Views and experiences of patients and carers – services provided by South London and the Maudsley NHS Foundation Trust (SLaM)

Healthwatch Lambeth, Lewisham and Southwark contributed to the Care Quality Commission (CQC) inspector information pack prior to their inspection of South London and Maudsley (SLaM) NHS Trust in the week beginning 21st September 2015. This document summarises the contribution, which was based on quality issues raised by patients and families relating to SLaM services between August 2014 and August 2015.

Inpatient services

Positive experiences

- **Staff behaviour and involvement of carers:** Positive professional behaviours (at Ladywell Unit and some Maudsley units) included empathy, appropriate introductions and ability to behave calmly and in a controlled, measured way. This made people feel confident in the care provided and helped families to be involved.
- **The activity room** at the Maudsley was praised as helping to relieve pressure and giving patients and relatives somewhere a means to engage.

Room for improvement

- **Staff behaviour:** Some negative experiences of staff being unresponsive and dismissive towards patients. Comments were also made about staff communicating amongst themselves, in a language not understood by patients.
- **Staff communication:** Two cases of poor communication about clinical care were reported, leading to patients feeling unable to ask questions or refusing to take medications. One relative felt that there was little information around transfer between services.
- A couple of experiences related to the **lack of introductions** by health workers.
- **Environment and access to the outdoors:** There were comments about cleanliness/rubbish in outdoor space. One person said they once spent 3 days inside and that he did not get enough physical activity.
- **Safety:** Two visitors were concerned at limited staff presence on the wards, with one feeling unsafe as a result. A former inpatient also said she had been frightened on the ward and had been attacked many times by other patients.

Community and outpatient services

Positive experiences

- Generally **clinical care** experienced by patients was very well perceived, with praise for psychotherapists, psychologists, clinical care at King's A&E, and support at Community Mental Health.

- Many people highlighted the exceptional **role of individual staff**, such as psychiatrists. Traits included honesty, compassion, confidence, and making the patient comfortable.

Room for improvement

- **Waiting times for treatment:** Developmental interventions (e.g. mindfulness) could take a long time to access and waiting times were seen to depend on the attitude and contacts of a patient's GP. Long waiting times following referrals to the CMHTs, both before and after the pre-assessment.
- **Support from GPs:** Opinions were mixed about the support provided during the wait by GPs. Some patients felt that by the time the CMHT responded to a referral it was too late.
- **Those waiting for assessment by CMHT cannot go on the waiting list for IAPT**, meaning that if their referral to CMHT is rejected, they then have to enter another waiting period for IAPT.
- Two patients reported delays and difficulties in **communication with the CMHT** (such as a referral getting 'lost'), resulting in them eventually being discharged without treatment.
- **Refused/inadequate treatment:** Two patients reported being refused care under CMHT – because treatment was unlikely to be successful and resources were limited, and because they were not sick enough. Healthwatch received calls from individuals who felt they were not getting the support they needed via CMHT – in some cases these people expressed that they had dangerously poor mental health.
- **Support around discharge:** One relative felt that a patient had twice been discharged abruptly with no follow-up call or care. Another patient was unsure he was ready to be discharged and concerned about the lack of clarity on how he would be supported after discharge.
- **Relationships with individual professionals:** While most patients cite positive relationships with therapists, not all find it easy to engage with the professional to whom they are assigned and this can make treatment less effective.
- **A&E:** Common across the experiences were the long wait at A&E to be seen and/or admitted. There were negative comments about the location of the psychiatric intervention unit at King's, with some finding it difficult and disorientating to enter and wait alongside patients without mental health issues. One family found it upsetting that police vans were used to transport a patient to A&E when ambulances were occupied.
- **Fragmented care:** There is fragmentation of service across the four boroughs where SLaM operates, particularly in accessing crisis services. Presenting at different A&E units, triage and inpatient wards can require repeated pre-assessments. It can be unclear who to contact due to the many teams working with individual patients.
- **Transitions between child and adult services** was consistently raised as an issue. There were changes for patients and families to get used to, particularly staff changes where relationships, trust and understanding had been built, alongside communication channels. Relatives highlighted a lack of robust handovers. Patients and families became less confident in the care that the patient was receiving as an adult patient.

Suggestions from patients and relatives about how SLaM can be improved

- **Better information:** including written information provided to the patient after A&E presentations, updates on the progress of referrals, and team photos of those involved in a patient's care.

- **Professional continuity**, and **patient choice of professional/therapist** where possible, can improve recovery.
- **Service integration**: including communication between frontline teams, good oversight, and shared access to patient records across local mental health services. Patients do not want to have to repeat information or wait for repeated assessments.
- **Closer access** to acute hospitals and **easier emergency access** to community psychiatry.
- **A gradual decrease in** support before CMHT discharge.
- **Discharge, crisis support and risk:**
  - Clear discharge plans for all CMHT patients, and patients with a diagnosed condition.
  - Crisis plans and contacts to be circulated to family to help avoid A&E if possible.
  - Need for more monitoring/oversight of 'at risk patients', particularly those without family members who are able to do this. GPs should have a risk register.
- **A&E:**
  - A&E receptionists need to ensure patients understand what will happen and when.
  - Light refreshments of food or water as patients may arrive at A&E having not taken care of themselves physically.
  - A separate space away from acute trauma patients, particularly as mental health patients may be more confused than usual.
  - Suggestion of an advocate (volunteer or staff) who can sit with the patient, talk or just provide companionship and support.

See also:

- Enter and View report to CAMHS, Snowfield Unit, Maudsley Hospital (March 2015).
- Enter and View report to AL1, Maudsley Hospital (April 2014)
- Joint HW Lambeth, Lewisham and Southwark response to SLaM's quality accounts (2014-2015) –
- Ladywell Unit Enter and View Report (April 2014)
- Lewisham Enter and View to Ladywell Unit - response from SLAM