**2022/23 CQUIN FAQ’s**

CCG12: Biopsychosocial assessments in mental health liaison services

# Policy guidance

What are we counting as the 100% that we need to achieve 80% of?

As per the indicator specification, the denominator for this CQUIN (the 100%) is the referrals for self-harm to liaison psychiatry that have been randomly selected for audit. Of that denominator, the CQUIN target is that 80% have to have had had evidence of a comprehensive biopsychosocial assessment concordant with [NICE guideline Section 1.3 of CG133](https://www.nice.org.uk/guidance/cg133/chapter/1-guidance#psychosocial-assessment-in-community-mental-health-services-and-other-specialist-mental-health) including:

* Assessment of needs
* Risk assessment
* Developing an integrated care and risk management plan

What constitutes a full biopsychosocial assessment?

We are not setting a precise definition at a national level (beyond what is in the NICE guidelines) of what constitutes a full assessment. Rather we will rely on the judgement of local clinical teams and colleagues conducting the audits to review whether the assessment was in line with the requirements and spirit of the NICE guidance.

An [audit tool](https://future.nhs.uk/MHCQUIN/view?objectID=33191024) has been provided as a guide to help self-audits. It has two purposes: to act as an aide memoire for the components of psychosocial assessments based on the NICE guideline, but more importantly to support local quality improvement work - self-audits may help to identify areas of practice that services wish to improve. The latter is not formally part of the CQUIN reporting process.

Use of the tool is not mandatory. Experienced clinicians may want to use their own judgement on whether assessments are consistent with the spirit of the NICE guidelines instead. However, we would suggest that using the tool might help with local quality improvement activity. The tool is a *guide*. We would not expect every filed to be completed for every patient and neither do we expect individual self-audit forms to be returned to the CQUIN team. Neither is it necessary for every item to be endorsed for an assessment to meet the required threshold.

In addition to the NICE guidance, further information on assessments are included in sections 1.3 and 1.5 of the [Service User Experience in Adult Mental Health NICE clinical guideline](https://www.nice.org.uk/guidance/cg136/chapter/1-Guidance#assessment-and-referral-in-a-crisis) and [quality standard.](https://www.nice.org.uk/guidance/qs14)

For more information on biopsychosocial assessments, please refer to page 44 of [Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care](https://www.england.nhs.uk/wp-content/uploads/2016/11/lmhs-guidance.pdf)

How will providers demonstrate they have met the indicator?

Providers will be required to submit audit data to demonstrate meeting of the this CQUIN indicator to a national collection on a quarterly basis. You can find out more about the collection in this [document](https://www.england.nhs.uk/publication/combined-ccg-icb-and-pss-commissioning-for-quality-and-innovation-cquin-indicator-specification/), with further details will be made available in due course.

For the quarterly collection, providers will only be required to submit the numerator and denominator for the indicator. To support providers in calculating their numerator and denominator for the quarterly self-audits, a [CQUIN Audit Spreadsheet](https://future.nhs.uk/MHCQUIN/viewdocument?docid=130560357) has been provided. The audit spreadsheet will provide a record of the quarterly self-audit been completed and ensure providers can evidence the audit to their commissioners (if this is required/requested). Clinicians can complete the audit spreadsheet whilst auditing by either using their clinical judgement and/or using the developed [audit tool](https://future.nhs.uk/MHCQUIN/view?objectID=33191024) (see question above).

Is there a time frame for how soon the biopsychosocial assessment needs to be done by after referral?

National guidance states that liaison psychiatry teams should respond and commence the face to face assessment within 1hr for referrals from emergency departments (or emergency referrals from wards) and within 24hrs for all other referrals from inpatient wards

There is no set guidance on how long the assessment should take and this is likely to vary by individual. Previous estimates that have informed the national guidance suggest that biopsychosocial assessments take on average around 60-90 minutes, but some may need longer and some may be done more quickly.

**Can we also get the term 'self-harm' clarified as the CQUIN definitions have**

**caused some confusion?**

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.

Is this an all age CQUIN, should we be including self-harm referrals to our CAMHS team that operate in ED as well?

Yes, this CQUIN is inclusive of all ages. The scope is any liaison mental health team and /or CYP equivalent mental health service who provide response to referrals to emergency departments and deliver biopsychosocial assessments

What happens with patients that decline or self discharge prior to assessment?

We wouldn’t expect that 20% of people would refuse to complete the assessment or would self-discharge prior to assessment and therefore the thresholds should allow for this.

Is there an expectation we achieve 80% each 1/4 or at the end of the CQUIN?

The performance is based on an average across the quarters of the year. So a provider doesn’t need to meet 80% in every quarter as long as it is exceed in other quarters.

We expect that some services will be undertaking quality improvement projects to support the CQUIN, and in that context they might hope to see gradual improvements over the course of the year.

We don't have a specific liaison offer for U18s, but Core 24 services for all 18+ How do we/ do we include the U18s?

Even without a standalone on-site liaison team, it is expected that CYP presenting to EDs having self harmed should receive a biopsychosocial assessment from another team, such as a CYP community or crisis team who would assess CYP in ED. In these instances, we would still expect the person to receive care in line with NICE guidelines and for it to be recorded on the person’s care record.

At a national level, CYP MH attendances/activity in A&E, crisis and acute services accounts for ~5-10% of total demand. Therefore even if it is more challenging to meet the CQUIN (eg because there are fewer on site 24/7 liaison services), the tolerance levels in the CQUIN should allow for the CQUIN to be met.

Focusing more on service improvement, can we think about best practice for liaison risk assessments and formulation as a result of this CQUIN?

Yes, any additional service improvements alongside the CQUIN are of course encouraged at a local level. At national level, we will also consider this. The direction of travel is away from risk assessment tools and risk categories and towards a focus on individualised assessments, needs, and the management of these needs (see NICE guidelines and the NCISH risk report[[1]](#footnote-1)).

Is there a plan for calibration between trusts/ checking inter-rater reliability and could we have any further guidance/ model examples?

There is no plan for this although it was considered. We have not opted for an approach to ‘spot check’ or calibrate local self-assessments. Instead we are relying on the intrinsic wish for clinicians to improve care in their local services, and to carry the work out in good faith and to the best of their judgement.

However, as the CQUIN is implemented with the support being offered from NCISH, we can consider what more can be done to share understanding of different models of care and share learning through the year

Lots of CAMHS assessments locally are phone/virtual, it would be good to have a steer on what constitutes a good phone assessment?

NHSE doesn’t recommend telephone assessments for people who present to ED having self-harmed and as such we do not have guidance on this. In situations where remote assessments are the only possible or preferred option we would expect the general principles of good quality care in the NICE guidelines to be followed.

Locally I understand that quite a proportion of people who attend ED won’t be referred to liaison psychiatry if they are considered 'low risk'. Should all patients who present to ED with intentional self-harm be referred to MH colleagues?

It is expected that all patients who attend having self harmed, and indeed all patients with mental health needs, should be referred to liaison psychiatry or an equivalent service as soon as a mental health need is identified. The current NICE guidance is clear – all patients who self-harm should receive a full assessment. Of course there may be individual services where non-mental health specialists carry out full assessements, but we are not aware of any areas currently operating this service model.

We would have some concern if ED staff are determining care based on their assessment of risk, as this expressly goes against the evidence base of safe ED care. The new draft NICE self-harm guidelines state that people should not be categorised by risk of suicide or harm (let alone by ED clinicians) and that care should not be determined based on that stratification.

While risk assessments are a key part of clinical practice, the evidence suggests that it is not possible to reliably categorise people into high / medium / low risk, and this may be actively unhelpful. Instead all people presenting to hospital with self-harm, irrespective of risk, should have personalised assessments and care plans based on their unique circumstances, and current presenting needs, from trained mental health professionals.

Whilst referral from ED to mental health is of course a very important area of clinical practice, it is not a core focus of the current CQUIN, which is intended to identify how many people referred into liaison psychiatry services after self-harm get a full assessment (see specification)

The 2013 study of psychosocial assessments in different trusts is rather old, has it been repeated so we have an up to date snapshot?

The NCISH study team are hoping to repeat this national study at some point. However, several more recent studies using data from selected hospitals in England have found similarly variable rates of psychosocial assessment.

Farooq, B., Clements, C., Hawton, K., Geulayov, G., Casey, D., Waters, K., ... & Kapur, N. (2021). Self-harm in children and adolescents by ethnic group: an observational cohort study from the Multicentre Study of Self-Harm in England. *The Lancet Child & Adolescent Health*, *5*(11), 782-791.

Opmeer, B. C., Hollingworth, W., Marques, E. M., Margelyte, R., & Gunnell, D. (2017). Extending the liaison psychiatry service in a large hospital in the UK: a before and after evaluation of the economic impact and patient care following ED attendances for self-harm. *BMJ open*, *7*(8), e016906.

Geulayov, G., Kapur, N., Turnbull, P., Clements, C., Waters, K., Ness, J., ... & Hawton, K. (2016). Epidemiology and trends in non-fatal self-harm in three centres in England, 2000–2012: findings from the Multicentre Study of Self-harm in England. *BMJ open*, *6*(4), e010538.

Carroll, R., Metcalfe, C., Steeg, S., Davies, N. M., Cooper, J., Kapur, N., & Gunnell, D. (2016). Psychosocial assessment of self-harm patients and risk of repeat presentation: an instrumental variable analysis using time of hospital presentation. *PLoS One*, *11*(2), e0149713.

Steeg, S., Emsley, R., Carr, M., Cooper, J., & Kapur, N. (2018). Routine hospital management of self-harm and risk of further self-harm: propensity score analysis using record-based cohort data. *Psychological medicine*, *48*(2), 315-326.

Pitman, A., Tsiachristas, A., Casey, D., Geulayov, G., Brand, F., Bale, E., & Hawton, K. (2020). Comparing short-term risk of repeat self-harm after psychosocial assessment of patients who self-harm by psychiatrists or psychiatric nurses in a general hospital: cohort study. *Journal of affective disorders*, *272*, 158-165.

# Information and resources:

Can we get access to the CQUIN webinar slides and recording?

Yes, the slides and recording have been uploaded to the [MH CQUIN collaboration platform.](https://future.nhs.uk/MHCQUIN/view?objectId=33151312)

Is there any further guidance for this CQUIN?

Yes, we have an additional guidance document that can also be accessed via the [MH CQUIN collaboration platform.](https://future.nhs.uk/MHCQUIN/view?objectId=33151312)

Where can I access the audit tool?

Yes, we have published the audit tool on the [MH CQUIN collaboration platform.](https://future.nhs.uk/MHCQUIN/view?objectId=33151312)

Is there any further guidance on the overall 2022/23 CQUIN scheme?

Yes, the CQUIN team have published the [Commissioning for Quality and Innovation (CQUIN) scheme for 2022-2023.](https://www.england.nhs.uk/publication/combined-ccg-icb-and-pss-commissioning-for-quality-and-innovation-cquin-guidance/)

# Data reporting and audit tool:

Are we expected to use the audit tool for a 100 cases per quarter or are we providing you with a figure of how many people we saw?

The audit tool is not mandatory nor does it need to be comprehensively checked-listed for each psychosocial assessment. It is intended as a *guide*. Experienced clinicians may use their own judgement on the concordance of the assessment to NICE guidelines instead. However, we are making the tool available as we feel it might be helpful to the process. The purposes of the audit tool are to: (1) act as a reminder of the areas of relevance within the NICE guidelines, and (2) identify areas to focus local quality improvement efforts. Please see also our sections above on what constitutes a full assessment, and CQUIN reporting requirements and data collections.

How will providers demonstrate they have met the indicator?

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How long will it take to audit one person’s notes?

The answer to this question may vary, however a reasonable estimate could be around 15 minutes per record. Clinicians familiar with both the self-harm service and electronic records systems should help to make the process more efficient. Please also refer to answers above on the definition of assessment and the audit tool. We would stress the tool is a *guide.* We would not expect every field to be completed on every patient and the tool is not part of the reporting process. Neither is the use of the tool mandatory. Its main purpose is to faciliiate local quality improvement.

Is there guidance for how liaison teams should be recording 'Biopsychosocial Assessments' in the MHSDS?

Biopsychosocial assessments are not required to be recorded in the MHSDS for the purposes of this CQUIN. There is a SNOMED code for ‘biopsychosocial assessments’ that can be flowed to the MHSDS however this is currently used in less than 1-2% of referrals to psychiatric liaison services.

Instead, for this CQUIN 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](https://www.england.nhs.uk/publication/combined-ccg-icb-and-pss-commissioning-for-quality-and-innovation-cquin-indicator-specification/). Also, see sections above on data collection.

Are we including suicidal acts when the intention was to end one’s life, not to self-harm but therefore they harmed themselves?

Yes, these should be included. We are using the NICE definition of self-harm :

‘Self-harm refers to any intentional act of self-poisoning or self-injury carried out by an individual, irrespective of the motivation’.

<https://www.nice.org.uk/guidance/cg133>

<https://cks.nice.org.uk/topics/self-harm/background-information/definition/>

Why isn't the MHSDS being used as the source of evaluation against the CQUIN?

There is a SNOMED code for ‘biopsychosocial assessments’ that can be flowed to the MHSDS however this is currently used in less than 1-2% of referrals to psychiatric liaison services. Therefore the data quality is too far from being able to use the MHSDS to assess this. Moreover, simply recording a code in the data set would not necessarily identify the quality of the assessments.

If we are only counting liaison referrals rather than A&E attendances, how are we going to show that we have improved compared to the (rather old) data in 2013?

The proportion of people presenting to EDs/Hospitals who receive a psychosocial assessment is not the main focus of the study. As discussed at the launch webinar, this is a very important metric. It was considered as the CQUIN was being developed but was not judged to be feasible because of service and data collection complexities raised by stakeholders. Whether more people are getting assessemnts after self-harm than they did in the past (for example the 2013 study) will require bespoke investigation that NCISH and others would hope to undertake.

The current CQUIN focuses on the quality of assessments undertaken by liaison psychiatry teams but it is not a robust academic study. It relies on local self-assessment as part of a national financial incentive scheme. It is therefore not the intention that this will *demonstrate* progress compared to the 2013 data with research rigour, but the hope is that it will provide an impetus to local quality improvement.

Are we also considering the number of patients who also decline for liaison psychiatry assessment/intervention? these are 'received referrals' but would not have a full BPS assessment

It would be challenging to make a blanket national rule on this question, so it can be left to local discretion to apply reasonably. There may be many reasons people do not get seen by liaison psychiatry – some may be more outside the control of services than others. But in general the denominator will include all received referrals - the 20% margin is intended to allow for service users refusing assessment or leaving before assessment can be completed.

If a 'provider' manages more than one LP team, will each team audit a proportion of the 100 per quarter?

Yes, in this case the provider is usually the mental health trust. It is recommended that where there are multiple teams in the MH trust area each liaison team will audit a proportion of the 100 per quarter as a minimum. Where the sites are different sized teams, it is recommended that this is done proportionally to the number of referrals and/or the size of the teams.

Shall we include referrals where self-harm is either a primary and secondary referral reason, or just primary?

All self-harm referrals are included in the NICE guidance, we suggest any referral where self-harm is a prominent feature be included as part of this CQUIN. This may include referrals where self-harm is a secondary reason for referral.

Will this CQUIN only being measured on referrals that have perverse outcome on assertive patient finding? It could lead to prioritising referrals over patients missed by ED clinicians

The CQUIN is focussed only on one particular element of care, namely the quality of interventions provided by liaison services. The CQUIN wont address issues across the whole ED care pathway - the CQUIN guidance highlights the issue raised as one to prioritise, namely that liaison teams and ED teams should work together to ensure that all patients are referred (and in a timely manner).

1. The assessment of clinical risk in mental health services. National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). The University of Manchester, 2018. https://sites.manchester.ac.uk/ncish/reports/the-assessment-of-clinical-risk-in-mental-health-services/ [↑](#footnote-ref-1)