PLAN PSYCHIATRIC LIAISON ACCREDITATION NETWORK
RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

ISSUE Autumn/Winter December 2019

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# WELCOME

The PLAN team have been busy this year. We have this year held three special interest days: pain, cognitive assessment of older adults and personality disorder, we held our annual forum in Sheffield where we heard from a wide range of people including Professor Tim Kendall, Chris Wright, the liaison team from North Middlesex Hospital and then hosted a range of workshops in the afternoon.

In addition, we have facilitated three peer-reviewer training sessions, with one in Leeds. We have revised the 5th edition of the PLAN standards. The new edition includes our children and young people standards and will be published this year!

With the new standards, we are also launching a new membership option—developmental. This is open to new teams and those who previously received a decision of 'not accredited'. Teams are able to gain an understanding of the process before going through the accreditation process and enables teams to be involved in quality improvement!

The accreditation committee have been hard at work, you can see the teams who have been accredited on page 10.

It has been a wonderful year, and we have welcomed new services to the network who I hope will enjoy the experience.

Thank you to all of you, whether you have supported the network in attending peer-review visits, speaking at our events or being a part of the discussion group, we appreciate your support.

From the PLAN team, we wish you a Merry Christmas and a wonderful New Year!

*Cassie Baugh, Deputy Programme Manager, PLAN*

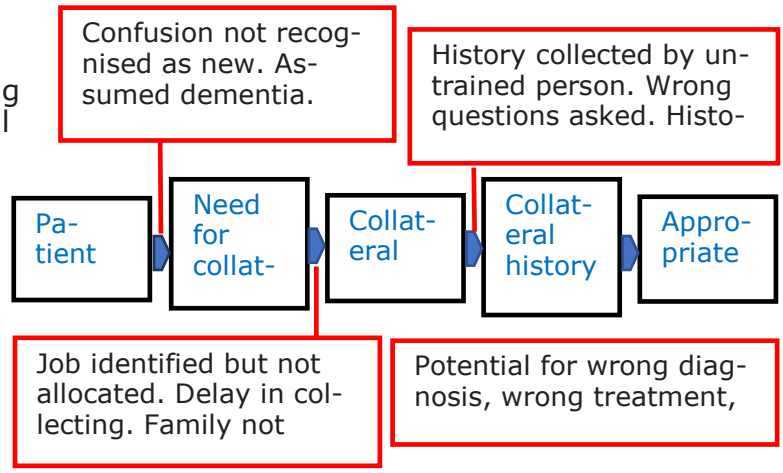
# A quality improvement project regarding the collection of collateral cognitive history from informant carers

A quality improvement (QI) project completed during a 6-month long training placement with Salisbury Hospital Mental Health Liaison Team. I am a Consultant Practitioner Trainee with Health Education England specialising in Older People and Frailty.

Patients with confusion of undetermined history and cause are common in the acute hospital setting and collateral history collection practice has been reported as poor (1, 2). An early diagnosis, supported by investigation including collateral history, is essential (3). A local audit showed poor collateral cognitive history taking in our hospital, with delays in taking the history, repetitious questioning of relatives, failure to act on information and incorrect labelling with dementia diagnoses. Incorrect labelling was committed by both clinicians and carers. Staff reported a concern that this mislabelling can persist into discharge summaries and clinical coding, with negative implications for patient care. Local clinicians reported that delirium screening tools are used inconsistently and tools such as the 4AT (4) are not designed for obtaining further history from informants. A local survey of clinicians suggested no formal training on collateral history taking occurs and, although they consider this is a task which requires skill and experience, it is often delegated to the most junior staff, who report a lack of guidance and confidence. Complaints from families frequently quote poor internal and external communication as a major issue, including carers repeatedly being asked for the same information by different clinical teams.

Project Problem Statement: Poor collateral cognitive history taking puts confused patients at risk of harm through delayed or incorrect diagnosis and treatment. A scoping literature review and responses from a Twitter conversation supported this project problem statement. The aim of the project was to develop a teaching programme to support better collateral cognitive history taking practice. Langley's (5) 'Model for Improvement' methodology was followed.

This process map shows an 'ideal' practice with added variations as found in our local audit:




A questionnaire revealed most staff on the acute medical unit lacked confidence in collecting this type of history and would appreciate training. After a literature review and consultation with experienced local clinicians a set of criteria for proposed areas of questioning of an informant was developed. A teaching plan was then produced to explore the following points with clinicians:

- What is a collateral cognitive history?
- How does this help with diagnosis?
- ho should collect it (and when)?
- How should we get a collateral history?
- what should we do with the information?

An acronym was used to assist staff in remembering the proposed key criteria of

the collateral history (**HAD PIMMS):**

- **H**istory of confusion: Onset, Course and Features (this episode and any previous episodes, acute and chronic).
- **A**DL's (Change in: Mobility, toileting/ bathing, managing finances, independence).
- **D**epression and other mood or personality changes.
- **P**hysical signs and symptoms suggestive of underlying cause (e.g. Infection, falls, incontinence, constipation, pain).
- **I**ntellectual function – education and employment history.
- **M**edication history including non-prescribed drugs and alcohol.
- **M**emory and Dementia (investigations or diagnosis (actual vs. assumed)).
- **S**ensory deficits – hearing, sight, speech.

Multiple 10-15 minute teaching sessions were administered on the Acute Medical Unit to junior doctors, nursing and therapy grades 5-7, and staff were given pocket copies of the 'HAD PIMMS' acronym. A further audit showed improvements in the confidence of staff in collecting collateral cognitive histories and that the acronym was useful in guiding the questioning of informants. Once further training has been completed a second audit will be carried out to see if there has been any change in the quality of the collateral cognitive history taking.

**References**


1. Shenkin et al. 2014 *Screening for dementia and other causes of cognitive impairment in general hospital inpatients.* **Age and Ageing** 43; 166-168

2. Rodwell et al. 2010 *How well is cognitive function documented by medical staff in the over-65 age group at the time of acute medical admission?* **New Zealand Medical Journal** 123: 1317

3. National Institute for Health and Care Excellence. 2010. Delirium: prevention, diagnosis and management (CG103). London: National Institute for Health and Care Excellence.

4. Bellelli, G., Morandi, A., Davis, D.H., Mazzola, P., Turco, R., Gentile, S., Ryan, T., Cash, H., Guerini, F., Torpilliesi, T. and Del Santo, F., 2014. Validation of the 4AT, a new instrument for rapid delirium screening: a study in 234 hospitalised older people. **Age and ageing**, 43(4), pp.496-502.

Langley, G.J., Moen, R.D., Nolan, K.M., Nolan, T.W., Norman, C.L. and Provost, L.P., 2009. The improvement guide: a practical approach to enhancing organizational performance. John Wiley & Sons.



I would like to acknowledge the support of Dr Janet Butler and Helen Sarvar RMN.



*James Lee, Consultant Practitioner Trainee, Salisbury NHS Foundation Trust*


**Follow us on twitter to keep up -to-date with our work**

**#ccqiplan** **@ccqi_**

# Tips for the PLAN Peer-Review Visit

In the last edition of our newsletter, we wrote about tips for the self-review.

After a team has completed their self-review, there will be a peer-review visit.

A visit usually consists of:

- A PLAN representative to facilitate the day
- 2-3 staff from other liaison services
- A service user or carer representative.

The main aim of the peer-review day is to validate the self-review data. Remember, it is a supportive process **not** an inspection.

There are different meetings throughout the day including:

- Staff meeting (no managers should be present)
- Managers meeting (team manager, operational lead, consultant psychiatrists)
- Case note audit
- Patient and carer meeting
- Acute colleagues
- Tour of the site (mainly to see the high risk assessment room in the ED).

The peer-review team will focus on type 1 standards, and any type 2 and 3 standards that are 'not met', or the survey responses that are less than 75%.

**Tips**:

- If you've taken a whole team approach during the self-review period, this should help with the day as the team know what to expect and what the peer-review team will be looking at.
- Use our invitation letters and posters to ask patients and carers to attend and give feedback about their experience. We need to talk to a minimum of 3 carers and 3 patients particularly for teams going through accreditation.
- Read through the information beforehand. We will include the key contacts for the service in the email to the peer-review team, so you will have all the same information.
- Invite acute colleagues.
- Book 2 rooms for the duration of the day. There are a number of simultaneous meetings and we will need to split the peer-review team.
- Let us know if you would like to amend the timetable before the day.
- Share the workbook with the team before the day.

**Involving patients and carers**

- We have developed invitation letters with our service user and carer representatives, use this and send out to lots of people!
- You may wish to invite people to the lunch, the meeting with patients and carers is directly after.
- Link in with the patient experience team within the Trust, they may be able to organise travel arrangements.

# Co-production within PLAN

In August, the PLAN team invited our service user and carer representatives to meet at the College.

The aim of the day was to get everyone together to meet one another, network and share ideas about how we can improve the network.

As part of the day, we asked our reps to support in the co-production of some of our tools for the review process.

Throughout the day we updated and revised our:

- **Posters**. We developed new posters that teams can display advertising the surveys. They have been created to be inviting and appealing to people. These will be sent to teams going through the self-review process.
- **Invitation letters**. We now have template letters that teams can amend to invite patients and carers to the peer-review day. The reps wanted to ensure they are informal and open.
- **Surveys**. The reps reviewed the surveys to ensure they were easy to understand, accessible and clear.

We have also changed our timetable template. The patient and carer meeting now takes place straight after lunch. This is to allow teams to invite people to lunch as it can be a good way for patients and carers to meet the peer-review team/ liaison team informally, before the meeting.

The day was a fantastic opportunity for everyone to get together and work to improve the network and we received lots of positive feedback about their inclusion.

## Contribute to our Newsletter!

We want to hear from you!

**If there have been any interesting or innovative developments in your psychiatric liaison service recently, and you would like to tell others about it please send your ideas or submissions to:**

PLAN@rcpsych.ac.uk

# Psychological input into psychiatric liaison services

The PLAN team, along with HTAS and AIMS-WA were recently invited to a meeting organised by the Division of Clinical Psychology and Association of Clinical Psychologists to discuss psychological input into adult acute mental health care.

There was a range of people including psychologists, nurses, those with lived experience, psychiatrists and of course, staff from CCQI at RCPsych.

The aim of the day was to seek everyone's views on what works well with psychological input into acute mental health inpatient services, crisis and home treatment teams and psychiatrist liaison mental health services and identify what we would like to see in the recommendations to commissioners.

The current psychological input in teams is currently under revision as there is a lot of variation of service user access to evidence based psychological interventions and to improve the access.

We spoke about the direct and indirect interventions including assessment and formulation, brief psychological therapies, but also providing staff support in terms of reflective practice and supervision.

There was a lot of discussion throughout the day. The consensus was that psychological input is important and brings a whole MDT approach to the way a team works and are valued within teams.

The organisers of the meeting had prepared an idea as to what psychological input would be needed for each of the different types of services and are looking to submit their recommendations in Spring/Summer 2020.

The core staffing would be:

- 1 full-time band 8b clinical psychologist—working in ED (over view and supervision of psychology staff).
- 1 full-time band 8a clinical psychologist for adults—ED and wards.
- 1 full-time band 8a clinical psychologist for older adults—ED and ward work.

The comprehensive staffing would be:

- 1 full-time band 8b clinical psychologist—ED _overview and supervision psychology staff).
- 1 full-time band 8a clinical psychologist for adults—ED and ward.
- 1 full-time band 8a clinical psychologist for older adults—ED and ward.
- 1 band 5 assistant psychologist.

It will be interesting to see what follows with the publication of the recommendations next year.

# Upcoming events

Save the dates for the events below. Don't forget you receive a CPD certificate for attending!

## Annual forum

**Date**: 05 March 2020

**Location**: Royal College of Psychiatrists, 21 Prescot Street, London, E1 8BB

*Member services receive 2 free places and a discounted rate for additional places.*

*Non-member service can attend for £100 per place.*

**We are accepting workshop and poster submissions. If you would like to present, please get in contact with the team.**

## Special Interest Day

**Date**: 30 September 2020

**Location**: Royal College of Psychiatrists, 21 Prescot Street, London, E1 8BB

*Member services receive 2 free places and a discounted rate for additional places*

*Non-member service can attend for £100 per place.*

## Special Interest Day

**Date**: 16 April 2020

**Location**: Royal College of Psychiatrists, 21 Prescot Street, London, E1 8BB

*Member services receive 2 free places and a discounted rate for additional places*

*Non-member service can attend for £100 per place.*

## Peer-Reviewer Training

**Dates**: 26 February 2020 **and** 06 May 2020

**Location**: Royal College of Psychiatrists, 21 Prescot Street, London, E1 8BB

*There are unlimited places for staff from our member services.*

## Discussion Group

Joining the discussion group will allow you to:

- Share best practice and quality improvement initiatives
- Seek advice and network with other members
- Share policies, procedures or research papers
- Advertise upcoming events and conferences

To sign up, email the word 'join' to plan-chat@rcpsych.ac.uk

# Working well Together

**@ National Collaborating Centre for Mental Health**

NCCMH is a department within RCPsych. NCCMH have taken on the mantle of developing co-production in all its facets, and their genuine commitment to make it real has driven Working Well Together, the paper on co-production and mental health commissioning, which was published on 10th May.

The first thing to state is that the team was made up of more people with personal experience of mental health distress and using services than there were professionals, although many had both hats.

One area of discussion during the development of this paper was around establishing key principles for co-production, which came down to:

Another central conversation in the development of this paper was about ensuring that we acknowledge the range of involvement and engagement - as well as acknowledging that co-production may not fix everything! Co-production should, however, run through all work streams as a 'golden thread', from the start.

Recognising power is fundamental and something that everyone within teams, services and organisations needs to do, and support the equalisation of. Accessibility is another key factor that can create a level playing field for all people, while recognising the equalities and inequities that people experience.

| | |
|---|---|
| C | **Celebrate involvement –** All types of involvement are important and fundamental to the process, and should be celebrated at each stage and be received with an open and fair approach. Co-production is a continuous process rather than an aim or event and there should be ownership, understanding and support of the process from everyone involved throughout. |
| A | **Adaptable** – The approach to co-produced commissioning should be adapted to ensure that the community of interest's" voice is heard at every level, ensuring that inequalities are identified and addressed throughout. |
| R | **Resources –** Co-production should be built into every level of work programmes and business plans and resourced as a fundamental integrated part of the whole commissioning process. There should be a dedicated member of staff to champion co-production in practice. |
| I | **Influence of power** – There should be a collective understanding that acknowledges the power of individuals and organisations, the influence it can have and the perceptions it can lead to. A culture of honesty, value and respect should be fostered, with each person being committed to sharing power and taking responsibility for the decision-making they take part in. |
| N | **Needs-led** – Accessibility is fundamental to co-production, so people's needs should be considered and any barriers minimised. This includes consideration of the location of meetings and events, travel to and from venues, and preferred methods of communication. Terminology should be discussed and agreed at the start, and communication should always be clear and available in agreed formats. The environment and space must also be accessible, inviting and supportive of the overall values of co-production. The environment needs to foster creativity, courage and curiosity, so that everyone present has an equal opportunity to be involved. |
| G | **Growth** – Quality assurance needs to take place to maintain, improve and grow the co-produced commissioning process as well as the quality of services. This should be evidenced through outcome measures. |

NCCMH already models what we want commissioners to do. By being open to improvements and individual requests, they have made the process of co-production more inclusive while being aware that more can be done. This is the mindset we hope others will take on.

A member of the co-production working group said, *"I couldn't have got to the meetings at all without taxis and 2 nights in a hotel, for a 2-hour meeting. This commitment of resource meant someone who would otherwise not have been at the table at all was able to attend."*

Another person reflected on the support they were given so that they could continuing to access benefits while being involved in co-production: *"Being on Employment and Support Allowance was also a barrier to being able to take part. While I worked hard and earned my payments, the flexibility of expectations, the low frequency of meetings and the level of support I needed to engage with the process couldn't really be reproduced in a job. Involvement in work like this shouldn't be used to assess capacity to work. Even though they had no experience doing this before, NCCMH agreed to write a supporting letter to be sent in with my permitted work form.*

*This flexible approach of listening to what I needed is a vital part of working well together, inclusively."*

Links to the paper can be found at https://youtu.be/sA5z82cMWvY

*Further information about this support can be found here:

'Coproduction throughout' and 'framework illustration' by Julia Hayes, Inclusion Creativa, 2018

*Steph de la Haye, PLAN Peer-Reviewer , National Advisor at NCCMH and Co-production Working Group*

# Co-production and Quality Improvement

In November, RCPsych hosted a Quality Improvement day led by Amar Shah.

He described QI as 'a systematic approached to testing new ideas, measuring them and these projects are led by those closest to the issue'. Throughout the day we heard from so many different mental health teams about how they are using QI in their services. I went to workshops on 'design thinking', 'improving MDT meetings' from a liaison psychiatry team and 'co-production in QI' from an inpatient service.

The coproduction in QI began with everyone in teams using a bag of lego to follow the instructions and build a house. Once teams were about half-way through, you began to hear 'I don't have a window', 'I don't have a door'. It was then the team would respond with 'continue as best you can'. This was to highlight that although the work you do may be OK, it won't be fit for purpose if there is a missing piece, i.e. patient and family/carer involvement.

This team had piloted and now launched a QI team, that included people with lived experience both as a patient and as a family member/carer.

It was a wonderful to see what amazing work the team have done with coproduction. Their work has led to improvements with how nurses are spending their time on the ward—now more time in therapeutic activities with people on the ward and less time in the office. We then celebrated the end of the workshop with a quiz and sweets.

It was a thought-provoking workshop highlighting the important for both staff, patients and carers to be fully involved in service development and improvement.

# Teams Accredited 2019

Congratulations to our teams for all of their hard work. This year all these teams have received accreditation from the network:

**Swansea Department of Liaison Psychiatry**, Swansea Bay University Health Board

**St Mary's Hospital Department of Liaison Psychiatry**, Central and Northwest London Mental Health NHS Trust

**Leeds Liaison Psychiatry Service,** Leeds and York Partnership NHS Foundation Trust

**St George's Hospital Liaison Psychiatry Service,** South West London And St George's Mental Health NHS Trust

**Bristol Royal Infirmary Liaison Psychiatry Service,** University Hospitals Bristol NHS Foundation Trust

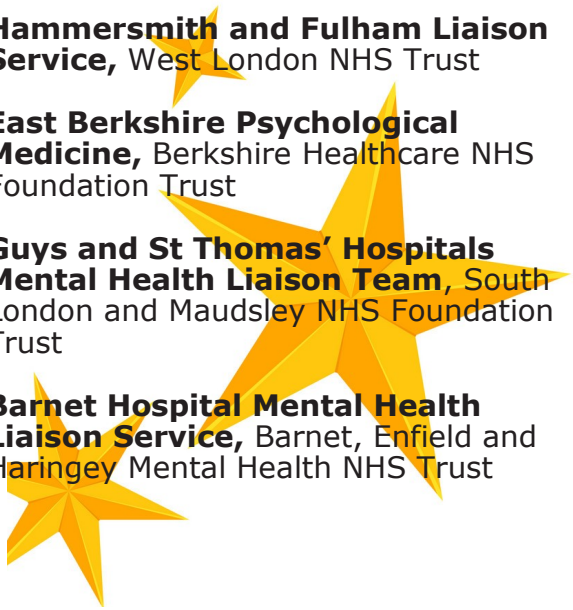
**Ealing General Hospital Liaison Psychiatry Team,** West London NHS Trust

**Hammersmith and Fulham Liaison Service,** West London NHS Trust

**East Berkshire Psychological Medicine,** Berkshire Healthcare NHS Foundation Trust

**Guys and St Thomas' Hospitals Mental Health Liaison Team**, South London and Maudsley NHS Foundation Trust

**Barnet Hospital Mental Health Liaison Service,** Barnet, Enfield and Haringey Mental Health NHS Trust



## Feedback Survey

We want to hear from you! As part of our own on-going quality improvement, we have a members feedback survey. We want to hear from our members, what do you like about the network. Is there anything we can improve on? What do you find valuable? This will then be used to support in improvements in the coming year.

**Closing date: 13 January 2020**

# Developmental Membership

PLAN has launched a new option—developmental membership.

Currently teams who wish to join PLAN have gone through the accreditation process:

- Self-review
- Peer-review
- Accreditation Committee
- Final report

However, we now have a developmental option. The process is very similar and includes:

- Self-review
- Peer-review
- Report

During the peer-review visit there is the additional of an 'open discussion'. This is an opportunity for the host team to discuss an area of challenge they are currently facing with the peer-review team.

The developmental membership option allows teams to join a national network, gain an understanding of the accreditation process before going through the accreditation process and be involved in quality improvement. It also enables teams to have longer to work towards meeting our standards.

Recruitment is currently open, with peer-review visits to take place summer/autumn next year.

If you are interested, or know anyone who is, please contact the team. The team details are on the back cover.

# Upcoming Peer-Review Opportunities

| | | | |
|---|---|---|---|
| East Surrey Hospital Psychiatric Liaison Team | Surrey and Borders Partnership NHS Foundation Trust | East Surrey Hospital, Redwood Annex, Canada Avenue, Redhill, RH1 5RH | **10/03/20** |
| Queens Medical Centre OA | Nottinghamshire Healthcare NHS Trust | Courtyard, A Floor, East Block, Queens Medical Centre, Nottingham University Hospital, Nottingham, NG7 2UH | **25/03/20** |
| Gateshead WA | Cumbria Northumberland Tyne and Wear NHS Foundation Trust | Queen Elizabeth Hospital, Queen Elizabeth Avenue, Gateshead NE9 6SX | **26/03/20** |
| Walsall OA | Walsall Healthcare Trust | Walsall Manor Hospital, Moat Road, Walsall, WS2 9PS | **21/05/20** |
| Salisbury Hospital Psychiatric Liaison Team | Salisbury NHS Foundation Trust | Salisbury District Hospital, Odstock, Salisbury, Wiltshire, SP2 8BJ | **28/05/20** |

# 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 continuum

**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/rainingpsychiatry/eventsand curses.aspx
Offers courses for professional development in mental health care.

**CARS**

www.cars.rcpsych.ac.uk

# Contact the PLAN team

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

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