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Liaison Psychiatry Teams Operational Policy

Lead executive	Medical Director
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Type of document	Policy
Target audience	All CWP staff
Document purpose	To set out a jointly agreed operational framework for the liaison psychiatry teams of CWP

Approving meeting	SMH Care Group Governance and Business Meeting Neighbourhood Care Group Governance and Business Meeting	Date 13-Nov-19
Implementation date	13-Nov-19	

CWP documents to be read in conjunction with	
CP3	Health Records Policy
CA2	Assessment and Outreach Team Policy
GR1	Incident Reporting and Management Policy
CP1	Admission Discharge Transfers of Care Policy
CP20	Operational Policy for CRHT Teams within AMH Service line
AMWC1	Out of Hours Service Standard Operating Procedure West Clinical Service Unit
AMEC2	Out of Hours provision Mental Health Guidance
HR22	Supervision Policy
CP5	Clinical Risk Assessment Policy
MH1	Mental Health Law Policy Suite
MP16	Non-medical Prescribing Policy
CA3	Guidelines for the assessment and management of psychiatric emergencies (CAMHS)
IM10	Information Governance Policy

What is different?	Policy updated to reflect changes in the locations and extent of teams work. New pathways for different parts of the trust.
Appendices / electronic forms	No
What is the impact of change?	The change reflects the extent of the work but the nature of the work is the same.

Training requirements	Yes - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP.

Document consultation	
Clinical Services	East Liaison Team Manager, Wirral Liaison Team Manager
Corporate services	via policy discussion board
External agencies	Not applicable

Financial resource implications	None

External references
N/A

Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Comments
Does this document affect one group less or more favourably than another on the basis of:		
- Race	No	
- Ethnic origins (including gypsies and travellers)	No	
- Nationality	No	
- Gender	No	
- Culture	No	
- Religion or belief	No	
- Sexual orientation including lesbian, gay and bisexual people	No	
- Age	No	
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
N/A		
Is the impact of the document likely to be negative?	No	
- If so can the impact be avoided?	N/A	
- What alternatives are there to achieving the document without the impact?	N/A	
- Can we reduce the impact by taking different action?	N/A	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted. If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

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1. The Service

1.1 Introduction

The purpose of this document is to set out a jointly agreed operational framework for the Liaison Psychiatry Teams of Cheshire & Wirral Partnership NHS Foundation Trust (CWP).

Liaison psychiatry is the sub-specialty of psychiatry that focuses on the interface between psychological and physical health. Services provide specialist assessment and interventions for patients undergoing assessment and treatment in acute trust settings, both inpatient and outpatient.

1.2 Philosophy

People with mental health problems are never unfairly discriminated against as a result of age, culture, gender, sexuality, race or disability.

The patient is at the centre of all clinical decisions: "No decision about me without me."

The development of positive, trusting and supportive relationships between the liaison team and the patient is a core element of the service. In order to provide best care to the patient, the liaison team cultivates excellent relationships and collaborative working with other professionals involved in their care, particularly with colleagues in the acute trust.

The service is provided in a way that aims to reduce and/or manage aspects of risk by involving appropriate people, listening, planning and acting upon any concerns raised.

Staff act at all times in a professional and competent manner, keeping fully up to date with the most effective treatment methods, to deliver high quality services in an efficient and cost effective way.

All staff are valued, supported and given maximum opportunity to develop within their role.

1.3 Service aims & objectives

The aims of the liaison psychiatry service relates to different stakeholders:

1. For the patients, we aim to provide therapeutic, holistic and evidence-based assessments and interventions and sign post patients to appropriate services where required.
2. For the acute trusts, we aim to support acute trust colleagues with challenging clinical, legal and ethical dilemmas where there is an overlap between physical and mental health; improve staff safety; provide education and training to acute trust colleagues; and improve patient flow.
3. For commissioners, we aim to provide high quality information and value for money services.

For each team, the specific service objectives and performance indicators will be agreed annually with the Service Line Manager and Clinical Director. In general the service objectives and performance are expected to relate to national guidelines such as NICE guidelines and PLAN standards (psychiatric liaison accreditation network) and to local needs. The teams will keep CWP colleagues and CCG colleagues informed about national developments within liaison that relate to service objectives and performance indicators.

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1.5 Team Bases

Liaison Psychiatry services are provided at the following sites:

- Liaison Psychiatry Team Wirral University Teaching Hospitals NHS Trust
- Liaison Psychiatry Team, Countess of Chester Hospital
- Liaison Psychiatry Central Team, Leighton Hospital
- Psychological Medicine Service, Clatterbridge Cancer Centre
- Liaison Psychiatry East, Macclesfield District General Hospital

The service is managed by Cheshire & Wirral Partnership NHS Foundation Trust, within each locality. Services are provided to partner organisations under service level agreements or service specifications detailing services provided and funding arrangements.

Contact details, staff and information about referral procedure for individual teams is outlined in section 2.0.

2. The Teams

2.1 Chester Team

Team Base

Liaison Psychiatry Team
Accident and Emergency Corridor
Countess of Chester Hospital
Liverpool Road
Chester
CH2 1UL

Contact Details

Tel: 01244 364398
Fax: 01244 364350
Duty bleep 3323

Hours of operation & age

From the end of January 2020: the team operates a 24 hour service seven days a week, including bank holidays. The team accepts referrals of patients over the age of 16.

Referral pathway

Emergency referrals made directly to bleep-holder/telephone and a Mental Health/Self Harm pathway referral form is completed for referrals from AED.
Urgent referrals are contacted via bleep/telephone.
Routine referrals are faxed or sent to printer from Meditech (COCH electronic system).

2.2 Central Cheshire

Team Base

Liaison Psychiatry Central

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Leighton Hospital
Middlewich Road
Crewe
CW1 4QJ

Contact Details

Tel:	01270 612239
Fax	01270 273455
Duty bleep	2239

Hours of operation & age

Seven days a week
This team operates a 24 hour service.
The team accepts referrals of patients over age 16

Referral pathway

Emergency referrals made directly to bleep holder
Urgent assessment made to team base by telephone
Non-urgent referrals made by faxed referral form

2.3 East Cheshire

Team Base

Liaison Psychiatry East
Macclesfield District General Hospital
Victoria Road
Macclesfield
SK10 3BL

Contact Details

Tel:	01625 712091
Duty bleep	3082

Email: cwp.liaisonpsychiatrycentral@nhs.net

Hours of operation & age

Seven days a week
This team operates a 24 hour service
The team accepts referrals of patients over age 16

Referral pathway

All referrals made by online forms via email from the wards *and* informing bleep holder from AED.
Form to cwp.liaisonpsychiatryeast@nhs.net

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2.4 Wirral Team

Team Base
Liaison Psychiatry Team
Top Floor Block D
Arrowe Park Hospital
Upton
Wirral
CH49 5PE

Contact details
Tel: 0151 6047723
Fax: 0151 604 7499
Email: cwp.liaisonpsychiatryaph@nhs.net

Hours of operation & age
Seven days a week
24 hours a day
The team accepts referrals of patients over age 16

Referral pathway
Emergency referrals made directly to bleep-holder by telephone *and* Cerner
Urgent and routine inpatient referrals made to team base by Cerner
Routine outpatient referrals made by letter.

2.5 Psychological Medicine Clatterbridge Cancer Centre

Team Base
CReST Corridor
Clatterbridge Centre for Oncology
Clatterbridge Road
Bebbington
Wirral
CH63 4JY

Contact Details
Tel: 0151 482 7899
Fax: 0151 482 7621
email: heather.lee@nhs.net

Hours of operation & age
The team operates between 09:00 and 17:00 Monday to Friday, excluding holidays
The team accepts referrals of patients aged over 25 years [or younger patients after discussion with the TYA (teenagers and young persons') team]

Referral pathway
The team is able to accept routine & urgent referrals only, which are made directly to the team secretary in writing.

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3. The Staff

3.1 Team Manager

Team managers provide management leadership to staff within the Liaison Psychiatry Service. They ensure that teams function effectively and efficiently putting the service users at the centre of the service and working in a culture of collaboration and partnership, ensuring that services meet national and local performance targets.

Depending on the size of the team, some team managers have clinical roles undertaking assessments and providing evidence based advice on patient care.

3.2 Clinical Lead

The clinical lead is a band 7 nurse who has clinical and managerial roles. The clinical lead supports more junior members of the team with regular scheduled supervision and ad hoc supervision. She/he often takes a lead in induction of new junior clinical staff both nursing and medical. She/he often represents the team at various meetings, particularly with the acute trust. Depending on the team, she/he may be responsible for allocating priorities and work during each shift. She/he supports the team manager in organizing the team in terms of rotas, team meetings etc.

3.3 Liaison Psychiatry Nurse

Liaison Psychiatry Nurses undertake assessments, and provide evidence based advice on patient care. They consolidate their own knowledge, training and development into the care process to further enhance skills & practice. Liaison Nurses work within the multi-disciplinary team and provide on-going support to the clinical lead and team manager.

3.4 Liaison Medical Staff

Consultant psychiatrists provide medical leadership within the liaison team and they and their trainee doctors carry out medical assessments, diagnosis and medical treatments within the teams. Medical care of patients remains the responsibility of the treating hospital team or for outpatients, the GP. Consultants act in an advisory capacity and/or provide specialist treatment. Consultants have an important role in providing advice to liaison team colleagues. Consultants take a lead on providing mental health training to the general hospital staff. They also take a lead in strategy affecting the mental health of patients in the general hospital.

Within CWP, some liaison teams have very limited liaison consultant input. Therefore these teams are not resourced to be able to always guarantee face to face consultant input. Out of hours, the on call medical staff are consulted by the liaison team.

Trainee doctors are attached to some liaison teams. They assess patients and offer interventions according to their level of experience. The training and service delivery components of their role is regularly reviewed by the trainee and consultant along with the rest of the team. The trainee will receive regular protected supervision on a weekly basis.

SAS doctors also work in some liaison teams. They are experienced doctors who are supported to develop their skills and areas of expertise in line with the team's requirements and their own interests. They receive regular supervision and attend PDP groups.

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3.5 Liaison Clinical Psychology

Clinical Psychologists will deliver high quality evidence-based psychological interventions to both in and out-patients. The Clinical Psychologist will act in an advisory capacity to liaison team colleagues including supervising and supporting psychological informed assessment and interventions, including ensuring that staff delivering psychological therapies are appropriately trained and supervised. The Clinical Psychologist will oversee the collection of outcome data to determine effectiveness of psychological interventions provided by the liaison team. Clinical Psychologists will also provide mental health training to the liaison team and to general hospital staff including informal supervision and reflective practice.

Within CWP, some liaison teams will not have Clinical Psychology input.

3.6 Clerical and Administrative Support

The admin teams are non-clinical members who play a crucial role in providing comprehensive secretarial and administrative support to the team. Details of roles and responsibilities are as set out in the individual job description.

3.7 Roles & responsibilities

Much of the work of the liaison psychiatry teams involves urgent and emergency assessment of adults and older people. The teams are configured so as to allow sharing of common roles and responsibilities e.g. triage, prioritization, initial assessment to allow maximum flexibility. Individual staff and professionals bring specific skills and knowledge to the team and these are acknowledged and utilized by the teams in providing care for patients e.g. ASW assessment, psychological therapy, OPMH nurse assessment.

3.8 Induction and Supervision

Staff members receive an induction programme specific to the service, which covers:

- The purpose of the service;
- The team's clinical approach;
- The roles and responsibilities of staff members;
- The importance of family and carers;
- Care pathways with other services.

Team members are guided to the Supervision Policy HR22.

Every team member will receive regular clinical supervision and managerial supervision and this time will be protected. All liaison staff receive an annual appraisal and personal development planning.

Clinical team members in liaison are frequently in a position where clinical decisions need to be made urgently – for example patients who have self harmed and who may wish to go home. In addition to regular scheduled supervision, it is therefore important that team members can access ad hoc supervision to think through the decisions that need to be made. Such supervision may be with peers or with more senior team members depending on the situation. There will be occasions, particularly out of hours, where such opportunity to discuss dilemmas will be with on-call medical staff (higher trainee or consultant on call) rather than with liaison

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staff. All staff are able to contact a senior clinical and managerial colleague for advice at any time.

Team members may also need support regarding legal concerns. If a legal question is causing concern, this should be discussed with senior members of the team or senior medical staff on call who can then decide whether to seek solicitors' advice.

3.9 Team meetings

Each team has regular, scheduled team meetings. The purpose of the meetings is to ensure good communication within the team, and between the team and the rest of the trust. All team members are invited and the minutes are circulated to team members who are not able to attend (and it is acknowledged that in a team offering 24 hour cover only a small fraction of the team will be able to attend at any given meeting). Issues relating to the organization and smooth running of the team are discussed, along with clinical matters including lessons learned. Meetings are used to keep each team member up to date with developments in the trust. Team developments, achievements and concerns that need to be communicated to higher levels in the trust are identified.

Teams will also hold regular meetings with other services in CWP and with the relevant acute trusts where necessary and where resources allow. The purpose of all these meetings is to optimize the care for patients, either directly by improving communication about the care for particular individuals, or indirectly looking at strategy, pathways, and mutual learning and support.

4. Pathways

4.1 Services provided

Services provided by teams, where commissioned, and within financial and resource constraints include:

Self-harm

A service for patients presenting to general hospitals with self-harm or risk of suicide.
A therapeutic interview is offered: this involves an assessment of the risks involved but is also seen as a therapeutic intervention in its own right, supporting the individual to find ways of keeping themselves safe. As well as identifying risk factors, there is a review of needs including mental health, physical and social needs. Self-help & education, brief interventions, harm-minimization, sign-posting or referral to other services may be provided.

Emergency Department (ED)

A service for patients presenting to emergency departments provides assessment and management advice to ED. There is a big overlap between this and the self-harm service but referrals include assessment of other emergency or urgent presentations of mental health problems or assessment of capacity. Assessment is undertaken in ED. A close working relationship with ED is essential for the optimum functioning of this service.

Ward consultation

A service for inpatients in general hospital which provides assessment and management advice to the individual patient and/or the hospital based teams caring for them. Referrals can

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be emergency, urgent or routine presentations of mental health problems or difficulties adjusting to physical illness and treatment. This includes assessment for previously undiagnosed dementia, support in diagnosing or managing delirium and second opinion capacity assessments.

Outpatient psychological medicine service

An outpatient service for patients presenting with complex physical and mental health needs, including adjustment to physical illness and treatment, co-morbidity, functional somatic symptoms and organic mental disorders.

Education & training

Education and training provided to clinical staff within general hospitals. This will take the form of impromptu teaching and more formal teaching. This is seen as a core aspect of liaison teams.

Liaison with teams & services

Joint clinics, support to specific teams, ward areas or groups of patients may be provided where commissioned. Working with acute trusts regarding their policies and strategy where it will affect patients with mental health problems is also seen as a core part of liaison services.

4.2 Prioritisation of referrals

Referrals to teams will be prioritised according to the matrix below.
Local agreements will determine which inpatient areas receive priority for referrals.

Priority	Description
Emergency	High risk self-harm/suicide, unlikely to wait for assessment (ED or ward)
	Mental Health Act assessment (ED or ward) where liaison team input is necessary to support the patient while MHA assessment is being organized.
	Presentation with likely acute & severe mental illness, agitated or disturbed behaviour (ED or ward)
	Mental health presentation to emergency department where accepted for assessment
Urgent	Patients where mental health advice required for immediate management decision e.g. capacity
	Patients admitted following self-harm or self-injury
Routine	Non-urgent inpatient referrals

4.3 Response times

Response times are dependent upon level of demand and current resources such as staffing levels and are from acceptance of referral to initial clinical contact with the patient.

Priority	Response time
Emergency	Within 1 hour
Urgent	Same working day (referred before 14.00hrs
	Next working day (referred after 14:00hrs)
Routine	48 hours
Outpatients	Less than 13 weeks

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4.4 Assessments

When accepted as an appropriate referral to the team, initial assessment will be undertaken by a member of the team. For routine referrals, the team will determine who the most appropriate person to undertake the initial assessment is.

Many patients referred to the liaison team are physically unwell. The assessor will use their judgement in conjunction with the referrer to decide whether the assessment should be postponed to allow the patient to recover more before an assessment is undertaken. In some cases this will be appropriate (and this is usually the case for patients who are under the influence of alcohol or drugs). In other cases it will be appropriate for the patient to be seen – this may be the case where recovery is not expected; where there are concerns about current behavior or risks and an urgent decision needs to be made; or where the patient may be receiving treatment , but will have capacity to engage in an assessment.

Acute trusts are busy environments. Where possible, the assessor will arrange to see the patient in a private area to respect confidentiality. This may be challenging if the patient is bedbound but in all cases the dignity of the patient will be respected and their wishes sought regarding the most appropriate interview area. The liaison team member will balance the need for safety for the patient and themselves with the need to respect privacy. The liaison team member will always ensure that other staff know where the interview is taking place. If there are particular concerns about safety, it may be appropriate to request security staff or other staff to remain in sight of the interview.

Wherever possible, a collateral history will be sought and this is particularly important where the patient has cognitive difficulties, or is very young or elderly. Permission from the patient will be requested where they have capacity to give such permission. History can be obtained from hospital colleagues, relatives, and electronic records.

Many assessments are completed at initial contact, allowing a decision to be made as to clinical needs and ongoing management. The assessor will clearly indicate to acute trust colleagues the outcome of the assessment, including whether the team will follow the patient up or whether no further assessment/ intervention is planned unless a re-referral is made.

In the event that a patient has been assessed as being able to return home but has shared that they have access to harming themselves the assessor will agree a plan with the patient, and this plan should be documented in the clinical record. This may include having contact with a relative, contacting the care coordinator, or referring to the CRHTT. The aim is to reduce the risk to the patient and where possible, to remove the opportunity to self-harm.

4.5 Mental Health Act (MHA) Assessments

Many of the EDs act as places of safety (Leighton ED is exception to this) and therefore patients are often brought under section 136 for MHA assessment. There is an Approved Mental Health Practitioners (AMHP) rota and a duty doctor rota for such assessments. Social services are accessed during normal working hours and the Emergency Duty Team (EDT) out of hours.

As such MHA assessments do not directly involve liaison teams. The role of liaison teams is to support the smooth running of such assessments if there are problems: for example in advising

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acute trust colleagues how to access AMHPs, facilitating communication between MHA teams and supporting the patient if interventions are required while the MHA assessment is being organized.

MHA assessments are required at times for in-patients. Depending on the resources of each liaison team, the consultant liaison psychiatrist may or may not be in a position to undertake the RC role. The consultant psychiatrists will work with CWP mental health act office to advise acute trusts about the use of MHA on acute trust premises.

4.6 Risk Assessment

The liaison team follows the CWP Clinical Risk assessment policy (CP5). Clinical risk is defined as the potential for the occurrence of harm with respect to self harm or attempted suicide, violence, serious neglect of self or dependents, abuse and exploitation of or by others (including sexual abuse, emotional and child abuse) (Webster, 1995). It is the possibility of beneficial as well as harmful outcomes in a dynamic social environment where continuous change and uncertainty are present. Clinical risk assessment and management is the systematic process of collecting detailed clinical information about the service user's clinical history and current clinical presentation to allow for a professional judgment to be made identifying whether the service user is at risk of harming themselves or others.

As such, every patient is assessed for risk at their first assessment. If any risks are identified this or if there are any changes in the patient's needs or risks, the risk assessment is repeated on subsequent assessments. At the end of the assessment, a management plan is agreed that addresses the risks. In a liaison setting such a management plan is often cross-organisational – for example the approach to reducing the risks of falls usually primarily lies with the acute trust but the liaison team will need to be aware of these risks in terms of any recommendations regarding medication. Where the liaison team is making recommendations regarding imminent risk, such recommendations will be made verbally to acute trust colleagues immediately following their assessment and confirmed in writing within 4 hours.

Prior to every assessment, the liaison team member will estimate the risk likely to occur within the assessment by checking patient records and liaising with colleagues from the acute trust and from other teams within CWP. Where the risk is anticipated to be high, the liaison team member will take appropriate steps. These may include arranging to see the patient in an appropriate room, removing furniture if required; seeing the patient with a colleague (either from within the liaison team or from the acute trust); arranging for a more senior liaison colleague to be involved; informing colleagues of the assessment and expected time to finish; and alerting security staff and/or the police.

4.7 Safeguarding

Where a safeguarding issue is identified by acute trust colleagues, the acute trust will consult with their own safeguarding team. If a liaison practitioner identifies a safeguarding issue they will contact the CWP Safeguarding team either by email or phone call to share information or get advice. If there is any uncertainty about who has reported, the liaison practitioner will report the issue to CWP to avoid a problem being missed.

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4.8 Advice on medication

There are non-medical prescribers in several liaison teams and staff are directed to the Non-Medical Prescribing Policy (MP16).

Doctors and non-medical prescribers (NMPs) in liaison are often asked for advice about prescribing. Offering such advice is part of supporting acute trust colleagues in developing their knowledge and expertise in mental health. However any prescriber will make it clear whether such advice is generic advice based on general principles or whether it is based on assessment of an individual patient.

Both prescribers and non-prescribers in liaison will stay within the limits of their knowledge. Non-prescribers may suggest that a patient's medication is reviewed (for example if a patient says they do not find their antidepressant to be effective) but they will not recommend specific alternatives and will make the limits of their knowledge clear.

4.9 Interface with other services

The liaison psychiatry teams interface with a wide range of acute health, mental health, voluntary and social services either to accept referrals or to make these to other services. It is part of the role of the liaison services to keep up to date with developments and availability of these other organizations as well as cultivating collaborative relationships with them to ensure easier pathways for patients.

Referral to other services will be made with the agreement of the patient. Where referrals are made to other CWP teams, a discussion will be held with the team to which the referral is made wherever possible. This discussion will be documented on CAREnotes.

4.10 Discharge from service

Discharge from service back to the acute trust will be made following completion of assessment or intervention or when referral to another service is indicated. Before discharge, a review of the contact will be discussed with the patient. A brief written summary will be offered along with the option to be copied into future correspondence. A leaflet will be offered that explains CWP's approach to confidentiality and information sharing.

If this is not possible e.g. where the patient has not attended and no further contact has been established, a letter will be sent to the patient.

The GP will be informed whenever a patient is discharged from service.

4.11 Interventions

The following treatments may be provided by the liaison teams where commissioned.

- Self-help and educational materials
- Brief, focused psychological therapies
- Social support
- Clinical management

The teams provide hospital-based services only and are not able to provide care co-ordination for those patients requiring enhanced levels of community care.

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4.12 Transfers to Mental Health Inpatient Unit

Staff are directed to the Admission, Discharge and Transfer of Care policy (CP1).

If an admission is to be considered the HTT will be invited to assess the patient as part of gatekeeping to determine whether an admission is the most appropriate option.

Where a patient has been accepted for transfer to the mental health inpatient unit, the decision about managing the transfer will be made by the senior nurse in charge of the ward or ED. CWP staff, both in liaison and as part of MHA assessment, will contribute to this decision based on their clinical knowledge. Liaison teams are not resourced to be able to provide escort staff during transfers.

5. Quality and governance

5.1 Record keeping

Staff are directed to CWP's Health Records Policy (CP3).

Written assessments and clinical notes will be made within the patient's case notes as part of that episode of care. For inpatients, this will usually be the general hospital case notes to facilitate effective communication between the liaison psychiatry team and treating medical team.

Assessments will be recorded within the Care Notes electronic record for that patient, along with a risk assessment (CARSO).

Assessments will be reviewed as part of Clinical Supervision to review that they are to the standard expected within the team.

5.2 Confidentiality and information Sharing

The liaison team works within the CWP Information Governance Policy (IM10). This stresses the need to balance sharing information according to patient (and sometimes public) need on the one hand, and respecting confidentiality on the other. All patients are told that a summary of the assessment will be sent to their GP and a discussion is held as to who else would helpfully be copied in. All patients are offered the opportunity to receive a copy of the assessment. Where patients lack capacity to decide about this, and where a family member or carer has been involved, the family member/carer is asked if they would like to be copied in. As the name of the team denotes, the liaison team is proactive in advocating for greater sharing of information if the patient agrees to this.

6.0 Essential learning training needs analysis

Topic:
Liaison Psychiatry operational policy

Learning Objectives:
Awareness of and adherence to policy

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Staff Group	✓ if appropriate	Frequency	Suggested Delivery Method *(traditional/ face to face / e-learning / handout)*
Consultant (liaison team)	Y	once	handout within team
Specialist Registrar (liaison team)	Y	once	handout within team
Junior Doctor (liaison team only)	Y	once	handout within team
Liaison practitioner	Y	once	handout within team
Inpatient Registered Nurse	N		
Inpatient Non- registered Nurse	N		
Community Registered Nurse	N		
Community Non Registered Nurse	N		
Psychologists	Y	once	handout within team
Therapists	N		
Non-clinical	Y	once	handout within team
Clinical bank staff – regular workers	Y	once	handout within team
Clinical bank staff – Infrequent workers.	N		

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