Evaluating care pathways for community psychiatry in England: a qualitative study

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Abstract

Objectives In view of forthcoming ‘payment by results’ (PbR) for mental health, increasing number of National Health Service (NHS) Trusts are reorganizing their community services for working age adults to create care pathways. However, research base for the care pathways model in mental health is limited. Our NHS Foundation Trust was one of the first to introduce care pathways for community psychiatry in the UK. We have carried out a qualitative study to evaluate how this model works out in practice, including its impact on quality of patient care, mental health professionals and primary care.

Methods We interviewed doctors, multidisciplinary staff and Trusts managers (19 in total). Transcripts of recorded interviews were coded and analysed thematically using a grounded theory approach.

Results Overall, despite teething problems, working in pathways was generally seen as a positive change. It led to more focused interventions being offered, and practitioners being held to account over clear standards of care. It is more cost-effective and allows for active case management and clear clinical leadership. It is recovery focused and encourages social inclusion. The arbitrary time frame, strict criteria and thresholds for different teams can create issues. Improved communication, flexible and patient-centred approach, staff supervision, and increasing support to primary care were felt to be central to this model working efficiently and effectively.

Conclusions Introduction of care pathways is an important step towards effective implementation of PbR for mental health. Our study would inform future research into care pathways, facilitate organizational learning and help to improve effectiveness of services.

Introduction

Since the 1980s, care in the community has been the mainstay of psychiatric care within the British National Health Service (NHS) [1]. Over the last decade, there has been a major shift in how mental health services for adults of working age are provided in the UK. Below we briefly describe the major changes in service in order to orientate our readers, and to put into context the aims of our study. Traditionally, Mental Health Trusts divided their areas into geographically defined sectors. Each sector was served by a consultant psychiatrist and a community mental health team (CMHT), which provided catch-all service for all types of mental illness in the community. Each sector also had access to its own hospital beds where patients were treated by the same consultant. The National Service Framework (NSF) for mental health was launched in 1999, which set out national standards as well as clear guidance on how services should be organized at the local level [2]. Specialized care, social inclusion and recovery were central to this. As a result, many specialist teams were created. For example, the crisis resolution and home treatment team as an alternative to hospital admission for the acutely unwell, and the assertive outreach team for difficult to engage patients with serious mental illness.

This was followed by another initiative which replaced traditional geographically sectorized model of care with a functional one [3]. In the functional model, now consultants were allocated to
teams, either in the community or based in a hospital. They were no longer responsible for patients across the full range of treatment settings. Implementation of the NSF and functional model helped to improve focus and specialism in psychiatric services. Alongside this, increase in the demand of services required reorganisation of the workforce. This was addressed by another initiative known as the New Ways of Working, which expanded professional roles within the multidisciplinary teams (MDTs) [4].

NSF for mental health was followed by New Horizons, launched in 2009. This outlines the UK government’s strategy for mental health in the future [5]. New Horizons emphasized prevention and well-being, as well as improving access to services, quality and cost-effectiveness. In addition, forthcoming practice-based commissioning [6], and ‘payment by results’ (PbR) for mental health [7], is now leading to a new wave of major changes in services. Potential introduction of the PbR means that services provided by mental health trusts will have to be quantifiable, for example, in terms of episodes of care.

As a result, over the last few years several mental health trusts moved towards a new design of service delivery, known as the care pathways model. This approach groups service users into different bands, based on their needs or characteristics, and offers standardized care packages for each group. This was first piloted by six NHS Trusts in the north of England [7]. Although there are many different definitions of care pathways, most include two specific components [8]. The first is having a clear menu of interventions, and the second is an explicit time frame over which care will be provided. In short, as a result of these reorganizations in mental health services, community care for adults of working age has moved from generic teams providing open-ended care (‘old fashioned’ CMHT), to specialist teams providing specific time limited interventions.

One criticism of rapid and multiple changes in services has been the lack of evidence base for these changes [8]. Evaluations of the functional model [3], and some specialist teams have been published recently [9,10]. However, an extensive literature search failed to identify any studies on care pathways for mental health. It is now leading to a new wave of major changes in services. Potential introduction of the PbR means that services provided by mental health trusts will have to be quantifiable, for example, in terms of episodes of care.

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researchers working independently (GMK and CRMD). Themes were coded manually. Codes included purely descriptive ones arising directly from the transcript and more interpretive codes. Any differences in interpretation of statements were resolved by discussion with the wider research team until consensus was reached. Then the coded data were grouped according to related themes.

**Results**

Both doctors and non-medical staff discussed similar themes. Generally, these were related to their specific area of work rather than their professional background. Below we describe the main themes that were discussed by our participants. We also illustrate some of the themes with individual quotes, which represent both the most commonly expressed themes and/or the ones that capture salient aspects of the change.

**Reasons for change**

Multiple factors were identified. These include need to streamline mental health services in view of how services might be commissioned in future, drive towards specialism and equality of service provision across the Trust.

**Financial reasons**

It was expected that reorganization would make community services more cost-effective, and lead to efficiency savings, through active case management, while maintaining quality. To quote: ‘if you are wasting resources in one place, you are wasting opportunities in another’. Besides, in light of PbR, the care pathways model should make it easier to calculate costs, for example, in terms of episodes of care.

**Drive towards specialism**

Following the creation of various specialist teams directed by NSF, it was felt that CMHTs became (to quote) ‘dumping grounds for patients who did not fit the criteria for specialist teams’. Some staff pointed out that following the introduction of the functional model, both CMHTs and inpatient wards gained their dedicated consultant psychiatrists, which improved clinical leadership. However, some staff felt further change was needed to make community services more focused and structured.

**Equality**

Mental health trusts cover wide geographic areas, where sometimes access to specialist services is down to (to quote) ‘postcode lottery’. It was felt that the pathway model would promote equality by offering a set menu of interventions. However, the locality of our study is characterised by high immigration, migrant workers and socio-economic deprivation. These factors are different from other areas within the same Trust. Some staff pointed out that as well as ensuring equality, future service reorganizations should be mindful of unique local needs. (To quote): ‘services need to fit the local population rather than the population being made to fit the service’.

**Recovery model**

While senior clinicians and managers were more aware of the strategic and financial reasons for service redesign, nearly all staff indentified the ‘recovery model’ as the philosophy behind these changes. It was hoped that early discharge from mental health services would not only reduce pressure on resources, but also foster independence and stop patients from being ‘institutionalised’. This is in keeping with the recovery model, which emphasizes that having an illness does not equate to being a patient for life (see Discussion for more on the recovery model).

**Community care pathways in practice**

Several opportunities and concerns were discussed. Staff reported that the main effect of introduction of care pathways was change in their focus of work.

**Change in work**

The pathways model led to focused working, increased throughput and better accountability. Patients were no longer ‘stuck’ in outpatient receiving six monthly reviews. Intake and Treatment team staff described their work as more (to quote) ‘time-centred’ and ‘task-centred’. There was a clear focus on what patients should expect when they enter services. An outcome-driven approach also led to better accountability and increased scrutiny on individual clinicians and the team as a whole.

The Intake and Treatment team felt that positive risk taking had increased and patients were discharged back to primary care quicker. Some staff expressed concerns about risk of relapse or re-referral as a potential consequence.

**Professional role and responsibility**

It was felt that the pathways model promoted shared responsibility and whole team approach to patient care. Senior clinicians felt that medical staff exhibited higher levels of ownership and were more integrated in the team. There was a shift towards increased multi-disciplinary working compared with doctors managing many patients on their own in outpatient clinics.

It was pointed out that focus on a specific group of patients within each pathway can lead to deskilling of staff in other areas. Members of MDT who acts as care coordinators for individual patients were more proactive in planning and delivering care. This empowered MDT members. This also meant that responsibilities about clinical decisions were now shared by doctors and MDT members. The pathways model also promoted professional development and expansion of professional roles. For example, many MDT staff completed training in psychological interventions. However, some staff pointed out that expansion of roles, to some extent, eroded the professional identities of various members of the MDT.

**Capacity and workload**

It was felt that the Intake and Treatment team was faced with an increased volume of referrals from the primary care. Enhanced detection and identification of mental health needs due to recent
government initiative to improve access to psychological therapies were partly responsible. There was pressure on the Intake and Treatment team to move people on after a year, but discharging patients back to primary care was not always easy. As a result, the Rehabilitation and Treatment team which takes patients from the Intake and Treatment team was nearly full and had a waiting list.

Senior managers pointed out that reorganization of community services happened simultaneously with cost improvement initiatives which involved rigorous vacancy management and freezing of some posts. This also contributed to an increase in individual workload and pressure. Many thought increased workload affected quality of work and team morale. Some staff, particularly in the Intake and Treatment team, reported a feeling of (to quote) ‘continuous fire fighting’.

Changing work patterns, such as flexible working, were suggested as a way to avoid burnout. Use of a zone board was suggested to enable discharge and prioritization of care for individual patients. Effective screening of referrals by adequately trained and experienced mental health professionals at the primary care level was suggested to reduce the number of referrals to secondary care.

Criteria for service

While all teams have clear inclusion criteria, this was reported not to be the case for the Intake and Treatment team. At the same time, strict inclusion criteria mean that certain patients may not be eligible for any service. Co-morbidity and dual diagnosis posed challenges to the pathways model as these patients have needs that overlap between pathways/teams. This was pointed out by many staff. They felt that criteria for a service need to be dynamic and not rigid, and clinical need should override all criteria. To quote: ‘patients should come first rather than getting stuck on thresholds and criteria’.

Time frame

One key component of the pathways model is clear time frame. Intake and Treatment team pointed out that the 1-year time frame felt arbitrary, and was too short for a large number of their patients. This posed particular challenges for psychological interventions given that many patients could not start therapy straightway. Both staff and managers largely agreed that it was reasonable to hold on to patients longer than the prescribed time frames in order to complete a piece of work. However, teams found it difficult to discharge some patients back to primary care. To quote: ‘Pressure to move people on has created a “them” and “us” scenario, where teams are blaming each other for delays or problems in managing care and transfers’. On the other hand, the recovery team had a different take on this issue. They felt that transfer of patients within pathways should be based on individual needs rather than arbitrary time frame.

Continuity of care

Many staff pointed out that the pathways model has added to the number of interfaces. To quote: ‘too many assessments were done by too many different people who are not joined up’. Establishing a therapeutic relationship can be tricky when patients are being passed on from team to team. This can potentially affect patient satisfaction. However, advantages of this system were also pointed out; for example, a ‘built in’ second opinion. While long-term engagement with a patient can be helpful, this can also create certain level of dependency.

Effective communication between teams and professionals was seen as the key to alleviate issues of continuity of care to some extent. It was felt that better access to patient notes and electronic records would facilitate this. Other measures, such as regular meeting between team managers, care coordinators from community teams attending ward rounds, etc., were found to be useful. Co-location of different teams also helped communication and joined-up working.

Perceived expectations from primary care

Staff reported that GPs want a simple referral system and quick access to advice. In the pathways system, teams now relate to a wider group of GP surgeries resulting in loss of close working relationships. The inability of GPs to gain quick advice partly contributed to an increase in referral rate.

Teams reported difficulties in discharging patients back to primary care. They speculated that many GPs still saw mental health as a service for life, and did not have a clear understanding of the recovery principals. Supporting GPs in order to improve their ability to work with mental health patients was suggested. One way may be through increasing the number of dedicated multidisciplinary mental health professionals working closely with GP surgeries (gateway workers), bridging the gap between primary and secondary care.

A summary of the results is presented in Fig. 1.

Discussion

Our study summarizes the perceived impact of transformation of CMHTs into care pathways. Staff pointed out several benefits of the care pathways model. They also offered practical solutions for many of the concerns. As more Trusts move towards care pathways, it is important to address some of the issues highlighted here for successful implementation of this model.

Workload and capacity are problems familiar to all community psychiatry teams, and are not specific to pathways. To deal more effectively with capacity issues, the pathway model offers a more structured approach over a set time frame. This brings focus to service delivery and encourages independence of the service user.

It was clear that the 1-year time frame for the intake and treatment team is not realistic for many of their patients. It was widely accepted that the time frame needs to be less rigid and tailored to the need of individual patients. Similar patient-centred approach should be taken for inclusion criteria for the various specialist teams. Rigid criteria almost certainly increase the possibility of some patients ‘falling between two stools’ and not being offered a service. Therefore, it is vital that services are more flexible.

One prediction of the NSF for mental health was that the creation of various specialist teams would make services fragmented [2]. Care pathways add to this. Multiple assessments can be detrimental to patient satisfaction and cost-effectiveness of services. Our staff suggested various measures which can improve joined-up working and communications between different pathways.
Frustration of GPs with mental health services is not new. Some feel that with repeated changes over the last decade, provision of mental health services has been effectively eroded. In reality, over the last decade mental health services in the UK have enjoyed unprecedented growth. The number of specialist teams and mental health professionals working at the front line is now more than ever before. Closer inspection reveals that GPs’ dissatisfaction mainly stems from the loss of intimate working relationships with secondary care. In the past, the CMHTs worked directly with individual surgeries providing a one-stop service. In keeping with the government’s visions of promoting well-being, prevention and early intervention as outlined in the New Horizons [5], some Trusts are now setting up teams and/or deploying consultant psychiatrists to work more closely with primary care. As well as reducing number of referrals, giving easy access to advice, this should improve GP satisfaction. This may also enable discharge of patients back to primary care, and therefore social inclusion and integration into society.

Reorganization of community psychiatric services into care pathways is in line with the recovery model. Recovery has recently been endorsed by both the UK and US governments as a guiding principle of mental health service provision [14–16]. As opposed to the medical model which describes recovery as symptomatic cure, the recovery model emphasizes how to live with enduring symptoms and vulnerabilities [15]. It promotes individual empowerment through realistic hope [15]. This means an individual’s life is not defined by his/her illness. It does not equate to being a patient for life. This fits with the time-limited nature of the care pathways.

Many staff pointed out that interventions offered within care pathways were the same as that offered by traditional CMHTs. However, the pathways system allowed them to follow recovery principals more appropriately. It was clear that MDT staff needed close supervision to deliver recovery focused work, and active management of caseload. Therefore, the recovery approach may be possible within a traditional CMHT model, but close supervision of staff is the key.

PbR is an activity-based funding system which pays health care providers on the basis of a national tariff for a particular intervention applied to a category of patients [8]. However, there are several challenges to implementing PbR for mental health; for example, defining episode of illness. Specifying a menu of interventions that would be suitable for a specific cluster of patients is also difficult, as mental health patients often have several co-morbidities or dual diagnosis. However, allocation of patients into different care clusters, and determining end of an episode of illness, can be aided by the use of standard assessment tools, such as the Health of the Nation Outcome Scale for PbR (HoNOS-PbR) [17]. Care pathways are based on specific interventions that are outcome focused and time limited. Therefore, introduction of care pathways is an important step towards the effective implementation of PbR for mental health.

**Limitations of the study**

In our Trust, introduction of care pathways for community psychiatry was preceded by reorganization in services along the functional model earlier in that year. Staff opinions might have been influenced by this. However, we employed theoretical sampling and did reach saturation of themes, which should increase transferability of the results. We also acknowledge that some of the themes discussed by our staff might be local issues rather than be relevant to care pathways in general. However, in order to increase generalizability of our findings, interviewees were specifically probed to divide their comments into what they thought were related to the care pathways model and issues related to the Trust or locality.

**Implications for clinical practice and research**

To our knowledge, this is the first attempt to evaluate the impact of care pathways for community psychiatry in the UK. We have identified several opportunities and concerns regarding this service model. This would be a useful resource for other Trusts planning similar changes in service. Our findings would facilitate organizational learning and contribute towards improvement in quality of patient care. Our work has also identified key themes for future quantitative research on care pathways.

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