

PLAN
PSYCHIATRIC LIAISON
ACCREDITATION NETWORK



Psychiatric Liaison Accreditation Network Annual Report

Cycle 1: 2009 – 2010

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Publication number: CRTU102

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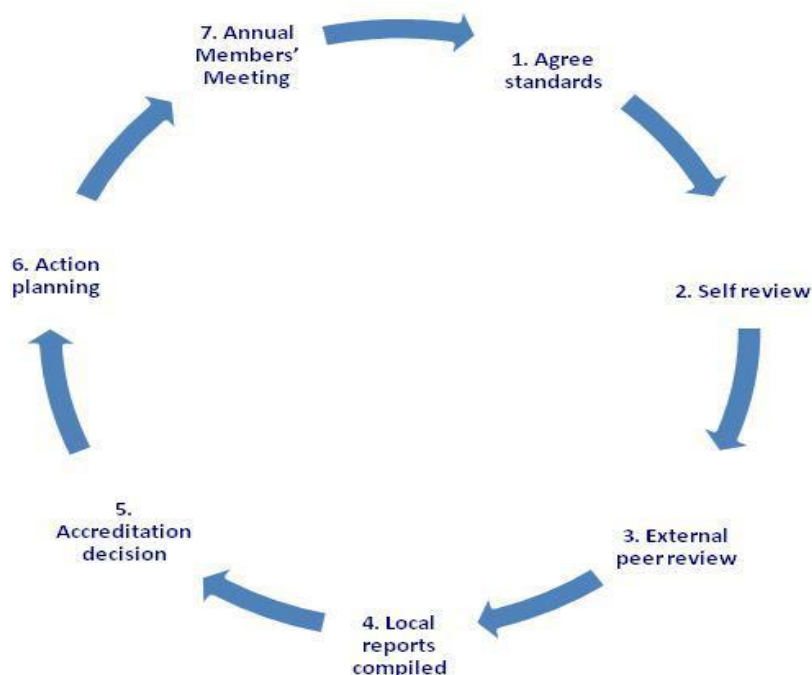
Introduction

PLAN is a network of liaison psychiatry services run by a central project team at the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI). PLAN exists to facilitate quality improvement and development in liaison psychiatry services through a supportive peer review network. PLAN is open to all liaison psychiatry services in the United Kingdom and Ireland.

The network facilitates communication between services and the sharing of best practice, recognises achievement and identifies areas for improvement. PLAN also raises awareness of the value of these teams and provides funders with the confidence to invest in accredited services.

During each annual cycle, mental health liaison teams are evaluated against the PLAN service standards, and strive for improvement year on year. Figure 1 outlines the stages of the accreditation process. For more detailed information, please see Appendix 1.

Figure 1: The annual accreditation cycle



The main stages of the accreditation cycle are self review and peer review. During self review, participating teams have 8-10 weeks to submit data using a number of data collection tools which are designed to collect a broad range of viewpoints to assess whether or not that service is meeting the quality standards for accreditation. PLAN provides the data collection tools and guidance and undertakes analysis of the data at its central office.

How to use this report

This report summarises the key findings from the first cycle of PLAN, which took place from 2009-2010. **Section 1** focuses largely on the data that were collected by participating teams during the self review. This section highlights the emerging themes common to many of the participating services. These findings are divided into four categories and illustrate the findings from the following self-review tools:

1. Psychiatric liaison staff survey
2. Referrer and acute hospital staff surveys
3. Service user and carer surveys
4. The team checklist

The full self review data can be found in Appendix 2.

Section 2 of the report describes some of the key improvements that were made by teams *between the self review and the accreditation decision*.

Section 3 allows teams to benchmark themselves anonymously against other PLAN members. The figures in the benchmarking section relate to the number of standards being met by liaison teams *at the point of accreditation*, therefore representing the most current data PLAN holds for each team.

The final section of the report makes some suggested recommendations for liaison teams.

Please note that the data found in the appendices are quantitative only. Qualitative data, in the form of comments made in the surveys, are quoted throughout the report and were selected as representative of the most frequent comments by respondents.

Section 1: Key findings

Characteristics of participating teams

A total of seventeen members from around the UK participated in the first cycle of PLAN.

Figure 2: Map of members' locations



Participating teams differed greatly in a number of ways, with variation in location, case load, staffing levels and hours worked.

In terms of case load, hospital size varied between teams, ranging from a hospital with approximately 300 beds, to others with as many as 1800 beds, and an overall average of 930 beds.

The vast majority of participating teams worked from 9am to 5pm, Monday to Friday, although two teams did provide a service 24 hours a day, seven days a week. Other teams offered slightly extended hours, with partial cover or special services for self harm referrals at weekends.

Just over half of participating teams provided a full service to adults of all ages, dealing with emergency and routine referrals. A slightly smaller proportion served working aged adults only (18-64 years) and of these, some provided emergency-only care to older adults (65+ years). One team was a dedicated older people's liaison service. Both psychiatric consultant- and nurse-led teams participated in PLAN.

Staffing levels differed greatly between teams and did not necessarily increase in line with the number of beds served. The Mental Health Policy Implementation Guide gives suggested staffing levels according to hospital size¹.

¹ Aitken, P (2007). Mental Health Policy Implementation Guide: Liaison psychiatry and psychological medicine in the general hospital.

Psychiatric liaison staff survey

Each PLAN team lead was asked to circulate the liaison staff questionnaire to all members of the liaison team and encourage them to complete it within an 8-week period, either online or if requested, using a paper version. A total of 194 liaison professionals responded to the questionnaire.

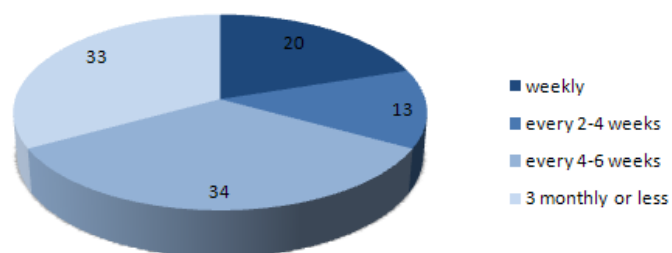
Table 1: Breakdown of respondents per job role

Job role	Percentage
Mental Health Nurse (Registered)	37
Psychiatrist (Consultant level)	16
Psychiatrist (Non-consultant level)	16
Administrator/Secretary/Clerical	12
Psychologist	6
Manager (e.g. Team Manager, Clinical Service Manager etc)	5
Social Worker	3
Therapist (e.g. Occupational Therapist, Speech Therapist etc)	1
Healthcare Assistant/Clinical Support Worker/Unqualified Nurse	0

Supervision and support

Liaison staff were asked how often they receive clinical supervision; for two thirds of staff this takes place at least once every six weeks. A third of respondents reported receiving supervision just once every three months or less.

Figure 3: Percentage of staff receiving clinical supervision (all staff)



Half of the staff who reported receiving little or no supervision in the past 3 months were consultant psychiatrists. Some consultants did not view this as a problem but others pointed out the need for (at the very least) some kind of regular peer support on an individual or group basis, especially for lone professionals.

Overall, a fifth of all liaison staff – and almost *half* of all liaison nurses - would like more frequent supervision; this is an area that many PLAN teams have begun to address. The importance of providing regular clinical supervision is summarised by this respondent:

"Supervision has been very effective especially in solving clinical issues, improving communication...and motivating further acquisition of clinical experience."

The majority of staff (90%) can contact a senior colleague at any time and 91% were satisfied with the peer support they receive. Many of the respondents volunteered extremely positive comments about how supportive they find their team:

"The best psychiatry team I've worked for. Excellent support and supervision."

"I am very satisfied working with this team - the team is supportive and effective, and I believe provides optimal care for patients due to the fact the team functions with a high level of support, education and communication, and has high standards for itself."

The vast majority of staff (97%) also reported that they were able to access advice about legal issues when needed.

Communication

Although the majority of liaison staff (90%) felt that communication between the team was effective, there were some suggestions for improvement:

"A regular open forum for discussion such as a monthly team business meeting."

"Some of the processes have become cumbersome and there is duplication which we need to smooth out and rationalise."

"Ensuring all clinicians are on the email system and can access shared drive would help."

Interestingly, administrators on the liaison team were slightly less likely than clinicians to describe team communication as effective.

Access to training for liaison professionals

The majority of liaison staff were reasonably satisfied with their access to appraisals and training (see figure 4 below) but there were suggestions for improvement.

Figure 4: Number of staff who answered yes to the following questions:



Whilst 84% of consultant liaison psychiatrists had received at least six days training in the past twelve months, just under half of the nurses surveyed had.

Encouragingly, 85% of all staff surveyed had been asked about their training needs and very few respondents reported being denied training due to lack of funds (14%) or staff cover (17%).

However releasing staff for training once it has actually been organised can be an issue for many teams. The result is that staff across all disciplines can sometimes feel reluctant to ask for training in the first place:

"Able to attend all mandatory training however put off from applying for any that requires funding or time away from work due to current constraints of the service."

"I have not put myself forward for training due to staff shortages and work overload...am aware I could if I had a full compliment of staff, which has not happened in two years."

Respondents were asked to state whether or not they had received training in a number of areas pertinent to liaison mental health. Table 2 overleaf lists the most commonly met areas of training, as well as the topics that respondents would most like to receive more training in.

Table 2: A list of the most and least frequently met areas of training for all liaison staff

Most frequently <u>met</u> standards	Percentage of staff who rated training as insufficient or not provided
Assessing risk (93%) Suicide awareness (90%) Self harm (89%) Vulnerable adults/child protection (89%) Referral pathways (88%) Detecting alcohol misuse (85%) Conducting assessments (85%)	Learning disability (47%) The use of therapeutic approaches in assessments (27%) Recognising special needs and knowing how to arrange support for people with visual, hearing, literacy or learning disabilities (26%) Medically Unexplained Symptoms (25%) Adjusting to illness (25%) Working with older people (20-25%) Working with 16-18 year olds (19%) Emotional response to trauma (19%)

There were some differences between staff groups:

- Overall, consultants were more likely to rate their training as sufficient and also tended to have different training needs compared to other disciplines – for example, consultants wanted more training in providing person-centred care planning (16%).
- Nurses were most likely to want more training in the use of therapeutic approaches in the assessment process (46%), medically unexplained symptoms (39%) and adjustment to illness (39%).
- For trainee psychiatrists, the most common unmet training needs were having a better understanding of the liaison team’s role following major incidents (42%) and the needs of people with learning disabilities (36%).

Some staff were very positive about the quality of training they had received and many commented on how valuable in-house training and on-the job learning can be:

"I have personally found the in house training particularly useful but equally I have learned a great deal from working alongside colleagues from different disciplines."

"The best training is through reflective exercises carried out as part of weekly meetings."

Liaison staff were acutely aware of the difficulty of fitting in training and learning opportunities when the team is already working to full capacity:

"It would be good if there was more opportunity for in depth case presentations and sharing of relevant papers. This side of things has got rather lost in the 'onslaught' of huge numbers of referrals. The balance between meeting targets and allowing time and space for the team to develop is a hard one to strike."

Training for liaison staff working with older people

In addition to the training questions asked to all staff, liaison staff who regularly work with older people were asked to rate their training in this area in more detail. A significant number of these staff expressed the need for more training, education or guidance in:

- Undertaking specialist assessments (30%)
- Detecting and managing dementia (25%)
- Detecting and managing delirium (22%)
- Signposting older people and their carers to other relevant agencies and services (22%)
- Detecting and managing depression (19%)
- Referral pathways/working arrangements with local health services (19%)

Given the high numbers of older people presenting to General Hospitals and the prevalence of conditions such as dementia and delirium, it is imperative that liaison staff are provided with high quality education and training in this area.

Training for liaison staff providing interventions

There is an increasing body of evidence to suggest that providing psychological interventions to liaison psychiatry patients is highly effective and cost efficient. 82% of the services who took part in cycle 1 of PLAN reported that they provide some ongoing interventions to service users.

Staff who do provide interventions were asked to rate the training and support provided to them in relation to the interventions. The majority were satisfied with the training they had received, but around a fifth asked for further training in areas such as Dialectical Behavioural Therapy, Interpersonal Therapy, Multi-Sensory Stimulation and group based Cognitive Behavioural Therapy. Upon closer discussion during the peer review visits, it emerged that some staff had listed these areas because they wanted more training for their personal development, but were not actually practising these interventions. The PLAN staff questionnaire has now been changed to differentiate between training needs that are core to a person's role and those which are not.

The majority of liaison staff expressed a reasonable level of satisfaction regarding their role, their access to training and the support provided from liaison colleagues. There was however, an underlying theme which suggests that many liaison team members are feeling increasingly over-stretched and that the pressures facing liaison teams are not always well understood by other professional groups and organisations. Liaison teams are often uniquely positioned between both the mental health and acute organisations. At best, this can mean the liaison team is well integrated into both organisations, supported by both, involved in senior decisions and explicitly commissioned. At worst, this can leave a liaison team stranded between the two, with a lack of recognition, lack of support and staff feeling marginalised and undervalued. These issues are adequately summed up by the following respondent:

"We need funding and commissioning. We need more staff; we need to be consulted about our future. We are always 'under fire' from psychiatric colleagues including management, yet regular audits continually show higher rates of referrals, more user satisfaction etc than our much larger community teams."

Referrer survey

PLAN team leads within each liaison service were sent a link to an online survey, which they then forwarded to acute staff in the General Hospital. A paper copy of the survey was available for staff who were unable to access the online version. Each liaison team was asked to aim for a response rate of two thirds of those who regularly refer patients to the liaison team.

A total of 458 General Hospital staff completed an anonymous survey online during the self review period. Tables 3 and 4 show the departments and professions most frequently represented in the questionnaire. A full list can be found in Appendix 2 (ii).

Table 3: Survey respondents by department

Department	Percentage
Accident and Emergency	27
General and Acute Medicine	13
Elderly Care	9
Medical Assessment Unit	2
All other departments	49

Table 4: Survey respondents by profession

Job role	Percentage
Nurse	40
Consultant	38
Trainee Doctor	11
Physiotherapist	1
Occupational Therapist	1
'Other'	9

Three areas emerged as key to having effective relationships with General Hospital staff:

1. Referral procedures
2. Speed of response
3. Communication

Referral procedures

The majority of referring staff (88%) stated that the referral process was straightforward, with minimal obstacles. A similar proportion (85%) had received guidance on how to refer to the liaison team. Despite these figures, there were a number of specific requests from acute staff for further and clearer guidance to be continually made available, especially for new staff.

Around a third of all referring staff reported that they had *not* received guidance - written or verbal - about which patients should be referred to the liaison team, and half of all staff had *not* received guidance on which types of cases should take priority when referring. When looking solely at staff feedback from the Emergency Department (ED), these figures were somewhat smaller, suggesting that ED staff feel better informed about referral procedures than other colleagues (20% and 40% respectively).

It is possible that ED staff generally have stronger relationships with the liaison team compared to colleagues in acute wards, due to their typically close proximity to the liaison team. This may allow for greater ease of communication and advice seeking, verbal information, and on-the-job learning:

"Having the liaison team based within the Emergency Department provides a service much needed. Relations and communications, I feel, have always been excellent. [They are] always available for advice on patients if unsure as to whether referral is required."

A lack of understanding about the liaison team's functions and referral procedures can have important implications. In some cases, the liaison team may face a larger proportion of inappropriate referrals, thereby using up valuable time and resources. In other cases, acute staff might be unaware of the role that the liaison team can play in patient care, and may refer too few patients, thereby missing a valuable opportunity to provide psychological intervention. In any case, it is important that guidance materials, which may include posters, leaflets or up to date and easily accessible information on Trust intranet pages, continue to be disseminated as widely as possible.

Speed of response

Referring staff were asked whether or not they were satisfied with the liaison team's speed of response to different types of referrals, which are described in more detail in the box below.

Definitions:

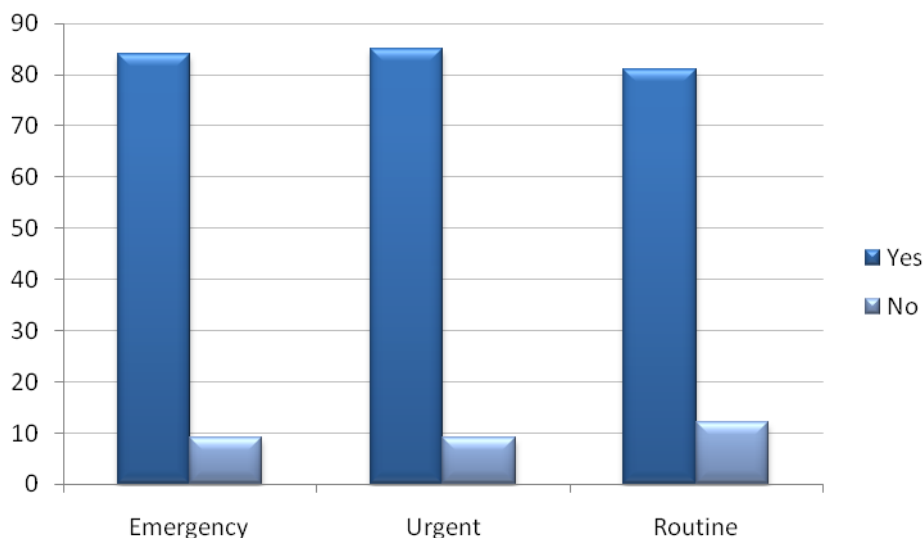
Emergency referrals: An acute disturbance of mental state and/or behaviour which poses a significant, **imminent** risk to the patient or others.

Urgent: A disturbance of mental state and/or behaviour that poses a significant risk to the patient or others, but does not require immediate mental health involvement.

Routine: All other referrals, including patients who require mental health assessment, but do not pose a significant risk to themselves or others, and are not medically fit for discharge.

As shown in figure 5 below, referring staff were generally satisfied with the response times for emergency (84%) and urgent (85%) referrals, and were marginally less satisfied with speed of response to routine (81%) referrals.

Figure 5: Referrers response to the question: "Are you generally satisfied with the liaison team's speed of response to emergency, urgent and routine assessments?"



Many referrers stated that slower response times are a consequence of lower staffing levels:

"Response times are dependent on how many of the team are around at the time."

"The team are completely overwhelmed by the amount of referrals due to the limited number [of staff] on the team."

Whilst feedback was generally positive regarding the liaison team, it is apparent that the response out of hours and at shift change is somewhat less consistent.

"The difficulty is referring to the out of hour's liaison/crisis team. We have an in-house team working from 10.00-23.00. Whilst it sometimes feels they stop taking referrals early in the evening, for no communicated reason, it is usually easy to refer to them and they provide a good service."

The service provided by the crisis team was often perceived by referrers as 'poorer' than the in-hours service and referrers are keen to have a smoother transition to out of hour's services. Almost one third of respondents were not aware of their liaison service's working hours and who to contact outside of these hours. Some referrers suggested that it would be helpful for the liaison team and out of hour's team to share one contact number, providing a more seamless referral procedure.

Another grievance amongst referrers was that delays can occur when waiting for a patient to be medically cleared, when in fact the patient appears not to have any physical symptoms. In these cases, both referrers and service users alike can experience unnecessary delay.

"I have watched patients whose psychiatric welfare is compromised and just wish to know their case is being dealt with, waiting to be seen for several days as they are not 'medically' fit."

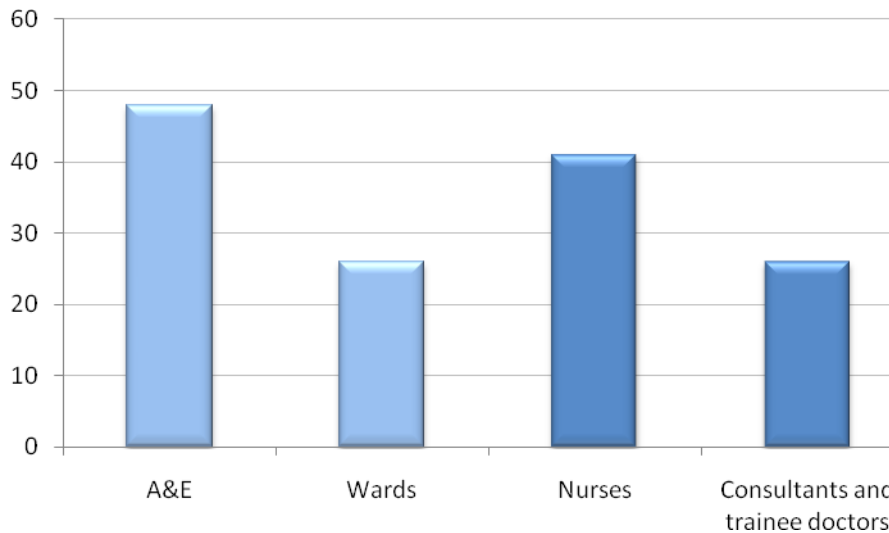
Communication

In terms of satisfaction with initial communication - which includes information on waiting times or delays and telephone advice on how to manage the patient - 84% of referrers were happy with this. The majority (89%) of respondents also reported that they were satisfied with the level of communication post-assessment, which includes details of formulations and care plans. The advantage of communicating information about delays pre-assessment is that this information can be passed on to the patient, who is more likely to feel updated and respected, potentially reducing the likelihood of absconding. Better communication post-assessment around care planning can also help to ease discharge.

When respondents were asked about their experience of delays in getting a senior opinion and final decision once the assessment itself has been carried out, variation emerged between different groups of referrers. As indicated in figure 6 overleaf, staff from the ED were more likely to experience regular delays in

accessing a senior/final decision (48%) compared with other wards (26%). There was also a difference in the experience of nursing staff to that of consultants and junior doctors, with 41% of nurses reporting regular delays, compared with just 26% of medical staff.

Figure 6: The percentage of different departments and staff who regularly experience delays in receiving a senior opinion or final decision.



Overall, feedback was very positive, with liaison services frequently described as 'approachable, friendly and knowledgeable'. There is a culture of informal advice giving, where telephone support is readily available to acute staff and a knock on the door for advice is also welcomed.

The presence of liaison staff on ward rounds or regular multi-disciplinary team meetings was cited as hugely beneficial, in terms of joint working and information sharing, and in raising the profile of the liaison service itself.

"I think working with people you know and see on a day to day basis helps enormously - they understand the pressures of acute care in a non mental health hospital."

When asked if the involvement of the liaison team generally improved patient outcomes, an encouraging 92% agreed that it did. It was frequently stated that psychiatric liaison teams can have a positive impact not only upon the patient experience, but also in reducing the costs associated with length of stay.

With this increased awareness of the liaison team's function and recognition of the benefits their interventions can bring to both the patient experience and the organisation's finances, many liaison services are facing increasing numbers of referrals.

The referrer survey highlighted that acute staff are highly aware of the pressures that liaison teams face, as it is often the case that the staffing levels are not proportionate to the high throughput of referrals they see. In fact, the peer review visits occasionally revealed that some referrers are consciously *not*

referring some patients, as they know that the liaison team are sometimes overwhelmed by referrals. This means that there are a proportion of patients who would otherwise benefit from psychiatric liaison intervention, who do not receive this care.

"My impression is that the liaison team is a victim of its own success in that they are now referred many more patients than in the past. I suspect the expansion of the team to cope with this has not been rapid enough to keep up."

In cases where the liaison professional cannot immediately attend to a patient, it is particularly important that acute staff are able to manage and care for these patients themselves. This is where the training provided by liaison services is particularly valuable.

"They give us the skills and confidence to deal with non-complex issues ourselves."

The referrer survey revealed that 48% of all respondents had received some training from the liaison team. A further survey exploring training and support in more detail is described in the following section.

Acute staff training survey

General Hospital staff were invited to complete a brief online survey which looked at the training and support provided by psychiatric liaison teams. A total of 222 General Hospital staff completed this second survey. Respondents represented a range of departments, with some of the most common including general and acute medicine, elderly care and the ED. A full list of departments can be found in Appendix 2 (iii).

Table 5 below shows the different professionals who completed the surveys. Of those listed under the 'other' category, respondents included a wide range of specialist physiologists, counsellors, clinical psychologists, dieticians, and in smaller numbers, researchers, radiographers, receptionists and porters, who may also come into contact with people experiencing mental distress.

Table 5: Survey respondents by profession

Job role	Number of respondents
Doctor (Trainee)	78
Nurse (Qualified)	32
Other	31
Consultant	28
Nurse (Senior)	26
Nurse (Unqualified/Trainee)	13
Manager	7
Administrator	2
Midwife	2
Paediatrician	2
Pharmacist	1

Training

Acute staff were asked whether or not they had received training in a number of areas. If training had not been provided, staff had the option of commenting on which topics they would like to see delivered in the future.

Nurses (including senior, qualified and unqualified), trainee doctors and consultants made up the largest proportion of respondents. Of these groups, nurses had received the most training from the liaison team (42%), followed by

junior doctors (34%) and lastly consultants (28%). Full details of all responses to the questionnaire can be found in Appendix 2 (iii).

Respondents were *more* likely to have received training in the use of:

- Mental health legislation (57%)
- Understanding self harm (57%)
- How to make an initial mental health assessment (55%).

The unmet training needs of acute staff varied between professions, with nurses and junior doctors requesting more additional training than consultants. Table 6 details these differences.

Topics such as detecting the misuse of drugs, recognising and responding to emotional responses to trauma and recognising medically unexplained symptoms were frequently requested by all three groups.

Other areas, such as how to make an initial mental health assessment, detecting and responding to acute disturbance and preventing and managing challenging behaviour were more requested by the nursing group. This may reflect the amount of time that nursing staff spend on the 'front line', having to deal with these kinds of behaviour in the General Hospital in the first instance.

Whilst 80% of respondents were satisfied with the quality of training, only half were satisfied with the amount of training provided. Nursing staff are more satisfied (62%) with the quantity of training than consultants (32%) and junior doctors (35%).

Table 6: Percentages of respondents requesting further training in particular topics, divided by professional group.

Type of training	Nurses	Trainee doctors	Consultants
How to make an initial mental health assessment	30	16	14
Working with adults aged over 65, including the detection and management of dementia, delirium and depression	35	37	11
How to assess and manage the patient's risk to self and others	35	22	18
The use of mental health legislation (e.g. the Mental Health Act etc)	21	18	14
Detecting and responding to acute disturbance in physically ill people of all ages (e.g. delirium, psychosis etc)	32	28	18
Understanding why people self-harm and the difference between self-harm and acts of suicidal intent (including for older people)	13	19	18
Suicide awareness, prevention techniques and approaches	16	31	25
Preventing and managing challenging behaviour	41	49	18
Recognising and responding to organic mental health disorders	35	37	7
Detecting the misuse of alcohol	23	40	11
Detecting the misuse of drugs	32	41	21
Recognising and responding to emotional responses to trauma (e.g. shock, anxiety, avoidance etc)	34	45	21
Recognising and responding to medically unexplained symptoms (such as unexplained pain, or unexplained fatigue)	44	42	25
Awareness of the processes involved in adjusting to illness, including issues of non-adherence and phobic responses to illness	31	37	21
The impact of cultural differences on mental health and use of services	35	36	18
Mental health and stigma	31	26	14
Ageism and stigma	37	32	18
Working with people diagnosed with personality disorder	39	44	11

Support and supervision

Although the majority of acute staff do not receive formal supervision from the psychiatric liaison team, 53% reported being able to access ad hoc support or advice when needed. These staff were satisfied with the amount of support and supervision received, and highly satisfied with the quality of this support.

The survey revealed that in-house lectures or seminars would be the preferred method of any future training or support, although some staff would also welcome written information and online training exercises. Opportunities for formal supervision and the chance to shadow colleagues from mental health were also listed as good alternatives. A number of respondents would also like to have more training delivered by/with service users.

Service user survey

Service users who had been in recent contact with any one of the seventeen psychiatric liaison teams in PLAN were asked to complete a survey about their experience with that team. Teams were sent 60 questionnaires each to hand out following assessments, with the option to request more if required. Overall, 217 completed questionnaires were returned to PLAN.

Liaison professionals

The majority of service users gave very positive feedback regarding their experience with the liaison professional:

- 98% of service users agreed that they were treated with support, understanding and warmth.
- 94% felt encouraged to talk about their problems and what sort of help they might find useful
- 95% were satisfied with the amount of time the person spent talking to them.

"They were very professional and willing to spend time listening to the issues I had."

Comments made in the returned questionnaires revealed that service users greatly appreciated supportive liaison staff who involved them in the assessment by thoroughly discussing the problem at hand as well as answering any questions.

The attitude of the liaison professional was also imperative to the user experience; service users highlighted the importance of being treated in a non-judgmental manner by the liaison professional; this can be an important factor in helping to put the service user at ease.

Communication

Many service users (40%) stated that they were not given written information about what had been discussed in the assessment and what future care (if any) was being offered. Similarly, 29% said that they were not copied into written communication between the liaison service and other services. For some service users this is problematic, however the qualitative data suggested that opinion is divided on this - whilst many service users commented that being fully informed of discussions between liaison professionals made them feel included, others felt

that seeing comments written down about them could have a detrimental effect. Consequently, this qualitative data illustrates the importance of giving service users the *option* of being informed of any discussions related to them, but not making it compulsory. This is something which has been incorporated in the revised PLAN standards for cycle 2.

"Wasn't copied in or given a written summary, but I understood that I could request one later if I found it helpful."

Finally, several service users commented on the drawbacks of not being able to see the same professional throughout their care – it made them feel uncared for and having to explain their history with each appointment was frustrating, as well as being a hindrance to their recovery process. This preference for familiarity exemplifies the need for consistency across appointments.

"Yes they didn't know about my long term history of problems, which means I have to explain it from scratch which is very stressful."

Individual needs

With regard to feeling safe, private and comfortable, 93% of service users were satisfied with the room or area that their mental health assessment took place, with privacy of the room being a key factor. A number of service users also commented that having sufficient time to talk and ask questions was particularly beneficial.

*"Clear with explanations and questions. Polite.
Appropriate length of time to allow to talk (not rushed)."*

Some of the suggestions from service users were not necessarily expressed frequently but are nevertheless relevant - for example one service user thought that liaison professionals should be made more aware of non-western cultural beliefs and others greatly appreciated the chance to have a home visit from members of the liaison team. Such comments demonstrate the worth of considering service user needs ideographically and not just in a collective manner.

Carer survey

Carers were invited to complete a survey about their experience with the liaison team. Each liaison team was sent 40 carer questionnaires to distribute, with the option to request more if needed. Overall, 41 completed questionnaires were returned to PLAN, which was a considerably lower response rate than for the other tools. This might reflect a low number of carers coming into contact with liaison services.

Given the small number of responses from this group it is difficult to draw any definitive conclusions from the data. For this reason, the information below only highlights the main findings without any interpretation.

Carers were generally positive about their experience with liaison professionals:

- 98% found the liaison professional to be supportive and friendly
- 85% said they would recommend their liaison team to someone else.

"I found the team to be welcoming and easy to talk to."

On the other hand, comments made highlighted some potential areas for improvement. For example, some carers wanted liaison professionals to better describe mental illness and treatment in terms they could understand.

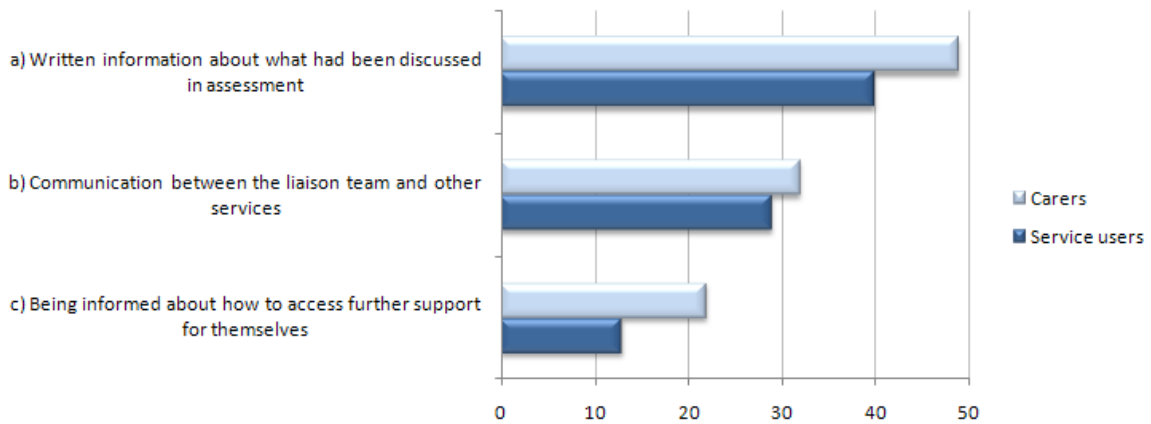
"I find some of the things said to be difficult to understand. When asked for clarification the answers tend to be very similar to the original."

Carers also felt that it would be beneficial to have the option of being able to talk to the liaison professional privately, as they may not always be comfortable talking about the person they care for in front of them. This is particularly the case when carers need to discuss sensitive topics; for example problems that they may be having themselves.

Approximately half of the carers who responded to the questionnaire were not provided with written information about what had been discussed in the assessment, and around a third said they were not copied into written communication between the liaison team and other services (despite having permission to do so from the person they cared for). As a group, carers were more likely than service users to comment on the need for better communication from the liaison professional (see figure 7 on next page).

Similarly, 22% of carers felt they were not given enough information about how they could access further support for *themselves*, such as how to access an assessment of their own needs as a carer and also how to contact relevant social, health, advocacy, voluntary support services etc. This is comparable to 13% of service users who said they weren't given information about further support (see figure 7 on next page).

Figure 7: Comparison of the percentage (%) of *negative* responses from carers and service users, in relation to whether they received sufficient communication in areas a), b) and c)



On the contrary, around two thirds of carers said that they were given enough information about how the person they care for could access further support. Two thirds were also involved in discussions about what sort of future support would be useful for the person they cared for. An implication is that the well-being of carers is something that needs to be prioritised to the same extent as ensuring the welfare of service users.

Team checklist

Each liaison team was asked to complete a team checklist questionnaire and they were encouraged to do this as a group exercise, involving as many different members of the team as possible. The full aggregated quantitative data from this survey can be found in appendix 2 (vi) of this report, on page 58.

Commissioning

Almost a third of liaison services were not explicitly commissioned against agreed service standards and over a third of services were not developed and reviewed by a joint planning forum that meets at least quarterly. It is conceivable that these issues might often arise hand in hand because service level agreements (SLA) include a process by which the service is regularly reviewed against the agreed performance indicators, therefore without a clear SLA, a development and review process would be difficult to implement.

The drawbacks of not having a clearly defined SLA are not restricted to within the liaison team but can also impact on the quality of the service provided by that team. A lack of formal agreement about what the service provides, and a lack of formal commitment to regularly develop and review the service can hinder efforts to resolve any problems that exist within the service.

Assessment facilities

The team checklist specified that the use of a curtain around a patient's bed does not suffice as a private space and should only be used as a last resort. The data showed that nearly a quarter of liaison teams could not access sufficient space in the Emergency Department to conduct assessments in privacy and for the General Hospital this figure was much higher (41%); this is an important area that needs to be addressed.

Another key area relates to the assessment of patients considered to be at high risk. Almost a third of teams did not have a procedure for determining risk and deciding whether or not a patient should be assessed in a more secure area. The same proportion of teams could not access safe facilities for conducting high risk assessments. It must be noted that these findings were based on data from the self-review and since then some of the teams have worked towards rectifying this problem.

"The A&E is being rebuilt and as part of the plans we will have access to two interview rooms and a dual purpose room. The General Hospital access to suitable rooms is there but not always available or practical for the patient group."

Collaborative working in the hospital

This section of the team checklist explored the working relationships between the liaison team staff and various other staff groups in the hospital. These other groups included staff in the Emergency Department, staff in the General Hospital and the out-of-hours liaison team.

The majority of teams (82%) had a system in place allowing the liaison team and General Hospital staff to alert each other to service users who are at risk. However, there was room for improvement regarding meetings with other staff groups. In 29% of hospitals, there are no regular (at least quarterly) meetings between a member of the liaison team and General Hospital staff. In contrast, liaison teams were much more likely to have regular meetings with colleagues from the Emergency Department (ED); only 6% of teams did not meet regularly with the ED.

On a similar note, 29% of teams did not have a forum or procedure in place for the liaison team and acute staff to discuss differences of clinical opinion, with one team commenting that it was 'hard to get all the relevant people together'.

Likewise, over a third of liaison teams did not have joint protocols with out-of-hours teams regarding out-of-hours cover. In some cases a policy was in place but it was not developed in consultation with the out-of-hours liaison staff, resulting in the two teams having separate policies. Considering that policies should ideally include guidance on the working hours and clinical responsibilities of each service, it is essential that joint protocols are in place and so this is an area that needs to be improved upon.

Other data illustrated that approximately a quarter of liaison teams did not have joint care pathways with the out-of-hours service and 29% did not have shared strategies for patients who attended regularly. As mentioned in the questionnaire for service users, many patients found it stressful and frustrating to explain their case to different staff members who did not know their health history. Ensuring formal handover meetings between liaison staff and out-of-hours liaison staff could help address these issues.

Section 2: Key improvements made by teams

Teams participating in PLAN were given time to make improvements to their services between the self review period and the peer visit. There were also opportunities for teams to provide further evidence about any subsequent changes made between the peer review and final accreditation decision. This helped the vast majority of teams to become accredited.

With time and support, many liaison teams were able to make sufficient improvements to ensure that accreditation was achieved. Changes made tended to be ones which were in the control of the liaison team themselves. Some of the most common improvements that liaison services implemented relatively quickly were:

1. Improved training for liaison staff; particularly in areas such as the needs of people with learning disabilities, working with older people and awareness of the team's role following major incidents.
2. Increased supervision and support for liaison staff
3. Improved patient information leaflets
4. The writing and implementation of new policies
5. Improved guidance to referrers.

One team was able to work with their Trust to improve the assessment facilities for high risk assessments and two others were able to secure additional funding for a perinatal and older people's service.

It is not possible to give an exhaustive list here of all of the improvements made by teams during the accreditation cycle, however, a series of three case studies which provide more information are available on our website www.rcpsych.ac.uk/plan. Additionally, we welcome anyone with a query about how to implement a particular change to their service to write to our email discussion group, PLAN-chat@cru.rcpsych.ac.uk, to initiate dialogue and idea sharing with our membership.

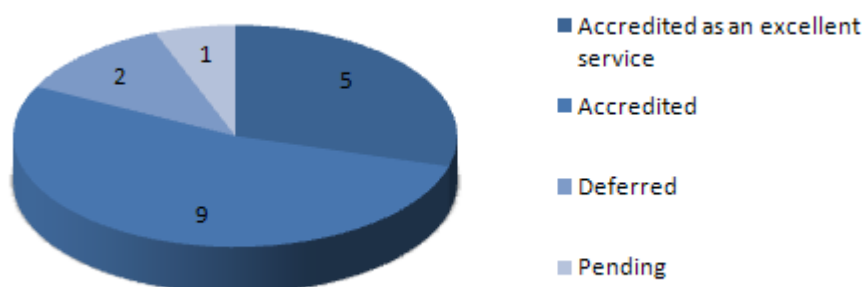
Section 3: Benchmarking final data

This section refers to the number of met and unmet standards after both the self and peer reviews; therefore capturing the important improvements made between the self review and final accreditation decision.

Overall performance of PLAN members

Figure 8 shows the accreditation status of the 17 members at the end of cycle 1. Nine teams were accredited, with a further five accredited as excellent services. Two teams were deferred and one team was yet to receive a final decision at the time of writing. This last team has been excluded from the benchmarking graphs on pages 29-32.

Figure 8: The number of teams falling under each accreditation category



The following graphs illustrate the proportion of standards met for each liaison service in the five areas outlined below:

- **Commissioning and resources** - how well the service is commissioned; whether the liaison team has access to appropriate facilities and resources.
- **Referral procedures** - whether the liaison team provides an effective service to referrers.
- **Service users and carers** - whether the liaison team informs service users and carers about all aspects of their care, considers their needs and views and has the resources to communicate effectively with them.
- **Collaborative working in the hospital** - whether the liaison team communicates effectively with staff in the Emergency Department, General Hospital and also the out-of-hours liaison team (if applicable).
- **Staffing, support and communication** - whether the service is adequately staffed and supervised; how good communication is within the liaison team; training, education and guidance within the liaison team.

PLAN members can use these charts to anonymously benchmark how their liaison service is performing in comparison to other teams, using a unique code letter for each team. If you are a PLAN member who has misplaced details of your team's letter, please contact either Melanie or Mira by telephone: 020 7977 6646 or email: plan@cru.rcpsych.ac.uk.

Please note that the red line in the chart indicates the *average* percentage of standards that were met across the teams.

Figure 9: Commissioning and resources

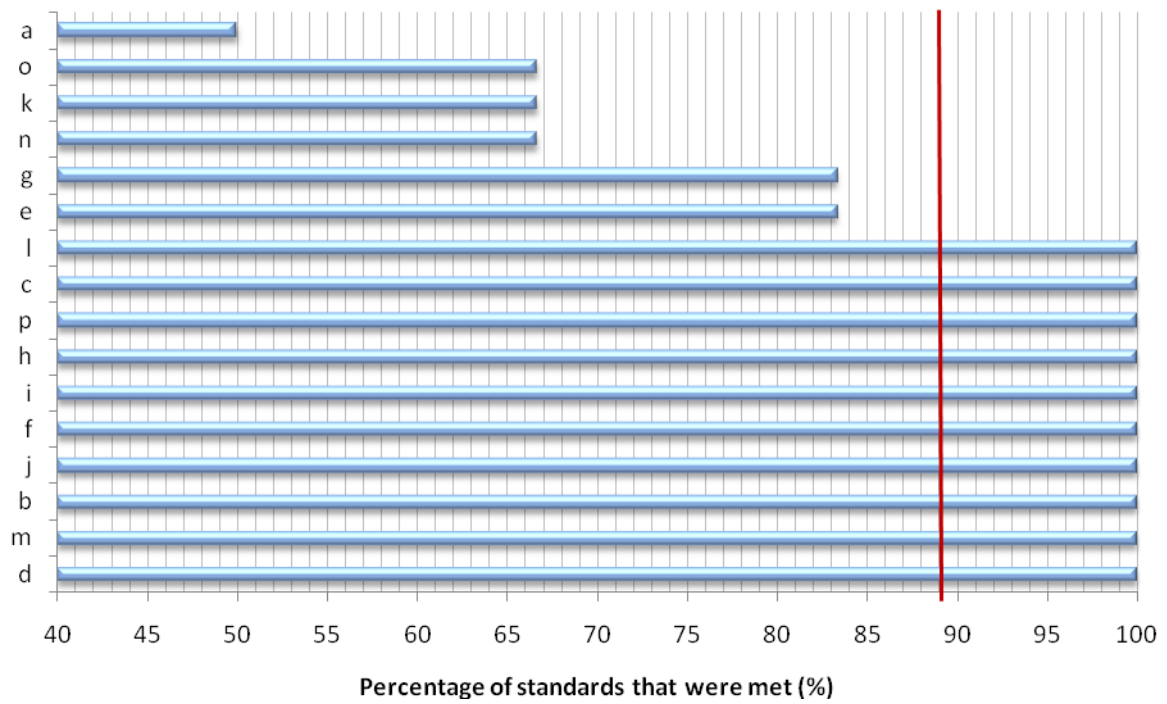


Figure 10: Referral procedures

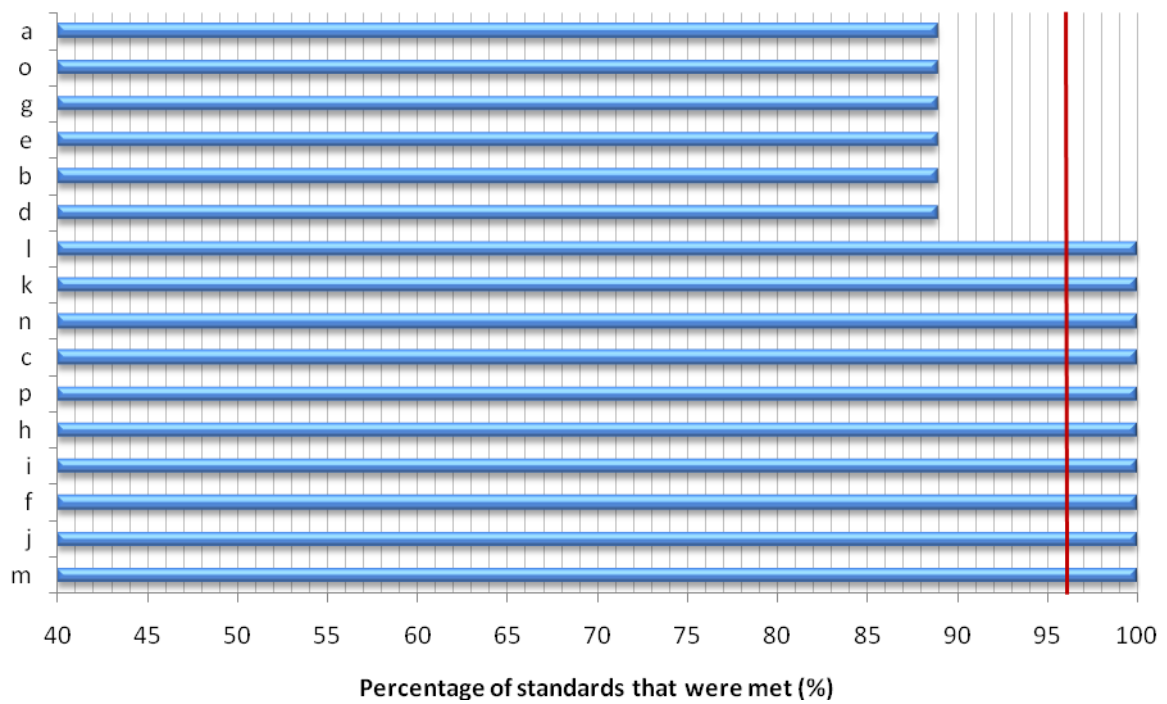


Figure 11: Service users and carers

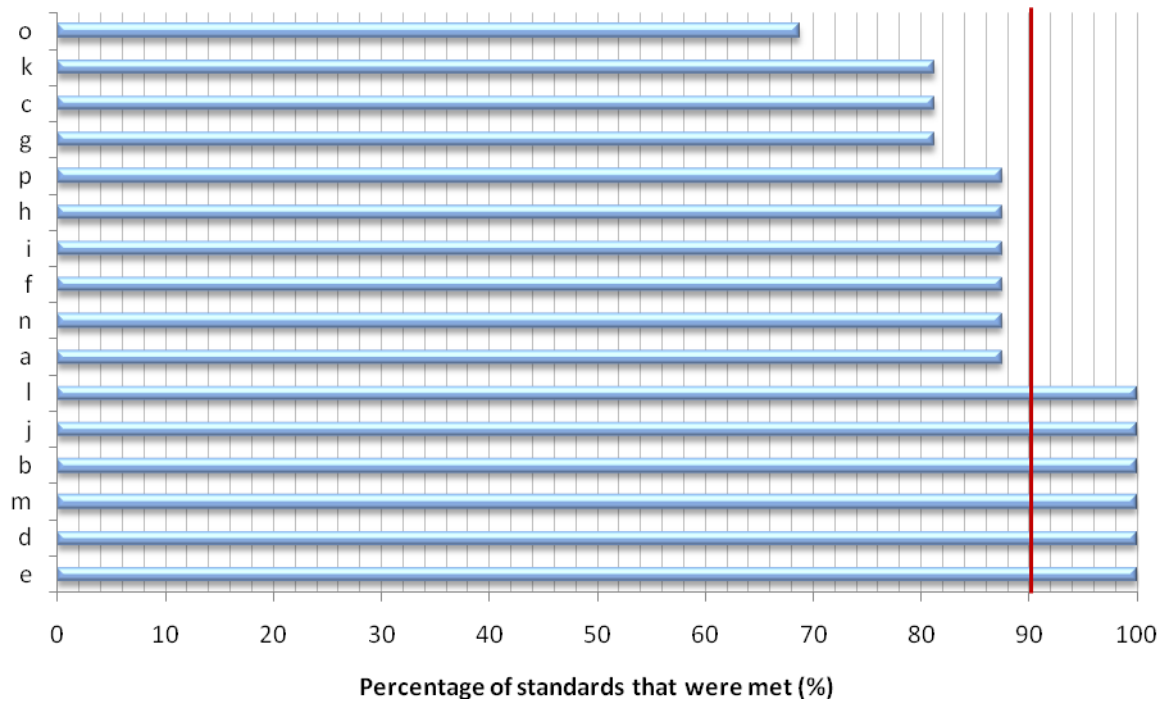


Figure 12: Collaborative working in the hospital

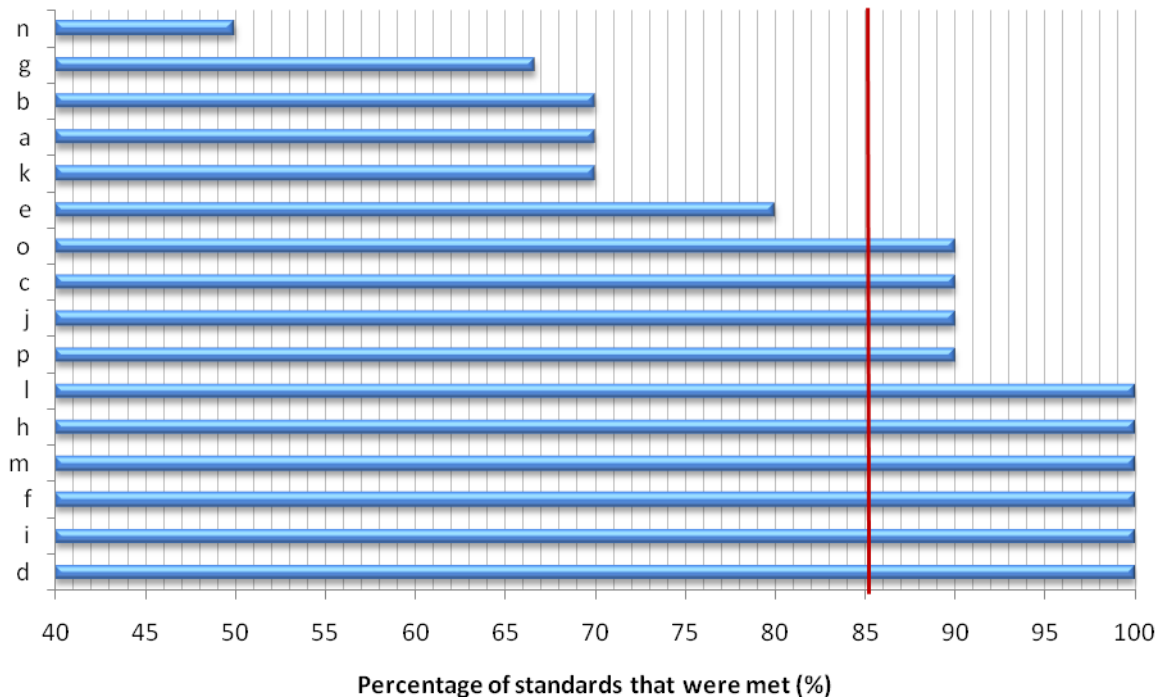


Figure 13: Staffing, support and communication

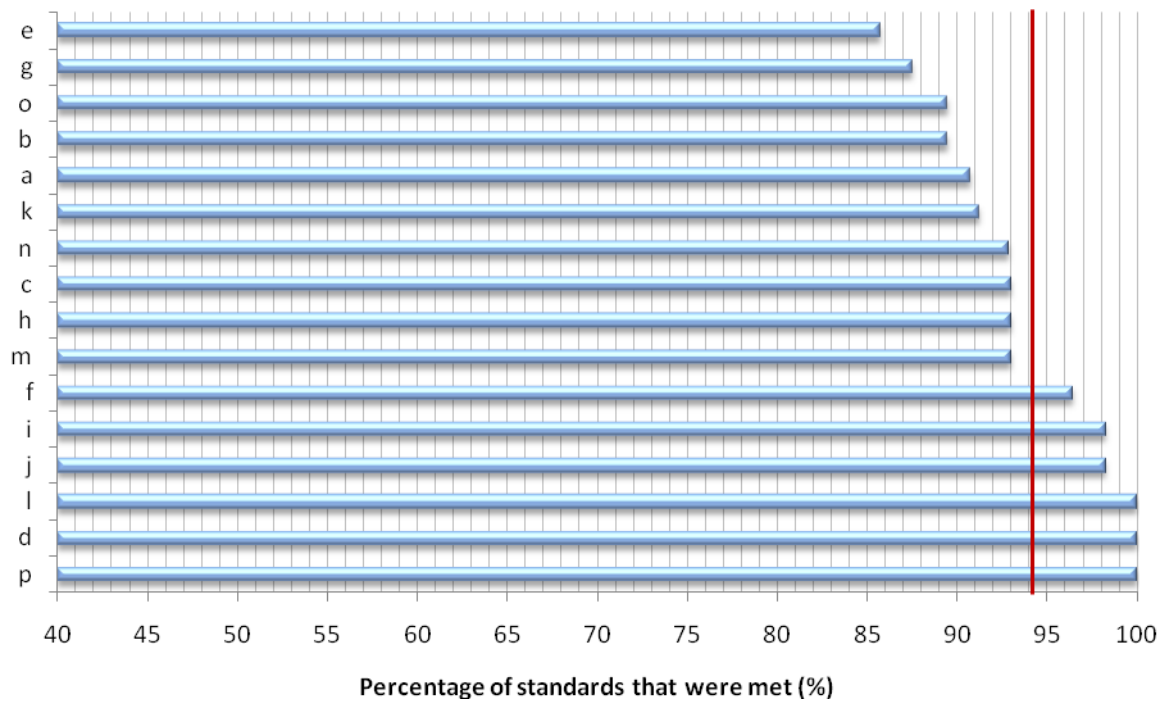
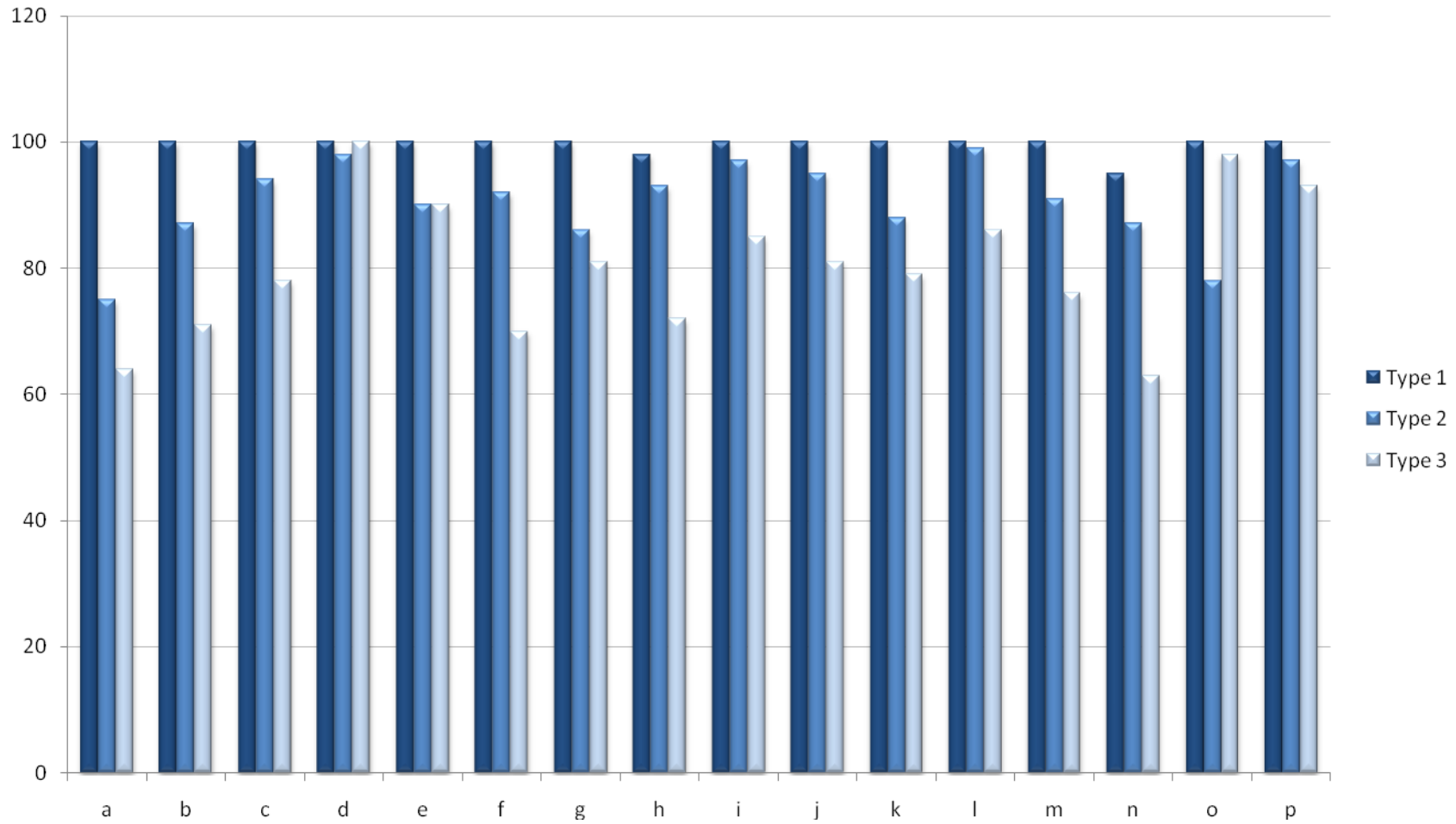


Figure 14: Services' overall performance against type 1, 2 and 3 standards



Section 4: Future recommendations

For liaison services

- Clinical supervision should be offered to staff on a regular basis. For example, protected time can be incorporated into timetables and group reflective practice sessions could be offered to staff.
- There should be an internal rolling training programme which is made available to all staff, not just new staff. Service users should be invited to develop and/or deliver training where possible.
- The liaison team should review the skill mix of the team annually in order to identify any gaps in the team. This would help to inform business cases and recruitment.
- The liaison team should ensure that guidance on which types of presentations should be referred to the team is clear and easily accessible by referrers, for example, posters, leaflets, intranet, inductions etc.
- The transition between liaison staff and out of hours cover could be made smoother, for instance, by having just one point of contact for all referrals 24 hours.
- Liaison staff should record the training that is provided to acute staff and demonstrate to commissioners that this has a positive effect on their ability to manage patients in the short term, as well as on staff attitudes and, ultimately, on the patient experience.
- Best practice should be shared with other liaison teams, for example, to avoid reinventing the wheel in developing a service user and carer information leaflets.
- Liaison staff should consistently offer service users the option of being copied into correspondence and record that this has been done.

A note for commissioners

Psychiatric liaison services are highly valued by general hospital staff and service users alike. They play a key role in a wide range of cases, including dementia, delirium, medically unexplained symptoms, self harm, and many more.

Various studies have shown that involvement of these teams leads to better diagnostic accuracy, increased adherence to the recommended management of conditions, and improved outcomes for service users (No Health without Mental Health, 2009).

Additionally the support they provide to their colleagues can improve morale, especially in those working in areas such as self harm and attempted suicide. Importantly, liaison intervention has a noticeable impact on length of stay in hospital and the associated costs, meaning that the cost of the service itself is often offset by the savings it brings to the Trust overall.

However, liaison services can only continue to deliver these benefits if they are provided with adequate staffing levels, safe assessment facilities and the full support of both the Mental Health and the Acute Trust.

Goals for PLAN

PLAN is currently in its second cycle with a current membership of 32 services, and is still growing.

Our aim is to continue supporting our members to progress – we hope to do this through the development of an online resource library and by holding study days as well as an annual forum where members can come together to share experiences and best practice. We can only do this with your input - if you have any resources to share or suggestions for study/special interest days, please get in touch at plan@cru.rcpsych.ac.uk.

A new subproject, a 'Mental Health Friendly' Quality Mark for Emergency Departments is currently in the early stages of development. Once this new piece of work is underway it will provide Emergency Departments around the UK with the necessary resources to support their teams to deliver high quality care to people with mental health and alcohol problems.

Appendices

Appendix 1: The accreditation process

There are three phases to the accreditation process:

- Phase 1: Self review
- Phase 2: Peer review visit by external team
- Phase 3: Accreditation decision

Phase 1: Self review

The self review has a number of components. Unless otherwise stated, these will be completed online using a simple web-based survey, which will be anonymous and returned directly to the central PLAN team. All of the data collection tools are designed to help us understand how well the team is meeting certain standards. Respondents will also be invited to highlight the strengths of the liaison team as well as suggestions for future development.

A questionnaire for members of the liaison team

This contains questions for the liaison team about their skills, knowledge, training and support as well as around working arrangements, communication and collaboration between the liaison team and other departments.

A referrer questionnaire

This contains a brief series of questions about the relationship between the service and the departments and organisations that refer patients, including questions on ease of referral, communication, training and support.

Patient and carer questionnaires

These contain a brief series of questions about the person's experience of the service, focusing on what they found most helpful and any improvements they would recommend.

The questionnaire for users and carers stresses that filling in a questionnaire is entirely voluntary, anonymous, and will not affect the care that they receive. It is important that individuals are not at all pressurised into taking part.

Note: If the service user is likely to require assistance filling in the questionnaire then an independent person (e.g. advocate), member of staff from another service or a carer/relative can be approached if this is acceptable to the service user; **staff from the service should not assist the service user.**

In addition to the surveys, PLAN leads will also be asked to complete:

- **A brief audit of 20 case notes** – looking at assessments, care planning and communication.
- **A one-off team checklist** – designed to help us understand the arrangements which underpin the team's work.

Target numbers of returns

Every member of the liaison team will need to complete the staff survey. Two thirds of acute staff who refer to the service are required to complete a survey. Teams should aim for at least 15-20 responses from service users and/or carers.

Phase 2: Peer review visit by an external team

The purpose of the one-day peer review visit is to:

- Validate the results of the self review and contribute to the accreditation decision
- Enable staff to demonstrate the quality of their service
- Facilitate the sharing of information and advice

Each peer review team will include three or four people (drawn from different services and locations):

- Two or three liaison professionals
- A lead reviewer (either a member of the PLAN central team or PLAN steering group)
- A service user or carer

The data gathered from the self review is compiled by the PLAN Project Team into the peer review booklet, which forms the basis of discussions on the peer review visit.

What happens on the peer review day?

A number of meetings take place on the day and are accommodated within a set timetable, including:

- Interview with the liaison team
- A presentation/discussion of the case note findings
- Discussion with patients and carers (if available)
- A multi-agency discussion where acute staff and referrers meet with the liaison team to talk about how care pathways and communication can be improved

During and following the peer review visit, the peer review booklet is completed to include the review team's comments.

The role of the peer reviewer

Peer review teams have an essential role in assuring a successful visit that is supportive to staff and which aims to enthuse and educate.

The primary responsibilities of members of peer review team are to:

- Validate the self review data
- Share ideas about both achievements and problems
- Offer advice and support based on their expertise
- Feed back comments or suggestions regarding the network to the PLAN Project Team
- Help to promote the programme to existing and potential members

Phase 3: The accreditation decision

The results of both the self and peer review will be collated into a report for your service. It will then be discussed by the PLAN Accreditation Advisory Committee (AAC). The AAC consists of nominated professionals representing:

- The Royal College of Psychiatrists' Faculty of Liaison Psychiatry
- The Royal College of Nursing
- The Royal College of Physicians
- Mind
- The College of Emergency Medicine
- Service user and carer representation

The AAC will recommend an accreditation status for each team, which is ratified by the Royal College of Psychiatrists' Education, Training and Standards Committee.

There are four categories of accreditation status, according to how many standards are met at the point of peer review:

Category 1: "accredited as an excellent service", for teams which:

- meet 100% of Type 1 standards;
- meet 95% of Type 2 standards;
- meet 80% Type 3 standards, with a clear plan for how to achieve the others.

Category 2: "accredited", for teams which:

- meet 100% of Type 1 standards;
- meet 75% of Type 2 standards;
- meet 60% Type 3 standards.

Category 3: "accreditation deferred", for teams which:

- fail to meet one or more Type 1 standards but demonstrate the capacity to meet these within a short time;
- fail to meet a substantial number of Type 2 standards but demonstrate the capacity to meet the majority within a short time.

In this case, the service would receive a list of the standards that need to be addressed for accreditation to be awarded. Time and support would be provided and follow up data would be collected through a further self and (if necessary) peer review, to determine if the service now met the criteria for Category 2 approval.

Teams are given every opportunity to demonstrate that they are meeting the standards before a final accreditation decision is awarded.

Category 4: "not accredited", for teams which:

- fail to meet one or more Type 1 standard and do not demonstrate the capacity to meet these within a reasonable time;
- fail to meet a substantial number of Type 2 standards and not demonstrate the capacity to meet these within a reasonable time.

In this case the service would receive a list of the standards that need to be addressed for accreditation to be awarded. Time and support would be provided and follow up data would be collected through a further self and peer review, to determine if the service now met the criteria for Category 2 approval.

If a team meets the thresholds stated to be accredited, but those 'unmet' standards appear to cluster around a particular area, such as training, service user involvement, communication etc, the AAC may decide that there is sufficient reason to ask for reasonable changes to be made to redress this.

Note: In the event that PLAN finds evidence that the trust's/organisation's liaison psychiatry service seriously threatens the safety, rights or dignity of patients, the trust/organisation will be informed, in writing, and expected to take appropriate action. If the Royal College of Psychiatrists is not satisfied that appropriate action has been taken, it reserves the right to inform those with responsibility for the management of the service and/or the relevant regulatory body.

Appendix 2: Raw data

(i) Psychiatric liaison staff survey

In this survey staff were asked about training, support and communication within the liaison team.

The questions that were asked in the staff survey are presented below and alongside these is the percentage (%) of each response that was given.

Please note that in some cases not all questions were answered. Therefore some of the response percentages (for a given question) do not add up to 100%.

Hospitals that responded

<i>Hospital</i>	<i>Number of responses</i>
Addenbrookes' Hospital, Cambridge	17
Arrowe Park Hospital (Wirral University Teaching Hospital), Wirral	19
Chelsea and Westminster Hospital, London	18
City Hospital, Birmingham	14
Countess of Chester Hospital, Chester	11
Hammersmith Hospital, London	9
Kent and Canterbury Hospital, Canterbury	17
Mid Staffs General Hospital, Stafford	4
Newcastle General Hospital, Newcastle	7
Newham University Hospital, London	5
Northern General Hospital, Sheffield	12
Princess Anne Hospital, Southampton	3
Queen Alexandra Hospital, Portsmouth	8
Royal Free Hospital, London	7
Southampton General Hospital, Southampton	5
Southern General Hospital, Glasgow	17
St Helier Hospital, Surrey	6
St Thomas' Hospital, London	15
Total number of responses	194

Professional roles of liaison staff

Professional Role	Response (%)
Administrator/Secretary/Clerical	12
Manager (e.g. Team Manager, Clinical Service Manager etc)	5
Mental Health Nurse (Registered)	37
Psychiatrist (Consultant level)	16
Psychiatrist (Non-consultant level)	16
Psychologist	6
Social Worker	3
Therapist (e.g. Occupational Therapist, Speech Therapist etc)	1
Other	5

Which group of patients do you work with?	Response (%)
Working aged adults (18-64)	42
Older people (65 and over)	13
Both	45

How many sessions of clinical supervision have you had in <u>the past three months</u>?	Response (%)
None	18
1	16
2 (i.e. approx every 6 weeks)	16
3 (i.e. monthly supervision)	19
4	2
5	3
6 (i.e. fortnightly supervision)	6
12 (i.e. weekly supervision)	17
More than 12 (i.e. daily supervision)	4

Answer 'yes' or 'no' to the questions below	Yes (%)	No (%)
Does supervision allow you to reflect on your emotional responses to work?	91	9
Are you satisfied with the <i>quality</i> of the supervision you receive?	89	12
Are you satisfied with the <i>frequency</i> of the supervision you receive?	79	21
Do you have the opportunity to meet with peers for support (informally or formally)?	91	8

Answer 'yes' or 'no' to the questions below	Yes (%)	No (%)
Are you clear about what your responsibilities are in the liaison service?	99	1
Are you clear about who you are accountable to (i.e. who your line manager is)?	99	1
Can you contact a senior colleague at any time?	91	9
Do you have the opportunity to debrief following violent or traumatic incidents?	92	7
Do you think that communication within the liaison team is generally effective?	90	10
Do you know how to access the liaison team's policies, procedures and written guidance relevant to your role?	91	10
Can you access advice about legal issues when needed – for example, advice about sharing patient information, the use of legal frameworks, capacity, consent etc?	97	3
Did you receive a satisfactory induction when you first joined the liaison team?	89	11

<i>In the past 12 months, how many days have you spent on training, professional development, education or learning? Include any conferences, events, courses etc that you have attended – either externally or internally – during work time</i>	Response (%)
None	7
Between 1-2 days	13
Between 3-5 days	24
Between 6-8 days	26
Between 9-12 days	15
More than 12 days	15

<i>In the past 12 months have you:</i>	Yes (%)	No (%)
Received an appraisal?	76	22
Been asked about your training needs?	85	15
Been unable to access training due to a lack of funds?	14	85
Been unable to access training due to a lack of staff cover?	17	83

<i>Rate the guidance, training or education you have received, including formal training and informal 'on-the-job' learning. If any of the areas listed are not applicable to your current role, please select 'N/A'</i>	<i>Sufficient (%)</i>	<i>Insufficient or not provided (%)</i>	<i>N/A to my role (%)</i>
A basic awareness of common mental health problems	88	1	11
A basic awareness of risk	90	2	8
Information sharing and confidentiality	93	5	1
Culturally sensitive practice, disability awareness and other diversity and equality issues	88	8	4
Mental health and stigma	87	6	7
Ageism and stigma	72	17	11
Recognising special needs and knowing how to arrange support for people with visual, hearing, literacy or learning disabilities	62	27	11

<i>Rate the guidance, training or education you have received, including formal training and informal 'on-the-job' learning. If any of the areas listed are not applicable to your current role, please select 'N/A'</i>	<i>Sufficient (%)</i>	<i>Insufficient or not provided (%)</i>	<i>N/A to my role (%)</i>
Working with 16-18 year olds, if appropriate	38	19	42
Working with older people, including detection and management of dementia, delirium and depression	59	21	20
Conducting mental health assessments in people with complex physiological and psychological problems	84	13	2
Assessing and managing a patient's risk to self and others	93	5	1
The use of legal frameworks, such as conducting assessments, deprivation of liberty, assessing capacity and providing medico-legal advice to colleagues	81	14	4
Detecting and managing acute disturbance in physically ill people of all ages (e.g. delirium, psychosis etc) and the use of rapid tranquilisation, if used	77	15	7
The protection of vulnerable adults and child protection issues, including responding to suspected abuse or domestic violence	89	8	2
Understanding why people self-harm and the difference between self-harm and acts of suicidal intent (for working age adults and for older people)	89	8	1

Suicide awareness, prevention techniques and approaches	90	9	1
Preventing and managing challenging behaviour	84	12	4
Detecting the misuse of alcohol	85	12	2
Detecting the misuse of drugs	80	15	4
Recognising and managing emotional responses to trauma	77	19	3
Recognising and managing medically unexplained symptoms	70	25	3
Recognising and managing organic health disorders	74	18	6
Person-centred care planning	79	15	3
The use of therapeutic approaches in the assessment process, such as motivational interviewing, cognitive behavioural therapy techniques, or psychotherapeutic or systemic theories	68	28	2
Awareness of the processes involved in adjusting to illness, including issues of non-adherence and phobic responses to illness	72	25	2
Working with people diagnosed with personality disorder	78	18	2
The impact of cultural differences on mental health and use of services	82	16	1
The needs of people with learning disabilities	44	47	8
Awareness of the liaison team's role following major incidents	51	42	4
Referral pathways and joint working arrangements with the hospital and other services	88	11	0

<i>Rate the guidance, training or education you have received, including formal training and informal 'on-the-job' learning. If any of the areas listed are not applicable to your current role, please select 'N/A'</i>	<i>Sufficient (%)</i>	<i>Insufficient or not provided (%)</i>	<i>N/A to my role (%)</i>
Detecting and managing <u>dementia</u> in older people	68	25	7
Detecting and managing <u>delirium</u> in older people	69	22	8
Detecting and managing <u>depression</u> in older people	78	19	3
Undertaking specialist assessments for older people	60	31	8
Assessing capacity in older people	57	31	11
Referral pathways and joint working arrangements with local health services for older people	76	19	5
Signposting service users and carers to voluntary organisations, service user and carer groups for older people	71	22	5

<i>Rate the guidance, training or education you have received in the interventions you deliver. Please include both formal training and 'on-the-job' learning. If you do not personally deliver these interventions, select 'N/A to my role'.</i>	<i>Sufficient (%)</i>	<i>Insufficient or not provided (%)</i>	<i>N/A to my role (%)</i>
Individual Cognitive Behavioural Therapy (CBT)	52	17	26
Group Based Cognitive Behavioural Therapy (CBT)	14	18	61
Couples Therapy	10	14	67
Dialectical Behavioural Therapy (DBT)	8	23	59
Integrative Therapy	12	17	62
Interpersonal Therapy (IPT)	17	23	51
Multi-Sensory Stimulation	1	19	71
Psychoanalytic Therapy	16	16	60
Psychodynamic Therapy	31	13	48
Psycho-Educational Groups	20	16	55
Structured Problem Solving	46	16	26

<i>Rate the <u>supervision and support</u> you receive in relation to these interventions:</i> <i>If you do not personally deliver these interventions, select 'N/A to my role'.</i>	<i>Sufficient (%)</i>	<i>Insufficient or not provided (%)</i>	<i>N/A to my role (%)</i>
Individual Cognitive Behavioural Therapy (CBT)	32	23	30
Group Based Cognitive Behavioural Therapy (CBT)	10	11	58
Couples Therapy	5	11	60
Dialectical Behavioural Therapy (DBT)	3	15	57
Integrative Therapy	5	13	58
Interpersonal Therapy (IPT)	7	12	57
Multi-Sensory Stimulation	0	13	62
Psychoanalytic Therapy	11	10	56
Psychodynamic Therapy	17	11	50
Psycho-Educational Groups	8	14	53
Structured Problem Solving	21	18	33

(ii) Referrer survey

Referrers were asked to complete this questionnaire in order for PLAN to understand more about the needs of the liaison team's acute colleagues.

The questions that were asked in the referrer questionnaire are presented below and alongside these is the percentage (%) of each response that was given.

Please note that in some cases not all questions were answered. Therefore some of the response percentages (for a given question) do not add up to 100%.

Hospitals that responded

Hospital	Number of responses
Addenbrookes' Hospital, Cambridge	37
Arrowe Park Hospital (Wirral University Teaching Hospital), Wirral	32
Chelsea and Westminster Hospital, London	44
City Hospital, Birmingham	18
Countess of Chester Hospital, Chester	60
Freeman Hospital, Newcastle	9
Hammersmith Hospital, London	22
Kent and Canterbury Hospital, Canterbury	26
Mid Staffs General Hospital, Stafford	21
Newcastle General Hospital, Newcastle	6
Newham University Hospital, London	20
Northern General Hospital, Sheffield	16
Queen Alexandra Hospital, Portsmouth	28
Royal Free Hospital, London	27
Royal Hallamshire Hospital, Sheffield	3
Southampton General Hospital, Southampton	21
Southern General Hospital, Glasgow	13
St Helier Hospital, Surrey	31
St Thomas' Hospital, London	16
Walkergate Hospital, Newcastle	7
Other	1
Total number of responses	458

Departments that referrers were from

Department	Response (%)
Cardiology	2
Clinical Decisions Unit	1
Critical Care/Intensive Care	1
Elderly Care	9
Emergency Department (A&E)	27
Gastroenterology	3
General and Acute Medicine	13
General Surgery	1
Haematology	1
Maternity Department	2
Medical Assessment Unit	2
Nephrology	1
Nutrition and Diabetics	1
Obstetrics and Gynaecology/Women's Health	2
Occupational Therapy	1
Oncology	1
Orthopaedics	2
Pain Management	1
Physiotherapy	1
Renal Unit	2
Rheumatology	1
Sexual Health/ Genito-Urinary Medicine	1
Urology	1
Other	27

Professional roles of referrers

Professional Role	Response (%)
Consultant	38
Trainee Doctor	11
Nurse	40
Occupational Therapist	1
Physiotherapist	1
Other (for example Midwives, Psychologists and Ward Managers)	9

Referring to the liaison team, please answer 'yes' or 'no'	Yes (%)	No (%)
Have you been provided with guidance on <u>which patients</u> should be referred to the liaison team?	67	32
Have you been provided with guidance on <u>how</u> to refer patients to the liaison team?	85	14
Have you been provided with guidance about <u>which types</u> of cases will take <u>priority</u> ?	49	50
Do you find the referral process straightforward to use with minimum obstacles?	88	9
Are you satisfied with the initial communication from the liaison team (i.e. updates on waiting times or delays, telephone advice about how to care for the patient etc)?	84	15
Are you satisfied with the communication provided by the liaison team post-assessment (i.e. formulation, care plan etc)?	89	10
Do you regularly experience delays in getting senior opinion and final decision once the initial assessment has been carried out?	32	67

Referral Definitions

Emergency referrals: An acute disturbance of mental state and/or behaviour which poses a significant, **imminent** risk to the patient or others.

Urgent: A disturbance of mental state and/or behaviour that poses a significant risk to the patient or others, but does not require immediate mental health involvement.

Routine: All other referrals, including patients who require mental health assessment, but do not pose a significant risk to themselves or others, and are not medically fit for discharge.

Are you generally satisfied with the liaison team's speed of response to:	Yes (%)	No (%)
Emergency referrals	84	9
Urgent referrals	85	9
Routine referrals	81	12
Regarding training and hands-on support from the liaison team, please tick 'yes' or 'no':	Yes (%)	No (%)
Are you aware of the liaison team's working hours and who to contact outside of these hours?	66	31
In your opinion, does the involvement of the liaison team generally improve patient outcome?	92	3
Has the liaison team provided you or colleagues in your department with any training in mental health issues?	47	49
Does the liaison team provide support and supervision to your department?	67	30

(iii) Acute staff training survey

Acute staff were asked to complete this questionnaire in order to understand more about the training and support provided by the liaison team.

The questions that were asked in this questionnaire are presented below and alongside these is the percentage (%) of each response that was given.

Please note that in some cases not all questions were answered. Therefore some of the response percentages (for a given question) do not add up to 100%.

Hospitals that responded

<i>Hospital</i>	<i>Number of responses</i>
Addenbrookes' Hospital, Cambridge	38
Arrowe Park Hospital (Wirral University Teaching Hospital), Wirral	10
Charles Clifford Hospital, Sheffield	1
Chelsea and Westminster Hospital, London	4
City Hospital, Birmingham	3
Countess of Chester Hospital, Chester	21
Kent and Canterbury Hospital, Canterbury	37
Mid Staffs General Hospital, Stafford	20
Newham University Hospital, London	14
Northern General Hospital, Sheffield	7
Queen Alexandra Hospital, Portsmouth	7
Royal Free Hospital, London	9
Royal Hallamshire Hospital, Sheffield	2
Southern General Hospital, Glasgow	2
St Helier Hospital, Surrey	40
St Thomas' Hospital, London	6
Unspecified team	1
Total number of responses	222

Departments that acute staff were from

Department	Response (%)
Cardiology	4
Clinical Decisions Unit	1
Critical Care/Intensive Care	1
Elderly Care	7
Emergency Department (A&E)	14
Gastroenterology	1
General and Acute Medicine	10
General Surgery	3
Haematology	2
Maternity Department	1
Medical Assessment Unit	5
Nutrition and Diabetics	1
Obstetrics and Gynaecology/Women's Health	1
Occupational Therapy	1
Oncology	6
Orthopaedics	1
Pain Management	1
Physiotherapy	1
Renal Unit	3
Urology	1
Other	35

Professional roles of acute staff

Department	Response (%)
Administrator/Secretary/Ward Clerk	1
Consultant	13
Trainee Doctor	35
Manager	3
Midwife	1
Paediatrician	1
Pharmacist	1
Nurse (Senior)	12
Nurse (Qualified)	14
Nurse (Unqualified, Trainee or Healthcare Assistant)	6
Other (for example, Clinical Psychologist, Counsellor, Dietician, Porter, Receptionist, Research Assistant)	14

<i>In the past twelve months, has anyone from the liaison team provided you with education, training or guidance in the following?</i> <i>If not, please indicate in the final column whether this is education/training/guidance that you would like the liaison team to deliver in the future.</i>	<i>Yes they have (%)</i>	<i>No they have not (%)</i>	<i>No, but I would like this in the future (%)</i>
How to make an initial mental health assessment	55	19	19
Working with adults aged over 65, including the detection and management of dementia, delirium and depression	32	33	28
How to assess and manage the patient's risk to self and others	54	14	23
The use of mental health legislation (e.g. the Mental Health Act etc)	57	17	17
Detecting and responding to acute disturbance in physically ill people of all ages (e.g. delirium, psychosis etc)	46	22	25
Understanding why people self-harm and the difference between self-harm and acts of suicidal intent (including for older people)	57	19	17
Suicide awareness, prevention techniques and approaches	53	16	22
Preventing and managing challenging behaviour	34	23	36
Recognising and responding to organic mental health disorders	36	24	29
Detecting the misuse of alcohol	35	29	27
Detecting the misuse of drugs	28	32	32
Recognising and responding to emotional responses to trauma (e.g. shock, anxiety, avoidance etc)	32	29	32
Recognising and responding to medically unexplained symptoms (such as unexplained pain, or unexplained fatigue)	23	31	37
Awareness of processes involved in adjusting to illness, including issues of non-adherence and phobic responses to illness	29	32	31
The impact of cultural differences on mental health and use of services	25	35	31
Mental health and stigma	41	30	23
Ageism and stigma	19	44	29
Working with people diagnosed with personality disorder	28	29	36

<i>In the past six weeks, have any members of the liaison team provided you with:</i>	<i>Yes (%)</i>	<i>No (%)</i>
Formal supervision?	14	79
Ad-hoc support or advice?	53	41
<i>Are you generally satisfied with:</i>	<i>Yes (%)</i>	<i>No (%)</i>
The amount of training provided by the liaison team?	100	0
The quality of training provided by the liaison team?	88	12
The amount of support and supervision provided by the liaison team?	94	6
The quality of support and supervision provided by the liaison team?	82	18

<i>If you were to receive further guidance on mental health, what format would you like this take?</i>	<i>Response (%)</i>
In-house lectures, workshops or seminars	86
Written information	43
Shadowing mental health colleagues	36
Training with input from mental health service users	26
Supervision from the liaison team (including regular updates/ feedback on performance)	36
A series of brief online training exercises (e.g. case studies, quizzes etc)	38
Other (please specify below)	2

(iv) Service user survey

Service users were informed of PLAN and were given the option of completing this survey. It was made clear that should they choose not to complete the survey, their care would not be affected.

The questions that were asked in this survey are presented below and alongside these is the percentage (%) of each response that was given.

Please note that in some cases not all questions were answered. Therefore some of the response percentages (for a given question) do not add up to 100%.

Hospitals that responded

<i>Hospital</i>	<i>Number of responses</i>
Addenbrookes' Hospital, Cambridge	17
Arrowe Park Hospital (Wirral University Teaching Hospital), Wirral	12
Chelsea and Westminster Hospital, London	19
City Hospital, Birmingham	14
Countess of Chester Hospital, Chester	14
Hammersmith Hospital, London	9
Kent and Canterbury Hospital, Canterbury	5
Mid Staffs General Hospital, Stafford	21
Newcastle General Hospital, Newcastle	2
Newham University Hospital, London	18
Northern General Hospital, Sheffield	11
Queen Alexandra Hospital, Portsmouth	15
Royal Free Hospital, London	4
Royal Hallamshire Hospital, Sheffield	1
Southampton General Hospital, Southampton	17
Southern General Hospital, Glasgow	9
St Helier Hospital, Surrey	14
St Thomas' Hospital, London	11
Walkergate Hospital, Newcastle	1
Other	3
Total number of responses	217

Thinking about the time you spent with the liaison professional, please answer the following. Some examples are provided in case you need them, but don't worry if these do not apply to you - they are only examples.	Yes (%)	No (%)	Don't know, can't remember or N/A (%)
Were you satisfied with the room or area where your mental health assessment took place? <i>For example, did it feel reasonably safe, private and comfortable?</i>	93	4	2
Did the liaison professional treat you with support, understanding and warmth?	98	1	1
Were you given the choice of being alone or having someone else with you in the assessment (such as a friend or family member)?	57	24	18
Were you encouraged to talk about your problems and say what sort of help <u>you</u> might find useful?	94	3	1
Were you given enough information about the sort of problems you were having? <i>For example, if you were given a mental health diagnosis, did the professional explain what this meant?</i>	79	10	10
If you were being referred to another professional or service, were you given enough information about why this was, and what to expect?	60	6	30
Were you given enough information about how you could access further support yourself? <i>For example, who to contact in a mental health crisis, or details of other health, social, advocacy or voluntary services that might be useful to you.</i>	73	13	12
Were you satisfied with the amount of time the person spent talking to you?	95	5	0
Were you given written information explaining what had been discussed in the assessment and what future care (if any) was being offered?	42	40	15
Were you copied into written communication between the liaison service and other services? <i>For example, a letter from the liaison team to the GP?</i>	47	29	22
If someone else was in a similar situation to you, would you recommend this particular liaison service to them?	94	1	5

(v) Carer survey

Carers were informed of PLAN and were given the option of completing this survey. It was made clear that should they choose not to complete the survey, neither their own care nor that of the person they care for would be affected.

The questions that were asked in this survey are presented below and alongside these is the percentage (%) of each response that was given.

Please note that in some cases not all questions were answered. Therefore some of the response percentages (for a given question) do not add up to 100%.

Hospitals that responded

<i>Hospital</i>	<i>Number of responses</i>
Addenbrookes' Hospital, Cambridge	2
Arrowe Park Hospital (Wirral University Teaching Hospital), Wirral	3
Chelsea and Westminster Hospital, London	2
City Hospital, Birmingham	1
Countess of Chester Hospital, Chester	3
Freeman Hospital, Newcastle	1
Hammersmith Hospital, London	1
Kent and Canterbury Hospital, Canterbury	3
Mid Staffs General Hospital, Stafford	4
Newcastle General Hospital, Newcastle	2
Newham University Hospital, London	5
Queen Alexandra Hospital, Portsmouth	1
Royal Free Hospital, London	3
Southampton General Hospital, Southampton	2
Southern General Hospital, Glasgow	2
St Helier Hospital, Surrey	3
St Thomas' Hospital, London	2
Walkergate Hospital, Newcastle	1
Total number of responses	41

Thinking about the liaison professional the person you care for had contact with, please answer the following questions. Some examples are provided in case you need them, but don't worry if these do not apply to your situation - they are only examples. Please note - if the person you care for did not give permission for the professional to share all of their information with you, you might not be able to answer all of the questions. If this is the case, please tick the 'Don't know/Can't Remember/Not applicable' column.	Yes (%)	No (%)	Don't know, can't remember or N/A (%)
Was the liaison professional supportive and friendly?	98	0	0
Were you given enough information about the mental health problems the person you care for was having? <i>(For example, things such as the person's symptoms, behaviour or diagnosis).</i>	73	5	15
Were you given enough information about how the person you care for could access further support? <i>(For example, information about who to contact in a mental health crisis, or details of other services such as health, social, advocacy or voluntary sector services).</i>	68	10	17
Were you involved in decisions about what sort of future support would be useful to the person you care for? <i>(provided the person you care for agreed).</i>	66	12	15
Did the professional give you a written summary of what had been discussed in the assessment and what future care (if any) was being offered?	32	49	17
If the person you care for was being referred to another professional or service, were you given enough information about why this was and what to expect?	44	10	39
Were you copied into written communication between the liaison team and other services, such as GPs etc? <i>(Provided the person you care for agreed).</i>	42	32	22
Did the liaison professional advise you on how to access further support for yourself? <i>(For example, how to access an assessment of your own needs as a carer, how to contact services etc).</i>	51	22	20
If you knew someone with a problem similar to the person you care for, would you recommend this liaison service?	85	2	10

(vi) Team checklist

Team members were asked to go through this checklist with other colleagues from the liaison team and answer 'yes' or 'no' to each question.

Space was provided at the end of each section for comments to be added – which was particularly useful for any achievements and explaining why standards have not been met, however only the quantitative data is presented here.

The questions that were asked in the team checklist are presented below and alongside these is the percentage (%) of each response that was given.

Please note that in some cases not all questions were answered. Therefore some of the response percentages (for a given question) do not add up to 100%.

Hospitals that responded

<i>Hospital</i>	<i>Number of responses</i>
Addenbrookes' Hospital, Cambridge	1
Arrowe Park Hospital (Wirral University Teaching Hospital), Wirral	1
Chelsea and Westminster Hospital, London	1
City Hospital, Birmingham	1
Countess of Chester Hospital, Chester	1
Freeman Hospital, Newcastle	1
Hammersmith Hospital, London	1
Kent and Canterbury Hospital, Canterbury	1
Mid Staffs General Hospital, Stafford	1
Newcastle General Hospital, Newcastle	1
Newham University Hospital, London	1
Northern General Hospital, Sheffield	1
Queen Alexandra Hospital, Portsmouth	1
Royal Free Hospital, London	1
Royal Hallamshire Hospital, Sheffield	1
Royal Victoria Infirmary, Newcastle	1
Southampton General Hospital, Southampton	1
Southern General Hospital, Glasgow	1
St Helier Hospital, Surrey	1
St Thomas' Hospital, London	1
Walkergate Hospital, Newcastle	1
Weston Park Hospital, Sheffield	1
Other	2

Core standards for all adult teams

(Includes teams dedicated to working age adults, older adults and both)

Answer 'yes' or 'no' to the questions below	Yes (%)	No (%)
Is your liaison service explicitly commissioned (i.e. against agreed service standards)?	7	29
Is the service planned, developed and reviewed by a joint planning forum which meets at least quarterly? <i>Note: this should include senior clinicians and managers from mental health and acute trusts and where appropriate, commissioners, service users and carers.</i>	65	35
Does commissioning include provision for local advocacy services?	35	65
Does the team have office space with the essential facilities (i.e. computer equipment, telephone, fax machine and internet access)?	100	0
Does the team have an additional breakout room for confidential activities such as supervision?	76	24
Is the team's office space adequate (i.e. not overcrowded, uncomfortable or unpleasant)?	65	35
Do liaison professionals proactively seek referrals and raise awareness of the liaison team's function, for example, through staff training and multi-disciplinary meetings? <i>Note: it is acknowledged that this is not practical for teams which are already operating well beyond their means; however this is an aim which teams should aspire to in the long term.</i>	100	0

Assessment Facilities

Answer 'yes', 'no' or 'N/A' to the questions below	Yes (%)	No (%)	N/A (%)
Can you access sufficient space in the <u>Emergency Department</u> to conduct assessments in privacy? <i>Note: Sufficient private space should exist to ensure that patients and liaison staff do not have to travel far through the hospital to find a room for assessment. The use of a curtain around a patient's bed does not ensure privacy and should only be used as a last resort, i.e. if there is significant risk and no safe alternative place for assessment, or if it is not physically possible for the patient to be moved to a more private setting.</i>	71	24	6
Can you access sufficient space in the <u>General Hospital</u> to conduct assessments in privacy?	59	41	0
Does the liaison team have a procedure for determining risk and deciding whether or not a patient should be assessed in a more	71	29	-

secure area? <i>Note: guidance might include a list of rooms and areas which are considered suitable for high risk assessments</i>			
Can you access facilities for conducting high risk assessments? <i>Note: facilities suitable for high risk assessments might include:</i> · A door which opens both ways and is not lockable from the inside · Means of contacting nearby staff, such as a panic button or alarm system · Polycarbonate (or similar) observation panels in the door · Furniture and fittings which are unlikely to be used to cause harm	71	29	-
If the Emergency Department is an allocated 'place of safety' is there a policy in place in line with legislation? <i>Note: the Mental Health Act 1983 (section 136), Mental Health (Care and Treatment) (Scotland) Act 2003</i>	35	12	53
For liaison patients seen in the Emergency Department - does the assessment area have lighting which can be controlled from outside the room? <i>Note: this can help to reduce stimuli for patients who are elated.</i>	29	65	6

Policies on risk, consent and confidentiality

Answer 'yes' or 'no' to the questions below	Yes (%)	No (%)
Do you have a written policy on managing different levels of risk?	88	12
Are members of the liaison team able and available to advise colleagues on issues around mental capacity? <i>Note: it is not the sole responsibility of the liaison team to assess mental capacity; this should be undertaken by the medical professional proposing the action being taken. However, in complex or borderline cases, the liaison professional may be able to offer valuable insight, and should endeavour to do so.</i>	100	0
Do you have a policy on confidentiality and information sharing? <i>Note: this includes informing service users where information about them is being sent, and why</i>	88	12

Involving service users and carers

Answer 'yes' or 'no' to the questions below	Yes (%)	No (%)
<p>Are you able to provide patients with information on how to access emergency out-of-hours help?</p> <p><i>Note: this might also include helping the service user draw up an action plan for future mental health crises (if this has not already been undertaken by any other mental health team.)</i></p>	100	0
<p>Can you access information in a range of formats to suit individual patient needs?</p> <p><i>Note: the hospital trust/health board should be able to access key information in languages other than English, and for people with sight, hearing, learning or literacy difficulties.</i></p>	88	12
<p>Can the liaison team access professional interpreters through the provider trust/organisation?</p> <p><i>Notes:</i></p> <ul style="list-style-type: none"> · <i>Relatives should not be used as sole interpreters;</i> · <i>Ideally the interpreter should have some knowledge of the needs of people with mental health problems;</i> · <i>Telephone interpreters should not be used for initial assessments, but may be used for follow up visits if a live interpreter is not available.</i> 	94	6
<p>Can the liaison team access equipment to facilitate communication with people with visual and/or hearing impairments, cognitive impairment, or learning disability?</p> <p><i>Note: this might include a white board, marker pen and other visual aids, a hearing amplifier and similar aids.</i></p>	82	18

Collaborative working in the General Hospital

Answer 'yes', 'no' or 'N/A' to the questions below	Yes (%)	No (%)	N/A (%)
Is there a system in place between the liaison team and General Hospital staff, allowing both parties to alert each other to service users who are at risk?	82	18	-
If the liaison team provides a service to the <u>Emergency Department</u> , does a member of the liaison team meet with ED staff at least quarterly?	88	6	6
If the liaison team provides a service to the <u>General Hospital</u> , does a member of the liaison team meet with hospital staff at least quarterly?	71	29	0

Can liaison professionals access the physical health records of their patients?	100	0	-
Do the acute and mental health trusts ensure that the acute and mental health I.T. systems are compatible?	71	59	-
Do liaison and acute managers ensure that there is a forum or procedure which allows the liaison team and acute staff to discuss differences of clinical opinion?	71	29	-

Collaborative working in the General Hospital, including out-of-hours services

Answer 'yes' or 'no' to the questions below	Yes (%)	No (%)
<p>Are joint protocols for out-of-hours cover in place with the relevant service(s)?</p> <p>Note: the policy should be developed in consultation with out-of-hours staff and is likely to include guidance on:</p> <ul style="list-style-type: none"> · The working hours and days of the liaison service and the out-of-hours team(s) · The clinical responsibilities of each service · The handover responsibilities of each service 	65	35
Do the liaison team and out-of-hours services ensure that joint care pathways are in place?	76	24
Do the liaison team and out-of-hours services have shared strategies for patients who attend regularly?	71	29
<p>Does the liaison team have working arrangements detailing who is responsible for assessing patients who may need to be detained under mental health legislation?</p> <p><i>Note: For example, this might include approved mental health professionals and/or Section 12 (England) and Section 20 (Scotland) doctors, or the Crisis Resolution Home Treatment Team and details of how to contact Independent Mental Health/Mental Capacity Advocates.</i></p>	100	0

Interfaces with other services

Please answer 'yes' or 'no' to the questions below	Yes (%)	No (%)
Does the liaison team have written guidance regarding referral/discharge to local mental health services (i.e. Community Mental Health Teams, inpatient units, Home Treatment Teams etc)?	88	12
Does the liaison team have written guidance regarding referral/discharge to local primary care services?	82	18

Does the liaison team have written guidance regarding referral/discharge to specialist mental health services for older people? <i>Note: decision to refer someone to services for older people should be based on need and not just age.</i>	76	24
Do members of the liaison team have access to the Trust's dementia care pathway?	71	29
Does the liaison team have written guidance regarding referral/discharge to local social services departments, according to local practice?	76	24
Is there a written agreement stating when it is appropriate for an adolescent patient to be seen by the working age adult liaison team? <i>Note: this should be based on need and not just the person's age.</i>	65	35
Do liaison professionals actively follow up referrals to other services to ensure that action has been taken?	53	47

Do liaison team members know how to contact and (if necessary) make referrals/share information with other relevant services in its catchment area, including: (Please answer 'yes', 'no' or 'N/A' to the questions below)	Yes (%)	No (%)	N/A (%)
Learning disability services?	94	6	0
Eating disorder services?	100	0	0
Child and adolescent mental health services?	94	0	6
Specialist services for older people?	100	0	0
Services for people who misuse drugs or alcohol?	100	0	0
Non-statutory agencies such as Samaritans, MIND, Rethink, Hearing Voices groups and local service user and carer-led groups?	100	0	0
Police services?	100	0	0
Ambulance services?	88	12	0
Prison staff and probation officers?	82	6	12
Criminal justice liaison services?	82	6	12

Staffing, Training and Communication

<i>Please answer 'yes' or 'no' to the questions below</i>	Yes (%)	No (%)
Does the liaison team comprise a number of staff that is proportionate to the size and throughput?	65	35
Do staffing levels allow for cover to be provided in the event of absence, including sickness, maternity or annual leave?	59	41
Are there up-to-date documents which state the managerial and clinical responsibility and accountability of staff?	82	18
Does the liaison team meet regularly (e.g. daily contact and handover and weekly meetings)?	100	0
Does the team use one set of integrated multi-professional healthcare notes? <i>Note: if social workers within the team use a different set of notes, these should be communicated and made available to colleagues in the liaison team.</i>	59	41
Is there a rolling training programme for liaison professionals which is repeated to account for staff rotation and changes?	88	12
Can liaison staff access the intranet of their provider Trust/organisation?	100	0
Can liaison staff access online journals, reference guides or text books?	94	6
Are there opportunities for liaison staff to shadow colleagues or attend placements in other areas of the hospital (e.g. Emergency Department, assisted medical units, general medical wards)?	94	6
Are there opportunities for liaison staff to shadow colleagues from Crisis Resolution/Home Treatment Teams?	100	0
Are service users and carers involved in the <u>planning</u> of training?	24	76
Are service users and carers involved in the <u>delivery</u> of training?	35	65
Does training include input from acute hospital staff?	65	35
Is there training which is planned and delivered jointly by acute and mental health staff?	53	47

Quality, Audit and Feedback

<i>Please answer 'yes' or 'no' to the questions below</i>	Yes (%)	No (%)
Has the team undertaken at least one clinical audit or service review in the past twelve months?	94	6
Has the team monitored its performance against clinical outcome measures or performance indicators in the past twelve months?	88	12
Has the team involved service users and carers in reviews of the service in the past twelve months?	59	41
Is information available to service users and carers about how to give feedback to the team, including comments and complaints?	94	6
Is there evidence of action and feedback from comments and complaints?	71	29
Does the liaison team have a written document detailing key performance indicators? <i>Note: for example, response times to referrals.</i>	100	0

Providing emergency mental health care

Emergency referrals = an acute disturbance of mental state and/or behaviour which poses a significant, imminent risk to the patient or others

<i>Please answer 'yes' or 'no' to the questions below</i>	Yes (%)	No (%)
Does the liaison team provide emergency mental health care?	100	0
Is the liaison service commissioned to provide urgent care to all service users, regardless of the service user's <u>address</u> ?	88	12

Is the liaison service commissioned to provide emergency/urgent assessment and treatment to adults throughout the hospital (including older people)?

76% Yes, all adult ages

12% No, only working age

6% No, only older people

6% We are not commissioned to provide any of the above

Routine/non-urgent mental health care

i.e. patients who do not present an acute disturbance or risk; those who require input but not immediately

Please answer 'yes' or 'no' to the questions below	Yes (%)	No (%)
Does the liaison team provide routine (i.e. non-urgent) mental health care to working age adults?	100	0
Is the liaison service commissioned to provide routine assessment and care to working age adults throughout the hospital?	88	12
Is the liaison service commissioned to provide routine assessment and care to all working age adults, regardless of the service user's address?	88	12

Routine mental health care to older people

Please answer 'yes' or 'no' to the questions below	Yes (%)	No (%)
Does the liaison team provide routine (i.e. non-urgent) mental health care to older people?	59	41
Is the liaison service commissioned to provide routine assessment and care to older people throughout the hospital?	90	10
Is the liaison service commissioned to provide routine assessment and care to all older people, regardless of the service user's address?	90	10
Does the liaison team have a designated lead for older people's mental health who attends management meetings at least quarterly?	80	20
Does a designated lead for older people's mental health meet with <u>Emergency Department staff</u> at least quarterly?	40	60
Does a designated lead for older people's mental health meet with <u>General Hospital staff</u> at least quarterly?	80	20
Does a designated lead for older people's mental health meet with colleagues from <u>Care of the Elderly wards</u> at least quarterly?	80	20
Does the liaison team have a policy on its role in shared care agreements, if relevant?	10	90

Providing Interventions

<i>Please answer 'yes' or 'no' to the questions below</i>	Yes (%)	No (%)
Does the liaison team provide follow-up services/interventions for patients?	82	18
Is the liaison service commissioned to provide follow-up services for patients?	79	21
Is the liaison team able to provide brief, time-limited interventions? <i>Note: sessions are likely to involve supporting the service user develop problem solving skills and coping mechanisms. Sessions might incorporate cognitive behavioural therapy techniques, psychodynamic approaches and others.</i>	100	0
Does the liaison team have a policy regarding the use of medication (if the team prescribes medication)? <i>Note: this should be in line with local medicines management and include:</i> ·The team's agreed use of different medication; ·The importance of checking contraindications between different medications being taken for mental and physical problems; ·The importance of monitoring side effects and advising the patient on self-monitoring, where appropriate; ·The different responses to medication in different age groups; ·The importance of the safe administration and storage of medication; ·How to access a pharmacist.	57	43
Does the liaison team have access to a substance misuse worker to provide drug and alcohol assessments, interventions and signposting?	86	14
Is there expertise <u>within</u> the liaison team to provide assessments, interventions and signposting to people who may be misusing <u>drugs</u> ?	64	36
Is there expertise <u>within</u> the liaison team to provide assessments, interventions and signposting to people who may be misusing <u>alcohol</u> ?	93	7
Do liaison professionals actively follow up service users when an appointment with the liaison team has been missed?	100	0

Providing Training and Support to Acute Colleagues

<i>Please answer 'yes' or 'no' to the questions below</i>	Yes (%)	No (%)
Does the liaison team provide training to General Hospital colleagues?	100	0
Is the liaison team funded to deliver mental health training to staff in the Emergency Department?	59	41
Is the liaison team funded to deliver mental health training to staff in the General Hospital (wards, ACUs and so on)?	53	47
Does the liaison team have a rolling programme of training for Emergency Department staff which is repeated to account for staff changes?	65	35
Does the liaison team have a rolling programme of training for General Hospital staff which is repeated to account for staff changes?	76	24
Does the liaison team record details of the training it provides, such as the curriculum, a list of attendees and a summary of feedback?	65	35
Has the liaison team developed the training programme in consultation with training participants?	100	0

Does the liaison team provide a comprehensive range of appropriate mental health training to other hospital professionals where relevant: <i>Please answer 'yes', 'no' or 'N/A' to the questions below</i>	Yes (%)	No (%)	N/A (%)
How to make an initial mental health assessment	88	12	0
Working with adults aged over 65, including detection and management of dementia, delirium and depression	71	24	6
How to assess and manage patient's risk to self and others	94	6	0
The use of mental health legislation	88	12	0
Detecting and responding to acute disturbance in physically ill people of all ages (e.g. delirium, psychosis etc)	94	6	0
Understanding why people self-harm and the difference between self-harm and acts of suicidal intent (including older people)	94	6	0
Suicide awareness, prevention techniques and approaches	94	6	0
Preventing and managing challenging behaviour	65	35	0
Recognising and responding to organic mental health disorders	82	18	0
Detecting the misuse of alcohol	71	18	12
Detecting the misuse of drugs	59	29	12

Recognising and responding to emotional responses to trauma	47	53	0
Recognising and responding to medically unexplained symptoms	82	18	0
Awareness of the processes involved in adjusting to illness, including issues of non-adherence and phobic responses to illness	59	29	12
The impact of cultural differences on mental health and use of services	41	59	0
Mental health and stigma	76	24	0
Ageism and stigma	47	47	6
Working with people diagnosed with personality disorder	65	35	0

Does the liaison team provide support and supervision to non-mental health colleagues, including: <i>Please answer 'yes', 'no' or 'N/A' to the questions below</i>	Yes (%)	No (%)	N/A (%)
Emergency Department staff	82	12	6
General Hospital staff	88	12	0
Trainee psychiatrists and doctors	94	6	0

<i>Please answer 'yes' or 'no' to the question below</i>	Yes (%)	No (%)
Does the liaison team provide support and advice about mental health issues on an ad-hoc basis?	100	0

(vii) Case note audit

Team members were asked to record details of at least 20 service users who had been referred to the liaison team. The case notes were selected via a systematic random sampling method (i.e. every third case was used).

Space was provided at the end of each section for comments to be added in order to allow explanation of why standards had not been met, however only the quantitative data is presented here.

The questions that were asked in the team checklist are presented below and alongside these is the percentage (%) of each response that was given.

Please note that in some cases not all questions were answered. Therefore some of the response percentages (for a given question) do not add up to 100%.

Hospitals that responded

<i>Hospital</i>	<i>Number of responses</i>
Addenbrookes' Hospital, Cambridge	20
Arrowe Park Hospital (Wirral University Teaching Hospital), Wirral	20
Chelsea and Westminster Hospital, London	20
City Hospital, Birmingham	24
Countess of Chester Hospital, Chester	33
Hammersmith Hospital, London	20
Kent and Canterbury Hospital, Canterbury	40
Mid Staffs General Hospital, Stafford	20
Newcastle General Hospital, Newcastle	21
Newham University Hospital, London	20
Northern General Hospital, Sheffield	20
Queen Alexandra Hospital, Portsmouth	26
Royal Free Hospital, London	22
Southampton General Hospital, Southampton	41
Southern General Hospital, Glasgow	21
St Helier Hospital, Surrey	48
St Thomas' Hospital, London	32

Answer 'yes', 'no' or 'N/A' to the questions below	Yes (%)	No (%)	N/A (%)
Has formulation or diagnosis been recorded in the case notes?	95	3	12
Does the written care plan attempt to address the problems identified in the formulation or diagnosis?	95	3	2
Is there evidence that the liaison team has made efforts to access past notes on the patient?	83	8	9
Do the notes contain a plan for future care on onward referral?	94	3	3
Do the notes demonstrate that the assessor has considered levels of risk to the patient and others?	92	5	3
If a risk has been established, has a risk management plan been put into action and communicated with others? <i>Note: this might not be a specific form but it should be a clear summary of risk which has been recorded and well communicated with others.</i>	77	2	21
Has the assessor communicated the outcome of assessment with all other relevant services? <i>For example, information about what will happen next has been sent to the referrer, GP, mental health team, or anyone else who needs to know about it.</i>	93	5	2
Was information communicated to others in a timely manner? <i>For example, if it is a high risk case, has contact been made on the same day? If not high risk, has contact been made within 7 working days?</i>	89	5	6
Do the notes demonstrate that attempts were made to fully involve the patient in discussions about their problems and the different interventions available?	85	10	5
Was a written summary of the assessment, discharge or care plan offered to the patient (and/or carer, if permitted)?	25	60	15
Was the patient (or carer, if permitted) copied into written communication between the liaison team and other services? <i>For example, letters to the GP referrer etc.</i>	18	65	17
If the person was referred to another service, did the assessor provide the service user/ or carer with basic information on this?	52	12	36

For example, the name and contact details of a link person at the service, and information about what to expect?			
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These are the PLAN definitions of Emergency, Urgent and Routine assessments:

Emergency = 60 minutes.

Patients with an acute disturbance of mental state and/or behaviour which poses a significant, imminent risk to the patient or others.

Urgent = same working day.

Patients with a disturbance of mental state and/or behaviour which poses a risk to the patient or others, but does not require immediate mental health involvement. Or, patients who are judged medically fit for discharge from an acute hospital and are awaiting a mental health assessment before leaving.

Routine= within two working days.

All other referrals, including patients who require mental health assessment, but do not pose a significant risk to themselves or others, and are not medically fit for discharge.

Answer 'yes', 'no' or 'N/A' to the questions below	Yes (%)	No (%)	N/A (%)
If the service user was seen by the liaison team, were they seen within the timescales outlined above?	86	9	5
If the person was not seen within these timescales, did any of the following apply? Tick as many as apply:			
• Patient was unfit for assessment or treatment	4	-	-
• The assessment was not requested by the medical team soon enough	1	-	-
• Patient was fit but there were no liaison staff available	0	-	-
• A member of the liaison team provided telephone advice instead	1	-	-
• Other	9	-	-
For EXTRA points:			
Was the person seen by the liaison team more rapidly than the times recommended above? (e.g. Was the patient seen: Emergency= 30 minutes or less, Urgent = 3 hours or less, Routine= 1 working day).	59	27	11

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