

# Management by geographical area or management specialised by disorder? A mixed-methods evaluation of the effects of an organisational intervention on secondary mental health care for common mental disorder

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## Scientific summary

### Evaluation of an organisational intervention on mental health care

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# Scientific summary

## Background

This report describes an organisational change within South London and Maudsley NHS Foundation Trust (SLaM) associated with its entry into the King's Health Partners (KHP) Academic Health Sciences Centre (AHSC) in 2009. KHP brought together three NHS foundation trusts and two academic institutions and its aim was to promote better integration of research, education and training and clinical care for the benefit of patients. The main 'integration engines' identified by the AHSC were new operational units called Clinical Academic Groups (CAGs), single management structures that brought together the academics, clinicians and managers whose work focused on a single specialty or group of related specialties. In SLaM there was an early decision that these new operational units would be management units and would replace the directorates through which SLaM had previously managed its operations, including the four geographically based SLaM directorates that had hitherto provided comprehensive adult mental health services to the populations of four boroughs in south and south-east London. Bar their academic component, the SLaM CAGs closely resembled the services lines (operational units based on diagnosis or need or the nature of the service provided) that other mental health service providers were developing to replace borough-based services at around the same time. This report focuses on the changes associated with one of the SLaM CAGs – the Mood, Anxiety and Personality CAG (MAP CAG) – which took on SLaM's assessment and treatment teams and psychotherapy services.

## Objectives (research questions)

This study explored three main questions: how the SLaM CAG programme (as exemplified through the MAP CAG) was conceptualised and implemented by SLaM staff; the extent to which there were changes in activity levels and in the quality of patient care over the 5 years since the start of the programme in 2009 and the extent to which those changes could reasonably be attributed to the CAG programme; and the main lessons that could be learned and applied more generally. The aim was to undertake an evaluation that would (1) be meaningful to the managers, clinicians, academics, service users and commissioners who were involved in or who were affected by implementation of the MAP CAG; (2) take advantage of their detailed contextual knowledge; (3) support replication and (4) support research utilisation.

## Methods

The SLaM CAG programme had numerous objectives and multiple interacting active components, all subject to a changing environment. A combination of qualitative and quantitative methodologies was used.

### Qualitative work

The qualitative work included semistructured interviews at the start and end of the project and a review of relevant documents. It drew on the methods of realistic evaluation to explore what happened when SLaM introduced CAGs and to consider the context in which this occurred, the key mechanisms of change and the outcomes that were produced. Data collection occurred in two phases, during the first 4 and last 3 months of the study. Staff respondents were recruited on the basis of their closeness to and knowledge of the programme; service users came from the CAG's advisory group and through local service user organisations. In phase 1 five group meetings were held: three service user-only meetings, one MAP CAG staff meeting and one final joint meeting with people from both categories at which the findings from the

first four meetings were presented and discussed. The service user-only meetings were co-facilitated by the two service user researchers on the study team, who also attended the final joint meeting in phase 1. Six senior managers from the MAP CAG were later interviewed to obtain a more detailed understanding of the history and implementation of the MAP CAG, and relevant KHP, SLaM and MAP CAG documents were reviewed. In phase 2 (months 31–33) three senior MAP CAG staff were reinterviewed to confirm the understandings developed in phase 1, identify external and internal developments since the first round of meetings and interviews and present and seek views on the findings from the quantitative analysis. All of the interviews and meetings in both phases were transcribed and analysed using NVivo software version 10 (QSR International, Warrington, UK) to yield key themes. The interview and documentary data were also used to develop an understanding of the programme components and their associated context–mechanism–outcomes.

### **Quantitative work**

The quantitative work used data covering episodes of care by community mental health teams (CMHTs) and psychotherapy teams taken from a database of anonymised electronic patient records, combined with internal accounting data that allowed us to estimate costs associated with CMHT care.

Seven data sets were defined.

1. Periods of CMHT and psychotherapy team care joined to data on demographics, diagnosis, referral date, face-to-face contacts, costs, previous service use, receipt of psychotherapy including through Improving Access to Psychological Therapies (IAPT), and outcome measures.
2. 200 randomly selected periods of care under a CMHT, a borough-based psychotherapy team or both with a coded diagnosis of depression, including free-text progress notes.
3. Current CMHT and psychotherapy caseloads per borough on any given calendar day.
4. Waiting times in CMHTs and psychotherapy services per borough on any given calendar day.
5. Self-harm presentations in accident and emergency among current or recent CMHT patients.
6. Self-harm leading to acute admissions among current or recent CMHT patients.
7. Episodes of individual cognitive–behavioural therapy treatment within each borough IAPT service.

The qualitative interviews gave little indication of which changes to expect and so we chose indicators covering the following domains: cost and activity (caseload, count of new episodes per month, episode length, number of contacts per episode, cost in the year following the start of an episode), effectiveness [subdivided into process – psychotherapeutic and pharmacological treatment of depression – and outcome – effects of treatment on Health of the Nation Outcome Scales total score and Clinical Outcomes in Routine Evaluation 10-item version (CORE-10) total score], safety (risk of self-harm among current or recent CMHT patients) and patient centredness (waiting times). Appropriate statistical analyses were performed for each indicator.

## **Results**

### **Qualitative findings**

The need to restructure SLaM's services was widely accepted among managers, senior clinicians and academics, even though their reasons for doing so differed somewhat from the KHP vision. Setting up CAGs was seen as an opportunity to sort out long-standing difficulties in the trust; managers also favoured doing this quickly before NHS finances deteriorated further. The structure decided on for the adult mental health CAGs did not have universal support, but there was a willingness to make it work. The MAP CAG's main services were Assessment and Treatment services, mainly serving patients referred from primary care, and psychotherapy services. Other adult services were managed by other CAGs and so referrals and transfers across CAGs within the same borough were common.

We identified two components of the CAG programme: (1) the CAG restructuring itself, which placed similar teams together under unified management across boroughs, and (2) the use of care pathways to manage and transform services. We found that the CAG restructuring had led to major changes including reorganisations in Croydon and of psychotherapy services, with the mechanisms including increased oversight, changes to accounting arrangements and the need for CAG compliance. Much of the context for these mechanisms was specific to SLaM. The move to CAGs was seen as an opportunity for SLaM to fulfil an ambition to introduce care pathways. The development of care pathways was initially imposed on each CAG, but later turned into an evolving experiment, with the promotion of a general principle that care pathways should be used whenever possible to solve the problems faced by clinical and service managers as they attempted to maintain and develop services. The MAP CAG made little progress in implementing care pathways such as those in the literature that emphasised the delivery of specific treatments. However, what SLaM called high-level pathways – pathways that described in schematic flow the sequences of processes within a particular kind of team – became a ubiquitous part of the vocabulary of clinical and service managers. These were effective via two mechanisms – supporting service redesign and supporting everyday performance management – in both cases through providing a means of representing the work process.

There were important influences external to the CAG programme, which in some cases curtailed what the CAGs could do. Initially, financial considerations dominated, determining which parts of the service needed to be urgently reformed. Arguably, the most important outcome by 2014 was that the process of 'recovering the CAG position' had been negotiated successfully such that the MAP CAG's finances were in order. The views of borough-based commissioners also still mattered; even after the introduction of the CAG, some changes came about and other changes were delayed because of the commissioners. SLaM was not able to act autonomously. Another constraint evident by 2014 was the primary care interface. A key idea behind the changes was that service users would not continue to be held in secondary mental health services but would be discharged back to their general practitioner with a clear care pathway for rapid rereferral if need be. However, this depended on capacity in primary care and SLaM staff argued that it was not yet clear how to build this.

Service users were generally unfamiliar with the CAG programme, bar those few who were part of the MAP CAG Service User Advisory Group. Most of the service users who had experienced the reorganisation were unclear about its rationale and were inclined to see the CAG programme as a cost-cutting exercise. Despite this, service users suggested that it would be possible to construct a persuasive justification for CAGs around predictable pathways through care and better oversight and managerial responsibility for rationally set-out services.

There were still unresolved issues in 2014. In particular, there was an ongoing debate about the configuration of the adult mental health CAGs. The development and implementation of care pathways in principle provided a framework within which service users could move between the CAGs as necessary, but there was evidence that these interfaces between CAGs are not always well handled. Given these pressures, the adult mental health CAGs began in 2014 to develop an Adult Mental Health Plan involving more joint working and co-ordinated service development. This was beginning to be implemented as the present evaluation ended.

### Quantitative findings

The quantitative analyses showed a pattern of mixed results. There was clear evidence of reduced activity: only in the borough provided with a new psychotherapy service did caseload increase; all other psychotherapy services and all CMHTs saw reduced caseloads. This finding could not be explained in terms of the context–mechanism–outcome configurations detailed above but could be related to the broader context of financial stringency in which CAGs operated. There was no evidence of altered treatment effectiveness; this applied both to processes (prescribing patterns in depression were unchanged and psychotherapy use in depression was either stable or, in one borough, reducing) and to outcomes (the effects of CMHT treatment on the Health of the Nation Outcomes Scales either reduced over time or did

not change, with no evidence that these trends altered with the introduction of CAGs, and psychotherapy effects on the CORE-10 did not change). There was also no evidence that CAG implementation had altered trends in self-harm among CMHT patients. There was some evidence of increased patient centredness in the reformed psychotherapy services in the form of reduced waiting times. CMHT costs in two boroughs had altered, but there were no effects on care costs for CMHT patients when home treatment team use and inpatient bed use were included.

## Conclusions

- Since October 2010 the MAP CAG has engendered significant and far-reaching changes in the management structures that it took over and has achieved financial stability.
- The use of care pathways represents an important shift in the culture of management within SLaM, but the CAG programme and the associated care pathways were poorly understood by service users.
- The typical understanding of care pathways (as a form of evidence-based clinical protocol) was replaced in SLaM by a dual meaning that covered the work of a group of teams operated by the CAG and the representation of that work in schematic form (high-level pathways).
- These high-level pathways are primarily tools to improve service management. They have proven to be of use to the organisation but leave many aspects of quality of care unexamined and unmanaged.
- What may be required in addition are care pathways that complement and support the existing high-level pathways and assist continuing efforts to improve the quality of the health care.
- Our research does not directly address the effectiveness of the CAG structure chosen, but our respondents generally did not provide positive reasons for it and the early benefits of that structure as a prompt for service redesign will be non-recurring.
- There was little evidence that the CAG programme affected effectiveness, safety, patient centredness and the costs of CMHT care. Although activity generally reduced in the post-CAG period, this was probably not ascribable to the CAG programme.

## Recommendations for research

- Research into the use and effectiveness of care pathways in mental health services.
- Research into the genesis and implementation of managerial innovations.

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