

Quality Standards for Psychiatric Liaison Services 8th Edition

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Contents

Foreword	3
Introduction.....	5
Sustainability Principles.....	6
Standards for Psychiatric Liaison Teams.....	8
Assessment, care planning and treatment.....	8
Patient and carer experience	17
Collaborative working	20
Workforce	24
Quality, audit and governance	31
Children and young people.....	34
Glossary of terms.....	37
References.....	40
Appendix 1: Examples of Liaison Psychiatry Staffing Levels	42

Foreword

It is with a sense of privilege and responsibility that I write this foreword for the 8th edition of the PLAN standards in my role as chair of the PLAN Advisory Group.

My mind drifts back to 2014, when Jo (Mental Health Nurse) and I (a new Consultant) sat across a wooden table with a sheet of blank paper to write standards for our then fledgling liaison service to the Royal Hampshire County Hospital. It was an existential requirement to produce evidence about how Liaison Psychiatry Service adds value to the care and treatment of elderly patients in an acute hospital in order to continue receive funding for our service. Later in 2015, the Royal College of Psychiatrists recognised our team by shortlisting us for the Older People's Mental Health Service Award.

I am convinced that all of us working in Liaison Services across the country will be able to narrate such anecdotes where we were involved in providing care for patients and families, in supporting our acute hospital colleagues and in developing invaluable mental health services. It is this ethos that has brought together groups of mental health clinicians across wide ranging professional backgrounds and lived-experience members in co-producing this edition of PLAN standards.

PLAN as a network of mental health services, aims to 'facilitate quality improvement and development in Liaison Psychiatry Services through a supportive peer review model and enabling communication and the sharing of best practice between services.' The focus of this edition of standards development has been towards enabling liaison services across the country to have SMART metrics towards showcasing their high-quality services and the inspiring work carried out by clinicians in providing mental healthcare to patients and families in acute hospitals. The revised standards also aim to provide Liaison Services to take ownership of the process of evidencing their high-quality work, towards the goal of PLAN accreditation visits becoming a day for recognising and reflecting on the highest standards of care provided by individual teams with a sense of pride.

I am hoping that in working with these standards, Liaison Services will be able to present their work of excellence at learning events organised by PLAN for shared learning and development of liaison services across the country, as well as encourage clinicians in member services to become peer reviewers for PLAN accreditation visits. I am also inviting feedback on this edition of standards for us to continue developing services that can then produce outcomes that would highlight the importance of holistic care and treatment of patients in acute hospitals.

Finally, my sincere thanks to PLAN team led by Cassie Regan and CCQI for their support and scrutiny in producing this 8th edition of PLAN standards.

Dr Vellingiri Raja Badrakalimuthu

**Doctor who looks after older people
Chair of the PLAN Advisory Group**

Introduction

The Psychiatric Liaison Accreditation Network (PLAN) was established in 2009 to support in the quality improvement of Psychiatric Liaison Teams in the UK and Ireland. It is one of almost 30 networks within the College Centre for Quality Improvement (CCQI) within the Royal College of Psychiatrists.

How have these standards been developed?

The standards against which services are measured have been developed with reference to the literature, current guidance on best practice, and in consultation with key stakeholders including patients, clinicians, service leads and national charities. To comment on the standards, suggest changes, or provide suggestions for new standards, please email plan@rcpsych.ac.uk.

Standard types

Each standard has been categorised as follows:

Type 1: Failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law. These standards also include the fundamentals of care, including the provision of evidence-based care and treatment.

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

Type 3: Desirable standards that high-performing services should meet. Some standards may be outside the direct control of the liaison team.

The full set of standards is aspirational, and it is unlikely that any service would meet them all. In order to achieve accreditation, a service must meet 100% of type 1 standards, at least 80% of type 2 standards and 60% of type 3 standards.

Acknowledgements

PLAN would like to thank everyone who contributed to this edition of standards, whether it was through feedback in the e-consultation, attending our workshops or sharing information. PLAN would also like to thank all of its member services for their contributions, and the Advisory Group and Accreditation Committee for their support and dedication in the on-going development of the network.

Sustainability Principles

The PLAN standards have been mapped against sustainability principles developed by the Royal College of Psychiatrists Sustainability Committee [Sustainability and working sustainably | Royal College of Psychiatrists \(rcpsych.ac.uk\)](https://www.rcpsych.ac.uk/sustainability)

The Royal College of Psychiatrists is striving to improve the sustainability of mental health care, by designing and delivering services with the sustainability principles at the core. The aim of this process is to raise awareness around sustainability in mental health services and to work towards making psychiatric services sustainable in the long run. In recent years the mounting economic, social and environmental constraints have put the mental healthcare system under enormous pressure and it is vital to ensure that high-value services continue despite these constraints. Developing a sustainable approach to our clinical practice is a crucial step in ensuring that mental health services will continue to provide high-quality care in the 21st century in the face of these constraints.

Sustainability in health services involves improving quality, cost and best practice, with a particular focus on reducing the impact on the environment and the resources used in delivering health interventions. A sustainable mental health service is patient-centred, focused on recovery, self-monitoring and independent living, and actively reduces the need for intervention.

Sustainability is written into the NHS constitution (Department of Health, 2013). In Principle 6, it states that the 'NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources'.

It is vital for professionals involved in designing mental health services to have a good understanding of sustainability i.e. the resources needed for each intervention, and to have an awareness of the effects of these interventions across economic, environmental and social domains. Adoption of these principles across mental healthcare would lead to a less resource-intensive and more sustainable service.

The five Sustainability Principles are listed below:

1. **Prioritise prevention** – preventing poor mental health can reduce mental health need and therefore ultimately reduce the burden on health services (prevention involves tackling the social and environmental determinants alongside the biological determinants of health).
2. **Empower individuals and communities** – this involves improving awareness of mental health problems, promoting opportunities for self-management and independent living, and ensuring patients and carers are at the centre of decision-making. It also requires supporting community projects that improve social networks, build new skills, support employment (where appropriate) and ensure appropriate housing.
3. **Improve value** – this involves delivering interventions that provide the maximum patient benefit for the least cost by getting the right intervention at the right time, to the right person, while minimising waste.
4. **Consider carbon** – this requires working with providers to reduce the carbon impacts of interventions and models of care (e.g. emails instead of letters, tele-health clinics instead of face-to-face contact). Reducing over-medication, adopting a recovery approach, exploiting the therapeutic value of natural settings and nurturing support networks are examples that can improve patient care while reducing economic and environmental costs.
5. **Staff sustainability** – this requires actively supporting employees to maintain their health and well-being. Contributions to the service should be recognised and effective teamworking facilitated. Employees should be encouraged to develop their skills and supported to access training, mentorship and supervision.



Services that meet 90% or more of the standards relevant to Sustainability Principles (marked with the logo, left) will be awarded a Sustainable Service Accreditation certification in recognition of provision of a sustainable mental health service.

Sustainability will automatically be examined alongside the usual review process and services will not have to submit extra evidence for this. Whether a service is awarded the sustainability certification or not will not affect the accreditation status of the service.

Standards for Psychiatric Liaison Teams

Assessment, care planning and treatment				
No.	Type	Standard	Rationale	Reference
1	1	The team provides information to acute hospital clinicians about the process for referral and services offered by the team.	To ensure there are clear processes to enable access to the service and joint working with acute colleagues.	1
2	2	The team provides information to acute colleagues on how to conduct an initial mental health assessment and risk assessment of an acute hospital patient, including the patient's risk to self and others.	Supports acute colleagues in working with patients with mental health needs and in line with CQC AMSAT report.	14
3	1	The team works with acute hospital staff to ensure patients are safe and supported whilst waiting for a mental health assessment. Guidance: <i>The team provides appropriate guidance to acute colleagues on the patient's history (including risk) and how to support them. Where a patient is struggling with challenging behaviour, the liaison psychiatry team should offer face-to-face support for acute colleagues where possible.</i>	Patient experience and safety.	3, 14
4	1	Private rooms are available so conversations cannot be overheard. These rooms offer dignity and privacy to conduct assessments and interventions.	Patient and carer experience.	1, 5

5	1	<p>Staff members introduce themselves to patients and explain the purpose of the clinical encounter.</p> <p>Guidance: <i>Staff members address the patient using the name and pronouns the person identifies themselves with.</i></p>	Patient experience.	1
6	2	<p>If the patient presents with a companion, the patient is offered the choice of them being present during the assessment.</p>	Patient care and experience.	7
7 	1	<p>Patients have a comprehensive biopsychosocial assessment which includes consideration of their:</p> <ul style="list-style-type: none"> • Mental and physical health; • Medication; • Psychosocial needs; • Support system; • Treatment and care needs. 	Patient care.	1
8	1	<p>The team has a procedure for assessing the level of risk to the clinician and others in the clinical area whilst conducting an assessment.</p> <p>Guidance: <i>This includes:</i></p> <ul style="list-style-type: none"> • <i>Checking past notes and/or liaising with other services;</i> • <i>Discussion with the referrer;</i> • <i>Speaking to friends, family/carers, if appropriate;</i> • <i>An initial risk assessment carried out by the referring clinician including patient's awareness of, and willingness to engage in an assessment.</i> 	Patient and staff safety.	7

9	1	The team records when patients are responsible for the care of children or adults at risk. Safeguarding action is taken where appropriate.	Safety.	1
10	1	Patients referred for mental health care by the Emergency Department are seen within one hour of referral.	National guidance.	3, 5
11	1	Patients recognised as needing emergency mental health care from inpatients wards are responded to within one hour.	National guidance.	3, 5
12	1	Patients referred for mental health care from the hospital inpatient wards are assessed within 24 hours of referral.	National guidance.	3
13	1	<p>Within four hours of referral to the team from the ED, the patient, where able to participate in an assessment, receives a full biopsychosocial assessment (as needed) and has an urgent and emergency mental health care plan in place.</p> <p>Guidance: <i>Where there is a delay in progressing further for the patient's care, the service should collect data on this.</i></p>	National guidance, NHS England operational statistic.	3
14	1	There is a Standard Operational Procedure, that both the team and acute services are aware of, that is implemented when a patient leaves the hospital before an assessment is completed.	Safety.	1

15	1	<p>The team has access to assessment rooms suitable for conducting high-risk assessments.</p> <p>Facilities should:</p> <ul style="list-style-type: none"> • Be located within the main emergency department; • Have at least two doors which opens outwards and are not lockable from the inside; • Have an observation panel or window which allows staff from outside the room to check on the patient or staff member but which still provides a sufficient degree of privacy; • Have a panic button or alarm system (unless staff carry alarms at all times); • Only include furniture, fittings and equipment which are unlikely to be used to cause harm or injury to the patient or staff member. For example, sinks, sharp edged furniture, lightweight chairs, tables, cables, televisions or anything else that could be used to cause harm or as a missile are not permitted; • Have a ceiling which has been risk assessed. Where risks are identified, there is a plan in place to mitigate the risk; • Not have any ligature points. Where these are identified, there is a plan in place to mitigate the risk; • If there is a bed within the room, this should be weighted with no ligature risks; 	Safety for patients and staff and facilities.	3, 5, 8
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		<ul style="list-style-type: none"> • Be checked for compliance with these standards prior to their use for patients. 		
16	2	<p>The high-risk assessment room should also:</p> <ul style="list-style-type: none"> • Be appropriately decorated to provide a sense of calmness; • Have sharp corners, such as at the corners of protruding walls covered to reduce the risk of harm; • Have a process in place to ensure the patient is monitored whilst in the room that is jointly agreed with Liaison and acute colleagues. 	Safety for patients and staff and facilities.	3, 5, 8
17	1	Assessments of patients' capacity (and competency for patients under the age of 16) to consent to care and treatment in hospital are performed in accordance with current legislation.	Legislation.	1
18 	1	<p>Patients have a risk assessment and management plan which is co-produced where possible and shared where necessary with relevant agencies, such as acute colleagues (with consideration of confidentiality).</p> <p>Guidance: <i>The assessment considers risk to self, risk to others and risk from others and takes into account the environment where the patient is being seen.</i></p>	Patient safety and care.	1, 3

19	1	<p>Staff are able to access and input patient notes onto the acute hospital note system. Notes are updated following contact and input from the team.</p> <p>Guidance: <i>Following a mental health assessment/review there should be a clear and concise summary and care plan in the general hospital notes. Please refer to the NCEPOD report for further details on what notes should contain.</i></p>	<p>From NCEPOD Treat as One Report Recommendations: Liaison psychiatry review should provide clear and concise documented plans in the general hospital notes at the time of assessment. As a minimum, the review should cover:</p> <ul style="list-style-type: none"> a. What the problem is (diagnosis or formulation) b. The legal status of the patient and their mental capacity for any decision needing to be made if relevant c. A clear documentation of the mental health risk assessment – immediate and medium term d. Whether the patient requires any further risk management e.g. observation level e. A management plan including medication or therapeutic intervention f. Advice regarding contingencies e.g. if the patient wishes to self-discharge please do this ‘...’ g. A clear discharge plan in terms of mental health follow-up (Faculty of 	15
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			Liaison Psychiatry, Royal College of Psychiatrists).	
20 	1	<p>Where appropriate, the team signposts patients to access organisations which offer:</p> <ul style="list-style-type: none"> • Housing support; • Support with finances, benefits and debt management; • Social services. 	Patient care.	1
21	1	<p>When medication is prescribed or recommended, specific treatment goals are set with the patient, the risks (including interactions) and benefits are discussed, a timescale for response is set and patient consent is recorded.</p> <p>Guidance: <i>Where people lack capacity to consent to medication, a discussion should take place involving the medical team and next of kin.</i></p>	Safety.	1
22 	1	<p>Patients have their medications reviewed regularly.</p> <p>Guidance: <i>Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime. Side effect monitoring tools can be used to support reviews.</i></p>	Safety.	1
23	3	Staff are able to discuss medications with a specialist pharmacist.	Patient care and experience.	1

24	1	<p>Information about the patients' care and treatment plan and additional services is provided in a format suitable for the patient. This includes:</p> <ul style="list-style-type: none"> • Information about the service including a simple description and the contact details; • How to access help from mental health services 24 hours a day, seven days a week; • Information about the patient's mental illness and treatment; • A summary of the assessment and the care plan. <p>Where appropriate, this information can be shared with the carer, with patient's consent.</p>	Patient care	1
25	1	<p>Where a patient has received a full assessment, a discharge letter is sent to the patient within seven days of discharge. The patient is informed that relevant professionals will receive the discharge letter. The letter includes the plan for:</p> <ul style="list-style-type: none"> • On-going care in the community/aftercare arrangements; • Crisis and contingency arrangements including details of who to contact; • Medication, including monitoring arrangements; • Details of when, where and who will follow up with the patient as appropriate. 	Patient care and information.	1

26	3	The team makes sure that patients who are discharged from hospital are followed up within 72 hours, such as requesting the CMHT or CRHTT to follow up.	Safety in line with research into increased risk of suicide upon discharge from hospital and NHS England guidance.	1
27	1	The team has written working arrangements detailing who is responsible for assessing patients who may need to be assessed under the mental health legislation.	Patient care.	5

Patient and carer experience				
No.	Type	Standard	Rationale	Reference
28	1	The team works with interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The patient's relatives are not used in this role unless there are exceptional circumstances.	Patient and carer experience and access to care.	1
29	1	Staff treat patients and carers with compassion, dignity and respect.	Patient and carer experience.	1
30	1	Patients feel listened to and understood by staff.	Patient and carer experience	1
31	2	Staff assess patients in an environment that is clean.	Patient and carer experience	1
32	1	There is a system by which staff are able to raise an alarm if needed.	Safety throughout the hospital. <i>This is throughout all areas staff work.</i>	1
33	1	Patients are actively involved in shared decision-making about their mental and physical health care (where applicable), treatment and discharge planning and supported in self-management.	Patient and carer experience.	1
34	1	Confidentiality and its limits are explained to the patient and carer at the first meeting with staff, verbally or in writing. Patient preferences for sharing information with third parties are respected. Guidance: <i>Where the care episode includes more than one interaction with the team, patients' preferences are reviewed regularly.</i>	Patient and carer experience and legislation.	1

35	1	<p>Where applicable, patients are given accessible written information which staff members talk through with them as soon as is practically possible. The information where relevant includes:</p> <ul style="list-style-type: none"> • Their rights regarding admission and consent to treatment; • Rights under the Mental Health Act; • How to access advocacy services; • How to access a second opinion; • How to access interpreting services; • How to view their health records; • How to raise concerns, complaints and give compliments. 	Patient care and knowledge.	1
36	2	<p>The team provides carers with accessible carers' information and encourages them to attend carer support networks and groups.</p> <p>Guidance: <i>Information is provided verbally and in writing (e.g. carer's pack) and includes:</i></p> <ul style="list-style-type: none"> • <i>The names and contact details of key staff members in the team and who to contact in an emergency;</i> • <i>Local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.</i> 	Carer experience and support.	1
37	3	There is an identified lead for supporting carers.	Carer experience and support.	1

38 	1	Carers (with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning.	Patient care.	1
39 	2	Carers are offered individual time with staff members to discuss concerns and their own needs.	Carer experience and support.	1
40	1	The team knows how to respond to carers when the patient does not consent to their involvement. Guidance: <i>The team may receive information from the carer in confidence.</i>	Patient and carer experience and legislation.	1
41	2	The team provides carers with information about how to access a statutory carer's assessment.	Carer support.	1

Collaborative working

No.	Type	Standard	Rationale	Reference
42	1	<p>Clear information is made available, in paper and/or electronic format, to acute colleagues on:</p> <ul style="list-style-type: none"> • A simple description of the service and its purpose; • Clear referral criteria; • How to make a referral; • Main interventions and treatments available; • Contact details for the service, including emergency and out-of-hours details; • Escalation process for accessing emergency advice and support. 	Information sharing with acute colleagues.	2
43	2	Referrers can access advice from a Consultant Psychiatrist during the team's normal working hours.	Integration of mental health in the hospital and patient care.	3
44	1	Staff are available to advise acute colleagues on mental capacity in complex cases.	Integration of mental health in the hospital and patient care.	7
45	1	The team support acute staff in providing advice for managing the mental state of patients who are intoxicated.	Integration of mental health in the hospital and patient care.	3
46	3	 Staff promote the team within the hospital by raising awareness through visiting wards and providing staff training.	Integration of the team within the hospital.	7
47	2	<p>There is a shared educational plan for acute colleagues that is delivered in part by the team and is regularly reviewed and evaluated by both the team and the acute hospital.</p> <p>Guidance: <i>The team sets an annual educational plan</i></p>	Integration of mental health within the hospital.	5

		<i>with acute hospital ED in the main and targeted wards which includes regular teaching and training sessions.</i>		
48	1	<p>There are interface meetings with managers of the service and acute hospital counterparts as part of shared governance around risk and serious incidents.</p> <p>Guidance: <i>These occur at a frequency according to the Standard Operating Procedure.</i></p>	Integration of mental health within the hospital and part of NCEPOD recommendations.	5, 15
49 	1	<p>The team has a clear joint procedure for managing cases where there are significant concerns about risk, which is agreed and shared with acute colleagues.</p> <p>Guidance: <i>The procedure includes:</i></p> <ul style="list-style-type: none"> • <i>Guidance on the frequency of checks and level of observations (e.g. eyesight, arms-length level), depending on the nature of the concern;</i> • <i>Discussions about more experienced liaison or acute staff being present during the assessment, if appropriate;</i> • <i>Agreements for involving security staff where needed, or police in some circumstances;</i> • <i>Clear communication of risk, including development of a risk management plan and procedures and timescales for communicating the plan to relevant colleagues.</i> 	Safety.	7
50	1	Staff and acute colleagues have effective systems in place to alert each other to potentially at-risk patients.	Safety.	7

51	2	<p>The team works in collaboration with the alcohol care team and substance use team for the acute hospital.</p> <p>Guidance: <i>This includes working in parallel to support patients and attending joint operational meetings.</i></p>	Patient care.	7
52	1	<p>Staff and acute colleagues work side-by-side, conducting parallel assessments.</p> <p>Guidance: <i>This is to reduce the patient's time waiting for assessment and treatment and staff do not wait until the patient is deemed medically fit to provide support.</i></p>	Patient care and experience and NICE guidelines.	11
53	1	<p>Care plans for patients awaiting a mental health bed are developed with input from both mental and physical health teams.</p>	Patient care.	15
54	1	<p>The team works collaboratively with other relevant services beyond the acute and mental health Trusts to develop care plans for those with complex needs and those who present frequently.</p>	Integration of mental health care into the hospital and patient care.	7
55	1	<p>The service has a care pathway for the care of patients in the perinatal period (pregnancy and 12 months' post-partum).</p> <p>Guidance: <i>The pathway includes:</i></p> <ul style="list-style-type: none"> • <i>Assessment;</i> • <i>Care and treatment (particularly relating to prescribing psychotropic medication);</i> • <i>Referral to a specialist perinatal team/unit unless there is a specific reason not to do so.</i> 	Patient safety/specialist care.	1

56	1	<p>Staff know how to refer to other community services based on agreed care pathways.</p> <p>Guidance: <i>This may include local mental health services, mental health services for older people, local social services, children and adolescent services, drug and alcohol services and primary care services.</i></p>	<p>Staff knowledge and capability. Enabling staff to refer patients when lone working.</p>	7
57	1	<p>The team supports patients with dual diagnosis with specific support for alcohol and drug use. This includes providing advice about referring to local specialist services.</p>	<p>Patient care.</p>	7

Workforce				
No.	Type	Standard	Rationale	Reference
58	2	<p>The team comprises a number of staff and mix of disciplines that is proportional to national best practice guidance.</p> <p>Guidance: <i>Please see Appendix 1: Examples of liaison psychiatry staffing levels for a summary of the best practice guidance.</i></p>	Appendix 1 outlines the national guidance on liaison staffing. This standard aims to support teams to ensure adequate staffing levels.	3
59	2	There has been a review of the team composition and skill mix within the past three years. This is to identify any gaps in the team and to develop a balanced workforce which meets the needs of the service.	Help ensure the service is well resourced and meeting patient need.	2
60 	1	<p>The service has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including:</p> <ul style="list-style-type: none"> • A method for the team to report concerns about staffing levels; • Access to additional staff members; • An agreed contingency plan, such as the minor and temporary reduction of non-essential services. 	Business continuity.	1
61	2	<p>There is dedicated sessional time from psychologists in order to:</p> <ul style="list-style-type: none"> • Provide assessment and formulation of patients' psychological needs; • Ensure the safe and effective provision of evidence based psychological interventions adapted to patients' needs through a defined pathway. 	In line with national guidance from BPS and ACP.	1, 16

62	2	There is access to psychologists to support a whole-team approach for psychological management.	In line with national guidance from BPS and ACP.	1, 16
63	1	The team meets regularly with daily contact and weekly meetings to discuss clinical management.	Communication, team working and patient care.	1
64	1	Staff have access to a dedicated space which is fit for purpose and access to relevant IT systems. Guidance: <i>Where there are challenges, the team is able to escalate concerns to the acute hospital.</i>	To ensure the service has enough resources and access to acute hospital systems.	7
65	1	For services that are not 24/7, there is a Standard Operating Procedure between the service and the service providing cover. A written summary should be developed in consultation with out-of-hours staff and include information on: <ul style="list-style-type: none"> • The working hours and days of the liaison service and the out-of-hours team(s); • The clinical responsibilities of each service; • The handover responsibilities of each service. 	Business continuity and patient care.	7
66	1	A clinical member of staff is available to discuss emergency referrals during working hours.	Patient care and support for acute colleagues.	1
67	1	There is an identified senior mental health clinician available at all times who can advise and attend if needed. Guidance: <i>Local agreement on the provision of medical cover is detailed within the team's Standard Operating Procedure.</i>	Patient care.	1

68 	1	Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing.	Staff empowerment.	1
69	1	All clinical staff members receive formal individual clinical supervision at least monthly, or as otherwise specified by their professional body. Guidance: <i>Supervision should be profession-specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications. Clinical supervision should be in addition to managerial supervision. If the two are provided together, there is a clear differentiation between them.</i>	Staff support.	1
70	2	All staff members receive monthly individual line management supervision. Guidance: <i>This should be in addition to clinical supervision. If the two are provided together, there is a clear differentiation between them.</i>	Staff support.	1
71	1	All staff who deliver structured psychological therapies are appropriately trained and supervised.	Staff support and patient safety.	1
72 	3	Staff are able to access reflective practice groups at least every six weeks where the team can meet together to think about team dynamics and develop their clinical practice.	Staff support and service development.	1

73 	1	<p>The service actively supports staff health and well-being.</p> <p>Guidance: <i>For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.</i></p>	Staff support.	1
74 	1	<p>Staff, patients and family members, friends or carers who are affected by a serious incident are offered post-incident support.</p>	Care and support.	1
75	1	<p>Staff are able to take breaks during their shift that comply with the European Working Time Directive.</p> <p>Guidance: <i>Staff have the right to one uninterrupted 20-minute rest break during their working day if they work more than six hours a day. Adequate cover is provided to ensure staff members can take their breaks.</i></p>	Staff support and well-being.	1

76	1	<p>New staff members, including bank staff, receive an induction based on an agreed list of core competencies.</p> <p>Guidance: <i>This should include arrangements for shadowing colleagues on the team, jointly working with a more experienced colleague, and being observed and receiving enhanced supervision until core competencies have been assessed as met.</i></p> <p><i>There are opportunities for staff members to shadow colleagues in other areas of the hospital (e.g. the emergency department, general medical wards, elderly wards etc.) and shadow mental health colleagues from outside of the hospital.</i></p>	Staff support and competency.	1, 6, 7
77	1	<p>Staff receive training consistent with their role and in line with their professional body. This is recorded in their personal development plan and is refreshed in accordance with local guidelines. This training includes:</p> <ul style="list-style-type: none"> • The use of legal frameworks, such as the Mental Health Act (or equivalent), the Mental Capacity Act (or equivalent), Deprivation of Liberty Safeguards; • Assessing capacity and providing medico-legal advice to colleagues; • Equality and diversity; • Information governance; • Basic life support; • The inequalities in mental health access, experiences, and outcomes for patients with different protected characteristics. 	Staff competency and development.	1, 3

78 	1	<p>Staff receive training on safeguarding adults at risk and children.</p> <p>Guidance: <i>This includes recognising and responding to the signs of abuse, exploitation or neglect.</i></p>	Staff competency and development.	1
79 	1	<p>Staff receive training on risk assessment and risk management.</p> <p>Guidance: <i>This includes, but is not limited to, training on:</i></p> <ul style="list-style-type: none"> • <i>Assessing and managing suicide risk and self-harm;</i> • <i>Prevention and management of aggression and violence.</i> 	Staff competency and development.	1
80	1	Staff receive training on recognising and communicating with patients with cognitive impairment and learning disabilities.	Staff competency and development.	1
81	2	Staff receive training on carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	Staff competency and development.	1
82	1	Staff receive training on suicide awareness, prevention techniques and approaches.	Staff competency and development.	3
83	3	Patient and carers are involved in developing and delivering staff training.	Co-production.	1

<p>84</p> 	<p>1</p>	<p>If members of the team prescribe medication, there is a policy regarding this.</p> <p>Guidance: <i>The policy should be in line with local medicines management. It should include guidance on the roles and responsibilities of Liaison prescribers in the hospital setting, standards of communication between hospital staff and the Liaison Team and governance arrangements for monitoring prescribing.</i></p>	<p>Safe prescribing practices.</p>	<p>7</p>
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Quality, audit and governance

No.	Type	Standard	Rationale	Reference
85 	1	The team asks patients and carers for their feedback about their experiences of using the service and this is used to improve the service.	Service development.	1
86	2	Feedback received from patients and carers is explored to identify any differences of experiences according to protected characteristics, where statistically possible. Guidance: <i>Complaints, compliments and other feedback sources include the option to share demographic information.</i>	Service development and health inequalities.	1
87	3	The team uses findings from service evaluation to support or inform business cases and changes to the service.	Service development.	7
88	1	There is an agreed protocol in place for reporting and responding to safety concerns raised by staff from either Trust/organisation.	Safety.	3
89	1	Clinical outcome measurement is collected for all patients accepted onto the caseload for an intervention and/or monitoring. Guidance: <i>This includes patient-reported outcome measurements where possible.</i>	Patient care, experience and service evaluation.	1, 3, 17
90	2	The service's clinical outcome data are reviewed at least six monthly. The data is shared with commissioners/managers, the team, and patients and carers, and used to make improvements to the service.	Patient care, experience and service evaluation.	1

91 	1	There is an effective system in place for the team to routinely collect data on the response time to referrals. Guidance: <i>Action is taken to address any barriers in responding to referrals in the agreed timeframes.</i>	Patient care, experience and service evaluation.	7
92	2	The team is actively involved in research and/or Quality Improvement (QI) activity.	Service development.	1
93	3	The team actively encourage patients and carers to be involved in QI initiatives.	Service development and coproduction.	1
94	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.	Safety.	1
95	1	When mistakes are made in care this is discussed with the patient themselves and their carer, in line with the Duty of Candour.	Safety and legislation.	1
96 	1	Staff have opportunities to learn from discussions on critical incidents, near-misses and other adverse incidents. Guidance: <i>The Service Manager can attend the learning meetings and cascade learning to the team.</i>	Safety and service development.	1
97 	3	Patient or carer representatives are involved in the interview process for recruiting potential staff members. Guidance: <i>Representatives should have experience of the relevant service.</i>	Service development and coproduction.	1
98	3	The service is developed in partnership with appropriately experienced patient and carers who have an active role in decision making.	Service development and coproduction.	1

99	2	The team reviews data at least annually about the people who use the service. Data are compared with local population statistics and action is taken to address any inequalities of access that are identified.	Improving access and reducing inequalities.	1
100	1	All patient information is kept in accordance with current legislation. Guidance: <i>This includes transfer of patient identifiable information by electronic means. Staff ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.</i>	Data protection legislation.	1
101	3	The service is able to demonstrate active involvement in wider Trust activities to improve patient flow.	Improving access.	18, 19

Children and young people

For Paediatric Liaison teams and those that see patients under the age of 18

No.	Type	Standard	Rationale	Reference
102	1	A trained child and adolescent mental health clinical practitioner/psychiatrist can be contacted at all times for advice, and can attend for assessment if and when required.	National guidance.	13
103	1	Young people under 18 presenting with mental health conditions to the emergency department should receive a full biopsychosocial assessment in a timely manner.	In line with NICE guidelines.	11
104	2	Appropriately trained staff are available to provide one-to-one support for under 18s as required.	In line with NICE and RCPCH guidelines.	11, 13
105	1	All clinical mental health staff working with young people under 18 have level 3 training in Child Protection/Safeguarding. Guidance: <i>This training can be obtained by a combination of online and face-to-face teaching.</i>	Patient safety.	9, 12
106	1	Staff can liaise with Child Protection and Social Work colleagues for safeguarding advice and management at all times if required including processes to identify young people on the Child Protection Register.	Patient safety.	9, 11

107	1	<p>All staff working independently with young people under 18 are assessed as competent in the assessment and management of this patient group to deliver developmentally appropriate care.</p> <p>Guidance: <i>This includes completing relevant CAMHS training or meeting competencies, e.g. NHS Scotland/UCL Competence Framework for Children and Adolescent Mental Health Services. Training includes:</i></p> <ul style="list-style-type: none"> • <i>Mental health presentations in children and young people;</i> • <i>Legal issues relevant to working with children and young people;</i> • <i>Ability to engage and work with families, parents and carers;</i> • <i>Ability to communicate with children/young people of differing ages, developmental levels and backgrounds;</i> • <i>Working with vulnerable groups of young people under 18 including those with a Learning Disability, Autism Spectrum Disorder, who are Looked After and Accommodated or have a history of adverse childhood experiences.</i> 	In line with NICE guidelines.	9, 11, 13
108	2	Meetings involving the team and acute hospital leads occur at least quarterly and include discussion of key operational, clinical and governance issues including safety.	In line with NICE guidelines.	13

109	2	<p>The team has written guidance that outlines joint working arrangements and how to refer young people under 18 to other agencies.</p> <p>Guidance: <i>This includes local health and social care services, community, Place of Safety or inpatient-based Child and Adolescent Mental Health Services and working age adult Liaison Teams when appropriate.</i></p>	Staff knowledge and patient care.	9, 10
110	1	<p>There is a clear escalation policy that can be triggered when young people present with complex presentations and there are concerns about risk.</p>	Team processes and patient care.	9, 10
111	2	<p>For young adults aged 16-18, there is a policy in place which specifies:</p> <ul style="list-style-type: none"> • Which service/team provides assessment and, • If admission is required to an acute hospital bed, there is an agreement about suitable ward and appropriate staff to provide one-to-one support. 	Team processes and patient care.	9, 10

Glossary of terms

Term	Definition
Acute colleagues	Clinical staff members working in the acute hospital.
Carer	Anyone, including children and adults who support a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction. This includes, but is not limited to, statutory carers.
Clinical diagnosis	The process of identifying and determining the nature of a disease or disorder by its signs and symptoms, through the use of assessment techniques (e.g., tests and examinations) and other available evidence.
Clinical formulation	A theoretically-based explanation or conceptualisation of the information, obtained from a clinical assessment to help understand a person's problems.
Clinical outcome measurement data	Clinical outcomes are measurable changes in health, function or quality of life that result from our care. Clinical outcomes can be measured by activity data such as re-admission rates or agreed scales, to determine progress and efficacy of care and treatment provided by healthcare providers.
Confidentiality	When collecting patient information every organisation that provides health and care services has the responsibility to: <ul style="list-style-type: none"> - Keep data secure - Use data that cannot identify the patient whenever possible - Use data to benefit health and care - Not use data for marketing or insurance purposes (unless the patient requests this) - Make it clear why and how data is being used.
Consent to care and treatment	A person must give permission before they receive any type of medical treatment, test or examination. This must be done on the basis of an explanation by a clinician.
Co-production	Refers to engaging and communicating with the service user and their family members (where appropriate) in the development of various documents to ensure that support is person-centred.
Disabled access	The design of products, environments, and services that ensure people with disabilities can access them.
Duty of Candour	Obligation under <i>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20</i> . Stipulates that service providers need to be open and transparent with people who use their services.

European Working Time Directive	Initiative designed to prevent employers requiring their workforce to work excessively long hours, with implications for health and safety.
Evidence-based	The integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences.
Handover	The process of a structured patient handover during transitions of care. This includes sharing complete and up-to-date care information with the new care provider and clearly defining roles and responsibilities between current and new care providers.
Lone working	Any situation or location in which someone works without a colleague nearby or when someone is working out of sight or earshot of another colleague.
Mental Capacity Act	A law which is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment.
Mental Health Act	A law under which people can be admitted or kept in hospital, or treated against their wishes, if this is in their best interests or for the safety of themselves or others.
Neurodevelopmental disorders	Types of disorder that influence how the brain functions and alters neurological development, causing difficulties in social, cognitive, and emotional functioning.
Patients	People who receive care from the Psychiatric Liaison Team.
Peer support groups	Groups that bring together people with shared experiences to help and support each other.
Protected characteristics	Everyone is protected under the <i>Equality Act 2010</i> from discrimination because of: <ul style="list-style-type: none"> - Age - Disability - Gender reassignment - Marriage and civil partnership - Pregnancy and maternity - Race - Religion or belief - Sex - Sexual orientation.
Psychological therapies	Effective and confidential treatments delivered by fully trained and accredited practitioners.
Quality improvement	A method used to make improvements. This includes identifying the quality issue, understanding the problem, developing a theory of change, testing potential solutions and implementing the most appropriate solution.

Referral	The professional makes contact with the referral service and/or professional directly on behalf of the person needing support.
Reflective practice	The ability for people to be able to reflect on their own actions and the actions of others to engage in continuous learning and development.
Safeguarding	Protecting people's health, well-being and human rights, and enabling them to live free from harm, abuse, and neglect.
Signpost	The professional directs people to useful information and/or other professionals to offer support and advice.
Statutory carer's assessment	An assessment that looks at how caring affects a carer's life including, for example, physical, mental and emotional needs, the support they may need and whether they are able or willing to carry on caring.
The service/the team	This refers to the Psychiatric Liaison Team.
Whistleblower	A whistleblower is a worker who reports certain types of wrongdoing. This will usually be something they have seen at work, though not always. The wrongdoing they disclose must be in the public interest.

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Appendix 1: Examples of Liaison Psychiatry Staffing Levels

The extracts and diagrams below are taken from Mental Health Partnerships' Model Service Specifications for Liaison Psychiatry Services. These extracts should be read in conjunction with the full report which can be found on the Mental Health Partnerships website.

Four models of hospital-based liaison psychiatry service are described each with their own colour code to help the commissioner follow the text relevant to that model through the document:

- Core Liaison Psychiatry Services
- Core 24 Liaison Psychiatry Services
- Enhanced 24 Liaison Psychiatry Services
- Comprehensive Liaison Psychiatry Services

Core Liaison Psychiatry Services

These services have the minimum specification likely to offer the benefit suggested by the literature. Core will serve acute health care systems with or without minor injury or emergency department environments where there is variable demand across the week including periods of no demand where a 24-hour staffed response would be uneconomical.

Core 24 Liaison Psychiatry Services

These services have the minimum specification likely to offer the benefit suggested by the literature where there is sufficient demand across the 24-hour period to merit a full service. Typically, these acute health care systems are hospital based in urban or suburban areas with a busy emergency department.

Enhanced 24 Liaison Psychiatry Services

These services have enhancements to the minimum specification to fit in with gaps in existing pathways and services. Often, they have additional expertise in addictions psychiatry and the psychiatry of intellectual disability. Demography and demand may suggest additional expertise with younger people, frail elderly people or offenders, crisis response or social care. This may extend to support for medical outpatients.

Comprehensive Liaison Psychiatry Services

Comprehensive services are required at large secondary care centres with regional and supra-regional services. These services include Core24 level services but will have additional specialist consultant liaison psychiatry, senior psychological therapists, specialist liaison mental health nursing, occupational and physiotherapists. They support inpatient and outpatient areas such as diabetes, neurology, gastroenterology, bariatric surgery, plastic and

reconstructive surgery, pain management and cancer services. They may include other condition specific elements such as chronic fatigue and psychosexual medicine teams. Some may include specialist liaison psychiatry inpatient beds. Comprehensive services run over office and extended hours supported by the core service running 24 hours, seven days a week.

Table 1: High-level summary of differences between models

Staff	Core 24	Enhanced 24	Comprehensive (illustrative for a 2000-bed hospital)
Consultants	2	4	5
Other medical	2	2	2
Nurses	6 band 7	3 band 7	2 band 8b
	7 band 6	7 band 6	17 band 6
			10 band 5
Other therapists	4	2	16
Team manager	1	1	
Clinical lead	0.4	0.4	1
Admin and business support	3	3	13

Commissioners and providers should consider other roles that could be utilised in liaison mental health services, including clinical support workers and new roles such as nursing associates. All considerations regarding indicative staffing and skill mix levels for liaison mental health services should be flexible and take into account the forthcoming Health Education England national mental health workforce strategy and the forthcoming Department of Health Mental Health Core Skills Education and Training Framework.

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