Introduction
Mortality rates from medical disorders are high in older people with severe mental illness. The inpatient admission is a ‘window of opportunity’ to prevent premature deaths. Access to specialist medical advice on psychiatric wards is akin to access to liaison psychiatry in acute hospitals. Despite this, there is limited evidence of its efficacy or acceptability. Cambridge and Peterborough NHS Foundation Trust introduced a consultant geriatrician service to older adult psychiatric wards.

Results (1) – cohort evaluation
There were 222 admissions during the study period (102 prior to geriatrician intervention and 120 after). Reasons for consultation with a geriatrician were diverse but predominantly cardiovascular, infection, and electrolyte disturbances. The main reason for emergency transfer was for falls, followed by suspected infections. There was no difference in emergency transfers, but an increase in geriatrician consultations and decrease in speciality consultations (Frequency tables).

Length of stay was significantly higher in the control group compared to the intervention group (median 79 vs 52, U = 4664.5, p = 0.02, r = -0.20, indicating small to medium effect size, figure 2). There was no significant difference in non-psychiatric drug changes or change in discharge destination.

Conclusion
The liaison geriatrician service did not reduce emergency transfers but may reduce length of stay. The intervention was highly valued by psychiatrists and geriatricians.

Methods
We performed a retrospective cohort evaluation using electronic health records six months prior to and six months after the introduction of the geriatrician service and measured emergency transfers, geriatrician consultations, and other speciality consultations, length of stay, medication changes and discharge destination. We conducted semi-structured interviews of consultants and trainees who had worked with or prior to the service.

Results (2) – survey
Prior to the introduction of the service interviewees highlighted complexity and comorbidity, and a lack of senior support. With the service interviewees reported avoiding unnecessary transfers and referrals, reassurance and education. 100% were in favour of the service with 45% reasonably and 55% very satisfied.

Figure 1. Frequency tables and Mann Whitney U ranks for emergency transfers, geriatrician consultations, and other speciality consultations in the intervention (cases) and control periods. No significant difference in emergency transfers (p=0.499) but significant increase in geriatrician consultations (p=0.03) and decrease in speciality consultations (p<0.01).

Figure 2. Violin plots for length of stay in the control and intervention (case) periods and showing significant reduction in length of stay (Mann Whitney U test, p = 0.02)

‘We developed confidence in managing physical health, this did not just help us on the old age ward but on the on call rota’

‘We get more skilled and need less help over time. They (the geriatricians) will learn about complex psychiatric patients too, so win-win’