REPORT

Centre for Mental Health

Commissioning liaison psychiatry services

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Executive summary

Liaison psychiatry services offer specialist mental health expertise within general hospitals. Both the *Five Year Forward View for Mental Health* (2016) and the *NHS Long Term Plan* (2019) have committed to ensuring that all English hospitals with an emergency department have a liaison psychiatry service working to agreed quality and access standards.

This report is based on research that sought to identify the issues and challenges experienced by staff responsible for commissioning liaison psychiatry services in England, and to see if these issues and challenges were shared by hospital managers and mental health clinicians working in liaison psychiatry services.

We identified four key, interrelated issues for commissioners:

Funding and commissioning: Commissioners felt that liaison services had been developed idiosyncratically, often based on charismatic leadership from clinicians in hospitals, but that they were now much more tightly defined by national targets and frameworks which limited their flexibility to respond to local needs.

Systems and pathways: Liaison services were not always well connected with other mental health services in hospitals or in the community.

Partnership working and coproduction: There is an opportunity with the arrival of Integrated Care Systems for joint commissioning of liaison services which could help to improve their consistency and connections with other services.

Data: Commissioners did not feel they had enough data about the activities or outcomes of liaison services which reduced their ability to bring about improvements.

We also compared the views of commissioners, liaison psychiatrists and hospital managers. All agreed that liaison psychiatry services were an important part of any acute hospital and that they could generate savings. There was less agreement about how well they measure their outcomes and whether they should be more integrated with community services. All, however, were concerned about gaps in community services that led too many people to have to go to A&E in a mental health emergency.

We recommend:

1. Acute hospital-based liaison psychiatry services should adopt the outcome measurement framework proposed by the Royal College of Psychiatrists.
2. Acute hospitals should undertake a thorough audit of all of their mental health provision.
3. Local care pathways for mental health crisis care should be reviewed annually by clinicians, managers and commissioners.
4. Commissioners should work with liaison psychiatry clinicians and hospital managers to improve access to patients' mental health records, especially in emergency departments.
5. The Royal Colleges and academic institutions should collaborate to develop an interprofessional learning module to upskill both acute and community-based staff in the clinical management of mental health and long-term conditions and medically unexplained symptoms.
6. Commissioners, hospital managers and clinicians should work collaboratively on the planning of liaison psychiatry services.

1. Introduction

Liaison psychiatry services offer specialist mental health expertise within general hospitals. Both the Five Year Forward View for Mental Health (2016) and the NHS Long Term Plan (2019) have committed to ensuring that all English hospitals with an emergency department have a liaison psychiatry service. These commitments drew from evidence that liaison psychiatry services provide both improved mental health support to patients in acute hospitals.

This report is based on research that sought to identify the issues and challenges experienced by staff responsible for commissioning liaison psychiatry services in England, and to see if these issues and challenges were shared by hospital managers and mental health clinicians working in liaison psychiatry services.

We carried out a focus group of commissioners of mental health services working in clinical commissioning groups (CCGs) in England. This enabled us to identify key themes for a survey which went to other commissioners nationwide as well as psychiatrists working in liaison teams and hospital managers. We compared these to help us to understand the perspectives of each and consider what this means for the future commissioning of liaison psychiatry services. All quotes in this report were provided by commissioners with responsibility for liaison psychiatry and mental health services.

2. Key themes for commissioners

We identified four clusters of issues from our focus group with commissioners. The four are inextricably linked, but they all need attention to help improve the commissioning of liaison psychiatry services.

1. Funding and commissioning

Historically, the growth of liaison psychiatry services in the UK has been idiosyncratic, with some of the earlier services to emerge being led by a charismatic and resourceful clinician (Parsonage *et al.*, 2012). This idiosyncratic design has also historically been coupled with insecure and often unreliable funding, securing resources opportunistically and often with short-term arrangements. As one participant noted:

"…liaison service which was originally funded by non-concurrently Winter Pressures money because the local system…identified a problem with 'people presenting with mental health problems in ED' which could include anyone who is intoxicated. So money went in and, you know, I think probably more by accident than design to some extent, and it has kind of continued."

This situation is changing with the growing priority afforded to liaison psychiatry services in national policy and funding arrangements. But for some it has come at a price of reduced local flexibility. The *Five Year Forward View for Mental Health* requires hospitals in England to have in place liaison psychiatry services using the 'CORE 24' configuration – that is, access to these services 24 hours, seven days a week (Barrett *et al.*, 2015, Aitken *et al.*, 2014). This approach was developed in North West London (Plumridge, 2012) and is the basis for the Royal College of Psychiatrists' Quality Standards for Liaison Psychiatry Services (Brightey-Gibbons *et al.*, 2017). The commissioners we spoke to were critical of this model, believing it to be less applicable outside London:

"[The CORE 24 model] is…too prescriptive and I think that puts a lot of smaller CCGs at a massive disadvantage."

Commissioners felt that they were placed in a position whereby local need and local nuances were superseded by the need to provide a nationally mandated service model:

"All the systems are different, yet we are in a position that we are trying to impose one model which is drawn from small numbers of evaluations from services that have grown from particular circumstances and may not be transferable."

2. Systems and pathways

Commissioners told us that liaison psychiatry services within acute trusts must be considered within the broader delivery of mental health care in the community and within the hospital. They should not be seen in isolation.

One commissioner told us that they had identified significant levels of 'health psychology' provision in their acute hospital, costing millions of pounds but not well connected with the liaison psychiatry service. They felt that improving the links between these services and with community based services such as Improving Access to Psychological Therapies (IAPT) and having a more robust system of measuring outcomes would generate savings and improve coverage:

"The health psychology function in our acute hospital costs a lot of money. I am sure they do a very good job but it is not measured and if we connect that up with IAPT we probably don't need to train a load more practitioners in long term conditions etc because a lot of it is going on [already]… We've just got to connect the pathways."

While the drive within the *Five Year Forward View for Mental Health* is the delivery of a robust liaison psychiatry offer in Emergency Departments, commissioners articulated that most cost savings could be made elsewhere in the pathway. This is in line with the findings of previous research (Tadros *et al.*, 2013, Parsonage and Fossey, 2011). As one commissioner pointed out:

"Well the big numbers are in the back end of the acute hospitals aren't they? It's not acute mental health at all, its frail older people."

Commissioners appeared frustrated that the approach to delivering mental health and psychological interventions continues to be idiosyncratic and often driven by the clinical interests of consultant physicians. There was a perceived lack of coordination within and across clinical departments, with the potential for a number of complications. First, there is no clear understanding of the net cost of delivering mental health interventions across the hospital. There is also no way of accurately recording the type and number of patients that receive interventions, what these interventions are, and importantly what the outcomes are. Second, some concerns were raised by the commissioners about clinical governance. Who is providing supervision and clinical governance for these disparate clinicians? The Royal College of Psychiatrists' guidelines for liaison psychiatry accreditation propose that appropriate governance structures should be an integral element of any service (Brightey-Gibbons *et al.*, 2017). Mental health clinicians, such as psychologists, working within outpatient clinics, may not have any formal connection with liaison psychiatry teams working in the hospital.

3. Partnership working and coproduction

Integrated Care Systems (ICS) are being introduced into all areas of England (NHS England, nd). Mandated in the NHS Long Term Plan, ICSs are designed to bring commissioners into closer partnership with one another and with the providers of health services in a larger geographical area than most CCGs cover (of approximately one million population). Existing arrangements to jointly commission liaison psychiatry services were seen as positive by survey respondents, and commissioners in the focus group felt that the move towards ICSs may be potentially beneficial for liaison psychiatry services.

However, it was also noted that partnership working remains one of the biggest challenges for commissioners:

"…if you have a system that starts off being very sceptical and reluctant you need something that starts to prompt the dialogue … I find it very difficult to get into a co-commissioning dialogue with either my acute or mental health trust on [liaison psychiatry] that really is meaningful"

"…we reviewed our [mental health] services two years ago and they are performing really well and actually our clinical leads didn't want to hand over that shared commissioning arrangement to the acute [hospital]s – they are very passionate about it and didn't want anything that might place that at risk."

4. Data

Data, or the lack of it, would appear to be one of the most challenging areas for commissioners, and this is particularly pertinent for liaison psychiatry. With only a few exceptions in England (for example, provision at the John Radcliffe Hospital in Oxford, where inpatient acute services are commissioned by the JR and services in ED are provided by the local mental health trust), liaison psychiatry is provided by mental health providers who deliver their expertise within the acute hospital. This often means that data systems are not compatible and liaison psychiatry staff are recording in multiple notes (Parsonage *et al.*, 2012). This may become worse as specialist services are consolidated on fewer sites. Fragmentation of records and lack of continuity has the potential to become a significant problem. Alongside the obvious clinical and time management challenges, this also means it is very difficult for commissioners to access data to effectively understand the impact these services are having:

"Well you can't track to what extent their people who are impacting on acute hospital and also actually on what secondary care, mental health case-loads because you have all of the information sharing issues there."

"The difficulty… being able to pull the data from the acute providers that says 'actually because there is a [liaison psychiatry] team in place, they have saved you x number of days in inpatient admission, your length of stays have been reduced', all of that rich data stuff that actually should be presenting a case or showing that actually helping people to get back into the community quicker…"

Commissioners argued that obtaining good data on mental health admissions – or, more importantly, on patients who have a co-morbid mental health presentation – is more to do with the quality of the initial coding of patients.

"What you actually get out is only as good as the coding that happens in ED."

Having better quality data would empower commissioners to make more informed decisions about service provision across the entire patient pathway.

"….the sheer number of ED breaches associated with mental health… trying to understand the problem of how our patients get there in the first place and then really robustly answer the question 'what proportion of people seen by liaison psychiatry had a medical problem that necessitated their attendance at ED?'"

This is a perennial problem and the challenges of poor data have been identified by both the Royal College of Emergency Medicine (Swires-Hennessy and Hayhurst, 2017) and the Royal College of Psychiatrists (Brightey-Gibbons *et al.*, 2017). Without access to accurate and up-to-date mental health clinical records it is not possible to undertake a comprehensive mental health assessment. Swires-Hennessy and Hayhurst (2017) also point out busy staff in emergency departments do not always accurately record mental health presentations, often focusing on physical injuries. This incomplete or partial clinical picture may have an impact on decision-making further along the patient pathway.

As well as the problems associated with accessing mental health clinical records, problems with accessing basic information about liaison psychiatry service performance was also identified as a problem by all respondents. Gathering data on performance appears to be idiosyncratic and often driven by the requirement of local services to justify and account for their effectiveness to funders (Parsonage *et al.*, 2012) rather than as a tool for service development and improvement.

Nevertheless, a set of principles for data collection has been developed to aid services (Trigwell *et al.*, 2015; Fossey and Parsonage, 2014). This research did not investigate whether the framework for routine outcome measurement in liaison psychiatry (FROM-LP) has been widely adopted. Nor have we explored how this data is used to inform service managers or commissioners or if it is used as a tool to improve services.

3. Comparing the views of commissioners and providers

Our survey sought the views of commissioners, clinicians in liaison psychiatry services and managers in acute trusts. This brought to the surface different views about the value for money liaison psychiatry services offer, the ways they link with other mental health crisis services and how their outcomes are measured.

Value for money

A large majority of respondents agreed or strongly agreed (83.2%) that liaison psychiatry can save the acute trust money. However, a far higher percentage of clinicians agreed or strongly agreed (91.5%) with this statement compared to commissioners (64.3%).

This view is supported by research that provides a compelling argument about the economic burden of mental and physical co-morbidities (Bermingham *et al.*, 2010, Naylor *et al.*, 2012) and that suggests liaison psychiatry services can save money in acute trusts (Parsonage and Fossey, 2011; Tadros *et al.*, 2013) with a recent French study also finding similar economic benefits (Yrondi *et al.*, 2016).

Most respondents agreed that liaison psychiatry provision should be a key function in acute settings (83%), while a smaller majority (59%) of respondents agreed that liaison psychiatry should be integrated into community services, despite some evidence suggesting that provision in primary care had an impact on outcomes for patients and GPs and was shown to be cost-effective (Parsonage *et al.*, 2014).

Crisis services and liaison psychiatry

A large majority of survey respondents (83%) agreed that patients in mental health crises were being signposted to Emergency Departments (EDs) despite the concerns raised by the Royal College of Nursing about the appropriateness of using Emergency Departments as a place of safety (Merrifield, 2017). The Commissioning Dashboard (NHS, 2018) is driving the commissioning of liaison psychiatry provision in EDs and the Royal College of Emergency Medicine has developed guidelines for the treatment of patients in mental health crisis (Swires-Hennessy and Hayhurst, 2017). This may eventually alleviate some of the challenges.

A majority of respondents also agreed that GPs were not equipped to manage patients in mental health crises (87%) and there was agreement amongst respondents that acute staff are also not trained to understand mental illnesses (81%). Therein lies a persistent ambiguity. Psychiatrists, hospital managers and commissioners all agree that GPs are not managing mental health emergencies well, and acute hospital staff do not have the adequate training, yet EDs appear to be the default option when people face a crisis. As one commissioner commented… “sometimes patients are being sent to ED to get a Zopiclone out-of-hours prescribing service, the misuse of ED.”

What came across very strongly in the responses to the questionnaire and in the focus group, particularly among clinicians, was consistency in agreeing that community services were not coping well with demand (92%).

Outcome measures

There was disagreement between clinicians and commissioners about whether clinical outcomes data was routinely collected by liaison psychiatry teams: nearly 86% of commissioners disagreed or strongly disagreed with this statement compared to 69% of clinicians. And when asked about whether patient experience measures were routinely collected, 35% of both commissioners and clinicians were unsure, while 50% of commissioners said they were not and 48% of clinicians said they were.

4. Conclusion

This pilot research is the first time that commissioners have been interviewed about their views on the delivery of liaison psychiatry services, and then these views tested against a broader range of clinicians and hospital managers. On the whole these three groups broadly agree on the challenges that liaison psychiatry services face and how they could be improved. Where significant differences in responses were identified these related to the collection of both clinical and user-reported outcome measures and a degree of doubt among commissioners as to the economic benefits of delivering liaison psychiatry services – a view that was not shared by clinicians.

Recommendations

1. **Acute hospital-based liaison psychiatry services should adopt the outcome measurement framework proposed by the Royal College of Psychiatrists** (Trigwell *et al.*, 2015 - second iteration FROM-LP (II) is in production and due for publication later in 2019). The data collected using this framework alongside performance data should be shared regularly with commissioners.
2. **Acute hospitals should undertake a thorough audit of all of their mental health provision** and this should be done in collaboration with mental health commissioners, clinicians and the hospital management team. This audit should focus on identifying where services are operating in isolation and consider the clinical governance and resource implications.
3. **Local care pathways for mental health crisis care should be reviewed annually** by clinicians, managers and commissioners. This should form part of the implementation of the NHS Long Term Plan at ICS level, for which there is significant investment planned over the next five years and which will require a whole system approach across all mental health crisis services to achieve the best outcomes.
4. **Commissioners should work with liaison psychiatry clinicians and hospital managers to improve access to patients' mental health records**, especially in emergency departments.
5. **The Royal Colleges and academic institutions should collaborate to develop an interprofessional learning module** to upskill both acute and community-based staff in the clinical management of mental health and long-term conditions and medically unexplained symptoms. This should draw on the existing Royal College of Psychiatrists' CPD module, Psychiatry for the modern physician: common psychiatric presentations in general medicine.
6. **Commissioners, hospital managers and clinicians should work collaboratively on the planning of liaison psychiatry services.** They should also meet regularly to review the performance of services to identify where service improvements and patient benefits could be better achieved.

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