Case for change – mental health liaison service for dementia care in hospitals

Evidence
West Yorkshire Commissioning Packs are tools to help commissioners improve the quality of services and minimise unwarranted variation in service delivery. Each Pack provides a tailored set of guidance, templates, tools and information to assist commissioners in commissioning services from existing providers or for use in new procurements.
Case for change – mental health liaison service for dementia care in hospitals

Evidence

Prepared by the Strategic Commissioning Development Unit (SCDU)
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Case for change – evidence

Purpose of the document

The purpose of this document is to explain the evidence that has been used:

1. to identify eligible patients for mental health liaison services in general and community hospitals
2. for the design of a mental health liaison service and its core components.

The information contained in this document is designed for use by commissioners in building a business case, and includes:

- evidence for eligible patients
  - an overview of patients eligible for mental health liaison services
  - a description of evidence sources for eligible patients
- evidence for the service design of the hospital support service
  - description of evidence for service design.

Mental health needs, including dementia, represent a large and growing demand on hospital resources

Up to 70% of hospital beds are currently occupied by older people,\(^1\) of whom half may have cognitive impairment, including dementia and delirium.\(^2\) This trend is likely to continue, and it has major implications for the use of hospital resources and good patient care:

- From 2000 to 2031, the number of older people in the United Kingdom (aged 65 and over) will rise by 59%.\(^3\)
- Over the next 40 years, the number of people in the UK with dementia will more than double – to 1.7 million.\(^4\)

There is evidence concerning both the impact of an ageing population on hospitals and the resource pressures associated with mental health needs:

- Information from Hospital Episode Statistics shows that hospital stays for those aged between 60 and 74 increased by more than 50% between 1999/2000 and 2009/10. Hospital stays for patients aged 75 and over increased by 66% in the same period.\(^5\)

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• A typical general hospital with 500 beds will admit 5,000 people a year, of whom 3,000 will have or will develop a mental disorder. In some cases, patients will be admitted with an apparent mental disorder, while in others it will develop in hospital.

• A study of 60,000 admissions for hip fracture (clinically known as fractured neck or femur) by the National Audit Office (NAO) showed that people with dementia stayed in hospital for significantly longer than those who were psychiatrically well:

<table>
<thead>
<tr>
<th></th>
<th>Psychiatically well</th>
<th>People with dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fractured neck or femur admissions</td>
<td>18,188</td>
<td>25,709</td>
</tr>
<tr>
<td>Length of stay</td>
<td>26 days</td>
<td>43 days</td>
</tr>
<tr>
<td>Bed days</td>
<td>480,000</td>
<td>1,100,000</td>
</tr>
<tr>
<td>Expenditure on acute episode</td>
<td>£0.6 billion</td>
<td>£1 billion</td>
</tr>
</tbody>
</table>

Meeting the needs of older people with mental health conditions in general hospital remains a challenge

The majority of mental disorder co-morbidity affecting older people in general hospital is due to three disorders: dementia, depression and delirium. While this case for change focuses on dementia, it also recognises that any response should provide for a range of mental health needs that affect older people.

The frequency and impact of mental disorder in the care of older people are such that providing specialised physical care without attention to mental health will fail to meet the needs of patients and of their carers/families and is likely to build in extra cost pressures on the health service.

The health service has responded by developing specialised departments, wards and multi-disciplinary teams in most hospitals. However, where these services do not exist, patients may be admitted to wards where their complex care needs are not adequately met. In terms of the effectiveness of current provision, the NAO’s 2010 report on dementia noted:

‘Joined-up working remains very patchy and as a result people with dementia are still being unnecessarily admitted to hospital, have longer lengths of stay and enter residential care prematurely. Whilst we found examples of good practice, these are not being adopted widely.’

The same report noted that the failure to organise services appropriately for people with dementia meant that, for a typical general hospital, excess costs are around £6 million a year.

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7 National Audit Office (2007), Improving Services and Support for People with Dementia. London: TSO.
The National Audit of Dementia included data from 210 hospitals in England and Wales (88% of the total number).9 Key findings from the audit were:

- Despite the finding of a 2009 Care Quality Commission survey that four in ten older people in hospital may already be suffering from malnutrition, nutritional assessment had not been recorded in a third of audit case notes.

- Only a minority of hospitals collected information on recurring factors that would cause or exacerbate distress, or on support or actions that could calm the person, if necessary.

- A minority of hospital boards routinely reviewed delayed discharge, and very few routinely reviewed readmissions of patients with dementia.

- Few hospitals had in place a system to ensure that staff on the ward were aware that a person had dementia and how it affected them, and that the necessary information was imparted to other staff with whom the person came into contact.

- Very few hospitals reported that training in awareness of dementia was mandatory for all staff, and the majority of hospitals did not identify necessary skill development in working with and caring for people with dementia.

- The majority of hospitals did not have in place a policy/protocol governing challenging behaviours, agitation and aggression that was suitable for use with people with dementia.

- Less than a fifth of case notes recorded a referral to liaison psychiatry. Of those that did, less than half of the patients were seen within 48 hours, and over a third had not been seen after 96 hours.

- A minority of hospitals had guidelines in place to ensure that the carer knew how much information would be shared with them and the extent to which they could be involved in caring for the person with dementia during admission.

A mental health liaison service can help both to improve outcomes and ensure that hospital resources are used efficiently

Better management of mental health problems can have major implications both on the quality of care for older people and on the efficacy of acute hospitals and the efficient utilisation of health and social care resources.

The provision of a mental health liaison service for older people in hospital is accepted as good practice in the National Dementia Strategy10 and in the National Institute for Health and Clinical Excellence (NICE) clinical guideline for dementia.11

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9 Royal College of Psychiatrists (2010), *National Audit of Dementia (Care in General Hospitals)*. London: Royal College of Psychiatrists’ Centre for Quality Improvement.


The service can provide assessment and diagnosis of mental health need, offer management support and contribute to the training of hospital staff in relation to good dementia care.

There is also evidence that such services are effective, with Strain et al. reporting that an average of 2.39 hours per patient of a psychiatrist’s time can lead to a reduction in the average length of stay of 2.2 days.\(^{12}\)

In Leeds, where a mental health liaison service was established in 2006, key findings include:\(^{13}\)

- There have been cost savings of around £2 million per year.
- There has been a reduction in hospital stay of four days per admission for people with dementia.
- Had the liaison team not been in place for 2008/9, there would have been 4,106 additional bed days for patients with dementia, equating to 11.2 extra beds.
- More patients are referred on to appropriate services: around half of all patients seen by the service in 2008/9 were transferred rapidly on to mental health pathways. Of these, around half had had no previous connection with, or involvement in, mental health services, which serves to indicate the importance of the mental health liaison team in the detection of mental illness and referral on to appropriate services for treatment.

The NICE clinical guideline on dementia recommends that acute trusts should ensure that a mental health liaison service is in place to assist with the assessment, diagnosis and management of patients with dementia.\(^{14}\) The guideline also notes that this service could assist in helping to train hospital staff in the provision of good dementia care.

The role of the mental health liaison service is to:

- provide support and advice on making the diagnosis of dementia and other mental health conditions
- provide support and advice on management and care planning, including discharge planning for people with confirmed or suspected mental health problems such as dementia
- contribute to mental health education and training for hospital staff, to governance and audit arrangements to promote good dementia care, and to the development of policies and procedures for good-quality mental health care.


\(^{13}\) Thornton, J, Leeds Poppins Programme End of Year 2 report, 2008

Why assessment and diagnosis are important

Before a patient can be treated or referred for mental health assessment, the problem must be identified. It is not uncommon to have a missed diagnosis rate of 50% or more for cognitive impairment, which means that the care needs of large numbers of people with memory problems and dementia are not being adequately met.

People with dementia are particularly vulnerable in general hospitals, as they are highly susceptible to environmental change and quickly suffer loss of function. The presence of dementia is a major risk factor for delirium: people with dementia are five times more likely to develop delirium. Consequently, there are multiple reasons why it is important to identify this diagnosis at point of admission and for general care staff to realise the impact that cognitive impairment will have for a person’s management and discharge.

Admission to hospital may also be the first opportunity to identify dementia and put the patient and carer in contact with specialist services that will support their well-being after discharge.

Why support and advice on management is important

The mental health liaison service is able to provide management advice to all parts of the hospital where mental health skills may not be available, and it may provide advice and support where there are difficulties with the management of patient behaviour or where urgent advice or support is required. The service can advise on de-escalation and symptom-management techniques, including advice on the use of, and alternatives to, antipsychotic medication. A short response time for urgent cases may prevent further escalation and distress to the patient, ward staff and other patients.

Care planning advice can help avoid complications and unnecessary distress for a patient with dementia or other mental health needs, and can also ensure that the needs of patients are addressed in a systematic way that helps a sense of well-being and reduces distress.

The service can provide support on decisions in relation to the Mental Capacity Act 2005 and can, if required, offer advice on independent advocacy support, so that the legal rights and the best interests of the patient are protected.

One of the roles of the service is to provide links with community services, in order to help ensure that discharge arrangements are not delayed and that patients are discharged to the most appropriate place of care. Where required, this might include advice on accessing intermediate care or reablement services and advising on the best place of residence, post discharge, as appropriate. The service is not intended to replicate the role of discharge support teams, and the responsibility for providing good-quality care remains with ward staff.

By providing knowledge transfer to ward staff, the service should increase their confidence and their ability to provide better care for patients, and is also likely to contribute to their job satisfaction.

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Why contributing to staff training and organisational development is important

The aim of the mental health liaison service is to build the capability of existing ward staff to meet the needs of older people with organic and functional mental health problems. This may be achieved, in part, by providing knowledge transfer to ward staff on a case-by-case basis, but building a dementia-capable workforce will require a more systematic approach at an organisational level.

The service can contribute to the development of training for existing hospital staff, and this is likely to be the most cost-effective option for increasing the capacity and capability to improve dementia care.

Where required and resourced to do so, the mental health liaison service may assist in establishing protocols to help ward staff manage the needs of patients with dementia, so that, in time, the liaison service becomes a point of advice for more complex cases only.

The service may also contribute to the implementation of audit and governance arrangements to ensure quality and safety and to assess the effectiveness of the delivery of good dementia care and the capability of staff to provide good care for older people with organic and functional mental health problems.

What evidence has been used to inform service design?

Evidence for the design of the hospital mental health liaison service is taken from NICE clinical guidelines, guidelines from the Social Care Institute for Excellence (SCIE) and other supporting evidence that is consistent with those guidelines.

**NICE/SCIE 2007 (CG42) Supporting people with dementia and their carers in health and social care**

This guideline offers best-practice advice on the care of people with dementia. In terms of hospital care, the guideline:

- recommends the establishment of a mental health liaison service for assessment and diagnosis, management and planning, and training of hospital staff
- provides recommendations on diagnosis and assessment
- offers recommendations on therapeutic interventions
- gives guidance on legal and ethical concepts in connection with dementia care.

See: http://guidance.nice.org.uk/CG42/Guidance/1-7/pdf/English
NICE 2010 (CG103) Delirium: diagnosis, prevention and management

This guideline notes that it can be difficult to distinguish between delirium and dementia, that some people may have both conditions and that, if clinical uncertainty exists over the diagnosis, the person should be managed initially for delirium. More specifically, it provides recommendations on the management of behaviour that challenges.

See: www.nice.org.uk/nicemedia/live/13060/49908/49908.pdf

NICE 2010 (CG90) The treatment and management of depression in adults

People with dementia are more at risk of depression, and most of the mental health co-morbidity that affects older people in general hospital relates to dementia, depression and delirium. The NICE guideline on dementia provides guidance on the management of dementia co-morbid with depression. This guideline provides further guidance on the treatment and management of depression.

See: http://guidance.nice.org.uk/CG90/Guidance/pdf/English