Royal College of Psychiatrists in Wales
Consultation Response

DATE: **12 September 2016**

RESPONSE OF: **THE ROYAL COLLEGE OF PSYCHIATRISTS in WALES**

RESPONSE TO: **The Health, Social Care and Sport Committee Winter Preparedness 2016-17**

The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom.

The College aims to improve the outcomes of people with mental illness, and the mental health of individuals, their families and communities. In order to achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their organisations. Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

RCPsych in Wales is an arm of the Central College, representing over 550 Consultant and Trainee Psychiatrists working in Wales.

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Health, Social Care & Sport Committee,
National Assembly for Wales,
Cardiff,
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9 September 2016

The Health, Social Care and Sport Committee Winter Preparedness 2016-17

1. Thank you for giving us the opportunity to respond to your inquiry into Winter Preparedness 2016-17. Local Health Boards develop annual winter pressure plans to avoid major incidents during this time of year yet services continue to struggle for a number of reasons. It's unlikely that we can eradicate these problems but there are ways to prepare for the inevitable increase in admissions.

2. The LHB winter pressure plans are based on data held by the LHBs. The College does not hold or have access to this information. For this consultation, we offer our views based on anecdotal evidence and we highlight those areas specifically impacting on psychiatry.

Psychiatry and Emergency Care

3. A significant element of unscheduled care involves psychiatric provision. In approximately 5% of all emergency department attendances mental health issues are the presenting feature.[1] Up to 60% of inpatients and outpatients can experience poor mental health.[2] The most common conditions amongst inpatients are self-harm, depression, delirium, dementia, adjustment reactions and alcohol-related disorders.[3] Poor health outcomes and increased health care costs can be due to common co-morbid mental and physical health concerns.

4. Although studies have shown that the numbers of psychiatric admissions in A&E and inpatient wards and the prevalence of self-harm and suicide attempts and completions decreases prior to Christmas; this trend is reversed immediately after Christmas and should be cause for concern for psychiatric services.[4] It would be helpful to have data on this for Wales.

5. There is a large population of elderly patients being treated in hospitals. The average age of patients in acute hospitals in the UK is 80.[5] Over 40% of older people in acute hospitals in England have dementia, depression, or delirium.[6] About a quarter of all inpatients are thought to have dementia. These patients are at greater risk of dehydration and falls. They experience more delays when being

[1] Royal College of Psychiatrists (2013) *Liaison Psychiatry for Every Acute Hospital*, CR183. P10
[2] Ibid.
[3] Ibid. p.11
[4] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3257984/
[5] Cornwell, J. (2012) *The care of frail older people with complex needs: time for a revolution*. Kings Fund. p.2.
[6] Department of Health (2012) *Using the Commissioning for Quality and Innovation (CQUIN) Payment Framework: Guidance on New National Goals for 2012–13*. Department of Health.

discharged (twice as long than patients without dementia), which significantly adds to winter pressures.[7]

6. It is estimated that older people account for 80% of all hospital bed-days occupied by adult patients with co-morbid physical and mental health conditions. The most common psychiatric emergencies in the elderly are depression with suicidality, delirium, dementia with behavioural disturbance, substance abuse, elder abuse, conditions resulting from iatrogenic causes and stupor.[8]

7. Pressures on services (not just psychiatric) would be eased if:

    a. The NHS maximised the first point of contact; providing proper assessment of the person's needs as they present to primary, secondary or emergency care;

    b. there were sufficient beds or appropriate alternatives in the community;

    c. there were a full complementary of staff, including in social care, with appropriate training in dementia, delirium, mental illness including alcohol and substance misuse;

    d. there were better integration of services: between health and social care; primary, secondary and tertiary care; with pooled budgets, shared IT systems, and less paperwork. It can take days to assign a social worker to a patient, which lengthens hospital stays and causes delays in discharge.

Liaison Psychiatry

8. Liaison Psychiatry services provide psychiatric treatment to patients attending general hospitals, in out-patient clinics, emergency departments or in-patient wards. The London School of Economics and the Mental Health Network NHS Confederation published a joint report on the *Economic Evaluation of a Liaison Psychiatry Service*, which looked at the Rapid Assessment, Interface and Discharge (RAID) liaison psychiatric services model in City Hospital, Birmingham.[9] RAID was introduced in the hospital in 2009, and is said to have saved the hospital between £3.4 and £9.5 billion a year, primarily due to the reduced bed use amongst elderly patients. New liaison psychiatry services in Cwm Taf, ABMU and Aneurin Bevan are based on the RAID model. (Components of the RAID model in City Hospital Birmingham can be found at the end of our response.)

9. During the winter months, when there is a marked increase in the number of elderly people admitted to hospitals for common ailments associated with the cold season (flu, respiratory illness, falls etc.), liaison psychiatry services will ease winter pressures.

10. The Psychiatric Liaison Accreditation Network (PLAN) of the Royal College of Psychiatrists has set standards for liaison psychiatry service including Standard

[7] Alzheimer's Society (2013) *Making hospitals more dementia friendly*, London: Alzheimer's Society magazine.
[8] Nazir, Ejax (2015), *Emergencies in older persons psychiatry, Emergency Psychiatry*, RCPsych. P228
[9] Parsonage, M and Matt Fossey, Economic evaluation of a liaison psychiatry service, LSE and the Mental Health Network NHS Confederation, 201X? p.3

21 for people with mental health needs with assessment timelines.[10] Services in Wales are not accredited by PLAN. These services are also not meeting the standards set by PLAN. It is also important that the liaison psychiatry services should serve all age groups.[11]

11. Until recently, liaison psychiatry services were woefully underfunded in the UK but more so in Wales. In 2014, the NHS Delivery Unit (Wales) found that provision was at best patchy and at worst not available or not adequate to meet the needs of those presenting with challenging behaviour, in crisis, intoxicated, or suicidal.[12] The Unit was responding to calls that waiting times in emergency departments (ED) breached time targets largely due to problems accessing liaison psychiatry services.

12. The Welsh Government has provided additional investment to ensure that every District General Hospital has effective liaison psychiatry services and we believe that this should go some way to alleviating existing pressures in terms of identifying psychiatric need and managing patient flow. We understand that recruitment to these post has been successful, although LHBs are at various stages of rolling out the services. We also feel that LHB signing up to the PLAN[13] would enable further improvements to delivery, better data collection and increased learning through peer review.

Bed Closures and Delayed Discharge from Hospital

13. Over the years, there has been a general move to reduce the number of psychiatric hospital beds and wards and provide greater support for people requiring treatment for mental illness in the Community. There appears to be an understanding that that community care negates the need for admission beds, but this is not the case. We are still concerned that costs saved from psychiatric bed closures have not been transferred to community care.

14. We are still facing a crisis in community and care home provision for patients. This means that patients who are fit for discharge remain in hospital because there are no beds available in the community. When a patient is discharged, the responsibility of the patient shifts from the NHS to local authorities. This process is overly bureaucratic and time consuming. IT systems between and two are incompatible.

[10] RCPsych (2014) *Quality standards for liaison standards for liaison psychiatry services* http://www.rcpsych.ac.uk/pdf/Standards%204th%20edition%202014.pdf

[11] An evidence base for liaison psychiatry – Guidance (2014). Strategic Clinical Network for Mental Health, Dementia and Neurological Conditions South West.

[12] NHS Delivery Unit (2014) *National Review of Psychiatric Liaison Services Provided to Emergency Departments - Overarching Final Report*.

[13] http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/liaisonpsychiatry/plan.aspx

Community Care

15. It is crucial that we learn from best practice and develop new models of care proven to meet the specific needs of people needing psychiatric care. In Cardiff and the Vale Health Board, there has been a change to Mental Health Services of Older People (MHSOP) to address the increase in demand from a growing elderly population. The focus of the care is provided in the community to support service users to remain in their homes or community placements for as long as possible. Prior to 2012, there was no service available to meet the urgent mental health needs of older people or that operated outside of 9am to 5pm Monday through Friday. It was common for elderly patients in crisis to contact their local CMHTs, placing great strain on these services and disrupting proactive support for CMHT patients. This resulted in a climate of crisis support.

16. The community Response Enhancement Assessment and Crisis and Treatment (REACT) Serviceis a crisis intervention and home treatment service for older adults with both functional illnesses and dementias. Although REACT is not a liaison psychiatry service it has shown significant impact on unscheduled care through cost savings for its work in the community. This impact is through admission avoidance, facilitating discharge from inpatient dementia and functional wards and also the district general hospital wards. There is a need for joint working between liaison psychiatry across all ages and REACT. The service model was changed to ensure continuity of care by Band 6 and Band 7 Psychiatric nurses and Consultant assessment within 24-48 hours of referral. This has led to significant reduction in length of stay in some months from 21 days to 8 days.

17. Detailed economic analysis of the service was undertaken and the results will be presented in detail in due course. Initial findings showed that £1 invested had saved £2.14 for admission avoidance work alone. After the change in the service model with continuity of care and rapid Consultant assessment every £1 invested had saved £4.64.

Next Steps

18. The current problems are deep rooted and would require a cultural shift in order for any positive changes to be realised. In the ongoing reviews of the health and social care workforce in Wales, an additional focus can be on assessment and then implementation of unified training to enhance a collaborative patient-centred approach. The aim should be to initiate a plan to integrate services and share budgets and responsibilities with patient at the heart of it.

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Chair of Liaison Psychiatry Faculty, RCPsych in Wales

Components of the RAID model in City Hospital, Birmingham

A comprehensive range of mental health specialities within one multi- disciplinary team, where all patients over the age of 16 can be assessed, treated, signposted or referred appropriately regardless of age, address, presenting complaint, time of presentation or severity	Available 24 hours a day, 7 days week, emphasising rapid response, with a target time of one hour within which to assess referred patients who present to A&E and 24 hours for seeing referred patients on the wards.
Meets the mental health needs of all adult patients in the hospital, including those who self-harm, have substance misuse issues or have mental health difficulties commonly associated with old age, including dementia	(At the time of the internal evaluation) the service ran a number of follow-up clinics for patients discharged from the hospital, including clinics for self-harm, substance misuse, psychological input and a general old age psychiatry clinic and an adjoined memory clinic.
Provides formal teaching and informal training on mental health difficulties to acute staff throughout the hospital	Emphasises diversion and discharge from A&E and on the facilitation of early but effective discharge from general admission wards