

Liaison Mental Health – Frequently Asked Questions

1. How is Core 24 going to be judged to have been reached – is it relate to workforce or function?

NHS England determines that a service as at core 24 based on the following three criteria:

- *Teams are commissioned to operate as an on-site, distinct 24/7 services*
- *Teams are resourced in line with (or close to) the recommended staffing numbers and skill mix which enable them to operate on a 24/7 basis (including access to older adult clinical expertise) (see workforce section (3.4; pp. 18-22) of the implementation guidance: <https://www.england.nhs.uk/wp-content/uploads/2016/11/lmhs-guidance.pdf>)*
- *Teams are commissioned to meet recommended response times (1hr for emergencies, 24hrs for urgent ward referrals)*

2. How will success against the 1 hour and 24 hour targets be measured? Will it be based on outcome data?

From April 2017, liaison mental health services that are provided by mental health trusts will be expected to submit data items in the Mental Health Services Data Set to begin measurement of times and interventions related to this pathway, including on response times to referrals. (See new implementation guidance <https://www.england.nhs.uk/wp-content/uploads/2016/11/lmhs-guidance.pdf> section 4.5; pp. 35-7: 'Measuring and reporting performance against the pathway and standards'.)

3. Are services required to include an alcohol nurse?

pp. 21-2 in the implementation guidance sets out the key competences of a liaison mental health team. Common to all roles is the need for knowledge and skills around the care and treatment of people with drug or alcohol use problems, including specialist training for nursing staff, and knowledge of local services for people who use drugs or alcohol. While there is no 'requirement' for liaison services to include a separate alcohol nurse, the skills of such a professional can be valuable and we welcome integrated working between mental health and drug/alcohol staff (and others, such as social care staff). Services that follow the enhanced 24 model provide more specialist care, offering enhanced expertise in addictions and drug and alcohol use.

4. How do you protect those areas that have innovative services that are different to Core 24 but still provide the same functionality – links to Q1?

While we welcome innovative approaches, the national policy position is that based on the evidence base which shows that the peak hours of presentation for mental health crisis are 11pm-7am. Mental health liaison services should respond to emergency referrals within one hour, and therefore need to be on-site and 24/7. The national policy is that where size and demand of a hospital and its population warrants a 24/7 A&E Department, should be equipped 24/7 with specialist mental health liaison expertise.

Liaison teams are distinct, specialist teams with psychiatric, psychological and medical expertise of co-morbid physical and mental health conditions as well as urgent and emergency mental health care expertise. Community crisis teams have a distinct, complementary, but separate function – and where crisis teams offer in-reach to acute hospitals, this does not constitute a Core 24 mental health liaison service in line with the evidence base.

5. How do you protect services which are already functioning at Enhanced Core24/ Comprehensive levels?

Future annual national workforce surveys of liaison mental health will show the progress that each acute hospital in England is making towards improving its liaison mental health services. For the majority of hospitals, this means progress towards achieving the Core 24 standard. The progress of other hospitals which have already reached or superseded the minimum Core 24 standard will also be tracked and monitored with equal scrutiny. The 'gold standard' services are the 'Enhanced 24' or 'Comprehensive' models, which deliver the most clinical and financial benefits. Services should therefore be able to provide evidence to demonstrate these benefits to commissioners through routinely monitoring and analysing activity, productivity and outcomes. NHS England encourages the largest acute hospitals to aim for these service standards, and strongly encourages those that are already at those service standards to at least maintain current levels of provision.

In spring 2017, NHS England will be launching a national quality assessment and improvement scheme for urgent & emergency mental health services, including mental health liaison in acute hospitals. This will allow local services to identify gaps and to benchmark themselves against the recommended standards set out in the forthcoming implementation guides.

6. Is the 1 hour turnaround target implicit in Core 24?

One of the key three criteria of whether a liaison service is determined to be at core 24 is whether the team responds to all emergency referrals within one hour.

7. What is the consequence of the 4 hour disposal target not being reached? How is this measured and what is the necessary compliance e.g. 95%?

The 4 hour standard is a currently recommendation that works within the existing 4 hour A&E target. From April 2017, liaison mental health services that are provided by mental health trusts will be expected to submit data items in the Mental Health Services Data Set to begin measurement of times and interventions related to this pathway, including the interventions required to stop the 4 hour liaison clock. (See new implementation guidance <https://www.england.nhs.uk/wp-content/uploads/2016/11/lmhs-guidance.pdf> section 4.5; pp. 35-7: 'Measuring and reporting performance against the pathway and standards'.)

8. How critical is the banding of nursing staff? Are teams required to meet the defined split of band 6 and 7 nurses?

The recommended staffing levels are a guideline. Where staffing numbers are below but close to this level, but services can demonstrate persuasively that the service is operating a

24/7 rota effectively to meet the demand of the A&E and inpatient wards, they may be considered to be meeting the staffing indicator for core 24.

We will accept flexibility where a compelling and evidenced case is made. Some key considerations are set out in the workforce section (3.4; pp 18-22) of the implementation guidance: <https://www.england.nhs.uk/wp-content/uploads/2016/11/lmhs-guidance.pdf>

9. What happens to the services where there is insufficient demand for Core 24 Services? Should these services be aiming for Core? Should these services still put in a bid?

We have taken the approach that if an A&E department provides 24/7 care for people with physical health problems, then it should provide 24/7 care for people with mental health problems – not to mention that the huge prevalence of people with co-morbid mental and physical health issues means that liaison services being available 24/7 improve overall care for many more people than ‘just’ those with primary mental health needs.

Evidence from the CQC and other sources suggests that the peak time of A&E presentations by those with urgent & emergency mental health needs are ‘out of hours’ – often late at night or in the early hours of the morning.

We also know that where liaison services have extended their operating hours to 24/7, they have seen significant increases in unforeseen and unpredicted demand – what was effectively unknown and unmet need previously. Exeter saw an overall increase in referrals of 40%, and an increase of over 80% just for referrals from A&E.

However, we of course expect local partners to base any planning on their understanding of demand – including how that demand is measured and confidence in the reliability of such measurements – and strategic regional considerations. Different liaison MH service models will require different levels of staffing, which will also need to be adapted according to local need, hospital size, population size and ED footfall.

10. Could you bid for the money to run a pilot to demonstrate the potential recurrent savings? Would such a bid be considered?

The pump prime money that is available in Wave 1 of the transformation funding is to ‘top up’ existing locally committed funding to help acute hospitals reach the core 24 standard within a year of receipt of the transformation funding. It is a requirement that for any bid to be successful, applicants must confirm that the service standard will be funded at least at the same level locally on a recurrent basis in future years.

11. How do you demonstrate that the service brings financial savings? Will there be any guidance on financial modelling? The majority of savings will be for the acute trust so how do suggest we persuade them to commit to reinvestment in Liaison and not elsewhere?

The advice we would give is that the financial benefits from liaison teams flow directly from clinical benefits i.e. reduced length of inpatient stay, reduced emergency admissions/re-admissions, reduced repeat attendances at ED – so an emphasis on the clinical benefits and the financial benefits that accrue accordingly is encouraged. A helpful way to frame it is as the counterfactual i.e. what would happen if the liaison team wasn’t in place and able to provide high quality interventions 24/7 i.e. how many bed days with a better-resourced liaison service could be saved to improve productivity and generate income for the hospital?

Section 3.2 in our new implementation guidance for urgent and emergency liaison may be helpful if you haven't already seen it: <https://www.england.nhs.uk/wp-content/uploads/2016/11/lmhs-guidance.pdf>

There may also be some helpful material here:

<https://www.centreformentalhealth.org.uk/priorities-for-mental-health-economic-report>

12. Could a definition of "all age" be provided?

All-age includes specialist care for children and young people, and older people. So the aims as per the Five Year Forward View are that by 2021, no acute hospital is without an all-age liaison mental health service, and that at least 50% of acute hospitals are operating at the core 24 service standard for adults and older adults.

13. How will you measure services adherence to the recommended standards?

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In spring 2017, NHS England will be launching a national quality assessment and improvement scheme for urgent & emergency mental health services, including mental health liaison in acute hospitals. This will allow local services to identify gaps and to benchmark themselves against the recommended standards set out in the forthcoming implementation guides, as well as allowing NHS England to undertake a baseline audit and gap analysis of national adherence.

14. Will you be referring to the local baseline information which we have provided to Clinical Networks, or are decisions to be based on the latest national survey (LPSE 3) or both?

We have shared the acute hospital-level LPSE-3 data with regional teams to help inform their planning and support for prospective applicants to the fund. However, we have made very clear that for any acute hospitals that have been 'earmarked' for bids, the liaison services within them need to be approached for their current, up-to-date provision, which also needs to be made clear in application forms.

The significant work already undertaken at a regional/clinical network level to establish a baseline (over and above submissions to LPSE-3) should certainly help to ensure that any bids from the region are strong, detailed, and evidence-based, and will provide the A&E Delivery Boards submitting bids and the regional UEC PMOs assuring them with invaluable information. This work should also help medium- and longer-term planning to support liaison services in the region to implement and meet the standards in the pathway implementation guidance.

15. How will disinvestment in Liaison services be monitored? How will acute/ mental health trusts/ CCGs be held to account if there is no investment/ if there is no willingness to bid for funding where this would be appropriate i.e. where the service is already close to Core 24?

NHS England is tracking CCG investment in all mental health services against the Mental Health Investment Standard, and the finance tracker asks for CCGs to break down their mental health spend by service type, including for urgent and emergency liaison. We will therefore for the first time be able to transparently see where money is going and how much – and the expectations are that these services should be expanding through local investment (see also [the Five Year Forward View for Mental Health Dashboard](#)).

Future annual national workforce surveys of liaison mental health will show the progress that each acute hospital in England is making towards improving its liaison mental health services. For the majority of hospitals, this means progress towards achieving the Core 24 standard. The progress of other hospitals which have already reached or superseded the minimum Core 24 standard will also be tracked and monitored with equal scrutiny.

One of the liaison indicators in [the CCG Improvement and Assessment Framework](#) asked CCGs if they have liaison service development plans in place – and the vast majority reported that they did.

Urgent and emergency liaison mental health services are also identified explicitly as a priority within the [guidance for the development of STP proposals](#) and the [2017-19 planning guidance](#).