2022/23 CQUIN Guidance

Biopsychosocial assessments by Mental Health Liaison services

NHS England and NHS Improvement

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Indicator Specification

CCG12: Biopsychosocial assessments by MH liaison services

Description	Achieving 80% of self-harm[1] referrals receiving a biopsychosocial assessment concordant with NICE guidelines.	
Numerator	Of the denominator, those that had evidence of a comprehensive biopsychosocial assessment concordant with NICE guideline Section 1.3 of CG133 including: • Assessment of needs • Risk assessment • Developing an integrated care and risk management plan[2]	
Denominator	The total referrals for self-harm to liaison psychiatry.	
Exclusions	N/A	
Data reporting and performance	Quarterly submission via national CQUIN collection. See the section on *Understanding Performance* in the CQUIN 2022/23 guidance for details about auditing as well as data collection and reporting. Data will be made available approximately six weeks after each quarter. Performance basis: Quarterly.	
Scope	Services: Mental health liaison teams	Period: All quarters
Payment basis	Minimum: 60% Maximum: 80%	Calculation: Quarterly average %

Supporting documents

- Mental Health CQUIN Future NHS Collaboration Platform (contact policy lead for access)
- **New** draft NICE self-harm guideline (published on 18 January 2022)
- NICE clinical guideline CG16, Self-harm in over 8s: short-term management
- NICE clinical guideline CG133, Self-harm in over 8s: long-term management
- NICE quality standard QS34, Self-harm
- NICE/NHS England guidance on liaison urgent and emergency mental health services for adults/older adults
- HQIP assessment of clinical risk in mental health services

[1] The term 'self-harm' for this CQUIN is defined as in the NICE guideline to refer to any act of self-poisoning or self-injury carried out by an individual irrespective of motivation. This excludes harm to the self arising from excessive consumption of alcohol or recreational drugs, or from starvation arising from anorexia nervosa, or accidental harm to oneself. Please see the Mental Health CQUIN Future NHS Collaboration Platform for further information about identifying codes for self-harm referrals in local data sets

[2] NHS Personalised care and support planning describes best practice for care planning: https://www.england.nhs.uk/ourwork/patient-participation/patient-centred/planning/

Policy aims and rationale

This CQUIN has been developed by NHS England and Improvement's national mental health team in consultation with the National Confidential Inquiry into Suicide and Harm (NCISH), the Royal College of Psychiatry's Liaison Faculty and the Royal College of Emergency Medicine's mental health committee. Leading experts from NCISH have been contracted by NHS England and Improvement to support all local teams to implement the CQUIN (more detail in section below).

The intention of this CQUIN is to improve care for people of all ages who have self-harmed and attend emergency departments, specifically seeking to:

- reduce risk of repeat self-harm; and
- prevent suicide
- improve patient experience of mental health care in A&E

NICE CG133 guideline (section 1.3) recommends mental health liaison services undertake comprehensive biopsychosocial assessments for people who have presented to emergency departments due to self-harm.

People who have self-harmed are at much greater risk of future episodes of self-harm and suicide than the general population. It has been estimated that one in five people will repeat self-harm in the year after a self-harm related hospital attendance, and that the risk of suicide is elevated by between 30 and 100-fold in the year after self-harm[3,4]. This includes children under the age of 18, where a report by the National Inquiry in to Self-harm among young people[5] and media coverage has described the rise in teenagers self-harming as an 'epidemic', who often find it difficult to seek professional help.

However, despite good evidence that shows that conducting biopsychosocial assessments and care planning can significantly reduce the risk of repeat self-harm and suicide, the proportion of people who receive an assessment from mental health professionals in emergency departments has long-remained disappointingly low (studies estimate this to be ~50% of people).

This CQUIN presents an opportunity to address an issue which has long been highlighted by NCISH as one of the top priority actions that NHS services can take to prevent harm and suicides. There are few other presenting conditions with such a high risk of mortality, where people are routinely discharged from EDs without

[3] Hawton et al., 2003
[4] Cooper et al., 2005
[5] https://www.mentalhealth.org.uk/file/1248/download?token=r23RZDZJ

receiving the evidence-based interventions that could reduce this. The expansion in recent years of 24/7 liaison psychiatry teams working in every emergency department presents an opportunity to seek to bring a step change in the quality of mental health care in emergency departments.

The proposed CQUIN seeks to achieve a reduced risk of repeat self-harm and prevent suicide for all ages by driving improvement in the coverage and quality of care by implementing NICE guidelines for meeting the needs of self-harm presentations, including detail on the assessment *(NICE self-harm guideline CG16[6] and NICE self-harm quality standard QS34[7])*. The guidance requires awareness and response by all ED staff to make early referrals, and on specialist mental health staff working in EDs (on site liaison mental health teams in majority of cases) performing a comprehensive biopsychosocial assessments, care planning and brief interventions.

CQUIN scope

The teams in scope are any liaison mental health team and/or CYP equivalent mental health services who provide response to referrals to EDs, and deliver biopsychosocial assessments. Although the majority of liaison teams are funded by mental health providers, it is understood that a very small minority of liaison services are entirely funded through a provider other than the mental health provider (such as via the acute trust or children's trust contract). These services will also be in scope of this CQUIN indicator.

For more information on implementation of the CQUIN scheme, please see section 19 of the CQUIN 2022/23 guidance.

Patients in scope are all those who have self-harmed, defined in the NICE guidelines as any act of self-poisoning or self-injury carried out by an individual irrespective of motivation. This excludes harm to the self, arising from excessive consumption of alcohol or recreational drugs, or from starvation arising from anorexia nervosa, or accidental harm to oneself.

It is expected that staff record biopsychosocial assessments on patient records. CQUIN data reporting will take place on a quarterly basis, via submission to the national CQUIN data collection. Each quarter, in scope Trusts are expected to self-audit a random sample of 100 records per quarter (or all records where there are fewer than 100 records); you can find more detail on this process in the 'Understanding Performance' section of the Commissioning for Quality and Innovation (CQUIN) scheme for 2022/23 annex document. Many Trusts will have

[6] 'Self-harm in over 8s: short-term management and prevention of recurrence' (https://www.nice.org.uk/guidance/cg16)
[7] 'Self-harm' (https://www.nice.org.uk/guidance/qs34)

more than one liaison team, and in these cases, the minimum requirement is for 100 records per quarter across all the teams in the Trust, broadly proportionate to the size of each site or the number of self-harm attendances at each site. An audit tool has been developed to assist with the audit process. This is shared below at **Annex A**

New evidence published in January 2022

- NICE published a new draft NICE self-harm guideline on 18 January 2022. This represents the first update to the self-harm guidance in 11 years and is well timed to inform implementation of this CQUIN.

- At the time of launch of this CQUIN, the existing guideline (rather than the new one) will be the basis of the CQUIN. This is because the new guideline remains in draft and it is not possible to pre-judge the outcome of the public consultation. However, all professionals are encouraged to familiarise themselves with the new draft guidelines. It should be noted that the relevant sections (1.3 in the current guideline and 1.5 of the new draft guideline) are not significantly different. The audit tool template at **annex A** has been 'future-proofed' to include some of the key expected changes to the guidance. For ease of reference, **Annex B** sets out the differences between the current guideline (section 1.3) and the new draft guideline (section 1.5) on psychosocial assessments.

- A new qualitative study was published on 17 January 2022 which sought experiences on why people don't receive psychosocial assessments in emergency departments after self harm. An extract is set out below:

This study indicated that people often do not receive a psychosocial assessment because they leave the emergency department early. Reasons for this included long-waiting times, feeling anxious, not having visible self-harm, perceptions of the act and intention to self-harm again.

People may benefit from waiting in safe and private spaces, with regular check-ins from staff. These check-ins could be opportunities to humanise the process of seeking emergency medical care for self-harm. The methods of self-harm or a person's mental capacity should not influence whether they receive a psychosocial assessment. Increased medical training on reducing the stereotypes associated people with self-harm could increase psychosocial assessment prevalence in emergency departments.

Further considerations and recommendations alongside implementation of the CQUIN

Below are some further considerations relating to the CQUIN, including a mixture of responses to questions during the consultation and further suggestions for implementation to support this care pathway some of which extend beyond the specific scope of the CQUIN scheme (but have been highlighted as important in improving self-harm care in EDs).

- **Gaming:** feedback during consultation suggested that as the CQUIN is a self-assessed audit, it could be easily gamed. This is recognised, and NHSE/I therefore hopes that it is not treated as a check box exercise to achieve the financial incentive, which would still require effort from teams but with minimal gains to patient care. Rather, the intention is to appeal to the intrinsic motivation of clinical teams to use the clinical audit process to improve an area of mental health care that has long been identified as among the highest national priorities for suicide prevention.

- **Quality improvement and clinical leadership:** teams are encouraged to consider quality improvement initiatives in implementing the CQUIN, including senior clinical leaders reflecting together with their teams on the quality of assessments, with a view to improving the quality of assessments and care planning across the team.

- **Ending the practice of requiring patients to be 'medically cleared' before liaison psychiatry teams can attend.** There is sometimes a misconception that it is a national requirement for patients to be medically cleared before referring to liaison psychiatry. National guidance (p32) in fact states the opposite - that liaison psychiatry services should be notified and seek to attend as soon as a mental health need is identified and the person is ready to be seen, **working in parallel with physical health care pathways**. It further states that waiting for patients to be 'medically cleared' before referring to liaison psychiatry causes undue delays in ED pathways, and in the context of this CQUIN it may increase the likelihood of people leaving the department before they have had the opportunity for a biopsychosocial assessment.

- **Routine outcome measurement** RCPsych's Liaison Faculty has published a framework for Routine Outcome Measurement in Liaison Psychiatry (FROM-LP) that seeks to measure patient and clinician reported outcome measures as routine in all liaison psychiatry services. All liaison psychiatry

services are encouraged to adopt this as soon as possible, if they are not doing so already.

- **Patient cohort beyond those who have self-harmed:** the priority is for patients who have self-harmed given the evidence base and high risk of repeat harm for this group. Some more established services felt that the CQUIN wouldn't be stretching if limited only to people who had self-harmed (and for example requested that they include people with thoughts of self-harm in their CQUIN project). While this isn't technically the scope of the national CQUIN, all services are encouraged to go beyond this by embedding the practice of carrying out biopsychosocial assessments for all patients with mental health needs, beyond just those who have self-harmed.

- **Ensuring ED teams make referrals to liaison psychiatry:** dataset linkage of the Emergency Care Data Set and Mental Health Services, suggests that a large proportion of people who attend EDs with mental health needs, do not get referred to liaison psychiatry teams. All liaison mental health teams are encouraged to work with emergency departments to ensure that all mental health attendances are referred to them. The Royal College of Emergency Medicine has issued a toolkit for emergency department staff in supporting people with mental health needs.

- **Data quality in the ECDS:** all EDs are now returning data via the ECDS, and mental health liaison teams are asked to work with ED clinicians and BI teams to ensure that mental health coding is as good as possible. The ECDS includes data on chief complaint, diagnosis and injury intent, which allows identification of a subset of codes that are deemed to be 'mental health attendances'. Full completion of the 'injury intent' field is particularly important to identify self-harm attendances when the chief complaint may have been recorded as a physical health reason for attending ED. For example, in case of an overdose, the chief complaint might be recorded as 'self harm' but it could also be recorded as 'poisoning', in which case it would need the 'injury intent' to be further recorded as self-harm to be able to identify in the data set that the attendance was mental health related.

Support

The Mental Health Team at NHS England and NHS Improvement will offer support throughout the 2022/23 CQUIN scheme.

NCISH has been contracted by NHSE/I to offer support to local services on this CQUIN, given their extensive research in this field, this will include:

- **A virtual kick-off event covering on Wednesday 2nd February:**
  - an update on the evidence base around hospital treated self-harm and provision needed to achieve the CQUIN
  - the central importance of biopsychosocial assessment
  - an introduction to the CQUIN and guidance on self-audit
- **Quarterly interactive webinars:**
  - update on new evidence
  - an opportunity for sites to share progress and learning
  - advice on audits
  - interactive component to answer queries
- **Regular email contact and support**

Support **from the NHSE/I national** team includes:

- **A Mental Health CQUIN monitored inbox**: England.MHCQUIN@nhs.net will be continually monitored to answer any questions or queries that you might have about the scheme.
- **FutureNHS Collaboration Platform–** will provide a range of useful resources to help you manage the CQUIN schemes. This includes supporting documentation, FAQs, and more. A discussion forum on this page is available for discussion between providers.

If you would like support in other ways please contact us on England.MHCQUIN@nhs.net and we will work on accommodating your request.