

## JISC update June – July 2017

### CQUIN for patients who attend A&E frequently – data sharing

**Question asked** – ‘Dear group - Have you encountered problems with the mental health trust having access to acute trust data in order to capture the most frequent attenders? We have been told for information governance reasons that we can only use our data set for this CQUIN – which is OK but we don't feel captures fully the data A&E may want to use’.

**1. Homerton:** Their SLA allows data sharing. ‘Given it's a joint CQUIN it's in the acute trusts interests to provide data - the frequent attender portion here is being largely overseen by the acute trust, who have existing funds for a frequent attender lead’

**2. North London:** ‘regardless of who pays our wages, liaison psychiatry staffs are providing direct care to the acute trust's patients; therefore have a legitimate relationship and a duty to have access to the acute trust's record systems. By analogy, when the acute trust contract with an employment agency, agency nurses & doctors are not on the acute trust's payroll but nevertheless need access to medical records to discharge their responsibilities. The sharing or third-party issues occur only at the point where the liaison psychiatry dept. makes onward referrals to CMHTs – which are governed by the usual requirements around implicit and explicit consent to share information. Any transfer of data between acute trust and mental health trust databases would also require information sharing agreements’.

### Mortality reviews in acute trust

**From Homerton:** Who asks if anyone is involved with acute trusts' mortality reviews into patients with MH or LD diagnoses? ‘Accurate coding of MH problems in acute trusts is unreliable if the patients haven't been referred to the psychiatric liaison team, and I am struggling with how we identify patients for inclusion’.

**Response from North London** is in agreement that acute trust data can be unreliable. Their process is to review all deaths of patients on their caseload asking two questions:

Has their mental illness or its treatment contributed to their death?

Has their medical treatment been compromised by having a mental illness?

It may though be that they miss cases where the patients were not referred to their team.

### Relationship with the ED in a time of limited resource; for better for worse

**A south coast service asks:** With mounting pressure on MH services – especially MH inpatient beds – MH patients waiting for admission in the general hospital setting is seriously affecting our relationship with A&E and associated wards – more than ever before. Are others experiencing this? Beyond being honest about MH resource pressures, being receptive to A&E concerns and raising overall issue with our managers, is there more we can do?

**Bristol:** we've got exactly the same things where I work at Bristol. So we made a flow chart escalation chart with timings.....

Call the bed manager. If no bed identified in an hour, then call the managing director for the mental health trust and notify the manager on call for the acute trust. No bed in 4 hours, call the director of ops for the mental health trust and let the acute trust manager know. There's a chart with everyone's mobile phone numbers. Seems to empower the nurses in the team to call up the organisation, and by the time we get to director of ops, we pass it over to the acute manager. And out of hours, it gives the ED department someone to call so they feel better too.

We've had the CEO s from both trusts speaking to each other about finding a bed for a patient when we really are stuck. And that seems to contain these difficult situations; which make it better for the patient too.

**Hammersmith:** Our trust is looking at system wide flow issues and using planned EDD approach and daily bed meetings with senior clinicians across the services to ensure that patients are being “pulled through system”. This is the Virginia Mason model and has just started; ‘watch this space ...feels very tense’.

**Exeter:** ‘Same all over, relationships key, relentlessly reasonable, liked the St Mary's BBC hospital episode. We are taking timeouts with the ED staff to keep the relationships right’

### NHSE document concerns discussed – with differing views

**A colleague in Homerton** is wondering about this group's reactions to the NHSE document – which in case people aren't aware of it, “the clock stops” for MH patents in A&E now at the point that a MHAA starts, or a management plan is in place, or the patient en route to an admission etc.

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**Northwick Park:** 'This is from Nov 2016 so has been around for a while without much fuss and we probably shouldn't bring it to people's attention if they haven't seen it. I've highlighted this to Viral in NHS England as a retrograde step. Ideally they should withdraw or revise it. Locally you can report back that this is not nationally accepted practice – it's not even regionally accepted practice - and should be questioned.'

**Oxford:** suggests that NCCMH, the authors of this document, may not fully understand how acute trusts operate. 'We have been working to address this and do hope it may improve'

A Liaison faculty member reports: 'The Liaison faculty was involved in drawing up the document. I think I'm right in saying that the additional funding coming to most liaison departments over the next four years under Transformation funds/Core 24 is justified by us needing to meet the targets in the NHSE document, so if we try to undermine the targets we will call into question the need for additional funding.'

**From Sunderland,** an experienced colleague writes: 'I was on the ERG (expert reference group) for this guidance. I think that perhaps the guidance has been misinterpreted.' Our clock is not the mandated 4hr A&E clock as per the NHS Constitution. What we published is not mandated. We have new MHSDS data items which services started to submit in April 2017; and we are working with NHS Digital colleagues leading the implementation of the new Emergency Care Data Set from October 2017; so are measuring part of the full ED pathway now via MHSDS, with a view to moving towards being able to measure it all via the ECDS in the coming months. New data will give us national transparency we've never had before on what is actually happening to people with mental health needs in EDs.

**Northwick Park** second response: there will soon be TWO 4-hour standards:

1. Patients leaving ED within 4h
2. Patients referred to mental health receiving a psychosocial assessment and management plan within 4h

The standard referred to in this guidance is the latter: the ED clock would keep ticking, and the liaison psychiatry clock would stop.

**Exeter** – probably amongst others (including this author) finds this potentially confusing. 'Personally as a service I think we have to aim to deliver for patients aspirationally but measure pragmatically; until the admin and technology systems progress to support both. I do understand that targets can drive this -but day to day the alternative is anxiety/effort about the wrong things- is it not?'

## Case Discussion

A woman in her 60s with a 3 year history of progressive cognitive decline was discussed - problems with comprehension and expressive difficulties. Normal MRI brain, voltage gated K channel antibodies, anti-NMDA antibodies. Neurologist initially referred as 'MUS' to this team.

The Cerebral function unit diagnosed neuro-degenerative aphasia.

**Manchester:** Thinks that an onset of functional symptoms at this age in someone completely free of them before or without a history of mental health problems would be very unusual. A neurodegenerative disorder is likely (possibly with some functional symptoms secondary to an underlying decline in cognitive function).

**Gateshead Old Age Liaison:** Thinks this may be early onset Alzheimer's to me; possibly plus epilepsy; and recommends either the local young-onset team or an old age psychiatry opinion.

**Southampton:** I will think either a young onset dementia clinic or a neuropsychiatry unit will be useful if diagnostic uncertainty is an issue for the family.

They may also make recommendations on suitable community options that will improve quality of life and support carers.

We have had a few interesting cases here in young people which we can't find the usual antibodies but clearly an autoimmune type presentation with persisting cognitive changes in temporal areas.

**Northwick Park:** Is not sure what a more specific diagnosis would achieve. Regardless of diagnosis, this patient is quite disabled and needs of supportive, rather than curative care. She can have empirical treatment trials of medication in parallel with needs assessment. If neuropsychological rehabilitation exists in your patch then she can have an empirical trial of this too. If the need for a diagnosis relates to occupational health and employment matters, then she doesn't sound likely to return to work either way, and the question about workplace injury can be resolved by medicolegal specialists.

**A senior trainee:** Thinks these findings do seem to point to early onset (probably Alzheimer's type) dementia; and recommends a memory clinic for clarifying the diagnosis and offering management strategies. In particular, neuropsychology input can assist not only outlining specific cognitive deficits but also consider strategies to support areas of cognitive function; this is likely to be available within a memory service. If there is a significant

wait for a memory service in your local area, you could signpost the patient/family to Alzheimer's Society who provides information and practical tips about living with memory problems of any cause. You may also wish to consider advance care planning with the patient, as there may be tasks she would like to delegate to people she trusts should her health problems interfere with her ability to manage her finances or health decisions independently - again, Alz Soc have information on this.

**A well-known colleague from Leeds:** 'A bit of liaison in order? Any chance you could get together for a half hour chat the neurologist, neuropsychologist and you'. This could help in two ways if you can agree a shared view now '[1] on likely differential diagnosis - earlier atypical presentation will have muddied the waters but it's pretty clear now that it's xxx [2] on best type of management (more likely to get, than agreement on the specifics). It then will put you in a position to have an honest discussion with the family.

**Sydney:** also suggests repeating the thyroid autoantibodies that were previously elevated to exclude Hashimoto's encephalopathy. 'Normal TFTs doesn't exclude it. Empirical trial of steroids could be worthwhile'.

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