PLAN
PSYCHIATRIC LIAISON ACCREDITATION NETWORK

ISSUE 08 August 2016

In this issue

WELCOME!

Hello from the PLAN team! It has been some time since our last newsletter and there have been a number of exciting developments that we're keen to share with you all. We are delighted that the PLAN network has really expanded over the past year—we now have 62 active members, and are still continuing to grow!

Since we last wrote to you we have been working hard towards a number of improvements which will be rolled out during 2017. These include the implementation of an easier data collection system (CARS); a developmental membership option to help liaison teams to prepare for accreditation; recruitment of additional PLAN service users to strengthen the peer review teams we recruit for you.

Several other developments will also be taking place in the coming months, including the revision of the PLAN standards which will incorporate the Achieving Better Access to Mental Health Services work driven by NHS England—watch this space!

We hope that you enjoy this issue and we look forward to working with you all in the future!

The PLAN team

Meet the new PLAN team!

There have been several changes to the PLAN team in the last 6 months. At the end of last year, we said goodbye to Ro and Ella, and more recently Jamal.

The current PLAN team includes:

Sophie Hodge as Programme Manager for PLAN

Francesca Brightey-Gibbons as Deputy Programme Manager

Alice Ryley & Emily Patterson as PLAN Project Workers

New to Liaison: My first six months

I joined the liaison team with some anxiety. I'm not a mental health professional I'm an adult (general) nurse and I as such I wondered if I would be the wrong person for the job within a 'Mental Health Liaison Team'; however I reminded myself why I did liaison work in the first place and this carried me through. I started alcohol and drug liaison nursing in 2001 and back then there were not many of us around. The reason I started was that I could see that people with alcohol and drug problems often got a poor service in the NHS and I knew this was wrong and something I could help change for the better. It is well recognised that people with alcohol and drug problems do not always get the care they need and this is true in primary care, mental health settings and in general hospitals. As such people with addiction problems need professionals who are there to ensure care delivery is as good as it can be. The evidence is clear, if we do this they are less likely to need to come back to hospital and less likely to be in hospital for extended periods if they do come back.

The role of the substance misuse liaison professional has a few main themes: to ensure evidence based interventions in the medical management of dependence and related conditions such as Wernicke-Korsakoff-Syndrome; to deliver evidence based assessment and psychological interventions to promote behaviour change; to provide support to general hospital colleagues though education, polices, guidelines, referral processes etc; and to provide a communication bridge between the general hospital and community services.

At the time of writing I've been with the liaison team for around 6 months and in this time I have seen compassion and enthusiasm in my colleagues that makes me proud to be part of the team. I can see how their compassion can be built on with a greater awareness of the evidence base specific to substance misuse and am confident that this will be a straightforward process; I'm pushing at an open door! In my previous roles I have worked in a substance use liaison team that worked closely but separate from the mental health liaison team; a clear advantage I see in this model is the ability to consider the patient's holistic needs via our multidisciplinary clinical and case discussion approach.

We are in a privileged position to have access to people with substance misuse problems - the majority of people with alcohol and drug problems do not go to specialist community services and we are likely to be the only people with specialist knowledge who will have direct contact. We have a duty therefore to make these contacts count, to make it more likely that they will recovery from their drug or alcohol problems and to make it more likely that the will avoid the harms associated with ongoing use. The two big themes in the substance misuse field are harm reduction and recovery. All practitioners in mental health and in health care generally can learn a lot from the substance misuse field and harm reduction and recovery should be well understood and practiced by us all.

David Henstock, Specialist Clinical Lead Nurse

Liaison Team
Derbyshire Healthcare NHS Foundation Trust

Star in the PLAN newsletter!

We are very grateful for the contributions made to this edition of the newsletter—many thanks to David Henstock, Alison Salvadori and the LP MAESTRO team for sharing some of their recent experiences and work.

We are always keen to hear about what you've been up to in your teams so that we can help to share your ideas and best practice with the rest of the network. If you'd like to submit something for inclusion in the next newsletter (due at the end of the year) then please do get in touch. We welcome all contributions, from advertising events and conferences, to showcases of the work you've been doing, or even giving recognition to a member of your team who you think deserved to be praised!

Feedback from the PLAN Forum: Improving Mental Health Care in General Hospitals

Thank you for your feedback after the PLAN forum. The PLAN team has been working on some of the areas you would like us to help you with. Below is an outline of the feedback you gave us, and what PLAN has been working on as a result.

You said….

The session on maternal mental health by Professor Margaret Oates was excellent, and would like to learn more about the topic

We did…

We're organising a special interest day on maternal mental health for 10 October.

You said….

You would like us to circulate the posters

We did…

All the posters and presentation slides are available to download on the PLAN website (rcpsych.ac.uk/plan)

You said….

You would like some training on legal highs, substance misuse and managing dual diagnoses.

We did…

We're organising a special interest day on problematic drug and/or alcohol use and will include a session on legal highs.

You said….

You would like PLAN to advocate on behalf of teams to support them to action any recommendations required by the acute hospitals.

We did…

We regularly write to acute hospital Trusts recommending changes to support teams to gain accreditation.

You said….

Better online access to resources, such as your final reports would be useful.

We did…

We will be rolling out the data collection and management system (CARS) in 2017 which will provide instant access to team-specific resources.

Upcoming PLAN events:

There are a number of events coming up for PLAN members over the next year. Do keep an eye out on PLAN-Chat for more information, dates and how to register your interest!

- January 2017 — **Special Interest Day (Suicide and Self-harm Awareness)**
- March 2017 — **Annual Forum**
- September 2017 — **Special Interest Day (Dual Diagnosis and Legal Highs)**

Have an idea for an event? Email the PLAN team with your suggestions!

The Structures of Liaison Psychiatry Services in England: Existing models and a novel statistical approach to identifying services which are similar to each other.

There is no single model for characterising Liaison Psychiatry service structures. Here we describe an initial attempt to develop one.

The Liaison Psychiatry Survey of England 2015 (LPSE-2015) identified 179 acute hospitals with Emergency Departments, of which 168 had Liaison Psychiatry services. Services were defined as Liaison Psychiatry activities within the acute hospital which are provided by staff with specified Liaison Psychiatry roles. Services were also required to be physically located within or very near the acute hospital. Within each service, components were identified (e.g. provision of service in the Emergency Department, wards, outpatient clinics, etc.). These components may have had different characteristics such as staff mix, working hours, performance targets, patient-groups seen, etc.

This is what was found:

- 12 services were staffed only by nurses. 141 services (84%) included a consultant psychiatrist. 95 services (56%) included other doctors (not in training posts) and 42 services (25%) included a psychologist or psychological therapist as part of the team.
- 141 services provided a 7-day service and, of these, over half (78, 55%) reported a 24-hour / 7-day service.
- Half of the services (86, 51%) had target response times of one hour or less for referrals from the Emergency Department and a few more (90, 54%) reported target response times to referrals from the wards as one day or less.
- 99% of all services saw patients referred after self -harm (167).
- Two thirds of services saw patients for assessment of alcohol and substance misuse (106, 63%).
- One in four services (44, 26%) had separate older adult and working age adult teams.
- One in three services (57, 34%) did more than serve the needs of the acutely ill, and 59 services reported running follow-up clinics.

The picture is diverse, consistent with a specialty whose history of development concerns local relationships, perceived needs and enthusiasms. To assist commissioners, models based on real existing services were published as the Commissioning Guides for Liaison Psychiatry. These are named Core, Core24, Enhanced24 and Comprehensive and specify provision levels for levels of function. We also compared services against a well-resourced and well known service known as RAID. The specifications for that service itself has been changed and we term this specification as 'modified RAID'.

We looked at the survey results with these classifications in mind:

- Of the 168 services, one was rated as Comprehensive, three were Enhanced24, 13 were Core24, 18 were Core and 133 were SubCore (figure 1). This is a striking finding given that 78 services said they provided a 24-hour / 7-day service.
- 19 services had a service name that included the term 'RAID'. Of these, one service met the original RAID criteria (figure 2) and eight met the criteria for modified RAID (figure 3).
- Of the 149 LP services without RAID in their name, five met the criteria for RAID and 27 met the criteria for Modified RAID - collectively accounting for 22% of services without RAID in their name.
- 41 (24%) of services met either of our sets of criteria for being RAID-like.
- Of those services that met the RAID criteria, 28/41 (68%) were rated as Core or SubCore.

There is little relationship between these ways of describing even the acute-response components of liaison services, suggesting these systems did not adequately describe Liaison Psychiatry services in England in spring 2015.

To try to better understand the variation in provision and structure we used a statistical technique called model-based clustering to place each hospital into a 'cluster' (or group). Four clusters emerged. We avoided naming the clusters as there are no components or characteristics a hospital must or must not have to be in a given cluster. Cluster 1 contained smaller and relatively undifferentiated services.

Services in Cluster 2 were more likely to be larger than Cluster 1 and operate 24/7 but without age-specific teams or outpatient clinics. In other larger services there emerged separate older adult and working age adult teams (Cluster 3) or specialist Liaison Psychiatry outpatient services (Cluster 4).

The four clusters, however, are not on a scale and so Cluster 3 should not be interpreted as 'superior' to Cluster 2 or 'inferior' to Cluster 4, for example. Moreover, allocation to a Cluster tells us nothing about how well the service meets the needs of the patients or their commissioned brief, but rather which other services they are most like and the characteristics and components they share.

Feedback from respondents about this exercise, coupled with targeted telephone interviews, tells us a number of things. First it reminds us that while it is possible to produce (as here) a broad-brush description of the national scene, the variability of Liaison Psychiatry service provision indicates the difficulty in attempting to apply simple descriptive labels which define whole services. Second, it alerts us to the difficulty of deciding what defines an adequate 24/7 service or the role of age-specific teams in providing 24/7 cover. And third, even in a survey aimed primarily at understanding acute care pathways a picture emerged of widespread and highly varied specialist and outpatient work – activity that can easily be neglected in a national debate focused predominantly on emergency provision.

The next steps are to repeat the national survey to capture changes in a fast-moving landscape (LPSE-2016 is coming soon), and in the next phase of LP-MAESTRO to undertake case studies to improve our understanding of the nature of variability in liaison services, and the contextual and individual factors that drive such variability.

Andrew Walker, Allan House, William Lee, Jessica Barrett

Acknowledgements

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Figure 1: Classification of Liaison Psychiatry services

SubCore = less than Core.

Core = (scaled to a 500 bed hospital)
2 consultants, 0.6 other medical,
2 band 7 nurses,
6 band 6 nurses,
0 other therapists
1 band 7 team manager,
0.2 band 8 clinical services manager
2.6 admins
9-5 hours
Sees everyone aged 16+

Core24 = (scaled to a 500 bed hospital)
2 consultants, 2 other medical
6 band 7 nurses
7 band 6 nurses
4 other therapists
1 band 7 team manager
0.2-0.4 band 8 clinical services manager
2 admins
1 business support
24/7
Special older adults
Special Drugs and alcohol

Enhanced = (scaled to a 500 bed hospital)
4 consultants, 2 other medical
3 band 7 nurses
7 band 6 nurses
2 other therapists
1 band 7 team manager
0.2-0.4 band 8 clinical services manager
2 admins
1 business support
24/7
Special older adults
Special Drugs and alcohol
Outpatient services.

Comprehensive = (scaled to a 2000 bed hospital)
5 consultants, 2 other medical
2 band 8b nurses
17 band 6 nurses
10 band 5 nurses
16 other therapists
3 band 7 team manager
1 band 8 clinical services manager
12 admins
1 business support
24/7
Special older adults
Special Drugs and alcohol
Outpatient services
Specialties

The use of Cognitive Analytic Therapy within the Psychological Medicine Service

Cognitive Analytic Therapy (CAT) is an integrated, time-limited therapy which usually consists of 16-24 sessions. CAT combines cognitive behavioural approaches and psychodynamic psychotherapy. The therapist and patient work together to understand patterns of behaviour which may be causing distress. This approach is used within the Psychological Medicine Service (PMS) at the Royal Berkshire Hospital with patients who present with persistent physical symptoms which may be referred to as 'medically unexplained' symptoms.

From a CAT perspective, the habitual ways in which we respond to other people, situations and problems originates from patterns of relating learned in early life. The therapist uses an empathic and collaborative approach to help the patient understand, recognise and then revise problematic patterns of relating.

A case example

Joe (a pseudonym) is a 70 year old man with severe back pain and a pronounced limp causing him significant mobility problems. He has made repeated visits to his GP and the Emergency Department seeking a medical diagnosis and treatment for his debilitating symptoms. Joe's physical problems are not congruent with findings from extensive medical investigation and he is becoming increasingly angry and depressed.

Joe was referred by the neurology team to the Community PMS (CMPS). This team is allied to the hospital based liaison team and offers a joint psychology/psychiatry service with two CAT practitioners and strong links into primary care and the local Improving Access to Psychological Therapies (IAPT) service.

Joe undertook 16 sessions of CAT with the CPMS clinical psychologist. He shared with the psychologist his childhood experiences of abuse and bullying. During their work together Joe came to understand that these dreadful experiences shaped the way he responded to his ill health. For example, Joe experienced his leg as 'bullying' him and feeling terribly vulnerable he was seeking 'rescue' and 'ideal care' from medical staff. Desperate to avoid further rejection and torment he gave a strong invitation to others to care for him which was increasing his dependency on others leaving him further disabled.

The therapeutic relationship gave Joe an opportunity to have his story heard for the first time. Joe was able to express his emotional pain and anger and understand the personal impact of his childhood experiences. He then worked at finding 'exits' from the problematic patterns he had adopted in a vain attempt to avoid feeling vulnerable. Joe stopped avoiding social situations and worked at increasing his independence by joining several clubs. He also learnt ways to soothe himself and his pain by improving his self-care. Joe's mood, mobility and independence increased significantly over the course of therapy and gains were maintained at a three month follow-up.

Dr Alison Salvadori

Principal Clinical Psychologist and Accredited CAT Practitioner,
Psychological Medicine Service,
Berkshire Healthcare NHS Foundation Trust

Upcoming Peer-Reviewer Training

If you're interested in visiting other teams as part of the review process and to share best practice/ideas you could become a trained peer-reviewer.

Peer-reviewer training takes place 2/3 times a year. The next sessions are:

02 February 2017

06 May 2017

Training takes place at the RCPsych offices in London.

If you are interested in attending please email Emily (Emily.Patterson@rcpsych.ac.uk)

Opportunities to join the PLAN Accreditation Committee

The PLAN Accreditation Committee has the following vacancies:

- Carer Representative

The PLAN Accreditation Committee (AC) meets 4/5 times a year to examine the reports and other documents submitted as part of the self– and peer-review process that describe the performance of psychiatric liaison teams. The AC reviews this evidence and makes recommendations on the team's accreditation status.

The AC also has an advisory role, providing feedback on the standards and methods, and guiding the development of the project.

Opportunities for service users to become PLAN peer reviewers

PLAN is currently looking for new patient and carer representatives to join the network as peer-reviewers.

Working with the CCQI provides many opportunities to improve mental health services. The patients and carers we currently work with have said that:

- They feel good about helping to improve services;
- They learn about standards of care and what food practice looks like;
- They feel their voice is heard and that their opinion is important;
- They value meeting other service users and carers and hearing their views.

If you are interested in either of the roles, please visit the PLAN website (rcpsych.ac.uk/plan) or contact Francesca (Francesca.brightey-gibbons@rcpsych.ac.uk, 0203 701 2649).

Making the most of YOUR network

With a growing number of liaison teams joining the PLAN network, we wanted to highlight a few of the ways you can make the most of your membership and help support each other, and ultimately improve service provision.

You can...

- Get involved with peer reviews
- Contribute to the PLAN newsletter
- Use the PLAN discussion forum to reach out to peers, at PLAN-Chat@rcpsych.ac.uk
- Help us revise the PLAN standards in the Autumn of 2016
- Send any comments or suggestions to the team on PLAN@rcpsych.ac.uk

Contact us...

We love hearing from our members and helping to facilitate communication amongst our members—after all, it's what being part of a network is all about!

If you would like more information regarding the contents of this newsletter, have any ideas for something you'd like to see next time, or would like to contact us about anything else at all then do get in touch! We can be contacted via the below methods:

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Useful links

Department of Health
www.doh.gov.uk

Health and Social Care Advisory Service
www.hascas.org.uk
An evidence based service development organisation working in all spects of mental health and older people's services across the health and social care contiuum

Institute of Psychiatry
www.iop.kcl.ac.uk
The largest academic community in Europe devoted to the study and prevention of mental health problems.

National Institute for Health and Clinical Excellence
www.nice.org.uk
An independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. Includes the National Collaborating Centre for Mental Health (NCCMH), a partnership between the RCP and BPS.

Centre for Mental Health
www.scmh.org.uk
An independent charity that seeks to influence mental health policy and practice and enables the development of excellent mental health services through a programme of research, training and development.

QIPP
www.dh.gov.uk/health/category/policy-areas/nhs/quality/qipp

College Centre for Quality Improvement
www.rcpsych.ac.uk/quality.aspx

College Training
www.rcpsych.ac.uk/trainingpsychiatry/eventsandcurses.aspx
Offers courses for professional development in mental health care.

Contact the PLAN team

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