



Richmond Early Intervention Service

The Maddison Centre, 140 Church Road, Teddington,
TW11 8QL

Project Report, January 2018

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Introduction

Mental health remains an area of priority for Healthwatch Richmond going into 2018/19. It is evident from our work with patient groups and looking at emerging trends in our patient experience database that people are experiencing difficulties with accessing care and in some cases experience poor quality of care in community mental health services. Given the NHS continual pledge to move service provision away from inpatient settings and allocate more resources to care in the community, there is a growing and present need to cast a spotlight over these services and ascertain if they are meeting local residents' needs. The Early Intervention Service is the first community team we visited in 2018. This will be followed by visits to the Richmond Wellbeing Service, Recovery and Support Team and Home Treatment Team later in the year.

About the Early Intervention Service

Nationally, Early Intervention for Psychosis services provide care for people who are experiencing their first episode of psychosis. According to NHS England, psychosis is a mental health problem which can be defined by symptoms such as hallucinations, delusions, disorganised thinking and speech or lack of insight and self-awareness. Each particular set of symptoms will be unique to the individual and their circumstances but overall is characterised by individuals feeling disconnected from or interpreting reality differently to others. Early intervention is seen as key to improving patient outcomes and in preventing psychosis from becoming a long term and enduring mental health problem. In 2016, NHS England introduced access and waiting standards to ensure people experiencing their first episode of psychosis receive NICE-approved psychological and pharmacological interventions within two weeks of referral.

The Richmond & Kingston Early Intervention Service (EIS) treats people aged 18-65 for a period of up to 2 years. The treatment window was originally 3 years when the service was commissioned for adults 18-35 but was reduced to help manage the increase in caseload brought on by the increased number of referrals due to the wider age range that it now supports. Clinicians are however able to be flexible around the length of treatment for patients who were accepted during the original 3 year commissioning terms of service. The EIS model of care includes the provision of cognitive behaviour therapy (CBT) for Psychosis to patients and deliver family interventions using a CBT approach to support carers to manage their own wellbeing and help play an important role in the patient's recovery. Treatment is delivered by a Multi Disciplinary Team, including Psychiatrist's, Occupational Therapists, Psychologists and Nursing Practitioners some of whom who are formally trained in CBT interventions.

In the main, referrals to the EIS are made through Kingston & Richmond Assessment Team whose role is to screen, triage and carry out initial assessments

and acts as a Single Point of Access for all secondary mental health services in Richmond or Kingston. Direct referrals are also accepted from other EIS services, inpatient wards and Psychiatric Liaison services. Accepted referrals to EIS should be seen, assessed and allocated a named Care Coordinator within 14 days from the date the referral was received. This key target is overseen by the Trust so that the service is accessible and that it remains in accordance with NICE guidelines and NHS quality standards. Currently, there are approximately 75 Richmond residents that are on the EIS active caseload. The main clinic for the EIS is located at the Maddison Centre in Teddington. The Trust also operate satellite clinics at Tolworth and Queen Mary's to facilitate access to treatment for residents who find the Maddison Centre too far to travel.

Aims of the Project

1. Gather the current views and experiences of staff, patients and their carers of the Richmond & Kingston Early Intervention Service
2. Conduct an observational audit to assess the level of signposting at the Maddison centre to local support groups, community events and whether the waiting area is fit for purpose
3. To gain a snapshot of staff awareness around local commissioning changes to mental health services in Richmond

Method

There was a preliminary meeting between Healthwatch Richmond and the service manager of the EIS in November 2017 to discuss the project objectives and how they could best be achieved. In view of the relatively low footfall to the Maddison Centre where there may only be 1 or 2 EIS patients presenting per hour, the decision was taken to collect patient feedback through phone interviews. The EIS agreed to ask a random selection of 20 Richmond patients for their consent to participate. To safeguard patient's confidentiality, Healthwatch Richmond was only provided with the patient's first name and a contact phone number.

Face to face interviews with staff were conducted on Monday, 22nd January. This was arranged to coincide with the team meeting so as to maximise the opportunity to collect staff experiences as most staff should be on site and available.

To reach carers, Healthwatch Richmond met with Richmond Mind to discuss the scope of the project and how to work together to distribute the questionnaires to carers. It was agreed that Richmond Mind would send the questionnaire electronically to carers on their mailing list and carers could either respond to Healthwatch directly through email or over the phone with their feedback. Healthwatch Richmond received feedback from 3 carers.

Limitations

This research project was not designed nor does it claim to provide a representative view of the staff, patients and carers with the Richmond & Kingston Early Intervention Service. The sample size of 11 patient interviews represents approximately 15% of the Richmond caseload and as the sampling was carried out by the provider we cannot guarantee that the selection of the sample was entirely free from bias. We were not able to reach the 9 other patients put forward for this survey.

Some of the questions in the patient interview audit pertained to a time when the patient was actively experiencing psychosis symptoms or events which happened a long time ago. Consequently, they may not be able to recall their experience entirely accurately.

Qualitative analysis was solely used in this report which allowed us to identify key themes. However, qualitative analysis is not able to provide an accurate sense of scale to issues raised as the data cannot be robustly quantified.

Analysis

The qualitative data analysis was conducted using an approach based on the following:

- Individual interviews with staff, patients and carers were reviewed and answers were categorised into themes
- Preparing a descriptive summary of the themes including assigning an overall tone to comments (i.e positive, neutral, negative or no data)

The following themes that have emerged have been grouped according to audit questions and some have been narrowed into sub-themes.

Findings

Referral process into EIS

With the exception of one patient, where it took over a month for their initial assessment; most patients told us they were seen very quickly by the EIS team. Some patients recalled their referral being fast tracked which was a great relief for them and their families given the severity of their symptoms. While patients could not pinpoint the exact number of weeks, none of the patients felt like it was a long wait for their first assessment or for being allocated a care coordinator.

The welcoming attitude by staff and smooth transition from primary care were also highlighted as making a significant positive contribution to the referral process. One patient said:

"I remember being seen very quickly. I felt welcome from my first interaction with the team. All my concerns were instantly put at ease"

The referral process and handover from the assessment team were described as "seamless" by staff. Being co-located in the Maddison Centre makes it easy to organise joint assessments for borderline or complex cases and helps keep close adherence to the 2 week waiting time standard for initial assessment.

Package of Care

CBT

CBT for Psychosis is part of the standard package of care offered to patients in line with NICE guidelines. In addition to a full-time psychologist, the EIS also share a psychologist with the Recovery and Support Team and are allocated 2 days a week to help cover psychological interventions. The current waiting list for CBT is approximately 4 months. The list is triaged so urgent cases can be brought forward. Two care coordinators are currently undertaking training in CBT for Psychosis. This opportunity is open to all staff with a nursing or social work qualification and it is hoped by the team will help create a more sustainable capacity to provide timely access to therapies.

The patients we spoke to who had started CBT said they were pleased with the effects it had had on their general functioning and coping skills in day to day life. A large part of this was attributed to the practical strategies therapy had provided. One patient said:

"Without CBT progress with personal life and adapting to my illness would have been far slower. It has given me a practical approach to improve my wellbeing. Being given actual tasks in the real world to strive towards has been very helpful".

For some patients it had taken time for the principles taught in CBT to manifest in their personal life or be introduced in therapy which could be a frustrating experience. One patient had found talking about their experiences quite repetitive and reasoned it could have been done as easily over the phone. Overall, most patients felt the therapy had been taught in ways that were easy to understand and had enabled them to navigate social situations which they previously found difficult.

Feelings of anxiety also emerged as a dominant area of concern for some patients. Anxiety and low mood are common co-morbid symptoms with first episode psychosis. Therefore, it was encouraging to hear that staff were responsive to this and can tailor therapy to address these concerns. One patient said the graded exposure to anxiety-provoking situations had made "a real difference" to their

work and personal life and had particularly lessened the physical symptoms they associated with their anxiety.

Occupational Therapy

Care coordinators can also refer patients to the Occupational Therapist (OT) if patients are struggling with daily living skills or for specialist help in finding activities that are meaningful to the patient. The EIS has a full time locum OT who helps patients improve their daily functioning through graded exposure work and education on skills such as budgeting and healthy eating. Patients told us they found their interactions with OT to be very helpful. Patients felt the OT was approachable. The sessions had particularly improved their organisational skills and ability to identify future goals and ways to work towards these.

Family Intervention

Family intervention work forms another core part of the EIS care package. Staff told us that patients and their families are interviewed together to help get a sense of family dynamics and how these can be managed to support the patient's recovery. Families are also talked through challenging scenarios commonly seen in psychosis and given tools to support the patient in areas such as self-harm or coping with potential side-effects from medication.

Family intervention was highlighted by staff as being central in the EIS approach to patient recovery. This therapeutic approach was largely reflected in patient experience. Several patients said that raised awareness in their family had enabled family members to help spot relapse signs and provide therapeutic back up outside of appointment times.

Care Plan

Responses from patients were mixed when talking about the role of care plans in their treatment. Care plans should be used to identify recovery goals and skills the patient wants to achieve in therapy and are formulated through discussions between the care coordinator, the patient and their family. Physical health and mental health care plans are mandatory. Staff can also create a crisis care plan. Some patients felt they were reasonably involved in their care plan formulation and said it played a central part in sessions at the beginning of treatment when they were being seen once or twice a week. However, this seems to decline as treatment progresses and one patient commented they would like to re-visit their care plan more regularly as they are unsure of what the next steps are. Other patients we spoke to could not recall setting up a care plan or were not familiar with the concept.

The content and the way care plans are set out were criticised by staff. One care coordinator said the forms are overloaded with text and encourages the use of jargon. There is a general feeling of the Trust needing to "tick all the boxes" rather than highlighting the patient's main needs. Consequently, in communication with GPs, other professionals and patients, staff choose to use the doctor's

correspondence which includes a summary of the care plan and is in a format which is much easier to read.

Patient Perceptions of Therapy

Most patients were aware of the range of interventions available to them and felt they could easily access these. One patient told us however, that they had not been able to access CBT within the EIS and had been told this was only available with the Recovery College or the Wellbeing Service. This resulted in them feeling that the EIS was only geared towards managing psychosis through medication. Another patient said they were not having CBT and care was limited to weekly chats with their care coordinator.

We also asked patients how well the service meets their needs and if there were other service provisions that could have improved their experience. Most were universally positive about the treatment package that was open to them and could not suggest any improvements. One patient described the EIS as a “near perfect experience”. One patient who was on the waiting list for CBT said, “knowing there is support from a dedicated professional has been nice and therapeutic in itself”. One patient suggested that grief counselling would have made a useful addition to complement their CBT. Patients who had been able to attend group therapy sessions also reported these to be constructive as they provided help and support in different areas such as healthy living that were not necessarily covered in individual CBT.

Medication

Overall, patients were content with the EIS approach to medication. One patient commented that doctors had been helpful and “keen” in finding the right medication and dosage to suit them. Another patient described staff as “proactive” in suggesting alternatives when their initial medication caused too many side effects. One patient highlighted the contrast in approach by doctors in the EIS to doctors in their previous hospital stay who were not responsive to the patient’s concerns that the prescribed dosage was causing auditory hallucinations, whereas EIS staff trialled a different dose the first time the patient raised it with them.

One patient felt that staff attitudes came across as quite medicalised when they were first referred. The patient emphasised they did not feel forced to take the medication and that it remained their decision. However, they were made to feel like they were going against the doctors’ advice by not accepting the recommended medication.

Patients also felt supported through regular medication reviews and said the education provided around potential side effects was sufficient to meet their needs. Most patients got their prescriptions through their GP. One patient thought it would be a useful provision if they could access prescriptions through the EIS as this would be more convenient than going to their GP.

Staff told us that all medication is reviewed by the team's psychiatrist. Staff are mindful about the use of the medication and try to encourage it being used as a short term measure to bring symptoms under control so the patient is at a level of functioning to be able to engage in therapy.

Access to a Psychiatrist

The EIS has funding for a psychiatrist 5 days a week. Currently, there is no waiting list and the psychiatrist is available for appointments at the patient's home where there is clinical need. However, overall accessibility could not be clearly drawn out from patients and carers feedback. One carer said the psychiatrist came for a home visit once which was useful but access to a psychiatrist on a more regular basis would have been helpful to their daughter's recovery. One patient was also under the impression that there was a waiting list and had not yet been put forward. Other patients were not able to identify whether they had seen the psychiatrist or one of the junior doctors. Patients who were clear they had met the psychiatrist said they had found her friendly and easy to talk to.

Physical Health Needs

When we asked patients about the level of support or monitoring EIS provides around their physical health, most patients felt assured their needs were being met. All patients were able to confirm they had received BMI checks during their initial assessment and had regular blood tests to check for effects from antipsychotic medication. To encourage healthy living, several patients had been able to benefit from free gym membership, although one patient was unsure if this provision was still available. Of slight concern to us, two patients reported previous test results being lost which may highlight a need for a more robust storage procedure.

Staff are mindful that their particular cohort of patients may have additional physical health needs. In view of this, the EIS has additional targets for cholesterol and lipid checks and cardio metabolic assessments. Currently, patients can go to their GP for physical health checks although this can present difficulties for some patients and can impact on meeting these targets. Therefore, it was encouraging to hear that staff are setting up a physical health clinic at the Maddison Centre to streamline this process. Staff believe having everything centrally located will improve accessibility for patients who may prefer to maintain regular health checks with the EIS. Staff remain mindful that it is important to maintain connections between the EIS and the patients' GP when it comes to communication around the patients' physical health care needs.

Crisis Care

For out of hours' care, patients can access a Trust run crisis phone line which offers emotional support and advice to patients and their carers. Almost all patients were aware of the Trust's crisis line but had not used it. One patient who had used the crisis line could not recall whether it was a positive or negative

experience. Another patient said they had not found it beneficial but this may partly be because they do not feel comfortable talking over the phone. Beyond the crisis line, one patient described mental health services as feeling “full” with not enough resources or facilities to help people all the time and felt they “had to be at the point of dying” to receive help. This patient was aware of the crisis line but had not used it as they thought it sounded similar in function to The Samaritans helpline which they had not found helpful in the past.

Other patients were quite vague on how they would support themselves outside of therapy. Some patients said they would access support through friends and family. One patient had utilised their CBT skills to teach their friends on how to spot relapse warning signs.

In addition to the crisis line, one patient was signposted to group therapy sessions to help manage anxiety symptoms which can make them vulnerable to crisis. Two patients also highlighted the provision of being able to text their therapist and ask for an earlier appointment which they found very reassuring and to that end preventative as well.

Integration of social issues

Alongside psychological and pharmacological interventions, NICE guidelines recommend patients are supported with social issues such as education, employment, housing and finances. Levels of staff support in social issues varied between patients. Several patients had accessed an employment specialist through the EIS. Other patients remembered their care coordinator arranging specialist help for benefits or financial advice but not assessing other areas. Other patients stated they had not received any signposting advice but would feel comfortable in asking their care coordinator.

Staff generally felt there was a lack of community resources in Richmond, particularly in relation to vocational or volunteering opportunities that would improve patients’ social skills or confidence. Richmond Adult Community College has been a useful asset but locally there is little else in this domain. Richmond Mind run various peer network groups where Richmond residents can self-refer. However, this is not commonly well known amongst other colleagues or patients and staff thought the collective advertising of this could be improved. Staff also agreed the addition of a support worker who could link to community assets would be an invaluable role to the team. Unfortunately, current roles in the team do not allow enough time to signpost to other organisations in any depth or that is particularly tailored to the patient’s personal interests.

Care coordinators do refer patients to the Recovery College at Springfield Hospital for group workshops which teach strategies in self-care and management of specific symptoms such as hearing voices. Patients told us that these courses have been useful but their experience could have been made better by having local workshops and being able to mix and learn with other people experiencing first

episode psychosis. Therefore, it was encouraging to hear that EIS staff are currently working with the Recovery College on bespoke programmes in early intervention.

Communication

Patients described the staff at EIS as “very dedicated”, “likeable” and good at communicating in and out of sessions. Patients showed particular appreciation for the listening skills and approachability of EIS staff. One patient said:

“All staff that I have met there have been very attentive. My care coordinator is really receptive to my needs and concerns and always feels approachable”

When patients were asked about what improvements could be made to communication, two patients suggested a better coordinated phone system as they or a family member had previously been put on hold for prolonged periods on several occasions. Another patient wanted more focussed advice on how to stay stable between therapy sessions now that there is an increasing gap between their appointments as they continue to make progress in their recovery.

Family Support

Staff explained that part of the EIS ethos is to encourage openness and transparency amongst patients and their families. This way of working ensures the team get a full picture of the family dynamics and find the best methods to support the patient in the recovery.

Carers praised EIS staff for their approach to patient care and the family support they provide. One carer said they had always felt very involved in decisions. Another carer commented that EIS staff were providing all the care possible that was reasonably within their remit and funding available and said, “they are following the rules and the work ethics as much as their time permits”. One patient also said their sister attends some sessions with them and found their therapist to be equally open and transparent as when they have attended sessions independently.

When carers feedback regarding communication was reflected back to the EIS, staff explained that there are ways to adhere to patient confidentiality and also be sensitive to carers’ concerns. Staff use a pragmatic approach and consider patient and carers’ needs on a case by case basis.

Staff Support

Staff were in widespread agreement that the EIS feels like a cohesive team with good morale. There is a good communications system in place through three multidisciplinary meetings a week where staff can share their concerns and collaborate on complex cases. The consultant psychiatrist also operates an open door policy to optimise accessibility and staff feel their queries can be answered easily. A reflective practice workshop takes place every 4-6 weeks, where

professionals from different services attend to offer “a fresh perspective” for the team.

Staff also talked about everyone “owning their roles and responsibilities” which means there is little room for misunderstandings. Changes made to their way of working are not driven by teams higher up within in the Trust, staff will instead address any changes together. Staff highlighted informal chats with colleagues and their manager as a daily source of support. All staff had formal monthly supervision and reported no issues with the occurrence of these. The EIS team manager was universally described as approachable and accessible by staff.

Staff Training & Development

Staff told us they felt there were good opportunities for professional development at the EIS. One care coordinator had completed additional family therapy work last year. The team manager was described as responsive to training needs and will email staff with additional training modules which may be of interest to them.

Most training is done online through the Trust’s portal, Compass. Some locum staff were still waiting for access to this at the time of our interview. Mandatory face to face training takes place at Springfield Hospital.

Challenges in EIS

Maintaining caseloads which are manageable for clinicians whilst maintaining timely access to interventions was highlighted as the single biggest challenge for the team. Partly underpinning this, is the difficulty in recruiting and retaining permanent staff. Stretched funding and the resultant pressure on other services has also led to an increase in complex referrals. For people with underlying diagnoses of emotionally unstable personality disorder, ADHD or autism, staff have seen cases where referrers have superimposed symptoms of psychosis on to these conditions to try and make them a fit for EIS so these patients have a treatment option.

Reduced window for Interventions

It has also been problematic for the team to adapt to a reduced treatment window of 2 years after a long exposure of being geared towards a 3-year treatment period. Care coordinators said this has resulted in “a real push” in some cases to meet all of the NICE guidelines. For example, for a patient with severe psychosis it may take 6-8 months to build up a rapport, so they are receptive to suggestions of therapy and have the capacity to engage and learn the principles taught in CBT. Psychological intervention can then be further delayed if there is a waiting list for CBT. Some carers in Richmond have also been quite vocal over the reduction to the length of treatment and have said they will take this to judicial review. Staff have so far been able to be flexible around patients who were accepted during the original 3 year commissioning period and have not discharged anyone before they are clinically ready.

Managing Caseloads

Anecdotally, there has been an increase in referrals by approximately 30% since the change in commissioning 6 months ago where the service is now open to referrals for 18-64 year olds. Previously, the service was commissioned to treat those aged 17-35. Increased referral activity has impacted caseloads with most staff experiencing a rise to their number of allocated patients.

Currently, EIS care coordinators are holding 23-24 patients on their list which is markedly higher than the limit of 18 patients that National Commissioning guidelines recommend for a population size of Richmond and Kingston (420,000 residents). Staff caseloads were even higher in the summer of 2017 when 2-3 vacancies were not filled.

Recruitment

Finding permanent staff has been difficult for posts based in Richmond. The Inner London allowance is not included in staff wages which historically has been a deterrent. Lack of affordable accommodation in the locality has also made recruitment and retention of staff challenging. However, high quality locum staff including psychologists have always been easy to obtain. Staff said there is a possible Trust-wide recruitment issue as nationally, early intervention services are viewed as an attractive service model for professionals to work in. In the past adverts have been generalised and not specified what team the post is under, which has been known to reduce the number of applicants. The EIS manager said that the Trust has largely been responsive to the need to manage capacity and will continue to fund locum staff until the next recruitment drive is successful. New vacancies are expected within the team as 2 or 3 staff are leaving in the next 3 months.

Staff turnover had affected some patients we spoke to with some having 2 to 3 different care coordinators in the last 3 years. One patient was concerned about future staff changes and said, "the care coordinator is always your first port of call and therefore it is important to have consistency of care". However, patients did emphasise that transitions have been managed well and usually their appointments are with the same care coordinator.

Administrative Systems

The Trust has recently reduced the administrative support available to clinicians and now operates a pool system where administrators support several different teams. Administrators are no longer able to minute team meetings and their support is limited to transcribing psychiatric reports and sending appointment letters. Therefore, non-clinical tasks have become more time-consuming for staff and has contributed to a sense of having less patient-centred time. Patient documentation that was viewed as excessive included care plans, external referrals and social care applications.

Discharge Planning

Two patients told us their discharge was discussed with them and they were satisfied with the plan. However, most patients had not been informed of what options were available to them after discharge. Staff acknowledged that communication around discharge planning could be done earlier as there is high potential for this to be a pressure point for patients and carers. For patients who are discharged before their 2-year allocation of treatment, there is a fast track referral pathway in place for the 3 months after discharge which staff believe acts as an effective safety net. For patients who have completed their 2 years of treatment and require further intervention, staff will make a referral to the CMHT. In Richmond, this is the Recovery & Support Team (RST) who can provide longer term support. Currently there is a 50/50 split in discharge where patients either move into primary care or are transferred to the RST.

Bottlenecks in primary care have affected some patient discharges. Notably, there are no Trust targets for discharge from secondary care services back into primary care whereas other Trusts such as Central North West London NHS Foundation Trust (CNWL) do maintain targets to help monitor bottlenecks in the system. Staff felt that more confidence needs to be created so GPs feel they can manage patients independently in primary care.

Bottlenecks can also occur with local community mental health teams (CMHT) where patient referrals have been delayed due to a lack of capacity within a CMHT to take on new patients.

GPs and Mental Health

There was little consistency across patient experiences of GPs and their understanding of mental health needs with most feedback having a negative overtone. One patient said their GP has been “reasonably understanding” of their mental health and has provided sick notes when the patient has needed them. Several patients felt their GP was limited by their skill or capacity to oversee their recovery. Consequently, patients were unsure whether they could manage their symptoms in an isolated primary care setting.

However, another patient’s experience was more positive and said they did feel listened to by their GP and felt confident in their GP’s knowledge of their mental health needs.

All staff reported variable engagement from GPs. Staff frequently found GPs hard to access over the phone and had to resort to written communication which can significantly delay the feedback process. There is little administrative support to help staff in these tasks which further compounds the situation. For some patients, staff can access their Summary of Care Records, which is an electronic summary of key clinical information (including current medication, known allergies) sourced from GP records which has been a constructive and useful development.

Some GPs' decision making around mental health was described as "frustrating" by staff. These GPs tend to panic over certain psychiatric symptoms leading to an unnecessary escalation. From a staff perspective, this highlights a need for more education around mental health in primary care or improved communication protocols with mental health teams.

In terms of patient safety, there have been cases where GPs have prescribed medications like benzodiazepines and not informed the EIS. Communication breakdowns around medication could be potentially hazardous to patients due to medication interactions. There have also been similar incidences where GPs have not shared abnormal results of recent blood tests.

Role of Social Services

Staff told us that communication about patient care was easier when a social worker was embedded into mental health teams. This is increasingly apparent to staff when social workers are frequently hard to reach over the phone. The situation is further exacerbated by patient records not being synchronised which makes it difficult for staff to find out where their patient is on a referral pathway. Staff have also seen the procedure for safeguarding referrals and mental health act assessments become more truncated following the separation of social services.

However, staff explained that when issues need to be raised over child protection or related concerns, responses from staff in both services are usually prompt and time sensitive to sharing these issues.

The removal of social workers has also resulted in the EIS becoming mostly "health led" which one care coordinator explained was not ideal given that many patients have additional social care needs. Care coordinators have added to their workload by taking responsibility for low level social care tasks such as benefits applications. They believed it is unreasonable to expect patients and families to take on this task themselves when they are recovering from an acute episode of psychosis.

Patient Safety

The EIS manager is able to discuss patients with a high level of risk or need at the Richmond Interface meeting where local service providers and primary care are represented. One objective of this meeting is to make sure there are "no closed doors" to patients with complex health needs. It is also set up to support relationships and maintain an open channel of communication with other local providers such as the Richmond Wellbeing Service.

In the event a patient does not attend their appointment, staff showed a consistent approach in managing patient safety in this situation. If the patient could not be reached by phone, staff would contact a family member and plan a home visit if those attempts were not successful. Staff have also involved the patient's GP or a probation officer if a long time has elapsed with no communication.

Staff Safety

Staff generally described themselves as feeling safe at work. Alarms are installed in all therapy rooms. For home visits, the team operates a buddy system where staff will conduct visits in pairs for less well known patients. For solo home visits, staff will text a colleague the patients' address and the time they expect to finish. Staff should conduct an independent risk assessment for each patient before agreeing to make home visits.

Staff agreed that the system normally works well. An addition which has been discussed and may enhance staff safety during home visits is a device called a Sky Guard. This is a key fob where staff can press a button which automatically links to an operator who can listen in to staff requests for police assistance or can call the police themselves if they can hear the situation becoming dangerous. However, funding issues may present a barrier to acquiring these.

The Maddison Centre

Accessibility

All of the patients we talked to said they found it easy to get to appointments and that public transport made the Maddison Centre very accessible. The building is suitable for wheelchair users.

External Environment

There is a large display sign for the Maddison Centre beside the entrance which is visible from the main road and should be adequate in directing first time visitors. The path and garden area leading up to the front entrance were tidy and well maintained. There is an additional patio area accessible from the waiting room inside where visitors have the option to relax outside. Visitors are prohibited from smoking in this area but according to staff continue to do so. Despite this, the area is well maintained and largely free from cigarette waste.

Internal Environment

The reception area is clearly visible upon entering the building and is immediately to the left. While screens are in place on either side of the reception desk as a safety measure, the receptionist did not feel cut off or hard to communicate with. The receptionist was friendly and welcoming on the 3 occasions we visited and we were asked to sign in and out on a register at the front desk. The waiting area has an ample amount of seating arranged around a large coffee table. Staff had made good use of the coffee table and placed various information leaflets on a wide range of subjects including the Trust's Recovery College and local safeguarding procedures. The addition of floor to ceiling windows overlooking the patio area provided a light and open feel to the waiting area. Visitors have access to a water cooler which is placed in a visible position. Adjacent to the main waiting area are several large noticeboards which were mostly filled with leaflets on upcoming local events and various support groups that meet in Richmond. Additionally, there were

information posters on how to give feedback to the Trust and Care Quality Commission, the current disability champions and local drug and alcohol services. We were able to ascertain that the therapy rooms were adequately soundproofed. However, some of the curtains used in the rooms facing the front of the building do not meet in the middle and could impact on patient privacy. We were assured that steps were being taken to address this.

Outcome

The primary aim of this project was to capture the views and experiences of patients with the Richmond and Kingston Early Intervention Service. An open access approach alongside clear and consistent communication throughout the team were seen by patients as integral to their recovery and enabled them to build a high level of trust in their relationship with staff. Furthermore, an open and transparent attitude across the EIS is highly evident in carers' experiences and plays an important role in meeting their needs as a carer.

For staff, regular multidisciplinary team meetings appear to provide a stable underlying structure for maintaining communication and an appropriate outlet to raise concerns and address current issues. A lack of administrative support and excessive documentation were highlighted as significant factors in undermining their experience as a professional working in the EIS. Staff also alluded to deeper concerns that a preoccupation with non-clinical tasks may eventually filter down and affect patient experiences of care.

Recommendations

We have shared the results of our surveys with South West London and St Georges' NHS Trust and would welcome an update on the following recommendations:

1. A tailored recruitment strategy by the Trust to fill permanent posts in Richmond
2. A care plan redesign to improve accessibility for staff and patients
3. Improved interface with the EIS and social services through regular scheduled meetings
4. A change in team approach to the concept of care plans to ensure they are regularly re-visited with patients
5. Make use of the vacant space in the visitors' noticeboards and advertise peer network groups run by Richmond Mind and course timetable for the Recovery College.
6. Promote local recovery cafes as part of crisis prevention work
7. Consider a bespoke psychoeducation programme for GPs and professionals working in primary care settings

Areas of Good Practice

We have identified the following as areas of good practice and ask the Trust to consider highlighting these practices to other teams:

1. Transparent communication and tailored support for families including practical strategies to support patients outside of appointments.
2. Open access to earlier appointments.
3. Promotion of additional group therapy to manage common symptom triggers.

Acknowledgements

Healthwatch Richmond would like to thank the staff at Richmond and Kingston Early Intervention Service for their cooperation and assistance during this survey. We would also like to extend a special thank you to the EIS manager for their proactive collaboration on this project.

South West London & St Georges' NHS Trust Response & Action Plan

Trust statement on the feedback received from the families of patients under the EIS

"It is really positive that the Richmond Healthwatch report has picked up the work that the Richmond Early Interventions Service has been doing with carers. As a Trust we are very aware of the debt we owe our carers in supporting the people who use our services with managing their mental health problems on what can sometimes be a long journey towards recovery. We realise that carers offer more than just support and advocacy for patients, they are often the mainstay of our patients lives, enabling them to live at home and to enjoy the best possible quality of life. We realise that carers have often found negotiating their way through mental health services stressful and frustrating. As a result, the Trust has committed to the Triangle of Care, which is an accredited framework spearheaded by the Carers Trust UK. The Carers Trust are a group of carers who sought to develop a process to help improve communication between carers and mental health services.

The first step is for services (wards and community teams) to undertake an honest self-assessment of their services. The Trust has committed to this and we have organised a series of meetings over the next few months (April and May) with team managers, carers representatives, carers and service users to re-launch the initiative. There are ongoing meetings with carers reps, service user reps and Trust employees to manage the roll out of the self-assessment tool and continued planning that will result from the self-assessment tool findings. So far we have had a number completed self-assessments from the wards and we are now targeting the community Teams with the aim of having these completed by the late Spring."

Trust Action Plan

Richmond Healthwatch Report January 2018 - Action Plan

Recommendations	Actions	Completed By	Date
1 A tailored recruitment strategy by the Trust to fill permanent posts in Richmond	A new Graduate recruitment programme has been developed to facilitate newly qualified Band 5 nurses to be recruited directly into the team and supporter to develop their clinical skills using a bespoke competency framework.	Michael Hever (HoNQ)	Apr-18
	<ul style="list-style-type: none"> • Monthly meeting with trust Chief Operating Officer to report on all recruitment activity. • For second consecutive month Community Adult Mental • April 16th 2018 - Meeting with HR and Head of Service Line to produce a detailed systematic way for all team managers to be actively involved in vacancy rate management. • Commitment to move agency staff who are reliable and functional to substantive trust posts. 	S. Wylie (DHoSD)	
2 A care plan redesign to improve accessibility for staff and patients	Care planning training for EIS staff to support them to use the system to maximum effect.	Michael Hever (HoNQ)	May-18
	Six sets of noted are to be audited on a monthly basis to ensure that care plans are of an acceptable quality.	Shaun Hare (EIS Team Leader)	On-going
3 Improved interface with the EIS and social services through regular scheduled meetings	Weekly Richmond Interface (statutory and 3 rd sector services) meeting are in place and Social Services will be invited.	Shaun Hare (EIS Team Leader)	April -18

4	A change in team approach to the concept of care plans to ensure they are regularly re-visited with patients	See action 2 above		
5	Make use of the vacant space in the visitors' noticeboards and advertise peer network groups run by Richmond Mind and course timetable for the Recovery College.	Team notice board to be regularly updated and to contain information about all trust and local third sector services including information about Recovery(crisis) Cafés	Shaun Hare (EIS Team Leader).	Apr-18
6	Promote local recovery cafes as part of crisis prevention work	Care Coordinator to provide information about local Recovery Cafés, and where possible to incorporated into the Collaborative Crisis plan.	Shaun Hare (EIS Team Leader)	Apr-18
7	Consider a bespoke psychoeducation programme for GPs and professionals working in primary care settings	All GP's must be invited to CPA Reviews. GP's must receive written feedback from all reviews in a timely fashion (within 7 days) GP Lead for Richmond attends the weekly Interface meeting. EIS Team Leader to liaise with GP Lead for Richmond and offer a Master Class in the role and function in Early Interventions in Psychosis	Shaun Hare (EIS Team Leader)	Apr-18