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31 March 2015 | Europe

Lubitz started training with Lufthansa in 2008 before landing a job with Germanwings

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Features

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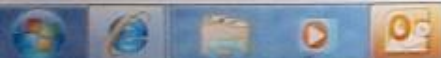
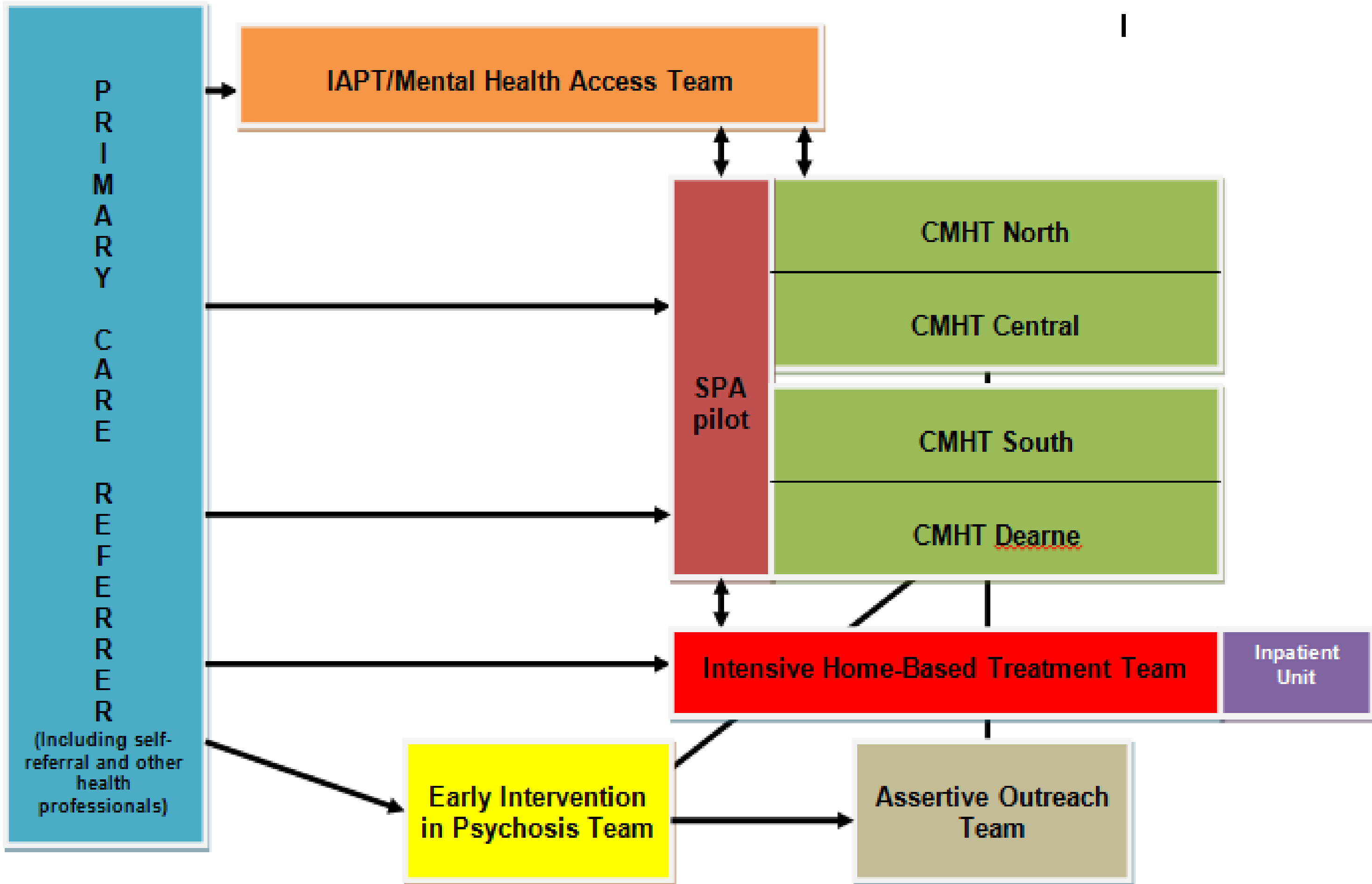
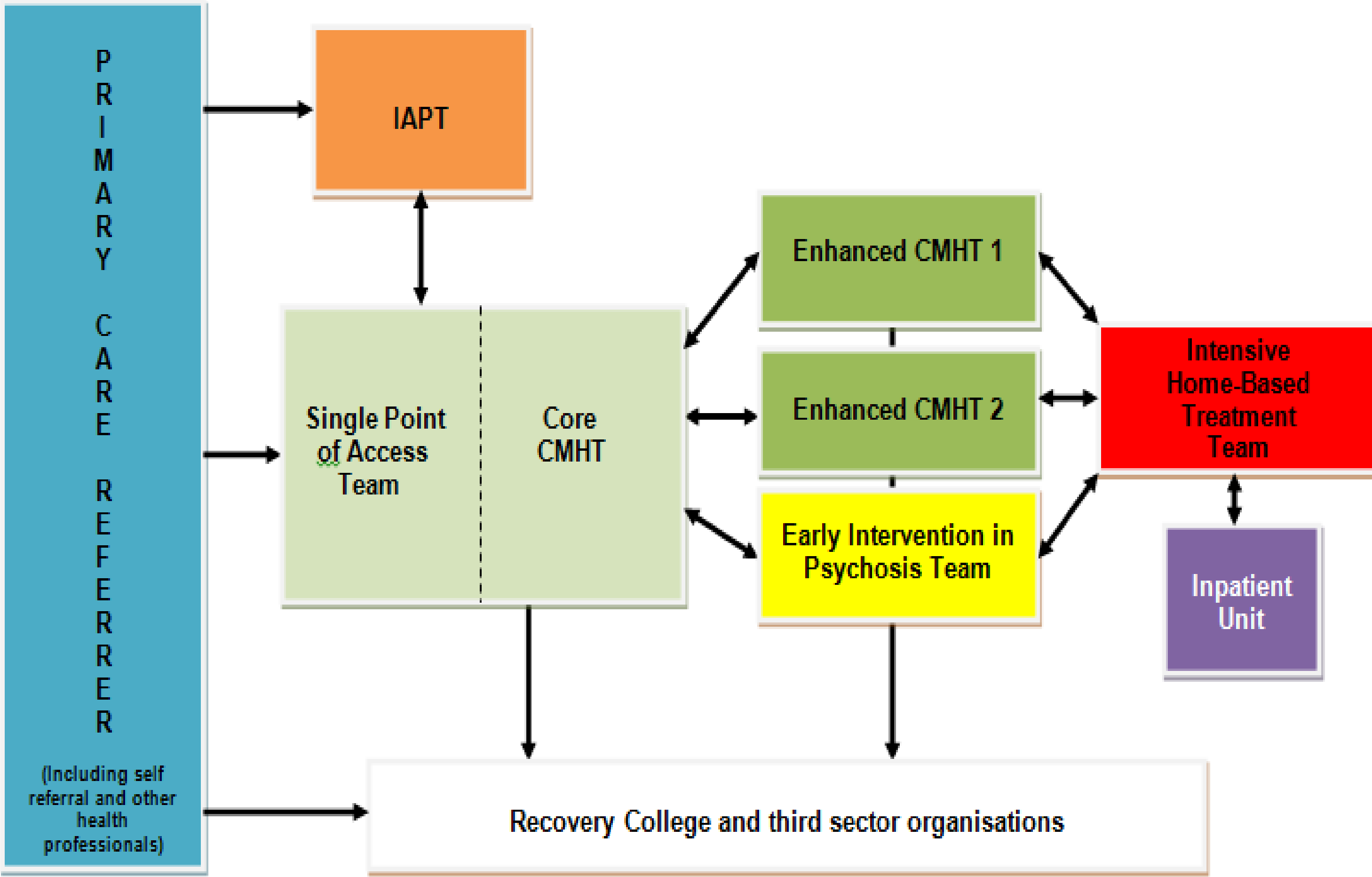


SPA - key interface between GPs and MHS

Gill Kirk

Consultant Psychiatrist, Central CMHT, currently seconded to SPA


PRIMARY CARE REFERRER
(Including self-referral and other health professionals)
IAPT/Mental Health Access Team
SPA pilot
CMHT North
CMHT Central
CMHT South
CMHT Dearne
Intensive Home-Based Treatment Team
Inpatient Unit
Early Intervention in Psychosis Team
Assertive Outreach Team


PRIMARY CARE REFERRER
(Including self referral and other health professionals)
IAPT
Single Point of Access Team
Core CMHT
Enhanced CMHT 1
Enhanced CMHT 2
Early Intervention in Psychosis Team
Intensive Home-Based Treatment Team
Inpatient Unit
Recovery College and third sector organisations

As a GP, what do I need to know about SPA?

- It's the single point of access to adult MHS (though direct referral possible to EIP, Dementia Services and IAPT - MHAT) - so use it as such!
- If in doubt, phone up and discuss – may save time and effort and shape referral better
- Shortly an evening medical discussion slot will be available for booking calls after surgery, once a week (Tuesdays till eight pm, from April 28th)
- Understanding new ways of working and implications for medical care/responsibility
- MHS Transformation is coming – soon! (see your pack)

Psychiatry is different

- “Accountability in multi-disciplinary and multi-agency mental health teams” GMC
- No longer direct referral to named Consultant or indeed to a Consultant at all, but to MHS (not new?)
- Medical T and C haven’t changed however, so if it is something that a Consultant needs to see, highlight this (or may not be recognised)
- Reality of modern MHS and especially psychiatry – continuity? Linguistic ability? Shared culture?

Distributed v Delegated responsibility

- “

Psychiatrists can delegate the care of those patients for whom they agree to take responsibility.

But many psychiatrists work in systems that are not based on referral of patients to a specific consultant. Instead, the multi-disciplinary teams of which they are a member may provide health and social care services to a substantial number of patients.

Referrals are made directly to such teams and decisions about allocation to an appropriate professional are made according to the teams’ policies.

In these teams, the responsibility for the care of the patients is distributed among the clinical members of the team.

GMC ctd…

Consultants retain oversight of a group of patients who are allocated to their care and are responsible for providing advice and support to the team.

They are not accountable for the actions of other clinicians in the team. However, in accordance with paragraph 2, they must do their best to ensure that arrangements are in place to monitor standards of care, and to identify potential or current problems.

They should notify their employer about any unresolved concerns or problems.

(Para 2 = quality assurance and safety of systems)

What's different with SPA?

- Transformation : concentrate on our core business, with fewer resources. Recovery ethos, but tempered by reality (chronicity)
- Signposting to other relevant services, MHS are not a catchall
- Mental disorder v social distress
- At long last, clearer thinking about how resources are used and who should provide which bit of care – which means CHANGE

Other drivers for change

- NICE and PD - psychology, not psychiatry, chiefly
- Lack of clarity around funding in MHS for things historically provided but not necessarily ever commissioned
- Difference between Barnsley and rest of SWYT re "Shared Care"
- Reality of psychiatry as a changing medical discipline
- PbR and MHCT – "clustering"…

And in primary care too…

- Sandwell project, Royal College of GPs seeing MH as an enduring priority, training and accredited pathway to provide specialist primary care
- "Inverting the triangle, or pyramid"
- Health and recovery v illness and dependence
- Benefits reform - and worse to come (why was IAPT created?) – who is there to assist?
- Commissioning and CCGs etc
- Massive change in primary care delivery coming…

Local issues too

- Barnsley as a hotspot for prescribing antidepressants (and benzos?)
- Historical expectations – patients, GPs etc
- Legacy of industry and social deprivation
- Drugs
- Primary care recruitment and retention issues

Manage your expectations and those of your patients too

- Seeing a psychiatrist is going to be less frequent and generally time limited
- May well be “one off” to offer advice to you to manage the patient better
- Does it need to be a psychiatrist who gives you advice? What about pharmacists?
- Why do patients fail to attend? Consider this before referring them!
- Why are you referring? What are the aims?

Joint working

- Joined up thinking and care
- Seeing patients together (and where)
- CPA – GP supposed to be a core participant
- Prescribing and safety, single point of prescribing best
- Timely access to services must be coupled with throughput and timely stepdown/discharge
- Third sector partners
- Growing role of private practice?

Whose referral is it?

- Self referral and the associated pitfalls – hence need to communicate and check the patient isn’t trying to bypass primary care
- Patient consent (capacity/competence)
- Motivation? Initial and ongoing?
- Patient expectations v reality
- What do patients really want?
- Who is best placed to provide that?

SPA

- Gatekeeping function
- Sieve v leaky bucket
- Reality check on future of all secondary care not just MHS
- Good relationships matter and we are up for working with you as our partners and equals
- Information sharing and valuing your views