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Preface

This guidance sets out the evidence gathered from lay people, professionals, commissioners and the literature about what is needed from liaison psychiatry services. It was commissioned by the Strategic Clinical Network for Mental Health, Dementia and Neurological Conditions South West.

This guidance is part of a suite of four related documents, each with increasing levels of detail:

- **Liaison Psychiatry Services - Guidance** - sets out the key consideration to be made when commissioning liaison psychiatry services.

- **An Evidence Base for Liaison Psychiatry - Guidance** - sets out the evidence gathered from lay people, professionals, commissioners and the literature about what is needed from liaison psychiatry services.

- **Developing Models for Liaison Psychiatry Services - Guidance** - provides the technical information needed for commissioning liaison psychiatry services.

- **Model Service Specifications for Liaison Psychiatry Services** - sets out exemplar service specifications for four models of liaison psychiatry.
With thanks and appreciation

We would like to recognise and appreciate the contribution of the following people for their work in putting together this guidance:

- people with an experience of our services, commissioners and commissioning supporters
- the Faculty of Liaison Psychiatry at the Royal College of Psychiatrists
- the Academy of Emergency Medicine
- the National Clinical Director for Mental Health
- the Centre for Mental Health
- the Strategic Clinical Network for Mental Health, Dementia and Neurological Conditions South West
- the research and development team at Devon Partnership NHS Trust, and
- Dr William Lee, Reader in Psychiatric Epidemiology, Plymouth Peninsula Schools of Medicine and Dentistry.

Dr Peter Aitken's time was funded by the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care for the South West Peninsula (PenCLAHRC).

The views and opinions expressed in this paper are those of the authors and not necessarily those of NHS England, the NIHR or the Department of Health.
How we gathered the evidence

The methodology for the development of this guidance involved 4 parallel work-streams:

- Expert group meetings with feedback opportunities
- Literature synthesis and searching for evidence
- Connecting with other national work-streams, and
- Creation of a useable template for the output document.

We asked three groups of experts:

- People with an experience of services
- Commissioners and their supporters, and
- Professionals working in liaison psychiatry services.

We referenced their ideas and questions against the available literature. Information was gathered through focus groups, the use of surveys and one-to-one interviews. The narrative emerging from these sessions was reviewed against the literature to check that statements were defensible within the evidence base. Literature was also collected and synthesised in parallel to the group process.

Connections were made with other relevant work being undertaken by the Centre for Mental Health, Royal College of Psychiatrists Faculty of Liaison Psychiatry, Joint Commissioning Panel of the Royal Colleges of General Practice and Psychiatry, Department of Health Product Review Group and the Willet review of unplanned and emergency care and resulting concordat.

The guidance was tested with stakeholder groups and developed throughout the process. An advisory board was convened to provide peer review on the emerging document and process.

How this guidance is set out

The aim of this document is to set out clearly the evidence upon which the proposed models for liaison psychiatry are built. As such, each section sets out in a series of bullet points the
views of the lay group, the professional group, the commissioners’ group and the evidence from the literature. The subsequent documents, 3 and 4, synthesise this evidence into recommendations and service model specifications for liaison psychiatry.

1. The case for liaison psychiatry

This section outlines what liaison psychiatry is, where it sits in the world of mental and physical health provision, the current policy and strategy setting, why it is important, and the key benefits to individuals and providers.

1.1. Defining liaison psychiatry

Liaison psychiatry, also known as Psychological Medicine, is the medical specialty concerned with the care of people presenting with both mental and physical health symptoms regardless of presumed cause. The specialty employs the bio-psychosocial model being concerned with the inter-relationship between the physiology, psychology and sociology of human ill health.

Liaison psychiatry services are designed to operate away from traditional mental health settings, in the main in general hospital emergency departments and wards, and medical & surgical outpatients.

Liaison psychiatry teams are multidisciplinary, clinically led by a consultant liaison psychiatrist who will have higher specialty training in general adult psychiatry with sub specialty endorsement in liaison psychiatry. Many liaison psychiatrists will also have higher specialty training in general medicine or general practice.

The multidisciplinary liaison psychiatry team will typically include specialist mental health nurses, clinical psychologists, occupational therapist and social workers. Liaison psychiatry services address people’s mental health, physical health and social care needs; and they can also formulate and deliver brief psychotherapeutic interventions most commonly cognitive behavioural therapy or psychodynamic interpersonal therapy.

Liaison psychiatry services hold expert knowledge on the safe operation of the Mental Health Act and Mental Capacity Act in general hospital settings.
1.2. The issue to be addressed: what people told us

Lay group

- Mental health problems are not currently given the same importance as physical health problems. This needs to be addressed.

Commissioners

- There is a need to fill the gap around the mental health needs of people with physical health problems.
- Somatic disorders (e.g. Medically Unexplained Symptoms) are poorly understood and that needs to be addressed.

Professionals

- Connections need to be made between mental and physical health. Service provision is one or the other and there needs to be opportunity for the overlap to be considered.
- Liaison psychiatry services can work closely with physicians and surgeons to manage patients with a combination of medical and psychiatry problems (e.g. delirium, dementia, depression).

Literature

- The NHS spent £14 billion on mental ill health in 2010-11. In addition, mental illness raised the costs of physical healthcare by an estimated £10 billion in 2010-11.
- It is estimated that 5% of all Emergency Department (ED) attendances are due to mental disorders.
- Self-harm is predominant within this group, accounting for 150,000 – 170,000 ED attendances per year in England. These presentations are often resource heavy and labour intensive.
- Chronic repeat attenders to ED are also an issue in terms of resource cost, and these account for 8% of all ED attendances. The most common reason for frequent attendance is an untreated mental health problem.
The use of acute hospital services by people with dementia is a rising problem. Emergency admissions for people with dementia account for nearly 10% of all hospital admissions. 95% of acute hospital admissions for people with dementia occur in an emergency, with over 60% of these coming through ED, even though 25% of all emergency presentations in people with dementia are preventable.

25 – 33% of patients with a long-term physical health problem also have a concurrent mental illness, which increases the risk of physical health complications and increases the costs of treating the physical illness.

There is a clear evidence base demonstrating the costs of mental health problems generally, and in relation to the impact on physical health conditions.

There is policy support to mental and physical health becoming more equal in value.

1.3. What are the benefits of liaison psychiatry?

Lay group

• “What liaison psychiatry teams do best is to provide someone to talk to in a setting when the physical side is just being “done to” and fixed, liaison is about listening to you talk and helping guide emotionally”.

Commissioners

• Liaison psychiatry services helps break down people working in clinical silos and can create healthcare partnerships.

• Liaison psychiatry services can help reduce bed days/length of stay and prevent unnecessary admissions.

Professionals

• It is a multi-disciplinary way of working that can bring together different disciplines and create useful links between services.

• “Liaison psychiatry provides a crucial link between physical and mental healthcare providers to help ensure excellent delivery of physical and mental healthcare to people using Acute Hospital services.”
Literature

- The recent evaluation of the RAID service in Birmingham has provided compelling evidence of the cost effectiveness of an integrated liaison psychiatry service for people with dementia showing a benefit:costs ratio of 4:1.
- The piloting of an optimal liaison psychiatry model in North West London has demonstrated potential financial efficiencies.
- There is limited evidence on evaluation of outcomes, but there is descriptive evidence.
- Descriptive evidence shows a list of benefits including decreased length of stay, reduction in psychological distress, improved service user experience, improved dementia care and enhanced knowledge and skill of general hospital clinicians.

“The status of liaison psychiatry should change. It needs to be recognised as an essential ingredient of modern health care and not an optional extra which is merely nice to have.”

(Parsonage, Fossey and Tutty 2012: 6)
2. Service model considerations
The expert groups contributing to this guidance and the literature point to several key elements of service that should be considered in any model of liaison psychiatry service.

2.1. Views on service settings and models

Lay group

• A liaison psychiatry service based in an acute care hospital is the most recognised model, but the lay experts also stress the importance of links being made to primary care as the main gatekeeper to mental health support, as well as the constant denominator in care.

• Liaison psychiatry could become part of all specialties, but there is a particularly valuable place for it in relation to long-term conditions, severe mental illness and self-harm.

Commissioners

• Hospital-based is traditional, but there should preferably be outpatient follow-up as well.

• Links to the community are very valuable, and there should be links between liaison psychiatry services and community hospitals, nursing homes and so on.

Professionals

• The focus is on hospital-based services, but consideration should be made to providing outpatient services and the importance of linking into primary care.

• Six key patient groups stand to benefit from effective hospital-based liaison psychiatry:
  1. People who self-harm and need medical or surgical treatment as a consequence.
  2. People with the physical and psychological consequences of alcohol and drug misuse.
  3. Frail elderly people where there is a possible diagnosis of delirium, depression and / or dementia and a perceived need for basic physiological support, supportive nursing and further investigation.
  4. People with known severe mental illness particularly when in relapse.
  5. People admitted with primarily physical symptoms which, on assessment, have mainly psychological or social causation.
6. Vulnerable groups including homeless people, people with personality disorder, people who may be subject to domestic violence and abuse, children and young people at risk.

Literature

- There is significant variation in provision of liaison psychiatry services in hospitals which have historically been developed according to local enthusiasms and funding arrangements.
- Evidence shows the value of working with severe mental illness, older people, people with long-term conditions, medically unexplained symptoms, self-harm and perinatal services.
- Services are traditionally hospital-based, dealing with emergency and inpatient support.
- There are variations in capacity and hours of operation.
- Increasingly, value is being seen in outpatient and community-based services and linking into primary care.

2.2. Key messages from the literature on hospital-based services

- There is no single established model, but liaison psychiatry services in acute hospital-based care tends to be split between emergency and inpatients, with some services operating in office hours and others 24/7.
- It is recognised as an imperative that liaison psychiatry services should be situated in acute care hospitals.
- As well as assessment and diagnosis, the services should provide training to other hospital professionals, conduct Mental Health Act and Mental Capacity Act assessments, link with other services and provide brief interventions or advice.
- Liaison psychiatry services should serve all-ages.
- Services should provide advice, supervision and direct clinical activity into primary care when required.
Emergency departments

- There is a gap in evidence on effectiveness and cost-effectiveness of liaison psychiatry in emergency departments.
- The main areas of work tend to be in relation to people who self-harm, people with severe mental illness, alcohol use in adults, and dementia and delirium in older people.
- There is a possibility of high impact intervention with re-attenders. There is an example from Hull of liaison psychiatry staff working with ED staff to assess and follow-up re-attenders which reduced re-attendance by 60%.
- It is recommended that liaison psychiatry services are based within the hospital, close to ED, as this facilitates referrals, training, links with other services and good working relationships with hospital staff.

Inpatients

- Evidence shows high value returned from liaison psychiatry services for older inpatients as older people account for 80% of all hospital bed-days occupied by people with co-morbid physical and mental health problems.
- It is recommended that older people’s liaison psychiatry services are rapid-response and multi-disciplinary and include risk assessment, identification of mental health conditions, regular review during stay, participation in discharge planning, liaising with other services, education and training of hospital staff.
- It is important to include mental health nurses and people with rehabilitation skills in an older people’s liaison psychiatry team.
- There is potential for the conditions encountered to be very wide, and therefore there is a need to consider what other specialist services there are, who is working with what, and make clear the focus of liaison psychiatry.
- Liaison psychiatry services for working age adults should focus on complex and costly cases.
- There is limited evidence about psychiatric liaison services for children and young people, and also limited provision. This is recognised as an area that needs to be focused on and it is thought that providing all-age services will help meet this need.
2.3. Key messages from the literature on out-of-hospital services

“The way ahead for the long-term development of liaison psychiatry is likely to lie primarily in the expanded provision of community-facing services.”

(Parsonage et al 2012: 5)

This section assumes that the community-facing services are provided by liaison psychiatry, when the contemporary and emerging models are for integrated primary care mental health services with liaison psychiatry as an integrated component.

Whilst the majority of liaison psychiatry services are acute care hospital-based, and our recommended models focus on services within the hospital, there is growing evidence of the potential for community-based and community-outreach liaison psychiatry services.

- There is value in providing services at outpatient and primary care level to avoid referrals to secondary care services.
- Options are for outpatient clinics following up patients after hospital visits, outpatient clinics running from hospitals and taking referrals from hospitals or from primary care organisations, or primary care based organisations.
- Liaison psychiatry services can support primary care in better managing people with long-term conditions, medically unexplained symptoms and perinatal mental health problems. There are key connections to be made with psychological therapies and wellbeing services.
- The importance of directly supporting primary care is emphasised by our lay experts and professionals, who point towards the value of supporting GPs to better understand mental distress better and to create better links between secondary and primary care for those who have been seen by liaison psychiatry services.
- Professionals also point towards the value of being able to carry out follow-up and more lengthy assessments for more complex cases, as an outpatient option can facilitate discharge and potentially reduce re-attendance. Outpatient and primary care based clinics are particularly valuable for the management of people with medically unexplained symptoms.
The prevalence and cost of mental health co-morbidities among people with long-term conditions is such that developing community-based collaborative care services with an integrated liaison psychiatry component should be high priority for all clinical commissioning groups working with local providers.”

(Parsonage et al 2012:5)

Examples

- The Integrated Care Pilot in North West London - a partnership between five local authorities, two major acute trusts, two community trusts, two mental health trusts, two third sector organisations and over 100 general practices, focusing on the integrated management of diabetes and people over the age of 75.

- The Primary Care Psychotherapy Consultation Service in City and Hackney - work with local GP practices in management of frequent users of health services. Provides clinical service for patients with complex needs and supports GPs in management of less complex cases. [http://www.tavistockandportman.nhs.uk/cityandhackneyprimarycarePCS](http://www.tavistockandportman.nhs.uk/cityandhackneyprimarycarePCS)

- King’s College Hospital liaison psychiatry service run a diabetes and mental health service and an outreach clinic integrated with three community diabetes clinics in Lambeth and Southwark.

- LIFT Psychology in Swindon and Wiltshire - an extension of Improving Access to Psychological Therapies programme to benefit the management of physical symptoms associated with anxiety and depression. [http://lift.awp.nhs.uk](http://lift.awp.nhs.uk)
3. Planning a hospital-based service

Any model for an acute care hospital-based liaison psychiatry service should have the following features.

Lay group recommendations

- 24 hour services are preferable. However, if it is not possible, then it is important to ensure that out of hours services are of the same quality as daytime services. Also, that the links between out-of-hours services and other services are as good as those with the liaison psychiatry team.

- A very important feature of a liaison psychiatry team is that they spend time listening. It is important to include staff on the team who have the time to listen. This does not have to be expensive, senior staff.

- The role of liaison psychiatry teams in training other hospital staff is of vital importance and will help reduce stigma as well as improve outcomes for people with mental health problems.

- Good communication between teams is very important, especially in terms of making sure that everyone has read the same notes and is reporting back to the same set of notes.

- The role that liaison psychiatry teams play in linking services and ensuring other services know what is happening is extremely important. It helps ensure continuity of care, but also reduced emotional distress and burden, as the quotation below explains.

“There are too many people in hospital when you’re on a ward. It’s confusing. You have to start from the start every time you meet someone new. You have to use a lot of mental energy to explain everything all over again. No-one reads notes. Sometimes you’re in a difficult mental state from when you started so it is difficult to explain each time. Then you leave hospital and have to start again, explaining to your GP, to other specialists, to the CMHT…”
Commissioners’ recommendations

• Services should be all-age to ensure that the under-18s are not disadvantaged.
• Services should be delivered 7 days a week, and beyond office hours, but this will depend on local conditions.
• If there is no 24/7 service then there should an alternative service to provide support and avoid admissions out-of-hours.
• As well as the basic set of consultants and nurses, liaison psychiatry teams should include social workers, occupational therapists, Support Time Recovery (STR) workers, drug and alcohol workers and learning disability nurses.
• Linking with health psychology is very valuable.

Professional groups’ recommendations

“Liaison psychiatry makes the medicine of what acute hospitals do easier to take, work more smoothly and with less tears.”

• Liaison psychiatry improves the safety culture of hospital care by helping us all manage stressful and difficult situations better.
• Liaison psychiatry team members need to be very skilled with assessment and good at getting on with other generalist colleagues.
• There is value in linking hospital psychology teams into the work of the liaison psychiatry team, and also to link to alcohol and drug workers.
• Liaison psychiatry could be a lead in a confederation including perinatal psychiatry, health psychologists, CAMHS, learning disabilities link nurses and all involved in psychiatric/psychological work across the hospital.
• The liaison psychiatry team needs to be well supported by the hospital with whom they work.
• Need good relationships with other teams, with managers and very good administration systems.
• Coordinating care is an important role.
Literature

- Evidence shows that hospital-based liaison psychiatry services work best with specialised, fully-integrated teams with multi-professional staff.
- There is a need for strong links with other mental health services and local resources, clear referral mechanisms, and clear communication and clinical record systems.
- Team size and skill mix will depend on the setting.
- The service should be clinically led by a consultant liaison psychiatrist, working full time.
- Liaison psychiatry services benefit from a service manager experienced in the work.
- This is specialist nursing, and the recommendation is for sufficient band 7 nurses to ensure clinical team leadership and professional supervision of other team members across the hours of operation of the service.
- The literature recommends access to experts in psychological therapies able to supervise team members in their delivery of psychological interventions and help with complexity in the multidisciplinary management of patients.
- Liaison psychiatry services require significant and adequate administrative support as the activity is fast paced and much of it about effective communication and information exchange with surrounding agencies.
- Core liaison psychiatry services can be developed within an integrated approach to include elements of drug and alcohol services and other complementary service. There is evidence that a wider "psychological medicine" team could be effective and efficient.
- Hours of operation will depend on the setting and be informed by an analysis of activity examining when people with need to attend across the 24-hour period and through the week and the response offered out of working hours by other mental health services.
4. Key skills in the liaison psychiatry workforce

As well as the basic practicalities of setting, staffing and hours of operation, there are key skills required of the liaison psychiatry workforce.

Lay group recommendations

- Good listening skills are key.
- Training others is very important.
- Being able to easily and consistently share relevant information and link with a range of services will help care to be consistent.
- Liaison psychiatry staff need a different type of training as they have to be very easy to talk to and easily able to reduce anxiety in what is often a highly anxiety-provoking setting.

Professionals’ recommendations

- The work of liaison psychiatry involves effective listening, communicating with distressed and anxious people, searching for, synthesising and analysing large amounts of information, negotiating, prescribing in complexity and delivering brief psychotherapeutic interventions.
- In addition, every case requires care planning and communication and information exchange with partner agencies and a range of health, social care and criminal justice professionals.
- The work is high risk, often dealing with the uncertainty of incomplete or inadequate information in rapid flow, rapid pace clinical pathways, negotiating conversations with already busy hard-pressed colleagues.
- Liaison psychiatry services need to be clinically led by a consultant liaison psychiatrist with the appropriate training, peer support and supervision to qualify them for the work.
- The consultant must have expertise in psychopharmacology in the medical and surgical setting and be equipped to deliver and supervise brief psychotherapeutic interventions within an evidence-based model.
- Consultant liaison psychiatrists need the support and challenge of a multidisciplinary team with specialist liaison mental health nurses equipped with the skills required of the
tasks set out above including expertise in recognising medical ill health, being able to recognise abnormal investigational findings, drug interactions and side effects.

- Liaison psychiatry team members all need to be equipped with training in brief, evidence based psychotherapeutic interventions.

- The team must have access to a senior practitioner expert in psychological therapies able to supervise their use of brief psychotherapeutic intervention, help them with cases of complexity and help the team more generally manage its feelings towards the work.

- All team members must have the skills to teach and train other health professionals about mental health practice.

- The team should be managed in a culture of peer level relationships rather than hierarchy and have time and place to meet regularly to discuss their work and challenge each other on their approach.

- The work is high risk and must be reliably recorded and communicated.

- The activity of the team and its performance outcomes need to be recorded for the purpose of management and governance and for this, high quality dedicated administrative support is essential.

**Literature**

- Variation in demand may suggest different staff skills mix depending on setting, however, staff need to have good communication skills, the ability to maintain clear notes, be willing and able to cover across disciplines, and to have a broad understanding of the medical and mental health needs of patients.

- The “liaison” function of liaison psychiatry is central to the success of the role.

- Training is a core function.

- The roles of the liaison psychiatrist are described as communicator (developing trust and rapport, conveying information effectively), as collaborator and health advocate (collaborating within an inter-professional healthcare team, and advocating for the patient), as manager (managing multidisciplinary care delivery), as scholar (teaching to others in the hospital), and as professional (commitment to medical practice).

“Models of service need to be amenable to local flexibility and close working relationships between all key stakeholder will enable the best arrangements to be developed in each locality”

(Mental Health Policy Implementation Guide 2007)
5. Planning and costing the service model for your locality

In making decisions about the type of service model best suited to an area, there are particular considerations to be made.

Lay group recommendations

“A good liaison psychiatry service could and perhaps should pay for itself if it helps to reduce hospital attendances for those with self-harm and facilitate community support for those in distress. It will be least cost effective if it operates in isolation from other services and when it does not act as an agent of change.”

Professionals’ recommendations

- There is a need to clarify funding for local needs and specialist needs.
- There is a need to ensure that all ages get an equitable service.
- We need to scope demand (not just number of referrals and time of referral but also time mental health input is most beneficial), related services (e.g. local alcohol services) and impact on other services.
- We need to consider what is achieved by different staff groups and consider unsocial hours payments.

Literature

- Parsonage et al say that if there is no existing service, then the first and most basic step should be a generic, all-age, all-conditions service for assessment, day-to-day management and onward referral.
- The next step should be the development of an outpatient service.
- All models should be developed based on an analysis of local need and service use.

Recommendations

Many services already exist partly serving the work of liaison psychiatry. The evidence suggests that many of these services, whilst working hard, are insufficient to deliver the cost and quality benefits suggested by the evaluation of RAID. Nevertheless, it makes sense to
test this assumption in each locality by setting out what is already available and how much is being spent on it.

When setting up a service it is recommended that a project team be established with an executive commissioning lead and day-to-day management from commissioning support. The team will need support from finance, human resources, estates and representatives from the acute and mental health trusts. The team, whilst small and focused, should include a person with experience of the care pathway and where possible access to advice from a consultant liaison psychiatrist.

It is recommended that the following be undertaken before decisions are made about the type of liaison psychiatry service to commission.

5.1. **Undertake demand / supply analysis**

- Start with analysis of need (prevalence)
- Analyse data on current activity – attendance at ED; admissions to hospital
- Acknowledge problems with coding of mental health problems/co-morbidities; what assumptions can be made?
- Review and cost current liaison psychiatry services
- Map ‘gaps’

5.2. **Identification of activity**

Having established the local situation, the next step is to build a picture of the likely work. National statistics, hospital episode statistics, information from emergency department, mental health trusts, first responder and pre-hospital agencies can inform the pattern of demand. The outputs from these pieces of work should be used to construct a model of service best suited to the locality.

Use hospital system information including Hospital Episode Statistics (HES) and the mental health minimum data set to estimate:

1. numbers and demographic of people seen,
2. nature of their problems,
3. times of day when seen
4. any outcome data.

5.3. **Identification of existing skills-set**

**Look for**

1. Nurses working with self-harm. Note: numbers, grades and hours worked, who employs them.

2. Psychiatrists in-reaching to the hospital or providing outpatient clinics for general hospital consultant-to-consultant referrals Note: programmed activities and specialism served, who employs them.

3. Psychologists working in health psychology, neuropsychology, clinical psychology. Note: numbers, grades, hours worked, employer.

4. IAPT workers, counsellors and other professions allied to medicine trained in psychological therapies. Note: numbers, hours worked, who employs them.

5. Out of hours on call arrangements. Note: who provides, grades of staff, nursing, psychiatry, social work.

6. Management, administrative & supervision arrangements for all of this work.

5.4. **Financial audit**

Describe how all the existing liaison psychiatry work is commissioned, where budgets sit, and their value.

Consider current service provision and methods of delivery (models) in relation to recommendations from this guidance.

The four model service specifications recommended in this guidance can then be selected from and adapted for local use.

For an example of how to find the optimal service model for your locality can be found in Appendix 3.
6. Outcomes framework and quality assurance

It remains one of the most discussed areas of mental health service; specifically how outcome benefit should be measured for the person, their carers and families, their referrers and the wider health care system. We set out what our lay, commissioner and professional experts considered important, evidence from the literature and recommendation on the direction development should take.

Lay group recommendations

- Outcomes should be made up of a mix of feedback from patient experience, community teams and general hospital.
- “A good experience with liaison is when they’ve liaised effectively with community teams.”
- “It would be a good service if I felt I was looked after afterwards.”

Commissioners’ recommendations

The following should be included in outcomes.

- Patient experience
- Patient satisfaction
- Referrer satisfaction
- Rapid co-produced formulation and agreed care plan
- Integrated physical and mental health care plans
- Discharge summary back to GP, referrer and patient within 24 hours
- Improved outcomes as measured by outcome scales
- Use of standardised assessment tools and outcome measurements
- Patient 360 degree feedback
- Multidisciplinary team including acute staff 360 degree feedback
- Emergency department service requirements met e.g. 4 hour waits
- Confidence of acute care staff in being able to access liaison psychiatry input
- Reductions in repeated detentions where inappropriate
• Agreed access levels
• Time from referral to access reduced
• Diversions from ED
• Prevalence of frequent re-attending
• Reductions in admissions to acute and mental health trust beds
• Reductions in care home admissions
• Shortening length of stay in acute wards and emergency departments
• Use of Mental Health Act and Mental Capacity Act
• Reductions in police custody S136 Mental Health Act placements
• Reduction in repeat detentions by care plan review
• Rapid access to mental health beds when needed
• Diversions to community alcohol detoxification services
• Reductions in acute outpatient clinical attendances for medically unexplained symptoms
• Up to date directory of services for local mental health services
• Accurate identification of co-morbidities
• Improved data quality in Hospital Episode Statistics and Mental Health Minimum Data Set coding
• Improved data quality, ICD10 coding of both physical and mental health conditions
• Health outcomes for excluded groups
• Increased patient safety through medicines reconciliation
• Reduction in the use of analgesics and anti-psychotics
• Improved medicines adherence at point of assessment and at discharge
• Audit of workload and caseload
• Percentage of acute care hospital staff trained in mental health
• Improved rates of diagnosis of dementia
• Evaluations of teaching sessions
• Routine update sessions for continuing professional development
Professionals’ recommendations

The following should be included in outcomes.

- Reduced length of stay.
- Reduced attendance at outpatients and GPs.
- Prevalence of frequent attending amongst self-harmers.
- Confidence of acute care staff in being able to access liaison psychiatry input.
- Audit of workload and caseload.
- Reduced length of stay.
- Process outcomes.
- Clinical improvement.
- Patient satisfaction.
- Referrers satisfaction.
- Health outcomes - e.g. improvement in symptoms and reduction in admissions.

Literature

- Liaison psychiatry services bridge the gap between mental and physical health conditions. It is often the case that the complexity of the patients seen, their presentations and multiple morbidities make it difficult for clinical improvements to be attributed solely to any involvement that may have been provided by liaison psychiatry services.

- Assessing outcomes is a very complex area, which is still under development. It is difficult to attribute change to inputs provided by a liaison psychiatry service, and methods are currently in development to achieve this.

- A balanced score card approach is most commonly considered useful. This uses clinical outcomes, Patient Reported Experience Measures (PREMS) and Patient Reported Outcome Measures (PROMS), environmental factors and process measures to get a full picture. A balanced score card for liaison psychiatry is currently under development in partnership with the Centre for Mental Health.

- The Psychiatric Liaison Accreditation Network (PLAN) sets Quality Standards for Liaison Psychiatry Services.
• The main beneficiaries of liaison psychiatry interventions stand to be the patient and their carers / families, the referrer and their team, the hospital and the supporting health and social care system.

• Benefits fall in terms of clinical outcome, experience of care and cost benefit.

• Being able to demonstrate the effectiveness of a liaison psychiatry service should be an integral element of any service model and should support a robust commissioning arrangement.

• Liaison psychiatry services are provided in a range of settings where the type and frequency of client contact may differ greatly, e.g. emergency department assessments for self-harm, ward-based evaluations, out-patient therapeutic sessions etc. This too will have an impact on the types of clinical outcome measures and service-level information that can be collected.

• All liaison psychiatry services should aspire to the highest levels of PLAN accreditation.
7. Models and levels of liaison psychiatry service

Transformation in the way acute hospital care is provided in the next decade suggests a need for four models for commissioners to consider, to be adapted to the nature of the work of the hospitals and the clinical pathways.

Each model builds on the previous level from the core minimum regarded to be effective in managing emergency department and admissions work sufficient to return the cost and quality benefit suggested in this guidance:

1. **Core** Liaison Psychiatry Services, working or extended hours only.
2. **Core24** Liaison Psychiatry Services, twenty-four hours, seven days a week.
3. **Enhanced24** Liaison Psychiatry Services, twenty-four hours, seven days a week with extensions to fill local gaps in service and some outpatient services.
4. **Comprehensive** Liaison Psychiatry Services, twenty-four hours, seven days a week, enhanced with inpatient and outpatient services to specialties at major centres.

**Core Liaison Psychiatry Services**

These services would have the minimum specification likely to offer the benefit suggested by the literature. Core will serve acute health care systems with or without minor injury or emergency department environments where there is variable demand across the week including periods of no demand where a 24-hour staffed response would be uneconomical. This model mainly serves emergency and unplanned care pathways.

**Core24 Liaison Psychiatry Services**

These services have the minimum specification likely to offer the benefit suggested by the literature where there is sufficient demand across the 24 hours period to merit a full service. Typically these acute health care systems are hospital based in urban or suburban areas with a busy emergency department. This model mainly serves emergency and unplanned care pathways.
Enhanced 24 Liaison Psychiatry Services

These services have enhancements to the minimum specification to fit in with gaps in existing pathways and services. Often they have additional expertise in addictions psychiatry and the psychiatry of intellectual disability. Demography and demand may suggest additional expertise with younger people, frail elderly people or offenders, crisis response or social care. This may extend to support for medical outpatients. This model mainly serves emergency and unplanned care pathways but extends to support elective and planned care pathways where mental health problems co-exist.

Comprehensive Liaison Psychiatry Services

Comprehensive services are required at large secondary care centres with regional and supra-regional services. These services include Core24 level services but will have additional specialist consultant liaison psychiatry, senior psychological therapists, specialist liaison mental health nursing, occupational and physiotherapists. They support inpatient and outpatient areas such as diabetes, neurology, gastroenterology, bariatric surgery, plastic and reconstructive surgery, pain management and cancer services. They may include other condition specific elements such as chronic fatigue and psychosexual medicine teams. Some may include specialist liaison psychiatry inpatient beds. Comprehensive services run over office and extended hours supported by the core service running twenty four hours, seven days a week. This model serves emergency and unplanned care pathways as well as planned and elective care where mental health problems co-exist.

These models, their staffing and set-up, are described in detail in document 3 “Developing Models for Liaison Psychiatry Services - Guidance for Commissioning Support”.

8. Key references


Joint Commissioning Panel for Mental Health (2012) *Guidance for commissioners of liaison mental health services to acute hospitals*. Available at [www.jcpmh.info](http://www.jcpmh.info)


9. Bibliography


Joint Commissioning Panel for Mental Health (2012) Guidance for commissioners of liaison mental health services to acute hospitals. Available at www.jcpmh.info


Royal College of Psychiatrists’ Faculty of Liaison Psychiatry (2012) *Liaison psychiatry and the management of long-term conditions and medically unexplained symptoms.* Faculty Report.


Royal College of Psychiatrists (2013): College Report 183; Liaison Psychiatry for Every Acute Hospital; Integrated Mental and Physical Health Care


Appendix 1: Who should provide liaison psychiatry services? Acute or mental health providers?

It has been long debated as to who should provide the services. Historically, where services are effective, the role has fallen to the provider with the passion and skill to do it well, because they value the benefit of the work to their patients, the referring teams and the hospital.

Commissioners increasingly recognise a benefit to the system and will need to ensure that the provider they choose is able to consistently deliver to the commissioned specification.

Commissioners are recommended to consider the principal risks and benefits in provision, and providers bidding should be asked to describe how they will manage those risks and deliver those benefits.
<table>
<thead>
<tr>
<th>Strengths</th>
<th>Acute Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Used to managing &amp; governing mental health work.</td>
<td>• Have the need to make the service work because it addresses their activity and cost pressures.</td>
</tr>
<tr>
<td>• Peer support for the work force with easy access to cross cover.</td>
<td>• Can set priorities for the service and manage use of the resource balanced with their activity.</td>
</tr>
<tr>
<td>• Training rotations are aligned.</td>
<td>• Single system for managing complaints and incidents.</td>
</tr>
<tr>
<td>• Connection with mental health provider pathways.</td>
<td>• Common IT performance and clinical records platform.</td>
</tr>
<tr>
<td></td>
<td>• Common space in general hospital.</td>
</tr>
<tr>
<td></td>
<td>• Easy collegiate relationships.</td>
</tr>
<tr>
<td></td>
<td>• Clear place and presence of mental health in general hospital life.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Weaknesses</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Vulnerable to cost pressures in mental health trusts directing priority away from liaison psychiatry.</td>
<td>• Vulnerable to Cinderella status unless ably led in competition with hospital technical specialties.</td>
</tr>
<tr>
<td>• Management of the people divorced from the function and task.</td>
<td>• Loss of connection with mental health peers, workforce, and mental health clinical supervision.</td>
</tr>
<tr>
<td>• IT performance and clinical records system duplication.</td>
<td>• Inexperience operating and managing Mental Health Act.</td>
</tr>
<tr>
<td>• Team often situated off the main general hospital site.</td>
<td>• Tariff, outcomes framework and commissioning landscape not aligned to enable commissioning of mental health services into acute and chronic care pathways.</td>
</tr>
<tr>
<td>• Stigma of mental health for patients who may not recognise themselves as having mental health needs.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2: Exemplar acute care hospital based services

**RAID**

24/7 to all people aged over 16 within the hospital. Includes drug/alcohol service. Rapid response with a target time of one hour to assess referred patients who present to ED and 24 hours for seeing referred patients on the wards. Provides formal teaching and informal training on mental health difficulties to acute staff in the hospital. Focus is on diversion and discharge from ED and facilitation of early but effective discharge from general wards. Also run a number of follow-up clinics for patients discharged. Cost is around £1.4 million a year for a hospital of circa 600 beds, and generates incremental benefits in terms of reduced bed use valued at £3.55 million a year – benefit:cost ratio of more than 4:1.

**St. Helier Hospital liaison psychiatry service**

Provided by South West London and St. George’s. 550 bed hospital. Cost of liaison psychiatry service is just under £1 million. Older person’s and general liaison team. Inpatients and emergency. All conditions 18 – 64 years for general service. Older person’s team also attends discharge planning meetings on the Medicine for the Older wards. Separate liaison psychiatry service for children and adolescents provided by CAMHS but this is not on-site. Links into outpatient clinics to provide sessional psychology. They also run their own outpatient clinics and accept outpatient referrals. Close links with local community services. They provide training for Foundation Doctors, Trainee GPs and ED Medical staff. Also training for all hospital staff and development of hospital guidelines.

**Royal Devon and Exeter Hospital**

Provided by Devon Partnership NHS Trust. 877 beds. Cost £0.7 million. Principle liaison psychiatry for adults aged 18 – 65 plus separate older person’s service. Inpatient and emergency. 9 – 5, Monday to Friday. Out of hours provided by duty psychiatrist. Older adults service adopts proactive approach to case finding and attends multidisciplinary team meetings and discharge planning meetings on the care of the elderly wards. Links into diabetes outpatient department and supports MUS services in general practice. Training provided to trainee doctors and to general hospital staff. Input to hospital guidelines and leaflets.
**Arrowe Park Hospital and Clatterbridge Hospital**

Provided by Cheshire and Wirral Partnerships NHS Trust. 900 beds. Costs just under £1 million. Primarily services ED but also offers consultant and nurse-led outpatient clinics, specialist self-harm clinics, specialist perinatal clinics and ad hoc review clinics. Provides service to adults of all ages and routine mental health care to older people. Provides mental health training to hospital colleagues. 24 hour service. Links with maternity, oncology and pain clinics. Key differences: they have advocates as integral team members to help patients with a range of non-clinical problems that can affect their recovery. They are trialling a single point of access for primary care through which primary care colleagues can contact the team to seek advice.

**Hull Royal Infirmary and Castle Hill Hospital**

Provided by Humber NHS Foundation Trust. 1490 beds plus 40 dialysis stations. Liaison is within the Department of Psychological Medicine. They have a very wide range of specialist staff. Operating seven days a week from 8am to 10pm. Multidisciplinary team including a range of professionals who focus on people who deliberately self-harm and/or who have mental health problems within the acute care pathway. Ageless service for people who have self-harmed. General liaison psychiatry for people aged 18 – 65. Plays part in management of patients with long-term conditions. Learning disabilities service. Perinatal mental health service. Older adults service. Links to neurology OP clinics and holds Huntington’s Disease outpatients service and also a Chronic Fatigue Syndrome Service. Training provided.

**St. James Hospital and Leeds General Infirmary**

Provided by Leeds and York Partnership NHS Foundation Trust. Circa 2,100 beds. Focus is on specialist rather than generic liaison psychiatry service. Liaison psychiatry service for people aged 18 – 64 which includes outpatient and therapeutic services. Older people’s service. Drug and alcohol service. ED mental health services. They provide staff and support to a range of services, including palliative care and psycho-oncology, psychosexual medicine, CBT outpatients, Self-harm service, Yorkshire Centre for Psychological Medicine, Chronic Fatigue syndrome service etc. Overall cost is £4,493,583. Mostly operate within office hours, apart from ED which is 24/7 and self-harm services which have weekend cover. The ED service has a dedicated self-harm service. They have a dedicated inpatient unit – the Yorkshire Centre for Psychological Medicine, with 8 beds.
Out of hospital examples

**North West London Integrated Care Pilot**
The Integrated Care Pilot in North West London – a partnership between five local authorities, two major acute trusts, two community trusts, two mental health trusts, two third sector organisations and over 100 general practices, focusing on the integrated management of diabetes and people over the age of 75.

**King’s College Hospital Diabetes Service**
Includes two dedicated mental health professionals, a liaison psychiatrist and a clinical health psychologist who are integrated into the multidisciplinary diabetes team. Liaison psychiatrist provides a consultation service and training for colleagues in the recognition and basic management of comorbid psychiatric disorder and diabetes.

**Primary Care Psychotherapy Consultation Service in the City of Hackney**
Clinical service for patients with complex needs and support to GPs.
[http://www.tavistockandportman.nhs.uk/cityandhackneyprimarycarePCS](http://www.tavistockandportman.nhs.uk/cityandhackneyprimarycarePCS)

**LIFT Psychology in Swindon and Wiltshire Improving Access to Psychological Therapies Programme**
To benefit the management of physical symptoms associated with anxiety and depression.
[http://lift.awp.nhs.uk](http://lift.awp.nhs.uk)

**Combining IAPT and liaison psychiatry in Cambridge**
Liaison psychiatry run by primary care as part of the IAPT provision.
[http://www.cpft.nhs.uk/services/primary_care_liaison_psychiatry.htm](http://www.cpft.nhs.uk/services/primary_care_liaison_psychiatry.htm)

**Pennine Musculoskeletal Partnership Integrated Clinical Assessment and Treatment Service, Oldham**
Community-based outpatient clinic led by two GPs. For patients with a range of rheumatological and orthopaedic conditions. Community based with a multidisciplinary team with both physical and psychiatric expertise. Service users receive specialist liaison psychiatric assessment and a detailed management plan.
Hull Specialist Perinatal services
Specialist service which takes referrals from obstetrics department and from other services in the community.

Whittington Hospital Paediatric service
Based in the paediatric and neonatal departments to provide support relating to long-term conditions and MUS. Referrals from hospital but GPs can refer through a Consultant Paediatrician.

Yorkshire Centre for Psychological Medicine
Inpatient care for people with MUS and physical/psychological comorbidities in an 8-bed specialist inpatient unit originally established at Leeds General Infirmary. Staffed by consultants, nurses, occupational therapy, physiotherapy, dietetics, pharmacy and administrative staff. Staff with dual (general/physical and mental health) training. [http://www.leedspft.nhs.uk/our_services/YPCM](http://www.leedspft.nhs.uk/our_services/YPCM)

Tees, Esk and Wear Valleys NHS Trust
Evaluation of the use of £35,000 to fund a nurse for a liaison psychiatry team. The team saw more patients (up to 546 from 476), admission rates of patients with psychiatric illness to medical beds dropped from 39% to 35%, average bed stay for patients with psychiatric illness in the acute hospital was one day, crisis team referrals dropped from 35% to 24%, savings associated with decreased attendances and admissions were £59,000. (Briefing Mental Health Network April 2009).
### Optimising your Liaison Psychiatry Model to Local Context

<table>
<thead>
<tr>
<th>Description of approach</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Define population with greatest impact</td>
<td>- HES, MHMDS, clinical evidence,</td>
</tr>
<tr>
<td>2. Calculate savings based on current service levels</td>
<td>- Local working group</td>
</tr>
<tr>
<td>3. Identify the incremental resources required</td>
<td>- MHTs, working group, LSE report on RAID (Birmingham), excess bed-days data</td>
</tr>
<tr>
<td>4. Calculate additional costs</td>
<td>- Local Working Group</td>
</tr>
<tr>
<td>5. Estimate net impact across varying scenarios</td>
<td>- Local Working Group, local Analysis</td>
</tr>
<tr>
<td>6. In next phase: refine estimates</td>
<td>- Local analysis, Local Working Group, LSE report on RAID</td>
</tr>
</tbody>
</table>

- Identify patients most likely to benefit: 65+ years patients with Mental Health needs, patients aged 16-64 with MH needs, and where/how team impacts these patients e.g., referrals in A&E, referrals from wards, benefits through training of staff.
- Establish hospital’s current service level to determine potential impact of implementing localised model liaison team and reduce savings by this percentage.
- Estimate reduced LOS for patients referred to and indirectly benefitting (e.g. through training of hospital staff).
- Calculate savings split between commissioner and hospital.
- Identify the psychiatric team required (number of WTEs, staff groups and bands).
- Reduce these resources by those already in place that can be used for this service.
- Calculate additional start up and ongoing costs.
- Deduct costs from savings for each hospital site to determine incremental benefit of Optimal Standard service to Commissioners and Providers.
- Adjust key driver – cost per bed day – to assess impact across 3 potential scenarios.
- Refine estimates to take into account local circumstances e.g. availability of Local Authority accommodation.
- Future work.
Forecast liaison psychiatry savings (and how these may split between commissioners and providers under current contracts)

- **£ Savings**
  1. Net Impact to Hospital
     - Savings from all bed reductions (including excess bed-days)
     - Less Income lost from excess bed days
     - Less Income lost from excess bed days
     - Less Income lost from reduced A&E tariff payments

  2. Net Impact to Commissioner
     - Savings to Commissioner from reduced excess bed days
     - Savings from reduced A&E tariff payments

  **Total Savings (for Hospital & Commissioner)**

- **£ Costs**
  1. Incremental cost of liaison team
  2. Other incremental costs

  **Total Costs**

  **£ Net System Impact (Total Savings - Total Costs)**

---

1 Take into account local contracting arrangements made between commissioners and acute trusts

**SOURCE:** local working group
## Reduced length of stay: estimating reduction in bed days saved per annum

### Hospital A

<table>
<thead>
<tr>
<th>Reduction in # of Bed Days for patients 65+</th>
<th>Reduction in # of Bed Days for patients 16-64</th>
</tr>
</thead>
</table>
| **Number of patients aged 65+ admitted**
  - Via A&E  a
  - Via other Channels b | **Number of patients aged 16-64 admitted**
  - Via A&E  c
  - Via other Channels d |
| Re-admissions avoided | Prevalence of Mental Health² |
| | Reduction in bed days per patient³ |
| | Expected impact⁴ |
| | Reduction in bed days |
| | |
| | X 40% |
| | X 3 bed days |
| | X 71% |
| | bed days |
| | X 18% |
| | X 1 bed day |
| | X 71% |
| | bed days |

Total number of bed days reduced = \( \text{bed days} \)

---

1. Hospital Episode Statistics, 2009 – 2010, via other channels excludes elective admissions and maternity
2. Holmes and House, 2000, Counting the Cost Report, Alzheimer’s Society 2009, 65+ age group = 40% with dementia
3. Original RAID report claims reductions of 7.5 bed days for patients with dementia; Centre of Mental health & LSE assessment reduced savings from LOS by approximately 30%, therefore only 3 bed days were used
4. Local Working group assumption based on gap between baseline level of liaison and Optimal Standard
## Reduced re-admissions: estimating reduction in bed days saved per annum

<table>
<thead>
<tr>
<th>Hospital A</th>
<th>Typical number of emergency re-admissions</th>
<th>Reduction in # of Bed Days from reduced re-admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of emergency admissions</strong>¹</td>
<td>17%</td>
<td>70%</td>
</tr>
<tr>
<td>Proportion of patients directly affected by liaison team²</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of emergency admissions directly affected by liaison team</td>
<td></td>
<td>71%</td>
</tr>
<tr>
<td>Hospital’s average rate of readmissions³</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Typical number of emergency readmissions</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Average LOS per re-admitted patients</strong>⁴</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impact achievable given current service levels⁵</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduction in bed days</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

1. Hospital Episode Statistics (HES), 2009 – 2010, via other channels excludes elective admissions and maternity (includes re-admissions)
2. Assumption estimated from RAID
3. Local Emergency readmissions rate for individual trusts
4. Findings from LSE and CMH report on RAID
5. Calculated from acute hospitals data sourced from HES
6. Working group assumption based on gap between baseline level of liaison and agreed model based on Guidance
Reduced Emergency Department admissions: estimating reduction in bed days saved per annum

<table>
<thead>
<tr>
<th>Hospital A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Typical number of avoided A&amp;E admissions</strong></td>
</tr>
<tr>
<td>Number of A&amp;E admissions for mental health coded patients¹</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

| **Reduction in # of Bed Days from reduced A&E admissions** |
| Total number of A&E admissions avoided | Average LOS per mental health coded patient³ | Reduction in bed days |
| | | |

| **Commissioner saving** |
| Total number of A&E admissions avoided | Unit tariff⁴ | Commissioner saving |
| | | |

---

1. A&E admissions for patients coded with mental health problems
2. Local working group assumption, based on case study evidence
3. ALOS for mental health coded patients based on local figures for patients coded with mental health problems
4. A&E admissions data for patients coded with mental health problems (unit tariff is agreed locally)
## Estimating net savings to commissioner

<table>
<thead>
<tr>
<th>Commissioner opportunity – Hospital A</th>
<th>Total bed days reduced</th>
<th>% of excess bed days</th>
<th>Excess bed days reduced</th>
<th>Cost per excess bed day</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Savings from reduced excess bed days</td>
<td>1</td>
<td>16%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Scenarios with alternative bed-day costs should be developed with validation meetings to agree range around £mean / bed-day is considered reasonable.**

<table>
<thead>
<tr>
<th>Net Savings</th>
<th>£</th>
</tr>
</thead>
</table>

---

1. Local working group calculate local excess bed days proportion for acute trusts
### Estimating net savings to provider (conservative scenario)

<table>
<thead>
<tr>
<th>Provider opportunity – Hospital A</th>
<th>Total bed days reduced</th>
<th>Annual # of days</th>
<th>Occupancy Rate(^1)</th>
<th>Beds reduced</th>
<th>Savings(^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Savings from reduced (all) bed days</td>
<td></td>
<td></td>
<td>99%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduced income from saved excess bed days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduced income fewer A&amp;E admissions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^1\) Local data.

\(^2\) Savings estimate is dependent on number of beds reduced; e.g., if hospitals take out 15 beds, they can make savings of £380,000, if hospitals take out a ward (30 beds), they can make savings of £1.1million
Localised approach to attributing LOS savings between commissioners and providers as a result of liaison psychiatry team activity

If LOS is reduced before trim point:
- Hospital can potentially make savings from reduced bed usage (and other savings from reduced LOS)

**Trim point (5 days)**

In addition, the following overall principles could be applied to savings realised:
- Funding for liaison psychiatry teams needs to come out of the savings
- Savings generated will be distributed to CIP & across the pathways served

If LOS is reduced after trim point:
- Commissioner no longer pays for excess bed days
- Hospital can potentially make savings from reduced bed usage

**Illustrative patient**

**Length of stay**

1 day 5 days

**SOURCE:** local analysis