Developing an effective business case: the art of persuading engagement and investment in liaison psychiatry

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18 OCTOBER 2013
Ingredients

- Getting the key players together
- Strategic steer and oversight
- Clinical buy-in
- Presenting the evidence
- Not reinventing the wheel
- Considering examples of good practice and local fit
- Sustainability
- A long term vision
Literature
Key References:


Tadros, G et al. (2013). Impact of an integrated rapid response psychiatric liaison team on quality improvement and cost savings: the Birmingham RAID model. *The Psychiatrist, 37*(1), 4-10. doi: 10.1192/pb.bp.111.037366

The Case

THE EVIDENCE
The general case for liaison psychiatry

• High proportions of people with physical health conditions also have co-morbid mental health problems, including 30-65% of inpatients in acute hospitals.

• Many of these problems go undiagnosed and untreated, leading to poorer health outcomes and higher costs of care.

• Mental health co-morbidities increase hospital costs by 45-75% per case. Midrange £6 billion a year in total, or by £25 million a year in a typical 500-bed DGH.

• The extra costs of physical health care associated with mental health co-morbidities and medically unexplained symptoms amount to around £13.5 billion a year.
HOWEVER......
The evidence base on liaison psychiatry

- Not a well-researched area; evidence base is incomplete or inconclusive in important respects
- Not an easy area for evaluative research (heterogeneous groups of patients, complex interventions, attribution problems, multiple outcomes etc.)
- Wide diversity of service models (e.g. assessment/management v. treatment)
- Based on the available evidence liaison psychiatry interventions typically achieve only modest improvements in health outcomes but produce significant savings in health service costs
RAID Recap

- focused solely on reductions in inpatient bed use

- total bed-days saved are estimated at 14,500 a year (which would allow the hospital’s capacity to be reduced by 40-45 beds)

- the value of savings is estimated at £3.55m a year, set against the incremental cost of RAID of £0.8m a year.

- these figures imply a benefit:cost ratio of more than 4:1, i.e. every £1 invested in RAID yields a financial return of over £4.

- the service is clearly good value for money, particularly as benefits are assessed on a conservative basis and are over and above any improvements in health and quality of life

- older patients accounted for 90% of the savings
Other Drivers

- The inclusion of the RAID model within the 2012/13 NHS Operating Framework as an example of QIPP good practice
- NHS-wide clinical quality indicators – e.g. patients’ care being met within 4 hours in A&E (where mental health patients need specialist support and assessment that cannot be delivered by the ED staff)
- Good practice guidance – e.g. NICE guidance for managing self-harm, which states that all patients should have a comprehensive assessment of their psychological needs
- National clinical commissioning priorities – e.g. the development of a national CQUIN for the identification and management of dementia
- Current DH work on developing a MH concordat for EDs
- Developing an outcomes framework for LP
- NIHR call
Key Strategic Questions
Key Strategic Questions

Is the culture of the local healthcare system amenable to the development of liaison psychiatry services?

In your view, is liaison psychiatry addressing mental health or physical health needs?

What is the current provision and do you think the current system of provision is effective?

How do you see liaison psychiatry contributing to the longer term vision for local healthcare provision?
Building a service model

THE KEY INGREDIENTS
Liaison Psychiatry in the Modern NHS (1)

- every hospital should have a dedicated in-house liaison psychiatry service
- the scale and nature of operations should be geared to local needs
- sustainability is important (critical minimum size and level of expertise; secure funding)
- incorporate related services (clinical psychology, addictions services etc)
- integrate within the hospital
Liaison Psychiatry in the Modern NHS (2)

- start with a rapid-response generic service, then consider add-ons
- core work in medical wards and A&E
- an all-ages service; work with older inpatients should be a top priority
- focus on complex and costly cases
- emphasise education, training and supervision of general hospital staff
- change the hospital culture
Liaison psychiatry beyond the hospital

- Liaison psychiatry needs to reflect and reinforce wider trends in health care, especially more care closer to home.

- This means more provision of community-facing liaison psychiatry services across the primary/secondary care boundary.

- Main area of development is in supporting integrated care for people with long-term physical conditions and co-morbid mental health problems.

- Other options include (i) outpatient treatment clinics for MUS, self-harm etc, and (ii) perinatal mental health services.
Potential Model

APPLYING THE EVIDENCE
LA
Dementia Services
District Nursing
Ambulance
IAPT

Community Services

Training and Education

Acute ward work

ED, Admissions etc.

Outpatient Clinics:
Dementia
Delirium
ED
LTC/MUS

Primary Care

NGH/KGH

Community

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Developing the Local Case

NEXT STEPS
Developing a Business Case

The clinical/economic argument (already been made for you QIPP)

The national argument (Francis’ Mid Staffs report; Policy drivers; QIPP)

The local argument
- Appetite of acute providers
- Baseline – what services are currently provided
- Thorough demand analysis
- Provision matching
- Compare to existing models (Parsonage et al 2012; Parsonage and Fossey 2011)
Thank you

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