Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

A University Teaching Trust

BARNET HOSPITAL LIAISON PSYCHIATRY SERVICE
SPRINGWELL UNIT, BARNET HOSPITAL, WELLHOUSE LANE, BARNET EN5 3DJ
Tel: 0208 216 4876/4893 Fax: 0208 216 5206

Barnet Hospital Mental Health Liaison Service

OPERATIONAL FRAMEWORK

1.0 Introduction

The Barnet Hospital Mental Health Liaison Service (under Barnet, Enfield and Haringey Mental Health Trust) provides rapid assessment and treatment of adult patients in Barnet Hospital, who present with mental health difficulties. In addition, the service will provide support and education to the staff of Barnet Hospital.

2.0 Purpose, Vision and Values

The mental health liaison service will deliver multidisciplinary specialist mental health input to both A&E and the wards of Royal Free Foundation Trust, Barnet Hospital. The service is committed to providing timely and thoughtful input when invited, working closely together with our acute sector colleagues to support optimal, patient-centered 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 centered and flexible
2. Mindful and therapeutic
3. Professional, safe and boundaried
4. Open, enthusiastic and innovative
5. Empowers through education
6. Promotes integration and partnership

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

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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 in referred patients.
- 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 aged 18 and over presenting to A&E with mental health problems and those who are an inpatient of Barnet Hospital, 24hours a day, 7days a week (including bank holidays). All clinical staff will 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 will have 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

The service will be staffed by:

- Team Manager 0.5 WTE
- Consultant Psychiatrists (old age and adult) 2WTE

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- Nurses (4 x Band 7 and 7 x Band 6) 10 WTE
- Social Worker 1WTE
- Occupational Therapist 1WTE
- Associate Mental Health Worker 1WTE
- Administrators 2WTE

Therapeutic Engagement:

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

3.3 Hours of service

The service is a 24 hour, 7 day a week service (including bank holidays).

3.4 Referral Criteria

1. Patients must be in A&E or admitted to an adult ward in Barnet hospital and be 18 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 will not be limited to these patient groups – we are open to all appropriate referrals.

3.5 Referral Process

A&E: Referrals will be taken via the Liaison bleep (Bleep 2405). For full workflow see Appendix 3.

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Wards: Referrals will be taken through the EPR (Electronic Patient Record System). The EPR referral form is pre-formatted. 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.

3.6.1 Young Persons (16 and 17 year olds):

For young person aged 16 and 17 year old) presenting to A&E with mental health problems and who are in-patients of Barnet Hospital they should be referred to the Paediatrician. The Paediatrician would need to discuss the presentation with Child and Adolescent Mental Health Service (CAMHS) clinician depending on borough address and the GP of the young person. During out of hours, weekends and bank holidays the Paediatrician would need to discuss with the out of hours CAMHS Consultant Psychiatrist on-call, again this is dependent on borough address and the GP of the young person.
See Adolescent flowchart in appendix.

3.6.2 Section 136 Patients

Ideally section 136 patients should only be bought to A&E if they have a medical need for treatment. Barnet General Hospital is a place of safety but not a designated place of safety. There is no section 136 suite at Barnet hospital for patients to be managed safely. Liaison will support/ facilitate A&E to locate a S136 suite within BEH. However, if a S136 suite has not been identified the liaison team facilitate the MHA assessment taking place in the department or ward by liaising with the duty AMHP. The team can also access psychiatric records and assist if a S136 suite has not been identified with management problems whilst the patient is in the department, if required.

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.

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A separate record of the assessment will be documented on the mental health trust patient record system (RiO) for all patients referred to the mental health liaison team.

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 mental health liaison services will not do formal care planning and we 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 mental health 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, behavioural activation and emotional regulation approaches)
9. Advice to the referrer

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

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expertise of participants. Education is central to the working of mental health liaison psychiatry. (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.

Additionally both the Mental Health Liaison Operational Management Group and the 'in-house' Mental Health Liaison Groups will meet on a regular basis to ensure the high quality of the service continues and outcomes are being met effectively.

5.0 Clinical Responsibility

Clinical responsibility for the service overall lies with the lead psychiatrist in Mental Health Liaison through to the Clinical Director of Barnet Service-Line.

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 mental health liaison 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 two Consultant Psychiatrists.

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In practice the two consultants 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 Responsibility

Management responsibility is with BEH MHT

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 mental health liaison 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 Barnet Service Line.

7.0 Performance

Performance is monitored local, by the CCG and Royal Free

- Robust data collection and analysis is undertaken to evaluate the impact of the service;
- Funding streams are identified to sustain the service in the long term.

The table in appendix 1 identifies key performance indicators and targets to be delivered.

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8.0 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 discussed in Mental Health Liaison Clinical Governance 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 joint investigation or 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.

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Appendix 1 KPIs

Performance Indicator	METRIC	TARGET	REPORTING FREQUENCY	Location of Data	RESPONSIBILITY
1-hour response time for A & E referrals	% Assessments begun within 1 hour in A&E	95%	Monthly	Barnet Liaison E-log	Barnet Mental Health Liaison Service
	Number of assessments started within 1 hour (time in mins) between referral and Liaison response time/ divided by total referrals.				
	Average A&E Liaison response time Calculated as mean of above				
24-hour response time for ward referrals	% Assessments begun within 24 hours on wards	95%	Monthly	Barnet Liaison E-log	Barnet Mental Health Liaison Service
	Number of assessments started within 24 hours (calculated in hours from referral to start assessment time)/divided by total referrals				
	Average ward Liaison 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		Quarterly	Barnet PAS Acute Trust	Barnet Acute Performance Team
	Total occupied bed days (numerator) for those above)	Decreasing trend			
	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	Barnet PAS Acute Trust	Barnet Acute 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*	Decreasing trend	Quarterly	Barnet PAS Acute Trust	Barnet Acute Performance Team

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	days/all Patients with a Chapter V ICD-10 diagnosis				

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Performance Indicator	METRIC	TARGET	REPORTING FREQUENCY	Location of Data	RESPONSIBILITY
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	Barnet PAS Acute Trust	Barnet Acute 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	BARNET PAS Acute Trust	Barnet Acute Performance Team
	Subjective judgement- 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	Barnet PAS Acute Trust	Barnet Acute 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	Barnet Liaison E-log	Barnet Mental Health Liaison Service
Increase in ICD-10 dementia diagnosis	Number of patients with ICD-10 codes for dementia in any diagnosis field	Increasing trend	Quarterly	Barnet PAS Acute Trust	Barnet Acute Performance Team
Increase in ICD-10 delirium diagnosis	Number of patients with ICD-10 codes for delirium in any diagnosis field	Increasing trend	Quarterly	Barnet PAS Acute Trust	Barnet Acute Performance Team
Communication with GPs	% Liaison patients who had Liaison letter sent to GP within 7 days of discharge from Barnet Hospital	90%	Monthly	Barnet Liaison E-log	Barnet Mental Health Liaison Service
Communication with patients	% Liaison patients who had Liaison letter copied to them within 7 days of discharge from Barnet Hospital where clinically appropriate	90% of the clinically appropriate cases	Monthly	Barnet Liaison E-log	Barnet Mental Health Liaison Service

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Performance Indicator	METRIC	TARGET	REPORTING FREQUENCY	Location of Data	RESPONSIBILITY
Patient/carer experience	Score on 6 point scale		Quarterly	Barnet Mental Health Liaison Service	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	Barnet Liaison 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 Barnet	Barnet Training Department

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Acute staff – improved knowledge and confidence	Evaluation forms completed at each training session		Quarterly	Barnet Liaison Training log	Barnet Mental Health Liaison Service

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Appendix 2 Training programme for acute trust staff

Proposal outline for training modules: Mental Health Liaison model at Barnet Hospital

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 Mental Health Liaison Service model, identified clinical staff from Barnet Hospital will receive a package 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 Barnet 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 proposes targeted half day training sessions. This can be delivered flexibly, ranging from several x 1 hour sessions to a longer 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.

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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.

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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 behaviour 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

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- 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.

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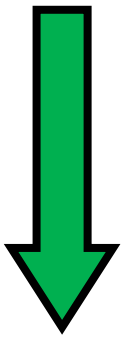
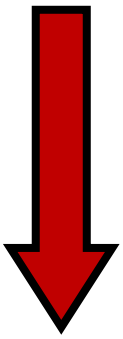
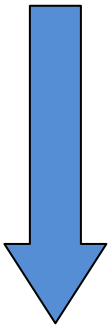
Vertical themes:







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

Tailored Training – appropriate for the professional group

Topics include:

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Dementia

Delirium

Depression and Mania

Psychosis

Anxiety

Medical Unexplained Symptoms

Self-Harm / Suicide

Alcohol and Substance Misuse

Challenging behaviour and Personality Disorder

Adjustment reactions and coping with physical illness

Capacity and the Mental Health Act

Neuropsychiatric and Eating Disorders

Psychotropic medication

Perinatal mental health

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 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 programme.

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- 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.

<u>Process data- monitoring improvements in clinical outcomes</u>:

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)

Reference List

1. Parsonage M, Fossey M & Tutty C; Liaison Psychiatry in the Modern NHS; Centre for Mental Health (London School of Economics, Mental Health Network); 2012

2. Parsonage M, Fossey M & Tutty C; Liaison Psychiatry in the Modern NHS; Centre for Mental Health (London School of Economics, Mental Health Network); 2012

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A&E WORKFLOW GUIDE

Patient in A&E – Referrer bleeps 2405

↓

Bleepholder answer immediately – take referral info required on data sheet, enter on EPR

Ensure patient is assessable, may need to give advice in meantime until we can see

↓

Check Rio notes / shared drive / contact other trust / GP if out of area. Open referral on Rio.

If busy, may need to allocate to ensure seen within one hour. If high risk, see in pairs or with security present

Attend A&E, inform flow coordinator you have arrived, ensure wearing safety alarm

Read A&E notes and LAS sheet, ensure seen medically also as appropriate, check results on EPR

Observe patient from distance, find appropriate space to see, majors 1 if high risk

Introduce self, obtain consent if seen with others present. Take history and mental state on back of data form

Obtain collateral with consent

Give liaison leaflet and patient/carer survey

↓

Safety evaluation: Is patient safe on own? Think observation level, need for security. Risk to self/others/abscond

Inform flow / nurse in charge plan prior to going and writing notes

If patient absconds, inform nurse in charge and security bleep 2911 or dial 3333

↓

Write notes and liaise with other services as appropriate; consider need for MHA assessment, informal admission, recovery house, crisis team, triage team, referral to IAPT, specialist services or back to GP

A&E notes need brief summary/overview and suggestions to include level of observation, what to do if agitated or tries to leave, how to contact us. Photocopy to bring back to office, with copy of front sheet

Psychiatric notes need full history as on back of data sheet. Progress notes and risk assessment

↓

Once plan formulated with involvement of the patient or/ and carer when appropriate, inform patient / carer and give relevant info leaflet on mental health condition

Take back survey in sealed envelope

↓

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WARDS WORKFLOW GUIDE

Patient on ward – Referral on EPR, or bleep 2405 and EPR if emergency

↓

Twice daily check EPR for new referrals, fill in data capture form, put on board

↓

Check Rio notes / shared drive / contact other trust / GP if out of area. Open referral on Rio.

Allocate to team in handover, aim to see within 24 hours if routine, 72 hours if OT referral

If high risk, see in pairs or with security present

Attend ward, ensure wearing safety alarm. Introduce self to referrer / nurse in charge and get update/summary

Read medical notes, bedside folder (observations, behaviour, food, fluid, bowel charts, drug chart) and LAS sheet, check results and letters on EPR

Observe patient from distance, find appropriate space to see if patient mobile

Introduce self, obtain consent if seen with others present. Take history and mental state on back of data form

Obtain collateral with consent

Give liaison leaflet and patient/carer survey

↓

Safety evaluation: Is patient safe on own? Think observation level, need for security. Risk to self/others/abscond

Inform nurse in charge plan prior to going and writing notes if high risk

If patient absconds, inform nurse in charge and security bleep 2911 or dial 3333

↓

Write notes and liaise with other services as appropriate; consider need for MHA assessment, informal admission, recovery house, crisis team, triage team, referral to IAPT, specialist services or back to GP

Medical notes need brief summary/overview and suggestions to include level of observation, what to do if agitated or tries to leave, how to contact us. Photocopy to bring back to office in patient file

If ongoing input needed: 'we will continue to review'. If discharged: 'please contact us again if you would like further review'

Psychiatric notes need full history as on back of data sheet. Progress notes and risk assessment

↓

Once plan formulated with involvement of the patient or/ and carer when appropriate, inform patient / carer and give relevant info leaflet on mental health condition

Take back survey in sealed envelope

↓

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Interim In Hours Protocol for under 18s presenting at Barnet Hospital who require urgent mental health assessment 01 July 2015

There is a 24/7 rota for urgent mental health assessment of under 18s presenting to Barnet Hospital with Royal Free site. Referral forms fo and social care plus further guidance is available on the following link http://www.bcf.nhs.uk/intranet/children/index?_ts=29 and in Galaxy W

YP aged 0-17 in need of urgent mental health assessment
(eg acute self-harm, suicidal behaviour, acute psychosis)

Age 0-15 – Paed A&E + paediatrician assess and admit to Galaxy Ward.

Age 16 or 17 – A&E initial assessment

Medically cleared? Consider neuro causes.

No

Yes

Paediatrics fax CAMHS referral form to Edgware CAMHS on **020 8732 6686** *and* call **020 8702 4500** to confirm receipt for ALL young people regardless of borough.

Referrals received **before 10am** are usually seen on same day. Patient will be seen on following working day if referral received after 10am.

Weekdays 9am-5pm:
For young person aged 16 and 17 year old) presenting to A&E with mental health problems and who are in-patients of Barnet Hospital they should be referred to the Paediatrician. The Paediatrician would need to discuss the presentation with Child and Adolescent Mental Health Service (CAMHS) clinician depending on borough address and the GP of the young person.

9am-5pm: Edgware CAMHS alerts Barnet CAMHS clinician on duty who will assess on ward.

If suitable for Galaxy Ward, follow age 0-15 pathway (see left). If not, consider psychiatric admission. NB Where psych admission needed, the BEHMHT bed manager is responsible for bed-finding with help from Beacon Centre, duty CAMHS Consultant. Only CAMHS consultant can authorise admission.

Where there are safeguarding concerns: paediatrics/A&E complete social care referral form. Duty SWs are available via Edgware CAMHS during working hours for discussion and/or joint assessment. Out of hours - contact borough SW via social care. **Please also copy referral to safeguarding administrator** at rf-tr.bcf-safechild@nhs.net.
CAMHS out-patient follow-up is available according to borough.
NB If there is concern regarding the YPs behaviour and an admission to the ward would not be appropriate please refer to the guidelines for the management of children with disturbed behaviour.

Useful contacts

The **paediatric liaison CAMHS team** are also available on site Monday-Thursdays on **bleep 2270** to assess or advise on YP presenting to paediatrics with conditions **other than** self harm.
Daytime CAMHS clinician and consultant rota - via **Edgware CAMHS** on 020 8702 4500
Daytime Enfield SAFE CAMHS team 020 8379 2090

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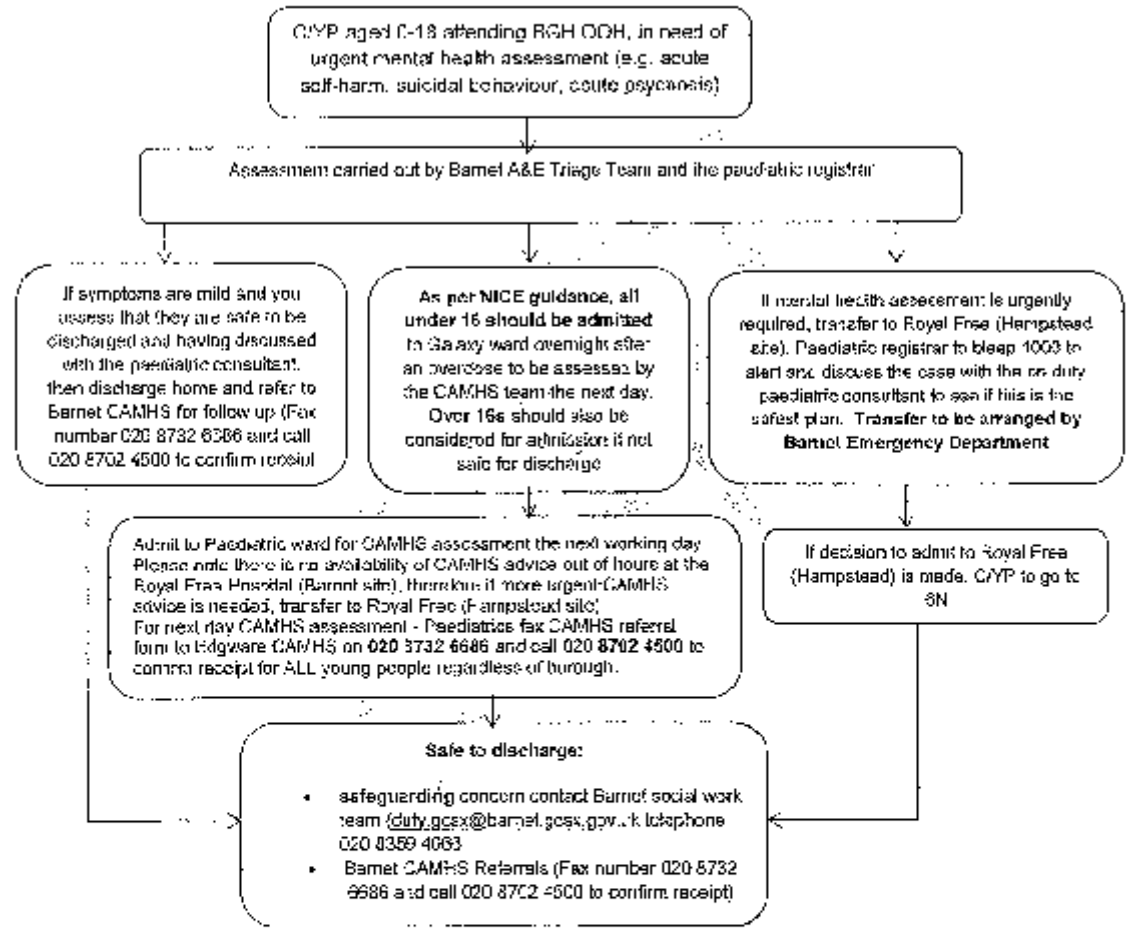
Interim protocol for CAMHS "Out of Hours" provision (5 pm to 9 am and weekends) for Children and young people aged 0 to 18

This is an Interim arrangement, for children and young people attending the Barnet General Hospital (GH) site who require a CAMHs mental health assessment out of hours (OOH) (July 2015)



- USEFUL NUMBERS:
- There is a national process for finding CAMHS beds. Please log onto the following site, it has the most up to date guidance with all the documents and the latest copy of the bed state. http://beds.northwestcsu.nhs.uk Username: bedsUser Password: beds_0115
- The paediatric liaison CAMHS team are also available on site Monday-Thursdays on bleep 2270 to assess or advise on CYP presenting to paediatrics with conditions other than self-harm.
- Daytime CAMHS clinician and consultant rota - via Edgware CAMHS on 020 8702 4500
- Daytime Enfield SAFE CAMHS team 020 8379 5555
- Barnet Hospital switchboard 020 8216 4600 Galaxy Ward 020 8216 5193/4
- Barnet social care/MASH team: duty.gcsx@barnet.gcsx.gov.uk 020 8359 4066
- Enfield social care team: child.protectionadvice@enfield.gcsx.gov.uk 020 8379 5555
- Hertfordshire social care team: Professionalreferral.cypher.scg.gcsx.gov.uk 0300 0173 4043

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Local smoking cessation service.
Barnet- 0800 328 2784
Enfield – 0800 652 8405
Haringey – 0800 772 0066

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Appendix B
LOCAL INDUCTION PROGRAMME CHECKLIST

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Managers must go through this local induction programme with all newly appointed staff. Those marked * must be covered on the first day and all others must be completed within the first week of employment with this Trust. Managers will discuss each item with the new member of staff and record the date completed.

During these discussions, training needs should be highlighted and incorporated into the initial Personal Development Plan and KSF for induction into the job and for future training needs. **The manager must delete those not applicable to the post and add any further details as necessary.**

1. Employee Details		
Name:	Department:	
Job Title:	Start Date:	
Service Area:	Manager:	
2. Introductions	✓ or n/a	Date completed and manager's initials
* Introduce to relevant colleagues/teams		
* Rotas/Shift patterns/key training		
* Line management/reporting structures		
Partnership working		
3. Facilities		
* Tour of office/work area including use of equipment		
Tour of site		
* Restaurant/coffee facilities		
* Staff facilities, e.g. toilets, etc.		
4. Health and Safety		
* Fire safety/evacuation		
* Trust security/alarms		
Risk assessment (including observation of service users)		
Accident and incident reporting		
VDU and work station assessment		
Control of infection		
Waste disposal		
Moving and handling		
COSHH		
Sharps injuries		
* First Aid		
Occupational health medical – book appointment		

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* Local safe systems of work, etc.		
5. Terms and Conditions		
Corporate and local policies		
Medicine policies		
* Complete any additional paperwork		
* Breaks/Office cover		
Annual leave		
* Sickness or other absence – notification procedure		
6. Working Arrangements		
* Issue of Identification Badge		
* Own hours of work/rota		
* Telephone/communication Systems		
Photocopier/Fax Machine		
PC access/access to systems e.g. RiO/ESR		
Management of Finance		
Clinical Governance/Quality Management		
* Department Dress Code		
7. Communication		
Staff Handbook – has a copy been read and understood? (on intranet)		
Team Briefings/meetings		
Trust Intranet		
8. Policies and Procedures		
Equal Opportunities		
Disciplinary and Grievance		
Harassment and Bullying		
Drugs and Alcohol		
Smoke Free Policy		
Whistleblowing		
Confidentiality		
Data Protection		
Records Management		
* Lone Worker		
9. Staff Development and Training		
Corporate Induction - ensure booked on next course		
KSF outline given and explained		
Commence a Personal Development Plan (so can meet Foundation KSF outline within a year)		
Mandatory training identified and booked		
Access to Trust training schedule/training information		
Introductory Workbook to Mandatory training -completed		
10. Performance Management		

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Review job description		
Discuss service and job objectives		
Arrange appropriate visits/work-shadowing outside the team		
Arrange date for review of progress with induction into the job		
11. Local Induction (additional items not already covered)		

Signature of Staff Member ……Signature of Line Manager …….
Date: …….. Date ……

THIS FORM MUST BE FULLY COMPLETED AND RETURNED WITHIN 2 WEEKS OF NEW EMPLOYEE COMMENCING WORK TO:

PEOPLE & ORGANISATIONAL DEVELOPMENT:

Barnet, Enfield and Haringey Mental Health NHS Trust, L2, St Ann's Hospital, St Ann's Road, London, N15 3TH .