided privacy for assessment of patients who presented with mental health needs.

The rooms were clean and suitably furnished. The service had taken steps to minimise ligature points that people could use to attempt to harm themselves.

Staff could observe patients in the assessment rooms via viewing panels in the doors, and the rooms had alarms that staff could use if they needed assistance.

Our findings

Safe staffing

The service had enough staff, who received basic training to keep people safe from avoidable harm.

In 2016, NHS England outlined the requirement for Core 24 liaison services to be implemented by 2020/21. The mental health liaison teams differed in size and structure depending on the size of the acute hospital and historic organisational development. The skill mix for the teams was not standardised across the service.

The provider had commissioned a safer staffing review, which covered the period of July 2021 to January 2022 and concluded in March 2022. The review focused on the mental health liaison teams. It took account of increasing demand. It also acknowledged the different staffing needs in the mental health urgent assessment centres.

From the review, recommendations were made to the board of directors in relation to investment needed to meet increasing demand across the mental health liaison teams. The recommendations suggested changes leading to a strengthened staffing model and improved quality, through an increased multi-disciplinary workforce, a shift pattern enabling robust handovers and a skill-mix providing strong clinical leadership, clinical expertise with complex cases and supervision covering 24/7. This was approved by the board of directors in March 2022.

The provider was making progress in implementing the review's recommendations. For example, staff had been recruited to work specifically with patients who attended the service frequently, to identify their unmet needs and build on partnerships with other services. Staff had also received extra training around issues such as older adults and frailty, and a learning disability nurse had been recruited

Nursing staff

The service had enough nursing and support staff to keep patients safe.

The teams were still working to the staffing establishment calculated prior to the safer staffing review. All the teams described how they were able to access additional funding to increase staffing levels if they needed to.

Most vacancies were new vacancies. Recruitment was in progress in order to meet the recommendations for the new staffing model before it could be fully operational; thus, where posts had been filled, some teams had more staff than the current calculated establishment. At the time we inspected, staffing across the teams met or exceeded the calculated establishment, with the exception of Blackpool. However, the vacancies in Blackpool at Band 6 were mitigated by over-establishment at Band 7, so that actual vacancies amounted to 36%.

In the four months prior to this inspection, the percentage of shifts filled ranged from 61% to 270% across the teams. The provider's bank staff, who were familiar with the service, provided cover for unfilled shifts. Team managers also provided cover. In the main, the teams did not use agency staff. However, it was not possible to report the numbers of shifts left unfilled as the way the rotas were set up did not enable that data to be collected. This was due to be resolved when the new staffing model was implemented.

The mental health liaison teams worked closely with the home treatment teams. They shared staffing resources across the urgent care pathway where necessary, to ensure adequate service cover during staffing shortages, such as due to sickness absence and whilst recruitment was underway to fill vacancies.

Our findings

The provider participated in the global learners and international nurse recruitment programme, and had recruitment incentives in place for registered nurses.

Managers limited their use of bank and agency staff and requested staff familiar with the service, via block booking. For example, at Furness General Hospital, the team used established bank staff who were familiar with the service, and this team had one long-term agency nurse at the time we inspected.

Substantive staff also had the option to work additional hours, which was monitored by team leaders to ensure staff health and wellbeing was maintained.

Levels of sickness in the 12 months before this inspection ranged between 5% and 11%. This was above the provider's target of 4%. This level of sickness was considered a special cause concern, and factors such as ongoing COVID infections and staff burnout post-pandemic were taken into consideration in addressing sickness.

Managers supported staff who needed time off for ill health via a range of resources, such as counselling support and flexible working. Managers had access to a wellbeing toolkit to help them support staff.

Medical staff

The service had enough medical staff.

Following the safer staffing review, a further review of the medical input into the mental health liaison teams was in progress, including a medical workforce transformation programme comprising work streams designed to address the need to attract, recruit and retain a substantive consultant workforce.

Where there were gaps at consultant level in the mental health liaison teams, specialty doctors had been used to mitigate risks.

Each team we inspected had at least one consultant psychiatrist attached to them, and they could access psychiatrists from other teams if they needed to. They used the doctors' rota out of hours, and a consultant was always on call.

This meant the service could get support from a psychiatrist quickly when they needed to.

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 worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

Assessment and management 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.

Staff used a recognised risk assessment tool. They could recognise when to develop and use crisis plans and advance statements according to patient need.

Our findings

Staff carrying out triage in the emergency departments used an assessment tool that helped them to identify patients presenting with possible mental health conditions, including assessing immediate risks of harm patients might present to themselves or others. They referred identified patients to the mental health liaison team.

The mental health liaison staff used a mental health assessment tool that was a standard part of the electronic recording system. It included risk factors such as substance misuse, social risk and self-harm. The assessment tool included a further tool for enhanced risk assessment for patients whose risk was considered to be high, and a section for crisis management and safety planning. Staff said they usually had enough time to consider and prioritise risk. They reviewed risk when necessary while patients remained in their care, including after any incident and at least every day, and responded appropriately when risk changed.

Any physical health needs were treated by the emergency department staff or ward staff before patients were assessed by the mental health liaison teams.

At Furness General Infirmary, the mental health liaison team had recently increased the number of health care support staff in the team. These posts could be used to support patients who presented with higher risks whilst they remained in the emergency department.

We reviewed 24 records. The risk assessments in the records we reviewed were current and comprehensive. In assessing and managing risks, staff took account of each patient's presentation at the time of the assessment, and their history where it was known.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Staff received training on how to recognise and report abuse, appropriate for their role, and they knew how to apply it. They described different types of abuse and gave examples of what they would look out for.

Staff gave clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They told us how they would ensure patients were protected from harassment and discrimination.

Staff knew how to recognise adults and children at risk of or suffering harm and they explained how they worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Each team had a safeguarding champion, and the trust had a safeguarding team to advise staff.

Staff access to essential information

Staff working 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. When patients transferred to a new team, there were no delays in staff accessing their records. Records were electronic and stored securely via password protection and IT governance.

Our findings

The mental health liaison teams had access to patients' previous health records via the mental health trust's recording system. This meant they could identify patients who were already accessing mental health services, and any current treatment.

They also had access to the acute trust's recording system. They made notes on both systems so that essential information was available to acute staff, such as a brief summary in the notes so that emergency department staff were aware when patients were known to the service.

They had access to patients' GP records via a portal, and had conversations with other relevant organisations patients may have accessed, with the patients' agreement.

The teams carried out a comprehensive handover at each shift change. This included whether the referral was urgent or routine or via the emergency department, and time frames to see whether one hour, four hour and 12-hour targets were met. Staff also completed a daily pressures report that contained current data relating to numbers of patients in the emergency department, waiting for a bed, in the health-based place of safety, the number of 12-hour breaches in the last 24 hours, and expected discharges from inpatient beds.

Is the service responsive?

Inspected but not rated

Access and discharge

The mental health liaison service was available 24 hours a day. The referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated people promptly.

The mental health urgent assessment centres were created in response to the pandemic, as trusts were required by NHS England to create an alternative environment to emergency departments, to provide a safe assessment space for patients with urgent mental health needs, who were not displaying signs of COVID-19 or physical ill health, as a point of access into mental health services.

The service had clear criteria to describe which patients they would offer services to, set out in the standard operating procedure. All patients where only a mental health need was identified and the mental health urgent assessment centre environment could safely support the person's needs were included. There were limited exclusions that included, for example, drug or alcohol intoxication that meant the patient was not fit for assessment until the effects had reduced, self-harm such as overdose or injury that required treatment prior to assessment, and COVID-19 positive or symptomatic and untested.

Staff supported patients when they were referred, transferred between services, or needed physical health care. The teams had established good relationships with emergency department staff and other teams, such as learning disability teams and street triage, and with external organisations, such as crisis housing providers and drug and alcohol services.

The mental health liaison services we inspected operated within the Core 24 standard, a standard for adult liaison mental health services to provide services 24 hours a day, seven days a week.

Our findings

The teams included mental health nurses, psychiatrists, health care support staff and social workers, including approved mental health professionals. Some teams included a pharmacist. The multi-disciplinary teams met every day and discussed plans for all patients open to the team and those who had been referred.

The Core 24 standard states that mental health liaison services will provide a response to mental health crises in emergency departments and inpatient wards within one hour, and to urgent ward referrals within 24 hours.

The provider had developed guidance to encourage engagement and access to mental health services for patients who frequently disengaged and missed or did not attend appointments, to promote a consistent approach to their safe and effective management.

The team had skilled staff available to assess patients 24 hours a day seven days a week. The service met the target times seeing patients from referral to assessment and assessment to treatment. Staff saw urgent referrals quickly and non-urgent referrals within the target time. Patients referred to the mental health liaison teams from the emergency department were seen within one hour. Those on the emergency pathway had their needs addressed and a decision to discharge or admit to a bed within four hours, and those on the urgent care pathway within 12 hours. Patients referred from wards were also seen within a target time of 24 hours.

Staff told us that prior to April 2022, the clock began to run when patients were accepted for assessment by the mental health liaison teams, but that from April 2022, it began from the time patients were admitted to the emergency departments.

However, the standard operating procedure was clear that the 12-hour breach clock started once a patient in the mental health urgent assessment centres had been given a decision to admit to a bed.

We reviewed data for the six months prior to this inspection, which showed improved response times to mental health presentations in the emergency departments. There had been isolated drops in performance due to Omicron-related staff sickness but these had been recovered.

Data relating to one-hour performance showed compliance ranging between 77% and 100% across the locations, against a target of 95%.

Staff in the emergency departments and the mental health liaison teams told us that sometimes there were delays when patients needed medical treatment or to recover from the influence of drugs or alcohol before assessment could take place. Medical care was provided by emergency department staff before the patient was transferred to the mental health liaison team. Where possible, parallel assessments were carried out between emergency department staff and the mental health liaison team.

Data relating to four-hour performance showed that all locations were compliant against a target of 95%.

Data concerning 12-hour breaches of time in the mental health urgent assessment centres showed there had been an increase in 12-hour breaches since April 2021. This related to increased mental health presentations seen in emergency departments. Attendances had increased by 35%.

The data showed that the main reason for 12-hour breaches was bed availability. Bed requests had increased by 18%. Discharges from the provider's assessment beds had dropped during the Omicron outbreak in 2021. Bed availability in

Our findings

the independent sector had also reduced due to COVID cases in those hospitals, and to temporary bed closures. Staff also told us that 12-hour breaches were usually due to waiting for beds, or for clarification of plans from external organisations. The provider was in the process of carrying out a thematic analysis of 12-hour breaches, and a focused improvement week was planned in May 2022.

The trust had taken steps to reduce clinical need for admission, such as investment in the mental health urgent assessment centres to provide a more therapeutic environment for patients, in the mental health liaison teams and the home treatment service to support increased demand, and medical director support to the bed hub, to support alternatives to admission. In the 12 months before this inspection, there had been 851 requests for inpatient beds. Alternatives to admission had been found for 98 of those patients. The provider also had longer term plans to increase its bed base in line with expected admission rates.

Every patient waiting for a bed was discussed and prioritised every day at a flow and capacity meeting. Attendance included a doctor, an approved mental health professional and a crisis housing representative.

The incidence of 12-hour breaches ranged between 0.9% (10) and 7.1% (72) during the 12 months before this inspection.

However, at the Royal Preston Hospital we were told of concerns that some approved mental health professionals did not make applications to detain patients under the Mental Health Act if there was no mental health bed available. Approved mental health professionals are managed by the local authority, not by the provider.

The provider recognised that the approved mental health professionals are required to document the rationale for any decision to not detain someone who has had a Mental Health Act assessment and they are required to review any decision on whether to detain a service user under the Mental Health Act, to ensure that it is in the service user's best interests.

The provider had raised these concerns with the local authority. They also proposed to discuss the concerns at the urgent care forum to raise awareness.

The provider had a 10-point improvement plan that set out actions to improve the crisis pathway.

This document was under review at the time we inspected. It included aims such as embedding the model on all wards to increase capacity, improved clinical processes for admission and alternatives, proactively managing patients with long waiting times, close working with partners and ensuring full utilization of the mental health urgent assessment centres.

The provider had an established service user council to facilitate service user engagement and involvement in service development and quality improvement. Patient experience was reviewed as part of the crisis pathway 10-point improvement plan.

During our inspection, we saw evidence of the plan being implemented.

Meeting the needs of people who use the service

The service met the needs of all patients, including those with a protected characteristic.

Our findings

Patients presenting at the emergency department, or who were already on a ward, and who were identified as having mental health needs were referred to the mental health liaison service.

The mental health liaison team carried out an assessment of each patient at each attendance and referred them to appropriate teams and organisations for care and treatment.

The mental health liaison teams met regularly with staff from the acute trust, adult social care and the police to consider how patients could be better supported. Attendance also included the probation service and ambulance service.

For example, the teams took part in multi-agency meetings that discussed use of the health-based places of safety, including breaches of section 136 and the reasons for them.

In Blackpool, the provider was involved in developing a multi-agency team to offer a supportive and collaborative approach to emergency mental health presentations via 999 calls.

The team at Furness General Hospital had recently recruited a learning disability nurse.

For people who frequently attended the emergency department, the teams worked to support them and to reduce their attendance by offering appropriate alternatives depending on need.

There were relevant care pathways for a range of patient groups, such as children and young people with mental health problems, antenatal and perinatal women, people with drug and alcohol use problems, and older patients. Staff described these care pathways, and there was written guidance that explained how the mental health liaison teams worked with these groups, including referral to other services. The teams had established relationships with external providers, to support patients with such issues.

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.

The provider had a standard operating procedure that described the care pathway.

Performance was monitored via weekly breach meetings and monthly meetings with executive oversight. Leaders gathered information and used it to measure performance against targets and ensure development in line with the improvement plan. This included looking at recovery plans and actions to address non-compliance.

Managers understood the issues and priorities for the service. There was a clear ethic of supporting improvement, through developing links and supporting staff development.

Our findings

However, there was no high-level agreement between the provider and the acute trusts that set out the roles and responsibilities of each, or governance around the Mental Health Act and its use in acute settings.

Culture

Staff said they 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.

There were regular team meetings and all staff received both individual and peer supervision every month. They had opportunities for development and there were team training sessions every month. Staff told us about development initiatives, such as quality improvement team days.

Staff we spoke with said they felt able to raise any concerns with their managers.

We saw professional, effective communication between mental health liaison team staff and emergency department staff and the teams spoke well of each other.

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 provider kept a risk register. Managers used information from sources such as audits and data collected to inform risk.

Managers described how they would deal with staff performance issues, including discussing the issues and putting support measures in place.

Learning, continuous improvement and innovation

The teams at Blackpool and Preston told us how they were working towards Royal College of Psychiatrists accreditation. Ongoing work included involving carers and family members. A support worker had been allocated to gather feedback every week from patients who had been treated by the teams. Patients reported that speaking to staff when they were feeling well again increased their morale.

Managers audited records and used their findings to make improvements, such as developing a mental health urgent assessment centre leaflet for patients, amending some wording on the assessment forms and providing risk awareness training for emergency department staff, which included communication and de-escalation skills.

The teams had also provided training to ward staff in the acute trust, such as around eating disorders.

Our findings

Areas for improvement

- The provider should continue to make improvements to the staffing establishment, in line with the recommendations from the safer staffing review.
- The provider should ensure that they have oversight of all shifts at each location so that they understand whether they are meeting the safe staffing establishment.
- The provider should ensure that the standard operating procedure corresponds with practice in relation to the clock starting for 12-hour breaches.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, three other CQC inspectors and an inspection manager. The inspection team was overseen by Brian Cranna, Head of Hospital Inspections.

How we carried out the inspection

Before the inspection visit, we reviewed information that we held about the service.

During the inspection visit, the inspection team:

- visited the service at each location;
- looked at the facilities at each location, including assessment rooms and offices;
- spoke with the service managers at each location;
- spoke with 19 other staff members, including doctors, nurses and senior managers;
- spoke with five emergency department staff;
- noted communication and interaction between mental health liaison staff and emergency department staff
- looked at the care records of 15 patients, following the care pathway from referral and assessment to treatment;
- looked at a range of policies, procedures and other documents relating to the running of the service.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.