The UCLPartners Integration Matrix

Integrating mental healthcare in general hospital settings

UCLPartners

In collaboration with

UCL INSTITUTE OF MENTAL HEALTH

The UCLPartners Integration Matrix

Integrating mental healthcare in general hospital settings

As health systems develop to tackle the challenges of aging populations and widening inequalities, physical-mental comorbidity is becoming the norm for patients rather than the exception. In acute hospitals, *at least* **one third of inpatients** will experience a diagnosable psychiatric illness (not including substance misuse or dementia), with this figure rising dramatically for older adults. Improving the integration of mental and physical healthcare has been **shown to support** improved patient outcomes, reduced lengths of stay, fewer readmissions, and improved adherence to treatment, as well as enabling 'whole person' care that meets the three quality domains (safe; effective; person-centred).

To support the integration of mental healthcare within acute hospital settings, UCLPartners has developed the UCLPartners Integration Matrix. This is a practical tool for assessing the maturity of integration between mental and physical healthcare services, generated through a combination of clinical expertise, existing innovations, and the standards set out in the 2019 **CQC report on mental healthcare in acute trusts**. It is purposefully broad-ranging, and the self-assessment can be completed quickly and easily – typically in under 30 minutes – and can be applied to the hospital as a whole or to individual wards.

The three dimensions of integration included in our matrix are:

1. **Normative integration**

   Where all hospital staff have a common frame of reference in relation to mental healthcare, with shared values and goals for service delivery.

2. **Clinical integration**

   The organisation of physical and mental healthcare into a seamless, patient-centred process. This will range from establishing shared guidelines and protocols to co-created and co-delivered care.

3. **Functional integration**

   The coordination of overarching clinical structures and operations e.g. electronic patient records, funding streams, and governance frameworks.

The three dimensions of integration can help you:

- Establish a baseline of existing practice
- Prioritise, breakdown and structure any changes to mental healthcare that you decide to make
- Define and measure success
- Identify if you are missing anything important

By using the matrix, it is possible to see a step-by-step journey to more integrated care in the hospitals.

Each of the three dimensions of integration have three levels, or stages, of maturity. Each stage builds on what has been achieved in the stage before, and represents a greater depth of integration. To help you identify where you are currently, the matrix includes self-assessment questions which detail the minimum requirements to meet each stage of maturity, as well as a set of actions to consider if you do not meet the threshold for that stage. As part of a process of integration, all dimensions must be considered but they **do not all have to occur at the same pace or target stage**. Included on the last page of the tool is a description of how each stage may be experienced by different staff groups, and, importantly, by patients. The patient statements were co-developed with people with lived experience of general hospital use and mental illness.

Using the matrix in this way will help to clarify the choices of the hospital trust around mental healthcare and the resource allocation required, supporting you with a **step-by-step journey** to more integrated care. The different dimensions of integration and the progressive stages of maturity can directly inform new or existing Mental Health Strategies and allow you to track your progress. As services move towards full integration, the number of processes and systems involved in treating a patient will reduce. The service will begin to **wrap around the patient** rather than being separated into distinct episodes of care. Additionally, care will be more proactive, with all patients who need mental health expertise receiving early assessment and treatment.

1. Normative Integration

Where all hospital staff have a common frame of reference in relation to mental healthcare, with shared values and goals for service delivery.

As part of Normative Integration, you will need to consider: *What is the attitude or ethos towards mental health in the hospital?*

Stage 1

Minimum Requirement for Stage 1 Normative Integration

- ☐ *Does the hospital have a board-level commitment to improving mental healthcare, with strong relationships between the Acute and Mental Health Trusts?*
- ☐ *Are there regular Operational meetings, e.g. at least monthly, between the Acute Trust and Mental Health Trust?*
- ☐ *Do clinical staff understand the role of the mental health liaison service and urgent/crisis mental healthcare pathways?*
- ☐ *Are mental health liaison services able to provide regular mental health training to clinical colleagues?*

Actions to support Stage 1 Normative Integration

1.1 Establish regular Operational meetings between Acute Trust and Mental Health providers, to focus on problem solving, planning care, and sharing knowledge. This should not only focus on crisis and urgent care, but also broader mental health need in the hospital.

1.2 Establish a clear route for escalation between the Acute and Mental Health Trust, with direct points of contact, daily, for clinical input/escalation.

1.3 Establish whether all staff are aware of the importance of mental health and its relevance for physical health e.g. by attending Mental Health First Aid or Making Every Contact Count training.

1.4 Mental health liaison teams to provide regular training to those teams with frequent or acute mental health demand e.g. A&E, acute medicine, older adults etc.

1.5 All new starters in A&E to shadow the mental health liaison team.

1.6 Check that the role of and pathways for mental health liaison services are fully understood by all clinical staff.

Stage 2

Minimum Requirement for Stage 2 Normative Integration

- ☐ *Does your hospital have a formal mental health strategy?*
- ☐ *Is there one executive level person accountable for mental health as part of their role?*
- ☐ *Does the hospital executive team receive updates on mental healthcare in the hospital?*
- ☐ *Does your hospital have a senior mental health coordinator?*

Actions to support Stage 2 Normative Integration

1.7 Develop a mental health strategy that considers both crisis care as well as the broader psychological and psychiatric needs of patients.

1.8 Establish a Mental Health Strategy Group, to improve and review the provision of mental health services. This should have several work streams e.g. for strategy, operations, workforce and governance, all accountable to the Strategy Team, who report into the hospital executive team.

1.9 Include patient representatives as part of the steering groups for these teams.

1.10 Appoint one member of the executive team as accountable person for mental health as part of their role.

1.11 Appoint at least one senior mental health 'coordinator' to work with the executive lead, and to focus on turning strategy into action.

1.12 Each ward to appoint a 'Mental Health Champion' to promote mental health and training amongst colleagues.

1.13 All new nursing intakes to have a full day of training dedicated to mental health as part of their preceptorship programme.

1.14 Establish or include within already existing Patient and Public Involvement and Engagement (PPIE) groups, a mental health patient focus group to better understand patient experience.

Stage 3

Minimum Requirement for Stage 3 Normative Integration

- ☐ *Does the hospital have a strong culture of 'whole person' care, rather than the mind/body split, with a clear mandate from the trust board?*
- ☐ *Does the executive team prioritise mental health via (at least) monthly mental health meetings?*
- ☐ *Is mental health training mandatory for all hospital clinicians and other relevant staff?*
- ☐ *Are there named mental health leads appointed across all wards and clinics?*

Actions to support Stage 3 Normative Integration

1.15 Establish a dedicated team with a joint membership across the Acute and Mental Health Trust to operationalise the mental health strategy.

1.16 Establish an executive-led mental health oversight meeting, in compliment to the Mental Health Strategy Group, with representatives from different groups e.g. the security team, safeguarding, emergency department, physicians, psychologists, occupational health, commissioning, and patient representatives.

1.17 Appoint named mental health leads across all wards and clinics, accountable for improving standards of mental health care within specified timescales for action as per the mental health strategy, presenting each month to the mental health oversight meeting.

1.18 Put in place mandatory mental health and psychological skills training for acute staff on a rolling basis in the same fashion as Basic Life Support i.e. face-to-face only, with annual refreshers.

2. Clinical Integration

The organisation of physical and mental healthcare into a seamless, patient-centred process.

As part of Clinical Integration, you will need to consider: *Which medical patients receive mental healthcare and from whom? Where are the mental health specialists located?*

Stage 1

Minimum Requirement for Stage 1 Clinical Integration

- ☐ *Does your hospital have a 24/7 mental health liaison service providing care for adult inpatients with severe or complex presentations, resourced to the* **Core24 standard***?*
- ☐ *Does your mental health liaison service include qualified psychological therapists?*
- ☐ *Does your mental health liaison team comply with the* **NICE guidelines'** *standard for urgent and emergency mental healthcare waiting times?*

Actions to support Stage 1 Clinical Integration

2.1 Resource mental health liaison teams to the **Core24 standard** (national baseline).

2.2 Employ qualified psychological therapists as core members of mental health liaison teams, to provide specialist and comprehensive assessment, formulation, and evidence-based interventions for inpatients or short-term outpatient follow-up.

2.3 Verify that your mental health liaison team is compliant with the **NICE guidelines'** standard for urgent and emergency mental healthcare waiting times, and identify and resolve any issues which impede this.

2.4 Secure sufficient space within the hospital building itself to house the mental health liaison team, to support ease of access and quick response.

Stage 2

Minimum Requirement for Stage 2 Clinical Integration

- ☐ *Do all hospital services follow service guidelines if embedded psychiatry and/or psychology is recommended?*
- ☐ *Do integrated psychological therapists/ psychiatrists operate as equal members in medical specialty teams, to deliver joint care planning and interventions, from the beginning of care?*
- ☐ *Have you identified the wards/services with acute or frequent mental health, learning disabilities, dementia, and safeguarding needs?*

Actions to support Stage 2 Clinical Integration

2.5 Resource the mental health liaison team with the skill mix to enable genuine multidisciplinary input for complex cases. This may include specialist nurses, psychological therapists, social workers or occupational therapists.

2.6 Integrate psychology/psychiatry in medical teams where this input is recommended in service guidelines. Such input could range from e.g. using teleconferencing to facilitate psychologically informed complex case discussions and supervisions with MDTs, to fully integrated psychiatrists who plan and deliver care in collaboration with specialty teams.

2.7 Secure specialist mental health training for pharmacists within acute trusts or ready access to a pharmacist with expertise in the use of medicines to treat mental health conditions, as well as access to all approved psychotropic medication.

2.8 Appoint ward link nurses for mental health, learning disabilities, dementia, and safeguarding where there are acute or frequent needs.

2.9 Identify opportunities for digital integration and partnership working across the care pathway e.g. virtual joint clinics at the interface of community-hospital care to work across physical/mental health/primary/secondary/ tertiary divisions, with input from psychiatry or psychology as appropriate.

Stage 3

Minimum Requirement for Stage 3 Clinical Integration

- ☐ *Is mental health related data (e.g. from screening) used to identify demand and inform resource allocation, alongside service guidelines?*
- ☐ *Are ward teams resourced to provide integrated mental-physical care when mental health demand is identified?*

Actions to support Stage 3 Clinical Integration

2.10 Develop or invest in digital screening and monitoring tools to identify hospital patients who may be in need of mental health support, particularly for long stay admissions or areas of high demand. See KCL's **Integrating Mental and Physical healthcare: Research Training and Services' (IMPARTS)** or a digital version of the Royal National Orthopaedic Hospital's **Stanmore Nursing Assessment of Psychological Status (SNAPS) tool** (NEWS chart style mental health monitoring).

2.11 Initiate joint ward rounds/clinics/fully integrated psychology or psychiatry (depending on need identified) in medical teams based on scoping work and data, where mental health need is most acute, complex, or frequent.

2.12 Resource mental health liaison teams to the skill mix and size to be able to provide specialist care for patients with addictions or learning disabilities. See the **Enhanced24 liaison model**.

3. Functional Integration

The coordination of overarching clinical structures and operations e.g. electronic patient records, funding streams, and governance frameworks.

As part of Functional Integration, you will need to consider: *How is mental healthcare for medical patients organised and funded? How much is clinical information shared?*

Stage 1

Minimum Requirement for Stage 1 Functional Integration

- ☐ *If mental health trust and acute trust electronic patient records are not interoperable, do mental health clinicians have access to both systems, and enough time to reliably share data between the two?*
- ☐ *Is there a clear and describable supervision and governance structure for mental health clinicians, particularly psychological therapists?*

Actions to support Stage 1 Functional Integration

3.1 Outline a clear standard operating procedure (SOP) between the acute and mental health trusts, detailing the reciprocal arrangement between the two trusts.

3.2 Establish at least monthly joint governance meetings between liaison teams, psychology, and acute managers to discuss incidents, quality assurance, and service improvements, with good attendance from both clinical and operational leads.

3.3 If mental health and acute trust electronic patient records are not interoperable, consider how to ensure reliable and consistent data sharing in collaboration with the informatics team, e.g. by employing admin staff or providing liaison staff with two monitors to make it easier to copy and paste information, and devising a plan to work towards interoperability.

3.4 Undertake a data quality audit to inform action plans for improving the consistency and reliability of mental health liaison team data.

3.5 Check that all hospital psychologists are receiving adequate supervision and have clear lines of management. For clinical psychologists, the **minimum standard** is 60–90 minutes of supervision for every 20 sessions worked. Newly qualified clinical psychologists will require more than this.

Stage 2

Minimum Requirement for Stage 2 Functional Integration

- ☐ *Is there a clear, 'gold-standard' governance framework in place for mental health clinicians (both psychiatry and psychology)?*
- ☐ *Do mental health professionals (both psychiatry and psychology) have robust leadership and clear lines of ownership and accountability?*
- ☐ *Is there an overall lead for mental health clinicians to act as a responsible officer?*
- ☐ *Are there processes in place to facilitate jointly delivered mental-physical healthcare, to respond to identified mental health demand?*

Actions to support Stage 2 Functional Integration

3.6 For all mental health/psychology/psychiatry clinicians in the hospital to be co-located in one entity e.g. a 'department' or 'faculty'. This would not equate to a centralised referral system but would have a 'psychiatry' wing and a 'psychological therapies' wing, with one 'integrated medicine lead'. Clinicians would therefore have two 'homes': (1) the service they are embedded in to provide integrated team-based care and (2) a mental health professional home for supervision and governance, and to foster better collaboration between mental health liaison teams and psychological therapists in the hospital.

3.7 For the integration lead to have protected non-clinical time to focus on developing psychology and psychiatry in the hospital e.g., business cases, scoping, organising and utilising graduates/trainees etc. This person must have a good understanding of the different needs of psychological therapists and psychiatric clinicians or could be a shared post between a psychologist and psychiatrist.

3.8 Establish mechanisms to enable integrated commissioning for responsive, jointly delivered mental-physical care e.g. contractual agreements between the Mental Health Trust and Acute Trust for joint ward rounds, clinics, or services. Such agreements should be agile enough to respond to locally identified mental health demand.

3.9 Consider how the EPR is configured to capture mental health data and support awareness and decision making e.g. how does it record mental health act status/ therapeutic observations/ structured care planning?

Stage 3

Minimum Requirement for Stage 3 Functional Integration

- ☐ *Is there clarity about who is accountable for the quality of mental health care delivered to patients whilst they are receiving care from an acute provider trust, including outpatient services?*
- ☐ *Is the hospital tracking different mental health related metrics to drive improvement and innovation?*
- ☐ *Does the hospital regularly audit the effectiveness and timeliness of its mental health provision?*

Actions to support Stage 3 Functional Integration

3.10 Establish the means to track different mental health related metrics e.g. prevalence, service demand and delivery, and quality and outcomes.

3.11 Work towards creating a culture in which data is routinely used to inform understanding of the mental health of patient populations, with a view to providing a seamless, integrated approach across the primary/secondary/ tertiary divide.

3.12 Establish regular auditing of clinical interventions offered as part of mental healthcare, particularly in relation to their effectiveness and timeliness, and how this compares with physical health interventions.

3.13 Invest in the technology that will enable the use of natural language processing (NLP) (or other tools) to convert free-text electronic patient records into meaningful data.

3.14 Invest in the technology that will provide clinicians with the option to transfer notes easily between different electronic patient records

How we'll know when we get there

Stage 1

What lived experience contributors say

> *"It can be difficult to get someone to take on what I'm saying as a genuine concern, so I have to fight for the mental health support I need. Sometimes it feels like I've fallen into a hole between things.*

Hospital staff perspective

Generally mental healthcare will be seen as important for patient care but as something to be delivered separately by psychologists or mental health liaison teams.

Mental health staff perspective

Mental health clinicians will feel supported by the acute trust and confident about their role and position. However, they may not feel that they clearly 'belong' to either the acute or mental health trust.

Stage 2

What lived experience contributors say

> *"Where there is joint mental and physical care, it gives me the feeling that staff hear me in terms of my mental health and this helps me to feel secure and safe.*

Hospital staff perspective

Staff will consider good psychological care for patients as a core part of the care they provide, recognising how difficult and sometimes traumatising illness and hospital stays can be. Closer working with mental health clinicians empowers staff with the knowledge and confidence to support the mental health needs of patients.

Mental health staff perspective

Mental health clinicians will have a clear identity and role as part of the hospital, both in terms of belonging to a department with a lead, but also in terms of being fully integrated into medical teams as equal members (where appropriate).

Stage 3

What lived experience contributors say

> *"I feel understood. The whole team understands the whole picture so I don't need to constantly repeat myself about my mental health, and I can concentrate on my physical condition. The worst aspects of general hospital care are eliminated so I don't leave with additional trauma.*

Hospital staff perspective

Staff will recognise their hospital as having a strong commitment to mental health. They will feel able and willing to discuss mental health demand and any problems with ward mental health leads, who in turn feed back to the executive team. Staff will also receive regular mental health training so will confidently and consistently provide whole-person, trauma-informed care for patients.

Mental health staff perspective

All staff will clearly understand the value and benefit to their teams of mental health work, as evidenced by the hospital's use of mental health metrics and data. Mental health staff will feel essential to the core business of the hospital.

UCLPartners

In collaboration with

UCL INSTITUTE OF MENTAL HEALTH