



# briefing

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## Healthy mind, healthy body

### How liaison psychiatry services can transform quality and productivity in acute settings

This *Briefing* looks at opportunities to improve quality and efficiency in acute services by focusing on the needs of the significant number of patients who also have mental health problems complicating their care and discharge. It sets out some good practice examples together with academic evidence to build a business case for liaison psychiatry services.

#### Key points

- One quarter of acute inpatients have mental health problems.
- Evidence suggests that identifying and treating the mental health needs of acute inpatients early has a direct impact on the recovery of their physical health.
- Liaison services can improve care and bring costs savings as patients can be discharged earlier if their mental health needs are addressed.
- Services can also bring savings for primary care trusts (PCTs) by reducing re-attendances.

#### Mental health needs in acute settings

Patients with a physical illness are three to four times more likely to develop a mental illness than a member of the average population. Patients admitted to an acute setting have a 28 per cent chance of also having a diagnosable psychiatric disorder. A further 41 per cent have sub-clinical symptoms of anxiety or depression. The rates of psychiatric illness for older adults in general hospital beds are as follows: up to 40 per cent have dementia, 53 per cent have depression and 60 per cent have delirium. During an economic downturn these figures are likely to increase.

Most of these mental illnesses are treated very quickly and effectively if the symptoms are identified early. However, the current composition of some acute and mental health services means that the physical and mental conditions of patients are treated separately. This means that many general hospital inpatients with co-morbid physical and mental illness have little access to appropriate mental health services, either while in hospital or following discharge.

There has also been a lack of specific policies to incentivise the creation of an integrated service. Commissioning for mental and physical health are often separate processes and it is rare for the special needs of patients

This is part of a series of briefings for commissioners and providers looking at opportunities for improving quality and safety through the implementation of policies or service models which are tried and tested. Some of these offer significant efficiency savings; others represent opportunities to prevent significant risks to patients.

*'The mental health needs of acute inpatients go untreated on many occasions'*

with both physical and mental health problems to be considered in either funding stream. Also, following NHS re-organisation, the management of physical and mental healthcare have often moved further apart geographically.

Aligning mental and physical healthcare is a key opportunity identified in the NHS Next Stage Review, but plans are still at an early stage. *This Briefing* provides commissioners with evidence of an approach that works, while also explaining how providers could benefit from this approach without having to wait for specific input from commissioners.

### A solution: liaison psychiatry

The focus of the NHS Next Stage Review on quality and on aligning mental and physical health services

#### Key facts

- One quarter of all patients admitted to hospital with a physical illness also have a mental health condition which, in most cases, does not receive necessary treatment while the patient is in hospital.
- Most patients who frequently re-attend the A&E department do so because of their untreated mental health problem.
- Two thirds of NHS beds are occupied by older people and up to 60 per cent have or will develop a mental disorder during their admission.

is a positive step. However, a more direct steer on the best way to achieve these outcomes may take some time. In the meantime, providers need a solution to the unequal treatment of patients with both mental and physical healthcare needs in acute settings. Evidence suggests that liaison psychiatry could be the answer.

Liaison psychiatry brings together the diagnosis, treatment and management of patients with co-morbid physical and mental disorders. Most services are based in acute hospitals or stay somewhere in between the primary and secondary care border. Services in England are patchy, although there has been a gradual expansion over the last ten to 15 years, which has been driven by local clinicians.

#### Benefits for acute hospital trusts

There is good evidence, from a variety of different sources, to suggest that liaison psychiatry services can improve care in general hospitals and can contribute to improving on other important health targets. These include improvements in both quantitative and qualitative outcomes. In summary, liaison services can:

- improve clinical outcomes
- decrease length of stay
- ensure patients receive adequate treatment while using less healthcare resources
- reduce re-admissions and costs
- treat and reduce healthcare costs for patients with unexplained symptoms
- reduce psychological distress following self harm and repetition of self harm.

Above all, liaison psychiatry teams can significantly improve the quality of

#### Case study: North East service

The impact of additional funding of £35,000 to a liaison psychiatry service for a liaison nurse in the North East was evaluated over one year and compared with the previous year. As a result of the additional funding:

- the team saw more patients (an increase from 476 to 546)
- admission rates of patients with psychiatric illness to medical beds dropped from 39 per cent to 35 per cent
- the average bed stay for patients with psychiatric illness in the acute hospital was one day
- crisis team referrals dropped from 35 per cent to 24 per cent
- savings associated with decreased attendances and admissions were £59,000
- an additional two more liaison nurses were funded on the back of these results.

Source: Tees, Esk and Wear Valleys NHS Trust

care received by patients. The quality outcomes of liaison services include:

- improved service user experience and care outcomes
- improved access to mental healthcare for a population with high morbidity
- reduced emergency department waiting times
- reduced admissions, re-admissions and lengths of stay
- reduced risk of adverse events, thus protecting the reputation of the organisation
- enhanced knowledge and skills of general hospital clinicians
- improved compliance of acute

trusts with the legal requirements under the Mental Health Act and the Mental Capacity Act 2005

- improved compliance with NHS Litigation Authority (NHSLA) Risk Management Standards and the Clinical Negligence Scheme for Trusts (CNST) standards.

## Benefits of liaison psychiatry

It is difficult to calculate the exact benefits of liaison psychiatry since the services vary across the country and the concept has been developed quite recently. Some of the already proven benefits are detailed below.

### Improved care and cost savings

The most striking benefit is the improved care for the patient. Although it will need an initial investment, in the medium to long term liaison psychiatry can bring savings for the trust.

### The needs of older adults

The inequality of access to full healthcare is most noticeable within the older population. Two-thirds of NHS beds are occupied by older people and up to 60 per cent have or will develop a mental disorder during their admission, with delirium and dementia being the most common. Mental disorder in older people is an independent predictor of poor outcome, including increased mortality, greater length of stay, loss of independent function and higher rates of institutionalisation.

These outcomes are exacerbated by the inadequate funding of mental health services for older people and the fact that general hospital staff often lack specialist knowledge and support. For example, acute staff may not recognise delirium in 50 per cent of cases. This is important

as a UK study has shown that where dementia, delirium or depression are present after hip fracture, length of hospital stay is increased by an average of 11 days.

Improving and aligning mental and physical health is a key concern to older patients. Evidence shows that most complaints are made by older patients and that liaison psychiatry could improve the level of satisfaction by providing a more complete service.

### Dementia

Failure to detect and manage dementia at early stages leads to longer length of stay. Liaison psychiatry reduces length of stay while it also improves patient outcome.

### Re-attendance

The untreated mental health problems of patients make them more likely to re-attend A&E departments. Early assessment and treatment of all the needs of the patient can decrease the rate of re-attendances considerably.

## Case study: Royal Liverpool Hospital

The Royal Liverpool Hospital has a specific service for older people in the general hospital setting, which includes liaison social work. In a recent study of 324 older people managed by the liaison social worker team, patients were found to have about 24 per cent lower re-admission rates than older people discharged from the general hospital without social work involvement. Also, of the re-admissions, only 13 per cent were for non-medical reasons.

Source: Mersey Care NHS Trust

## Case study: University of Leeds

Recent work carried out at the University of Leeds has shown that older people with dementia have lower lengths of stay in general hospitals where there is a liaison psychiatry service. Furthermore, the difference in length of stay between hospitals which have a liaison service and those that do not can be as much as ten days. Liaison services help staff manage common problems (like delirium) better and drive up standards of care. This work has shown a saving of £1.5 million over a two-year period.

Source: University of Leeds

### Psychological reaction to physical illness

Many patients are admitted to hospital following traumatic events – for example, road traffic accidents – or develop major depression or anxiety as a consequence of their physical disorder. Evidence suggests that liaison psychiatry can treat depression and this leads to reduced healthcare costs. There is a strong cost-effective argument for treatment of depression in cancer patients.

### Decreased rates of self harm

Self harm is one of the most common reasons for admission to a general medical bed. The patients who are admitted are those who have made the most serious attempts to kill themselves. There is robust evidence that liaison services can effectively assess and treat self harm.

### Medically unexplained symptoms

Of all new referrals to general hospital outpatient departments 30 per cent have no demonstrable organic illness to account for their symptoms. These patients are high users

## Case study: Hull and East Yorkshire Hospitals NHS Trust

Liaison psychiatric services to the emergency department in Hull and East Yorkshire Hospitals NHS Trust were recently expanded to cover evenings until 8pm and weekends from 9 to 5pm. In addition, monthly meetings were established between liaison services and emergency department staff to discuss regular attendees, who were proactively managed with a variety of other services or agencies. Attendance rates in the six months before and after the expansion in the service were recorded. After the service expanded, there was a reduction in the number of patients with mental health problems:

- who re-attended the A&E department (35–40 per cent)
- who frequently – five or more times a year – re-attended the A&E department (60 per cent)
- who left the department before an assessment could be completed.

Source: Humber Mental Health Teaching NHS Trust

of healthcare resources. Studies demonstrate that liaison psychiatry interventions can improve patient outcomes and reduce costs.

### Alcohol abuse

Of all male medical inpatients, 20 per cent have significant alcohol problems. There is poor management of alcohol withdrawal states resulting in unnecessary increased length of stay. Robust evidence shows that brief liaison interventions can be effective in the reduction of alcohol use by patients identified as having alcohol problems in the general medical setting.

### Severe mental illness

A small proportion of medical inpatients have severe mental illness (for example, schizophrenia). Hospital staff are normally specialised in physical healthcare. They may be anxious when a patient presents several mental illnesses. Liaison services can respond rapidly and provide a continuity of service between community and hospital while the patient's physical needs are being attended to in the general hospital setting. They can also provide

the necessary training to general acute staff.

### Capacity

The introduction of the Mental Capacity Act 2005 has highlighted the need for rapid assessments of capacity to consent to medical treatment in the general hospital setting. For patients with complex physical and mental health problems, an experienced liaison psychiatrist is a key professional with appropriate training to make an informed judgement.

## Training

Professionals in acute services currently lack a wide knowledge about the mental health needs of patients. A liaison mental health team ensures that:

- there are assigned members of staff with the specific responsibility of understanding developments in mental healthcare
- members of the liaison psychiatry team are able to improve the knowledge and skills of the rest of the staff members.

## Setting up a liaison team

There are different models of service, but liaison services work most effectively when they are embedded into general hospital work. In this model, mental health problems staff work closely with general staff to improve rapid detection and treatment of patients with mental health problems. Most services include training and educational components to improve the overall quality of service provision and ensure appropriate guidelines (for example, NICE guidelines) are being followed and clear pathways of care

## Case study: Wirral liaison psychiatry services

Wirral liaison psychiatry services recently implemented a psychological treatment service for patients presenting with self harm who discharged themselves against medical advice – these patients are at high risk of further self harm and suicide. The psychological treatment is known as PIT and has been evaluated in a randomised controlled trial. It consists of just four sessions of psychotherapy. From August 2007 to January 2008 42 patients were offered treatment. The self harm attempts for these patients for the three months prior to the index episode of self harm were 41 attempts by 18 patients and the number of self harm attempts in the three months following the treatment were 11 attempts by six patients.

Source: Cheshire and Wirral Partnership

are developed for patients with particular mental health problems.

Liaison services should 'map' onto the specific needs of an acute hospital. As acute hospitals vary in size and service delivery, the size and composition of each liaison service will also vary.

### Staffing

A liaison psychiatry team needs to be multi-disciplinary, requiring a range of skills. Teams are better suited when they incorporate the skills of nursing, psychiatry, psychological therapy and social work. The psychiatric input should be from a consultant level doctor who will provide leadership and manage and supervise risk. The nursing, psychological and social work will need to reflect the needs of the patients.

## Easing the way for liaison psychiatry

As identified above, liaison psychiatry can be a cost effective service for both providers and commissioners. There are key components that make up a liaison team, but there is no single model for all settings. Therefore hospitals are increasingly designing a version of the team that suits their needs. The NHS Confederation agrees that team structures should be designed according to local needs and the system should allow a certain flexibility.

However, while the implementation of the service should be decided locally, strong evidence suggests that there should be a more co-ordinated effort to make liaison services more widely available. The structural barriers to developing these services need to be addressed and new approaches explored to enable liaison mental health services to be

## Case study: North East trust

Strategic health authority (SHA) monies have been provided in a North East Trust to evaluate the development of a liaison psychiatry alcohol service for a general hospital. The aim is to improve detection and ensure appropriate management of patients with alcohol problems and implement an alcohol pathway to facilitate rapid (but appropriate) discharge. This post has just been implemented.

Below are the potential cost savings which were calculated during the development of the bid.

- Over a six-month period, there were 113 admissions associated with 343 bed days (primary code alcohol). The cost for the alcohol intoxication group was based on 78 patients. (S16 tariff was used: one day £321; two days £641; additional days £169). Total cost for these patients was £60,022.
- Reducing length of stay for these patients to an average of one day by intervention of the liaison psychiatry service would result in savings of £34,987 over six months (£69,974 for 12 months). The cost of the liaison psychiatry service is £32,000 resulting in a potential saving of £37,974 per annum, and improved care for patients with alcohol problems.

provided more consistently. The following are options to explore, but local organisations will develop their own approaches.

### Directly commissioned liaison services

There may be a business case for PCTs to provide funding for acute trusts to commission this service from a mental health trust or commission a mental health trust to provide the service in the acute trusts.

The costs of liaison services are not currently separated from general care package costs when calculating tariffs, therefore there is not a specific healthcare resource group for additional mental health needs. At some point it may be possible to distinguish costs in reference costing and incorporate them into the tariff. However, for the foreseeable future liaison services will be commissioned directly as an off-tariff option.

The first step is for commissioners and providers to collaborate to assess the level of need and existing provision before making a decision as to whether it will be cost-effective for the service to be directly commissioned.

### Providers

There are potential financial benefits of introducing liaison services to acute providers. Reduced length of stay and easier discharge can reduce costs per patient. Therefore if commissioners do not view liaison services as a priority for investment it may still make sense for providers to audit their services and analyse the need for a liaison mental health team. Liaison psychiatry teams can bring many benefits to hospitals, including reducing costs, freeing beds and improving the quality of care.

Where there are potential benefits for commissioners – in terms of cost effective services, improved outcomes and reduced need – and for providers – in terms of improvements in quality

and productivity – there could be an argument for both to share the cost and benefits of liaison services, as some of the improvements will reduce income to the acute trust.

## Confederation viewpoint

A liaison service is an example of a quality improvement with a strong business case as long as the service is well-designed and based on good data about the numbers of patients that could benefit. The system will also be supported by current policy, such as the dementia and learning disability strategies or the personalisation agenda, which insists on a holistic approach to care. Many of the streams in Lord Ara Darzi's report, *High quality care for all*, also mention the importance of providing services that treat both mental and physical health.

The service is a good example of an innovation developed in the field (rather than centrally) which has made a significant improvement in quality and efficiency.

We are interested in hearing from members with other examples of using service redesign, cross-sector working and improvement techniques to create higher-quality and more efficient services.

For more information on the issues covered in this *Briefing* contact [patricia.suarez@nhsconfed.org](mailto:patricia.suarez@nhsconfed.org)

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## Further information

For annexes to this *Briefing* (references, related policy documents and examples of liaison mental health teams) please visit: [www.nhsconfed.org/publications](http://www.nhsconfed.org/publications)

*Who cares wins*. Working group for the Faculty of Old Age Psychiatry, Royal College of Psychiatrists, 2005.

*Psychiatric services to accident and emergency departments*. Royal College of Psychiatrists, British Association for Accident and Emergency Medicine, 2004.

*Managing urgent mental health needs in the acute trust*. Academy of Royal Colleges, 2008.

## The Mental Health Network

The Mental Health Network was established as part of the NHS Confederation to provide a distinct voice for mental health and learning disability service providers. We aim to improve the system for the public, patients and staff by raising the profile of mental health issues and increasing the influence of mental health and disability providers.

The NHS Confederation is the only independent membership body for the full range of organisations that make up today's NHS. Its ambition is a health system that delivers first-class services and improved health for all. As the national voice for NHS leadership, the NHS Confederation meets the collective needs of the whole NHS as well as the distinct needs of all of its parts through its family of networks and forums. The Mental Health Network is one of these.

To find out more about the Mental Health Network, visit [www.nhsconfed.org/mhn](http://www.nhsconfed.org/mhn) or email [mentalhealthnetwork@nhsconfed.org](mailto:mentalhealthnetwork@nhsconfed.org)

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