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Invited commentary

Invited commentary on… Continuity of care in the community for people with severe mental illness: does it matter?†

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Summary

In this issue, MacDonald *et al* have used data from the South London and Maudsley NHS Foundation Trust electronic patient record to investigate the relationship between service change, routine outcome data and 'continuity of care'. The period they have looked at was one of huge change in the configuration of services and the background to this is explored here.

Declaration of interest

F.H. was a clinical director of South London and Maudsley NHS Foundation Trust and its predecessor organisations from 1991 to 2010.

Keywords

Mental health care; austerity; EPR.

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Alistair MacDonald and his colleagues have used data from the South London and Maudsley NHS Foundation Trust (SLaM) electronic patient record (EPR) to investigate the relationship between service change, routine outcome data and 'continuity of care'.[1] This is a product of an ambitious project to harness the SLaM EPR as an augmented case register, the clinical record interactive search (CRIS).[2] The time frame for their analysis is from 2006, when recording of outcome data began, to 2016. They describe a steady increase in the morbidity of people with a diagnosis of schizophrenia in contact with community mental health services, as measured by the Health of the Nation Outcome Scale,[3] and a decrease in their chosen measure of continuity of care, the Modified, Modified Continuity Index.[4] Continuity of care is a complex construct with multiple dimensions.[5] The Modified, Modified Continuity Index is a numerical measure developed in 'family practice' in the USA, which inevitably decreases as the complexity of the individual's needs increases. It has no necessary relationship with patient experience.

The timing is significant. In 2006 Matt Muijen, then regional adviser for mental health for Europe at the World Health Organization, described mental health services in England as 'better funded, better structured and better supported than anywhere in Europe'.[6] This was midway through a decade of sustained investment in adult mental health services that saw a real-terms (i.e. taking inflation into account) increase in spending of 59% from 2001/02 to 2011/12.[7] This investment was targeted towards specific government priorities, initially assertive outreach, early intervention in psychosis and crisis resolution/home treatment teams and latterly psychological therapies (although in absolute terms spending on psychiatric intensive care and secure in-patient care grew the most). We have good data on trends in spending to 2011/2, which was the first year where a real-terms decrease was identified.[7]

That was the last year the Department of Health commissioned a financial mapping exercise and it has subsequently been hard to get a clear picture of spending on mental health services in England. What evidence we have strongly suggests that, difficult though things are for the National Health Service as a whole, they have been disproportionately worse for mental health services. This is despite an avowed policy aim of 'parity of esteem' between mental health and acute services. Cash-terms growth (i.e. ignoring inflation) for mental health trusts was 5.6% over the 4 years to 2016/17 compared with 16.8% for acute trusts.[8] The Kings Fund report from which these data are taken describes the consequences of these financial constraints thus:

> 'NHS mental health providers have focused on transforming care and restructuring services to reduce costs, to shift demand away from acute services and prioritise approaches that support recovery and self-management. This has prevented many mental health providers from falling into deficit, but the scale and pace of change, a lack of robust evaluation and an underlying focus on cost reduction has resulted in increased variations in care and reduced access to services.'

In contrast the official narrative of the state of mental health services in England describes progress towards achieving the goals set by current policy (*The Five Year Forward View for Mental Health*[9]) in relentlessly positive terms.[10]

It was in the inauspicious context of austerity that SLaM began in 2010 a major service reconfiguration. This reorganised adult mental health services, which had previously been based on the four London Boroughs served by SLaM and a range of national specialist services, into clinical academic groups (CAGs). These were initially structured for adults around a set of broad diagnostic categories: 'addictions', 'psychosis' and 'mood anxiety and personality disorder' and two portmanteau groupings 'behavioural and developmental psychiatry' and 'psychological medicine'.[11] The vision behind the CAGs was to bring academic expertise to bear on service provision to the mutual benefit of research and clinical care, with a key element being a set of 'care pathways' that would deliver National Institute for Health and Care Excellence-compliant interventions.

The 2010 reorganisation in SLaM splintered services that were previously based on geographical catchment areas into a set of functionally differentiated services aligned with a CAG. This move was fully in line with the direction of travel of mental health services over the preceding decade towards increasing specialisation and the introduction of service-line management.[11] A careful analysis of the evolution of the 'mood anxiety and personality disorder' CAG, which also made use of CRIS, did not demonstrate obvious benefits at the clinical level and the promised care pathways did not develop.[12] This CAG was subsequently absorbed into a 'psychological medicine and integrated care clinical academic group'

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(which included the function of initial assessment and brief treatment).[13] A new CAG, 'acute care', was developed covering acute in-patient and crisis response services.[14]

One of the consequences of the financial constraints experienced by mental health providers in England has been relentless pressure to discharge 'stable' patients back to primary care. Discharging people who are doing relatively well will automatically result in an increase in the average morbidity of patients in contact with specialist services. Those who relapse will return to secondary care, presumably with yet higher morbidity. Some organisations have developed a metaphorical pathway (in practice skilled staff that may include peer support workers) to provide enhanced support to primary care in supporting people with severe and enduring mental illness returned to them.[15]

A second consequence has been a tendency for trusts to continually reconfigure in-patient and community services in a search for 'efficiencies' to reduce costs. In-patient beds have closed. Established assertive outreach teams have frequently been disbanded. Some organisations moved to a model that involves assessment and brief treatment followed, for the selected few, by care from a longer-term team. MacDonald *et al*[1] do not provide a history of the changes at a team level that have taken place within SLaM, although there is a clear signal in their data that something significant occurred in 2010 as patients were divided between CAGs. Change is a recurrent theme in the annual surveys of patient experience of community mental health services undertaken by the Care Quality Commission. The latest survey, which covers 2017, notes that 42% of respondents had experienced changes in the mental health professionals they were seeing in the previous year.[16] This will be the result of staff turnover, change in the patient's needs (for example moving from an early intervention in psychosis team to its longer-term alternative) and service reconfiguration.

Providers of mental health services in England are squeezed between diminishing real resources and rising demand. Contemporary policy emphasises the need to bring health and social care agencies together in 'sustainability and transformation partnerships' and 'integrated care systems'.[17] The operational reality is often one of increasing fragmentation, with the fragments glued together by the local EPR. Services are adopting strategies for managing excessive demand not seen since the 1990s (neatly summarised as 'deterrence, deflection, dilution, delay and denial'[18]). Sadly there are no easy answers to the current challenges faced by the mental health system. A dispassionate appraisal of the successes and failures of policy and practice over the past 40 years would be a good start.

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