

# Report of the 8th Survey of Liaison Psychiatry in England (LPSE-8).

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

*Kate Welsh, Senior Research Nurse, Cornwall Partnership NHS Foundation Trust.*

*William Lee, Consultant Liaison Psychiatrist, Cornwall Partnership NHS Foundation Trust.*

## Executive Summary

This is the eighth Liaison Psychiatry Survey of England (LPSE-8). It concerns the Liaison Psychiatry services in acute hospitals with Emergency Departments (EDs) in England. These surveys tracked the progress towards Core 24 provision for adult and older adult services against Government targets of 50% by 2020/21, 59% by 2021/22, 64% by 2022/23 and 70% by 2023/24. This survey describes service provision in 2024/25, one year after the last target.

Core 24 or equivalent standards were met in 67% (114/170) of services in LPSE-7 against a target of 70%. Of the 170 eligible hospitals in 2024 (LPSE-8), Core 24 or equivalent standards being met reduced to 62% (106/170) of services by late 2024. The staffing levels refer to actual FTE in post at point of survey completion and not commissioned posts: 82% (139/170) of services are commissioned for Core 24 or equivalent standards and many respondents indicated they had vacant posts. For actual staff in post, when adjusted for NHSE approved alternatives the number of services which met the Mental Health Practitioner (MHP) Core 24 staffing criteria (11 MHPs) was 80% (121/151), exceeding the target, and the number of services which met the Consultant Core 24 staffing criteria (1.5 Consultants) was 64% (96/151), below target. Altogether, LPSEs 1-8 recorded 9, 16, 22, 58, 60, 104, 114 and 106 Core 24 or equivalent services respectively.

The number of services meeting Core 24 or equivalent standards has fallen for the first time this year and fluctuations in the workforce remain the biggest challenge. Consultant numbers have decreased this year, while MHP numbers have recovered to 2022 levels after decreasing last year. Sustained vacancies and instability in the workforce across England may continue. The original commissioning model for Core 24 standards was based on staffing numbers for c500 bedded hospitals, many of the acute hospitals participating in this survey have bed numbers which far exceed this. Therefore, there is a risk of applying the minimum Core 24 standard of 11 MHPs and 1.5 Consultants inappropriately to any individual hospital which can create an erroneous perception among integrated care boards (ICBs) that services are adequately resourced.

## Introduction

Liaison Psychiatry is the sub-specialty of Psychiatry which addresses the mental health needs of people in general clinical settings.<sup>1</sup>

In England, Liaison Psychiatry has grown over the last decade, in part because of evidence showing that well-resourced services make acute hospitals function more efficiently, with shorter admissions and fewer readmissions<sup>2,3</sup>, although this is not a universal finding.<sup>4</sup>

The Five Year Forward View for Mental Health (FYFV), published by NHS England in 2016, committed the Government to providing adequate Liaison Psychiatry in all acute hospitals with Emergency Departments (EDs) in England.<sup>5</sup> Their NHS Long Term Plan, published in 2019, expanded the programme further so that 70% of these services meet the Core 24 standard for adults and older adults by 2023/24.<sup>6</sup>

The Liaison Psychiatry Surveys of England (LPSEs) assess the progress towards these targets.<sup>7,8,9,10,11,12,13</sup> This is the report of the 8th of these surveys, this edition (LPSE-8) is funded by NHS England and the Liaison Faculty of the Royal College of Psychiatrists.

---

<sup>1</sup> Lloyd G, Guthrie E. Handbook of Liaison Psychiatry. Cambridge University Press; 2012.

<sup>2</sup> Parsonage M, Fossey M. *Economic evaluation of a liaison psychiatry service*. Centre for Mental Health, 2011  
[https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/Economic\\_evaluation\\_final.pdf](https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/Economic_evaluation_final.pdf)

<sup>3</sup> Tadros G, Salama RA, Kingston P, Mustafa N, Johnson E, Pannell R, et al. Impact of an integrated rapid response psychiatric liaison team on quality improvement and cost savings: the Birmingham RAID model. *The Psychiatrist* 2013; 37(1) 4-10. <https://doi.org/10.1192/pb.bp.111.037366>

<sup>4</sup> House A, West R, Smith C, Tubeuf S, Guthrie E, Trigwell P. The effect of a hospital liaison psychiatry service on inpatient lengths of stay: interrupted time series analysis using routinely collected NHS hospital episode statistics. *BMC Psychiatry* 2020; 20:27. <https://doi.org/10.1186/s12888-020-2441-8>

<sup>5</sup> NHS England. *Implementing the Five Year Forward View for Mental Health*. NHS England 2016  
<https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf>

<sup>6</sup> NHS. *The NHS Long Term Plan*. NHS 2019  
<https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf>

<sup>7</sup> 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

<sup>8</sup> Barrett J, Aitken P, Lee W. Report of the 2nd Annual Survey of Liaison Psychiatry in England.  
<https://www.crisiscareconcordat.org.uk/inspiration/report-of-the-2nd-annual-survey-of-liaison-psychiatry-in-england/>

<sup>9</sup> 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>

<sup>10</sup> Whalley S, Aitken P, Lee W. Report of the 4th Annual Survey of Liaison Psychiatry in England (LPSE-4)  
<https://www.england.nhs.uk/wp-content/uploads/2019/07/fourth-annual-survey-liaison-psychiatry-england-report.pdf>

<sup>11</sup> Whalley S, Lee W. Report of the 5th Annual Survey of Liaison Psychiatry in England (LPSE-5)  
<https://future.nhs.uk/AdultMH/view?objectId=163063365>

<sup>12</sup> Welsh K, Lee W. Report of the 6th Annual Survey of Liaison Psychiatry in England (LPSE-6)  
<https://future.nhs.uk/AdultMH/view?objectId=163065829>

<sup>13</sup> Welsh K, Lee W. Report of the 7th Annual Survey of Liaison Psychiatry in England (LPSE-7)  
<https://future.nhs.uk/AdultMH/view?objectId=14170800>

## Methods

A questionnaire survey sent out by email, similar to LPSEs 1-7. Responses were invited by email and/or telephone.

## Selection of Questions

Before the survey, we contacted respondents to LPSE-7 for feedback. We also consulted with NHS England and the Liaison Faculty of the Royal College of Psychiatrists to ensure all areas of interest were covered in LPSE-8.

With the exception of one additional question, LPSE-8 remained unchanged from the previous survey. Answers remained free-text to allow for explanations of complexity. Only questions which could be answered by any reasonably well-informed clinician working within Liaison Psychiatry services were included. The questions can be seen in Appendix 1.

## Sample

We used the NHS England and NHS Acute Trust websites to identify Trusts with type 1 (ordinary) EDs and reconciled this with the list used for LPSE-7. Some acute trusts operate more than one ED, in which case each hospital with an ED was included separately. A list of all the acute hospitals in England with type 1 EDs was created. The number of type-1 EDs in England remained unchanged from the previous survey (170).

## Data Collection

On 11<sup>th</sup> June 2024 we emailed the people who responded to LPSE-7, explaining the nature of the survey and asking them to complete and return the questionnaire. In the email we included a link to a live map and graph showing which hospitals had responded and which had not, with the aim of encouraging prompt participation and preventing duplication of work by respondents.

The email included a MS Word version of the survey, to complete electronically and return by email. Respondents could also request a telephone appointment where KW would enter the answers provided in a Word document, which was then emailed to the respondent for verification and for their records and processed in the usual way.

Where we had no active email contact for the Liaison Psychiatry service at an acute hospital, we telephoned the acute hospital switchboard or, where it was listed, the Liaison Psychiatry service and requested an email contact.

Four further mailings were sent to non-responder sites between end of June 2024 and end of September 2024. Sites were also followed-up individually by telephone and by email, where necessary.

## Data Processing

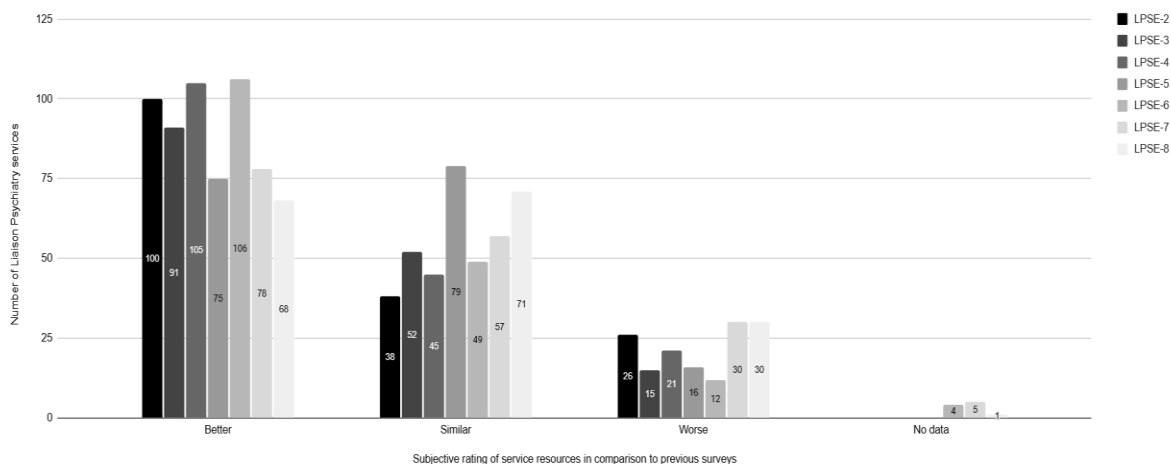
We entered the data from each response in a secure Google Sheet, shared within the survey team. One row represented one acute hospital, and there were separate worksheets for working age adult and older age adult liaison psychiatry services. Where one response covered more than one age range, the response was in the first instance entered in the working age adult sheet and signposted from the corresponding sheet. Any duplicate responses were checked and merged where appropriate.

As for previous surveys, there was no patient-record level data collected or processed. Responses were free-text to allow respondents maximum flexibility in describing their services. These were manually coded by two people (KW 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 170 (100%) of the acute hospitals in England with type-1 EDs.

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



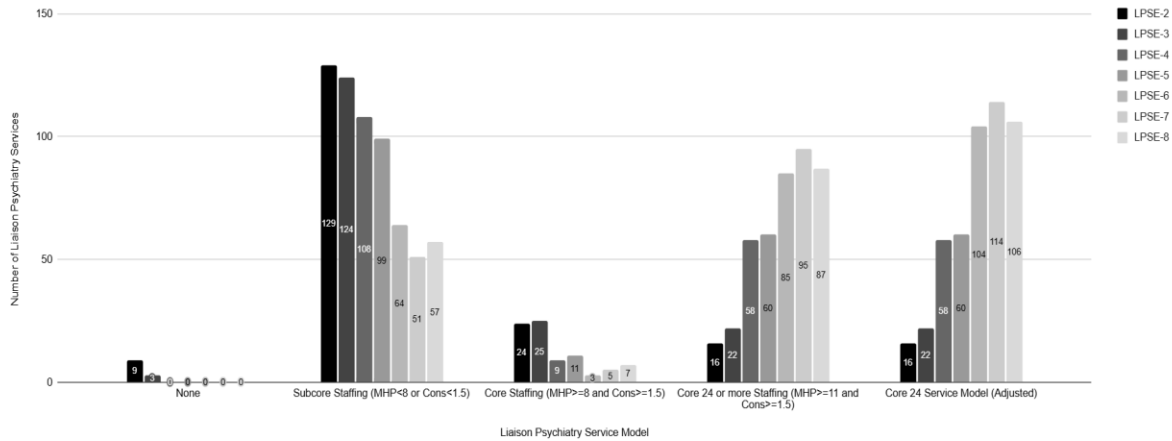
Overall, the number of services reporting an improvement in resourcing (staffing levels) compared to the previous year continues to decrease: 40% (68/170) of services in 2024 compared to 46% (78/170) in 2023. 42% (71/170) of services reported no change and 18% (30/170) of services reported worse resourcing, unchanged from 2023/24.

Of the 30 services reporting worse resourcing in 2023, 37% (11/30) saw an improvement by 2024, 40% (12/30) saw no change, and 23% (7/30) reported a further decline.

Of the 57 services reporting similar resourcing in 2023, 26% (15/57) saw an improvement by 2024, 67% (38/57) saw no change, and 7% (4/57) reported a decline.

Of the 78 services reporting better resourcing in 2023/24, 53% (41/78) continued to improve by 2024, 24% (19/78) saw no change, and 23% (18/78) reported a decline.

Figure 2. Number of Liaison Psychiatry Services by service model



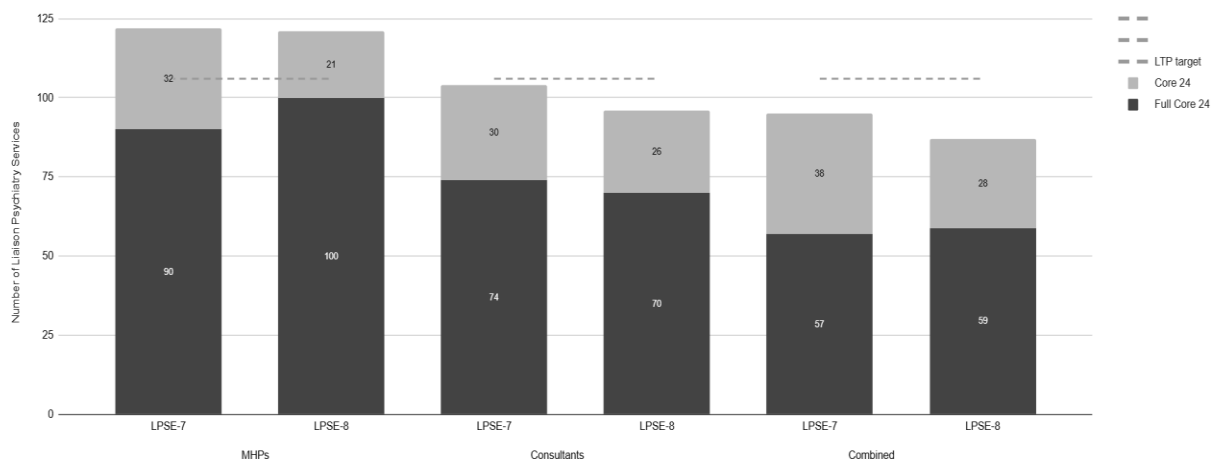
Between LPSE-5 and LPSE-6, NHSE approved alternatives to Core 24 which were suitable for smaller hospitals with lower demand, typically with fewer than ~400 beds (and/or areas with lower mental health demand). Their functions are the same as Core 24 with 24/7 coverage, face to face response time within 1 hour of referral from ED and 24 hours from wards, however the staffing model may vary if an on-site 24/7 team is not warranted. A total of 19 hospital sites have been approved as alternatives equivalent to Core 24, therefore the denominator used for the remaining services is 151.

The number of hospitals with Subcore Liaison staffing levels has increased slightly from 34% (51/151) in 2023 to 38% (57/151) in 2024. The number of services meeting the Core 24 staffing criteria has decreased by 8, from 63% (95/151) in 2023 to 58% (87/151) in 2024. When adjustments are made for NHSE approved alternatives a further 19 services meet Core 24 or equivalent standards, 62% (106/170) of services in total, a decrease from 67% (114/170) in 2023. Many services indicated they have employed Specialist and Specialty doctors in vacant Consultant posts, when adjusted to include SAS doctors in the criteria, 69% (117/170) of services meet Core 24 or equivalent standards in 2024.

Note: Of the 64 services which do not meet Core 24 staffing criteria (MHP>=11 and Consultant >=1.5) in over half of these services (34/64 = 53%) the criteria are missed by Consultant numbers alone, often by small fractions of FTE e.g. 79% (27/34) of these services were 0.5 FTE or less below Core 24. 33% (21/64) of services missed the criteria by both MHP and Consultant staffing numbers, and 14% (9/64) by MHP numbers alone.

Note: The criteria by which service models are determined has changed between the surveys. For LPSEs 4 to 8 the Core 24 criteria were 1.5 FTE Consultants and 11 FTE MHPs (compared to 2 FTE consultants and 13 FTE MHPs previously). The 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.

Figure 3. MHP, Consultant and combined staffing levels, with results from one prior survey and Long Term Plan target



As in Figure 2, the 19 approved alternative sites have been subtracted from the denominator and the following figures refer to the remaining 151 sites across England.

66% (100/151) of services have MHP staffing to Full Core 24 criteria (13 FTEs), an additional 14% (21/151) of hospitals have MHP staffing to Core 24 criteria (11 FTEs). The number of services meeting the Core 24 criteria for MHPs has remained stable compared to the previous survey at approximately 80% (121/151).

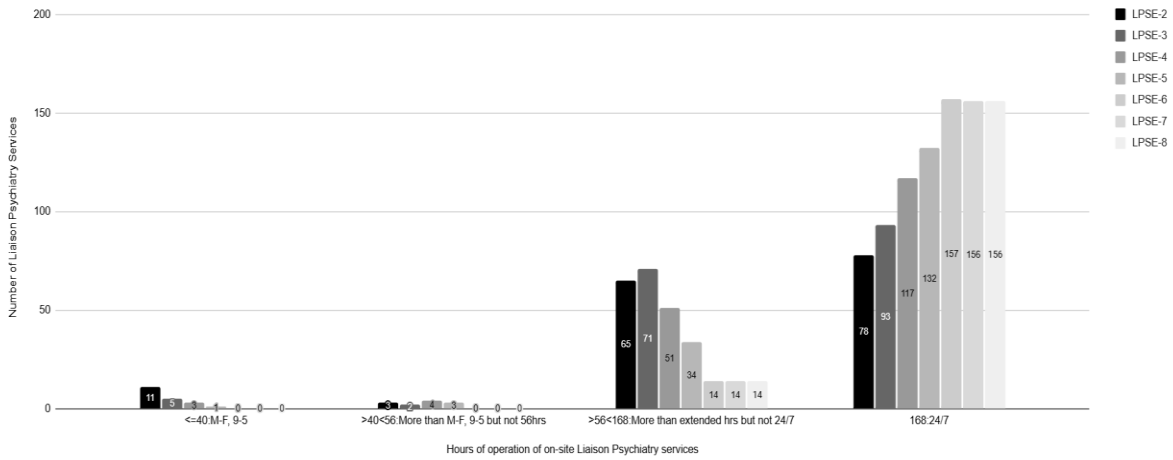
46% (70/151) of services have Full Core 24 Consultant staffing levels (2 FTEs). An additional 17% (26/151) of hospitals have Core 24 Consultant staffing levels (1.5 FTEs). The number of services meeting the Core 24 criteria for Consultants has decreased compared to the previous survey from 69% (104/151) to 64% (96/151).

A service is only considered to be staffed to Core 24 at the less stringent level, if they have *both* 11 FTE MHPs *and* 1.5 FTE Consultants. 58% (87/151) of services are staffed to Core 24 levels, with at least 11 FTE MHPs *and* 1.5 FTE Consultants, a decrease from 63% (95/151) in the previous survey.

Note: When adjusted for NHSE approved alternatives, the number of services at a Core 24 or equivalent level increases by 19 sites to 62% (106/170). If SAS doctors are included in the criteria for Consultants, the number of services staffed to Core 24 or equivalent standards increases to 69% (117/170).

Note: The staffing levels refer to actual FTE staff in post at point of survey completion, not commissioned posts. Many respondents indicated they had vacant posts and were trying to recruit. 82% (139/170) of services were commissioned to Core 24 or equivalent level.

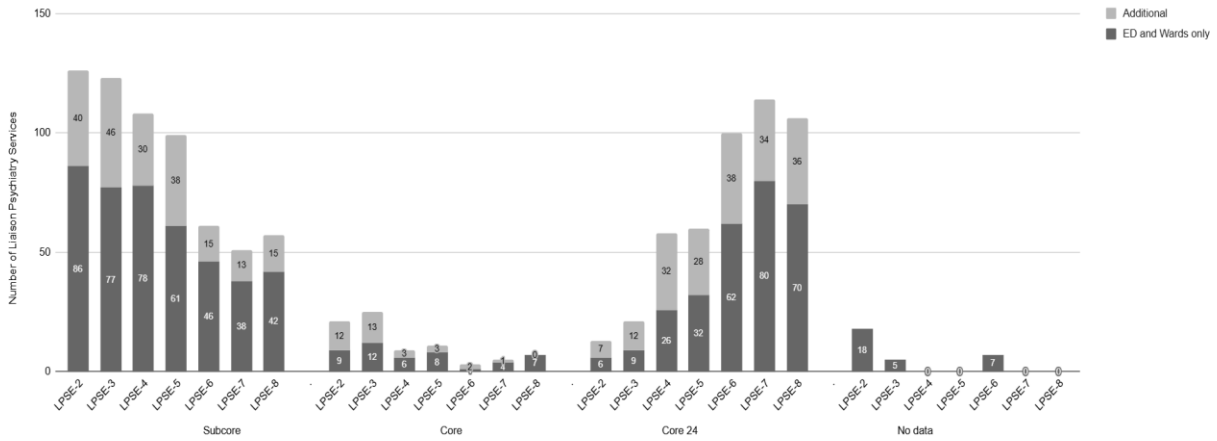
Figure 4. Hours of operation, with results from six prior surveys



All services except one reported offering face to face access to a liaison service or local crisis team on a 24/7 basis. 92% (156/170) of services are now operating an on-site liaison service on a 24/7 basis. Of the 14 services which are not staffed 24/7 by an on-site liaison service, 13 services have out of hours covered by a local crisis team or equivalent, and the one service mentioned above has the option of transferring the patient to another hospital with a 24/7 on-site liaison service.

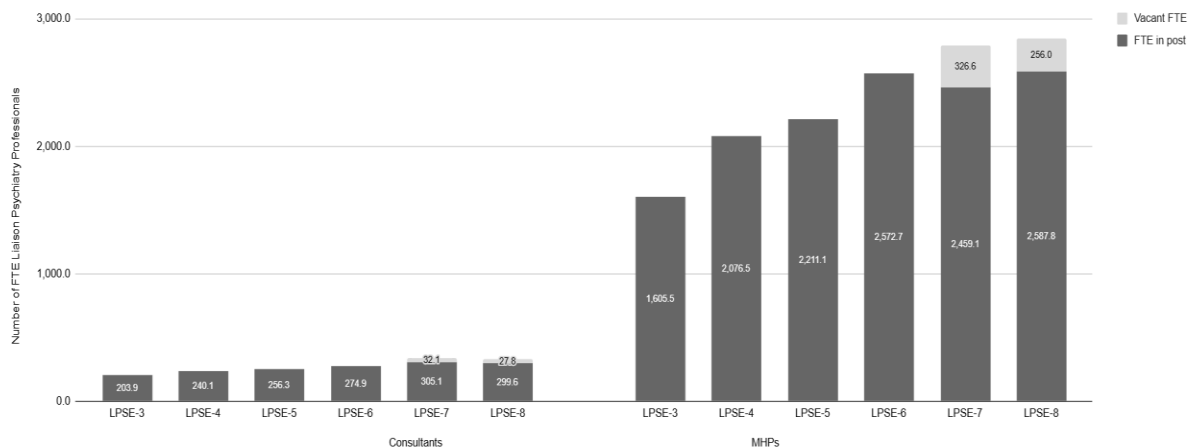
The number of services open between 0900 and 1700 Monday to Friday only remains at zero, and the number of services which operate only extended hours remains unchanged at approximately 8% (14/170).

Figure 5. Services divided by service model and whether they offer non-acute additional activities, with results from six prior surveys



As in prior surveys, many services offer non-acute interventions such as neuropsychiatry clinics, clinics for people with medically unexplained symptoms, medication reviews, short term psychological input, or follow up clinics for people who do not meet the threshold for secondary mental health services. These interventions are led by a range of disciplines including Consultant Psychiatrists, Nurses and Psychologists. The number of services offering non-acute interventions is largely unchanged at 30% (51/170) of all services, compared to 28% (48/170) in 2023.

**Figure 6. Total Consultant and MHP FTE numbers in Liaison Psychiatry Services in England's acute hospitals with EDs, with results from five prior surveys.**



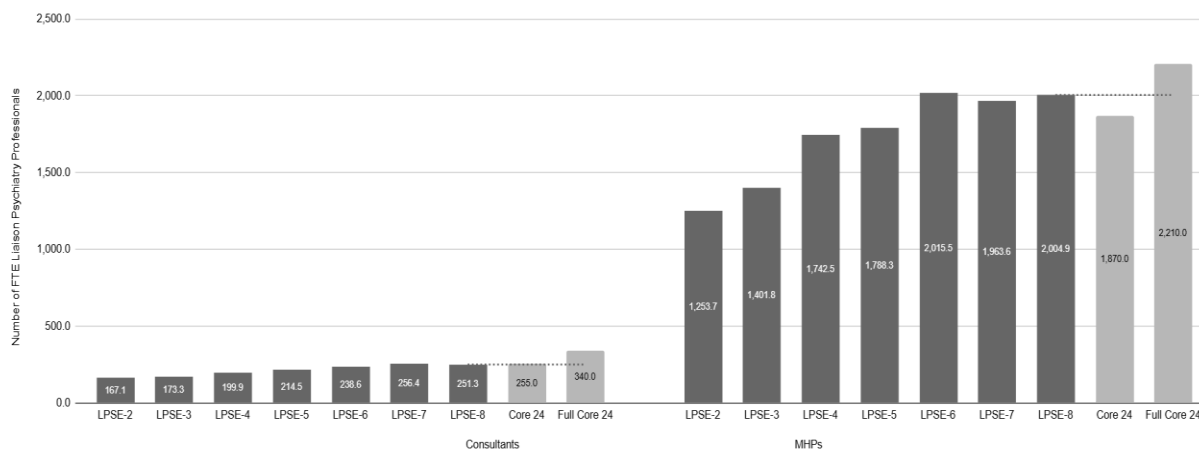
327.4 FTE commissioned Consultant posts were recorded across all 170 sites in England, with 299.6 FTEs in post, giving a vacancy rate of approximately 9% (27.8/327.4) compared to 10% (32.1/337.2) in 2023. There is a small reported decrease in commissioned Consultant posts from 337.2 FTE in 2023 to 327.4 FTE in 2024.

2843.8 FTE commissioned MHP posts were recorded, with 2595.8 FTE MHPs in post, giving a vacancy rate of approximately 9% (256.0/2843.8) compared to 12% (326.6/2785.7) in 2023. The majority of MHP vacant posts are for Band 6 staff, approximately 87% (223/256) of total vacant MHP posts.

The total Consultant FTEs in post has fallen by 5.5 since 2023, while the MHP FTEs in post has increased by 128.7 FTE.

The total figures take no account of the size and complexity of needs of larger hospitals, and unrealistically assumes FTEs are divisible and mobile without limit. For LPSE-3, 4, 5, 6, 7 and 8, 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 additional Liaison Psychiatry professionals. These capped figures can be seen in Figure 7.

**Figure 7. Capped Consultant and MHP FTE numbers in Liaison Psychiatry Services in England's acute hospitals with EDs: past provision, current provision and requirements for nationwide implementation of Core 24 staffing criteria**



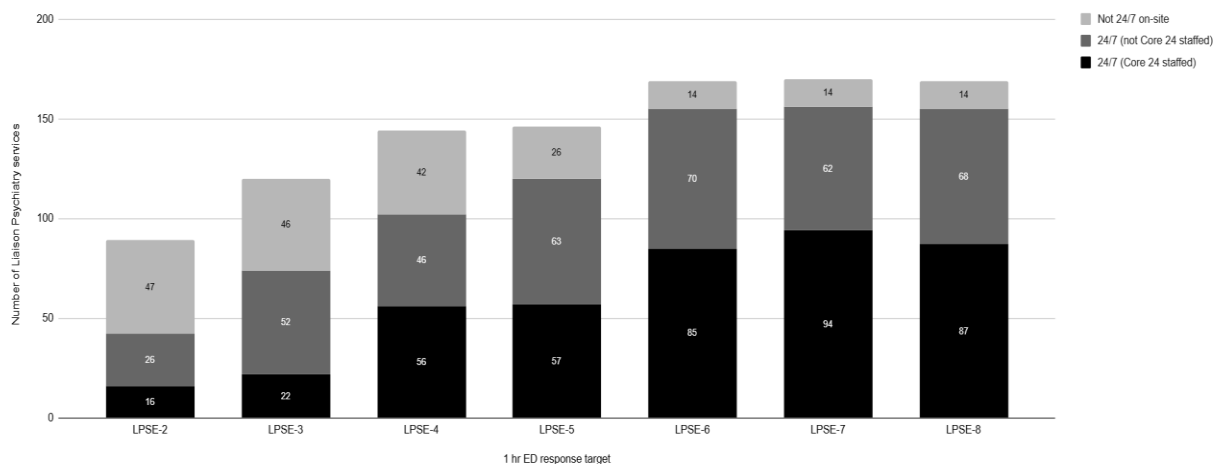
For Consultants, 99% (251.3/255) of FTEs are in post of the total required for Core 24 provision (1.5 Consultants) across the 170 sites, with an additional 88.7 FTE Consultants required for full Core 24 provision (2 Consultants) across all sites.

For MHPs the FTEs in post (2004.9/1870 = 107%) exceeds the total required for Core 24 provision (11 MHPs) across the 170 sites, with an additional 205.1 FTE MHPs required for full Core 24 provision (13 MHPs).

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. The new term for the same role, undertaken by registered health professionals from a variety of backgrounds, is Mental Health Professional, abbreviated to MHP. It is these clinicians who were counted in LPSE-3 onwards unless a separate, bounded, role was specified. In this case, these professionals were recorded separately (not shown).

Note: The 'Full Core 24' column refers to the number of professionals needed to staff 100% of the 170 ED-equipped acute hospitals with Liaison Psychiatry services with 2 FTE Consultants and 13 FTE MHPs. The Core 24 column refers to staffing Liaison services with 1.5 FTE Consultants and 11 MHPs.

Figure 8. Services with a 1 hour ED response time target, with results from six prior surveys

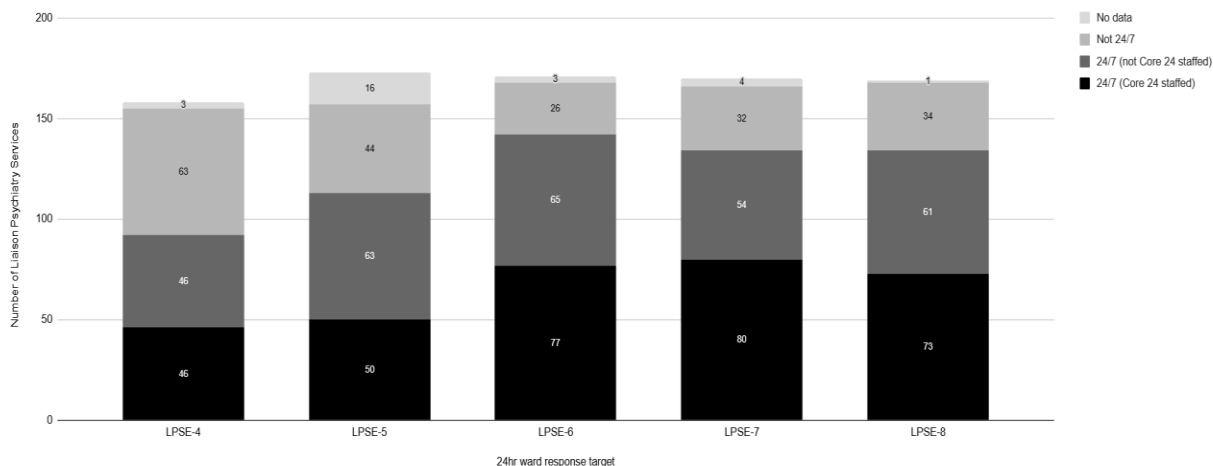


99% (169/170) of services indicated a one-hour response time target to ED, one service reported they had a two-hour response time target. These figures show where services have a one-hour response time target. We do not measure how often this target is met.

The number of services which have a one-hour response time to ED and are on-site 24 hours per day is  $87+68 = 155$ . 44% (68/155) of these services are staffed below the criteria for Core 24 and may be less able to meet quality and response targets consistently and sustainably than better resourced services. This represents a 4% increase from the previous survey ( $62/156 = 40\%$ ).

The remaining 14 services have a one-hour response time to ED but are not on-site 24/7 services.

**Figure 9: Services with a 24 hour ward response time target, with results from four prior surveys**

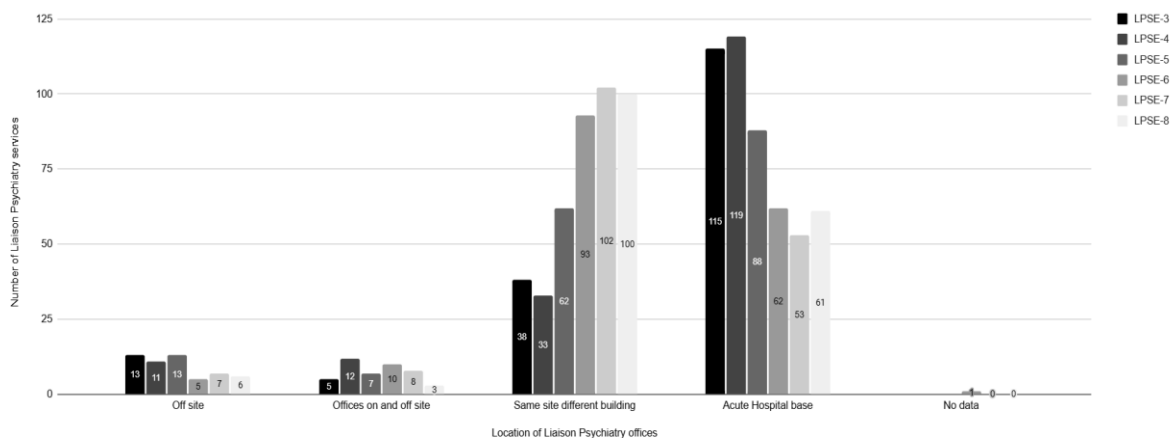


99% (168/170) of services indicated a response time within 24 hours to wards. 33% (56/170) additionally specifically mentioned a response time of within 4 hours for urgent and/or MAU referrals. These figures show where services have a response time target.

One service did not provide data for this question and one service indicated a 48-hour response time target.

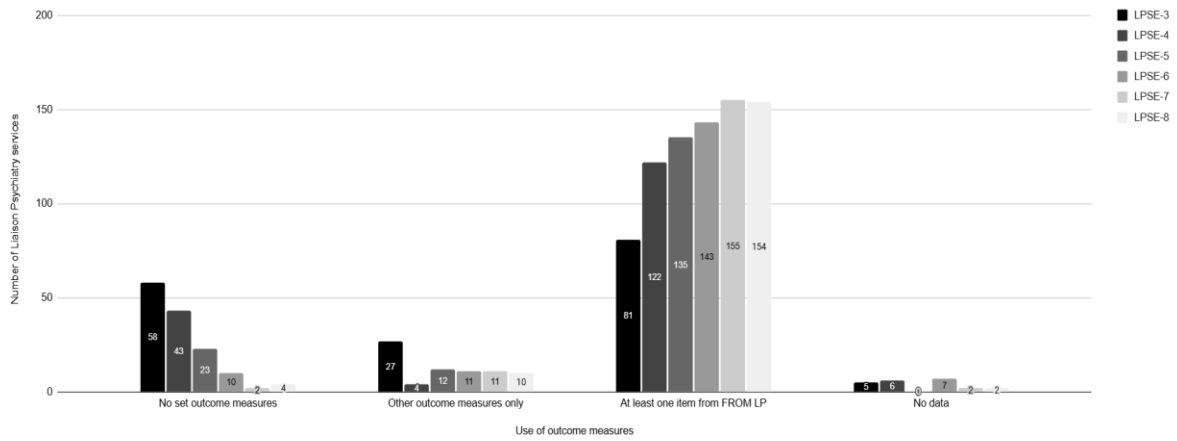
20 services indicated different hours of operation for services to wards compared with services to ED. This accounts for the additional services recorded as not 24/7 in this chart.

Figure 10. Location of Liaison Psychiatry services, with results from five prior surveys



Liaison Psychiatry services located in the main hospital building have increased slightly from 31% (53/170) to 36% (61/170). Services located in different buildings on the same site as the acute hospital are relatively stable at 59% (100/170), and the number of services located off site also remains stable at approximately 4% (6/170).

Figure 11. Use of outcome measures in Liaison Psychiatry services, with results from five prior surveys



The use of FROM-LP/FROM-LP2 outcome measures remains high at 91% (154/170) of services. The number of services which use no outcome measures has increased slightly to 4/170, approximately 2% compared to 1% in the previous survey.

## Discussion

This survey found a decrease in the number of liaison psychiatry teams for adults and older adults reporting an improvement in staff resourcing compared to 2023. The number reporting lower staff resourcing remains unchanged at nearly 1 in 5 services, and of the services which reported lower resourcing in 2023, nearly two thirds saw no growth or a further decline.

The number of services commissioned to Core 24 or equivalent standards continues to rise and is currently at 82% (139/170). However, the number of services staffed to the Core 24 criteria or more saw a decrease for the first time and remains below target at 58% (87/151). When adjustments are made for NHS England approved alternatives the number of services meeting Core 24 or equivalent standards increases to 62% (106/170), a 5% decline from 2023.

For staff in post, Core 24 MHP staffing levels remain stable at 80% (121/151) of services, Core 24 Consultant staffing levels have decreased to 64% (96/151) of services. However, to qualify as staffed to Core 24 levels, services must have sufficient MHPs *and* Consultants, an additional 23% (34/151) of services missed achieving Core 24 staffing standards at point of survey completion by Consultant numbers alone, often by small fractions of FTE. Many services indicated they have employed Specialist and Specialty doctors in vacant Consultant posts. If we include SAS doctors in the criteria for Consultants, 69% (117/170) of services meet Core 24 or equivalent standards in 2024/25, which is much closer to the target of 70%.

The most valid way to describe the service development needs of the 170 services in 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. England needs 340 full-time Consultant Liaison Psychiatrists in post for there to be 2 FTE Consultants in all 170 acute hospitals. 74% (251.3/340) of the Consultants needed for the Full Core 24 are now in post. Similarly, England needs 2210 FTE MHPs in post for 13 full-time MHPs in all 170 acute hospitals, to be fully met. 91% (2004.9/2210) of the MHPs required are now in post.

The original commissioning model for Core 24 standards was based on staffing numbers for c500 bedded hospitals. Many of the acute hospitals participating in this survey have bed numbers which far exceed this, including large hospitals with regional and national tertiary and quaternary services. Many services also provide cover to additional hospitals which do not have a type-1 ED. Therefore, there is a risk of applying the minimum Core 24 standard of 11 MHPs and 1.5 Consultants inappropriately to any individual hospital which can create an erroneous perception among ICBs that services are adequately resourced.

The provision of on-site 24/7 liaison services is unchanged at 92%. However, the proportion of services providing a 24/7 service while staffed below Core 24 criteria remains large and is increasing, potentially impacting on the sustainability, quality and consistency of the service, including meeting response time targets. Many teams continue to offer non-acute additional

services, even those which are relatively poorly resourced, although the proportion of the least well-resourced services offering additional services has fallen from 22% in 2019 to 9% in 2024.

While the provision within Liaison Psychiatry services has grown over the course of the LPSE surveys, recent changes in staffing numbers have seen a decline in the number of services meeting the Core 24 standard. Consultant numbers have fallen in 2024, while MHP numbers have risen, a reversal of staffing changes in the 2023 survey. 46% of services continue to cite recruitment and retention as a significant challenge. Although general psychiatry numbers have been steadily expanding since 2017<sup>13</sup>, Consultant Psychiatrist provision can be expected to be slower than that of MHPs, due to the smaller supply and long training time. Ongoing issues with tax and pension systems may incentivise part-time working and early retirement for many senior clinicians. Nursing vacancies across England remain high, particularly in Mental Health Nursing, and although the overall number of mental health nurses is rising, this follows a substantial decline between 2010-17, with numbers only now restored to 2010 levels.<sup>13</sup> Difficult working conditions and the lack of a fair pay offer for nurses impacts on the recruitment and retention of skilled and experienced staff. Vacancy rates in liaison psychiatry are highest for Band 6 MHP posts and rising.

Of course, Liaison Psychiatry teams consist of staff other than the Consultants and MHPs. In particular, the number of administrative staff, often the mainstay of teams and vital to the delivery of a high-quality service, were not included in the service model criteria in this report.

The use of outcome measures, specifically from FROM-LP/LP2 remains high at 91% of responders to this survey. The number of services which use no outcome measures remains low at approximately 2%.

Increasingly, services are located on the same hospital site as the ED. The number of services located in different buildings on the same site has remained stable and there has been a slight increase in services located in the same building as the ED/wards. This may have been influenced by the Covid-19 pandemic with some Liaison services moved away from ED/ward-based offices now returning, alongside a continuing trend for alternate location due to increasing staffing numbers within teams.

Services are increasingly 24/7 with a one-hour response time to the Emergency Department and within 24 hours to wards, however with a significant number of services continuing to provide a 24/7 service staffed below Core 24 criteria, the provision of sustainable, high-quality services may be negatively impacted.

The LTP commitments for mental health were set before the Covid-19 pandemic. Post-pandemic referral rates, acuity and complexity have seen a sustained increase with no concomitant re-evaluation of resourcing requirements. Pre-pandemic assumptions about

---

<sup>13</sup> Gilbert H, Mallory S. *Mental health 360: workforce*. The Kings Fund 2024 <https://www.kingsfund.org.uk/insight-and-analysis/long-reads/mental-health-360-workforce>

prevalence, need and requirements to address the mental health treatment gap now appear to be outdated and despite the extra resourcing in place, services describe struggling to keep pace with increasing demands.

## Strengths and weaknesses

LPSE-8 is the 8th Liaison Psychiatry Survey of England. These surveys are led by a clinician, delivered by clinicians, with the expectation that it will be clinicians answering the survey questions. With this in mind, 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 LPSEs 4-8. Continued engagement with the community of participants facilitated authentic relationships between the research team and participants. Indeed, the researchers are themselves participants in this study.

As with any survey, LPSE-8 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-8 is no exception to this, both in terms of frequency and direction. We reduced this tendency by emphasising to respondents that it is the quality of the data which is desired rather than any particular value. We were careful to give no expectation of whether a well-resourced or a poorly-resourced liaison team was more 'desirable' to us, ensuring the questions had unlimited free-text opportunities to respond, avoiding forced-choice situations which can aggravate information biases. The free-text responses allowed respondents to describe their situation and the LPSE-8 team then coded it appropriately.

Liaison Psychiatry continues to have difficulties with both vocabulary and definitions. There is no universally accepted definition of Liaison Psychiatry, even among practitioners. The term Liaison Psychiatry can be 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. It is thought that the benefits of Liaison Psychiatry are enhanced when the mental health workers are well known to other professionals in the acute hospital, rather than being visiting professionals who are based elsewhere, though this is difficult to quantify. Some Liaison teams operate over several hospitals, so the need for allocating the staffing to one hospital or another for the purposes of these surveys may make some of our results misleading.

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 rapidly out of date. Overall, LPSE-8 provides the best picture of the state of Liaison Psychiatry in England but any single datapoint still may be in error.

## Concluding Remarks

LPSE-8 is the last planned of a series of staffing surveys of Liaison Psychiatry teams in England. LPSE-1 was developed in 2013 to inform Government how much extra investment would be needed to have adequate Liaison Psychiatry in every acute hospital with an Emergency Department in England. These surveys existed to monitor progress towards this important policy goal, largely now achieved. Lack of a target and ongoing scrutiny risks Liaison service provision being challenged, unreported, in response to cost pressures and other factors.

# Appendix I

## Questionnaire

### Eighth Liaison Psychiatry Survey of England (LPSE-8)

This is the 8th Liaison Psychiatry Survey of England. We are asking about the staffing and activities of services which provide mental healthcare in Acute Hospitals with Emergency Departments in England. All responses are read and understood by a person, so please just describe your situation if the questions don't address your circumstances very well. The answer boxes can be expanded, so please write as much as you'd like to.

#### 1. Your details

<b>Name</b>	
<b>Email</b>	
<b>Telephone</b>	

#### 2. Service overview

<b>Acute Hospital</b> If your team operates in more than 1 acute hospital please describe.	
<b>Acute Trust</b>	
<b>Provider</b> Usually a Mental Health Trust.	
<b>Team Name</b>	
<b>Does your team offer Liaison Psychiatry to any other sites?</b> e.g. another hospital, GP surgery etc.	
<b>Are there any other Liaison Psychiatry teams operating in your Acute Hospital?</b> e.g. Paeds Liaison Psychiatry. Please provide a contact for these.	
<b>Where is your main team office?</b> E.g. same building as ED/Wards, different building on-site, off-site etc.	
<b>Is your service securely and recurrently funded?</b> If not, please describe.	

### 3. Workforce

If your service delivers clinical 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. Note: "Liaison" includes Liaison in ED, Wards, Outpatients, co-clinics, MDTs etc. Non-liaison might be Home Treatment functions or similar.

#### Administrators, MHPs and Doctors

Role description	Commissioned FTEs	FTEs in post Do not include vacant posts in this column.	Employment status e.g. Substantive/ Fixed term/ Temporary/ Winter pressures.
Administrators Band 2			
Administrators Band 3			
Administrators Band 4			
Administrators Band 5			
MHP Band 5			
MHP Band 6			
MHP Band 7			
MHP Band 8			
Dr F1			
Dr F2			
Dr CT1-3 (SHOs)			
Dr ST4-6 (SpR)			
Dr SAS (Staff Grade/ Associate Specialist)			
Psychologists			
Others with non-MHP roles, and their bands e.g. Associate Physician/ Social Worker/ Pharmacist/ Drug and Alcohol Worker/ HCA/ Clinical Associate Psychologist etc.			

**Consultants**

Please use one row for each consultant

<b>Commissioned FTEs</b>	<b>FTE in post</b> Only include time assigned to Liaison service.	<b>Certificate of Completion of Training (CCT)</b> General Adult/ Old Age/ CAMHS etc.	<b>Endorsements</b> Liaison/ Addictions etc.	<b>Employment status</b> Substantive/ Locum/ Temporary/ Fixed term.

**4. ED Activity**

<b>Service referral criteria from ED:</b> Include age range.	
<b>Which teams/services see the ED referrals your service doesn't see?</b> e.g. primary alcohol presentations, different age ranges etc.	
<b>Hours of service (incl. days per week)</b> Do not include transfer to crisis team or on call doctor out of hours.	
<b>Who sees the patients outside the above hours? (if applicable)</b>	
<b>What are the target wait times to see ED referrals?</b>	

**5. Ward Activity**

<b>Service referral criteria from wards:</b> Include age range.	
<b>Which teams/services see the ward referrals your service doesn't see?</b> e.g. primary alcohol presentations, different age ranges etc.	
<b>Hours of service (incl. days per week)</b> Do not include transfer to crisis team or on call doctor out of hours.	
<b>Who sees the patients outside the above hours? (if applicable)</b>	
<b>What are the target wait times to see ward (incl. MAU) referrals?</b>	

**6. Other activity**

<b>Does your service offer outpatient clinics?</b> Please include criteria.	
<b>Does your service have local protocols/ guidelines?</b> e.g. low BM, delirium, opiate withdrawal etc.	
<b>Does your service have established relationships with other MDTs/ service lines in the hospital?</b> Please indicate which service.e.g. Paint team, Safeguarding, Alcohol etc.	
<b>Other activities your service undertakes:</b> e.g. teaching, student attachments, etc.	

**7. Outcome measures**

<b>Does your service use a competence framework?</b> Please describe.	
<b>Do you use FROM-LP outcome measures?</b> Please indicate which elements.	
<b>IRAC</b>	
<b>CGI-I</b>	
<b>CORE-10</b>	
<b>Patient Satisfaction Scale</b>	
<b>Friends &amp; Family Test</b>	
<b>Referrer Satisfaction Scale</b>	
<b>CROM</b>	
<b>GOMM</b>	
<b>Do you use any other outcome measures?</b> Please describe.	

**8. Final queries**

<b>Is your service worse, similarly or better staffed than it was in July 2023?</b>	
<b>What does your service do well?</b>	
<b>What in your service is a challenge?</b> e.g. recruitment/ retention, facilities etc.	
<b>Is there anything else you would like to contribute to this survey?</b> e.g. contributing to research studies, piloting initiatives etc.	

Thank you for taking part in the Eighth Survey of Liaison Psychiatry in England (LPSE-8)  
Please email your response to [cft.lpse@nhs.net](mailto:cft.lpse@nhs.net)

## Appendix II (Abridged coding manual)

### Staffing:

- Adult and older adult workers only are included in this report, paediatric staff are excluded.
- Band 5 and upwards count towards MHP numbers.
- Bands 5, 6, 7, 8 are equivalent.
- Where there are services across the lifespan, all people are counted.
- Where services cover two or more acute hospitals, the staff are divided at best approximation based on bed capacity, unless otherwise specified.
- Psychologists and pharmacists are excluded from MHP numbers. Other PAMs are included, unless a specific bounded role is described.
- Social workers working as MHPs are included in MHP numbers. The minority with a bounded social work role are coded in 'other'.
- Drug and Alcohol workers of Band 5 or above are included in MHP numbers, regardless of source of funding, employer etc., if included as part of liaison team.
- Assistant psychologists are included in 'other'.
- Therapists are included in 'other'.
- Staff on sick leave are included.
- Staff on maternity leave are excluded.
- Part-time are assumed to be half time, unless otherwise specified.
- Where FTE not specified, a calculation based on 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, unless otherwise specified.
- Shared with other teams: FTE shared equally between the teams, unless otherwise specified.

### 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.