

# Psychological Medicine in Bart's: improving access and awareness

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## Abstract

Providing good quality psychiatric services to patients who attend general hospital has been an area that has attracted a lot of interest.<sup>(1)(2)</sup> We know that more than one quarter of general hospital patients have a mental disorder, mental ill health impedes recovery from physical illness, and mental disorders are often unrecognised in patients with physical illness. By improving the quality of our service we hope that we can achieve better integration with the medical teams and thus tackle the aforementioned problems.<sup>(3)(4)</sup> In our trust, relevant work has been completed by the clinical health psychology team in Cardiac Rehabilitation wards.

Our liaison team provides psychiatric assessment and treatment to inpatients at St Bartholomew's hospital that have been referred to us by our medical colleagues. We first observed that not all the medical teams are fully aware of the referral process and that they were keen on having training sessions and further education on the area of psychological medicine. Another area that we focused on during this process was making sure that we maintained quality of service provision while our service was in transition due to relocation.

Ward based information sessions and meetings were held. An introductory session to psychiatry was also provided on medical induction. Information leaflets with referral process and contact numbers were produced for staff at ward level and for administrative support. A liaison psychiatry pathway was created to incorporate the changes that occurred after the relocation of our service. Following these interventions there was significant improvement among the staff in recognising and referring patients with psychiatric issues through the use of liaison psychiatry pathway. There was also increase in satisfaction amongst staff.

Education improves understanding and awareness of mental illness and a care pathway focuses attention on this area, improving patient safety and quality of care.<sup>(5)(6)</sup>

## Problem

We are a team of mental health professionals who are based at the St. Bartholomew's Hospital. We provide psychiatric assessment and treatment to inpatients that have been referred to us by our medical colleagues. We first observed that not all the medical teams are fully aware of the referral process to our team and thus the access to service was sometimes based on personal involvement and our presence on the medical wards. We also identified by using questionnaires that the medical teams were keen on having training sessions and further education on the area of psychological medicine. Finally, we didn't have a systematic way of collecting data for our patients. The latter would also be useful for service audit in the future. Another area that we focused on during this process was making sure that we maintained quality of service provision while our service was in transition due to relocation.

### Aim statement

We want to improve access to our liaison service by the end of 2014 and identify further issues due to relocation by the end of March 2015. We have identified specific areas of intervention and change. We think that we can achieve this by improving awareness about psychological medicine and liaison psychiatry. We found out that medical teams were sometimes reluctant to refer to our services as they weren't familiar with the sub-specialty of liaison psychiatry and they weren't sure about the services that we can

offer. Some of our tasks will be to have a clear and structured referral process, an easier and clearer pathway (new landlines, service email for routine referrals, referral forms, and out of hours contact numbers), being more present within the medical teams and providing better support and knowledge to medical teams (evidence based practice), introducing screening tools, and organizing training sessions.

## Background

We discussed with current and previous team members and identified areas that need improvement in order to reflect the current focus and interest on the integration of mental health into physical healthcare systems. Providing good quality psychiatric services to patients who attend general hospital has been an area that has attracted a lot of interest.<sup>(1)</sup> We know that more than one quarter of general hospital patients have a mental disorder, mental ill health impedes recovery from physical illness, and mental disorders are often unrecognised in patients with physical illness. By improving the quality of our service we hope that we can achieve better integration with the medical teams and thus tackle the aforementioned problems. In our trust, relevant work has been completed by the clinical health psychology team in Cardiac Rehabilitation wards.

Physical and mental health are inextricably intertwined. Long-term conditions (LTCs), such as diabetes, are associated with high rates

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of mental illness. Some 70% of NHS spend goes on the treatment of LTCs, a great deal of which currently involves treatment in acute hospitals.

- Psychological stress is often expressed as physical symptoms, which are an example of medically unexplained symptoms (MUS).
- The mental health needs of a patient in a physical health care setting often remain undiagnosed and therefore untreated. To optimise the physical health care of patients, it is essential that their mental health and wellbeing are addressed at the same time.
- Liaison services should be provided throughout the acute hospital, including in A&E departments. Services should be provided to meet the needs of patients with a mental disorder secondary to their physical disorder, or a physical disorder alongside their mental disorder, and for patients (particularly those with MUS) where it is impossible to separate the two.
- Acute liaison services operate within existing (often ad hoc) local networks of other generic and disorder-specific clinical health psychology and multidisciplinary services. This should be mapped out by commissioners so that acute liaison becomes a primary partner in the effective management of the emotional and adjustment/behavioural needs of all patients presenting to acute services.
- A liaison service should be an integral part of the services provided by acute hospital trusts – trusts that have incorporated a liaison service have demonstrated much better cost effectiveness.
- Acute liaison services should have the resources and skills needed to support all age groups.
- Liaison services may, over time, extend their remit to help primary mental health care to manage people with LTCs and MUS, in order to avoid unnecessary admissions to secondary care.

See supplementary file: ds4453.pdf - "LiaisonPsychiatryCommissioning"

### Baseline measurement

For this project, two measures were considered and used. The first was a satisfaction/awareness scale that we designed and was completed by a sample of doctors and psychologists that have been responsible for doing referrals to our team. We were thus able to measure their satisfaction with the service and identify specific areas for improvement. The second was the design and the completion of a detailed database, including information on the number of the referrals and the type of interventions that we have been providing.

See supplementary file: ds4936.docx - "LiaisonPsychiatryAwarenessSatisfactionQaire 14 10 14 (3)"

### Design

When considering the underlying causes of this problem, it became apparent that teams would need further support and gain more knowledge and confidence in being able to recognise psychiatric problems. We would also need to provide them with a clearer referral pathway. We considered several different ways of achieving our goals and making changes. First of all we started using the questionnaires in order to collect information and uncover specific areas for improvement. We then made posters with our contact numbers and the structure of our team. We also made posters with referral information and contact numbers for the administrator taking referral. We managed to organise teaching sessions and incorporate training about psychiatric emergencies during the induction day for new doctors. We started using database for retrospective data analysis and auditing purposes. Finally, we tried to increase our presence in medical wards by attending ward rounds and thus facilitating integration.

### Strategy

#### Improvement (PDSA) cycle 1

Assessment of the problem through a satisfaction and awareness questionnaire revealed a gap in the knowledge of staff in recognising and referring patients with mental illness. It was noted that the majority of staff would like to have further teaching on common liaison psychiatry topics. As a result, information session was organised as part of the induction for new doctors.

These educational sessions used information from the NICE delirium awareness workshop session guide (1). Information leaflets on cancer psychology services were distributed.

#### Improvement (PDSA) cycle 2

Our service was relocated in December 2014 and this revealed a further gap in the referral pathway. Medical staff were not aware of our contact details and how to make a referral. We also had to operate from out of site and this would have an impact on the delivery of our services. As a result we created laminated charts with our contact details and referral pathway for working hours and out of hours psychiatric cover. We also had to clarify the timeframe of our response. Also, we created an email address, nhs.net, for non urgent referrals.

#### Improvement (PDSA) cycle 3

Due to changes in our administrative staff, we identified that there was no sufficient cover to receive referrals and staff were not trained to take referrals and respond to liaison psychiatry emergencies. We created a charter with referral protocol and contact details. We also decided to circulate a rota on weekly basis indicating the clinician covering all emergencies.

See supplementary file: ds4937.docx - "PDSA Cycles (1)\_2"

### Post-measurement

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For this project, two measures were considered and used. The first was a satisfaction/awareness scale that we designed and was completed by a sample of doctors and psychologists that have been responsible for doing referrals to our team. We repeated the measurement after the training sessions. Most of the medical doctors (90%) were "very satisfied" with our service and "knew how to make a referral to the liaison psychiatry". All doctors would like to have further training in liaison psychiatry. The second tool we used was a detailed database, including information on the number of the referrals and the type of interventions that we have been providing. After our intervention, the number of referrals remained the same with minimum one referral per week and maximum four referrals per week.

### Lessons and limitations

This project was run by the liaison psychiatry team, a relatively small team, which consists of three doctors and one psychologist. A process of staff education along with the introduction of a clear referral pathway increased psychiatry awareness and satisfaction within the medical staff. Our view is that both components of the intervention programme were required to improve awareness. As well as improving our liaison service we learnt valuable skills during the process including; team working, organising meetings, negotiating, and organising teaching and information sessions. Most importantly we realised that quite simple changes can improve the systems and processes that we use, ultimately improving the quality of care for not just our patients but the wider patient population. This project had almost no financial cost attached to it and we worked willingly in our own time.

One of the most important lessons was about pre-intervention data. As our intervention was focused on satisfaction and awareness we had to create a qualitative tool and therefore we could not do statistical analysis.

Engaging the medical teams is an essential part of rolling out our intervention. Liaison psychiatry works closely with medical teams and by communicating efficiently we were able to identify the areas that need to be improved. Medical staff are often too busy and therefore it was difficult to organise teaching and information sessions. In addition the sample size for our measurement tool was very small.

In the process of making those changes we had to relocate our service and this meant that we had to try and maintain the quality of service provision while in transition. For that reason we had to adjust our referral protocol and train our administrative staff.

### Conclusion

Providing good quality psychiatric services to patients who attend general hospital has been an area that has attracted a lot of interest. According to existing literature a large number of general hospital patients have a mental disorder, mental ill health impedes recovery from physical illness and mental disorders are often unrecognised in patients with physical illness. By improving the

quality of our liaison service we hope that we can achieve better integration within the medical teams and thus tackle the aforementioned problems. The Bart's liaison psychiatry team ran this project. A process of staff education along with the introduction of a clear referral pathway increased psychiatry awareness and satisfaction within the medical staff. As well as improving our liaison service we learnt valuable skills during the process including team working, organising meetings, teaching and information sessions. Most importantly, we realised that quite simple changes can improve the systems and processes that we use, ultimately improving the quality of care of not just our patients but of the wider patient population.

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### Declaration of interests

Nothing to declare

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### Ethical approval

According to the policy activities that constitute research at East London Foundation Trust this work met criteria for operational improvement activities exempt from ethics review. We used the following criteria for determining if improvement activities require ethics review.

Policy criterion: The work is primarily intended to improve local care, not provide generalisable knowledge in a field of inquiry and

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not a study on human subjects. Explanation: We sought only to evaluate the improvements in compliance with referral process and education of medical teams as a result of feedback of access and awareness questionnaires given to hospital staff.

# QIR

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