Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

North Middlesex University Hospital NHS
NHS Trust

NMUH Mental Health Liaison Service

OPERATIONAL FRAMEWORK

1.0 Introduction

The North Middlesex Mental Health Liaison Service (under Barnet, Enfield and Haringey Mental Health NHS Trust) provides rapid assessment and treatment of adult patients in the North Middlesex University Hospital (NMUH) who present with mental health difficulties. In addition, the service provides support and education to the staff of NMUH. The Service works according to the principles of the RAID (Rapid Assessment, Interface and Discharge) model.

2.0 Purpose, Vision and Values

The Mental Health Liaison Service delivers multidisciplinary specialist mental health input to both A&E and the wards of the North Middlesex University Hospital. The service is committed to providing timely and thoughtful input when invited, working closely together with our acute sector colleagues to support optimal, and patient-centred care. We seek to educate and empower the patients we work with and through both informal and formal training improve attitudes, knowledge and skills among staff on mental health within the acute setting.

The values outlined below describe some of the key intentions behind the team and how we strive to be in relationship with those with whom we come into contact in the delivery of the service. Our approach is:

1. Person-centred and flexible
2. Mindful and therapeutic
3. Professional, safe, boundaried
4. Open, enthusiastic, innovative
5. Empowers through education

These values will also incooperate the BEH trust values of Compassion, Respect, Being Positive and Working together

Specific aims include:

- To reduce length of stay of in-patients
- To divert patients presenting to A&E to appropriate services e.g. Crisis Resolution and Home Treatment Teams (CRHTT), voluntary sector organizations etc.
- To support the facilitation of discharges as much as possible where there is mental health issues.
- To reduce care home admissions
- To improve integration with community health services (including primary care)
- To optimize Safeguarding procedures (children and adults)

3.0 Service Description

3.1 Service Model

The service model is based on timely assessment of all patients (age 16 and over) presenting to A&E with mental health problems or who are in-patients of NMUH, 24 hours a day, 7 days a week. All clinical staff have the generic skills to assess all referred patients. Staff members specialise in the key areas of dementia, self-harm, alcohol problems, mental capacity issues, and medically unexplained symptoms.

The team has a high profile both in A&E and on the inpatient wards and endeavours to identify patients as early as possible in the care pathway where appropriate working collaboratively with our acute sector colleagues. We explore alternatives to in-patient care where clinically appropriate.

The team has good links with community services so that patients can be accurately signposted and make the transition from hospital to community care with minimal disruption and delay.

The team will work proactively with hospital staff to improve their care pathways in mental health services.

3.2 Service Personnel

- Team Manager 0.5 WTE
- Consultant Psychiatrists 2.0 WTE
- Nurses (4 x Band 7 and 5 x Band 6) 9.0 WTE
- Psychologist 1.0 WTE
- Associate Mental Health Worker 2.0 WTE
- Team Administrators 1.5 WTE
- Peer Support Workers (One year Fixed Term Project 5. 8 WTE

Therapeutic Engagement:

The Liaison Service will work in a therapeutic manner. All interactions will be therapeutic to support best practice and treatment and be evidence-based.

3.3 Hours of service

The hours for assessing patients in A&E and ward-based patients are 24 hours a day, every day.

3.4 Referral Criteria

1. Patients must be in A&E or admitted to an adult ward in the NMUH and be 16 years or older.

2. Patients must have a (possible) mental health component to their presentation.

Note: There are no other exclusion criteria as the principle of the service is to work with patients and clinical teams wherever mental health expertise would be of benefit. The decision to assess a patient is a matter of clinical judgment exercised by the Mental Health Liaison Team.

Typical presentations include:

- Primary mental health problems, presenting acutely (including self-harm, suicidality and psychosis)
- Co-morbid mental health problems (including dementia, substance misuse, and depression) that may be impacting on their physical health problem.
- Medically unexplained symptoms
- Perinatal mental illness

Our input is not limited to these patient groups – we are open to all appropriate referrals.

3.5 Referral Process

Referrals for both A&E and the wards will be taken by phone extension 3207
Out of hours, if there is no answer from ext. 3207, bleep 899
For full workflow see Appendix 4.

3.6 Assessment

Referrals will be screened and then if appropriate assessed by multi-disciplinary team (MDT) members. A comprehensive bio-psycho-social assessment along with a mental state examination and assessment of safety will be conducted.

Assessment to include:
Current problem
Background history of the problem
Relevant physical health problems and history
Drug and alcohol use
Social and Personal History
Family and carers views
Contact with children or young people
Mental State Examination
Risk assessment
Formulation including working diagnosis
Co-Produced Care Plan

Young Persons (16 and 17 year olds):
These cases will be routinely discussed with Child and Adolescent Mental Health Services (normally either the on call Consultant or out of hours on call ST5-6 doctor). CAMHS related consultation and bed management, when required, is to be provided to the Mental Health Liaison team consistently in line with CAMHS operating policies. Adult bed managers will be able to provide additional support where an admission is necessary and there are delays in finding an appropriate route for admission of a young person.

3.7 Consent

Patients will be asked to explicitly consent to the assessment by the referring clinician. Where a patient lacks capacity to consent to assessment a decision will be made in the patient's best interests under the MCA (2005) and recorded in the acute trust notes.

3.8 Documentation

All clinical interactions will be contemporaneously documented in the acute trust notes. The level of detail and personal information recorded will be sufficient to keep the clinical teams appropriately informed and this will be judged on a case by case basis by the mental health liaison team member.

The MHLS also use Proformalyse – a NMUH electronic database which duplicates the hospital paper records and is used record activity and KPIs. Where appropriate a separate record of the assessment will be documented on the mental health trust patient record system (RiO) i.e. if a patient is already known to or is being referred to mental health services.

3.9 Care planning, care co-ordination and care management

Where appropriate and possible, patients will be provided with a copy of their GP letter and details for contacting appropriate services in the event of a crisis. They will also be signposted to appropriate services. The liaison services will not do formal care planning and do not have a care coordination function. If required the patient will be referred to community mental health services.

3.10 Care and treatment interventions

The liaison service will provide a range of interventions for patients. These will include:

1. A&E / Ward based assessments and clinical advice
2. Signposting
3. Mental Health Act assessment
4. Second opinions on capacity (particularly complex cases or when mental illness is complicating the picture)
5. Advice re. pharmacotherapy (including rapid tranquilisation and detoxification)
6. Onward referrals (to CRHTT, Community Mental Health Teams - CMHT, specialist mental health services, voluntary sector organisations, social service, social care and other)
7. Psycho-education
8. Brief psychotherapeutic interventions (including motivational interviewing, Cognitive behavioural interventions and emotional regulation approaches)
9. Advice to the referrer
10. Advice to patients and carers with regards to advocacy services. For those detained under the MHA, we will provide contact details of how to contact Independent Mental Health Advocates/Independent Mental Capacity Advocates

3.11 Training

The service is committed to providing our acute sector colleagues with high quality informal education as well as delivering formal modular based training programme tailored to the level of expertise of participants. Education is central to the working of mental health liaison. (See Appendix 2 below)

4.0 Governance

Formal supervision systems are in place, both professional and management, within BEH Mental Health Trust to ensure the appropriate training, support and skills mix within the service. The team will collect data on its performance, meet regularly and through peer education and support, ensure high standards are consistently being met.

Management of Quality in the service includes peer reviews, monitoring of patient experience, patient safety and clinical effectiveness.

Local BEH Mental Health Trust clinical governance meetings are in place to share best practice, monitor quality and learn from serious incidents, complaints and feedback from patients. The MHLS have monthly Clinical Governance meetings, this serve to feedback from BEH clinical governance meetings and review local policies, procedures and practice and ensure high quality service improvements.

5.0 Clinical Structure

5.1 Clinical Responsibility

Clinical responsibility for the service overall lies with the lead psychiatrist in Mental Health Liaison through to the Clinical Director of the borough

The service operates within a framework of distributed responsibility. The service will have a system of staff rotation to facilitate staff professional development and experience across a range of activities relating to assessment and treatment.

There will be regular team meetings, including business, the clinical governance, white-board and handover meetings. The team will be responsible for identifying, recording, and managing clinical and organisational risk and for sharing risk information within the relevant organisation – including Local Social Services and the Mental Health Trust.

For the most part, in line with the models of liaison psychiatry services nationally, the service will be 'advising' in nature with formal clinical responsibility held by the acute sector teams, under whom the patients are admitted (or managed).

When the patient is under a section of the Mental Health Act, the 'Responsible Clinician' (for the purposes of the Act) will be one of the Consultant Psychiatrists.

In practice, the lead consultant psychiatrist will be the Clinical Lead for the service but all staff hold responsibility for their clinical work. All staff will receive regular supervision.

As a corollary of this, no practitioner can be held accountable for the action of others, except under circumstances where:

a. The other is acting under their advice

b. They have incorrectly delegated responsibility for a task to someone they had, or should have had reason to believe was not competent to carry it out.

6.0 Management Structure

The Team manager's responsibility is:

- to be accountable for the operational management and governance of the Mental Health Liaison Service, ensuring the delivery of high quality services to service users within policies and joint frameworks agreed by the Trust, the acute hospital and relevant partners;

- To ensure that the allocation and deployment of resources are managed and supervised efficiently and effectively in accordance with the agreed priorities and standards within the team's operational policy.

- To have overall responsibility for the management and development of an integrated liaison psychiatry service and for developing working partnerships with internal and external stakeholders in order to meet the needs of service users and their carers where appropriate.

- To lead, support and deliver continuous service improvement within the boundaries of the role.

- To be responsible to the Service Manager and accountable to the Assistant Director for the Dementia and Cognitive Impairment Service Line.

7.0 Performance

Robust data collection and analysis is undertaken to evaluate the impact of the service. This KPI data is monitored by BEH performance team who work with the commissioners.

8.0 Accommodation

The team are located within a suitable office environment at NMUH with the required information and communications technology networks and equipment.

9.0 Compliments, Complaints & Incidents

Compliments and complaints will be monitored and discussed through the regular clinical governance and team meetings. Any complaint, which is not resolved informally, will be referred to the BEHMHT complaints office for investigation and subsequent response from the Chief Executive in line with the Trust complaints policy and timescales.

All incidents that occur in the course of operating the service will be reported via the BEHMHT DATIX system. These will be reviewed and signed off by the team manager and a regular report collated and reviewed through the Mental Health Liaison Clinical Focus Group to ensure learning from incidents is embedded.

Any Serious Incidents (moderate and severe) directly linked to the service, its staff or patients will normally be investigated in accordance with the BEHMHT Serious Incidents Policy. Incident investigation reports may be shared with the acute Trust for their own clinical governance and learning where necessary or appropriate. Some circumstances may mean it is more appropriate for the incident investigation to be carried out by the acute Trust in accordance with their own policy and in some cases both acute and mental health Trusts will both choose to carry out incident investigations, which then can be shared.

10.0 Equality Statement

Barnet Enfield and Haringey Mental Health Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

It takes into account the Equality Act (2010) including the Human Rights Act 1998 and promotes equal opportunities for all. This document has been assessed to ensure that no employee receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

Members of staff, volunteers or members of the public may request assistance with this policy if they have particular needs. If the member of staff has language difficulties and difficulty in understanding this policy, the use of an interpreter will be considered. Barnet Enfield and Haringey Mental Health Trust embraces the four staff pledges in the NHS Constitution. This policy is consistent with these pledges.

Appendix 1 KPIs

Performance Indicator	METRIC	TARGET	REPORTING FREQUENCY	Location of Data	RESPONS-IBILITY
1-hour response time for A & E referrals	% Assessments begun within 1 hour in A&E	95%	Monthly	NMUH MHLS Elog	MHLS-NMUH
	Number of referrals responded to within 1 hour (time in mins) between referral and MHLS response time/ divided by total referrals.				
	Average A&E MHLS response time Calculated as mean of above				
4-hour response time for AMU referrals	% Assessments begun within 4 hours in AMU	95%	Monthly	NMUH MHLS Elog	MHLS-NMUH
	Number referrals responded to within 4 h between referral and MHLS response time/ divided by total referrals from AMU				
	Average AMU MHLS response time (Calculated as mean of above)				
24-hour response time for ward referrals	% Assessments begun within 24 hours on wards	95%	Monthly	NMUH MHLS Elog	MHLS-NMUH
	Number of assessments started in 24 h (calculated in hours from referral to start assessment time)/divided by total referrals				
	Average ward MHLS response time Means of above (in hours)				
Length of stay	Average length of stay: mean average number of bed-days per stay for non-elective admissions with an ICD-10 Chapter V recorded in any diagnosis field	Decreasing trend	Quarterly	PAS-NMUH Acute Trust	NMUH Performance Team
	Total occupied bed days (numerator) for those above)				
	Number of admissions (denominator) for those above				

Re-admissions	% Patients with a Chapter V ICD-10 diagnosis recorded in any diagnosis field, admitted non-electively within 28 days	Decreasing trend	Quarterly	PAS-NMUH Acute Trust	NMUH Performance Team
Re-attendance at A and E	% Patients with a Chapter V ICD-10 diagnosis recorded in any diagnosis field re-attending within 7 days of last A&E attendance i.e. *no. Patients re-attending within 7 days/all Patients with a Chapter V ICD-10 diagnosis*	Decreasing trend	Quarterly	PAS-NMUH Acute Trust	NMUH Performance Team
Admission Avoidance (AMU admissions from A&E)	Patients seen by MHLS in A&E who would otherwise have been admitted to AMU	Increasing trend	Quarterly - (3 Monthly x 2 Monitor only)	NMUH MHLS Elog	MHLS NMUH
Avoidance of transfer from AMU to ward	No of Patients seen by MHLS in AAU/AMU who would otherwise have been transferred to a ward	Increasing trend	Quarterly - (3 Monthly x 2 Monitor only 6/12)	NMUH MHLS Elog	MHLS NMUH
Mental health diagnosis recording	Number of non-elective admissions with a Chapter V Mental Health ICD-10 diagnosis recorded in any diagnosis field	Increasing trend	Quarterly	PAS-NMUH Acute Trust	NMUH Performance Team
A&E 4-hour breaches	Number of A&E breaches of 4-hour wait identified as being related to mental health issues eg awaiting MHA, transport OOA	5%	Quarterly	PAS-NMUH	NMUH Performance Team
	Subjective judgment- record all breaches where a Chapter V ICD-10 diagnosis is entered, to be discussed and evaluated in meeting between acute trusts and mangers)				

Discharge destination	% of patients with a Chapter V MH diagnosis recorded, discharged to new long term placement	N/A	Quarterly	PAS-NMUH	NMUH Performance Team
Delayed Transfer Of Care	% of patients not transferred to psychiatric bed within 24 hours of need being identified / total patients transferred	10%	Quarterly	NMUH MHLS Elog	MHLS NMUH
Increase in ICD- 10 dementia diagnosis	Number of patients with ICD-10 codes for dementia in any diagnosis field	Increasing trend	Quarterly	PAS-NMUH	NMUH Performance Team
Increase in ICD-10 delirium diagnosis	Number of patients with ICD-10 codes for delirium in any diagnosis field	Increasing trend	Quarterly	PAS-NMUH	NMUH Performance Team
Communication with GPs	% MHLS patients who had MHLS letter sent to GP within 7 days of discharge	90%	Monthly	NMUH MHLS Elog	MHLS NMUH
Communication with patients	% MHLS patients who had MHLS letter copied to them within 7 days of discharge	90%	Monthly	NMUH MHLS Elog	MHLS NMUH
Patient/carer experience	Score on 6 point scale		Quarterly	NMUH MHLS	BEH MHT Performance Team (Meridian)

	Do you have trust and confidence in the mental health worker you saw?				
	Did the mental health worker treat you with respect and dignity?				
	Were you given enough time to discuss your condition and treatment?				
	Your general satisfaction with liaison psychiatry				
	Were you seen in a timely manner?				
	Has your diagnosis been discussed and explained with you?				
	Did seeing the mental health worker help you?				
Referrers' experience	Survey of attitudes questionnaire: multiple choice with free text box		Quarterly	NMUH MHLS Training log	BEH MHT Performance Team
	Mode of delivery: Survey monkey				
Acute Trust Staff trained	No. of Acute Trust Staff receiving formal training		Quarterly	Register kept by NMUH	NMUH Training Department
Acute staff – improved knowledge and confidence	Evaluation forms completed at each training session		Quarterly	NMUH MHLS Training log	NMUH MHLS

Appendix 2 Training Programme for acute trust staff

Proposal outline for training modules: Mental Health Liaison model at NMH

The prevalence of mental illness among people with physical illness is two to three times higher than in the rest of the population. In the hospital setting around half of all inpatients suffer from a mental health condition[1].The absence of effective mental health intervention not only leads to poorer health outcomes and increased morbidity and mortality but also increases the costs of physical health care. It is estimated that for a 500 bed general hospital this is equivalent to extra costs of around £25 million per year[2].

The substantial cost savings as a result of the RAID liaison psychiatry model at Birmingham City Hospital were partially generated by the reduction in length of stay. The London School of Economics estimated that the team was able to save at least 44 beds, resulting in financial savings of around £3.5 million[3]. Of total bed days saved 91% came from the 'RAID-influence group'. These were not patients directly managed by the RAID team but by acute hospital staff that had benefitted from the formal teaching sessions and informal hands-on training provided by the RAID training programme. There may also have been further savings as a result of the RAID influence group in the training of A&E staff in preventing inpatient admissions[4]. The importance of formal and informal training in improving outcomes should not be underestimated.

As part of the implementation of the RAID model, each appropriate NMUH Hospital staff member will receive 14 hours of formal training from the liaison team to support them to be able to quickly identify patients who may be exhibiting signs of mental illness, to refer to the team for expert advice and support in the development of a management and discharge plan.

They will also be supported in how to care for and manage patients with signs of mental illness, to improve the quality of care patients receive at the hospital and improve the skills and confidence of NMUH staff in the management of this patient cohort.

Research evidence from the RAID model demonstrated that the training and development of hospital staff was the critical element to the sustained reduction in length of stay and improved quality of care as well as patient experience[5]. Results from this model also suggest that following training, staff were better able to decide which patients could be managed by acute hospital staff and who should be referred to specialised psychiatric services[6].

Training time

The training programme will offer 14 hours equivalent of training in order to complete the foundation programme. This can be delivered flexibly, ranging from 14 x 1 hour sessions to a two day teaching programme. There will be a preliminary package of e-learning that will need to be completed prior to attendance at specific sessions. This has not been directly factored into training times.

Group size
The suggested teaching group sizes should consist of 10-20 staff. We advise that all hospital staff should attend the foundation modules. The groups will consist of both non clinical and clinical staff of mixed banding.

Modules
The intermediate and advanced modules can be attended according to staff speciality, clinical need and interest. A tiered approach will be used to tailor the content and depth of topic to the likelihood of the staff caring for, and making management decisions about the topic in question. Examples of tailoring education to different staff groups include greater emphasis on:

- Self-harm and alcohol use disorders for staff in the Emergency Department and Acute Medical Unit
- Dementia for staff in Elderly Medicine, the Acute Medical Unit and Trauma services
- Organic mental disorders and medically unexplained symptoms for staff in Neurology services
- Training in legal frameworks and de-escalation for security staff dealing with disturbed behavior or absconding patients.

Examples of tailoring depth and content of training to staffing expertise, taking the scenario of a patient with depression who lacks capacity to comply with treatment:-

- Nutrition, self-care, activity and medication refusal for ward-based staff
- Diagnosis, medication, treatment refusal and the role of mental health legislation for senior medical staff
- Specific communication skills and simple techniques to improve mood and behavioural activation for all staff

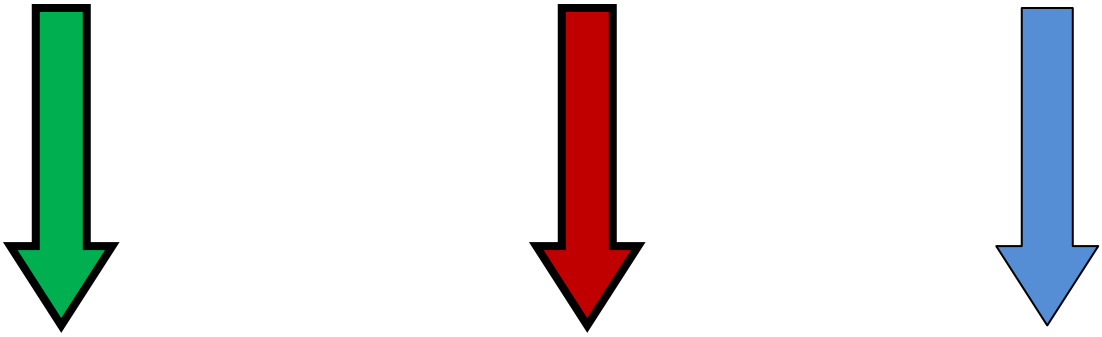
Training format
There will be a wide variety of training formats to maximise learning and the development of practical skills. These will include:

- Lectures
- Educational videos
- Communication skills workshops
- Case studies
- Clinical scenarios
- Patient representative presentations and Q&As
- E-learning packages
- Videotaped sessions
- Peer teaching
- Discussion groups
- Quizzes
- Handouts
- Ward teaching.

Curriculum:
We have taken a person centred approach to understanding the variety of core mental health liaison presentations in the acute hospital setting. There is strong emphasis on patient experience and improving confidence in approaching and caring for patients with mental illness as well as management of common emotional and behavioural reactions to physical illness (including adjustment reactions).

There are 3 vertical themes integrated within the programme. Each module will have clear learning objectives achieved through creative teaching and learning methods, revolving around these 3 vertical themes.

Vertical themes:



COMMUNICATION	**RISK**	**SAFEGUARDING**
(and other psychological skills)		
"MY PATIENT WON'T…" identifying difficulty	Identifying risk in different presentations	identifying need in different presentations
"HOW WOULD YOU FEEL IF…" assessment	Identifying risk in different environments	Identifying need in different environments
"WHAT DO THEY NEED…" formulating response	Identifying need for action	Identifying need for further investigation
Communication techniques, including: • De-escalation • Reframing • Relaxation • Motivational interviewing • Behavioural activation • Understanding what patients' make you feel and why (transference / countertransference)	What to do	What to do

Horizontal modules:

Module	Foundation	Intermediate	Advanced
1	Dementia I • Recognition • Basic problems that patients with dementia face • What its like to be in an acute hospital with dementia - a patient's perspective.	Dementia II • Impairments and retained abilities at different stages of dementia • BPSD and management – what is the patient trying to tell you?	Dementia III • Different types of dementia • Paranoid symptoms and their management
2	Delirium I	Delirium II	Delirium III
3	Depression & mania I	Depression & mania II	Depression & mania III
4	Psychosis I	Psychosis II	Psychosis III
5	Anxiety I	Anxiety II	Anxiety III
6	Medically unexplained symptoms I	MUS II	MUS III
7	self harm / Suicide I	SH/ suicide II	SH / suicide III
8	Alcohol and substances misuse I	Alcohol and substances misuse II	Alcohol and substance misuse III
9	Challenging behaviour and personality disorder I • Frequent attenders	Challenging behaviour and P.D. II	Challenging behaviour and P.D. III
10	Adjustment reactions & coping with physical illness I	Adjustment reactions and coping with physical illness II	Adjustment reactions and coping with physical illness III
11	Capacity and the Mental Health Act I	Capacity and the Mental Health Act II	Capacity and the Mental Health Act III
12	Neuropsychiatric and eating disorders I	Neuropsychiatric and eating disorders II	Neuropsychiatric and eating disorders III
13	Psychotropic medication I	Psychotropic medication II	Psychotropic medication III
14	Perinatal mental health I	Perinatal mental health II	Perinatal mental health III

Programme evaluation plan:

Outcome data

Monitoring improvement in staff confidence and knowledge:

1. % of acute staff who received training (A&E and wards)
    - Register attendance during formal training programme modules
    - Individual staff training recorded on MHLS outcome sheet

2. Acute staff improved knowledge and confidence
    - Prior to the commencement of the training programme all staff members will be asked to complete a questionnaire using a Likert scale to measure perceived confidence in identifying and dealing with people with mental health issues.
    - The same questionnaire will be taken 2 months post implementation of the MHLS service
    - Training evaluation form to be taken following individual training sessions

3. Dementia management on the acute ward
    - Perceived sense of competence is measured using the 'Sense of Competence in Dementia Care – Staff Questionnaire (SCIDS) taken from the evaluation programme currently supporting the UCLP acute hospital staff dementia training programme[7] The questionnaire comprises of seventeen items categorized into four subscales: professionalism, building relationships, care challenges and sustaining personhood. The scale has good internal consistency.

Process data- monitoring improvements in clinical outcomes:

Prioritisation of screening and detection of delirium as per NICE guidelines[8] and the National Audit of Dementia care in general hospitals 2012 – 2013[9]

1. Detection of delirium:
    - assessment for the presence of delirium in dementia (PAS and retrospective audit of hospital notes)
    - increase in detection of delirium in all age groups (PAS and note audit)

2. Reduced risk of adverse events linked to mental health (comparison of pre and post hospital datix system)

3. Reduced neuroleptic prescribing for behavioural disturbance, especially in people with dementia (pharmacy prescribing records)

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3. Tadros G et al. Impact of an intergrated rapid response psychiatric liaison team on quality improvement and cost savings: the Birmingham RAID model. The Psychiatrist 2013; **37**:4-10

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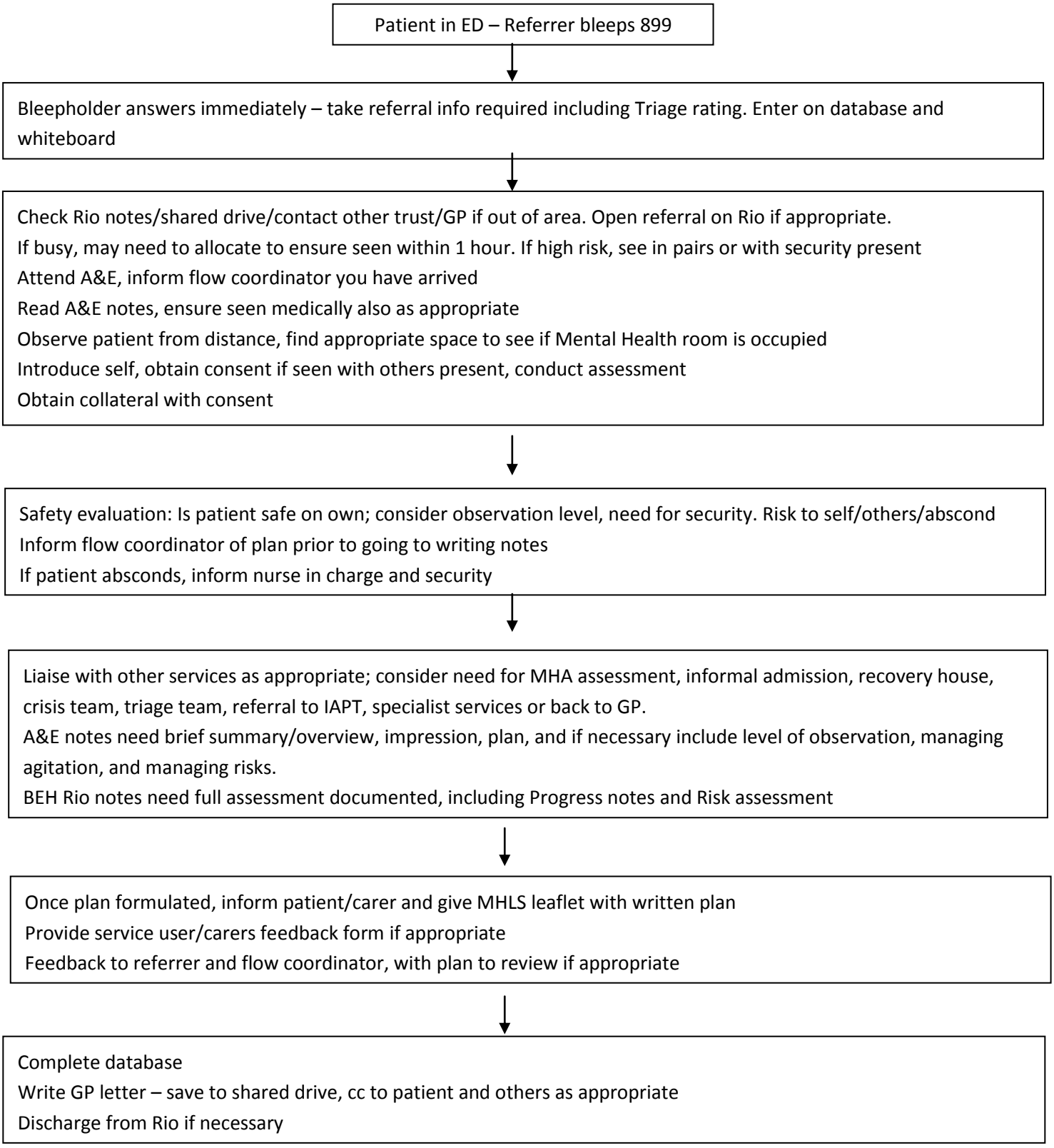
Appendix 3 ED Workflow

ED (EMERGENCY) WORKFLOW GUIDE



Appendix 4 Ward referral workflow

WARD (ROUTINE) WORKFLOW GUIDE