

Research that makes a real difference

Mental health matters: improving
mental health services in acute
settings and understanding how
innovation spreads

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About HSMC

HSMC has been one of the leading UK centres for research, personal and organisational development in health care for 40 years. Commissioning of healthcare and provision of healthcare outside hospitals have become specific areas of expertise in recent years, underpinned by a continuing commitment to issues of quality improvement and public and patient engagement. This reputation has also extended to adult social care, with a growing track record in inter-agency commissioning and provision of health and social care services. HSMC has also developed a national reputation for both organisational and leadership development across all health settings. For further information visit: www.birmingham.ac.uk/hsmc

Introduction and background – pressures on acute care

In recent years there has been a growing policy focus on the pressures building up in A&E departments and in acute care more generally (see Box 1). Although hospitals are held to account for their performance in terms of access and waiting times, such pressures on acute care are arguably a product of the system as a whole over-heating – and, as such, are a good proxy measure of the challenges faced by the local health and social care system as a whole.

To date, these debates have focused on a range of issues, from access to general practice, the availability of support for out-of-hours services, difficulties accessing social care and the impact of cuts in public service funding. However, a key issue has also been the number of people believed to be presenting in A&E with mental health problems and/or the number of patients with a mix of physical and mental health problems. It is estimated that 28% of acute hospital inpatients have a diagnosable psychiatric disorder; in older adults, where delirium and dementia are more prevalent, the proportion rises to 60% (Plumridge & Reid, 2012). As in the US, where frequent attenders in A&E were likely to be homeless, have developmental delays, have substance abuse issues and have a mental health history (Pasic, Russo, & Roy-Bryne, 2005), it has been demonstrated that in the UK frequent attenders at A&E have longer psychiatric histories, higher rates of schizophrenia, and are more likely to be prescribed anti-psychotics (Chaput & Lebel, 2007; Okorie, McDonald, & Dineen, 2011). Against this background, this review was been commissioned by the West Midlands Academic Health Science Network with a view to understanding and sharing lessons learned from a series of commissioned services designed to provide greater access to mental health expertise for patients and staff in A&E, outpatients and inpatient units (the Rapid Assessment, Interface and Discharge service - or 'RAID').

Box 1

NHS crisis as struggling A&E departments fail to meet waiting time targets for A YEAR

The Mirror, 18th July 2014

A&E 'winter crisis': Call to put GPs in hospital emergency departments

The Independent 16th July 2014

GPs told to avoid referring patients to A&E after hospital placed on 'black alert'

Pulse, 14th July 2014

A&E departments 'could reach breaking point'

HSJ, 9th September 2013.

Box 1 *continued***Rise in number of delayed hospital discharges shows "crisis in care", Labour claims**

The Northern Echo, 30th July , 2014

Patients forced to wait in ambulances outside 'too full' A&Es, says Labour

The Guardian, 10th August 2014

Nearly 2 million NHS days lost since 2010 as people remain in hospital waiting for social care

Age UK, 11th June 2014.

The importance of mental health

The government's No Health Without Mental Health (Department of Health, 2011) strategy recognised that mental health was closely linked to physical health, and that there was a need to increase awareness of mental health issues within primary care and acute hospital settings. The mental health needs of different patient populations are often complex. As a whole, services need to be able to deal with people presenting with self-harm or substance issues (predominately at A&E) as well as assessing and treating other conditions such as dementia or depression throughout acute care. The effective triaging and treatment of these conditions is necessary in order to achieve better outcomes for patients, prevent unnecessary admissions to hospital, reduce waiting times, and also to prevent readmissions.

Historically, A&E units have not always been well equipped to identify and support people with mental health issues. Some have argued that staff prefer to address concrete physical needs and to typify mental health attenders as low status (Crowley, 2000). Attenders at A&E can often experience a long wait for the appropriate service to be delivered, waiting in environments that are less than ideal, particularly for people in such acute distress. Outside of A&E Units, staff may feel ill-equipped to deal with patients who may have developing or existing mental health needs. There has often been unmet need on older adults' wards, where staff frequently deal with dementia, delirium and depression, although comorbidity of mental health difficulties with other conditions extends throughout acute care.

In response to such challenges, the RAID service was first established in City Hospital in Birmingham in 2009. It received accreditation from the Psychiatric Liaison Accreditation Network (PLAN) and the Royal College of Psychiatry. It won a Health Service Journal Award for Innovation in 2010 and was also the subject of an economic evaluation by Michael Parsonage and Matt Fossey which demonstrated significant economic savings and found a benefit: cost ratio of 4:1 (Parsonage & Fossey, 2011). Another paper (Tadros et al., 2013) presented even more impressive cost savings and improved outcomes. RAID was designed not only as a “front door” service, existing to assist A&E to meet their 4-hour target, but also to streamline the patient journey, carrying out in-reach work in acute hospitals and helping professionals to manage discharge back into the community – aiming to prevent readmissions.

The key features of the initial RAID service (as identified by Parsonage & Fossey, 2011) are as follows:

- The service offers a comprehensive range of mental health specialities within one multi-disciplinary team, so that all patients over the age of 16 can be assessed, treated, signposted or referred appropriately regardless of age, address, presenting complaint, time of presentation or severity.
- The service operates 24 hours a day, 7 days a week. It emphasises rapid response, with a target time of one hour within which to assess referred patients who presented to A&E and 24 hours for seeing referred patients on the wards. (Data collected in the internal evaluation show that over the period December 2009 – July 2010 the A&E target was met in all but 6.8% of cases and the ward target in all but 10.2% of cases.)
- The service aims to meet the mental health needs of all adult patients in the hospital, including those who self-harmed, have substance misuse issues or have mental health difficulties commonly associated with old age, including dementia.
- The service provides formal teaching and informal training on mental health difficulties to acute staff throughout the hospital.
- The service puts an emphasis on diversion and discharge from A&E and on the facilitation of early but effective discharge from general admission wards.
- At the time of the internal evaluation the service ran a number of follow-up clinics for patients discharged from the hospital. These included clinics for self-harm, substance misuse, general old age psychiatric care and an adjoined memory clinic, and psychological input.

Information given in the draft evaluation report showed that the service had an average of 250 referrals a month during the period December 2009 – September 2010 (Tadros et al., 2011). Details of origin of referral and patient ages are shown in Table 1.

Table 1.

Origin of referral	Number of referrals	16-64 years	65+ years
A&E	1022	95.6%	4.4%
West Midlands Poison Unit	638	95.9%	4.1%
Wards	837	40.4%	59.6%
Total	2497	77.2%	22.8%

Since the initial service was commissioned, RAID has been rolled out to a range of different sites across the West Midlands. In different sites different providers were commissioned, some services were delivered by the mental health trust, some by the acute trust and some were jointly commissioned. During this process, the project attracted the attention of the West Midlands Academic Health Science Network (AHSN), which was keen to support a promising innovation and also saw the opportunity to learn more about how innovation spreads and is adapted/implemented in practice. The initial RAID model described above was implemented in different ways across a variety of sites, and this review was commissioned to help collate and share learning from these commissioned services. These services varied in scale and focus.

Methodology

In order to identify key lessons for the future roll-out of RAID, HSMC undertook twelve semi-structured interviews with a key manager or a clinician involved in the implementation of RAID across six sites. Sites were selected to include the following:

- Two sites which were early adopters with significant experience of RAID and fidelity to the initial model
- A new site trying to implement RAID
- A site that has concerns about RAID and/or may not have implemented fully
- A site that considered RAID and decided not to implement
- Existing Trust RAID service (site of pilot).

In each interview we asked a series of open questions about

- the decision to implement (or not) and the approach to implementation
- the barriers and the success factors
- the outcomes achieved and lessons learned (including asking whether, if people knew then what they know now, would they still have adopted RAID, and asking what advice participants would give to others contemplating this model).

Interviewees were encouraged to comment freely on aspects of the RAID service in order to capture their experiences in enough detail. Twelve telephone interviews were completed and the findings of these interviews are presented thematically below.

The decision whether or not to implement RAID

The need for some form of effective psychiatric liaison service - that deals promptly with people's mental health problems, prevents unnecessary hospital admissions, and signposts patients more effectively - was universally expressed. Across the different sites there were a number of different service configurations, but the need to deal effectively with substance use and self-harm, and to develop effective care for older adults and people with learning disabilities, was felt across the board. In some areas no liaison psychiatry service was in existence and in others mental health teams, such as Home Treatment teams, effectively filled this role. This in turn had an impact on the service Home Treatment teams were commissioned to provide in the community. One participant spoke about the level of need in an acute hospital:

[There] is a huge amount of mental illness in acute hospitals, the bulk of it is related to elderly care - dementia, depression and delirium - the three D's, these actually have significant effects on outcome measures, increased re-admissions, increased falls, infection and mortality, increased stay, we have the evidence, it's not something new.

The problem with liaison psychiatry in the past is that it's been very under-funded and very piecemeal. So different hospitals have different ideas for what this means. It only normally exists out of absolute necessity, like [for] frequent self-harm. It's always been very patchy, never a coordinated approach to managing the mental health and care for patients, so some of us had an opportunity to try and review the different models to see if we could try and persuade locally to invest in it.

It [was] difficult for them within the trust to cover [...] anyone that comes in with mental health issues. The services at the time were very limited, people could wait up to three to four hours to be assessed, and obviously it will be more difficult out of hours - it can be difficult to see them. We had the crisis team from the community to assess them in the hospital, but they also assessed people in the community, that could take even longer...

Other interviewees spoke about the previous level of service being 'ad hoc' with no 'service level agreement'. Some participants mentioned that they had campaigned for a while for an improved liaison psychiatry service, and reported that it was only since the development of RAID, and crucially with it the evidence of significant cost savings, that they were able to design and implement the type of service they had wanted for a long time:

We had fairly piecemeal on-call psychiatric service, mainly delivered from off-site provision which led to problems with regard to speed of patients being seen, quality of care, decision making so it caused problems from a patient's perspective, and obviously these are patients who are often distressed etc. and also there are problems with having any patients waiting at [an emergency department] for a long time.

Looking across the system, interviewees could identify disjointed care pathways that they felt caused delays in the system, such as not providing effective discharge into the community:

Mental health was not seen as something we [acute hospital staff] did, even though the commonest conditions we saw [were mental health conditions].

Although for most people the need for a “RAID-type” service was clear, some predicted that there might be resistance in some sectors. A few participants discussed in detail what they perceived to be the poor level of training for doctors and nurses in mental health issues, and also the lack of priority and attention mental health issues were given within acute trusts. Therefore the training element of the RAID programme was seen as particularly important. However, one participant mentioned that resistance had come from within mental health teams:

But surprisingly [the people who] were apprehensive to this, [were] from mental health, and from the existing liaison nurses. They are the ones who actually know the local system, the pathways, and the community as well, and they told the commissioners we don't have enough resources to actually do what you want to happen.

One interviewee felt that the need for RAID was a natural result of concentrating on the patient journey rather than on staff specialisms. RAID aims to meet important needs that are more prevalent than some people realise in acute care – but the route in to getting such issues addressed has often been through framing the service as being able to contribute to key policy priorities that acute care understands and is focused on. While this is presumably a helpful way of getting mental health onto the agenda, it might also distort the issues at stake – there's a risk that Trusts are trying to meet mental health needs because it helps with their access targets, rather than because it is simply the right thing to do.

However others felt that, although services could always be improved, in some settings mentioned by participants there were already specialist teams in place which were delivering some of the services that RAID would provide:

The implementation was about the front door, there wasn't a huge emphasis for patients in the ward, [the hospital] had quite a strong dignity in care team, quite a specialist service on the wards for people with dementia were quite developed.

The approach to implementation

The approach to implementing the RAID service was different across the six sites. Overall this was reported as arising from the following: the different level of investment the RAID service received, the working relationship staff had with senior clinicians, the configuration of services within the local area and the different levels of need across a range of populations in rural and urban locations.

One of the biggest differences described across the interviews was where the service was positioned within the framework of existing services. In one hospital, general and older age psychiatry were fully integrated. Much of the service was aimed at improving care for patients with dementia, delirium and depression. However in other sites RAID was positioned as a 'front door' service that aimed to deal more effectively with A&E attendees and reduce waiting times.

I think, from our trust perspective, it was more about speeding up the process for patients who present in A&E with mental health conditions, it was getting them in quicker and getting them treated more rapidly, and, as such, one of the benefits was the reduction in A&E waiting times.

When we set up the services I was convincing [the commissioners] that the front end has to be prioritised, and that's why they provide an hour response [in the emergency department], and then in the acute ward they provide 4-6 hour wait, and 24 hour in other wards

In other sites clinicians recognised the need and were campaigning to get increased resources for the RAID service, or, in one site, any RAID service at all.

Financial resources differed considerably between sites as well and RAID was generally recognised as an expensive service to implement, but one which had the potential to produce savings (which may or may not have been realised in practice). In the original pilot service, services were generally thought to have been sufficiently financially resourced. However there was debate within other services as to whether they achieved the level of resources appropriate for the service they were operating:

We'd need more than one consultant, a clinical psychologist has always been promised but never been delivered. They are definitely needed, we don't have any exit strategy for these patients.

One site did not receive the full funding it requested to fully staff a RAID service and was not able to establish office space within the same hospital as the ED. The service had far fewer staff members than in the original RAID study and was felt to be under-resourced. In another site a service was designed, and staff were interviewed, yet the funding for these services was cancelled. Another site was unable to provide a 24/7 service across two different sites and therefore had to alternate between the two.

The level of training that was offered to staff varied considerably. In some sites training was regularly delivered, particularly for new starters, and staff felt that this training had been effective in both raising the awareness of mental health issues and providing appropriate referrals. The training aimed to empower staff to feel able to deal with psychological distress. However in other sites training was never fully established. The training element of the RAID service is addressed more fully within the following sections.

Success factors

The need for mental health problems to be dealt with better in older adult wards, A&E and in other hospital departments was relatively uncontroversial. However different levels of resources were available across the different sites, and the configuration of services and the make-up of their patient populations varied considerably.

The embedded and connected nature of a RAID service seemed important for many, and this was something that often took time to develop. Working relationships with other staff had to be developed and the usefulness of each team had to be demonstrated:

Relationships have changed, improved, a familiarity [has developed] that wasn't there before and an acceptance that we are there. People appreciate they can make a referral in a far more efficient way. It has gone some way to closing the gap that exists between acute and mental health. There have been some negative things but for our own staff group, everyone was anxious, but the staff team have come together, and started to deliver a top class assessment service. We have achieved quite a lot, in terms of nursing standards and delivery of care.

You won't get the finished product immediately and you will need to grow staff and grow expertise. You should employ staff with different skill sets, particularly around older adults. If the medical cover is all general medical, the older adults can be slow to get started even though that's where you get most of the benefits. Also the staff can feel unsupported, so it really is important to understand it will evolve with time, and you'll need to support staff in particular areas and you may not be able to justify that immediately.

We tried a model of parallel processing, so [when] someone comes in with a paracetamol overdose they have a medical need and a mental health need, and you can either look at those things as being two separate things, so you do the medical bit first then the psychiatric bit, or you can do them in parallel, which is more efficient. As someone is waiting around an hour to do a blood test, you can do their mental health assessment. So part of that was a cultural thing, the mental health staff [needed to feel] comfortable doing that, which they are now, and [it needed to] change from them waiting to be called, to actively case find, which they will do now to a greater extent but that can go further.

But with having RAID built into the trust, by providing teaching and sharing experience, then the acute nurses have the experience, and they are able to gain that benefit, they understand more about the needs of patients with a mental health problem and even though [the patient] is staying in the acute trust, we are still providing for their [mental] health needs.

People should make sure that [RAID] involve the ED teams, in terms of guidelines, in terms of face to face stuff, meeting the ED teams, [RAID] need a physical presence, close to ED, because they do need some office space to go off and check things, with regard to what they know about a patient, that makes for more efficient working from their point of view.

Working relationships with other clinicians were often considered vital, but it was emphasised that they sometimes took time to develop. Support from other teams, the local authority and commissioners was also important.

The training of other teams concerning what RAID was, how it operated, and how clinicians could identify and deal with mental distress was also seen as key to RAID's success. One participant mentioned how, by training senior members of staff, knowledge and competence around mental health issues 'cascaded down':

The training element of RAID couldn't be over-emphasised, the service ran for some months without any clinical contacts, to provide an opportunity for training and bedding down within the [hospital]. Some time to bed in at the beginning can't be overemphasised. Building in training, rather than clinical contacts, would be important.

Teaching and training is a big element of this - not pathologising mental distress. Acute hospital staff need training to empower themselves to deal with psychological distress. Acute hospital [staff] should manage it themselves, and are under pressure themselves, and they see an opportunity to use RAID. Someone who has a psychotic diagnosis, then refer them in, but some referrals are for usual human distress like dealing with a diagnosis or losing a relative. General hospital doctors can struggle with the emotional issues of the patients. They don't complete the 360° aspect of their clinical role.

Where RAID worked well, training was embedded. It was available for all new starters and for other existing members of staff – the training of junior doctors was given as an example of a successful outcome. Although many mentioned "hard" outcomes, such as cost savings (achieved by reduced stays), others mentioned "soft" outcomes, like the increase in staff confidence and competence as a result of training. This was sometimes harder to evaluate.

The ways in which the service established itself was important and interviewees spoke about the need to recognise the different populations they served and the different ways local services were configured across different sites. Investigating

how to do this worked better where teams were embedded, and where they had a close working relationship with clinicians. However where staff were on short term contracts, and/or they did not have time to develop working relationships with existing teams, efficient referral patterns were harder to establish.

This is a joint service. The initial findings [might be interpreted as] you pay this money, get this service and you don't have any problems. That's not how it works. It evolves, adapts, the staff get used to you, you get used to them, you understand the referral process, you understand what they can and can't do. The team grows over time, additional skill sets, more psychologists on the team, the team can then do more. The team grows and it's important.

In a couple of sites, the RAID team often made referrals to the Home Treatment team which reportedly created a delay in the system. However this delay was alleviated by working together with the mental health trust more closely and the RAID team could then deal with the patient directly without the need for an additional referral.

What we worked through was [...] there were delays because of waiting for a separate psychiatric team to make a decision that "Yes this person needs to be sectioned", but by agreement with the mental health trust, RAID themselves could make a decision, [and this] wouldn't be duplicated by a home treatment team coming in and effectively repeating it. [...]

Barriers

There was a considerable amount of disagreement as to whether the implementation of RAID had been successful and what the reasons were for this. Two of the most discussed issues were i) the level of investment in the service and ii) the level of support the RAID team received, particularly amongst senior clinicians and managers.

Investment and resources

Some services that had implemented a "RAID type model" felt that they weren't resourced in the same manner as the original RAID service and therefore could not expect to see similar results. In essence they were being 'set up to fail' as they were being assessed by the same outcome criteria as the original RAID service. In one site where the RAID service had been designed, staff had been interviewed and were about to receive appointment letters, but funding was withdrawn. In others, the service was felt to be under-resourced:

We have a semblance of a service with similarities to RAID. We are in no way to say we are a replica. It was under-resourced, the model, the modus operandi couldn't replicate RAID. RAID has expanded and had investment in all the provider sites, they have dedicated teams by each site, and the majority of them, they all deliver a 24 hour service, but we don't.

Initially the relationship between the acute hospitals and ourselves was a potential barrier, because it wasn't 100% clear. There were different expectations around different acute hospitals. That was a barrier. We have developed a service which is a version of the RAID model, but we are not fully up and running, and that's down to funding. As time progressed, working through those issues, we worked through those issues quickly and built up some good solid relationships with the lead for the hospital.

I don't know at what point the finances got stuck, I was unable to establish where it went wrong, everyone was saying all the right things, everyone was verbally convinced by all the evidence, but then it just dried up. There is a signed agreement between the acute and the mental health trust about it. I'm at a loss to know where the problem was. [...] We are having to say no we are not coming to see patients at your hospital, and it is very difficult indeed not to support colleagues.

When we started RAID in October 2012, we decided to provide an enhanced liaison service 24/7, for both sites [hospitals]. Within the first month we realised that we didn't have enough nurses or resources to provide that. We had to change the way to provide the services. Rather than having 24/7 on both sides, they alternated. We had a few hiccups.

In other areas there is dispute as to who should be funding the RAID service:

The idea is that acute hospitals will put up some of the cost, and it looks like they should pick up 60-70% of the cost, they can see the integrated model and are committing themselves. In the [hospital name] they are not committing the funds. They only offer locum posts, for short periods of time, they don't attract the highest quality of old age psychiatrists, people of quality find substantive posts somewhere else.

Embedding the service and support

A RAID service can take time to develop, to allow working relationships with other staff to build, to develop different referral patterns and also to provide effective education to staff via a series of training programmes. Some commented that commissioners and providers wanted to see results straight away or that they had never supported the service. One participant remarked:

The biggest [barrier] is to think that RAID is going to come and solve all of your problems, you have to work with them, a liaison happens between two people, liaison psychiatry has to work with you. [...] Also there is a great deal of prejudice against mental health, particularly if they have had low services prior. Those are the things that you need to overcome in your own organisation.

I know they probably argue it hasn't been properly resourced. From [the front door] they are, the back end part of it is probably nearly endless, in terms of the need for dementia, and what could be put in there, they have to cut their cloth depending on what services they have available. If you consider the proportion of patients who get admitted to beds, who have dementia, psychogeriatrics, it is an area of increasing need.

Changing the patterns of referral and working with mainstream mental health services could present some important difficulties for RAID teams that were just setting up. Participants recognised that there could be different priorities in different settings (for example, A&E waiting time targets, or attention around the implementation of the Mental Health Act following a CQC inspection) but also that there could be powerful personalities within different areas who concentrated the resources into particular specialisms:

Internally you need to have a skill mix, you need to have appropriate investment and a team for clinical work. If you don't have clinical leadership you don't have clinical credibility. In terms of working within the acute hospitals, if you don't have clinical buy-in from the acute hospitals, you need senior clinicians in the RAID team, and that in turn seems to make it happen. Lower levels of investment you get less experienced people.

Two things have to work together, you need the right skill mix and a critical mass. To give you an example from [site name] you have a bit of unhappiness, [...] which you can contrast with [site name] and see the difference. There is no older age psychiatrist there at all, they are crying out for one, the nurses came from alcohol and substance abuse backgrounds, with the exception of one. The right skill mix [is essential] you need the team to support the hospital.

If you have strong gastroenterologists you will have the agenda driven by self-harm and alcohol use disorders, if you have strong older adult services, then you will get a steer towards an older adults agenda. There is a lot of politics, and clinical partnerships, it can skew the nature of the work, and it can work well. If you have movers or drivers around acute hospitals, the issue with RAID is that it is a relatively small team of people who are expected to cover all of those issues within a time limit. Within that there is a challenge to maintain a balance of the service, depending on the pressure and the work load.

The implementation was about the front door, there wasn't a huge emphasis for patients in the ward, they had quite a strong dignity in care team, quite a specialist service on the wards for people with dementia were quite developed. The RAID team never had a psychogeriatrician and we couldn't expand, and coupled with this around the time RAID [was being established] the A&E attendances [went up and we] mostly had to focus on the front and not been able to offer the level of support.

Adapting the RAID model

For others the barriers to the successful implementation of RAID were about the perceived unsuitability of a RAID model for the location or patient population, so that there could be a series of unintended consequences arising from its implementation:

We get more overdoses, and there is a significant drift of unwell patients towards the [hospital name] because there is a RAID service, they come here. We are also a tertiary service. [For RAID] we'd need more than one consultant, a clinical psychologist has always been promised but never been delivered. They are definitely needed, we don't have any exit strategy for these patients.

RAID is not a one-model service. Work out what the hospital needs and what it will do. If you want a front-door service then you will get that. The backdoor service consumed a lot of money,implementation can be improved in a significant way.

The thing to consider is that RAID has to cover a lot, it's all things to all people. If you're trying to deal with all mental health pathology, the challenges are that everyone thinks it's there for them. If you think about RAID in a general hospital setting, A&E setting, people will think about self-harm and getting people out of it really quickly. One of the biggest frustrations is that some people just saw it as an A&E service. If you said to acute hospital services, you're really just an A&E department, all of those people would be furious. A&E is only an element of this service. RAID is

seen as an A&E service and is judged on that. Financially A&E is a loss maker for everyone, if you tried to evaluate RAID that way you'd fail. Within the acute hospital, there are particular strong characters who will drive and steer the nature of the work.

The other thing is that the population that you serve is different. For [area] we serve a slightly elderly population, we also serve patients from [a rural area], and the geography is actually quite spread, if you look elsewhere they are all in urban centres, they have better family support, they probably have diverse ethnicity. Before [you] implement, you [have to consider the population]. You can't take the same model and put it in another trust. You need to understand your local area.

Practical and logistical barriers

Some of the barriers that staff faced were logistical problems which then in turn had an impact on clinical care. In some sites staff did not have access to patient records, which affected the speed and accuracy of referrals. In other places the RAID team was stationed in a different building from the team they worked most closely with and did not have access to Wi-fi, or experienced other problems with IT systems. Care pathways altered both as a result of the RAID team and also as the result of external policy changes:

A negative impact is because we've had more patients brought to us, the change with the way police don't offer a place of safety [has happened] and they don't have anywhere else to take them. [The hospital has] become the reception centre for people. They have far more people turning up, that has been perceived negatively by clinicians, that's not been positive.

We actually purchased several tablets [so] that [staff] could scribe onto the tablet, that hasn't been successful, the testing of those was done pretty sporadically, these had minimal testing before they went out and committed to buying these. More robust testing of these, and what IT solutions were out there, that would be far more beneficial.

Lessons learned and advice to others

There was considerable disagreement as to whether RAID had worked in different locations. Whilst some participants felt it was an essential service and that the lessons learned from implementing RAID were primarily about its successful implementation, other sites were looking at commissioning other models altogether.

One of the clearest messages across all the sites was that RAID needed to work within the local context and that the best outcomes could be achieved by working within older adults wards, and not just within A&E departments:

RAID is not a one-model service, you can't send a team into one hospital and it will fix it. Essentially you need to know what the hospital needs and tailor it to that. If you want a front-door service, then it's actually quite easy to work out what that front-door service is. The problem is that when you implement the backdoor service there is quite a lot of need, and that can consume a lot of the time associated with the RAID service. A lot of time essentially, and it is implemented in an incremental way. So if it is implemented at the front door we will scope what is needed in the rest of the hospital in conjunction with the commissioners and the hospital itself.

Older adults, CPNs, older adults psychologists, they're not all that common and getting funding for them is sometimes quite difficult. They can be choosy about where they want to work, if they are respected they'll want to come, if RAID is being treated as a second-class service, they'll go somewhere else. A clinician should work with them, that's your accelerant, to get the maximum out of a RAID service in the minimum time, if there is a relationship with another clinician, and if that is joint then that is even better, that is the really big thing. If we were going to have RAID again, that is the first thing I'd do.

People spoke about the need to develop a 'critical mass', for teams to be well implemented and for a focus to be in-reaching into hospitals with a focus on older adults. Some people felt that services for older adults produced the best results from the RAID service:

I think the lesson is that you have to have complete integration of RAID team with the hospital, they have to be embedded in the hospital, working in the hospital and there are principles of RAID, like 24 hours, like older age and general psychiatry, and rapid response. The other important point for me is to make sure you make sure you have the older age psychiatrist, clearly built up in this. [You need to] collect outcome measures, you need to find feed-back to the team.

Throughout many of the interviews there were clear messages about the ways in which the RAID team was established and resourced. Others also felt that everyone involved with RAID ought to agree on what the RAID service was there to do, and how its success was going to be assessed:

Operational perspective – if I was doing it today I would engage senior acute clinicians first, to make allies, and insist the acute hospitals' senior managers bought into the process. There was a disconnect between operational and directorate levels. There were quite frustrating breakdowns in communication. There were compromises made, to operationalise the service, we may need 14 but only put in 11, or [we needed] 3 psychiatrists, but only afforded 1 or 2. You set yourself up to fail.

I think when people look at the justifications, in terms of the parts of being re-commissioned, they need to look at all of the parameters. You might be looking at management who are very focused on four-hour target breaches in A&E, as opposed to looking at the totality of care, the agreed metrics are important – what are we going to collect. How do we assess this service? What do we expect from each other? [These] are really important to get at the outset. [...] and if you're looking at savings and funding it on an on-going basis with those savings, they can be quite difficult to materialise within individual budgets, so a degree of caution [is needed] as regard to that.

Outcomes

One of the primary reasons that RAID was rolled out to different sites is that it demonstrated the potential to produce cost savings by preventing unnecessary admissions to hospital, reducing waiting times, and also preventing readmissions:

The economic evaluation was a good one. When it was delivered again, the initial evaluation was if you spend £1million you realise £4 million invested in the service. I'm loath to call it savings because it's not really savings, it's just diversion and reinvestment, you get that £4 opportunity for every pound that's spent. You then get that tweaking of methodology. The next evaluation is that there is still £2.50 reinvestment; that is still pretty good.

Even these 'hard' outcomes in terms of cost savings could be difficult to establish when dealing with a complex system:

They are very hard [to demonstrate]. The business cases that are put around those types of services, when you try and remove costs, to reinvest, you just find that it's a bit like water sloshing around the place, you know, you carve out a benefit it tends to get absorbed by something else.

Other outcomes also mentioned by participants could be harder to measure:

There hasn't been any proper thought given to outcome measures, there doesn't seem to be a lot of data out there that actually supports one measure or another. There is some value in looking at how the performance of such services can be measured. RAID performance targets – they will respond to referrals within an hour, but not dealt with, and has been misconstrued by our commissioners as the person would be seen, done and dusted and on their way. You have to have the resources to meet that demand. Again I don't think this was properly thought through. From our experience they can't respond if there is no one there.

As a performance measure it isn't valuable, apart from meeting the A&E four-hour target. The danger is that ascribing times to service in terms of a bench-mark of success just keeps us in a culture of targets rather than improved patient outcomes, reduced length of stay. The devil is in the detail.

People haven't taken into account wider benefits, people [patients] can be quite challenging, A&E nurses are having to support those people, one-to-one nursing, and security, diverting resources away from others. Morale goes down, they are difficult to manage and stressful. What we know anecdotally on the ground is that it impacts there. Reception staff, security operators, are grateful for the service that they get. There is no good way of articulating that.

Objectively when you're measuring it, you can say these patients have their care delivered more quickly, and the episode is finished more quickly, the other parts are harder to measure, like assessments, teaching, increasing expertise of staff, and certainly they're components of them, to say it's gone from 60% to 65%.

It has definitely been a great benefit. When I think back to when I started as a consultant 15 years ago, where you were getting often very junior SHOs they didn't really have a clue what they were doing. They were people who were often trained in general practice etc. as compared to people who can properly assess people – CPNs, people who know what they are doing - and I think, quality care wise, it's better, and it's safer. It's hard to demonstrate that on a graph but I think it's certainly better for patients.

We need to think about what we had, and before [that] was pretty shoddy and pretty poor. We're grateful for small mercies. I would say, well for any other trust that is going to implement this then actually look at what they as an individual trust need, rather than what someone else has got, and don't aspire to something that is the [full] model then not deliver.

The amount of time it took for outcomes to be produced was also a matter of dispute:

If say, you were going to implement RAID at your hospital, that's great I want that, you'll get it, but it won't happen immediately and you'll need to be patient.

Conclusion

Overall, this rapid review of the RAID service has raised important questions about the service itself - but also about the way innovation spreads and is implemented/adapted elsewhere. From modest origins RAID has achieved significant reach, and the evaluations to date (referenced in this review) have been positive about its impact. However, how best to roll out and develop the initial model is more contested – and there may be broader lessons for the AHSN (with its commitment to identifying, nurturing and disseminating innovation). Perhaps the most themes and lessons from this brief review are that:

- Innovative new approaches can make an important contribution to improving outcomes and relieving pressures on other parts of the health system – but there are unlikely to be ‘magic answers’ or panaceas. Even where a new model appears to have significant early success it is unlikely to be something that can simply be imported/bought in in order to solve all problems locally.
- It was clear that many participants felt that RAID had delivered (or had the potential to deliver) real benefits. However the way in which RAID was planned, resourced, staffed and supported were perceived to be key factors influencing its success.
- New services do better when they receive the support of senior managers and where the service is sufficiently resourced – a number of participants talked of a ‘critical mass’ that was needed to instigate real change.
- RAID was more favourably evaluated by participants in this review when services included a focus on older adults and where the service addressed the needs of inpatients, in addition to having a role in reducing waiting times in A&E.
- The RAID service, designed to operate across a number of different services, could not be sufficiently evaluated by using single outcome measures i.e. reduced waiting times or cost savings.
- New models are designed in a specific way for a reason, and there needs to be a degree of fidelity to the underlying model if the successes of early service models are to be replicated. Only partially implementing a new approach is unlikely to work. Certainly, those Trusts that have taken the RAID model and implemented only a proportion of the new approach shouldn’t be surprised if it doesn’t deliver what a full model might.
- At the same time, new ways of working need to be designed and implemented in ways that are appropriate within the context of existing local services, personalities and relationships. This means that models cannot be imported wholesale, but that there is a legitimate process of adaptation (which may take time to plan and implement).
- Taken together, the two bullet points above suggest a tricky balance between being clear on/remaining true to the key elements of a successful model, whilst also being flexible about how best to implement in different local contexts. Adaption of the model needs to be mindful of existing services that are in operation and of local populations.
- ‘Soft’ outcomes matter too – even if they are harder to measure. It may take time for all outcomes to be produced because of “teething difficulties” as a service establishes itself and because an attitudinal change towards mental health is hard to achieve.

- Paying attention to practicalities is important (for example, access to IT and appropriate accommodation/space near to linked services). In order to have an integrated service, teams need to be physically close to each other and be able to access joint notes.
- Developing new ways of working takes time, and is as much about developing new relationships as anything else. By definition, liaison is a two-way process, and attention needs to focus on the host organisation as well as on the new service.

Above all, this review suggests that we need to be clear about the outcomes we are trying to achieve by looking to a new service. Improving patient experience is a different type of outcome from trying to hit a 4-hour access target, which is different again from raising awareness of mental health issues amongst hospital staff, facilitating swift discharge, preventing readmissions and/or freeing up staff time to focus on other priorities. While it may be possible for one approach to do a number of these things at once, being clear about what success would look like seems to be an important precursor to knowing whether or not something has actually succeeded in practice.

Bibliography

Chaput, Y., & Lebel, M. (2007). Demographic and clinical profiles of patients who make multiple visits to psychiatric emergency services. *Psychiatric Services*, 58, 335-41.

Crowley, J. (2000). A clash of cultures: A&E and mental health. *Accident and Emergency Nursing*, 8(1), 2-8.

Department of Health. (2011). No health without mental health: a cross-government mental health outcomes strategy for people of all ages. London: Department of Health.

Okorie, E., McDonald, C., & Dineen, B. (2011). Patients repeatedly attending accident and emergency departments seeking psychiatric care. *Psychiatric Bulletin*, 60-62.

Parsonage, M., & Fossey, M. (2011). Economic evaluation of a liaison psychiatry service. London: Centre for Mental Health.

Pasic, J., Russo, J., & Roy-Bryne, P. (2005). High utilizers of psychiatric emergency services. *Psychiatric Services*, 56(6), 678-87.

Plumridge, N., & Reid, S. (2012). Liaison psychiatry can bridge the gap. *Health Service Journal*, 6 December 2012, 24-26.

Tadros, G., Salama, R. A., Kingston, P., Mustafa, N., Johnson, E., Pannell, R. and 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.

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