healthwatch Richmond upon Thames

Richmond Wellbeing Service

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Introduction

It was increasingly evident from our work with patient groups and from emerging trends in our patient experience database that a significant number of people were having difficulties accessing care and in some cases experiencing a poor quality of care in community mental health services.

Given the NHS 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 ascertain whether these services are meeting local residents' needs. Our report on the Richmond Wellbeing Service is part of our wider programme of work in mental health.

Our objectives for this survey were to capture the views and experiences of patients and RWS staff and provide a snapshot of the care provided by the Richmond Wellbeing Service.

About the Richmond Wellbeing Service

NHS England estimates that in the UK, 1 in 4 people will experience a mental health problem in any given year. According to NHS Digital, the severity of common mental health problems has been rising since the 1990s, with approximately 70 million working days lost in the last year due to mental illness. In a drive to meet the population's growing mental health needs, the government in 2005 commissioned the setup of Improving Access to Psychological Therapies services (IAPT). Richmond's IAPT service is provided within the Richmond Wellbeing Service (RWS), provided in partnership by East London NHS Foundation Trust (ELFT) and Richmond Borough MIND.

The Richmond Wellbeing Service provides NICE (National Institute for Health and Care Excellence) recommended psychological therapies for people with common mental health problems. Additionally, the RWS was one of a small number of pilot sites chosen to develop access and treatment pathways for people with long term medical conditions, focussing on diabetes, cardiac and respiratory conditions and medically unexplained symptoms. This pilot was completed at the end of the 2017/18 financial year.

For most people, therapy is initially delivered through a series of group workshops which entails cognitive behavioural therapy (CBT) based skills training. The aim of CBT is to enable patients to effectively self-care and make behavioural changes that sustainably improve their wellbeing and independence. The RWS operates through a stepped care model whereby the least intensive (in terms of a patient's time and commitment) intervention is offered first. This stepped care model consists of:

- **Low Intensity Service** – psychoeducation seminars/workshops (6-8 sessions), or individual guided CBT self-help through an online system with telephone support or a paper based CBT course. This service is sub-contracted to Richmond Borough MIND and is led by a team of psychological wellbeing practitioners who have specialist training in low-intensity cognitive behavioural interventions.
- **High Intensity Service**
  - **CBT seminars** (10-12 sessions) which focus on cognitive re-structuring skills to break up negative thought cycles and expands on the behavioural skills taught in low intensity workshops.
  - **Individual therapy** - the service provides up to 20 sessions of individual CBT or alternative NICE-recommended therapies to people who are unable to participate in a group setting or require further treatment after completion of the therapeutic seminars. Direct referrals to individual therapy can be made for people with the following conditions:

    - Individuals who require individual treatment due to access issues (language, communication needs or disability).
    - Individuals with social anxiety who express a preference for individual therapy.
    - Individuals with post-traumatic stress disorder where the severity and the complexity of their presentation can be accommodated within 16-20 sessions.
    - Where previous interventions (low intensity or high intensity seminars) have been insufficiently effective.

The High Intensity Service is run by East London Foundation NHS Trust.

Primary Care Liaison Team

In addition to the IAPT treatment programme, the RWS also runs a primary care liaison (PCL) team which is psychiatrist-led. The primary care liaison team provides outpatient consultations for all mental health difficulties, but does not offer crisis or emergency support, as the GP remains the primary responsible clinician. The team also liaises closely with secondary care teams (home treatment team; community mental health team) to facilitate patients transferring back to the care of their GP.

While this report focusses on the IAPT service, people using the service may have moved between the IAPT and PCL team and therefore we may naturally pick up feedback around people's experiences of the PCL team during interviews.

How is patients' progress monitored?

Once referred, every patient should be allocated to a psychological wellbeing practitioner or high intensity therapist as part of a tracking system to ensure individuals are moving through the system and accessing the appropriate part of

the service at the right point. Before each session, patients are asked to complete standardised self-assessment questionnaires which measure for depression (PHQ-9) and anxiety (GAD-7), as well as condition specific questionnaires where appropriate. Patient recovery scores should be regularly reviewed as the course progresses with a final individual review at the end of the course. If there is not a significant improvement in their evaluation scores patients can be stepped up to a higher intensity treatment.

Key statistics on the Richmond Wellbeing Service 2016-17

Referrals

Total number of referrals received	Total number of referrals entering treatment	Total number of referrals finishing treatment
5,360	**3,743**	**1,851**

To be considered eligible for the Richmond Wellbeing Service (RWS), patients must be registered with a GP in Richmond. The IAPT team is unable to provide care for people having psychotherapy with another service or who are under the care of another psychiatric team. Exceptions can be made for people receiving follow up care for ADHD and for mothers under a perinatal service.

People who are assessed and found by the RWS to be using street drugs or alcohol in a dependent manner are referred on to the local drug and alcohol service for specialist treatment. Where substance use is not the primary presenting problem, NICE guidelines state that people should be accepted into IAPT if they can attend sessions free from the effects of substances and be sufficiently sober between sessions to carry out self-treatment. Due to the long duration of effect from cannabis, the RWS asks cannabis users to abstain for a 4 week period before they can engage with the service.

The RWS refers people with complex trauma either arising in childhood or adulthood onward to secondary care. This is because treatment duration is likely to exceed the maximum commissioned 20 session duration.

Recovery Rates

Presenting complaint	Recovery rates
Adjustment disorders	61.4%
Agoraphobia	71.4%
Bipolar affective disorder	83.3%
Depressive episode	53.4%
Dysthymia	50.0%
Generalised anxiety disorder	60.2%
Hypochondriacal disorder	42.3%
Mixed anxiety and depressive disorder	46.1%
Obsessive-compulsive disorder	61.2%
Panic disorder	50.6%
Post-traumatic stress disorder	44.8%
Recurrent depressive disorder	36.7%
Social phobias	50.0%
Specific (isolated) phobias	76.2%

Recovery is measured through patients' scores on self-assessment questionnaires at the start and end of treatment (NHS England). In 2016-17 the overall recovery rate for RWS was 55.2% which is above the national target of 50%.

Method

In February 2018, Healthwatch Richmond met with the lead clinician and service manager of the Richmond Wellbeing Service (RWS) to introduce our role as an independent watchdog and explain the rationale and objectives of our borough-wide review of adult mental health care.

We agreed that our representatives would attend 5 Patient Feedback Forums which take place at the end of the penultimate session of both low and high intensity seminars. These sessions would run as focus groups where we would ask a series of open-ended questions in a confidential environment and collect rich, qualitative data. Healthwatch Richmond were able to attend one feedback forum in April however the remainder of patient forums for our initial planned period of data collection were cancelled as a result of staff not being available to run them.

As our initial method was unavailable we carried out interviews with patients in the main waiting area before the start of their seminars.

Healthwatch Richmond also ran an online survey as an alternative means of participation. This was widely advertised using the communication channels of 7 local voluntary sector organisations and in local parish magazines. The online survey was intended to pick up the views and experiences of past patients, including those who may not have been able to access the service or had dropped

out of the programme early. We also attended various community groups at Richmond Borough MIND and Change Grow Live (CGL, drug and alcohol service) to further expand our public engagement.

To ensure that the responses we collected were not influenced by a patient's experience of care under other providers, our survey questions were specific to the Richmond Wellbeing Service and during the introduction to patients we clarified that our survey focussed solely on their experiences of the Richmond Wellbeing Service.

Limitations

The waiting room environment presented barriers to collecting feedback versus our planned focus group approach including:

- Time-constraints due to the patient's session starting
- The close proximity of reception staff which may have affected patients' ability to speak candidly regarding certain aspects of their experience

The small number of focus groups that we were able to attend demonstrated that they would have been a preferable route to engaging patients as they provided richer data. However, interviewing patients in waiting rooms did present an opportunity to reach people at different stages of treatment and it is possible that some of the people we spoke to might have dropped out by the time the focus groups took place.

Qualitative data was mostly collected thereby allowing us to identify key themes. However, the data cannot be robustly quantified.

This research project presents the views of the people that we spoke to. It was not designed, nor does it claim, to provide a representative view of the staff and patients of the Richmond Wellbeing Service.

Analysis

The qualitative data analysis was conducted as follows:

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

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

Findings

From March to May 2018 we received feedback from 110 people about their experience of using the Richmond Wellbeing Service including:

- 54 interviews with people who were currently receiving treatment or had recently experienced treatment or referral (within the last 2 years)
- 52 online survey responses
- 4 interviews with members of staff

Referral & Assessment Process

The RWS told us that in order to strike a balance between demands on patients' time and service resources, patients are initially offered a telephone assessment. Depending on their preference, patients should also be offered a face to face assessment where there are specific communication needs (language, hearing difficulties etc) or in cases where further review is needed to identify the right treatment option.

Ten patients expressed a need for more flexibility around the times offered for assessment, including out of hours options. This particularly applied when patients needed an additional face to face assessment. One patient told us they had to hide in the toilets at work during the initial telephone assessment and were only able to attend the face to face assessment because they had time owing from working overtime the night before. Another patient said it was *"near impossible"* for them to take any protracted time away from their current job which had caused them significant stress. These patients were relieved that therapeutic seminars are run outside of normal office hours and thought this way of working should also apply to assessments.

Several patients also expressed frustration when their initial assessment was cancelled as they had arranged childcare or taken time off work to participate in the assessment. One patient said *"I had to keep chasing up my initial assessment as it was cancelled several times. It was getting so stressful that I almost gave up"*.

Delays in initial assessments may occur when the allocated therapist is ill or has to prioritise a patient crisis situation. Data from the RWS' internal system showed that 76.1% had a first appointment within 2 weeks and 97.3% within 6 weeks. Whilst this data demonstrates that it is a minority of patients who experience a long wait to initial assessment, the feedback we received shows the impact of this can be significant. Some staff reasoned this situation could be resolved by introducing a reserve system where another therapist or the clinician of the day could step in to conduct any planned assessments.

How well do assessments meet patients' needs?

The vast majority of patients we spoke to felt the assessment questions were sufficiently thorough to identify their needs. For patients who could not previously vocalise their particular issues with much clarity, the assessment questions were able to pick up underlying traits and played a significant role in patients making the realisation that they needed help in this area.

Patients generally linked their perceptions of how tailored the assessment was to their needs to how personable they found their assessor. Where patients were dissatisfied, they generally felt their assessor was either a trainee or their communication style should have been more compassionate and considerate towards mental health needs. Eight patients told us the assessment process felt *"impersonal"* and came across as a *"tick-box exercise"*. Another patient described their assessment as *"rather clinical and off-putting"*. Three of these patients also raised concerns over not feeling *"listened to"* during the phone assessment with some of their assessor's comments described as patronising; one patient for example was told *"you have a very vivid imagination"*.

There was evidence of some polarisation in patient preferences for how initial assessments should be conducted. Several people told us they would have benefited from a face to face assessment from the outset. One patient said that as English is not their first language, it is difficult to communicate over the phone as they do not have the aid of non-verbal cues. Five patients we spoke to found it generally uncomfortable discussing their mental health in depth over the phone and felt it presented a barrier in organising their care. For other patients, however, discussing intimate and personal issues for the first time was made less daunting by not doing it face to face. Overall, the strength of feeling from this group of patient experiences suggests a continuing need for flexibility from the RWS in this area.

Progression in IAPT

The RWS operates through a stepped care model. If utilised correctly, it should allow patients to flow between appropriate treatment pathways depending on clinical need. According to the RWS, patients should always be encouraged by staff to access the right part of the service in line with their diagnosis and current presentation. However, this model does not appear to be communicated effectively to patients which can create several challenges.

Generally, patients reported being told limited information about the different layers or steps in the RWS model of care. When first referred, patients were provided with little information beyond the name of the course and the time and venue.

Most of the patients we spoke to would have found it reassuring to be told about the different steps in the RWS earlier. One patient stated that *"it can make you feel like you're out there on your own again if you have not recovered by the time the course closes"*. Another patient felt the lack of disclosure about the High Intensity Service or other groups running was counter-productive as they felt they were *"put under more duress"* when they did not feel they were progressing earlier on in the course. Four patients would have also appreciated more information about what the group seminars actually entail and the course duration

for logistical reasons such as arranging childcare or time off work and so they could prepare themselves emotionally.

Tailoring therapy to individual needs

How patients progress through the RWS system is largely down to how responsive the team are to patient recovery scores (see *"How is patients' progress monitored?"*, page 3). It was therefore encouraging to hear that for patients who did not recover during their first intervention that further support was offered either in the form of high intensity (HI) seminars or individual therapy. For example, 3 patients who felt they needed more focused support than a group set-up could provide were offered individual therapy. Overall, this cohort of patients described the team as being accommodating to their needs and welcomed the candour around waiting list times and limited number of sessions that could be offered for individual CBT.

Some patients highlighted the capacity to talk with the course leader in private after the seminars as a meaningful opportunity to raise individual concerns. For one patient, this resulted in them getting the form of therapy they needed without having to wait for the end of the course review. However, 7 patients told us they did not feel there was an opportunity to speak with the course leader in private which did detract from their experience feeling personalised and in some cases presented a barrier in communicating their needs.

We were informed that every patient has an individual end of course review over the phone where additional interventions are discussed if the patient feels they need further support. While this may provide an effective safety net for many patients, the feedback above suggests earlier personal intervention may protect against potential disengagement and address emerging anxieties for some patients.

Low Intensity Seminars

During our data collection period 2 low intensity groups were running. The feedback for each if these is presented below.

Overcoming Worry

There was a strong consensus amongst patients that the content included in this group was relevant and that the material was presented well. One patient described the content as *"phenomenal"* and had given them a great understanding of how anxiety can be triggered. Two other patients said the course leader managed to get the language right for a group setting and described the speaking style as *"engaging"* that kept their attention throughout the course.

Group size emerged as a significant determinant on how involved patients felt in seminars. Low intensity (LI) seminars are designed to accommodate up to 20 people to optimise service capacity so that new patients do not have to wait too long to be allocated to a group. However, this can have adverse effects on the quality of patient care. Two patients said the learning process can feel quite slow

as the course leader needs to check everyone's understanding before moving to the next topic. One patient said there was little time to ask questions or for group interaction so the sessions came across as lectures rather than seminars. Another patient said this feeling was reinforced by being sat in rows which made the environment feel quite academic and stated *"you feel like islands"* which can limit incentive to share personal experiences.

All patients agreed that changing the seating formation would be a conducive step to creating a more comfortable sharing environment. The above sentiments may particularly apply to people who are less confident about speaking in groups. One patient highlighted that as the group size reduced as people dropped out over the duration of the course there was naturally more time and space to communicate which eased their previous reticence around speaking up. Another patient was only able to open up about their anxieties once they had moved to a high intensity (HI) group, *"I struggled with the first seminar I took about general anxiety as there were too many people for me to feel comfortable speaking up. But at a smaller seminar like the one for social anxiety I found the set up eased me into talking about my issues"*.

In response to the comments made above around the seating formation, East London Foundation Trust said "*This was an intentional part of the service model, in the design process people using the service reported an aversion to hearing and sharing personal information therefore the intent was to create an initial culture that limited this, but supporting the later development of a sharing culture in the high intensity programme once people had acclimatised to the seminar programme*".

Overcoming Low Mood

Overall, patients were more mixed in their feedback around this group compared to the patients who attended the Overcoming Worry seminars. Some patients highlighted the content as useful for developing recognition of low mood triggers but not in prevention.

Two patients described the content as being *"very basic"* and not suitable for people with a long history of depression. One patient said: *"the self-help techniques suggested are obvious to anyone who has previously looked at online resources or self-help books for depression"*. From discussions with other patients, these patients sensed the group was split half and half in terms of who was benefitting from the course. Another patient who withdrew from the course early stated that, while the material taught was useful for maintaining general wellbeing, the techniques were not specialised enough to touch on their chronic depression. This patient shared their concerns with the course leader and was referred for individual therapy which they described as helpful so far.

Two patients echoed previous concerns around how low intensity seminars are set up. One patient stated, *"we were sat in rows and even though we were taught as*

a group, we couldn't engage with one another during sessions which left me feeling cut-off". As a result of this, another patient deliberately got to sessions early so they could talk to other patients about how they were making practical use of the strategies taught and said *"it's a shame we could not carry on this camaraderie in sessions"*.

Most patients found the homework tasks manageable and easy to fit in their lives. One patient suggested adapting some tasks to be more holistic in aim so that it also encourages healthy living for example.

High Intensity Seminars

We collected data relating to many high intensity groups which makes presenting the data by individual group impractical.

Course Content & Delivery

Most patients taking part in the high intensity (HI) seminars were effusive in their praise about how effective and relevant the taught techniques and strategies were. One patient said *"it's amazing to have this service in Richmond"*.

The approachability of course leaders and how they structured the seminars was well-received by patients. Patients described their therapists as *"fantastic"*, *"so helpful and supportive in making sure my needs are met"*, *"their experience of dealing with complex mental health clearly shows through"* and *"they are very good at getting to the heart of what the problems are"*. One patient also highlighted their therapist's skill at balancing the needs of the group to communicate and share their experiences but not letting that override the learning of new techniques and theory behind them. Responses to our online survey show that 76.7% of patients felt the sessions were paced correctly and 83.3% of patients thought enough time was given to reflect on previous learning.

However, there was some disquiet amongst patients we spoke to attending generalised anxiety seminars. One patient suggested these seminars should be increased by 2-3 sessions as currently *"the learning feels quite rushed and it would allow the course leader to be more detailed in the explanations underlying the techniques"*. Another patient agreed and also said *"the course booklet is quite thick which can be off-putting at first, especially as the course leader has to skim over the details to fit everything in"*.

It was encouraging to hear that staff could be responsive to adapting some of the therapy programme to suit new expectations or needs from patients. For example, patients in one of the OCD groups had requested more mindfulness tools to be incorporated into the content to help with common comorbid symptoms associated with OCD such as low mood.

Finally, in marked contrast to low intensity seminars, patients spoke of being able to easily speak with the therapist in private after sessions, a provision which was

effective in alleviating private concerns or queries and lent a strong personal touch to their care under the RWS.

Group Communication

Appropriate group dynamics within seminars emerged strongly as a key determinant in patients' engagement with therapy and how beneficial patients found the programme. This sentiment was prevalent across all therapy groups.

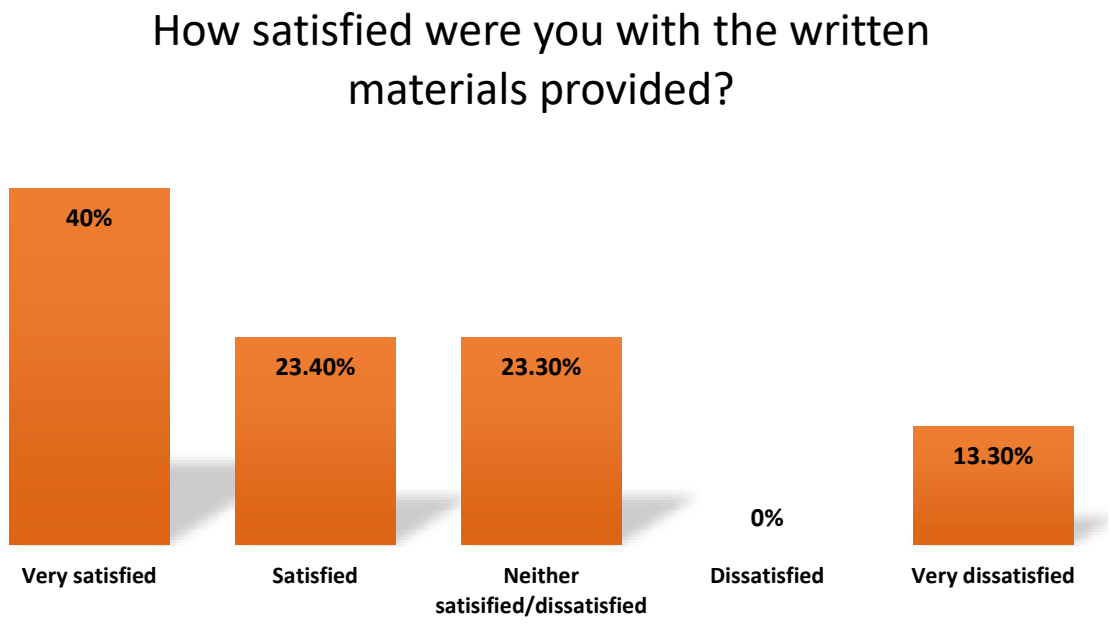
Patient feedback suggests that seminar groups who had bonded well reduced feelings of social isolation that can accompany having common mental health symptoms. Fifteen patients said being able to share their experiences and reactions to practising CBT had definitely aided in their recovery. One patient said that learning as a group made their experience *"even more enriching, as you can feed off one another"*.

Patients emphasised that course leaders in high intensity seminars worked hard to ensure patients had enough opportunities to communicate their progress and provide an environment conducive to sharing experiences. One patient described it as *"quite daunting"* at first to speak up but the course leader is always *"very welcoming"* and skilled at creating a *"supportive environment conditioned to talking about intimate or personal details"*.

Despite this approach from staff, our feedback suggests this may not be effective for people who still struggle with sharing their experiences in a group setting due to underlying anxiety. One patient said they felt the onus was on them to share as they seemed to be the least reticent in terms of personalities within the group which had created unexpected pressure: *"I feel like I have been amusing the group"*. Another patient stated *"I find the seminars somewhat uncomfortable and continue to feel reluctant to speak up in front of other people"*. Notably, this group of patients also expressed dissatisfaction with the course and said it was currently not meeting their needs or initial expectations. This group of patients' experiences is further discussed in the 'Patient Disengagement' section on page 21.

Written Materials

Most patients were satisfied with the quality of the information included in the workbooks and handouts. Three of the patients we spoke to thought the RWS could make better use of IT and distribute extra reading material through email rather than physical handouts. One therapy group had asked for handouts to be made available online as materials potentially being visible from bags could impact on patients' privacy.



***Number of survey respondents: 30**

Help with long term physical health conditions

We spoke to 3 different groups of patients who were attending high intensity courses on coping with a long term physical health condition (these groups were Breathe Well, Cardiac Wellbeing, Living with a Long Term Condition). Eight people spoke about the service having a transformative effect on their lives mainly through the ability to better understand and cope with their psychological concerns about their condition and re-direct negative thoughts, one patient said *"this course has helped me mentally, not physically"*.

All patients said they felt *"lucky"* to access this service as previously all intervention had been entirely focused on medical care, which does not address the considerable psychological symptoms that can accompany a long term condition. Most people agreed on the importance of having a course that is specific to these concerns. Four patients for example had previously attended a LI course and found the content to be too generic.

There was a clear sense of regret amongst this group of patients that they had not heard of the RWS sooner. The patients we spoke to and survey responses both

highlighted the continuing need for holistic care from GPs and to signpost patients accordingly. One patient felt they had to reach crisis point: *"I was practically on my knees"*, before their GP suggested the RWS, and would have valued psychological help much sooner.

Notably, the primary care liaison team within the RWS had been short-staffed by 2-3 practitioners since January which would have impacted its ability to effectively promote IAPT services in primary care. It was therefore encouraging to hear that a recruitment drive has taken place with a new team manager now in post. Regular outreach sessions to GP surgeries will be prioritised to maximise working relationships and maintain awareness of the RWS.

Patient feedback also suggests better or more sustained promotion is needed amongst non-mental health NHS professionals in hospitals and outpatient clinics. Three of the patients we spoke to heard about the service through the RWS reaching out to various outpatient clinics. We understand that funding for this outreach has now ceased. Given that approximately 60% of patients self-refer, it is vital that the service is effectively promoted throughout Richmond. If funding cannot be reinstated, we would strongly recommend a visual presence is maintained in the form of flyers or posters in outpatient areas with high footfall.

Managing depression

Chronic or recurrent depression is one of the hardest conditions to treat for professionals working in IAPT services. The current recovery rate for recurrent depressive disorder in the RWS is 36.7% whereas patients with first onset depression have a recovery rate of 53.4%. We therefore hope the feedback we obtained from patients currently undergoing treatment for recurrent depression is particularly useful in driving service improvements going forward.

Alongside aforementioned concerns expressed from some patients about the content being too basic in the low intensity (LI) 'Overcoming Low Mood' seminars, 2 patients also criticised the actual delivery of the programme. These patients said the 2 LI group leaders running the programme could come across as patronising in their tone of voice and choice of questions. For example, they would ask everyone how their day has been, in a tone they perceived as condescending and *"child-like"*. When comparing their current high intensity (HI) therapist who they described as "very knowledgeable", the LI course leaders generally came over to them as *"inexperienced in understanding depression as a condition and its implications"*.

Overall, the 6 patients we spoke to who attended the HI depression groups felt more positive about the content included in these seminars. One patient said *"the course is good at teaching you how to reframe negative thoughts and exploring the common causes of depression"*. Two patients arrived at the same conclusion where they felt the current course could be condensed as the earlier sessions tend

to *"regurgitate the same content"* which they are already familiar with. Notably, another patient, who was halfway through the HI course for depression expressed confusion over the difference between the LI and HI seminars and thought they had been re-enrolled on to the same course again. Two patients felt too many of the earlier sessions were spent looking at the general causes of depression at the expense of prevention work, expressing frustration that the course was not teaching them how to avoid getting into a negative mind-set from the outset.

This group of patients however acknowledged that people on the course are likely to be at different stages in their understanding of depression and thought individual differences could be addressed in the service by introducing extra reading sooner on prevention work and different coping strategies.

Individual therapy

The Richmond Wellbeing Service staff see their main challenge as managing expectations of patient choice against service demand and resources available. Current demand indicates that if the RWS moved from their current model of care to offering solely individual treatment for the same number of patients, this would rapidly result in progressively increasing waiting times of over 6 months.

It was reassuring to see that for patients whose symptoms were not resolved through group seminars were now seeing the benefits of one to one therapy. One patient we spoke to had initially tried psychoanalytic counselling (through the RWS) but found the methods used not far ranging enough to help their chronic depression and had switched to individual CBT which they felt reached *"the right middle ground"*. Another patient had used the RWS for individual therapy several times since 2015 and said the therapy had helped them in every area of their life and described their experience with the RWS as *"starting at the bottom of a well and being pulled out bit by bit"*.

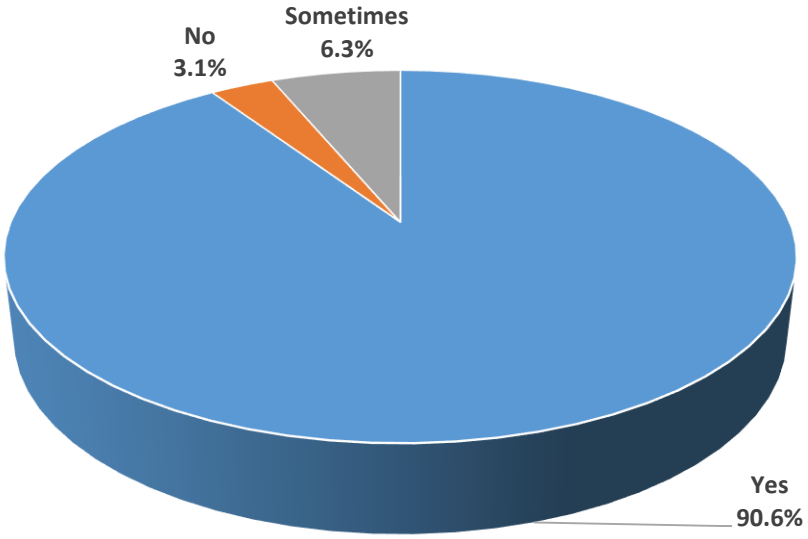
Staff at the RWS appreciated that group seminars may not be effective for all patients and that some individuals will ultimately need very specific, focused support on isolated issues that a group level of intervention could not reach. For this group of patients, staff were open to offering individual therapy provided they had tried to engage with therapeutic seminars first as the seminars *"lay the groundwork"* for individual therapy.

Venue & Environment

Most patients did not express any major reservations over St John's Health Centre as the main location for Richmond Wellbeing Service. Several people commented negatively on the environment noting that the therapy rooms felt clinical and that posters from the building's previous occupier were displayed. We have since been told the centre remains a shared building with the Children's Health Team occasionally using some space on the first floor for patient care. Additionally, some people described the chairs as uncomfortable to sit in for long period of time

and one patient noted that there is nothing to lean on which could be problematic for their arthritis.

Were your appointments at a time and place that suited you?



***Number of survey respondents: 32**

We asked the RWS for a breakdown of referrals by postcode from 2016-17. The number of referrals received appear to be reasonably proportionate to the geographical distribution of the borough.

Two patients with partial deafness felt hearing problems could be handled more sensitively by the RWS. One patient *"felt like they were on show"* as the therapist seemed to address the whole group rather than them as an individual and *"made a big deal"* of asking the patient to come and sit at the front *"next to me"*. Another patient turned down therapeutic seminars as their poor hearing had previously made meaningful participation in a group setting difficult and did not receive adequate assurance during their assessment to counter this belief. We note that RWS does have a hearing loop available and should make information about this more prominent.

The main reception area appeared well-maintained on each of our visits with the surrounding noticeboards fully utilised with literature on other support services and internal policies and procedures for the RWS such as safeguarding and data protection. The RWS also offers free WiFi which patients appreciated. One person said *"it makes it so much easier to check in with colleagues through my work iPad in the spare time before the course starts"*.

Crisis Care

Feedback from the patients we spoke to and the online survey shows significant variation in how much information patients were told about out-of-hours support and the lengths staff went to in checking patients had social supports in place. Twenty patients said that staff were dedicated to ensuring that they felt supported between sessions by regularly informing patients that they could call the service in the interim to speak to them or the clinician of the day. Some course leaders also made a particular effort to draw attention to the helplines listed in the course literature which one patient said they found very useful *"in their lowest moments"*.

It is inevitable that some patients' presentations will significantly change from when they were first referred to the RWS and become too complex to benefit from the level of therapeutic intervention IAPT can provide. However, patient feedback demonstrates the importance of timely intervention and working closely together with secondary mental health care services to ensure individuals receive the necessary care appropriate to their needs.

We heard a particularly distressing story from a past patient who had attended the RWS for support with their postnatal depression. The group they were referred to was cancelled several times due to either staff illness or the group size not being big enough to warrant running it. Over a period of 7 months, the patient told the RWS staff they were feeling increasingly desperate and needed more therapy or medical intervention. Unfortunately, they did not feel staff were responsive as they were only given basic self-care tips such as *"have a long bath"*. This culminated in the patient feeling very distressed and ringing a local crisis line where, thankfully, they received immediate intervention from the community mental health team the next day.

Beyond IAPT services, some patients told us about wider problems in crisis care in Richmond. One patient said, *"services need to provide more support during evenings and weekends as there is nowhere in Richmond apart from A&E that can help people with their mental health issues"*. Another patient stated, *"mental health is not just 9 to 5. Richmond can feel like a desert if you need help out of hours"*.

We have heard about crisis care in Richmond from other sources and will review it in more depth in future projects.

Discharge & Aftercare

Amongst the 12 patients we spoke to who were approaching the end of their course, there was a sense of concern over what aftercare options were available to them. This was particularly tangible from patients who felt they might need further support. One patient said they were keen for a further individual review as *"I need time to fully explain my situation and I am now feeling worried about not*

knowing what's going to happen next". Another patient questioned the outcome and purpose behind filling in evaluation forms before sessions and was anxious to know if these would be properly evaluated to resolve any residual *"red flag"* symptoms.

Given that patients are not told about aftercare support until their end of course review, this lack of patient awareness is not entirely unexpected. This feedback also fits with dissatisfaction shown by other patients around the limited advance information provided on treatment options within the RWS. This was highlighted earlier in the report (please see 'Progression in IAPT' section, page 7). Overall, the level of anxiety exhibited by a significant number of patients may demonstrate that a systematic change in the timing of information provision is required to prevent future incidents and reduce patient stress.

For 8 previous patients who had otherwise a very positive experience of using the RWS, the discharge process stood out as an area which could be improved with patients describing it as feeling slightly abrupt and rushed. One patient for example stated, *"it felt like you were a tickbox being checked off"*. Another patient suggested aftercare signposting could be increased, by staff highlighting local voluntary support groups or helplines to reinforce patient awareness, further stating *"it's important for staff to take the initiative on this as otherwise I wouldn't have known to ask for it"*.

Finally, patients particularly valued the provision within the RWS to come back for a series of refresher or booster sessions. One patient said *"it was really reassuring to know I could be re-referred quickly if I felt my wellbeing was lapsing again"*.

Patient Disengagement

The lead clinicians at the Richmond Wellbeing Service highlighted patient withdrawal as one of the foremost concerns for the team. Referral statistics from 2016-17 show that of the 5,360 people referred, 30% did not enter treatment and of those who did, 51% did not complete the full course. The section below summarises feedback we received that is suggestive of being a causal factor in a person's decision to withdraw from the service.

Assessment

The patients we spoke to highlighted the assessment process as being crucial to their experience as this is when *"you need the most help"* and trust is built up with the service and its staff.

Dissatisfaction arose when patients experienced delays of over 2 weeks for their assessment or when they perceived the approach and communication by their assessor as lacking empathy or compassion (a full summary of these findings can be found under 'Referral & Assessment Process' on page 6).

Overall, these patients said they were really happy with the care provided once they had started therapy but the assessment process was at first quite discouraging. It is therefore possible that experiences such as these may have deterred other patients from engaging with the service initially.

Long wait time to treatment

Some people said that a long wait time to a course starting may act as a deterrent leading them to seek more immediate intervention. According to NHS England long waits are known to impact on recovery rates and patient experience in IAPT services. Data from the RWS shows that in 2017-18, average waiting times for HI courses are around 4 weeks and never more than 7 weeks. Individual treatments had slightly longer waits but the average never exceeded 10 weeks.

A small number of patients said that delays before starting a course exacerbated their distress. One patient had a *"stressful"* wait of 7-8 months for a cardiac wellbeing course but chose to wait for this group as it was *"specific and relevant to my condition, rather than a generic stress or depression course"* despite this being available sooner. For another patient it took 6 months to get on to an Overcoming Worry course due to clashes with work commitments and one of the courses being cancelled in January 2018. The course cancellation created added stress as they had *"mentally built"* themselves up for it and arranged time off work. Long wait times may particularly apply to certain courses which do not run as frequently such as those for long term physical health conditions.

As part of this research project, we spoke to the manager of the Richmond & Kingston assessment team which screens all referrals to secondary mental health services and coordinates step-down care back to IAPT or the primary care liaison team. We were told that patients have presented in crisis while they are waiting for an available course which in turn highlights the need for effective interim support.

With current resources, the RWS said that they are very limited in what they can do to reduce wait times to some seminars. Potential holding measures to alleviate patient distress such as reading materials or signposting to local support groups should therefore be considered going forward.

Triaging & Social Anxiety

Undiagnosed social anxiety at assessment may have led to inappropriate triaging to group seminars for some people. Six patients told us that underlying social anxiety affected their ability to benefit or fully utilise the therapeutic work done in group seminars. One person dropped out of the service as a result of this. Engagement issues around undiagnosed social anxiety was particularly apparent for those who attended low intensity seminars.

> *"I think smaller groups work better than bigger ones, especially in seminars related to anxiety as in the first seminar I felt like there*

were too many people with prominent personalities and louder voices for me to feel comfortable sharing my experience (alongside lack of time to hear everyone's opinion). While the social anxiety seminar was excellent and very helpful, as the smaller group made me feel comfortable speaking about my experience and sharing thoughts, which I found most helpful."

"I found the background information and the details about the science very interesting and also reassuring. I find the seminars somewhat uncomfortable though and I am reluctant to speak in front of other people. I also find it hard to listen to other people's problems and the things that they are struggling with, so one-to- one would have been better for me."

"I attended the overcoming worry seminars, and the facilitator was really good at presenting and helped a lot of people. However, I was yet to understand my main issues with social anxiety and did not fully benefit from the course because of this, as it was not specific to my needs. It also meant that ironically I was too socially anxious to benefit from the social anxiety group once that had been assessed, but in the two sessions I attended, the content seemed relevant."

"Very little help. My anxiety around new people was worsened by attending a group seminar."

Social anxiety is one of the criteria where people can be referred directly for individual therapy and these stories highlight why all efforts should be made to closely adhere to this NICE recommendation. One patient suggested including additional social anxiety screening in the initial assessment to safeguard against missed diagnosis and a potentially inappropriate treatment pathway. In view of this group of patient experiences, we agree that this could be a proactive and beneficial suggestion for new patients coming into the service.

Triaging & Depression

Feedback from 10 patients using the RWS for depression could indicate a need to take into account patients' previous exposure to psychological therapies, including self-help guides. These patients felt the content in low intensity seminars was too *"familiar"* to previous therapy or self-help books and should have been triaged directly to the HI group. Conversely, 2 patients noted that other people in their HI depression group who had not previously attended the LI groups or had previous therapy struggled with some of the CBT concepts introduced.

Drugs & Alcohol

The National Institute for Health and Care Excellence (NICE) has issued the following clinical guideline regarding access to IAPT for people with a history of substance misuse:

> *"Substance misuse clients with mental health problems should have access to NICE-recommended psychological interventions, including CBT for depression and anxiety. There is no evidence that substance misuse per se makes the usual psychological therapies ineffective" (Source IAPT positive practice guide)*

Six people reported that they were denied access to the RWS as a result of their assessor's conclusion that their use of alcohol or drugs was prohibitive to engaging with psychological therapies. One patient who significantly drank 2-3 times a week said that RWS had *"put their own label on"* this and consequently denied them access to treatment. Two other patients said it felt like they were being *"fobbed off"* and *"we were someone else's problem"* because of substance misuse issues that they didn't believe should have prevented them from engaging with the service.

Patients who had been turned away by the RWS also reported inconsistent messages and variation in referral thresholds for accessing the service. People who were using the same substance were told that they would need to demonstrate differing periods of stability or abstinence before they could be reconsidered.

Patients and professionals told us that going forward they would benefit from a publicly available RWS policy on patients with substance misuse to ensure consistency of care and equal access.

Overall, the feedback we received suggests an urgent need for effective joint working for individuals with drug and alcohol use, who may need a multi-professional package of care to fully address their mental health and substance misuse.

It is therefore encouraging to hear that a joint pathway for cannabis use is currently under consideration between CGL Richmond and the RWS. NICE guidelines and patient experience strongly suggests this way of working should be extended to alcohol and other drugs.

Outcome & Service Recommendations

Overall, the Richmond Wellbeing Service provides a high quality package of care which is in line with NICE recommendations for IAPT services. Patients speak highly of the service that they receive from IAPT and in particular the High Intensity service and the staff. It is evident that RWS staff are committed to providing consistent and patient-centred care and appear well supported through weekly group and individual line management supervision.

The issues that local residents may encounter are mainly related to assessment, access, clarity over the service that is available, and being triaged to the right level and type of treatment for their needs.

RWS Recommendations

Based on the feedback that patients had provided we produced a set of recommendations and submitted them to the Richmond Wellbeing Service. East London Foundation Trust told us:

> *"The Trust is grateful to Healthwatch for undertaking this thorough review of the Richmond Wellbeing Service and for acknowledging the excellent work of the RWS staff.*
>
> *We take seriously the recommendations made by Healthwatch and will act upon them in order to further improve upon the experience of our service users".*

The Trust provided a full action plan in response to our recommendations which can be found below. Healthwatch Richmond particularly welcomes:

- Refresher skills training for staff in identifying social anxiety to improve triaging to the right form of support and develop skills to help anxious patients engage in courses and seminars
- Improvement in staff capacity to offer face to face assessments where this is the patient's choice
- The introduction of condition-specific letters detailing the diagnosis and recommended treatment, including the duration and content of courses
- Revised assessment questions to increase recognition of people's previous exposure to psychological therapies and optimise triaging to the appropriate level of support
- Improved communication over the stepped care model where a description is included in patients' welcome letter and introductory lecture slides during the first seminar

Trust Action Plan – July 2018

Recommendation	Response	Action where applicable	Completion date
Assessment 1. Utilise the clinician of the day system to cover initial assessments when the allocated therapist is not available.	We will target the second appointment to avoid repetition of cancellation, therapists are currently fully deployed delivering care and providing standby resources will divert scarce resource.	We aim to offer the next available appointment if the initial appointment is cancelled and our Senior Clinician of the Day helps to ensure this is prioritised, where one appointment has been cancelled we will endeavour to prioritise this to allocate the appointment to another clinician at the same time.	15.08.18
2. Consider evening appointment slots for patients who struggle to participate in assessments during working hours.	Clinical resources are currently fully deployed offering therapeutic seminars to people in the evening and there is no spare capacity to deliver assessments. The provision of telephone assessment enables people to attend during working hours provided they can identify a confidential space. We will review resource allocation to see if one evening assessment slot can be allocated.	Routine provision is not possible, the administration team will attempt to manage problems by exception and see if isolated cases can be managed. Individual cases will be escalated by the administration team as they occur.	20.08.18
3. Introduce additional screening to identify	We acknowledge that low level social anxiety appears to be contributing to	A refresher skills session has been arranged in November for the clinical	20.10.18

undiagnosed social anxiety which may be additional to the patient's presenting complaint and influence patients' ability to engage in a seminar setting.	drop-out. There is already a specific screening questionnaire for social anxiety. We will provide the team with a refresher in identification of social anxiety. For people presenting comorbid with depression and social anxiety we will offer computerised CBT as initial intervention for the treatment of their depression.	team to look at the clinically different presentations for both social anxiety and generalised anxiety and to develop skills to help anxious patients engage in courses and seminars.	
4. Improve registration checks on patient preference for telephone or face to face assessment.	Reviewed by the Senior Team.	Face-to-face assessments are offered alongside TT's according to the patient's choice and needs. We will review the impact delayed face-to-face TT's may have and have asked staff to begin to identify times when they could offer an additional face-to-face slot	15.08.18
5. Review assessment questions to also account for patient's previous experience or exposure to CBT based therapies and optimise triaging to the appropriate level of IAPT.	We will review the assessment questionnaire to revise the specificity and remind team that allocation to a low intensity intervention when this is previously proven ineffective is inappropriate and provide a refresh of the layered RWS model.	This information has been emailed to all staff in the September clinical update which is composed collectively and sent out by our Clinical Lead.	Sept 2018
	We plan to provide additional information describing the layered process of care and add this to the group	New slide added to the groups with the step care model explained at the start of	10.08.18

Communication 1. Include a brief overview of the stepped care model as part of the first seminar to protect against potential patient stress around options for additional support or aftercare.	assignment letter	seminars. Letters reviewed and line added. In the waiting area we will develop a poster that outlines the layered approach to therapy used in RWS.	
2. Promote recovery cafes in Wandsworth and Merton and Richmond Mind peer network support groups in the service welcome pack and the main waiting area to develop patients' knowledge of crisis care and additional support outside of service hours.	We will revise the crisis leaflet and include the resources set out in item 2. This information will also be placed in the waiting area.	Service Manager has contacted the Clinical Interface team to request this information and it will be displayed and available in our waiting area and added to the crisis leaflet.	
3. Ensure that course leaders and welcome pack emphasise that patients can speak to staff after	This will be included in the information on allocation to the groups and in the first session	This information is now included.	16.08.18

sessions to raise private concerns and queries or contact the service for a call-back between sessions.			
4. Include information in appointment letters on the duration of the course and a brief description of how the group seminars work.	We will prepare condition specific letters giving information on the diagnosis and recommended treatment of the specific condition, including the expected duration and content of the courses/seminars. This will be attached to the first appointment letter.	Our Senior Team continue to work on developing diagnosis specific information for each seminar series.	Ongoing
Environment 1. Where possible, explore a change in seating formation in low intensity seminars which moves away from seats arranged in rows and towards an open seating arrangement.	We will ask service users attending the meetings to provide their views on which sitting pattern they prefer, to obtain representative views before making changes to the current format (chairs in rows facing the screen).	This was discussed in the LI Team meeting and has been discussed with service users, and the feedback was that it was the opinion of a minority of service users and that it would be very difficult and almost impossible to arrange the chairs in an open seated arrangement given the size of the group room. PWPs also reported that patients expressed that they felt more comfortable in the arranged rows facing the front as they did not want to be looked at by other patients and also felt	14.08.18

		pressure to participate when seated in a circle. Clinical Lead and Service Manager discussed at 2 "Have Your Say" forums and all but one person expressed a strong preference for being seated in forward facing row style.	
2. Invest in an induction loop system to meet the needs of patients with hearing impairments.	The service has an induction loop, we will remind service users and staff of the availability of this resource	A reminder has been sent to all members of staff regarding the location and availability of the induction loop.	16.08.18
3. Replace posters from previous site occupier with service appropriate materials, pictures or plants to enhance the aesthetics of therapy rooms.	This is a shared office which continues to be used by other organisations. We will explore with them what material can be removed.	Some material has already been removed and we will regularly review to ensure that information is placed appropriately for our partners, their patients and for the people who attend the RWS service to minimise confusion.	16.08.18
4. Consider new chairs with supports, or tables to aid patients with additional physical health needs.	We will make a further attempt to source chairs with supports and writing surfaces.	We continue to investigate the chairs with small desks with supports and writing surfaces.	Ongoing

Written Materials 1. Introduce optional supplementary reading to account for individual differences within group seminars in patients' level of understanding or course progress.	Supplementary information is provided to all seminar participants.	Completed	16.08.2018
2. Provide the option of having all written materials electronically available for patients to download.	Subject to copyright we will offer this when requested. We will look at the possibility of including more information on our website	When suitable material is identified it is passed to the webmaster who uploads it.	14.08.18
Seminars 1. Reconsider the content for high intensity depression seminars to ensure earlier content is not repetitive and has space for preventative strategy work.	We will review the content to ensure that there is no inappropriately repetitive material and include space for relapse prevention	LI lead will check the appropriateness and ensure there is no overlap	15.08.18
2. Review the content for generalised anxiety seminars to ensure the	We will review the content to ensure that the material is not excessively	We do follow NICE recommended guidelines. This has been reviewed with our senior clinical team and our Seminar	20/08/18

content is not excessively condensed and inhibit new techniques being taught at an appropriate pace.	condensed.	Lead to ensure pacing supports people in the seminars to use the information in a more helpful way.	
RWS Promotion in the Community 1. Ensure that the service is effectively promoted with consideration given to the following:			
1.1. Flyers or posters for hospital outpatient clinics advertising long term health conditions seminar groups.	A leaflet giving information on treatment for long term health conditions is available in GP surgeries and other community settings.	We will be providing additional information to appropriate clinics as we continue to develop these clinical pathways.	Ongoing
1.2. Posters in day centres and charities catering for older people	We will distribute our information leaflets in day centres and charities catering for older people	We are also developing relationships with local providers of care and support to older members of the community to ensure all people are aware of our service and how to access this.	

1.3. Information for mothers and families in children's centres.	We distribute our information leaflets in children's centres	We have a perinatal lead in all steps of care and we will ensure that they actively promote our service and ensure there is information available at all family centres	
Drug and Alcohol Screening 1. Produce and disseminate a policy which establishes clear referral thresholds for patients with substance misuse and make available to patients and professionals.	We are piloting a cannabis recovery programme with CRG We will review referral thresholds for patients with substance misuse and share with service users and professionals.	This programme is about to be rolled out and all staff were given training and information regarding the care pathway, eligibility criteria and the programme between CGL and RWS to develop this carefully. People will be offered treatment in RWS but this will be delivered by CGL clinicians and upon completion of this programme, further treatment (chosen by an RWS therapist) may be offered.	Ongoing

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