19 May 2014

Dear Mr Lamb

Failure of personal continuity of care in Mental Health Services. The high cost to patient and practitioner welfare and the health economy

I am a long-serving GP with much additional experience working alongside and within mental health services.

Recently, I heard you talking on the *Today* programme (6.5.14). You were responding to concerns about our services' difficulty in providing good quality response and containment for the acutely mentally distressed.

It is a common view that our major problems are primarily due to inadequate resources, training or management. This may be partly true. But I think there is a more important though more subtle problem: the progressive loss of *personal* continuity of care throughout the NHS. I have watched this with growing alarm for many years: my long view motivates this long letter.

Our loss of more personal types of understanding and care is not easy to understand. It is a kind of 'collateral damage': its evolution is insidious, complex and paradoxical. For example, it can seem incontestably beneficial to always increase the schematic and 'objective' in our healthcare: but pastoral healthcare (ie our human responses to all those problems that do not have quick and definitive fixes) is chimeric, and these measures can then easily displace or destroy its many kinds of meaningful but fragile bonds: our relationships. This often happens without much awareness: we later awake and are shocked by their absence. Our current mental health services – both acute and chronic – are replete with such paradoxes: of how density of schematic management is often inversely proportional to therapeutic meaning for the patient. Every working day I do what I can to rectify many exigencies from this. I have forged for myself and my patients a precarious respite to do this: I have battled to retain a stable small practice. So, for many years I have

still, with some difficulty, provided a kind of countervailant personal perspective and continuity: this kind of vantage is now very rare.

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Throughout pastoral healthcare our best therapeutic engagements come from personal understandings. And these must come from growing bonds, each of which – like each individual – has both commonality and uniqueness. By not heeding this we are creating many more problems. For such personal bonds fare poorly in services that are complexly remote, highly managed, sharply boundaried and fragmented. The human casualties from this make for some shocking stories: I have witnessed and documented many. Yet these industrial kinds of services design do have a better place: for example, they are much more compatible with clearly anatomised physical disease – though even there we are finding serious problems emerging; even the most biomechanical needs some carefully bespoke care.

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Pastoral and biomechanical healthcare are countervailant, yet complementary and synergistic. They are apparently opposite, yet we must combine them in innumerable ways. The art of evoking this synergy is a good definition of *holism*. But such holistic practice is now ailing and imperilled, for recent schematised healthcare reforms have often deracinated our personal bases of pastoral care. Inevitably, we then lose our more holistic views and understandings. In General Practice and Psychiatry – my areas of work – the losses are most clear and grievous.

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How can we repersonalise our now humanly enucleated pastoral care? In the wide spectrum of the NHS the remedial principles converge, but the applications vary. Yet whatever the variation, we need to retain this seminal anchoring principle: personal continuity of care. For it is primarily from the development of personal attachment, affection and understanding that

healing and palliation can take root. What we are now witnessing is serial examples of how all of this disintegrates in large, fragmented organisations that tend to standardised procedures. So, what specifically can we do to restore NHS Psychiatric Services? Here, in outline, are my summarised suggestions and bridging explanations:

- We need to bring back Consultant general psychiatrist-led 'Firms' (this is an old term for consultant-led teams).
- These teams would be locality-based and would take the vast majority of the wide variety of more severe mental and behavioural distress.
- The Consultant, with necessary deputies, would take overall responsibility for the complete cycle of mental healthcare from first contact to (provisional) discharge. (The bracketed word is necessarily important, if unwelcome.)
- The Consultant's Firm would have three major 'limbs': for Out-Patient consultations, for Home Visiting and for In-Patient Care. These three limbs would have some cross-flow and overlapping of staff (eg a patient is likely to be seen by the same practitioner(s) in a clinic, a ward, a Day-Centre, or at home).
- Most importantly, patients could move dextrously between different aspects or phases of care (Out-Patient, Day-Care, In-Patient and Home-based) with the kind of speedy and intelligent sensitivity that can come from personal continuity.
- Such personal continuity confers personal and economic benefits. Lengthy, cumbersome-yet-blind, bureaucratic assessments, procedures and documents become unnecessary. This cuts administrative burdens, costs, errors and frustrations drastically. Patients, generally, feel more contained, understood and comforted by people with whom they have an enduring bond. Staff have the slow, deep 'parental' satisfactions of seeing things through – the therapeutic effects of personal continuity are not confined to the patient!
- Obviously the Consultant Psychiatrist needs help with all this. The typical Firm would also contain trainee and deputy psychiatrists, psychologists,

nurses, occupational therapists and social workers. As in well-functioning families there is, generally, easy and apt overlap and interchangeability of roles, though some important areas of sequestration.

- Most therapeutic encounters would thus be delivered and monitored within the Firm. When other skills are required (eg for more intensive psychotherapy, Day-Centres, or more unusual or refractory cases) the Consultant would (with the help of their other professional staff) make tertiary referrals to more specialised units.
- The Consultant's Firm would therefore be looking after patients in Clinics, In-Patient Units, Day Centres and at home. Ideally all of these are easily commutable from one another.
- Much psychiatric work is with people whose complaints fluctuate over many years. A relapse can be much more humanely and effectively responded to and contained by staff who already have developed bonds of personal knowledge and understanding.
- Likewise In-Patient discharges are likely to be far less problematic if a patient continues to receive guidance and support by the same team that tended them in times of greater distress.
- Of course, personal continuity of care is never complete or perfectible. It is a value and a guiding principle. In the untidy and buffeted real world all kinds of compromises are inevitable or advisable.
- The General Psychiatrists' work would thus resort to a wider base of more 'parental' personal responsibility. Their professional development and appointment would depend, as in previous eras, more on length and breadth of experience and education. This is in contrast to what we have now: a pressure to successive, modular, technical-type trainings to accelerate earliest promotion. (This itself raises many questions about the selection and process of medical trainings *v* education.)

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What do I base these ideas on, and why do I think they will work?

From the early 1970s I worked in Psychiatry for many years. In that time we were able to provide much better personal continuity and quality of care than is generally available now. This more personally continuous care was not only more meaningful and satisfying for staff and patients, it was also more efficient: our decisions had greater speed, sensitivity and appositeness. This was less expensive.

Almost all my cohorts from that period take this view. They are, however, at retirement age and most are too beleaguered or weary to argue: their resonance with these views now exceeds their public articulation.
If you are interested in reading about particular scenarios and patient-situations, together with my expanded analysis of the problems and our responses, then I would like you to read my letters and submissions to senior managers and clinicians of our Mental Health Services. They are available via my Home Page.

In addition I have collected hundreds of relevant NHS documents over many years. Each one provides salutary and graphic evidence for these ideas.

I want to end this letter with another paradox and an ensuing invitation. The paradox: I prefer pithy, live dialogue to prolix, abstract documents. The invitation: my Practice is ten minutes of easy Underground travel from (or to) Westminster. If you, or one of your deputies, wish to discuss these matters, it would please me greatly.

Thank you for your good work and attention.

Yours sincerely

David Zigmond (GP)

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