Good

Mersey Care NHS Trust

Mental health crisis services and health-based places of safety

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RQ6	Royal Liverpool University Hospital	Hospital A&E Liaison Team	L7 8XP
RW4	Clock View	Assessment and Immediate Care Team	L9 1EP
Q75	University Hospital Aintree	Mental health Liaison Team	L9 7AL
Q75	Southport and Ormskirk Hospital	S136 Suite	L39 2AZ
RW4	Hesketh Centre	South Sefton Neighbourhood Centre	PR9 0LT

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

Summary of findings

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.

Where applicable, we have reported on each core service provided by Mersey Care NHS Trust and these are brought together to inform our overall judgement of Mersey Care NHS 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 the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are 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

We rated the health based places of safety as good overall because:

- There was evidence of good inter-agency working including shared forums for reviewing issues, strategic meetings, addressing continued service improvements and positive relationships within the operational services.
- Joint protocols were in place across Merseyside police, Mersey Care NHS Trust, the acute hospital trusts, local authorities and ambulance services involved in the detention, assessment and conveyance of people detained under section 136 of the Mental Health Act.
- Joint procedures included a 10 step pathway for all involved in the process of section 136 to follow. The police used a traffic light rating system to support joint decision about remaining at the assessment or leaving.
- There was a designated health-based place of safety in the city for children under the age of 16 years.
- There had been no detentions of anyone subject to section 136 to police cells within Merseyside in the previous 12 months.
- There was a culture of continued development. This included the street car initiative and the development of a heath-based place of safety within adult mental health inpatient services. There was also the implementation of employing health care assistants within accident and emergency services to provide one to one support for people detained under section 136.

However

- The section 136 room at Aintree University Hospital did not provide a safe and a suitable environment for the assessment of patients detained under section 136 of the Mental Health Act (MHA) 1983 and there was a privacy and dignity issue at the Royal Liverpool University Hospital as the toilet door had been removed for safety reasons.
- There were some considerable waits for section 136 assessments to be concluded. The reason was not clearly recorded in all the instances.
- All of the forms that we reviewed required multi-agency input to record each stage of the 10 step care pathway retained within the A&E departments were incomplete.

Summary of findings

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

Are services safe?

Good

We rated health based places of safety as good for safe because:

- There was good inter-agency working and shared procedures ensuring a clear pathway and good communication was in places between all agencies involved..
- Detentions under section 136 were dealt with efficiently following a 10-step pathway.
- Staff reported incidents and there was a culture of learning within the trust.
- There was a member of Mersey Care NHS Trust staff identified to respond to section 136 attendance 24 hours per day.

However,

- Standards of 136 room provision at Aintree University Hospital was poor. There was a ligature risk in the toilet area that was used by people detained under section 136. This had not been reflected on to the Mersey Care mental health team risk register and Mersey Care did not have a protocol detailing actions to take to mitigate against the ligature risk. Since this inspection a new section 136 suite has been opened.
- The toilet door at the RoyalLiverpool University Hospital section 136 room had been removed. This compromised the privacy and dignity of patients. The provider fitted a new door within days of our inspection visit.
- There were at times significant delays in concluding section 136 assessments. We were informed this was often due to availability of non-Mersey Care NHS staff however this was difficult to quantify as documentation indicating this was not always completed fully.

Are services effective?

Good

We rated health based places of safety as good for effective because:

- There was evidence of good inter-agency working
- Implementing the Street Cars project had resulted in reduced numbers of people being detained under section 136 MHA 1983.
- There were appropriate trust and multi-agency forums in place to review effectiveness, discuss operational issues and seek agreement for new ways of working such as the Street Car initiative.
- Physical health checks were being undertaken either by the ambulance crew pre conveyance or on arrival to the health-based place of safety.

Summary of findings

- People brought to the department under section 136 were told about the powers and responsibilities under section 136 to ensure they understood what was happening to them, and were able to understand what the process was and their rights.

However:

- Not all section 136 paperwork was being completed in full. This was important information such as consent, time assessment was completed or details as to reason why the person was detained under section 136 and where they were detained from.
- Line management supervision was not fully embedded within all the teams.

Are services caring?

Good

We rated health based places of safety as good for caring because:

- Patients who had recent experience of attending the department in a mental health crisis told us that staff were respectful, courteous and knowledgeable.
- Staff were enthusiastic about their role and the improvements associated with service changes.
- People who had been detained under section 136 had their rights explained to them and if required Interpreting services were available including out of hours.

Are services responsive to people's needs?

Good

We rated health based places of safety as good for responsive because:

- No-one in Merseyside detained under section 136 had been taken to a police cell in the previous 12 months.
- People who used the service felt valued and involved in the decisions made about their care
- Staff were able to access a range of information leaflets and contact details for local services and support. These could be printed out and given on discharge.
- There were referral pathways for additional post discharge support including referral on for ongoing mental health support.
- There was a separate health-based place of safety in place for children under the age of 16 years.

However:

Summary of findings

- At times people were subject to delays due to awaiting attendance of AMPHs, Section 12 doctors or awaiting an inpatient bed.
- Data completion by the multi-agencies involved, which included the police, A&E nurses, AMHPs and doctors, was incomplete and this may affect the accuracy of the business information reports.

Are services well-led?

Good 

We rated health based places of safety as good for well-led because:

- Staff understood the trust vision and values these were embedded within the work they did.
- Staff described positive relationships at all levels and felt empowered to raise concerns and offer solutions.
- Morale was good and despite pressures the staff felt well supported.
- There were joint policies and evidence of good multi-agency working.

However:

- Line management supervision was not happening consistently across all teams.

Summary of findings

Information about the service

The policing and criminal justice bill (2015) and the Mental Health Crisis Care Concordat (2014) indicated the need to review the efficacy and efficiency of health-based places of safety. The Care Quality Commission report, 'Right Here, Right Now' (2015) has identified effective crisis care is most effective where partnership working is in place.This inspection was undertaken to assess the quality of service provision for health based p[laces of safety within the trust and to provide a rating.

Section 136 of the Mental Health Act 1983, allows for someone, believed by the police to have a mental disorder, and who may be in need of care or control, to be detained in a public place and taken to place of safety. Whilst there a mental health assessment can be carried out. People may be detained for a period of up to 72 hours for the purpose of enabling them to be examined by a doctor and assessed by an approved mental health professional to consider whether compulsory admission to hospital is necessary. The health-based place of safety offers a 24 hour, 7 day a week service, and is open 365 days per year.

Health-based places of safety across the footprint of Mersey Care NHS Trust were located within acute hospitals at the time of this inspection. This was in line with the CQC national review of health-based places of safety (2012) which noted 14% of national provisions were located within emergency departments of acute trust hospitals.

The existing heath-based places of safety accommodation provision were the responsibility of the acute trusts from where they were hosted. Mersey Care NHS Trust provided mental health input in to each of the emergency departments through the mental health liaison teams. These included assessments of people attending the accident and emergency department where there were concerns regarding the persons mental health. Each mental health team also responded to people being brought to the department subject to section 136 and assisting in the coordination of the required Mental Health Act assessments.

The facilities within the scope of this report were:

- Section 136 suite at Royal Liverpool University Hospital covering Sefton and Liverpool.
- Section 136 room at Aintree University Hospital covering Sefton, Knowsley and Liverpool.
- Section 136 suite at Southport and Ormskirk Hospital covering Sefton and Lancashire.

The mental health teams at the three locations were required to undertake three specific functions:

- to respond to referrals from the wards based within the acute hospital
- to provide mental health assessments and crisis response for people presenting via the A&E department
- support the coordination of section 136 assessments for people brought to the health-based place of safety.

Mersey Care NHS Trust was in the final stages of completing a health-based place of safety within its new inpatient facility at Clock View. Anticipated to open in March 2015 it had been delayed and the 136 unit will open in September 2015. In preparation for this change an additional health-based place of safety at Rathbone Hospital had been decommissioned and patients subject to detention under section 136 were being taken to The Royal Liverpool Hospital facility.

There was a partnership between Mersey Care NHS Trust and Merseyside police providing a Street Triage Service This had resulted in two mental health nurses being seconded to work full time as part of a triage/diversion team alongside Merseyside police officers responding to incidents where mental health concerns were indicated. This service was available 7 days per week between 4pm – midnight. This service was evaluated in April 2015 and was identified to have reduced detentions under section 136. The multi-agency teams are intending to submit a case to extend the hours of operation and refine the core skills of the personnel working within it.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Dr Paul Gilluley, Head of Forensics at East London Foundation Trust and Professor Jonathon Warren, Executive Director of Nursing at East London Foundation Trust.

Head of Inspection: Natasha Sloman, Care Quality Commission

Team Leader: Serena Allen, Care Quality Commission

The team that inspected the core service included a CQC inspector, three specialist advisors from nursing and psychology backgrounds, a Mental Health Act reviewer and an expert by experience.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, 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?

Prior to the inspection we reviewed a range of detailed information including policies, minutes of meetings and evaluation reports. CQC hosted focus groups seeking the views of people who use Mersey care services, their carers and staff. We accessed detailed information CQC had collated as part of the **Mental Health Crisis Care thematic programme and which informed the, 'Right Here, Right Now' report (2015)**

During the inspection the team:

- Visited the current section 136 room provision at three health-based places of safety.
- Visited two section 136 room provisions which were to be brought in to operational service.
- spoke with eight patients who had recent experiences of using crisis services at Mersey Care NHS Trust
- Spoke with three managers of the mental health liaison teams.
- Spoke with 12 other staff members; including doctors and nurses.
- Spoke with the senior operational manager with responsibility for the services and coordination of section 136 assessments for Mersey Care NHS Trust
- Observed three multi-disciplinary meetings.
- Held a telephone discussion with a carer of a patient recently subject to detention and assessment under section 136.
- Held a telephone discussion with mental health lead for Merseyside police regarding section 136 inter-agency working across Merseyside.
- Reviewed 116 section 136 paper records located within the A&E departments.
- Looked at 20 detailed records of section 136 assessments and reviewed the corresponding clinical records in the Epax computer records system. .
- Case tracked two specific care pathways of patients subject to detention and assessment under section 136
- Looked at a range of policies, procedures and other documents relating to the provision of section 136 within the trust
- reviewed the reports following the 2014 assessment and application for detention reports completed by the CQC mental health act reviewers.

Summary of findings

What people who use the provider's services say

- Patients told us they were offered choices around their treatment and what care options were available to them.
- They said they felt involved in decisions about their care.
- They said their pathways between different parts of the service were efficient and met their needs.
- People had been given information about advocacy services and had been involved in discussions about ongoing support post discharge.
- Everyone we spoke to confirmed that they knew who to contact for help including out of hours.

Good practice

There was a commitment to build upon and extend the street car initiative following the positive evaluation of the service's role in reducing detentions under section 136.

Areas for improvement

Action the provider SHOULD take to improve
Action the provider SHOULD take to improve

- The trust should ensure that the planned recruitment to the vacant posts across the mental health liaison teams is concluded.
- The trust should ensure that section 136 documentation is completed in line with the Code of Practice.
- The trust should ensure that all staff receive line management and clinical supervision in line with trust policy.

Mersey Care NHS Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Health- based place of safety	Royal Liverpool University Hospital
Health- based place of safety	University Hospital Aintree
Health- based place of safety	Southport and District General Hospital
Assessment and Immediate Care Team	Clock View

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.

- Staff had a good understanding of the guiding principles and their duties when providing care to people detained under section 136.
- The 10 step pathway outlined requirements at each stage of the detention and acted as an aide memoir for staff ensuring all agencies involved in the process could be clear in their role and responsibilities.
- Records showed that people had their rights explained on admission to the health-based pace of safety but recording of consent was less consistent.
- The trust was in the process of providing training in the new code of practice.
- The teams were able to show information they had available about advocacy and independent mental health advocacy services that they gave to individuals.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had a good knowledge of the core principles of the MCA and DoLS. Staff had access to Mental Capacity Act training in the form of scenario based learning. Staff were aware of the implications the Act had for their clinical and professional practice.

There was evidence in the clinical records that assessment of capacity was considered in relation to admissions.

We were told someone who was significantly under the influence of substances would be encouraged to rest and have food and drink. Assessment would be deferred until they have restored capacity and would be more able to collaborate with their care.

Staff confirmed they had access to additional advice and support in relation to the Mental Capacity Act and the Mental Health Act in the event this was required.

Good

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

Our findings

Safe and clean environment

- Each of the section 136 rooms were appropriately furnished with weighted furniture which meant people were unable to easily move or throw it.
- There was a privacy and dignity issue at the Royal Liverpool hospital as the toilet door had been removed. The Mersey Care staff informed us that the acute trust had removed this as it was a ligature risk. We understand a new door with no ligature risks was fitted within days of the inspection occurring.
- At Aintree the section 136 room was the only clinical space available for use by the mental health team. If more than one person was in the department the bay areas were used for assessment. The staff we spoke to told us this was not appropriate due to difficulties maintaining confidentiality. The team were hopeful this would be improved in the new A&E facility due to open the following week. There were more clinical areas available at the Royal Liverpool and Southport Hospitals.
- The toilet provision at University Hospital Aintree was in the main A&E department and was not ligature free. The mental health team did not have a local written protocol in place relating to this risk. The provision failed to comply with Royal College of Psychiatrists' recommended minimum standards. This room was planned to be decommissioned the following week and a new suite was to be provided due to the department relocating.

Safe staffing

Mersey Care mental health liaison teams attended the locality A&E department in response to referrals. The liaison teams provided assessment and intervention to the acute hospitals inpatient wards where they were based. We saw each team allocated workers to either A&E response or liaison to the acute inpatient wards by the staff rotas. The managers stated this enabled them to oversee and manage work load and aim to achieve key performance indicators for both interventions.

- There was an allocated qualified worker on the majority of shifts. There were two staff to provide accident and emergency cover 24 hours a day 7 days per week. Royal Liverpool mental health liaison team was short staffed and were actively recruiting into vacant nursing posts. Four staff were in the process of completing the recruitment process into the seven vacant posts.
- Sickness levels had been up to 14% over the last 12 month period. However there had been an improvement in sickness levels across all the teams in the previous month. There was no use of agency staff and additional staff were provided via the trust nurse bank system.
- Staff told us that it was difficult to oversee the needs of everyone awaiting an assessment or awaiting an admission to an inpatient bed if there were multiple presentations of mental health crisis. If there were few presentations their work load was manageable.
- There was adequate medical cover during the day. Out of hours a CT1 (core trainee) doctor could attend. There were on call arrangements in order to access senior medical staff over 24 hours in place for all the teams.
- Approved mental health professionals (AMHP) were employed by one of the three local authorities covering the geographical area. These were accessed by an on call system 24 hours a day. During core hours three or more AMHPs covered the rota and usually one AMHP out of hours.
- Staff informed us that at times there were delays awaiting the arrival of the AMHP usually out of hours. This was not recorded on the trust electronic recording system in all instances. These operational difficulties were discussed at the section 136 Work stream meeting on 9th December 2014 and section 136 operational meeting 18th December 2014 and 19th March 2015 and it was agreed that there would be work undertaken to find out why delays were occurring.

Good

Are services safe?

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

- Staff informed us that at times there were delays locating section 12 approved doctor attendance when it was required. This was not recorded on the trust electronic recording system in all instances.
- The mental health team based at Royal Liverpool University Hospital had employed 10 health care assistants. These posts were to support section 136 attendances by working alongside the qualified mental health liaison staff member. The health care assistants would provide ongoing support to the person awaiting completion of the section 136 assessment for the time that they remained within the section 136 suite.
- Teams knew of the trusts' 'Zero suicide strategy' and were in support of its implementation.
- Staff told us they were accessing mandatory training and were able to access other training in relation to their roles and personal development plans. 81% of staff had completed required mandatory training and managers confirmed there were plans in place to support full completion.

Assessing and managing risk to patients and staff

- At each health-based place of safety the process for receiving and initially coordinating assessment was the responsibility of the acute hospital staff. They contacted the on call AMHP
- Acute care staff gave people a leaflet detailing section 136 information.
- The mental health liaison team attended as soon as possible to ensure the coordination of the required assessment commenced as quickly as possible. At Royal Liverpool University Hospital health care assistants were more able to make immediate contact on arrival.
- The inter-agency section 136 procedure detailed how the police should undertake a risk assessment using a RAG rating scale. The police determined if a situation was of risk that required them to remain: red, for the police to remain at that time,amber indicating that the situation remained risky and for the police to remain for a period of time then review and green all were in agreement that the hospital staff could manage the situation or the situation was settled and it was appropriate for the police to leave.
- Following joint discussion about the RAG, agreement would be made about whether the police needed to remain until the Mental Health Act assessment was concluded. In the event of a disagreement, the joint section 136 procedure detailed how to escalate so a definitive decision could be made.
- We were told that at each location acute staff would support people awaiting inpatient beds post section 136 assessment if admission was delayed. In addition to each room having couches, which could be rested upon, each acute area had an additional area identified in the minors department of A&E, a side ward or the observation area. We were told that patients would be able to move into these areas if they were faced with an extended wait
- Teams had access to support from the acute hospital security staff if there were specific concerns regarding the safety and welfare of people.
- Staff had access to alarms for use within the dedicated section 136 rooms and staff from the emergency department and security services responded if these were activated.
- Staff had a good knowledge about safeguarding, how to recognise abuse, information sharing agreements and how to report effectively.

Reporting incidents and learning from when things go wrong

- There had been no serious and untoward incidents within the health-based places of safety in the previous 12 months.
- Staff knew how to recognise and report serious and untoward incidents on the trust electronic system.
- Two staff informed us that they failed to record every incident but those not recorded were not serious and severe incidents. An example of which was problems locating a bed for admission because they were busy dealing with clinical need.
- Managers had access to business information reports which included information from incident recording and achievements against key performance targets per team.
- Performance and incident data was reviewed in senior management meetings, team meetings and individual supervision.
- There were Oxford Learning events across the directorate where feedback following serious and untoward incidents, which included lessons learned, were shared with groups of staff.

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

Our findings

Assessment of needs and planning of care

- Comprehensive assessments were completed and physical health checks were undertaken either by ambulance crews undertaking conveyance or soon after arrival in to the department. This ensured baseline physical assessments were completed prior to being admitted to the health-based place of safety.
- Each health-based place of safety was located within an A&E departments and there was access to ongoing medical interventions if this was required.
- Section 136 records were located in a central area and were stored appropriately.
- None of the forms reviewed during the inspection were completed in full. Of the records reviewed the following issues were identified :

- The reason for detaining someone under section 136 was not clearly documented in every case
- Delays were not always explained
- Outcomes following assessment were not always recorded

- Forms from the three health-based places of safety areas were faxed to a central point and an administrator uploaded the information on to the electronic system. This system enabled services to audit the use of section 136 and the use of health-based places of safety.
- A decision to admit form was always competed by the bed management team and enabled an audit of the time between the request for a bed being made and a bed being allocated.
- The child and adolescent mental health team (CAMHS) were contacted for discussion regarding any attendance by 16-18 year olds and there was evidence of this in the clinical records.
- The inter-agency section 136 procedure stated there would be an attempt to coordinate a joint assessment between a doctor and AMHP within two hours of the arrival at the department. The data the trust collected did not allow for this information to be easily understood. This target was not met in the majority of cases.
- The procedures stated a doctor could undertake an assessment in isolation if this was agreed by the AMHP. This was to avoid delay in the person being assessed and processing the conclusion of the detention. This had been done by the mental health liaison team doctors in a number of cases. Outcomes were clearly communicated within the clinical notes.

Best practice in treatment and care

- Merseyside police and Mersey Care NHS Trust worked in partnership providing the street car initiative. The service was available from 4 pm – midnight 7 days per week and had been in operation for two years.
- The evaluation concluded in April 2015 and identified the following benefits:

Suite

S136 presentations pre street cars

29/12/2013-29/06/2014

s136 presentations post street cars.

01/12/2014-10/05/2015

Aintree

31

24

Rathbone 136 Suite

1

dept. closed

Royal Liverpool

127

96

Southport

12

4

- Mersey police estimate the reduction in section 136 amounted to a saving of £131,000 in police time.
- Of those that had presented to a health-based place of safety there had been an increase in the numbers requiring either hospital admission or ongoing community support to 85%.

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.

- Both agencies involved reported improved relationships between police, A&E staff and the mental health teams
- The evaluation report indicated improved experience of people who were in receipt of street car
- The liaison team at Royal Liverpool hospital was supplemented by 10 health care assistants providing direct support to detained people brought to the department. Shifts covered 24 hour 7 days per week. The staff were able to sit with people, undertook observations if there were multiple people in the department awaiting follow up, provided swift access to drinks and snacks, and found additional information about local resources for individuals. There was positive feedback regarding these roles. These roles were funded by the clinical commissioning group in response to the number of section 136 presentations there.
- The mental health liaison staff provided short-term post crisis follow up following incidents of self-harm via HOPE clinics. These looked at assisting prople to develop coping strategies to manage self-harm using psychologically informed interventions. Staff had received additional specialist training. This therapy was available to anyone seen within the department who required interventions but not specifically secondary care mental health service follow up.
- People assessed in the A&E department were provided with information explaining the powers and responsibilities under section 136. These were also detailed as a large flow chart on the wall of Royal Liverpool University Hospital section 136 room.
- Information regarding people's mental health presentations at health-based places of safety was collated centrally and this informed detailed business intelligence data for the benefit of audit and review. This detail was reviewed at the multi-agency strategic meetings.
- The work within the teams around self-harm and the provision of HOPE clinics was being evaluated in conjunction with Liverpool University at the time of the inspection.

Skilled staff to deliver care

- Qualified staff from the mental health teams undertook coordination of admission into the health-based place of safety where possible but responsibility for its initial implementation was with the acute hospital staff.
- There was a clear 10 step approach giving clear directions at each stage. All the staff were aware of the steps and who carried responsibility at each stage. The mental health liaison staff member would lead. They would collate as much information as possible in preparation for the AMHP attendance.
- There was a supervision policy in place for staff but it was not occurring regularly within all three teams. The mental health liaison team based at Royal Liverpool Hospital had completed less than 45% compliance with staff supervision in the previous six months.
- Team managers were encouraged to undertake leadership training and told us of their intent to do so.

Multi-disciplinary and inter-agency team work

- Multi-agency collaboration was good across all services and there was clear understanding of each other's roles. This was supported by clear inter-agency procedures.
- There were forums and strategic meetings where joint working and operational issues were addressed and these were well attended by a variety of the agencies.
- Staff described positive relationships and reciprocal benefits of partnership working.
- Teams held regular meeting to discuss complex cases, received peer supervision and the opportunity for reflective practice.
- Ambulance crews did not contribute to discussion during this inspection but had described improvements in joint working over the previous two years when CQC undertook an assessment and admission for detention review in 2014. North west ambulance service informed there had been a lot of work in developing a regional protocol to support conveyance to hospitals.
- Members of the AMHP forum described an AMHP hub which was responsible for responding to all section 136 requests. Staff were satisfied with this arrangement and felt it had streamlined response and assisted in meeting the target of commencing assessment within two hours.
- Information was shared across the different agencies on a strictly need to know basis. This was in line with recommendations within the Crisis Care Concordat and there was intention to further review information sharing protocols.
- There was a monthly meeting where complex cases were discussed and proactive measures identified aiming to minimise risk and reduce possible attendances detained under section 136.

Adherence to the MHA and the MHA Code of Practice

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 had a good understanding of the guiding principles and their duties when dealing with people detained under section 136.
- The 10 step pathway outlined requirements at each stage of the detention and acted as an aide memoir for staff.
- Records showed that people had their rights explained on admission to the health-based place of safety but recording of consent was less consistent.
- The trust was in the process of providing training in the new code of practice.
- The teams were able to show information they had available about advocacy and independent mental health advocacy services that they gave to individuals.

Good practice in applying the MCA

- Staff had access to Mental Capacity Act training in the form of scenario based learning.
- Staff were aware of the implications the Act had for their clinical and professional practice.
- There was evidence in the clinical records that assessment of capacity was considered in relation to admissions.
- We were told someone who was significantly under the influence of substances would be encouraged to rest and have food and drink so assessment could be deferred until they have restored capacity and would be more able to collaborate with their care.
- Staff confirmed they had access to additional advice and support in relation to the mental capacity act and the mental health act in the event this was required.

Good

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

- Patients told us that staff were respectful, courteous and knowledgeable.
- Staff were observed to be courteous, kind and respectful in interactions with people who used services.
- Staff described good peer support within the mental health liaison teams.
- Staff were enthusiastic about their role and the improvements associated with service changes such as the street car initiatives and the employment of health care assistants within the mental health liaison team..

The involvement of people in the care they receive

- Three patients admitted to Clock View told us that they were offered choices around the treatment, the care pathways available to them and they felt involved in decisions about their care.
- One described that their mother accompanied them when they felt in a crisis and this has always been very positively responded to.
- They said their pathways between different parts of the service were efficient and met their needs.
- People had been given information about advocacy services and had been involved in discussions about ongoing support post discharge.
- Everyone we spoke to confirmed that they knew how to contact for help including out of hours.
- A carer told us they had seen a consistent and sustained improvement over their years of contact. This was in both the standard of care their relative received and the attitude of staff in acknowledging their role as a carer and family.
- One person told us they had to wait over six hours before being seen at A&E but that during that time they had been well informed and things were clearly explained.
- One person positively commended the attitude and support from the police officers involved in their detention under section 136.

Are services responsive to people's needs?

Good

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

Summary of findings

Our findings

Access and discharge

The mental health teams at the three locations were required to undertake three specific functions:

- to respond to referrals from the wards based within the acute hospital
- to provide mental health assessments and crisis response for people presenting via the A&E department
- support the coordination of section 136 assessments for people brought to the health-based place of safety.

- Staff told us it was more difficult to oversee and check upon the progress of section 136 assessments when the departments had multiple attendees.
- The length of time to complete a section 136 assessment ranged from less than two hours to in excess of 12 hours. The main reasons for the delays in the process were recorded as:

- Person was not medically fit
- Awaiting attendance by AMHP
- Awaiting attendance by section 12 approved doctor.

- These delays were usually outside of the control of the trust because they related to the availability of assessing doctors and the availability of AMHPs.
- Data was incomplete so it was not possible to understand how long people had to wait in the A&E department after the section 136 assessment was concluded.

The facilities promote recovery, comfort, dignity and confidentiality

- Two of the section 136 suites met the majority of the Royal College of Psychiatrists' minimum standards. At Royal Liverpool University Hospital the door to the toilet had been removed as it was a ligature risk. This compromised the privacy and dignity of people using the toilet. We were informed this door was replaced a few days after this inspection.
- The section 136 room at University Hospital Aintree was in poor decorative repair and afforded less privacy for people brought to the section 136 room . This was due to the window into the suite being located on the main hospital corridor. We were informed the section 136 room was being closed the following week as the accident and emergency department at the hospital was being relocated and a new section 136 suite was being provided.
- Each of the section 136 suites had appropriate weighted furniture that would allow people to be comfortable and rest if there was an extended wait for the assessment to be completed.

Meeting the needs of all people who use the service

- The inter-agency procedure detailed a 10 stepped approach to section 136 presentations including key roles and responsibilities This included completion of an initial health screen by ambulance staff that followed the paramedic pathfinder tool.
- Merseyside police cells have not been used as a place of safety at any time over the last 12 months.
- 14 under 18 year olds were detained on section 136 throughout 2014/15. These were appropriately dealt with at either the health-based place of safety detailed in this report or to the under 16 year specific health-based place of safety provided at Alder Hey Children's Hospital.
- Child and adolescent mental health services attended to ensure joint assessment if required and there was a similar support from the learning disability service, both of which were available out of core hours.
- Teams had access to interpreter services, including the dual telephone provided by language line for immediate translation.

Listening to and learning from concerns and complaints

- Patients told us they would feel confident to speak up if they were unhappy with any aspect of their care and treatment and that when they had, they felt staff listened to them.

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

Our findings

Vision and values

- The partnership working demonstrated a clear vision was shared across the agencies involved.
- There were aspirations to further develop the successful initiatives which included an extension of the street car scheme and to review the impact of the health care assistant posts working directly within A&E.
- Multi-agency working had resulted in a reduced use of section 136.
- Trust vision and values were clearly displayed throughout the areas visited.
- Staff were aware of the aspiration of the trust to aim for perfect care and zero suicide and were fully in support of it.

Good governance

- Staff knew how to recognise and report incidents in to the trust electronic system.
- There were good business intelligence systems in place which provided service specific detailed reports.
- Managers and teams used the business information to identify trends and to review outcomes of key performance indicators relevant to the work of the mental health liaison team.
- There were good arrangements for multi-agency review and action planning relating to the management of section 136 detentions. These included reviewing data completeness, reviewing AMHP delays, delays due to "medical fitness" and looked at monitoring progress against expectations of the Mental Health Crisis Concordat.
- Ligature risks identified at the Aintree University hospital section 136 provision were not detailed on the mental health team risk register and no protocol was in place within the team to mitigate against these risks. The manager reported that there had been no untoward incidents relating to the ligature risks.
- Completed assessments for 16 – 18 year olds were routinely sent to the trust lead for safeguarding to allow for review and to seek guidance about quality.

Leadership, morale and staff engagement

- Staff felt well supported by their managers and peers.
- Staff were aware that each of the teams was in the process of active recruitment and the additional pressures due to staffing issues would be resolved in the near future .
- Staff felt able to openly raise concerns and were encouraged to offer opinions about service developments.
- Managers described positive relationships within the management teams and felt included.
- Morale was good and staff were clearly passionate and committed to the vision of the service.

Commitment to quality improvement and innovation

- There was enthusiasm to continue to develop successful initiatives such as the Street Car partnership and the health care assistant roles.
- Performance and service developments were jointly reviewed through a multi-agency membership which included commissioners, the trust, emergency departments, the police and ambulance services.
- Further work was ongoing to refine data quality and support development of improved knowledge relating to the demographics of those subject to section 136 detention and to improve recording of key indicators including time of arrival, time of assessment conclusion and time of departure from the health-based places of safety.