healthwatch
Lambeth

Healthwatch Lambeth
Enter and View:
Mood, Anxiety and Personality Community Mental Health Team (CMHT) Visit Report

November 2016

About Healthwatch Lambeth

Healthwatch Lambeth is the independent health and social care champion for local people.

We work to ensure your voice counts when it comes to shaping and improving services. We address inequalities in health and care, to help ensure everyone gets the services they need. We are a charity and membership body for Lambeth residents and voluntary organisations.

There are local Healthwatch across the country as well as a national body, Healthwatch England.

About Enter and View Visits

Our Enter and View programme involves visiting publicly funded health and social care services in Lambeth to see what is going on and talk to service users, their relatives and carers, as well as staff.

Every local Healthwatch has a legal responsibility to carry out an Enter and View programme. But we are not inspectors. Instead, we focus on what it is like for people receiving care. We provide extra eyes and ears, especially for the most isolated and vulnerable. Our visits are carried out by trained and police checked volunteers.

Visit overview

Service	**Mood, Anxiety and Personality Community Mental Health Team, 308-312 Brixton Road, SW9 6AA**
Date of visit	Wednesday 9 November, 2016 1pm - 3pm; Thursday 24 November 2016, 12pm – 2pm
Enter and View Team	Janaki Kuhanendran, Anna Jones, Kate Damiral and Catherine Pearson
Service liaison link	Gillian Paul (Lead Community Practitioner, Treatment Team)

Purpose of visit

Mental health is a priority work area for Healthwatch Lambeth. Considering the current NHS intention to move treatment delivery away from secondary services and into the community, we decided to conduct a series of six Enter and View visits to community mental health services in 2016. These included supported accommodation services, employment support services and clinical services. The final visit we made was to South London and Maudsley NHS Foundation Trust (SLaM)'s Mood, Anxiety and Personality (MAP) Community Mental Health Team (CMHT) in November 2016.

The aim of this visit was to:

- Listen to how service users experience the services and support they receive at Lambeth's MAP CMHT
- Speak to staff about their experiences of working at the MAP CMHT, and
- Observe the physical environment of the service.

About the Mood, Anxiety and Personality Community Mental Health Team

Lambeth's MAP CMHT consists of 11 care coordinators: four of whom are social workers, five of whom are mental health nurses and two of whom are Occupational Therapists. Four of these care coordinators are senior practitioners with managerial responsibilities. In addition to these roles we have two Dialectical Behavioural Therapy (DBT) practitioners and one and a half Cognitive Behavioural Therapy (CBT) practitioners two psychiatrists and three part-time SLaM psychologists also work with the team. A community lead practitioner manages the team. Since our visit the establishment of the team has been cut by one social work post – there were previously 12 care coordinators. The team receive assessments from the Assessment and Liaison Team (ALT) based in Streatham, various treatment teams, increasingly from perinatal departments, the Living Well Network (LWN) and from Urgent and Emergency Care (UEC) services.

Each care coordinator in the team has a caseload of approximately 20 to 25 patients. After an initial assessment, care coordinators design a care plan with service users and see them weekly to help implement this. Typically, service users attend the MAP CMHT offices for these meetings. Clients are also visited by their care coordinators at home. If they are housebound this will be the regular means of contact but even where they are able to travel, care coordinators endeavour to visit their home at least once.

Since 2014, the CMHT has been working to introduce a psychotherapeutic element to their approach. This has led to the introduction of CBT and DBT therapists into the team. Currently, the MAP CMHT holds two weekly groups for people with diagnoses of Emotionally Unstable Personality Disorders (EUPD); one is a therapeutic group and the other is a psycho-educational[1] group which draws on DBT principles and techniques.

Both groups typically support service users who self-harm and experience suicidal feelings. They accept referrals of people who have severe presentations and require longer term treatment. The team typically offer treatment for 12-18 months, although this can be extended. Once clients have been discharged, they can return to the service within six months.

Participants

We visited the MAP CMHT on two different occasions, on a Wednesday and a Thursday afternoon, with the hope of coinciding with the end of the two therapy groups. Our initial Thursday afternoon visit had to be rescheduled due to the group being cancelled on our first visit. In total, we spoke to nine service users at the MAP CMHT who were receiving different services; they were either part of the Wednesday or Thursday DBT groups, or were being supported by a care coordinator at the centre.

We asked service users about their experiences of using the service, the quality of the support they received, their relationships with staff and whether they felt able to give feedback to the service. We also asked service users about their goals for the future and their experiences of using mental health services in Lambeth more widely.

Two weeks before our visits, we sent out questionnaires to the staff at the MAP CMHT. These asked questions around roles and responsibilities, job satisfaction, professional development, relationships with service users and general comments on working in mental health in Lambeth. We did not receive any written survey responses, but we were able to speak to nine members of staff including the service manager, reception staff, the clinical treatment team and care coordinators during our visits. The Healthwatch Lambeth Enter and View team also designed an observation checklist of the service environment, which was completed during the first visit.

Location

The MAP CMHT is based at 308–312 Brixton Road, alongside SHARP (the Social Inclusion, Hope and Recovery Project run by SLaM). The main entrance is on a busy road, near numerous bus stops and about a ten minute walk from Brixton station. The actual MAP building is set back off the main road, along a

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[1] A group which educates its members about their diagnosis and teaches recommended ways of coping with the symptoms of a disorder.

small pathway which goes through a well kept front garden.

External environment

The entrance to the two projects is understated, with a small sign simply stating '308-312 Brixton Road'. The lack of SLaM signage ensures privacy for those entering and leaving the premises. The front garden and the pathway were well kept, tidy and had a calm atmosphere. There was a small bench just outside the main MAP building which was used by service users as an extra space when they were distressed, or when they were waiting for transport to arrive. There is an entrance buzzer on the door of the MAP building, and the windows were partially blacked out so you were unable to recognise who was sitting inside. The building is wheelchair accessible.

Internal environment

Layout and atmosphere The front door of the CMHT opens into the main waiting area. On both visits, the waiting room area was calm and quiet. The walls with ceiling to floor windows that look out into the front garden, made the room feel open and light. The room itself had a calm and uncluttered feel and was not overly 'clinical'. Upon entering, it is clear where to approach as the reception desk faces the front door. On both visits the receptionist was friendly and helpful and we were asked to sign in and out.

There were eight chairs in the waiting room and a coffee table with up to date magazines and newspapers. There was a water cooler and a small kitchenette off to the side, although this appeared to be for staff rather than service users. An accessible toilet was clearly labelled next to the waiting area, which was clean. The waiting room was decorated by a series of multicultural flags which gave the room a welcoming feel.

Notice boards, signposting and information

There were numerous leaflets and posters around the waiting room, and two large noticeboards were in eyesight of the main seating. A leaflet rack underneath the main reception contained information about a variety of topics and services including: insomnia, suicide prevention, what to do in a mental health crisis, information and support for carers and parents, depression, anger management, alcoholics anonymous, domestic violence, bipolar workshops, Mosaic Clubhouse leaflets, a comments and complaints poster, and posters for SLaM Improving Access to Psychological Therapies the involvement register, young carers, local football groups, Lesbian Gay Bisexual and Transgender support groups, free SLaM workshops and information about a MAP CMHT Christmas party.

The most recent Care Quality Commission (CQC) ratings were visibly displayed in the waiting area and there was a suggestion box on the wall near one of the noticeboards.

Staff had also displayed posters about our visit around the waiting area. One area had a display of staff photos with names and job titles underneath.

We noticed that service users seemed confident with approaching the reception area and signing in, and the staff in the reception area were friendly and approachable. We were offered a small side room attached to the waiting area to speak to service users and staff in. The room itself was small and comfortable, and again did not feel too clinical.

Meeting the service users: Experiences of support and treatment at the MAP CMHT

During our visit, we asked service users about their experiences of the support and treatment that they received at the CMHT. We heard mixed feedback on several issues, ranging from relationships with staff to opinions on treatment.

Relationships with staff

One service user described the CMHT as a ‘comfort’ to her. Another told us ‘*I love it here! I live for Wednesdays now*’; a large part of this focussed around the emotional support she received from the service which she described as attentive and focussed. She told us ‘*in the private therapy I’ve been in before, once the hour that you’ve paid for is up, you can’t contact them. Here you can ring and speak to your therapist during office hours, and there’s peer support. You feel like you’ve got something to fall back on… with the nature of EUD [Emotionally Unstable Personality Disorder] you need that emotional support; this service caters well for that. It’s about people taking you seriously… here, you feel like people actually care about you*’. Similarly, another service user told us: ‘*They really treat you as a person. You feel included in your treatment rather than people not really caring*’.

Other positive comments about staff included: ‘*they’re lovely and friendly… I like them*’, ‘*I get on with my care coordinator*’ and ‘*[staff are] good… they’re friendly, it feels welcoming; they’re relaxed*’. One service user explained that she had seen a few different therapists at the CMHT, predominantly forming positive, supportive relationships: ‘*my therapist is really good, I really believe in her, I believe she has good skills. The man I had originally was really good… you’re not so alone with your problems, I feel like a plan is in place. I’m in a good place at the moment, but it comes and goes… I don’t feel so desperate now*’. Although this service user also commented that one therapist she had seen had not been as helpful, she thought that might have been because her perspective at the time had been quite negative which might have prevented her from forming a strong relationship with that therapist.

However, we also spoke to one service user who did not have a positive relationship her care coordinator, and whose main goal was therefore to get discharged from the service. Whilst being visibility upset, she told us that the staff were: '*bloody useless. [The service is] not helpful, I only came today because I wanted to be discharged*'. She could not identify anything that she liked about the service. This in part stemmed out of a recent experience of being hospitalised without support from her care coordinator: '*when I was in hospital it was really frightening. Because of the abuse and trauma that I have had, I thought that I would never go back to hospital. So the first day I rang my care coordinator here and I left her a message… it was three weeks before I heard from her again. That ruined the trust there because she knew how difficult that would be for me and she didn't care at all*'.

Most staff we spoke to felt that they had good relationships with service users and that they knew their key clients well. One told us '*I've got good relationships with patients. I often make them a cup of tea. It's all about building relationships really. If I see new [patients] I'd go over and welcome them in. For those I know, we can have a good conversation.*'

Recommendation 1

Communication between care coordinators and service users ought to be consistent and reliable. This is especially important when clients are in crisis. See recommendation five for further actions.

Provider response

We recognise that good effective and consistent engagement with service users is one of the key corner stones of good quality community mental health provision. The client group we see in the Lambeth treatment team, are by the nature of the service, complex and present with co morbid diagnosis, and social issues which may further complicate the clinical presentation.

Ensuring our staff team have the necessary skills in working with this complex and diverse client group; and provide a consistent and reliable approach is of utmost importance. We have Dialectical Behaviour Therapy Leads embedded in the service who provide regular skills training, supervision and support within the team.

Careful and considered crisis planning is an integral part of care coordination work and the role entails building a rapport and developing engagement with service users in order to carefully plan crisis and contingency planning to involve:

- *Early warning signs*
- *Relapse indicators*

- *What can be a trigger/what exacerbates a crisis - for instance; excessive alcohol consumption.*
- *What is helpful*
- *Who to contact in a crisis.*

Considering a stepped approach, when for example sleep becomes an issue, how this may be addressed, before it reaches a crisis and relapse concern.

Further, regular clinical reviews with the team consultant, are provided on a weekly basis to ensure the staff can discuss as a team difficult and concerning and high risk issues, and come up with a plan for care and treatment particularly in a crisis which can be discussed with the service users to ensure continuity. Care coordinators can further suggest medical and psychological reviews for patients which can be very helpful in crisis planning.

Previously a staff reflective practice was held which was well received by the team, and this will be reintroduced. This is a space where staff can use to discuss complex cases and which is facilitated by an external experienced therapist and provides the necessary space to reflect on issue, and gather support and helpful advice from others and get to know forth the team case load and how to crucially support one another in the team.

Clinical treatment

We spoke to clients about their experiences of the treatment they received. Although one service user had waited a long time to enter the service, she told us '*once you get seen, it's really good.*' She felt listened to by the staff, and was particularly impressed by the way they discussed her eventual discharge from the team: '*the way they talked about discharge was completely different from everywhere else… they told me they had a vision that I would be well enough to move on. On paper, it may seem the same [as previous discussions in other services], but it felt completely different*'.

We asked service users about their goals and whether they felt the service was supporting them to reach them. One service user identified that her treatment involved '*re-learning everything I know… but I can see that it's beginning to work*'. She already felt that she had a better understanding of her symptoms due to what she had learned at the CMHT.

Other comments about reaching goals included: '*I can see this helping me long term*', and '*it's teaching me new things that are important for what I am going through*'. One service user wanted help to clear her house as she was a hoarder; although her current therapist would not come to the house to work on that, she told us it was because they were working on other more imperative issues first, and she was happy with that.

Other aspects which service users appreciated were help with medication and the access to a psychiatrist. We heard that care coordinators helped service users by writing letters to support housing issues. Another person told us that she appreciated she could be re-referred to the service if she left, which meant she felt supported even after discharge.

However, some service users were not fully satisfied with the service they had received. Issues included being treated in a group; '*ten is too much. People with our condition can be quite needy, it's hard for me to say what I need to. I think one to one would be better for me*'.

Another service user told us that she had previously experienced problems with her care crisis plan. Although she was not currently talking to her family, she had been asked to fill in 'next of kin' on the form; '*I didn't feel like I could relate to the plan, I didn't feel like I was in charge of it*'. However, on returning to the service this time, she told us it had been different and she had felt fully involved. Nonetheless, a month later she still had not received a copy of this new care plan in the post.

Recommendation 2

Clinicians ought to consistently design care crisis plans in partnership with service users, taking into account individual circumstances. Hard copies need to be shared promptly with service users in order to be a useful source of support.

Provider response
It is our policy to develop care and crisis plans with service users and where appropriate their carers and design it to meet their individual needs. Service users should routinely be offered a copy of their care plan. Service users are usually asked for a contact person in case of emergency but it is their choice who to nominate and does not have to be a family member.

Staff turnover and illness

Relationships with staff were clearly important to service users. Staff turnover and illness therefore had a strong effect on service users. One service user told us how hard it was to change therapist part way through treatment: '*I had a man originally and he was really good. Then they changed my therapist; that was really upsetting. It takes time to get used to seeing a new person*'.

The same service user told us that cancellations and communication can be an issue as '*cancellations have happened a few* *times and I travel quite a long way to get here'*. This service user was also seeing a private, low-cost therapist where she felt that she had received a more consistent service: '*For change to really happen, it's like you need to practice regularly - otherwise you don't get a hundred per cent involved in the treatment'*.

Another service user also described staff absences as an issue. Her care coordinator only worked at the service three weeks out of four, and she had not originally been informed that she could speak to another care coordinator when hers was unavailable: '*I just wasn't speaking to anyone at that point, I need consistency with my treatment... it can end up being a long time if they are off sick for instance. They don't have the resources for someone to cover properly if someone is ill'*. One member of staff told us that clients were not told about the CMHT's duty process in their introduction to the service but suggested that '*the duty process is standard across all services. So if you have come through A&L [Assessment and Liaison], you will know that. It should be in their care plans though I suppose'*.

Recommendation 3

Service user inductions to the MAP CHMT and/or care plans should explain their right to access a duty care coordinator when an assigned coordinator is not available. This should be recapped with service users as and when they are told about staff sickness/absence.

Provider response
Service users are given welcome packs on entering the service with "who to contact" details on, explaining the role of the duty coordinator and including what to do in a crisis both in and outside of office hours. All services users receive this and it contains information on how to make a complaint or comment, what to do in a crisis, a leaflet on PALS (Patient Advice and Liaison Service) information for patients and carers, an overview of the service and information about use of personal information. When someone calls to inform service users that a staff member is off sick, it is explained that they can contact the duty coordinator in the absence of their usual care coordinator. In cases of longer term sickness service users are sent letters with the same information on. It should also be on the crisis and care plans developed with service users.

One service user had found the transition from child services into adult services difficult and mentioned staff relationships and turnover as contributing towards this: '*I* *was transferred here in June and I'm on my third care coordinator. They leave. I haven't had an opportunity to get to know them and build trust with them. It doesn't feel like the support is making any difference - there's no difference to being in or out of services. Children's [Michael Rutter Centre, SLaM) was so different. I had a psychologist who was really supportive. They were always there whenever I needed them. She would cancel appointments to escort me to A&E past work hours. Coming from that to this was really hard'*. She did not feel that she had been adequately warned or prepared for these changes, and was concerned that she had not had a medication review after being put on new medication a few months earlier.

Recommendation 4

With respect to young people transitioning from child and adolescent mental health services (CAMHS) to adult services, CMHT staff should ensure that expectations of support by the service are discussed and plans to address any differences in expectations are incorporated into the development of an individual's care plans.

Provider response
It is recognised that times of transition can be very difficult and need to be managed in a very careful and considered manner. It is of utmost importance that young people transitioning to adult services and their carers are fully informed on the transition process, and consulted and that this is all done in a very managed and planned way.

Thought needs to be given to the right care coordinator and also that all information on the new service and where to go in a crisis and meeting the new care coordinator and consultant and ensuring full briefing and information is shared.

Recommendation 5

Noting that staff turnover and non-response has disruptive effects on care provision, all service users should be given an alternative contact number to raise concerns about their care (i.e. such as requiring a medication review).

Provider response
This information is in the welcome packs given to all service users on entering the service, it is also displayed in the waiting area and on appointment cards.

Although we were told by one staff member that staff turnover was in line with the rest of the sector, we heard from others that there had been numerous staff illnesses within this service, including long term stress and physical illness.

We were told that when staff are signed off work long term, their clients are informed via a letter and then allocated another case worker. When staff are signed off with shorter term illness, their appointments for the day are cancelled by phone. The impact on clients was noted by staff; '*there's too high a turnover in staff – they join and then the next thing you know they're leaving… the last couple of years the team has changed so much… [the clients are] seeing different people all the time- no wonder they are upset. I've had enough.*' This staff member felt that because those who answer telephone queries from service users are not always fully updated about staff absences and expected return dates, clients end up ringing every week to find out if they are back and understandably '*get very angry*'.

Recommendation 6

Management teams within MAP CHMT should review existing mechanisms to improve how information about staff absences is shared with members of the team who interface with service users, to ensure the communication of accurate and timely information.

Provider response

At times within any service there may be periods when staff may experience sickness. It is very important that when the care coordinator is off sick this is communicated to the service users, and that they have the information about who else may be covering in the care coordinators absence and also who is available if in crisis.

There is a duty senior available everyday who can be spoken to and this can be very reassuring. A letter will usually also be sent to follow up what the arrangements are for the period of illness. The consultant and temporary team manager, or senior duty lead, or interim head of pathways can also be a point of reference.

We will revisit how these arrangements are conveyed to service users to ensure the information is available as it can be very reassuring to know who is covering in the absence of the care coordinator, and also ensure all the team is aware of the arrangement to include the receptionist who can often times be the first port of call when attending the service and can allay anxieties about cover arrangements.

Communication with staff

Communication with staff was cited as a problem by service users as at times they had found it hard to get into touch with care coordinators or clinical staff. One woman told us '*it's difficult for me to reach out by phone, it takes a lot of building up to. Then, when I call but I can't speak to them [care coordinator], it's really hard… by the time they call me back, I'm kind of not ready at that point*'.

There were also issues with paper communication. One service user who had used the service previously had received a letter after her discharge confirming a diagnosis of Emotionally Unstable Personality Disorder. This had come as a surprise to her and as she had already at this point left the service she had no clinical support processing what it meant. Another service user had told us that she had received a letter on New Year's Eve informing her of her (unexpected) discharge from the service. Although this turned out to be an administrative error, it had been upsetting to receive.

One member of staff discussed with us the issues of communication in the team. She agreed that clients were not well notified about changes in the service: '*[as with] the new change of CAG [Clinical Academic Groups]; they told us to just write a line at the top of our headed paper so that when clients get a letter they will know, but that's not right- what about the clients who don't get letters? They need to know - and other people need to know*'. She felt that these issues included the CMHT's communication with other services such as with GPs who are still referring service users to the MAP CMHT for assessments, for which the service is no longer responsible for.

Recommendation 7

Where structural changes to the service are identified as having an impact on service user care and treatment and/or referral processes, SLaM must plan communication strategies in an effective and equitable way. This may involve consulting a small sample of target stakeholders to identify the most appropriate ways of sharing information on the intended changes.

Provider response
Stakeholder groups are offered by SLAM ensuring that all stakeholders including service users and their carers are consulted and made aware of any impending changes and how these may affect the service and also the provision and how the particular service will be supported in the changes.

The impact on service user and carers is always carefully considered, and any consultation will be widely reaching in its scope and to ensure we have full collaboration and that all in the network are included and have the information required to make decision about changes suggested, in order to drive up quality and ensure we are constantly striving for the highest quality service provision.

Accessing services

The service users we spoke to had accessed the MAP CMHT via different pathways, which were often long and complicated. For instance, two service users told us about long journeys through various mental health services before they were referred into the MAP CMHT. One had been under various treatment teams for ten years and the other for five years. During this time they both had been on various medications, given numerous diagnoses and spent time in hospital. Although they both felt that finally getting an appropriate diagnosis meant they were now receiving good support, their journeys into the MAP CMHT had been very difficult.

One told us: ‘*it’s taken so long to get here… until I got so drastically unwell and was in hospital, it was hard for me to get anything. You get loads of assessments and it is hard telling loads of people the same things. I felt like I had to go to the doctor with something physical for them to take me seriously... it’s actually about one person seeing your symptoms and understanding you. This [diagnosis] is hard for some people to see*’.

Another service user had similarly received incorrect diagnoses in the past, which again, had not been addressed until she reached crisis point and was admitted to hospital. For her, it had been a ‘*nightmare*’ accessing the service as the Assessment and Liaison Team had not diagnosed her ‘*properly*’ for months.

One service user told us that although she was desperate to get help, the delays in accessing treatment had meant that she had lost her children: *‘it’s too late. They say the treatment will take about two years to see an improvement. If I would have had the help earlier, I wouldn’t have had so many incidences which my kids saw… when social services got involved, it was downhill after that.’* Other service users we spoke to similarly described waiting months before they could access treatment.

Staff echoed that there had been issues with long waiting times to get into the service. and one member of staff we spoke to commented that this sometimes meant service users felt they were better off paying for private therapy even if they were not from very affluent backgrounds: ‘*the service has always been very person-centred… [it is] very hard to feel that we are doing a good job if people have to wait*’. We heard that these long waiting lists resulted from DBT being a very finite resource in the area with only one or two specialists in each borough, despite it being the National Institute for Clinical Excellence recommended treatment for people with EUPDs.

As well as having long waiting times, staff felt their caseloads were unmanageable, which for some made the service ‘unsafe’. Numerous staff told us that caseloads needed to be reviewed and lowered, so that they could spend more time with individual patients and to relieve the pressure on them:

'even if you stay late, you do not have enough time to complete things'.

The team's high caseloads seemed to come about for a variety of reasons. Although treatment time is supposed to be up to eighteen months, staff explained that it is often difficult to discharge people at this point as service users are not always ready to leave. Thus, caseloads are continually increasing, an issue which one staff member described as 'endemic across the sector'. One staff member felt increased caseloads were also the result of changing thresholds for treatment as well as the push to treat increasing numbers of service users in the community: '*what used to be high need is now actually seen as low need. There are all these people in the community now and it makes you wonder if they should be*'.

Numerous staff members told us that inappropriate referrals were also a problem. For example, an elderly person had recently been accepted into the service when in fact the older person's team would have been more appropriate. We heard other examples of referrals for people with learning disabilities or mild depression who were also accepted into the service, when their symptoms were not felt to primarily stem from a mood, anxiety or personality disorder. Furthermore, one clinician felt that other teams had at times 'watered down' service users' diagnoses so they would be accepted by the MAP CMHT.

We were told by staff that in order to transfer a case, it has to be agreed by the receiving team but we heard that some teams simply do not accept the referral which is to the detriment of the service user: '*we're not able to provide the appropriate treatment. They sit on our caseload not getting the help they need. The amount of time on our team's books goes up and up and up. There are too many people like this- it is wrong not looking at our criteria*'.

Such situations left staff feeling overworked and unsupported. Staff told us '*you struggle - we don't have the tools to support these patients. I'm burnt-out… do they want someone to be murdered before this person gets the help they need?*', and '*you feel helpless with supporting that person… there are cases like this on everyone's caseload.*' They felt that the MAP CMHT is seen by others in SLaM as a '*dumping ground*', and '*the end of the line*'.

Thus, staff repeatedly told us that their service needed to employ stricter criteria, guidelines and boundaries as to which referrals were accepted. Additionally, some staff felt unheard when attempting to highlight the issue internally; one person told us they had gotten to the point where they did not want to say anything anymore because it felt pointless.

One member of staff described the CMHT's relationship with the Assessment and Liaison Team A&L as good, and another as improving.

We were worried to hear from one staff member who suggested that the A&L team sometimes 'holds back' referring assessments to the MAP CMHT when the CMHT were under particularly strong pressure. The potential impact of this strategy on clients is concerning, especially given their feedback around inappropriate referrals and long waiting times.

Recommendation 8

SLaM and MAP CMHT service managers should review how referrals into the service are accepted and managed to ensure that frontline staff are assigned appropriate clients given their skills and capacity. The feedback we have collated suggests that eligibility criteria, treatment duration and relationships with other SLAM teams should be looked at. Importantly, the review process should ensure that the views and suggestions of staff are heard and responded to.

Provider response
Service users are allocated to staff based on their clinical need and the skills of the clinician rather than just capacity. Referrals are screened when they come in and if a referral form is not complete and has missing information (such as the service user's goals for treatment) referrers are encouraged to complete this prior to the referral being considered.

The eligibility criteria for the treatment team and therapies within the teams are clearly communicated to referrers, both CBT and DBT offer to consult referring clinicians to ascertain whether service user needs can be best met within these therapies or whether they need signposting to another therapy service within the Trust (e.g. IAPT / IPTT). CBT and DBT leads offer training, consultation, supervision and skills groups to front line staff. Treatment duration is specific to clinical need and engagement with the service.

Staff morale

During our visit, we asked staff about job satisfaction. Most staff told us that working with the clients was the best thing about working at the CMHT, as well as working alongside individual colleagues and the variety of the work. One person told us '*I enjoy working here. I like working with people with mental health problems, the impact of changing people's lives and helping them in crisis. Or signposting them to something they need*'.

However, we were surprised to see some staff struggle to identify anything which they liked about their job, mostly due to high stress levels and pressure. One person told us that burnout is endemic across the sector, and that the stress of working in mental health frequently leads to staff illness. The issues around case management were heavily impacting on her capacity to enjoy her work.

Another told us: ‘*I expected more from SLaM… SLaM really markets itself as a wonderful Trust, the name is up in ‘golden lights’ I’m really disappointed. They need to improve case management*’. There was also a sense of working in isolation for one staff member, who had worked in previous teams where there was a greater sense of collaboration and input from other teams and individuals. At this CMHT, she felt that she had to ‘work it out for herself’.

One clinician described the NHS as a ‘horrendous’ place to work as she felt that across the NHS staff are under constant pressure to do more with less resources. She discussed how she was continually balancing the need to do as much as possible with the awareness that it could easily lead to her becoming burnt out.

Some staff felt that when they did feedback how they were feeling and their challenges with coping, it was somewhat redundant: ‘*a lot of the time you say stuff and then it just doesn’t get done. Then you think, why bother? It just gets lost in everything… why bother if no one is listening. I know I shouldn’t think like that but sometimes you can’t help it… nothing ever gets followed up. Things come up and then nothing ever changes… we need to keep reminding them but that’s not my job*’. This member of staff did not feel that her views were valued and that there were issues within the team around hierarchy: ‘*we’re supposed to be a team but at times it feels so disjointed*’. This in part was because of constant changes in the service: ‘*there’s been no stability for a while. They’ve sent us backwards and forwards… [there’s been] a lot of upheaval and too many changes*’.

Staff supervision is provided to allow staff to speak in-depth about their cases and discuss any concerns or worries they have with them. However, we heard that lately supervision had not been happening as regularly as it should be due to some of the higher band staff being on sick leave. We also heard mixed feedback about supervision. Although one staff member told us it was helpful, another commented that monthly supervision was not enough to support her or others in the team fully: ‘*I think we need to have a debrief more regularly, about every week or so. People are breaking down - I think there needs to be some sort of support or help for care workers in the sector that they can go to… we are really struggling*’.

Recommendation 9

Recognising the strain described by staff in managing their work, MAP CMHT service managers should work collaboratively with staff to develop strategies to improve staff wellbeing. While this may mean lowering caseloads, it may also be necessary to increase the supervision and emotional support frontline staff have access to.

Provider response

At times the caseloads may be higher than the ideal, which may impact on staff wellbeing, and it is important as a staff team to look carefully at the caseload as a whole, and ensure that all team members, feel supported, and make use of the staff wellbeing opportunities available in the Trust. The team are responsible for the caseloads and can support one another, through joint working, medical reviews and referring to the groups in the service such as "the managing emotions group" and the mentalisation" group.

Further, looking at the caseload in the round, with all providers in the network is of key importance, such as the primary care providers, we are currently actively working with voluntary services, third sector providers and primary care services, to improve access to step down service such as the Lambeth Living Well HUB, and "Resolving Chaos", and "Look Ahead".

As stated Team Reflective Practice is well regarded as an excellent tool to ensure a robust and emotionally intelligent staff work force and this is being reinstated to support the team.

Team clinical supervision, and access to other opportunities within the Trust such as mindfulness, and staff wellbeing developments, is also fundamental. Staff receive regular supervision and appraisal, and excellent training opportunities, and other initiatives within the Trust, such as quality improvement training, a key tool to ensure a healthy and resilient staff force, and good outcomes for service users, and can access staff counselling service.

Staff training and continual professional development

We heard from staff that training was dependent on their roles but could include: an induction to the Trust, safeguarding, infection control, information governance and clinical risk. Staff had various backgrounds, such as psychology or social work. Clinical staff referred to more specialised training, for instance in CBT or Post Traumatic Stress Disorder (PTSD).

Some non-clinical staff felt they would benefit from aspects of clinical training as they also interact with clients and the public but did not feel the offer of such training was 'on the table': '*it would be good to have basic clinical understanding to help with that interaction and communication*'. One member of staff told us that with regards to training '*there's never time to do things you'd like to do*'.

Recommendation 10

Non-clinical staff who interact with service users should be offered basic mental health training (or whatever is deemed appropriate) as part of their professional development.

Provider response
Staff can access mental health awareness training co facilitated by service users from the Trust's education and training department.

Feedback and complaints

Service users' experiences of giving feedback

We asked both staff and service users about procedures around sharing feedback. One service user told us they had only been asked once to fill in a feedback form, while another told us he had been asked a few times and that he felt comfortable to provide honest feedback.

However, another service user told us that '*when they knew that [CQC] were coming around, it was then they asked me for feedback. That's the only time I think. Last time they asked me for feedback but that was when I was just leaving the service*'. She told us that she would not have known how to give feedback before that. When we asked one service user who was quite upset with the service whether she had complained directly to the CMHT, she asked '*what's the point? I don't have the energy to complain. When you've been fighting for X years, there's no point*'.

Staff comments on service user feedback

We heard that care coordinators encourage service users to feedback as much as possible. Multiple staff referred to SLaM's Patient Experience Data Intelligence Centre (PEDIC) survey which we saw advertised in the waiting room. The PEDIC feedback is collated and analysed centrally by SLaM, and results are later returned to the service. One staff member told us that service users had commented that they did not know what the PEDIC scheme was, and so staff had put explanatory posters on the wall. Staff also told us that they have a comments box which collects feedback: '*it's mostly good, i.e. that reception is helpful and friendly. We don't record it all formally, it's just shared within the building. Those comments also come through PEDIC*'.

One staff member felt that patient feedback leads to improvements, citing: '*In October, patients said they did not have a copy of their care plan. We put that right. [We are] always looking for ways to improve services*'. However, another disagreed saying: '*service user involvement is not a strength. They are not involved in deciding how services are shaped. I think it would be more useful for staff if they were involved in a more formal way. PEDIC does not generate feedback*'. We also heard from a separate staff member that although the CMHT does listen to feedback, they do not always deliver the changes that service users want: ‘*we might promise too much*’.

Recommendation 11

Alongside posters soliciting patient feedback in the waiting room, the service should communicate examples of how feedback has been acted upon to bring improvement, for example by creating a ‘you said/ we did’ board that is regularly updated.

Provider response
This is now in place in the reception area.

Other staff talked about collecting feedback directly from service users. One care coordinator told us that she generates feedback with clients every month, and another told us: ‘*In terms of service users shaping services, if care plans are delivered in the appropriate way, you’re doing it together. That’s how I do it, unless there’s a specific reason that a client can’t*’. One clinical staff member told us that service users are invited back to the service years after discharge to give feedback or present at SLaM meetings. She told us that service users are also active in the volunteering department including becoming befrienders or working in the gardens.

Staff feedback

On asking how staff would make a complaint, most replied that they would speak to the service manager. The service manager also agreed that approaching herself would be the first step for staff complaints. One staff member was unhappy as although she had recently found out that someone had made a complaint about her, she had never been approached by management about the issue face to face.

Suggestions for improvement

We asked staff and service users what improvements they would like to see made to this service. One service user told us that although she valued the support she had received, she would also have liked more input from other agencies such as housing support. Another service user told us that she would have liked to be able to bring her family into treatment with her for group therapy as her current family situation was making her distressed.

One person commented that although she sometimes had to travel with work, this was hard to plan as the treatment team did not allow for more than four weeks of absence before discharging a patient: ‘*I need more flexibility. The service is structured for people who have jobs and normal lives even though the essence of mental health services means that people don’t have normal lives*’. Finally, one service user told us that they would like to change the location of the CMHT as it was quite far from where they lived.

We also spoke to staff about what they would like to see improved. One member of staff felt that care coordinators should be given laptops to work with as they did a lot of remote working. This would help them complete paperwork between appointments and maximise their time. Another staff member suggested that there should be hot tea or coffee available for service users in the waiting room, especially as they could sometimes be kept waiting a while. Another suggestion was for an area where people could go to socialise, to help keep them occupied and curb their isolation.

Other improvements that staff wanted to see included more resources, therapists, care coordinators, group work and clinical space. One staff member suggested that she would like to see a buddying scheme for housebound patients set up using ex-service users as befrienders. Another felt that it would be better if the CMHT was open over evenings and weekends, or had a crisis number so that patients could contact them whenever they were in crisis: '*happiness, joy and support is quite difficult to get at A&E or other treatment teams. It gives people a backbone to lean on… extra hours would really make things better for the clients*'.

Nonetheless, most staff we spoke to said they would recommend the service to their friends and family. Comments included; '*yes… the way they engage with people is brilliant. They offer lots of therapies which help people cope with life*'; '*they get a good service… it's generally really positive*'; '*a lot of the team are brilliant. They do a lot for people, they really try… hopefully those people will stay this time*'. One person did note that the waiting lists would be a deterrent to recommending the service to people.

Using other local services

Service user involvement with other services

We heard from a few service users who had used the Living Well Network Hub in the past, with mixed feedback. One woman told us '*when I went [to the Hub] it was the first place where I actually felt someone had taken the time to read my notes*'. Another service user agreed that her experiences at the Hub had been very positive, and that they had helped her to get what she felt was her first appropriate diagnosis.

However, someone else talked about their distressing experiences of using the Hub, describing it as '*horrible, because of where it is. You go in and all the G4S staff are there. They say that they're person centred but they really aren't. Some people who work there are lovely but I also had a really bad experience. I got kicked out which was awful. It's very hard to trust a service again once they have let you down.*' She similarly described negative experiences of being an inpatient at Lambeth Hospital which she felt was the result of the staff being so overworked that they have no empathy left: '*the way they talk to you and treat you is awful*'.

One service user described her experiences on an Orthopaedic Ward as highly distressing. She had asked her doctor for psychological support but had been refused it which she felt was primarily because of her diagnosis: '*I had a security guard standing over me because they thought I was a risk. PTSD is stopping me getting any of the help I need. I don't have any control over my life anymore… I'd like some euthanasia pills. I just don't want to be here anymore, I've had enough*'.

Another service user did not feel that she had benefitted from being with the perinatal mental health teams as the only treatment they had provided was someone for her to talk to. Her situation had therefore become much worse.

We spoke to one service user who had just signed up to a peer mentor scheme, where she would see someone for two hours a week and was also doing a recovery course at SLaM. She had taken these steps as she was due to leave the MAP CMHT in a month and so was *'trying to build up other things around me that will continue to support me'*. Another service user currently paid for a highly valued carer to visit her home once a week: '*I can talk to her about anything, it is ideal*'. However, she was worried that she would not be able to afford this person for much longer.

We also heard that referrals from the GP to exercise schemes had been highly valued by one service user, but had been cut. '*I can't stress enough how helpful that was… people had different things there, physical problems as well, they didn't know I was depressed. It made me feel good, it spread endorphins and it gets you out and connected… the NHS really need to look at that, they shouldn't have cut those services.*' This service user felt that the NHS more widely was 'crumbling' despite the efforts of '*good people who work really hard*'. Another service user commented that the support they got from their GP was not enough: '*they absolve themselves of responsibility by saying they don't know anything about it, even though it's actually a huge proportion of what they are dealing with*'.

We heard from one service user that she was simultaneously seeing a local therapist. Another told us that she also visited Mosaic Clubhouse and SHARP: '*Mosaic Clubhouse is lovely, I can have a tea there, see my friends, have a little chit chat*'. She had been referred to these services by her care coordinator at the CMHT, and her housing support worker had gone with her the first couple of times to ensure she was confident and comfortable. One service user appreciated that her care coordinator referred her onto other useful services such as a careers support service.

Staff feedback on local services

We were told by staff that the aim with DBT was to support clients to reach a place where they do not need to use other mental health services, especially after long-term engagement with treatment. Indeed, one service user told us that although she had previously used other local support services, she did not feel she needed to anymore as she was coming to the CMHT weekly. However, alongside the additional schemes mentioned by service users above, staff also listed a range of other programmes accessed by their clients. In addition, the CMHT itself runs a DBT graduate support group which aims to support people getting into employment and training once they have finished active therapy.

One staff member told us that Look Ahead (a service providing psychological support in hostels) were '*brilliant*'; she felt that they provided a highly valuable service and that clients often reported positive experiences with them. She also reported good relationships with local police, social care services, Lorraine Hewitt House, safeguarding teams and Mosaic Clubhouse. Another staff member talked about the good relationships the CMHT has with the Home Treatment Team based in Lambeth Hospital, who provide clients with crisis management support when they are admitted into hospital.

However, staff also spoke frequently about the lack of local services available for their service users: '*a lot of people who come here are just lonely, there aren't any services for people... there used to be but a lot of them have closed down now. Usually we refer them to places like Mosaic Clubhouse, CoolTan Arts, the Dragon Café, but those places are really only open 9 to 5.*' Another staff member told us that there were particular problems presented by the lack of support for families and young people: '*family relationships are getting worse… I have at least 5 [cases] of 17/18 year olds… They have real issues with housing which affects their mental health. Basically, the way it is at the moment, if you are under 35 you have no chance of getting a place. Young people just aren't a priority*'.

Staff told us about several other specific barriers around housing: '*it can be difficult… staff try and help to find housing if patients are getting kicked out of their homes. It's quite an emotional place*'. Another told us: '*you need to support them to live with themselves the way they are. Some clients have high expectations which can't be met. They think we can help them with anything, like housing problems. They want you to be with them and go to meetings.*' He went on to describe how being in the service was seen by clients as a 'golden ticket' to accessing support, and how difficult it was for staff to juggle the needs of the clients versus their actual role: '*if you're firm with them, it could be interpreted as bad, so you see a* *blurred line of what treatment is and their other needs. I think that can be confusing for clients'*.

The impact of patients' benefits cuts was also discussed, as were the difficult social environments people were living in. One clinician commented '*there is such a lot of violence and therefore a lot of trauma. Horrific trauma in some people's lives… so people come about one specific incident and you discover that all of their life has been horrific'*. She described Lambeth as a borough with high levels of poverty, mental health difficulties, gang violence and child abuse.

The limitations with other services led to staff and service users feeling disempowered and disheartened: *'a lot of the times it's social… we do try our best. Sometimes the patients feel that we're not listening, we're not doing enough; but it's out of our hands a lot of the time. They get aggravated because they want things straight away and even when we refer, it still takes time.'*

Conclusion

During our visit to the MAP CMHT, we heard that the clinical and emotional support offered by the team was predominantly highly valued and respected by service users, who for the most part had good relationships with staff. The building itself was warm and welcoming, and staff came across as caring and sincere. Service users appreciated the long-term nature of the support as well as the individualised support plans and emotional support offered by staff. Staff themselves were committed to helping people and spoke highly of their relationships with service users.

The majority of the concerns that service users and staff spoke to us about seemed to stem from the service's lack of capacity and resource. With staff shortages and high caseloads, staff were under intense pressure to support highly complex needs. The implications of this were clear to service users and staff, and were significant. With staff questioning the safety of current practice, this needs to be addressed. We have suggested recommendations for the service itself, but SLaM NHS Foundation Trust and the NHS Lambeth Clinical Commissioning Group also have a responsibility to investigate wider issues such as referral pathways, staff wellbeing and the stretched capacity and resource of the team.

Recommendations

For ease of reference the recommendations appearing in the body of the report are repeated below:

Recommendation 1

Communication between care coordinators and service users ought to be consistent and reliable. This is especially important when clients are in crisis. See recommendation 5 for further actions.

Recommendation 2

Clinicians ought to consistently design care crisis plans in partnership with service users, taking into account individual circumstances. Hard copies need to be shared promptly with service users in order to be a useful source of support.

Recommendation 3

Service user inductions to the MAP CHMT and/or care plans should explain their right to access a duty care coordinator when an assigned coordinator is not available. This should be recapped with service users as and when they are told about staff sickness/ absence.

Recommendation 4

With respect to young people transitioning from child and adolescent mental health services (CAMHS) to adult services, CMHT staff should ensure that expectations of support by the service are discussed and plans to address any differences in expectations are incorporated into the development of an individual’s care plans.

Recommendation 5

Noting that staff turnover and non-response has disruptive effects on care provision, all service users should be given an alternative contact number to raise concerns about their care (i.e. such as requiring a medication review).

Recommendation 6

Management teams within the MAP CHMT should review existing mechanisms to improve how information about staff absence is shared with members of the team who interface with service users, to ensure the communication of accurate and timely information.

Recommendation 7

Where structural changes to the service are identified as having an impact on service user care and treatment and/or referral processes, SLaM must plan communication strategies in an effective and equitable way. This may involve consulting a small sample of target stakeholders to identify the most appropriate ways of sharing information on the intended changes.

Recommendation 8

SLaM and MAP CMHT service managers should review how referrals into the service are accepted and managed to ensure that frontline staff are assigned appropriate clients

Recommendations

given their skills and capacity. The feedback we have collated suggests that eligibility criteria, treatment duration and relationships with other SLAM teams should be looked at. Importantly, the review process should ensure that the views and suggestions of staff are heard and responded to.

Recommendation 9

Recognising the strain described by staff in managing their work, MAP CMHT service managers should work collaboratively with staff to develop strategies to improve staff wellbeing. While this may mean lowering caseloads, it may also be necessary to increase the supervision and emotional support frontline staff have access to.

Recommendation 10

Non-clinical staff who interact with service users should be offered basic mental health training (or whatever is deemed appropriate) as part of their professional development.

Recommendation 11

Alongside posters soliciting patient feedback in the waiting room, the service should communicate examples of how feedback has been acted upon to bring improvement, for example by creating a ‘you said/ we did’ board that is regularly updated.

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