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and Social Care  
Research

**Adult Mental Health Hospital Liaison  
Service Evaluation  
Evaluation Report**

**October 2016**



# Adult Mental Health Hospital Liaison Service Evaluation

## Evaluation Report

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September 2016

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## Glossary of Terms

Acronym/Abbreviation	Explanation
A&E	Accident and Emergency Unit, A&E is used in this document for consistency (increasingly referred to as the Emergency Department (ED))
CHSCR	Centre for Health & Social Care Research (SHU)
ED	see A&E above
HLS	Hospital Liaison Service
MCA	Mental Capacity Act
MH	Mental Health
MHA	Mental Health Act
MHLT	Mental Health Liaison Team
QIPP	Quality, Innovation, Productivity and Prevention
RDaSH	Rotherham, Doncaster and South Humber Trust
SHU	Sheffield Hallam University
TRFT	The Rotherham Foundation Trust
VARM	Vulnerable Adult Risk Management

## Executive Summary

Here we summarise the main findings from our evaluation of the impact of the Rotherham, Doncaster and South Humber (RDaSH) Mental Health Liaison Service (MHLS). The service began in April 2015 as part of a two year pilot with the aim of providing assessment and treatment to assist the management of adults with mental health problems who are admitted to Rotherham Hospital.

The benefits the service brings to the overall care offered in the hospital are valued, look set to continue and will expand as the service becomes more established. Based then on our findings we can recommend that the service be established on a permanent basis.

The service was initially delivered Monday-Friday, 9am-5pm but this was extended to 8am-8pm, over seven days and this has remained the pattern of service delivery. The 'out of hours' aspects of the service are provided by a separate Crisis Team that does not form part of this evaluation but, because of the close links, will be discussed.

The service is nominally providing a service for all adult ages. In practice this divides into those clinicians who focus on the needs of individuals with more acute mental health problems (Adult Mental Health Service) and those patients, usually older, who have a diagnosis of dementia (Older Persons Service). Officially the Older Persons Service starts at age 65 but age can be flexible as needed for patient care.

The day to day operation of the service is broadly similar in nature to other organisations across the country where the introduction of mental health liaison into acute care settings is becoming more widespread. The initiative is responding to core policy guidance messages from The Kings Fund (2016), the Joint Commissioning Panel for Mental Health (2013), and the Department of Health (2011).

## Methodology

A before-and-after analysis was carried out to analyse the health service utilisation data for patients registered with the RDaSH service. Due to recent changes on access to NHS data we were not able to access HES data. The quantitative analysis was conducted on pseudonymised NHS number-linked data from the hospital and RDaSH.

In order to broaden the scope of the service evaluation beyond merely data, stakeholder interviews were carried out with fifteen individuals who were either directly employed by RDaSH within the liaison team or who were The Rotherham Foundation Trust (TRFT) employees and whose role brought them into contact with the work of the liaison team. They were interviewed about the impact of the service and potential opportunities for enhancement.

## Findings

### Qualitative Data Generation and Analysis

One quote succinctly sums up the enthusiasm for the service by the hospital staff.

*"We would struggle if the team wasn't there. Our patients would suffer [because] we don't have the knowledge"<sup>1</sup>*

Colleagues working in TRHT in senior management positions as well as clinical staff have spoken very highly of the work the team does, focusing in particular on their knowledge/expertise and their willingness and availability to contribute to patient care. This is particularly appreciated where other factors, such as alcohol dependency/drug use or dementia make diagnosis and/or treatment more complex.

Feedback from service users and their relatives is also very positive emphasising *the speedy response from the liaison team as well as the very practical help they bring to people in distress.*

The potential for joint working with other specialisms is a key strength of the work of the team. Currently this is more evident in the links they have established with the emergency department (ED) and those wards which cater for the (mostly older) patients who present with dementia in addition to their clinical/medical needs.

But as the team has become more established their influence has spread. Input from the team, for example, now extends to discharge planning. Their attendance at these meetings is cited as having helped to reduce the numbers of delayed discharges.

The team is also represented at meetings with Adult Safeguarding where vulnerable adult risk management (VARM) often implicates some individuals known to the service.

This positive feedback reflects how the hospital as a whole is meeting the targets set in the Care Act (2014) where a key aim is that health and social care services should work together more closely to improve outcomes for patients.

The benefits the MHLT brings to the wider organisation are not limited to improving patient care. They also provide onsite training on legal requirements to front line staff to help them understand their responsibilities in relation to aspects of the Mental Capacity Act and the implications for Deprivation of Liberty which can result from the application of certain sections of the Mental Health Act (MHA). This is particularly important for those individuals who are discharged from hospital with some mental health issues and who need ongoing care under section 117 of the MHA.

In the final stages of preparation of this report we have also been made aware that further training opportunities are being instigated for junior doctors (F1s) and A&E staff on a rolling programme basis. This initiative will add to the knowledge and skills of frontline staff who come into contact with patients who experience mental health issues over and above any presenting condition.

The evaluation has noted limited areas where improvements could be made. The first is the MHLT is not always aware of how well they are regarded and how they are benefiting hospital targets. The second is the NHS-wide problem of unintegrated patient record systems and organisational structures in silos.

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<sup>1</sup> member of staff working in adult safeguarding

## Quantitative Data Generation and Analysis

The numbers are presented in graph/table form in the full report. Here we summarise the highlights.

Between 01 April 2012 and 31 March 2016, 799 Adult Mental Health and 1394 Older People who were/are RDaSH patients used acute healthcare services. Approximately 80% of RDaSH patients have had more than 1 visit to A&E or more than 1 hospital admission over the 4 years of the study.

We compared RDaSH patient use of acute health services after the start of the Hospital Liaison Service (2015/16 fiscal year) with their use over the previous 3 fiscal years (2012/13 to 2014/15) using data from the area CCG and RDaSH. Here we found:

- there has been a significant decline in the proportion of Adult Mental Health patients who visited A&E more than 6 times per year (Section 3.1.2)
- there has been an impressive increase in the number of Adult Mental Health patients referred into the Hospital Liaison Teams and other RDaSH services from A&E. (Section 3.1.3)
- there has also been a small increase of admission from A&E to RDaSH inpatient services. (Section 3.1.3)
- there is a modest increase in the number of Older Patients referred into RDaSH services. (Section 3.1.3)

Restricting our analysis to people who have visited A&E more than 10 times between 2012/13 and 2015/6, there was an increasing number of A&E visits in the patient cohort but this has begun to decline beginning with the establishment of the liaison service (see Figure 3). Nevertheless, to confirm a decline, this needs to be monitored for a longer period of time to statistically demonstrate a decreasing trend.

The number of hospital visits (planned and unplanned) in both groups appears to be levelling off from a previous continuously increasing trend (see Figure 5).

Readmission to hospital within 30 days has been declining steadily across the entire period of the study. But, as numbers are small this needs to be monitored for a longer period of time (Section 3.1.9).

Adult MH patients who had more than 5 unplanned hospital admissions a year declined from an average of 9 unplanned admissions a year to 7.6 (see Section 3.1.10).

Just over one-quarter of A&E data is missing information regarding where patients were discharged to. Nevertheless, the RDaSH records show a large increase in all types of referrals since the Liaison Service began. This highlights the benefit of having the HLS in place within the hospital.

## Recommendations

**These appear in full.....grouped under the headings 'Management, 'Team Building' and 'Education and Awareness' but the overall message from the evidence we have found is that the service be established on a permanent basis.**

## In conclusion

The work performed by the Liaison team is highly valued by those professionals in the wider hospital setting who can see the benefit it brings to patient care. It is also appreciated by the patients themselves, brings peace of mind to their relatives and families, as evidenced by the local evaluation 'Your Opinion Counts' and improves the operation of the organisation as a whole.

The steadily increasing amount of inter-professional working is gaining momentum. Commissioners and managers need to support this and develop mechanisms to bridge the current siloed structure of both data and management systems.

The quantitative data reflects a steady uptake of the liaison service - particularly with Adult MH patients who were frequent users of acute service. But the overall numbers are small, data needs to be collected for a longer period, and the new data access requirements need to be in place before any robust statistical analyses can be conducted.

The trend in both policy and practice is for psychiatric liaison to become more prominent within acute care settings. The local initiative has made an excellent start at providing this input. There are, of course, sticking points but the service is showing its potential and with the right support from managers and commissioners it can go on to demonstrate good practice.

Finally, the work the team does influences the practice of others. The next generation of practitioners seem to be impressed. A student nurse had this to say when asked to contribute to a local evaluation:

*"I have found the team welcoming and I have enjoyed my time there. I have seen the vision of mental health services for the future and feel that the liaison team are doing an amazing job".*

## 1.0 Introduction and project aims

This report provides the findings from the evaluation of the work of the Mental Health Liaison Team (MHLT). The two year pilot was initiated in April 2015. It aimed to:

- reduce A&E admission
- decrease length of stay
- improve access to assessment & appropriate services during MH crisis
- reduce re-admission

The initiative also had a broad remit to explore an 'all-age' service. It is a joint enterprise between Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) and The Rotherham NHS Foundation Trust (TRFT). From the rubric supplied by RDaSH the guiding principles were that people of all ages [would] be able to live as normal and inclusive a life as possible:

- supported by services that promote and enable recovery and well being
- have choices of care available locally, seven days a week
- with easy access to accurate information

### The Mental Health Liaison team - its origins and rationale

The provision of a mental health focused nursing presence to provide psychiatric liaison within general hospitals is not new. In the US, Nelson and Schilke (1976) saw it as a clinical specialism in which appropriately qualified nurses would use their skills to develop a 'framework within which the [general] nursing staff can understand the patient's experience of illness and hospitalisation and their own experience of caring for patients' (1976:64). Later, and in the UK, in a review of practice, the Department of Health (1994) described new roles which might be available to mental health practitioners such as, 'liaison nursing with accident and emergency services and general hospitals' (1994:4). Roberts (1997) then describes what he sees as the development of the role when he says 'liaison MH nurses will need to work collaboratively with their general colleagues in clarifying how best to share mental health knowledge and skills' (1997:106).

### Policy

The Kings Fund (2016) states that more integration is needed between physical and MH services. Despite this they also report that currently only 16% of acute hospitals in the country have access to such a service (figures derived from the Mental Health Taskforce, 2016).

Parsonage and Fossey (2011) add that hospital staff lacks the knowledge skills and training needed to provide a good service for those patients who present with mental health problems and this directly affects patient care.

The points were evident in our conversations with the staff who contributed to our evaluation. To compound the issue there is evidence that where patients with mental health problems do not receive optimal care during their admission to general hospital the likelihood of re-admission rises

(Joint Commissioning Panel for Mental Health, 2013). The same authors also claim cost saving for Trusts who have introduced liaison teams.

### **Evidence to Support the Introduction of Mental Health Liaison teams**

Mental health problems in patients admitted to hospitals account for approximately:

- 5% of A&E attendances
- 25% of primary care attendances
- 30% of acute inpatient bed occupancy
- 30% of acute readmissions

[Figures supplied by Royal College of Psychiatrists and British Association for Accident and Emergency Medicine, 2004, Psychiatric services to accident and emergency departments (CR118) London, Royal College of Psychiatrists]:

- 25% of all patients admitted to hospital with a physical illness also have a mental health condition that, in most cases, is not treated while the patient is in hospital
- most patients who frequently re-attend A&E departments do so because of an untreated mental health problem
- two thirds of NHS beds are occupied by older people, up to 60% of whom have or will develop a mental disorder during their admission

[Figures supplied by NHS Confederation (2009) Healthy mind, healthy body: how liaison psychiatry services can transform quality and productivity in acute settings. London: NHS Confederation].

### **Mental Health Liaison Service Evaluation Remit**

The evaluation focussed specifically on the following areas as requested by the commissioner to assess:

1. The impact the liaison service has had on reducing unnecessary admissions.
2. The impact on length of stay for people with mental health problems in TRFT, especially those with dementia.
3. The impact on readmissions +/- or attendance of people with MH problems at TRFT for their MH problems.
4. The impact in the number of readmissions into hospital from residential and care homes (relating to dementia).

5. Analysis of the impact of the liaison service freeing up staff time to work elsewhere in the community including crisis team.
6. Stakeholder (service delivery teams and managers) perspectives on MH referral processes.

### The Evaluation

The evaluation was undertaken by staff from the Centre for Health & Social Care Research, Sheffield Hallam University. It had the following specific aims based on what data was available for analysis:

Evaluation questions	Which analyses were conducted
The impact the liaison service has had on reducing unnecessary admissions	We clarified this as A&E visits or hospital admissions. We compared all admissions, unplanned hospital admissions, readmission within 30 days, and all A&E visits before and after the intervention. An additional important outcome from A&E is where the patient was discharged to as patients who need further service but are just discharged are at greater risk of appearing in A&E again.
The impact on length of stay for people with mental health problems in TRFT, especially those with dementia	We compared the length of hospital stay and the length of time in A&E before and after the intervention.
The impact on readmissions +/- or attendance of people with MH problems at TRFT for their MH problems	We determined the number of readmissions within 30 days of discharge before and after the intervention.
The impact in the number of readmissions into hospital from residential and care homes (relating to dementia)	We did not receive any information about whether the patients were in Care Homes in the data provided.
Analysis of the impact of the liaison service freeing up staff time to work elsewhere in the community including crisis team	The interviews and qualitative analysis addresses this issue. The quantitative data does indicate where patients are discharged to which provides some information.
Impact of the service on frequent attenders (where possible and where access to patients can be gained)	Selecting out the most frequent A&E visitors and those with many unplanned hospital admissions we compared their visits before and after the intervention. Numbers are small but we present this information.

In addition, we have identified some data quality and organisational issues which, if addressed, would improve service provisions for mental health patients.

## Layout of the Report

The main body of the report comprises qualitative data drawn from stakeholder interviews with fourteen staff and quantitative analysis drawn from numerical data

The report is arranged by section:

- Section 1 provides introduction, aims of the evaluation and MHLT - its origins and rationale
- Section 2 provides an overview of the methodology for the service evaluation: Quantitative & Qualitative analysis
- Section 3 provides quantitative analysis of data sets
- Section 4 provides evaluation of qualitative data
- Section 5 provides the conclusion and recommendation for the continuation of MHLT
- Appendix 1 "Diagnostic Overshadowing"
- Appendix 2 Case Studies

## 2.0 Methodology for the service evaluation

This evaluation used a mixed methods design that included interviews with a before-and-after analysis of hospital utilisation data.

### 2.1 Quantitative data analysis

The methodology applied a retrospective matched control analysis with a series of targeted interviews of staff (the project leads, hospital staff, and managers). But, recent restrictions on data accessibility from the NHS meant that we didn't have access to Hospital Episodes Statistics (HES) data and also that it was not possible to identify a comparison group (the match) for quantitative analysis. Therefore, a before- and-after analysis was conducted which is a quasi-experimental study design which is considered a robust form of evidence. Quasi-experimental designs, sometimes called the pre-post intervention, are frequently used when it is not logistically feasible or ethical to conduct a randomized controlled trial. Using the technique we compared patient health care utilisation data before and after the intervention. Before the intervention are the fiscal years 2012/13 to 2014/15. After the intervention is fiscal year 2015/16. It is important to remember that the Liaison Services began in the 2015/16 fiscal year and that new interventions take time to embed, therefore it was not fully operational from the first day of the new fiscal year. It is also important to note that the overall patient population (particularly high frequency users) is relatively small. This meant that a small sample size in some sub analyses also constrained what could reasonably be achieved.

The project was asked to provide RDaSH data with NHS numbers of all their patients which were sent directly to the CCG data analysts for linking with Hospital and AE utilisation data. All work was done under a Data Sharing Agreement. The team received the following data files containing pseudonymised NHS number so that data could be linked for analysis:

- admissions (to RDaSH inpatient care)
- all other referrals - to other RDaSH services
- referrals (to the RDaSH Hospital Liaison Service)
- acute admissions (to Rotherham Hospital)
- A&E attends (to Rotherham Hospital)

The first 3 were provided by RDaSH and the latter two are from the CCG data providers.

Before any analysis could be conducted, a relational database was built which links all the data files via pseudonymised NHS number. Care episodes were generated from the dates of service provision. For example the outcome of an A&E visit was linked, via dates, to what, if any, subsequent care was received by the patient in either the Acute or RDaSH systems. This statement makes the linkage process seem straightforward but it was often complex with multiple referrals and further complicated by incomplete or missing data. Without the usual HES data, which is cleaned, there are

problems with data incompatibility, such as date structures that required a lot of processing to allow linkage to occur.

Based on which RDaSH services they used, all patients who fell into: 1) Older People (n=5908), or 2) Adult Mental Health (n=5200) were selected for analysis. Please note these are **all** people who accessed RDaSH services at any point during the 4 fiscal years. Based on the data provided, we did not have any way to determine if the patients were still resident in the area and 'available' for A&E visits or Hospital Admissions.

Data analysis and reporting was stratified by HLS Service Arm (Older People or Adult Mental Health) and by NHS financial year. All analyses were conducted in Microsoft Access and SPSS v.23. Results are reported as counts as we did not have the necessary population-level data to calculate a rate nor a comparison group. This is not optimal as an increase in the number of patients could arise because there are an increasing number of people using the services. Nevertheless, we have no reason to think that there has been any significant change in the number of mental health patients in the local population and in-, and out-migration rates are low in this area.

Some outcomes are also reported from the August 2016 Service dashboard. We have indicated in the text when the finding arises from this information rather than our analysis.

## 2.2 Qualitative data analysis

The qualitative data collection was carried out via interviews and generated a service level critical reflection on the process of change and how the strategic ambition has translated into operational change. The data was used to identify factors that contribute to successful or unsuccessful delivery of the MHLT services; examining the nature of requirements of working together with partner organisations; exploring the contexts in which policies operate; and exploring organisational aspects of delivery. These aspects were based around the staff understanding of five areas:

- the purpose and scope of the liaison team
- their own role and function
- what impact they felt the team had on service delivery
- what challenges they faced
- general observations and future development

We undertook a series of interviews with a range of health professionals (stakeholders) both in the main hospital and with those working directly as part of the mental health liaison team.

The qualitative data was generated by two of the research team (MI and AMC) during one-to-one interviews conducted with staff on-site at Rotherham Hospital. The interviews lasted between 30 to 60 minutes. Staff were given an information sheet outlining the purpose of the interview and were then asked to sign a consent form indicating their understanding of the arrangement.

Fourteen interviews were held with staff. The recordings were sent to a professional company for transcription. All electronic recordings and transcripts were held on a secure drive on the university system.

Initially, transcripts were hand-coded by several research team members. Data is coded (labelled) to condense the large amount of information provided in the interview transcripts and to provide comparison across interviews. Using thematic analysis (Vaismordi et al 2013), we began data analysis by assigning preliminary codes and categories to the text. Emergent themes were subject to constant comparison and examined for goodness of fit until a final set of key themes were identified. We did not take what was said at face value. Rather, we used interpretative analytical techniques (latent-level analysis) to identify or examine the underlying ideas. Adopting an iterative approach, data analysis commenced with the first set of interviews. This means that subsequent data collection was informed by previous analyses thus ensuring that emergent, participant-generated themes that can be fully explored. The data were then subject to a more detailed analysis using Nvivo (version 10) which allowed for electronic coding of the raw data. To ensure methodological rigour and trustworthiness of our findings, a 'data clinic' amongst the research team was held to discuss the emerging themes to ensure consistency of coding and to agree on the key themes emerging from the data. Once agreement has been reached one researcher then coded all transcripts. A second 'data clinic' was held once coding was complete to ensure agreement on the key themes emerging from the data.

We have also been given access to a local survey 'Your Opinion Counts' which canvassed views on the service from a wide range of stakeholders - patients, families, allied health professionals and hospital staff. These insights have added to the overall impression of a valued service.

## 3.0 Quantitative evaluation of data sets

This section begins with an analysis of A&E visits, then examines hospital stays and finishes with some feedback about the nature of the data collected in hospitals and where specific improvements could be made.

We started by producing a central linkage file of all patients who had used RDaSH services over the 2012/13 through 2015/16 fiscal years in this analysis. Over the 4 years in this analysis there were 799 people who had used Adult MH services and 1394 who had used Older People services. All of these patients had the potential to use the HLS.

### 3.1 A&E visits

#### 3.1.1 Accident and Emergency (A&E) visits

Over the 4 years of the study the two groups had 11,108 A&E visits (see Table 1).

**Table 1** Total number of A&E visits by service arm and fiscal year

Service Arm		2012/13	2013/14	2014/15	2015/16
Adult mental health	N	779	1122	1523	2484
	% *		144%	136%	163%
Older people	N	856	1384	1375	1585
	% *		162%	99%	115%

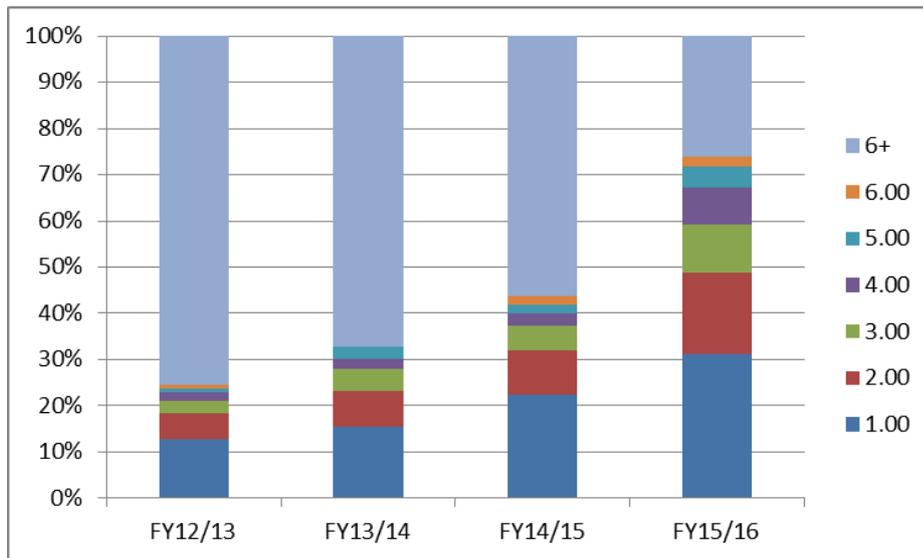
\* Increase over previous year

There has been a large increase in the overall number of visits to A&E with the Adult MH patients showing the greatest increase.

#### 3.1.2 Patients who are frequent visitors to A&E

To look at the A&E visits in more detail we calculated the annual number of visits to A&E for all of the patients in each service arm. Only patients who had any visits in that fiscal year are included in this calculation.

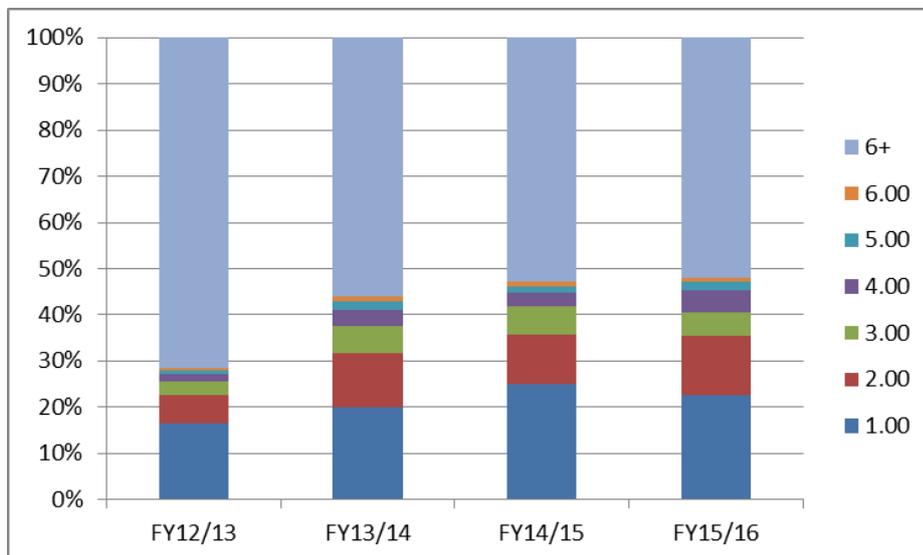
**Figure 1** Proportion of RDaSH Adult Mental patients who are frequent users (1 to 6-or-more visits per year) by Fiscal Year\*



\* excludes people who did no visit A&E during that year

The data suggests that the Service has had a significant effect on reducing frequent users in Adult MH as the proportion have 6 or more visits per year has declined dramatically (Figure 1) even though the overall numbers are up as seen in Table 2. The proportion of frequent users in the Older People arm remain very similar (Figure 2).

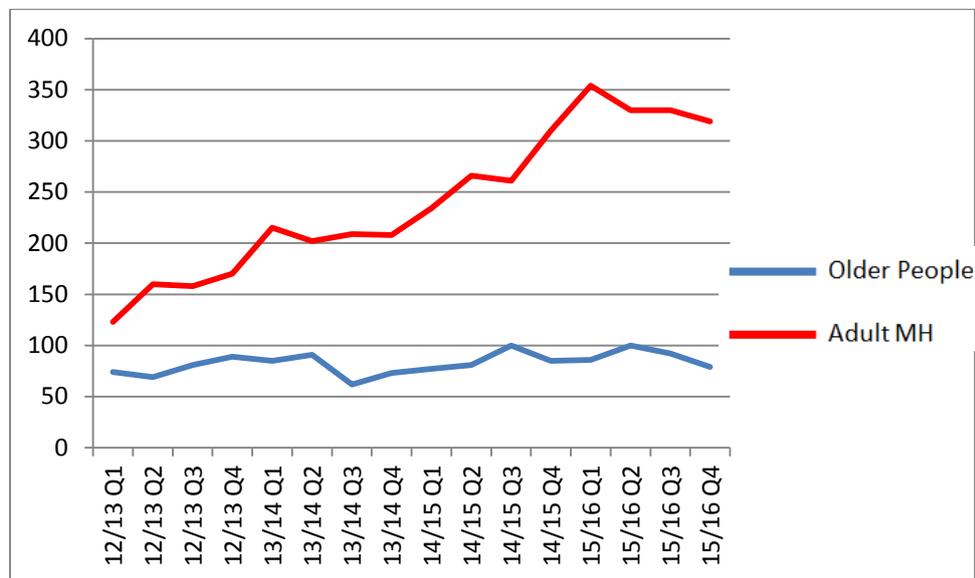
**Figure 2** Proportion of RDaSH Older People patients who are frequent users (1 to 6-or-more visits per year) by Fiscal Year\*



\* excludes people who did no visit A&E during that year

The qualitative research suggested that the most dramatic effect was on frequent attenders who are well known to RDaSH staff and quickly picked up by the service. To examine this in more detail we selected the subset of patients who had visited A&E 10 or more times during the 4 fiscal years. Below is a plot of the number of A&E visits for this subset by quarter within the fiscal year.

**Figure 3** Total number of A&E visits by patients who are Frequent Visitors\* to A&E



\* defined as those patients who have visited A&E more than 10 times during the 4 fiscal years.

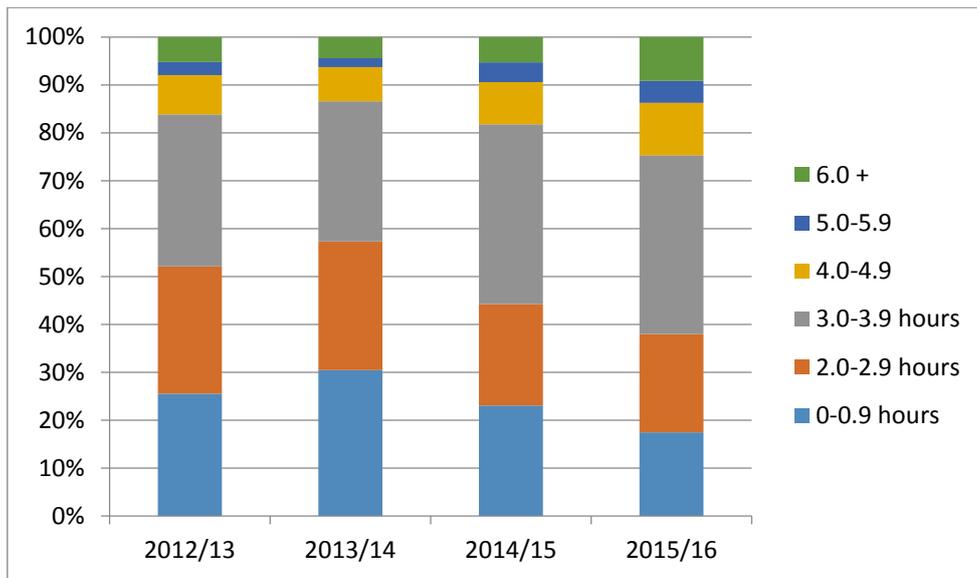
There is little change in the number of A&E visits from the Older People Service Arm. The patients in the Adult Mental Health Arm do seem to be going to A&E less. In order for us to detect a statistically significant declining trend we will need a further year's data.

### 3.1.3 Time in A&E (hours) by Financial Year adults and older people

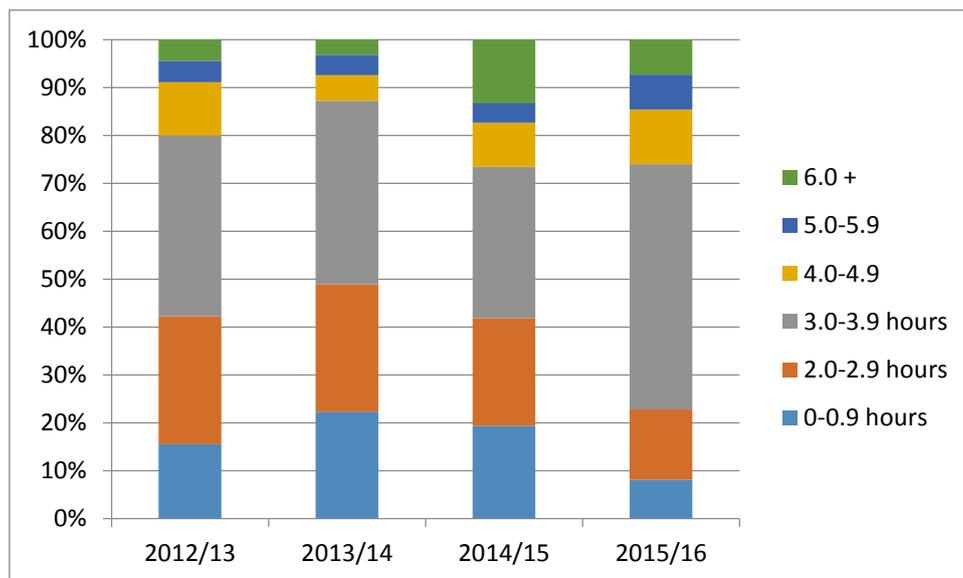
Even if the patients are attending A&E more often, are they spending less time in A&E? The length of time in A&E is driven largely by the national target of 4 hours. It is also driven by the problem of not having anywhere to send A&E patients who cannot just be discharged and is one of the key positive outcomes from this Service. Figures 4 and 5 are not encouraging but as we will discuss later there are practical and patient-behaviour issues which need to be considered. It is more important to consider where patients are discharged to and this analysis follows next.

It is also important to note that the times in Figure 4 are for all A&E visits by any patient who has used RDaSH services and do not represent the time till the liaison service sees the patient. From the Rotherham Hospital Liaison Service August 2016 dashboard we know that all patients who are referred to them are seen within 1 hour (KMP 4). The quick response from the liaison team acts to relieve pressure on A&E staff who are freed to focus on the core business of assessing and treating acute cases. Thus a closer integration of the two services would benefit both patient care and the management of A&E.

**Figure 4** Adult Mental Health time in A&E (hours) by financial year



**Figure 5** Older people Mental Health time in A&E (hours) by financial year



### 3.1.4 Where Are Patients Discharged To from A&E?

#### Outcome of A&E Visit based on the hospital records

There were significant problems linking the A&E information about discharge (termed disposal in the data) with just over one quarter of the discharge information missing in A&E data (see Table 2) and inaccuracies in the referral pathway. Therefore it was decided that data linkage between the files was likely to be a better marker of patient disposal from A&E.

**Table 2** Outcome of A&E Visit based on the A&E records

A&E Discharge Category	Adult	Older People
<b>01 Admitted to hospital</b>	1372 (23.1%)	1933 (37.2%)
<b>02 Discharged with GP follow-up</b>	946 (16.0%)	913 (17.6%)
<b>03 Discharged no follow-up</b>	855 (14.4%)	599 (11.5%)
<b>04 Referred to A&amp;E clinic</b>	55 (0.9%)	19 (0.4%)
<b>05 Referred to fracture clinic</b>	82 (1.4%)	80 (1.5%)
<b>06 Referred to other outpatient clinic</b>	132 (2.2%)	78 (1.5%)
<b>07 Transferred to other healthcare provider</b>	67 (1.1%)	80 (1.5%)
<b>10 Died in department</b>	1 (0%)	4 (0.1%)
<b>11 Referred to other healthcare professional</b>	222 (3.7%)	92 (1.8%)
<b>12 Left A&amp;E before being seen</b>	520 (8.8%)	25 (0.5%)
<b>13 Left A&amp;E refused treatment</b>	85 (1.4%)	7 (0.1%)
<b>14 Other</b>	16 (0.3%)	4 (0.1%)
<b>99 Missing</b>	1578 (26.6%)	1366 (26.3%)
<b>Total</b>	<b>5931</b>	<b>5200</b>

### Outcome of A&E Visit based on linkage between the datafiles

Tables 3 and 4 are patients who visited A&E and had a hospital or RDaSH admission, or referral to other RDaSH services the same or the next day. The transfer of patients from A&E to RDaSH inpatient services has increased by approximately 60% in both service arms although the overall numbers are much greater in the Adult MH Service Arm. A significant number of Adult MH patients are now receiving RDaSH services or other services with a 55% increase in referral to other RDaSH services as well as good uptake of the HLS. The qualitative sections provide further interpretation of this issue.

**Table 3** Adult MH - A&E Discharge to other services from linkage of data files

Fiscal Year	to Acute	to RDaSH inpatient	to HLS	to Other RDaSH	Total
<b>2012/13</b>	346	no data	no data	no data	
<b>2013/14</b>	409	34	0	223	666
<b>2014/15</b>	668	35	0	230	934
<b>2015/16</b>	1254	55	472	415	2195

**Table 4** Older People - A&E Discharge to other service from linkage of data files

Fiscal Year	to Acute	to RDaSH inpatient	to HLS	to Other RDaSH	Total
2012/13	497	no data	no data	no data	
2013/14	863	11	0	54	950
2014/15	1036	8	0	46	1090
2015/16	1329	13	83	56	1481

### 3.1.5 Other Findings from A&E Data Relevant to This Evaluation

#### Incident Location

A&E records information on where the patient was during the incident that led to their visit. This may impact on the decision to take them to A&E. For both groups (adults and older people) the majority of incident locations are at home (Table 5). Adult MH patients are more likely than older people to have an incident in a public place which may lead to an A&E visit. This highlights a need for a conversation with ambulance crews about the decision making process around where to take patients who present with mental health issues see conclusions in [section 5.2](#). Ideally, these proportions should be compared against the non-mental health population as it may be the social norm to visit A&E.

**Table 5** A&E incident location (all years combined)

	Adult n= (%)	OlderPeople n= (%)
<b>10 Home</b>	4150 (70.0%)	4486 (86.3%)
<b>40 Work</b>	68 (1.1%)	1 (0.0%)
<b>50 Educational institution</b>	5 (0.1%)	0
<b>60 Public place</b>	652 (11.0%)	151 (2.9%)
<b>91 Other</b>	686 (11.6%)	300 (5.8%)
<b>Missing</b>	370 (6.2%)	262 (2.0%)

#### First diagnosis during A&E visit

RDaSH patients visit A&E for a variety of conditions which may, or may not, be related to their mental health condition. Table 6 lists the first or initial diagnosis by A&E staff. The selection of a diagnosis will be driven largely by A&E staff's view of health - for example A&E training has been largely focused on trauma management which leads them to focus on physical health conditions.

For both groups (adult and older people) 50% of the reasons for an A&E visits are covered by only a few categories. For older people two-fifths of first diagnosis fall into 4 conditions (cardiac conditions, respiratory conditions, urological conditions and fracture) with a further 10% recorded as

"diagnosis not classifiable". For Adult MH 15.6% of first diagnosis are missing, and a further one third includes poisoning, psychiatric conditions and gastrointestinal conditions.

**Table 6** "First diagnosis" description from A&E admission (all years combined)

Code	Diagnosis Condition	Adult	Older People
	Total	5931	5200
01	Laceration	146 (2.5%)	148 (2.8%)
02	Contusion/abrasion*	174 (2.9%)	246 (4.7%)
03	Soft tissue inflammation	25 (0.4%)	12 (0.2%)
04	Head injury*	162 (2.7%)	377 (7.2%)
05	Dislocation/fracture/joint injury/amputation*	210 (3.5%)	421 (8.1%)
06	Sprain/ligament injury	67 (1.1%)	12 (0.2%)
07	Muscle/tendon injury	137 (2.3%)	165 (3.2%)
08	Nerve injury	0	0
09	Vascular injury	1 (0.0%)	1 (0.0%)
10	Burns and scalds*	14 (0.2%)	7 (0.1%)
11	Electric shock	1 (0.0%)	0
12	Foreign body	21 (0.4%)	6 (0.1%)
13	Bites/stings	10 (0.2%)	5 (0.1%)
14	Poisoning* (including overdose)	721 (12.2%)	60 (1.2%)
15	Near drowning	0	0
16	Visceral injury	0	0
17	Infectious disease*	21 (0.4%)	45 (0.9%)
18	Local infection	72 (1.2%)	63 (1.2%)
19	Septicaemia	17 (0.3%)	37 (0.7%)
20	Cardiac conditions*	274 (4.6%)	575 (11.1%)
21	Cerebro-vascular conditions	56 (0.9%)	173 (3.3%)
22	Other vascular conditions	3 (0.1%)	1 (0.0%)
23	Haematological conditions	8 (0.1%)	10 (0.2%)
24	Central Nervous System conditions* (excluding strokes)	320 (5.4%)	291 (5.6%)
25	Respiratory conditions*	262 (4.4%)	569 (10.9%)
26	Gastrointestinal conditions*	678 (11.4%)	309 (5.9%)
27	Urological conditions (including cystitis)	148 (2.5%)	424 (8.2%)
28	Obstetric conditions	11 (0.2%)	0
29	Gynaecological conditions	68 (1.1%)	10 (0.2%)

Code	Diagnosis Condition	Adult	Older People
30	Diabetes and other endocrinological conditions*	32 (0.5%)	69 (1.3%)
31	Dermatological conditions	15 (0.3%)	16 (0.3%)
32	Allergy (including anaphylaxis)	5 (0.1%)	3 (0.1%)
33	Facio-maxillary conditions	12 (0.2%)	2 (0.0%)
34	ENT conditions	24 (0.4%)	41 (0.8%)
35	Psychiatric conditions	687 (11.6%)	74 (1.4%)
36	Ophthalmological conditions	19 (0.3%)	22 (0.4%)
37	Social problem (includes chronic alcoholism and homelessness)	43 (0.7%)	91 (1.8%)
38	Diagnosis not classifiable	436 (7.4%)	527 (10.1%)
39	Nothing abnormal detected	103 (1.7%)	193 (3.7%)
	missing	928 (15.6%)	195 (0.04%)

Table 6 contains the full list of categories available in this data field and it is clear that it is not fit for purpose for mental health conditions as it has only a single category. At the very least it would be helpful to distinguish between dementia and severe mental health. As it stands the list offers an incomplete menu to clinical staff and as such it is unfair to criticise them for not selecting appropriate categories where none exist.

A new diagnostic coding framework which allowed for some initial assessment of mental health conditions would, when combined with local awareness training, allow for a closer working relationship between A&E staff and their colleagues in the liaison team. This might speed the assessment process and deliver better patient outcomes.

### 3.2 Hospital Stays

Information on hospital stays came directly from the linkage between the hospital data (Acute Admissions file) and the list of RDaSH patients. A hospital stay is only reported when the patient is discharged, thus patients who remain in hospital at time of data extraction are not included here. We removed people who were admitted before the 2012/13 fiscal year from the analysis as well. As with the general population, there are fewer hospital admissions than A&E visits. Again, without general population data from the same area we cannot comment on whether this level of health service utilisation is typical or not.

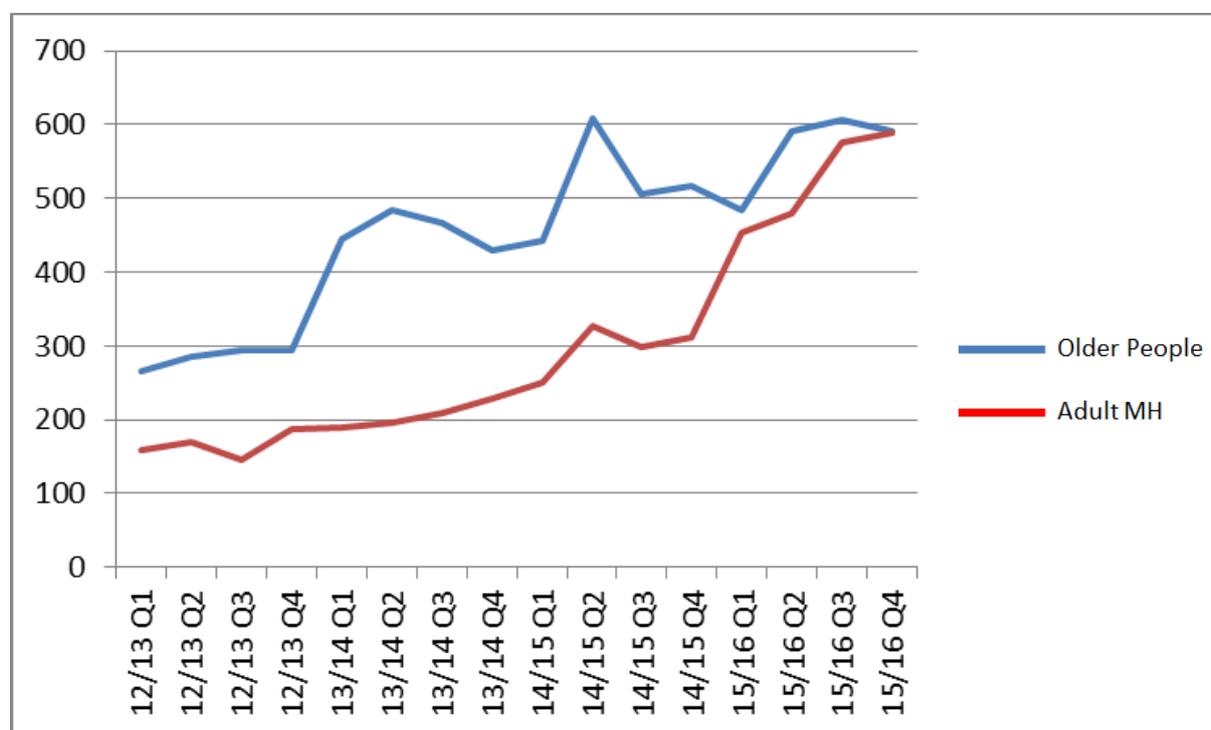
**Table 7** Hospital visits by service arm and fiscal year

Service Arm		2012/13	2013/14	2014/15	2015/16
Adult mental health	N	661	822	1187	2097
	% *		124%	144%	177%
Older people	N	1140	1824	2073	2271
	% *		160%	114%	110%

\* increase over previous year

When overall hospital discharges are examined by fiscal year and quarter (Figure 6) the, essentially, continuous increase over the past few years does appear to be levelling off. As with other analyses, a statistical test for trend cannot be done with these few months and data needs to be collected for another year.

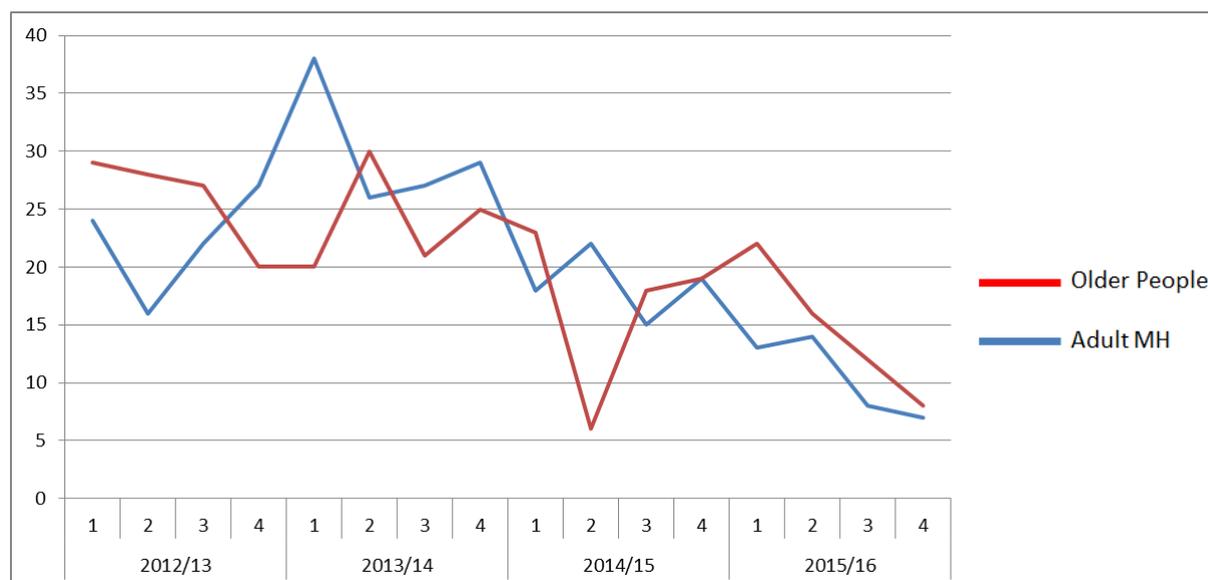
**Figure 6** Number of Hospital Visits by Quarter of Fiscal Year in Both Service Arms



### 3.2.1 Readmission to Hospital

Another important measure of success of the HLS is reduced readmissions within 30 days. Figure 7 shows that there has been a steady decline over the past 3 years. But, as with some other outcomes the numbers are small which is why the line is erratic. Another year of data collection will be needed to statistically confirm the impact.

**Figure 7** Readmission to Hospital within 30 days by quarter of fiscal year



### 3.2.2 Unplanned Admissions to Hospital

The hospital data indicates whether the hospital admission was planned or unplanned. We restricted the data to include only those who were frequent users (i.e., had 5 or more unplanned admissions) and calculated the mean number of unplanned admission per year for this subgroup.

**Table 8** Average Annual Unplanned Hospital Admission in patients who had 5 or more unplanned admissions per year

	Year	Adult Mental Health	Older People
<b>Pre</b>	2012/13-2014/15*	9.0	6.6
<b>Post</b>	2015/16	7.6	7.1
<b>Change</b>		-1.4	+0.5

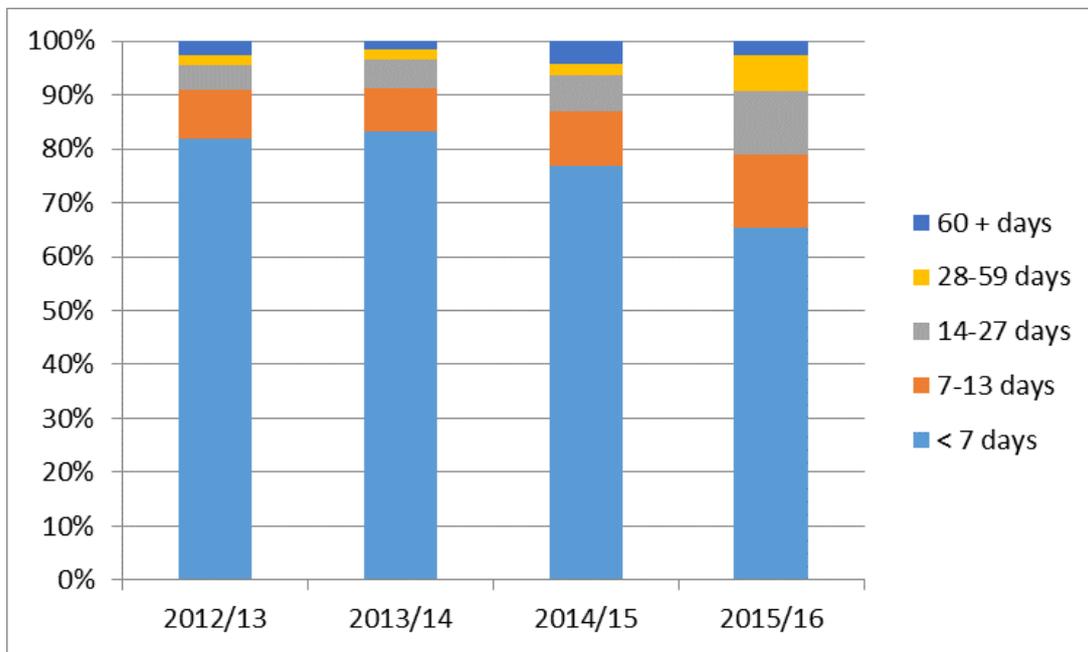
\* 3-year average

Table 8 shows there was a clear decline in the number of unplanned admission for the Adult MH Liaison Service. Given the small numbers and normal month to month variations, the service needs to run for at least another year to identify a trend.

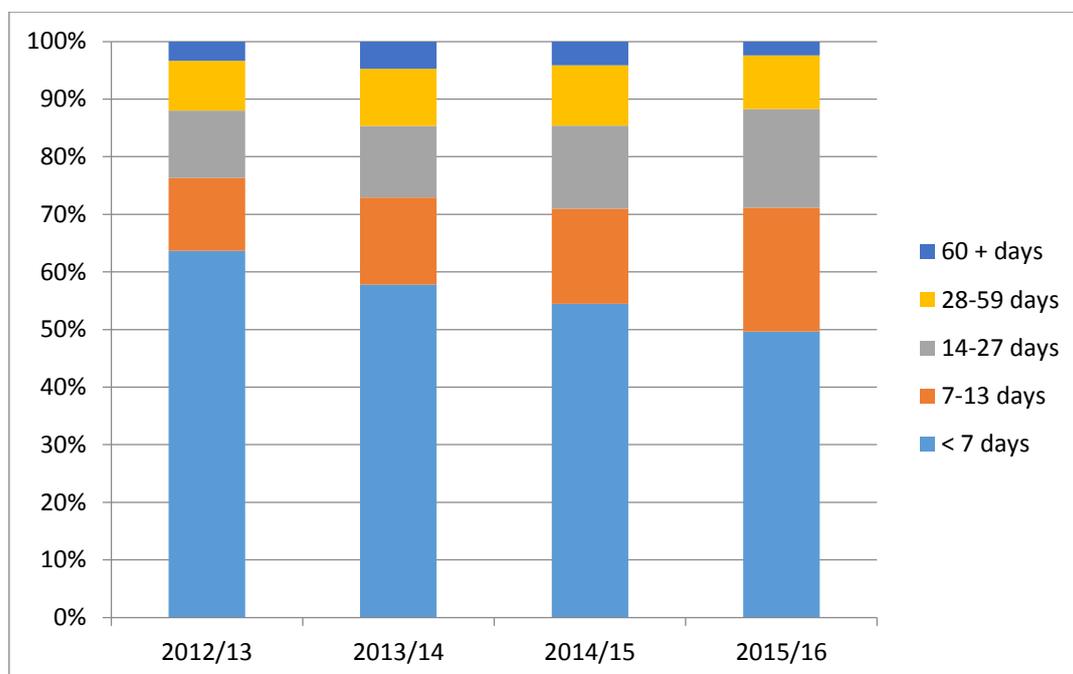
### 3.2.3 Length of Stay in Hospital

The total length of stay information is not encouraging for either group when examined at the fiscal year level as there is a decline in the proportion with a stay of less than 7 days and an increase in the longer stay categories (Figure 8).

**Figure 8** Number of Days in Hospital by Financial Year (MH: Adults)



**Figure 9** Number of Days in Hospital by Financial Year (MH: Older people)



As this conflicts with the DashBoard findings - it may be that patients are being missed by the Hospital staff who would benefit from HLS involvement.

## 4.0 Evaluation of qualitative data

The data have been grouped under themes and sub-themes (Ritchie and Spencer, 2003; Vaismoradi et al 2013) which describes the issues. We have supported this part of the evaluation with direct quotations taken from the interviews.

Considering the overall corpus of data it appears that there is one overarching theme which arose in our conversations with staff. This can be summarised as a form of dualism which treats as separate the mental and physical health of patients who present within the hospital system, broadly so defined, and more particularly in their dealings with the MHLT and other associated clinical areas and practitioners, with the A&E department prominent in discussion.

Out of this distinction five other sub- themes are apparent. These are:

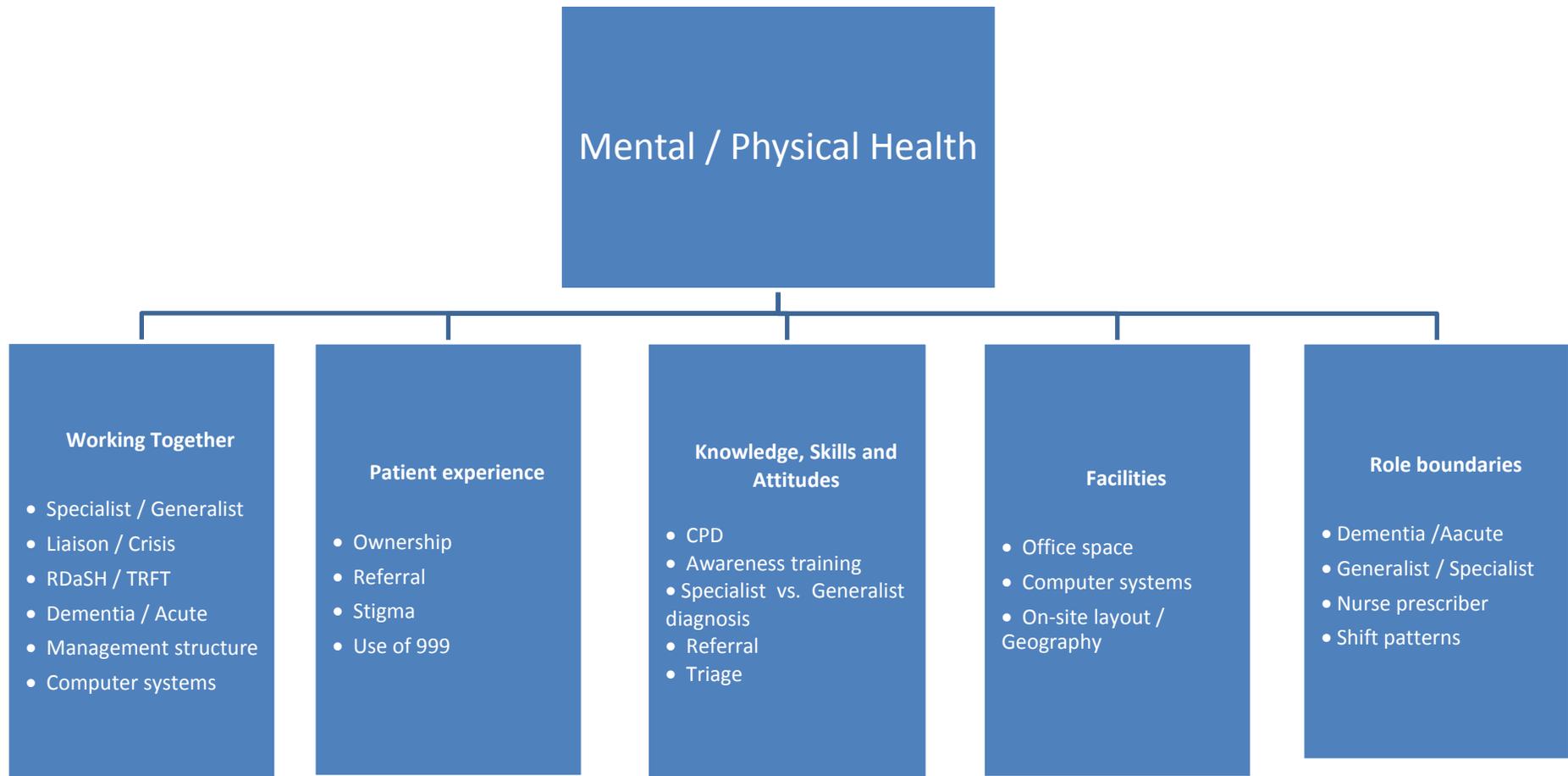
- working together
- impact on patient experience
- knowledge, skills and attitudes
- facilities
- role boundaries

These themes are constructs and should not therefore be read as factual descriptions of events. They represent an interpretation based on the narrative evidence we have collected and were not reported by a single individual but are issues that were raised again and again during the interviews. There is inevitably some spill over within and between these categories and this explains why some ideas occur under more than one heading.

The schema below (figure 9) represents the arrangement of the overall theme and sub-themes and contains examples of the topics that arose in our conversations.

In what follows we go on to explore each of the sub-themes in more detail with illustrative examples taken from our conversations to support the argument.

Figure 10 Emergent themes from stakeholder interviews (referrers and service delivery staff)



## 4.1 Working Together

*"The service is really fast. We only referred 15 mins ago"<sup>2</sup>.*

From interviews with staff who were employed within TRFT the perception of the work of the liaison team was very positive. This staff were universally in favour of the work the team did and rated their contribution very highly. With regard to the dementia patient population we received comments like:

*"I can't welcome them enough. From a dementia perspective, the knowledge they have. ...they bring extra expertise".*

*"the [patients'] relatives feel reassured, especially in dementia related cases..."*

These remarks were echoed in the evaluation 'Your Opinion Counts'. Here, various departments were canvassed to gain an insight into how they felt the work of the MHLT had impacted on their service. In their responses it is evident that the work of the team has had a positive benefit to patient care within TRFT. But perhaps more surprising is that even beyond the physical boundaries of the hospital premises the work the team does is being appreciated. The following remarks illustrate this:

*"Thanks for highlighting the issues with this case" (Immigration Worker)*

*"Thanks for your help with this person, it has helped us signpost in the right direction" (South Yorkshire Probation Service)*

*"This service is fantastic and is going to be an amazing place for the students to learn from. It's way ahead of the school of nursing curriculum – brilliant" (Sheffield Hallam University Mental Health Lecturer).*

*"Thank you for highlighting this. We need an Emergency Multi Agency meeting because of this and well done on the prompt action of the team. You have potentially averted a child death with your input" (Children's Social Services)*

Within TRFT colleagues working under an adult safeguarding remit were equally positive. They valued the team's input to VARM meetings. The 'insider knowledge' the team could provide for some clients known to the service was welcomed. This applied particularly where a patient might occupy a 'middle ground' as there is often a cross-over of client care. Colleagues from adult safeguarding were very pleased when the liaison team intervened to address mental health issues. This then meant that the involvement from a safeguarding perspective was *'more appropriate and only to do with safe guarding rather than trying to field mental health issues'*.

In addition we were told that the current working relationship between the liaison team and the operations side of the hospital was such that help was only a phone call away and that while the

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<sup>2</sup> Ward Sister (Your Opinion Counts)

liaison team was always willing to assist in the management of individuals with mental health issues the reverse was also true - help for physical symptoms was equally available for individuals with mental health problems. This has led, in the estimation of our interviewees, to a less siloed approach to care delivery with genuine multi-disciplinary collaboration.

*"The [manager] is a great resource and the relationships have just grown", we were told.*

This has to be tempered by the feelings of the TRFT staff themselves who value the input of the team. They [TRFT staff] are well aware that they may lack some specialist mental health skills but they are also willing to learn and appreciate the teaching sessions facilitated by their colleagues.

It may be that this evaluation has come too soon in the life of the pilot to adequately capture the extent of the learning engaged in by the staff in the acute hospital. Our own impression is that their levels of knowledge around mental health issues will only rise as the liaison team becomes more integrated and influential.

This has direct implications for the next theme we present - the patient experience.

## 4.2 Patient Experience

The patient experience *per se* is reflected in two ways. We have presented the findings from the internal evaluation (Your Opinion Counts) which allowed patients to comment on the service provided by the liaison team. The feedback is almost all positive. We reproduce some of it here. Under the subtheme 'Use of 999' we use data generated from our interviews with staff.

*"Thank you so much you have really helped me I want to get better and I think I will with the help I have received" (Patient)*

*"Thanks for helping me put things in place in the community it's a relief to know I am not alone" (Patient).*

But it is not only those individuals who present with mental health problems that the liaison team can help. These people have families too and as is evident from this quote the assistance the individuals receive as patients is also beneficial to their families.

*"On reflection I have realised that a lot of my pain is not real and its after having your help and self-help guides that is making me better. Having a clear understanding that my mental state is impacting on my physical health makes me feel so much better and that I'm not going crazy and there is light at the end of the tunnel and I will be home soon with my children. Thank you, you have helped so much".*

The presence of MHLT had also a greater impact on family members with dementia sufferers who struggled to cope with their condition "Thank you so much, you have made my partner look at life differently and given him hope for the future, and a reason to keep fighting his demons."

Where patients experiencing low mood and needed to boost their self-confidence, MHLT were able to tailor their approach to meet patient needs and provide help to enable them to deal with their situation

*"Thank you for taking the time to help me practice the coping techniques we discussed last week. Thank you for pushing me and helping me practice the techniques".*

### **The Use of 999**

*"I am sorry for coming to A&E I just thought I'd get something sorted quicker because home treatment were in a meeting and I wanted to speak to someone" (Your Opinion Counts: Patient A&E)*

When people are living with acute mental health issues they can sometimes try to take shortcuts with care. The A&E department was prominent in the conversations we had with staff. As with any emergency service it has to deal with patients on a priority basis. And at the time of our discussions there was a four-hour response time imposed on A&E staff. In order to rationalise its operation and maximise the effectiveness of the department there is a system of triage to decide on which patients need the most urgent clinical/medical attention. Individuals who present at A&E as a means by which to gain access to the liaison team are typically 'medically fit' and therefore not seen as a priority. As one of the respondents put it:

*"Remember it's an emergency department, it's an emergency department, we're not a drop-in service".*

The presence in the department of non-emergency patients with MH issues is a potential distraction to the other, more clinically urgent care that needs to be delivered. This can lead to either the risk of missing the four hour target time or a call to the liaison team to come and make some assessment. In one of the conversations we were told:

*"That in turn causes more problems for that patient, because their experience is that every time they come to A&E they get seen".*

The multidisciplinary team work of the MHLT and A&E staff had dramatically improved in identify the frequent attenders thus enabling staff to deal with them at early stage. They then elaborated:

*"...moving forward, when we're more entrenched within the A&E department we can see how we can really help service users manage their own mental health crisis".*

### **4.3 Knowledge, Skills and Attitudes**

The liaison team currently operate across an organisational divide with one group of staff focusing their attention on adults with acute mental health issues and the other who look after older adults where there is a preponderance of dementia cases. As with those who present with acute symptoms, the individuals with dementia tend to attract sub-optimal care.

We found that this was corroborated by some of our interviewees. We were told, for example, in a conversation about the prevailing attitude of staff in the general hospital

*'I don't think they view the parity of esteem between physical and mental health, and that's something that's become apparent over there [in the general hospital] when we've had people on the wards'.*

The same individual then added:

*"I think the knowledge of mental health is very limited and it's influenced by media and what they see. But we are trying with that. We've got a link worker now in A&E that's helping us develop that relationship".*

A more graphic illustration was provided by another of the interviewees. Here the conversation was on the understanding shown by staff on the hospital wards of mental health issues:

*"...I don't know whether you understand particularly delirium. It's an acute infection of anywhere, can make the confusion worse. During that time they become hallucinating, they become aggressive, they become disorientated and everything. They think this is part of our problem, but it's not. You can't do anything, you can't treat the delirium; you treat the acute infection".*

The point being made here is that the staff on the general ward tended to think that because the patient is confused the root of the problem lies in their mental health when our interviewee makes the point that it is very much a physical health issue to be dealt with, in this case, by antibiotics.

This raises two points. The first is clearly a need for general ward staff to have more insight into the cause of some behaviours that might appear to relate to mental health issues. The second is to treat the presenting condition rather than what they imagine it to be.

A less specific and more general problem can occur when there is no documentary evidence to support a diagnosis one way or the other. We heard this from one of our participants:

*"...a lot of patients come without anybody accompanying them. So you may have a patient confused, disorientated who's fallen over in the street, nobody with them, comes in confused. So obviously the staff in A&E diagnose oh they've got dementia ..."*

One area that attracted comment from our interviewees was the apparent lack of knowledge displayed by a range of staff on the differences in and between the MHA(1983) and the Mental Capacity Act (2007). In essence the MHA will be applied to individuals who have a pre-existing diagnosis or whose behaviour is such that there is a concern over their mental state.

The MCA can be applied to anyone at any time if it is felt that their intellectual functioning is such that they are not able to give full consent to treatment. There is a recognised two-stage test to assess capacity and it is understood that capacity is a fluid state and therefore needs to be continually re-assessed.

In a discussion on providing education to the wider staff group one interviewee told us;;

*"...we want to engage, we want to do work around mental capacity stuff and also Mental Health Act, because there are procedural issues that we need to explain to the senior staff in the general hospital".*

Another colleague talked of the difficulties in getting compliance around the legislation. They said:

*"...I find it very difficult to make them [doctors on the general hospital side] to understand and practice on that. I mean most of the patients coming there, particularly with the dementia and everything they treat in the Medical Capacity Act and the best interest, but that's not documented anywhere".*

The interviewee then went on to add some detail saying:

*"...they [doctors on the hospital] said OK, oh the patient is aggressive because we tend to, then you do, they are asking us, the mental health assessment. It's not a mental health assessment. You have a Mental Capacity Act and the DoLS<sup>3</sup> [Deprivation of Liberty Safeguards] and they don't understand the difference between, it's very difficult".*

On this particular point we note that in-house education and training is being incorporated for all A&E clinical staff and that this is being supplied by the liaison team.

#### **4.4 Facilities**

As with the dualism in medical and nursing training that tends to create separate ways of thinking about physical and mental health so too does the existence of two separate Trusts tend to construct differences in approaches to care delivery. These become apparent in various ways. Here we present some of the examples that arose out of our conversations.

It was apparent in our interviews that the geography of care was an influencing factor for staff employed both within the main hospital site and in the liaison team. Both physically occupy different premises. And the A&E department is further hampered by having a major re-building project take place currently.

Historically what is now the liaison service was even more divided with staff being situated miles from the main campus. Currently there are plans to have the Crisis Team relocate to the same building the liaison team operate from.

With reference to the current building works we heard this from one of our interviewees who was talking at the time about holding conversations with patients:

*"...we had an allocated room so we could take our patients to a room somewhere private, a bit more chilled out than a busy A&E. Now we don't have an allocated room. We have a really uncomfortable interview room that everybody can come in and out. So we'll say well we really need to speak to, we've got nowhere for you to see these patients".*

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<sup>3</sup> DoLS were an amendment to the MCA designed to secure the Human Rights of individuals whose treatment might mean that they were temporarily deprived of their liberty due to the imposition of restrictions and/or restraint

But the inconvenience, however great, will be temporary. Another member of staff was optimistic about the future:

*"The issue that we're having with the A&E department is that they're currently building a new A&E department. So they're actually in temporary A&E. .... so their space is very limited. But come 2017 when the new A&E department is made then we will have three workstations based up in the A&E department and then hopefully, touch wood, we will have 24 hour presence within the A&E department".*

They then went on to explain how this could improve the service offered to patients:

*"I think it will improve patient experience because of the interface that we will have with the A&E staff. They will have a face-to-face discussion. We can have more informal discussions about a patient that comes into the department. Mental health staff can also do kind of impromptu walks around the A&E department and just look at the boards, look and see what patient flow's like, see if there's any known patients in, if we need to get involved, before even the point of referral".*

Some of this opens up discussion on the need for further, closer integration of the A&E staff and the liaison team. The current arrangement places demands on both sets of staff to respond to externally imposed time-frames. A&E staff are only now being released from four hour response times. The liaison staff are still asked to respond to requests from A&E within the hour. This in-and-of-itself leads to a separation of responsibility to the patient. Below we see that this can get in the way of offering a comprehensive liaison service:

*"...a gold standard service for me would be, that we had a, for good patient care was that we were sited in the A&E department. And that we engaged immediately with the referrers within. And that initially the referrers were able to undertake a brief mental state examination for that patient, actually focus specifically on the mental health issues and defining what that person's need for a mental health assessment was and what was kind of, and that's even before it comes to mental health services. So I think that it's having the general staff being aware of the mental health issues, mental health assessments, mental state examinations and influencing factors – that to me is a key to liaison services".*

But the lack of space extends beyond the A&E department. We heard from one individual about dealing with patients admitted as in-patients on the wards:

*"...a lot of the time I have to say that our assessments take place at the patient's bedside. And it may be that there's another three patients if they're in a four bedded bay or another five patients. And curtains don't offer much privacy do they? And although you may talk quietly when you're assessing the patient, the patient could be quite loud. So everyone in that room knows why you're there. And we do try to be extra sensitive, but. And sometimes the physical health problems don't allow them to leave the bed space".*

Another aspect to the discussion on 'facilities' is separate from the geographical and buildings based discussions above. This refers to systems that operate in and between the two Trusts. In this

extract a member of staff is unhappy that the current arrangements lead to unnecessary duplication of effort:

*"...huge communication difficulties by fact that we don't use the same computer system. So I can't type something on here, upload it and then they have access to it. So the amount of work that's generated by duplication in this team, it probably takes up 50% of the worktime".*

## 4.5 Role Boundaries

The evaluation has taken place against a backdrop of change and indeed the presence of the liaison team has changed perceptions of role boundaries, making many other clinical staff appreciate the need to address the MH issues their patients live with as part of their ongoing care.

That said, perhaps more so than the others, this sub-theme gets to the core of the dualism that seems to pervade the operation of mental health liaison within a general hospital setting. Role boundaries exist between grades of staff, between different disciplines and across the whole healthcare spectrum. They are enforced by professionalism, by clinical specialism and by the geography of care. The delivery of care in any hospital is hugely complex. The organisation of that care relies on the collaboration of and between many different professions and specialisms spread across as many different departments and buildings, all dealing with sick, diseased, injured or otherwise unwell individuals. Against this background it is not surprising that the mental health of a patient is not always the first priority when assessing and diagnosing their presenting condition. The need then for specialist input from the liaison team is clear.

The issue of role boundaries is perhaps most obvious when contrasting the work of the liaison team with that of their colleagues in the general hospital. But boundaries exist wherever there is a division of labour and this occurs, partly due to shift patterns, where the remit of the liaison team crosses that of the crisis team. One of our interviewees told us:

*"...the times of the day when it's busy is whenever there's maximum activity in the hospital to generate referrals, and that's nine to five, Monday to Friday. That's when there's more staff on the wards, that's when there's doctors there, that's when the doctors do their ward rounds and say, Can you refer this person to the liaison team? That's not happening at 3am. So you're only really dealing with any crises, which is not quite the same as liaison, although we cover crisis as well in the eight until eight time period, that wasn't the original remit of the team".*

The porous role boundaries that exist here are perhaps a reflection of the 24 hour nature of health care but they also highlight the need to allocate resources in a way that maximises the effectiveness of the staff contribution to care. The same interviewee went on to add:

*"...because that is essentially their (crisis team) role, doing a bit more of the A&E cover and leaving our team a bit more time to do the, what I consider true liaison work, as in seeing people who are an inpatient for a physical health cause who also happen to have a psychiatric need that needs addressing".*

Boundaries exist too between the hospital, as a site of assessment/treatment and 'the community' as the more natural habitat of the sometimes patient. This territorial dispute can lead to difficulties:

*"...we work only in the hospital, so we're relying – one of the boundaries that's been quite difficult is when we see someone in A&E who we feel needs home treatment, we've found it really difficult to get them treatment on board with that..."*

This perhaps leads us into territory that is beyond the remit of the evaluation but care exists beyond the hospital perimeter and the liaison service needs to be able to make appropriate referrals to community based teams, with the collaboration of other colleagues, to ensure that when this is the best care pathway it can be accessed for the benefit of the patient.

The role boundaries are also emphasised by the physical separation of staff teams. Currently the liaison team operate out of separate premises on the hospital site. But building work is underway on a new A&E department which will house the liaison team beside their emergency department colleagues. One of our interviewees was very optimistic about the potential for these arrangements to harmonise the patient experience. This, they believed, would reduce the dependent aspects of the relationship whereby A&E staff would call for assistance when faced with a patient with a mental health diagnosis and begin to build cooperation. They said this:

*"...once we have staff there, staff will get to know staff, they will develop trust with each other, and in doing so, instead of us always responding to patients and assessing them and then keeping them in the department for long, we can actually advise the A&E staff to say, well you might be able to do this, what would you advise that patient to do. And then the patient experience and the expectation of what we offer in A&E".*

*"And we have quite a lot of, if people won't go, refer them to mental health, it's a mental health issue. It's not a mental health issue that they're refusing to leave hospital. We're not bouncers. And trying to get them to understand that is really difficult ..."*

The same individual had sympathy with the way general nurses perceive the liaison team. This explains their belief that by working in close proximity both the A&E nurses and the liaison team would become better acquainted, professionally and clinically, with better patient experience as an outcome. They put it this way:

*"...if someone comes in and the triage nurse says Oh they're suicidal. And then we say, Well, we know this patient, we know that when this, this and this happens that they'll come and say this, so we are not concerned. But having that face-to-face discussion will, that triage nurse would calm down straightaway because they'll take that, all the body language and stress that, we'll be looking on the system, the triage nurse will be able to look on the same system, because you'll be sat side by side. At the moment that doesn't happen. So what we get is, patient comes in saying that they're suicidal, we know that really how we react is quite important, but because we're not in the same room they expect us to just go and sort it".*

This individual then arrived at a key message. They recognised that the current system operates by transferring the care and the patient between two groups of professionals whose philosophies and practices can sometimes be very different. They saw a more integrated approach as being beneficial.

*"We'd work side by side. It wouldn't be a passing on. It would be more of an integrated, real integrated approach. That's probably key here: it's that integration. So that the service user doesn't really know that, doesn't really see the move from one service to another, it's seamless".*

## 5.0 Conclusion and Recommendations

This report has drawn together both qualitative and quantitative analysis of data generated during our evaluation of the MHLT and its work to date. In this section we summarise the main findings from the two strands to present an overall assessment of the work of the team.

But first we preface our own recommendations with some evidence gleaned from the literature. The Joint Commissioning Panel (2013) makes the point that for a liaison team to work well certain criteria ought to be met. These are:

- The team includes adequate skill mix
- The team has strong links with specialist mental health services and good general knowledge of local resources
- There is clear and explicit responsibility for all patients in the acute hospital setting
- There is one set of integrated multi-professional healthcare notes
- Consultant medical staff are fully integrated

These suggestions chime with the evidence we have gathered, address some concerns expressed by stakeholders and align with our own conclusions and recommendations.

The analysis of acute care data by RDaSH patients demonstrates some encouraging trends of fewer A&E visits and shorter hospital stays. Small numbers of frequent-user patients and number of months for analysis hampered any statistical analysis of trends but taken together the findings are that liaison services will optimise the total care of patients by paying attention to their overall wellbeing and changing the hospital staffs perceptions of the patients.

## 5.1 Recommendations

Based on the summary findings we recommend the following. These recommendations are organised under sub-headings.

### 5.1.1 Management

- Commissioners ought to make the service a permanent feature of the patient experience.
- Some consideration might be given to awarding honorary contracts to the liaison team so that they can act for their patients wherever the site of treatment might be.
- The acute Trust data should be monitored for another year. This would allow a more robust analysis of the numerical data which could then more confidently account for the impact of the team on patient care

- The current arrangement shift patterns for those frontline staff in the liaison team should be revisited to allow for an assessment of where and when demand falls and with which client group. The make-up of the staff team both in terms of subject specialism and wte/numbers might then be adjusted to better reflect the situation on the ground.
- The data collection for this evaluation could be used to identify when and where liaison staff are needed.
- Robust collection of numerical data would help to make the case for any future/proposed changes to the service.

### 5.1.2 Team Building

- We recommend that the organisation makes some time before the new A&E unit opens to develop some team building exercises, again aimed at a multi-disciplinary audience, which focus on fostering a shared sense of responsibility towards the population of patients who present with mental health problems.
- Topics that would benefit the organisation might include
  - stigma - its psychological and social origins, its clinical consequences and effects
  - diagnostic overshadowing - what it is and how to avoid it<sup>4</sup>
- There appears to be scope for a clarification of purpose of the where the roles and responsibilities of the liaison team begin and end and where and how they merge with other clinical staff. This which might then lead to a better appreciation of who does what, where, when and with whom.
- The HLS team ought to be informed and rewarded for their efforts by senior managers in the acute Trust as their work automatically helps the organisation to meet QIPP<sup>5</sup> targets by reducing length of stay and re-admissions.

### 5.1.3 Education and Awareness

- Topics that would benefit the RFT clinical and medical staff might include;<sup>6</sup>
  - an introduction to the Mental Capacity Act (MCA) and the MHA - what they are, the differences between them, when to use them, the legal responsibilities incumbent on professionals and the implications of the Deprivation of Liberty Safeguards.

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<sup>4</sup> See Appendix A

<sup>5</sup> (Quality, innovation, productivity and prevention).

<sup>6</sup> we appreciate that some of this has now begun as a new education programme

- an introduction to dementia awareness - the lead dementia nurse should be supported to deliver more training to all staff with an emphasis on diagnosis and assessment so that the staff can act appropriately when devising a plan of care.
- an introduction/workshop on the key messages from 'No Health Without Mental Health' (DH 2011) aimed at all practitioners to reinforce the idea that responsibility for the [mental health]patient is shared and should not be divided along artificial mental/health lines.

## 5.2 Looking Ahead

Looking ahead other avenues are available for the Liaison Team if funding and resources allow:

- They might usefully extend their remit to working more closely with the Ambulance Service who report that many frequent attenders are also living with mental health problems.
- They might contribute to smoking cessation activities. Smoking is one of the biggest preventable causes of death in the country and people with mental health problems are over-represented in the smoking population (McManus, S. Meltzer, H. Campion, J. 2010).
- Mental Health Liaison within acute hospital settings looks to be here to stay. But as yet there is no sign of physical health liaison within psychiatric settings. The team might consider this avenue. It would go some way to meeting the challenges described by Bailey, S. Thorpe, L. Smith, G. (2013).

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## 7.0 Project team

**Dr Jeff Breckon** is the Director of the Centre for Health and Social Care Research (CHSCR) and is a BPS Chartered Psychologist. He has published and presented internationally a number of high quality reviews ranging from systematic, reviews of reviews and scoping reviews using both quantitative and qualitative methods. Commissioned projects have included evidence reviews for Marie Curie, Public Health England, the NHS executive and the MS Society. Dr Breckon will oversee the project and support the development of the review process and write up phase of the final report.

**Professor Shona Kelly** leads the quantitative evaluation strand and had overall responsibility for quality management. Shona holds a Chair in Interdisciplinary Health Research. She works across a broad range of disciplines using her expertise in epidemiology, public health research and health services evaluation. Shona has over 3 decades of experience with multi-disciplinary teams from public sector organisations across the globe.

**Dr Keith Burley** is a specialist in Business Intelligence (BI) including Data Warehousing and Data Mining. He has a strong industrial background with significant expertise in software engineering and in using mathematical algorithms. He is currently supervising doctorate students in the area of Data Governance and Exploring Health Data using Data Mining Techniques. Keith will support the retrieval of the data from the 16 partners, and the clean-up, standardization, and effective mining of data.

**Dr Alex McClimens** has a background in learning disability nursing and contributed to data generation and analysis of the qualitative aspects of the report. He works locally with Sheffield City Council's Adult Safeguarding Board on their work with vulnerable populations and has published widely in learning disability journals and text books. Doctoral supervision currently includes studies on hospice care, Parkinson's disease and autism.

**Mubarak Ismail** is a research fellow in the Centre for Health and Social care Research. He specialises in health inequalities and methodologies focussing on qualitative enquiry, and analysis of public and population health projects aimed at increasing knowledge and addressing factors associated with health inequalities and improving the quality of life for most disadvantaged populations.

## 8.0 Appendices

### Appendix 1 Diagnostic Overshadowing

#### Diagnostic Overshadowing

'One form of disparity in diagnosis towards people with mental illness is “diagnostic overshadowing” or the mis-attribution of physical symptoms to mental illness. There is evidence of a similar phenomenon suffered by people with learning disabilities, or by old people. There is also evidence of an opposite phenomenon whereby non-recognition of some types of mental illnesses is higher for people with physical complaints or pain or for old people with medically unexplained physical symptoms.

There is some evidence of diagnostic overshadowing provided by users of mental health services. However, until recently little research was conducted in order to investigate the context in which diagnostic overshadowing of people with mental illness occurs and the mechanisms leading to it. In addition, while various studies evaluated the effectiveness of psychiatric liaison services, very few investigated their role in reducing diagnostic overshadowing' (346:2015).

Shefer, G. Cross, S. Howard, L. M. Murray, J. Thornicroft, G. Henderson, C. (2015).

Wand et al (2015) writing from an Australian perspective, make the point, familiar to us from our own observations, that "The Emergency Department (ED) is increasingly perceived as a point of access to services for individuals in varying states of mental ill health". Indeed this is part of the reason for the liaison team's existence. But in managing the hospital experience of individuals with mental health problems the impact of the response to this patient group from nurses and doctors working in general areas can have negative consequences.

Diagnostic overshadowing is a process by which the signs and symptoms of physical ill-health are misrepresented by the diagnostic process and wrongly attributed to an overlying condition, usually learning disability or a mental health issue (Jones et al, 2008). The authors then argue further that while some doctors may be unfamiliar with psychiatric conditions and that this may lead to a misdiagnosis it seems that the setting too can function in a discriminatory fashion. They say, "For example, emergency departments were one setting in which service users reported feeling that their physical problems were consistently attributed to mental illness without sufficient assessment" (2016:170).

We had corroborating evidence of this from our own study. As part of a conversation around the care and treatment of individuals with mental health issues attending A&E one of the interviewees told us this:

*"There's very much a sense that this person has been stamped with this psychiatric badge and we're not really going to take the same care of their physical health as someone who hadn't. We notice that quite a lot. Once you get tagged as mentally unwell, no-one's really that bothered about following up on other things".*

Such stigmatising and discriminatory behaviour contravenes the principles that inform both the Nursing and Midwifery Council (NMC) code of conduct and the General Medical Council's guidance document Good Medical Practice (2014).

Van Nieuwenhuizen et al (2013) found that within A&E departments there was a tendency to avoid patients known to have psychiatric issues, due in part to a fear of violence which was compounded by trying to meet 4-hour target waiting times. One of the participants in their study conceded that:

*"There probably is some degree of stigma, you know, because they can be very challenging patients to deal with" (2013:259).*

## Appendix 2 Case Studies

Some of the narratives provided good examples of the insights that the liaison team can bring to the care and treatment of individuals with a range of mental health issues such that their behaviours can be missed or misinterpreted by general staff. We present these short extracts which seem to incorporate issues around role boundaries, the patient experience, the sometimes antagonistic 'us & them' divide and the need for arbitration on whose knowledge, values and attitudes count more. The data never speaks for itself but in what follows it still manages to communicate effectively.

### Case Study A

In brief, a patient, known to services, has epilepsy. In their post-ictal phase, they exhibit behaviours that might appear to suggest they are experiencing some form of psychotic episode. The story is as follows:

*"They've got one guy who's been causing them problems over there, management problems. He's epileptic, he's been in a psychiatric hospital several times, thoroughly assessed for periods of months, found to have no mental illness and discharged, but every time he has an epileptic seizure he has a few days where he is quite disturbed and reporting to be seeing things and hearing things, and that's something that should be completely manageable by a physical health specialist. So it's ridiculous to suggest that someone who has epilepsy should get admitted to a psychiatric ward every time they have a fit, for a few days. So they just haven't really got where the boundary lies between what's a psychiatric problem and what's a physical health problem".*

### Case Study B

Below we have a different scenario which illustrates the problem of recognising what is and is not a mental or physical health issue from a different angle. In this case a member of the liaison team had, quite by chance, come across an individual known to the service who had been admitted to hospital and was being treated for malnourishment and dehydration. The staff were addressing her physical health needs and had no intentions of contacting the liaison team. So far so good:

*"..... I said oh I know that lady, are you referring her to? Oh no, I only know her historically from working in services. No, she's fine. I said oh is it all right if I say hello? Yeah no problem. And she was actively psychotic. The reason she wasn't eating and drinking is because the 'cameras' were telling her not to and the demons had told her to empty her fridge – and they'd missed that ..."*

### Case Study C

It is noted in the literature that analgesia is often not well understood in the context of the general ward (Sampson et al, 2015). In this instance we heard of an example where the underlying condition, in this case, dementia, had acted to divert the attention of the ward staff from the real cause of the problem. They asked for intervention from the liaison team, recognising the specialist

knowledge they could bring to the care and treatment of an individual with complex needs. Our interviewee takes up the story:

*"...we thought we were going to see a gentleman with dementia who was increasingly agitated. And the scenario that we got to was a gentleman that was naked in bed with the window open, and just a very thin sheet on him. And in great pain from, he'd got poor venous control and he'd got nasty sores, ulcers all up and down his leg.....we got the palliative care team involved, because the pain management had not been addressed. And then we went back the day after and it was a different gentleman. He was sat up, he was very, he was in pyjamas, he was smiling and talking. The palliative care team had been, prescribed him proper analgesia for his leg pain. So we actually didn't need any intervention from a mental health perspective, but we kind of signposted the team on to the right area".*

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