

MENTAL HEALTH SERVICES IN SOUTHWARK Whose concern is it?

Discussion Paper October 2011

1. PRIMARY CARE SERVICES ISSUES

1.1 Introduction

Change is happening within the Mental Health Service system in Southwark. As part of current disinvestment plans by Southwark Primary Care Trust (PCT) to South London and Maudsley (SLaM) approximately 600 caseloads of people with Mental Health Issues will be transferred from secondary care (Community Mental Health Teams-CMHTs) to Primary Care (GPs).

There are many significant implications on current service users and those who will use the service in the future. It is our aim for this paper to act as an advocate for these service users and those who care for them by asking questions to Commissioners and Providers, and lastly recommendations for improvements are made.

1.2 Main issues

Many individuals and organisations, including LINK Southwark members, have expressed their concerns about the following:

1.2.1 *The real need for the transfer of care*

Questions

- What criterion is being used to decide which service users are being transferred to their GPs? Who is involved in this decision making?
- How are service users being informed of the reason?
- What can the service user do if they disagree with the transfer?*

1.2.2 *Impact of Clinical Academic Groups (CAGs) on admission to SLaM services (see note 1 below).*

Question

What mechanisms are being used to ensure service users understand the changes relating to Clinical Academic Groups?

1.2.3 *Quality of care for service users with Dual diagnosis of drug addiction and a mental health diagnosis*

What assurance can be provided that service users with dual diagnosis receive the care they need?

1.3 Major concerns regarding GP care

GPs by their very title are not experts - their knowledge of mental health problems is usually quite minimal. Patients in general are not guaranteed the choice of seeing the same doctor each time they visit their surgeries. Thus a relationship in which trust is built up and consistency is assured is

now too often missing. GPs need to be able to recognise the early signs of a different kind of behaviour which the user may not themselves be aware of.

In addition to this an appointment with the GP is usually 10 minutes, far too brief for either the patient or the GP. A GP waiting area is not always an easy place to wait for someone in mental distress.

The imminent changes to welfare benefits from Incapacity / Income support to ESA / JSA is highly complex and controversial, and already the process of the Work Capability Assessment has proven very stressful. Patients who will undergo this process need support that is robust and practical from their CMHT. When they are transferred to primary care, this expertise will be denied them.

Questions:

- a) To date i.e. October 2011 how many GPs have undertaken specific Mental Health training?
- b) How can service users get back to secondary care quickly if needed?
- c) Will support be given to service users if they do not have a GP?
- d) What referral mechanism will be used by GPs when they need to refer their patient back to SLaM services?
- e) What support will be provided by SLaM to the GPs?
- f) How does the service user's experience get collected?
- g) Who is responsible for ensuring the care from the GP is of a high quality?
- h) There are services users on long- term prescribed medication and for some there is a risk that patients will be maintained on these drugs. What expertise will GPs require to assess those who need to have a more therapeutic level of care?
- i) Will service users be ensured of a longer appointment when necessary?
- j) What is being put in place within surgeries to ensure that all GP surgery staff members are able to support the service user?
- k) What role will the GP play in the changes to the welfare benefit system?

1.4 Recovery Agenda

The Staying Well Team is part of the psychosis CAG and is limited to 60 clients for 6 - 9 months. Therefore, this will not be of benefit to the vast majority of people being transferred.

As far as we are concerned, we can't have meaningful health care without the social care; they are both bound up with each other, and this is another major issues, as they are separately funded. People need to be able to socialise with others, as part of keeping ourselves well; the worst scenario is being isolated in primary care with nowhere to access this invaluable kind of social support, as day centres can only be accessed under secondary care services via referral from CMHT, and the future of voluntary providers is both limited in capacity and precarious, due to possible funding cuts.

Therapeutic activities also play a vital role in our continued well-being, and these, too, are much more easily accessed under secondary care services.

Questions:

- a) How will the service user be reassured that both their health and social care needs will be met?
- b) For those not receiving support from the Staying Well Team how can service users be helped to stay well?
- c) There are several plans that service users may have including Care plans, Personal Budget Plans & Discharge Plans. Who will have a care plan? What will be the impact of new care pathways on these plans?
- d) How will these plans be updated/reviewed and who will do this?

Miscellaneous Questions:

- a) *A major problem is the interface between primary and secondary care - who is responsible for this, SLaM or PCT?*
- b) *What will the role of the three hubs be in all this?*

2. RECOMMENDATIONS

Service Users are the experts in what care and support is needed and because of this the following recommendations are being made:

2.1 Holistic Care

- a) holistic approach is needed by NHS to care that provides for our physical and mental health, our social wellbeing; that acknowledges spiritual needs too.
- b) holistic needs including environment, secure income to be kept out of poverty, as this has been proven to be a major cause of mental health problems.

2.2 The Transfer from CMHT to GPs

We recommend that:

- a) GPs have a proper, effective system of support from SLaM throughout this process; lines of communication must be demonstrated;
- b) this is a gradual process, so that GPs aren't overwhelmed;
- c) this process is properly monitored;
- d) the patient gets the support they personally need throughout the handover, which may be provided by SLaM/GPs e.g. peer support;
- e) all plans to be in hard copy, and electronic where required, for the service user and all other parties, and this plan to be agreed by user and GP, and to include a review date;
- f) plans to include how to access secondary care services;
- g) transfer to include a handover meeting with SLaM care co-ordinator, GP and service user;
- h) where relevant, the plan includes a regular check-up with a psychiatrist / professional eg to review drug prescription etc.

2.3 Primary Care

We recommend that:

- a) A befriending / peer support service be set up as soon as possible, that GPs can access quickly and easily;
- b) social prescriptions be widened and lengthened, as for example exercise is very beneficial, but needs to be regular and ongoing, not limited to a brief 6 week course; especially as funding for current programmes provided in the community is rapidly being reduced;
- c) examples of good practice by GPs in their care of patients with Mental Health needs be collected and shared;
- d) access to a variety of therapeutic activities;
- e) easy and quick access to emotional support at our surgeries/Hubs;
- f) the day services have 24/ 7 presence of Mental Health trained staff;
- g) all GPs have Level 1 and 2 Mental Health training, with input from service users;
- h) an out-of-hours self-referral drop-in service that is robust and user-run;
- i) access to respite care that is robust and user-run;
- j) social support groups that are user-run;

Finally, we also recommend that all the above services be protected so that there is no risk of closure; as the stress of changes is a risk factor in itself.

THANKS

The LINK Southwark Mental Health Task Group would specifically like to thank Southwark Mind User Council Worker Joan Molyneux for initiating the production of this document.

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