Report of the 3rd Annual Survey of Liaison Psychiatry in England (LPSE-3)

Prepared for Health Education England, NHS England and the National Collaborating Centre for Mental Health, part of the Royal College of Psychiatrists.

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Introduction

Liaison Psychiatry addresses the mental health needs of people who also have physical health needs. Teams, usually consisting of psychiatrists and mental health nurses and often other professionals, are usually based in acute hospitals (see prior report[1] for more details).

There has been growth in Liaison Psychiatry provision in England in recent years because of the realisation of the extensive unmet mental health needs in acute medical settings and new evidence showing a well-resourced Liaison Psychiatry service 'pays for itself' several times over in prevented admissions, shortened admissions, and prevented re•admissions.[2]

There is a government commitment for there to be 24•hour, all•age Liaison Psychiatry in all EDs in England by 2021, with half of all EDs meeting the 'Core 24'[3] specification for the staffing of services for adults.[4]

To assess progress towards these goals NHS England, via Health Education England, commissioned the National Collaborating Centre for Mental Health (part of the Royal College of

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

[2] 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>

[3] "Developing Models for Liaison Psychiatry Services • Mental ..." 2014. 16 Jul. 2015 <http://mentalhealthpartnerships.com/wp•content/uploads/sites/3/3•developing•models•for•liaison•psychiatry•services.pdf>

[4] https://www.england.nhs.uk/wp•content/uploads/2016/02/Mental•Health•Taskforce•FYFV•final.pdf

Psychiatrists), and a research team at Plymouth Medical School, to carry out the third annual Liaison Psychiatry Survey of England (LPSE•3).

Methods

We undertook the 3rd annual survey of Liaison Psychiatry provision and activities in English Acute Hospitals with Emergency Departments. It was a questionnaire survey, sent out by email, similar to LPSE•1 and LPSE•2. In response to policy need, the number of questions has grown from 27 in LPSE•2 to 59 in LPSE•3. In response to feedback from LPSE•1 and 2, all answers were free•text to allow for explanation and elaboration, and responses were invited by email, phone, or any reasonable means the responding team would like to submit them.

Selection of Questions

We invited representatives of NHSE, HEE, Liaison Psychiatry Research, Liaison Psychiatry clinical practice and Liaison Psychology to join an Oversight Group (Appendix 1) to agree the proposed questions for LPSE•3. The process consisted of two conference calls from which notes were taken. A sub•group of six consisting of the Chair and representatives of the major stakeholders agreed the final questions (Appendix 2).

Sample

We downloaded the most recent list of NHS Trusts in England from the NHS England website[5]. We established which of these Trusts were Acute Trusts (rather than Mental Health Trusts) and which had one or more Emergency Department (ED). We established the names of the hospitals with emergency departments belonging to each Acute Trust. We created the dataset with one row per acute hospital.

The downloaded file also contained bed•number data by Acute Trust, except for Ipswich Hospital NHS Trust which did not submit data for that quarter. For that hospital, data from the previous quarter[6] were used. We populated one column in the dataset with bed number data for each acute hospital.

For the Trusts with a single ED, this bed figure was recorded in the dataset for the acute hospital. For the Trusts with more than one ED, the Trust website, the NHS Choices website, Wikipedia and the web more generally was used to find a figure for the number of beds for each acute hospital with an ED in England. Where there were data for the whole trust and for all but one of its acute hospitals, the number of beds of that last hospital were calculated by subtraction. Finally, figures from LPSE•2, our similar survey carried out a year ago, were used if none of the other sources yielded a figure.

[5] https://www.england.nhs.uk/statistics/wp•content/uploads/sites/2/2013/04/Beds•Open•Overnight•Web_File•Final•Q4•2015•16•9315.xlsx

[6] https://www.england.nhs.uk/statistics/wp•content/uploads/sites/2/2013/04/Beds•Open•Overnight•Web_File•Q3•2015•16•Final•49659.xlsx

Data Collection

On June 5th 2016 we emailed the people who responded to LPSE•2 explaining the nature of this survey and asking them to complete and return it to us. As previously, the needs of the answering clinician were considered at every stage: Questions were included in the body of the email so answers could be returned directly by replying to the email and writing answers after each question in the included text. The questions were also attached to the email in a Word document which suited some clinicians better, to either fill in and return by email, print out and fill in with a pen and then scan and email the scanned images, print out and fill in with a pen and return by post. Last, we also accepted telephone returns where either JB or WL would fill in answers provided by the respondent into the Word document which is then emailed to that respondent for checking and for their records.

Reminder emails were sent out at two weeks and four weeks. We also sent personal emails to 'regional champions' (liaison clinicians known to the investigators and supportive of the project) asking them to contact non•responding teams on behalf of the Survey. We later contacted the senior management of every mental health trust in England via NHS England. We used Twitter to publicise the Survey, attracting 'retweets' from many prominent clinicians. In addition, we circulated awareness•raising messages on appropriate email lists, including Liaison Jiscmail and TNC (Trainees and New Consultants) Jiscmail. Last, we contacted non•responding services by telephoning the acute hospital concerned and asking to be connected to the Liaison service.

In addition to the above, and in response to feedback from LPSE•2, we used four separate email lists to publicise the Survey to psychologists. This was because it was thought there are psychology•led Liaison mental health services (particularly for children) which were not detected by LPSE•2.

Previous rounds of LPSE intended to have a single return from each general hospital with an ED. This time separate returns were requested from each team providing mental health care within acute hospitals with EDs in England. We were aiming at collecting information about services for children, working age adults, and older adults, but this approach allowed for any configuration to be captured.

Data processing and analysis

Returns were processed and the dataset populated. When a return was received a public 'google sheet' was updated saying that that hospital had responded. A link to this google sheet had been included in the emails sent to potential participants so they could check whether their own service had already responded before responding themselves. We created graphs similar to the report of LPSE•2 and incorporated data from LPSE•2 and LPSE•1 into graphs where possible.

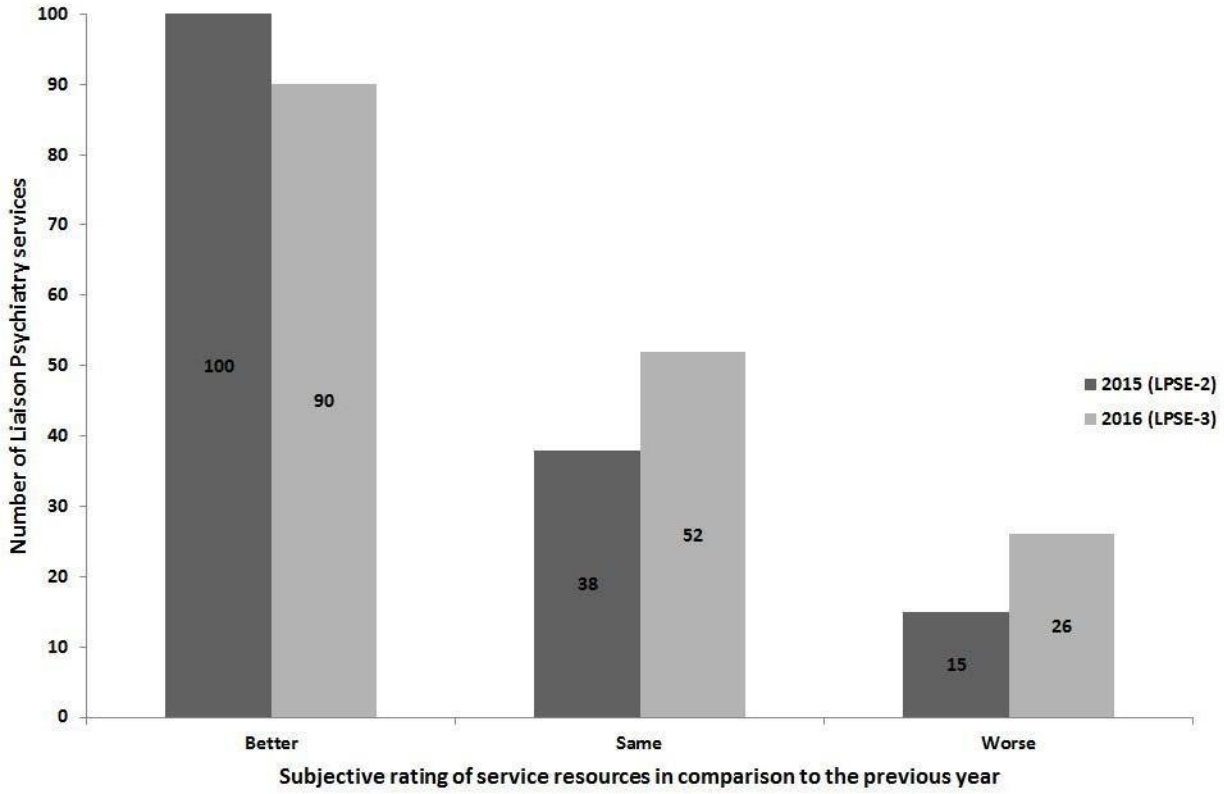
Results

Liaison for working age adults and older adults

As of 31/8/2016, data were returned by 173 (98%) of the 177 acute hospitals with EDs in England. The denominator figure of 177 EDs in England is less than LPSE-2's figure of 179.

The non•responding hospitals were Alexandra Hospital Redditch, Worcestershire Royal Hospital, Royal Blackburn Hospital, and Northampton General Hospital.

Figure 1: Number of Liaison Psychiatry services which report a better, same or worse resourced service than the service recalled from a year previously.

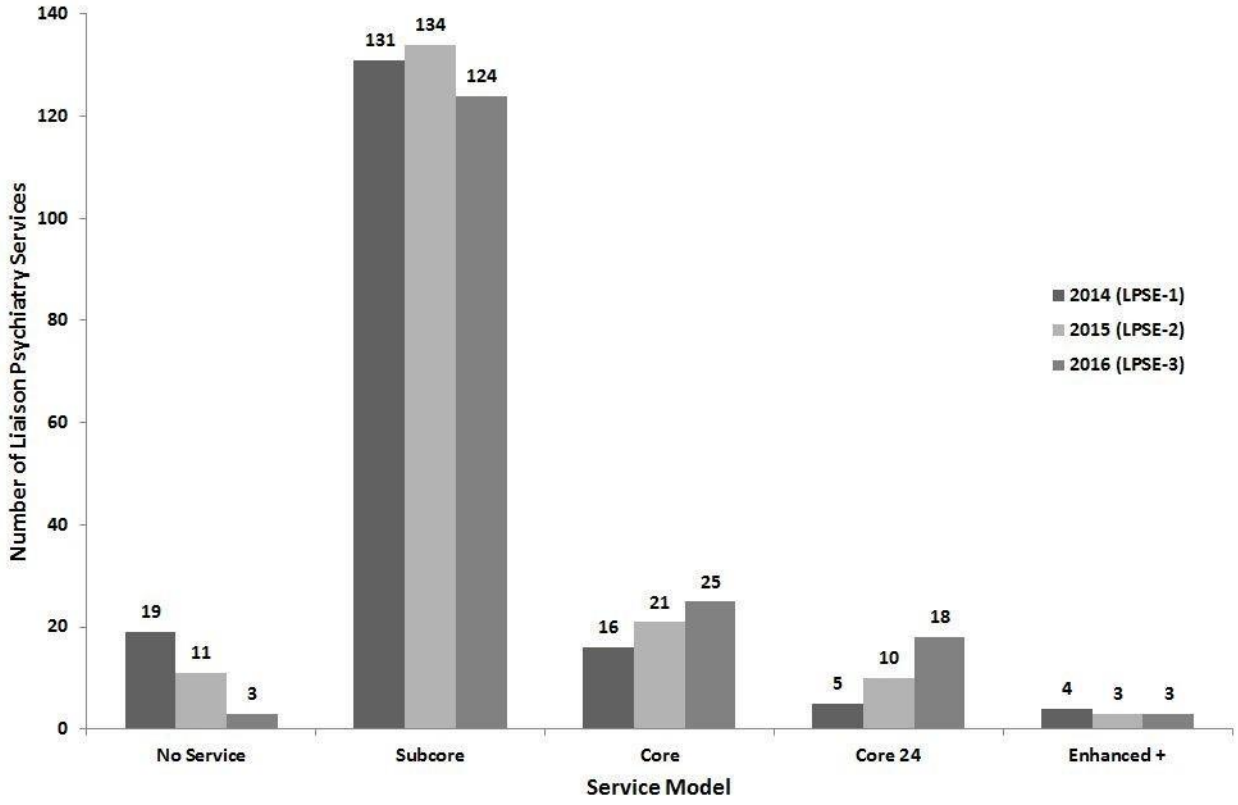


More than half (90/168 of teams which answered this question), said their service was better resourced than in April 2015. This is a decrease from the LPSE•2 figure of 100. The number of services staying the same and being worse•resourced than a year previously rose to 52 from 38 and to 26 from 15 services respectively (see Figure 1).

On this measure, the national situation could be summarised thus: Liaison provision is improving, but the degree to which it is getting better is less, with fewer services improving and more staying the same and getting worse in terms of resourcing than last year. To express the

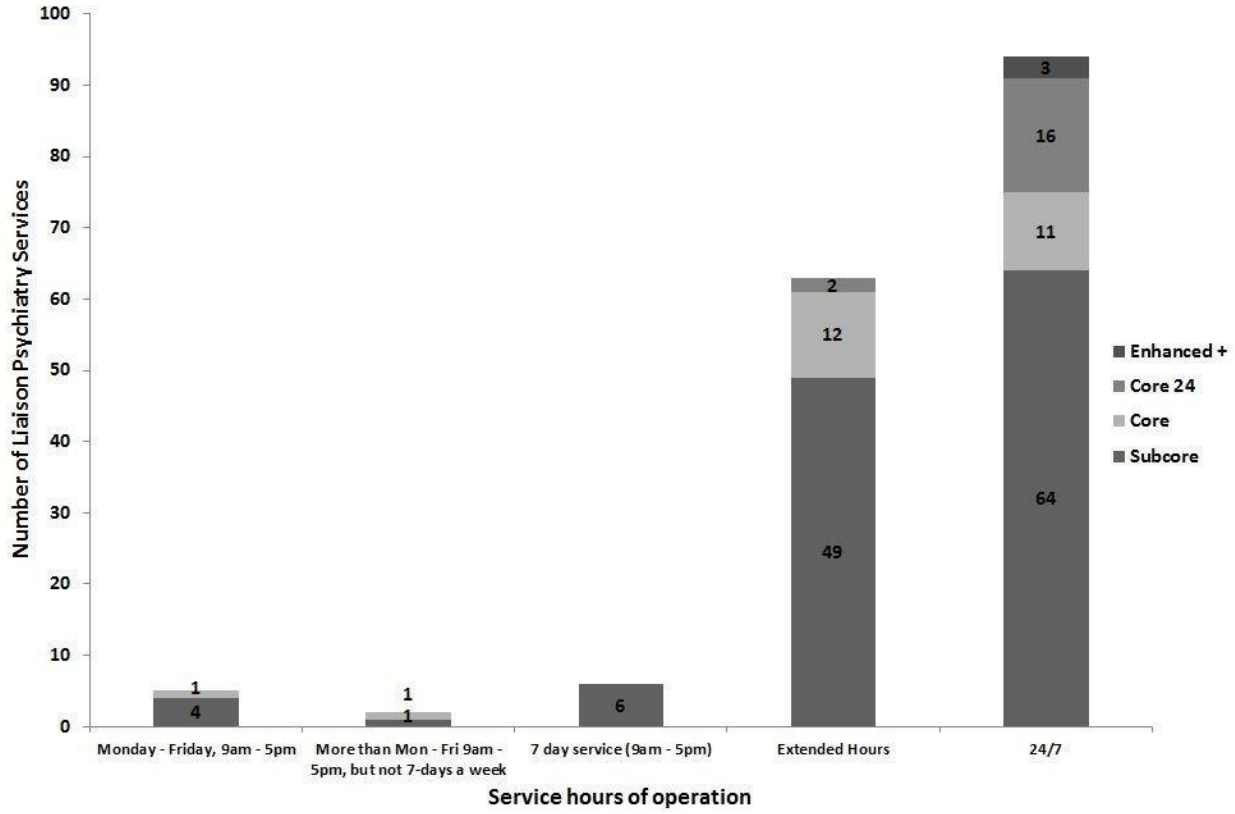
situation as a number, LPSE•2 had 85 more services getting better than getting worse, whereas for LPSE•3 that figure is 64.

Figure 2: Services in each service model for this survey with, for comparison, the results from similar Surveys from the two previous years.



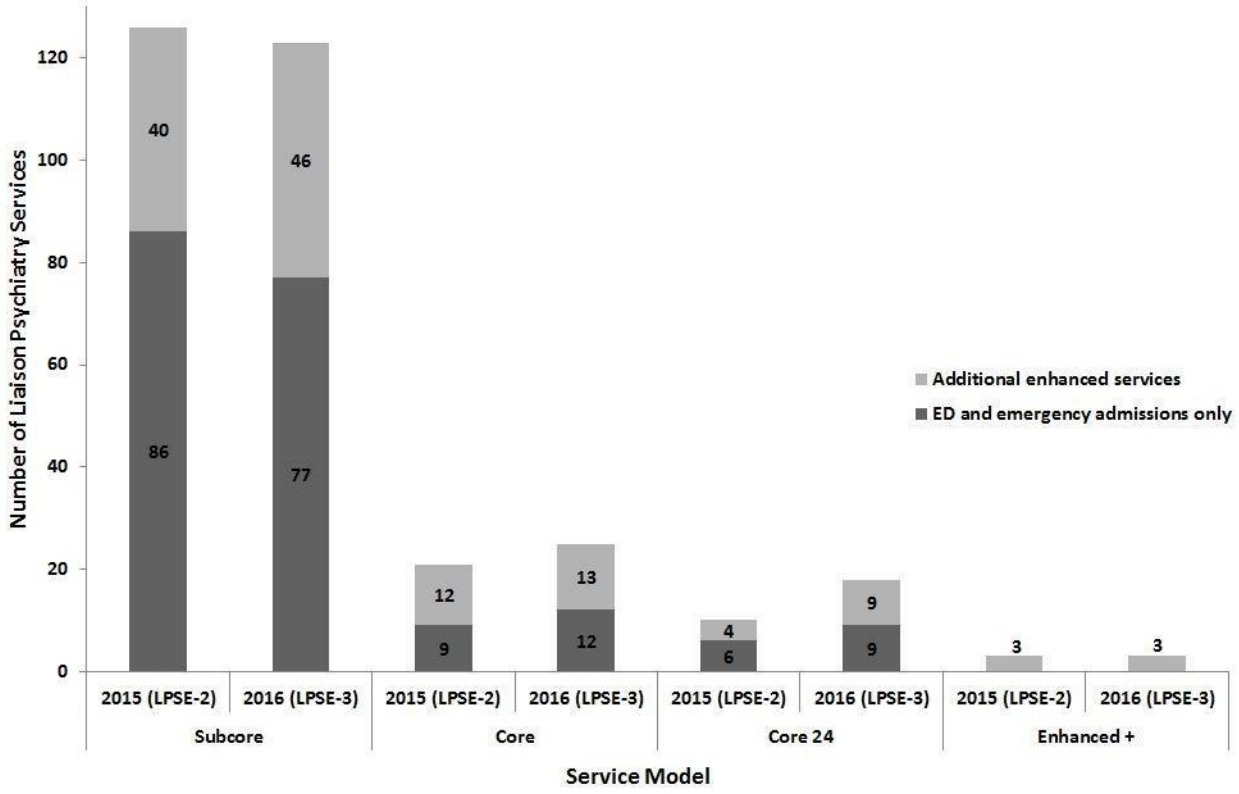
The number of hospitals with no Liaison service has steadily reduced over the three Surveys. Reciprocally, there is a steady increase in the number of hospitals meeting Core and Core 24 criteria. The number of hospitals which meet or exceed the Enhanced criteria has fallen slightly from four to three. The number of hospitals which meet or exceed Core 24 is now 21 • 12% of the total.

Figure 3: Services divided by their hours of operation and service model.



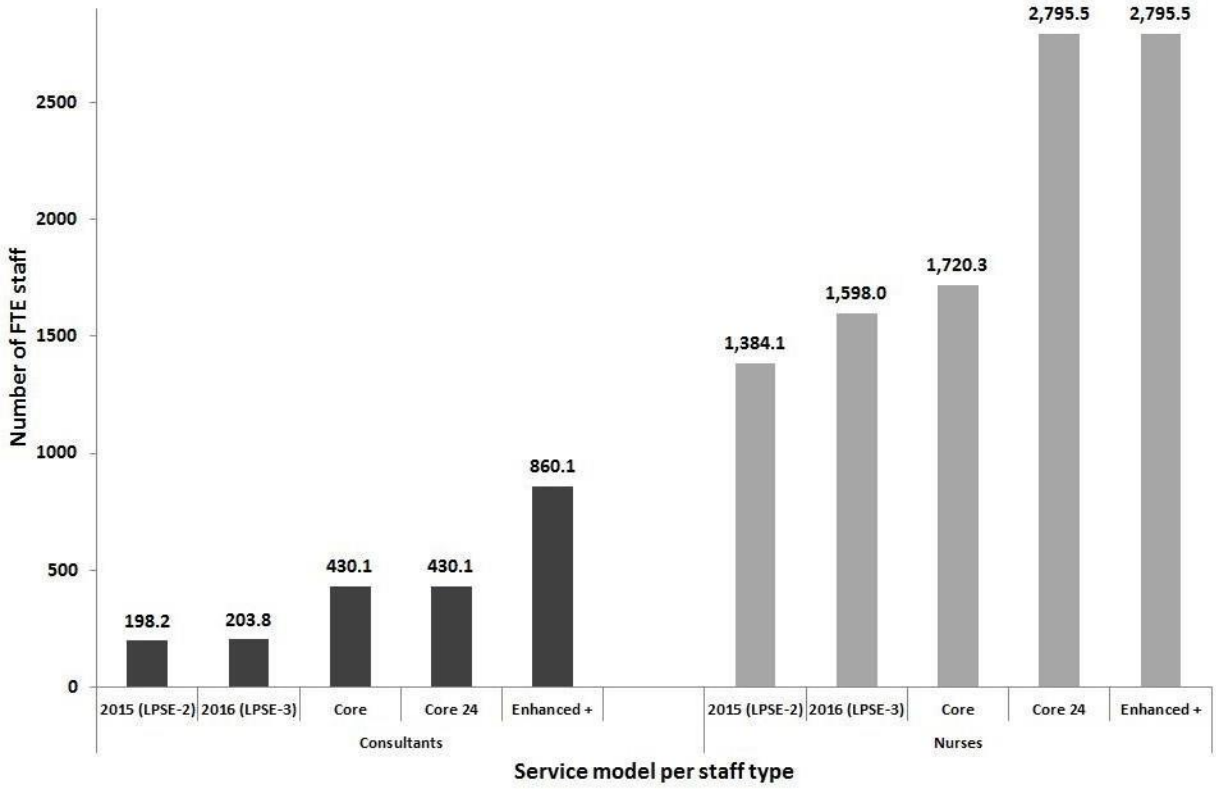
As with LPSE•2, the relationship between staffing and hours is not strong. There are 75 (64+11) where a 24 hour service is offered, but there are inadequate staff to do this in accordance with published staffing guidance.

Figure 4: Services divided by their service model and whether they offer non•acute additional activities.



As in LPSE•2, there are numerous acute hospitals with small Liaison services which have a non•acute aspect to them, despite not being properly staffed to deliver even a solely acute service. As expected, those places with very large teams (Enhanced +) all do have non•acute components.

Figure 5: Consultant and nurse numbers in Liaison Psychiatry services in England's acute hospitals with EDs: Current provision and that required for nationwide implementation for the different service models.

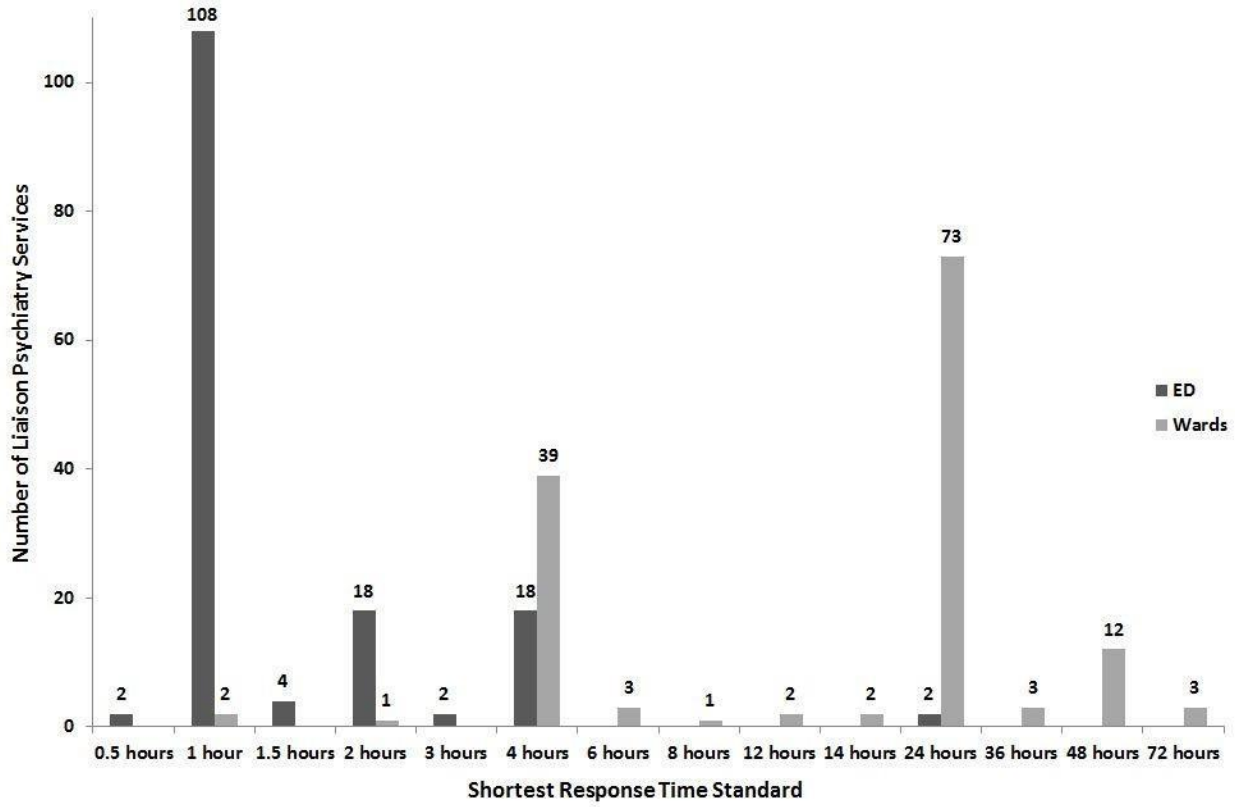


This graph shows the FTE (Full Time Equivalent) Consultant and Nurse numbers found in LPSE•2, LPSE•3, and the numbers required for the whole of England to have Core, Core 24 and Enhanced staffing levels.

England needs 430.1 FTE Consultant Liaison Psychiatrists for every acute hospital with an ED to be staffed at Core 24 level. In LPSE•2 there were 198.2 reported and in LPSE•3 there is a small increase to 203.8 FTEs. This is an increase of 5.6 FTEs, which is 2.4% of the deficit.

England needs 2,795.5 FTE Psychiatric Liaison Nurses for every acute hospital with an ED to be staffed at Core 24 level. In LPSE•2 there were 1,384.1 and in LPSE•3 there are 1,598. This is an increase of 213.9 FTEs, which is 15.2% of the deficit.

Figure 6: Response•time standards.

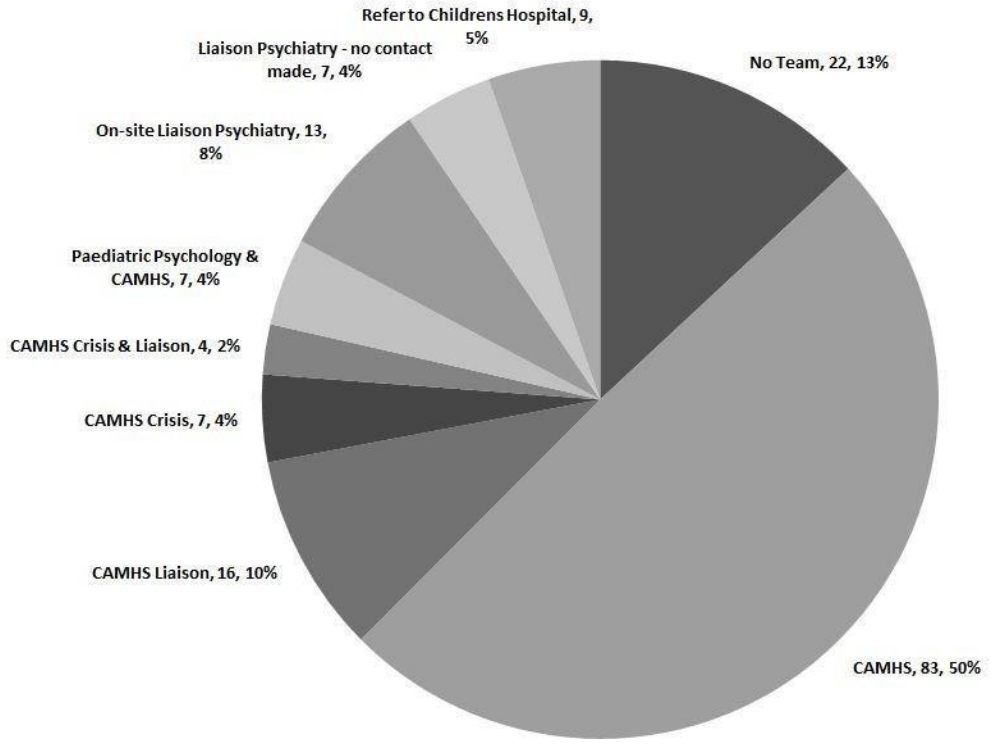


This graph shows the response time standards for Liaison services for people in EDs and wards (including CDU/MAU/SAU etc.). The published expected waiting times of 1 hour for ED and 4 hours for ward referrals are prominent, though there is variation in both directions from this standard.

Liaison for Children and Young People (CYP)

In this Survey, every team contacted was asked about other teams which see people with mental health needs in the acute hospital in which they work. If those teams were Liaison teams, we attempted to contact them. If they were not, we recorded the type of team they were.

Figure 7: What kind of service provides mental health care for CYPs

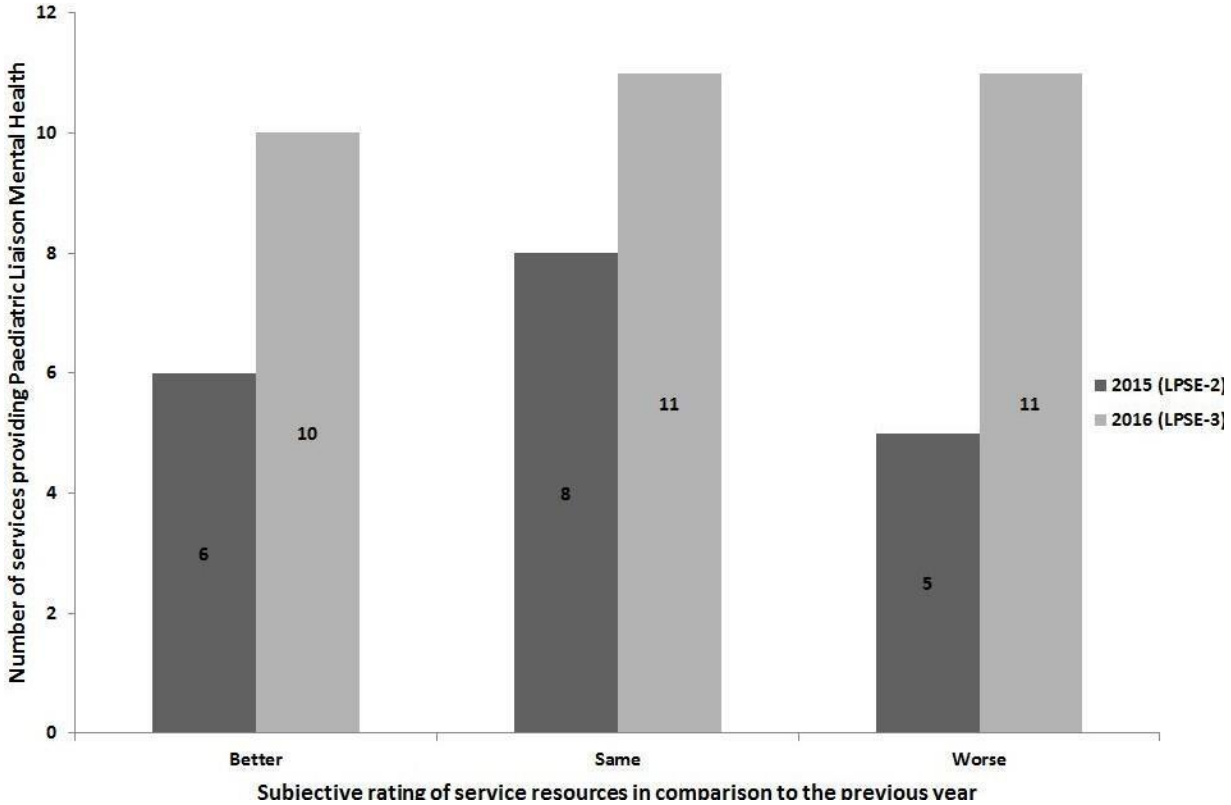


Twenty two (13%) hospitals reported no mental health team for CYPs (at least one of these hospitals had no child inpatients at all). We made contact with 13 on•site paediatric Liaison Psychiatry teams and had reports of seven more making a total of 20 (12%) of acute hospitals (not including children's hospitals) in England with EDs which have on-site paediatric Liaison teams.

Most of the remainder met the mental health needs of CYPs who attend by community CAMHS clinicians visiting the acute hospital. These teams were with or without a 'Liaison' designation. We had direct contact with only a small number of these services, including one where the whole community CAMHS team happened to be based in the acute hospital.

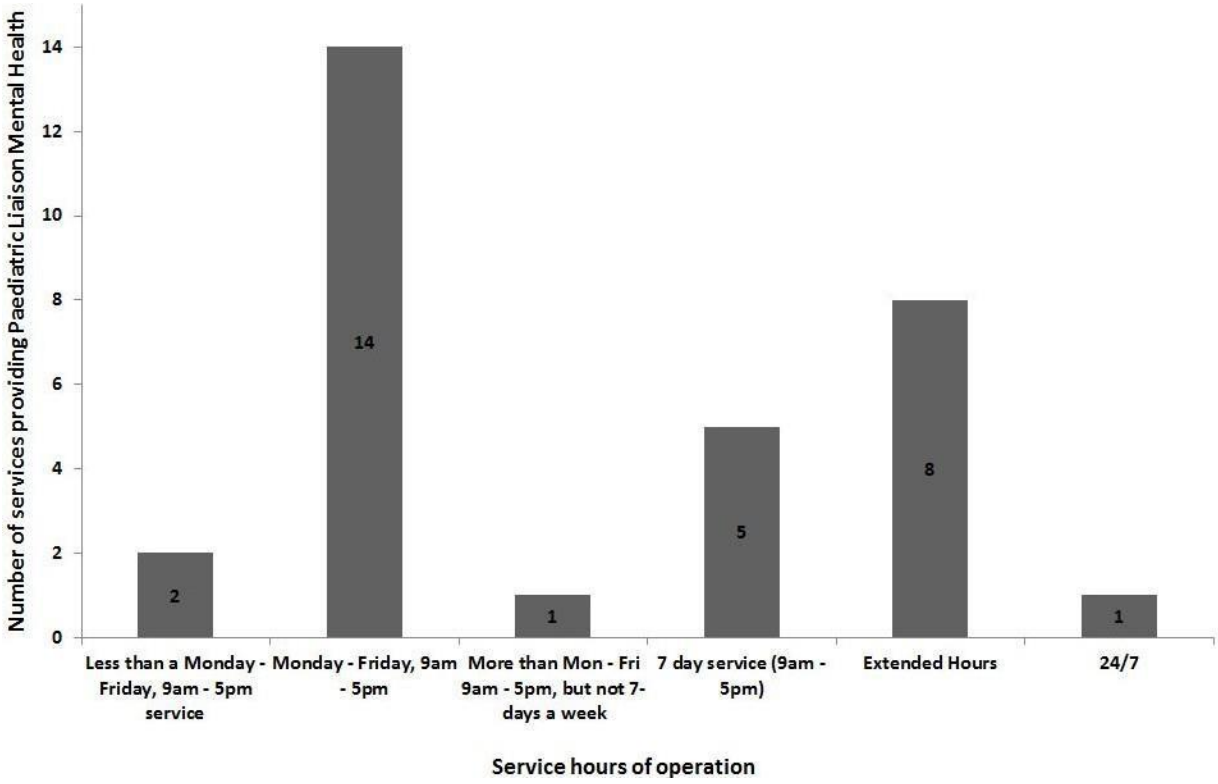
We received responses from five children's hospitals with their own EDs. Nine of the 177 acute hospitals with EDs refer patients to one of four of these children's hospitals teams - one of the children's hospitals does not have a Liaison Psychiatry service. The four children's hospital Liaison Psychiatry teams are not included in the figure above.

Figure 8: Number of paediatric Liaison Psychiatry services which report a better, same or worse resourced service than the service recalled from a year previously.



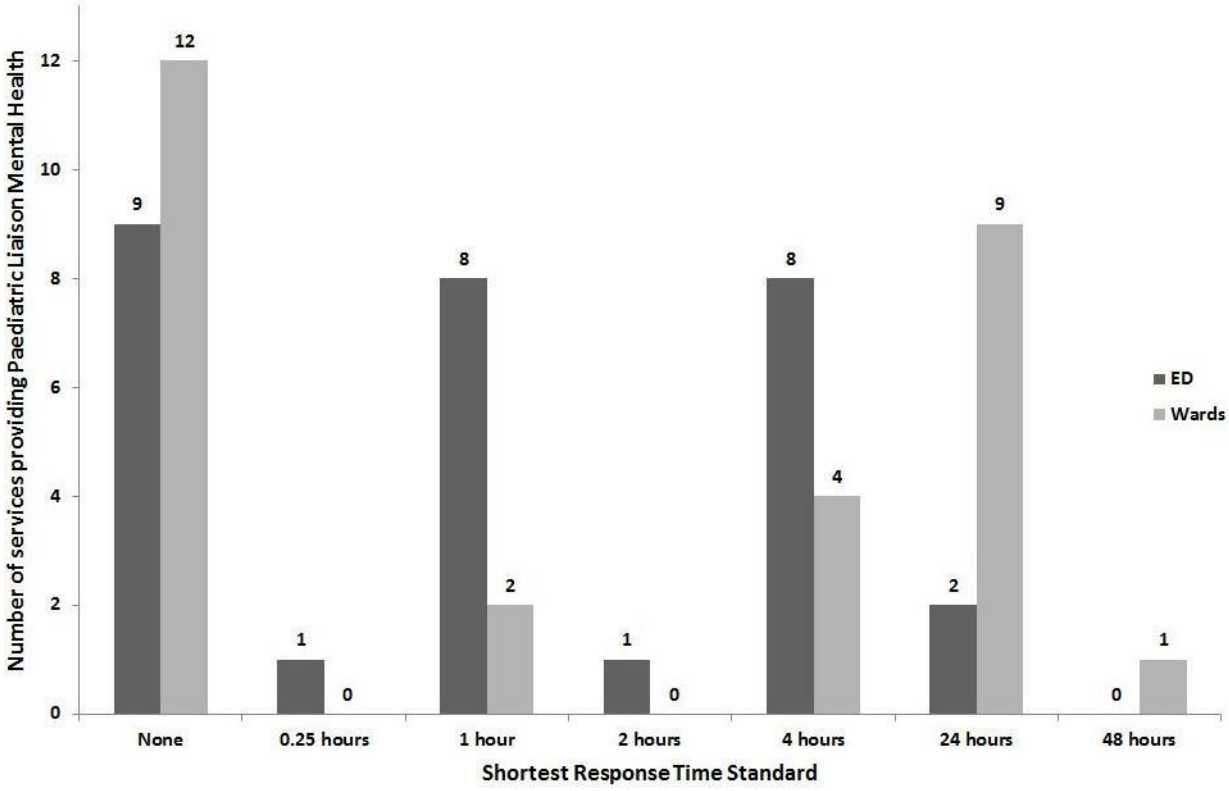
This graph indicates change in services for CYPs: Two thirds of services describe growing or shrinking, but no overall trend is apparent: For LPSE•2, there was one more team growing than shrinking. For LPSE•3 there is one more shrinking than growing. We made contact with more teams in LPSE•3 than in LPSE•2 (32 rather than 19).

Figure 9: Services divided by their hours of operation.



The bulk of CYP Liaison services are open Monday•Friday 9•5. There is one 24/7 service and two which are less than Monday•Friday 9•5.

Figure 10: Response time standards of Paediatric Liaison Psychiatry services.



This graph shows the response time standards for the paediatric Liaison teams we made contact with. The most frequent finding was there being no response time standard.

Discussion

Summary of results

Liaison for working age adults and older adults

We found many more Liaison teams for adults reporting being better resourced than worse resourced than they were a year ago, though this excess itself is less than it was a year ago. There is growth in services being staffed to the Core 24 level, though this is still only 12%. Most (94, 53%) teams undertake 24/7 working but many (75, 42%) are not staffed to do this. Many small teams offer non•acute services.

England needs 430 consultant liaison psychiatrists for every acute hospital with an ED to have a Core 24 Liaison team. The growth in consultant numbers, from 198 to 204 since LPSE•2, closes less than one fortieth of this gap. England needs 2,795 nurses to be Core 24. The numbers have grown from 1,384 to 1,598 since LPSE•2, which closes 15% of this gap.

The waiting time standards of one hour for ED and four hours for wards is the most common reported standard.

Overall, the picture from asking teams is that nationally the extent of growth is lower than it was a year ago.,The progress in getting new consultants into post has been poor. This may be due to a problem in supply, which is already being addressed by the new process of 'credentialing' of non•liaison consultants into Liaison. For nurses, the situation is better, but the rate of growth of posts will have to grow for the government target of adequate Liaison in every acute hospital with an ED to be met.

Liaison for Children and Young People (CYP)

The largest type of service was community CAMHS services coming into the hospital to see patients, but there was great variety with a minority of hospitals having dedicated CYP Liaison teams. About equal numbers of teams reported being better, similarly and worse resourced as a year ago. Most teams operated in working hours only, but one was 24/7.

Strengths and weaknesses

LPSE•3 is the 3rd annual survey of Liaison Psychiatry in England. These surveys are led by a clinician, with the expectation that clinicians (rather than managers) answering 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 and 98% for LPSE•3. These figures mean the results of these surveys can be trusted in a way few surveys can be, because the issues of participation bias which are the bane of many surveys of this kind, do not apply.

Further, being engaged with the community of participants (and being a participant) allowed authentic relationships to be built 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•3. Accordingly, many pressing policy questions can be addressed from its findings, making LPSE•3 an efficient undertaking.

Like any survey, LPSE•3 is vulnerable to certain problems. Foremost is errors in reporting. These are known to happen in a few percent of answers to most questions and it is likely LPSE-3 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 may aggravate information biases.

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. 'Liaison Psychiatry' is criticised because 'liaising' is only a fraction of what Liaison Psychiatry teams do. Third, there is an unfortunate distinction between 'doing Liaison', which 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, because many teams have no psychiatrist, and there may be teams led by psychologists. 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.

The above problems are managed not by exhaustive and precise definitions (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 simply describe their situation and have the LPSE•3 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 is out of date quickly anyway.

Overall, LPSE•3 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. As the number of questions grows, the burden on respondents, who ate busy clinicians, also grows. While the response rate for LPSE•3 remains very good at 98%, the feedback from respondents was that fewer questions would be more desirable in the future. In addition, the unstructured arrangement of including the questions in the body of the email so respondents could respond by writing in the gaps in the included text when they reply, is not suitable for a questionnaire of this length.

Concluding Remarks

LPSE•3 is the latest in 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 progress towards the Government goal of adequate Liaison in all acute hospitals with EDs in the financial year of 2020•21.

For working age adults and older adults, this is a relatively straightforward matter: The levels of necessary staffing are defined (half of all EDs will have Core 24 level teams by 2020/21, and all will have 24/7 access to Liaison within 1 hour). There has been some progress, but to meet this goal there needs to be a great increase in the creation and filling of consultant and nursing posts in coming years.

For CYPs this is more complex: There is an expectation of 24/7 access within 1 hour, but how this might be delivered remains open. There is great variety in how this is done at the moment, from full, separate, 24/7 service for CYPs, to no provision at all. All this Survey can do is to quantify the current provision to fully inform policy makers to help them prepare their next steps.

Appendix 1

Oversight Group:

Alex Thomson • Liaison Psychiatrist.
Alistair Burns • NHS England Director for Dementia and Older People's Mental Health.
Allan House* • LP•MAESTRO Lead.
Bobby Pratap • NHS England.
Busuttil Angela • Former Chair of Faculty of Clinical Health Psychology, British Psychological Society.
Chris Schofield • Liaison Psychiatrist.
Else Guthrie* • Chair.
Hannah Xanthe • NHS England.
Henrietta Mbeah•Bankas* • Health Education England.
Jessica Barrett* • LPSE Researcher.
Jim Bolton • Psychiatric Liaison Accreditation Network.
Julia Faulconbridge • Chair of Faculty for Children, Young People and their Families, British Psychological Society.
Katherine Chartres • Nursing lead for Liaison Faculty • Royal College of Psychiatrists.
Katherine Martin • Liaison Psychiatrist.
Peter Aitken • Chair of the Liaison Faculty, Royal College of Psychiatrists.
Peter Trigwell • FROM•LP Outcome Measure Lead.
Sara O'Curry - Chair of Paediatric Psychology Network, British Psychological Society.
Sarah Brown • Liaison Psychiatrist.
Sarah Burlinson • Liaison Psychiatrist.
Sarah Eales • Liaison Nursing Competency Framework.
Sridevi Sira Mahalingappa • Liaison Psychiatrist.
Steve Jones • NHS England.
Thirza Pieters • Liaison Psychiatrist and author of new Liaison postgraduate syllabus.
Tom Ayers* • National Collaborating Centre for Mental Health.
Viral Kantaria • NHS England.
Westphal Birgit • Chair of Paediatric Liaison Psychiatry, Royal College of Psychiatrists.
William Lee* • LPSE Lead.

* *Group which agreed the final questions.*

Appendix 2

LPSE-3 Questionnaire

Third Annual Survey of Liaison Psychiatry in England (LPSE•3)

Introduction:
The questions in this survey are directed to Liaison Psychiatry services within acute hospitals in England. This survey is a lot more thorough than those which have gone before and therefore is more complex to fill out. However, we have worked to keep it simple, relevant and not too long. There are seven sections, each of which have a set of related questions about your service. There is usually more than one service providing Liaison Psychiatry within one acute hospital (eg separate Older Adults, Paediatrics, etc.) and we ask for one response per service, please.
Before you start, you may want to check someone from your service has not responded already by looking at this link: https://docs.google.com/spreadsheets/d/1BKRZWfZdRtyR_C31JNe3PE42pjb2hame6L1i2VAhyM0/edit?usp=sharing
Please reply to this email (jessica.barrett@plymouth.ac.uk) and fill in the answers after each question in the included text. We'll take it from there. If you'd rather do it by phone, please get in touch and we'll arrange that too.
Thank•you very much for taking part in the 3rd Annual Survey of Liaison Psychiatry in England (LPSE•3)

Questionnaire:

1. Service overview. (7 questions)

   a. What is the name of the service or team which provides Liaison Mental Health services on behalf of which you are responding?
   (We will call this 'your service' throughout)

   b. 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.)

   c. Is your service physically based in an acute hospital building?
   If not, please say how far away it is from the acute hospital.
   If so, what is/are the names of the acute hospital(s) site(s) in which your service is based?

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

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

   f. Are there any funding anomalies?
   (eg Some services are paid for by only one CCG but see patients from any CCG, which can cause friction with commissioners. Please give details.)

   g. What other mental health care is provided for people in your acute hospital(s) that you know about, and how does your service fit into that context?
   Please list those you know about and give contact details if you have them.
   (This question is about two things. It is about other Liaison services (eg paediatric, working age adult, older adult, self•harm, ED, ward referrals, Liaison for people who live in a different area, etc). It also about other mental health practitioners working in acute hospitals (eg counsellors/psychologists/health psychologists). There is particular policy interest in the relationships between paediatric Liaison Psychiatry and other paediatric mental health workers in acute hospitals.)

2. Workforce. (5 questions)

For each of the following questions, a•e, 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, who is part of winter pressures, etc.

NB: 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.

a. Nurses • please include bands and details of advanced practitioners, prescribers, etc.
   I. Band 5s
   II. Band 6s
   III. Band 7s
   IV. Band 8s

b. Doctors • please include grades of juniors and include special interest sessions etc.
   I. F1s
   II. F2s
   III. CT1•3s (=SHOs)
   IV. ST4•6s (=SpRs)
   V. SASs (=Staff grade/Associate specialists)
   VI. Consultants

c. Psychologists (and bands if known)

d. Admins (and bands if known)

e. Other clinicians/non•clinicians (and bands if known)
(e.g. social workers, housing support officers, peer support workers…)

3. Competencies. (5 questions)

a. Does your service use a competence framework? Please give details.
(eg Liaison Mental Health Nursing Competence Framework).
If yes, please specify which framework and for which staff groups these are used, as well as how they are used. 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.

b. Does your service use any accredited training courses for psychiatric liaison nurses?
(e.g. City University certificate in Liaison Mental Health)

c. What CCTs do the consultants in your team hold? Are these CCTs endorsed in Liaison Psychiatry and/or Addictions Psychiatry?
(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.)

d. Are members of your team routinely expected to see patients for whom they have not had special age•specific training?
(eg Older adults/Children and Young People)

e. Does your service have an induction/training package for new starters? If so, please give some details of length/content/provenance.

4. Activities undertaken by your service. (14 questions)

a. Referrals from the Emergency Department.

I. Do you accept and see absolutely all referrals from the ED, with no exclusions or criteria?
(This is not about people who are referred in error. It is about people who do need to be seen but do not meet your service's criteria)
If not, what are the exclusions/criteria?
(Please be as specific as you can, particularly over timings: There is policy level interest in things like detoxes being overseen by alcohol services in hours but by Liaison out of hours. Similarly, if there is a difference between what is agreed and what happens, please document this too.)

II. What are the hours of operation of your service's ED activities?

III. What happens outside these hours?
(Who sees the patients? PLN? SHO? HTT? Crisis? Just ED?)
(Who provides senior cover? e.g. Liaison consultant? Other consultant?)

IV. Do you have a target wait time or similar to see people referred from ED? If so, please give details.

V. Please give names (and contact details if you didn't give them in Section 1) for all the other services which may see the people with mental health needs in ED whom your service does not see.
(e.g. Children, the elderly, substance users, people with dementia, people from out of area, people with learning disabilities, women in the perinatal period, etc.)

b. Referrals from wards (including MAU and CDU) in the acute hospital.

I. Do you accept and see absolutely all referrals from wards in the acute hospital, with no exclusions or criteria?
If not, what are the exclusions/criteria?

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

III. What happens outside these hours?
(Who sees the patients?)
(Who provides senior cover?)

IV. Do you have a target wait time or similar to see people referred from wards in the acute hospital? If so, please give details.

V. Please give names (and contact details if you didn't give them in Section 1) for all the other services in your acute hospital which may see people referred from the acute hospital wards whom your service does not see.

c. Outpatient activity.

I. Short term follow•up of people who have been seen by your service as an inpatient or ED attendee.
(We know of services which follow up people who have had delirium and services which follow up people who have harmed themselves.)

II. Clinics to which patients are referred, either by other specialist teams, from primary care, from out of area, or elsewhere.
(These clinics could be 'general' psychological medicine clinics, more specialist clinics for specific problems like MUS or chronic pain, clinics specifically related to particular specialties (e.g. diabetes). Patients may be seen by a Liaison professional alone or with a clinician from the other service. We know of existence of clinics for Medically Unexplained Symptoms, Neuropsychiatry, Pain, STD, Oncology, Neurology, Gastroenterology, Dermatology, Cystic Fibrosis, and Perinatal Medicine.)

d. Teaching.

Many Liaison services deliver teaching to ED staff, ward staff, managers, students, postgraduates etc.
Please describe all that happens, with an approx. total number of hours/year delivered. Please also document any student attachments with your service.

e. Other work. Please record any work undertaken by your service not captured above.

5. Interfaces with other teams: (10 questions)

a. Is there a Children and Young People's Liaison Mental Health service, separate to your service, within the acute hospital?
If so, do you have any formal links with that service?

b. Is there a Learning Disabilities service, separate to your service, within the acute hospital?
If so, do you have any formal links with that service?

c. Is there a Working Age Adult Liaison Psychiatry service, separate to your service, within the acute hospital?
If so, do you have any formal links with that service?

d. Is there an Older Person's Mental Health/Dementia/Frail and elderly Liaison Psychiatry service, separate to your service, within the acute hospital?
If so, do you have any formal links with that service?

e. Is there an Addictions/Substance Misuse service, separate to your service, within the acute hospital?
If so, do you have any formal links with that service?

f. Specialist clinical links to named teams:
Many services provide specialist expertise to named teams or departments. Here, there are organisational links beyond the sending of referrals. Examples might include a presence in an MDT or outpatient clinic of another service. Please outline the nature of the link and whether the extra resources are specifically commissioned or not: *(Examples of specialities with professional links include: Addictions, Bariatric , Cancer, Diabetes, Endocrinology, Gastroenterology, Gerontology, Hematology, Hepatology, Infectious Diseases, Perinatal/Obstetrics/Gynaecology, Medicine, Neurology, Neurosurgery, Orthopedics, Other (please specify), Pain Management, Palliative, Pediatrics, Rehabilitation, Renal, Respiratory, Spinal, Stroke, Toxicology, Transplant, Trauma)*

g. Is your service permitted to refer people with memory problems directly to your local memory assessment services?
(In many places these requests must go via the GP. This is about direct referrals.) (If your service does not see people with memory problems, please document this).

h. Please only answer these questions if your service sees Children and Young People:
   I. How many Paediatric beds are there in the acute hospital?
   II. How many Consultant Paediatricians are there within the hospital?
   III. Do you have any intensive care/neonatal beds? If so how many?

6. Outcome measures used by your service. (4 questions)

a. Do you use FROM•LP in any of your clinical activities?
If so, please indicate whether you use the tool routinely or occasionally.

b. Do you use any other outcome measures? (e.g. the GOMS).
If so, please indicate whether you use the tools routinely or occasionally.

c. If you do use FROM•LP, please indicate which elements are used:
   I. IRAC
   II. CGI•I
   III. CORE•10
   IV. Patient Satisfaction Scale
   V. Friends & Family Test
   VI. Referrer Satisfaction Scale.

d. How might FROM•LP be improved?
(eg to make it easier to use or more useful)

7. Roundup questions: (7 questions)

a. Please list your service's Key Performance Indicators, if you have any.

b. Has there been any research or audit (published or not) to support the development of your service? If so, can you describe it please?

c. Is your service worse/similarly/better resourced than it was in April 2015?

d. Is there is an expectation of changes in service configuration or staffing in the next year? or five years?

e. What does your service do well?

f. What in your service is a challenge?

g. What help do you need from NHSE, HEE, the College, and generally, to provide a better service?

THANK YOU FOR TAKING PART IN THE THIRD ANNUAL SURVEY OF LIAISON PSYCHIATRY IN ENGLAND (LPSE•3)

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