**Mental Health Strategy for Sheffield teaching Hospitals**

### DOCUMENT CONTROL

<table>
<thead>
<tr>
<th>Reference Number</th>
<th>Version</th>
<th>Status</th>
<th>Sponsor(s)/Author(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>177</td>
<td>1</td>
<td></td>
<td>Chris Welsh/Mark Cobb</td>
</tr>
</tbody>
</table>

| Amendments         | None                                      |

**Document objectives:** To describe the current prevalence of mental health needs in STH and the process by which Clinical Directorates can develop plans to address unmet needs.

**Intended Recipients:** Clinical Directors, Nurse Directors, Senior Clinical Staff, General Managers, Service Managers.

**Group/Persons Consulted:** Users & Carers, Clinical Directorates, Sheffield Care Trust, Sheffield PCT, Sheffield Mental Health Partnership Board, Mental Health Foundation

**Monitoring Arrangements and Indicators:** STH/SCT Mental Health Steering Group will monitor key steps and directorate development plans

**Training/Resource Implications:** Training and resource implications will be identified through directorate self-assessment process and fed into Trust planning processes.

**Ratifying Body and Date Ratified**
- TEG, February 2008; Trust Board, March 2008

**Date of Issue**
- March 2008

**Review Date**
- April 2009

**Contact for Review**
- Mark Cobb

**Chief Executive signature**
Mental Health Strategy

**Associated Documentation:**

**Policies:**
Sheffield Teaching Hospitals NHS Foundation Trust Patient Services Plan 2007/8

**Legal framework:**
Mental Capacity Act (2005)
Disability Equality Act (2005)
Mental Health Act (2007)

**External Documentation**
See NICE Clinical Guidelines and National Strategies listed on page 4

---

**For more information on this document, please contact:**

Mark Cobb
Clinical Directorate of Professional Services, Sheffield Teaching Hospitals NHS Foundation Trust
0114 271 3327
Email mark.cobb@sth.nhs.uk

---

**Version History**

<table>
<thead>
<tr>
<th>Version</th>
<th>Date issued</th>
<th>Brief summary of change</th>
<th>Owner’s name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>March 2008</td>
<td>First Edition</td>
<td>Mark Cobb</td>
</tr>
</tbody>
</table>

---

**Document Imprint**
Copyright © Sheffield Teaching Hospitals NHS Foundation Trust 2008. All Rights Reserved
Re-use of all or any part of this document is governed by copyright and the "Re-use of Public Sector Information Regulations 2005. SI 2005 No 1515. Information on re-use can be obtained from: The Information Governance Department. Sheffield Teaching Hospitals.
Mental Health Strategy
for Sheffield Teaching Hospitals

Published: March 2008
Contents

Executive Summary ................................................................. 1
1. Introduction ............................................................................ 2
2. The current position.............................................................. 5
3. The vision for the future and key outcomes......................... 13
4. Achieving the vision: Directorate Development.............. 14
5. Directorate self-assessment tool........................................ 17
6. Achieving the vision: Organisational Development. 20
7. The next steps ........................................................................ 22
8. Acknowledgements .............................................................. 23
References.................................................................................. 24
About this document

This document describes the vision we have to improve the ways we care for people with mental health needs and who use the services of Sheffield Teaching Hospitals. In particular it sets out the process by which the Clinical Directorates can understand the mental health needs of the people who use their services and develop plans to address these needs.

A draft of this strategy was produced by a joint working party from Sheffield Teaching Hospitals and Sheffield Care Trust. The draft was subject to a city-wide consultation exercise and the final version of the Strategy was approved by the Trust Executive Group and the Trust Board of Sheffield Teaching Hospitals in February and March, 2008.

Sheffield Teaching Hospitals NHS Foundation Trust is the provider of a wide range of acute adult healthcare from maternity services to care of the elderly across five NHS adult hospitals: the Northern General, Royal Hallamshire, Jessop Wing, Weston Park and Charles Clifford hospitals. Sheffield Care Trust delivers mental health services to adults and older people in the city and provides acute inpatient mental health services.
Executive Summary

- Many patients in Sheffield Teaching Hospitals (STH) have mental health needs which need addressing if we are to achieve high quality care and good clinical outcomes.

- STH provides services for people who are particularly vulnerable or present a high risk.

- People with a mental health problem or a learning disability tend to experience poorer physical health and die younger than other people. They also experience ignorance, prejudice and discrimination which may result in their health needs being misdiagnosed or missed altogether.

- There are examples of good practice in the promotion, prevention and intervention of mental health needs across STH.

- To achieve the vision of good mental health in STH will require directorates to undertake a baseline assessment to identify needs and plan for improved outcomes.

- STH has organisational development needs to support the improvement of mental health care which include training, practice development, communication and commissioning.
1. Introduction

- Why mental health matters to STH

Sheffield Teaching Hospitals (STH) is the major provider of hospital-based healthcare for the adults of Sheffield and the surrounding areas. Most of the services it provides focus upon an illness group or type of injury and consequently the emphasis of STH is that of physical health. However, physical health is not independent from other aspects of wellbeing and it is now widely recognised that physical and mental health are fundamentally linked:

Perceptions of the relationship between physical and mental disorders have changed. This has been a key development. It is now widely acknowledged that this relationship is complex, reciprocal and acts through multiple pathways. Untreated mental disorders result in poor outcomes for co-morbid physical illnesses. Individuals with mental disorders have an increased risk of suffering from physical illness because of diminished immune function, poor health behaviour, non-compliance with prescribed medical regimens and barriers to obtaining treatment for physical disorders. Moreover, individuals with chronic physical illness are significantly more likely than other people to suffer from mental disorders.\(^1\)

The occurrence of physical and mental conditions at the same time is common\(^2\). It is evident therefore that in order to achieve high quality patient care and good healthcare outcomes STH must be capable of understanding and responding to the mental health needs of the people who use its services. At its most fundamental level this is achieved through the humanity of care exercised in the multitude of interactions that take place between service users and staff. Building on this foundation and moving beyond the generic are the particular needs of people with a mental health problem or a learning disability who require the support of staff with specialist skills and the development of services that have the capacity to provide effective physical and mental health care.

However compelling the experience of the people who use STH services, and the research, national guidelines and legislation that underpin this strategy, it is important to acknowledge that people with a mental health problem or a learning disability are subject to widespread prejudice and disadvantage that contribute to their unequal access to services, treatment and health outcomes\(^3\). It would be naïve to think that poor levels of knowledge about mental health and learning disabilities, negative attitudes and discriminatory behaviour\(^4\) will be absent from STH. But we also know from the Stakeholder Day that there are many people who understand...
A patient with mental health needs was admitted to STH after taking an overdose. She told us that on the whole she received very good treatment but that she was given a lecture during her stay by a doctor about her ‘duty’ to her family, and that some of the nurses found it too difficult or frightening to ask her how she felt. On a separate appointment, a nurse talked to her social worker as if she were not there.

"The fears of staff dealing with mental health patients need to be addressed. I and fellow mental health service users that I have talked to have experienced preconceptions about patients with mental health problems, including degrees of judgementalism by some of the staff towards us."

This is the first time that STH has produced a strategy about mental health, and it is a clear recognition of the interrelationship between the physical and mental aspects of health. It aims to orientate STH services to the mental health needs of patients, to support a positive approach to mental health promotion and care, and to provide a clear direction of travel for the development of services provided by STH. In doing so it recognises that it cannot achieve these aims alone and it builds upon the collaborative work already underway between services users, carers and health and social care professionals.

- **What the strategy will enable STH to do?**
  - assess and develop STH capacity and capability in mental health
  - understand and learn from the experience and needs of patients and their carers
  - develop alliances and collaborations across Sheffield
  - implement the STH vision to improve mental health
  - improve quality of care and clinical outcomes

- **What is the wider context of the strategy?**

There is an array of statute, clinical guidelines, national and local strategies that provide the wider context within which this strategy is placed including the following key documents:
Legislation
Mental Capacity Act (2005)
Disability Equality Duty (2005)
Mental Health Act (2007)

NICE Clinical Guidelines
Antenatal and postnatal mental health (2007)
Anxiety (2004)
Dementia (2006)
Depression (2004)
Drug misuse: opioid detoxification (2007)
Drug misuse: psychosocial interventions (2007)
Schizophrenia (2002)
Violence (2005)

National Strategies
A National Service Framework for Mental Health (1999)
Valuing People (2001): A Dept of Health Strategy for people with learning disabilities
Essence of Care: Patient-focused benchmarking for health care practitioners (2003)
Everybody’s Business: Integrated mental health services for older adults (2005)
Choosing Health: Supporting the physical health needs of people with severe mental illness: Commissioning framework (2006)
Mental Health: New Ways of Working for Everyone: Developing and sustaining a capable and flexible workforce (2007)
National Dementia Strategy (expected 2008)

Local Strategies & Protocols
Sheffield Health and Social Care: Functional Mental Health Strategy for Older People (2005/6)
Sheffield Health and Social Care: The Sheffield Strategy for People with Dementia (2007)
Sheffield Learning Disabilities Service Plan (2005)
STH Learning Disability Guidelines (2007)
2. The current position

- What we mean by mental health

The concepts and terminology of mental health vary considerably in usage and can be contentious in meaning. In this strategy we take a pragmatic approach that allows us to focus on the diseases and problems that impact upon the health and wellbeing of patients. We intend mental health needs to include psychiatric illness, psychological problems, cognitive impairments and learning disabilities.

It is important that we respect the way people describe their own mental health needs, but we also have a need to classify the problems that people present in order that they can receive effective treatment and support. Regardless of the classifications used a fundamental principle that has guided our approach to the strategy is that people are indivisible:

In reality, neither minds nor bodies develop illnesses. Only people (or, in a wider context, organisms) do so, and when they do both mind and body, psyche and soma, are usually involved.\(^7\)

- Prevalence

Understanding the nature and extent of the mental health needs of patients in STH is a difficult exercise. The primary reason for most admissions is not a mental health need and we capture less information about mental health needs. One form of data that is available is the codes by which we classify the diseases and health problems of patients. The codes are derived from a clinical coding procedure\(^8\) that uses the International Classification of Disease (ICD10)\(^9\). If a mental health condition coexists or develops during an admission and is recorded in the clinical notes of a patient then it will be subject to coding. Chapter V of ICD10 categorises mental and behavioural disorders and these all have a code beginning with F, for example F01 is Vascular Dementia.

In 2006-7 there were 6341 patients classified with an F Code in 2006-7. Very few patients admitted for Day Care or Elective procedures are classified with an F Code, most (90%) are associated with non-elective patients admitted as emergency cases. People with a mental health code are spread across the entire age range of patients with a significantly higher proportion of older people associated with an F Code. The proportion of patients with mental health disorders is approximately double in the age group 85 and above compared with the age group 18-84 (table 1).
### Table 1: Patients with F Codes by age group for non-elective admissions and as a proportion of all admissions (2006-7).

<table>
<thead>
<tr>
<th>Age Group</th>
<th>All non-elective admissions</th>
<th>with F Code</th>
<th>% of non-elective admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-17</td>
<td>1011</td>
<td>37</td>
<td>3.66</td>
</tr>
<tr>
<td>18-64</td>
<td>41830</td>
<td>3187</td>
<td>7.62</td>
</tr>
<tr>
<td>65-84</td>
<td>17651</td>
<td>1497</td>
<td>8.48</td>
</tr>
<tr>
<td>85+</td>
<td>5694</td>
<td>1009</td>
<td>17.72</td>
</tr>
<tr>
<td>Total</td>
<td>73468</td>
<td>5730</td>
<td>7.80</td>
</tr>
</tbody>
</table>

When the data are broken down according to the F Code sub categories there are three prominent mental health conditions (Fig 1): mental and behavioural disorders due to psychoactive substance use (F10s), organic mental disorders including dementia (F00s) and mood affective disorders including depression (F30s). Patients with F10 codes are substantially in the 18-64 age group whereas dementia (F00s) is typically a disease of older people (64+).

![ICD10 Code](image-url)

**Fig 1. Number of non-elective patients according to F sub category and age (2006-07)**

We looked at the categories which patients with clinically similar treatments and diagnoses are admitted under known as the Healthcare Resource Group (HRG) code. An example would be a patient admitted following a fall requiring a surgical procedure. The surgical procedure would determine the HRG code but in addition the patient may be classified with dementia using ICD codes. Patients with an IDC10 F classification were admitted in 2006-7 under 349 HRG Codes. The leading codes...
related to patients with alcohol or drug related conditions, dementia and complex elderly conditions (table 2).

<table>
<thead>
<tr>
<th>HRGs</th>
<th>HRG description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>T12</td>
<td>Alcohol or Drugs Dependency</td>
<td>348</td>
</tr>
<tr>
<td>S16</td>
<td>Poisoning, Toxic, Environmental and Unspecified Effects</td>
<td>320</td>
</tr>
<tr>
<td>T01</td>
<td>Senile Dementia</td>
<td>268</td>
</tr>
<tr>
<td>D99</td>
<td>Complex Elderly with a Respiratory System Primary Diagnosis</td>
<td>240</td>
</tr>
<tr>
<td>H99</td>
<td>Complex Elderly with a Musculoskeletal System Primary Diagnosis</td>
<td>157</td>
</tr>
<tr>
<td>A99</td>
<td>Complex Elderly with a Nervous System Primary Diagnosis</td>
<td>141</td>
</tr>
<tr>
<td>E99</td>
<td>Complex Elderly with a Cardiac Primary Diagnosis</td>
<td>115</td>
</tr>
<tr>
<td>D41</td>
<td>Unspecified Acute Lower Respiratory Infection</td>
<td>113</td>
</tr>
<tr>
<td>L09</td>
<td>Kidney or Urinary Tract Infections &gt;69 or w cc</td>
<td>113</td>
</tr>
<tr>
<td>S99</td>
<td>Complex Elderly with a Haematology, Infectious Disease, Poisoning, or Non-specific Primary Diagnosis</td>
<td>101</td>
</tr>
</tbody>
</table>

Table 2: HRGs with ≥ 100 EM patients with F codes (2006-07)

- **Distribution**

People with a mental health problem or a learning disability are likely to be present in any ward, clinic or unit across the Trust. However, most patients with F Codes follow a typical pattern of being admitted to STH onto a medical assessment unit and one in five patients will be discharged from these wards after a short stay. Most patients (83%) admitted as an emergency are discharged to their usual place of residence, however over 400 patients with a coded mental health condition die in hospital (table 3) representing 13% of all deaths in the trust.

<table>
<thead>
<tr>
<th>Discharge Destination</th>
<th>Non-elective patients</th>
<th>% of total non-elective patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death</td>
<td>406</td>
<td>7.09</td>
</tr>
<tr>
<td>Usual place of residence</td>
<td>4766</td>
<td>83.18</td>
</tr>
<tr>
<td>Nursing &amp; Residential Home</td>
<td>146</td>
<td>2.55</td>
</tr>
<tr>
<td>Temp. place of Residence</td>
<td>136</td>
<td>2.37</td>
</tr>
</tbody>
</table>

Table 3: Destination of non-elective patients with with F codes ≥ 100 (2006-07)

- **Under-representation**

F codes provide a very limited source of data to determine the prevalence and distribution of people with mental health needs and represent only a fraction of actual need. In order to test the extent to which F Codes are an indicator of the prevalence of mental health needs we took the number of non-elective patients for the age group of 65 years and above and applied the prevalence estimates for dementia in the general population¹⁰. We then compared these predictive figures
against the number of patients with codes for dementia (F00). This produced an under-representation of 663 patients (28%) mostly in the age range of 80 years and above (fig 2). However, this figure is conservative when compared to the estimates of dementia for older people in hospital\textsuperscript{11} which would suggest an under-representation of 5529 patients (76%) who should have an ICD10 F00 code.

![Graph showing population prevalence vs patients with F00 code](image)

**Fig 2.** Comparison of prevalence of dementia in general population with non-elective admissions (2006-07)

This suggests that dementia is either not being diagnosed or is not being recognised in the coding process for large numbers of patients. The data for STH supports more general findings that mental health problems are not being recognised and addressed in acute healthcare settings. For example in relation to older people, who are the main users of acute hospital services, a major UK Inquiry has reported that:

> Admission to an acute hospital is often the first opportunity to diagnose and respond to mental health problems in older people. Yet all of the available evidence indicates that they are under-diagnosed, under-treated and poorly managed in acute care\textsuperscript{12}.

- **Unmet needs & High Risks**
  - **Dementia**

It has been estimated that 31% of older people in hospital have dementia\textsuperscript{13} which is an independent predictor of a poor outcome, increased length of stay and mortality. Young onset dementia (before the age of 65 years) is comparatively rare (34 cases coded in STH). If the population prevalence of dementia remains constant then it is forecast that the number of people with dementia will increase by 38% over the next 15 years\textsuperscript{14} as a result of demographic ageing. Dementia is going unrecognised in many patients: in STH we estimate this could be as many as 76%. The National Audit Office reports that:
Detection of cognitive impairment in medical units after admission, including those specifically for older patients, is very patchy – there appears to be significant underdiagnosis. Formal diagnosis of dementia in these wards is not seen as a priority, which denies patients access to possible drug treatment or specialist support, and would not be the case for a similarly serious physical complaint\textsuperscript{15}.

**Diagnostic Overshadowing**

There is a recognised tendency in healthcare staff to attribute symptoms of ill health to a person’s learning disability or mental health problem – known as diagnostic overshadowing. This can lead to symptoms being misdiagnosed or missed altogether. In relation to people with a learning disability the *National Patient Safety Agency* has reported that “access to treatment is often delayed because symptoms are not diagnosed early enough or in some cases, at all.\textsuperscript{16}” This can have clinically significant and even fatal consequences\textsuperscript{17}. Diagnostic overshadowing is compounded by problems patients may have in communicating with healthcare staff, and a related tendency to consult with carers.

**High rates of co-morbidity**

The largest clinical data analysis of primary care and mental health needs reports higher rates of significant and life-threatening conditions for people with a mental health condition compared to the rest of the population:

... someone with a major mental health problem is more likely to develop a significant illness like diabetes, CHD, stroke or respiratory disease than other citizens, more likely to develop it before 55, and – once they have it – more likely to die of it within five years. This combination of facts means that people with schizophrenia die younger than other citizens, even after accounting for suicide. The same is true for people with bipolar disorder in relation to CHD, stroke and respiratory disease. People with depression also have higher risks of key physical illnesses than other citizens. The impact on them, their families, friends and fellow service users should not be underestimated\textsuperscript{18}.

**Dual Diagnosis**

It is estimated that about a third to a half of people with severe mental health problems have problematic substance misuse the most common of which is alcohol misuse. A mental health problem experienced with problematic substance misuse is referred to as a dual diagnosis. Substance misuse is related to serious health conditions such as cardiac disease, respiratory disease, HIV and Hepatitis B and C\textsuperscript{19}.
Maternal Mental Health

It has been reported that “Perinatal mental health problems are common, many are serious and they can have long-lasting effects on maternal health and child development.” Pregnant women attend maternity services at the Jessop Wing with existing mental health problems, some will develop problems during pregnancy, and others will develop a mental health condition during the postnatal period. The concurrence of mental health disorders with other risk factors such as substance abuse, domestic violence and financial hardship elevate the potential harms and risks to mother and baby. In addition related lifestyle hazards may lead to child protection issues.

Self-harm

People with certain mental health disorders are more likely to self-harm and most of those who attend A&E following such an act will meet the criteria for one or more psychiatric diagnoses that could include depression, phobic and psychotic disorders, and schizophrenia. Self-harm is a major issue among young people and a national inquiry recommends that:

There is an urgent need for many professionals and others working in health ... to reflect on, and update, their practice in relation to young people who self-harm. To do this they need to re-connect to their core professional skills and values: empathy, understanding, non-judgemental listening, and respect for individuals.

Suicide

The majority of suicides occur in young adult males and it is the most common cause of death in men under 35. High rates of suicide are particularly associated with acute episodes of mental illness, recent hospital discharge, social factors such as living alone and deprivation, and clinical features such as substance misuse and non-fatal self-harm. Older men also have a higher levels of suicide risk which is associated with depression, social isolation and alcohol use.

Examples of good practice

A&E

The Mental Health Liaison Team is a joint venture between STHFT and SCT to provide a service to patients with mental health needs who attend the Accident and Emergency Department at the Northern General Hospital and the Minor Injuries Department at the Royal Hallamshire Hospital. Of the first 139 patients seen 113 were discharged home and received various types of follow up ranging from simple advice to referral to community teams. Only one patient referred to the team required admission to STHFT.
Accelerated Dementia Discharge Team (ADDT)

This is a service established at NGH in collaboration with SCT to provide specialist support in planning discharges for people with dementia. The ADDT provides a multi-disciplinary assessment of a person’s home situation, current needs, cognitive functioning and mental health. The service can also provide a diagnosis of dementia, including pre and post diagnostic counselling, information, support and advice to the person with dementia and their carers.

Emotional Care Plan

Clinical Psychology has developed with the multidisciplinary team on the Stroke wards a care plan approach to achieve and maintain emotional well being for patients following a stroke. Mood is now routinely and systematically assessed and monitored for all patients and recorded in the care plan which also summarises the relevant interventions. Consequently rehabilitation gains are not slowed down, mortality is reduced, and length of stay is shortened.

Geriatric Fractured Hip Pathway

The pathway is led by a consultant in geriatric medicine and places the surgical procedure following a hip fracture within a wider care of the elderly pathway. The aim is to provide a multidisciplinary approach to the care of patients with multiple needs and a comprehensive geriatric assessment.

Learning disability

A Nurse Director is the lead for the promotion of good practice across the Trust in relation to people with a learning disability. This is promoted through 10 key standards and supports good practice including a Learning Disability User Group, patient and carer satisfaction surveys, patient information projects and an e-learning training package.

Liaison Psychiatry

The Liaison Psychiatry Team provide mental health assessment and ongoing mental health care for inpatients and outpatient care for people with chronic physical health problems and mental health difficulties. The team runs joint clinics, such as the pain clinic and the Huntington’s clinic, and it has recently taken responsibility for providing input to the Emergency Department.
Patient Partnership

A group for service users with a learning disability has been established to address issues and discuss projects including patient information leaflets, training, volunteering and audit. People with a learning disability or a mental health need are also actively involved in volunteering within the Trust. There is a Lead Officer in the Trust’s Patient Advice and Liaison Service (PALS) for people with a learning disability and a number of leaflets in easy read/symbol supported format have been produced.

Stepped Care

The stepped care model used with Neurology patients follows national guidelines as a means of providing effective psychological care that balances high demand with limited specialist resources. The care is offered at different levels with the simplest and least intrusive interventions offered at first presentation, only stepping up to more complex interventions as and when necessary. People can move up and down the steps allowing more flexible responses from services. Neuropsychology has developed a stepped care approach to working with MS and Epilepsy patients.

Existing resources

The principle resources available within STH to meet the needs of people with a mental health problem or learning disability are the staff who have mental health training and clinical experience. This will range from basic skills and knowledge through to specialist professional qualifications and practice. In particular Liaison Psychiatry and Clinical Psychology are provided by SCT and their staff work within the some of the admitting directorates of STH.

Key staff groups include:
- Chaplains
- Clinical Psychologists
- Counsellors
- Doctors, particularly those specialising in Care of the Elderly, Neurology, Stroke
- Liaison Psychiatrists
- Nurses, particularly those with a mental health registration
- Occupational Therapists
- Social Workers
3. The vision for the future and key outcomes

- The vision for mental health in STH

  *STH is a place where people are cared for as a whole and not artificially divided into mental and physical categories. It is a place in which our service users participate in the planning, delivery and evaluation of services that support people’s mental health needs.*

  *STH is an organisation that plays its full role in the prevention, treatment and rehabilitation of people with a mental health condition or a learning disability. It is a partner in city-wide initiatives to improve the mental health of the people of Sheffield and included in the relevant pathways of care when mental health services are being commissioned.*

- Key Outcomes

  1. Increased awareness of mental health across STH
  2. Improved understanding by directorates of the particular needs of people with a mental health problem or a learning disability using their services
  3. More accurate and early diagnosis of mental illness
  4. Equal access to consistent high quality treatment and care
  5. Improved health outcomes for people with a mental health problem or a learning disability
  6. Better collaborations with health and social care partners and the voluntary, community and faith sectors so that care is integrated and provided in the most appropriate care setting.

- **Links with STHFT Patient Services Plan Objectives (2007/8)**

  1. Continue to work to implement the aims of the National Service Framework for Older People’s Services and the New Ambition for Old Age, including care pathways to improve mental health (2.5)

  2. Improve management of patients with mental health problems in acute hospital settings (9.2)

  3. Work with the SCT to best determine how best to improve Mental Health Liaison within the Trust (10.12)
4. Achieving the vision – Directorate Development

- **Assessment of current position in each directorate**

The clinical directorates are fundamental to achieving the aims of this strategy and the starting point is to understand their current position in terms of three key aspects:

1. the particular needs of people with a mental health problem or a learning disability who use services in the directorate
2. the capacity and capability of services to meet these needs according to best clinical practice
3. the development needs of services and staff

To ensure a consistent approach to this assessment a *directorate assessment tool* (Section 5) has been developed to support Nurse Directors and their colleagues in reviewing services and identifying the key elements to be included in a development plan. Elements of the directorate plans will also feed into the Trust’s organisational plan, for example trust-wide training.

- **Involvement of the people who use STH services**

The involvement of people who use STH services takes many forms including service user groups, Trust patient governors, patient partnership initiatives and the patients’ council. They all support two important principles, firstly, that we can learn much from the people who directly use our services and their unpaid carers, and secondly, that by involving them in the planning and development of our services they help us to shape and deliver better services. These principles are established good practice in government policy, the NHS White Paper and the mental health sector.

There are different degrees of involvement and different levels of participation required in an engagement process and these can be categorised as:

| Communication: | activities involved in providing information. |
| Consultation:  | activities involved in securing ideas, suggestions and feedback. |
| Negotiation:   | activities involved in securing agreement to decisions. |
| Participation: | activities involved in working together to make decisions |
Involvement requires commitment, resources and the appropriate levels of support. A report about mental health service for older adults considers that:

Involvement of carers and people who use services is a complex and challenging task. Although user and carer involvement is central to quality improvement within health and social care, there is still much to do. Overall, there has been better progress in involving carers than in involving people with mental health problems\textsuperscript{25}.

A challenge in the implementation of this strategy will be how directorates can involve users with a learning disability or mental health disorder so that their experiences can be translated into service improvements. The purpose and process of involvement needs to be carefully considered and “there needs to be a range of models of involvement, depending on the time and intensity of activity that participants wish/are able to engage in”\textsuperscript{26}.

- **Involvement of other services**
  
  Mental healthcare must be compassionate and understanding, and spare people battles with services that do not help them fast enough, well enough or indeed at all\textsuperscript{27}.

People may be first diagnosed with a mental health problem when they are admitted to STH or they may have an existing condition, but what is certain is that most people will spend only a brief period in STH. Consequently it is critical that STH interfaces effectively with other services and support within Sheffield and collaborates with them to achieve better mental health for the people of Sheffield. Colleagues in the health and social care community as well as the voluntary, community and faith sectors (VCF) have knowledge, expertise and experience which may be a valuable contribution to directorates as they review their services and plan developments.

- **Planning to achieve improved outcomes**

Directorate management teams will need to consider the results of the self-assessment exercise, prioritise key outcomes and incorporate them into their strategic planning. This provides another opportunity to involve service users and relevant organisations beyond STH. Planning should be directed at improving outcomes relative to the baseline of the self-assessment and should be set out in realistic milestones.

Improving the identified outcomes will depend upon directorates developing the necessary capacity and capability to meet the mental health needs identified. This
could include re-aligning clinical practice to national guidelines and adopting local protocols, redesigning pathways and clinical processes, developing collaborations with other services, and trialling evidence based service innovations.

A critical element of directorate planning will relate to the development or enhancement of competences within clinical teams to meet particular mental health needs. This will result in training and development objectives and in workforce planning. Services may need to consider extending the scope of existing professional roles and whether new assistant or practitioner roles are required, for example associate mental health practitioners and psychology associates.

- **Implementation**

Improving outcomes will depend on staff at all levels contributing to changes in the way STH recognises and responds to people with mental health needs. Effective leadership at all levels will support this process and promote the STH vision for mental health. Directorates should identify key staff who can lead on the mental health agenda and help them achieve the improvement and changes required. The process will need supporting by the management and governance systems of the directorate and may require input from colleagues in other services within STH including Clinical Effectiveness, Training and Education, Professional Practice & Development, and PALS. Collaboration and input may also be required with services and staff in SCT, SPCT and Social Care Services.

- **Monitoring and Evaluation**

Directorates will need to track their progress in implementing strategic objectives in mental health. Existing mechanisms should be adequate for this task and could include patient surveys, clinical audits and the analysis of clinical data and service activity such as benchmarking using Dr Foster Intelligence. Consequently objectives should be related to verifiable outcomes and aligned to key strategic milestones.
5. Directorate self-assessment tool

The tool aims to support Nurse Directors and their colleagues in the clinical directorates to assess the type and level of mental health needs present in their patient groups and to evaluate the directorate’s capability and capacity in meeting these needs. This process will assist directorates in identifying existing good practice and their development needs.

The self-assessment process should have input from:
- Patients and their carers
- Assistant staff
- Healthcare professionals
- Social Workers

Step 1  Differentiate the type of mental health needs present in the patient groups who use the directorate’s services.
Sources of information include:
- User groups, PALS, patient surveys, stakeholder groups and local intelligence
- PAS/HIS data available from Information Services using ICD10 F Codes as a proxy
- Clinical audit
- Published prevalence data

Step 2  For each type of need identified evaluate the level of need
Use the four levels model (see p. 2)
Level 1 is a minimum requirement for any need identified

Step 3  Identify the resources you have available to meet each specific need and level
This should include:
- All staff involved in the patients’ pathway including reception & support staff and differentiate levels of skills and competencies
- Services & facilities
- Clinical protocols & guidelines
- Access to services beyond the directorate
- Access to existing training
Step 4  Determine the development needs resulting from any gaps between the specific mental health need and the resources available
This could include:
► Involvement of users
► Training
► Networking and collaboration with specialist staff within STH and across the city
► The implementation of clinical protocols and guidelines
► Clinical pathway redesign including interfaces with other services and agencies
► Service or workforce re-design
► Commissioning new services

Step 5  Identify the outcomes you aim to improve
Outcomes could include:
► Changes which make a difference to service users
► Explicit and deliverable goals
► Measurable clinical outcomes
► Reduced risks
► Better Information

Step 6  Plan and monitor
► Determine the priority of service developments
► Prepare a plan on how the outcomes will be achieved
► Identify the people with key responsibilities
► Set the plan within a realistic timetable
► Identify how the outcomes will be measured and progress evaluated

The process should be documented and the completed self-assessment should be subject to consultation with the key stakeholders to ensure that it is comprehensive and accurate. The implementation plan should be agreed and monitored through existing directorate management structures.
### Four levels model of need:

<table>
<thead>
<tr>
<th>Level</th>
<th>Staff Group</th>
<th>Assessment</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Healthcare workers</td>
<td>Understanding of mental health problems</td>
<td>Effective communication, empathic care, general psychological support and promotion of mental health</td>
</tr>
<tr>
<td>2</td>
<td>Health &amp; social care professionals</td>
<td>Screening for particular mental health problems</td>
<td>Information &amp; signposting to support services, initial management and referral pathways, use of counselling and psychological skills.</td>
</tr>
<tr>
<td>3</td>
<td>Health &amp; social care professionals with mental health training &amp; expertise</td>
<td>Clinical assessment of particular mental health disorders</td>
<td>Treatment according to local protocol or NICE Guidelines</td>
</tr>
<tr>
<td>4</td>
<td>Mental health specialists</td>
<td>Diagnosis of severe or high risk psychiatric illness or severe disorder</td>
<td>Specialist psychological and psychiatric interventions.</td>
</tr>
</tbody>
</table>
6. Achieving the vision – Organisational Development

- **Involvement of key stakeholders and ownership of strategy**
  There are many people who have a stake in the mental healthcare that STH provides and the development of this strategy has provided opportunities for them to contribute their experience, knowledge and skills. A stakeholder day involving over 70 people was held on 15th June 2007 to raise awareness and inspire motivation, provide an opportunity for stakeholder involvement and collaboration, and to identify key strategic issues. The outputs from that day have been incorporated into this strategy and stakeholders were also asked to participate in a consultation exercise on the draft of this strategy. The strategy also supports the involvement of stakeholders on a meaningful and long-term basis both at a Trust-wide and directorate level.

- **Planning to achieve improved outcomes**
  This document was presented to the Trust Executive Group for approval and support. The strategy will be linked to the Trust’s strategic objectives and will underpin any directorate business cases taken to the Business Planning Team to ensure that plans are coherent, aligned with organisational objectives and affordable.

- **Communication and Information**
  In order to sustain a focus on this strategy and support the network of people involved in its implementation there will need to be an effective flow of information within STH and with the wider health and social care community. In addition to gathering and disseminating information the message of positive mental health needs communicating and promoting. The Trust’s Communication Department and Information Services both have a role in this important task.

- **Training, Education and Practice Development**
  Developing the capability of staff and supporting changes in clinical practice will require access to learning and development resources at an organisational level. There are three main frameworks that underpin the learning and development agenda in mental health: the Ten Essential Shared Capabilities, the National Occupational Standards (NOS) for Mental Health and the NHS Knowledge and Skills Framework (KSF). An organisational approach will ensure consistent standards related to national and local agendas, provide the opportunity for multidisciplinary learning and support coordination and sharing across directorates and with organisations and services in the wider health and social care community.
• **Research**

It is evident from the reports and guidelines consulted in preparing this strategy that there is limited research relating to mental health in an acute healthcare setting. The Trust and its partner universities should consider developing research projects related to mental health and a more active engagement with the local hub of the UK Mental Health Research Network (MHRN) which is one of the topic specific networks under the umbrella of the UK Clinical Research Network (UKCRN).

• **Service Development & Commissioning**

Services need developing in line with current legislation, NHS Service Frameworks and Clinical Guidelines. The baseline assessment exercise has the potential to articulate the organisational capacity and capability for meeting mental health needs and therefore should identify unmet needs and significant risks. However, a key question for STH is how the services it provides to meet the mental health needs of patients sit within the wider context of seamless services framework set out in the National Service Framework for Mental Health. To answer this question requires STH to engage with its partners in the wider health and social care community and with the relevant commissioners.
7. The next steps

The strategy sets out a vision for improving the way we care for people with mental health needs and outlines what needs to happen to achieve the vision. The implementation of the strategy is based upon a developmental cycle that starts within directorates and feeds into the organisation.

The following steps will be necessary over the next 12 months:

1. Roll out the strategy to all the Clinical Directorates [April 2008]
2. Clinical Directorates to consider how to implement strategy and carry out a baseline review using the self-assessment tool [December 2008]
3. Service developments identified and prioritised at directorate level and where necessary incorporated into business plans [January 2009]
4. Organisational developments identified and prioritised at Trust level including training, clinical effectiveness, facilities, information and contracts [January 2009]
5. Exchange contracts that describe the exchange of services between the two Trusts so that there is clarity of understanding of what services are provided each to the other, what the financial agreements are and where the initiative rests for initiating future service developments [April 2009]
6. Review of strategy implementation by the STH/SCT Mental Health Steering Group. [April 2009]
8. Acknowledgements

This strategy was produced by a joint working party from Sheffield Teaching Hospitals and Sheffield Care Trust:

Alan Anderson, Consultant Physician/Clinical Lead, Geriatric Medicine (STH)
Andy Bragg, Assistant Service Director, Recovery, Rehabilitation and Specialist Services (SCT)
Mark Cobb, Clinical Director of Professional Services (STH)
Gwyneth DeLacey, Interim Director of Psychological Health Sheffield (SCT)
Margaret Gibson, Strategy and Specification Manager: Older People (Sheffield PCT)
Paul Gill, Consultant in Liaison Psychiatry (SCT)
Fiona Goudie, Clinical Director, Specialist Community Services for Older Adults (SCT)
Sue Humphrey, Service Development Manager (STH)
Julie Smith, Nurse Director, Emergency Care/Acute Medicine (STH)
Pam Stirling, Executive Director for Adult Mental Health, Allied Health Professions and Strategic Development (SCT)

We wish to thank all those who have contributed to the development of this strategy, and in particular the people who took part in the Stakeholder Day and those who responded to the consultation including patients and users, representative groups, and health and social care staff.
References

6. Includes a Benchmarks for Safety of Clients with Mental Health Needs in Acute Mental Health and General Hospital Settings
8. There are a number of caveats about the reliability of the data: (1) the coding procedure is not currently consistent across specialties, (2) there is variation among clinicians in terms of the secondary diseases and health problems recorded, (3) there is variation among specialties in terms of assessing and diagnosing mental health conditions.
13. ibid
23. University of Manchester (2006) *Five year report of the national confidential inquiry into suicide and homicide by people with mental illness*. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness


based upon the model in NICE (2004) Improving Supportive and Palliative Care for Adults with Cancer. London: NICE. p.78

