Healthwatch Birmingham and Healthwatch Solihull

Summary of evidence

Healthwatch Birmingham and Healthwatch Solihull would like to share with the committee the work we have done recently on Community Mental Health services. We would also like to share with the committee a summary of what people have told us about their recent experiences of Community Mental Health Services in our areas to demonstrate the challenges they face accessing these services. Our key role is to make sure that patients, the public, service users, and carers are at the heart of service improvement in health and social care across Birmingham.

As part of the investigation conducted by Healthwatch Birmingham, and from looking through the feedback we received from the public between April 2023 and December 2024, we identified a number of key issues faced by people accessing community mental health services in Birmingham and Solihull:

- Quality of access (e.g waiting times, mode of access, lack of support while waiting for appointments)
- Quality of appointments (e.g rushed or cancelled appointments, lack of face-to-face appointments)
- Quality of treatment (e.g overreliance on prescription medication, and strategies or activities offered)
- Consistency and continuity of care (e.g. relationship continuity, knowing who to contact, and access to Community Psychiatrist Nurses)
- Care planning and review (numbers of people having a care plan and how well it captures people's needs)
- Support with health and wellbeing (e.g. support with physical health, money, work, housing, relationships, trauma, abuse, and addiction)
- Poor communication from services (e.g inability to contact services to follow up on issues)
- Medication issues (e.g issues obtaining medications prescribed by services, being prescribed inappropriate medications)
- Unprofessional behaviour from staff (e.g inappropriate conduct, breaches of privacy)

Following the publication of Healthwatch Birmingham's report a number of steps have been taken to address these issues for the people of Birmingham. These steps include:

- Active recruitment to the Community Mental Health Team resulting in a reduction of 14% in the number of people waiting for CMHT assessment between February and August 2024
- Decrease in individuals waiting longer than 40 weeks for talking therapy from 341 in August 2023 to 0 as of July 2024.
- Waits for first contact have been reduced from 13 weeks in June to 9 weeks in August.
- Developed guidance for clinicians to better manage cancellations of appointments ensuring that there is a review of cases by clinicians before and after cancellations.

- Increased the collection and analysis of feedback from FFTs and PALS contacts which are informing practice. 59 FFT responses received by April 2024 – 80% are positive and 12% negative.
- Introduced meet and greet staff to welcome service users to community hubs and help identify any issues they might have.
- Introduced DIALOG+ a collaborative and needs led care planning tool. Also focuses on 11 key areas of day to day living such as employment, housing, and relationships. Monthly audits of care plans are being carried to monitor standard and quality.
- Since February 2024 the number of DIALOG+ plans for service users on a Care Programme Approach (CPA) has increased from 358 to 886 and from 113 to 236 for those on Care Support.
- Introduced health passports and buzz cards to Improve service user access to information about their care and key points of contact including emergency contacts.
- Introduced Support Time Recovery workers into CMHTs who work closely with our service users and VCFSEs to support in accessing and signposting to support for a arrange of social needs that can impact on mental health.
- 76.6% of BSMHFT staff have undertaken the Oliver McGowan training1 after it was made mandatory early 2024. 68% of those trained are from Birmingham Healthy Minds and 74.6% from Older Adult Community Services.

Healthwatch Birmingham and Healthwatch Solihull's response to the UK Parliament's call for evidence regarding Community Mental Health Services

Healthwatch Birmingham and Healthwatch Solihull welcome the opportunity to respond to The UK parliamentary call for evidence regarding Community Mental Health Services. Our key role is to make sure that patients, the public, service users, and carers are at the heart of service improvement in health and social care across Birmingham.

We welcome that the Health and Social Care Committee are looking into this important topic, as we have heard feedback on it from many people across Birmingham and Solihull. We monitor the demographics of the people we hear feedback from, to ensure our feedback is representative of the diverse communities across Birmingham and Solihull.

Evidence from Healthwatch Birmingham's report: Experiences of NHS community mental health services in South and East Birmingham

In February 2024 Healthwatch Birmingham published a report detailing the experiences of patients trying to access NHS community mental health services in South and East Birmingham. Our full report can be found here:

[Experiences of NHS Community mental health services in South and East Birmingham - Healthwatch Birmingham]

This report showed that while some had positive experiences around awareness of the support available, consideration of needs in care planning, mode of access, and treatment by staff. Many more people had faced challenges when accessing community mental health services which highlighted the following key issues to address:

- Quality of access (e.g. waiting times, quantity of sessions, mode of access, and lack of support while waiting for appointments).
- Quality of appointment (e.g. being disbelieved, feeling rushed, and cancelled appointments).
- Quality of treatment (e.g. overreliance on prescription medication, and strategies or activities offered).
- Consistency and continuity of care (e.g. relationship continuity, knowing who to contact, and access to Community Psychiatrist Nurses).
- Care planning and review (numbers of people having a care plan and how well it captures people's needs).
- Support with health and wellbeing (e.g. support with physical health, money, work, housing, relationships, trauma, abuse, and addiction).

In November 2024 we published an impact report detailing the steps that had been taken to address these issues within Birmingham sine the original report was published:

[Impact report: Improving NHS Community mental health services in Birmingham - Healthwatch Birmingham]

These changes included:

- Active recruitment to the Community Mental Health Team resulting in a reduction of 14% in the number of people waiting for CMHT assessment between February and August 2024
- Decrease in individuals waiting longer than 40 weeks for talking therapy from 341 in August 2023 to 0 as of July 2024.
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Evidence from feedback gathered between April 2023 and December 2024 across Birmingham and Solihull

We have received 218 pieces of feedback about community mental health services within this timeframe from people across Birmingham and Solihull which we would be happy to share upon request. Of these 218 pieces of feedback 85 were from Solihull residents and 133 were Birmingham residents.

We received 38 pieces of feedback detailing positive experiences with community mental health services:

"I had a wait of 6-7 months from being referred, during that time I was provided with information of crisis numbers and support groups. I have been seeing a mental health practitioner weekly. I am really feeling the benefit of these appointments and the consistency of them."

"Really helpful. I have been in remission for 2 years, but they touch base every 6 months with psychiatrists and see how I'm getting on. Very happy with them."

"The community mental health team sorted my medication and were helpful. I had 2 psychiatric nurses to help me. Brilliant."

"They come out very prompt. Any new referrals made, and they are straight over. They're very good to work with and I feel like they're there to help people."

"I have been under the care of the community mental health team for the past two years. My CPN has been very good and I feel like they are really helping me."

"I see a psychiatrist there every 3 months and I'm under a consultant. They're very nice people and I like talking to them. They are very understanding and ask the right questions and I answer them honestly."

"I was listened to and believed, very important when you feel alone with your struggles with mental health conflict."

Despite these positive experiences 81% of the feedback we have heard regarding community mental health services in Birmingham and Solihull has been negative. Across this timeframe we have heard 162 negative experiences which are largely consistent with the issues highlighted in Healthwatch Birmingham's 2024 report:

Quality of access and wait times for appointments

One of the most common concerns expressed in the feedback we received was that it was too difficult to access community mental health services. Many of the people who shared their experiences told us that the wait time for an appointment was too long:

"I've been waiting five years for treatment for learning and emotional difficulties. Having been referred to these to cull the wait time I haven't heard anything back at all. I had no clarification or aim for a treatment plan. That was a year ago. Been in hospital for my conditions before and it seems like these could not care less where you end up"

"It took 9 months to hear back from this service after I requested support."

"Waiting lists are too long. I waited 5 years for long term art therapy for suicidal feelings and a personality disorder."

"I have been waiting 6-9 months for some sort of Counselling CBT or something similar to that effect. My question is why am I waiting so long?"

"I am overdue an appointment with them by over a year. I phoned and they gave me an appointment. A couple of days since and they cancelled it. They said they would give me another appointment but that was in July and there has been nothing. The appointment was due in 2022. They say they will pass on details to receptionists. The psychologist has left but I have not seen anyone since. Still waiting for an appointment. They gave me a list of things to help but they weren't helpful."

A number of people also expressed concerns that following an initial consultation they were waiting a long time for a follow-up with little support from staff:

"I had an appointment with forward thinking Birmingham and the doctor didn't show up. I received a brief apology from the receptionist who then said she couldn't escalate it and it would be months until my next appointment. I needed that appointment to finalise a diagnosis before moving area."

"They've cancelled two of my husband's appointments, one in March and another in June which has been rearranged for July. My husband is getting worse. They have not offered any support in the meantime and I am struggling."

"I have had one appointment and have not been seen since. I have chased up appointments to be told that they are understaffed and that I just have to wait to hear from them with another appointment. Disappointing support from a poorly run service."

"Since they got involved in my relative's care it's as if they are only interested in whether he's alive. Appointments only come through every 6-12 months and the follow-on care is awful. It's disgraceful."

We also received 2 comments from Solihull residents detailing issues accessing services in their local area and having to rely on public transport to attend appointments which is preventing them from accessing treatment:

"Mental health support is lacking in certain areas of Solihull. To access support services and community and/or charitable groups you have to travel either into the north of the borough or into Birmingham. My mental health makes it difficult for me to navigate public transport to access these services and I feel isolated and that this is a barrier to me getting the help I need and want."

"I feel that there are not enough mental health services available in the Balsall Common area. Travel to and from services in Solihull is difficult due to public transport limits. I have tried to access support services but with the last buses running at 6pm from Solihull to Balsall Common I am unable to access some of the services that operate. Travel to Coventry from Balsall Common is easier and public transport is more reliable and convenient but I am unable to access the service there because of where I live. We live in a postcode lottery and I feel our community is greatly disadvantaged, having a Coventry postcode but being in the Solihull Borough."

Lack of face-to-face appointments

Several Birmingham residents expressed concerns around the lack of face-to-face appointments offered by community mental health services:

"I haven't seen them in a while. They used to not be as good but they have improved more recently. They do call me but I don't have much face to face appointments with them."

"Phone calls are no good. I need something more face to face. I told them I need to see them and they don't listen to me or offer that one to one support. They could do more."

"The computer system has been down for several months so they have no access to patient details. The receptionist said this is 'very difficult'. My relative has no medication but can't get any until they see a psychiatrist. My relative is in crisis but cannot access any face to face appointment. The service is for young people up to the age of 25 yet they are being left with no meds and no support. Poor service not fit for purpose."

"I see the psychiatrist but they don't give regular appointments. I am supposed to have face to face appointments but I had the last one over the phone. I have been down to see her since though"

Poor communication

We heard experiences from people in both Birmingham and Solihull regarding poor communication from services. Many people told us that they had issues getting in touch with the service when trying to follow up on issues they are having:

"The mental health care at this clinic is currently atrocious. My 3 monthly appointments have been changed to every 6 months without any consultation. When you phone the main number they either don't answer or if they do they cannot communicate effectively and can't understand you. If you make a complaint about

the service it can be used against you. I believe that it's too late to offer help at the point of crisis when support should be given to prevent a crisis."

"My husband was given a diagnosis of a new mental health condition by letter. We had to look it up on the internet. He then had to wait six months for an appointment to understand what it was and what it meant to him. Appointments are about every six months and consist only of a medicine check rather than any meaningful support."

"I was discharged from the service and wasn't informed. They told me to call them on the crisis line when I was having any issues but they said they couldn't help me as I'd been discharged."

"They are meant to see me every 6 months and I haven't been contacted or interacted with for over 8 months. The psychiatrist doesn't see me. I have no CPN in place, no number to contact, no contact with the mental health team since April 2023. I told them my medication wasn't working and they said they would make a note and still they didn't contact me since December 2023. It's not good enough."

"The staff are good and helpful but communication is not that good. It's very hard to get them on the phone. Our appointment letters have got lost a number of times."

"Not helpful at all. No communication and they need to do better. I managed to speak to the CPN yesterday. They wanted an email but I wanted to speak to someone. They put me through and they told me that the social worker should be dealing with the issues not them."

Consistency and continuity of care

Several people in Birmingham and Solihull told us that they had experienced issues with continuity and consistency of the care they received:

"It was hard going there as I would never see the same person twice. I saw a lot whilst in the army and had to speak to someone, saw someone different every time and had to relive experiences over and over again. Ended up leaving the service because there was not continuity."

"The care was initially quite good but over a period of time it worsened. The appointments I was sent were repeatedly delayed and this did not help my depression."

As noted in the community mental health services report by Healthwatch Birmingham, many of those who experienced issues with consistency told us that these were caused by workforce issues, including high staff turnover:

"They were good and I used to be seen every month. I feel like the lady who took over my care took a dislike to me. She said I had missed an appointment, but I had not, but they refused to see me. I had to get another referral from my doctor. They now only see me once every four months. I have told them how desperate I feel, and about my suicidal thoughts but this did not change anything. I do not feel well supported."

"There are no psychiatrists! They keep leaving. My young adult is suffering badly because of lack of appointments. Oaklands needs extra funding urgently to find and retain psychiatrists!!!"

"When my nurse practitioner left there was no one to take over her patients.. So have been passed from pillar to post since. Appointments cancelled and no follow ups."

"You don't get as many appointments as you should and you get 2 face to face appointments that are 30 minutes long. My psychiatrist left and I didn't have an appointment for 6 months."

"I have been a patient at Lyndon Clinic for many, many years. Over these years I have been given a wrong diagnosis, then changed Psychiatrist to be given a totally different diagnosis. I was never told when my psychiatrist was leaving, this has happened to me 4 times so far and I am now waiting to be given an appointment to see another Psychiatrist."

"I am not seen as regularly as I need or want to be. There have been a number of staffing changes with doctors disappearing just as you build rapport with them. I also feel that mental health support could be better as waiting lists are too long currently."

"I had a really great psychiatrist who listened to me and was very thorough in providing excellent care. They felt that my previous diagnosis was not correct and supported me in getting the right diagnosis to ensure that I got the help I needed and had access to the right medication. Unfortunately, they have now left and I have been unhappy with the service provided by my newly appointed psychiatrist. They do not listen to what I want to say and I feel like they dismiss me. The mental health nurse I see is okay."

Issues with medications

Various issues were reported regarding prescriptions provided by community mental health services. Some patients felt that medications that they were prescribed were inappropriate for their needs:

"This clinic is awful. They prescribed medication for me and I took the prescription to my pharmacist who knows me well and knows my medical history. They told me in no uncertain terms that I should not take the medication as it could make me seriously ill and relapse. I have made an official complaint but have not received an adequate response"

"I was referred to the maple leaf centre with stress related issues. They diagnosed me with depression and gave me drugs for sleep that turned out to give me psychosis, no one picked up on this and I somehow managed to discharge myself."

"The caller says for the past three weeks he has been forced to take risperidone by the team there. Someone from the mental health team comes everyday feeding him these tablets. He does not want to take this medicine because of the side effects. He feels they are making him ill, unsteady on his feet, dizzy. This is difficult because he is looking after someone who is 91years old. He says the mental health team has threatened to take him away if he refuses to take the medication. He wonders why

over the past three weeks he has been forced to take these meds when they have only seen him twice over the past two years."

Several people told us that they have had issues obtaining medications that they have been prescribed by community mental health services. When trying to rectify these issues they have experienced poor communication from service providers:

"I have been without one of my medications for over a week now. I have been to the [service redacted] and I have made a number of calls to them. I have put a complaint in in writing and was promised that the manager would get back to me the next day but they did not. I have been told by staff there to rely on another medication and to increase the dose, but I am a recovering addict and I have been clean for 14 months. The increase in this particular medication would not be good for me as it is highly addictive. I just want my prescription and I do not understand why they cannot just write one for me. They have not given me any other reason as to why the medication is not being prescribed and it is just a case that someone needs to write it up. The service has been awful and for a service that is supposed to be supporting my mental health they are only making it worse. The longer I am off the medication the increasing chances I have of my mental health becoming unstable and when I start the medication I will suffer the horrific side effects that you get when you first start on it."

"I expressly ordered my prescription from them 8 days before my medication ran out so as not to be left with nothing and explicitly asked for it to be a digital one for delivery and yet, my prescription was made a paper one without notifying me and now I'm left with absolutely no medication."

"They are okay but sometimes when I need to get my medication you can't get through and I have to have them authorised as they're a controlled drug. I then have to wait."

Others reported issues due to practitioners taking them off medications that they had previously been prescribed for their mental health issues:

"The doctor looked at my medication and reduced my medication to put me on the straight and narrow. She wasn't interested and didn't want to listen. I am down to 1 tablet a day. It does nothing. Took a year and a half to try and get my medication reinstated. They want me to sit there and talk and not have medication."

"Dr took me off all my meds cold turkey during crisis. Gave me a month script days after an attempt on my life and then discharged me in crisis after another attempt. Such a joke of a service and so dangerous"

Poor organisation

We have also received several pieces of feedback discussing issues with the overall organisation of services. This includes frequent cancellation of appointments and poor communication between staff:

"I am overdue an appointment with them by over a year. I phoned and they gave me an appointment. A couple of days since and they cancelled it. They said they would give me another appointment but that was in July and there has been

nothing. The appointment was due in 2022. They say they will pass on details to receptionists. The psychologist has left but I have not seen anyone since. Still waiting for an appointment. They gave me a list of things to help but they weren't helpful."

"I have dealt with frequent cancellations and re-book letters, once 3 times in a row. I had bad side effects from one medication, I contacted them but I was unable to see or speak to anyone. I hoped my GP could speak with them about this but no, I had to endure the side effects for 5 months."

"I was referred to Chapman Road by my GP approximately 5 years ago and I have been under there care since then. The support is poor with appointments only taking place approximately every 4/5 months. I think that I need appointments more regularly than this. I only ever see a community mental health nurse. My most recent appointment letter said that I would be seeing a consultant psychiatrist but when I attended it was just the community mental health nurse. I queried why I was not seeing the consultant, the nurse told me that they were not there and tried to call them but could not reach them. I did not get to see or speak to the consultant but the nurse eventually spoke to them via the telephone and relayed a message to increase my medication. I was very disappointed with the service, care and treatment. I have had more help and support from community charity groups than I have from the mental health service team."

"I care for my sister who has mental health issues. She was referred to [Service redacted] and had an appointment booked for July. Just before the appointment she received a letter cancelling the appointment and we have not heard anything since. She is in desperate need of help, and as her carer so am I. Her getting better will help me care for her and life is very difficult at the moment with her mental health problems."

Unprofessional behaviour from staff

We also received several concerning pieces of feedback regarding unprofessional behaviour from the staff working for community mental health services in Birmingham:

"Had really bad experience from their people who visit you at home. They cancel on you then you get a letter saying you weren't in at the time of the new appointment that you never even knew about and try to discharge you."

"I've been under home treatment team for a number a months and every time my mental health is at breaking point I find them very unhelpful and misunderstanding by making false promises and some of the staff acting and speaking unprofessionally to the extent of them asking me when my thoughts of suicide are going to stop , they keep signposting me to other places for treatment but never help fill in the forms, they contradict themselves especially regarding my medication which has led to me being confused and potentially unintentional overdosing due to their miscommunication, I have spoken to several managers and all there answer is that there facing extreme pressures which my argument is - they still have a duty of care for their service users"

"My CPN arrived out of the blue while I was out having dinner with her daughter. He also wanted to smoke with me outside on another occasion. This is very unusual and unlike anything else I have experienced"

"I mostly feel like that they are on your side and want to help you. Other things they do are more questionable. They gave me and my partner the same psychologist, didn't think they could do that."

We also heard from 2 Solihull residents that staff breached their privacy whilst receiving support from community mental health services.

"Privacy doesn't exist within this service. I contacted them for help, now all of my family and neighbours know. They do not care that they could damage your life further. The executive board are a disgrace and it filters down. Executive meetings are online, but you can't hear them. If you complain they try to come after you. I wouldn't even recommend them as a last resort!"

"Caller is very upset, they are autistic and struggle to walk. callers family who they live with, constantly bully them about their condition. Their father has bullied the caller for 50 years and they are very worried. They have been in touch with BSOL MHFT and Lyndon Clinic who they have lost all faith in as they asked to NOT call the house phone - which they did and informed the father about all of their case. Causing greater difficulty at home. Caller needs help from Mental health services"

Healthwatch Birmingham and Healthwatch Solihull hope that this information will be useful in creating meaningful change in the community mental health care people receive. We look forward to seeing the further work of the committee and to reading the final report once the evidence gathered has been reviewed.

Healthwatch Birmingham and Healthwatch Solihull