Surrey and Sussex Healthcare
NHS Trust

Mental Health Strategy

(2020-2025)

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Putting people first
Delivering excellent, accessible healthcare

An Associated University Hospital of
Brighton and Sussex Medical School

For far too long, people of all ages with mental health problems have been stigmatised and marginalised, all too often experiencing an NHS that treats their minds and bodies separately. With chronic underfunding many people with mental health needs have received no help at all.
In recent years, this has started to change. Public attitudes towards mental health are improving, and there is a growing commitment among communities, workplaces, schools and within government to change the way we think about it, with a real desire to shift towards prevention and transform NHS care.

Quote from the mental health task force, informing the five year forward view for mental health.

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1. Why do we need a mental health strategy?

Outcomes for most of the people using the clinical services that we provide at SASH are of high quality. We have tried hard to nurture a culture of continuous improvement, with strategic decisions led by clinical leaders; improvement led by people who do the work; investment in people and estate led by clinical and educational strategies and enabled by able managers; and a focus on measurement and comparison with peers to understand what we do well, and to learn from others. However, despite these successes, and our 2019 CQC inspection awarding us a rating of Outstanding, like many organisations we are not making the same advances in the offering we make and the outcomes we achieve in mental health. This is true for those people in our care with crises relating to mental health diagnoses, and for people with acute and chronic somatic disease who are experiencing acute or relapsing mental health disease.

Physical and mental health are closely linked – people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England. Two thirds of these deaths are from avoidable physical illnesses, including heart disease and cancer, many caused by smoking. There is also a lack of access to physical healthcare for people with mental health problems – less than a third of people with schizophrenia in hospital received the recommended assessment of cardiovascular risk in the previous 12 months.

In addition, people with long term physical illnesses suffer more complications if they also develop mental health problems, increasing the cost of care by an average of 45 per cent. Yet much of the time this goes unaddressed. There is good evidence that dedicated mental health provision as part of an integrated service can substantially reduce these poor outcomes. For example, in the case of Type 2 diabetes, £1.8 billion of additional costs can be attributed to poor mental health. Yet fewer than 15 per cent of people with diabetes have access to psychological support. Pilot schemes show providing such support improves health and cuts costs by 25 per cent.

These figures reveal some of the gap between what is needed and what is provided at present. Like the NHS long-term plan, the reason for developing this strategy is not to underline how the NHS fails those with mental health need, but to describe our improvement strategy and what we want and expect to achieve. This is what delivering the parity of esteem called for at a national level means for people living with acute, or more chronic mental health needs.

The strategy describes how we will work with community, primary care, voluntary sector and mental health partners and the advantages the change in environment to sustainability and transformation Plans (STPs) or integrated care systems (ICS) bring. It describes how we can use our learning from other areas in which we have improved. It is also an acknowledgement that we don't do all we can and there is a much better way of working with carers, with the third sector and even with academia and industry to make a better, more effective offering to people. However, above all else it describes a strategy for giving our staff the confidence and skills that all the people we employ should have in order to confidently and effectively support and signpost the people we look after, as we expect for basic life support and basic safeguarding.

There is no health without mental health and we want the best health and outcomes for everyone who uses our services. In this strategy you will see numbers that relate to the scale of the challenge, expressed as incidence of disease, or pre-disposing factors, or cost, which help show that even where we can measure this is not a small problem. What we recognize though is that for a long time

mental health illness has been underreported and counted. These numbers therefore represent the visible tip of the iceberg and it's now time to address this and what lies beneath the water.

The NHS Long Term Plan sets out plans for the future and suggests that mental health investment will proportionally far outstrip that of the NHS nationally. Milestones for mental health services for adults include:

- New and integrated models of primary and community mental health care will give 370 000 adults and older adults with severe mental illnesses greater choice and control over their care and support them to live well in their communities by 2023-24

- By 2023-24 an additional 380 000 people per year will be able to access NICE-approved IAPT services

- By 2023-24, NHS 111 will be the single, universal point of access for people experiencing mental health crisis. We will also increase alternative forms of provision for those in crisis, including non-medical alternatives to A&E and alternatives to in-patient admission in acute mental health pathways. Families and staff who are bereaved by suicide will also have access to post-crisis support

- By 2023-24, we will introduce mental health transport vehicles, introduce mental health nurses in ambulance control rooms and build mental health competency of ambulance staff to ensure ambulance staff are trained and equipped to respond effectively top people experiencing a mental health crisis

- Mental health liaison services will be available in all acute A&E departments and 70% will be at 'core 24' standards in 2023-24, expanding to 100% thereafter

For children (including learning disability and autism):

- Improved access to mental health services so that 100% of children and young people requiring access to mental health support will receive it

- Expansion of age-appropriate crisis services to improve the experience of children and young people and reduce pressures on accident and emergency departments, paediatric wards and ambulance services. All children will be able to access crisis care 24/7.

- A new approach to young adult mental health services for people aged 18-25 will support the transition to adulthood.

- The whole NHS will improve its understanding of the needs of people with learning disabilityies and autism, and work together to improve their health and well-being.

- Increased investment in intensive, crisis and forensic community support will enable more people to receive personalised care in the community closer to home and reduce preventable admissions to inpatient services. Every local health system will be expected to use some of this growing community health services investment to have a seven-day specialist MDT service ad crisis care

- By 2028 we aim to move towards service models for young people that offer person-centred and age appropriate care for mental and physical health needs, rather than an arbitrary transition to adult services based on age not need.

Our plans as a system need to reflect the requirements of the Long Term Plan and we will work with our Surrey Heartlands Integrated Care System and Sussex Health and Care Partnership colleagues to develop plans to meet these requirements.

The Mental Health Taskforce have placed the experience of people with mental health problems at the heart of national strategy. Over 20,000 people told the enquiry of the changes they wanted to see so that they could fulfil their life ambitions and take their places as equal citizens in society. They told the task force that their priorities were **prevention, access, integration, quality and a positive experience of care.** As a Trust we intend to respond to this and ensure we address each of these aspects within our strategy.

2. What are the needs of our community?

Approximately 1 in 4 people in the UK will experience a mental health problem each year. Reports from both England and Wales suggest that approximately 1 in 8 adults with a mental health problem are currently receiving treatment. Medication is reported as the most common type of treatment for a mental health problem.

People with mental health conditions in our area live up to 20 years less than the general population and are around 2-4 times more likely to die of cancer, circulatory or respiratory disease than the rest of the population.

Prevalence of mental health and suicide in the area is lower than the national average and the prevalence of learning disabilities is higher. However, suicide levels are such that suicide is considered a public health emergency.

20% of emergency admissions are for people with mental health conditions despite accounting for 7% of the overall population.

Access to children's and young people's services are below the national standard throughout our geography.

Spend per head of the population on mental health services is well below the national average.

There is a high % of ladies access perinatal mental health services compared to the national average

Local authority ranking for Alcohol treatment is one of the lowest in the country. Wait times are poor and there are a high number of drinkers not receiving treatment.

Compared to other local authorities treatment for substance misuse is poor and there are a high number of opiate users not in treatment. Expenditure on substance abuse is high.

High proportion of resident population with dementia and numbers expected to double in next 20 years. There are higher numbers of admissions for those with dementia compared to peers.

One in five older people living in the community and 40 per cent of older people living in care homes are affected by depression. Diagnosing depressive symptoms can be difficult, and we know that some clinicians believe treatment for depression is less effective in older people, despite evidence to the contrary.

People in marginalised groups are at greater risk, including Black, Asian and Minority Ethnic (BAME) people, lesbian, gay, bisexual and transgender people, disabled people, and people who have had contact with the criminal justice system, among others. BAME households are more likely to live in poorer or over-crowded conditions, increasing the risks of developing mental health problems.

MIND, a mental health charity, note that the most common mental health problems are mixed anxiety and depression (7.8 in 100 people), generalised anxiety, post-traumatic stress disorder, depression and phobias (2.4 in 100 people). Antisocial personality disorder and bipolar disorder are measured over a lifetime rather than annually and these also have similar prevalence levels to depression and phobias. Also measured over a person's lifetime prevalence of self-harm (7.3 in 100 people) and

suicidal thoughts (20.6 in 100 people) is significant and rising. These numbers are provided in greater detail within the Appendix and they describe the main mix of mental health conditions that are affecting the 25% of the population.

If 25% of the population are affected by these mental health conditions we should assume that at least 25% of patients accessing our health services every day either in inpatient care, outpatients, diagnostics, maternity etc have other needs over and above the care we provide. Some people will already be receiving care from mental health services but many will not. There is currently limited support within existing services.

Suicide rates have fallen since 2014 (4,882 deaths) but is a leading cause of death for men aged 15–49. Men are three times more likely than women to take their own lives. A quarter of people who took their own life had been in contact with a health professional, usually their GP, in the last week before they died. Most were in contact within a month before their death. More than a quarter (28 per cent) of suicides were amongst people who had been in contact with mental health services within 12 months before their death, amounting to almost 14,000 people in the ten years from 2003-2013. However, suicides amongst inpatients in mental hospitals have significantly declined over the same period, as a result of better safety precautions.

All areas of England have multi-agency suicide prevention plans in place. Within the long term plan reducing suicide remains an NHS priority.

Mental health accounts for 23 per cent of NHS activity but NHS spending on secondary mental health services is equivalent to just half of this. Years of low prioritization have led to Clinical Commissioning Groups (CCGs) underinvesting in mental health services relative to physical health services, but the degree of the disparity has largely been obscured by the way spending on mental health conditions is grouped together and reported, unlike spend on physical health care, which is disaggregated by specific conditions. Spending per capita across CCGs varies almost two-fold in relation to underlying need. Within the long-term plan there is a commitment that growth in funding for mental health will outstrip the overall rise in funding negotiated for the next five years.

3. How have our community, staff and partners helped to shape our strategy?

We consulted with our local citizens, patients, staff and partners on our draft mental health strategy. As an acute Trust we know there are otehrs that are better qualified and members of ur community with experiences that we wanted to undertand in order to finalise our strategy and make sure that we are focusing on the right things.

Our patients told us:

- A mental health strategy was an excellent step forward but a patient friendly version should also be produced.
- Some patient groups have not sufficiently been included within the strategy and as such further work is required to describe who the strategy.
- There needed to be a recognition of mental health underfunding generally and the impact this has on the services but ultimately families and carers.

Our staff told us:

- We need to be able to suport mental health for all of our patients in all settings and this will require a robust training programme and access to resources for patients to access.
- We need to include more around the mental health and well-being of our staff.
- We need to consider our mental health support offering for all patients with long term conditions whch should include psychological therapies.

Our partners told us:

- The strategy needs to recognise the role of the voluntary sector and the large number of organisations that can support the Trust in delivering better care for patients. Use the expertise that exists.
- A system approach to mental health and well-being with prevention as key is needed. Funding will be key and a commitemtn from the whole system.
- The system needs to be joined up whilst also recongising the constraints on some services and the impact that long standing shortfalls in investment have had on; these issues need to be addressed to improve system wide access to mental healthsupport as well as focusing on integration.

4. Our pledge

All of the people we look after should be able to say:

- Services and professionals listen to me and do not make assumptions about me.
- Those who work with me bring optimism to my care and treatment, so that I in turn can be optimistic that care will be effective.
- The staff I meet are trained to understand my condition (be it mental, physical or both) and able to help me as a whole person.
- Staff support me to be involved in decisions at the right level. They respond flexibly and change the way they work as my needs change.
- Wherever possible, there are people with their own experience of using services who are employed or otherwise used in the services that support me.
- As far as possible, I see the same staff members during a crisis
- I do not have to keep repeating my story to get the help and care I need
- My culture and identity are understood and respected when I am in contact with services and professionals. I am not stigmatized as a result of my health symptoms, diagnosis or history, or my cultural or ethnic background.
- The strengths of my culture and identity are recognized as part of my recovery. My behaviour is seen in the light of communication and expression, not just as a clinical problem

5. How will we deliver change?

As stated previously, although we have improved the performance of many of our clinical pathways so that the people using them have a higher quality experience and a better outcome, we have not done enough to improve the identification and support of people with mental health diagnoses. This strategy is a call to arms to change this. This strategy confirms we believe not just in parity of esteem for those living with mental illness, but that we will use the partnerships we have and the empowered and enthusiastic staff we employ to ensure the best outcomes for people using our services. We will do this through staff education and through building our external partnerships to the advantage of our population. We explicitly recognise the role primary care plays and we will work with them around individual needs and on the methods of communication and information flow that enable this to be effective.

This strategy has been developed by the Trust Board, its executive, and in consultation with partner organisations and the public. It forms a covenant with our staff to improve the care for people with mental health illness. A covenant is an agreement which emphasises what is required to meet a need, the gives and the gets. Through our education strategy, our estates strategy, our clinical and quality strategies, we will co-design the skills, tools and knowledge that staff require to be confident and effective in dealing with mental health issues as well as physical health challenges. Working with our partners in Sussex Health and Care Partnership and Surrey Heartlands, we will deliver better care joining up of pathways for people that more effectively cross traditional boundaries, centred on the individual, whatever their mental health need.

The Taskforce that helped inform the 5 year forward view for mental health heard a strong message that staff across the NHS need to have training that equips them to recognize and understand mental health problems and to treat people with mental health problems with dignity and respect: treating ‘the person, not the diagnosis’. This is critical in enabling people with mental health problems to play a more active role in making choices about all aspects of their care, based on a more equal and collaborative relationship between the person and professional(s). A number of people described encountering poor and unhelpful attitudes from some staff within mental health services as well as staff in the wider NHS (including GP surgeries, hospitals and non-clinical staff). Developing a paid peer support workforce had considerable support. People also wanted clearer protocols for staff when they are working with carers.

The covenant we would like this strategy to underpin is that for all 4,500 SaSH staff to give the maximum benefit to all the people in our care, they must feel comfortable in recognising and talking to and about mental wellbeing, and in bringing it to the attention of staff who need to know and can provide greater help themselves or through referral. This recognition and support must extend to recognizing the signs of stress and distress in colleagues. This came through clearly in our own consultation on the first draft of this strategy. To quote one contributor:

We have to lead by example. Managers need training in recognizing and dealing with mental health problems in their staff. There needs to be a culture of positive stress management. Staff work exceptionally hard but they *have* to look after themselves. You can’t pour from an empty cup.
To do all this staff require training and permission and evidence that what they are doing makes a positive difference for the public we look after. As an acute hospital trust we will give that training and develop ways in which we can demonstrate its effect, including the qualitative patient stories that have worked so well in focusing our efforts on need, and quantitative information that we can measure and publish.

The following programmes of work will support delivery of our ambition. Each of these will be delivered with system partners and colleagues with a focus on co-design, utlisation of SASH+ methodology to "have a go" at new ways of working, evaluate its effectiveness and build upon our cycle of continuous improvement. We will develop key performance indicators that will tell us whether we are having the impact as a system and as a Trust in the way that we want to; an impact that improves patient experience as well as targets the health inequalities described at this start of this strategy. This is a Board owned strategy and as such it will be subject to six monthly review with a team of leaders involved in delivery at a tactical level. An overview of our strategy is provided in the diagram below but is then expanded in the narrative that follows.

Overview of our mental health strategy

Staff mental health and well-being	**Mental health training for staff**	**Meet the needs of our patients**	**Consistency of offer (regardless of county)**	**Targeted intervention**	**Addiction Services**
Ensure our staff are able to **maintain mental health and well –being** both in the workplace and at home.	Work with partners to develop a **comprehensive mental health training** programme	Ensure systems are set up to collect **data** that is needed throughout a patients pathway which then enhances the way we care for patients	Develop a **long term strategy for the Integrated Care Partnership** outlining how mental health services should support the population of the future	Develop services that **meet the needs of children and young people** whilst within our services as well as supports **ongoing prevention** initiatives	Work with partners to establish better pathways for **substance misuse** providing support for patients in the community
Equip our staff with the skills to **support each other** to access support services when it is needed	Develop **resources** that support staff to **signpost patients, families and carers** to the right services	Develop a **capacity and demand tool** to support ongoing system conversations that **close gaps** in services	Develop **standard pathways, referral protocols, access thresholds and information** for families regardless of postcode	Systematically review the support available to all patients with **long term conditions** and work with staff and partners to ensure training and pathways meet patient need	Work as a system to address **rising alcohol consumption levels**, inpatient admissions for detox purposes and provide alternatives that help people to manage their addiction
Create **ambassadors for mental health** and well-being	Promote well-being to all patients by **making every contact count**	Develop **joint policies** for mental health act implementation, rapid tanquilisation, medications and restraint	Develop a plan for **commissioning services as an ICP** with a single provider for tertiary mental health services	Develop an approach to **suicide prevention** that supports system plans	

5.1 Staff mental health and well-being

Our staff are our most important resource and as with the rest of the population they also have challenges and needs for their mental health. We must meet these needs to ensure a happy, motivated and well workforce that are able to provide the best care for our patients. In doing this we will:

- Develop a health and well-being strategy that focuses solely on our staff. This will be delivered as a key part of our Workforce and Organisational Development Strategy and will focus on healthy living, availability of exercise at work, stress management, support following difficult or

traumatic experiences and shaping how we improve staff health and well-being in partnership with our staff.
- Develop mental health ambassadors along the lines of our successful culture champion work.

5.2 Mental health training for staff

- Promote well-being in the form of diet, exercise, alcohol and substance misuse, social networks, social prescribing, the impact of isolation.
- Develop standard paperwork that all staff will be trained to use that support a systematic way of evaluating a patients mental health
- Develop online resources for staff, patients, carers and their families that describe patient pathways and the help that is available throughout. Make links with statutory services and voluntary sector websites to help patient navigate through the complex variety of services and support that is available.
- Promote early intervention, resilience and recovery through use of appropriate services including third sector and light touch psychological interventions that staff can use themselves
- Work with our partners to make best use of their skills and experience to shape our training programmes for example, public health, mental health NHS Trusts, alcohol and substance misuse services, MIND, Autism Partnership Board. Through our consultation it was clear that many partners wish to work with the trust to develop a truly rounded and supportive training programme
- Develop novel, effective tools for education and training so that staff have confidence in what to look for and what to do to support people with mental health conditions as well as be able to easily access the resources they need regardless of the environment they are in. A member of staff delivering outpatient appointments at Horsham should be able to access resources as easily as a member of staff working out of care of the elderly ward at the East Surrey hospital site
- Develop service specific training for example, Emergency Department staff will require different training to staff in a paediatric environment to those supporting patients with chronic and long term conditions.

5.3 Meet the needs of our patients

In order that we can meet the needs of our patients we need to be able to quickly identify those patients with a need, respond appropriately and track progress. This requires robust data collection, the right information systems for tracking mental health status and the ability to track referrals to other services.

In an Emergency setting we need to be able to quickly refer to the Core24 psychiatric liaison service, monitor how long patients are waiting for their assessment, admission, onward referral to another service and overall length of stay.

On a ward setting staff need to know that where specialist mental health input is needed that it is being delivered, care plans are in place and discharge planning is coordinated with the hospital clinicians.

In an outpatient setting staff need to know beforehand if there are special arrangements that may be needed for a patient; this could include the way someone is greeted to how they can be most comfortably accommodated in a busy waiting area. Furthermore earlier knowledge of a mental health

need can facilitate better management of the pathway eg multiple appointments can be coordinated to occur at the same time, additional information could be provided at the time of sending the initial outpatient appointment letter.

With better data both within the Trust and as a system we will be able to plan services, plan activity flows and better meet patient demand. Key things to be developed with system partners moving forward include:

- Data improvement plan that is system owned
- a capacity and demand model developed with commissioners to understand patient flows and ensure that onward capacity within mental health services meet demand; this would need to include community services as well as inpatient mental health services and specialist tier 4 services. Capacity needs to be understood at county level for both adults and paediatrics with supporting commissioning plans to address known gaps.
- Develop a dashboard that enables management of patients with mental health problems to be more visible to support reductions in delays both in assessment and time waiting for onward support.
- Development of a system dashboard that looks at patient pathways and delay throughout the system

Through this programme of work we would expect to be able to demonstrate the benefits and reductions in delay that patients will experience as a result of this strategy.

Shared Policies
There is a opportunity to bring together how SASH and parner orgnaisations work by having a set of shared policies these might include implementation and oversight of the mental health act, rapid tranquilisation, observations, covert medication, restraint etc. A group should be established to consider how to bring together these concepts and have shared ways of working.

5.4 Consistency of offer regardless of Surrey or Sussex residency

In line with the NHS Long Term Plan the Trust will work with partners to develop a geographic based approach to pathway development and service planning. Through this work we would expect to see the same excellent, timely services offered to patients of all ages within our geography. All services should be set up to meet the needs of patients and should have the same thresholds for access. This will simplify the system which is incredibly complex and difficult not only for professionals to manage but also for patients, carers and families. We will work with our partners through our Integrated Care Partnership (ICP), patients and citizens to co-design services that reduce variation in service provision and standardise the approach for assessment, onward referral, thresholds for admission to mental health beds and integrated inpatient care.

In support of this we would ideally work with a single mental health provider for all of our patients and deliver a *Gold Standard* service with agreed standard work, pathways and quality outcomes. This would ensure that children, adults and older adults all have the same patient pathways regardless of postcode. The Trust recognises that this would be a longer term plan but there are already elements of this model work as can be seen with the Core 24 psychiatric liaison team. Next steps will include a paediatric psychiatric liaison team working in the same way; plans for the longer term would need to be developed through the ICP.

Silver standard would involve standard approach to assessments, thresholds for mental health beds, inpatient support, CAMHS service provision and trusted assessor models provided onsite but by existing Trusts. This would be an interim model that the system should explore to try and streamline our offer to patients.

Bronze standard is what is currently in place and does not meet the needs of our patients.

5.6 Targeted Interventions

Children's and Young People's Services

Demand for children's and young people's mental health services far outstrip capacity and due to long wait times in both Surrey and Sussex for CAMHS and Neurodevelopmental services families often feel unsupported and unable to get the help they need when they need it. In times of crisis children, carers and families will often arrive at paediatric Emergency Department in need of support and care. An acute setting is often not the right environment but as it is the place that many people associate with the place they can guarantee support we need to respond to this. A psychiatric liaison team providing quick assessments (for children with mental health, neurodevelopmental and behavioural conditions) and onward referral and crisis intervention is needed which will require not only the development of an appropriate team but also pathways and crisis response services to meet the needs of both patients and carers and families.

The NHS Long Term Plan specifically highlights the need to think about how we provide services to young people aged 16-25 and feedback from our strategy consultation suggests that there is more to do about how we configure our services and also the networks that we establish to support our patients. This may impact on how we use our inpatient beds, how we manage our waiting areas and the material we provide to our young people that might need to be different to the material we provide to children and to adults. Suicide prevention and mental health support provided through colleges and Universities should also be considered so that onward pathways are utilised as appropriate. When developing resources for patients, carers and families, this age group should be considered separately.

Children with long term conditions would benefit from access to psychological therapies in the same way that children with diabetes currently receive. We should learn from what works well in one specialty and spread this to others through using existing services aswell as considering expanding the current long term condition support on offer.

Our plans for enhancing our services for children must take account of patients with mental health conditions, neurodevelopmental disorders, behavioural conditions and learning disabilities. We heard this message throughout our consultation and we will work with our partners and third sector colleagues to ensure we deliver the best services possible.

Patients with Long Term Conditions

Current mental health support services within SASH include psychological support for patients that have had a stroke, patients nearing end of life, patients with cancer and patients on the Intensive Care Unit. As with children it is recognised that there is a higher likelihood of depression and anxiety amongst those with a long term condition and services that already exist could support patients to

better manage their mental health. Initially the Trust will ensure that our resources, training and signposting services support patients accessing these services but longer term we would want to see routine access to psychological support on our wards, within our outpatient settings and in the community (through our partners).

Suicide Prevention
Suicide is the predominant reason for all patients arriving at the Emergency Department that then get referred to the psychiatric liaison team. It is a growing concern and suicide prevention strategies are now a requirement up and down the country. The Trust can do more to learn from these strategies, integrate their approaches within our training programme and support our staff to identify and support patients at risk. Our Core 24 psychiatric liaison team are skilled in these areas and will work with Trust staff to share their skills and resources.

5.7 Addiction Services

Substance misuse services should be better understood in terms of the capacity within existing services as well as evidence based best practice in order to inform a model for the future which would benefit our patients. Commissioners, providers and patients should co-design how services can be delivered through mainstream services as well as through bespoke services for those with greater need.

Alcohol rehabilitation services have a notoriously high threshold level and as such patients are often admitted to hospital, provided with limited advice and guidance, provided with a detox programme and discharged. As the community support is not in place the process becomes cyclical. The system needs a better response and we also need to make more use of third sector organisations. Better data will help us understand the level of need and a system response should be developed.

How will we know if we are making a difference?
Supporting this programme will be the development of a system wide dashboard and key metrics that will enable us to see if as a system we are making a difference. Patient outcomes and quality will be the priority and these will be developed with our patients. Delivery of the strategy will be overseen by our Trust Board as well as contribute to the Integrated Care Partnership plans for the next five years. The governance around this will evolve as the Integrated Care Partnership evolves.

6. Understanding existing services and how they are used

The psychiatric liaison team provides a 24 hour service for assessing patients requiring mental health assessment within the acute setting this can be either through ED or via inpatient referrals. They provide assessment and care within the Emergency Department and on within our inpatient wards.

The service is provided by Surrey and Borders Partnership NHS Foundation Trust (SABP) on behalf of SABP and Sussex Partnership NHS Foundation Trust (SPT), our local mental health care trusts. A trusted assessor approach is in place to support this arrangement. The team has a dedicated area and is PLAN compliant in recognition of the environment and quality of services provided. Referral data shows that 57% of psychiatric liaison referrals come through ambulance conveyances, 7% by police and the rest through walk ins. Whilst it is clear there are gaps in data the main reasons for being seen via the Emergency pathway relate to suicidal thoughts and substance misuse. Ward referrals (which are likely to be predominantly older adult) will have depression, dementia and/ or delirium as the main reason.

SABP also support the Trust to oversee the use of the Mental Health Capacity Act supporting education and training and review of all paperwork to ensure that patients are not detained inappropriately.

SASH
In SaSH, the highest reason for a 0 length of stay is for a mental health diagosis. The 10 Critical Decision Unit beds in ED are often used to accommodate patients with mental health problems and an analysis of average length of stay suggests that patients stay in CDU beds for 4 days. The reason for this length of stay is due to bed shortages within acute mental health settings.

Approximately 16,000 patients with an underlying mental health illness are admitted to SASH per annum. Between 2,000 and 4,000 of these patients are supported to varying degrees by the psychiatric liaison team. There is a potential gap in mental health support for these 16,000 patients (which could also be an underestimate for reasons of non-disclosure or under reporting). The most common mental health diagnoses for inpatients are depression, anxiety disorders, dementia/ delirium and substance misuse. It should be noted that although there are a large number of patients not being provided with mental health support this could well be appropriate as many people manage their mental health independently and do not wish for specialist support; there may be a requirement for lower level support which might include signposting.

In 2016, in England, only 14% of adults surveyed felt they were provided with the right response when in crisis, and only half of community teams were able to offer an adequate 24-hour, seven day crisis service. Only 12% hospital ED had an all-age mental health liaison service meeting the 'core 24' service standard.

Children and young people

Of the 16,000 inpatient admissions where a mental health diagnosis code has been noted 901 of these related to children 0-19. Depression and anxiety continue to be the main diagnosis group but this is followed by pervasive disorder (communication and socialisation skills difficulties) and hyperkinetic disorders (ADHD, hyperactivity and attention difficulties).

Whilst inpatient numbers are small within the paediatric areas the input required is often significant and as such the physical and mental health packages of care currently provided are not sufficient to meet the needs of the children being cared for at SASH.

Our staff

The mental and physical health needs of our staff are as important as the needs of our patients. Stress and anxiety and other mental health challenges are a key reason for underperformance and sickness absence within the NHS and within SaSH. Our partnership with South London and the Maudsley Mental Health trust has helped us as an organisation to promote mental health and wellbeing but there is more that can be done. Over and above this staff as well as patients experience physical and verbal aggression from patient and the public because of anxiety and anger as well as from underlying mental health problems. It is important our response is always appropriate, demonstrates compassion and ensures safety for all. Our work force strategy must reflect work force needs not just in addressing mental health challenges within our patient group, but also within our staff.

We think of services as defined by age group - children and young people's services (CAMHS), working age mental health (which numerically is dominated by liaison psychiatry) and old age psychiatry, which again we quite often refer to as services for people living with dementia. Some of these services are provided by our own staff, especially in respect to care of the elderly and safeguarding and these staff have peer networks within SaSH and out with, to the community. Other services are provided by partner organisations, particularly Surrey and Borders Partnership NHS Foundation Trust, and Sussex Partnership NHS Foundation Trust. In addition, much of the continuing care that people with mental health diagnoses receive is provided by primary care. For many of these care pathways we are unclear of detail and performance metrics, and therefore of the efficacy of these pathways for the people who access services via presentation to us.

Mental Health Trusts in our geography:

- Surrey and Borders Partnership NHS foundation Trust (SABP)
- Sussex Partnership NHS Foundation Trust

Services provided include:

- Assessment and psychiatric liaison services
- Community teams and intervention
- Learning disability services
- Inpatient services
- CAMHS community team including psych liaison services for under 16s.
- Early Intervention
- Personality disorder services

- Easting disorder services
- Forensic services
- Dementia care
- Memory assessment
- Prison care
- Perinatal mental health

Access to mental health services is generally via a GP referral and access in a crisis is via a psych liaison team or a Crisis Resolution team. Ongoing mental health care is provided via Community teams with out-patient style appointments being provided in patients' homes and in community mental health trust bases. Capacity at both Trusts is limited, and activity outstrips the commissioned levels of capacity.

SASH provision of mental health support:

- SaSH spends approximately £750k per annum on bank and agency registered mental health nurses for giving ad hoc 1:1 care, as required ('specialling), approximately 1000 shifts per year.
- Alcohol liaison nurse
- Detoxing of substance misuse patients although not with psychobiological support/ therapies
- Dementia care programme and dementia lead
- Mental Health CQUIN to support top attenders in ED with coordinated care plans
- A recognised place of safety

Over and above this SaSH employs many staff with an interest in mental health and wellbeing and small groups have come together to try to improve local recognition, care to patients and support to carers and staff (for example within Paediatrics on Outward ward).

7. Conclusion

Our patients, staff and partners have responded positively to the development of our first Mental Health Strategy. We have further developed our strategy based upon the feedback that we have received making it more ambitious, responsive, wide-ranging and integrated. The most important element of delivery of this strategy will be the care that is ultimately provided to our patients in all of the settings we work within. These range from in a person's home when they receive a text, a letter, a telephone call, to an outpatient setting, to a busy emergency department to an inpatient ward. In all of these settings we will deliver services that are in line with our values. Mental health care and physical health care will be treated as one in an environment and by a team that focuses on:

- **Safety and quality**
- **One team (the whole system not just SASH)**
- **Dignity and Respect**
- **Compassion**

This strategy will support our staff and partners to work together to do this and improve the patient experience for our patients, their carer's and their families. It is deliberately ambitious in a world where NHS funding is compromised and where mental health services have been underinvested in for years. Much of this strategy can be delivered through partnership working and co-design but it is also important to recognise that investment is needed throughout the system to fund gaps that have been present for yours. This strategy will help inform system planning and shape new ways of thinking that brings mental and physical health together to address the health inequalities that must be addressed within our patient population.

Surrey and Sussex Healthcare NHS Trust

Appendix 1 – SWOT Analysis

Strengths

- Committed Psychiatric liaison team with PLAN status
- Dementia friendly
- Compassionate workforce
- Mental Health CQUIN
- Alcohol and substance misuse nurse
- Core 24 funded service

Weaknesses

- Gaps in data within psych liaison team and CAMHS
- CAMHS assessment provision not consistent across Surrey and Sussex
- Inpatient support for both adults and paediatrics with mental health problems
- Longer lengths of stay for patients with mental health problems and particularly dementia
- No way of managing patient delays on a daily basis and escalating issues to mental health Trust

Opportunities

- 16,000 patient with mental health problems that could be supported whilst an inpatient
- An educated, empowered workforce
- Different commissioning arrangements within integrated care systems
- More money coming to deliver better mental health outcomes
- Optimising bed flow through CDU beds if pathways are more streamlined
- Maximising services and partnerships with the third sector
- Development of mental health dashboard
- A success ful Applied Research Collaborative bid to NIHR brings a link between communities and academia, and money.

Threats

- Increasing mental health needs amongst patients and the population could result in rising spend on RMNs for specialling
- Recruitment and retention of appropriately skilled mental healt workforce
- Rising demand for mental health beds and lack of availability could result in longer lengths of stay for patients whilst they wait for a bed

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