

PLAN
PSYCHIATRIC LIAISON
ACCREDITATION NETWORK



Quality Standards for Liaison Psychiatry Services

Third Edition

**Edited by: Mira Soni, Jennifer Webb, Lucy Palmer, Melanie Dupin,
Maureen McGeorge**



A manual of standards written primarily for:

Professionals who deliver liaison psychiatry services

Commissioners

Managers

Also of interest to:

People with physical and mental health problems

Carers of people with physical and mental health problems

Non-mental health professionals in the general hospital

Crisis Resolution/Home Treatment Teams

Out-of-hours mental health services

Researchers

Policy makers

Third Edition: October 2011

Publication number: CCQI114

Correspondence:

Lucy Palmer, Mira Soni or Jennifer Webb

Psychiatric Liaison Accreditation Network

Royal College of Psychiatrists' Centre for Quality Improvement

4th Floor Standon House, 21 Mansell Street, London, E1 8AA

Tel: 020 7977 6646

Fax: 020 7481 4831

Email: plan@cru.rcpsych.ac.uk

This document can be downloaded from our website at:

www.rcpsych.ac.uk/PLAN

©Royal College of Psychiatrists 2011.

Contents

Section	Page
How to use these standards	4
Introduction	5
Domain 1: Core Standards for Working-age and Older Adult Teams	10
• Commissioning and Resources	10
• Referral Procedures	11
• Mental Health Assessment and Care Planning	12
• Involving Service Users and Carers	16
• Collaborative Working in the General Hospital	20
• Interfaces with Other Services	22
• Staffing, Support and Communication	23
• Audit, Quality and Feedback	28
Domain 2: Providing Emergency/Urgent Mental Health Care to Adults of all Ages	29
Domain 3: Providing Routine Mental Health Care to Working Age Adults	30
Domain 4: Providing Routine Mental Health Care to Older People	31
Domain 5: Providing Interventions	33
Domain 6: Providing Training to Hospital Colleagues	34
Appendix 1: Examples of Liaison Psychiatry Staffing Levels	37
Appendix 2: Examples of Interventions recommended by NICE	40
Appendix 3: Key to References	41
Appendix 4: Bibliography	43
Appendix 5: Acknowledgements	48

How to use these standards

Below is an explanation of the various terms used throughout this document. Should you require further information; please contact the PLAN team on 020 7977 6646.

Standard: *this describes the overarching aim or value of a particular group of criteria*

Criterion: *a more specific statement explaining what needs to happen. Please note, in order to pass a standard, a team must meet the majority of criteria within it.*

Standard 1: Liaison psychiatry services to general hospitals are adequately planned and commissioned			
No.	Type	Criterion	Ref.
1.1	2	Liaison services are explicitly commissioned/contracted against agreed service standards	ACAD
1.2	2	Liaison services are planned, developed and reviewed by a joint planning forum	JOINT
1.3	2	Commissioning includes provision for local advocacy services	GPP

Type: *this relates to the rating of the standard i.e.:*

Type 1: *Failure to meet these criteria would result in a significant threat to patient safety, rights or dignity and/or would breach the law.*

Type 2: *Criteria that an accredited service would be expected to meet.*

Type 3: *Criteria that an excellent service should meet.*

Some criteria, though very important, are not the direct responsibility of the liaison team and therefore can only be rated as either Type 2 or 3.

No: *this relates to the criterion number.*

Ref: *this refers to the source that inspired or relates closely to the criterion in question. Please see Appendix 3 on page 39 for full details of the references.*

Please note

- Where there are notes underneath some criteria (*in italics*) these are for additional guidance.
- The standards and criteria in this document exist to guide best practice and do not override the individual responsibility of a professional to make appropriate decisions on a case-by-case basis.

Introduction

What is the Psychiatric Liaison Accreditation Network (PLAN)?

PLAN is a network of mental health liaison psychiatry services run by a central project team at the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI). PLAN exists to facilitate quality improvement and development in liaison psychiatry services through a supportive peer review network. PLAN is open to all liaison psychiatry services in the United Kingdom and Ireland. To speak to a member of the PLAN team, please telephone 020 7977 6646 or email plan@cru.rcpsych.ac.uk.

Each year, mental health liaison teams are evaluated against the PLAN service standards. The process is ongoing, rather than a single iteration, and members are expected to take part in a self review every year and a peer review every two years.

The network enables communication between services and the sharing of best practice. Liaison psychiatry touches a wide range of healthcare professionals and service users, but liaison teams themselves can experience isolation and a lack of recognition. Some services report a lack of practical and financial support required to really thrive, or in some cases, simply to survive. PLAN aims to support members in their endeavors to improve and develop, at a pace which suits the individual service. By applying standards developed from literature reviews, consultations with experts, and using proven quality improvement methods, PLAN:

- recognises achievement and identifies areas for improvement;
- raises awareness of the value of liaison services;
- encourages services to constantly strive for improvement;
- provides funders with the confidence to invest in accredited services.

The PLAN annual cycle



How have the standards been developed?

The standards were initially developed following a review of the literature and a period of consultation with various experts, including:

- service users and carers;
- liaison mental health professionals, including nurses, psychiatrists, social workers, therapists and psychologists;
- experts from voluntary sector organisations;
- healthcare professionals from emergency departments and general hospital wards;
- managers and directors;
- individuals with expertise in quality improvement, research and audit.

The consultation process involved a written consultation exercise, expert group meetings, telephone and email discussions and an exercise where people independently rated the standards.

How are the standards measured?

The standards are measured in two stages; the self review and peer review.

The self review

During the self review period (8-10 weeks), PLAN members are provided with brief, anonymous questionnaires (either online or on paper) for:

- all members of the liaison team;
- professionals who refer to the liaison team;
- service users and carers who have recently seen the liaison team.

An audit of liaison team case notes also takes place, along with a checklist for the liaison team to complete. Liaison teams are provided with ready-made tools and guidance notes.

Members are also given an action planning document, which details changes and improvements to the service that they have made either during the self review period, or that they are planning on making in the future. These changes may be based on the PLAN standards or may have already been in the pipeline.

The peer review

The peer review is a one day visit from a review team made up of other PLAN members as well as a service user or carer. It offers an opportunity for multi-disciplinary and multi-agency discussions, and gaining an insight into other services.

The aim of the peer review is not to inspect the service, but to validate the data from the self review and record any changes that have taken place since the self review. Liaison professionals, referrers, users and carers are all invited to reflect on the achievements of the liaison team and discuss how the service could be improved or developed in the future.

How is accreditation decided?

Data from the self and peer review are compiled by the central PLAN team into a summary report of the service's strengths and areas for improvement. This report is then considered by the PLAN Accreditation Committee (AC), which makes a recommendation about accreditation status. The liaison team in question is provided with ample opportunity to comment on their report and inform the committee of any new developments to support the decision.

How many standards must be met to gain accreditation?

There are four **categories of accreditation status**

Category 1: "accredited with excellence". The service would:

- meet all Type 1 standards;
- meet at least 95% of Type 2 standards;
- meet at least 80% of Type 3 standards, with a clear plan for how to achieve the others;
- excel in other areas, such as research, audit or teaching;
- have positive feedback from service users and carers.

Category 2: "accredited". The service would:

- meet all Type 1 standards;
- meet at least 75% of Type 2 standards;
- meet at least 60% Type 3 standards.

Category 3: "accreditation deferred". The service would:

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

Category 4: "not accredited". The service would:

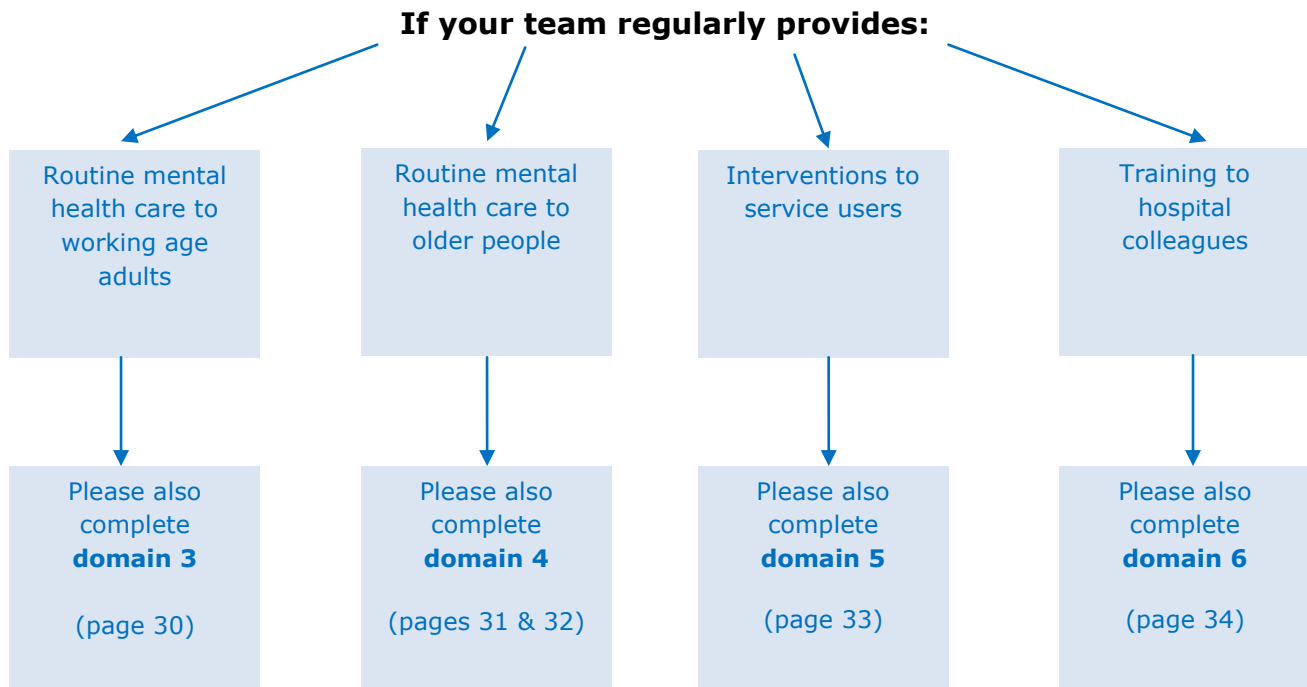
- fail to meet one or more Type 1 standard and not demonstrate the capacity to meet these within a reasonable period of time;
- fail to meet a substantial number of Type 2 standards and not demonstrate the capacity to meet these within a reasonable period of time.

In cases where accreditation cannot be awarded at the first attempt, the central PLAN team will provide the service in question with a list of the standards that need to be addressed. Time and support will be offered to help the team develop an action plan to make positive changes, giving teams the best chance of meeting the standards required. After an agreed period of time, the PLAN team will follow up the work through a further self and/or peer review, to determine if the service now meets sufficient standards to be accredited.

Which standards will teams be measured by?

All teams must complete **domain 1** (core standards for all liaison services) and **domain 2** (providing emergency mental health care to adults of all ages).

In addition, the team will need to complete any applicable domains from the following:



Please note:

- If you wish to opt out of any of the domains in the boxes above, you will be asked to provide a letter or written document outlining the remit of your liaison team.
- Accreditation certificates will state which domains each team has and has not been measured against. They will also state that accreditation is for the liaison team, and not any other services, such as out-of-hours services.

Notes about the standards

- For standards that refer to **'the majority'** of staff, service users or carers, the majority is taken to mean **75%** or more.
- Many of the standards relating to service user involvement assume that the service user in question has the required capacity to engage in their treatment and understand the information being provided. In some situations, this may not be the case. The PLAN data collection process recognises that the involvement of carers and/or the instigation of best practice decisions may sometimes be required.
- In order to meet these standards, teams operating across multiple sites must be able to demonstrate a consistently high service on all sites. For example, the standards around assessment facilities need to be met at all sites the team operates at.

Domain 1: Core standards for all Liaison Services (Working-age and Older Adults)

Core Commissioning and Resources			
Standard 1: Liaison psychiatry services to general hospitals are adequately planned, commissioned/contracted and managed			
No.	Type	Criterion	Ref.
1.1	2	Liaison services are explicitly commissioned/contracted against agreed service standards	ACAD
1.2	2	The liaison service is commissioned/contracted to provide emergency/urgent assessment and care to adults <i>of all ages</i> throughout the hospital <i>Note: if care is provided to one age group it must be clear which other services provide care to the other age group.</i>	GPP
1.3	2	The liaison service is commissioned/contracted to provide emergency/urgent care to adults <i>of all ages</i> , regardless of the service user's address	GPP
1.4	2	Liaison services are planned, developed and reviewed by a joint planning forum which meets quarterly, and includes the discussion of key operational, clinical and governance issues including safety <i>Note: this should include a senior liaison clinician, manager and other relevant managers from Mental Health and Acute Trusts/Health Boards. Where appropriate, commissioners, service users and carers will also be involved.</i>	JOINT
1.5	1	The managing Trusts/organisations have an agreed protocol in place for reporting and responding to safety concerns raised by staff from either Trust <i>Note: this should link to governance structures.</i>	GPP
1.6	2	Liaison professionals are involved in Trust/organisational meetings which address critical incidents, near-misses and other adverse incidents, where relevant to the liaison team	GPP

Please note:

- Standards relating to the commissioning of routine mental health care for working age adults can be found on page 30.
- Standards relating to the commissioning of routine mental health care for older people can be found on page 31.

Standard 2: The liaison team has access to appropriate facilities and resources			
No.	Type	Criterion	Ref.
2.1	1	The liaison team has office space with essential facilities (i.e. computer equipment, telephone, fax machine and internet access)	GPP
2.2	2	The liaison team has an additional breakout room for confidential activities such as supervision	PIG
2.3	2	The liaison team's office space is fit for purpose and meets health and safety standards	GPP

Referral Procedures			
Standard 3: The liaison team provides an effective service to referrers			
No.	Type	Criterion	Ref.
3.1	2	The majority of acute colleagues are satisfied with the amount of mental health input provided within the liaison team's working hours	GPP
3.2	1	The majority of referrers understand <u>how</u> to refer patients to the liaison team (i.e. contact details and who to contact when the liaison team is off duty)	GPP
3.3	1	The majority of referrers know the liaison team's working hours	GPP
3.4	2	The majority of referrers understand which type of situations or presentations require a referral to the liaison team	JOINT GPP
3.5	2	The majority of referrers are satisfied with the referral procedure	GPP
3.6	2	The majority of referrers are satisfied with the communication provided by the liaison team between initial referral and assessment <i>Note: this includes updates on waiting times and any delays and telephone advice to the referrer about how to manage the situation.</i>	GPP
3.7	2	The majority of referrers are satisfied with the time it takes to receive a senior opinion/final decision from the liaison team	GPP
3.8	2	The majority of referrers are satisfied with the communication provided by the liaison team after the assessment (including the care or discharge plan in the physical health notes)	GPP
3.9	3	Liaison professionals can demonstrate that they proactively seek referrals and raise awareness of the liaison function, for example through staff training and multi-disciplinary meetings <i>Note: it is acknowledged that this is not practical for small or over stretched teams but this can be a long term aspiration.</i>	JOINT

3.10	1	<p>There is a clear pathway for referrers to access advice from a consultant psychiatrist where needed during the liaison team's normal working hours</p> <p><i>Note: It should not be assumed that a consultant psychiatrist's opinion is always needed but where it <u>is</u> necessary, acute staff should be able to access input either through the liaison team or another mental health service, either through the liaison team or other mental health service..</i></p>	ACAD
3.11	2	<p>The majority of referrers are satisfied with the time it takes to access advice from a consultant psychiatrist during the liaison team's normal working hours</p> <p><i>Note: this may be through the liaison team or from a psychiatrist in another mental health service.</i></p>	ACAD

Mental Health Assessment and Care Planning

Standard 4: Mental health assessments take place in an appropriate and safe environment

- *Important! In order to meet these standards, teams operating across multiple sites must have access to some acceptable facilities at all sites.*
- *Sufficient private space should exist to ensure that patients and liaison staff do not have to travel far through the hospital to find a room suitable for assessment.*
- *The use of a curtain around a patient's bed does not ensure privacy and should only be used as a last resort, e.g. if there is significant risk and no safe alternative room or if it is not physically possible for the patient to be moved to a more private setting.*

No.	Type	Criterion	Ref.
4.1	2	<p>The liaison team can routinely access sufficient space in the Emergency Department to conduct assessments in privacy</p> <p><i>Note: if the majority of the liaison team's assessments take place on the Medical Assessment Unit, Acute Medical Unit, Clinical Assessment Unit (or similar), space for assessments must be accessible there.</i></p>	PIG
4.2	2	<p>The liaison team can routinely access sufficient space in the General Hospital to conduct assessments in privacy</p> <p><i>Note: on wards where there is no dedicated space for mental health assessments, the liaison team has arrangements in place with acute staff to access suitable rooms. This might include relatives' rooms, a sister's office or any other private space that is available and suitable.</i></p>	PIG
4.3	1	<p>The liaison team has a procedure for determining the level of risk involved in conducting an assessment (i.e. checking past notes, liaising with other colleagues) and takes the necessary precautions if needed</p>	GPP

4.4	1	<p>The liaison team has a clear procedure for managing 'high risk' assessments</p> <p><i>Note: written guidance should include:</i></p> <ul style="list-style-type: none"> • a description of suitable facilities for high risk assessment (see 4.5); • arrangements for alerting acute colleagues that the assessment is taking place, including where it is taking place; • guidance on the frequency of checks and observations, depending on the nature of the concern; • agreements about other liaison or acute staff being present during the assessment, if appropriate; • agreements for involving security staff where needed; • arrangements for removing furniture where needed. 	GPP
4.5	1	<p>The liaison team has access to facilities and equipment for conducting high risk assessments</p> <p><i>Note: facilities suitable for high risk assessments must ensure the safety of staff and service users. They should:</i></p> <ul style="list-style-type: none"> • be located close to, or within, the main Emergency Department or Acute Medical Unit; • have a door which opens both ways and is not lockable from the inside; • have an observation panel or window; • have a panic button or alarm system (unless the staff carry alarms <u>at all times</u>); • only include furniture, fittings and equipment which are unlikely to be used to cause harm; • ideally, the facilities should also include two doors. <p><i>Important! If a team is unable to meet all of the points above, staff must be able to satisfy the peer review team and Accreditation Committee that facilities and procedures ensure the safety of service users and staff.</i></p>	ASS'T
4.6	1	<p>If the emergency department is an allocated 'place of safety' there is a policy in place in line with legislation</p> <p><i>Note: the Mental Health Act 1983 (section 136), Mental Health (Care and Treatment) (Scotland) Act 2003.</i></p>	GPP
4.7	1	<p>The majority of service users and peer reviewers agree that the assessment facilities are safe</p>	ASS'T GPP
4.8	2	<p>The majority of service users and peer reviewers agree that the assessment facilities are private</p>	ASS'T GPP

Standard 5: Mental health assessments are comprehensive, supportive and focus on patient needs			
No.	Type	Criterion	Ref.
5.1	2	The majority of liaison professionals are satisfied with the length of time they are able to spend on each assessment (including face-to-face time, reading notes and writing up notes)	PIG GPP
5.2	2	The majority of service users (or carer, if present) are satisfied with the length of time spent on the mental health assessment	GPP
5.3	1	The peer review team (and/or Accreditation Committee) agree that the majority of care plans are well constructed <i>Note: care plans should:</i> <ul style="list-style-type: none"> • <i>Demonstrate that the assessor has made efforts to access past notes;</i> • <i>Include a clear formulation or diagnosis;</i> • <i>Indicate a care/discharge plan which aims to address problems and build on the service user's (and carer's) strengths and needs.</i> 	PIG
5.4	2	If the service user presents with a companion, the assessor offers service users the choice of them being present during the assessment <i>Note: if involving carers, it is good practice for the assessor to spend time alone with the service user first, to ensure that the service user can speak privately. In other cases, where the carer wishes to speak to the assessor in private, this should also be facilitated (with the service user's permission).</i>	SH
5.5	1	If the service user has dementia or suspected dementia, the liaison professional establishes whether a specialist assessment is needed, and either carries this out or signposts to a service that can complete an assessment <i>Note: if assessment is needed but the liaison team does not have the necessary expertise, they should refer the patient to liaison services for older people, specialist community mental health teams, or a local memory service. People who are assessed for the possibility of dementia should be asked if they wish to know the diagnosis and they should be asked with whom the outcome should be shared.</i>	NICE1 GPP

Standard 6: Assessment includes consideration of issues around risk and mental capacity			
No.	Type	Criterion	Ref.
6.1	1	<p>The quality of risk assessment (regarding the patient's risk to self and others) is judged by the peer review team and/or Accreditation Committee to be sufficient</p> <p><i>Note: the risk assessment is likely to include some of the following:</i></p> <ul style="list-style-type: none"> • <i>harm to self - i.e. current suicidal intent, hopelessness, depression and self neglect;</i> • <i>vulnerability - e.g. risk factors for older people and the protection of vulnerable adults, including people with learning disabilities;</i> • <i>triggers to symptoms and behaviours;</i> • <i>deterioration;</i> • <i>absconding;</i> • <i>non-adherence to treatment;</i> • <i>harm to others, including child protection issues.</i> 	PIG GPP
6.2	1	<p>The liaison team has a written policy on managing different levels of risk</p> <p><i>Note: this is likely to include:</i></p> <ul style="list-style-type: none"> • <i>developing a risk management plan;</i> • <i>procedures and timescales for communicating the plan to relevant colleagues.</i> 	GPP
6.3	1	<p>If risk has been established, the assessor records a risk management plan in the case notes and communicates this with colleagues</p>	GPP
6.4	1	<p>Liaison professionals are able and available to advise colleagues on issues around mental capacity</p> <p><i>Note: it is not the sole responsibility of the liaison team to assess mental capacity; this should be undertaken by the medical professional proposing the action being taken. However, in complex or borderline cases, the liaison professional may be able to offer valuable insight, and should endeavour to do so.</i></p>	PIG

Standard 7: When a person is being discharged from the liaison team and/or referred onwards, the team shares all relevant information			
No.	Type	Criterion	Ref.
7.1	1	The assessor communicates the discharge/care plan to other relevant services	GPP
7.2	2	The discharge/care plan is communicated to other services in a timely manner <i>Note: i.e. for high risk cases, on the same day; for others, within 7 working days.</i>	PIG GPP
7.3	1	The liaison team has a policy on confidentiality and information sharing <i>Note: this includes informing service users about where information about them is being sent, and why.</i>	GPP

Involving Service Users and Carers			
Standard 8: Service users are fully involved in, and informed about, all aspects of their care			
<i>Note: the default position should be to involve the service user as fully as possible. It is acknowledged that there may be occasions where patients cannot be fully involved and informed (i.e. where it would cause distress, or where the patient lacks the capacity or cognitive skills to understand what is being said or written, even with support). Carers should also be involved when it is in the service user's best interests.</i>			
No.	Type	Criterion	Ref.
8.1	1	The majority of service users report that they were involved in discussions about their problems and the different treatments or interventions available <i>Note: this includes encouraging individuals to express preferences and involving them as fully as possible in all decisions about discharge or onward care. For those patients with emergency care plans, crisis cards or advance directives, the contents of these should be taken into account when deciding when and how to intervene.</i>	NICE
8.2	2	The majority of service users report that they were treated with dignity, respect and understanding by liaison professionals	NICE
8.3	1	The liaison professional <u>offers</u> service users written information explaining what was discussed in the assessment and what will happen next <i>Note: this may be in the form of a handwritten summary, or information filled in on a patient leaflet, or a copy of a letter to another professional.</i>	NICE

8.4	1	<p>If future or ongoing care is being offered (whether by the liaison team or another service), the liaison team provides the service user with basic information about this</p> <p><i>Note: information about another service is likely to include:</i></p> <ul style="list-style-type: none"> • the name and contact details of a link person at the service; • in broad terms, what to expect from the other service and the purpose of referral. 	PIG
8.5	3	<p>The liaison team record in the case notes whether or not the service user was offered written information about the care/discharge plan</p> <p><i>Note: the notes should detail any reason why these were not offered.</i></p>	GPP
8.6	2	<p>Service users are <u>offered</u> the choice of receiving copies of letters between the liaison team and other services, unless there is good reason not to do so</p> <p><i>Note: this guidance derives from Department of Health guidance for services in England and Wales. Services in other jurisdictions should have similar means of informing patients of their rights to view their records.</i></p>	DH
8.7	3	<p>The liaison team record in the case notes whether or not the service user was offered the choice of being copied into letters to other services</p> <p><i>Note: the notes should detail any reason why these were not offered. Letters in the notes which show that a patient/carer was copied in are also acceptable evidence of this standard.</i></p>	GPP
8.8	2	<p>The liaison team can access advocacy services, including PALS, Independent Mental Health Advocates, Independent Mental Capacity Advocates and Mental Health Act Advocates.</p>	GPP

Standard 9: The liaison team considers the needs and views of carers			
No.	Type	Criterion	Ref.
9.1	1	<p>Where appropriate, and with the service users consent, the liaison professional <u>offers</u> carers written information explaining what was discussed in the assessment and what would happen next</p> <p><i>Note: designated carers should be involved as fully as possible.</i></p>	NICE
9.2	2	<p>Where appropriate, and with the service user's consent, the appointed carer is offered the choice of being copied into written communication between the liaison team and other services</p>	DH

9.3	1	Where appropriate, and with the service user's consent, the liaison team involves the carer in decisions about the service user's care and treatment	JOINT
9.4	2	The majority of relatives/friends/carers report that the liaison team were supportive and helpful	NICE
9.5	3	Where appropriate, the liaison team advises carers on how they may continue to support the service user in the general hospital <i>Note: for example, this may include re-orientation or stimulation for patients with dementia, reading material from home for patients with depression, etc.</i>	GPP
9.6	3	The liaison team advises carers on how to access further support for themselves. For example, how to access an assessment of their own needs and how to contact carer support services	CCQI2

Standard 10: The liaison team provides service users and carers with information appropriate to their needs			
No.	Type	Criterion	Ref.
10.1	1	The liaison team offers accessible information on how to access emergency out-of-hours help, where needed <i>Note: where appropriate, this might include helping the service user draw up an action plan for future mental health crises, if this has not already been undertaken.</i>	PIG
10.2	2	The liaison team offers accessible information about common mental health problems	GPP
10.3	2	The liaison team offers accessible information on how to access further support through other health services, social services, advocacy and voluntary sector services <i>Note: this may include local community mental health teams, memory clinics, dementia services, substance misuse services, eating disorder services, housing and accommodation services, self harm support, voluntary sector organisations and user groups and advocacy services.</i>	GPP
10.4	2	The liaison team offers a leaflet describing the role of the liaison service	GPP

10.5	2	<p>The majority of service users, carers and peer reviewers agree that the liaison team offers satisfactory information in the majority of the areas below:</p> <ul style="list-style-type: none"> • emergency out-of-hours help; • common mental health problems; • accessing further support through other health services, social services, advocacy and voluntary sector services; • the role of the liaison service. 	GPP
-------------	---	---	-----

Standard 11: The liaison team has the resources required to communicate effectively with service users and carers			
No.	Type	Criterion	Ref.
11.1	2	<p>The liaison team can access information in a range of formats to suit individual patient needs</p> <p><i>Note: the hospital Trust/Health Board should be able to access key information in languages other than English, and for people with sight, hearing, and learning or literacy difficulties.</i></p>	JOINT GPP
11.2	2	<p>Liaison professionals have timely access to professional interpreters/signers through the provider Trust/organisation</p> <p><i>Note:</i></p> <ul style="list-style-type: none"> • <i>Relatives should not be used as sole interpreters;</i> • <i>Where appropriate, telephone interpreters can be used, but ideally should not be used for initial assessments;</i> • <i>The Trust/organisation should have agreed timescales for providing interpreters/signers.</i> 	CQI1 GPP
11.3	2	<p>Liaison professionals can access equipment to facilitate communication with people with visual and/or hearing impairment, cognitive impairment or learning disability</p> <p><i>Note: this might include a white board, marker pen and other visual aids, hearing amplifier and similar aids.</i></p>	GPP

Collaborative Working in the General Hospital			
Standard 12: There is effective collaboration between the team and general hospital staff			
No.	Type	Criterion	Ref.
12.1	2	The liaison team and general hospital staff have an agreed system which allows both parties to alert each other to service users who are at risk	CR118
12.2	2	If the liaison team provides a service to the <u>Emergency Department</u> , a member of the liaison team meets with emergency department staff at least quarterly	GPP
12.3	2	If the liaison team provides a service to the <u>general hospital</u> , a member of the liaison team meets with relevant hospital staff at least quarterly	GPP
12.4	1	Liaison professionals can access the physical health records of their patients	JOINT
12.5	2	Members of the liaison team can access both mental health and acute information systems	GPP
12.6	3	Liaison and acute managers ensure that there is a forum or procedure which allows the liaison team and acute staff to discuss differences of clinical opinion	PIG
12.7	1	<p>If members of the liaison team prescribe, there is a policy regarding the use of medication</p> <p><i>Note: this should be in line with local medicines management and include:</i></p> <ul style="list-style-type: none"> • <i>the team's agreed use of different medication;</i> • <i>mechanisms for checking contraindications between different medications being taken for mental and physical problems, including over-the-counter products, that may adversely affect cognitive functioning;</i> • <i>mechanisms for monitoring side effects and advising the service user on self-monitoring, where appropriate;</i> • <i>the different responses to medication in different age groups;</i> • <i>mechanisms for the safe administration and storage of medication;</i> • <i>guidance on how to access a pharmacist;</i> • <i>the use of honorary contracts for the liaison team.</i> 	GPP

Standard 13: Unless the liaison team provides 24 hour cover, there is effective collaboration between the liaison team and out-of-hours services (e.g. Crisis Resolution Home Treatment Teams, on-call staff, etc.)

No.	Type	Criterion	Ref.
13.1	1	<p>Joint protocols for out-of-hours cover are in place with the relevant service(s)</p> <p><i>Note: a written summary should be developed in consultation with out-of-hours staff and is likely to include guidance on:</i></p> <ul style="list-style-type: none"> • <i>the working hours and days of the liaison service and the out-of-hours team(s);</i> • <i>the clinical responsibilities of each service;</i> • <i>the handover responsibilities of each service.</i> 	ACAD PIG GPP
13.2	3	<p>The liaison team has working arrangements in place with other services, allowing shared strategies/care plans to be developed for service users who attend regularly</p> <p><i>Note: for example, the various teams and agencies relevant to that service user (e.g. mental health teams, social services, ambulance staff, etc) may collectively agree a care plan which should then be reflected in the patient notes.</i></p>	GPP
13.3	1	<p>The liaison team has written working arrangements detailing who is responsible for assessing patients who may need to be detained under mental health legislation</p> <p><i>Note: e.g. Approved Mental Health Professionals and/or Section 12 (England) and Section 20 (Scotland) doctors, or the Crisis Resolution Home Treatment Team. Details of how to contact Independent Mental Health/Mental Capacity Advocates should also be included.</i></p>	CR118

Interfaces with Other Services

Standard 14: The liaison team has written guidance with relevant services

Note: The liaison service should have written guidance for those services it deals with on a regular basis, including:

- *contact details of the other service;*
- *referral procedures and relevant forms;*
- *defined responsibilities of the referrers and the onward service;*
- *expected follow up times.*

No.	Type.	Criterion	Ref.
14.1	2	The liaison team has written guidance regarding referral/discharge to local mental health services (i.e. community mental health teams, inpatient units, home treatment teams etc).	GPP
14.2	2	The liaison team has written guidance regarding referral/discharge to local primary care services	GPP
14.3	2	The liaison team has written guidance regarding referral/discharge to specialist mental health services for older people <i>Note: a decision to refer someone to services for older people should be based on need and not just age.</i>	JOINT
14.4	2	Members of the liaison team have access to the Trust's/organisation's dementia care pathway (if the team is in England or Wales)	NDS (England)
14.5	2	The liaison team has written guidance regarding referral/discharge to local social services departments, according to local practice	PIG
14.6	2	There is a written agreement stating when it is appropriate for child or adolescent patients to be seen by the working age adult liaison team <i>Note: this should be based on need and not just the person's age. A written summary should be developed in consultation with Child and Adolescent Mental Health Services (CAMHS). This may include guidance regarding referral/discharge to CAMHS, if appropriate.</i>	GPP
14.7	2	Liaison professionals actively follow up referrals to other services to ensure that the referral has been received	GPP

Standard 15: Liaison professionals are able to contact and make referrals to other relevant services in their catchment area, including:			
No.	Type	Criterion	Ref.
15.1	2	Learning disability services	GPP
15.2	2	Eating disorder services	GPP
15.3	2	Child and Adolescent Mental Health Services (CAMHS)	GPP
15.4	2	Specialist services for older people	GPP
15.5	2	Services for people who misuse drugs or alcohol	GPP
15.6	2	Non-statutory agencies such as Samaritans, Mind, Rethink, Hearing Voices groups, and local service user and carer-led groups, etc.	PIG
15.7	2	Police services	PIG
15.8	2	Ambulance services	PIG
15.9	3	Prison staff and probation officers	PIG
15.10	3	Criminal justice liaison services	PIG

Staffing, Support and Communication			
Standard 16: The service is adequately staffed by a skilled team			
No.	Type	Criterion	Ref.
16.1	1	The liaison team comprises a number of staff to ensure that it can perform its core functions safely	PIG GPP
16.2	2	The liaison team comprises a number of staff that is proportional to national best practice guidance (see appendix 1)	GPP PIG
16.3	2	Staffing levels allow for cover to be provided in the event of prolonged absence, including sickness, maternity or annual leave <i>Note: in cases where cover is insufficient, the service has an acceptable contingency plan, such as minor and temporary reduction in non-essential services. This should be in the form of a written summary which is agreed with other services, if appropriate.</i>	CCQI1
16.4	3	There has been a review of the staff and skill mix of the liaison team within the past 12 months to identify gaps in the team <i>Note: the review should result in an action plan or business plan being submitted to the host organisation. This plan should then be used to inform decisions on recruitment and staff training.</i>	GPP

Standard 17: Structures are in place to provide clear lines of accountability and adequate staff supervision			
No.	Type	Criterion	Ref.
17.1	2	There are up-to-date documents which state the managerial and clinical responsibility and accountability of staff	CCQI3
17.2	2	All staff have up-to-date job descriptions and job roles	CCQI3
17.3	1	All members of the liaison team are clear about what their responsibilities are	CCQI2
17.4	1	All members of the liaison team are clear about who they are accountable to (i.e. who their line manager is)	CCQI2
17.5	2	All staff receive an annual appraisal	CCQI1
17.6	1	All staff are able to contact a senior clinical colleague at any time	CCQI2
17.7	2	All staff are able to meet with their peers for support	CCQI3
17.8	1	There are debriefing opportunities for staff following traumatic incidents	GPP
17.9	1	Members of the liaison team are offered regular clinical supervision <i>Note: frequency of supervision should be in line with whichever national guidance exists for the person's particular professional group (i.e. nurses, psychologists, psychiatrists, etc.).</i>	CCQI1
17.10	1	Supervision allows staff to reflect on their emotional responses to their work	SH
17.11	1	The majority of staff are satisfied with the frequency of supervision they receive	GPP
17.12	1	The majority of staff are satisfied with the quality of supervision they receive	GPP
17.13	1	Liaison professionals can access legal advice when necessary (i.e. on the use of legal frameworks, capacity and consent issues etc.)	JOINT

Standard 18: There is clear communication within the liaison team			
No.	Type	Criterion	Ref.
18.1	1	The liaison team meets regularly (e.g. daily contact and weekly meetings) <i>Note: for larger liaison teams which operate across various sites and shifts, arrangements are in place to ensure that staff from each group are represented in core team meetings.</i>	PIG
18.2	2	The liaison team uses one set of integrated multi-professional healthcare notes	PIG
18.3	2	The majority of the liaison team agree that communication within the team is effective	GPP

Standard 19: Structures are in place to ensure that the liaison team has access to training, education and guidance			
No.	Type	Criterion	Ref.
19.1	2	Liaison staff are asked about their training needs, at least annually, by their line manager	GPP
19.2	2	Staff are not routinely denied relevant training due a lack of funding	CCQI2
19.3	2	Staff are not routinely denied relevant training due a lack of staff cover	CCQI2
19.4	3	There is a rolling training programme for liaison professionals which is repeated to account for staff rotation and changes <i>Note: training programmes should include regular updates for long-term staff and not just new staff.</i>	GPP
19.5	2	All liaison staff know how to access the team's policies, procedures and written guidance relevant to their role	CCQI1
19.6	2	Liaison staff can access the intranet of their provider Trust or organisation	CCQI2
19.7	3	Liaison staff can access online journals, reference guides or text books	CCQI2
19.8	3	There are opportunities for liaison staff to shadow colleagues or attend placements in other areas of the hospital (e.g. emergency department, assisted medical units, general medical wards)	PIG

19.9	3	There are opportunities for liaison staff to shadow colleagues from Crisis Resolution/Home Treatment Teams	GPP
19.10	2	The liaison service provides an induction to new team members which is based on an agreed list of core competencies <i>Note: an induction checklist can be used to list the competencies new staff are expected to demonstrate, with timescales attached.</i>	GPP

Standard 20: Clinical and non-clinical members of the liaison team have access to training and education in:

No.	Type	Criterion	Ref.
20.1	1	A basic awareness of common mental health problems	SH
20.2	1	A basic awareness of risk <i>Note: including safety issues relating to the hospital environment, such as ensuring that service users are not isolated for long periods and staff knowing when to alert colleagues to potential hazards.</i>	SH
20.3	1	Information-sharing and confidentiality	CCQI1
20.4	2	Culturally sensitive practice, disability awareness and other diversity and equality issues	CCQI1
20.5	2	Mental health and stigma	GPP
20.6	2	Ageism and stigma	GPP
20.7	2	Recognising special needs and knowing how to access support for people with visual, hearing, literacy or learning disabilities	GPP

Standard 21: Clinical members of the liaison team have access to advice, training, and development opportunities appropriate to the service users they work with, in order to allow them to perform their core role

No.	Type	Criterion	Ref.
21.1	1	Clinical liaison staff have access to advice and training or development opportunities in <u>all</u> of the following areas: <ul style="list-style-type: none"> • Working with 16-18 year olds, if relevant • Working with older people, if relevant, including the detection and management of dementia, delirium and depression • Conducting mental health assessments of acute hospital patients • Assessing and managing a patient's risk to self and others • The use of legal frameworks, such as conducting assessments, deprivation of liberty, assessing capacity 	GPP PIG CCQI1 SH

		<p>and providing medico-legal advice to colleagues</p> <ul style="list-style-type: none"> • Detecting and managing acute disturbance in physically ill people of all ages (e.g. delirium, psychosis etc) and the use of rapid tranquilisation, if used • The protection of vulnerable adults and child protection issues, including responding to suspected abuse or domestic violence • Understanding why people self-harm and the difference between self-harm and acts of suicidal intent (for working age adults and for older people) • Suicide awareness, prevention techniques and approaches • Preventing and managing challenging behaviour • Detecting the misuse of alcohol and knowing where to signpost if necessary • Detecting the misuse of drugs and knowing where to signpost if necessary 	
21.2	2	<p>Clinical liaison staff have access to advice and/or training and/or development opportunities in at least <u>60%</u> of the following areas:</p> <ul style="list-style-type: none"> • Understanding the interface between complex physical and psychological problems • Recognising and managing emotional responses to trauma • Recognising and managing medically unexplained symptoms • Recognising and managing organic mental health disorders • Person-centred care planning • The use of therapeutic approaches in the assessment process, such as motivational interviewing, cognitive behavioural therapy techniques, or psychotherapeutic or systemic theories • Awareness of the processes involved in adjusting to illness, including issues of non-adherence to treatment and phobic responses to illness • Working with people diagnosed with personality disorder • The impact of cultural differences on mental health and use of services • The needs of people with learning disabilities • Awareness of the liaison team's role following major incidents • Referral pathways and joint working arrangements with the hospital and other services • The role of nutrition and diet in liaison psychiatry patients 	<p>PIG JOINT GPP SH ACAD CR118</p>

Standard 22: Liaison team training is planned and delivered in collaboration with key partners			
No.	Type	Criterion	Ref.
22.1	2	Service users and carers are actively involved in the planning of training to liaison professionals <i>Note: this might be through the Trust/organisation or third sector and may include developing a training session, developing materials, DVDs, etc.</i>	PIG
22.2	2	Service users/carers are actively involved in the delivery of training to liaison professionals <i>Note: this might be through the Trust/organisation or third sector.</i>	PIG
22.3	3	Liaison team members have received training delivered directly by service users/carers in the past 12 months	GPP
22.4	2	Training includes input from acute hospital staff	PIG
22.5	2	There is an ongoing programme of training which is planned and delivered jointly by acute and mental health staff	ACAD

Quality, Audit and Feedback			
Standard 23: The liaison service is regularly reviewed			
No.	Type	Criterion	Ref.
23.1	2	The liaison team has undertaken at least one clinical audit or service review in the past twelve months	PIG
23.2	3	The liaison team has monitored its performance against clinical outcome measures or performance indicators in the past twelve months	GPP
23.3	2	The liaison team has involved service users and carers in reviews of the service in the past twelve months	PIG
23.4	2	Written information is offered to service users and carers about how to give feedback to the team, including positive comments and complaints	PIG
23.5	3	There is an ongoing, formal mechanism for collecting feedback from service users and carers	PIG
23.6	2	There is evidence of action and feedback from comments and complaints	CCQI2
23.7	3	The liaison team has a written document detailing key performance indicators, e.g. response times to referrals	GPP
23.8	3	The liaison team uses findings from service evaluation to support/inform business cases, reconfiguration exercises etc	GPP
23.9	2	If providing an outpatient service, the team monitors waiting times	GPP

Domain 2: Providing Emergency/Urgent Mental Health Care to Adults of all Ages

Definitions of 'emergency' and 'urgent' referrals

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

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

Standard 24: People with mental health needs are assessed within the appropriate timescales

Important notes:

- The following standards relate to the responsiveness of the liaison team within its usual operating hours and not the response of other services such as out-of-hours teams.
- When standards relating to response times are being measured, the process will take into account legitimate reasons for delayed assessment (such as patients not fit for assessment).
- The definitions of 'emergency' and 'urgent' referrals above are provided for the purpose of these standards only. We are not suggesting that each team adopts this system of classification.

No.	Type	Criterion	Ref.
24.1	1	Service users who are referred for emergency mental health care are seen within 60 minutes <i>Note: if the liaison team is not based on site and unable to respond to emergency assessments, there are clear arrangements regarding whose responsibility it is to do so. There should also be clear arrangements for immediate telephone advice to the referrer.</i>	CR118 GPP
24.2	1	Service users who are referred for urgent mental health care are seen within the same working day	GPP
24.3	2	The majority of referrers are satisfied with the liaison team's speed of response to emergency referrals	GPP
24.4	2	The majority of referrers are satisfied with the liaison team's speed of response to urgent referrals	GPP

Domain 3: Providing Routine Mental Health Care to Working Age Adults

Definitions of referral type

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

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

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

Standard 25: Liaison psychiatry services for the routine care of working age adults are adequately planned and commissioned/contracted

Note: 'routine' refers to all cases which are not emergency or urgent referrals.

No.	Type	Criterion	Ref.
25.1	2	The liaison service is commissioned/contracted to provide routine assessment and care to all working age adults throughout the hospital	GPP
25.2	2	The liaison service is commissioned/contracted to provide routine assessment and care to all working age adults, regardless of the service user's address	GPP

Standard 26: People with non-urgent mental health needs are assessed within the appropriate timescales

No.	Type	Criterion	Ref.
26.1	1	Service users who are referred for routine mental health care are seen within two working days	GPP
26.2	2	The majority of referrers are satisfied with the liaison team's speed of response to routine referrals for working age adults	GPP
26.3	3	<i>For teams that are striving for an 'excellent' accreditation status:</i> the two day target for non-urgent referrals, is consistently bettered	GPP

Domain 4: Providing Routine Mental Health Care to Older People

Please note: these standards are not the only standards relating to the care of older people; *all of the other standards* relate to the provision of emergency mental health care to older people. This section relates to services which also provide routine mental health care to older people.

Definitions of referral type

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

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

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

Standard 27: Liaison psychiatry services for older people are adequately planned, commissioned/contracted and managed			
No.	Type	Criterion	Ref.
27.1	2	The liaison service is commissioned/contracted to provide routine assessment and care to older people throughout the hospital	GPP
27.2	2	The liaison service is commissioned/contracted to provide routine assessment and care to all older people, regardless of the service user's address	GPP
27.3	2	A designated lead for older people's mental health attends <u>management meetings</u> at least quarterly	WCW
27.4	2	A designated lead for older people's mental health meets with <u>Emergency Department</u> staff at least quarterly	GPP
27.5	2	A designated lead for older people's mental health meets with <u>General Hospital</u> staff at least quarterly	GPP
27.6	2	A designated lead for older people's mental health meets with colleagues from <u>Care of the Elderly Wards</u> at least quarterly	GPP
27.7	2	A designated lead for older people's mental health meets with colleagues from the <u>Neurology Department</u> at least quarterly	GPP

Standard 28: The liaison team responds promptly to routine referrals for older people			
No.	Type	Criterion	Ref.
28.1	1	Service users who are referred for <u>routine</u> mental health care are seen within two working days	GPP
28.2	2	The majority of referrers are satisfied with the liaison team's speed of response to routine referrals for older people	GPP
28.3	3	<i>For teams that are striving for an 'excellent' accreditation status: the two day target for routine older adult referrals, is consistently bettered</i>	GPP

Standard 29: Liaison teams which regularly provide assessment and care to older people have access to advice, training and development opportunities appropriate to their core role, including:			
No.	Type	Criterion	Ref.
29.1	1	Detecting and managing <u>dementia</u> in older people	GPP
29.2	1	Detecting and managing <u>delirium</u> in older people	GPP
29.3	1	Detecting and managing <u>depression</u> in older people	GPP
29.4	1	Undertaking specialist assessments for older people <i>Note: this might include:</i> <ul style="list-style-type: none"> • <i>examination of attention and concentration, orientation, short and long-term memory, praxis, language and executive function;</i> • <i>formal cognitive testing using a standardised instrument, e.g. the Mini Mental State Examination (MMSE);</i> • <i>arranging for more in-depth neuropsychological testing as indicated, e.g. for early onset or complex dementia.</i> 	GPP
29.5	2	Undertaking subjective and objective assessments of a person's life <i>Note: this is likely to include:</i> <ul style="list-style-type: none"> • <i>social, family and carer history, circumstance and preferences;</i> • <i>physical and mental health needs;</i> • <i>current level of functioning and abilities;</i> • <i>an interview with an informant.</i> 	GPP
29.6	2	The roles of the different health and social care professionals, staff and agencies involved in the delivery of care to older people	GPP
29.7	2	Referral pathways and joint working arrangements with local health services for older people	GPP

Domain 5: Providing Interventions

Guide to timescales for interventions

Brief interventions: time limited therapy, often focusing on a specific problem with a limited number of sessions (usually fewer than 10)

Longer term interventions: over a longer or open-ended timescale and cover a range of problems

Standard 30: The liaison team is able to provide effective interventions, where needed			
No.	Type	Criterion	Ref.
30.1	2	The liaison service is commissioned/contracted to provide brief, time-limited follow-up care to service users	NIMHE
30.2	2	The liaison team provides brief, time-limited interventions <i>Note: sessions are likely to involve supporting the service user develop problem-solving skills and coping mechanisms. Sessions might incorporate cognitive behavioural therapy techniques, psychodynamic approaches and others. See Appendix 2 for interventions recommended by NICE.</i>	PIG GPP
30.3	3	The liaison team is commissioned/contracted to provide longer term therapeutic interventions in the general hospital	NICE GPP
30.4	3	The liaison team provides longer term therapeutic interventions	NICE
30.5	2	The liaison team can access sufficient space in the hospital to provide therapeutic interventions safely	GPP NICE
30.6	2	The majority of service users were satisfied with the length of time it took them to receive an appointment with the outpatient team	GPP
30.7	2	The majority of service users were satisfied with the number of follow-up sessions that are offered to them	GPP
30.8	2	The majority of service users and peer reviewers agree that the outpatient facilities are safe	GPP
30.9	2	The majority of service users and peer reviewers agree that outpatient facilities are private	GPP
30.10	2	The liaison team has access to a substance misuse worker to provide drug and alcohol assessments, interventions and signposting	GPP

30.11	3	There is expertise <u>within</u> the liaison team to provide assessments, interventions and signposting to people who may be misusing drugs	GPP
30.12	3	There is expertise <u>within</u> the liaison team to provide assessments, interventions and signposting to people who may be misusing alcohol	GPP
30.13	2	Liaison professionals actively follow up service users when an appointment with the liaison team has been missed	NICE
30.14	1	Liaison professionals have received training in any therapeutic interventions they provide	PIG
30.15	1	Liaison professionals receive supervision relating to any therapeutic interventions they provide	GPP

Domain 6: Providing Training to Hospital Colleagues

Standard 31: Formal structures are in place to allow the liaison team to provide training to other hospital professionals			
No.	Type	Criterion	Ref.
31.1	2	The liaison service is funded to deliver mental health training to staff in the Emergency Department	ACAD
31.2	2	The liaison service is funded to deliver mental health training to staff in the general hospital (wards and so on)	ACAD
31.3	3	The liaison team has a rolling programme of training for Emergency Department staff which is repeated to account for staff changes	CR118
31.4	3	The liaison team has a rolling programme of training for general hospital staff which is repeated to account for staff changes	GPP
31.5	3	The liaison team records details of the training it provides, such as the curriculum, a list of attendees and a summary of feedback	GPP
31.6	3	The liaison team has developed the training programme in consultation with training participants	GPP

Standard 32: The liaison team provides a comprehensive range of appropriate mental health training to other hospital professionals, including where relevant:

No.	Type	Criterion	Ref.
32.1	2	How to make an initial mental health assessment of an acute hospital patient	CR118
32.2	2	Working with adults aged over 65, including the detection and management of dementia, delirium and depression	GPP
32.3	2	How to assess and manage the patient's risk to self and others	CR118
32.4	2	The use of mental health legislation	CR118
32.5	2	Detecting and responding to acute disturbance in physically ill people of all ages e.g. delirium, psychosis etc	CR118
32.6	2	Understanding why people self-harm and the difference between self-harm and acts of suicidal intent (including older people)	NICE
32.7	2	Suicide awareness, prevention techniques and approaches	PIG
32.8	2	Preventing and managing challenging behaviour	PIG
32.9	2	Recognising and responding to organic mental health disorders	GPP
32.10	3	Detecting the misuse of alcohol	JOINT
32.11	3	Detecting the misuse of drugs	JOINT
32.12	3	Recognising and responding to emotional responses to trauma	JOINT
32.13	3	Recognising and responding to medically unexplained symptoms	GPP
32.14	3	Awareness of the processes involved in adjusting to illness, including issues of non-adherence to treatment and phobic responses to illness	GPP
32.15	3	The impact of cultural differences on mental health and use of services	ACAD SH
32.16	3	Mental health and stigma	GPP
32.17	3	Ageism and stigma	GPP
32.18	3	Working with people diagnosed with personality disorder	GPP

Standard 33: The liaison team provides support and supervision to non-mental health colleagues, including:

No.	Type	Criterion	Ref.
33.1	2	Informal supervision, such as case reviews, multi-disciplinary discussions, etc. to acute colleagues	CR118
33.2	3	Formal regular supervision to acute colleagues	GPP
33.3	3	Formal regular supervision to trainee psychiatrists and doctors	JOINT

Appendix 1: Examples of Liaison Psychiatry Staffing Levels

Three tables are provided here, giving recommended staffing levels for liaison teams. The first table is from the Mental Health Policy Implementation Guide, and the second and third tables are from the Faculty of Old Age Psychiatry report into psychiatric services for older people.

To many experts, the staffing levels in the first table represent **minimum numbers** and additional cover would almost certainly be required, depending on the population served, for example:

1. To provide a comprehensive liaison service which caters for the special needs of older adults and/or people with complex needs and dementia, greater numbers of staff are required and further disciplines are needed. Occupational therapy, social work, sessions from a support worker and additional administrative support would also be required.
2. Additional staffing would be required if the team's remit includes the management of patients with alcohol problems in the general hospital.
3. If liaison professionals are to provide teaching, training and support to colleagues within their team and throughout the general hospital, staffing would need to be increased to allow for this.
4. Finally, the tables that follow do not include Child and Adolescent Mental Health Services (CAMHS) to general hospitals.

Guidance from the Policy Implementation Guide

Different team structures agreed locally will require different staffing structures and there can be a degree of flexibility. For example, the proportions of nurses and psychologists may vary depending on staff availability.

Guidance from the joint report by the Royal College of Psychiatrists and the College of Emergency Medicine (formerly BAEM)

Teaching hospitals require increased staffing levels to cope with demands from tertiary medical services. Some hospitals have developed special liaison services to manage patients following self-harm and those with alcohol and drug problems. These developments should be supported.

Table 1: Example of suggested levels and skill mix for a team serving a general hospital with 650 beds and 750 new self-harm patients per year (Mental Health Policy Implementation Guide, Liaison Psychiatry and Psychological Medicine in the General Hospital, 2008)

Role	Grade	Time	Comment
Medical	Consultant	10 PA (programmed activity/sessions)	Accessible consultant leadership is essential to team functioning.
Nursing	Band 8	Whole time	One of the nursing roles should be as team leader.
Nursing	Band 7	3 x whole time	The nurses operate as autonomous practitioners.
Clinical Psychology	Band 8	1	May be provided from health psychology team.
Team PA	Band 4	1.5 x whole time	Core to referral, management, information gathering and communication.

If providing service for people with learning disabilities, the Policy Implementation Guide also recommends the following additional staff:

Role	Grade	Time	Comment
Nursing	Band 7	Whole time	Increased bed side work load, managing communication and hand holding in outpatients and during investigations.

If providing training, the Policy Implementation Guide also recommends the following additional staff:

Role	Grade	Time	Comment
Medical	ST 4-6	8PA	Trainees of all disciplines enrich the team but should be planned to be supernumerary to the core team.
Medical	F 1/F2	1-2 whole time	Foundation trainees can provide basic medical skills and learn more from nurse practitioners.

Table 2: Example of suggested staffing for a liaison service for older people in a hospital with 300-500 beds (2006 report of Old Age Psychiatry Faculty 'Specialist services for older people with mental illness')

Role	Time	Comment
Registered Mental Health Nurses	2 x whole time	
Senior Occupational Therapist	1 x whole time	
Social Workers	1.5 x whole time	Ideally able to fulfill responsibilities of mental health legislation.
Support Worker or Technical Instructor	1 x whole time	
Old-age Consultant Psychiatrist	Dedicated weekly sessions	
Medical Secretary	1 x whole time	
Clinical Psychology	Equivalent to 1 weekly session	

Table 3: Example of suggested staffing for a liaison service for older people in a large teaching hospital with 500-1000 beds (2006 report of Old Age Psychiatry Faculty 'Specialist services for older people with mental illness')

Role	Time	Comment
Registered Mental Health Nurses	3 x whole time	
Senior Occupational Therapist	2 x whole time	1 senior 1 grade and 1 senior 2 grade
Social Workers	2.5 x whole time	Ideally able to fulfill responsibilities of mental health legislation.
Support Worker or Technical Instructor	2 x whole time	
Old-age Consultant Psychiatrist	3 dedicated weekly sessions	
Medical Secretary	1 x whole time	
Administration secretarial support	1 x whole time	
Clinical Psychology	Equivalent to 2 weekly sessions	

Appendix 2: Examples of Interventions Recommended by Nice

Anxiety: <http://guidance.nice.org.uk/CG22/Guidance/pdf/English>

- Cognitive Behavioural Therapy (CBT)
- Structured problem solving

Dementia: <http://www.nice.org.uk/nicemedia/pdf/CG042NICEGuideline.pdf>

For those who have depression and/or anxiety:

- CBT
- Reminiscence therapy
- Multisensory stimulation

Depression: <http://www.nice.org.uk/nicemedia/pdf/CG23fullguideline.pdf>

- Structured problem solving (mild-moderate depression)
- Brief CBT
- Counselling
- Interpersonal therapy (IPT) (moderate –severe depression)
- Psychodynamic therapy (complex co-morbidities)

Depression with a chronic physical health problem–guideline in development:

<http://www.nice.org.uk/nicemedia/pdf/DCHPPPCFullGuideline.pdf> pg 215

- Group-based CBT or individual CBT for patients who decline group-based CBT or for whom it is not appropriate, or where a group is not available
- Couples therapy
- For patients with initial presentation of severe depression and a chronic physical health problem, consider offering a combination of individual CBT and an antidepressant.

Drug misuse: <http://guidance.nice.org.uk/CG51/NiceGuidance/pdf/English>

- Group based psycho-educational interventions
- Contingency management
- Behavioural couples therapy
- CBT for co-morbid depression and anxiety

Schizophrenia: <http://www.nice.org.uk/nicemedia/pdf/CG82FullGuideline.pdf>

- Cognitive Behavioural Therapy
- Arts therapy

Self-harm: <http://guidance.nice.org.uk/CG16/Guidance/pdf/English>

- Behavioural Therapy

Appendix 3: Key to References

The documents listed below demonstrate those which inspired, or those which closely relate to, the various PLAN criteria. Although many of the PLAN criteria map closely to these documents, some criteria have been adapted and revised slightly, and should therefore not necessarily be interpreted as direct quotes from the source documents.

ACAD	Academy of Medical Royal Colleges (2008). Managing urgent mental health needs in the acute trust. A guide by practitioners, for managers and commissioners in England and Wales. http://www.aomrc.org.uk/aomrc/admin/reports/docs/MHdoc.pdf
ASST	Royal College of Psychiatrists (2004). Assessment following self-harm in adults. Council report CR122. http://www.rcpsych.ac.uk/files/pdfversion/cr122.pdf
CCQI 1	Royal College of Psychiatrists (2009). Inpatient services for people with learning disabilities standards. http://www.rcpsych.ac.uk/pdf/LD%20standards_Pilot%20version.pdf
CCQI 2	Royal College of Psychiatrists (2009). Standards for Acute Inpatient Wards – Working Age Adults. http://www.rcpsych.ac.uk/pdf/Standards%20for%20Acute%20Inpatient%20Wards%20-%20Third%20Edition.pdf
CCQI 3	Royal College of Psychiatrists (2008). Quality Improvement Network for Multi-Agency CAMHS: Service Standards (second edition). http://www.rcpsych.ac.uk/pdf/QINMAC%20Standards%202nd%20Edition%202008%20.pdf
CR118	Royal College of Psychiatrists and British Association for Accident and Emergency Medicine London (2004). Psychiatric services to accident and emergency departments. Council report CR118. http://www.rcpsych.ac.uk/files/pdfversion/cr118.pdf
GPP	'Good Practice Principle': established by expert consensus, July 2009 and August 2010 (see acknowledgements on page 46 for details of those who contributed).
JOINT	Royal College of Psychiatrists and the Royal College of Physicians (2003). The psychological care of medical patients: A practical guide. College report CR108. http://www.rcpsych.ac.uk/files/pdfversion/cr108.pdf
NDS	Department of Health (2009). Living well with dementia: A National Dementia Strategy. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_094051.pdf
NICE	National Institute of Clinical Excellence (NICE) and the National Collaborating Centre for Mental Health (2004). The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. http://www.nice.org.uk/nicemedia/pdf/CG16FullGuideline.pdf

NICE1	National Institute for Health and Clinical Excellence (2006). Dementia: The NICE-SCIE guideline on supporting people with dementia and their carers in health and social care. http://www.nice.org.uk/nicemedia/pdf/CG42Dementiafinal.pdf
NIHME	Stuart-Smith, M and Foster-Smith, D (2006). Mapping report of accident & emergency self-harm services across the South East region.
NO-H	Royal College of Psychiatrists and Academy of Medical Royal Colleges (2009). No health without mental health: the supporting evidence. http://www.rcpsych.ac.uk/pdf/No%20Health%20without%20mental%20health%20the%20Evidence.pdf
NSF	Department of Health (1999). National Service Framework for mental health: modern standards and service model. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4077209.pdf
PIG	Aitken, P (2007). Mental health Policy Implementation Guide: Liaison psychiatric and psychological medicine in the general hospital. http://www.rcpsych.ac.uk/pdf/Policy%20Implementation%20Guide%20-%20Liaison%20Psychiatry.pdf
SH	Royal College of Psychiatrists (2006). Better services for people who self-harm: Quality standards for healthcare professionals. http://www.rcpsych.ac.uk/PDF/Self-Harm%20Quality%20Standards.pdf

Appendix 4: Bibliography

Academy of Medical Royal Colleges (2009). *No Health without Mental Health: the ALERT summary report*.

http://www.aomrc.org.uk/aomrc/admin/reports/docs/NMMH_EMAIL.pdf

Archinard M, Dumont P & de Tonnac N. Guidelines and evaluation: improving the quality of consultation-liaison psychiatry. *Psychosomatics* 2005; 46, 425-430.

<http://psy.psychiatryonline.org/cgi/content/abstract/46/5/425>

Audit Commission. *Acute Hospital Portfolio. Review of National Findings. Accident and Emergency* Audit Commission, 2001.

[http://www.audit-](http://www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/aande.pdf)

[commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/aande.pdf](http://www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/aande.pdf)

Bell G, Reinstein DZ, Rajiyah G & Rosser R. Psychiatric screening of admissions to an accident and emergency ward. *Br J Psychiatry* 1991; 158, 554-557.

<http://bjp.rcpsych.org/cgi/content/abstract/158/4/554>

Bolton J & Kaneza N. Benchmarking a Liaison Psychiatry Service [correspondence]. *Psychiatr Bull* 2007; 31, 467.

<http://pb.rcpsych.org/cgi/reprint/31/12/467-a>

British Geriatrics Society, the British Association of Accident and Emergency Medicine, and the Royal College of Nursing (2001). The older person in the accident and emergency department.

http://www.bgs.org.uk/Publications/Compendium/compend_3-2.htm

Burlinson S & Guthrie E. Senior house officer training in liaison psychiatry – are college guidelines being implemented? *Psychiatr Bull* 2001; 25, 191-193.

<http://pb.rcpsych.org/cgi/reprint/25/5/191>

Crawford MJ & Wessely S. Does initial management affect the rate of repetition of deliberate self harm? Cohort study. *BMJ* 1998; 317, 985-990.

<http://www.bmj.com/cgi/content/full/317/7164/985>

Davies M. Towards the development of a reciprocal liaison service. *Psychiatr Bull* 2000; 24, 379-381.

<http://pb.rcpsych.org/cgi/reprint/24/10/379>

Department of Health. *A new ambition for old age. Next steps in implementing the national service framework for older people*. DH, 2006.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4133947.pdf

Department of Health. *Checklist: Improving the management of patients with ill mental health in emergency care settings - Checklist*. DH, 2004.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4089197.pdf

- Department of Health. *Copying letters to patients. Good practice guidelines*. DH, 2003.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4064281.pdf
- Department of Health. *Everybody's business: Integrating mental health services for older adults: a service development guide*. DH, 2005.
<http://www.mentalhealthequalities.org.uk/silo/files/everybodys-business-development-guide.pdf>
- Department of Health. *Fast-forwarding primary care mental health: Graduate primary care mental health workers – best practice guidance*. DH, 2003.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005784
- Department of Health. *National service framework for older people*. DH, 2001.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4071283.pdf
- Department of Health. *Providing patients with better information in emergency departments' – Toolkit*. DH, 2004.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4081348.pdf
- Department of Health. *Report of the high level group on clinical effectiveness*. DH, 2007.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_079814.pdf
- Department of Health. *Saving Lives: Our Healthier Nation*. DH, 1999.
<http://www.archive.official-documents.co.uk/document/cm43/4386/4386.htm>
- Department of Health. 8 tips for quick wins - improving responses for older people. DH, 2005.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4112224.pdf
- Dutta R, Bolton J, Heerah H & Turner E. Should liaison psychiatry change its name? *Psychiatr Bull* 2005; 29, 470.
<http://pb.rcpsych.org/cgi/reprint/29/12/470>
- Guthrie G & Creed F. *Seminars in Liaison Psychiatry*. London; Gaskell, 2006.
- Guthrie, E. (1998). Development of liaison psychiatry. Real expansion or a bubble that is about to burst? *Psychiatr Bull*, 22; 291-293.
<http://pb.rcpsych.org/cgi/reprint/22/5/291>
- Hawton K, Arensman E, Townsend E, Bremner S, Feldman E, Goldney R et al. Deliberate self harm: systematic review of efficacy of psychosocial and pharmacological treatments in preventing repetition. *BMJ* 1998; 317, 441-447.
<http://www.bmj.com/cgi/content/full/317/7156/441>

Howe A, Hendry J & Potokar J. A survey of liaison psychiatry services in the south-west of England. *Psychiatr Bull* 2003; 27, 90-92.

<http://pb.rcpsych.org/cgi/reprint/27/3/90>

Isacsson G & Rich CL. Management of patients who deliberately harm themselves. *BMJ* 2001; 322, 213-215.

<http://www.bmj.com/cgi/content/extract/322/7280/213>

Joint Royal Colleges Ambulance Liaison Committee (2006). UK ambulance service clinical practice guidelines.

http://www2.warwick.ac.uk/fac/med/research/hsri/emergencycare/prehospitalcare/jrcalcstakeholderwebsite/guidelines/clinical_guidelines_2006.pdf

Kendell RE. The distinction between mental and physical illness. *Br J Psychiatry* 2001; 178, 490-493.

<http://bjp.rcpsych.org/cgi/reprint/178/6/490>

Kewley T & Bolton J. A survey of liaison psychiatry services in general hospitals and accident and emergency departments: do we have the balance right? *Psychiatr Bull* 2006; 30, 260-263.

<http://pb.rcpsych.org/cgi/reprint/30/7/260>

Kingdon D & Young AH. Research into putative biological mechanisms of mental disorders has been of no value to clinical psychiatry. *Br J Psychiatry* 2007; 191, 285-290.

<http://bjp.rcpsych.org/cgi/reprint/191/4/285>

Lloyd GG. Origins of a section: liaison psychiatry in the college. *Psychiatr Bull* 2001; 25, 313-315.

<http://pb.rcpsych.org/cgi/reprint/25/8/313>

Lloyd GG & Mayou RA. Liaison psychiatry or psychological medicine? *The British Journal of Psychiatry* 2003; 183, 5-7.

<http://bjp.rcpsych.org/cgi/reprint/183/1/5>

Lloyd GG & Guthrie E. *Handbook of Liaison Psychiatry*. Cambridge: Cambridge University Press, 2007.

London Liaison Mental Health Nurses Special Interest Group. *A Competence Framework for Liaison Mental Health Nursing*. Edited by Chris Hart and Sarah Eales, 2004.

Masterton, G. Liaison psychiatry and general hospital management. *Br J Psychiatry* Oct 2003; 183, 366.

<http://bjp.rcpsych.org/cgi/content/full/183/4/366-a>

Molodynski A, Bolton J & Guest L. Is liaison psychiatry a separate speciality? Comparison of referrals to a liaison psychiatry service and a community mental health team. *Psychiatr Bull* 2005; 29, 342-345.

<http://pb.rcpsych.org/cgi/reprint/29/9/342>

Morgan JF & Killoughery M. Hospital doctors' management of psychological problems – Mayou & Smith revisited. *Br J Psychiatry* 2003; 182, 153-157.

<http://bjp.rcpsych.org/cgi/reprint/182/2/153>

Mujic F, Hanlon C, Sullivan D, Waters G & Prince M. Comparison of liaison psychiatric service models for older patients. *Psychiatr Bull* 2004; 28, 171-173.

<http://pb.rcpsych.org/cgi/reprint/28/5/171>

National Service Framework. *A national service framework for mental health*. NHS, 1999.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4077209.pdf

NHS Centre for Reviews and Dissemination, University of York (1998). *Effective Health Care: Deliberate Self-Harm*.

<http://www.york.ac.uk/inst/crd/EHC/ehc46.pdf>

NHS. *The NHS cancer plan. A plan for investment. A plan for reform*. NHS, 2000.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4014513.pdf

National Institute of Clinical Excellence (NICE) and the National Collaborating Centre for Mental Health. *The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care*. NICE CG16, 2004.

<http://www.nice.org.uk/nicemedia/pdf/CG016NICEguideline.pdf>

O'Keeffe N, Ramaiah US, Nomani E, Fitzpatrick M & Ranjith G. Benchmarking a liaison psychiatry service: a prospective 6-month study of quality indicators. *Psychiatr Bull* 2007; 31, 345-347.

<http://pb.rcpsych.org/cgi/reprint/31/9/345>

Pickereurope, Europe (2004). *Improving Patient's Experience. Sharing Good Practice/ Improving the Emergency Department Experience*.

http://www.pickereurope.org/Filestore/Quality/Factsheets/emergency_dept_newsletter_nov04.pdf

Price A, Hotopf M, Higginson IJ, Monroe B & Henderson M. Psychological services in hospices in the UK and Republic of Ireland. *Journal of the Royal Society of Medicine* 2006; 99, 637-639.

<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1676317>

Royal College of Paediatrics and Child Health, 2002. *Children's Attendance at a Minor Injury / Illness Service (MIS)*.

<http://www.rcpch.ac.uk/Publications/Publications-list-by-title#C>

Royal College of Psychiatrists. *Assessment following self-harm in adults*. *College Report CR122*. RCPsych, 2004.

<http://www.rcpsych.ac.uk/files/pdfversion/cr122.pdf>

Royal College of Psychiatrists. *Good Psychiatric Practice: Council Report CR83*. RCPsych, 2000.

<http://pb.rcpsych.org/cgi/reprint/26/7/278>

Royal College of Psychiatrists. *Managing deliberate self-harm in young people*. RCPsych, 1998.

<http://www.rcpsych.ac.uk/files/pdfversion/cr64.pdf>

Royal College of Psychiatrists. *Psychiatric services to accident and emergency departments. Council Report CR118*. RCPsych, 2004.
<http://www.rcpsych.ac.uk/files/pdfversion/cr118.pdf>

Royal College of Psychiatrists. *Raising the standard: Specialist services for older people with mental illness*. RCPsych, 2006.
<http://www.rcpsych.ac.uk/PDF/RaisingtheStandardOAPwebsite.pdf>

Royal College of Psychiatrists. *Who cares wins. Improving the outcome for older people admitted to the general hospital: Guidelines for the development of Liaison Mental Health Services for older people*. RCPsych, 2005.
<http://www.bgs.org.uk/PDF%20Downloads/WhoCaresWins.pdf>

Royal College of Psychiatrists and the Royal College of Physicians, 2003. *The psychological care of medical patients; a practical guide*.
<http://www.rcplondon.ac.uk/pubs/contents/75859822-65a2-4c9e-8110-887a7c820f59.pdf>

Solomons L, Thachil A, Burgess C, Hopper A, Glen-Day V, Ranjith G and Hodgkiss A (2009). From Liaison Psychiatry to Integrated Acute Services: referrer perceptions of an inpatient Liaison Psychiatry Service, *General Hospital Psychiatry*, 33(3): 260-6.

Appendix 5: Acknowledgements

We would like to thank the following people for their continued advice and support in compiling and editing these standards:

Steering Group

Simon Baston, Co-chair PLAN steering group, Mental Health Liaison Nurse, Emergency Care Directorate, Sheffield Teaching Hospitals NHS Foundation Trust

Else Guthrie, Co-chair PLAN steering group, Honorary Professor of Psychological Medicine and Medical Psychotherapy, University of Manchester

The late Janey Antoniou, Service User Advisor, London

Derek Bell, RCP representative/Professor of Acute Medicine at Imperial College/Consultant Physician at Chelsea and Westminster Hospital NHS Foundation Trust

Jim Bolton, Consultant Liaison Psychiatrist/Honorary Senior Lecturer, St. Helier Hospital, Surrey, and St. George's University of London

Paul Gill, Chair of the PLAN Accreditation Advisory Committee, Consultant Liaison Psychiatrist, Sheffield Health and Social Care NHS Foundation Trust

John Holmes, Senior Lecturer in Old Age Liaison Psychiatry, University of Leeds

Jackie Macklin, Service User Advisor/Patient Experience Diversity Manager, Kingston Hospital Trust, Surrey.

Satveer Nijjar, Service User Advisor, Wolverhampton

Richard Pacitti, Deputy Chair of the PLAN Accreditation Advisory Committee, Chief Executive of Mind in Croydon

The late Guy Sanders, Consultant in Emergency Medicine, Mental Health Lead for the Brighton and Sussex University Hospitals NHS Trust, Brighton and Hove

Barbara Woodworth, Clinical Service Manager, Liaison Psychiatry, Cheshire and Wirral Partnership Foundation NHS Trust

Other contributors

Deborah Agulnik, Quality Improvement Worker, Royal College of Psychiatrists' Centre for Quality Improvement

Richard Brownhill, Head of Nursing Unscheduled Care, Jersey Hospital

Stephen Burton, Consultant in Old Age Liaison Psychiatry, South London and Maudsley NHS Foundation Trust

Janet Butler, Consultant Liaison Psychiatrist, Hampshire Partnership Foundation Trust

J.B, Carer, London

Lisa Carden, Team Manager Wrexham Liaison Psychiatry, North East Wales NHS Trust

Sarah Eales, Lecturer in Mental Health, City University London

Tim Farmer, Team Manager, Mental Health Liaison, 2gether NHS Foundation Trust

Jane Glossop, Mental Health Social Worker, Liaison Psychiatry, Sheffield Health and Social Care NHS Foundation Trust

Clifford Greenhalgh, Carer Advisor, Llangollin

Lesley Herbert, Service User/Consumer Advisor, Hampshire Partnership NHS Foundation Trust

Jez Hill, Clinical Nurse Specialist, Liaison Psychiatry, South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Carole Holcroft, Deputy Team Manager, Mental Health Liaison Team, Portsmouth City Primary Care Trust

Paul Hosker, Health Liaison Nurse - Mental Health Lead, Betsi Cadwaladr University Health Board

Alison Langford, Mental Health Social Worker, Liaison Psychiatry, Sheffield Health and Social Care NHS Foundation Trust

Kirsten Lawson, Consultant Psychiatrist, Kent and Medway NHS and Social Care Partnership Trust (KMPT)

Paul Lelliott, Director, Royal College of Psychiatrists' Research Unit

Jamie Middleton, Mental Health Social Worker, Liaison Psychiatry, Sheffield Health and Social Care NHS Foundation Trust

Paul Morris, Lead Nurse - Mental Health, Chelsea and Westminster Hospital NHS Foundation Trust

Elizabeta Mukaetova-Ladinska, Consultant in Old Age Psychiatry, Northumberland, Tyne & Wear NHS Trust

Angela Nicholl, Clinical Nurse Manager, NHS Greater Glasgow and Clyde

Samantha O'Brien, Service User Advisor, Lincolnshire

Joanie Preston, Liaison Nurse Manager, Central & North West London NHS Foundation Trust

Elena Riseborough, Consultant Liaison Psychiatrist, Brighton and Sussex University Hospitals NHS Trust, Brighton and Hove

Angharad Ruttley, Consultant Liaison Psychiatrist, Imperial College Healthcare NHS Trust

Luke Solomons, Consultant in Old Age Psychiatry, Berkshire Healthcare NHS Foundation Trust

Kim Thorne, Team Manager, Mental Health Liaison Team, Portsmouth City Primary Care Trust

Lynn Tourle, Service User Advisor

Keith Waters, Team Leader/Clinical Nurse Specialist, Mental Health Liaison Team, Derbyshire Healthcare NHS Foundation Trust

Edwina Williams, Consultant Liaison Psychiatrist, Central & North West London NHS Foundation Trust

Members of the London Liaison Mental Health Nurse's Special Interest Group

Psychiatric Liaison Accreditation Network (PLAN)
Royal College of Psychiatrists' Centre for Quality Improvement
4th Floor Standon House
21 Mansell Street
London
E1 8AA

Registered Charity
Number 228636