Faculty of Liaison Psychiatry
Annual Conference 2015
‘From Hospital to Home’

Royal College of Psychiatrists
London
Wednesday 13-Friday 15 May 2015

Conference Booklet

Supported by
Please note a presentation link (with non-editable pdf versions) will be sent shortly after the conference to all delegates after obtaining the authorisation of the authors of the presentations.

Unfortunately, it is not always possible to supply presentations due to some items being unpublished and copyright issues.
**Final Programme**

All sessions will take place in room 1.7 unless otherwise stated.

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<tr>
<td>12.00-12.55</td>
<td>Registration and lunch</td>
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<tr>
<td>12:55–13:00</td>
<td>Welcome Chair of Faculty of Liaison Psychiatry</td>
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<td>Dr Peter Aitken, Chair of Faculty of Liaison Psychiatry, Director of Research &amp; Development, Devon Partnership NHS Trust, and Hon Associate Professor, University of Exeter Medical School, PenCLAHRC</td>
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<td>13:00–13:30</td>
<td>Plenary speakers</td>
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<td>Professor Jane Dacre, President, Royal College of Physicians and Professor Sir Simon Wessely, President of the Royal College of Psychiatrists</td>
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<td>13:30–14:15</td>
<td>Self-harm: assessing risk and managing patients</td>
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<td>Professor Nav Kapur, Head of Research, Centre for Suicide Prevention, Manchester University</td>
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<td>Crisis Care Concordat</td>
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<td>Dr Steve Reid and Dr Peter Aitken</td>
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<td>14:30–15:00</td>
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<td>15:00 – 15:45</td>
<td>A &amp; E and Mental Health</td>
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<td>Dr Clifford Mann, President, The Royal College of Emergency Medicine</td>
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<td>Liaison psychiatry...so far ...so good.....what next?</td>
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<td>Dr Anne Hicks, Plymouth Hospitals NHS Trust</td>
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<td>15:45 – 16:15</td>
<td>Future Hospitals</td>
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<td>Dr Gerrard Phillips, Senior Censor/Education and Training Vice President, Royal College of Physicians</td>
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<td>16:15 – 16:30</td>
<td>Importance of Cross College work</td>
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<td>Professor Dame Sue Bailey OBE DBE, Chair, Academy of Medical Royal Colleges</td>
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<td>16:30 – 17:00</td>
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<td>17:00</td>
<td>Trainees and New Consultants Business Meeting</td>
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<td>18:00 – 19:00</td>
<td>AGM with drinks</td>
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<td>Opportunities for members include meet Professor Dame Sue Bailey OBE DBE informally and Ann Paul, Director of Development to show members around the new college building</td>
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| 09.00-09.30  | **Oncology today: we have got the biology right, what about the rest....?**  
Professor Martin Gore, Medical Director, The Royal Marsden and Professor of Cancer Medicine, The Institute of Cancer Research |
| 09.30-10.00  | **The century of the system: depression and cancer**  
Professor Mike Sharpe, Professor of Psychological Medicine, University of Oxford |
| 10.00-10.30  | **Psychiatry at the edge of life**  
Dr Jane Walker, Senior Clinical Researcher & Honorary Consultant Psychiatrist, University of Oxford |
| 10.30-11.00  | Panel discussion with Dr Clare Gerada, Medical Director of the NHS Practitioner Health Programme and Hurley partner |
| 11.00-11.30  | Morning refreshments                                                                                                                   |
| 11.30-12.00  | **DSM-5 Classification of Mood Disorders; old, new, borrowed and blue?**  
Professor Allan Young, Director, Centre for Affective Disorders, Institute of Psychiatry, Psychology and Neurosciences (IoPPN), King’s College London |
| 12.00-12.30  | **Hospital to home with the liaison psychiatrist: evaluating liaison services in primary and secondary care**  
Professor Allan House, Professor of Liaison Psychiatry, Leeds Institute of Health Sciences |
| 12.30-14.00  | **Working Lunch with workshops**                                                                                                       |

**Room: 1.1**

**Workshop 1: What does it take to make a great MH Liaison nurse in A&E?**  
Dr Sarah Eales, Senior Lecturer in Mental Health Nursing, Bournemouth University and Ms Kate Chartres, Nurse Consultant, Sunderland Royal Hospital

**Room 1.6**

**Workshop 2: The Highs and Lows of setting up and implementing a Post Discharge older persons liaison team**  
Ms Paula Atkinson, Nurse Consultant, Tees, Esk and Wear Valleys NHS Foundation Trust, Ms Helen Howe, Advanced Nurse Practitioner, Tees, Esk and Wear Valleys NHS Foundation Trust and Dr Chris Hilton, Consultant Liaison Psychiatrist, West London Mental Health NHS Trust

**Room: 1.7**

**Workshop 3: Towards Excellence: how to use PLAN to develop and strengthen your liaison service**  
Dr Jim Bolton, Consultant Liaison Psychiatrist, St Helier Hospital, Ms Satveer Nijjar, Independent Self-Harm Awareness Trainer and Ms Rohanna Cawdron, Project Worker, RCPsych Psychiatric Liaison Accreditation Network (PLAN) Team
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<td><strong>New Research</strong>&lt;br&gt;Professor Sir Simon Wessely and Dr Adrian Flynn, Consultant Liaison and General Adult Psychiatrist, Cornwall</td>
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<td>Psychiatric morbidity, seizure frequency and quality of life in refractory epilepsy&lt;br&gt;Dr Maurice Clancy</td>
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<td>Anticipating Behaviour that Challenges: Designing an Interprofessional Simulation-Based Training for Acute Medical Staff&lt;br&gt;Dr Ros Humphreys</td>
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<td>What proportion of patients referred to a liaison service need to be seen by a psychiatrist, as opposed to any other member of the liaison team?&lt;br&gt;Dr Aaron McMeekin</td>
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<td>CORE-10 as a predictor of service utilisation in liaison psychiatry&lt;br&gt;Dr Sofia Nilsson</td>
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<td>Are stigma scores a useful clinical marker for suicide-related outcomes after traumatic bereavement?&lt;br&gt;Dr Alexandra Pitman</td>
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<td>14:40-14:45</td>
<td><strong>Memorial for Dr Wayne Katon</strong>&lt;br&gt;Professor Mike Sharpe</td>
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<td>15:00-15:45</td>
<td><strong>Far from the Madding Symptoms: a personal overview of MUS</strong>&lt;br&gt;Professor Else Guthrie, Consultant in Psychological Medicine and Honorary Professor of Psychological Medicine, Manchester Mental Health and Social Care Trust</td>
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<td>15:45-16:30</td>
<td><strong>Increasing capacity to manage MUS and long-term conditions</strong>&lt;br&gt;Professor Chris Williams, Professor of Psychosocial Psychiatry (Mental Health &amp; Wellbeing, University of Glasgow)</td>
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<td>16:30-17:00</td>
<td><strong>Panel Discussion chaired by Ms Satveer Nijjar</strong></td>
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<td>19.00</td>
<td><strong>Conference dinner, Royal College of Physicians with after dinner speaker</strong>&lt;br&gt;Dr Geraldine Strathdee, National Director for Mental Health</td>
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<td>Introduction</td>
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<td>09:00-09:30</td>
<td><strong>Classification and nosology of ‘medically unexplained’ symptoms</strong></td>
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<td>Professor Peter White, Professor of Psychological Medicine, Barts and The London School of Medicine and Dentistry</td>
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<td>09:30-10:00</td>
<td><strong>PTSD and MUS</strong></td>
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<td>Professor Jonathan Bisson, Institute of Psychological Medicine and Clinical Neurosciences, Cardiff University School of Medicine</td>
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<td>10:00-10:30</td>
<td><strong>‘5 Year Forward View – Training and Working Together’</strong></td>
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<td>Opportunities from the 5 year forward view in relation to Mental Health Community Services and training doctors to work in these services</td>
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<td>Professor Maureen Baker, Chair, Royal College of General Practitioners</td>
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<td>10:30-10:45</td>
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<td>10:45-11:15</td>
<td><strong>Endocrine disorders with a psychiatric overlap</strong></td>
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<td>Professor John Wass, Academic vice president, Royal College of Physicians</td>
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<td>11:15-11:45</td>
<td><strong>National Diabetes Audit</strong></td>
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<td>Dr Gerry Rayman, Consultant Physician and Head of Service at the Diabetes and Endocrine Centre, Ipswich Hospital NHS Trust</td>
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<td>11:45-12:30</td>
<td><strong>Diabetes: the future is bright, the future is psychiatry</strong></td>
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<td>Professor Khalida Ismail, Professor of Psychiatry and Medicine, King’s College London and Honorary Consultant Liaison Psychiatrist, King’s College Hospital NHS Foundation Trust</td>
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<td>12:30-13:00</td>
<td><strong>Panel Discussion</strong></td>
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<td>Dr Angela Busittil, Consultant Clinical Psychologist Professional Lead Clinical Health Psychology at Sussex Partnership NHS Foundation Trust</td>
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<td>13:00-14:30</td>
<td><strong>Working Lunch with workshops</strong></td>
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<td><strong>Workshop B: What do you want from a Diploma in Psychological Medicine</strong></td>
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<td>Dr Peter Aitken</td>
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<td>15:00-15:30</td>
<td><strong>Feedback from Research on Adequacy</strong></td>
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<td>Dr Will Lee, Reader in Psychiatric Epidemiology</td>
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<td>Plymouth University, Peninsula Schools of Medicine &amp; Dentistry (PUPSMD)</td>
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<td>15:30-16:00</td>
<td>Psychology and Psychiatry in Liaison</td>
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<td>16:00-17:00</td>
<td>Closing remarks and prizes</td>
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Useful information

Certificates of attendance
Certificates of attendance will be emailed to delegates within one week of the conference. This conference is eligible for 3.5, 5.5 and 6 CPD hours on Wednesday, Thursday and Friday respectively, subject to peer group approval.

Speaker presentations
A link to all of the speaker presentations we have permission to share will be emailed to registered attendees after the meeting.

Feedback
A detailed online feedback form can be found at https://www.surveymonkey.com/s/Liaison15
All comments received will remain confidential and are viewed in an effort to improve future meetings. This link will be emailed to all delegates after the conference.

Cloakroom
The cloakroom can be found on the first floor, on the left near the entrance to Room 1.1.

Multi-faith room
This is located on the lower ground floor. Please ask a member of staff for access.

Fire exit
No fire drills scheduled for today, so if alarm sounds it is a real fire! Please take the stairs to reception and out through the front doors (where you came in this morning). Then turn left and the assembly point is on the corner of Prescot Street and Chamber Street. There’s an alternative exit at the back of the building. Diagrams can be seen on the fire route plans around the room.

Wi-fi
There is free wi-fi available through-out the building. The network name is ‘RCP guest’ and the password is ‘RCP2013!’

Mobile phones
Please turn off or switch to silent.

Toilets
1st floor - out of the double doors and follow the railings around to the right and then through the white door. There are also toilets on the ground floor in the same position.

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Save the dates 2016

Faculty of Liaison Psychiatry
Annual conference

Wednesday 11- Friday 13 May 2016

Holiday Inn, Birmingham

Details will be available over the coming months
**PRESENTATION ABSTRACTS AND BIOGRAPHIES**  
*(LISTED BY PROGRAMME ORDER)*  
*Wednesday 13 May*

**Welcome Chair of Faculty of Liaison Psychiatry**  
Dr Peter Aitken, Chair of Faculty of Liaison Psychiatry, Director of Research & Development, Devon Partnership NHS Trust, and Hon Associate Professor, University of Exeter Medical School, PenCLAHRC

**Dr Peter Aitken** is chair of the Faculty of Liaison Psychiatry at the Royal College of Psychiatrists. Peter graduated in medicine from the University of Glasgow in 1987. Following vocational training in general practice in Southwest London he trained in psychiatry at St George’s Hospital, London. A founding member of the higher education academy in 1999 he was appointed to the posts of senior lecturer in medical education at St George’s Hospital Medical School, and Consultant Liaison Psychiatrist. He joined Eli Lilly UK as clinical research physician in neuroscience in 2001 with an honorary contract as Consultant Liaison Psychiatrist to the Wessex Neurology Epilepsy Surgery Team. From 2003 Peter has been Consultant Liaison Psychiatrist at the Royal Devon & Exeter Hospital and Director of Research & Development at Devon Partnership NHS Trust.

Now honorary associate Professor in the University of Exeter Medical School, he has published in liaison psychiatry, primary care mental health research, suicide prevention and medical education.

Peter is an executive coach working with senior leaders across several industries and in his spare time is Lifeboat Medical Advisor and Crew at RNLI Exmouth.

**Plenary speakers**  
Professor Jane Dacre, President, Royal College of Physicians

A joint plenary session between Prof Jane Dacre, President of the Royal College of Physicians, and Prof Simon Wessely, President of the Royal College of Psychiatrists

**Professor Jane Dacre** was elected president of the Royal College of Physicians in April 2014.

She is an honorary consultant physician and rheumatologist at the Whittington Hospital in north London, professor of medical education, and director of UCL Medical School in London. She was also the medical director of MRCP(UK) until December 2013, and prior to that academic vice president of the RCP.

Professor Dacre was a GMC council member, and chaired the GMC Education and Training Committee (2008–2012). She also leads a research programme in medical education focussing on assessment.

She was the clinical lead for the development of the first Clinical Skills Centre in the UK, and a co-author of the GALS screen. Professor Dacre has been instrumental in the development, implementation and evaluation of assessment systems in medicine.
In 2012 she won the ‘medicine and healthcare’ category for the Women in the City: Woman of Achievement Award. In 2013 she was named in the Health Service Journal’s inaugural list of 50 inspirational women in healthcare.

Professor Sir Simon Wessely MA BM BCh MSc MD FRCP FRCPsych FMedSci FKC FMedSci (born Sheffield, 1956) is a British psychiatrist. Simon is professor of psychological medicine at the Institute of Psychiatry, King’s College London and head of its department of psychological medicine, vice dean for academic psychiatry, teaching and training at the Institute of Psychiatry, as well as Director of the King’s Centre for Military Health Research. Simon is also honorary consultant psychiatrist at King’s College Hospital and the Maudsley Hospital, as well as civilian consultant advisor in psychiatry to the British Army. In his academic career Simon has authored over 750 scientific papers on a variety of subjects. In 2014 Simon was elected president of the Royal College of Psychiatrists.

Self-harm: assessing risk and managing patients
Professor Nav Kapur, Head of Research, Centre for Suicide Prevention, Manchester University

Professor Nav Kapur is Professor of Psychiatry and Population Health at the University of Manchester, UK, and an Honorary Consultant Psychiatrist at Manchester Mental Health and Social Care Trust. He is Head of Research at the Centre for Suicide Prevention in the University of Manchester and leads the suicide work programme of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. He was Chair of the Guideline Development Group for the National Institute for Health and Clinical Excellence (NICE) self-harm guidelines (longer term management) and Chair of the group that developed the NICE Quality Standards for self-harm. He is currently chairing the NICE guidelines for depression in adults. He is a member of the Department of Health’s (England) National Suicide Prevention Strategy Advisory Group. He has published extensively on suicide and self-harm with much of his research focussing on how health services might best contribute to suicide prevention and care for people who have self-harmed.

Crisis Care Concordat
Dr Steve Reid is a Consultant Psychiatrist with Central and North West London NHS Foundation Trust. After training in psychiatry at St George’s, London and some time as a research fellow at the Institute of Psychiatry he crossed the River Thames where when not banging the drum for the better integration of physical and mental health, he is to be found loitering in the corridors of St Mary’s Hospital, Paddington in his job as a liaison psychiatrist. Of late he has been working with UCL Partners looking at new models of crisis care in mental health.

Dr Peter Aitken
See above
A & E and Mental Health

Dr Clifford Mann, President, The Royal College of Emergency Medicine

Professing no particular expertise is an unusual opening gambit to a conference presentation. However my presentation with my colleague Dr Anne Hicks seeks to give context to the challenge of providing good care for mental health patients in an A&E department in 2015. I will highlight the lack of progress made by A&E department staff in delivering timely and high quality mental health care over the last 10 years and some of the reasons for this. I will argue that we need to provide a more stable and more expert resource than relying on A&E staff. I will also raise the issue of mental illness in A&E doctors and link each of these problems to the solutions proposed by the Royal College of Emergency Medicine’s STEP campaign.

Dr Cliff Mann is an emergency medicine consultant in Taunton, Somerset. He trained initially to be a GP before deciding on a career in EM. He has worked in Plymouth, Portsmouth, Auckland and Adelaide. In the SW region he was TPD and then Head of School for EM training. He has been an officer of the Royal College of Emergency Medicine since 2010, first as Registrar and then President.

He has sought to publicise the many challenges facing A&E departments and emergency medicine in the UK and in doing so has highlighted the hurdles facing both patients and staff in relation to mental health problems.

Liaison psychiatry...so far ...so good.....what next?

Dr Anne Hicks, Plymouth Hospitals NHS Trust

Dr Anne Hicks has been mental health lead for RCEM for some years. She has worked with RCPsych for some time trying to help develop better care for mental health patients in emergency departments. She has sat on the PLAN accreditation committee and on the Mental Health Concordat steering committee. Last year she published a Mental Health Toolkit for ED on the RCEM website. She works as an emergency department consultant in Plymouth, and is medical director for the British Antarctic Survey Medical Unit.

Future Hospitals

Dr Gerrard Phillips, Senior Censor/Education and Training Vice President, Royal College of Physicians

The talk will cover the RCP’s flagship Future Hospital Programme. This is aimed at improving the care of medical patients not only in secondary care, but also across care interfaces. The programme is about...
service re-design. It is centred around the creation of an acute care hub under the leadership of a “chief of medicine.” It aims to deliver better care, in particular for the frail elderly patient, in part by improving relationships with social and community services, primary care, mental health services, GIM and the specialties. Key features are continuity of care, shared decision making and supported self management.

Dr Gerrard Phillips was elected senior censor/education and training vice president in July 2014. He leads for the RCP on all matters relating to education and training, and is medical director of the RCP’s Medical Education Department. He qualified from Oxford and Barts. After initial training as a surgeon, he ‘saw the light’ and trained in respiratory and general internal medicine in Southampton (research), and as a senior registrar at St Georges’ and the Royal Brompton Hospitals, London. He has published over 40 research and other articles. Gerrard has been a consultant physician at Dorset County Hospital, Dorchester, since 1994. He is a ‘jobbing’ clinician, still very active in both the acute medical take and his specialty. He has been involved in medical education for more than 15 years. He has been chair of the British Thoracic Society Education and Training Committee, Wessex regional training programme director for respiratory medicine and SAC Chair for respiratory medicine (8 years). He wrote the 2007 and 2010 UK RM curricula and co-wrote the European RM Curriculum. He has co-written national training programmes and advised on the consultant scientist curriculum. Recently, he has been a member of the GMC Curriculum Advisory Group and an RCP Censor. He is currently treasurer of the BTS and deputy head of the Wessex School of Medicine.

Importance of Cross College work
Professor Dame Sue Bailey OBE DBE, Chair, Academy of Medical Royal Colleges

Clinical: Professor Dame Sue Bailey OBE DBE is a Consultant Child and Adolescent Forensic psychiatrist and Professor of Mental Health Policy in North West of England.

Research: Interests include development of needs and risk assessment measures for use with young offenders with mental illness and development of community and secure inpatient treatment for young offenders both nationally and internationally.

Policy: As a past President of the Royal College of Psychiatrists, she worked with health and social care professionals, patients and carers to help bring about Parity of Esteem between mental and physical health which is now enshrined in Primary Legislation in England.

Current Senior Clinical Advisor for Mental Health and Learning Disability for Health Education England.

Made an OBE in 2002 for services to Mental Health and young offenders and in 2013 made a DBE for services to Psychiatry and for voluntary service to People with Mental Health Conditions.
International: Current Chair of UEMS CAP Section, elected member of EPA Council, secretary of EFCAP and member of programmes meeting of the WPA.
Thursday 14 May

**Oncology today: we have got the biology right, what about the rest....?’**
Professor Martin Gore, Medical Director, The Royal Marsden and Professor of Cancer Medicine, The Institute of Cancer Research

*Not available at time of print*

**The century of the system: depression and cancer**
Professor Mike Sharpe, Professor of Psychological Medicine, University of Oxford

Atul Gawande, the American surgeon and writer has argued that the 21st century in medicine will be the century of “the system”. The reality is we have a lot of effective treatments in medicine in general and psychiatry in particular, that patients do not get the full benefit of because they are not well delivered. With colleagues, I have developed a system for the delivery of existing depression treatments to a neglected population: patients with cancer. Whilst ten percent of patients with cancer suffer from major depression only a small minority of these receive an existing, evidence based treatment. By implementing a system of care that is systematic and integrated and delivers these treatments to a high standard, patient outcomes can be transformed. The SMaRT oncology 2 trial (Lancet 2014) shows that patients whose GP’s were told they had major depression only had a seventeen percent improvement rate (fifty percent drop in symptoms score) at six months compared with nearly seventy percent of patients who were given the depression care treatment system. The implication is that if we want to improve the outcomes for the patients we see in liaison psychiatry services, we need to “get systematic”.

**Professor Michael Sharpe** is Professor of Psychological Medicine at the University of Oxford and Trust Lead for Psychological Medicine at Oxford University Hospitals Trust. The focus of his work is to integrate psychiatry into medical care through both research and service development. A major thread of his work over the last fifteen years has been the better management of depression in patients with cancer. He is a Council Member of the American Academy of Psychosomatic Medicine and was Royal College “Psychiatrist of the Year” 2014.

**Psychiatry at the edge of life**
Dr Jane Walker, Senior Clinical Researcher & Honorary Consultant Psychiatrist, University of Oxford

Survival has improved substantially for many cancers, but the outcome for some, such as lung cancer, remains poor. Treating depression and other psychiatric disorders is challenging when patients have a poor prognosis: the treatment needs to be rapidly effective and it needs to be deliverable as the patient’s physical condition deteriorates. I have worked with colleagues to develop and evaluate a depression treatment programme for patients with lung cancer, delivered by a team of cancer nurses and liaison psychiatrists. We found that it was possible to effectively treat major depression in this patient group, by
engaging patients quickly and by being proactive and systematic. The liaison psychiatrist plays a key role in this challenging but rewarding race against time.

**Dr Jane Walker** is a senior clinical researcher at the University of Oxford. She is also a consultant psychiatrist at Sir Michael Sobell House Hospice, Oxford University Hospitals NHS Trust. Her research interests are the development of complex interventions for medical patients with psychiatric comorbidity and the evaluation of these in clinical trials. She has coordinated large multicentre clinical trials and has an MSc in clinical trials from the London School of Hygiene and Tropical Medicine. Her clinical interests include the management of depression and anxiety in the medically ill, in particular in patients towards the end of life. She also has an interest in training and supervising non-psychiatric staff to manage psychological distress and the integration of psychiatric and medical care.

**Dr Clare Gerada** is the Medical Director of the NHS Practitioner Health Programme, a confidential service for doctors and dentists with mental health or addiction problems. She is also a GP partner in the Hurley Group, a member of the Welsh government’s Review of the NHS Workforce, Chair of The Founders’ Network, an Honorary Fellow of University College London and former Chair of the RCGP. She was awarded an MBE for services to medicine and substance misuse. Dr Gerada lectures, teaches and publishes regularly on substance misuse, workplace health and well-being and practitioner resilience.

**DSM-5 Classification of Mood Disorders; old, new, borrowed and blue?**
Professor Allan Young, Director, Centre for Affective Disorders, Institute of Psychiatry, Psychology and Neurosciences (IoPPN), King’s College London

The recent DSM-5 diagnostic manual revised the diagnostic criteria for mood disorders. The major implications for clinical practice will be reviewed and discussed.

**Professor Allan Young** holds the Chair of Mood Disorders at King’s College Hospital London where he is Director of the Centre for Affective Disorders and an Honorary Consultant in the Bethlem and Maudsley Hospitals. He is Academic Director of the Mood, Anxiety and Personality Disorders Clinical Academic Group in the South London and Maudsley Trust; Cluster Lead for Experimental Medicine and Clinical Trials Cluster (incorporating Neuroimaging, Biogenomics and Biomarkers) in the Biomedical Research Centre and Associate Director of the NIHR Clinical Research Network. Professor Young is President of the International Society for Affective Disorders; Chair of the Psychopharmacology committee of the Royal College of Psychiatrists and Executive Member of the Academic Faculty of the Royal College of Psychiatrists and Council member of the British Association for Psychopharmacology.

Professor Young has published over 300 full academic papers and is one of the most cited authors in psychiatry worldwide and has held grants from the National Institute of Mental Health (USA); Medical Research Council (UK) and various other grant funding agencies. His research and clinical work focuses on the causes and treatment of severe mental ill-health with particular emphasis on Mood Disorders.
Hospital to home with the liaison psychiatrist: evaluating liaison services in primary and secondary care

Professor Allan House, Professor of Liaison Psychiatry, Leeds Institute of Health Sciences

Hospital-based liaison psychiatry services are not new but have been little evaluated. One reason is that service heterogeneity makes it difficult to come up with a simple framework. Some factors to take into account when characterizing services look like staff numbers and discipline-mix; range of service components (defined by target population and location); the balance of assessment v. longer-term management in the service model, and interfaces with other parts of the mental health service. I will discuss how we are approaching the problem of characterizing inputs and outcomes in the NIHR-funded project LP MAESTRO

http://medhealth.leeds.ac.uk/info/615/research/1541/liaison_psychiatry_measurement_and_evaluation_of_service_types_referral_patterns_and_outcomes_lp-maestro.

Liaison psychiatry in primary care is much newer and there aren’t even enough models of how services might work in the UK to produce challenging heterogeneity. It’s worth thinking about because the idea fits so well with what’s adumbrated in the NHS 5 Year Forward View about new forms of integrated care across what is traditionally-called the primary-secondary care boundary. I will discuss the approach being taken in two CCG-funded local projects in which I am involved with the evaluation.

Professor Allan House graduated from St Bartholomew’s Hospital in London. Since 1999 he has been Professor of Liaison Psychiatry in the Academic Unit of Psychiatry and Behavioural Sciences in the School of Medicine in Leeds. From 2005 to September 2013 he was Director of the Leeds Institute of Health Sciences, a multidisciplinary institute in the School of Medicine with a substantial portfolio of activities in applied health research.

His personal research interests include: the overlap between physical and mental disorder, medically unexplained symptoms, suicide and self-harm. Allan chairs the Yorkshire and Humber Research Funding Committee of the National Institute for Health Research’s Research for Patient Benefit programme. He sits on the NIHR career development and Senior Research fellowships committee and he has served as a member of the HTA Commissioning Board and is a member of the NIHR Panel of Experts. Allan teaches medical students in Leeds. He plays clarinet to a distressingly low standard given how long he’s been at it.

Workshop 1: What does it take to make a great MH Liaison nurse in A&E?

Dr Sarah Eales, Senior Lecturer in Mental Health Nursing, Bournemouth University and Ms Kate Chartres, Nurse Consultant Sunderland Royal Hospital

An interactive workshop. Participants will be asked to consider the skills/ competence required to be a Mental Health Nurse working within a Psychiatric Liaison Team into the emergency department.
Participants will be asked to share the methods used to build capacity in the identified competencies and to consider innovative ways to further meet the identified competencies. Sharing across services will be encouraged. Participants across the range of professionals involved in liaison mental health care are encouraged to attend to share experiences and insights.

**Dr Sarah Eales** has worked within the field of Liaison Mental Health Care for fifteen years, as a researcher, clinician and academic. Sarah completed a PhD on the Service User Experience of Liaison Mental Health Care in 2013. Until 2014 Sarah ran a BSc/ MSc 15 credit module in Liaison Mental Health Care at City University, London. The module was based on the original Liaison Mental Health Nursing Competencies written in 2004. Sarah was part of the group which developed the Liaison Nursing Competencies and led the 2014 update. Sarah is a member of the Faculty of Liaison Psychiatry Executive Committee and the Psychiatric Liaison Accreditation Network Accreditation Committee. As a Senior Lecturer in Mental Health at City University London Sarah was the Programme Manager for the Pre-registration Mental Health Nursing programme for 6 years. She joined the academic staff at Bournemouth University on 2014 as a Senior Lecturer in Mental Health Nursing.

**Ms Kate Chartres** has recently commenced the role of Nurse Consultant in Psychiatric Liaison. The Sunderland Team has just received news of successful accreditation by the RCP with excellence (PLAN). My previous experience has included extensive time within Crisis Services, work in Primary Care, EIP and the Clinical Management of a range of diverse Psychiatric Liaison Teams across Northumberland Tyne and Wear. I have undertaken further development in a variety of therapeutic modalities which enables me to develop innovative treatment packages for people presenting with complex clinical difficulties utilising an eclectic approach which I believe is necessary within this specialist field. My interests include developing truly integrated services, engagement and developing the body of evidence to underpin future Psychiatric Liaison practice.

**Workshop 2: The Highs and Lows of setting up and implementing a Post Discharge older persons liaison team**

Ms Paula Atkinson, Nurse Consultant, Tees, Esk and Wear Valleys NHS Foundation Trust, Ms Helen Howe, Advanced Nurse Practitioner, Tees, Esk and Wear Valleys NHS Foundation Trust and Dr Chris Hilton, Consultant Liaison Psychiatrist, West London Mental Health NHS Trust

In this workshop we will present what we have achieved in our innovative post discharge liaison service for older people, present case studies and have a panel based discussion with members of our multidisciplinary team around how to set up a service, overcome challenges and develop in the future. It will also provide key networking opportunities that can continue post conference.

**Ms Paula Atkinson** has been working in the NHS for 31 years. Over the years have worked in adult and older peoples mental health, on wards, day units and community teams and have had three terms as a lecturer at Teeside University. For the last 10 years I have been fortunate enough to have been
part of the development of acute hospital liaison services in Durham and Darlington, which are now extensive and well developed and have been in the role of Nurse Consultant for the last 3 years.

**Ms Helen Howe** was born in Middlesbrough and continue to live there with my husband, 2 sons and rather large Siberian husky.. I started my nursing career as an SEN(M) in 1986 and converted to RMN in 1996.

My professional pathway has remained within services for older people, having worked within the inpatient wards, day hospital and community settings.

I started working in Liaison psychiatry in 2009 and have been practicing as an Advanced Nurse Practitioner for the past 3 years. I was the lead in setting up the post discharge liaison service which was both exciting and challenging at times.

**Dr Chris Hilton:** West London Mental Health NHS Trust (WLMHT) provides comprehensive mental health and wellbeing services to the local populations of three boroughs in West London, as well as regional forensic and specialist services accepting referrals from across the UK.

An emerging integrated care service line within the Trust includes liaison psychiatry and clinical health psychology teams working in partnership with acute and community providers to enhance a holistic approach to care across seven acute hospital sites. Our ageless (16+) Core 24/7 model for liaison psychiatry, developed with North West London partners, has been replicated in national commissioning guidelines as a standard for acute hospital mental health.

Dr Christopher Hilton is a Consultant in Liaison Psychiatry and Lead Clinician for Strategic and Commercial Development with WLMHT. He is also Honorary Senior Clinical Lecturer at Imperial College London.

He joined WLMHT in 2013 and works clinically in a service which provides mental health care for patients in general hospital wards and emergency department, integrated with their medical care and rehabilitation. He also supports primary care practitioners to plan care for complex patients with diabetes, CHD and COPD as part of the North West London Integrated Care Programme. He recently successfully bid for funding to enhance the Ealing Liaison Psychiatry Service to outreach into community and intermediate settings and undertake intensive therapeutic work with frequent users of emergency services.

Dr Hilton’s professional interests also include integrated sexual health, HIV, mental health and substance misuse and the problems associated with novel psychoactive substances.

As Lead Clinician, his remit is clinically to inform the work of the Trust’s Business and Strategy Team, and to support WLMHT further to develop primary care, wellbeing and integrated health pathways. He was named as an HSJ “Rising Star” in January 2015.
Chris is a trustee of the Medical Council on Alcohol, and the chair of the Trainee and New Consultant’s Group of the Liaison Faculty of the Royal College of Psychiatrists. He is an avid theatregoer and also tweets as @drchrishilton and @WLLiaisonPsych.

**Workshop 3: Towards Excellence: how to use PLAN to develop and strengthen your liaison service**

Dr Jim Bolton, Consultant Liaison Psychiatrist, St Helier Hospital, Ms Satveer Nijjar, Independent Self-Harm Awareness Trainer and Ms Rohanna Cawdron, Project Worker, RCPsych Psychiatric Liaison Accreditation Network (PLAN) Team

The Psychiatric Liaison Accreditation Network (PLAN) aims to assure and improve the quality of services, engage staff and patients in comprehensive review, recognize good practice and high quality care, help services identify and address areas for improvement, and disseminate good practice.

The workshop aims to identify and discuss ways in which PLAN has supported services to improve quality and effectiveness, including a specific focus on the service users’ perspective.

The workshop will also discuss the single commonest reason why services may fail to achieve accreditation – provision of a psychiatric assessment room in the emergency department.

It is hoped that delegates will share their own examples of good practice and make suggestions for the evolution of PLAN in helping services achieve excellence.

**Dr Jim Bolton** is Consultant Liaison Psychiatrist at St Helier Hospital, Surrey, and Honorary Senior Lecturer at St George’s University of London. Jim’s own service was one of the first to be accredited by PLAN. He subsequently went on to join the Accreditation Committee and was appointed as its Chair in 2012. Jim represents PLAN on the Executive Committee of the Faculty of Liaison Psychiatry of the Royal College of Psychiatrists. He has published on various aspects of liaison psychiatry. Jim is also the Royal College of Psychiatrists’ Associate Registrar for Public Engagement. He has a broad experience in providing accessible patient information and assisting the media in the accurate representation of mental illnesses and their treatment.

**Ms Rohanna Cawdron** has worked at the Royal College of Psychiatrists as an administrator and then project worker on PLAN for the past three years.

**Ms Satveer Nijjar:** My passion for improving service experience by increasing confidence and reducing stigma and discrimination in mental health, specifically self-harm, has led me to becoming a freelance trainer delivering self-harm awareness to professionals nationally. Since graduating in 2012 with a First Class Honours in Psychology I have committed myself to this full time. Alongside training professionals I also deliver PSHE sessions to pupils to raise awareness of the importance of emotional wellbeing and
give them a better understanding of self-harm. This has complimented the work I do with the RCPsych as a service user advisor on the PLAN project.

New Research

Psychiatric morbidity, seizure frequency and quality of life in refractory epilepsy

Dr Maurice Clancy is an ST6 in General Adult and Liaison Psychiatry working in East London NHS Foundation Trust. He has recently been awarded his MD thesis on Psychiatric and Psychosocial Morbidity before and after epilepsy surgery. He won the Royal College of Psychiatrists Faculty of Neuropsychiatry Trainee Research Prize in 2014. He is currently developing an education module on Medically Unexplained Symptoms for Physicians in conjunction with the Royal College of Psychiatrists and the Royal College of Physicians. He is a member of the International League Against Epilepsy Neuropsychiatry Commission on Psychoses. He is due to complete his higher training in August 2015 and plans to work as a Consultant Liaison Psychiatrist in the future.

Anticipating Behaviour that Challenges: Designing an Interprofessional Simulation-Based Training for Acute Medical Staff

Dr Rosemary Humphreys is a London-based higher trainee in Old Age and General Adult Psychiatry and currently represents London trainees on the College Psychiatry Trainee Committee. Prior to starting psychiatry training, she completed core medical training in Bristol, which triggered a particular interest in the interface between mental and physical health. She is currently a Medical Education Fellow at the Maudsley Centre for Mental Health Simulation, whilst working one day a week in Liaison Psychiatry at Guy’s Hospital. In addition, she is embarking on research exploring end of life decision making amongst clinicians caring for patients with advanced dementia as part of an MSc.

What proportion of patients referred to a liaison service need to be seen by a psychiatrist, as opposed to any other member of the liaison team?

Dr Aaron McMeekin is a Higher Trainee in General Adult Psychiatry in the North West Deanery, sub-specialising in Liaison psychiatry

CORE-10 as a predictor of service utilisation in liaison psychiatry

Dr Sofia Nilsson is working as an FY1 trainee at Guy’s & St Thomas’ NHS Foundation Trust. She is currently working at the department of Head & Neck Surgery, and has previously worked in Liaison Psychiatry and General Medicine. She has a great interest in psychiatry and did a quality improvement project whilst working in liaison psychiatry.
Are stigma scores a useful clinical marker for suicide-related outcomes after traumatic bereavement?

Dr Alexandra Pitman is a Higher Trainee in General Adult Psychiatry on the UCLP Higher Training Programme, and an Honorary Research Associate in the UCL Division of Psychiatry, where she recently gained her PhD. With funding from a MRC Population Health Scientist Fellowship, she conducted a national cross-sectional survey of young bereaved adults to investigate the association between bereavement by suicide and suicide attempt. She was subsequently awarded a Guarantors of Brain post-doctoral fellowship to analyse the qualitative data collected in this survey, which explores the nature of the stigma reported by people who experience sudden bereavement. Her most recent clinical post was in a primary care liaison clinic in South Barnet.

Far from the Madding Symptoms: a personal overview of MUS

Professor Else Guthrie, Consultant in Psychological Medicine and Honorary Professor of Psychological Medicine, Manchester Mental Health and Social Care Trust

Not available at time of print

Increasing capacity to manage MUS and long-term conditions

Professor Chris Williams, Professor of Psychosocial Psychiatry (Mental Health & Wellbeing, University of Glasgow

Patients with long term and medically unexplained physical symptoms present in a range of settings, with only a minority of people being seen within Liaison psychiatry settings. This session provides an overview of alternative methods of service delivery including books, classes and online approaches to communicate key principles of self-management based on the cognitive behavioural therapy approach.

The aim is that the CBT approach is communicated by training resources, thus requiring shorter support from the health worker. Uncertainties in delivery, selection, support type and content remain. Results of a RCT led by colleagues in Edinburgh and Oxford will also be presented.


Dr Chris Williams is Professor of Psychosocial Psychiatry and Honorary Consultant Psychiatrist at the University of Glasgow, Scotland, UK. His main clinical and research interest is in the evaluation of cognitive behavioural therapy (CBT) approaches that provide wider access to care. This includes the free-access www.livinglifetothefull.com life skills course. He has an interest in written and computer-based self-help treatments for anxiety, depression, anorexia and bulimia and is a Past-President and Honorary Fellow of the British Association for Behavioural and Cognitive Psychotherapies - the lead body for CBT (www.BABCP.com). He is a Director of Glasgow Institute of Psychosocial Interventions (GIPSI) - which has a focus on training and research in evidence-based psychosocial interventions. He is medical adviser to Anxiety UK (www.anxietyuk.org.uk) and Patron of Triumph over Phobia (www.topuk.org). His
research has focused on the evaluation of CBT and CBT self-help interventions in low mood, bulimia, anorexia, medically unexplained symptoms and community-based classes for low mood and stress. His work has included developing online and also class based life skills programmes- which have been translated into Somali, Chinese and Romanian, as well as books in six other languages.

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**Classification and nosology of ‘medically unexplained’ symptoms**

Professor Peter White, Professor of Psychological Medicine, Barts and The London School of Medicine and Dentistry

“Medically unexplained” symptoms (MUS) are the “orphans” of Medicine, with neither internal medicine nor psychiatry taking ownership of them. This is shown in our classifying them arbitrarily across different chapters of the ICD-10, with many duplicate entries in different chapters. It is also shown in the multiple names we give them as a group from MUS through functional somatic syndromes and somatoform disorders to conversion disorders. We even cannot decide whether to lump them together or split them apart. This confusion is driven in particular by our Cartesian dualistic view that MUS are either undiscovered “organic” diseases or “functional-mental-psychosomatic” conditions. It’s a mess.

So what is the way forward? We already know that MUS are not “medically unexplained”, so we should drop this term. There is good evidence that both physical and psychological factors are important, and we know that these cannot be divided dualistically. We know enough to classify these conditions within single chapters, but run into difficulty when we have to choose either neurological or psychiatric chapters for conditions primarily of the brain, such as centrally sensitized pain disorders or chronic fatigue syndrome. This is because the brain is the only organ of the body which has conditions classified almost arbitrarily into two different chapters; this cannot be sustained in the light of our current knowledge. Nervous system and mental disorders should in future be classified in one chapter of disorders of the brain and nervous system.

**Professor Peter White** is professor of psychological medicine at Barts and the London medical school, Queen Mary University of London. He is a liaison psychiatrist at Bart’s hospital and co-leads a chronic fatigue clinic, which treats patients with chronic fatigue syndrome (CFS), secondary fatigue and chronic widespread pain (fibromyalgia). His research interests have included illnesses affecting both mind and body and understanding the links between them. He has particularly studied CFS, helping to establish its existence, particularly after infections, as well as helping to establish safe and effective behavioural treatments.

**PTSD and MUS**

Professor Jonathan Bisson, Institute of Psychological Medicine and Clinical Neurosciences, Cardiff University School of Medicine

Medically unexplained symptoms commonly co-occur with PTSD, especially more complex forms of PTSD. The relationship between them will be reviewed with reference to findings from the all-Wales PTSD Registry.

Professor Jon Bisson is a professor in psychiatry at Cardiff University, a consultant psychiatrist with the local traumatic stress service and Director of Health and Care Research Wales. He developed an interest
in traumatic stress during his time in the British Army and leads Cardiff University’s Traumatic Stress Research Group. He has conducted various studies including two widely cited randomised controlled trials of early psychological interventions following traumatic events and Cochrane systematic reviews in the traumatic stress field. He was co-chair of the Guideline Development Group for the UK’s NICE guideline on the management of PTSD in primary and secondary care and chair of the Update Group. He has been awarded 25 grants, mainly in collaborations, totalling over 6,500,000 Euros and published 109 peer-reviewed papers. He is a past president of the European Society for Traumatic Stress Studies and chair of the Global Meetings Committee of the International Society for Traumatic Stress Studies. He developed the All Wales Veterans Health and Wellbeing Service and has supervised and mentored a large number of researchers and clinicians.

‘5 Year Forward View – Training and Working Together’

Opportunities from the 5 year forward view in relation to Mental Health Community Services and training doctors to work in these services

Professor Maureen Baker, Chair, Royal College of General Practitioners

Professor Maureen Baker, Chair of Council, RCGP. Professor Baker joined NHS Connecting for Health (CFH) in 2007 which is now Health and Social Care Information Centre (HSCIC), and is currently their Strategic Adviser for Patient Safety holding this position jointly with that of Chair, RCGP. She has previously held appointments with the National Patient Safety Agency, NHS Direct and the University of Nottingham. Her work in patient safety includes establishing a formal clinical safety management system for NHS CFH, the development of safety standards for Health IT for the NHS in England and the development of e-learning modules on patient safety for doctors in training. Professor Baker has a long history with RCGP and was the Honorary Secretary there during 1999-2009. She was elected Chair of Council, RCGP in November 2013. Since this time she has worked tirelessly to make return to British General Practice safe, supported and proportionate and she also started a nationwide campaign, Put Patients First, to increase funding for General Practice from 8.39% to 11% of the UK NHS budget by 2017. Additionally, she has set up an independent Inquiry into Patient-Centred Care for the 21st Century to be led by Mike Farrar. She is still a practising GP in Lincolnshire.

Endocrine disorders with a psychiatric overlap

Professor John Wass, Academic vice president, Royal College of Physicians

A number of endocrine conditions can present with major psychiatric manifestations or complications. These include thyroid disease with hypo and hyper thyroidism, hyperparathyroidism and hypercalcaemia, hypoglycaemia, insulinoma, Addison’s disease as well as phaeochromocytoma.

Unless people are wary of these they may be missed in psychiatric diagnosis and examples of all of these will be discussed.
**Professor John Wass** is the Professor of Endocrinology at Oxford University and was Head of the Department of Endocrinology at the Oxford Centre for Diabetes, Endocrinology and Metabolism, Churchill Hospital Oxford, UK until 2012.

His research interests include all pituitary tumours, especially acromegaly, adrenal disease, angiogenesis in endocrinology, and the genetics of osteoporosis and thyroid disease.

Since 1975 he has published over 380 articles in scientific journals and as well as written many reviews and chapters in textbooks including the Oxford Textbook of Medicine and DeGroot’s Textbook of Endocrinology. He has also edited a number of different textbooks including the Oxford Textbook of Endocrinology, Clinical Endocrine Oncology and the Oxford Handbook of Endocrinology (3 editions). He was President of the European Federation of Endocrine Societies from 2001-2003 and was Chairman of the Society for Endocrinology (2006-2009. He has also served as President of the Pituitary Society.

He has won a number of prizes and given named lectures including the Jubilee Prize of the Society for Endocrinology. He was recently in June last year awarded the Distinguished Physician of the Year Award by the American Endocrine Society; the first non American to ever receive this award.

Amongst his charitable activities, he is Patron of the St. Pauls Way School (with Professor Brian Cox) and he founded the Pituitary Foundation.

He is Academic Vice President of the Royal College of Physicians in London, since August 2012.

**National Diabetes Audit**
Dr Gerry Rayman, Consultant Physician and Head of Service at the Diabetes and Endocrine Centre, Ipswich Hospital NHS Trust

*Not available at time of print*

**Diabetes: the future is bright, the future is psychiatry**
Professor Khalida Ismail, Professor of Psychiatry and Medicine, King's College London and Honorary Consultant Liaison Psychiatrist, King’s College Hospital NHS Foundation Trust

*Not available at time of print*

**Panel Discussion**
Dr Angela Busittil, Consultant Clinical Psychologist Professional Lead Clinical Health Psychology at Sussex Partnership NHS Foundation Trust

*Not available at time of print*
Workshop A: Towards Excellence: how to use PLAN to develop and strengthen your liaison service
Dr Jim Bolton, Ms Satveer Nijjar and Ms Rohanna Cawdron
Please refer to 14 May for details.

Workshop B: What do you want from a Diploma in Psychological Medicine?
Dr Peter Aitken

Siloing and specialisation in medical & nurse training. A bias to knowledge and skill in the use of technology. The separation of provider organisations into acute or mental health

These have all reduced general medical and nursing exposure to mental health knowledge & practice

Similarly mental health specialists operating in the community or the residual estate of mental health wards have little or no exposure to general health care or general practice and have suffered a similar erosion of physical health care skills.

If re-integration is the aim how do we recover opportunity to train together, learn together and share qualifications or credentials in psychological medicine that stand for expertise in biopsychosocial medicine?

GPs, physicians, psychologists, nurses and psychiatrist, come and argue for what we need - and make sure you've been to the nurse led workshop on similar things yesterday!

Feedback from Research on Adequacy
Dr Will Lee, Reader in Psychiatric Epidemiology, Plymouth University, Peninsula Schools of Medicine & Dentistry (PUPSMD)
Not available at time of print

Psychology and Psychiatry in Liaison
Professor Jamie Hacker Hughes, President, British Psychological Society

This presentation will showcase examples of excellence where our two professions are already working together in a number of medical and other healthcare settings and will explore the possibilities of developing such services much further, using the considerable and distinctive skills that psychologists bring, after substantial training, to the greatest benefit of our patients and to complement the existing and developing work of psychiatry in this field.

Professor Jamie Hacker Hughes is the new President of the British Psychological Society, I am determined that the old rivalries between our two professions should be set aside and that we might instead grasp the opportunity of realising the potential, through greater cooperation and dialogue, of
becoming a powerful and united force at the cutting edge of healthcare, taking our insight, knowledge and experience into new areas.

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1. A Cross-Sectional Investigation of Cognitive Function in Palliative Care Inpatients

*Ms Brid Áine Davis, Dr Mas Mohamad, Dr Karen Ryan, Prof David Meagher*

Cognitive problems are common in palliative care settings and impact considerably upon patient management and outcome. Patients with cognitive impairment pose challenges relating to pain management and have poorer outcomes in respect of survival time, patient and carer distress. Aims: The study examined the prevalence and severity of cognitive impairment in a palliative care population using the Montreal Cognitive Assessment tool (MoCA). Method: The MoCA was used to investigate cognitive status in 75 consecutive patients admitted to a specialist palliative care in-patient unit in Limerick, Ireland. The MoCA is a 30 point tool which assesses a range of domains such as: short-term memory; executive and visuospatial functioning; attention; language and orientation. Visual and physical impairment were accounted for by adjusting total scores using a mathematical formula. Results: From the 75 patients assessed, 3 participants completed less than half of the MoCA and were excluded from the aggregate analysis. Of the 72 participants (Female=31, male=41; Mean age 68.9±9.93), 97.2% (n=70) had a diagnosis of cancer. The mean MoCA score was 18.8±5.85, with the majority (>90%) scoring in the range for significant cognitive impairment. 55.6% (n=40) met the criteria for mild cognitive impairment. Furthermore, 25% (n=18) were in the moderate cognitive impairment category and 9.7% (n=7) met criteria for severe cognitive impairment. Only 9.7% (n=7) had normal cognitive function. A small proportion of the sample achieved a full score in the following domains: 4.2% (n=3) for delayed recall, 8.3% (n=6) for executive functioning, 15.3% (n=11) for language and 31.9% (n=23) for attention. Conclusion: These results emphasise how common cognitive issues are in palliative care populations. Given the relatively high prevalence of delirium within this population, further research employing serial assessments is required to determine if cognitive impairment is static or fluctuating in nature.

2. Liaison Psychiatry: a comprehensive approach to optimising learning in a multidisciplinary team

*Dr Nicholas Andreou, Dr Lucienne Aguirre, Dr Hina Raza, Dr James Bolton*

Aims and hypothesis: We aim to construct an effective multidisciplinary educational programme within the liaison psychiatry team. Background: Liaison Psychiatry, as a team, has a unique construct. Team members from different professional backgrounds are required to perform very similar tasks. It is a team where awareness of one’s learning needs can be utilised to create an educational programme designed to align competencies. Methods:
Semi-structured interviews with two nurses and two doctors from the liaison psychiatry team were used as the basis for designing a questionnaire for wider distribution. The questionnaire included multiple-choice questions as well as free-text, non-prescriptive questions. Questions were designed to identify the perceived usefulness of a multidisciplinary educational programme, identify what liaison psychiatry team members would like others to learn from them and identify what the learning needs of each team member were. In addition, we recorded data on the preferred format and setting of the teaching sessions. Results were triangulated with official guidelines in order to design a best-fit educational programme.

Results:
15 responses were analysed. 100% felt that their own teams learning needs could be addressed by colleagues from a different professional background and knowledge-base to theirs. Free-text responses regarding declared learning needs were formulated into two tree-diagrams one for what team members want others to learn and one for what team members want to learn from each other. The free-text responses were coded into three hierarchical categories: specialty, theme, and topic. These were then triangulated with a derived gold standard from PLAN and the Royal College of Psychiatrist curriculum to form a list of teaching topics and suitable teachers. The preferred (mode) format and setting was: 20-minute sessions in a work-based environment on a monthly basis.

Discussion and Conclusion:
Encouraging learners to think as teachers and vice versa helps describe previously unidentified learning needs and form a comprehensive and widely acceptable teaching programme. Combining bottom-up and top-down methods improves participation, motivation and engagement with the programme. This method of designing teaching curricula may have a wider applicability in the general hospital.

3. Mental health awareness training for London Ambulance Service and emergency department staff

Dr G. Alice Ashby (nee Lomax), Dr Ruth Freeman, Dr Emma Browde, Dr Bennett Alakakone, Mr Edward Sammons, Dr Amrit Sachar

AIMS AND HYPOTHESIS
The project aims to improve training in mental health for staff working in the emergency care pathway: paramedics, control, and emergency department staff.

BACKGROUND
Patients presenting with psychiatric illness present a range of challenges for healthcare staff, and may engender feelings of helplessness, frustration, or fear. This can impact adversely on patient care, staff absence, and team working. Current training in mental health tends to be knowledge-based, when what we really need is for every healthcare professional to respond safely and with compassion to someone who presents with a mental illness.

London Ambulance Service (LAS) have identified mental health as a training need. In 2011, LAS attended 30,000 calls for patients with mental health presentations, including 19,239 overdoses,
479 hanging incidents, and 21,439 episodes of panic. A 2011 audit by the LAS Clinical Audit & Research Unit showed that ambulance staff focussed on gaining history but did not routinely assess capacity, or safeguarding.

METHODS

Phase 1 (completed) has been to create four professionally filmed videos, using actors and real healthcare professionals:

Case 1 - John: Management of psychosis, dealing with agitated behaviour and legal frameworks
Case 2 - Taru: Management of anxiety in a long term condition: chronic obstructive pulmonary disease, in a frequent caller of 999 and attender of ED
Case 3 - James: Management of delirium in a person with dementia
Case 4 - Eva: Risk assessment for self-harm

The stories depicted have all been created with the input of service users and carers.

Phase 2 of the project (to be completed April-June 2015), will compare the use of the videos in face-to-face and e-learning sessions, including analysis. We will focus on thinking about alternatives to admission, attitudes and stigma, as well as ensuring knowledge and skills such as risk assessment and mental state examination. Before and after scales will be used to assess participants attitudes and skills.

RESULTS and CONCLUSIONS

Awaited as phase 2 (evaluation) has yet to be completed we would like to present initial results and conclusions at the conference in June once completed.

4. Psychosocial Assessments for Self-harm: Are we continuing to Comply?

Dr Ramanand Badanapuram, Dr Itoro Udo, Dr Amanda Gash

Aim and Hypothesis:

An audit to determine compliance with NICE Guidelines on management of self-harm (2004) by evaluating whether psychosocial assessments are received by patients presenting with self-harm at University Hospital of North Tees, Stockton-On-Tees and any trends associated with this implementation.

Background

Services for self-harm are expected to be commissioned from and coordinated across all relevant agencies, to encompass comprehensive care. This includes assessments of physical health, mental health, social circumstances, safeguarding concerns, risks of repetition and suicide. All patients are expected to receive a comprehensive psychosocial assessment. Adherence to current guideline is delivered through the Integrated Care Pathway (ICP) in our trust.

Methodology

50 patients were randomly selected from presentations in September 2014. Information evaluated were the number of patients placed on the ICP on admission, number that received psychosocial assessment prior to discharge, method of self-harm, method of hospital presentation, SAD score recorded, gender, length of hospital stay and discharge outcome.

Results
The sample consisted of 32 (64%) females and 18 (36%) males. 49 patients presented with self-poisoning. 42 (84%) presented via ambulance, 7 (14%) self-presented and 1 (2%) was brought by police. 43 (86%) were assessed by Liaison team and discharged within the 48 hours of presentation to Accident & Emergency. Only 28 (56%) of patients had their SAD score recorded.

39 (78%) of patients who presented with self-harm were referred to Liaison Psychiatry. 29 (58%) patients were seen by the Liaison services even before they were deemed medically fit. Only 16 (32%) patients were previously known to the secondary mental health services.

Conclusions/Recommendations

Adherence to Integrated Care Pathway continues to ensure compliance with guideline through the provision of timely psychosocial assessments to patients presenting at North Tees Accident & Emergency. Improvement in practice through the recording of SAD score in the relevant assessment booklet was recommended.

5. Quality improvements in the psychiatry liaison service provided to Basildon General Hospital: Referrer perception

Dr Rajesh Balsubramanian, Dr Adedolapo Ademola, Dr Chike Onyechere, Dr Llewellyn Lewis

Aims: To investigate how clinical staff in Basildon general hospital have experienced recent enhancements to the psychiatry liaison service which had been implemented based on feedback from a previous survey. This would inform further service development.

Methods: All hospital staff were invited to complete an anonymous questionnaire that assessed the perceived quality of the service. The questionnaires included specific questions regarding the staff member experiences of previously suggested enhancements, referral pathways and perceived need for training around supporting patients with dementia or other mental health conditions and their carers. 12 semi-structured interviews were also carried out with hospital staff.

Results: There were 102 respondents, the majority of whom were doctors and nurses. Majority of respondents indicated satisfaction with the service and an improvement on previously suggested enhancements. Satisfaction with both working hours and out of hour referral procedures had significantly improved compared to the previous survey. There remained differing levels of satisfaction between working and out of hour referral procedures. The semi-structured interviews identified clear themes: positive impact of the service, quality of communication between psychiatric and medical teams (including concerns regarding psychiatric management plans and a lack of case conferences), particularly for working age adults and, areas for improvements. About half indicated not receiving training in working with patients with dementia or any other mental health conditions or their carers. Majority of respondents, both in the questionnaire and semi-structured interviews indicated a perceived need for improved skills and knowledge in both dementia and other mental health conditions.

Conclusions: Perceived quality of the liaison service was mixed although majority agreed that there have been significant improvements. There was more satisfaction with the services provided for older adults but note this was a targeted population. Constructive feedback and suggestions to inform service development was received. Common themes for improvement identified include out of hours
referrals and services for working age adults, including brief psychological interventions for general hospital patients.

6. Comparing the risk profiles of self-harming patients who leave paper suicide notes with those who leave messages via new media

Ms Jessica Barrett, Mr Hitesh Shetty, Mr Matthew Broadbent, Dr Sean Cross, Prof Matthew Hotopf, Prof Robert Stewart and Dr William E Lee

Background: In cases of self-harm, suicide notes are a major risk factor for repeated self-harm and also later completed suicide. As well as on paper, suicide notes can now be left on new media services, emails, text messages or similar.

Aims: To compare, among people who have harmed themselves, those who left new media notes and those who left paper notes with those who left no note. They will be compared demographically and by risk factors.

Method: Using appropriate search terms, clinical notes and correspondences of patients who presented to two London Emergency Departments with self-harm over a two-year period were anonymously searched to identify new media users. These were then categorised and groups established for comparison.

Results: New media note leaving was associated with younger age and substance use - both risk factors for repeated self-harm. When types of note were compared, the level of suicidal intent was higher in those who left paper notes.

Conclusion: Paper note leavers remain at greatest risk, however new media note leaving is correlated with risk factors related to repeated self-harm and suicide, placing this group in between the paper note leavers and those who left no note. Mental health teams should enquire about new media use during Emergency Department assessments of self-harm.

Declaration of Interest: None.

7. Mindfulness Training to Improve Staff Health and Well-being - a pilot project

Dr Emma Browde, Dr Amrit Sachar

Background:
It is also well known that staff experience impact patient outcomes. The NHS Staff Management and Health Service Quality Results indicated that the more positive the experience of staff within the NHS Trust, the better the outcomes of that Trust.

The WLMHT NHS staff survey in April 2013 showed that there was significant room for improvement in the areas of staff relationships and work-related stress. In addition, on-going changes to services are accompanied by an expectation for our teams to increase productivity despite staff and service cuts.

All of these factors lead to stress and burnout which in turn impacts staff health and well-being, leading to destabilization of the workforce and poorer quality of care for our patients.

The Kings Fund explains that in order to develop a culture of compassionate, patient-centered care, our staff as a whole have to feel supported.
Can mindfulness training - which is well documented to have positive impacts on stress and burnout symptoms - be used as an intervention to support staff health and well-being?

AIM: Primary: To explore whether delivering mindfulness training for a Liaison Psychiatry Senior Management Team (SMT) will be associated with decreased burnout symptoms. Secondary: To explore whether or not this will impact on the burnout symptoms of the individuals within the teams they manage, and look at absenteeism in the team as a whole.

Methods:

Mindfulness training delivered to the SMT - two half-day sessions with self-guided practice at least 3 times per week over approximately 8 -12 weeks.

We will be measuring the Maslach Burnout Inventory for the senior management team but also looking at the burnout levels of the managers respective teams; along with measurements of mindfulness and self-compassion for the SMT. We have collected baseline data and will be measuring again post completion of mindfulness training, and then 6 months follow-up. We will also be collecting data on absenteeism, including retrospective and prospective data.

Results:

We have collected our baseline measurements and mindfulness self-guided practice is currently under way. Results will be completed in time for conference.

8. North West London Sector - CQUIN for people who frequently attend A&E

Dr Emma Browde, Dr Steve Reid, Dr Angharad Ruttley, Mrs Katherine Murray, Mrs Nicola Wilson

Background:

A small number of patients frequently attend hospital emergency departments (EDs) and utilise a disproportionate amount of healthcare. In addition to placing demands on ED staff, they are more likely to receive unnecessary investigations and have potentially avoidable hospital admissions. It has been identified by The Kings Fund that these patients have a high level of need and that this should be an area for NHS commissioning focus, and that targeting such groups would produce the most significant impact in terms of both the healthcare economy and individual patient outcomes.

Aims and Method: In 2013/2014, a new CQUIN (Commissioning for Quality and Innovation) payment framework was developed in the North West London Sector with the aim to identify people that frequently attend the ED and to provide an intervention that reduced their ED attendance. An innovative sector-wide operational model was developed collaboratively between liaison psychiatry services in CNWL and WLMHT and applied across the 9 ED departments in the sector. The model engaged primary care services, acute trusts, drug and alcohol services, ambulance services and social services to develop a whole systems approach. Clinical interventions incorporated both patient facing contact and non-patient facing liaison work.

Results: A total of 108 patients were included in the project. Despite there being complexity to their presentations, we were able to identify common clinical themes which in almost all cases incorporated a mental health component. A 3 month post intervention evaluation showed a decrease in ED attendance as well as improvement in health outcomes as measured by the EQ5D scale. There was also positive feedback from key stakeholders involved in managing this patient group.
Clinical Implications: There are challenges in relation to providing interventions to this complex patient group. These include clinical factors and also difficulties with negotiating the supporting healthcare infrastructure and the practicalities of working across services, organisations and disciplines. Utilising established models of working and networks, Liaison Psychiatry Services are well placed to co-ordinate and support this type of work. This work is becoming part of usual practice across all sites going forward.

9. Outcome of Renal Transplant in Patients with Bipolar Disorder and Schizophrenia

Dr Mary Butler

Introduction: Severe psychiatric disorders such as schizophrenia and bipolar disorder have been considered a contraindication to renal transplant in many centres. Concerns in relation to a perceived lack of adherence with treatment regimens and the possibility of pharmacodynamic and pharmacokinetic interactions with psychotropic medications are some of the reasons for this exclusion. There is little data in the literature in relation to the outcomes of renal transplantation in these patients.

Methods: We retrospectively reviewed all records of patients with a diagnosis of bipolar disorder or schizophrenia that underwent renal transplantation in our centre since the commencement of our transplant programme in the 1960’s. There were 18 patients in total; 14 with bipolar disorder and 4 with schizophrenia. We randomly selected 40 age and sex matched controls. Primary outcomes assessed were patient survival and graft survival. Secondary outcomes included treatment adherence, post-graft hospitalization, post-graft infection and graft function.

Results/Conclusion: To follow

10. Primary Care Liaison Psychiatry Service Models: A Literature Review

Dr Alexandros Chatziagorakis, Dr Najma Siddiqi, Prof Allan House

Aims

To review the literature describing [1] Primary Care Liaison Psychiatry service models and service components [2] approaches to case identification and referral to such services [3] evidence of effectiveness or cost-effectiveness of such services.

Background

Liaison Psychiatry has a role in the integrated management of long-term conditions, multi-morbidity and medically unexplained symptoms. Services in primary care are not well-established - despite the prevalence there of these complex problems, and widespread dissatisfaction with management based upon referral to existing mental health services.

Methods

We searched: PubMed, PsycINFO, EMBASE, CINAHL, AMED, BNI, HBE and HMIC. Search terms included synonyms for: liaison psychiatry, primary care, collaborative care, medically unexplained symptoms, long-term conditions, depression and anxiety. Titles and abstracts were screened and potentially relevant papers were acquired and evaluated for eligibility. References from eligible papers were also searched by hand and authors were contacted. A data extraction form was used to extract data. Heterogeneity allowed only for narrative synthesis.
Results
Most Primary Care Liaison Psychiatry service models described in the literature are within the context of research studies; RCTs of collaborative care and consultation clinics are the most frequent. Case identification was mostly by researchers rather than General Practitioners and information on referral mechanisms is therefore scarce. We found only 5 studies describing practice in the UK.

Conclusions
Although there is evidence for the effectiveness of primary care liaison services in improving clinical outcomes and reducing health resource use, description of such service models is limited outside the context of trials. We found little evidence to help guide the translation of the general principles suggested by research studies into routine clinical practice in NHS primary care. Local service developments and their evaluation are therefore being planned on the basis of expert opinion and consensus.

11. Therapeutic value of Tattoos in Emotionally Unstable Personality Disorder: A case report
Dr Arabinda Narayan Chowdhury, Dr Arabinda Narayan Chowdhury

Introduction: Tattooing has an important psychological implication and is found to be displaying personality attributes of the person. Studies have shown that tattooing in psychiatric cases, especially in Personality Disorder cases are quite frequent and have psychodymanic significance.

Case presentation: The case of a 35-year-old woman with a diagnosis of Emotionally Unstable Personality Disorder- Borderline type (ICD 10 Code: F60.31) is presented. Detailed psychiatric history shows the presence of difficult childhood experiences including sexual abuse, substance abuse in teens, antisocial behaviours and conflict with the law, interpersonal difficulties and repeated self harm by superficial cuts on arms, legs and trunk. Her three-year relationship broke down because of the violent and abusive partner. Have two children out of this relation, with whom she displayed very emotional attachments. Currently she is living with a very supportive same-sex partner. Since last six months she stopped self-harming behavior by ornamenting with Tattoos on the specific self-harming body areas. A detailed qualitative narrative analysis of each of the six Tattoos (out of a total 9) with photographic display, which exert anti-self harm motivations, is done. In the discussion the detailed analysis of each of the Tattoos with their implied meaning to her is presented. She asserted that after having these tattoos she developed a strong motivation to avert any self harming attempts. Psychiatric aspects of tattooing are also discussed.

Conclusion: Cosmetic Tattooing is a recognized medical scope for tattooing and some are raising concern to its availability in Psychiatric services. Similarly, if further studies show the evidence of deterrent role of tattoos in EUPD cases in preventing self harm, it may be a part of potential positive clinical decision in suitable cases.

Consent: Patient is full capacity and gave written informed consent for publication of this case report and the accompanying images. A copy of the written consent is available for review.
Conflict of Interest: None.
12. Psychiatric and psychosocial morbidity before and after surgical treatment for refractory epilepsy

Dr Maurice Clancy, Dr Helen Barry, Prof Kieran Murphy, Prof Mary Cannon, Prof David Cotter

Objective/Aims: The literature on psychopathology in refractory epilepsy is conflicting. In refractory epilepsy, surgical intervention is considered to reduce seizure frequency and to prevent seizures. It has been claimed that neurosurgical intervention for epilepsy is associated with significant undesirable psychiatric consequences including psychosis, depression and anxiety disorders. This study looks at psychiatric and psychosocial comorbidity pre-operatively and at one year post-operatively to see whether surgery has positive or negative consequences on patients’ mental health.

Methods: A prospective cohort study was conducted. All patients with refractory epilepsy who were potential candidates for epilepsy surgery in the National Neurology and Neurosurgery centre in Beaumont Hospital, Dublin were recruited to the study. Patients who proceeded to surgery had psychiatric follow up at one year post-operatively. Structural Clinical Interview for DSM IV (Axis I) (SCID 1), HADS (Hospital Anxiety and Depression Scale) and Quality of Life in Epilepsy (QOLIE-89) were administered at baseline and at one year follow up.

Results: A total of 48 patients had pre-operative and post-operative assessments at one year. Twenty four patients had a pre-operative SCID I diagnosis and 14 had a post-operative SCID diagnosis (p<0.021). There was a highly significant reduction post-surgery in the numbers of patients with a diagnosis of a psychotic disorder (p<0.004). There was no significant difference in rates of SCID-diagnosed mood or anxiety disorders post-surgery. There were 3 cases of de novo depression and anxiety post-operatively. There was a small non-significant increase in HADS score post-operatively compared to pre-operatively. There was a marked improvement in the subjective quality of life (QOLIE 89) scores post-operatively (69.9 v 74.8)(p<0.002). Forty-two patients had complete seizure freedom or significant reduction in seizure frequency post-operatively.

Conclusions: There is a high prevalence of psychiatric comorbidity in patients with medically refractory epilepsy. This study has demonstrated that patients undergoing surgery for medically refractory epilepsy had an overall positive impact on mental health with a significant reduction in the severity and prevalence of psychiatric symptoms and an improved quality of life. Future studies need to assess longer term psychiatric morbidity following epilepsy surgery.

13. The Journey of a Service User Through Liaison Mental Health Care (LMHC)

Dr Sarah Eales

AIMS & BACKGROUND

There is a paucity of literature regarding service users experience and engagement with LMHC. A systematic review of the literature from 1975 to 2013 identified only seven satisfaction surveys. Therefore understanding the service user experience and effective interventions from the service user perspective required further investigation.

METHOD

This presentation reports the findings of a qualitative study. Seventeen service user interviews were analysed using a constant comparative method, drawn from the grounded theory approach. Service users had used liaison mental health services within the general hospital setting. A theoretical model
of the journey of the service user is proposed. The research was completed as part of a PhD study by the author.

RESULTS
The theoretical model is presented as a road map detailing the negotiation and navigation that a service user undertakes when accessing LMHC. The road map takes into account the phases of the journey, namely pre-contact, arrival, assessment and outcomes. The model proposes that within the journey there are enablers and barriers to effective service provision from the service user perspective. Using the analogy of a journey the model identifies activities and attitudes within the general hospital and LMH staff that have the potential to progress the service users journey or alternatively to delay or stall that journey. Service users often enter LMHC with feelings of hopelessness and with the potential of greater physical or psychological harm occurring. Recognising the need for LMHC, collaborating and working in partnership with the service user have the potential to instil hope and allow a successful outcome from the experience. Diagrams elucidating the journey and the barriers and enablers to effective assessment and outcomes will be discussed.

CONCLUSIONS
This study offers new insights into the experience of LMHC from the service user perspective. Using the analogy of a journey, practitioners can gain greater insight into how the service users experience of LMHC can be impacted by our approach to treatment and care.

14. How do we make our assessment and formulation effective? The service user perspective
Dr Sarah Eales

AIMS & BACKGROUND
Liaison Mental Health Care (LMHC) contact with service users is often time limited, particularly in the Emergency Department (ED). Referrals frequently lead to one off interactions with service users. Very little is known about the service user experience of LMHC is currently under researched. This poster aims to help us understand how to make our interventions effective from the service users point of view.

METHOD
This poster reports aspects of the findings of a grounded theory constant comparative analysis of 17 detailed interviews with people who had used LMHC within the general hospital. The research was completed as part of a PhD study by the author.

RESULTS
The essence of a therapeutic assessment from the service user perspective will be presented. A proposed model which identifies how LMHC can support service users and their carers to understand their psychological distress will also be displayed. The model takes the form of a jigsaw puzzle. When service users present to LMHC the commonality is that they only have, at best, part of the information that they and or their carers need to understand their situation. In essence they have only some of the pieces of the puzzle which makes up a complete understanding of their psychological distress. There are three aspects to the jigsaw which can be provided by the LMHC; acknowledging distress & diagnosis, symptoms and coping strategies. Each piece will be of benefit to the service user but only if
they already have the other pieces. Alternatively if they leave without all the jigsaw pieces the referral onwards must serve to provide more pieces of the jigsaw and help the service user fit them together.

CONCLUSIONS
One off assessment and interventions form a significant part of the Liaison team workload. Understanding the essence of a therapeutic assessment not only from our own but also the service users perspective could improve LMHC. Utilising the principles of the jigsaw could improve engagement with the process and referral onwards.

15. Assessment of effectiveness of a Liaison Psychiatry service: Patient and staff feedback on a new integrated liaison and assessment team service at a North London hospital

Dr Maria Filippidou, Dr Reshad Malik, Dr Muffazal Rawala

AIMS AND HYPOTHESES
Assessment of patient and staff satisfaction is part of the outcome framework for all UK liaison services and is a recognized method to assess service performance. The aim of the project was to gather views from both service users and clinical colleagues regarding the structure, quality, and impact on the patient care pathway and reliability of the ILAT service. The feedback forms the basis of any future developments and funding. We hypothesize that there will be areas of the service that can be further developed with patient involvement.

BACKGROUND
Liaison services address the mental health needs of people who attend hospital primarily for physical health needs. The prevalence of mental illness in the population of physical healthcare seekers is around 2-3 times greater than the rest of the population. This is due, in large part, to either psychological manifestations of physical illness or physical complications of a psychiatric illness.

METHODS
A feedback survey ran from August till October 2014. Questionnaires were sent to patients and clinical staff via post, hand delivered or emailed. The data was entered electronically and then analysed.

RESULTS
A&E patients raised issues such as waiting times and the A&E environment, while ward patients felt management plans were not always clearly explained to them. Staff raised issues surrounding waiting times, effective communication, greater need for integrated care and clarity of mental health legislation.

CONCLUSIONS
As we hypothesized, due to being a relatively new service, the questionnaire has highlighted areas for development. We felt these may be useful guidance not only for us, but also for other liaison teams and commissioners. As per the recommendations, we have improved written and verbal communication, implemented weekly consultant meetings to improve integrated care and have developed the psychiatry training programme. We also undertake daily ward rounds and provide regular opportunities for acute staff to shadow the Liaison Psychiatry team.
16. Two-week Wait for Cancer comes to Psychosis

Dr Fatima Ghazi, Dr Peter Carter, Mr Kirit Singh, Ms Benedicta Sarfo-Adu

Introduction

For decades psychiatry has been treated as the poor cousin of medical specialties in the UK. Timely access to services and then for treatment is one of the most obvious imbalances. For example, whilst patients suspected of cancer are to be seen within 2 weeks by secondary-care, there is no such deadline in psychiatry. The government is finally aiming to reverse this historical trend and achieve parity of esteem between mental and physical illness. One of the targets that is being rolled out is treatment within 2 weeks for more than 50% of people experiencing a first episode psychosis in 2015, increasing to 95% by 2020.

Aims

We were interested in knowing how long it takes EIP to see a patient and commence treatment from point of referral, before the government initiatives had been disseminated.

After reviewing the audit results carry out interventions - which will take place with the ring-fenced government funding.

Undertake a re-audit.

Method

The initial audit collected all consecutive referrals between 23rd-September to 28th-November 2014, amounting to 29 patients. The referrals were assessed on demographics (age and gender), origin, appropriateness and the time it took to see a patient after they had been accepted.

Results

The initial audit highlighted a number of areas of poor practice and identified specific points for improvement.

One-third of all referrals where inappropriate, mostly because referrers are unaware of the remit of EIP.

Only 25% of accepted referrals are seen within 2 weeks, with the majority (60%) seen between 2-7 weeks. The delays were often due to needing a joint assessment with other professionals and poor patient response.

10% of patients were discharged by EIP without being seen as they were not responding.

Interventions

Senior management review pathway to EIP
better documentation by EIP staff members e.g. why a referral is rejected, timely entries, dates of referral noted
more structured guidance for EIP staff e.g. how long we should keep a non-responding patient
improving links with referring teams and educating them about EIP’s remit
attendance at NHS England Workshops
17. Whole Person Care: A cross-speciality, integrated health education innovation led by liaison psychiatry

Dr Vishaal Goel

Aims and Hypothesis
To develop a teaching session for medical students regarding the interaction between mental health and long-term medical conditions (LTCs), which is both feasible, and acceptable to learners. We also postulated that this session would have a positive effect on learner attitudes towards those with mental illness.

Background
LTCs (e.g. COPD, stroke, arthritis, dementia) have high rates of mental health co-morbidity. If left unrecognised and untreated, this can have huge negative effects on prognosis, quality of life, concordance and increased healthcare costs due to readmission and frequent ED attendance. NHS leaders agree that integrating physical and mental health is a priority. This should be reflected in the medical curriculum.

Method
Students were split into four small groups, each given a written case history of a patient with an LTC. They were facilitated by a senior clinician (e.g. physician, surgeon, psychiatrist). Output was a poster presentation to the larger group, demonstrating their understanding of whole person assessment, the relationship between mental and physical health and the importance of multidisciplinary working.

Students provided written feedback (Likert scale and free text). Attitudinal change was measured with the Attitudes to Mental Illness Questionnaire (AMIQ), online, before and after the session.

Results
27 students participated.
Expectations either largely or completely met 81%.
Content/Experience very good or excellent 74%.
Average overall rating - 72% (higher = better).

Qualitative feedback confirmed that the session was seen as an enjoyable, novel experience.

Pre-session AMIQ: weakly positive attitudes towards depression; weakly negative attitudes towards alcohol dependency and schizophrenia; strongly negative attitudes towards drug addiction.
Post-session AMIQ: more strongly positive towards depression; no other significant changes.

Conclusion
Teaching whole person care is feasible, and acceptable and enjoyable to medical students. It can have a significant effect on attitudes towards those with depression. Integrating teaching in this way may have hugely positive effects on patient experience of healthcare. Liaison psychiatry is well placed to coordinate and deliver this teaching, and should seek to place itself at the centre of future educational development. Integrating across professions should be a future goal.
18. A Case of F20 Treatment Resistant Paranoid Schizophrenia complicated with Myelodysplasia

Dr Mohan Gondhalekar, Dr Anjali Gondhalekar, Dr Theodoulou, Dr Dale

Introduction
This complex clinical case presented several significant learning points and challenges for the clinicians involved.

Brief Synopsis of Case
HW is a 51 year old lady who was diagnosed with Paranoid Schizophrenia in her early twenties. Before this clinical diagnosis was made, HW had several inpatient admissions in London and in the West Midlands; both as an informal patient and a formal patient detained under Section 2/3 of the Mental Health Act 1983.

Over the past 12 years, HW had been managed well by her community mental health team (CMHT). She had not needed to be re-admitted to inpatient services during this 12 year period secondary to the excellent relapse prevention strategies used by her CMHT.

HW had been trialled on both older typical antipsychotic agents and newer atypical antipsychotic agents. These medications could not control her symptomatology sufficiently. HW was subsequently commenced on clozapine and this was augmented with sulpride. This kept her free from relapses for over 12 years.

However, in 2013, HWs full blood count showed a pancytopenia picture. This prompted a timely referral to the Haematology Team. In clinic, HW had a bone marrow biopsy and the blood film was analysed. She was subsequently diagnosed with High-Risk Myelodisplasia and was required to have several cycles of chemotherapy to treat and control this condition.

Discussions were held between the Psychiatry Liaison Team, the CMHT and the Haematology team. It was subsequently decided to continue to prescribe HWs clozapine off licence whilst she had the chemotherapy treatment and bone marrow transplantation. HWs mental state remained very stable whilst she was having treatment and she made a successful recovery.

Learning Points
This case highlighted the importance/benefits of efficient inter-team and intra-team working. Excellent communication was observed between the three teams involved. They took collective responsibility for HW mental and physical wellbeing.

This case also reminds us about the risks and benefits associated with clozapine. It also looks at the dilemmas clinicians face when prescribing this medication off-licence becomes necessary. Finally it also teaches psychiatrists about high risk myelodisplasias.

19. Delirium in the acute hospital setting

Dr Rachel Gore

Background: Delirium is a complex neuropsychiatric condition with multifactorial aetiology. Delirium is common in hospitalized patients and associated with increased mortality, longer hospital stays and dementia. In July 2014, NICE published a quality standard covering the prevention, diagnosis and management of delirium.
Aims: To determine if Gateshead Health NHS Trust are adhering to NICE quality standard 63 (communication with patient/family/GP). Additional data collected to compare against published statistics.

Methods: Data collected from medical notes and discharge summaries on three acute wards in December 2014.

Results: 70 inpatients 65 years+ screened; 69 included. Average age 80.9 years. 29/69 (42%) had a diagnosis of delirium. The underlying cause was UTI in most cases (21%). Pre-existing dementia was present in 48.2% of delirium cases vs 22.5% of non-delirium cases. Average AMTS on admission was 3 points lower in the delirium group. The mental health liaison team (MHLT) was involved in 72.4% of delirium cases vs 15% of non-delirium cases. Half of the delirium cases required 5+ MHLT contacts. The diagnosis of delirium was conveyed to the patient in 1/28, and to the family in 8/29 (27.6%). It was not documented that written information was offered in any. The GP was informed of the diagnosis in 65.5%. Average length of stay in the delirium group was 22.65 days vs 15.03 days in the non-delirium group. 51.7% of delirium patients got home from hospital vs 85% of non-delirium patients. A third of delirium cases required a long stay unit on discharge. Follow up was offered in 16/29 with psychiatric follow up being most common. Mortality in the delirium group was 17.24% vs 7.5% in the non-delirium group.

Conclusions: Delirium is common in inpatients over 65. Delirium is a drain on liaison mental health teams, increases length of inpatient stay, and patients are less likely to go home. Delirium also increases mortality. Improved communication of the diagnosis is needed and written information to aid this is not being offered; this area should be developed.

20. A Psychological Support Service for Patients with Inflammatory Bowel Disease

Dr Jemima Gregory, Dr Melissa Smith, Ms Anja St Clair-Jones, Dr Lisa Page

AIMS AND HYPOTHESIS

This abstract describes a pilot service offering psychological and psychiatric support to patients with inflammatory bowel disease (IBD). The pilot is due to commence in 2015 at Brighton and Sussex University Hospitals (BSUH).

We predict that by providing an integrated high quality psychological/psychiatric assessment and treatment service, we will improve patients psychological wellbeing, improve their interactions with services (e.g. by reducing inappropriate service use) and improve their quality of life.

BACKGROUND

IBD, consisting mainly of Crohns Disease and Ulcerative Colitis, is a lifelong condition affecting up to one in a hundred people. Education, work, social and family life can all be disrupted in distressing ways. Unsurprisingly, patients are twice as likely to suffer from depression and are more likely to suffer anxiety than those without the condition.

The British Society of Gastroenterology and NICE quality standards state that a psychologist or counsellor is amongst the essential supporting services within an IBD team. Furthermore the need for psychological support has been identified as a priority by our local IBD Patient Panel. Previously there has been no dedicated access to psychological support for patients with IBD at BSUH.
The initial pilot model will consist of a Liaison Psychiatry SpR (two sessions) and a Health Psychologist (three sessions), integrated into the IBD team and attending the weekly multidisciplinary meeting.

METHOD
Data will be collected from all patients referred to the psychological arm of the IBD service, and will reflect a balanced scorecard of four dimensions: clinical effectiveness, cost effectiveness, patient satisfaction and referrer satisfaction. The pilot will run for between twelve and eighteen months.

RESULTS
For each patient, data will be collected at the time of initial assessment and at three and six months post-assessment.

CONCLUSIONS
This pilot will enable subsequent funding decisions for psychological support for patients with IBD in Brighton to be based on robust data. Detailed information will be available on how effective and acceptable the service is to IBD patients and staff.

21. A Case of Intentional Overdose and Refusal of Medical Treatment: Mental Capacity Assessment and the Role of Liaison Psychiatry
Dr Matthew Hartley, Dr Christopher Hilton
BACKGROUND: Managing the medical issues of patients with mental illness can present unique problems for doctors in an acute hospital setting. One such challenge is the difficulty experienced when assessing the mental capacity of an individual with a psychiatric disorder to refuse medical treatment. The situation becomes an emergency when the treatment in question is likely to be life saving. Although it is not uncommon for clinicians to have to assess mental capacity, confusion arises from parallel mental health and mental capacity legislation, which may delay timely assessment and treatment when appropriate. It is proposed that underconfidence regarding capacity assessment amongst staff is another important issue. CASE REPORT: An account is given of a 25-year-old female who presented to the emergency department following a large overdose of paracetamol taken while on day leave from a psychiatric hospital, where she was detained under S.3 MHA 1983. Blood paracetamol levels indicated treatment with N-acetyl cysteine (NAC). She refused medical treatment and explained that her intention was to die. After assessment by a liaison psychiatrist, she was deemed to lack capacity to refuse because her wish to die was inextricably linked to her mental illness and was impairing her ability to weigh up the information involved in the decision. She was treated with NAC under a best interests standard. DISCUSSION: This case study discusses some of the clinical, legal and ethical issues that arise from the scenario and identifies the particular confounding factors that made capacity assessment more complex: 1) the subtle effect of her mental illness on her capacity, and 2) her partial engagement with assessment. OUTCOMES: Practical advice is set out for doctors in emergency situations to help optimise capacity assessments and reduce delays in necessary treatment. The importance of timely referral to liaison psychiatry in uncertain cases is highlighted. Suggestions are made about how doctors without psychiatric training could be better prepared to deal with more difficult capacity assessments. Plans for future research are proposed and various educational approaches are suggested that aim to improve both individual confidence and the quality of assessments.
22. The assessment and management of children and young people presenting to North Manchester General Hospital Emergency Department with self-harm and overdose: A joint project between The Pennine Acute Hospitals NHS Trust and Central Manchester University Hospital

Dr Matthew Higgins, Dr Sarah Whitaker, Prof Andrew Rowland

Background:
Self-harm describes deliberate attempt to harm oneself. It is a common problem amongst young people and suicide rates are higher amongst those who self-harm. Acute presentations of self-harm require a physical and mental health assessment to evaluate risk of further harm to self and also of completed suicide.

Aim:
To improve standards of care of paediatric patients presenting to North Manchester General Hospital (NMGH) Accident and Emergency (A&E) department with self-harm.

Objectives:
To analyse A&E assessments and management of paediatric patients presenting with self-harm, and evaluate whether current practice is in accordance with guidelines.

Standards and Guidelines: The standards set for young people presenting to NMGH A&E with self-harm are based upon guidance by the National Institute for Health and Care Excellence (NIHCE); the Royal College of Psychiatrists; and The Pennine Acute Hospitals NHS Trust (The Trust).

Methodology: A random sample of 50 patients age 0-16 attending NMGH A&E between 01/01/14 and 01/10/14 presenting with self-harm were included. Data was gathered from scanned medical records.

Observations:
Areas of good practice:
The advanced paediatric nurse practitioners mental health assessments were comprehensive and of high quality.
If discharged without referral, a crisis plan was discussed with the on-call CAMHS SpR.

Areas for improvement:
Physical and mental health assessments were documented in 88% of cases.
52% of patients were referred to paediatrics.
68% of patients were admitted to a children's ward.
78% of patients were admitted, transferred or discharged from A&E within 4 hours.

Recommendations:
A&E practitioners should receive teaching on assessment and management of young people presenting with self-harm.
The expired Pennine Acute Hospitals Trust Care Pathway for Children and Young People who present with mental health problems should be updated in consultation with Central Manchester University Hospitals NHS Foundation Trust (CMFT) child and adolescent mental health services (CAMHS) and information cascaded to trained A&E staff.
Young people presenting with self-harm should be admitted for further assessment.
23. Quantifying the population of imprisoned Men who have Sex with Men (MSM) as first step to reaching parity of physical and mental health care

Dr Bradley Hillier, Dr Alison Barbour, Dr Aseel Hegazi, Dr Pamela Walters, Dr Mark Pakianathan

Gay, bisexual and other MSM form around 2-3% of the UK male population and are known to demonstrate health inequality, including elevated morbidity in physical (e.g. HIV) and mental health problems and substance misuse, including in a sexual context ("chemsex"). Prisoners have a significantly elevated risk of mental health problems and substance misuse, thus the MSM prison population may have particular risk. Nevertheless there are no data quantifying the MSM prisoner population. Public Health England identify the issue of health inequality in MSM as a focus of policy (Promoting the health and wellbeing of gay, bisexual and other men who have sex with men policy, PHE 2015); parity of healthcare for prisoners has been an important political driver in provision of NHS services within prison.

Method: Sexual orientation and clinical data routinely collected by a GU/HIV in-reach service at a category B remand prison in London was analysed as part of a service improvement project to quantify the MSM population. Data were analysed using Excel statistical package.

Results: The total number of individuals attending the clinic was 920 from a broad range of ethnicities. Data analysis revealed 5.33% MSM (48 attendees). There was no significant difference in mean age between the two groups, although a greater range was observed in the heterosexual group.

Conclusions: This data demonstrates for the first time the possible number of imprisoned MSM. Correlating with known increased risk for HIV, mental health problems and substance misuse indicates a significant and specific need for this group. We recommend routine data collection on sexual orientation, screening for mental disorder, substance misuse and choice of substance, chemsex behaviour, HIV status and risky sexual behaviour in this group. We also highlight a need for greater integration between GU/HIV, substance misuse and mental health inreach. There is real opportunity to further characterize the needs of this group, and formulate a care pathway focused on MSM issues similar to that of at the gate which already attempts to address social and housing issues amongst prisoners on release.

24. Community Liaison Psychiatry: Ealing Model of Integrated Care

Dr Christopher Hilton, Dr Neil Sarkar, Dr Ksenia Marjanovic-Deverill

Aim To assess impact of Community Liaison Psychiatry input in three areas of work beyond the Core 24 Commissioned Service following successful pilot in 2013-14.

During the winter period 2014-15 West London Mental Health NHS Trust, in partnership with London North West Healthcare NHS Trust, Care UK and Smokefree Ealing received £400,000 additional funding to provide an enhanced Liaison Psychiatry Service.

Methods

Three projects were undertaken:

- enhanced pathway out of hours for patients presenting to the Urgent Care Centre adjacent to the Hospital A&E Department
- integrated mental health expertise within an intermediate care team
recruitment of a clinician with therapy skills proactively to work with patients who were Frequent Users of Emergency Services (FUES).

Data were collected about the activity within each of these projects. Additionally, referrer, patient and carer satisfaction was measured.

The impact of the FUES worker was also calculated in terms of reduction of ED visits.

**Result**

**Intermediate care (ICE):**
Psychiatric input was requested 38% cases referred to ICE, with 18% requiring face to face interventions.

MH staff were able to provide considerable informal advice and support as well as formal education and in-service training including 32 formal teaching and supervision sessions.

**UCC:**
We were able to successfully implement new pathway for joint working between Liaison Psychiatry and UCC which has diverted 22% of emergency work away from ED.

We were also able to maintain a 97% 1 hour response time despite a 40% increase in attendances between 10pm and 8am compared with last winter.

**FUES:**
The therapist successfully worked with 32 complex clients identified through the ED system and referred by clinicians in ELPS and the Emergency Department. She co-produced multidisciplinary care plans for 19 patients to reduce the impact of their attendances.

Her intervention contributed to an 80% reduction in attendances.

Feedback from all sources was overwhelmingly positive.

**Conclusions**
We hope to ensure these projects continue, to bring Liaison Psychiatry into community settings.

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**25. Assessment of attitudes toward psychiatry among different teams of non-mental health professionals**

**Dr Christopher Hilton, Dr Katie Pigott, Dr Neil Sarkar**

**Acknowledgements:** Michael S, Harun A, Dobbs T, Sackey F;

**AIMS:** To use an adapted version of the Attitudes Toward Psychiatry-30 items questionnaire (ATP-30) to assess the attitudes towards psychiatry at Ealing General Hospital among: intermediate care Ealing rapid response team (ICE RR) and the intermediate care Ealing short term rehabilitation (ICE STR) teams, the London ambulance service (LAS), and the emergency department (ED).

**BACKGROUND:** The ATP-30 is a well-validated tool, originally designed to assess medical student attitudes to psychiatry. Attitudes of general practitioners towards psychiatry were subsequently surveyed, however there is a lack of literature assessing the attitudes of other health professionals towards psychiatry. The Ealing liaison psychiatry service (ELPS) Resilience Project was set up to improve integration of mental and physical health and sought to measure this objectively.

**METHODS:** Questionnaires were distributed among 4 teams with a 4 week timeframe to respond. Managers provided data about the breakdown of disciplines in their department so differential
response rates between the teams could be calculated and discussed. Response options were on a 5-point Likert scale. Total scores were calculated (minimum 30, maximum 150). High scores indicate a positive attitude towards psychiatry.

RESULTS: 116 participants responded. Highest score: 145; Lowest score 59; Average score across all groups: 105.8; ICE RR team: 15 questionnaires, average score 117.8; ICE STR: 13 questionnaires, average score 120.7; LAS: 32 questionnaires, average score 103.4; ED: 56 questionnaires, average score 100.4;

CONCLUSIONS: Scores were generally higher for intermediate care teams compared to emergency services and the emergency department. Detailed analysis of the viewpoints of fellow health professionals towards psychiatry has the potential to make large improvements in psychiatric service provision in general hospital settings, and shared understanding of the different roles of psychiatric services in terms of meeting training needs and providing appropriate support and collaboration.

26. Development of a Palliative Care Pathway for Palliative Care: a Higher Trainee service development project

Dr Puja Sharma, Dr Christopher Hilton

Aim
To design, implement and evaluate a pilot project over one year which aims to integrate Liaison Psychiatry into a palliative care service in a community setting, within existing resources.

Method
A new clinical pathway and dedicated integrated sessions were provided in the hospice. In parallel with clinical interventions, a programme of regular teaching was offered to the Palliative Care Team. The clinical project commenced in September 2014 and the results of the evaluation were analysed after 6 months. Information about referrals and interventions was collected and pre and post intervention survey of the mental health skills of the Palliative care team was undertaken after this period of integrated working.

Results:
In comparison to the pre-study survey the palliative care MDT longer felt that any aspect of the current referral pathway was poor. The majority of respondents stated that they were aware of how to refer routine or emergency cases for psychiatric input. In line with the pre-study survey the team rated themselves as fair at identifying and managing mental health problems in their patients (although nobody rated their abilities as more than 4/6 where 6 was "excellent"). Staff members were asked to rate training they had received about mental health in last three months: 61% felt that this was good and 23% fair, in contrast to the previous rating of 75% feeling it was poor (range 0-2 on scale 1-6).

Recommendations:
In view of the positive impact of input from Ealing Liaison Psychiatry service, it will continue to provide input to Meadow House Hospice while it is co-located with Ealing General Hospital. There is however on-going discussion with SMT regarding feasibility of this arrangement, as it is an unfunded service.

**27. An Integrated Medical and Psychosocial Approach to Reduce Inappropriate A&E Attendance**

*Dr George Hutchinson, Dr Catriona Reid, Dr Emma Schofield*

**AIMS AND HYPOTHESIS**

The aim of this project was to identify and manage the medical and psychosocial issues of patients with high attendance rates to Accident and Emergency (A&E).

Our hypothesis is that using a multidisciplinary approach to address psychosocial and physical issues in patients who present most frequently to A&E reduces inappropriate attendance.

**BACKGROUND**

There are a small number of patients who repeatedly attend A&E departments utilising disproportionally large amounts of time and healthcare resources. A retrospective review of the top 10 attenders in our A&E department showed the majority had multifactorial reasons for presentation including medical (87%), alcohol (31%), psychiatric (28%) and social (25%).

**METHODS**

15 patients with the highest number of attendances to an A&E department over the previous year were selected. Each received a medical assessment by a senior A&E clinician and a psycho-social assessment by the Liaison Psychiatry Team.

Individual Attendance Plans tailored to each patient’s medical and psychiatric needs were drawn up with the patient.

The attendance plans were adapted weekly by Liaison Psychiatry, A&E Clinicians and relevant services, such as Social Services, Drug and Alcohol Liaison, and London Ambulance Service.

Patients were also seen in Frequent Attenders’ Clinics for further intervention and review.

Monthly attendance rates following intervention were compared to attendance rates of the previous year and a T-test was conducted.

**RESULTS**

1 patient left the study as they declined a treatment plan. The remaining 14 patients showed a significant reduction in A&E attendance following the introduction of a multi-disciplinary attendance plan (P = 0.0014).

The mean monthly attendance rate of these patients had been 2.56. In the year following intervention the monthly rate for the group decreased to 1.14.

**CONCLUSION**

Although frequent attending patients commonly presented with physical symptoms, many had psychiatric issues such as anxiety disorders or cognitive impairment which had not been fully addressed in previous attendances.
Our project showed that multidisciplinary management significantly reduces unnecessary attendances by addressing medical with psychiatric and social issues. This approach improved patient care and saved money and resources.

28. How well psychiatrists understand Driver and Vehicle Licensing Agency guidance on driving and mental illness: a trust-wide survey

Dr Lena Jawad, Dr Fiorenza Shepherd, Dr Lena Jawad,

AIMS: To investigate the proportion of doctors working in mental health that regularly assess patients fitness to drive, and examine how well informed doctors are of the Driver and Vehicle Licensing Agency (DVLA) guidance regarding mental illness.

METHODS: An online survey comprising ten questions was sent to all doctors working in mental health in both, West London Mental Health Trust (WLMHT) and Central and North West London (CNWL). The survey was open for two months. Results were collected and graphs were produced for visual representation of data.

RESULTS: The number of participants reflected a poor overall response rate (WLMHT n=65, CNWL n=38). Of the doctors that did respond, the majority were consultants in WLMHT (44%) and core trainees in CNWL (50%). Only 48% of doctors in WLMHT enquired into whether their patient drove. This number was slightly higher in the CNWL group (53%). 75% of WLMHT and 76% of CNWL doctors were aware of DVLA guidance on mental illness, with 80% WLMHT and 76% CNWL knowing how to access it. In both trusts the proportion of doctors who asked their patients about driving was highest amongst those working in older adults (88% and 71% respectively). Conversely, figures were demonstrably lower in CAMHS, with only 33% in both trusts asking their patients whether they drove.

CONCLUSIONS: A significant portion of doctors working in mental health do not routinely ask their patients whether they drive however the majority of doctors are aware that DVLA guidance on mental illness exists. A low overall response rate is poorly representative of practice but could highlight a general apathy with regards to driving and mental illness or a lack of knowledge, stressing the need for integration into formal training.

29. Bringing Therapeutic Observations to the General Hospital

Dr Kirsten Lawson

INTEGRATION

Nurse training is becoming increasingly specialised and staff do not necessarily feel confident in managing 'mental health patients' - we have created a tool which not only helps identify potential risk but allows clear signposting as to nursing strategies which can maintain the overall safety of that patient whilst within the general hospital. This important step not only challenges stigma associated with mental illness but could also literally save lives.

CONSISTENCY OF COMMUNICATION

It is becoming increasingly understood across commissioners and service providers that patients within general hospitals do not just have physical health problems; 80% of all hospital bed days are occupied by people with comorbid physical and mental health problems. Within EKHUFT, the KMPT Liaison Psychiatry Service has worked with the general hospital staff to create a 'tool which can aid
general nurses to risk assess and care for patients with mental health symptoms, whilst they are in the general hospital. This led to the creation of the Safeguarding, Managing Risk Tool (SMaRT). The tool itself allows staff to use the symptoms that the patient is describing, alongside behaviours that they are observing to come to a traffic light like system of risk. The levels of risk then have recommendations for management, as per our therapeutic observation policy. The form also allows clear documentation of the resultant care plan.

PARITY OF ESTEEM
In real life people are not like textbooks at all. When they are in a general hospital, they cannot leave symptoms or signs of mental illness 'at the door'. Staff have reported an increased confidence in managing these complex patients by using the SMaRT, but continued training is required.

We would hope that in time, asking about self harm or thoughts of suicide will become as common place with general hospital staff as asking about pain or shortness of breath and that therapeutic observations are used similarly to physical observations.

The SMaRT won the HSJ 2014 Patient Safety Award for Patient Safety in Hospital Care.

30. From Hospital to Home A CAT perspective
Dr Gillian Lee, Dr Alison Salvadori, Dr Abrar Hussein, Dr Lowe Matthew, Dr Babu Mani,
CAT(Cognitive Analytical Therapy) is a therapeutic approaches which makes use of a relational model to understand psychological distress. It proposes ways of addressing maladaptive behaviours by offering healthier alternatives.

The Psychological Medicine Service in Berkshire uses this model as a tool to support patients with medically unexplained symptoms (MUS). We have had particular early success in addressing the needs of frequent attenders to A&E. In this poster, we propose a framework to understand the Hospital to Home journey for a patient with MUS from a CAT perspective. We present a case study which illustrates this approach and identifies its key successes. Early evidence suggests that addressing psychological needs using the CAT model in the community significantly reduces attendance at A&E.

The CAT model uses a three step process which involves the reformulation, recognition and revision of unhelpful psychological patterns.

Patients with MUS present challenges to health professionals as they generate frustration and powerlessness in clinicians which leads to a sense of therapeutic nihilism. This is often communicated to patients in subtle or very obvious ways such as frequent changes in medication, rapid discharge or a reluctance to discharge, multiple referrals to other specialities, unnecessary procedures etc.

Patient with MUS seek care from A&E due to their perceived sense that there needs are not being met elsewhere. We will look at this cycle using reciprocal roles and identifying CAT tools such as sequential diagrammatic reformulation.
31. Psychiatric Presentations breaching 4-hour targets in an inner-city London Accident and Emergency Department

Dr Angela McGilloway, Mr Matthew McGilloway, Mr Tim Stevens, Dr Frankie Connell

Introduction

The 2001 DOH document Reforming Emergency Care, outlined new targets for NHS A&E departments. Included was the guidance that no patient should wait more than 4 hours from door to discharge. Government target stipulated this should be met in at least 95% of patients presenting to hospital. Media attention has highlighted the failure of UK hospitals in achieving this target; 2013 resulted in the highest percentage of people exceeding the four hour wait since 2004. Psychiatric patients are thought to significantly contribute to these breaches for multiple reasons.

Aim

The aim of this study was to identify factors regarding psychiatric attendees to an inner-City London A&E department who breached the four hour waiting time, as a baseline for service enhancement and further research.

Methods

A detailed retrospective audit of psychiatric attendees to the A&E department of the Royal London Hospital over a three month period (April - June 2013) was undertaken. Attention was paid to the length of the breach and reasoning, in order to ascertain common causes and potential solutions leading to better adherence to government targets.

Results

In the three month, 459 patients were referred to the Psychiatric Liaison Team from A&E. Of these 459 patients, there were 69 breaches of the four hour target, equating to 15%. The average breach time was exactly 6 hours, with a median breach of 5 hours and 45 minutes. Breaches that exceeded double the recommended target of 4 hours were statistically more likely (at 95%), to be patients who were out of the local catchment area for the hospital. However, the most common reason for breaches was determined with 95% confidence, to have no identifiable cause.

Conclusions

Given that most breaches had no identifiable cause, this causes problems in identifying factors that may be modified to improve on this government target. However it supports clinical opinion that psychiatric patients require a greater depth of assessment, involving the whole person from several aspects not considered in physical health care, as well as careful examination and attention to the risk assessment and most suitable option of follow-up.

32. Delirium education program - A collaborative approach in NHS Ayrshire & Arran

Dr Ajay Macharouthu, Dr Claire Copeland

Aim

In September 2013 a collaborative, multidisciplinary team was formed from within Care of the Elderly and Elderly Mental Health Directorates to deliver the Delirium Pathway in NHS Ayrshire and Arran. Delirium if unrecognized is associated with a worsening cognitive function, increased mortality and institutionalization and increased length of stay. Local data would suggest 40-60% of people >65yrs are admitted with delirium. An audit highlighted the lack of awareness of delirium and its management. An
education program was created for all Healthcare Professionals prior to rolling out the Delirium Pathway.

Methodology
To ensure consistency between trainers the course content and objectives were agreed. Traditional methods included access to LearnPro modules. There are twice monthly, Consultant lead, drop in sessions for all staff on both sites. Cases are used to facilitate the learning. The most successful modality has been the use of social media in particular the NHS A&A Delirium Facebook page. There are over 300 members. It is a closed group with no patient identifiable material allowed. There are posts about all aspects of delirium and dementia. These were also posted on Vine, Wordeo, Twitter, Scoopit and Google+.

Results
A local audit carried out has shown encouraging results. There is an increased documentation of delirium in medical notes, medico legal paperwork (Adults With Incapacity) has improved. Over the past 10 months 241 Healthcare professionals have passed the LearnPro module on Adults with Incapacity. 94 people have passed the module on delirium. To date ~150 people have attended the Consultant lead drop in sessions. An additional 140 referrals were made to our local Elderly Mental Health team suggesting increased awareness of delirium. The Older Persons Acute Care (OPAC) team a division of Health Improvement Scotland (HIS) rated our work very highly on a recent visit.

Conclusion
A change in culture is happening with the majority of healthcare professionals in NHSaaa aware of delirium and will actively screen people for it. Also our training program supports us to ensure staff have the necessary knowledge and skills to meet the needs of people with delirium and dementia, their families and carers.

33. Consultation to integration: The development of a mental health liaison service for older people in general hospitals

Dr Ajay Macharouthu, Mrs Heather Kerr, Mrs Joanne Davidson, Ms Maryann McEwan, Ms Julie Crabtree

Background
The Elderly Mental Health Liaison Service in Ayrshire and Arran was established in 2008 with the appointment of one Mental Health Liaison Nurse. Referral rates have increased by 50% since its inception and in response to this demand the service has expanded to include a Consultant Psychiatrist, Dementia Nurse Consultant, Team Leader, 2.5 Mental Health Liaison Nurses and two Liaison Nurses in A&E. The service provides skilled and collaborative assessments and intervention to meet core mental health demands within general hospitals.

Aims
The introduction of a liaison service has been shown to improve the quality of care and dignity of patients whilst improving mental health skills in non-mental health professionals. The service arose out of a recognised need to improve outcomes for older people with a mental health problem such as increased mortality, greater length of stay, loss of independent function and higher rates of institutionalisation.
Methods & Results
Our philosophy affirms a recovery-based person-centred approach by promoting equitable, non-discriminatory practice putting the older adult at the centre of all clinical decisions. The service aims to provide a safe, effective and efficient model by developing a highly skilled staff, who responds timeously with recommendations. Currently, the service is proactive in working collaboratively with colleagues in the acute setting in piloting a delirium pathway and a frail elderly pathway in A&E, which has shown to reduce hospital admissions, ward moves, improve treatment pathways, deliver AWI training and supporting staff.

Conclusions
Future directions are to further develop a multidisciplinary specialist mental health team that integrates the assessment and treatment of mental health disorder into routine general hospital practice. Targeting local priorities such as enhancing psychotropic, dementia and delirium pathways will be a key area for development.

34. Frail Older People Pathway - NHS Ayrshire & Arran

Dr Ajay Macharouthu, Ms Maryann McEwan, Dr Rowan Wallace

Introduction:
Analysis of data over 10 days in 2012 uncovered a significant burden of frailty within University Hospital Crosshouse. Higher frailty meant longer length of stay and delays in senior medical and multidisciplinary review. People over 65 represent the minority of Emergency Department (ED) attendances but the majority of those admitted to hospital. The data demonstrated a clear need to reduce unplanned admissions and improve the flow of patients through the front door. We needed to design a system around the needs of frail older people.

Objective:
The interdisciplinary team within ED included a Consultant Geriatrician, Elderly Mental Health Liaison Nurse (MHLN), Pharmacist, Allied Health Professional from the Intermediate Care and Enablement Service (ICES) and an Advanced Nurse Practitioner. Over 65s attending ED were screened using a tool developed at Crosshouse identifying frail patients. A comprehensive Geriatric assessment was completed. Appropriate patients were admitted direct to specialty beds, step-down beds, or discharged home. Cognitive screening was completed using the 4AT. Input from Mental Health Liaison nurse (MHLN) ensured seamless referrals to the CMHT or general hospital MHLN. The MHLN and pharmacist worked closely to review and/or reduce psychoactive medications with input from the Liaison Psychiatrist if required. Any prescribed anti-dementia drugs were documented. Patients were identified for the delirium pathway if they were admitted to hospital.

Results:
Results showed a reduction in admissions to hospital, increase in alternatives to hospital admission, reduced length of stay, reduced waiting time in ED, improved flow for all patients within hospital and direct admission to speciality areas increased. Longer term data analysis revealed improved mortality rates and a reduction in readmission rates. Quantitative results have been positive. 70% of patients were screened by the MHLN.
Conclusion:
The Frail Older Persons Pathway has been proven to reduce unplanned admissions, channel direct admissions to speciality areas and improve, in a cost effective way, patient experience and flow providing person-centred care. Based on this data the Team is now embedded in ED as Best Practice.

35. Audit on effectiveness of Adults with Incapacity act (AWIA) training in reducing number of emergency detention of elderly patients in general hospital

Dr Ajay Macharouthu, Dr Mithun Barik

AIMS AND HYPOTHESIS
To assess the impact of AWIA training in reducing the number of emergency detentions of people over the age of 65 years

BACKGROUND
Since its inception, the Elderly Mental Health Liaison Service in Ayrshire and Arran has been proactive in working collaboratively with general hospital colleagues in improving service by different initiatives e.g. piloting a delirium pathway and a frail elderly pathway in A&E.

One such initiative was developing an online training programme about Adult with Incapacity Act. This arose out of a recognised need to improve knowledge as concerns were raised about inappropriate use of emergency detentions under the mental health act in General Hospital where use of AWIA probably would have been more suitable. The AWIA training programme in Learnpro went live in January 2014 and the participation and response has been very good so far. The audit aims to analyse the effect of this by comparing emergency detentions before and after introduction of the AWIA training.

METHODS
Data related to emergency detentions of elderly patients over the age of 65 years in the year 2013 and 2014 was collected from computer records. The data included number of Emergency detention certificate (EDC) issued, demographics, date, time and location and who issued the EDC. The data was then analysed for a range of outcomes.

RESULTS
The total number of emergency detentions of elderly patients over the age of 65 years was 30 in 2013 and 29 in 2014. There were 6 detentions in psychiatric hospitals compared to 3 detentions in 2013. Overall the percentage of detentions in general hospital and community was 90% in 2013 and 79.6% in 2014.

CONCLUSIONS
It appears that there has been some reduction in number of emergency detention compared to previous year. The next phase of the audit would involve qualitative analysis of detention papers to get a better idea about the circumstances behind detention and whether AWIA could have been more appropriate.
36. Senior out of hours psychiatry cover in A&E

Dr Omer Malik, Dr Brent Elliot, Dr Jan Falkowski

AIMS AND HYPOTHESIS:
To reduce the number and duration of mental health breaches occurring in A&E, due to mental health issues.
To improve patient and A&E staff satisfaction with flow through A&E.

BACKGROUND:
The Royal London Hospital is a tertiary trauma hospital based in Tower Hamlets; high rates of significant mental illness in the background of co-morbid physical illness, substance misuse and socio-economic deprivation. The analysis of A&E breaches during April till June 2014 revealed that 31% of all A&E attendances occurred between 5 to 11pm on weekdays; 47% of all A&E breaches occurred during this time period; unsupported junior doctors in A&E. There were increases in A&E 4 hour breaches, we consistently failed to meet the 95% target during this time.

METHODS:
10 Senior Psychiatry doctors were recruited to cover 5 - 11pm shifts at A&E on weekdays; project duration from 1/11/14 till 30/4/15. We designed a A&E staff and patient satisfaction questionnaire and data on breaches was collected on weekly basis.

RESULTS:
There were one 12 hour and two 8 hours breaches, due to transport issues.
We were able to achieve about 98% of 4 hours breach target.
The duration of A&E breaches was reduced from an average of 6 hours to 5 hours 20 minutes.
The patient satisfaction with the service remained consistently above 75% but we scored relatively less in waiting times and speed of transfers. The A&E staff satisfaction remained above 80% but we scored relatively less on speed of transfers.

CONCLUSIONS:
There is no standard mental health breach definition.
Only 33% of 4 hours mental health breaches were attributed to psychiatry liaison team; others being due to late A&E referral (47%) and late transport (20%); breaches only occurred due to adolescents and Mental health act assessments followed by local and out of area admissions.
Cost-effective project (£57,000 over 6 months).
Business case for long-term continuity of this project
Further data analysis to determine breach causes and commencing quality improvement project.

37. Screening and case-finding for depression with the PHQ-9 in non-psychiatric settings - a meta-analysis

Laura Manea, Dr Dean McMillan, Prof Simon Gilbody, Dr Andrew Moriarty

Importance:
The patient health questionnaire (PHQ-9) is a widely used screening and case-finding tool for major depressive disorder (MDD). The most commonly used cut-off point for MDD is 10 based on an initial validation study, though a subsequent meta-analysis suggested that the performance of the PHQ-9 at this cut-off point may be lower. This meta-analysis also highlighted that different cut-off points may be
required in different settings, but also showed that there may be selective reporting at cut-off points other than 10. Numerous studies of the PHQ-9 have since been published, allowing for a better exploration of these issues.

Objective:
- to establish the diagnostic performance of the PHQ-9 at the standard cut-off point (10)
- to compare the diagnostic performance of the PHQ-9 at the standard cut-off point in different clinical settings.

Study Selection:

Main Outcomes and Measures:
Pooled sensitivity, pooled specificity, positive likelihood, negative likelihood ratio and diagnostic odds ratio for cut-off points 7 to 15.

Results:
36 cross-sectional studies (21,292 patients) met inclusion criteria. Pooled sensitivity for cut-off point 10 was 0.78 (95% CI 0.70-0.84) and pooled specificity was 0.87 (95% CI 0.84 0.90). At cut-off point 10, the PHQ-9 has a better sensitivity in primary care pooled sensitivity 0.81 (95% CI 0.68 0.89) - compared with secondary care settings pooled specificity 0.70 (95% CI 0.56 0.81). However, we found very high levels of heterogeneity; therefore these pooled results should be interpreted with caution.

Conclusions and Relevance:
The PHQ-9 has acceptable diagnostic properties for MDD at cut-off point 10 in different settings. However, sensitivity was lower than that reported in the initial validation study across settings. There was selective reporting at cut-off points other than 10.

38. Prevalence, Precipitating factors, Patterns of self-harm and Outcome of Psychiatric assessment (following the self-harm) in different ethnic populations in The Borough of Blackburn with Darwen

Dr Maryam Manzoor, Dr Ranji Thomas

AIM:
The aim of this study is to examine the Prevalence, Precipitating factors and Patterns of self-harm with outcome of Psychiatric assessment (following the self-harm) in different ethnic populations in East Lancashire.

BACKGROUND:
Britain is a multicultural country and prevalence of self-harm is generally reported as more amongst White British population. Though there are some studies which have shown an increasing and interesting trend towards suicide and self-harm in British Minority Ethnic groups when compared to White population e.g. Hussain et al (2006). However our crude clinical observations in East Lancashire suggest relatively increased prevalence of self-harm in the White British Population (with subtle differences in patterns of self-harm) despite a very high proportion of non-white residents.
METHOD:
The study is a retrospective data analysis for two months (01/08/2014-30/09/2014).
All patients between the age group of 16-64 with self-harm, regardless of intention to die or severity of self-harm are included who presented to Accident & Emergency and Urgent Care Centre Departments in Royal Blackburn hospital
RESULTS:
The study is still ongoing and so far we have collected the data of 82 patients. We aim to finish the study by Mid of April 2015. So far, we have found out that 71% of the patients were White British, 5% were Asians and ethnicity was not recorded in 24% of the patients.
Overall self-harm by overdose was the most common used method with 51% of White British patients and 75% of Asian patients-followed by other less common methods.
Significant differences were found between different ethnic populations in terms of repetitive episodes of self-harm, alcohol use; illicit drug use and precipitating factors prior to self-harm.
Outcome of the assessment did not differ much across ethnic groups and most of the patients were discharged with no further mental health follow-up.
CONCLUSION:
Self-harm is more common and openly reported in the White British population of East Lancashire. There is a strong possibility of under reporting in other ethnic populations, especially Asians.

39. Assessing the Rates and Appropriateness of Admission to Mental Health Inpatient Units from North Middlesex University Mental Health Liaison Team

Dr Edward Middleton, Dr Justin Shute

Aims:
There have been concerns the NMUH Mental Health Liaison Service has high and increasing numbers of referrals for admission to mental health inpatient units, due to many inappropriate referrals. This audit aims to assess the number of admissions from the Liaison team and the reasons behind each admission. We aim to assess appropriateness of referral for admission, based on patients’ subsequent inpatient stay.
Methods:
All referrals for mental health inpatient stay made by the NMUH Liaison team in June and July 2014 were included. Referrals were identified from the Liaison team patient database. Patients were identified on RiO and details of their admission were recorded.
Results:
The admission rate across the two months was 6.3%; 30 admissions out of 491 patients. An additional three recommendations for admission were not implemented. 14 (47%) admissions concerned patients being seen by the Home Treatment Team immediately before attendance.
Of the approved admissions, six (20%) lasted for less than a week. Only one episode lasted for a single day, after the patient self-discharged from an informal admission, against the recommendation of the inpatient team.
Discussion:
This data suggests no inappropriate admissions resulted from referrals made by the NMUH Liaison Team during this period. The findings are limited by the retrospective design and subsequent possibility of recording errors. It also uses length of stay as a proxy for appropriateness. Some inappropriate admissions may have lasted more than one or two days because inpatient teams wished to be certain about a patient's risk status, and barriers to keeping a patient in are sufficiently low to permit prolonged assessment.

**40. Integrating physical and mental health in maternity setting: impact of an obstetric psychiatric liaison clinic on crisis referrals to the general liaison psychiatric service**

**Dr Mythili Jayasundaram, Dr Maddalena Miele, Dr Pepe Catalan, Dr Edwina Williams**

Introduction. Gestational syndromes appear when maternal adaptation to pregnancy unmask latent diseases and pregnancy outcome predicts future maternal health (Smith et al, 2001 Lancet 357:2002-6); in a similar fashion maternal adaptation to pregnancy may unmask subclinical psychiatric presentations or precipitate mental illness de novo. Untreated mental illness is associated with an increased risk of obstetric complications and poorer psychiatric outcomes.

Clinical set up. A weekly obstetric psychiatric liaison clinic session (1PA) was set up in the maternity division of Chelsea & Westminster Hospital for 16 months. The clinic session was provided by an adult perinatal consultant psychiatrist who worked jointly with the Mental Health Lead Obstetrician and Midwife. Women at elevated risk of developing or suffering from a mental illness were referred to the clinic by the booking midwife, assessed and a management plan incorporating mental and physical needs was discussed and agreed in collaboration with the maternity team and the patient.

Data collection and results. The clinical data were collected manually by the consultant psychiatrist and compared with data from previous audits recording the activity related to referrals to the general liaison services requesting urgent psychiatric assessment and management of women under the care of the maternity division. The number of referrals received was 111, 70% engaged with the clinic; 11% were seen more than two times in the clinic, before being referred onto other local services or discharged to primary care. Depression accounted for 28% of the presentation, followed by anxiety (25%) and adjustment disorders (16%); 8% had a severe and enduring mental illness (Schizophrenia and BPAD). There was a considerable reduction in the number of urgent referrals for management of perinatal mental health needs to the general liaison psychiatric team and one elective admission to a MBU.

Conclusion Early identification and proactive management of psychological disturbances and psychiatric conditions in the perinatal period is likely to reduce the number of admissions to psychiatric units, result in better compliance with antenatal care, minimise the requests for elective C-section motivated by irrational fear of childbirth and promote the emotional and physical well-being of infants and children.
41. A Cross-Sectional Analysis of Depressive Symptoms in Palliative Care Inpatients

Dr Mas Mahady Mohamad, Ms Brid Davis, Dr Maeve Leonard, Dr Karen Ryan, Prof David Meagher

Introduction:
Depression is common in the palliative care setting, in both cancer and non-cancer patients. Despite being associated with a significant array of detrimental outcomes, depression remains under-recognised.

Aim:
To examine the frequency and severity of depressive symptoms in consecutive admissions to an inpatient palliative care unit using the Patient Health Questionnaire (PHQ-9).

Methods:
We measured depressive symptoms using the PHQ-9 in consecutive admissions to a specialist palliative care inpatient unit in Limerick, Ireland. The PHQ-9 is a brief 9-item tool designed to screen for depression according to Diagnostic and Statistical Manual of Mental Disorders (DSM-V) criteria.

Results:
We assessed 75 patients [55% male (n=41); mean age 68.6 ± 10.2 years, range: 43-88]. The majority (n=72; 96%) had a cancer diagnosis with almost a third (n=22) with gastrointestinal malignancy. Of the 71 who completed the PHQ-9, the mean total PHQ-9 scores were 10.01, with 45% (n=32) falling into the moderate and moderately-severe depressive illness categories. Three patients (4.2%) had scores indicative of severe depression. Palliative care patients scored particularly highly on the item for feeling tired, with 48% (n=34) describing low energy almost every day in the past two weeks. 89% (n=63) denied having any death wish or thoughts of self harm in the two weeks prior to assessment.

Conclusions:
Depressive symptoms are common in the palliative care setting with almost half of patients scoring moderate to severe depression on the PHQ-9. Longitudinal studies are required to clarify the relationship between depressive symptoms and possible confounding factors including fatigue, pain and delirium.

42. Supporting injured minds in the community - The Hounslow Pilot Clinical Service for Acquired Brain Injury

Dr Christoph Mueller, Dr Vanessa Raymont

AIMS AND HYPOTHESIS
To use qualitative research in the establishment of a traumatic brain injury (TBI) clinic to facilitate patient-centered, integrated long-term care.

BACKGROUND
Each year an estimated 1 million people attend hospital emergency departments in the UK following TBI. These patients frequently have a wide range of cognitive, psychiatric, behavioural and social problems. At present most TBI patients fall through the gaps of clinical mental health and neurological services: A&E, psychiatric liaison and medical teams find it difficult to arrange appropriate follow-up for this patient group.
METHODS & INTERVENTION
The novel Pilot Clinical Service for Acquired Brain Injury in Hounslow provides outpatient assessment, neuropsychological and psychiatric treatment, and nursing outreach to monitor the effectiveness of treatment plans.

A qualitative research project was initiated together with the clinic. Semi-structured interviews with up to 15 patients and carers are used as they allow exploring the perspective of a small group of patients and carers in detail and depth.

OUTCOME MEASURES
The principal research questions of the qualitative study are:

- How do patients with TBI and their carers experience current services in West London?
- What are their expectations of a new service specifically for patients with TBI?
- What are their wishes from an ideal service?

The results will be used to inform the development of the Pilot Clinical Service for Acquired Brain Injury in Hounslow as well as further service design. This qualitative pilot study will also generate findings useful in developing larger-scale quantitative research on TBI and TBI services.

CONCLUSIONS
Given the range of long-term needs after TBI, a specialised psychiatric and psychological community based service is ideally placed to address these multi-factorial problems. The novel service is truly cutting edge in the nature of its work and will be refined using qualitative research techniques.

43. Not Everything that Counts can be Counted: A Patients Recovery from Somatisation

Dr Foluke Odeyale, Dr Richard Arthur, Dr Itoro Udo, Dr A Gash

Aims: While quantitative data may be held to represent facts; narrative recounts of care may elucidate the quality of facts. We aimed to understand an individuals experience of treatment and factors that lead to recovery. Patient attended Liaison Outpatient Clinic for 8 months for medically unexplained hand tremors.

Methods: With patients consent, experience was gathered through interview with predetermined guide questions, at Liaison Outpatient Clinic, at point of discharge. Interview focused on the nature and severity of presenting illness; effects of symptoms on patients life; expectations at beginning of treatment; changes that had taken place; perceived effects of treatment; patients expectation for services and patients hopes for the future.

Results: Patient was extremely stressful, depressed, anxiety attacks had really bad tremors in my hands and in my neck. They have nearly gone, well they have goneEffects were irritable and bad tempered towards family, with no work or social life. Very apprehensive when I first came and then I could see where it was working and how it was affecting me.

Now, I can understand things better. I know whats happening and when its happening and I can deal with it better. And things don’t prey on my mind so much. I think its a thing between what we do here and the antidepressants and that they work together.

I think its just people who haven’t been involved don’t realise what can be done through having support (from a psychiatrist).
He talks of his future as rosy I hope and would definitely recommend the service to his family and friends.

Comments: Patient received complex pharmacological and psychotherapeutic interventions. Pharmacological was Escitalopram and Mirtazepine combination. Psychotherapeutic was integrative, involving Formulation Letter, Clinical Hypnosis for chronic pain, Eye Movement Desensitisation and Reprocessing for traumas of physical illnesses and Behavioural Activation.

44. Sorry, its a Taxi Number: Validity of Contact Numbers used in Liaison Service Delivery
Dr Foluke Odeyale, Dr Richard Arthur, Dr Itoro Udo

Aims: To find out if contact details in liaison patients treatment and care plans were accurate, up to date and valid and to find out if contact details used by staff on Liaison assessment packs were also accurate, up to date and valid

Methods: All phone numbers on standardised liaison patients treatment and care plans were rung up to check if they are accurate, valid and up to date. These were treatment and care plans for Stockton, Hartlepool, Easington /Peterlee/Durham localities. Assessment booklets/files used by staff were reviewed and contact phone numbers for services were also rung up. As at February 2014, all phone numbers had been checked and were accurate and valid at the time. Audit was carried out between 24th and 27th of Nov 2014.

Results: A total of 141 phone numbers were rung. 122 (87%) of contact numbers were still accurate, valid and up to date. Patients treatment and care plans had 3 non-valid numbers. Staff assessment packs had 16 non-valid numbers. Reasons for non-valid numbers included teams that had changed numbers; teams that had changed names.

Comments/conclusions: When teams change contact numbers, they should consider sharing such information trust wide and especially with teams they work closely with. Phone numbers used in delivering liaison services should be reviewed regularly, at least 3 monthly. A trust policy concerning the updating of contact information is necessary.

45. Improving Pathway for Frequent Attenders to an Emergency Department
Dr Foluke Odeyale, Dr Richard Arthur, Dr Itoro Udo, Mr Kayode Adeboye

This audit aimed to review care plans of all identified frequent attenders or complex patients against the best practice guidelines & recommend specific improvements to practice & pathway.

Identification processes & pathway for frequent attenders were reviewed; existence or not of care plans was noted; existing care plans were reviewed; frequent attenders supervision meetings were observed; Discussions were held with Liaison and A & E staff. Standards used were the Mental Health in Emergency Departments (2013) & Care of Frequent Attenders at Multiple Emergency Departments (2014) of the College of Emergency Medicine, UK.

All patients who are frequent attenders were identified (n=16) & had tracking cards on the visual board of Liaison Psychiatry. Of the 13 patients who had care plans; all care plans documented patients history, actions to be taken, relevant contacts; identified the involvement of liaison psychiatry with methods to limit harm to patient and staff involved in care of patients. On discussion with liaison staff; the availability of care plans has increased confidence in managing Frequent Attenders consistently.
especially out of hours. On discussion with A & E staff, availability of the care plans & easy access to liaison psychiatry has improved their management of Frequent Attenders. On observation & discussion with Liaison staff; care plans are consistently followed/referred to in management of frequent attenders. Areas that needed improvement: 3 patients (18%), of 16, had no care plans. Only 6 patients (33%) had frequent attender alerts on their A & E erecords. Of the 16 patients, only 3 patients (18%) had paper copies of their care plans in the A&E frequent attender file. 1 patient (6%) had both paper copy of plan and electronic documentation of alert. 8 patients (50%) had no records of their care plans being shared with other agencies. Various reasons were given for the shortfall observed e.g. non-agreement between liaison & community teams about management in A & E. Improved record keeping; Improved documentation & communication with all agencies involved would improve re-audit results. Challenges noted in the pathway were its resource intensive nature; integration of patient experience into the project & educational need for emergency staff especially on personality disorders.

46. Evaluation of a Core 24 Liaison Service at First Six Months
Dr Foluke Odeyale, Dr Itoro Udo, Dr Krishnana Mani, Dr Lorraine Ferrier

Aims: Increased investment from local Clinical Commissioning Group enabled the upgrading of a core psychiatry service (North Tees) to a Core 24 service in 2013. Performance over the first six months of operation (April to September 2013) is reviewed against agreed outcome measures.

Methods: Agreed outcome measures were response within timescales of 1 hour for A&E and 4 hours for wards; reduced length of hospital stay; increased number of people discharged to their usual place of residence; reductions of inappropriate/unnecessary admissions for self-harm; improved detection of dementia, delirium, depression.

Results:
Of 561 referrals, 501 (89.3%) were seen within an hour in A&E. Of 333 ward referrals, 258 (78.18%) were seen within 4 hours.

Length of stay pre and post April 2013 for wards commonly referring patients with suspected dementia were compared. A total of 166 referrals of persons > 65 years of age were received, with an average of 5.4 days reduction in hospital stay and a total of 896.4 days reduction, corresponding to savings of at least £192,726, at £215/bed per day.

For over 65s; 75% of patients admitted from their homes who received input from Liaison Psychiatry returned to their homes.

Compared to the previous year, out of 108 self-harm presentations, only 24 (22.22%) were admitted into hospital, a reduction of 33.75%. Patients with self-harm were 60.30% less likely to be admitted following establishment of the new service.

Probable dementia was detected in 230 patients, depression in 160, and delirium in 215 patients between April and September 2013 in both North and South Tees. There was an overall increase in the detection of dementia (5.4%), depression (14.81%) and delirium (91.30%) from quarter 1 to quarter 2 within the considered period.

Comments: Enhanced investment in liaison service appears to have delivered improved patient outcomes and cost savings.
**47. A retrospective Audit to investigate the reasons for young peoples choice of Treatment for PTSD in a generic CAMHS service**

**Dr Nnedimma Cynthia Okoro, Dr Elizabeth Procter**

NICE Guidelines for Post Traumatic Stress Disorder recommend that sufferers should be given information about effective treatments and their preferences taken into account. People should be allowed to reach informed decisions about their care.

All young people aged between 0 -18 who had been offered an assessment by the Trauma clinic between January 2012 and January 2015 were contacted by telephone and invited to participate. 57 young people suffering with PTSD had been offered an assessment appointment, but only 43 had attended and then opted for treatment. Of these 10 then did not attend appointments. 33 young people opted in. Treatments offered were Trauma focussed Cognitive Behavioural Therapy (TF-CBT), Eye Movement Desensitisation and Reprocessing (EMDR), or Childrens Accelerated Trauma Treatment (CATT). There were no significant differences in terms of the reason for their choice of therapy. 9% made their choice based on the gender of the therapist, a male therapist offered CBT and a female therapist EMDR or CATT. 85% felt their choice was best for them at the time; 3% stated choice of EMDR was based on recommendation by the referrer and another 3% stated the choice of CATT was because of its practical nature.

The most popular choice of therapy was CBT (49%) followed by EMDR (30%) and then CATT (21%). There were differences according to age. The average age of those choosing EMDR was 10.5 years, compared to 14 years for CATT and 15 years for CBT.

Females accounted for 73% of the sample and this was evenly reflected in the treatment choice. There was no significant difference between symptom reduction and choice of therapy, nor in the number of sessions required.

The responses indicate that there was no specific reason for the clients choice of therapy. CBT was mostly chosen by the clients followed by EMDR and then CATT. Some respondents provided positive feedback about the helpfulness of the staff in explaining the treatment options to them and allowing them to make their choice.

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**48. A Liaison psychiatry team triaging patients for admission to a ‘step down unit’**

**Dr Nilika Perera, Rachel Price, Dr Katheryn Hayden**

Introduction: The Later Life Liaison team has been gatekeeping admissions to a step down unit in our Trust. The unit has a combination of general and mental health nurses and aim to provide patients with complicated delirium a place to recuperate in a supportive and therapeutic environment following admission to the Acute Hospital. The unit also provides personal cantered discharge planning considering the patients physical and mental health risks and needs. The role for the Liaison team is to assess, identify and prioritise appropriate patients for the step down unit based on their function, current and discharge needs and risks. Reviewing the needs of the patients admitted to the step down unit help develop the service to provide quality care for the patients. Aim: 1. The review the comorbid mental health diagnosis of patients admitted to the unit 2. Review the liaison team aims at admission to the step down unit. Method: We reviewed the aims of admission and the pre-existing mental health diagnosis for patients triaged to be admitted to the step down unit in the months of December 2014-February 2015.
Results: 39 patients were triaged to be admitted within the three months. 19 patients had the capacity to decide regarding admission and 20 patients were admitted under the Mental Capacity Act. 17 patients had a diagnosis of dementia prior to admission. 5 patients had a diagnosis of depression, 1 patient had a diagnosis of paranoid schizophrenia and another of alcohol misuse. 24 patients were admitted to give time for the delirium to resolve. Of this 6 patients had behavioural difficulties. 13 patients were observed for a possible relapse or beginning of mental illness such as depression, anxiety or psychosis. 15 patients were admitted for detailed discharge planning. Conclusion: A significant cohort of patients admitted to the step down unit has a comorbid mental health diagnosis in addition to delirium. Mental health training and knowledge of the Mental Capacity Act are essential to managing patients in a step down unit.

49. Description of a CAMHS paediatric liaison service in a tertiary teaching hospital

Dr Nelli Preiss, Dr Anthony Crabb, Dr Sarah Nicholson

Aims. Evaluation of the service provided to patients, paediatric colleagues as well as compliance with the response time standards.

Background. CAMHS Paediatric Liaison (CAMHS-PL) bridges acute paediatrics and psychiatric and psychosocial care for the unwell child, their siblings and carers. It has been demonstrated that effective adult liaison psychiatry services save money and improves health; but studies on CAMHS-PL cost-effectiveness are missing. We describe a paediatric liaison service in a tertiary teaching hospital and reflect on the service evaluation.

Methods. Following data were collected on referrals to the Southampton Children's Hospital CAMHS-PL service: age, sex of children and young people, the paediatric specialty of referrers, presenting mental health concerns and response time in tax year 2013-2014. Basic descriptive statistical methods were used and anonymised feedback from referrers via an online survey was analysed.

Results. 339 referrals received by the team (excluding self harm), almost 95% were accepted. Records of 306 patients were looked at in detail. The age of referred children varied between 2 months and 17 years. 37% were seen on paediatric wards, 76% of which within 48 hours. Just over half of referrals for outpatient CAMHS-PL input were seen within 4 weeks. Most frequent referrers were General Paediatricians, Paediatric Gastroenterologists, Paediatric Orthopaedics and Paediatric Neurologists. 22% were seen due to concerns about anxiety and mood; 15% for somatic symptoms problems.

Qualitative feedback from paediatricians indicated general satisfaction with the different aspects of the service provided. Routine referrals were responded to longer than expected. UHS CAMHS-PL service appears to be valued by referring colleagues, especially in terms of the approachability, accessibility, prompt responses and willingness to support colleagues. Some areas for improvement were suggested.

Conclusions. CAMHS-PL provides prompt and valued service to children and young people admitted to paediatric wards at UHS. More resources to bring outpatient response time in line with the targets may be required. Economic evaluation of CAMHS-PL services similar to the Birmingham RAID study needed in demonstrating the cost benefit for these. More information about the CAMHS-PL service was requested by our paediatric colleagues.
50. Prevalence of Post Traumatic Stress Disorder (PTSD) in Firefighters, Factors Predicting its Development and the Benefit of Trauma Focused Psychological Treatment

Ms Lauren Rutter, Dr Tracey Vick, Dr Tayyeb Tahir, Dr Deborah Lancastle, Dr Bev John,

AIMS AND HYPOTHESIS: This study aimed to provide support for previous findings, that firefighters are at increased risk for PTSD and PTSD symptomology and provide evidence to shape future provision for firefighters. As prevalence rates in firefighters are higher than civilian samples, it was hypothesised this would be the case with this sample. Based on previous literature, it was hypothesised previous psychiatric history, gender, employment status, years of fire service and marital status would predict PTSD symptoms. It was also hypothesised firefighters diagnosed with PTSD who received trauma focused psychological treatment would have reduced PTSD symptoms. BACKGROUND: High risk occupational groups are exposed regularly to potentially traumatic events which could increase susceptibility to PTSD, suggesting occupational health units should identify exposure to stressful incidents. Additionally, high risk occupations may benefit from rapid psychological treatment (e.g. Kitchiner, 2002). A partnership between South Wales Fire and Rescue Service (SWFRS) and the Liaison Psychiatry department at University Hospital of Wales has taken this approach. METHODS: Participants (N=117) were SWFRS personnel referred to the Liaison Psychiatry department. A cross-sectional design was used with data routinely collected by the cognitive behavioural psychotherapist using a clinical diagnostic interview supplemented by self-report measures. A pre-test post-test design was used to assess the effect of therapy on PTSD symptoms. Predictors of PTSD symptoms were assessed using a correlational design. Five predictor variables were included (gender, previous psychiatric history, employment type, years in fire service and marital status). The criterion variable was probable PTSD symptoms assessed by the Impact of Event Scale-Revised (IES-R). RESULTS: Prevalence of PTSD was 18% using a clinical interview and 46% of participants met criteria for probable PTSD using the IES-R. Years of fire service was the only predictor of probable PTSD symptoms. There was a significant difference between probable PTSD symptoms pre and post trauma focused therapy. CONCLUSIONS: Findings showed prevalence of PTSD is high in firefighters. This study also found years of fire service was a predictor of probable PTSD symptoms. In addition trauma focused psychological treatment may be beneficial in reducing PTSD symptoms.

51. Diabetes mental health provision at the top of the pyramid of need- a service evaluation

Dr Amrit Sachar, Mrs Modupe Adu-White

It is well established that depression and anxiety is 2-3 times more prevalent in people with diabetes than their peers. There is a smaller evidence base for the prevalence of personality disorder and cognitive impairment and yet all of these conditions can significantly impair a person's ability to effectively self care for their long term condition. In north west london we found through an extensive integrated care programme, that 80% of the people being discussed in the complex case MDT discussions, had at least one mental health issue and that these were often too complex for IAPT but did not meet the criteria for secondary mental health services. The majority of them had poor self care and management of their diabetes. We won a grant for a 12 month pilot to target this group that was at the top of the pyramid of psychological need.
Methods
We set up a service to provide diagnosis, medication review, and cognitive analytic therapy which has an evidence base for eating disorder and personality disorder.
We set up the service to be responsive to the needs of the patient group and so offered appointments in the home, at the GP surgery or in the acute hospital as they desired in order to improve engagement.

Results
10 months into the pilot, we have found that there is a significant degree of impairment with 90% of our cohort having at least two mental health diagnoses and 20% having previously undetected cognitive impairment.
The average baseline PHQ9 was 18.5 (moderate depression) and the average GAD 7 was 11.5 (moderate anxiety). These reduced by an average of 3.5 and 3 respectively within three months.
The average baseline WSAS was 34 (significant work and social dysfunction).
The average baseline HbA1c was 98.9 mmol/mol (good control in diabetes).

52. Whole Person Care: Evaluation of an integrated COPD pathway
Ms Emma Shickle, Dr Vishaal Goel

Aims and Hypothesis
Poor symptom control and frequent ED attendance in some of those with COPD is driven by undiagnosed and untreated mental illness. We sought to evaluate the efficacy of an integrated COPD pathway after its first 6 months.

Background
50% of patients with COPD have anxiety and as many as 42% have depression. Many patients confuse symptoms of anxiety as an exacerbation of COPD. Utilisation of helpful behaviours often leads to deconditioning of their condition, further deterioration in mental health and worsening of prognosis. Healthcare costs are increased due to frequent ED attendances.

Method
The COPD team identified suitable patients by their symptom profile. These were seen in a liaison nurse-led clinic, with access to a consultant liaison psychiatrist. Each patient underwent psychiatric assessment. Interventions included psycho-education and CBT-based psychotherapy. Medication was utilised as appropriate. Patients were followed up, at home if necessary.

Symptoms were measured using a self-rated scale at the beginning and end of treatment. Average ED attendance frequency was also measured.

Results
16 patients seen - 15 completed treatment; 1 dropped out.
Average number of liaison contacts/patient 7.
Average length of contact: 60 minutes (assessment); 45 minutes (treatment).
Nature of contact: 8% Band 3; 23% Band 5 Therapist; 3% Occupational Therapist; 63% Band 7 Nurse Specialist; 3% Consultant.
Symptomatic change measured levels of self-confidence, symptom control, coping ability and overall symptom impact. The range was 0-40, where 0 = severe, uncontrolled symptoms and 40 = symptom-free.
Average total score pre-intervention: 13 (range 13-31)
Average total score post-intervention: 29 (range 20-40)
Clinical data indicated some patients reported less reliance on oxygen, nebulisers and inhalers.
Average ED attendance/month/patient pre-intervention: 0.32, which equals about 4 per year.
Average ED attendance/month/patient post-intervention: 0.1, just over 1 per year.

Conclusions
Psycho-education utilising a CBT approach from a skilled clinician most likely improves quality of life, reduces physical symptom burden, improves patient outcomes and reduces reliance on healthcare services such as acute hospital Emergency Departments. In fact, the level of impact is remarkable.

53. Prevalence of Depressive Disorder in Rheumatology Patients and Use of Emotional Thermometers as a Screening Tool

Mrs Natalie Swales, Prof Tayyeb Tahir, Dr Tracey Vick, Dr Deborah Lancastle, Dr Bev John

AIMS
The aim of this study was to determine the prevalence of depressive disorder in a rheumatology clinic and to investigate the validity of a visual screening tool called the Emotional Thermometers, that can be administered in 55 seconds, compared to validated screening tools for depressive disorder in this population that take up to 10 minutes to administer.

BACKGROUND
The interest in comorbid depressive disorder within the rheumatology population has been increasing, but little or no attention has been aimed at finding a suitable means of screening for comorbid depressive disorder in rheumatology clinics, this is despite much research that has found negative effects of comorbid depressive disorder on many aspects of the patients life, including rheumatic outcomes.

METHODS
All participants were initially screened using the PHQ-2. Those that were eligible were then issued with a full screening pack which included Patient Health Questionnaire- 9 (PHQ-9), Hospital Anxiety and Depression Scale (HADS) and 7 emotional thermometers to establish validity of the emotional thermometers using previously validated screening tools.

RESULTS
Of the 95 participants that completed all relevant screening tools the prevalence of depressive disorder was between 21.1% and 37.9% and prevalence of anxiety disorder was found to be 27.4%. At present the ability of the emotional thermometers to identify cases of depressive disorders was not high enough to use as a primary screening tool. It was also found that not all emotional thermometers may be necessary to identify depressive disorder, with only a few being predictive of validated screening tools scores and case/non-case status. However, it was found that the emotional thermometers may be a useful tool to identify anxiety disorders within the rheumatology population.

CONCLUSIONS
More research needs to be carried out to determine which emotional thermometers are most useful in identifying depressive disorder and how their ability to identify cases can be improved. But also the identification of depressive disorder in rheumatology needs to be addressed and patients treated to improve their future outcomes.
54. Survey of reliability of classification using Bristol Matrix
Lucy Bigham, Deepali Mahajan, Simon Amphlett, Lee Cook, Dr Tayyeb Tahir

Several referrals are received by the Department of Liaison Psychiatry from a very busy Emergency Department (ED). It is important to enhance the quality of the referrals for an appropriate response and follow up through the assessment and management pathway. Bristol Matrix has been recommended for use in the Mental Health Toolkit by the College of Emergency Medicine. The tool defines the urgency of assessment based on the colours: Red (within 4 hours), Amber (within 48 hours) and Green (no assessment by the psychiatric team).

AIM: The main aim was to assess the number of Amber colour coded referrals using Bristol Matrix. This was to try and identify patients known to the community mental health team (CMHT). Secondary aim was to assess the reliability of classification of psychiatric patients by the ED staff.

METHOD: The staff in ED were trained refer patients using Bristol matrix. The assessor then assessed the patients and provided the information on the appropriateness of the referrals following their assessments.

RESULTS: Eighty one referrals were received over the two months period. The ED staff classified 60 as Red, 19 Amber and 2 Green. These were assessed by the liaison psychiatry service who could reclassify Red to Either Green or Amber. Only 15, of all the 81 referrals, required either crisis team intervention or admission.

CONCLUSION: There is an increased need to enhance the quality of the referrals received so that the appropriate services can be provided to the ED.

55. Recovery from Somatoform Pain Disorder: A Patients Experience
Dr Itoro Udo, Dr Richard Arthur, Dr Amanda Gash

Aims: Patient experience, clinical effectiveness and patient safety have been identified as the cornerstones of good quality care. The details of the clinical management of this patient with Somatoform Pain Disorder was presented at last yearâ€™s conference. Here, we meet up with the patient, pain free for 19 months, at the time of interview in October 2014. Patients stories describing recovery from somatoform disorders are uncommon.

Methods: Patients experience was gathered through interview with predetermined questions sent ahead of meeting, held at patients home, at patients convenience.

Results: Patients responses, here, may be divided into 5 parts. In Part 1, patients experience of acute illness is described; Effects of illness on her family (Part 2); Experience of care from liaison psychiatry (Part 3); Suggestions for service provision for persons with chronic pain and a mental health condition (Part 4) and patients hopes for the future (Part 5).

In Part 1, a feeling of being dominated by illness is described. This was associated an emotional state of hypervigilance. In Part 2, the traumatic effects of illness on the whole family is described. Part 3 describes how liaison psychiatry helped in managing chronic somatoform pain. In Part 4, the need to identify and provide for mental health needs of persons experiencing chronic pain is stated. Part 5 demonstrates that recovery is possible and a fulfilling life can be forged from a traumatic past.
Comments: It appears that therapeutic rapport; feeling of unconditional support from mental health service, acceptable psychotherapy and effective medication management were pivotal to this particular patients recovery.

56. Occupational Mental Health - Firefighter Trauma
Ms Lauren Rutter, Prof Tayyeb Tahir, Dr Deborah Lancaster, Dr Tracey Vick

AIMS: This study aimed to provide support for previous findings, that due to firefighters frequent exposure to traumatic events they are at increased risk for PTSD and PTSD symptomology (e.g. Meyer et al, 2011). It aimed to provide evidence that could be used to shape future provision for firefighters.

BACKGROUND: High risk occupational groups are exposed regularly to potential traumatic events which could increase susceptibility to the development of PTSD. Therefore, occupational health teams should attempt to identify exposure to stressful incidents by these employees.

METHODS: A pre-test post-test design was used to assess the effect of therapy on PTSD symptoms in South Wales Fire and Rescue Service (SWFRS) personnel (N=117) that were referred to the Liaison Psychiatry department at Cardiff for Cognitive Behavioural Therapy (CBT). Routinely collected data included five predictor variables (gender, previous psychiatric history, employment type, years in fire service and marital status) and the criterion variable for PTSD symptoms using the Impact of Event Scale-Revised scores (IES-R).

RESULTS: A prevalence rate for PTSD identified was 18% using a structured clinical interview and 46% of participants met the criteria for probable PTSD using the self report clinical measure, IES-R. Years of fire service was the most powerful significant predictor of PTSD symptoms with a positive relationship. However employment status, previous psychiatric history, marital status and gender were not significant predictors of probable PTSD symptoms. There was a significant difference between probable PTSD symptoms pre and post trauma focused therapy.

CONCLUSIONS: These findings suggest that enhanced years of fire service may be predictive of PTSD and the greater the length of service the worse the PTSD symptoms. Psychological treatment appeared beneficial in reducing PTSD symptoms.

57. Who you gonna call? Improving referrals to a psychiatric liaison team
Dr James Soldan, Dr Shuo Zhang, Dr Isabel McMullen

BACKGROUND:
The liaison psychiatry service at King's College Hospital takes referrals from inpatient wards via an on-call bleep.

AIMS:
Monitor our inpatient referral activity
Improve the triage of referrals by clinical urgency
Support our referrers to make appropriate referrals

METHODS:
A three stage mixed methods project was undertaken in November:
Audit of electronic notes from a consecutive sample of accepted referrals, looking specifically at documentation of urgency
Audit of on-call bleep activity over a week
Group interview with bleep-holders on their experiences of holding the bleep and taking referrals

RESULTS:
In November, 72 referrals were accepted by the team. The documentation audit examined the notes of 20/72 in detail. In 10% of cases referral priority was not documented at all. In the remaining 90%, there was no clear reasoning to how cases were prioritised.
The bleep audit demonstrated that there was no pattern to the volume of calls. 74% of calls were requesting updates or required redirection to other specialist teams (e.g. substance misuse).
The qualitative data revealed that referral-takers had a clear idea of what constituted a good referral. Those judged as poor stemmed from the referrer being unclear about:
what we could offer
what they were asking for
the psychiatric or medical history

CONCLUSIONS:
On the basis of our findings, we have introduced the following:
Electronic referral form to structure the referral so that all relevant information is included. It also asks referrers to rate the urgency of the referral.
Training for referrers about what we offer and how to make good quality referrals
Training for our team on inter-professional communication to elicit relevant information from referrers, and how to prioritise referrals according to clinical need.
We aim to repeat the process in three months to monitor any change.

58. Adequacy of community care planning in patients with Emotionally Unstable Personality Disorder, borderline type
Dr Angeliki Zoumpouli, Dr Ranjith Gopinath

AIMS
We aimed to establish the level of adequacy of care planning in the community for patients with emotionally unstable personality disorder (EUPD), as well as whether the care plans were updated by the emergency department.

BACKGROUND
Patients with EUPD often present to Emergency Departments in crisis. Ready availability of care plans made by community teams will help ED clinicians manage patients more effectively.

METHODS
The standards against which the project was set were derived from the NICE guidelines for Borderline Personality Disorder: Assessment and management by Community mental health services.
We collected data of 44 patients with an established diagnosis of EUPD, who presented in the Emergency Department in two consecutive months. We searched Patient Journey System, the electronic patient record system of our trust to extract the data. In addition to the above, we assessed components of the care plan such as responsibilities and roles of team members, patient specific triggers of self-harm and self-management strategies.

RESULTS
Our results revealed that most of the patients had some care planning put in place (61%) and when available, the care plan did not always include all areas specified by NICE guidelines. More precisely:

1. 66.6% of the plans specified responsibilities and roles of team members
2. 63% of the plans specified patient-specific triggers of self-harm
3. 74% of the plans included self-management strategies
4. 81% of the plans included the service user

Liaison Department updated the majority of the care plans (77.7 %) of patients who presented in A &E department.

From the total of patients (including the ones who had care plan or not) 18% were admitted in psychiatric hospital (1 of which under section) and 15.9% were referred to HTT.

CONCLUSION
At least in some cases, adequate care planning might have prevented admission in hospital or crisis team involvement. This signifies the importance of community care planning as a preventative measure to crisis admissions of EUPD patients.
Places to eat & drink

Below is a selection of restaurants & bars, all are within walking distance of RCPsych.
For the most complete and up to date guide to restaurants and bars in London we recommend visiting Time Out London http://www.timeout.com/london

Aldgate/Aldgate East

**Cafe Spice Namaste** – 16 Prescot Street, London E1 8AZ
Right next door to the College, this Indian restaurant specialises in traditional dishes with a contemporary twist. Ingredients are local and seasonal.
www.cafespice.co.uk

**Commercial Tavern** - 142-144 Commercial Street, London E1 6NU
Victorian corner pub with small upstairs cocktail bar, large windows and eccentric decoration
http://www.timeout.com/london/bars-and-pubs/commercial-tavern

**Indo** – 133 Whitechapel Road, London, E1 1DT
Small pub with a bohemian feel. Offers all the usual drinks plus a wide selection of pizzas.
http://www.timeout.com/london/restaurants/indo

**Jamie’s Wine Bar** - 119-121 The Minories, London EC3N 1DR
Bar with comprehensive wine list featuring a selection from all over the world, together with beers, champagne, spirits and cocktails. Menu consisting of mainly British food also available.
http://www.jamiesbars.co.uk/index

**Kasturi** – 57 Aldgate High Street, London EC3N 1AL
Authentic and high quality regional Indian dishes with a focus on healthy eating.
http://www.kasturi-restaurant.co.uk/

**Lahore** - 2-10 Umberston Street, London E1 1PY
Lahore is one of the few restaurants in London which offer real authentic Pakistani cuisine.
http://www.lahore-kebabhouse.com/


**Miss Chu** – 91 Whitechapel High Street, London E1 7RA
Good quality Vietnamese street and cafe food.
http://www.misschu.co.uk/

**Oliver Conquest** - 70 Leman Street, London E1 8EU  
Warm, friendly pub & Gin House with a fantastic selection of over 200 Gins & Meantime beers on draught.  
https://twitter.com/oliverconquest

**Tayyabs** - 83-89 Fieldgate Street, London E1 1JU  
Much-loved Punjabi restaurant serving aromatic, spicy dishes in a no-frills, contemporary interior.  
http://www.tayyabs.co.uk/

**The Dispensary** – 19a Leman Street, London E1 8EN  
The Dispensary won the Campaign for Real Ale (CAMRA) ‘Pub of the Year – East London and City’ award in both 2014 and 2009. All of their produce is sourced daily from local Smithfield and Billingsgate markets.

Great pub food and à la carte fine dining menus are available – or you can simply savour the wide selection of real ale, fine wines and spirits.  
http://www.thedispensarylondon.co.uk/

**Whitechapel Art gallery** – 77-82 Whitechapel High St, London E1 7QX  
With new exhibitions opening on a regular basis as well as historic archives, dining room and bookshop, there’s always something new to see and entry is free.

**Liverpool Street/Shoreditch**

**Andina** - 1 Redchurch Street, London E2  
Peruvian Ceviche bar, street food, smoothies and cocktails in a trendy, South American-inspired setting.  
http://andinalondon.com/home

**Clove Club** – Shoreditch Town Hall, 380 Old Street, London EC1V 9LT  
The Clove Club is comprised of two rooms - in the restaurant, they serve an ambitious five course menu, featuring interesting and often overlooked British ingredients and produce. The bar is more lively, with the option to pop in for a drink, or stay for a full meal of dishes that are simpler than in the restaurant but of the same ethos.  
www.thecloveclub.com

**Crown & Shuttle** – 226 Shoreditch High Street, London E1 6PJ  
Pub specialising in craft ales. The food truck in the garden serves up a number of good pub food dishes.  
http://www.crownandshuttle.com/
Devonshire Square – London EC2M 4WQ
A beautiful courtyard with a variety of bars and restaurants including Devonshire Terrace and Cinnamon Kitchen.
http://www.devonshiresq.co.uk/

Drunken Monkey - 222 Shoreditch High Street, London E1 6PJ
Dim Sum is served all day and there's an a la carte menu in the evening. There's a happy hour every night.
http://www.thedrunkenmonkey.co.uk/

Heron Tower - 110 Bishopsgate, London EC2
This 755 ft tall (46 storeys) has enhanced the city's skyline. Heron Tower boasts three restaurants and bars: The Drift, Duck & Waffle and Sushi Samba. Advanced booking necessary – all of these restaurants can be fully booked months in advance.
http://www.herontower.com/restaurants

Spitalfields market - Commercial Street, London E1 6AA
You'll find a great choice of restaurants here including Carluccio’s, Leon, Canteen, Giraffe, Galvins, Spinanata & Co and Patisserie Valerie.
http://www.spitalfields.co.uk/

The Blues Kitchen, Shoreditch – 134-146 Curtain Road, Shoreditch, London EC2A 3AR
American style restaurant, bar and music venue.
http://www.theblueskitchen.com/

The Diner - 128-130 Curtain Road, London EC2A 3AQ
American style diner serving burgers, shakes and chilli cheese fries.
http://www.goodlifediner.com/locations/shoreditch

The Water Poet - 9-11 Folgate Street, London E1 6BX
Expansive pub with sofas, dining room, beer garden and basement cinema, plus bar and barbecue menus.
http://www.waterpoet.co.uk/
Tramshed – 32 Rivington Street, London EC2A 3LX
Chicken or steak to share in a disused tram shed with original tiling and beams with a Damien Hirst formaldehyde sculpture of a cow and a cockerel taking centre stage.
http://www.chickenandsteak.co.uk/

The City

1 Lombard Street – Lombard Street, London EC3V 9AA
The official residence of the Lord Mayor of the City of London and directly opposite the Bank of England, this Bar-Brasserie is a City Institution. One of the more expensive options on this list.
http://www.1lombardstreet.com/

Leadenhall market – Gracechurch Street, London EC3V 1LT
Offers a wide range of international restaurants, bars and cafes – from fine dining to traditional pubs. Options include Chamberlains’s fish restaurant, La Tasca, Pizza Express and The Lamb Tavern.

The Mercer – 34 Threadneedle Street, London EC2R 8AY
An old bank that has been converted into a British classic and contemporary food restaurant. Cheaper and more relaxed than some of the other City alternatives.
http://www.them Mercer.co.uk/

Borough

Borough market – 8 Southwark Street, London SE1 1TL
London’s most renowned food market, filled with trader stalls serving up gourmet options to suit all tastes. There’s also a number of pubs and bars surrounding the market.
http://www.boroughmarket.org.uk/

Royal Oak – 44 Tabard Street, London SE1 4JU
This Victorian corner pub has been lovingly restored to an authentic city beer house. Real Ale enthusiasts certainly regard this house as special, Cask Mild is a firm favourite.
http://www.harveys.org.uk/pubs-tenancies/find-our-beer/the-royal-oak-london

The Gladstone – 64 Lant Street, London SE1
Home to live music, Pieminister pies, and a great atmosphere. Cosy and welcoming, They have a bar downstairs (with free entry to gigs every Wednesday, Saturday and Sunday), and an upstairs lounge, perfect for dining and playing the variety of board games they have on offer.
http://www.thegladpub.com/
Tower Hill

Butler’s Wharf – Shad Thames, London SE1 2YE
Once the largest warehouse complex on the Thames, Butler’s Wharf is now home to a number of restaurants including Butler’s Wharf Chop House, Browns, Pizza Express and Cantina del Ponte.

St Katherine’s Dock
St Katharine Docks is proof that there are still hidden gems waiting to be discovered in modern-day London. Central London’s only marina, the docks are now home to a collection of high quality offices, restaurants, bars, shops and homes. Restaurant options include Ping Pong, Zizzi, The River Lounge, Tom’s Kitchen, Cafe Rouge.
http://www.skdocks.co.uk/
Courses that may be of interest to you .....  

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<thead>
<tr>
<th>Course</th>
<th>Date</th>
<th>Time</th>
<th>Type</th>
<th>Venue</th>
<th>CPD</th>
<th>Fee</th>
<th>Audience</th>
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<tbody>
<tr>
<td>Suicide Awareness training course: Revisiting skills in assessing risk &amp; helping people in crisis</td>
<td>Thursday 11 June 2015</td>
<td>09:30 - 16:30</td>
<td>Course</td>
<td>RCPsych, 21 Prescot Street, London E1 8BB</td>
<td>6 CPD  hours</td>
<td>£225 standard, £112.50 discounted</td>
<td>Psychiatrists including Foundation doctors</td>
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<tr>
<td>Autistic Spectrum Disorders - CPD Update course</td>
<td>Thursday 18 June 2015</td>
<td>09:00 – 16:30</td>
<td>Course</td>
<td>RCPsych, 21 Prescot Street, London E1 8BB</td>
<td>6 hours</td>
<td>£150</td>
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<td><strong>Date</strong></td>
<td>Thursday 15 October 2015</td>
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<td><strong>Audience</strong></td>
<td>Psychiatrists, Nurses, and other professions who are members of a multi disciplinary team.</td>
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<tr>
<th><strong>Working with Long Term Physical Illness &amp; Medically Unexplained Symptoms</strong></th>
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<td>Using the five areas assessment CBT model to help patients improve</td>
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<th><strong>Date</strong></th>
<th>Tuesday 24 November 2015</th>
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<tr>
<td><strong>Time</strong></td>
<td>09:00 - 16:30</td>
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<td><strong>Type</strong></td>
<td>Course</td>
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<tr>
<td><strong>Venue</strong></td>
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<tr>
<td><strong>CPD</strong></td>
<td>6 CPD hours</td>
</tr>
<tr>
<td><strong>Fee</strong></td>
<td><strong>£225 standard, £112.50 discounted</strong></td>
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<tr>
<td><strong>Audience</strong></td>
<td>The day will be relevant to all clinicians who work with patients who have prolonged physical illnesses and medically unexplained symptoms, for example, GPs, Psychiatrists, Psychologists, Nurses, Occupational Therapists, and Physiotherapists</td>
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In house training

**Suicide Response Training**
Called ‘Connecting with People’, this one day course is designed to reduce stigma, increase empathy and enhance participants’ skills of assessing and responding to people with suicidal thoughts in a compassionate way. It promotes collaborative care using the concept of suicide mitigation and improves the ability to conduct an effective assessment and instigate a safe, clinically appropriate management plan.

**This course aims to:**
- Support Specialist NHS Teams
- Increase the transparency of assessing people with suicidal thoughts using tools which promote a collaborative assessment and response to identified suicide risk, as recommended in the Department of Health National Risk Management Programme ‘Best practice in managing risk’, DoH 2007
- Promote realistic ways for dealing with very distressed suicidal individuals in a busy morning clinic/ward setting/ home visit
- Develop simple strategies for instillation of hope and co-creation of ‘safety plans’

**Who should attend:**
- Psychiatrists
- Specialist Mental Health Teams

**Course Fee:** £3,900.00 plus VAT for up to 30 delegates. This includes speaker fees, travel and all course materials.

**Maximum group size:** 30 delegates.

**Timings**
- 9.30am Registration
- 10.00am Welcome
- 5.00pm Close

**Accreditation**
These courses are eligible for 6 CPD hours subject to your peer group approval.

For more information and enquiries please contact Emma George on 020 3701 2611 or egeorge@rcpsych.ac.uk

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**Suicide Awareness – Train the Trainer**
This one day Train the Trainer session develops capability to deliver the ‘Connecting with People’ 2 hour Suicide Awareness Training for General Hospital professionals and aims to maximise its take up and impact. Delegates will be taught enhanced presentation and facilitation skills and will have the opportunity to practice them in a supportive environment.

The ‘Connecting with People’ Suicide Awareness Training aims to reduce stigma, increase empathy and understanding and enhance skills. It is particularly suitable for the Emergency Department (A&E), medical and nursing professionals, F1 and F2 doctors, medical and nursing students.

**This course is a valuable career development opportunity:**
- Meets the need for concise, clinically based training on suicide and self harm for busy General Hospital and Emergency Department professionals
- Helps to create a common language between organisations and community groups, to ensure support, both for people experiencing suicidal thoughts and those assisting them and encourage more joined up working between services
- Improves the consistency of response at the point at which people are requesting help
- Builds local capability to deliver training on site, needing less time for staff to be released from front line duties, thus providing sustainable, greener, lower cost training to people who would not normally attend

**Who should attend:**
Experienced practitioners with relevant experience including a good understanding of the General Hospital and Emergency Department, credibility to deliver the suicide awareness session and the potential to have excellent facilitation skills.

**Course Fee:** £3,900.00 plus VAT for up to 16 delegates. This includes speaker fees, travel and all course materials.

**Maximum group size:** 16 delegates.

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Please visit [http://rcpsych.ac.uk/traininpsychiatry/conferencestraining/courses.aspx](http://rcpsych.ac.uk/traininpsychiatry/conferencestraining/courses.aspx) for further information