Commissioning Brief
13/58 - Organisation, quality and cost-effectiveness of psychiatric liaison services in acute settings
Closing date: 12 September 2013

1. Remit of this call: main topic areas identified

Liaison psychiatry services are usually located in general or acute hospitals to address the mental health needs of people treated primarily for physical health problems. These services are often made up of staff employed by a mental health trust, but whose core work is based in emergency departments and inpatient wards. There is no single model for this service and levels of care vary greatly across the country. This can range from a general rapid-response or triage service to address patient crises, to more established services offering outpatient clinics for on-going treatment of medically unexplained symptoms. People using the service may also differ greatly, from those in hospital for medical or surgical treatment with co-morbid mental health problems, such as anxiety and depression (but who may not have had previous contact with mental health services), to those with established mental health conditions who have self-harmed and therefore present in emergency departments of acute hospitals.

There is little evidence on the cost-effectiveness of current services or optimal models of care. There is a growing body of literature in the US on new forms of outpatient services, but these may not be directly transferable. Existing research in this country is largely descriptive and small-scale. It does not provide a robust base for decisions about the strategic direction or future provision of these services. New research is needed to understand better how liaison psychiatry services can operate within complex health and social care systems. A key focus is on the effectiveness and cost-effectiveness of care and appropriateness to patients.

Out of scope

The main focus of this call is on liaison services within general and acute hospitals, although it is recognised that there is a growing trend for community-based liaison services to provide support to general practice and other primary care. Studies would be eligible which include work by hospital-led teams across the primary/secondary care interface, but not those which are entirely based in the community. The focus of this call is primarily the general adult population (working age and older adults), rather than specialist children services. This Programme is concerned with the delivery of health services, looking at broader impact on healthcare use, working practice and quality of care as well as patient outcome. Studies which focus exclusively on the clinical effectiveness of particular therapeutic interventions delivered by psychiatric liaison teams are out of scope. However, such studies could be within remit for the NIHR Health Technology Assessment Programme, which also has an interest in this area. Applications should be made to its Clinical Evaluations and Trials workstream.

Four particular areas of research need have been identified:

(1) **Mapping services**

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There is no standard model of liaison psychiatry services. Evidence suggests great variation in the staffing, skillmix, scope, coverage and activity of existing services. A national mapping study of general liaison psychiatry services is needed in order to understand the spread of services and existing models of care based in general and acute hospitals. A similar exercise was carried out in an extended survey of liaison mental health services for older people. This would include description of staffing, skillmix, range of services, coverage and interface with other mental health services (such as drug or alcohol). As part of this mapping study or census, a taxonomy of models of care would be helpful which could inform sampling for future studies and evaluations. Scoping from other health systems which may have different forms of liaison service might also provide useful comparative lessons for the NHS, with analysis of strengths and weaknesses of different models.

(2) **Assessing quality, including patient experience**

There are no national standards for measuring quality of liaison psychiatry services. Some studies have adapted international measures which include important process components such as timeliness of response, communication with referrers and follow-up agencies and supervision of trainees. The challenges of measuring quality and impact on health status has been noted given the rapid turnover of patients on medical wards and the brief nature of interventions by liaison teams. Careful work is needed which includes patient-centred studies to explore appropriateness and acceptability of services. Work would be useful to develop and validate measures to assess quality for different models of care provided and develop future national standards.

(3) **Evaluating cost-effectiveness of models of care**

Evidence to date has been limited to small-scale, descriptive studies or evaluation of single models of care, such as RAID in Birmingham. Research is needed which measures the impact of liaison services in a robust way. This may be difficult given the heterogeneity of service models. However, some common features of a liaison service have now been established, including mental health assessment and training of general staff. Studies are needed to support commissioning and service development decisions, with robust evidence on costs and benefits. This might include quasi-experimental methods, such as controlled before-and-after studies, as well as experimental studies which would need careful design to allow for context and complexity of the intervention/s. While single-site studies can be useful, care is needed to generalise findings. Studies should include different dimensions of impact, including measures of service use (such as length of stay, use of community services or readmission rates) as well as thoughtful selection of quality measures. Service leaders making investment decisions also need evidence on key questions such as the cost-benefits of dedicated older mental health liaison teams as opposed to general all-age adult liaison psychiatry services, given that greatest scope for bed savings appear to be from elderly care wards. Other cost-effectiveness questions may examine particular care pathways, such as the delivery of outpatient or community-based services for those with medically unexplained symptoms or

management of self-harm. Further work on newer models of outpatient services, including collaborative care models, could also be explored.

(4) **Examining team, workforce and organisation**

Research to date has highlighted the tension in a service which may be staffed by mental health professionals working in general acute settings. This can lead to duplication of activity, role confusion and gaps through which patients with complex needs may fall. Different models of ownership have developed locally, with a variety of ways of working and team composition. Organisational research which examines structure, culture, inter and intra professional dynamics and impact on performance and patient care would be welcome. This should result in practical learning for optimising team performance and organisational effectiveness.

2. Purpose of call

This topic emerged as a priority for service managers, clinical leaders and patients considering key knowledge gaps for the HS&DR programme. People with physical health problems are more likely than the general population to have some form of mental health condition. This is particularly true in the hospital setting, where around a third of all inpatients suffer some kind of mental health condition such as dementia, delirium or depression. Psychiatric liaison services were set up to address these mental health needs and aim to improve outcomes and reduce hospital stays. Services range greatly from crisis response teams to training of general acute staff and running outpatient services for particular patient groups, such as those with medically unexplained systems. Not enough is known about the appropriateness, use, impact and cost-effectiveness of these services in their different form. Research is needed to address uncertainties around current services and to inform the planning and delivery of future care.

This call specifies a range of research gaps, ranging from evaluation of service models to qualitative research on patient experience. A core focus of this study is the cost-effectiveness of services. Note that there is some overlap across the five identified areas of research need. Researchers may wish to put forward proposals which tackle more than one of these areas, perhaps in a phased programme of work, but would need to ensure that teams are staffed with range of expertise and sites to deliver learning on a national scale.

Further information on the background to this call, including knowledge gaps and relevant research is given in supporting information.

3. Notes to Applicants

The NIHR Health Services and Delivery Research (HS&DR) programme aims to produce rigorous and relevant evidence on the quality, access and organisation of health services, including costs and outcomes in order to improve health and health services. It is focused on research to support decisions by frontline managers and clinical leaders on the appropriateness, quality and cost-effectiveness of care.

The NIHR HS&DR programme is funded by the NIHR, with contributions from NISCHR in Wales, the HSC R&D Division, Public Health Agency in Northern Ireland, and case by case contributions from the CSO in Scotland.

The programme operates two funding streams; researcher-led and commissioned. Researchers in England, Wales and Northern Ireland are eligible to apply for funding from

either workstream under this programme. Researchers in Scotland may apply to the researcher-led workstream but are not eligible to respond to the commissioned workstream and should contact the CSO to discuss funding opportunities for healthcare delivery-type research

4. Application process and timetable

Please ensure you have read the supporting documents and application guidance notes provided to support this call.

Should you have any questions or require any further clarification please refer to the NETSCC FAQs at HS&DR programme - FAQs, if the answer to your question cannot be found please email your query to hsdrinfo@soton.ac.uk with the title for the call for proposals as the email header. Applicants should be aware that while every effort will be made to respond to enquiries in a timely fashion, **these should be received at least two weeks before the call closing date.**

The process of commissioning will be in **two stages** and applicants should submit **outline proposals** via the HS&DR website by **1pm** on **12 September 2013**. All proposals will initially be checked for remit and competitiveness[1]. No late proposals will be considered. No paper-based only submissions will be considered.

Applicants will be notified of the outcome of their outline application in **November 2013**.

Shortlisted applicants will be invited to submit a full proposal via the HS&DR website (a link will be sent to shortlisted applicants). Applicants will be notified of the outcome of their full proposal application in **April 2014**. Please note that these dates may be subject to change.

5. Transparency agenda

In line with the government's transparency agenda, any contract resulting from this tender may be published in its entirety to the general public. Further information on the transparency agenda is at:

http://transparency.number10.gov.uk/
http://www.ogc.gov.uk/policy_and_standards_framework_transparency.asp
http://www.contractsfinder.businesslink.gov.uk/

[1] '***Non-Competitive***' means that a proposal is not of a *sufficiently high* standard to be taken forward for further assessment in comparison with other proposals received and funded by the HS&DR programme because it has little or no realistic prospect of funding. This may be because of scientific quality, cost, scale/duration, or the makeup of the project team.