“Innovation – the word is ripe with the prospect of a better future. The most exciting part of innovation in healthcare is not the invention or discovery, it is that crucial part reaching many hundreds or even millions of people to benefit their mental and physical health.”

Tara Donnelly, Chief Executive, Health Innovation Network
Innovation is inherently risky but maintaining the present state may not be an option for providers. Like digitalisation, innovation requires investment to realise the benefits.

There is a great opportunity to learn from other sectors, public and private, and share good practice from outside the NHS.

Current situation

For the purposes of this resource, innovations are defined as new products, processes or services that offer a ‘step-change’ improvement in how a provider of mental health services fulfils its mission. An innovation could be invented within a provider, in collaboration with public and/or private sector partners, or elsewhere in the healthcare or other sectors.

Continuous improvement depends on innovation, and mental health service providers on an improvement journey are introducing innovations at every level of their organisations. The kind of innovations they make range from small-scale process changes in a ward or clinic, to online apps supporting specific user groups, to large-scale service redesigns, involving other health and care services. A number of established national initiatives, notably academic health science networks, are on hand to help trusts innovate faster and more effectively. Large-scale, structural networks, are on hand to help trusts innovate initiatives, notably academic health science networks, apps supporting specific user groups, to large-scale service redesigns, involving other health and care services. A number of established national initiatives, notably academic health science networks, are on hand to help trusts innovate faster and more effectively. Large-scale, structural networks, are on hand to help trusts innovate.

Innovation is hard work. It takes courage, persistence and preparedness, since people introducing radical change must both overcome resistance and inertia and anticipate risks. Thomas Edison was right – genius is 1% inspiration and 99% perspiration. So innovation takes time and effort, but it is a critical engine of continuous improvement.

Ideas for innovations come in different shapes and sizes from different sources. People on the service front line – staff, people who use services, their carers and families – are most likely to have ideas for small-scale innovations. Proven innovations from other trusts are a rich source of ideas for peers. Some organisations have developed systems for regularly ‘harvesting’ ideas from both internal and external sources, evaluating them, and then taking the ideas with high potential through development to piloting and rollout. One challenge for organisations is keeping such innovation management systems lean. Another is managing explicitly the inherent risks of innovation, including the risk that a pilot innovation that benefits one part of a care pathway may have negative effects elsewhere in the pathway or the rest of the organisation when it is rolled out at scale.

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Current thinking

A complex organisation builds its capacity to innovate because this is one of the main organisational assets that will maintain its edge over time (Kay 1983).

Building the capacity to innovate can be difficult in practice, not only because it challenges the status quo. It also requires particular skills. These include the ability to understand priority needs for change facing an organisation, to ‘scan the horizon’ internally and externally to make connections and spot innovations that could realistically meet those needs, and to develop and implement them, eventually operationalising new ways of doing things (Tidd and Bessant 2013).

According to Harvard academic Clayton Christensen (1997), even successful organisations with good management can fail if they miss disruptive changes to their environment. This happens when the leadership focuses on maintaining success through small, incremental improvements based on existing processes. Christensen’s point was that if successful companies listen only to their best customers and put all their effort into funding for technology and resources that predict future needs, they do not see the whole picture. The future can contain radical shifts or changes to which the organisation is not ready to respond.

By looking only at outcomes (eg targets), organisations become susceptible to disruption from innovations to processes. Subsequently they will resist delivery models that are radically different from the standard ways of doing things (Christensen et al 2015). In short, organisations must innovate to adapt.

Existing healthcare improvement tools and techniques, once embedded, tend to yield incremental improvements in services through continual small adjustments. Significant, rapid jumps in quality are more likely to stem from more radical forms of innovation.

There are a great many potential sources of innovation, such as when external events force a radical rethink, when changes are made to regulation, from good practice in otherwise unrelated areas, from research and development or just simple necessity (the mother of invention) and even by accident (Tidd and Bessant 2013).

Every sector has its own drivers for innovation. Factors influencing innovation in healthcare include:

- the complex system of parts, professions and functions that make up the service
- a continual evolution of available technology and underlying science
- occasional changes in direction and funding from policy-makers
- changes to regulation where regulators may be averse to risk
- internal political or emotional opposition to change (Barlow 2017).

Managing the risks of innovation

NHS trusts need to promote innovation if they want to make-step changes in the quality, safety, effectiveness, efficiency or responsiveness of their services, and to make sure people who use services, carers, families and staff feel fully valued and engaged. On the other hand, implementing innovation is inherently risky. Risk may be defined as:

“the uncertainty associated with an event [that] can be quantified on the basis of empirical observations or causal knowledge (physical design).”

(Gigerenzer 2014, page 274)

Managing risk means evaluating the possible consequences of both pursuing and not pursuing a potential innovation. It counterbalances the push for innovation in any strategic transformation process. Some innovation risks are general, such as the relevance of a proposed idea to an organisation’s core mission and purpose, or the probability of fully implementing a new process. Some innovation risks more particular to healthcare settings include.
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- Managing risk means evaluating the possible consequences of both pursuing and not pursuing a potential innovation. It counterbalances the push for innovation in any strategic transformation process. Some innovation risks are general, such as the relevance of a proposed idea to an organisation’s core mission and purpose, or the probability of fully implementing a new process. Some innovation risks more particular to healthcare settings include: resources may be wasted on ideas that go nowhere (innovations fail to be disseminated or adopted)

- testing new services alongside old ones may compromise the capacity of existing services

- cultural differences with commercial partners can lead to costly delays

- unforeseen consequences may dent a trust’s reputation.

At the individual level, perception of risk may be influenced by overconfidence in one’s own judgment, the extent of one’s aversion to loss, and a host of cognitive thinking biases (Westland 2008). At the organisational level, the importance of embracing risk in action is highlighted by the concept of groupthink, an irrational belief that the collective or group’s consensus thinking is rational because it is the consensus, thus blocking out alternative approaches or opinions.

Awareness of the various lenses used by people at all levels of the organisation is therefore a crucial part of innovation, a point reiterated by the national framework for leadership development set out in Developing people – improving care (NILD 2016). The politics of innovation and risk are often influenced by whatever levels of tolerance for uncertainty may be constraining regulators and funders. Such restraint manifests itself in a wish for change or improvement using initiatives that minimise uncertainty and control expenditures in what is a heavily regulated environment.

National initiatives supporting innovation

NHS England has launched the NHS Innovation Accelerator (2017a) to support innovation across the service. Mental health has topped the list of priorities for improvement and innovation among Healthwatch communities for the last two years (Healthwatch England 2016). The 2017 NHS England Innovator Challenge for Mental Health calls for projects which:

“have been co-designed with people (including carers, where appropriate) with lived experience of mental illness, [are] accessible to a diverse population and focus on delivering the most significant benefit in terms of outcomes and cost savings.”

(NHS England 2017b)

Currently the innovative ideas for service change in mental health are focused on STPs and integrated care systems. In time there will be other ideas and imperatives. The strength of the approach suggested here is that the same consideration of context and methodology is likely to prove useful at any time.

It is also helpful to bring different partners and providers together in a shared endeavour to improve care delivery, and examples are given below. It can be a major cultural challenge to bring together those responsible for delivering physical care and those responsible for mental healthcare delivery, alongside all other partners. However, the imperative to do so is increasing.

Academic health science networks

There are 15 academic health science networks (AHSNs) throughout England, and they were formed in 2013 to support innovation locally at pace. They have close academic ties locally, support innovation within the NHS and promote learning from other sectors.

These networks are a key part of identifying and understanding innovative suggestions. The establishment of innovation scouts has been received very positively in many areas.

Integrated care systems

It is envisaged that better outcomes for people who use services will be delivered by sustainable organisations operating as part of successful health and care systems. An important route to achieving this is through providers working more closely to deliver care across systems.

Integrated care systems will require effective leadership and robust governance arrangements to enable this sort of joint working and achieve their objectives.

Mental health providers are in a strong position to lead this work due to their history of partnership and collaborative working.

Summary

This chapter describes some of the rewards offered by innovative practices and how the rewards from innovative practice can be great. Risks can be managed through strong robust governance.

This chapter also provides case studies where trusts have innovated to bring about change.
References


Case study 49 - Innovation

**Integrated mental health care pathway**

North East London NHS Foundation Trust (NELFT)

**What was the aim?**

To support the national agenda promoting social inclusion and to support the principles of integrated care and care closer to home.

**What was the solution?**

Redesigning the mental healthcare pathway. The new pathway provides integrated mental healthcare, emphasising the provision of acute home treatment as an alternative to acute inpatient admission.

The new pathway introduces a single point of access in the community in addition to home treatment teams, who can manage people in crisis in the community instead of admitting them to hospital. Previous investment in community mental health services has ensured a genuine emphasis on treatment at home and driven up the quality of NELFT’s inpatient care, while achieving financial efficiencies.

**What were the challenges?**

NELFT is seeing an increase in the acuity of people who use services conditions and more people detained under the Mental Health Act. In particular, it is experiencing a surge in female admissions. The challenge for the pathway design was to manage these changing needs appropriately given the trust’s aim to support care closer to home.

**What were the results?**

Increased treatment at home, which has facilitated reducing the number of inpatient beds. Now 97.5% of all the trust’s mental health people who use services are treated in the community.

NELFT has purchased only five out of area mental health beds during the past 10 years. The trust went for nine years without purchasing any until a period in November 2016, when the trust temporarily closed for admissions.

**What were the learning points?**

The pathway would be strengthened by including Care Pathway Leads responsible for the patient journey. Making sure all teams are represented at core meetings would also maximise the benefits of the integrated approach.

**Next steps and sustainability**

Following very successful ‘integrated mental healthcare pathway development days’ in November 2017, NELFT’s future work will include implementing the agreed action plan to embed and further improve the pathway.

Dialogue with commissioners will continue to make sure the adult mental healthcare pathway is appropriately funded to meet demand.

**Want to know more?**

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Case study 50 - Innovation

Young Person's Home Treatment Team

North East London NHS Foundation Trust (NELFT)

What was the aim?
The trust wanted to offer an alternative to inpatient admissions in a move to modernise CAMHS care and make sure that any new model of care was clinically led. This move was driven partly by the temporary closure of Brookside, the trust’s Tier 4 CAMHS unit, partly by the desire for the clinical leadership team to develop a truly innovative solution for young people. NELFT aimed to offer 24 hour crisis provision, increasing scope for positive risk taking, and to treat young people in the least restrictive environment.

What was the solution?
The Young Person's Home Treatment Team (YPHTT) was created. This allowed Brookside to offer Tier 4 CAMHS provision in young people's own homes. It is the first such service to be nationally piloted by NHS England.

The YPHTT is staffed by a multidisciplinary team of professionals including doctors, nurses, occupational therapists and psychologists. It is a 24 hours, 365 days a year service and can support up to 12 people who use services at any one time.

What were the challenges?
Ensuring that commissioners, partners and families were part of the journey with the clinical leadership team was challenging but crucial to gain support for this new and very different service model.

What were the results?
Since opening in September 2016, the YPHTT has been providing a viable alternative to inpatient admission (reducing inpatient admission by approximately 60%) as well as facilitating earlier discharge for people with significant functional difficulties and a wide range of diagnoses. Initial data suggest that 244 inpatient admissions were avoided in the first year. The inpatient average length of stay has been significantly reduced since establishing the YPHTT's service.

The transformative new service model creates a seamless transition between inpatient and community CAMHS and improves continuity of care.

Rebekah Bewsey, Modern Matron, is “very proud of the achievements of the YPHTT to date. The new model has allowed us to bring our crisis pathway to meet expectations of transformation within the NHS and NELFT”.

What were the learning points?
The YPHTT is very effective at keeping young people with emotional dysregulation and self-harm out of hospital. Those young people who are admitted have more acute presentations and admissions are more appropriate.

Next steps and sustainability
The YPHTT has received significant interest from other NHS Trusts and Brookside is currently rolling out training in the model to a number of providers. A full service review will be undertaken. Caseload capacity is increasing as the model becomes embedded.

Want to know more?
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Case study 51 - Innovation

RAIDPlus: reducing the incidence and intensity of mental health crises

Birmingham and Solihull Mental Health NHS Foundation Trust

What was the aim?

To develop new and innovative technologies to reduce the incidence and intensity of mental health crises, and ensure that people who are experiencing mental illness are supported towards their recovery.

What was the solution?

The trust is the lead organisation for the NHS England RAIDPlus ‘test bed’, one of seven NHS and industry partnerships testing product and process innovations to improve outcomes for people who use services. RAIDPlus is developing:

- capacity and demand dashboard information (CADDI), developed with Midlands and Lancashire Commissioning Support Unit
- predictive analytics – digital tools to help predict, with a clinically useful level of accuracy, people who use services who are at the highest risk of a mental health crisis
- RAIDPlus crisis co-ordination centre, the ‘hub’ for information gathered from new RAIDPlus technologies, brought together in one central location. Specialist teams evaluate, monitor and co-ordinate care, according to a person who uses service’s needs. The centre houses a specialised mental health trainer who provides mental health and crisis care training programmes to frontline police, ambulance and community healthcare staff.

What were the challenges?

- RAIDPlus has huge potential for improving services, but as a complex innovation it carries substantial risks.
- Scale, complexity and novelty – it was not possible to predict with certainty the project’s cost or the time it would take.
- Value for money – having secured £2 million in funding, the project had to satisfy expectations.
- Leadership capacity – RAIDPlus needed senior clinical and management leaders; the trust had to ensure its day-to-day commitments did not suffer.
- Intellectual property – could the trust negotiate complex IP arrangements with commercial partners?
- Resistance to change – many people in many teams will need to change their way of working, and overcome a legitimate fear of trusting computers to predict crises.
- Unintended consequences – how could the trust ensure it had the capacity and know-how to deal with these?

What were the results?

RAIDPlus is still a live innovation project and its products are either in development or undergoing testing, evaluation and/or implementation. Results will be available at a later stage.

Want to know more?

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Case study 52 - Innovation

Promoting innovation and managing risk through a research and innovation department

Birmingham and Solihull Mental Health NHS Foundation Trust

What was the aim?

The trust’s research and innovation (R&I) department developed additional functions and expertise to those traditionally found in most trusts’ research and development departments. Anyone in the organisation, including people who use services, carers and families can suggest an innovation to the R&I team and get help taking it forward from the innovation lead or facilitator. The R&I department assesses innovations for economic, political, environmental, social, technological, organisational and legal risk.

The trust’s innovation pipeline has seven stages:

- generate – a staff members asks for help generating ideas or identifying innovations from elsewhere to address a problem; the R&I team brings together people facing similar challenges so they can discuss innovation ideas in ‘think tanks’
- assess – in relation to newness, likely success and value, risk, financial implications, feasibility and evidence base
- develop – identifying funds and supporting bids, testing, advising on intellectual property issues, accessing specialist advice, ensuring project management support
- implement – ensuring senior support, helping with adoption and culture change, linking with other departments such as IT, helping build in evaluation from the start of implementation
- evaluate – informing staff about different evaluation methods, providing proposal and final report templates, helping design tools and understand outcomes
- spread – holding roadshows to showcase innovations, developing adoption criteria and readiness checklists, identifying and targeting relevant services and organisations, developing adoption support packages and spread plans
- promote – publicising the innovation internally, regionally and nationally with support from the West Midlands Academic Health Science Network, identifying opportunities for presenting at events, entering the innovation for awards, approaching other trusts or regional partners that may be interested, helping the innovator identify means of publication.

What were the results?

Typically more than 60 innovations are in the pipeline at any one time. The trust was awarded the title ‘Innovative organisation of the year’ by the West Midlands Academic Health Science Network.

Want to know more?

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Case study 53 - Innovation

How locality data packs can drive improvement

Cheshire and Wirral Partnership NHS Foundation Trust

What was the aim?

To design and implement a fresh approach to continuous improvement and encourage more evidence-based decision-making, as part of the trust’s zero harm strategy.

What was the solution?

Locality data packs (LDPs), in PowerPoint format, contain key safety and quality information presented visually, with supporting analytical comment. Launched in 2015 and refined each year since, teams use LDPs to identify opportunities to deliver safe and effective care and to support continuous improvement.

What were the challenges?

Designing a product that clinicians and managers could interpret easily and a production process that would be sustainable given the volume of LDPs. LDPs are produced in Excel, pasted into PowerPoint, loaded onto the intranet and an e-mail sent to team managers with a link for easy access. All data included is already collected for statutory or internal reporting, so there are no extra data collection costs.

What were the results?

One team leader says: “By incorporating the LDP as a standing item on the team meeting agenda, essential issues are discussed and addressed … As a manager who has recently returned to manage the team in a time of crisis, the data pack has assisted me by highlighting areas needing immediate attention such as supervisions and appraisals. I have been able to focus on those areas and bring activity levels up to the trust’s requirement”.

CQC told the trust that staff had consistently described the value of LDPs in helping them deliver safe and effective care, supported by sound leadership.

What were the learning points?

- Design with the end user in mind with a particular focus on clarity and visuals.
- Get full backing from senior colleagues.
- Provide advice from experts who can explain complex statistical issues in a way people can understand.
- Develop ward and team managers’ skills in measurement and data interpretation.

Next steps and sustainability

The future challenge is to include more data about outcomes, and more comparator information to support more specific benchmarking.

Want to know more?

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Case study 54 - Innovation

Funding innovation and improvement

Hertfordshire Partnership University NHS Foundation Trust

What was the problem?

Turning an idea for an innovation or improvement into reality sometimes needs money – which can be hard to secure.

What was the solution?

The trust launched an innovation and improvement fund in autumn 2016 to pay for testing ideas and allow ‘proof of concept’. Ideas must contribute to one of these areas:

- improved experience for the person using services, carer or staff
- improved safety
- increased value
- better partnership working.

Applications are made on a single-page A4 template, and receive a response within four weeks. A panel of staff, people who use services and carers makes the awards. Staff members are drawn from clinical, corporate and other areas across the organisation. All panel members have equal status and have volunteered for the role. An executive director is chair, but decision-making is collaborative and egalitarian. Awards do not have an upper limit: the panel can make awards up to £25,000, while the executive team considers requests above that figure, which need a formal business case. The panel can endorse ideas before they go to the executive team.

What were the learning points?

Offer applicants the right support to progress their idea. Finance is not always the most crucial element: connecting the right people in the organisation, or practical help – such as measurement for improvement or project planning – can be more important.

What were the challenges?

After awards are approved and money distributed, people can still find it difficult to bring about change. The trust is promoting quality improvement approaches to address this. Its continuous improvement team provides advice and guidance on taking ideas forward.

What were the results?

The fund had 48 applications in its first 12 months and made 21 awards; some applications were directed to alternative funding sources or were supported through service budgets. Implemented ideas include:

- a portal system in the Essex IAPT (Improving Access to Psychological Therapies) service, reducing the effort in administering waiting lists and decreasing drop-out rates
- an interactive ‘cardio wall’ on an adult inpatient unit, to increase physical health, wellbeing, inclusion and general activeness
- a healthy eating interactive display to highlight an inpatient’s typical weekly food intake and the excess weight gain from this diet, to raise awareness and reduce weight gains
- creating and trialling a ‘living well with dementia kit’ with examples of potentially helpful products that people with dementia can buy.

Next steps and sustainability

The trust is evaluating the fund’s first year and examining ways to spread successful ideas across the organisation. Cash-releasing efficiency savings finance the fund, and the trust believes that investing in ideas will generate future efficiencies so the fund becomes self-sustaining to some degree. The fund acts as a catalyst for creative thinking and contributes to developing an improvement culture.

Want to know more?

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Case study 55 - Innovation

Developing alternatives to inpatient admission

Lancashire Care NHS Foundation Trust

What was the aim?
To develop intensive community support services as an alternative to inpatient admission for people with mental health conditions. The trust wanted to bridge the gap between support from mental health crisis teams and an inpatient stay, taking account of risk management and recovery model principles.

What was the solution?
Opening Willow House, which provides six short-stay crisis beds in a safe, non-clinical, less restrictive environment than a hospital. It focuses on timely support and takes an evidence-based, holistic recovery approach. The trust developed and runs the house in partnership with the Richmond Fellowship, to draw on third sector expertise in managing social crisis on a non-medical model. The trust’s crisis team provides specialist clinical interventions to people before, during and after their stay at the house; Richmond Fellowship staff help people learn how to manage their condition in a normal living environment. The crisis team manages access to the house, and its use is written into escalation plans.

What were the results?
Since the house opened in May 2017, 45 out of 89 referrals (50.6%) were of people who had had multiple hospital admissions. In all these cases, inpatient admission was avoided.

Want to know more?
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Case study 56 - Innovation

Awarding funds to innovative ideas

Mersey Care NHS Foundation Trust

What was the aim?
To stimulate innovation across the clinical divisions to solve complex issues.

What was the solution?
Creating an innovation fund by top-slicing the trust’s annual CQUIN funding. In the first year, teams were invited to bid for awards capped at £1,000 for initiatives that would enhance care of people who use services and/or safety of people who use services and staff safety. In the second year bids were invited for a handful of awards ranging from up to £2,000 to one of £25,000.

In addition, the trust holds regular events such as ‘innovation breakfasts’ to expose staff to new ways of working: one recently brought together creative small businesses from Liverpool and key staff from the clinical divisions.

What were the challenges?
The funding awards include an offer for the Centre for Perfect Care – the trust’s small in-house team of improvement and innovation experts – to help implement successful initiatives. This proved too ambitious given the sheer number of awards, and the centre found it difficult to work with all the teams.

What were the results?
In the first year more than 40 awards were made. But having fewer awards in the second year worked better: bids were of higher quality, more manageable in number and more successfully sustained.

The recent innovation breakfast sparked much development work that will benefit people who use services and staff. This includes using augmented reality to help people manage their self-harm outside hospital, and using technology to bring care information from primary and secondary care into one central place for staff and people who use services.

What were the learning points?
• Focus efforts to progress key organisational objectives.
• Many ideas were good but not a priority: this risks people feeling their ideas are not valued.
• The trust needs additional avenues for exploring some high quality ideas.

Next steps
The trust tries to improve the funding awards and innovation events annually for greater clinical engagement and maximum benefit.

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Case study 57 - Innovation

Improving access for urgent and non-urgent requests for help – Initial Response Service (IRS)

Northumberland, Tyne and Wear NHS Foundation Trust

What was the problem?

Despite the trust's crisis team working 24/7, contacting it was difficult: overnight and at peak times, callers often had to wait for a clinician to call them back – many attending accident and emergency instead – although less than 35% of callers/referrals needed admission or crisis home treatment. Older people, people with a learning disability or their carers had no access to urgent advice or crisis intervention. Routine referrals took up to a week to process and were often ‘bounced’ around services, creating further delays.

What was the solution?

After analysing data on demand, performance and skills, and cross-checking it with observations of staff at work, the trust worked with people who use services, carers and stakeholders to design a new service model that covered every aspect of the person's pathway from referral or asking for help, to discharge.

All referrals and external calls are routed to a single point for the locality with a single telephone number. Staff are trained to triage and manage requests for information, advice, help and support. The service is available 24/7, covers all ages and includes people with learning disabilities. Anyone can make a referral. The crisis team was strengthened with additional skills and expertise. If telephone contact is not enough to decide support, the team carries out rapid face-to-face triage at the individual’s home or a place of their choice, within an hour.

The trust centralised routine referral handling for all community mental health and learning disability teams to the new single point of access, and set up a multidisciplinary triage team. With the police, the trust developed a street triage service, also located with the single point of access and crisis team.

What were the results?

Over half of referrals are now made by people who need the service, their carers or families. Older adults and people with a learning disability have access to support around the clock. GPs have direct access to consultant psychiatrists, pharmacy, psychiatric nursing and social work advice in a single call; they can turn the advice into a referral request without additional paperwork.

More than 80% of calls are non-clinical – individuals asking for advice and information about services or their appointment, or wanting to contact their named nurse. Call-handling staff are trained in when to pass calls to clinicians, who triage them for urgency. In most cases they offer clinical advice and support by phone. These clinicians also make routine referrals to community teams where necessary (6% of calls). About 20% of calls passed to clinicians (4% of all calls) result in face-to-face triage or crisis assessment. Only 1% of all calls result in crisis home treatment and less than 0.5% in admission. Initial concerns that self and carer referrals would create excess demand are unfounded: referrals to crisis and community mental health teams are steady or have slightly reduced.

The new way of working also affected use of acute and psychiatric intensive care beds in the locality where it was implemented:

- admissions of Sunderland residents halved to below the national benchmark of 232 per 100,000 population
- the proportion of Sunderland residents admitted who were detained under the Mental Health Act increased – suggesting greater acuity was being managed in the community
- median length of stay for such people who use services fell from 23 to 15 days compared to a national benchmark of 32 days
- the street triage service reduced use of Section 136 detentions tenfold, with an average of fewer than five per month
- demand for psychiatric liaison services from people presenting at A&E has fallen
- bed costs have fallen by £3.5 million per year.

Want to know more?

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