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Psychological Medicine in Bart's: improving access and awareness

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Abstract

Providing good quality psychiatric services to patients who attend general hospital has been an area that has attracted a lot of interest.(1)(2) We know that more than one quarter of general hospital patients have a mental disorder, mental ill health impedes recovery from physical illness, and mental disorders are often unrecognised in patients with physical illness. By improving the quality of our service we hope that we can achieve better integration with the medical teams and thus tackle the aforementioned problems.(3)(4) In our trust, relevant work has been completed by the clinical health psychology team in Cardiac Rehabilitation wards.

Our liaison team provides psychiatric assessment and treatment to inpatients at St Bartholomew's hospital that have been referred to us by our medical colleagues. We first observed that not all the medical teams are fully aware of the referral process and that they were keen on having training sessions and further education on the area of psychological medicine. Another area that we focused on during this process was making sure that we maintained quality of service provision while our service was in transition due to relocation.

Ward based information sessions and meetings were held. An introductory session to psychiatry was also provided on medical induction. Information leaflets with referral process and contact numbers were produced for staff at ward level and for administrative support . A liaison psychiatry pathway was created to incorporate the changes that occurred after the relocation of our service. Following these interventions there was significant improvement among the staff in recognising and referring patients with psychiatric issues through the use of liaison psychiatry pathway. There was also increase in satisfaction amongst staff.

Education improves understanding and awareness of mental illness and a care pathway focuses attention on this area, improving patient safety and quality of care.(5)(6)

Problem

We are a team of mental health professionals who are based at the St. Bartholomew's Hospital. We provide psychiatric assessment and treatment to inpatients that have been referred to us by our medical colleagues. We first observed that not all the medical teams are fully aware of the referral process to our team and thus the access to service was sometimes based on personal involvement and our presence on the medical wards. We also identified by using questionnaires that the medical teams were keen on having training sessions and further education on the area of psychological medicine. Finally, we didn't have a systematic way of collecting data for our patients. The latter would also be useful for service audit in the future. Another area that we focused on during this process was making sure that we maintained quality of service provision while our service was in transition due to relocation.

Aim statement

We want to improve access to our liaison service by the end of 2014 and identify further issues due to relocation by the end of March 2015. We have identified specific areas of intervention and change. We think that we can achieve this by improving awareness about psychological medicine and liaison psychiatry. We found out that medical teams were sometimes reluctant to refer to our services as they weren't familiar with the sub-specialty of liaison psychiatry and they weren't sure about the services that we can offer. Some of our tasks will be to have a clear and structured referral process, an easier and clearer pathway (new landlines, service email for routine referrals, referral forms, and out of hours contact numbers), being more present within the medical teams and providing better support and knowledge to medical teams (evidence based practice), introducing screening tools, and organizing training sessions.

Background

We discussed with current and previous team members and identified areas that need improvement in order to reflect the current focus and interest on the integration of mental health into physical healthcare systems. Providing good quality psychiatric services to patients who attend general hospital has been an area that has attracted a lot of interest.(1) We know that more than one quarter of general hospital patients have a mental disorder, mental ill health impedes recovery from physical illness, and mental disorders are often unrecognised in patients with physical illness. By improving the quality of our service we hope that we can achieve better integration with the medical teams and thus tackle the aforementioned problems. In our trust, relevant work has been completed by the clinical health psychology team in Cardiac Rehabilitation wards.

Physical and mental health are inextricably intertwined. Long-term conditions (LTCs), such as diabetes, are associated with high rates

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of mental illness. Some 70% of NHS spend goes on the treatment of LTCs, a great deal of which currently involves treatment in acute hospitals.

- Psychological stress is often expressed as physical symptoms, which are an example of medically unexplained symptoms (MUS).
- The mental health needs of a patient in a physical health care setting often remain undiagnosed and therefore untreated. To optimise the physical health care of patients, it is essential that their mental health and wellbeing are addressed at the same time.
- Liaison services should be provided throughout the acute hospital, including in A&E departments. Services should be provided to meet the needs of patients with a mental disorder secondary to their physical disorder, or a physical disorder alongside their mental disorder, and for patients (particularly those with MUS) where it is impossible to separate the two.
- Acute liaison services operate within existing (often ad hoc) local networks of other generic and disorder-specific clinical health psychology and multidisciplinary services. This should be mapped out by commissioners so that acute liaison becomes a primary partner in the effective management of the emotional and adjustment/behavioural needs of all patients presenting to acute services.
- A liaison service should be an integral part of the services provided by acute hospital trusts – trusts that have incorporated a liaison service have demonstrated much better cost effectiveness.
- Acute liaison services should have the resources and skills needed to support all age groups.
- Liaison services may, over time, extend their remit to help primary mental health care to manage people with LTCs and MUS, in order to avoid unnecessary admissions to secondary care.

See supplementary file: ds4453.pdf - “LiaisonPsychiatryCommissionining”

Baseline measurement

For this project, two measures were considered and used. The first was a satisfaction/awareness scale that we designed and was completed by a sample of doctors and psychologists that have been responsible for doing referrals to our team. We were thus able to measure their satisfaction with the service and identify specific areas for improvement. The second was the design and the completion of a detailed database, including information on the number of the referrals and the type of interventions that we have been providing.

See supplementary file: ds4936.docx - “LiaisonPsychiatryAwarenessSatisfactionQaire 14 10 14 (3)”

Design

When considering the underlying causes of this problem, it became apparent that teams would need further support and gain more knowledge and confidence in being able to recognise psychiatric problems. We would also need to provide them with a clearer referral pathway. We considered several different ways of achieving our goals and making changes. First of all we started using the questionnaires in order to collect information and uncover specific areas for improvement. We then made posters with our contact numbers and the structure of our team. We also made posters with referral information and contact numbers for the administrator taking referral. We managed to organise teaching sessions and incorporate training about psychiatric emergencies during the induction day for new doctors. We started using database for retrospective data analysis and auditing purposes. Finally, we tried to increase our presence in medical wards by attending ward rounds and thus facilitating integration.

Strategy

Improvement (PDSA) cycle 1

Assessment of the problem through a satisfaction and awareness questionnaire revealed a gap in the knowledge of staff in recognising and referring patients with mental illness. It was noted that the majority of staff would like to have further teaching on common liaison psychiatry topics. As a result, information session was organised as part of the induction for new doctors.

These educational sessions used information from the NICE delirium awareness workshop session guide (1). Information leaflets on cancer psychology services were distributed.

Improvement (PDSA) cycle 2

Our service was relocated in December 2014 and this revealed a further gap in the referral pathway. Medical staff were not aware of our contact details and how to make a referral. We also had to operate from out of site and this would have an impact on the delivery of our services. As a result we created laminated charts with our contact details and referral pathway for working hours and out of hours psychiatric cover. We also had to clarify the timeframe of our response. Also, we created an email address, nhs.net, for non urgent referrals.

Improvement (PDSA) cycle 3

Due to changes in our administrative staff, we identified that there was no sufficient cover to receive referrals and staff were not trained to take referrals and respond to liaison psychiatry emergencies. We created a charter with referral protocol and contact details. We also decided to circulate a rota on weekly basis indicating the clinician covering all emergencies.

See supplementary file: ds4937.docx - “PDSA Cycles (1)_2”

Post-measurement

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For this project, two measures were considered and used. The first was a satisfaction/awareness scale that we designed and was completed by a sample of doctors and psychologists that have been responsible for doing referrals to our team. We repeated the measurement after the training sessions. Most of the medical doctors (90%) were "very satisfied" with our service and "knew how to make a referral to the liaison psychiatry". All doctors would like to have further training in liaison psychiatry. The second tool we used was a detailed database, including information on the number of the referrals and the type of interventions that we have been providing. After our intervention, the number of referrals remained the same with minimum one referral per week and maximum four referrals per week.

Lessons and limitations

This project was run by the liaison psychiatry team, a relatively small team, which consists of three doctors and one psychologist . A process of staff education along with the introduction of a clear referral pathway increased psychiatry awareness and satisfaction within the medical staff. Our view is that both components of the intervention programme were required to improve awareness. As well as improving our liaison service we learnt valuable skills during the process including; team working, organising meetings, negotiating, and organising teaching and information sessions. Most importantly we realised that quite simple changes can improve the systems and processes that we use, ultimately improving the quality of care for not just our patients but the wider patient population. This project had almost no financial cost attached to it and we worked willingly in our own time.

One of the most important lessons was about pre-intervention data. As our intervention was focused on satisfaction and awareness we had to create a qualitative tool and therefore we could not do statistical analysis.

Engaging the medical teams is an essential part of rolling out our intervention. Liaison psychiatry works closely with medical teams and by communicating efficiently we were able to identify the areas that need to be improved. Medical staff are often too busy and therefore it was difficult to organise teaching and information sessions. In addition the sample size for our measurement tool was very small.

In the process of making those changes we had to relocate our service and this meant that we had to try and maintain the quality of service provision while in transition. For that reason we had to adjust our referral protocol and train our administrative staff.

Conclusion

Providing good quality psychiatric services to patients who attend general hospital has been an area that has attracted a lot of interest. According to existing literature a large number of general hospital patients have a mental disorder, mental ill health impedes recovery from physical illness and mental disorders are often unrecognised in patients with physical illness. By improving the quality of our liaison service we hope that we can achieve better integration within the medical teams and thus tackle the aforementioned problems. The Bart's liaison psychiatry team ran this project. A process of staff education along with the introduction of a clear referral pathway increased psychiatry awareness and satisfaction within the medical staff. As well as improving our liaison service we learnt valuable skills during the process including team working, organising meetings, teaching and information sessions. Most importantly, we realised that quite simple changes can improve the systems and processes that we use, ultimately improving the quality of care of not just our patients but of the wider patient population.

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Declaration of interests

Nothing to declare

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Ethical approval

According to the policy activities that constitute research at East London Foundation Trust this work met criteria for operational improvement activities exempt from ethics review. We used the following criteria for determining if improvement activities require ethics review.

Policy criterion: The work is primarily intended to improve local care, not provide generalisable knowledge in a field of inquiry and

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not a study on human subjects. Explanation: We sought only to evaluate the improvements in compliance with referral process and education of medical teams as a result of feedback of access and awareness questionnaires given to hospital staff.

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Joint Commissioning Panel
for Mental Health

www.jcpmh.info

Guidance for commissioners of

liaison mental health services to acute hospitals

Volume Two:

Practical mental health commissioning

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Executive summary

- Physical and mental health are inextricably intertwined. Long-term conditions (LTCs), such as diabetes, are associated with high rates of mental illness. Some 70% of NHS spend goes on the treatment of LTCs, a great deal of which currently involves treatment in acute hospitals.
- Psychological stress is often expressed as physical symptoms, which are an example of medically unexplained symptoms (MUS).
- The mental health needs of a patient in a physical health care setting often remain undiagnosed and therefore untreated. To optimise the physical health care of patients, it is essential that their mental health and wellbeing are addressed at the same time.
- Liaison services should be provided throughout the acute hospital, including in A&E departments. Services should be provided to meet the needs of patients with a mental disorder secondary to their physical disorder, or a physical disorder alongside their mental disorder, and for patients (particularly those with MUS) where it is impossible to separate the two.
- Acute liaison services operate within existing (often ad hoc) local networks of other generic and disorder-specific clinical health psychology and multidisciplinary services. This should be mapped out by commissioners so that acute liaison becomes a primary partner in the effective management of the emotional and adjustment/behavioural needs of all patients presenting to acute services.
- A liaison service should be an integral part of the services provided by acute hospital trusts – trusts that have incorporated a liaison service have demonstrated much better cost-effectiveness.
- Commissioning of acute liaison services should be universally included in contracts for the provision of acute hospital services and concord to standards set by professional and regulatory authorities.
- Acute liaison services should have the resources and skills needed to support all age groups.
- Liaison services may, over time, extend their remit to help primary mental health care to manage people with LTCs and MUS, in order to avoid unnecessary admissions to secondary care.

Introduction

The Joint Commissioning Panel for Mental Health (JCP-MH) (www.jcpmh.info) is a new collaboration co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists, which brings together leading organisations and individuals with an interest in commissioning for mental health and learning disabilities. These include:

- Service users and carers
- Department of Health
- Association of Directors of Adult Social Services
- NHS Confederation
- Mind
- Rethink Mental Illness
- National Survivor User Network
- National Involvement Partnership
- Royal College of Nursing
- Afiya Trust
- British Psychological Society
- Representatives of the English Strategic Health Authorities
- Mental Health Providers Forum
- New Savoy Partnership
- Representation from Specialised Commissioning
- Healthcare Financial Management Association.

The JCP-MH is part of the implementation arm of the government mental health strategy *No Health without Mental Health*.[1]

The JCP-MH has two primary aims:

- to bring together service users, carers, clinicians, commissioners, managers and others to work towards values-based commissioning
- to integrate scientific evidence, service user and carer experience and viewpoints, and innovative service evaluations in order to produce the best possible advice on commissioning the design and delivery of high quality mental health, learning disabilities, and public mental health and wellbeing services.

The JCP-MH:

- has published *Practical Mental Health Commissioning*,[2] a briefing on the key values and principles for effective mental health commissioning
- provides practical guidance and a developing framework for mental health
- will support commissioners of public mental health to deliver the best possible outcomes for community health and wellbeing
- has published a series of short guides describing 'what good looks like' in various mental health service settings.

WHO IS THIS GUIDE FOR?

This guide describes what 'good looks like' for a modern acute liaison service. It should be of value to Clinical Commissioning Groups (who will be commissioning secondary services, both specialist mental and acute).

HOW WILL THIS GUIDE HELP YOU?

This guide has been written by a group of acute liaison experts in consultation with patients and carers.

The content is primarily evidence-based but ideas deemed to be best practice by expert consensus have also been included. By the end of this guide, readers should be more familiar with the concept of acute liaison and better equipped to:

- understand what a good quality, modern, acute liaison service looks like
- understand why a good acute liaison service delivers the objectives of the mental health strategy and the Quality, Innovation, Productivity and Prevention (QIPP) challenge – not only in itself but also by enabling changes in other parts of the system.

This guide also addresses issues relating to the commissioning of acute liaison services. It describes:

- the benefits of liaison services
- the optimum liaison psychiatry team
- the mental health needs in acute care settings that a liaison service addresses
- why a liaison service is important for commissioners of acute hospital services.

This guide draws on, and refers to, previously published guidance including:

- the Royal College of Psychiatrists College Centre for Quality Improvement PLAN standards[3]
- the Royal College of Psychiatrists CCQI Mental Health Policy Implementation Guide for Liaison Psychiatry and Psychological Medicine in the General Hospital[4]
- the Royal College of Psychiatrists briefing No Health without Mental Health: the Supporting Evidence[5]
- the NHS Confederation briefing Healthy Mind, Healthy Body.[6]

What are acute liaison services?

An acute liaison service is designed to provide services for:

- people in acute settings (inpatient or outpatient) who have, or are at risk of, mental disorder
- people presenting at A&E with urgent mental health care needs
- people being treated in acute settings with co-morbid physical disorders such as long-term conditions (LTCs) and mental disorder
- people being treated in acute hospital settings for physical disorders caused by alcohol or substance misuse
- people whose physical health care is causing mental health problems
- people in acute settings with medically unexplained symptoms (MUS).

The service aims to increase the detection, recognition and early treatment of impaired mental wellbeing and mental disorder to:

- reduce excess morbidity and mortality associated with co-morbid mental and physical disorder
- reduce excess lengths of stay in acute settings associated with co-morbid mental and physical disorder
- reduce risk of harm to the individual and others in the acute hospital by adequate risk assessment and management
- reduce overall costs of care by reducing time spent in A&E departments and general hospital beds, and minimising medical investigations and use of medical and surgical outpatient facilities
- ensure that care is delivered in the least restrictive and disruptive manner possible.

Why is acute liaison important to commissioners?

The problems acute liaison addresses are common:

- mental disorder accounts for around five per cent of A&E attendances, 25% of primary care attendances, 30% of acute inpatient bed occupancy and 30% of acute readmissions[7]
- self-harm accounts for between 150,000 and 170,000 A&E attendances per year in England[8]
- MUS may account for up to 50% of acute hospital outpatient activity[9]
- 13–20% of all hospital admissions and up to 30% of hospital admissions via A&E at weekends are related to alcohol[10]
- in England, alcohol-related hospital admissions doubled in the 11 years up to 2007, and alcohol-related deaths also doubled in the 15 years to 2006[11]
- one quarter of all patients admitted to hospital with a physical illness also have a mental health condition that, in most cases, is not treated while the patient is in hospital[6]
- most patients who frequently re-attend A&E departments do so because of an untreated mental health problem[6]
- two thirds of NHS beds are occupied by older people, up to 60% of whom have or will develop a mental disorder during their admission.[6]

MENTAL AND PHYSICAL HEALTH ARE CLOSELY LINKED

Mental illness increases risk of physical illness and complicates its management. Depression is associated with:

- reduced life expectancy of 10.6 years in men and 7.2 years in women[12]
- increased risk of coronary heart disease[13]
- four-fold increased risk of myocardial infarction (MI) and four-fold increased risk of death within six months of myocardial infarction[14]
- two-fold increased risk of type 2 diabetes[15]
- three-fold increased risk of non-compliance with treatment recommendations.[16]

Schizophrenia is associated with:

- reduced life expectancy of 20.5 years in men and 16.4 years in women[17]
- three-fold increased death rate from respiratory disease[18]
- two-fold increased risk of obesity, two to three-fold increased risk of smoking, two-fold increased risk of diabetes, two to three-fold increased risk of hypertension, five-fold increased risk of dyslipidaemia and two to three-fold increased risk of metabolic syndrome.[19]

Substance use disorder is associated with 13.6 year reduced life expectancy for men and 14.8 years for women.[12]

Smoking is the main cause of preventable death in the general population. People with a mental disorder smoke much more than people without a mental disorder: they consume 42% of all tobacco consumed in England.[20]

Why is acute liaison important to commissioners? (continued)

Physical illness increases the risk of mental illness. Depression is more common in those with a chronic physical illness.[21] Risk of depression is doubled for people with diabetes, hypertension, coronary artery disease and heart failure, and tripled in those with stroke, end-stage renal failure and chronic obstructive pulmonary disease.[22]

Depression is more than seven times more common among people with two or more chronic physical conditions.[23] One in five people newly diagnosed with cancer or first hospitalised with a heart attack will develop depression or anxiety within one year.[24]

Children with physical illness are at increased risk of emotional or conduct disorder.[25]

INTEGRATED MENTAL AND PHYSICAL HEALTH CARE

The close links between mental and physical health highlight the importance of an integrated approach to treating physical and mental illness. However, traditionally mental and physical health care have been commissioned separately; it is rare that the needs of patients with mental and physical health problems are provided for through a single funding stream.

Mental health and physical health are closely linked. Liaison services provide commissioners with a means to address this in the acute hospital setting. Liaison services can significantly reduce incidence of mental illness associated with physical illness and vice versa, thereby reducing the burden on both primary and secondary care. The focus of Improving Access to Psychological Therapies (IAPT) has been extended to cover psychological interventions for LTC co-morbidity and MUS.

Mental illness can frequently cause or aggravate physical disorder. These disorders are seen and treated in acute hospital settings. The commissioners of acute hospital services should therefore be responsible for commissioning acute liaison services to meet this need.

Liaison services are important in facilitating collaborative care approaches to both mental and physical health conditions. Closer working between primary and secondary care staff is particularly important in improving the confidence of specialist mental health staff in identifying, preventing and intervening early with physical health problems, and vice versa (see the companion primary mental health care commissioning guide).

THE QUALITY AND PRODUCTIVITY CHALLENGE (QIPP)

Commissioners are required to improve quality while at the same time increasing productivity (QIPP). Liaison services provide an excellent opportunity to do this by:

- improving clinical outcomes
- reducing admissions to and lengths of stay in acute settings
- ensuring patients with co-morbid long-term conditions receive better treatment while using fewer health care resources
- treating and reducing costs for patients with MUS
- reducing psychological distress following self-harm, and reducing suicide.

What do we know about the current provision of acute liaison services?

There is currently no single, uniform model for liaison services across the country. Where such services exist, they are often provided by the local mental health trust within the estate of the acute hospital trust, which may present logistical and operational challenges.

Liaison services are commonly commissioned by the commissioners of mental health services (rather than the commissioners of acute hospital care). This is despite the fact that the acute trust should be providing them, and the quality and productivity benefits that derive from the service are realised within the acute hospital setting.

Most acute liaison services could provide the following:

- advice, training and coaching on the management of mental health problems to other professionals in the acute hospital
- biopsychosocial assessment, formulation and diagnosis for people identified by acute hospital staff as experiencing impaired mental wellbeing or whose physical symptoms are unexplained
- brief interventions, advice and signposting to services in a range of agencies for patients in acute hospital settings
- participation in Mental Health Act and Mental Capacity Act assessments, and performing risk assessments for harm to self and others
- expert advice on capacity to consent for medical treatment in complex cases involving both physical and mental health problems
- acting as a Responsible Clinician under the Mental Health Act for people detained under the Act, and receiving care in the acute hospital
- rapid response to requests for assessment in the A&E department and on acute hospital wards (assessment and management of people who have self-harmed forms a significant proportion of this responsibility)
- development of care plans post-assessment
- arranging appropriate follow-up post-discharge
- assessment of people with MUS
- management of people with MUS who require a higher level of input than can be provided by lower intensity services such as IAPT – in association with primary care, specialist medical teams and other specialist multidisciplinary teams (eg. chronic fatigue syndrome/ME services)
- contributing to the management of people with long-term physical conditions in collaboration with primary care and specialist physical health multidisciplinary teams (eg. diabetes psychology and dietetics)
- assistance with the management of people with long-term physical conditions
- assessment, management and signposting of patients with alcohol and substance misuse disorders.

The service could bring the following benefits:

- increased mental health care capacity within the acute hospital through collaboration
- improved wellbeing of staff in acute hospital settings, by relieving the anxiety these staff sometimes feel when dealing with patients with complex needs – this may in turn help reduce levels of sickness absence
- improved patient self-management of their care
- improved physical care of people with mental disorder
- reduced stigma associated with mental health care.

What do we know about the current provision of acute liaison services? (continued)

Models of acute liaison service vary greatly, from those that provide a 'core' adult mental health liaison service to those that cater for more complex needs (learning disability, dementia, children and young people). However there is a considerable body of work that describes what liaison services should do, how they should be organised and what standards they should achieve.

Liaison psychiatry provision is often patchy, despite its core role in risk management and in facilitating good physical health care. The picture is further complicated by the range of other services that provide behavioural input to physical health care. Liaison services have a unique and essential role in providing broad cover across health care settings, and in their capacity to handle the most severe and risky mental health problems. However, commissioners will also need to consider the range of other services that provide evidence-based talking therapies and rehabilitation for physical health problems, including MUS and LTCs. These include:

- clinical health psychology embedded in medical teams, such as oncology, diabetes, renal, rheumatology or respiratory teams and providing specialist talking therapies, assessment, consultation, training and research
- chronic pain management teams and chronic fatigue teams, operating over a wider area than a single acute hospital
- cancer network of psychosocial support professionals, organised to support sophisticated training arrangements for medical and nursing oncology staff (and often including liaison psychiatrists)
- cardiac and pulmonary rehabilitation teams.

Existing liaison services tend typically to be for adults with mental health needs, and not for children and young people. An important development would be for commissioners to commission liaison services that are age-inclusive. The liaison needs of children and young adults may differ in some respects from those of adults and older people but the principles and benefits are applicable across all ages. This all-age approach will present challenges to the way in which services are currently organised but is important if the ambition of the English mental health strategy is to be realised through the commissioning process.

Furthermore, the current patchy nature of liaison services commissioning leads to patchy provision. There should be universal agreement to commission liaison services as part of the acute hospital care commissioning process.

What would a good liaison service look like?

MODEL OF SERVICE DELIVERY

A good liaison service functions best as a discrete, specialised, fully integrated team comprising multi-professional health care staff, under single leadership and management.

A core service should be based on the following principles:

- staff members sole (or main) responsibility is to the acute liaison team
- the team includes adequate skill mix
- the team has strong links with specialist mental health services and good general knowledge of local resources
- there is clear and explicit responsibility for all patients in the acute hospital setting
- there is one set of integrated multi-professional healthcare notes
- consultant medical staff are fully integrated.

KEY COMPONENTS OF THE SERVICE

A comprehensive liaison service will have the following features:

- ability to work closely with the acute hospital through integrated governance, open (pre-referral) discussion with the hospital's principal referring units, a single point of referral and the capacity to serve the agreed hospital population
- provision of comprehensive assessment and formulation, including risk assessment and joint assessment where appropriate, using recognised formal instruments to provide diagnosis and formulation that leads to an agreed plan that is communicated in a timely manner
- capacity to engage effectively with the patient in a safe place that allows a positive therapeutic relationship to be built
- provision of a range of interventions including signposting, support, psychosocial interventions, therapeutic interview, brief psychotherapeutic interventions, and pharmacotherapy
- effective liaison with other parts of the health system, including general practice, crisis and in-patient teams, specialist mental health teams, social services, emergency services and non-statutory agencies
- broad capacity building across the health and social care system so that mental health is much more readily recognised as a concomitant to physical health (liaison clinicians should be able to assess physical health as well as mental health, manage mental health issues, recognise the remit of their capabilities, and refer to psychiatric services when appropriate)
- provision of supervision, liaison and direct clinical activity outside the acute setting and into primary care when care pathways for patients with MUS, LTCs or other issues require consistency of care in order to avoid deterioration or re-admission
- all-age inclusive services, including liaison services for children, older people and adults with dementia
- holistic and culturally responsive services.

What would a good liaison service look like? (continued)

STANDARDS

Commissioners will need to commission liaison services that can demonstrate that they meet the recognised standards for the service.

These are set out in the Royal College of Psychiatrists College Centre for Quality Improvement (CCQI) Plan standards,[3] against which liaison services may be accredited. These are not currently mandatory. It is suggested that the PLAN accreditation process becomes a commissioning requirement, with the joining fee included in the commissioning process.

THE OPTIMUM LIAISON TEAM

To provide the breadth of services set out above, a range of staff operating within a multidisciplinary team is essential.

Table 1 sets out the absolute minimum staff requirements to provide an adult care liaison service working office-hours within an acute hospital with 650 beds, as described in the Royal College of Psychiatrists Mental Health Policy Implementation Guide.[4]

Table 1: Examples of levels and skill mix for a team serving a general hospital with 650 beds and 750 new self-harm patients per year. (Mental Health Policy Implementation Guide, 2008)

ROLE	GRADE	TIME	COMMENT
Medical	Consultant	Whole time	Consultant involvement is essential, including managing risk, providing supervision and training, and offering expertise on psychopharmacological treatment, complex patients, capacity and the Mental Health Act.
Nursing	Band 8	Whole time	One of the nursing roles should be as team leader.
Nursing	Band 7	3 x whole time	The nurses operate as autonomous practitioners, undertaking assessments, and brief treatment interventions, and liaising with mental health teams in primary care. Those working with older adults will become involved in detailed discharge planning.
Clinical Psychology	Band 8	1	May be provided from health psychology team, but should be an integral part of a liaison team to provide supervision, training and delivery of brief psychological treatments.
Team PA	Band 4	1.5 x whole time	Core to referral management, information gathering and communication.

ADDITIONAL STAFFING REQUIREMENTS

If liaison professionals are to provide teaching, training and support to colleagues within their team and throughout the general hospital, the staffing ratios above would need to be increased to allow for this.

Similarly, a greater number of staff will be needed to provide a comprehensive office hours liaison service for:

- adults with complex needs
- older-age adults –all senior staff will need experience in older people's mental health, and all teams should have the necessary requirements to allow training of juniors and students for all professional groups
- CAMHS – child and adolescent mental health services to general hospitals should be provided by specialist multidisciplinary CAMHS liaison teams, but current provision is patchy and further investment is required.

The model of acute liaison services outlined in this guide will require a number of additional therapists with experience of working with people with MUS. These therapists may come from a variety of backgrounds, including social work, occupational therapy and physiotherapy

For examples of guidance on appropriate staffing levels for older-age adults and other population groups please see references[26-31],as well as the existing JCP-MH series of guides on commissioning **(www.jcpmh.info)**.

OUTCOMES

The quality outcomes of liaison services include:

- improved service user experience and care outcomes
- improved access to mental health care for a population with high morbidity
- reduced emergency department waiting times for people with mental illness
- reduced admissions, re-admissions and lengths of stay
- reduced use of acute beds by patients with dementia
- reduced risk of adverse events
- enhanced knowledge and skills of acute hospital clinicians
- improved compliance of acute trusts with legal requirements under the Mental Health Act (2007) and Mental Capacity Act (2005)
- improved compliance with NHS Litigation Authority Risk Management Standards and the Clinical Negligence Scheme for Trusts (CNST).

RAID: AN EXAMPLE OF SERVICE INNOVATION

The Rapid Assessment Interface and Discharge (RAID) service is an age-inclusive, drugs/alcohol inclusive, consultant-led service that is fully integrated into the structure and function of an acute hospital in Birmingham. It has shown dramatic reductions in bed use,particularly use of acute/elderly ward beds by patients with dementia.

RAID is a new model for acute liaison services developed by Birmingham and Solihull Mental Health Foundation Trust and the University of Staffordshire. It has been piloted at Birmingham's City Hospital, an inner city general hospital with some 600 beds.[31]

The service offers consultation and liaison to A&E, the medical assessment unit and the medical, maternity and surgical wards, with response targets of one hour for A&E and 24 hours for inpatients.

RAID builds on existing liaison services, adding health and social care capacity to the liaison team, plus specialist skills in older adults and addictions – as such, it is a complete, all-age mental health service within an acute trust.

RAID is viable at a cost of circa £1 million for a hospital of circa 600 beds.

Economic evaluation of RAID, undertaken by the London School of Economics, has demonstrated that it can achieve the following outcomes, over and above traditional liaison services:

- reduce admissions, leading to a reduction in daily bed requirement of 44 beds per day, saving the NHS £3.55 million per annum through decommissioning acute beds
- reduce discharges to institutional care for elderly people by 50%, saving local authorities £3 million per annum in contributions to residential care
- produce a consequent cost-to-return ratio of £1 to £4.

Quality indicators have confirmed good patient feedback on improved holistic care in acute care settings. Staff feedback has confirmed that the team is popular and has built capacity and confidence in managing patients with mental health issues, reduced violence and improved morale (as evidenced in the annual staff survey).

In terms of hospital efficiency, waiting times for mental health patients in A&E have been reduced by 70%, which is reflected in an overall improvement in A&E waiting times.

The service is to expand across the Birmingham acute care health economy to cover five acute hospitals with 3,600 beds in total. Throughout this expansion it will be subject to ongoing evaluation.

Supporting the delivery of the mental health strategy

The JCP-MH believes that commissioning that leads to good acute liaison services, as described in this guide, will support the delivery of the mental health strategy[1] in a number of ways.

Shared objective 1: More people will have good mental health.

Commissioning acute liaison services will increase the number of people receiving appropriate care and support and reduce the number developing mental illness. This is because they provide early identification, diagnosis, and either treatment or referral, for people with mental health needs admitted to acute hospital.

Shared objective 2: More people with mental health problems will recover.

A patient's road to recovery is often made more difficult by the co-morbidity of physical and mental health needs. By commissioning a liaison service that addresses both physical and mental health needs together, the prospects of recovery are enhanced.

Shared objective 3: More people with mental health problems will have good physical health.

Ensuring that a person's mental health needs are also addressed when they are in an acute hospital for treatment for their physical health needs removes one of the potential barriers to provision of good physical health care. Liaison services can reduce the risk of self-harm and suicide while also addressing the long-term conditions and medically unexplained symptoms with which many patients present.

Shared objective 4: More people will have a positive experience of care and support.

By addressing both physical and mental health needs together, acute liaison services can improve the likelihood of patients experiencing more holistic and positive care in acute hospital settings.

Shared objective 5: Fewer people will suffer avoidable harm.

One of the key components of a good liaison service is to assess the risk of self-harm and harm to others. Commissioners should look to a liaison service to both provide short-term interventions and appropriate onward referral and signposting. Reducing outpatient attendance, hospital admissions and readmissions protects patients from avoidable harm.

Shared objective 6: Fewer people will experience stigma and discrimination.

By commissioning services that recognise mental and physical health as inseparable and inter-related, commissioners will be actively addressing the stigma that derives from the artificial separation of physical and mental health and increasing public and professional understanding of their frequent coexistence.

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Development process

This guide has been written by a group of liaison care experts, in consultation with patients and carers. Each member of the Joint Commissioning Panel for Mental Health received drafts of the guide for review and revision, and advice was sought from external partner organisations and individual experts. Final revisions to the guide were made by the Chair of the Expert Reference Group in collaboration with the JCP's Editorial Board (comprised of the two co-chairs of the JCP-MH, one user representative, one carer representative, and technical and project management support staff).

Resources

The Joint Commissioning Panel for Mental Health (JCP-MH)

www.jcpmh.info

This website describes the function and intended outputs of the JCP-MH

Quality standards for liaison psychiatry services (2nd ed).

Royal College of Psychiatrists College Centre for Quality Improvement Psychiatric Liaison Accreditation Network (PLAN) (2010)

www.rcpsych.ac.uk/pdf/PLANStandards%202nd%20Edition%20Final.pdf

This report sets out standards for acute liaison services.

Mental Health Policy Implementation Guide: Liaison Psychiatry and Psychological Medicine in the General Hospital

Royal College of Psychiatrists (2008)

www.rcpsych.ac.uk/pdf/PIG2.pdf

This report focuses on the key components that should be in place in a liaison team if the service is to operate effectively.

No Health without Mental Health: the ALERT summary report.

Academy of Medical Royal Colleges (2009)

www.rcpsych.ac.uk/pdf/ALERT%20print%20final.pdf

This report, produced by the PLAN team with the Royal College of Psychiatrists Liaison Faculty highlights the importance of liaison services and argues that every hospital should have access to these services.

Healthy Mind, Healthy Body

NHS Confederation (2009)

www.nhsconfed.org/Publications/Documents/Briefing_179_Healthy_mind_healthy_body_MHN.pdf

This briefing explains how liaison psychiatry services can transform quality and productivity in acute settings. It sets out some good practice examples together with academic evidence to build a business case for liaison psychiatry services.

Managing Urgent Mental Health Needs in the Acute Trust

Academy of Medical Royal Colleges (2008)

www.rcpsych.ac.uk/pdf/ManagingurgentMHneed.pdf

This report outlines the case for investing in liaison mental health services and sets out a set of recommendations and standards that should underpin these services.

Department of Health mental health website

www.dh.gov.uk/en/Healthcare/Mentalhealth/MentalHealthStrategy/index.htm

National Institute for Health and Clinical Excellence (NICE)

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