

Improving care in complex systems – collaborative care for people with severe and enduring mental illness (SMI)

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A Complex Adaptive System (CAS) is an open, dynamic and flexible network that is considered complex due to its composition of numerous interconnected, semi-autonomous, competing and collaborating members (McDaniel et al, 2003). A CAS approach focuses on local context, developing and implementing programmes that engage key actors through on-going problem-solving and adaptation (Paina, 2011).

Background

The co-ordination of care for people with complex needs and long term illness is poor, addressing the co-ordination of care between primary and community care is imperative for ensuring quality of care. Using CAS as a lens to conceptualise the improvement of care, specifically focussing people with severe and enduring mental illness (SMI) under the joint care of primary care and a community mental health team (CMHT), has ensured that complexity inherent in the system was not simply overcome, reduced or ignored, but viewed as a challenge to be managed and managed well to release its full potential.

Introduction

People with SMI die on average 15-25 years prematurely, with poor physical health being a major precipitating factor. Furthermore healthcare professionals can hinder timely diagnosis and treatment of physical health disease through:

- poor attitude
- inconsistent approaches
- lack of awareness of physical diseases
- insufficient skills and competencies
- Stigmatisation
- lack of knowledge about available services (Chadwick et al, 2012; Van Hasselt, 2013).

Methods & Data Collection

This study was conducted by CLAHRC GM, relying on data from the 'improving the care of physical health care of people with SMI' collaborative programme of work with Manchester Mental Health and Social Care Trust (MMHSCT) and Manchester Academic Health Science Centre (MAHSC). This solely focussed on people with SMI who were under the care of a CMHT. Five (n=5) GP Practices were sampled within Greater Manchester. Two (n=2) CMHT staff were seconded on a part time basis (0.4 WTE) to CLAHRC GM to develop, test, implement, facilitate and evaluate physical health orientated interventions.

A formative evaluation was conducted for the development and improvement of the programme; along with a summative evaluation to explore the impact of the programme. Data was collected via:

- Interviews with healthcare professional (n=28) across primary and community care.
- Two (n=2) focus groups with CMHT staff (n=10)
- A questionnaire completed by CMHT staff (n=13)
- Process and outcomes measures collected for all multi-disciplinary teams (MDT) meetings held
- Anonymised cardiovascular risk data for each service user under the care of the CMHT and GP Practice.

Findings

Adopting a CAS approach to quality improvement appreciates that whilst some system developments may make actions and actors more predictable through the **development of broad guiding principles or 'working norms'**, a key contribution is in enabling key actors to develop on-going problem solving and adaptation techniques across their respective boundaries. The development and implementation of a sustainable co-ordinated service user pathway, within in a complex system, required the following roles and principles:

- Boundary Spanning Role** - A Community Physical Health Co-ordinator (CPHC) role was integrated into the CMHT; this was taken on by a Care Co-ordinator part time; it was designed to bridge the gap between the CMHT and GP Practices. The CPHC role liaised with professionals across the divide, acting as an information hub
'we have a CPHC who comes in and obviously he/she's not the Care Co-ordinator for everybody, but he/she will find out what is going on... he/she either knows what is going on or is a conduit for finding that out, it's super' (GP1)
- Knowledge Integration** – To enhance co-ordination, the CPHC attended MDT meetings held within GP Practices; MDT meetings were the medium for knowledge integration within primary care. At a CMHT level, various processes for knowledge integration were used, such as a) direct email, b) clinical supervision, c) team meetings, and d) face-to-face meetings
'this sharing of information is enabling the surgery and the CMHT to work in a much more co-ordinated way' (GP2)
- Formalisation Process** – CPHCs developed new ways of working and processes to facilitate the transfer of knowledge across multiple organisational boundaries and complex systems, for example, emails were sent to GP practices via [NHS.net](#) one week prior to MDT meetings to nominate service users for discussion, formalised feedback loops were also created via the introduction of an MDT Traffic Light Action Feedback Form.

Conclusion

Single component interventions are often relied on to improve care, but within a complex system these often fall short. This study highlights the importance of a multiple, evolutionary (Plan-do-study-act), context sensitive approach, which involves direct collaboration with actors across multiple organisations.