

Cambridgeshire and Peterborough 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 effective?

Inspected but not rated ●

Are services caring?

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 of the liaison psychiatry service based at Peterborough City Hospital as part of a larger review of integrated care across the region. The inspection was focussed on the urgent and emergency care patient pathway and any barriers to discharge or transfer of patients with mental health needs out of the acute general hospital. We did not inspect all aspects of the key questions.

The liaison psychiatry service is part of the Cambridge and Peterborough NHS Foundation Trust mental health crisis service. The aim is to provide assessment, diagnosis and treatment for emotional and psychiatric problems for patients attending local general hospitals. Teams were based at Peterborough City Hospital in Peterborough, Addenbrooke's Hospital in Cambridge, and Hinchingbrooke Hospital in Huntingdon. We only visited the liaison psychiatry service based at Peterborough City Hospital.

The liaison psychiatry service has two arms, the team who assess people with mental health concerns arriving at the urgent and emergency care department and the team who cover the Peterborough City hospital inpatients. The urgent and emergency care team role is front facing within the department assessing patients' immediate needs and acts to gatekeep beds within the local mental health services. The inpatient arm of the service focusses on assessing and managing the mental health needs of those admitted to the acute hospital.

We did not inspect any other parts of the mental health crisis service or health-based places of safety core service at this time as they did not form part of the integrated care review.

We did not rate this service at this inspection as it was part of a review looking at urgent and emergency care systems. The previous rating of good for the mental health crisis service or health-based places of safety core service remains. We found:

- The liaison psychiatry team were easy to access. Staff assessed patients promptly. Those who required urgent care were taken onto the caseload of the liaison psychiatry team immediately. Staff and managers managed the caseloads of the liaison psychiatry team well. The services did not exclude patients who would have benefitted from care.
- The number of patients on the caseload of the liaison psychiatry service and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.
- Staff followed good practice with respect to safeguarding.
- Staff working for the liaison psychiatry service assessed patients and developed holistic, care plans in collaboration with families and carers.
- Managers ensured that staff received supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- The service was well led, and the governance processes ensured that procedures ran smoothly.

Our findings

However,

- Staff mandatory and required training in some areas was very low.
- Staff clinically assessed and managed patient risk well but there was inconsistent assessment and recording of patient risk.
- Staff had not fully reinstated clinical audit following cessation during the COVID-19 pandemic to evaluate the quality of care they provided.
- The liaison psychiatry team included but did not have access to the agreed psychologist specialist required to meet the needs of the patients.

During the inspection visit, the inspection team:

- Visited the liaison psychiatry service based in the urgent and emergency care department at Peterborough City Hospital.
- Spoke with 17 staff members; including the service lead, doctors, specialist nurses, clerical workers and managers.
- Observed one visit by staff to an inpatient who had been referred to the liaison psychiatry service.
- Spoke with one patient.
- Observed one handover meeting.
- Reviewed five care records of people referred to the liaison psychiatry service.
- Looked at a range of policies, procedures, meeting minutes and other documents relating to the running of the liaison psychiatry service.

Is the service safe?

Inspected but not rated



Safe environments

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and appeared fit for purpose.

The team had access to a designated assessment room in the urgent and emergency care department which had been risk assessed to ensure that the environment was safe.

The assessment room based in the urgent and emergency care department appeared well maintained, well furnished suitable for purpose and had alarms and staff available to respond. Staff did not leave patients at risk of self-harm alone in the room.

We observed staff following infection control guidelines, including handwashing.

Our findings

Safe staffing

The service had enough staff, but not all staff were up to date with basic training to keep people safe from avoidable harm. The number of patients seen within the urgent and emergency care department or on the caseload of the liaison psychiatry service, 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 specialist nursing staff to keep patients safe. All 15 nursing staff, based at Peterborough City Hospital, were band seven specialist nurses indicating a high level of knowledge and experience. The service did not employ unregistered nursing staff. Staff were divided into two teams to cover the urgent and emergency care department and the rest of the general wards although they were able to work across teams when required. The general ward team was further divided into working age adults (age 17 and above) and older adults. Staff had specialist nurse experience in these areas. The service did not accept referrals regarding young people under 17 years old as these were referred to the child and adolescent mental health service.

The service had low vacancy rates with one vacancy for a band seven specialist nurse that was in the process of being recruited to at the time of the inspection.

The service did not employ bank or agency staff due to the specialist nature of the service and staff covered absence from the existing staff base.

The service had low turnover rates. There had been two recent staff departures related to secondment and maternity leave.

The sickness rate was low (less than 1.5%) excluding COVID-19 isolation. Levels of sickness related to COVID-19 isolation were 4%.

The number and grade of staff matched the provider's staffing plan.

Medical staff

The service had enough medical staff and were able to cover sickness and absence. The medical staff establishment was 2.5 whole time equivalent consultant staff covered by four consultant psychiatrists with the addition of one junior doctor.

The staff could access support from a psychiatrist quickly when they needed to. Medical staff were available office hours Monday to Friday and staff could access support from a mental health crisis care consultant by telephone outside of these hours if required. Staff reported that this was effective and responsive when needed.

Mandatory training

The mandatory training programme was comprehensive to meet the needs of patients and staff.

Staff undertook a range of mandatory (16) modules and 'required by directorate' training (seven) modules. However, compliance varied with mandatory training compliance at 80% and required training compliance at 64% with an overall total compliance rate of 72%. The training course with the lowest compliance rate was suicide mitigation at 36%.

Our findings

Managers were aware of the low compliance rate in some areas and told us that several training modules were suspended during the COVID-19 pandemic as staff were involved in contributing to inoculation plans. Training sessions had only recently restarted and there was a waiting list for staff to attend them. We saw that this was monitored through the monthly business meetings.

Compliance with basic life support (BSL) training was also low at 29% however due to the location of patients within the urgent and emergency care department and on the wards, there was access to emergency physical health care from colleagues within the host hospital to mitigate the patient risk of staff not having the required BSL training.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessment of risks to patients and themselves was not always assessed and recorded consistently. Staff did respond promptly to sudden deterioration in a patient's mental health. Staff followed good personal safety protocols.

Assessment of patient risk

Staff recording of risk assessments was not consistent in-patient electronic records.

Risk assessment commenced at the point of referral with discussion with the referrer and review of previous patient notes if available.

The progress notes detailed that face to face risk assessments had been undertaken when patients were referred, and we saw that daily review of patients were being undertaken. Changes in risk and key information were documented in the progress notes.

Staff were however, managing patient risk well through regular handover meetings where actions were agreed and then allocated to a member of healthcare staff to complete.

We requested further data regarding oversight of patient records. For example, patient record audits. These had not been performed during the COVID-19 pandemic period due to availability of staff but we were told they had recommenced at the time of the inspection.

Management of patient risk

Staff regularly monitored patients on the wards and in the urgent and emergency care department and waiting areas for changes in their level of risk and responded when risk increased.

Staff followed clear personal safety protocols, including for lone working.

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.

Staff received training on how to recognise and report abuse, appropriate for their role.

Our findings

Staff kept up-to-date with their safeguarding training. Data supplied by the trust showed safeguarding adults training compliance level two at 100% and safeguarding children training level three at 78.5%.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

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

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The safeguarding lead for the liaison psychiatry service was the social worker within the team and all staff we spoke with were aware of the process and who to contact.

Staff access to essential information

Staff working for the liaison psychiatry team kept detailed records of patients' care and treatment. Records we saw were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. The service used electronic care records and had access to both the mental health trust and the Peterborough City Hospital electronic care records.

When patients transferred to and from other services there were no delays in staff accessing their records.

Care records were stored securely, with staff using password and card protected access.

Is the service effective?

Inspected but not rated



Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. Staff working for the liaison psychiatry service team worked with patients and families and carers to develop individual plans of care and updated them when needed. Care plans reflected the assessed needs, were personalised and holistic.

The liaison psychiatry team who worked mainly in the urgent and emergency care department ensured that patients attending the department received a mental health care assessment and were referred to other services as appropriate or admitted and plans of care put in place. We saw that there were occasional delays in the assessment process due to the medical condition of the patient, but that they were completed as soon as the patient was fit to participate.

Staff within the liaison psychiatry inpatient teams developed plans of care for patients but were not always able to implement comprehensive mental health care and treatment plans immediately due to the patients' acute physical health needs. Staff liaised with the acute occupational therapists to provide advice where appropriate.

Staff regularly reviewed and updated care plans when patients' needs changed. We observed this occurring at the daily handover meeting and on accompanying staff to visit a patient.

Our findings

Staff worked in collaboration with patients and their carers to develop individual plans of care which they reviewed regularly through multidisciplinary discussion and updated as needed. Staff detailed regular contact with patients and carers in patient records.

Staff had access to patients' full physical health assessments and treatments and knew about any physical health problems. Staff were fully involved in planning for discharge with the acute hospital staff, patients, carers and external providers.

Best practice in treatment and care

Staff working for the liaison psychiatry service delivered care according to national guidance and best practice but had not participated in clinical audit to assess outcomes during the COVID-19 pandemic.

Staff delivered care in line with best practice and national guidance from the National Institute of Health and Care Excellence and by the Royal College of Psychiatrists (RCPsych).

Staff used technology to support patients. The liaison psychiatry service had recently set up a texting service for patients which provided signposting to additional and external support.

Skilled staff to deliver care

The liaison psychiatry service had access to specialists required to meet the physical health needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided a comprehensive induction programme for new staff.

The service had access to a range of specialists to meet the physical health needs of the patients on the wards and attending the urgent and emergency care department. However, inpatients access to psychologist support was limited as the psychologist had been seconded to another department to work. Experienced nursing and medical staff were able to offer some psychology support in their absence.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care.

Managers gave each new member of staff a full induction to the service before they started work and we saw evidence of this with a new starter to the service who was still in the induction phase.

Managers supported staff through regular, constructive clinical supervision and appraisals of their work. The medical consultant staff provided monthly supervision for all liaison psychiatry service staff.

Managers made sure staff attended regular team meetings or gave information about the discussions to those they could not attend.

Managers identified any developmental training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

Staff we spoke with confirmed that their patient caseload was manageable and that support from team members was available if needed.

Our findings

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

The liaison psychiatry service was composed of medical staff, band seven specialist nurses, a social worker, an administration support worker and a psychologist who was seconded to another department at the time of inspection. Staff held weekly multidisciplinary meetings to discuss patients and improve their care. All the staff attended a multidisciplinary handover meeting every weekday morning to discuss all patients on the caseload.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. We observed positive staff discussions relating to discharge plans and patients and family and carers involvement was taken into consideration.

The liaison psychiatry service had effective working relationships with other teams in the organisation. The staff commented on the close supportive working relationship within the organisations wider mental health crisis team.

The liaison psychiatry service had very effective working relationships with external teams and organisations. The team provided teaching to the ward staff of the Peterborough City Hospital and on the staff inductions. The liaison psychiatry service had established good links with the Peterborough City Hospital general and older peoples' wards, attended ward rounds when appropriate and had good relationships with the 'link' psychiatric liaison ward nurses. Staff spoke of the support they were able to access from other external organisations and we saw a wide range of external support organisations contact details were available on the team office walls and in the patient leaflets available.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice but were not vigilant in ensuring all documentation was available to access.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Compliance for Mental Health Act training was 86%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Our findings

Staff received training in the Mental Capacity Act, however compliance with this training was 63%. Staff we spoke with had a good understanding of at least the five principles.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff knew how to apply the Mental Capacity Act to patients aged 16 to 18 and where to get information and support on this.

Is the service caring?

Inspected but not rated



Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

We observed one staff and patient interaction, spoke to one patient and reviewed a patient satisfaction survey for the service across both the Peterborough City Hospital, and the Hinchingbrooke Hospital sites.

We saw that staff were discreet, respectful, and responsive.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff in the mental health crisis teams involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had access to advocates when needed. Staff informed and involved families and carers appropriately.

Our findings

Involvement of patients

The patient satisfaction survey asked a range of questions relating to; overall satisfaction, privacy and dignity, time given, environment, involvement in care planning and written information provided amongst others. The number of patients and carers surveyed was 80 and included 49 patients and carers attending the urgent and emergency care departments and 31 inpatients and their carers. We saw that 41 out of 49 survey responses were positive for the urgent and emergency care department and 27 out of 31 for the inpatients were positive.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties.

Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff made sure patients could access advocacy services.

Is the service responsive?

Inspected but not rated



Access and discharge

The liaison psychiatry service was available 24 hours a day through the urgent and emergency care of the Peterborough City Hospital and was easy to access. The referral process for the liaison psychiatry service was clear and all clinical Peterborough City Hospital staff were able to access this electronically.

The liaison psychiatry service had skilled staff available to assess patients 24-hours a day seven days a week. The service had specialist nurses based in the urgent and emergency care department available to assess and treat patients attending the department and were also able to support the rest of the Peterborough City Hospital staff for patients on the general wards.

Staff supported patients' mental health needs when they attended the urgent and emergency care department for support or needed physical health care, were referred or when they transferred between services.

Staff saw urgent referrals quickly and non-urgent referrals within the trust target time. The service had key performance indicators (KPIs) for the referral to assessment times in line with the Royal College of Psychiatry and National Institute for Health and Clinical Excellence (NICE) quality standard 14. The KPIs were monitored in the monthly performance reports and although there were no mandated targets to achieve, service managers anticipated 85% compliance in line with national benchmarking. The KPIs were related to:

- Urgent and emergency care department referral to assessment within one hour
- Urgent ward referral to assessment within four hours
- Routine ward referral to assessment within 48 hours

Our findings

Between November 2021 and January 2022, the liaison psychiatry service compliance for urgent and emergency care department referrals ranged between 86% and 95%, and for inpatient referrals between 88% and 95%. During the same period, the number of patients referred averaged 200 per month in the urgent and emergency care department and 100 on the inpatient wards.

The service provided data to show that for the period December 2021 to February 2022 one patient out of 26 patients who required a mental health inpatient bed had waited for one day.

Staff confirmed that patients were admitted to an area that was the most suitable at the time.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the interview room in the urgent and emergency care department supported patients' treatment, privacy and dignity.

The interview room had sound proofing to protect privacy and confidentiality, and was suitably furnished. Patients waiting to see the liaison psychiatry staff in the urgent and emergency care department waited in the main waiting area. At the time of inspection, this appeared to have enough seating for patients.

Meeting the needs of all people who use the service

The liaison psychiatry service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Staff made sure patients could access information on treatment, local services, their rights and how to complain.

The service had a wide range of information leaflets available in languages spoken by the patients and local community.

The liaison psychiatry managers made sure staff and patients could get hold of interpreters or signers when needed.

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 service they managed and were visible in the service and approachable for patients and staff.

The liaison psychiatry service had a service lead who was based at a remote head office, representation by consultant staff at director level, and a team manager who managed the nursing staff based at the Peterborough City Hospital and the Hinchbrook Hospital locations.

Staff commented that leaders were approachable and supportive.

Our findings

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.

All staff we spoke with were positive about working within the organisation and described a supportive and collaborative culture with not only their own organisation, but also with the staff at Peterborough City Hospital.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Governance issues were discussed at the monthly team business meeting and the monthly trust governance meetings.

Lines of accountability for escalation of governance issues from the liaison psychiatry team were through the trust and Peterborough City Hospital governance structures. The reporting processes for the trust were through the specialist services division and directly to the clinical director and service manager via the team business meeting.

Governance was also monitored at the quarterly trust and North West Anglia NHS Foundation Trust mental health liaison committee.

The service had appropriate operating procedures and local agreements to provide guidance to staff. These were agreed through the governance processes and with North West Anglia NHS Foundation Trust.

Management of risk, issues, information and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The service had a risk register where risks to the service were monitored. We reviewed the risks associated with the liaison psychiatry service and saw that these reflected the risks we found, were regularly reviewed and updated by the risk owner and included appropriate actions to mitigate the risk.

The service measured its compliance against an agreed set of key performance indicators and managerial staff were able to monitor their progress regularly and report in their monthly performance report.

The service manager had oversight of the daily running of the service with a daily escalation report relating to; the number of patients on the liaison psychiatry service caseload, the number of patients waiting to be seen in both the urgent and emergency care department and inpatients, and those awaiting a mental health service bed.

Engagement

Staff engaged actively with other local health and social care providers to ensure that an integrated health and care system was provided to meet the needs of the local population.

Our findings

There were effective, multi-agency arrangements to agree and monitor the governance of the liaison psychiatry service. Managers of the service worked actively with partner agencies including the police, ambulance service, primary care and local acute medical services to ensure that people received help and support in the general hospital inpatient setting.

Learning, continuous improvement and innovation

Staff in the liaison psychiatry service provided education sessions to the Peterborough City Hospital staff during day-to-day clinical work and in formal teaching sessions. They were regular contributors on the Peterborough City Hospital induction programme.

The service was involved in joint neurology/pain/chronic fatigue clinics with Peterborough City Hospital colleagues.

The service had set up a text messaging service for patients to access for advice and signposting to external services.

The liaison psychiatry service worked closely with the occupational health department at Peterborough City Hospital to address the issue of staff mental health. Referrals were in line with expected figures for the size of the organisation and the service was working providing further support to staff.

Staff had participated in Royal College of Psychiatry peer accreditation since 2018. The most recent accreditation expired in December 2021 and the service had recently undergone an accreditation review and was waiting for the outcome at the time of inspection.

A new initiative was due to start in April 2022 to measure performance against a Commissioning for Quality and Innovation (CQUIN). The CQUIN framework supports improvements in the quality of services and the creation of new, improved patterns of care.

The service had not completed or participated in any recent clinical audits to provide assurance of compliance against local standards during the COVID-19 pandemic. Records and care plan audits had recommenced however the service managers recognised that clinical audit was an area for improvement coming out of the COVID-19 pandemic. The service was due to start quarterly clinical audit of patient records as part of the National Institute of Health and Care Excellence (NICE) Biopsychosocial assessment in Mental Health Liaison Service guidance in April 2022. The audit will cover assessment, risk assessment and care plans.

Our findings

Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

- The trust must ensure that staff compliance with mandatory and required training improves particularly the suicide mitigation training.

Action the trust SHOULD take to improve:

- The trust should ensure that it undertakes regular clinical audit in order to provide assurance of compliance to local and national standards.

Our inspection team

The team that inspected the service comprised two CQC inspectors and one specialist advisor.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment