Report of the 4th Survey of Liaison Psychiatry in England (LPSE-4).

Prepared for NHS England and the Liaison Faculty of the Royal College of Psychiatrists.

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Executive Summary

This is the fourth Liaison Psychiatry survey of England. It concerns the Liaison Psychiatry services in acute hospitals with Emergency Departments in England. There are Government targets for half of all of these services to be at 'Core 24' level by 2021. These surveys track this progress.

Of the eligible 175 hospitals, the Core 24 standard was met in 58 (33%) in mid 2018. This is ahead of the target by this stage of 20%. The first, second and third surveys recorded 9, 16 and 22 Core 24 services respectively.

The major potential barrier to continuation of this good rate of growth is workforce; psychiatrists more than other professionals.

Introduction

Liaison Psychiatry is the sub-specialty of psychiatry which addresses the mental health needs of people in general clinical settings.

In England, Liaison Psychiatry is growing as a specialty, in part because of evidence showing that well-resourced services make acute hospitals function more efficiently; shorter admissions, fewer readmissions.[1,2]

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[1] Parsonage, M. "Economic evaluation of a liaison psychiatry service" 2012. http://www.fadelibrary.org.uk/wp/wp-content/uploads/downloads/2012/01/An-economic-evaluation-of-a-liaison-psychiatry-service.pdf
[2] Tadros, G., Salama, R., Kingston, P., Mustafa, N., Johnson, E., Pannell, R., & Hashmi, M. (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 'Five Year Forward View for Mental Health' commits the government to providing adequate Liaison Psychiatry in all acute hospitals with Emergency Departments (EDs) in England.[3]

These Liaison Psychiatry Surveys of England (LPSEs) serve to assess progress towards these targets.[4,5,6] This is the report of the 4th of these surveys. This edition (LPSE-4) is funded by NHS England and the Liaison Faculty of the Royal College of Psychiatrists.

Methods

We undertook the 4th Survey of Liaison Psychiatry in England (LPSE-4). It was a questionnaire survey, sent out by email, similar to LPSE-1, LPSE-2, and LPSE-3. We emailed the survey to the people who responded to LPSE-3. In response to feedback, the number of questions was reduced from 59 in LPSE-3 to 30 in this survey. All answers were free-text to allow for explanations of complexity, and responses were invited by email, telephone, or any reasonable means the responder would like to send. Furthermore, we were able to accept one response or more than one responses from different Liaison Psychiatry services within a single hospital, depending on the preferences of respondents, primarily to allow for there being different services for different age groups of patients.

Selection of Questions

We examined the 59 questions from LPSE-3 and removed those about which there had been no requests for data. We consulted with NHS England and the Liaison Faculty of the Royal College of Psychiatrists, with user involvement, to ensure all areas of interest were covered. Questionnaires were piloted at the Liaison Psychiatry service at the Royal Devon and Exeter Hospital, and by members of the Liaison Faculty of the Royal College of Psychiatrists. Requests for additions from these stakeholders were also considered. As previously, the needs of the busy clinician were considered at every stage of the process. Only questions which could be answered by reasonably well-informed clinicians working within Liaison Psychiatry services were included. The final 30 questions can be seen in Appendix 1.

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[3] The Independent Mental Health Taskforce to the NHS in England, "The Five Year Forward View for Mental Health" 2016.
https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

[4] Walker A, Barrett JR, Lee W, et al Organisation and delivery of liaison psychiatry services in general hospitals in England: results of a national survey BMJ Open 2018;8:e023091. doi: 10.1136/bmjopen-2018-023091

[5] Barrett J, Aitken P, Lee W, "Report of the 2nd Annual Survey of Liaison Psychiatry in England" https://www.crisiscareconcordat.org.uk/wp-content/uploads/2015/10/2a-Report-of-the-2nd-Annual-Survey-of-Liaison-Psychiatry-in-England-20-.pdf

[6] Barrett J, Aitken P, Lee W, "Report of the 3rd Annual Survey of Liaison Psychiatry in England (LPSE-3)" https://www.hee.nhs.uk/sites/default/files/documents/Report%20of%20the%203rd%20Annual%20Survey%20of%20Liaison%20Psychiatry%20in%20England%20FINAL.pdf

Sample

We started with the list of acute hospitals with type 1 EDs which we used for LPSE-3. We reconciled this with a contemporary list of acute trusts with type 1 EDs from the NHS England website.[7] Many Acute Trusts operate more than one ED, so we examined the websites of all the 137 acute trusts with type 1 EDs in England to determine how many EDs they operate and in which hospitals they are found. We therefore created a list of all the acute hospitals in England with type 1 EDs (175). This is the denominator of this survey.

Data Collection

On May 11th 2018 we emailed the people who responded to LPSE-3, explaining the nature of the survey and asking them to complete the questionnaire and return it. The email contained a link to a live map and a live graph showing which hospitals had responded.

Again, the needs of the answering clinicians were considered at every stage: questions were included in the body of the email so respondents could simply reply to the email and write the answers in the included text under each question. The questions were also attached to the email as a Microsoft Word document, which suited many clinicians better, to either fill in electronically and return by email, print out and fill in with a pen and then email back scanned images, or even return the paper response by post. In addition, we also accepted telephone responses where SW or WL would complete a response on behalf of a respondent, with the completed response being emailed to the respondent for checking and for their records as well as being processed as a response like the other written responses.

Some of the initial emails had automatic responses. We looked at those which explained the email did not exist and corrected obvious errors, where applicable, and resent the emails. We also used nhs.net to find where recipients' emails had changed, made the changes and resent the emails. We compiled a list of hospitals for which we had no active email contact and telephoned their Liaison Psychiatry services to offer to complete the survey there and then, to request an email of the person we should write to to ask for a response, or to offer to call back at an arranged time.

On June 1st we sent a second mailing to non-responders, and on July 5th we sent a 3rd mailing.

From July 13th to July 26th, we emailed all the responders in each of the 12 NHS England regions (Cheshire and Merseyside, Yorkshire and Humber, South East, London, East, Central

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[7] https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2018/05/April-2018-AE-by-provider-X6gB2.xls

Midlands, Lancashire and Greater Manchester, South Central, North Midlands, Cumbria and North East, Wessex, South West). We used the "Bcc" field so responders' own confidentiality was not breached. We listed the non-responding hospitals in each region, and asked the responders in that region if they might contact the non-responding services on our behalf.

Data Processing

We entered the data from each response in a secure 'Google Sheet', shared within the survey team. One row represented one acute hospital, so where there was more than one response from a single hospital, those responses were entered into a single, shared cell.

There was no patient record-level data collected or processed. All responses were 'free text' to allow respondents maximum flexibility in describing their services. These were manually coded by two people (SW and WL) with the aid of a coding protocol, which was created in advance and developed during the coding process. This can be seen in Appendix 2.

Results

Data were returned by all 175 of the acute hospitals in England with EDs.

The results are a snapshot of the Liaison Psychiatry services in acute hospitals in England, as the services reported in May to October 2018. Given the pace of national investment, these figures may already be out of date. There is likely to be a fifth survey in 2019, to continue tracking these changes.

Figure 1: Number of Liaison Psychiatry services which report a better, same or worse resourced service than the service recalled from the prior survey. Results from two prior surveys are also shown.

Subjective rating of service resources in comparison to the previous survey
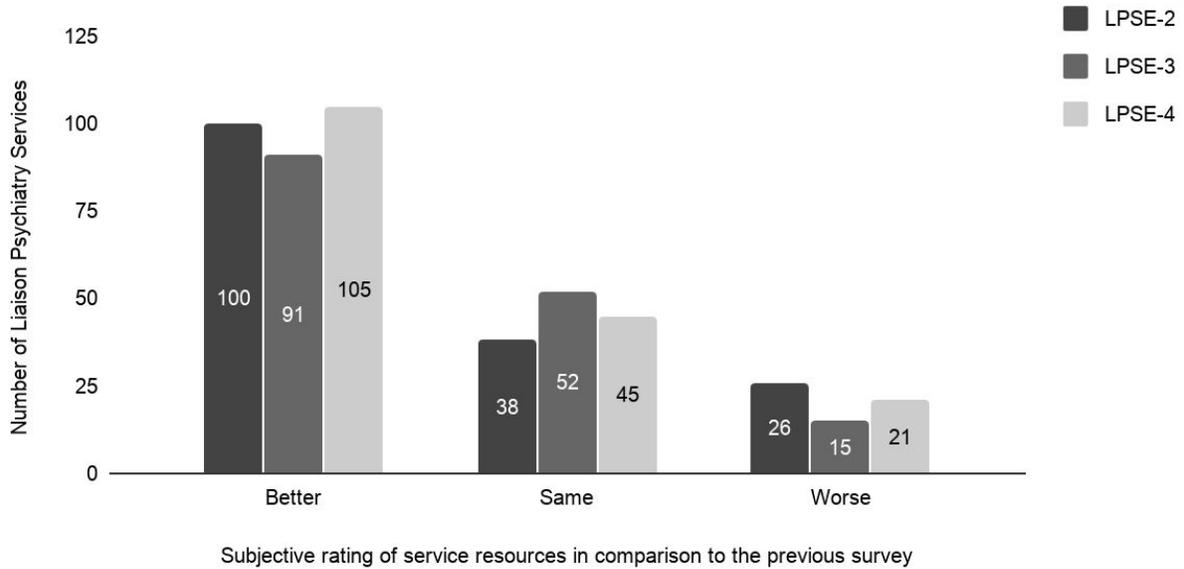
Again, more than half of the services reported an improvement in resourcing since the prior survey. This number is greater than it has ever been, reflecting continuing and accelerating growth in Liaison Psychiatry in England. The number of services reporting worse resourcing remains low.

Figure 2: Services in each service model with the results of prior surveys.
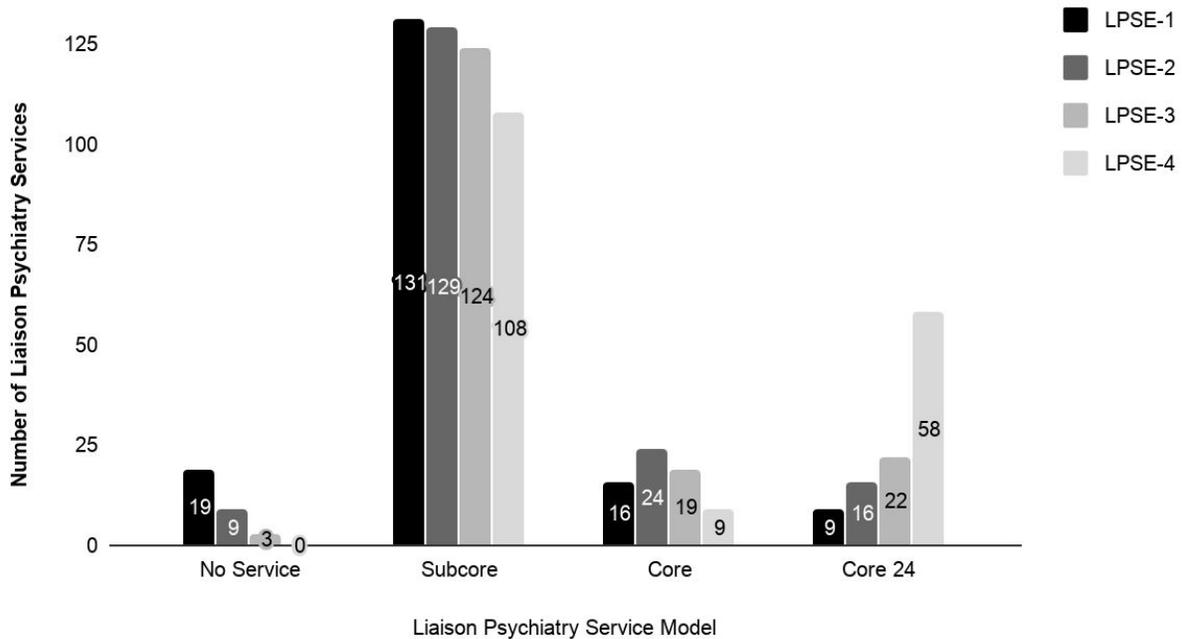

The number of hospitals with no Liaison service has now reduced to zero. Reciprocally, there is a continuing and growing increase in the number of hospitals meeting the Core 24 criteria.

Note: The absolute number of Liaison Psychiatry professionals has increased greatly, and the above figure is a fair representation of that increase. However, the criteria by which service models are determined has changed slightly between the different surveys. In particular, in line with the criteria for additional funding allocated for expansion of services, for this survey, LPSE-4, the criteria are 1.5 FTE consultants and 11 FTE MHPs (compared to 2 FTE consultants and 13 FTE MHPs). These new criteria were those used by the NHSE-convened panel which awarded development funding for Liaison Psychiatry to be sufficiently close to the Core 24 definition to be considered in that category.

'Implementing the Five Year Forward View for Mental Health' states the target for 2018/19 was to have 20% in place. This target has been met and exceeded with 58/175 having Core 24 services (33%).[8] The ambition is to have at least 50% (88/175) of acute hospitals with EDs having Core 24 Liaison Psychiatry services by 2021.

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[8] https://www.england.nhs.uk/publication/implementing-the-fyfv-for-mental-health/

Figure 3: Services in each service model with the results of prior surveys.



Hours of operation of Liaison Psychiatry services.
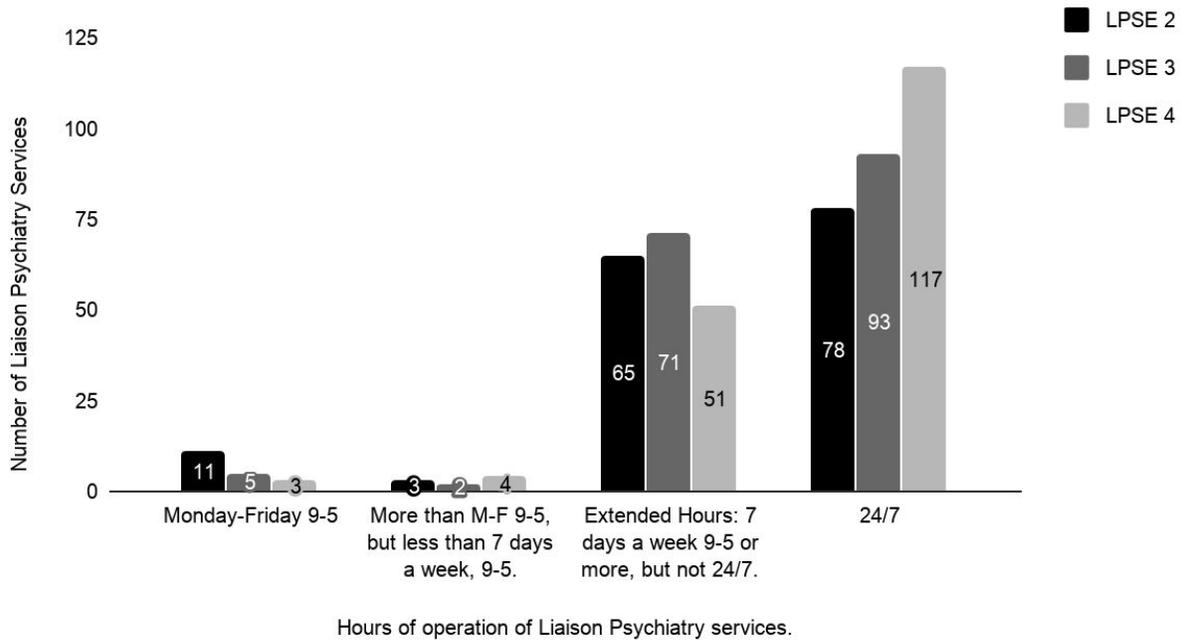
There has been consistent growth in the number of 24/7 services between the surveys. The number of services open only between 9am and 5pm Monday to Friday has been steadily reducing and now stands at three. Now, 117 services have moved to operating on a 24/7 basis. In between the 9am to 5pm Monday to Friday services and the 24/7 services is a range of services operating at a range of different opening times. We have presented these in two columns groups, with the cut-off at 9am to 5pm seven days a week.

Figure 4: Services divided by their service model and whether they offer additional, non-acute services.
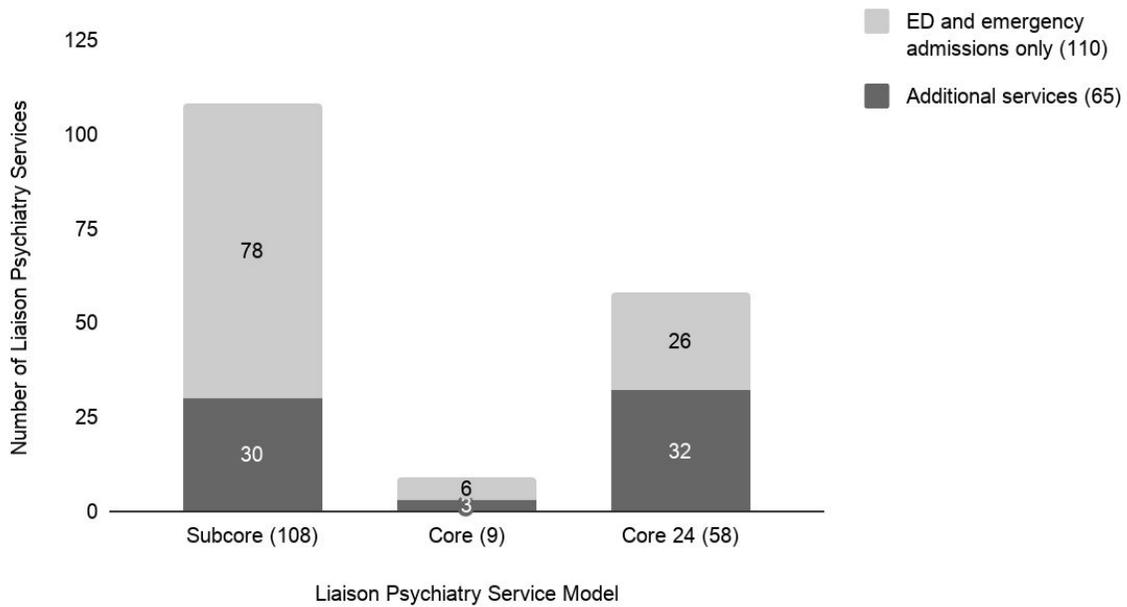
As in prior surveys, many services offer non-acute interventions such as psycho-oncology clinics or clinics for people with medically unexplained symptoms. These are present in about half of all liaison psychiatry services, with them being a little more common in those which are less well developed.

Figure 5: Consultant and MHP FTE numbers in Liaison Psychiatry Services in England's Acute Hospitals with EDs: Past provision, current provision and that required for nationwide implementation of Core 24 service model.
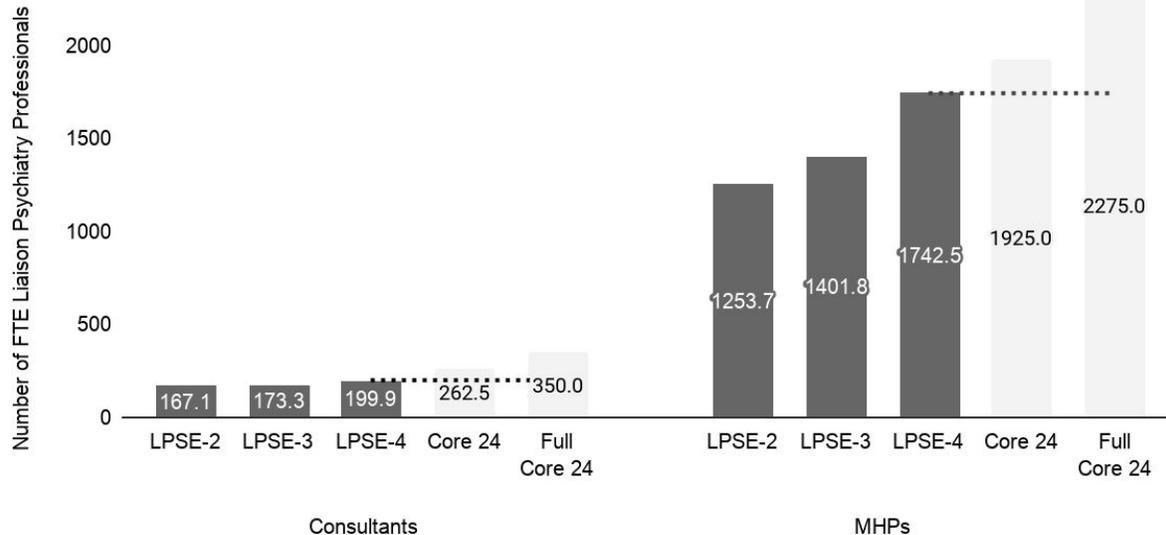
For consultants, there has been progress towards the target, with 32.8 additional FTEs having been filled, with 150.1 still to go. Growth in consultant provision can be expected to be slower than that of MHPs, due to the smaller supply of consultant psychiatrists and the lead time needed to train as a consultant (a minimum of 5 years undergraduate training and a minimum of 8 years postgraduate training).

For MHPs, there has been strong and ongoing growth in FTE numbers from LPSE-2 (2015) to LPSE-4 (2018). Exact FTE numbers were not recorded in LPSE-1. Nearly 500 additional FTEs have been filled, with 532.5 still to go to have the whole of England at full Core 24 provision.

Note: In LPSE-1 and LPSE-2, mental health nurses were counted. Since then, there has been growth in clinicians from other professional backgrounds carrying out the roles previously assigned to mental health nurses. This includes social workers, physiotherapists, drug and alcohol workers among others. This diversity can add a valuable expertise and skills mix to liaison services. The newer term for the same role, undertaken by qualified mental health professionals from a variety of backgrounds, is Mental Health Professional, abbreviated to MHP. It is these clinicians who were counted in LPSE-3 and LPSE-4, unless a separate, boundaried, role was specified. In this case, the professionals were recorded separately (not shown).

Note: The Full Core 24 column refers to the number of professionals needed to staff 100% all of England's ED-equipped acute hospitals with Liaison Psychiatry services with two FTE

consultants and thirteen FTE MHPs. The 'Core 24' column refers to staffing England with Liaison services with 1.5 FTE consultants and 11 MHPs.

Note: For LPSE-3 and 4, where individual Liaison Psychiatry services have greater than 2 FTE consultants or greater than 13 FTE MHPs, only 2 and 13 are counted toward the national total. This approach gives the clearest measure of England's need for Liaison Psychiatry professionals. The 'raw number' figures can be seen in Figure 6.

Figure 6: "Raw" consultant and MHP FTE numbers in Liaison Psychiatry Services in England's Acute Hospitals with EDs: What England had, has, and needs for the Core 24 service model to be inplemented across England.
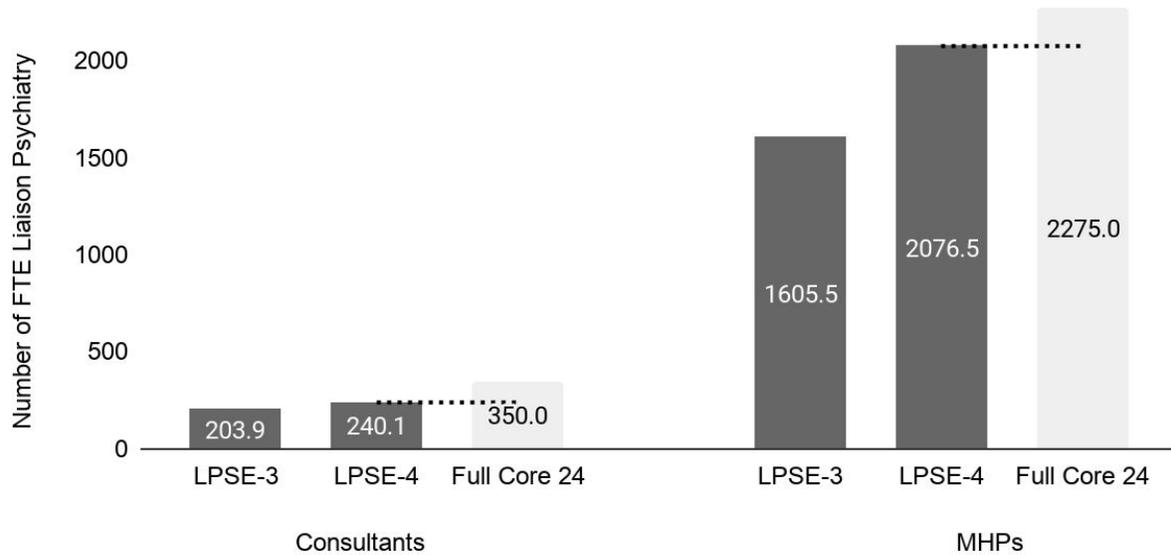
For Consultants, England has 240.1 FTEs, and 350.0 would yield Core 24 in every centre. England therefore needs 109.9 additional consultant FTEs. This approach takes no account of the size and complexity of the needs of larger hospitals, and assumes FTEs of consultants are divisible and mobile without limit.

For MHPs, England has 2076.5 FTEs, and 2275.0 would yield Core 24 in every centre. England therefore needs 198.5 additional MHP FTEs. As above, this approach takes no account of the needs of larger centres.

Figure 7: Services which have a one hour response time target to the Emergency Department, with results of prior surveys.
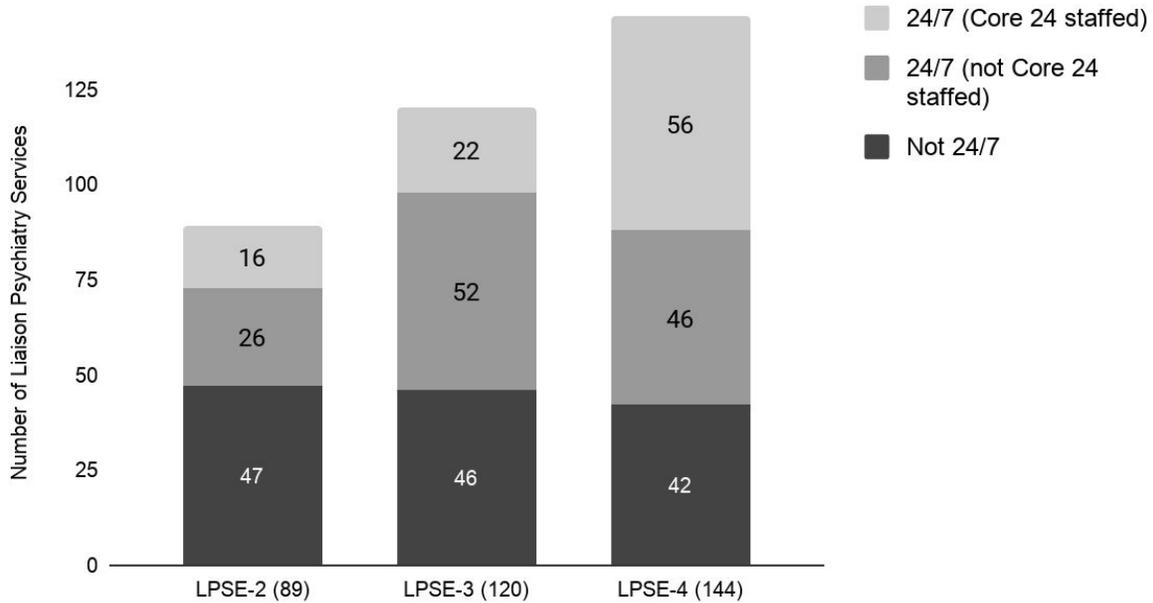
There has been consistent growth in the number of Liaison Psychiatry services with a one hour response time target to the ED. These figures show where services are working towards a one hour response, but does not measure whether they are able to meet this target consistently. See Appendix 2 for the coding manual. NHS England will be leading work in 2019 to improve patient level recording of liaison activity and response times in the Mental Health Services Data Set.

Many services which are working on a 24/7 basis and have a one hour response time to ED are staffed below the agreed level for this (Core 24), and therefore are relatively less likely to be able meet quality and response targets consistently and sustainably than better resourced services. There are two services which are not 24/7 services, but are staffed at the level of Core 24. This accounts for the difference between the figure of 56 Core 24 services, which are 24/7 and have a one hour response target in this Figure and the one found in Figure 2, of 58 services.

Figure 8: Location of the Liaison Psychiatry service, with the results of a prior survey.

This figure shows a small increase in the most desirable location of a Liaison Psychiatry service, in the acute hospital. There is also an increase in the also desirable configuration of services having two offices, one of which is in the acute hospital. Relatedly, there are also decreases in less desirable off-site and on-site but in a different building service locations.

Figure 9: Use of outcome measures in Liaison Psychiatry services, with the results of a prior survey.
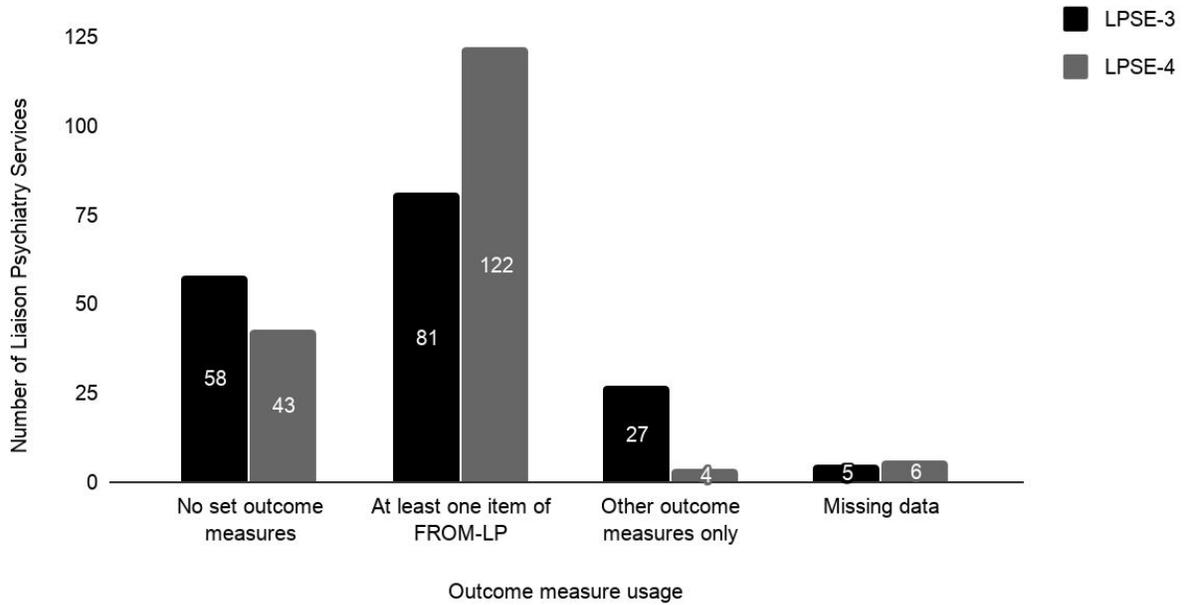
There has been a marked increase in the use of FROM-LP outcome measures, such that the majority of services now use them.

Discussion

We found more Liaison teams for adults reporting being better resourced than worse resourced compared to the previous surveys. There is strong growth in services being staffed to the Core 24 level or more, now standing at 58/175 = 33%. Most (117, 67%) teams undertake 24/7 working, but many are not staffed to do this in a sustainable way that can consistently meet response time standards and provide a high-quality response. Many teams offer non-acute services, even those which are relatively poorly resourced.

The most accurate way to describe the service development needs of England is to only count the FTE deficits in each centre below the full Core 24 standard of 2 FTE consultants and 13 FTE MHPs. This takes into account the uneven distribution of staff across the country and the needs of larger centres, where Liaison staff may undertake extended roles.

Using this approach, England needs 350 full time consultant liaison psychiatrists in post for the Government target, of 2 full time consultants in all 175 acute hospitals, to be fully met. The growth in consultant numbers, from 173.3 to 199.9 since LPSE-3, means more that 57% of the consultants needed for Full Core 24 are now in post. Furthermore, the funding round for service development allowed for 1.5 FTE consultants to be considered to be 'Core 24' specification. By this reckoning, 76% of the consultants required are in post.

Similarly, England needs 2,275 FTE MHPs in post for the Government target, of 13 full-time MHPs in all 175 acute hospitals, to be fully met. The numbers have grown from 1,401.8 to 1742.5 since LPSE-3. This means 77% of the MHPs required are in post; 90% of those required for the specification in the recent funding round.

Using the 'raw' figures, which count all the Liaison professional FTEs equally, England has 240.1 FTE consultants and needs 350, and has 2,076.5 FTE MHPs and needs 2,275.

Of course, Liaison Psychiatry teams consist of staff other than the consultants and MHPs. In particular, for simplicity, the number of administrative staff, often the mainstay of teams and vital to the delivery of a high quality service, were not included in service model criteria in this report. The expected minimum number of FTE administrative staff for a Core 24 service remains at three.

Overall, the picture from asking teams is that the growth of Liaison Psychiatry in England continues apace. As in previous surveys, the progress in getting new MHPs is stronger (24% growth between surveys) than that for consultants (15%).

Strengths and weaknesses

LPSE-4 is the 4th Liaison Psychiatry Survey of England. These surveys are led by a clinician, with the expectation that clinicians answer the survey questions. Keeping this in mind at every stage of the process - influencing choices of question number and content, communication methods and numerous other factors - facilitated the very high response rates of 95% for LPSE-1, 100% for LPSE-2, 98% for LPSE-3 and 100% for LPSE-4. These figures mean these surveys can be trusted in a way few can be, because the issues of participation bias, the bane of many surveys, do not apply.

Further, being engaged with the community of participants (and the lead being a participant) allowed authentic relationships between the research team and the other participants. This facilitated feedback which allowed and will continue to allow for the survey methods to be finessed to suit the community it serves.

We involved numerous senior mental health professionals and other stakeholders in choosing the questions for LPSE-4. Accordingly, many pressing policy questions can be addressed from its findings, making LPSE-4 an efficient undertaking.

Like any survey, LPSE-4 is vulnerable to certain problems. Foremost are errors in reporting. These are known to happen in a few percent of answers to most questions and it is likely LPSE-4 is no exception to this. Further, it is not impossible that 'wishful thinking', mischief or other factors may have affected these errors in terms of their frequency and (crucially) their direction. We reduced this tendency by emphasising that it is the quality of the data which is desired rather than any particular value. That is, we were careful to give no expectation of whether well-resourced or poorly-resourced Liaison teams was the 'desirable' answer, and we ensured that every question had unlimited 'free-text' opportunities to respond, to avoid 'forced-choice' situations which aggravate information biases of this kind.

Liaison has difficulties with vocabulary and definitions. First, there is no universally accepted definition of Liaison, even among practitioners. Second the name itself is in dispute, with 'Psychological Medicine' being an alternative, along with 'General Hospital Psychiatry'. 'Consultation/Liaison Psychiatry' is a further term which is in use internationally. The term 'Liaison Psychiatry' is criticised because 'liaising' is only a fraction of what Liaison Psychiatry teams do, and other mental health professionals undertake much liaison even though this is not acknowledged in the name of their specialties. Third, there is an unfortunate distinction between 'doing Liaison', may would include seeing a patient in an acute hospital, and 'being Liaison' which is being a team which undertakes such clinical activity. It is thought that the benefits of Liaison are enhanced when the mental health workers are well known to other professionals in the acute hospital. This is 'being Liaison' and is unlikely to be emulated by visiting professionals who merely 'do Liaison' and are based elsewhere, though this is difficult to quantify - and of course some teams which only 'do Liaison' may call themselves Liaison teams. Fourth, the term

'Liaison Psychiatry' is problematic because so much of the activity of Liaison is undertaken by mental health nurses, and many teams have no psychiatrist. In addition to the above, some Liaison teams also have Crisis, Home Treatment and/or community functions, so establishing the staffing levels of the Liaison part of the service may be problematic. Last, some teams operate over several hospitals, so the need for allocating the staffing to one hospital or another for the purposes of these surveys may be a problem.

The above problems are managed not by exhaustive and precise definitions, which may be taxing to read and understand, but by giving examples of what is meant under many of the questions in the questionnaire in an effort to clarify without being burdensome. As well as this, the completely free-text responses allows respondents to describe their situation and have the LPSE-4 team code it appropriately.

Even if one assumes all the data are understood and recorded correctly, teams change their make-up, functioning, processes and relationships with nearby teams frequently, so it is likely some of the data will go out of date rapidly anyway.

Overall, LPSE-4 gives a good, and by far the best, picture available of the state of Liaison Psychiatry in England, but any particular single datapoint may well be in error and this should be considered when the results are examined.

Lessons for future editions of LPSE

LPSE-1 simply asked respondents to describe the staffing of their teams and to 'grade' them according to the 'Core' system. LPSE-2 was more structured and had a total of 27 questions. LPSE-3 has 59 questions. Feedback from respondents was that fewer questions would be more desirable, so LPSE-4 had only 30 questions. The initial methodology, of including the questions in the body of an email so respondents could reply within their email software, was in response to feedback of the pilot phase of LPSE-1, in 2013. Technology has moved on, so for LPSE-5 a web-based questionnaire software package will be considered, along with other approaches, including simplifying the process to a telephone-only model. This is because most of the returns filled in by respondents needed to be clarified (with associated administrative difficulties), whereas none of those filled in over the telephone needed this extra element.

Concluding Remarks

LPSE-4 is the latest in a series of staffing surveys of Liaison Psychiatry teams in England. LPSE-1 came into existence to inform Government how much extra investment would be needed to have adequate Liaison Psychiatry in every acute hospital with an ED in England. It continues to exist to monitor the encouraging progress towards these policy goals.

Appendix 1 (Questionnaire)

Fourth Survey of Liaison Psychiatry in England (LPSE-4)

Service overview (6 questions)

1. What is the name of the service or team which provides Liaison Psychiatry on behalf of which you are responding? *(We will call this 'your service' throughout.) (If your hospital has more than one liaison service, more than one of these questionnaires should be completed. However, we will collate the results from each acute hospital for adults' and older adults' services, so whether there is a response for each of these, or one across both, does not matter as long as everyone is counted. Do what is easiest for you.)*

2. Does your service offer anything other than Liaison? If so, please outline the other services. *(Some teams are unified Crisis, Home Treatment and Liaison, for example.) (Many paediatric services offer Liaison as one of many activities undertaken.)*

3. Is your service physically based in an acute hospital building? *If not, how far away it is from the acute hospital? If so, what is the name of the acute hospital site where your service is based?*

4. Does your service provide Liaison to any other sites? *If so, please name them. (This may be another acute hospital, GP surgery, or something else)*

5. What is the name of the provider of your service? (*Usually this is a Mental Health Trust).*

6. Is your service securely and recurrently funded? I*s the whole service funded recurrently? If the term is fixed but long, please tell us when it is for review. Please describe if some or all of your service is recurrent but some is on short-term contracts. (There is policy interest in financial stability/instability of services, particularly ones which need to rejustify their existence regularly.)*

Workforce (4 questions) *For each of the following questions, for each professional group please list: The number of Full Time Equivalents at each level of seniority; The number of actual different people at each level of seniority; Please also detail who is substantive, who is a locum, who is temporary/fixed term, etc. If your service delivers care other than Liaison, please only include workforce figures for the Liaison part if you can. If there is no clear division, please describe the entire service and indicate approximately what fraction of the workload is Liaison.*

7. Mental Health Practitioners *(=Largely nurses) Please include bands and, if applicable, please identify which practitioners are primarily orientated in their role towards one client group or another (eg Older people/Children, etc*
Band 5s
Band 6s
Band 7s
Band 8s

8. Doctors *Please include grades of juniors and include special interest sessions etc.*
F1s
F2s
CT1-3s (=SHOs)
ST4-6s (=SpRs)
SASs (=Staff Grade/Associate specialists)
Consultants

9. Others *(and bands if known) e.g. Psychologists, psychotherapists, social workers, housing support officers, healthcare assistants, pharmacists, drug and alcohol workers, etc.*

10. Administrators *(and bands if known)*

Competencies (2 questions)

11. Does your service use a competence framework? *Please give details, particularly in how one is used. (eg Liaison Mental Health Nursing Competence Framework). If no competence framework is actually in organisational use, but its existence is known and there are plans to use it, please document this too.*

12. What CCTs do the consultants in your team hold? *(Consultants all have a 'Certificate of Completion of Training' (CCT). These may be 'endorsed', which means the consultant had special experience and training in certain specialities as a junior doctor.) (Consultants' CCTs are likely to be in General Adult Psychiatry, Old Age Psychiatry, Child and Adolescent Psychiatry, or a combination of these. Endorsements can be in Liaison and/or Addictions.)*

Activities (12 questions)

13. What are the criteria by which your service would accept a referral from the ED? *Please be as specific as you can. (The most usual criterion is one of age, but there are many others, and they often change over time as well. There is great policy level interest in things like this, so please be really detailed.)*

14. What teams or services would see the ED referrals who need to be seen, but your service does not see? *Please be as specific as you can. (eg "The children (0-17) are seen by CAMHS or are admitted to paeds. The older people are seen by our older adults service from M-F 8am-7pm, but out of those hours those referrals come to us. People with primary alcohol or drugs presentations are seen by A&Es own alcohol worker in hours, but out of hours come to us.")*

15. What are the hours of operation of your service's ED activities? *(This is about the functioning of your service. Transferring over to the on call SHO out of hours, or a crisis team, does not make a service 24 hours)*

16. What happens outside these hours? *(Who sees the patients? PLN? SHO? HTT? Crisis? Just ED? They wait?)*

17. What is the target wait time to see people referred from ED, if any?

18. What are the criteria by which your service would accept a referral from the wards (including MAU)? *Please be as specific as you can.*

19. What teams or services would see the Ward/MAU referrals who need to be seen, but your service does not see? *Please be as specific as you can.*

20. What are the hours of operation of your services' ward referral activities?

21. What happens outside these hours?

22. What is the target wait time to see people referred from wards, if any?

23. What are the criteria by which your service would see outpatients? *(If your service sees any outpatients at all. If there is more than one pathway into being seen as an outpatient, please list them all and their criteria.)*

24. What other activities does your service undertake, if any? *(Many Liaison services deliver teaching to ED staff, ward staff, managers, students, postgraduates etc. Please describe all that happens, and how frequently. Please also document any student attachments with your service. Please record any work undertaken by your service not captured above, in particular there are reports of non-ED s136s being undertaken by some Liaison services. This is of policy interest, so please include it here.)*

Final queries (4 questions)

25. Which outcome measures do you use, if any?

26. Do you use the FROM-LP outcome measure? *If so, please indicate which elements are used:*
IRAC
CGI-I
CORE-10
Patient Satisfaction Scale
Friends & Family Test
Referrer Satisfaction Scale

27. Is your service worse, similarly, or better resourced than it was in July 2016?

28. What does your service do well?

29. What in your service is a challenge? (In particular, are certain groups disadvantaged, especially age groups? *There is policy interest in whether unifying working age adult and older adult teams has resulted in older people being disadvantaged because of dilution of expertise and management being more focused on the needs of adults of working age.) (Everything you write is in confidence.)*

30. Is there anything else you would like to contribute to the survey?

THANK YOU FOR TAKING PART IN THE FOURTH SURVEY OF LIAISON PSYCHIATRY IN ENGLAND (LPSE-4)

Appendix 2 (Coding manual)

Staffing:

- Paediatric staff do not count for this, adult (and older adult) workers only are included in this report.
- Only Band 5 or more count towards nursing (= MHP) numbers.
- Bands 5, 6, 7, 8 are equivalent.
- Where there are cradle to grave services, all the people are counted.
- Where services cover two or more hospitals, the people are divided equally, unless specified.
- Psychologists and pharmacists never count in MHP numbers. Other PAMs do, unless a specific boundaried role is described.
- Service manager 'not specific to liaison' is halved.
- People on sick leave are counted.
- 'Part-time' are assumed to be half time, if not specified.
- A fraction of a service leader is recorded, or a value of 0.2 FTE placed.
- Shared senior leadership is included. Distant reporting structures are not.
- Band 8s included if mentioned. If said to be not part of team, or off site, not counted.
- Where options are placed ("1 or 2 band 8s") then we record the lower of the options.
- Where shifts covered by number of staff is specified, but the number of posts is not, a calculation assuming a full timer works 64% of days of the year for 8 hours was used to calculate the number of FTEs.
- Where FTE not specified, but hours are, a calculation based upon the hours worked was undertaken.
- Where there is another service which is melded with Liaison, the staffing is halved to assume equal activity in each.
- Drug and Alcohol workers of Band 5 or above count in the MHP numbers, regardless of which column they count in.
- Assistant psychologists are counted in 'other'
- Personal assistants count in 'other'.
- Therapists are counted in 'other'.
- Administrative support is coded as 0.25 FTE if FTE not specified.
- Shared with other teams: FTE shared equally between the teams.
- Half clinical administrators are only counted toward MHPs total if they are Band 5 or above.
- 'Tiny fragment of admin' = 0.05 FTE
- Additional administrators: 'psychology admins' or 'data analysts' are included.
- Administrative support which is an unspecified part of a large bank are coded as 1 FTE.
- Consultants' own personal assistants count in the administrators numbers.
- Drug and Alcohol workers are counted in the MHP numbers, regardless of source of funding, employer etc.
- Social workers working as MHPs are coded there. The minority with a boundaried social work role are coded in the 'other' column.

ED Response Time Target:

- Services are included regardless of hours of operation.
- If 1 hour target for urgent or emergencies only, this counts.
- If intoxicated people can't be seen, that does not undermine a 1 hour target.
- If the service is working towards a 1 hour target, this counts.
- Percentages within the target count.