Models of care

Faculty Report

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Authors

Professor Russell Razzaque
Faculty of General Adult Psychiatry

Dr Tom Stockmann
Faculty of General Adult Psychiatry

Sailaa Suntharajah
Research Assistant. North East London NHS Foundation Trust

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Executive summary

Mental health services have been predominantly community based for several decades, after a shift in the second half of the last century from an asylum-based system. Initially these community services were largely 'sectorised', that is, a consultant psychiatrist was responsible for both the inpatient and community-based care of patients who resided within a set geographical area. Policy changes originating twenty years ago then led to the current widespread adoption of a 'functionalised' model, where consultant psychiatrists work in either inpatient or community-based settings.

Concerns were raised by the College in the early days of the functionalised model, focusing on a lack of continuity of care and this has again returned as a focus for our report. In a 2018 survey of members at the General Adult Psychiatry Faculty annual conference, over 70% of responders reported working in a functionalised model, and of them almost 70% identified a lack of continuity of care as the main disadvantage with this model. In contrast, over 80% of responders working within a sectorised model identified continuity of care as the main advantage of that model.

Continuity of care is also valued by both patients and policy makers and there is an increasing evidence base to support it in research. A recent, large study showed that reduced continuity of care is associated with worse clinical outcomes and this is also illustrated in the report with a number of case examples in key sections. Different aspects of continuity have also been described, including relational continuity, which relates to cultivation of therapeutic relationships. Better therapeutic relationships, in turn, predict better outcomes for various common mental health conditions.

The evidence suggests continuity of care ought to be a priority for mental health service development and member surveys suggest that adjustments to promote it are also possible across different models. Seven recommendations for alterations to existing services are thus set out, with the aim of increasing continuity of care as experienced by the patient during their time in services. These acknowledge that a wholesale return to a sectorised model may not be feasible but are designed to at least improve the existing transitions between teams and help build more seamless care pathways.

Introduction

Mental health services have undergone several major transformation initiatives over the last half century. A move from an asylum-based, predominantly in-patient model of care towards a broad-based community provision took place over several years. As a result, most patients have received the bulk of their care in the community over the last several decades. Initially, this was largely provided under a sectorised model, where consultant psychiatrists oversaw all aspects of in-patient and out-patient provision within a geographical area.

The next fundamental shift in mental health service delivery was proposed in the National Service Framework for Mental Health[1] nearly 20 years ago, which eventually led to the changed consultant psychiatrist job roles known as 'New Ways of Working'[2]. As detailed in a 2005 College report[3], it led to a functionalised model, where consultant psychiatrists work in either inpatient or community-based settings.

By the early 2010s this model had become widespread. In 2014, the College produced a report on Models of Care, examining the pros and cons of the changes[4]. The report describes frankly some of the concerns raised about the changes at the time. It presciently notes:

"Multiplication of teams has adverse implications for the patient journey, almost always bringing internal referrals, repeated assessments and the opportunity to raise patient expectations only to dash them on issues of service boundaries and specifications. What we know about patient safety, quality of care and patient preferences all point to continuity of care being the single most important element of system design. Fragmented services create interfaces which can be both inefficient and unsafe: every interface implies a referral at least, usually a discussion and often a meeting. A high proportion of serious untoward incidents involve problems at system interfaces. Teams often put as much effort into protecting their boundaries as they do into seeing patients, leading to friction between teams."

Advantages of the new approach were also acknowledged, in particular on the impact it had on teamwork and other disciplines:

"The in-patient/out-patient split does have advantages. It is popular with in-patient nursing staff, as fewer multidisciplinary meetings are required and there are fewer consultants working to each ward, simplifying communication and saving time."

As a result, the report went on to list a series of principles that could help services decide which model to use and how to ensure optimal care within them. The principles aimed to encourage responsive, flexible, compassionate and patient-centred services.

It was acknowledged at the time, however, that the report was written at a relatively early stage in the country's experience of the functionalised model. An update report was therefore recommended for around 2018/19, once further experience had been gained by members and further research had been conducted.

Throughout this entire period, however, several Trusts and geographical areas in England had maintained the original sectorised model in their provision, either across the board or in some areas. This enables a comparison between these models. The May 2019 edition of the BJPsych published an 11-year study which analysed 5552 sets of patients notes for the impact on outcomes of different models of care, with a particular focus on the impact of differing degrees of continuity of care[5].

Data from this seminal study has also been combined with a survey of general adult psychiatrists, conducted at the 2018 General Adult Faculty annual conference in order to gauge current colleague opinion, experiences and ideas first hand.

This report is also being produced in the context of similar current discussions around models of care across a range of disciplines, including primary care. An exploration of different forms of continuity of care, outlined in the February 2019 edition of the BJGP[6] also provides a useful framework for the discussion.

Member survey

Aspects of the Delphi methodology were used in conducting a survey of members of the General Adult Faculty. This involves an initial questionnaire with open space for narrative answers to key questions. These narratives are then collated, and the respondents are then asked to rank the most commonly recurring narratives in order of importance. This way the research can unearth a detailed critique of the system or question being examined and then determine which critiques are most strongly held among respondents.

A survey was handed to attendees of the General Adult Faculty annual conference in October 2018 as they registered on entry. The following four open questions were asked.

1. In your area or Trust what service model is currently in operation?
2. What are the benefits of this model?
3. What are the limitations of this model?
4. What mitigating policies and initiatives might help to manage the above limitations?

72 colleagues completed the surveys in total. The majority of those who replied worked in a functional model - 72% - with 15% working in a sectorised model. The remainder worked in a hybrid between the two.

The responses were analysed by research assistants independent of the College. In terms of positive aspects of the respective models, greatest unanimity was found among those who worked in the sectorised model, 82% of whom said that *continuity of care* was a significant benefit they preferred in the model and it was ranked highest among all the narratives produced. There were, in addition, numerous narratives under this same theme including:

- better therapeutic relationships
- longitudinal knowledge of patient's history leads to better management and aftercare
- not relying on other teams to look after your patients
- less duplication of work between different teams (i.e. inpatient and outpatient).

There was less consensus among those who worked in the functional model when it came to positive aspects. *"A clear focus and approach"* was the most popular narrative provided in terms of benefits and this was shared by 18% of the respondents. Similar narratives that were also ranked more highly include:

- consistency of approach
- improved teamwork
- easier to manage workloads.

In terms of the negative aspects in each of the models, those who worked in the sectorised model had less consensus this time about what they found most problematic about their way of working. 19% stated that issues related to work planning and logistics and this was their highest rank problem. It tended to be listed as:

- time spent travelling between settings
- difficult to plan work.

Those working in the functionalised model this time shared a substantial consensus about what they found most problematic about their model and this related, again, to *continuity of care* with a lack of it cited by 68% of respondents as their greatest concern. Problems around this, which also ranked highly, included:

- barriers in moving between parts of service
- poor communication/agreement between teams
- patients are overwhelmed by the changes of the team and constant retelling of their story.

A consistent finding is therefore the prominence of responses and narratives around continuity of care. Where it exists - in sectorised settings - it is highly valued and its absence is highlighted as a significant concern where it does not.

Case Example: Sally

Sally and her family found that a lack of continuity across mental health services made accessing essential help difficult. When Sally first became unwell, she accessed and was seen by several different mental health care teams, including the crisis line, liaison psychiatry and the first point of access team. Sally wasn't too trusting of professionals and had a fluctuating presentation. Her family felt that her care was lacking because each separate team only saw their own snapshot view of Sally and didn't gain a good enough relationship with her or understanding of her overall situation. As a result, she ultimately ended up requiring a compulsory admission.

Sometime after she was discharged, Sally began to deteriorate again, and unfortunately, she and her family have reported similar challenges. Again, they found a 'disjointed' system, lacking in continuity across teams, which has meant a prolonged struggle to get help, consistency or for any clinician to possess an overall picture.

Continuity of care and patient outcomes

Continuity of care is valued by patients[7,8], staff and government agencies[9], and this has driven research to assess its relationship with quality of care. Two key studies are useful guides in exploring the relationship between continuity of care and patient care and outcomes.

Macdonald et al (2019) studied the relationship between continuity of care and clinical outcomes for people diagnosed with schizophrenia in a large London NHS trust[5]. This large study was required to provide more definitive evidence following previous underpowered studies[10].

Analysing the pseudonymised electronic patient records of over 5000 patients covering an 11-year period, they found a reduction in continuity of care over time, and that this was related to a reduction in clinical outcomes. One finding was that the more community teams involved in a patient's care over time, the worse the outcome. The authors concluded, in agreement with Engamba et al[6], that repeated service reorganisations had contributed to the decline in patient outcomes.

Some of this deterioration in outcomes is likely related to a deterioration in therapeutic relationship as a result of service fragmentation. McCabe and Priebe (2004) reviewed studies into the impact of therapeutic relationships[11]. They found various scales of acceptable reliability had been used, with no one dominant. Across all measures, a more positive therapeutic relationship predicted better patient outcomes, in both the short and long term. This was the case for a variety of mental health conditions, including psychosis and depression, and across both inpatient and outpatient settings; a better therapeutic relationship was associated with a better outcome at discharge from an inpatient setting, and at two year follow up.

Case Example: Alex

Alex described how problems with continuity of care between different wards and then between the ward and the home treatment team affected his wellbeing.

He spoke about being transferred from one ward, where he and the staff had got to know each other well, to a new ward. There, he said, the team did not know how good he was at masking his difficulties, he was discharged prematurely, and shortly readmitted thereafter with a manic relapse.

As was typical for him, he became depressed after the mania passed. He was discharged from the ward to the home treatment team. He felt that he needed to build a relationship with his team. At this point, however, he and his girlfriend described an abrupt transition between the ward and home treatment team and then, once home, being visited by different clinicians every time. This meant that it wasn't possible to engage in meaningful conversations and any attempt to do so meant each time he had to retell his story from the start. They felt this has not been productive for Alex's recovery.

Relational continuity

Examining the different aspects of continuity of care helps to further assess its benefits and to formulate recommendations. Defining continuity is not straightforward[12], but Engamba et al (2019) identified three types of continuity from the literature, in a study of how continuity could benefit the care of people with multimorbidity, including mental health problems[6]. *Informational continuity* is the sharing of patient information between appropriate parties. *Management continuity* is the harmonious provision of different services. The therapeutic relationship between a patient and clinician or service is described by *relational continuity*.

The authors describe how relational continuity is associated with improved patient satisfaction and several patient outcomes. They identify benefits especially relevant to mental health care, such as greater trust between patients and clinicians, enhanced shared decision making, and increased efficiency (e.g. avoiding unnecessary repetition of complex histories, overlapping here with informational continuity). These findings are consistent with a Kings Fund study[13] and the General Adult Faculty survey findings.

Engamba et al observe that relational continuity is declining in the UK, noting how continuity of care has decreased as organisational changes, such as increased specialisation (i.e. decreased management continuity), have taken effect. They suggest that continuity of care should receive more attention from policy makers.

Case Example: Suzanne

After forming therapeutic relationships with staff during a long ward admission, Suzanne found the lack of continuity within a community mental health team problematic. She rarely saw the same person twice and was allocated to a series of different consultants and care coordinators. She was referred back to the service several times over the years but there was never an effort to re-engage her with the same care coordinator as before, so each time it was someone new.

She and her husband spoke about the challenge of establishing the quality of rapport which had been so beneficial on the ward. It was frustrating to meet clinician after clinician who didn't know Suzanne and having to recap her history each time. It felt that these clinicians were never able to understand her, and a series of ever-changing strategies achieved little.

Her service has reorganised since to a new model – Open Dialogue – that prioritises continuity of care for all patients. As a result, she has seen the same clinicians for all her visits and episodes of care and she and her husband describe this shift as "life changing." Strong relationships have developed and she is now very content with the care she is receiving. The relational aspect, she says, is key and she believes it has helped her recover far more profoundly than she ever imaged possible.

Recommendations

By all accounts, improving continuity of care needs to be a key priority of future service development. This is already now a priority for a large number of service users and clinicians across the country and so translating this into some constructive suggestions for change is the next step. The member survey conducted for this report has been helpful in this regard. Consistent with the highest-ranking responses around continuity of care was also a larger number of more highly ranked narratives around mitigating factors that might improve continuity of care where it is currently lacking. Combining this with wider discussions with senior College and Faculty members has led to the formulation of seven key recommendations with relatively widespread applicability across services.

One option for some Trusts might be a return to the sector-based model where it currently does not exist. A number of Trusts are already engaged in this process, however, it also has to be accepted that a great many Trusts, due to the upheaval needed and the structures that are already well embedded, may not choose to follow this path. Another round of organisational change on a substantial scale may, in itself, impact negatively on patient experience and outcomes. Furthermore, a return to the sectorised model would not answer the issue of continuity of care for other non-medical professionals for whom the issue would remain. Our recommendations, therefore, are ones that would improve continuity of care globally for the whole service as it is experienced by the patient in their care pathway. The overarching theme therefore involves enabling teams to be more porous. This means allowing workers to extend their remit into teams with which they interface so that a relational continuity of care is more prevalent. The current system of abrupt transitions between teams where an entirely new set of professionals is suddenly introduced at multiple points in the care pathway is not at all conducive to the above definition of relational continuity. This could be prevented if there were more flexibility around which clinicians can attend which appointments and this could be determined on a case by case basis and very much more patient centred and patient led. In practical terms, implementing this would mean adopting the following seven initiatives:

1. Joint assessments on initial referral

The primary difficulty service users experience when there is a lack of continuity of care is the need to retell their story at repeated junctures throughout the care pathway. The point at which they would most naturally do this is at the start of their service engagement. It is at this stage, therefore, that involvement of professionals from across the care pathway would be important. On initial referral - at the triage stage - a decision could be made as to which clinicians may attend a joint assessment. This may include staff from different teams in the care pathway, so members of the crisis team as well as the CMHT may attend if needed, and also, if potentially necessary given the presentation and history, a member of staff from the in-patient ward too. That initial appointment may be the first of several such joint sessions if it is deemed that involvement of these different services may be required in order to build up some familiarity on all sides. The patient would develop familiarity with the clinicians attending, while they in turn also develop an awareness of the patient's issues and stories. An important aspect of this would be to make it a collaborative and systemic meeting, bringing key people from the patient's family and network into it so that all have an opportunity to share the space and engage with the team. This would serve to both deepen and broaden the therapeutic relationship going forward and the continuity it was built around. Continuing this culture of collaboration through trusted assessments would be an important addition to this so that repeated assessments by different teams – for the benefit of the service, rather than the patient – could be avoided wherever possible at different points along the care pathway.

2. Allocation/prioritisation of consistent staff

Once a pool of likely relevant staff members from across the care pathway have been introduced to the patient, it would be important to work to maximise their involvement with the patient going forward. In the community services this would mean allocating the attending worker as the care coordinator or key worker and in the crisis setting it would mean organising visits, wherever possible, when the member of staff they know is on shift. There is frequently flexibility around when exactly a visit occurs and currently there is rarely any priority given to continuity of care in shift allocations - specially a wider continuity that may date back to the patient's initial referral or previous episode. Keeping continuity as a priority, therefore, whichever team the patient is under, while of course allowing for any practical/logistical constraints, would make the experience a lot more seamless.

3. Ongoing engagement beyond immediate team boundaries

The joint working culture established at the start of care needs to be continued so that staff members are allowed, indeed encouraged, to continue their engagement beyond the immediate boundaries of their existing team, in a patient-centred way. This would not just occur at points of transition between teams but whenever collaboratively the patient, his/her family/network and the professionals involved feel it might be helpful and whenever it is practical. That ongoing support and commitment by staff to attend some appointments jointly from time to time would serve to cultivate a more flexible person-centred approach in the service as well as bring down some of the barriers between teams.

4. Regular joint team meetings

Currently the point of interface between the teams is often little more than a meeting between individual team leads or representatives to discuss certain cases or business. What would help with continuity more profoundly, however, would be if teams across the care pathway - e.g. the access and recovery team or the recovery and crisis team - had a regularly scheduled weekly or monthly joint team meeting where they discuss some of their shared cases together. With the above recommended increase in joint working the overlap between them, and thus the scope for fruitful discussion, would be far greater. In addition to routine meetings, joint staff development or away days would also be important once or twice a year to keep developing their joint working protocols and further cement the bonds between the teams.

5. Principle consultants

Though in a more functional service a patient will have different consultants at different times, a powerful suggestion was for there to be one consultant with an overseeing function. This would mean that they would need to be liaised and consulted with when major longer-term decisions around e.g. long-term psychotropic prescribing, accommodation or legal status are made. The lines of responsibility, e.g. RC responsibility, would remain as is, however, engagement with the overseeing consultant - who could also see the patient and attend clinical appointments anywhere along the care pathway - could ensure an ongoing continuity and consistency in care.

6. Information sharing

A consistent method of information sharing between teams and clinicians would be an important dimension to these changes. This way all involved could remain updated via a relatively simple, seamless and accessible system. Increasingly, patients are in charge and in possession of their own notes and, from a co-production standpoint this can only be encouraged. As a result electronic applications that enable the notes to be held by the

patient and reviewed with them at any time would be a good way to ensure consistent information sharing in a way that also increases collaboration with service users as well as between clinicians.

7. Continuity beyond discharge

Continuity of care need not end at the end of an episode of care. Where staff have worked closely with a patient and their family/network, it would be important for them to be able to continue that in the event of a referral back to service after discharge. This would involve the team, at point of discharge, making a commitment to the patient that, wherever possible, the same clinicians will see them again if they come back in future and if this involves a return to regular care then, again, the same team members will be allocated to them if at all possible. This would then need to be prioritised when it comes to assessment and staff allocation thereafter.

When put together these seven initiatives have the potential to profoundly impact continuity of care, therapeutic relationships and therefore outcomes, regardless of the model of service input provided. A lot of this is about prioritisation, culture and how the staff and team in general approaches care and thinks about what is important. However, more joint working is also easier with more capacity and harder when it is low. There will therefore be resource implications for its application in some areas making this a worthwhile focus for discussions around future investment. A return on this investment, however, may well be significant as a result of improved patient experience and satisfaction, better team cohesion and possible reduction in admissions with an improved quality of service and better outcomes.

These seven initiatives are also such that they could be applied across a variety of settings and service models and this might ultimately also incorporate transitions in and out of adult services potentially including child, older adult and even forensic services to some degree as well.

COVID-19 addendum

The COVID-19 pandemic occurred during the final compilation of this report and at the time of writing, evidence of a mental health surge after the initial wave of the pandemic is starting to emerge. Indeed, a predicted longer-term mental health tail effect will result in repercussions being felt for years to come in our services. This increases the urgency with which the recommendations – and adequate funding to enable them – need to be implemented. By improving the continuity and relational dimension of care as well as improving the patient-centred aspects of care and responding to the clear direction given by both patients and clinicians in terms of the recommendations made here, our system will be better prepared to deal with the escalations to come.

A clear highlight throughout the report are the hidden waiting lists that tend to arise between teams due to the issues described and so a concerted effort to reduce them with adequately funded reorganisation of services has probably never been more important. It is very much hoped, therefore, that these recommendations, alongside the relevant resource implications, can now be placed at the forefront of the response going forwards.

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