

## Liaison News

### The Newsletter of the Faculty of Liaison Psychiatry September 2007

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## **Editors Comment**

Welcome to your September edition of the bi-annual Faculty newsletter. It's a truth that you never quite appreciate the work that goes into something until you have to do it yourself – Thanks to Paul for all his hard work in producing the newsletter whilst in the Hon. Sec. post. I have a lot to live upto! In this my first attempt, I've tried to pull together what will hopefully be regular sections which will be added to by feature articles. Did try to get "news" style format and hoped to add some pictures / animation for interest but couldn't quite get the software to do what I wanted - maybe next time!

This is your newsletter and can be whatever you want it to be but it does rely on CONTRIBUTIONS AND FEEDBACK!  
PLEASE contact me with any suggestions, articles, pictures, of any sort (remember publishable by the college please....)

Mel

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### **1. Chairs Report – Prof Else Guthrie**

The faculty continues to thrive despite difficult times in the NHS in some areas. Liaison Psychiatry still seems to be expanding in some areas, whilst in other areas there remains the threat of reductions in service delivery.

The Faculty held its research strategy in June this year and has three main aims for the forthcoming year. First, the database survey is nearing completion and the data should be available by Christmas 2007. Amit Malik and colleagues have carried out a large survey of liaison services in England to establish an accurate picture of the nature of liaison services across the country. Second, as with all Faculties in the College, the Liaison Faculty is having to develop an educational infrastructure to deal with the changes in postgraduate training. Third, the Liaison Faculty has been in dialogue with the Department of Health to lobby for the development of a Tariff for Psychological Services in the General Hospital, in relation to Payment by Results. This work is ongoing.

The Faculty Annual Residential Meeting in March this year was a great success, with a high calibre programme and a large attendance. Mathew Hotopf has been a fantastic Academic Secretary and our next meeting in Newcastle will be his last. I would like to thank Mathew for his hard work on behalf of the Faculty.

Finally I would like to thank Gill Gibbins, our college administrator, for her support and kindness over many years. She is a meticulous and dedicated professional who has made a significant contribution to the Faculty and will be greatly missed. Gill is leaving the college at Christmas and we all wish her success and happiness in her new life.

Else

## **2. Finance Officer's Report – Peter Aitken**

### **What went wrong in Liverpool and right in Amsterdam?**

I'm not sure which was the greater shock, my realisation that I'd agreed to stand as finance officer, or the state of the faculties finances when first introduced to me. Can I express my gratitude to Max Henderson for holding the reins between George Ikkos moving on to be college finance officer and my election in July this year and thank you for electing me.

The role of finance officer is worth reviewing. The Royal College of Psychiatrists, as a registered charity, is bound by its charter to restrict its activities to its predefined role, to advance the science and practice of psychiatry and related subjects, to further public education therein and to promote study and research work in psychiatry and all sciences and disciplines connected with the understanding and treatment of mental disorder in all its forms and aspects and related subjects and publish the results of all such study and research.

Anything that the college does outside these objects would be invalid and would not be recognised. It is part of the role of the finance officer to make sure that any spend on faculty business is within this frame of reference. The remainder is to ensure effective business planning and advise the executive on the financial risks associated with proposed faculty business.

Good news first. We are recovering our financial position and the Amsterdam conference looks to be generating in the region of £8000. Well done Matthew Hotopf and the team for providing an excellent conference both in academic and financial terms. We should have enough income from Amsterdam to service the running of the faculty in balance for the remainder of the year. This needs to be our model for this year's residential meeting in the North East, and this summer sees the start of the business planning process we need to increase the wealth of the faculty and enable us to return to providing the prizes and bursaries we want to encourage students in the subject of our passion.

So what happened in 2006? Max Henderson and I have both looked at this in some detail and we must recognise the patience and support of Jimmy Tse and the Finance Team at the college who have helped us see that we earned too little and spent too much. We cannot afford to let this happen again. We earned too little because we planned to take £4000 in sponsorship and then changed our mind about accepting pharmaceutical sponsorship. We spent too much on 'social events', £4412 against a planned budget of £360. We spent £2000 more on audiovisual equipment than we had budgeted and nearly £1000 more on venue. Of concern, even if we had met our planned budget, we would only have generated £517 for the year ahead. That would have made little impact on our requirement to support the college development fund, a cost to the faculty of around £4000 in 2006, or run the faculty, a cost of a further £4000.

Looking around at other faculties and other interest groups has been useful. If we can manage the cost of the venue and the facilities and generate acceptable sponsorship partnerships within the values and objectives of the college and retain a high value academic programme, the money should flow in rather than out.

So my recommendation to the faculty through the elected executive is simply this. We need to debate and determine the value of our conference venue and facilities and decide which forms of sponsorship we will accept. The academic programme will have to be the best in the UK & Europe for Liaison Psychiatry and Psychological Medicine. (No pressure there then Mathew.....Ed)

Peter

### **3. Feedback from the Executive Committee & Regional Focus – Mel Temple**

The aim of this section is to provide feedback to the faculty members from the exec meetings, to give people a feel of what the exec has been up to and key issues in the go. On this occasion they have been well covered by articles within the newsletter and didn't leave me with much more to say!

Alongside the exec feedback I thought it would be good to get feedback from different regions to fill people in on activity in different parts of the country. On this occasion we are focusing on Yorkshire with information provided from our rep for the area – Peter Trigwell. Next time Amanda Gash will feedback for the Northern Region.

#### **Liaison Psychiatry in the Yorkshire Region**

The scope of the Yorkshire RCPsych Region has recently been clarified, with eight Trusts / Centres being named as existing within the Region. The latest information regarding the state of Liaison Psychiatry in each of these Centres is detailed below.

##### **Leeds**

- The largest Centre in the Region, with 6 Consultants in Liaison Psychiatry (4.8 WTE), including the Old Age Liaison Psychiatry element.
- Current developments include:
  - Increased A&E Mental Health Nurse coverage (via additional income secured from the Reforming Emergency Care Group).
  - The formation of a NICE SH Guidance Implementation Group, as part of the ongoing outline business case to expand the service.
  - The establishment of CFS CNCC and 3 MDTs (including additional 3 sessions of Consultant LP time plus 1.0 WTE LP Ed. Staff Grade post).
  - Development of Old Age LP MDT, including MH nurse, OT and SHO.
  - Work to evaluate need / demand for LP within some of the peripheral general hospitals for which there is currently no LP resource, as part of a move to provide new services.
- There is a possibility that funding for a further half-time Consultant may become available during 2005.
- We are hopeful that the work regarding peripheral hospital services may also lead to increased Consultant sessions.

##### **York**

- Still no dedicated Liaison Psychiatry Consultant / service.
- Two Consultants with some psycho-oncology sessions (recent appointment of Dr. Liz Elsworth with two sessions).
- Dr Paul Blenkiron is Consultant who acts as “Lead for self-harm policies” but without specific Liaison Psychiatry sessions.
- Due to appoint Mental Health Nurses to work in A&E very soon.

- Substance Abuse Nurse at York District Hospital also soon to be appointed.
- Both Acute Trust and PCT say that they want an organised Liaison Psychiatry service, “but for the other to pay”.

### **Harrogate**

- No Liaison Psychiatry Consultant sessions as such.
- A&E Mental Health Liaison Nurse post only.

### **Wakefield**

- Still no dedicated Liaison Psychiatry Consultant time for either general hospital.
- Nurse-led self-harm service, requesting back-up from Consultants on an ad-hoc basis according to the Sector within which the patient resides.
- Dr. Clive Cruickshank continues to provide a consultation service into Pinderfields General Hospital, but with absolutely no sessional time specifically scheduled for that role.

### **Hull**

- Currently 3 Consultants in Liaison Psychiatry (2.0 WTE).
- Service development in Liaison Psychiatry service in Hull over the past few years:
  - Specific CFS service, including 0.6 WTE Consultant in LP.
  - A&E Mental Health Team now has 4.1 WTE workers, working extended hours Monday to Friday including providing short-term interventions.
  - Increased input from Liaison Psychiatry service to the Self-harm Team.
  - Expanded ICU work.
  - Third year medical students to begin to be attached to the service next year.
  - The service has moved into a new modular building at Hull Royal Infirmary.

### **Hambleton and Richmond**

- Current bid for a self-harm nurse.
- One Consultant Old Age Psychiatrist provides 1 PA of OA liaison time, along with psychology input and full-time nurse.

### **Bradford and Airedale**

- No Liaison Psychiatry Consultant sessions as such.
- Urgent calls: on-call team / Consultant
- Non-urgent calls: sector team / Consultant
- Bradford A&E = 4 MH nurses, Airedale A&E = Multidisciplinary MH team, but all due to be ‘reconfigured’ with introduction of the Crisis Resolution Service.

### **Scarborough and Ryedale**

- No Liaison Psychiatry Consultant sessions as such.
- ? local interest (recent enquiry not responded to).

### **Mentoring System for Consultants in Liaison Psychiatry**

The Yorkshire Region has 6 Consultants in Liaison Psychiatry currently agreeing to act as mentors for new Consultants, as per the RCPsych mentoring system.

### **Dr. Peter Trigwell**

RCPsych Regional Representative for Liaison Psychiatry (Yorkshire)

#### **4. TNC Report – Max Henderson**

The Trainees and New Consultants (TNC) group held their AGM at the faculty residential meeting in Amsterdam and 14 March 2007. The meeting was attended by 37 members. This was a relief as even a few days before the meeting we were worried that we might not even reach double figures! It is possible that TNC members are not registering as such. It would greatly assist the organisation of the TNC if we were able to get a more accurate picture of who will be attending. We will be asking about people's plans to attend the Newcastle meeting via TNC Jiscmail. If there are any TNC members who are not signed up please let me know.

The finances of both the faculty and the TNC were discussed and the current difficulties of the faculty explained. There are unlikely to be subsidised places for trainees at the next faculty meeting. The TNC, however, is in a slightly more comfortable position, although some promised monies from the Leicester meeting were still outstanding. There was a short discussion about the role of industry sponsorship although this issue had been comprehensively discussed and settled in Leicester.

The next annual TNC meeting will be held in Bristol on the 9<sup>th</sup> and 10<sup>th</sup> of November. There was a lively discussion about the content and format of the meeting. Several member expressed a wish for an emphasis on disease- or system-specific topics rather than presentations about the *concept* of medically unexplained symptoms. These ideas have been taken on board.

The MMC and selection of junior doctors debacle was discussed although didn't appear to impact directly on any of the members present. At the other end of the scale, congratulations were extended to Bill Cutter who has been appointed to a split General Adult / Liaison post in Portsmouth. At the time of the meeting a part-time post was due to be interviewed for in Bristol – Johanna Herrod has since been appointed. Viv Mak has a part-time Old Age Liaison post at St Thomas's and Susie Waddington has a similar post in Leeds.

Alex Mitchell stood down as chair of the TNC after a very successful term of office and was warmly thanked. Alex has made a huge contribution to the group both in and out of office. The TNC is much stronger for his involvement and the meeting he organised in Leicester was both very high quality and great fun. Max Henderson, all too aware of the shoes he has to fill, stepped up from secretary to chair. Only one nomination for secretary was received and as such Thirza Pieters from Cambridge was elected unopposed. Adrian Flynn continues as TNC finance officer.

The meeting was closed and we moved onto dinner. That, however, is another story..... (and not one to be repeated – I'm sure all present and their wallets would agree. Ed.)

## 5. Research, Continuing Professional Development and Training Issues

- **New Research in Liaison Psychiatry and Psychological Medicine Autumn 2007**  
**Alex Mitchell**

Relieved from his duties as the chair of TNC, Alex has very kindly agreed to provide a round-up of interesting research articles for the newsletters to help out those of us less well read!

Type	Authors	Title
Editorial	Giovanni Fava, & Thomas n. Wise Am J Psychiatry 164:7, July 2007	Issues for DSM-V: Psychological Factors Affecting Either Identified or Feared Medical Conditions: A Solution for Somatoform Disorders
<b>Comment:</b> The authors propose a change the category somatoform disorders into “psychological factors affecting either identified or feared medical conditions” for DSMV. By expanding medical conditions to both “identified” and “feared,” they propose to use clinical phenotypes regardless of the functional/organic dichotomy or axis I or II co-morbidity. It remains to be seen whether this proposal will be accepted or indeed prove useful.		
Primary Study	Feldman et al. Lancet Neurol 2007; 6: 501–12	Effect of rivastigmine on delay to diagnosis of disease from mild cognitive impairment: the InDDEx study
<b>Comment:</b> There is great interest in attempting to slow progression of cognitive decline from MCI. In this intensive study there was no demonstrable benefit of rivastigmine on slowing the progression rate to AD or on cognitive function over 4 years. However, the overall rate of progression from MCI to AD was much less than expected which might explain the negative result.		
Narrative Review	Sechi G & Serra A. Lancet Neurol 2007; 6: 442–55	LN (2007) - Wernicke's encephalopathy- new clinical settings and recent advances in diagnosis and management
<b>Comment:</b> This is an excellent review of an overlooked but clinically relevant area. According to autopsy-based studies, the disorder is still greatly under-diagnosed in both adults and children. This is a good primer on this condition, relevant to everyday practice.		
Primary Data RCT	Alistair Burns et al. J Am Geriatr Soc 55:75–80, 2007.	Treatment and Prevention of Depression After Surgery for Hip Fracture in Older People: Randomized, Controlled Trials
<b>Comment:</b> In this unusual design of two linked RCTs of prevention and treatment of depression after hip replacement, there were no statistically significant benefits achieved from a psychiatric intervention in people who are depressed or a psychological intervention to prevent the onset of depression. This should be read in context of a series of depression prevention attempts in stroke, macular degeneration and other disorders.		

Systematic Review	Wayne Katon, et al. General Hospital Psychiatry 29 (2007) 147–155	The association of depression and anxiety with medical symptom burden in patients with chronic medical illness
<p><b>Comment:</b> Thirty-one studies involving 16,922 patients were included in this systematic review. Across the four categories of common medical disorders examined (diabetes, pulmonary disease, heart disease, arthritis), somatic symptoms were at least as strongly associated with depression and anxiety as were objective physiologic measures. Two treatment studies also showed that improvement in depression outcome was associated with decreased somatic symptoms without improvement in physiologic measures</p>		
RCT	Marianne Rosendal et al. General Hospital Psychiatry 29 (2007) 364–373	A randomized controlled trial of brief training in the assessment and treatment of somatization in primary care: effects on patient outcome
<p><b>Comment:</b> The aim was to evaluate the effect of an educational program designed to improve care for somatizing patients in primary care using a cluster randomized controlled trial in a large sample of over 500 individuals followed to 12 months. Although self-reported health improved in both intervention and control groups there was no difference between the control group and the intervention group with regard to our primary outcomes. Disappointingly training of primary care physicians showed no appreciable benefit.</p>		

- **Training for Liaison Psychiatrists and colleagues with the potential for much more..... [Liaisonpsychiatry.org](http://Liaisonpsychiatry.org)  
Ian Rogerson, Melanie Temple & Damien Longson**

Sometimes there's more to life and more to Liaison Psychiatry than the NHS and RCPsych. Heretic me? Well I'm not the only one that thinks this way. Sometimes there may be information we might wish to share that isn't appropriate to be loaded up on the RCPsych web site as this has to represent the college. One day in the future there may be 'plurality of services' and we might need to advertise our services individually or as groups. We might want a shop window for commissioners or to provide information for patients on how to access services or consultants, both through the NHS and privately.

We have the email discussion lists to share information, but these are limited to members only and storage of documents etc is limited.

To fill this gap, a few radicals have decided to set up a website **[liaisonpsychiatry.org](http://liaisonpsychiatry.org)** which in time we might develop in a number of ways. At the moment we have used it as an access forum for training but are very much open to suggestions and open for content. We will also upload the newsletter. If you'd like to contribute then visit and add your ideas.

The uploaded training package is on the business and management front of things. Developed from the three training days held over the last year, topics include the new NHS, FT, PBR, business cases and social enterprise. There are PDF downloadable

files of each of the areas and links to all the relevant documents, examples of business cases etc. A lot of time and effort has gone into the content of this and we would like to express our thanks to those who kindly allowed their information to be used and for Damien for the uploading and web – conversion of the files. Please trial it and feedback!

- **Liaison Curriculum - Faculty training matters**

During the past year or so, the college has recognised the importance of giving the faculties a larger role in training matters. Every faculty now has its own Faculty Education & Curriculum Committee. I have been given the honour of chairing the Liaison Committee.

We have been asked, alongside the other faculties, by the Dean, Dinesh Bhugra, to assist in rewriting the curriculum, with particular emphasis on liaison aspects. This is work in progress, and it is likely that we will be asking members for their opinions. In fact, any help will be gratefully accepted!

The work is in its early stages, and more news about it will appear in subsequent newsletters.

Paul Gill  
July 2007.

## **6. Feature Articles**

- **Emergency Care Tsar and DoH Commission report on Mental Health  
Developing the case for Liaison Psychiatry in A&E and the acute hospital.**  
**Paul Gill**

Over the last couple of years there has been considerable pessimism around the UK regarding the future of Liaison Psychiatry services. High profile service cuts, and threats of cuts to other liaison services, have served to heighten this gloomy mood.

There are concerns that future funding mechanisms within the NHS will fail to pay for the work that we do, and that in the new world of payment by results (PBR) nobody will want to pay for our services, and therefore there will be no more Liaison Psychiatry.

To counterbalance this gloomy mood, there have been growing signs that influential voices in the Department of Health, and senior Health Service managers, are becoming increasingly concerned that liaison services should not only be preserved, but developed. Various faculty members, led by Mel Temple and Else Guthrie, have done sterling work to prepare the ground for a pilot project to develop a tariff, under PBR, for the work that we do. This work is described elsewhere in this newsletter. Alongside this work, and associated with it, is a developing piece of work between our college, other Royal Colleges, and the Department of Health.

Last year, the Emergency Care Tsar, Sir George Alberti, wrote to the President, Sheila Hollins, to express his concerns about the input of mental health services to A&E departments, and asking for a meeting. Sheila Hollins requested that the faculty be involved, and therefore I attended the meeting. Sir George made it clear that he

wishes to look for ways in which mental health service input to both A&E departments and acute wards can be improved. Following this meeting I wrote a briefing paper, with the assistance of other members of the faculty and other faculties within the college. This paper was presented to a further meeting which included Sir George, others from the DoH, and senior members of our college, as well as the colleges of physicians and emergency medicine. This meeting was unanimous in agreeing that the way forward is to develop a national case for Liaison Psychiatry as an essential component of acute hospital services. A scoping group has been set up, under the chairmanship of Sir George, with the intention of developing a case to be presented to the DoH this autumn. There will be input from a number of Royal Colleges, including the RCN, and from service users. The intention is to develop recommendations regarding:

- Commissioning standards for liaison services.
- The development of a tariff, under PBR, for liaison services.
- The development of liaison services having the principle responsibility for input to A&E departments and acute wards throughout the NHS.
- The development of liaison services across the age range.
- Recognition of the importance of the training provided by liaison services.

There is no guarantee that this endeavour will be successful, but it is clear that there has been a change in the perception of the importance of liaison services within senior health service circle, and this is very encouraging.

In the meantime, any suggestions/advice/help would be much appreciated.

Paul Gill  
July 2007.

• **Deprofessionalisation, demoralisation and detachment in psychiatric settings**  
**Prof Bhugra**

If anything that has become clear from the recent MTAS fiasco, it is that the profession as a whole was led up the garden path by the people who were in charge of implementing the policy. Whether it was a cynical and deliberate ploy of epic proportions or a simple human frailty or a straightforward reflection of NHS relations and experience of Information Technology is unclear. The consequences of the fiasco are too well known to be described here and consequences are still reverberating. However, out of chaos comes order. It is possible that if the profession is allowed to take control it will lead to a degree of stability and future sensible development.

The deprofessionalisation of medicine started a few years ago when it became evident in the wake of series of scandals such as the Bristol Heart, Alder Hay, Shipman and Kerr/Haslam, that self regulation had failed to work and the medical establishment was perceived as self-serving. The doctors were seen as looking after their own and not their patients' needs. Combined with changes in public and patient expectations from the health services, increased globalisation, changes in knowledge and with massive movement of people and ideas around the globe, meant that the delivery of health services had to change. The MTAS fiasco is a prime opportunity for the profession to grab hold of professionalism by defining it clearly in the context of the 21<sup>st</sup> century and show the powers that be that we can indeed change things and do better.

The old professionalism which relied on characteristics of mastery, autonomy, privilege and self regulation within which mastery suggested control authority, power and superiority had to respond to the changing cultural shift and political context. The changes in social expectations and with the National Health Service flexing its muscles as a monopoly employer able to dictate what kind of doctors and how many it would require mean that privilege and mastery as concepts have become outmoded. Self regulation, a core of the principles of professionalism, was knocked on the head by various scandals. The 'new' professionalism sees itself as a set of values, behaviours and relationships that underpin the trust the public has in doctors.

The relationship with the patients is the core of what we as doctors do, even when doctors (such as some pathologists) do not see any patients. The components of new professionalism include leadership, teams, education, appraisal, careers and research. Leadership involves vision, strategic thinking, empowerment, motivation, trust, team-working and other functions. The question remains whether doctors will be given the leadership (not likely) or whether we have to grab it. The latter raises questions about the team-working and how leaders evolve and lead. Well functioning teams rely on leadership, not on worrying about the discipline of the leader. Liaison Psychiatrists work across medical disciplines and are in a very strong position to demonstrate their strengths in identifying professionalism.

The time is ripe to grab the initiative from the civil servants and politicians; to be absolutely clear about what psychiatry and psychiatrists can do and what we should not be in the field for. We should not be in the business of medicalising human emotions and distress and offering medical treatment for every condition under the sun.

We must ensure that we use our biopsychosocial models with very clear understanding of what we can and what we cannot do. We have to determine what our unique selling point is and what we need to do to maintain that. The focus on improving clinical services must be our first priority. This is the core of our professional activity and must be at the heart of our professionalism. Forging alliances with patients and families, public and voluntary agencies can only strengthen our cause. These relationships can allow us to take key stakeholders with us and create a new way of looking at the psychiatric services, health care delivery and at the same time continuing to aspire to achieve the highest possible standards. It is important that we challenge the powers that be to hand over the professionalism back to the professionals. The College is organising a series of meetings to explore this agenda later this year and early next year. I look forward to hearing from you with your thoughts, views and comments as to how to move this agenda forward.

Professor Dinesh Bhugra  
Dean, Royal College of Psychiatrists

These are personal views and do not necessarily reflect the College's views.

- **Funding of Services – News from Scotland & Wales**

A lot of the college and faculty press has centred around PBR and its impact which of course is only relevant to England, a fact sharply brought into focus to the Editor by running a workshop at the College Annual Meeting in Edinburgh. With this in mind it was felt to be useful to get updates from other areas of the country to complete the picture and are grateful to Dr [redacted] for his update on the situation in Edinburgh and the Tayeb Tahir for that in Wales.

- **Funding of Psychological Medicine at the Royal Infirmary of Edinburgh**

There is no consistent model of funding for Liaison Psychiatry services across the UK. The funding for Liaison Psychiatry within the Royal Infirmary of Edinburgh (RIE) has developed over the last 15 years in an evolutionary fashion, and in response to increasing medical need for psychiatric opinions and input.

Liaison Psychiatry within the Royal Infirmary of Edinburgh is provided by the Department of Psychological Medicine (DPM). In the early 90's this was a single practitioner service manned by Dr George Masterton. At that time 'priority service units' were being developed as an interim step to the formation of trusts.

Initially it was decided to place the DPM within the psychiatric priority service unit. Under this management system, while General Adult Psychiatry and Child and Adolescent Psychiatry were considered as discreet services, Liaison Psychiatry was bracketed with substance use, psychotherapy and forensic psychiatry as 'special services'.

Over time, two problems became apparent with these management and funding arrangements. Firstly, while day-to-day clinical management was via the medical clinical director on the RIE site, operational management was via another individual within the psychiatric service, based on a different site, who was inevitably less aware of the service's needs and problems. Secondly, problems arose when it came to planning and funding services under this model. Liaison Psychiatry did not provide any services visibly and directly to other psychiatric units, and therefore had less obvious priority for funding.

At about this time the opportunity came for the DPM to join the developing medical directorate with the RIE and this step was taken in 1994. On the instigation of trusts, funding for the DPM therefore came from within the acute medical budget. Subsequent expansion came as a result of increased medical demand for services leading to funding for a second consultant post in 1996, through the Trust Improvement Program.

Since then, DPM service developments have continued to be driven by medical demand for psychiatric input. While all units within the RIE can (and do) request consultation services for specific patients, funded by baseline unit funding, those units requiring liaison services, or guaranteed consultant level input provide additional funding, for additional consultant time.

The first unit to provide such additional funding was renal transplant, followed a short time later by the Scottish Liver Transplant Unit (SLTU) and more recently the obstetric service. Within the RIE, increased funding for psychiatry has followed on from increased medical demand for services rather than by psychiatrists bidding for funding to develop services they believe they need. Under this funding model we are

not competing with General Adult Psychiatry or Psychotherapy, but instead with other specialities within the acute hospital.

Currently one third of our funding is derived from the general medical directorate within the RIE, with specific funding from Renal Transplant / dialysis, the SLTU, and obstetrics. Additional funding was recently obtained from Scottish Executive monies linked to implementation of the new Scottish Mental Health Act. The consultant compliment has grown with the increased funding and service provision and now includes four practitioners (3.2 WTE).

- **Liaison Psychiatry in Wales: Services and funding.**

*'Designed for Life - Creating World Class Health and Social Care for Wales in the 21<sup>st</sup> Century'* is a Welsh Assembly Government (WAG) document that outlines the future of health and social care in Wales. This document describes principles that underpin the transformation from the national illness service into a truly national health service.

With recent developments in other parts of the UK and changing times in the NHS this seems like a good time to review the current situation with a liaison perspective.

**Services:**

In Wales Local Health Boards (LHB) are equivalent of PCTs. Twenty two LHBs are commissioners of primary, secondary, tertiary and community care. There are 12 regional Trusts that cover groups of local authority areas. There is a separate Welsh Ambulance Trust and a Velindre Trust for cancer services. The Health Commission of Wales of the Welsh Assembly of Wales (WAG) provides advice and guidance about specialist services to the NHS Wales.

A significant difference from our colleagues across the Severn Bridge is that the mental health is part of a bigger trust rather being a separate trust. This has number of benefits for psychiatrists overall and Liaison Psychiatrists in particular. Not only that it helps in dealing with stigma associated with mental illness it also breaks down the barriers that come as a package when the two trusts are independent.

A recent survey of eleven acute NHS trusts in Wales showed that the three Trusts did not have a dedicated liaison service and had crisis resolution home treatment team covering emergency liaison work.

Out of the eight trusts with a liaison service only one team had a full-time Consultant Liaison Psychiatrist but even that did not meet the Royal College of Psychiatrists recommendations of at least two full-time Consultant Liaison Psychiatrists in a teaching hospital.

Three trusts had a nurse led liaison service but none of them had five or more full-time equivalent nursing staff. The rest of the five teams were multi disciplinary with nursing and medical input including dedicated consultant sessions and input from other medical colleagues like SHO, staff grade and F1. Only two teams had a full-time junior doctor. None of the teams had a clinical psychologist and only one team had two full-time counsellors.

The Cardiff and Vale NHS Trusts has approved a Consultant in Old Age Liaison Psychiatry to enhance service provided by two Old Age Liaison Nurses. These nurses have so far provided service to two big teaching hospitals and a number of smaller units.

***Funding:***

While in England the NHS must compete at Westminster with other public services such as education and defence for its share of the monies raised. The situation in Wales is rather different. Wales spends over four billion every year on its health services and this figure is set to continue to rise. NHS Wales receives its allocation as part of the process of negotiation between Westminster and Wales, Scotland and Northern Ireland offices. The sum available for health and health services in Wales forms part of what is called the 'block grant' which is the total amount of money for all the areas for which the National Assembly For Wales (NAfW) has responsibility for and is devolved to the NAfW. Increases over and above the overall share of the NHS are subject to the Barnett formula which seeks to ensure that all increases are based on actual population.

Significantly, Payment by Results (PbR) does not apply to Wales but referrals outside of Wales will be subject to PbR. This experience in England would be useful to monitor for its impact on liaison services elsewhere.

***Dr Tayyeb Tahir, Consultant Liaison Psychiatrist, University Hospital of Wales, Cardiff, CF14 4XN [tayyeb.tahir@cardiffandvale.wales.nhs.uk](mailto:tayyeb.tahir@cardiffandvale.wales.nhs.uk)***

***Dr Divya Sakhuja, Specialist Registrar, Gwent NHS Trust, Newport***

• **Incapacity Act**

The Incapacity Act came into play April of this year and will be in full effect as of October 2007. Many areas are looking at how to assist with the implementation of the Act, cope with assessments and understand the process and when IMCA's are required. TEWV Trust and the local Social Services lead have developed some excellent pathways around this which we have been given permission to re-produce within the newsletter for people to have a look at as no doubt there will be implications within the general hospital and for liaison services.

**MENTAL CAPACITY ACT 2005**

**GUIDANCE DOCUMENT**

**1. INTRODUCTION**

The purpose of this guidance is to inform Tees, Esk and Wear Valleys NHS Trust staff of the provisions and their obligations with regard to the parts of the Mental Capacity Act 2005 (MCA) which came into force in April 2007. It will include information about the new criminal offence introduced by the MCA and the circumstances in which an Independent Mental Capacity Advocate (IMCA) must be instructed and when they may be instructed.

The guidance will also include in the appendices, capacity assessment and best interest assessment flow charts, and the documentation which will be piloted in our organisation to document assessments of capacity and best interests in circumstances where an IMCA may be involved. Documentation for referral to the IMCA service (dependant on the Local Authority area where the incapacitated person is situated) and contact details is also be included.

An overarching policy containing all of the provisions of the MCA, including those coming into force in October, will be going out for consultation soon with a view to it being ratified in preparation for implementation when the rest of the MCA is enacted in October. Any comments regarding the documentation piloted to record assessments of capacity and best interests should be forwarded at this time.

## **2. STAGED IMPLEMENTATION OF THE MCA**

### **April 2007:**

- IMCA Service became operational in England
- New criminal offence introduced
- Sections 1 – 4 of the Act came into force but only where an IMCA is involved
- The Code of Practice was issued and should be followed by all those who must have regard to it where an IMCA is involved

### **October 2007:**

- All other parts of the Act come into force
- The Code has statutory force for all of the Act and not only where an IMCA is involved

## **3. CRIMINAL OFFENCE**

The Act introduces two new criminal offences: ill treatment and wilful neglect of a person who lacks capacity to make relevant decisions (section 44 MCA). The offences may apply to:

- Anyone caring for a person who lacks capacity – this includes family carers, healthcare and social care staff in hospital or care homes and those providing care in a person's home,
- An attorney appointed under a Lasting Power of Attorney or an Enduring Power of Attorney, or
- A deputy appointed for the person by the court.

These people may be guilty of an offence if they ill-treat or wilfully neglect the person they care for or represent. Penalties will range from a fine to a sentence of imprisonment of up to five years – or both.

Ill treatment and neglect are separate offences. For a person to be found guilty of ill treatment, they must either:

- Have deliberately ill-treated the person, or
- Been reckless as to whether they were ill-treating the person or not.

It does not matter whether the behaviour was likely to cause, or actually caused, harm or damage to the victim's health.

The meaning of 'wilful neglect' varies depending on the circumstances. But it usually means that a person has deliberately failed to carry out an act they knew they had a duty to do.

Allegations of offences may be made to the police or the Office of the Public Guardian. They can also be dealt with under adult protection procedures (via adult services in social services departments).

#### **4. SECTIONS 1 – 4 MCA (TO BE IMPLEMENTED WHERE AN IMCA IS TO BE INSTRUCTED)**

- **Section 1 – Principles**

The following principles apply for the purposes of this Act.

1. A person must be assumed to have capacity unless it is established that he lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

- **Section 2 - People who lack capacity**

For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

It does not matter whether the impairment or disturbance is permanent or temporary.

A lack of capacity cannot be established merely by reference to a person's age or appearance or a condition of or aspect of behaviour which might lead others to make unjustified assumptions about capacity.

Capacity must be decided on the balance of probabilities.

The Act applies to people 16 years of age or over.

- **Section 3 – Inability to make decisions**

A person is unable to make a decision if they are unable to understand the information relevant to the decision, retain the information, use or weigh the information as part of a process of arriving at a decision, communicate the decision.

A person should not be regarded as unable to understand the information if they are able to understand an explanation given in a way appropriate to their circumstances such as using visual aids, simple language or any other means.

The fact that a person can only retain the information for a short time does not prevent them from being regarded as able to make the decision.

The information relevant to the decision includes information about the reasonably foreseeable circumstances of deciding one way or failing to make the decision.

- **Section 4 – Best interests**

In determining best interests, the determination must not be made on the basis of the person's age or appearance or a condition or aspect of behaviour that may lead to unjustified assumptions about best interests.

All the relevant circumstances must be considered and the following steps taken where there is a belief that a person lacks capacity.

- Consideration of whether the person may regain capacity and if likely, when will that be
- Permit and encourage the person to participate
- Where decision involves life sustaining treatment, in considering the person's best interests, the decision must not be motivated by a desire to bring about death
- They must take into consideration the person's past and present wishes and feelings, beliefs and values that may influence the decision if the person had capacity, other factors which the person might consider if they were able to do so
- If appropriate and practicable to consult, consider the views of anyone named by the person to be consulted, any carer, (also donee or deputy after October).

There must be a reasonable belief after following the above steps that the decision or act is in the person's best interests.

Life sustaining treatment means treatment, in the view of the person providing health care, which is necessary to sustain life.

Relevant circumstances are those of which the decision maker is aware and considers relevant.

## **5. IMPLEMENTATION**

- **Assuming Capacity**

Principle 1 of the Act means that we must always begin by assuming that a person is capable of making the particular decision unless it can be established otherwise. Before deciding that someone lacks capacity to make a particular decision, it is important to take all practical and appropriate steps to enable them to make the decision themselves such as considering:

- Does the Service User have all the relevant information needed to make the decision in question?
- Could the information be explained or presented in a way that is easier for the Service User to understand?
- Are there particular times of the day when the Service User's understanding is better or particular locations where they may feel more at ease?
- Can the decision be put off until the circumstances are right for the person concerned?
- Can anyone else help or support the Service User to make choices or express a view, such as an independent advocate or someone to assist communication?

Decisions will **not** be made about an individual's capacity to make a decision based on: person's age, appearance or unjustified assumptions about capacity based on the person's condition or behaviour.

*Chapter 3 MCA CoP expands on this information.*

- **Assessing Capacity**

Having mental capacity means a person is able to make their own decisions. A person can lack capacity for the purposes of the Act even if the loss of capacity is partial or temporary or if capacity fluctuates over time. A person may lack capacity to make a decision about one issue but not about others.

If there is a belief that a person lacks the capacity to make a specific decision then they need to be able to show *on the balance of probabilities* that the person lacks the necessary capacity to make the decision at the time it needs to be made. Where there is doubt about a person's capacity to make a specific decision, consideration should be given to:

- Does the decision need to be made immediately?
- If not is it possible to delay the decision till the Service User has capacity to make the decision himself/herself?
- Has everything has been done to help and support the person making the decision?

In supporting people to make decisions consideration should be given to:

- Does the Service User have all the relevant information needed to make the decision in question?
- Could the information be explained or presented in a way that is easier for the Service User to understand?
- Are there particular times of the day when the Service User's understanding is better or particular locations where they may feel more at ease?
- Can the decision be put off until the circumstances are right for the person concerned?
- Can anyone else help or support the Service User to make choices or express a view, such as an independent advocate or someone to assist communication?

In order to make a decision as to whether an individual has the capacity to make a particular decision, a "two stage test of capacity" will be used as set out below:

Stage 1. Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain

There will be an assessment as to whether there is an impairment of, or disturbance in the functioning of, the person's mind or brain, examples of which may include:

- Conditions associated with some forms of mental illness
- Dementia
- Significant learning disabilities
- The long-term effects of brain damage
- Physical or medical conditions that cause confusion, drowsiness or loss of consciousness
- Delirium
- Concussion following a head injury, and
- The symptoms of alcohol or drug use.

**If there is no impairment of, or a disturbance in the functioning of, their mind or brain, then the person cannot lack capacity for the purposes of this Act.**

Stage 2. Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?

If stage 1 of the test of capacity is met there will be an assessment as to whether the impairment or disturbance affects their ability to make a specific decision when they need to. A person is unable to make a decision if they cannot:

- Understand information about the decision to be made ('relevant information')
- Retain the information in their mind long enough to be able to make the decision
- Use or weigh that information as part of the decision making process
- Communicate their decision – this could be talking, using sign language or even simple muscle movements such as blinking an eye

A person should not be deemed to be without capacity because they make what seem to be "unwise" or "risky" decisions.

*Chapter 4 MCA CoP gives more in depth information about assessing capacity.*

• **Who Should Assess Capacity**

In order to comply with the Act, Tees, Esk and Wear Valleys Trust employees will be variously required to assess the mental capacity of our Service Users to make decisions. The person who is required to assess the Service Users capacity will be the person who wishes to take some action in connection with the Service Users care or treatment or who is contemplating making a decision on the Service Users behalf.

Employees during the course of their work, may be required to both assess or take part in others assessment of capacity.

*Paragraphs 4.38 – 4.43 MCA CoP*

**Assessments of capacity in relation to IMCA eligibility will follow the flow chart at appendix 1 and the assessment of capacity will be recorded on the document at appendix 1a and placed in the person's case notes. Any in depth detail of the assessment will also be recorded in the case notes.**

- **Determining Best Interests**

If a person has been assessed as lacking capacity, then any act done for, or decision made on behalf of the person lacking capacity must be done or made in that person's best interests (Principle 4).

Under the Act, many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for themselves. The person making the decision is referred to as the 'decision-maker', and it is the decision-maker's responsibility to work out what would be in the best interests of the person who lacks capacity.

Because every case – and every decision – is different, the law can't set out all the factors that will need to be taken into account in working out someone's best interests. But section 4 of the Act sets out some common factors that must always be considered when trying to work out someone's best interests. These factors are summarised in the checklist here:

- Working out what is in someone's best interests cannot be based simply on someone's age, appearance, condition or behaviour. *Paragraphs 5.16–5.17 MCA CoP.*
- All relevant circumstances should be considered when working out someone's best interests. *Paragraphs 5.18–5.20 MCA CoP.*
- Every effort should be made to encourage and enable the person who lacks capacity to take part in making the decision. *Paragraphs 5.21–5.24 MCA CoP.*
- If there is a chance that the person will regain the capacity to make a particular decision, then it may be possible to put off the decision until later if it is not urgent. *Paragraphs 5.25–5.28 MCA CoP.*
- Special considerations apply to decisions about life-sustaining treatment. *Paragraphs 5.29–5.36 MCA CoP.*
- The person's past and present wishes and feelings, beliefs and values should be taken into account. *Paragraphs 5.37–5.48 MCA CoP.*
- The views of other people who are close to the person who lacks capacity should be considered, as well as the views of an attorney or deputy. *Paragraphs 5.49–5.55 MCA CoP.*

#### *Exceptions to the best interest's principle*

There are two circumstances when the best interest's principle will not apply. The first is where someone has previously made an advance decision to refuse medical treatment while they had the capacity to do so. Their advance decision should be respected when they lack capacity, even if others think that the decision to refuse treatment is not in their best interests. *Guidance on advance decisions is given in Chapter 9 MCA CoP.*

The second concerns the involvement in research, in certain circumstances, of someone lacking capacity to consent. *Chapter 11MCA CoP.*

**Determination of best interests will follow the flow chart at Appendix 2 and determination of best interests will be recorded on the document at Appendix 2A and placed in the person's case notes. Any in depth detail of the determination of best interests will also be recorded in the case notes.**

## **6. INDEPENDENT MENTAL CAPACITY ADVOCATES**

The new Independent Mental Capacity Advocate (IMCA) Service became operational in England from 1<sup>st</sup> April 2007. It is a new statutory advocacy service, introduced by the Mental Capacity Act 2005 and developed further by regulations.

The purpose of the IMCA service is to provide independent safeguards and to help people who lack capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends (other than paid carers) that it would be appropriate to consult about those decisions.

Whether a person is appropriate to consult relates, for example, to whether they are able to be contacted, whether they are willing and able to be consulted or to represent the person. A person should not be deemed inappropriate to consult in circumstances where, for example, they disagree with the decision maker's proposed action.

### **• When an IMCA MUST be Instructed**

In cases where a person lacks capacity to make a particular decision and is "un-befriended" as above, decision makers in local authorities and NHS Trusts have a duty to instruct an IMCA where:

- The decision is about serious medical treatment\* provided by or proposed by the NHS (*but excludes treatment regulated under Part IV of the Mental Health Act 1983*);
- It is proposed by the NHS or Local Authority that the person be moved to long-term care of more than 28 days in a hospital or 8 weeks in a care home (*where that accommodation or move is not a requirement of the Mental Health Act 1983*);
- A long-term move (8 weeks or more) to different accommodation is being proposed by the NHS or Local Authority, for example a move to a different hospital or care home (*where that accommodation or move is not a requirement of the Mental Health Act 1983*).

\*It is impossible to set out all types of procedures that may amount to 'serious medical treatment', although some examples of medical treatments that might be considered serious include:

- Chemotherapy and surgery for cancer
- Electro-convulsive therapy

- Therapeutic sterilisation
- Major surgery (such as open-heart surgery or brain/neuro-surgery)
- Major amputations (for example, loss of an arm or leg)
- Treatments which will result in permanent loss of hearing or sight
- Withholding or stopping artificial nutrition and hydration, and
- Termination of pregnancy.

These are illustrative examples only, and whether these or other procedures are considered serious medical treatment in any given case, will depend on the circumstances and the consequences for the patient. It could be that the provision of antibiotics could be considered serious medical treatment where there are serious consequences if treatment is not provided.

- **When an IMCA MAY be Instructed**

Through regulations Local Authorities and the NHS have been given powers to apply the IMCA role to two further types of decisions if they are satisfied that an IMCA would be of particular benefit. These are:

- Care reviews about accommodation or changes to accommodation, and
- Adult protection cases where the person without capacity is or has been abused, or is or has been an abuser but only where protective measures have been, or are proposed to be taken (*this applies even if the person who lacks capacity has family and/or friends*).

**FOR IMCA REFERRAL DOCUMENTS PLEASE SEE THE RELEVANT APPENDIX DEPENDENT ON THE LOCAL AUTHORITY AREA IN WHICH THE PERSON LACKING CAPACITY IS CURRENTLY SITUATED.**

## **7. SOURCES OF FURTHER INFORMATION**

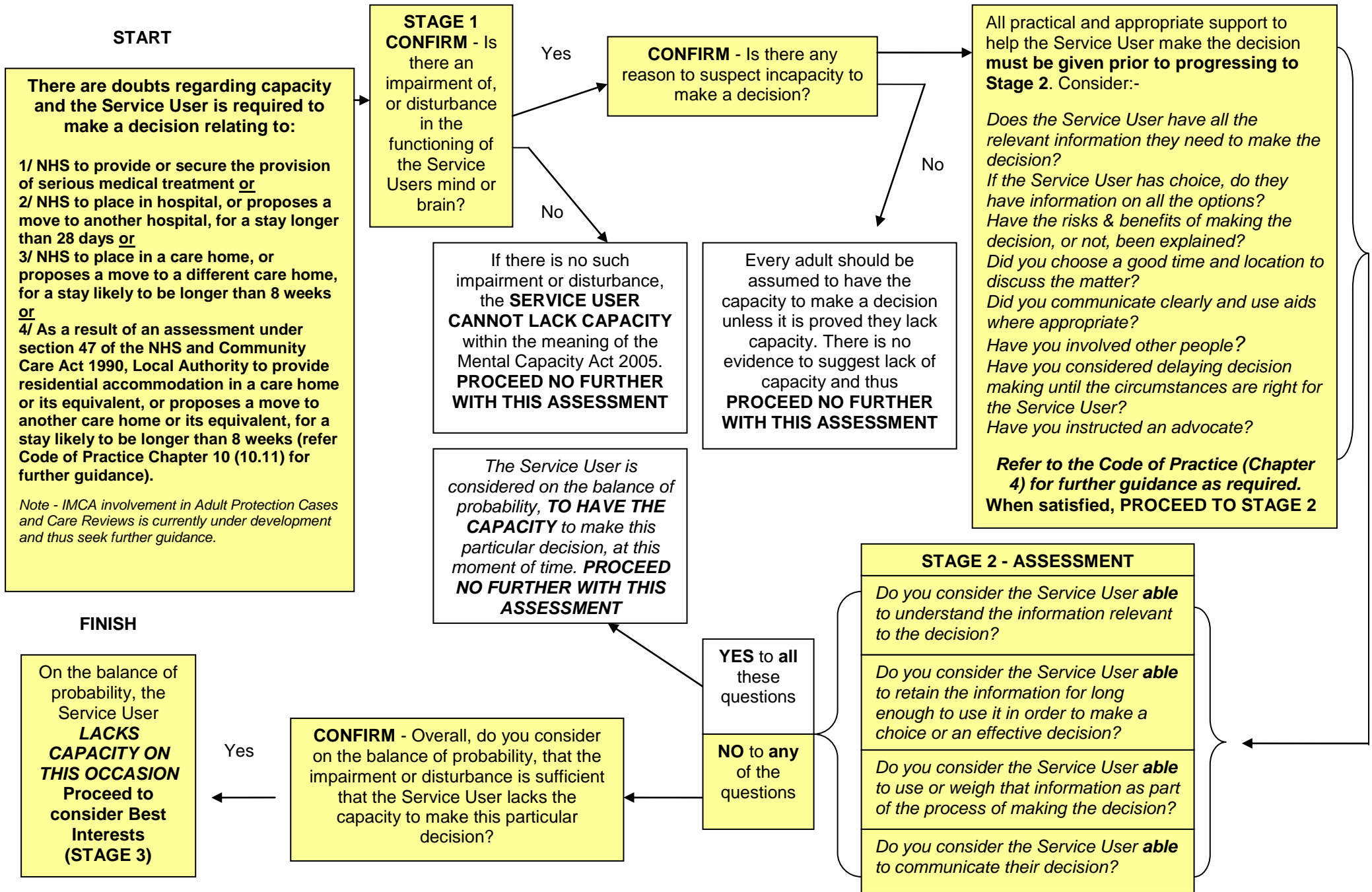
- **Code of Practice and other materials**

Copies of the Code of Practice will be supplied to all wards, CMHTs, Specialist Teams and any other areas where members of Trust staff may come into contact with a person who may lack capacity.

An electronic version of the Code of Practice, Making Decisions booklets, training materials and other useful information is available at [www.dh.gov.uk/mentalcapacityact](http://www.dh.gov.uk/mentalcapacityact)

For further information or advice about the Mental Capacity Act 2005 you can contact:

Mel Wilkinson  
 MHA Manager  
 TEWV NHS Trust  
 Tel: 01642 516082  
 E-mail: [Mel.Wilkinson@tney.northy.nhs.uk](mailto:Mel.Wilkinson@tney.northy.nhs.uk)



**STAGE 1 & 2 RECORDING ASSESSMENT OF CAPACITY - IMCA IMPLEMENTATION**

Name of Service User:

I D Number:

Today's Date:

Name of Assessor:

Professional Group:

Decision to be made by service user in relation to:-	Yes/No	<i>You must respond 'yes' to 1 or more of options a - d, to enable this process to be completed. If 'no' to all 4, proceed no further with this assessment.</i>
a/NHS to provide or secure the provision of serious medical treatment b/NHS to place in hospital, or proposes a move to another hospital, for a stay longer than 28 days c/NHS to place in a care home, or proposes a move to a different care home, for a stay likely to be longer than 8 weeks d/As a result of an assessment under sect 47 of the NHS & Community Care Act 1990, Local Authority to provide residential accommodation in a care home or its equivalent, or proposes a move to another care home or its equivalent, for a stay likely to be longer than 8 weeks. <i>Note - IMCA involvement in Adult Protection Cases and Care Reviews is currently under development and thus seek further guidance prior to considering a referral to the IMCA Service.</i>		

**STAGE 1 - DETERMINING IMPAIRMENT OR DISTURBANCE OF MIND OR BRAIN**  
 Every adult should be assumed to have the capacity to make a decision unless it is proved that they lack capacity. An assumption about someone's capacity cannot be made merely on the basis of a Service Users age or appearance, condition or aspect of their behaviour.

	Response		Comments
	Yes	No	
Q1. Is there an impairment of, or disturbance in the functioning of the Service Users mind or brain? <i>(For example, symptoms of alcohol or drug use, delirium, concussion following head injury, conditions associated with some forms of mental illness, dementia, significant learning disability, long term effects of brain damage, confusion, drowsiness or loss of consciousness due to a physical or medical condition)</i>			<i>Please detail:</i>

If you have answered **YES** to Question 1, **PROCEED TO STAGE 2**  
 If you have answered **NO** to the above, there is no such impairment or disturbance and thus THE SERVICE USER CANNOT LACK CAPACITY within the meaning of the Mental Capacity Act 2005. Sign/date this form, record the outcome within the Service User records and **PROCEED NO FURTHER WITH THIS ASSESSMENT**

**STAGE 2 – ASSESSMENT - Having determined impairment or disturbance (Stage 1) and given consideration to the ease, location and timing; relevance of information communicated; the communication method used; and others involvement (see guidance overleaf), you now need to complete your assessment and form your opinion as to whether the impairment or disturbance is sufficient that the Service User lacks the capacity to make this particular decision at this moment in time.**

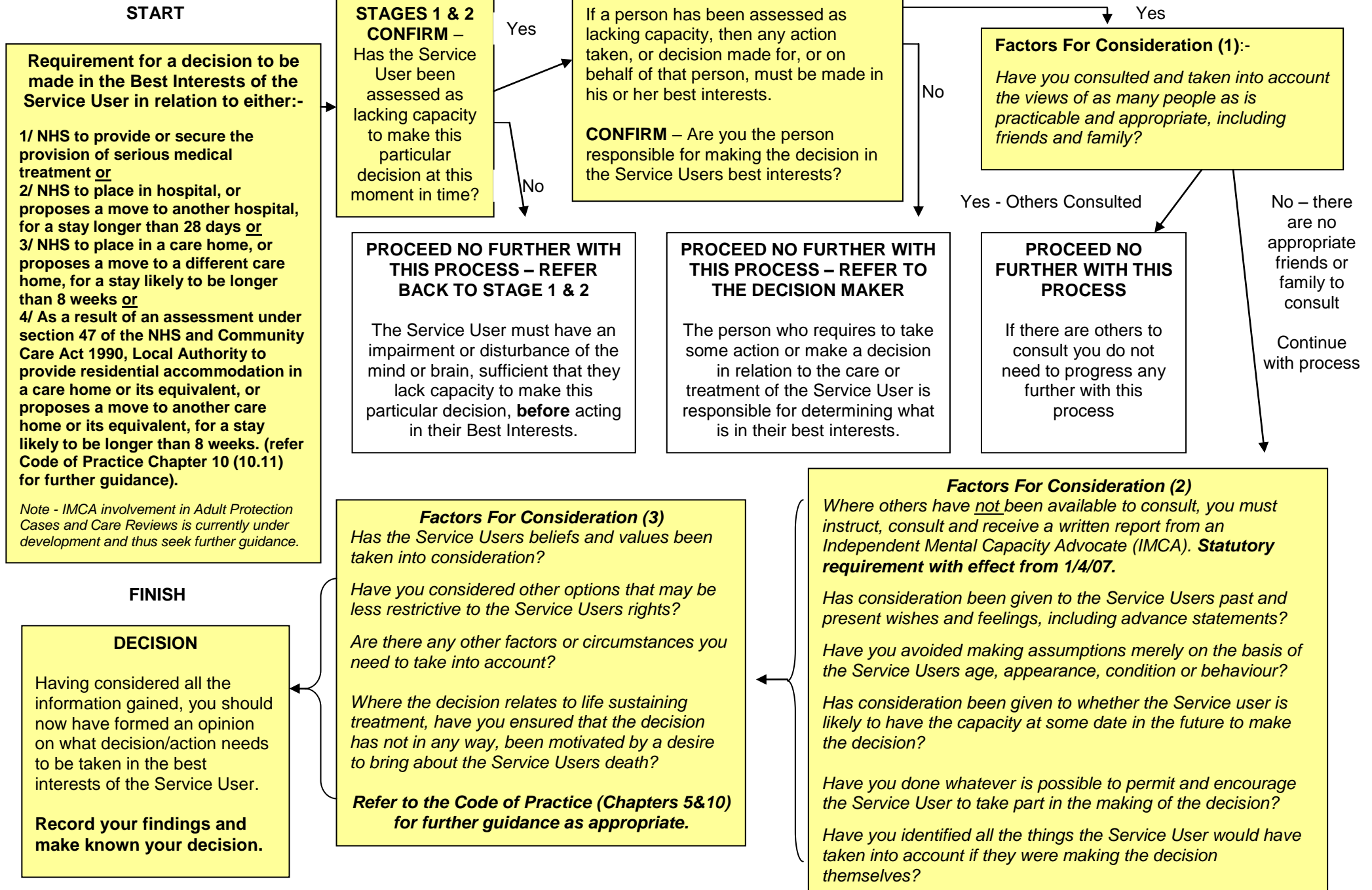
	Response		Comments
	Yes	No	
Q2. Do you consider the Service User <b>able</b> to understand the information relevant to the decision?			
Q3. Do you consider the Service User <b>able</b> to retain the information for long enough to use it in order to make a choice or an effective decision?			
Q4. Do you consider the Service User <b>able</b> to use or weigh that information as part of the process of making the decision?			
Q5. Do you consider the Service User <b>able</b> to communicate their decision?			

If you have answered **YES** consistently to Q2 to Q5, the Service User is considered on the balance of probability, **to have the capacity to make this particular decision at this time**. Sign/date this form, record the outcome within the Service User records and **PROCEED NO FURTHER WITH THIS ASSESSMENT**. If you have answered **NO** to any of the questions, **proceed to Q6**.

Q6. Overall do you consider, on the balance of probability, that the impairment or disturbance as identified in STAGE 1 is sufficient that the Service User lacks the capacity to make this particular decision?		<b><i>On the balance of probability, the Service User Lacks Capacity to make this decision at this particular time. Sign and date this form &amp; proceed to STAGE 3 to consider 'Best Interests'</i></b>
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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**DETERMINING BEST INTERESTS - IMCA IMPLEMENTATION APPENDIX 2**



Name of Service User:

ID Number:

Today's Date:

Name of Decision Maker:

Professional Group:

**Description of the decision to be made regarding the Service User (in relation to their care or treatment):**

<p>a/NHS to provide or secure the provision of serious medical treatment  b/NHS to place in hospital, or proposes a move to another hospital, for a stay longer than 28 days  c/NHS to place in a care home, or proposes a move to a different care home, for a stay likely to be longer than 8 weeks  d/As a result of an assessment under sect 47 of the NHS &amp; Community Care Act 1990, Local Authority to provide residential accommodation in a care home or its equivalent, or proposes a move to another care home or its equivalent, for a stay likely to be longer than 8 weeks.  <i>Note - IMCA involvement in Adult Protection Cases and Care Reviews is currently under development and thus seek further guidance prior to considering a referral to the IMCA Service.</i></p>	<p>Yes/No</p>	<p><i>You must respond 'yes' to 1 or more of options a - d, to enable this process to be completed. If 'no' to all 4, proceed no further with this assessment.</i></p>
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**STAGE 1 & STAGE 2 SUMMARY - CONFIRMING LACK OF CAPACITY**

Every adult should be assumed to have the capacity to make a decision unless it is proved that they lack capacity. An assumption about someone's capacity cannot be made merely on the basis of a Service Users age or appearance, condition or aspect of their behaviour.

	Response		Comments
	Yes	No	
<p>Has the Service User been determined as lacking capacity to make this particular decision at this moment in time?</p>			

If you have answered **YES**, PROCEED TO STAGE 3. If you have answered **NO**, you must complete stages 1 and 2 using the appropriate flowchart, checklist and guidance, prior to completing stage 3.

**STAGE 3 – DETERMINING BEST INTERESTS**

All steps and decisions taken for someone who lacks capacity must be taken in their best interests.

	Response		Comments
	Yes	No	
<p>Q1. <b>Consult Others</b> - Have you where practicable and appropriate, consulted and taken into account the views of others including those engaged in caring for the Service User, relatives and friends, persons previously named by the Service User, Attorney under a Lasting or Enduring Power of Attorney or Deputy of the Court of Protection?</p>			
<p><b>IF THERE ARE OTHERS AVAILABLE TO CONSULT (EXCLUDING PAID STAFF), YOU DO NOT NEED TO PROGRESS ANY FURTHER WITH THIS PROCESS. IF THERE ARE NO FAMILY OR FRIENDS TO CONSULT PROCEED TO Q2.</b></p>			
<p>Q2. <b>IMCA</b> – You must instruct, consult and receive a written report from an IMCA where there has been no-one other than paid staff to consult. Has an IMCA been consulted? (<b>Statutory requirement wef 1/4/07</b>)</p>			
<p>Q3. <b>Avoid Discrimination</b> – Have you avoided making assumptions merely on the basis of the Service Users age, appearance, condition or behaviour?</p>			
<p>Q4. <b>Relevant Circumstances</b> – Have you identified all the things the Service User would have taken into account when making the decision for themselves?</p>			
<p>Q5. <b>Regaining Capacity</b> – Have you considered if the Service User is likely to have capacity at some date in the future?</p>			
<p>Q6. <b>Encourage Participation</b> – Have you done whatever is possible to permit and encourage the Service User to take part in making the decision?</p>			
<p>Q7. <b>Special Considerations</b> - Where the decision relates to life sustaining treatment, have you ensured that the decision has not been motivated in any way, by a desire to bring about their death?</p>			
<p>Q8. <b>The Persons Wishes</b> - Has consideration been given to the Service Users past and present wishes and feelings, beliefs and values, that would be likely to influence this decision?</p>			
<p>Q9. <b>Avoid Restricting Rights</b> – Has consideration been given to options that may be less restrictive to the Service Users rights?</p>			
<p>Q10. <b>Other Considerations</b> – Please detail</p>			
<p><b>Q11. Having considered all the relevant circumstances, what decision/action do you intend to take whilst acting in the Best Interests of the Service User?</b></p>			

Signature:

Date:

## **7. Service Development & Management**

### **• Why Liaison Psychiatry? – Janet Butler**

No service seems to be immune to the “service review” at the moment, whether its as part of an overall review for trusts going in to FT or FT’s looking to reduce their outgoings, trusts looking to achieve their efficiency savings or means of creating new finance streams. As a result, all services need to have an of the shelf response which answers the why and gives an impact statement as to the any proposed removal of service.

Janet Butler in Southampton has collated together an excellent report looking at this with input from services leads from all over the UK, to hopefully make this task easier for you. Local data is always key in these things and where this needs to be entered (and therefore a good indication of what you should be collecting is listed for you.)

**More of this sort of information and suggestions can be found at [www.Liaisonpsychiatry.org](http://www.Liaisonpsychiatry.org)**

### **• RELEVANCE OF LIAISON PSYCHIATRY**

#### **CONTENTS**

#### **I. REASONS FOR A SPECIALIST MENTAL HEALTH SERVICE TO THE ACUTE HOSPITAL**

- a) Risk
- b) Need

#### **II. NATIONAL EVIDENCE OF NEED FOR SERVICES**

- a) PCT targets
- b) Acute hospital targets
- c) Mental health trust targets
- d) Clinical negligence scheme for trusts
- e) NSF and NICE guidelines

#### **III. LIAISON PSYCHIATRY AND FOUNDATION TRUSTS**

#### **I. REASONS FOR A SPECIALIST ON-SITE MENTAL HEALTH SERVICE TO THE ACUTE HOSPITAL**

##### **a. Risk Management**

Liaison Psychiatry provides a rapid response to patients detained under the Mental Health Act and is able to raise the profile of the requirements and criteria of the Mental Health Act through continuity of informal contacts with acute hospital staff.

Liaison Psychiatry is able to provide a prompt assessment to patients in the acute hospital who are identified as having suicidal ideation or acute mental or behavioural disturbance.

Liaison Psychiatry is able to provide a assessment to all patients in the acute hospital presenting with self harm as per NICE guidelines for self harm. Liaison Psychiatry helps PCTs, acute hospitals and mental health trusts meet relevant clinical negligence targets, NSF and NICE guidelines and other targets (see later).

**b. Other Needs**

Liaison Psychiatry is able to provide access to a service for patients with significant mental health needs who would otherwise have access (not meet community mental health team criteria for SMI or reside outside the local PCT area) or who would deplete resources from CMHTs or HTT.

Liaison Psychiatry is able to develop good partnership and multi-agency working with acute hospital staff and relevant voluntary sector services.

Liaison Psychiatry is able to provide a prompt assessment to patients in the acute hospital thus reducing waiting times in the Emergency Department and lengths of stay for admitted patients.

Liaison Psychiatry interventions can reduce healthcare utilisation for conditions such as somatoform disorders and depressive, anxiety or adjustment disorders complicating medical conditions.

On-site location and dedication to the acute trust improves patient and stakeholder experience.

Liaison Psychiatry sees many complex patients as in-patients where expertise is likely to be lacking in CMHTs.

The Emergency Department Tsar (Prof Sir George Alberti) has asked for a briefing paper from the Faculty of Liaison Psychiatry regarding mental health in acute hospitals and is expected to make strong recommendations about improving this in his forthcoming report.

**II. NATIONAL EVIDENCE OF NEED FOR SERVICE PROVISION**

**a) Performance Indicators for Primary Care Trusts: How Liaison Psychiatry can help**

EMERGENCY DEPARTMENT WAITS	<b>Role of Liaison Psychiatry Team</b>
<p><b>Percentage of patients waiting 4 hours or less in A&amp;E from arrival to admission, transfer or discharge</b></p> <p><b>Avoidance of admissions</b></p>	<p>Less mental health breaches and less non-medical related admissions.</p>

ACCESS TO QUALITY SERVICES	
<p><b>Percentage of patients whose transfer of care from hospital was delayed</b></p>	<p>Research demonstrates that psychiatric co-morbidity in patients with physical illness is a major cause for delayed discharge from acute hospital care. E.g. dementia, organic psychiatric disorders and depression.</p> <p>It is generally recognised that approximately two thirds of acute hospital beds are occupied by people aged over 65 years of age (<i>Department of Health 2001</i>) and that within this group there is a high psychiatric morbidity. Discharging older people with mental health problems is considered to be of a complex nature that requires special attention and a range of options (<i>Health &amp; Social Care Change Agent Team 2003</i>).</p>
IMPROVING HEALTH	
<p><b>Percentage change in mortality rate from all circulatory diseases in persons aged under 75 per 100,000 population (age and sex standardised)</b></p>	<p>"A recent review of the literature concluded that depression can be a major risk factor both for the development of cardiovascular disease and for death after a myocardial infarction." (<i>Mental Health NSF</i>)</p>
<p><b>Assessment of the effective use of health equity auditing in service planning, commissioning and delivery in order to tackle health inequalities</b></p>	<p>The Mental Health NSF Standard 2, Primary Care &amp; Access to services identifies the role of psychiatric services to A&amp;E departments in ensuring equitable access to mental health services for specific groups of patients who may otherwise not access mental health services.</p>
SERVICE PROVISION	
<p><b>Level of compliance against the NHS Litigation Authority (NHSLA) risk management standard for primary care trusts</b></p>	

**b) Performance Indicators for Acute & Specialist Trusts: How Liaison Psychiatry can help**

KEY TARGETS	Role of Liaison Psychiatry Team
Percentage of patients waiting less than 12 hours for admission via A&E as an emergency following decision to admit	Reduction of mental health related breaches. Fewer admissions and decreased lengths of stay
Percentage of patients waiting 4 hours or less in A&E from arrival to admission, transfer or discharge	
<b>CLINICAL FOCUS</b>	
Level of compliance against the clinical negligence scheme for trusts (CNST) general and maternity risk management standards	Specific support in development of Risk management strategies for SH and suicide within hospital, with rapid risk situational response.
Emergency readmissions to hospital within 28 days of discharge, as a percentage of live discharges for patients aged 16 years and over	<p>Research demonstrates that co-morbid mental health problems in patients with physical illness are associated with increased use of healthcare resources, including readmission to hospital e.g. panic disorder in adults presenting with CHD, poor diabetic control in Type I IDDM, chronic pain syndromes.</p> <p>A small proportion of patients who self-harm (major repeaters) also account for a disproportionate number of readmissions with further self-harm after the initial episode.</p>

**c) Performance Indicators for Mental Health Trusts: How Liaison Psychiatry can help**

PATIENT FOCUS	Role of Liaison Psychiatry Team
Obtaining feedback from patients and taking account of their views and priorities is vital	
<b>CLINICAL FOCUS</b>	
Level of compliance against the clinical negligence scheme for trusts (CNST) general and maternity risk management standards	

<p><b>3-year average suicide rate for mental health inpatients and recently discharged patients. The 'Saving Lives: Our Healthier Nation' target has been to reduce the suicide rate by at least one fifth by 2010</b></p>	<p>The National Suicide Prevention Strategy for England identifies patients who self-harm as a high risk group for suicide. Self-harm is frequently an early sign of deterioration in patients with severe mental illness.</p>
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**d) Clinical Risk Standards: How Liaison Psychiatry can help**

<p><b><u>i) NHSLA Acute Trusts</u></b></p>
<p><b>Criterion 1.2.2</b> There is evidence of management action arising from patient adverse incident reporting.</p>
<p><b>Criterion 1.2.6</b> The Trust applies the advice in the National Confidential Enquiries.</p>
<p><b>Criterion 7.1.1</b> All specialties have in place an integrated policy that identifies and addresses the needs of the patient prior to, and in preparation for, discharge from the hospital. (CHD NSF, RCEHS, Safety First)</p>

<p><b><u>ii) NHSLA Maternity</u></b></p>
<p><b>Criterion 2.3.1</b> The service audits its practice against the advice in the National Confidential Enquiries, and implements changes accordingly.</p>
<p>Risk Management processes are in place to address at risk women in the ante natal, intra partum and post natal period.</p>

<p><b><u>iii) NHSLA Mental Health Trusts</u></b></p>
<p><b>Criterion 1.2.6</b> The Trust has considered the advice from the National Confidential Enquiries, and local practice is reviewed in light of their recommendations.</p>
<p><b>Criterion 1.3.2</b> The Trust audits its practice against the advice and recommendations in the National Confidential Enquiries, and implements changes accordingly.</p>
<p><b>Criterion 2.1.3</b> Serious incidents (including suicides and homicides) are discussed, and lessons learnt across the organisation.</p>
<p><b>Criterion 2.3.1</b> There is evidence of the Trust sharing information and learning about serious incidents with other health providers and agencies to minimize the potential of such incidents reoccurring.</p>
<p><b>Criterion 6.1.2</b> The Trust has a written policy that identifies which staff who undertake assessments of service users are to be trained in relation to risk assessment and management of risk, and can demonstrate that there is a system in place to fulfil the policy.</p>
<p><b>Criterion 8.1.5</b> There are defined arrangements for in-patient service users who require care in the local acute hospital.</p>

## e) NSFs and NICE guidelines or other standards for Liaison Services

*Many NSFs and NICE guidelines make recommendations about psychological management. This is expected to mainly occur in treating teams in primary and secondary care – which has education implications and then is likely to lead to the need for psychiatric services to see complex cases*

**NSF for long term conditions** recognises the prevalence of psychological and cognitive problems in neurological conditions. It recommends mental health trusts are included in neuroscience networks.

**NSF for Coronary Heart Disease** states audit should include psychiatric outcomes.

**NSF for renal disease highlights** psychological support as a key part of the care pathway and recognizes that this can highlight the need for treatment, also implementation of psychological preparation for transplantation is regarded as a marker of good practice.

**NICE guidelines for chronic heart failure** recognise the prevalence of depression.

**NICE guidelines for stroke** recommend the presence of a mood disorder is assessed at all stages of care and patients have access to psychological therapy, and all staff involved have basic skills in assessment and management of mood disorders.

**NICE guidelines for MS** make lots of specific recommendations about the detection and management of anxiety and depression, with a specific psychiatrist and psychological service being available for advice and management.

**NICE guidelines for Parkinson's disease** emphasize the need to manage depression, psychosis and dementia.

**NICE guidelines for epilepsy** say psychiatric co-morbidity or non-epileptic seizures should be referred to a specialist centre with specialized psychiatry /psychological input.

**NICE guidelines for COPD** emphasize the need to recognize and manage depression and anxiety and highlight evidence that these are associated with increased admissions.

**NICE guidelines on cancer networks** recommend specialist psychiatric and psychological teams be linked within the network to provide patient assessment and treatment and to educate and supervise staff in cancer care and many cancer services guidelines emphasize the need for psychological management and liaison psychiatry.

**National guidance for Cystic Fibrosis** services emphasizes the integral role of psychological management.

**NICE guidelines for management of self harm** emphasize the need for integrated working between medical and psychiatric services, state that all patients should have a needs and risk assessment, state that assessments

should be shared with the patient, state overnight admission and reassessment should be considered in certain circumstances, consider therapeutic involvement for at least 3 months, advise that psychosocial assessment doesn't wait until the patient is medically fit for discharge, state that a brief capacity and risk assessment should occur at triage.

**NICE guidelines for PTSD** recommend all people at risk for PTSD are screened at one month. Trauma based CBT should be given to all sufferers of PTSD or severe PTSD symptoms.

**DoH report on psychological therapies** highlights the need for services to address co-morbidity between physical and psychiatric conditions and to address somatic complaints in primary and secondary care. It is recognized that there should be services for people with personality disorders (type not specified).

**RCP report on alcohol** says there should be specific mental health services to address alcohol problems in general hospitals.

### **III. LIAISON PSYCHIATRY AND FOUNDATION TRUSTS**

For the new trust to achieve foundation status it must pass a rigorous assessment of fitness for purpose by Monitor. The assessment process will look at several key areas and the presence of liaison psychiatry services can assist the trust meeting the standards within these:

1. **Performance & Quality**
  - a. Liaison services allow crisis teams to function more effectively and therefore meet their target by the team covering work in the acute trust
  - b. Jnr Dr EWTD by the team covering work in the acute trust
  - c. Liaison services achieve NSF & NICE and Royal College standards
  - d. Liaison Services help trusts meet Clinical Negligence Scheme standards
2. **External relations – Effective partnership working with other agencies**
  - a. Liaison services illustrate an excellent example of partnership working with a major local stakeholder in the health community
  - b. Liaison services are also increasingly involved with GP's, PCT's and STHA around the provision of services for management of psychological aspects of physical health so illustrating further external relations and partnership working
3. **Business & Strategic – Income Generation**
  - a. Liaison services have the ability to bring in significant income growth to the trust if their specific development around Acute Trust / PCT targets and needs is supported. This area has already been specifically recognised by other MH trusts undergoing foundation transition e.g. Leeds MHT

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- i. Teaching contracts – PCT's around chronic disease business case submitted for StHA wide area
- ii. Specialist psychological medicine services - Perinatal services, Chronic Fatigue, Pain Management, Obesity Management, Management of Functional Illness / Frequent Attendees, Occupational Mental health, PTSD services
- iii. Commissioning from acute trusts/PCTs to meet acute trust targets and standards

## **8. Management Speak – Terms to get your head around “ Reference Costs”**

Reference costs are a national reference costings of services which are based on total cost of a service against the number of contacts “actual face to face care episode” with patients. They are the target cost of services that trusts are trying to meet and are an indication of whether you are expensive!

Liaison services come under the “specialist service” reference cost - £205  
Basic premise if you take the cost of your service and divide by the number of contacts you should be sitting somewhere around there (It is more complicated than that but it's a basic way of understanding it).

They are worked out according to a DoH formula and will be completed by your finance dept on your service and reported nationally by trusts to DoH. Contacts are taken from whatever trust IT system you have and not paper records, re-enforcing the need to ensure efficient data entry systems – no contact info in, no retrieval available to finance and therefore you look very expensive!

They sit alongside other performance targets e.g. number patients seen by CRHT's

Why do you need to know the cost for your service?

All trusts are to make efficiency savings and are looking at means of achieving this. If your service is sitting well above the reference cost target you will be vulnerable. If you are on cost or even better below you are likely to be in a safer position.

Trusts going into FT are doing service reviews on all the services and cost efficiency is big part of this – reference costs are your proof.

In the absence of PBR in mental health commissioners are using Reference Costs as part of their criteria for deciding if they will commission a particular service – it is the accepted indication of efficiency.

If you are above the national cost then you have to identify quickly why so you can have the answer before the manager asks it!

Is it lack of data entry on your service contacts? – most likely.

Are all your staff allied to liaison services on the system else their contact data will be lost to that other service.

If you can't see a reason why you will want to be coming up with a plan of how you are going to get within cost – this may involve increasing the numbers seen, getting your data onto the system and worse case looking at staffing levels. Its always better to have the answers to the problems from you and your team rather than having them forced upon you!

Mel Temple

Fuller information on the collection for 2006-7 can be found on the DoH website:  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationPolicyAndGuidance/DH\\_074072](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationPolicyAndGuidance/DH_074072)

#### **9. Feedback from Events & Dates for your diary**

Despite requests no-one has forwarded on any reports from events they've been to recently including the Amsterdam event! If anyone has been to any events recently or have any dates for the diary please let me have them.

#### **UPCOMING:**

Sept 26-29 EACLP Annual Meeting, Bologna, Italy

Nov 9/10<sup>th</sup> TNC Annual Liaison Psychiatry Conference, Bristol

March 2008 Faculty Annual Residential Meeting, Newcastle