Dementia in Acute Hospitals

George Tadros
Consultant in Old Age Liaison Psychiatry, RAID Lead Clinician, Birmingham, UK
Honorary Professor of Old Age Liaison Psychiatry, Warwick Medical School, University of Warwick
Visiting Professor of Dementia Care in Acute Hospitals, Chester University
Hospitals on the edge.
Can our NHS hospitals survive without better and more effective dementia care?
Older People in Acute Hospitals

- Up to 70% of hospital beds are occupied by older people.
  - 30-50% of older people in acute hospitals have dementia, delirium or other cognitive impairment.
- 70% of older people referrals to liaison services are not known to mental health trusts.
- 500 beds hospital would have 5,000 elderly admissions/annum, of whom 3,000 will have or will develop a mental disorders.
  - Failure to organize dementia liaison services leads to excess cost of £6m/year
- 2000-2010, hospital stay for 60-74 increased by 50%, over 75 by 66%.
- The majority of mental co-morbidity in acute hospital affecting older people is due to three disorders: Dementia, Depression and Delirium.
- Dementia CQUIN (FAR)
- CQC
- **Mental disorder in older adults is a predictor of:**
  - Increased LOS
  - Increased readmissions
  - Increased Institutionalism (impacting on performance and efficiency)
  - Increased mortality
  - Increased falls
  - Other poorer outcomes
Rapid Assessment Interface Discharge (RAID)
The upgraded RAID service (cost £1m)

- Consultant in Old Age Liaison Psychiatry
- Consultant Liaison General Psychiatrist
- Clinical psychologist/ Band 8 or above
- Team Manager Band 8a

- Band 7 Nurse MHOP 1.0 WTE Currently Funded
- Physician Assistance
- FY1 or CT1 or SpR

- Band 7 Nurse Liaison 1.0 WTE Currently Funded

- Band 6 Nurse MHOP 1.0 WTE Currently Funded
- Band 6 Nurse MHOP 1.0 WTE Currently Funded
- Band 6 Nurse MHOP 1.0 WTE Currently Funded
- Band 6 Nurse Liaison 1.0 WTE Currently Funded
- Band 6 Nurse Liaison 1.0 WTE Currently Funded
- Band 6 Nurse Liaison 1.0 WTE Currently Funded
- Band 6 Nurse Substance misuse 1.0 WTE

- Assistant Research Psychologist
- Admin Band 4 1.0 WTE
- Admin Band 4 1.0 WTE
Top 7 reasons for referral (all age groups; 350 referrals/month)

- Deliberate self harm: 32%
- Anxiety: 6%
- Deliberate self harm: 32%
- Depression: 18%
- Alcohol misuse: 18%
- Psychosis: 9%
- Drug misuse: 4%
- Dementia/Confusion: 18%
A&E Response

- Targets Met: 73%
- Targets Not Met: 7%
- Not Recorded: 17%
- Not Assessed: 3%
Ward Response

- Not Assessed: 1%
- Target Not Met: 10%
- Not Recorded: 6%
- Target Met: 83%
Teaching and evaluation

- 4Ds (Dementia, Depression, Delirium and Dignity).
- Class room teaching and workshop.
- Theory and practice.
- 2 days training with a month gap for theory application.
- Day 1; theory and scales for measuring.
- Day 2: Management including BPSD.
- Feedback and evaluation.
Patient satisfaction: Feedback

- Very poor to poor rating: 8%
- Neither poor nor good rating: 8%
- Good to excellent rating: 84%

<table>
<thead>
<tr>
<th>Range</th>
<th>Mode</th>
<th>Median</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 5</td>
<td>5</td>
<td>4</td>
<td>4.2</td>
</tr>
</tbody>
</table>
Staff satisfaction: Feedback

- Referral to other services: 8%
- Advice on managing patients: 12%
- Support to family/carers: 17.81%
- Support of staff: 11%
- Education: 7%
- Information sharing: 7%
- Liaison with other services: 7%
- Providing information to patient: 10%
- Advice on medication: 11%
- Support to patient: 10%
- Signposting: 4%

<table>
<thead>
<tr>
<th>Range</th>
<th>Mode</th>
<th>Median</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.5 to 5</td>
<td>5</td>
<td>4</td>
<td>4.2</td>
</tr>
</tbody>
</table>
Savings and wider financial Benefits

Potential Benefits of RAID

Social care £

Complaints

Staff satisfaction

Patient satisfaction

Acute staff confidence in dealing with MH conditions

Staff sickness

A&E savings

Demand for community MH services

Discharge destination

MH outcomes

Quality

Acute staff training

Security

Referring / Signposting to community MH services

Outcomes Considered in this Study

1. Inpatient LoS

2. Readmission rates

3. Admission avoidance
3 Groups for the study !!

1. Pre- RAID group (control group)
   - December 2008- July 2009
   - No changes/confounders between pre and post!!

2. RAID_ influence group
   - December 2009- July 2010
   - RAID did not see patients, but had influence through training and support

3. RAID group
   - December 2009- July 2010
   - RAID patients

- Matched groups:
  - Matched age, gender, mental health code, medical diagnosis, healthcare resource group (HRG)

- RAID patients were the most complex
  - RAID: average 9 different diagnostic codes
  - RAID_ influence 3 different diagnostic codes
case-by-case Matched Control Study

Sub Control mean: 8.4
Sub RAID Inf mean: 5.2

Sub Control mean: 10.3
Sub RAID mean: 9.4

Control (2873 Patient)
Mean: 9.3 days

RAID Influence (2654 Patient)
Mean: 4.74

RAID (886 Patient)
Mean: 17.6
Cost savings: LOS/ all age groups

- **All ages:**
  - Saving over 8 months: $797 + 8,493 = 9,290$ bed days
  - Saving over 12 months: $13,935$ bed days
  - Per day: $13,935 \div 365 = 38$ beds per day

- **Older people only:**
  - Saving over 8 months: $414 + 8,220 = 8,634$ bed days
  - Saving over 12 months: $12,951$ bed days
  - Per day: $12,951 \div 365 = 35$ beds per day
2. Admission Avoidance at MAU: Cohort control study

- **All ages**
  - Control group;
    - 30% of avoided admission at MAU.
  - RAID and RAID influence group;
    - 33% avoided admission at MAU
    - Increase of 9%
  - Average LOS = 9.3 days
    - \(240 \times 9.3 = 2,232\) bed days
    - \(2232 \div 365 = 6\) beds/day

- **Older people**
  - Control group;
    - 17% of avoided admission at MAU.
  - RAID and RAID influence group;
    - 25% avoided admission at MAU
    - Increase of 47%
  - Average LOS = 22 days
    - \(111 \times 22 = 2,442\) bed days
    - \(2442 \div 365 = 6\) beds/day
3. Elderly Patient Discharge Destination

- 30% of elderly patients who come to acute hospitals from their own homes are discharged to care homes (national figures).

<table>
<thead>
<tr>
<th>Percentage of patients returning to their own homes</th>
<th>Pre-RAID</th>
<th>Partial RAID</th>
<th>RAID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>34%</td>
<td>44%</td>
<td>67%</td>
</tr>
<tr>
<td></td>
<td>(1350 of 2873)</td>
<td>(1247 of 2654)</td>
<td>(708 of 884)</td>
</tr>
</tbody>
</table>

- LSE estimated savings to our wider economy of £60,000/week (Social care cost).
## 4. Savings: Re-admission

<table>
<thead>
<tr>
<th>Group</th>
<th>Re-admission per 100 patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retrospective (3500)</td>
<td>15 (505)</td>
</tr>
<tr>
<td>Partial RAID (3200)</td>
<td>12 (408)</td>
</tr>
<tr>
<td>RAID (850)</td>
<td>4 (42)</td>
</tr>
</tbody>
</table>
Savings: through increasing survival

- The savings calculated from survival assumes patients readmission at same rate of retrospective patients.

- Over 8 months → 1200 admissions saved.

- Over 12 months → 1800 admissions saved.

- Saving 22 beds per day = one ward

- Saving 20 beds per day comes out of elderly care wards.
Combined total savings: beds/day

- **On reduced LOS**
  - saved bed days/12 months = **13,935** bed days
  - \( \div 365 = 38 \text{ days/day} \) (35 beds/day for the elderly)

- **Saved bed days through avoiding admissions at MAU**
  - Saved bed days = 6 beds / day
  - Elderly .. = 6 beds

- **Increasing survival before another readmission**
  - Admissions saved over 12 months = 1800 admissions
  - Average LOS 4.5 days
  - = 8100 saved bed days
  - \( \div 365 = 22 \text{ beds/day} \)
  - 20 for the elderly

- **Total Saved beds every day**
  - = 38 + 22+ 6 = **66** bed/ day (Maximum) {Elderly: 59 beds/day}
  - = 21 +22+ 6= **49** bed days (minimum) {Elderly: 42 beds/ day}

✓ **2010: City Hospital has already closed 60 beds.**
• Very thorough, detailed and vigorous review but conservative estimation

• Total savings:
  • £3.55 million to NHS
  • At least 44 beds/day
  • £60,000/week to social care cost

• Money value
  • Cost : return = £1: £4

• RAID expanded in Birmingham to 5 acute hospitals across three acute Trust, 3600 beds

• Now RAID is being implemented in over 20 trusts across the country.
Independent RAID Financial Evaluation by Central Midlands CSU
Steven Wyatt, 2013

Rapid Assessment Interface And Discharge Liaison Economic Evaluation of the Birmingham and Solihull Roll-Out

October 2012
Collate data on RAID contacts*;
- NHS Number
- Date
- Setting

Match to SUS A&E and IP tables and collate identifiers (not PI) of relevant attendances and admissions

Locate these attendances and admissions in local SUS and national HES tables
Wider Potential Benefits

Potential Benefits of RAID

Outcomes Considered in this Study

- Inpatient LoS
- Time in A&E
- A&E re-attendance rates
- Time to readmission
- Acute £ Prov / Comm
- Readmission rates
- Admission rates Fro A&E

Social care £

Complaints

- Staff satisfaction
- Patient satisfaction
- Acute staff confidence in dealing with MH conditions
- Demand for community MH services

Acute £

Referring / Signposting to community MH services

Security

MH outcomes

SUIs

Quality

Acute staff training
## A&E Activity Outcomes – Concurrent Controls

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Cases</th>
<th>Controls</th>
<th>Difference (95% CI)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission from A&amp;E</td>
<td>13.7%</td>
<td>22.4%</td>
<td>8.7% (6.8% - 10.6%)</td>
<td>Sig. at 99%</td>
</tr>
<tr>
<td>Average Duration in A&amp;E</td>
<td>4h 20m</td>
<td>2h 43m</td>
<td>97m (83m – 111m)</td>
<td>Sig. at 99%</td>
</tr>
<tr>
<td>Average Number of Re-attendances within 28 days*</td>
<td>1.14</td>
<td>0.64</td>
<td>0.50 (0.40 to 0.61)</td>
<td>Sig. at 99%</td>
</tr>
<tr>
<td>Average Number of Re-attendances within 90 days*</td>
<td>2.20</td>
<td>1.53</td>
<td>0.67 (0.57 to 0.78)</td>
<td>Sig. at 99%</td>
</tr>
</tbody>
</table>

* Applies to subset of cases seen between July 2012 and November 2012
<table>
<thead>
<tr>
<th></th>
<th>Commissioner Cost</th>
<th>Provider Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cases</td>
<td>Controls</td>
</tr>
<tr>
<td>All</td>
<td>2626</td>
<td>2626</td>
</tr>
<tr>
<td></td>
<td>14%</td>
<td>22%</td>
</tr>
<tr>
<td>Admitted</td>
<td>359</td>
<td>588</td>
</tr>
<tr>
<td></td>
<td>90%</td>
<td>91%</td>
</tr>
<tr>
<td>Located &amp; Costed</td>
<td>322</td>
<td>537</td>
</tr>
<tr>
<td>Cost</td>
<td>286,573</td>
<td>746,998</td>
</tr>
<tr>
<td></td>
<td>@£890</td>
<td>@£1,391</td>
</tr>
<tr>
<td></td>
<td>÷0.90</td>
<td>÷0.91</td>
</tr>
<tr>
<td>Grossed-Up Cost</td>
<td>319,502</td>
<td>817,942</td>
</tr>
<tr>
<td>Difference</td>
<td>-498,440</td>
<td></td>
</tr>
</tbody>
</table>
### Inpatient Activity Outcomes – Concurrent Controls

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Cases</th>
<th>Controls</th>
<th>Difference (95% CI)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Length of Stay Days</td>
<td>5.7</td>
<td>6.3</td>
<td>0.6 (0.5 to 0.7)</td>
<td>Sig. at 99%</td>
</tr>
<tr>
<td>Average Number of Re-admissions within 28 days*</td>
<td>0.28</td>
<td>0.31</td>
<td>-0.03 (-0.01 to -0.05)</td>
<td>Sig. at 99%</td>
</tr>
<tr>
<td>Average Number of Re-admissions within 90 days*</td>
<td>0.80</td>
<td>0.72</td>
<td>0.08 (0.04 to 0.13)</td>
<td>Sig. at 99%</td>
</tr>
</tbody>
</table>

* Applies to subset of cases seen between July 2012 and November 2012.
## Inpatient Financial Outcomes – Concurrent Controls

<table>
<thead>
<tr>
<th></th>
<th>Commissioner Cost</th>
<th>Provider Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cases</td>
<td>Controls</td>
</tr>
<tr>
<td><strong>All</strong>*</td>
<td>33,750</td>
<td>33,750</td>
</tr>
<tr>
<td></td>
<td>93.1%</td>
<td>93.1%</td>
</tr>
<tr>
<td><strong>Matched</strong></td>
<td>31,414</td>
<td>31,414</td>
</tr>
<tr>
<td></td>
<td>99.0%</td>
<td>99.0%</td>
</tr>
<tr>
<td><strong>Located &amp; Costed</strong></td>
<td>31,093</td>
<td>31,093</td>
</tr>
<tr>
<td></td>
<td>@£1,629</td>
<td>@£1,678</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td>50,656,320</td>
<td>52,162,644</td>
</tr>
<tr>
<td><strong>Difference</strong></td>
<td>1,506,323</td>
<td></td>
</tr>
<tr>
<td></td>
<td>÷0.990÷0.931</td>
<td></td>
</tr>
<tr>
<td><strong>Grossed-Up Difference</strong></td>
<td>1,635,107</td>
<td></td>
</tr>
</tbody>
</table>

*To avoid double counting, this number excludes cases seen by RAID in AE and then admitted*
<table>
<thead>
<tr>
<th></th>
<th>Full Tariff / Average Cost (£'000s)</th>
<th>Savings Share</th>
<th>Marginal (£'000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A&amp;E</td>
<td>Inpatient</td>
<td>Grossed-Up Total*</td>
</tr>
<tr>
<td>Commissioner Saving</td>
<td>498</td>
<td>1,635</td>
<td>2,133</td>
</tr>
<tr>
<td>Spend Provider Income</td>
<td>-573</td>
<td>-5,319</td>
<td>-5,892</td>
</tr>
<tr>
<td>Income Provider Saving</td>
<td>-498</td>
<td>-1,635</td>
<td>-2,133</td>
</tr>
<tr>
<td>Total Saving</td>
<td>74</td>
<td>3,684</td>
<td>3,758</td>
</tr>
<tr>
<td>Full Costs</td>
<td>5,892</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incremental Cost</td>
<td>3,295</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saving / Incremental Cost</td>
<td>1,976</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Activity Outcomes by Site

<table>
<thead>
<tr>
<th>Site</th>
<th>Admission via A&amp;E</th>
<th>Length of Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>cases</td>
<td>controls</td>
</tr>
<tr>
<td>Heartlands</td>
<td>14.3%</td>
<td>28.7%</td>
</tr>
<tr>
<td>Good Hope</td>
<td>19.4%</td>
<td>29.2%</td>
</tr>
<tr>
<td>Solihull</td>
<td>20.2%</td>
<td>11.2%</td>
</tr>
<tr>
<td>City</td>
<td>11.4%</td>
<td>17.3%</td>
</tr>
<tr>
<td>UHB</td>
<td>10.9%</td>
<td>19.1%</td>
</tr>
<tr>
<td>All</td>
<td>13.7%</td>
<td>22.4%</td>
</tr>
</tbody>
</table>
## Financial Outcomes by Site (£’000s)

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>HoEFT</th>
<th>City</th>
<th>UHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Cost</td>
<td>3,295</td>
<td>1,748</td>
<td>748</td>
<td>798</td>
</tr>
<tr>
<td>Incremental Cost</td>
<td>1,976</td>
<td>997</td>
<td>465</td>
<td>513</td>
</tr>
<tr>
<td>Commissioner Savings AE</td>
<td>-498</td>
<td>-322</td>
<td>-109</td>
<td>-69</td>
</tr>
<tr>
<td>Provider Savings AE</td>
<td>-74</td>
<td>-31</td>
<td>26</td>
<td>-80</td>
</tr>
<tr>
<td>Commissioner Savings IP</td>
<td>-1,635</td>
<td>-1,494</td>
<td>-293</td>
<td>162</td>
</tr>
<tr>
<td>Provider Savings IP</td>
<td>-3,684</td>
<td>-3,161</td>
<td>-1,028</td>
<td>535</td>
</tr>
<tr>
<td>Total Savings</td>
<td>-5,892</td>
<td>-5,008</td>
<td>-1,404</td>
<td>549</td>
</tr>
<tr>
<td>Net Savings (@ full cost)</td>
<td>-2,597</td>
<td>-3,261</td>
<td>-656</td>
<td>1,347</td>
</tr>
<tr>
<td>Net Savings (@ incremental cost)</td>
<td>-3,916</td>
<td>-4,011</td>
<td>-939</td>
<td>1,062</td>
</tr>
<tr>
<td>Savings / Full Cost</td>
<td>1.79</td>
<td>2.87</td>
<td>1.88</td>
<td>-0.69</td>
</tr>
<tr>
<td>Savings / Incremental Cost</td>
<td>2.98</td>
<td><strong>5.02</strong></td>
<td>3.02</td>
<td><strong>-1.07</strong></td>
</tr>
</tbody>
</table>
RAID Vs RAID+
A New RAID Model at MAU

1. What if we move RAID to the hospital front doors to proactively focus on dementia, depression and delirium in the elderly?

2. Does early screening improve patients’ outcomes?

3. Is RAID early intervention (RAID+) more cost effective than RAID?
   • MAU Discharge effect
     • Comparing current RAID with RAID+ MAU screening
   • LOS, RA rates, Discharge destination
Number of patients with a Mental Health Diagnosis – Dementia Delirium and Depression (Retrospective case notes and Screened patients)

![Bar chart showing number of patients with mental health diagnoses in retrospective and prospective data.]
RAID Screening - Groups

Screened 671

- ve Screened 250

+ ve Screened 421

Clinical Filter

+ ve Filter ~ 221

- ve Filter ~200

Referred to RAID 135

Not Referred to RAID ~86

+ ve RAID ~105

- ve RAID ~30
Patient Readmission Screening Effect

Cumulative Percentage

Days To Readmission

Not Referred by Screening
Referred by Screening
The most common reasons for referral were memory problems and dementia, low mood and depression, and anxiety and panic attacks.
The total number of patients who had no admissions increased by 58% (14 patients) from 6 months before a clinic appointment to 6 months after. The number of other admissions decreased by roughly 50% over this period of time.
The total number of admissions decreased by 34% from pre-clinic to post-clinic, with the average number of admissions decreasing from 0.89 to 0.59.
RAID Rapid Access Clinic: Readmission Reduction

The number of admissions were unaffected for 22 patients and 10 patients experienced a small increase in admissions, but 24 patients experienced a decrease in the number of readmissions from 6 months post-clinic compared to 6 months pre-clinic.
RAID Rapid Access Clinic: Reduction in LOS

Average length of stay (days)

The total number of bed days decreased by 46% from pre-clinic to post-clinic, with the average number of bed days decreasing from 11.4 to 6.21.
RAID Rapid Access Clinic: Reduction in LOS

24 patients had the same length of stay in pre-clinic and post-clinic admissions, and 9 patients had an increase in the length of stay (accounting for 172 days), but 23 patients had a reduction in the number of bed days (saving 465 days).
Rapid Access Clinic Savings

- Qualitative analysis of staff satisfaction

- Economic analyses
  - Number of bed days went down by 46%
    - Savings for 6 months = £87,900 (after excluding all cost)
  - Re-admission went down by 34%
    - Savings for 6 months = £75,000
  - Reduction in A&E
  - Total saving is more than £162,900/6 months (£325k/year).
Our Confusion Pathway

Confusion

History

Examination

PlnCHME

About Me 1

Known Dementia

FAR

Delirium

Delirium Resolved

Delirium Guidelines

Delirium

About Me 2

Dementia Care Standards

Dementia Communication Standards

Need for I.P Diagnosis

Dementia diagnosed

Dementia diagnostic standards

Dementia not diagnosed

No need for I.P Diagnosis

RAID to clarify

Finding Question

Question Positive

Question Negative No Delirium

Consider Psychiatric Presentation

eTTO as per guidance

No Known Dementia

Need for I.P Diagnosis

Dementia not diagnosed

RAID to clarify

Concerns
Our Reminiscence Pod on ward 30
Heartlands Hospital
Testimonials

- “We had 2 ladies who just sat by their beds and didn’t speak to anyone. After 20 minutes in the pod, they began to open up and talked for 2 hours about their lives. Pods really do improve patients experiences of hospitals and enable us to increase the level of dementia care which we offer, by understanding our clients more”.

- “With the stock of newspapers, different songs, films, radio and TV shows, there is always something to talk about”

- “I believe that Reminiscence Pods can be seen to improve services, reduce the use of anti-psychotics, improving outcomes for the individual, all of which can contribute to cost savings in an already overstretched sector… a real example of doing more for less”.

- [http://www.rempods.co.uk/index.html](http://www.rempods.co.uk/index.html)
My Life

Software

- Touch screen computer on wheels

Activities
- Games
- Music Player
- Sing-a-long
- Painter
- Bingo
- Quiz

Reminiscence media
- Different media types
  - Video Clips
  - Music Clips
  - Photos
- For different categories
  - Sport
  - People and Occasions
  - Entertainment and Humour
  - Youth
  - Pastimes
- Individual favourites
Digital My Life Story

- Create the pages of a digital book, containing information about a person's life.
- Relatives can bring photos in to be uploaded into the book.
- Individual therapy (working one-to-one) or in groups (enabling discussion about past jobs and hobbies etc.).
- Can help the caregiver and patient bond, allowing them to learn about the patient – covers “About me”.
- Books can be printed.
- Links with “All about Me”.
Testimonials

“Such was the level of interaction with the software; we were able to specifically reduce the need for sedative medication”.

“There was a patient with severe dementia who would often become upset at night and could sometimes display aggressive behaviour. The system enabled staff to establish that he was a really keen photographer and they spent hours with him, going through the various pictures on the system. This was a real turning point and allowed staff to establish a real connection with him”.

“A male patient with advanced dementia had been in hospital for 10 weeks. He was very quiet, disengaged and slept a lot. He was introduced to the system and he immediately became engaged. He particularly enjoyed the painting games, he went through all the video and music content, which lead to discussion on these topics. He even remembered how to use the system and started to show others how to use it”.

http://mylifesoftware.com/home
Third sector partnership

- Alzheimer’s Society
  - Free support to a weekly memory clinic.
  - Free access information and carers support weekly.
  - Alz café
  - Carers and patients voice.

- Volunteers' service
  - A good numbers of volunteers
  - Properly governed
  - Very useful

- Charities
  - Research
  - Training
  - Support
1. How would you negotiate starting a RAID team?
   - No funding!!
   - Who to negotiate with?
   - What would be your argument/evidence?
   - How would you fund it?

2. How would you start a RAID team?
   - Money has been made available!!
   - Who is in your team?
   - What are the preparations you put in place?
   - Training, Records/ data, Evaluation, Re-funding

3. How would you design a RAID team that would meet the local needs but also maintain the main RAID principles?
   - What would be your team specifications?
   - How would you meet them?
   - Who is in your networking team?

4. How would you evaluate your RAID team?
Group presentations and discussions

- Group 1
- Group 2
- Group 3
- Group 4
Project Processes

- Get appointed!
- Receive a Project Mandate / Brief
- Draft the Business Case / Project Initiation Document
  - Project Board & Project Team
  - Project Plan - stages / milestones / dependencies
  - Risk / issues / change control log
  - Quality Log - Customer Quality Expectations / Benefits
  - Project deliverables
  - Work packages & Team Leaders
  - Receive approval to start the first stage
Have you got a business case?

- Does it make any sense?
- Is it worth investing?
- Is it workable?
- What are the success outcomes and objectives?
Key RAID Principles: What is suitable for you?

- Single point of contact
- 24/7
- Rapid response
- Acute hospital based
- Services a broad spectrum of mental health disorders
- Integrated
- All adult age groups
- Physical and mental health staff working together
- Staff training
- Part of the hospital system and machinery
- Part of the community pathway and service delivery
- Flexible to local need
Human Resources and Leadership

- Permanent appointments
- Growth in team size – minimal risk to employment
- Recruitment strategy
- Operational stagey
- JDs
- Potential team members employed by different Trusts / authorities
- Recruitment timelines and processes
KPI’s / Outcomes / Clinical Pathways / Review

- **KPI’s**
- **Outcomes:**
  - Agreeing the KPI’s between 2 (or more) Trusts and commissioners

- **Clinical Pathways**
  - Positive placements with other services: transfers of care
  - Clinical conversations

- **Policies and Procedures**
  - Negotiating the boundaries between service teams
  - Expectations
  - Documentation

- **Communication:**
  - Media
  - Formal Launch
  - Networking
Start Up
# Project Deliverables

<table>
<thead>
<tr>
<th>Project Timeline</th>
<th>LEAD</th>
<th>Start</th>
<th>Finish</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forecast Project Timeline</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Human Resources: Recruitment and Leadership | | | |
| Training | | | |
| Estate: Designated working space | | | |
| North NHS 111 Implementation interface / integration | | | |
| IMT | | | |
| KPI's / Outcomes / Clinical Pathways / Review | | | |
| Policies and Procedures | | | |
| Communication / media | | | |
| Finance | | | |
| Research | | | |
| Evaluation - **Post Go Live** | | | |
| Sundry Items | | | |
| Post Project Review | | | |
Other vitally important issues

**Finance**
- How is funding your team?
- Where funding comes from?
- How would fund you if you succeed?
- What is your exit strategy if you don not succeed?

**Evaluation**
- What would you measure?
- Where would you find the data?
- Who owns the data?
- How would you collect data?
Thanks you