NHS East Sussex Clinical Commissioning Group & Sussex Partnership NHS Foundation Trust

Redesigning Inpatient Mental Health Services in East Sussex (RIS:ES)

Early-Involvement Programme

Integrated Report of Findings

Opinion Research Services

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1. Summary of key findings

Introduction

1.1 The NHS East Sussex Clinical Commissioning Group (East Sussex CCG) and Sussex Partnership NHS Foundation Trust (Sussex Partnership) are working to improve mental health services across East Sussex for adults and older people, including those living with dementia. They have established the Redesigning Inpatient Services: East Sussex (RIS:ES) Programme to develop proposals which will address that gap between current provision and a desired future state which meets both local and national ambitions.

1.2 In autumn 2020, East Sussex CCG and Sussex Partnership appointed Opinion Research Services (ORS) - a spin-out company from Swansea University with a UK-wide reputation for social research and major statutory consultations - to advise on and independently manage and report elements of an engagement programme with service users, their families and carers, clinicians and other NHS staff, and other stakeholders. The outcomes of this engagement will help programme development, with the early-involvement activities reported here helping to specifically inform the initial options development and appraisal processes.

Key findings and considerations

Broad recognition of challenges, priorities, and the case for change

1.3 There was broad recognition of the challenges facing inpatient mental health provision, and agreement with the vision and priorities identified by East Sussex CCG and Sussex Partnership. Therefore, there was strong agreement across all early-involvement activities with the need to make significant changes and improvement to address these issues. In the responses to the questionnaire, for example:

- An overwhelming majority (38 out of 40 who answered the question) agreed that changes need to be made, and 37 out of 38 agreed that the vision and priorities identified were appropriate; and
- A substantial majority (29 out of 35) agreed with the suggestion to prioritise improvements to acute inpatient mental health facilities in Eastbourne and Hastings.

Priorities for addressing challenges

1.4 Below is a summary of the feedback provided in relation to each of the challenges set out by the CCG and Sussex Partnership:

Dormitories and shared bathrooms

- Private rooms are important to provide privacy, safety and a place of calm;
- Dormitories can be distressing for those who are not used to sharing facilities;
- Conversely, dormitories can work for some individuals as they are less isolating and enable social interaction; and

- Several stakeholders felt that the provision of private rooms would *only* make sense if ensuite bathroom facilities were also included.

Mixed-sex vs same-sex wards

- Views were mixed, with some feeling that the company of people of the opposite sex was welcome, and that single-sex wards could be inflexible and result in empty beds; however
- Others stated strongly that mixed-sex wards can be highly triggering for some female services users, particularly those who have experienced domestic violence.

Communal areas and other facilities

- The lack of safe and suitable spaces for private meetings was identified as a major issue;
- There is also a severe lack of space for therapeutic, creative, educational or other holistic-wellbeing related activities, which were viewed as vital for recovery and rehabilitation;
- Even if same-sex wards and private rooms are implemented, it is key to have communal areas for people to socialise (with some calls for single-sex communal spaces as well); and
- Wards need modernising so that service users and visitors can use WIFI, laptops and their smart phones.

Accessibility and out-of-area transfers

- Service users currently being taken 'all over the place', both within East Sussex and out-of-area, to the strong detriment of service users' stabilisation and recovery; and
- These transfers are distressing and can make things worse and can result in a lack of quality and continuity of care, as well as poor or even non-existent communication with family and carers.

Needs of service users with multiple-complex or special needs, and other groups, not being met

- A lack of understanding and provision around neurodiversity;
- Specific challenges for people with sensory disabilities, as well as for nursing mothers;
- The needs of people of different ethnicities and cultural backgrounds; and
- The need for understanding of, and action on, the needs of non-binary and trans-people.

Staffing and resourcing

- Understaffing is affecting capacity and the provision of consistent care, and is linked to other challenges; and
- Improvements to staffing and increased training could lead to benefits, including:
    - Improving integrated working;
    - Reducing out of hours transfers; and
    - Fostering positive environments within inpatient ward.

Poor integration with other mental health services and community support

- Lack of Multi-Disciplinary Team (MDT) working and clear pathways for admission and discharge, as well as poor communication and co-ordination with community-based services, leads to "vicious cycle" for inpatient service users;

- More cohesiveness between mental and physical healthcare and well-being is needed; and
- Suggestions for improvements include:
    - 'Bridging the gap' between inpatients and community via third sector advocates;
    - Implementing a 'halfway house' transitionary model;
    - Co-location or closer proximity of mental health services; and
    - Implementation of holistic, bio-psycho-social models of care.

Approaches to improvements

1.5 Views on approaches to improvements were balanced between refurbishment and extension of existing buildings or building on a new site (or sites), although many stakeholders felt the Department of Psychiatry (DoP) at Eastbourne District General Hospital is unfit-for-purpose and should be replaced.

1.6 There was broad agreement among questionnaire respondents with the suggestion that improvements to acute inpatient mental health services, currently delivered at the DoP and Woodlands Centre, be prioritised, with the proviso that a broader programme of improvements is needed for all services.

1.7 Some stakeholders felt that, while "bricks and mortar" are important, real improvements to inpatient mental health services would come down to other factors such as staffing, greater investment, better co-ordination with community-based services, improved communication with carers and family, and better discharge pathways.

1.8 Overall views around refurbishment of existing sites, versus a brand-new campus site were mixed among those who participated in the qualitative early involvement activities, with most stakeholders and EBEs acknowledging the pros and cons of both.

1.9 Some participants expressed very clear support for a new campus site and strong opposition to refurbishment of existing sites on the basis that:

- Refurbishing current sites, particularly the DoP, is not sustainable or a good use of money;
- It is the better long-term option with opportunities for co-location and integrative, holistic services; and
- Quality of care is more important than access and improved public transport networks would mitigate for increased travel (as well as acknowledgement that existing sites are not always easy to access, with some services only available on a single site already).

1.10 Others preferred an approach which maintained existing services on current sites, citing:

- Concerns about impacts on travel, and loss of local provision (with some advocating *more* local inpatient mental health services or multiple but smaller campuses);
- The importance of accessibility for family and carers of service users, particularly as a key part of any treatment and discharge plan (although some others felt that services users sometime need to "escape" their local situations to improve their chances of recovery and rehabilitation); and
- The value of co-location of inpatient mental health wards with other hospital services.

1.11 Overall, there was a recurrent view that any immediate improvements to inpatient services need to be just one part of a long-term and far-reaching programme of changes to mental health service provision.

2. Overview of early involvement

Background

2.1 The NHS East Sussex Clinical Commissioning Group (East Sussex CCG) and Sussex Partnership NHS Foundation Trust (Sussex Partnership) are working to improve mental health services across East Sussex for adults and older people, including those living with dementia. East Sussex CCG and Sussex Partnership acknowledge the need to substantially change the way that inpatient mental health services are delivered in order to provide safe, effective, quality patient care where everyone is treated as an individual, focusing on their strengths, and helping them with their recovery and well-being in a safety-focused culture.

2.2 At present, the current inpatient provision is no longer fit-for-purpose, meaning that national and local strategic clinical ambitions are not being met, acting as a barrier to staff recruitment and retention, and preventing service users from feeling valued and cared for. Therefore, East Sussex CCG and Sussex Partnership have established the Redesigning Inpatient Services: East Sussex (RIS:ES) Programme to develop proposals for the vital improvements which are required.

2.3 As part of the RIS:ES Programme, East Sussex CCG and Sussex Partnership will be undertaking extensive engagement with inpatient mental health service users, their carers and families, and other stakeholders, initially in the form of early-involvement activities to inform options development. It is these early-involvement activities which have provided the basis for this report.

The commission

2.4 In autumn 2020, East Sussex CCG and Sussex Partnership launched the RIS:ES Programme and appointed Opinion Research Services (ORS) - a spin-out company from Swansea University with a UK-wide reputation for social research and major statutory consultations - to advise on and independently manage and report important aspects of the engagement programme.

2.5 ORS is grateful for the support from NHS colleagues and other community partners and stakeholder organisations in securing opportunities to engage with their networks of service users and carers, as well as to all those individuals who have taken part in the ongoing engagement programme to date.

Early-involvement activities

2.6 The early-stage engagement reported here took place during October to December 2020; service users, their families and carers, key clinicians and other service leads, and other stakeholders were invited to provide feedback through a range of methods, including:

- Sharing their views with ORS researchers who attended meetings arranged by NHS partners and community organisations;
- One-to-one interviews, recruited and undertaken by ORS research staff; and
- An open early-involvement questionnaire, accessible via the Sussex Partnership website[1].

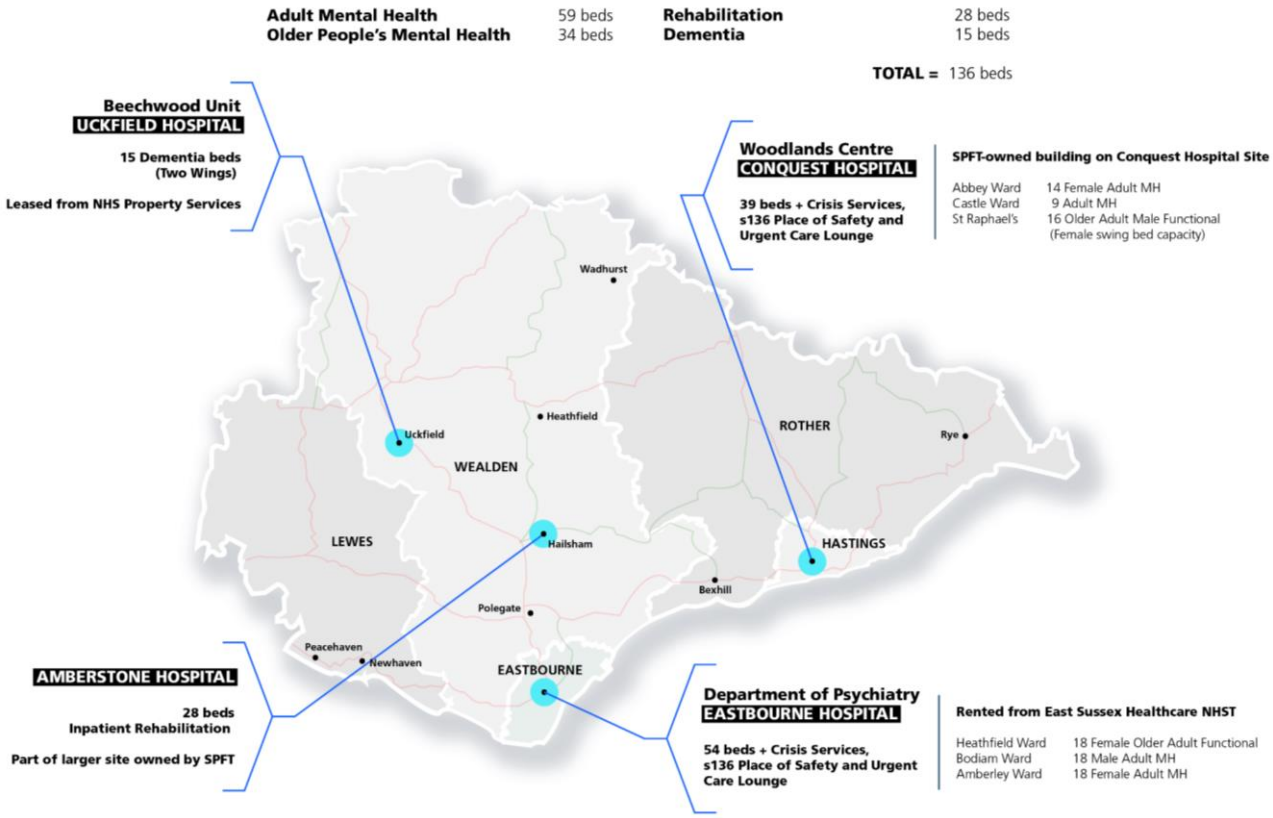
[1] https://www.sussexpartnership.nhs.uk/improving-mental-health-services-east-sussex

2.7 In addition, an online (videoconference) workshop was arranged for a group of "Experts by Experience" (EBEs) familiar with inpatient mental health services in East Sussex and surrounding areas, and representatives of charities and other stakeholder organisations. Three NHS clinicians working with service users in East Sussex also attended to answer questions and contribute to discussions.

2.8 All of the early involvement activities undertaken followed a similar format, with the questionnaire or – in the case of group discussions and interviews - an ORS facilitator, providing background information on the current inpatient mental health services in East Sussex (Figure 1) and on the specific challenges facing those services, as identified by East Sussex CCG and Sussex Partnership; namely:

- **Hospital wards which are old and in poor condition**, requiring service users to stay in out-dated dormitories rather than individual bedrooms with ensuite bathrooms;
- **Mixed-sex wards** which do not comply with Care Quality Commission guidelines;
- **Limited or unsuitable indoor and outdoor therapy spaces** for rehabilitation activities such as exercise or gardening, or for individual and group therapy, counselling, family meetings etc;
- **Failure to meet the needs of people with conditions such as autism, or with special needs**, as well as issues related to safety and security, and privacy, dignity and confidentiality; and
- **Lack of flexibility** related to, for example, the location of services across East Sussex, the layout of wards and accommodation, and the lack of space and opportunity for co-location and partnership with community services.

Figure 1: Current adults and older people's inpatient mental health services in East Sussex



2.9 Participants in the different early-involvement activities were invited to share their views on these challenges, based on their own work or personal experience, as well as to raise other issues, as well as on things that they felt were working well in East Sussex or elsewhere.

2.10 Secondly, the ORS facilitator outlined the clinical vision and priorities of East Sussex CCG and Sussex Partnership, which is to provide local, seven day a week mental health services that are based on evidence-based clinical practice, and to provide high-quality inpatient care for service users, and their carers and families, regardless of age, disability, gender and ethnicity. To achieve this vision, the following priorities have been identified:

- Developing services that better meet service users' mental and physical healthcare needs;
- Better integration with community partners to reduce lengths of stay;
- Reducing or eliminating out-of-area transfers and prioritising accessibility for service users;
- Better staffing/resourcing to improve resilience;
- Increasing capacity to accommodate future population growth; and
- Offering consistent care across all services.

2.11 Again, the participants were invited to share their views on the priorities identified by East Sussex CCG and Sussex Partnership in relation to mental health service provision, and to contribute their own ideas about other priorities which they felt should be considered when exploring options for improvements.

2.12 Finally, meeting participants, interviewees, workshop attendees and questionnaire respondents were invited to consider potential approaches to redesigning and improving inpatient mental health services in East Sussex, and the potential impacts, benefits and drawbacks of each. These potential approaches included:

- Refurbishment of existing hospital buildings;
- A combination of refurbishments and building new extensions onto some of the existing hospitals; and
- Building new hospital facilities on one or more new sites to replace existing facilities.

2.13 As part of this discussion, participants were also asked to consider issues such as whether specific sites should be prioritised for improvements first (namely the acute hospitals at Eastbourne and Hastings) on the basis that they are the most outdated wards with many beds in dormitory accommodation. In the questionnaire, participants were specifically asked to give their views on how the twin priorities of local access to hospital services, and maximum opportunity for improvements (which might require fewer hospitals and more travel for some people) might be balanced.

2.14 To facilitate discussion at the workshop held on 26th November 2020, attendees were invited to consider two scenarios as a starting point for discussions. In the first, services would be maintained entirely at existing sites (including DoP, from which inpatient mental health services might have to move in the next few years) with refurbishment and some extensions to existing wards at Eastbourne Hospital's Department of Psychiatry (DoP) and Woodlands Centre on the Conquest Hospital site in Hastings.

2.15 In the second scenario, services currently located at the DoP would be entirely relocated to a new site, wholly owned by Sussex Partnership NHS Foundation Trust, with a view to eventually relocating all inpatient mental health services and creating a "campus" with other services such as housing, education and community services. Attendees were also encouraged to explore ideas about other possibilities which might combine aspects of both of these scenarios or take an entirely different approach to service redesign and improvement.

Deliberative early involvement activities

2.16 The early-involvement activities reported in this document are part of an ongoing process, with provisional arrangements in place to conduct further engagement with services users with sensory disabilities and from BAME backgrounds (including non-English-speakers). This summary report, however, brings together the key themes arising from the following deliberative activities which took place between October and December 2020:

2.17 In all, more than 60 service users, carers and family members, stakeholder organisations and other individuals were engaged with directly and/or took part in one or several of these activities.

Early-involvement questionnaire

2.18 In addition to the deliberative meetings and other activities, East Sussex CCG and Sussex Partnership also commissioned ORS to design an early-involvement questionnaire (as outlined above). The questionnaire included several "closed" multiple choice questions regarding different aspects of the challenges, priorities and possible approaches to redesign and improvement identified. There were also opportunities for "open text" comments in which participants could: provide additional information to explain the reasons for their responses; raise other challenges or concerns; identify other issues or priorities which they felt should be addressed; or otherwise comment on the RIS:ES programme at this early stage.

2.19 While, in principle, the questionnaire was available for anyone to complete, in practice the main priority at this stage was to gather views from people with experience of inpatient mental health services in East Sussex. Therefore, while there was a link to the questionnaire available via the Sussex Partnership website, it was promoted by direct communication to existing networks of stakeholders, and by ORS and RIS:ES programme team members who attended the deliberative meetings outline above.

2.20 In total, 40 people fully or partially completed the questionnaire. Respondents were first asked to state what connection they had to inpatient mental health services in East Sussex – a breakdown of which can be found in Table 1 below.

Table 1: Consultation questionnaire completions by type of respondent

Stakeholder type	Number of respondents
Past, Current, or expected Future Service User	10
Carer/Family Member	8
Work for the NHS in East Sussex	10
Organisation based in or covering East Sussex	6
Other (including East Sussex residents)	6
Total responses	**40**

2.21 To understand the geographic spread and diversity of respondents, they were also asked to provide their postcode and some demographic information. It should be noted, however, that these questions were voluntary and those who chose not to answer them nonetheless had their feedback recorded for analysis and reporting. A summary of this demographic information can be found in Table 2 below.

Table 2: Questionnaire responses by demographics

Characteristic	Count
BY AGE	
Under 25	2
25 to 34	-
35 to 44	3
45 to 54	10
55 to 64	10
65 to 74	1
75 or over	1
Total valid responses	**27**
Not known	*13*
BY GENDER	
Male	7
Female	18
Other	-
Total valid responses	**25**
Not known	*15*
BY DEPENDENT CHILDREN	
Yes	6
No	21
Total valid responses	**27**
Not known	*13*
BY ETHNIC GROUP	
White	23
Mixed or Multiple Ethnic Groups	1
Asian or British Asian	-
Black, African, Caribbean, or Black British	-
Any other ethnic group	1
Total valid responses	**25**
Not known	*15*

Characteristic	Count
BY LOCAL AUTHORITY	
Brighton and Hove	3
Eastbourne	4
Hastings	7
Lewes	5
Mid Sussex	1
Rother	2
Wealden	2
Total valid responses	**24**
Not known	*16*
BY SEXUAL ORIENTATION	
Heterosexual or Straight	22
Gay or Lesbian	1
Bisexual	2
Total valid responses	**25**
Not known	*15*
BY CARING ROLE	
Yes	18
No	9
Total valid responses	**27**
Not known	*13*
BY DISABILITY	
Yes	9
No	18
Total valid responses	**27**
Not known	*13*

2.22 It should be noted that open questionnaires are not designed to be representative of the views of particular populations or groups. With that in mind, and given the limited number of respondents, the results of the questionnaire cannot be considered a robust indication of the views of a wider community. Rather, they provide a useful indication of the balance of opinion among those individuals and organisations who did choose to take part, to be set alongside the other findings reported below.

2.23 For simplicity and ease of access, results from the multiple-choice questions are presented graphically. Where possible, the colours used on the charts have been standardised with a 'traffic light' system:

- Green shades represent positive responses e.g., 'tend to agree' or 'strongly agree';
- Beige shades represent neutral responses e.g., 'neither agree nor disagree';
- Red shades represent negative responses e.g., 'tend to disagree' or 'strongly disagree'; and
- Other colours where the 'traffic light' system is less applicable.

2.24 In light of the small number of responses in this earliest stage of involvement, data in charts is presented as counts of responses, rather than percentages. The number of valid responses recorded for each question (base size) are reported throughout and, as not all respondents answered every question, the number of valid responses varies between questions. The very small number of 'don't know' responses received (never more than one per question) have not been included in the charts for the sake of clarity.

Covid-19, early involvement, and future engagement

2.25 The Coronavirus pandemic and subsequent lockdown and social distancing measures placed restrictions on the methods by which Sussex Partnership, East Sussex CCG and ORS could engage with and involve stakeholders. Activities that are normally undertaken face-to-face (e.g., group discussions, individual interviews) took place online or via telephone. This worked well, helped by the support of public and voluntary sector organisations who promoted the involvement programme to relevant stakeholders via existing channels and invited ORS researchers to join regular meetings which had already moved online.

2.26 Additional measures included ensuring that a telephone number, email address and postal address were included in communications so that people who might not be comfortable using video conferencing software were also able to engage, and paper copies of the early-involvement questionnaire were available on request. These measures will be repeated and built upon as plans for the next stage of engagement and consultation are prepared, including specifically seeking input from stakeholder organisations and advocates about accessibility and how best to ensure that those they represent will be able to take part, if lockdown measures and social distancing restrictions continue throughout 2021.

The report

2.27 This report, rather than separating out feedback from different strands of programme, presents a thematic summary of the feedback received through all of the early-involvement activities completed between October and December 2020. It combines the outputs of the questionnaire with those from the deliberative meetings, workshops and interviews to provide an overall picture of the main themes arising.

2.28 Verbatim quotations are used, in indented italics, not because we agree or disagree with them - but for their vividness in capturing recurrent or contrasting points of view. ORS does not endorse any opinions and has not sought to verify the accuracy of statements made by individual participants but seeks only to portray them accurately and clearly.

3. Early-involvement findings

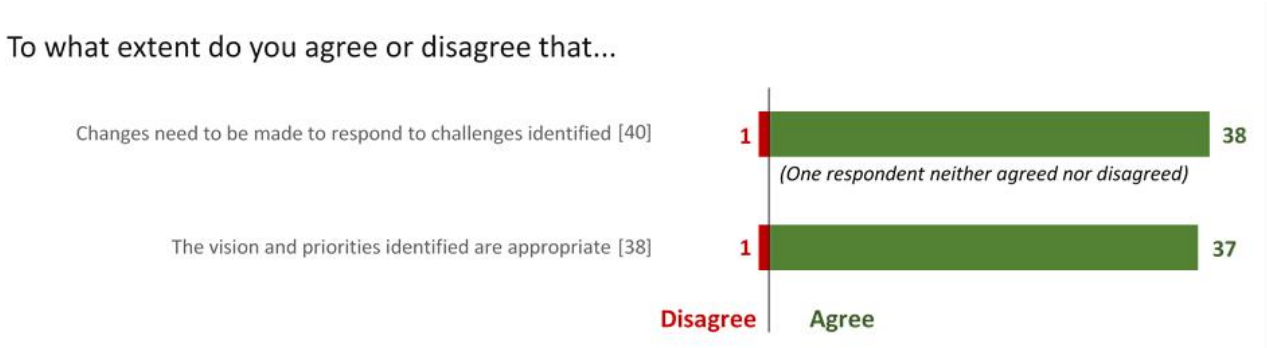
Views on challenges and priorities

3.1 Across all early-involvement strands and stakeholder types, all respondents recognised at least some of the challenges set out by East Sussex CCG and Sussex Partnership (if not all) and agreed that there is a case for change.

> *All of the challenges identified by the CCG and the Partnership are issues that I have discussed on very many occasions with people I have been working with in East Sussex. They have absolutely correctly identified all the difficulties and challenges; these are all the things that have been raised to me by people who have used inpatient services across East Sussex This is the perfect opportunity to redesign services. (Organisation representative)*

3.2 This trend was particularly clear in the response to the early-involvement questionnaire, in which the overwhelming majority of respondents of all types agreed that changes need to be made to address the challenges identified by East Sussex CCG and Sussex Partnership (Figure 2). Furthermore, the majority of respondents agreed that the vision and priorities for inpatient mental health services in East Sussex are appropriate.

Figure 2: Views of early-involvement questionnaire respondents on the challenges, vision and priorities identified in relation to inpatient mental health services in East Sussex [Base numbers in brackets]



3.3 Feedback in relation to specific issues currently affecting services is summarised below.

The overall quality of existing buildings and inpatient services

3.4 There was overall agreement that the quality of existing buildings is an issue, particularly the DoP and Conquest Hospitals, although there was uncertainty over how much of a priority it is to address this over other issues, such as staffing and quality of care. Indeed, some stakeholders found it difficult to understand how bricks and mortar connected to the wider challenges facing inpatient services currently.

3.5 One EBE felt that, although the DoP building itself needed work, the environment created by the staff was positive. This view was contradicted by several questionnaire responses from service users, who felt that there were significant issues with staffing and quality of care at DoP, in addition to the shortcomings of the buildings and facilities themselves.

At Eastbourne Amberley ward [there is] no privacy; three beds per ward with only a curtain separating you. Nurses invade your privacy constantly doing "checks". Respect and dignity are completely non-existent. (Questionnaire respondent - service user)

There are many, many problems at DoP and my times there were increasingly traumatic, and I suffer awful consequences a year later. (Questionnaire respondent - service user)

When it snowed the nurses used duvets to block the window in the lounge as it didn't close, this was winter when it snowed. (Questionnaire respondent - service user)

3.6 A few praised the layout of the Woodlands site, which was described as '*a nice building, with private rooms and bathrooms and nice outdoor facilities*.' Again, this was contrasted by other views that the Woodlands Centre, as well as DoP, needed significant improvements.

The quality of inpatient facilities is not necessarily a key priority in terms of mod cons/ quality of accommodation… (Organisation representative)

I think that the main thing that I would agree with is the condition of the buildings at Conquest and Eastbourne being not fit for purpose. I think that for me would be my number one priority. (EBE individual interview)

I think when you were running through some of the challenges that have been identified, it sparks sort of memories of conversations I've had with some of our volunteers who have lived experience. I know that some who have been inpatients of the Conquest for example wouldn't want to go back. (Organisation representative)

Dormitories and shared bathrooms

3.7 There were several participants who felt that dormitories are more suitable for some individuals as they are less isolating and enable social interaction. For example, one member of the Working Together Group said that they enjoyed '*making friends*' with the person next to them when they were admitted to an inpatient ward.

You need to bear in my mind that not all inpatients want to be on their own, so they won't necessarily want their own room. For some people, being in their own room with their little ensuite may be more determinantal. So multioccupancy ward spaces are not necessarily inappropriate. (Organisation representative)

I have worked on dormitory wards for years as a CMHN. I can see benefits (but of course recognise the limitations and drawbacks). (Questionnaire respondent - NHS staff member)

3.8 This was a minority view, however, and the majority of stakeholders across all early-involvement activities argued that dormitories can be distressing and triggering – especially for service users who are not used to sharing facilities.

My husband was in Eastbourne and big dormitories were not welcome. He ended up in a bed with no curtain around it with no privacy. Eastbourne really doesn't allow for space and privacy. (Working Together Group)

My husband hates dormitories and having to mix with other people. He hates it. Having his own private space with his own bathroom would be much better. (Care for Carers Discussion Group)

The dormitories gave very little privacy […] The lounges were old fashioned and had very little in them to help service users relax. (Questionnaire respondent - Carer/family member)

3.9 There were also reports of safety and security issues on dormitory wards, such as personal items being stolen and service users getting injured. Moreover, a mental health organisation representative explained that the provision of private rooms is particularly important for those with additional needs such as ASD. Therefore, private rooms were deemed important for providing much needed privacy, safety and calmness.

I had a bed next to the entrance door and a big window next to me so, however you pulled the curtain, there was never full privacy. (Working Together Group)

No privacy, 3 beds per ward and no locker when I was there. (Questionnaire respondent - Service user)

Single rooms are the future for this programme. (Working Together Group)

3.10 It was noted that implementing and designing private rooms to a specification which adequately meet all service users' needs would be '*a challenge*.' For example, a few participants from the Working Together Group and Engagement Workshop argued that the provision of private rooms would only make sense if ensuite bathroom facilities were also included, whereas others did not have strong views about it.

If you are spending [money], surely you would have ensuites with single rooms rather than shared bathrooms as this is all related to privacy and dignity. (Engagement Workshop)

3.11 For many questionnaire respondents, however, shared bathrooms were seen as an issue which urgently needed to be addressed, with several citing the poor facilities at DoP in particularly as being unconducive to "good" inpatient experience.

On Amberly ward at Eastbourne Hospital the bathrooms were awful. Hardly any water came out of the showers - just a trickle, the bath took about 30 mins to fill, the room was rarely clean, the bathroom smelt a bit stale and was in need of refurbishment. (Questionnaire respondent - Carer/family member)

Choice of three shared shower rooms where water pressure was a joke… Felt like being in prison. (Questionnaire respondent - Service user)

Mixed-sex vs same-sex wards

3.12 A few, predominantly male, EBEs did not regard mixed-sex wards a challenge and instead welcomed the company of people of the opposite sex whilst using inpatient services. They claimed that such wards simply need to be well managed to work well. Another warned that single-sex wards can be inflexible and result in empty beds – citing such a situation in West Sussex as an example.

It is be nice to have some female energy on a ward…if it's managed properly there is no reason for it to stick out like a sore thumb (Expert by Experience interview)

In West Sussex it was found that people did not want single sex wards because it is very inflexible. You can end up having empty rooms because you have less males than females which you can't fill. It doesn't reflect our world. A lot of people are really against it. The way it is done in West Sussex is that each wing tends to have a ward on it, one male and one female (Working Group Participant)

3.13 In contrast, a mental health organisation representative did consider this to be an issue. They explained that the vast majority of the women they work with have experienced domestic violence, and to be placed on a ward with men they do not know whilst facing a mental health crisis is highly triggering. Instead, the stakeholder would welcome the implementation of '*gender-informed approaches*' which address these challenges.

The fact that it's mixed wards as well would really not work well for the women we work with who have complex needs. We did some in-depth sort of look at our data a couple of years ago and the snapshot then was that 93% of the women we work with had experienced domestic abuse and violence so just to be placed on a ward with men that they don't know, they won't stay, they will just leave, or they will want to leave at that point. It's really triggering. Having a gender informed, trauma informed spaces would be key if the CCG is looking to get this right (Organisation representative)

3.14 This view was echoed by several questionnaire respondents, who cited a lack of single-sex spaces as a significant issue affecting outcomes for inpatient services users:

[There is a] depressing eating space with nowhere separate for women to eat away from the men. (Questionnaire respondent - service user)

[At DoP] there is no way of avoiding males. One of the worst experiences of my life. (Questionnaire respondent - service user)

Communal areas, wellbeing related activities and other facilities

3.15 The consensus across all early-involvement activities was that there is currently a severe lack of space for assessments and therapeutic, creative, educational, religious practice or other holistic-wellbeing related activities at inpatient mental health service locations. It was felt that the provision of such spaces would better facilitate the recovery process.

Please consider the aesthetics of health care and recovery in any new developments. Incorporating beauty (small or large) need not be expensive. Please allow patients/visitors/staff and all who use the buildings sufficient space... (Questionnaire respondent - NHS staff member)

Not enough activities and opportunities for confidence-boosting, creative achievement and engagement. Also, inadequate safe outdoor space for inpatients. There is space at the back of Woodlands by the Conquest to address this. I'm sure that grant funding and community support could be accessed. (Questionnaire respondent - Carer/family member)

I have been to visit a friend at the [DoP] before. I think a lot of upgrading needs to be done. A more positive atmosphere, and group activities. Things like MBCT and yoga classes could be very beneficial. Even, art therapy, or music therapy - anything creative so patients can express their pain into an art form. Learning ways to process pain, rather than hurting themselves. (Questionnaire respondent)

3.16 Specifically, the Working Together Group described acute wards as *'chaotic'* with no structure, which they felt (along with understaffing) is exacerbated by spaces being uninviting, unsafe, or not existing at all. They, along with several attendees among the Engagement Workshop, also discussed the difficulties this caused for service users' ability to speak with their family members and carers privately.

It's not a therapy space. There doesn't seem to be private areas for family visits. I had a chair thrown in on my family visit, it was scary for the family. We need to make sure therapy spaces include the term family visit rooms or legal access rooms. There were a number of times I was party to private conversations which I shouldn't have been able to hear. (Working Together Group)

There is a tiny family room which is stark and horrible especially with young children. They should be designed like ones on children's wards and children services rooms. For mothers who are having issues it would also be good if there was some way mothers and children could form a bond with their child, e.g., bathing, play massage etc. (Working Together Group)

Compared to secure wards, acute ones are chaotic and under resourced. (Working Together Group)

3.17 A mental health organisation representative urged for the provision of private spaces which are '*psychologically informed environments'* in order to facilitate safe, in-depth and private therapy to take place. This view was echoed by several questionnaire respondents in their comments, including service users:

For our client group, we know that having a trauma informed or sort of psychologically informed environment is key to them feeling comfortable and able to engage and feel safe and then from there do the more sort of in-depth therapeutic work. So, without that in place, that deeper level of care and support will never really unfold or materialise. (Organisation representative)

Lack of activities during the day and lack of professional intervention (apart from the ward round) was a shame as it would have been a great opportunity for some therapeutic input for his psychosis. (Questionnaire respondent - Carer/family member)

I think medication is great, but [service users] shouldn't be encouraged to depend upon it long term. Psychiatric drugs can be very damaging long term and I know this from personal experience and experience with loved ones. Discussions on self-care, self-love, and emotional regulation need to be taught. Hospital settings are awful for people who are ill. Especially more so, with mental health. A lot needs to be changed. (Questionnaire respondent)

… more of an emphasis on holistic healing and talking therapies to be implemented into the recovery programmes. Generally, people who have been sectioned are probably feeling hopeless about their future. (Questionnaire respondent - Service user)

3.18 The topic of provision for private discussions, meetings and therapeutic activities led several participants in early-involvement activities to raise concerns about staff behaviour in relation to service user treatment and care, a subject explored in more depth below.

> *Staff rarely interacted positively with service users - they were mainly holding clip boards standing at a distance and writing notes rather than engaging and chatting with the service users. Not helpful for those in psychosis who were already feeling paranoid. (Questionnaire respondent - Carer/family member)*

3.19 Participants from the Engagement Workshop and the early-involvement questionnaire felt that the provision of adequate space would allow inpatient services to invite external services onto wards to provide 'wellbeing activities' such as gardening, exercising and educational activities such as money advice.

> *We must remember that the Arts and Nature have been proven to assist in the healing processes involved in the recovery from mental illness. The spiritual wellbeing and fulfilment of patients should also be highlighted amongst the many tools available to aid the anguish of those in recovery. Beautiful, clean and simple environments are vital for wellbeing. (Questionnaire respondent - Other)*

3.20 Some EBEs also commented on the poor quality of frozen, re-heated food, and instead felt that more effort should be made to educate service users about the importance of healthy lifestyle in the context of recovery i.e., cooking fresh food from scratch using healthy ingredients. It was also suggested money should be invested in improving inpatient kitchen facilities to enable this.

> *I am passionate about the importance of food for our mental health… The problem with energy and recovery journeys is we could be setting out bad habits which could lead to a decline in healthy lifestyles. Simple learnings can be taken in – learning to eat healthily and looking at prevention – food is key. (Working Together Group)*
>
> *I hate these cook-chill meals. I have eaten them as a patient, lots of places don't have their own kitchens so they have to have these meals. There is a massive difference to when I have been in places which do have kitchens. The long-term benefit of having these facilities would be worth the extra cost in the short term. (Working Together Group)*

3.21 The Working Together Group also discussed the importance of communal areas more generally, which they felt are even more important to provide if same-sex wards and private rooms are implemented so that service users can socialise and integrate. They suggested that such spaces should be designed with '*service user input*.' This theme of co-design of spaces was also picked up by an NHS staff member who responded to the early-involvement questionnaire:

> *In West Sussex each one has two wings, one male and one female. Female wards also have a sperate tv room. There is also a communal area where you can chat. There are a lot of facilities there. The layout was all designed with service user input. (Working Together Group)*

I think there should be massive involvement with local artists and service users. New buildings should be light and airy (being able to 'look out' and see the world is vitally important and access to the sun (Vit D) - secure gardens/outdoor spaces are also areas I think should be considered. There should be space for 'alternative therapies'. (Questionnaire respondent - NHS staff member)

3.22 Lastly, it was felt important that wards need modernising so that service users and visitors can use WIFI, laptops and their smart phones to ensure they remain stimulated and connected to the outside world.

Accessibility and out-of-area transfers

3.23 Experiences of service users being '*constantly moved*' around different inpatient wards across East Sussex and out of county without any clear reason were relayed among the Working Together and Care for Carers group discussions. These experiences were corroborated by a mental health organisation representative who has worked with many carers whose loved ones have been sectioned and taken '*all over the place*', including into West Sussex – again, with poor or non-existent communication with the families and carers as to why the transfer has taken place and where the service user has been moved to.

What's worse is that when this does happen, families are not being informed of where their loved ones are. One family I was working with, their loved one had attempted suicide, had to be resuscitated and was sectioned. They weren't informed for 24 hours where they were. (Organisation representative)

My son was sent to Woodlands first, was discharged but then later sectioned by the police and sent to Crawley. He had an excellent psychiatrist there who understood him, and he ended up having some therapy there. But then, in the middle of the night, they moved him to Eastbourne without telling me. (Care for Carers Discussion Group)

This isn't something unique to East Sussex, but there are additional issues here in terms of location, such as access and transport. It has caused huge amounts of distress and anxiety for families when that vulnerable person they love is sectioned and taken really far away. (Organisation representative)

3.24 It was stated that such issues are not only distressing for families and carers, but also highly detrimental to service users' stabilisation and recovery due to re-traumatisation and lack of quality of care. One carer said that this lack of continuity resulted in their loved one becoming passive and deteriorating even further. Moreover, a mental health practitioner explained that out-of-area transfers are particularly harmful to those with multiple complex needs because they are further isolated from the few trusting relationships that they have been able to build up with local community services. As such, if they are placed out of area and '*lose connection'* to their community, they are at much greater risk of relapse.

In terms of out of area placements, it's something we advocate against in sort of housing placements for reasons of how it isolates people from the support they've built up. For our group, if they have built a few trusting relationships that's a huge step forward often in their connection to their community. If they are placed out of area, suddenly they are isolated again and extremely vulnerable to exploitation and potentially relapse so being placed out of area is not helpful for this group. (Organisation representative)

A carer's son was in inpatients for schizophrenia, being moved around and constantly having his medication changed, wasn't told what was going on and why. They became very passive, which did not enable them to get better. People need consistency in the support they receive. (Working Together Group)

3.25 Questionnaire respondents picked up on concerns about out-of-area transfers and the need for adequate beds to accommodate current and future demand. In particular, the issues of out-of-area transfers resulting in less contact with carers, family members and wider support networks was identified as a significant issue which needed to be addressed as part of any programme of improvements.

I do not think there are enough inpatient beds in mental health services within the catchment areas & people need to travel to see relatives. It is difficult enough for them to be inpatients in a mental health hospital without the ongoing support from family/friends. (Questionnaire respondent - NHS staff member)

People being moved out of area where carers cannot so well support them. (Questionnaire respondent - Organisation)

[There is] insufficient bed capacity for dementia. Given the population and demographics of East Sussex this appears to be woefully short. (Questionnaire respondent - Organisation)

Not enough beds and too many clients being placed out of area away from family/friends/ significant others. (Questionnaire respondent - Service users)

There are insufficient 136 suites and facilities to care for 'difficult to manage' patients who are being ECR'd well out of area… I would prioritise a better way of keeping our own patients cared for in our own Trust. (Questionnaire respondent - NHS staff member)

The needs of those with multiple-complex or special needs, and other groups

3.26 There was a strong feeling that there is currently a lack of understanding around neurodiversity; specifically, the needs of service users with spectrum disorders, conditions such as ADHD and other sensory and learning disabilities.

3.27 One carer described how their son, who has ASD, was simply perceived as '*difficult'* and severely regressed after spending time in inpatient services due to suffering from such high levels of distress. These issues were also addressed by an NHS staff member responding to the early-involvement questionnaire, who stated that the needs of such service users must be taken into consideration when designing new facilities.

Nursing patients with learning difficulties or with complex Autistic Spectrum Disorders on open wards has always been difficult (for the patient, their family and friends, other patients, and staff). Please consider areas that incorporate 'low stimulation/low volume' that can be used safely. (Questionnaire respondent - NHS staff member)

3.28 A mental health practitioner who undertook an individual depth interview felt that there is a general inability among staff to recognise these additional needs, as well as how they can impact on service users' cognition and behaviours, which is ultimately hindering recovery. Thus, they suggested that both additional staff training and adapted physical space are needed among inpatient services across East Sussex.

The design of things and how space is used is obviously very important for people's recovery. There is not the right space to be able to start working with people the minute they're admitted. I'm thinking of someone who has recently been diagnosed with ASD and a personality disorder as well other mental health problems. They were quite young, and it was their first experience of being sectioned. There wasn't a space of a private room, so they just clammed up and couldn't talk. Providing an appropriate and workable space is very important – more so than the standard of accommodation. (Organisation representative)

Training for staff around additional needs is also key. A lot of the things I have heard from very upset families is the staff's inability to recognise, deal with and separate out additional needs, particularly around conditions such as ASD and ADHD. There needs to be better understanding on how these conditions can impact on someone's ability to engage and be reciprocal to whatever they're being offered. (Organisation representative)

3.29 Further concerns specifically related to service users with ASD, learning disabilities and sensory disabilities were raised by carers and family members via several early-involvement channels, with serious concerns expressed about the suitability of current buildings and facilities for patients with multiple complex needs.

My son also has Autism and went into the Eastbourne unit last year and after being there he could no longer talk or communicate. Whilst he was in there, he had panic attacks but was just left in his room, all alone. He was also highly distressed that the toilets were always locked so he couldn't go to the toilet when he needed to…he also has issues with food, but they weren't equipped enough to let me bring them his own food for them to prepare… I complained to PALS but nothing happened as a result. My son is worse now than before he was admitted to hospital. (Carer for Carers Group Discussion)

There are significant safety and security issues, especially on split level wards... This is a very unsuitable environment for anyone with autism/ learning difficulties, accompanying sensory difficulties and additional MH needs… We believe there needs to be significant changes to the service for ourselves to have any confidence it could meet the needs of our son and others with similar multiple diagnosis. (Written submission - Carer/family member)

3.30 Several Engagement Workshop attendees also discussed the specific challenges for other types of people who are admitted to inpatient mental health services, which need better understanding action to meet their needs, such as nursing mothers and non-binary and trans-people. These and other issues related to specific protected-characteristics groups are covered below.

Staffing and resourcing

3.31 Staffing was another salient issue raised among most stakeholders. It was felt that the reliance on locum and non-permanent staff, along with sites generally being under-resourced and highly pressured, are severely impacting on the provision of consistent care. Specifically, participants argued that these issues are linked to many other challenges facing inpatient mental health services across East Sussex such as lack of security on wards (for example, escape attempts and the personal safety of both service users and visitors being put at risk), lack of communication with families and carers, out of area transfers and lack of therapeutic activities.

I have been on wards where there have been serious escape attempts which resulted in people getting injured. (EBE individual interview)

I warned staff that my son had told me he was going to try to escape and they assured me that he couldn't. But he did manage to escape and was found by the police wandering in the fields. (Care for Carers Discussion Group)

3.32 The same challenges were linked, by some discussion participants and questionnaire respondents, to issues related to quality of care - particularly in relation to staff communication and continuity between shifts. There was also a view that insufficient staffing and staff training was directly linked to excessive use of restraint and other actions deemed to be detrimental to the wellbeing of service users.

Lack of staff and using high numbers of agency staff mean continuity of care is compromised. Important information was not handed on to the following shift meaning my son was given leave when he was not safe to have this. (Questionnaire respondent - Carer/family member)

Having been a patient at DoP a number of times, the staffing levels were not suitable. This led to poor overall care […] lack of staffing led to dangerous physical restraints. (Questionnaire respondent - Service user)

I've experienced Woodlands when my son was admitted there…there wasn't enough staff to provide therapeutic care. The most significant issue was a lack of permanent staff and use of agency staff. It meant that a lot of staff were unfamiliar with the patients and important information was not passed on during shift changes, which put my son in danger. (Care for Carers Discussion Group)

3.33 Thus, it was felt that addressing the staffing issue would help to address these issues, as well as promoting integrated working and fostering positive environments. Indeed, it was stressed that there is little point in providing more facilities and redesigning services if there are not enough resources to adequately staff them.

The main problem is the staffing. It's all very well changing the layout but none of that's any good if the staff are still under too much pressure. Why there is such a shortage of permanent staff needs to be looked at. (Care for Carers Discussion Group)

You can put someone in a new building but if the staffing culture is still negative it won't make any difference. (Care for Carers Discussion Group)

If staff were better trained, more interactive with service users, people would probably feel better quicker and be ready to go home earlier. If the people chosen to work in mental health hospitals were more positive, caring, had excellent social skills and were given training into caring for mental health patients then things would be so much better even if buildings were not so adequate. (Questionnaire respondent - Carer/family member)

3.34 For some, the possibility of significant improvements to inpatient mental health service buildings and facilities would be a contributory factor in improving staffing levels - in particular if an approach was taken that would create a single site which might include staff accommodation.

Moving all [services] onto one site would improve staffing levels and the provision of nurses' accommodation would be feasible. (Questionnaire respondent - NHS staff member)

Integration with other mental health services and community support

3.35 Poor integration and lack of joined-up working was a major topic of discussion in all early-involvement activities. One of the main challenges was identified as the perceived lack of multi-disciplinary team (MDT)-working, including poor communication and co-ordination between inpatient mental health and community-based services as well as physical healthcare. For example, a mental health organisation representative voiced their frustration that compared with other areas, East Sussex does not seem to work in an integrated way insofar as there is little cohesion.

When I worked in London (Hackney) we worked in a completely integrated way. There would be a team of people including a GP, psychiatric lead from secondary care, community mental health services, adult social care, voluntary sector and various other people. I could see how this way of working impacted on the care pathways and outcomes for the patient. I have felt incredibly frustrated that this is not how it works here (in East Sussex). I understand that geographically it is very different, but there is a total lack of joined-up services. No cohesion between the different services, which has had a detrimental effect on patients. (Organisation representative)

There needs to be better integration between community and inpatient services, as well as mental and physical health services. These are a key priority. (Engagement Workshop)

A closer relationship with the police, who are often called to deal with mental-health issues that are getting out of hand. (Questionnaire respondent - Service user)

3.36 The lack of clear pathways for admission and discharge was another key issue for stakeholders. Specifically, the Working Together group claimed many people who are admitted to the DoP have complex problems beyond their mental health crisis, such as lack of support networks and financial, housing and substance abuse issues, but are being sent home without any support in place. This concern was echoed by several questionnaire respondents.

Support after discharge needs to be implemented, along with action plans and help towards the patient's goals. [AT DoP] I had to stay for 3 days and was discharged with no further help for weeks on end… Support after hospital will mean less of a chance of ending up in there again. (Questionnaire respondent - Service user)

Very poor communication with carers… At one stage led to agreeing discharge plan with patient to accommodation that they could not stay at […] patient stayed 2 weeks longer than necessary due to lack of input and support re: discharge. Whole admission led to significant decline in wellbeing of patient, only significant advantage was they got to see a psychiatrist and received some medication. (Questionnaire respondent - Carer/family member)

I came across a lot of people on the DoP ward who had many complex issues beyond their mental health crisis, such as lack of support networks, financial issues, housing issues, substance abuse issues etc. There was one lady who had been discharged to outpatients and didn't even know how to get the bus home! 'Transfer of care' is very important. (Working Together Group)

3.37 Similarly, individual interviewees and those who attended the Engagement Workshop highlighted the issues facing people with substance abuse and/or who are homeless in this context. Others had witnessed and experienced service users being '*rushed*' back into the community by inpatient services with no care plan or discussion with community services.

> *If somebody has got substance misuse issues, they are not able to go and access mental health inpatient services because they need to be clean; there is a dual diagnosis issue where two services don't necessarily talk to each other and it's detrimental to the patient. (Organisation representative)*
>
> *Friday afternoon discharges for people who are homeless. Good luck trying to sort that out; in a few hours try and get somebody's accommodation sorted. So again, the whole discharge protocols I think that would definitely be a key priority in this as well to be honest. (Organisation representative)*
>
> *Community services are given no guidance, or information about the patient from inpatients, meaning that they cannot effectively support them. It causes a vicious circle where the patient is back in inpatients within a few weeks. (Engagement Workshop)*
>
> *There is a fragmented relationship between inpatient and community services: there are some fantastic recovery and support services in the community, but they are not being fully utilised. (Engagement Workshop)*
>
> *Inpatient assessments often too quick and people discharged sometimes with insufficient signposting/support in the community. Then they keep bouncing in and out. There needs to be more focus on wellbeing beyond discharge. (Engagement Workshop)*

3.38 Stakeholders believed these issues lead to inpatient service users receiving disjointed and inadequate care, causing them to be in a constant '*vicious cycle*' of hospital readmission and poor outcomes. It was also reasoned that investment in joining up services will prevent the number of people reaching '*crisis point*.' Thus, a focus on providing and improving integrated care was considered a key priority and stakeholders put forward a number of suggestions as to how this could be enabled, such as:

- 'Bridging the gap' between inpatient and community care via third sector advocates and services such as Pathfinder;

> - *The Pathfinder service is good, these are occupational therapists based in the third sector. The idea is of building a bridge. When I was at a meeting with the head of OT, she had never even met people on the outside, she wanted to have an idea of who she could pass people onto. This brings in people from housing. Some people are too vulnerable to go back into the community. The housing issue in Brighton is a serious problem. People in the west and across Sussex they have brought care workers in to be discharged. There should be the use of advocates to work with everybody. Brighton have brought in voluntary advocates. The voluntary sector can start to help with this idea of working with people and having this transition supported. (Working Together Group)*

- Co-location or closer proximity between inpatient and community mental health services;

> - *Services need to be situated closer together. (Engagement Workshop)*

» *Buildings need to be collocated close to community services to help joined up working. (Engagement Workshop)*

» Implementing a 'halfway house' transitionary model as an integrated pathway to help people transition from inpatient care to the community. Specifically, the Working Together group suggested that the Partnership could buy properties in local areas to provide better short-term provision for such a 'transfer of care', including opportunities to learn new skills and develop current ones to help them re-integrate into society for the long-term;

» *I have come across something like this whilst working in Milton Keynes which worked very well. It really helped with individuals' confidence. The idea of an integrated pathway into the community rather than just kicking them out of hospital to fend for themselves. (Working Together Group)*

» Implementing clear 'discharge pathways' so that service users have holistic, bio-psycho-social care plans in place when they leave hospital (which focus on all aspects of their life), which will require joined-up working across different sectors and services;

» *… Making sure that as and when people are discharged, they are in a safe place and be able to be discharged. That's not just physical or mental, that is the whole social element around them, so you look at it holistically rather than just one problem… That would be really cool to see in there as a key priority (Organisation representative)*

» *There should be involvement with Adult Social Care… The inability to discharge patients to supported or appropriate accommodation has blocked beds for years. No new service will function any better than the current services if patients still have nowhere to be discharged to promptly. (Questionnaire respondent - NHS Staff member)*

Equalities impacts and implications

3.39 East Sussex CCG and Sussex Partnership are committed to providing high-quality inpatient care for service users and their carers and families, regardless of age, disability, gender and ethnicity. In this context, they and ORS have, and will continue to, engage with individuals and groups with protected characteristics under the Equalities Act 2010, and their advocates, to understand the specific needs and concerns of members of these and other communities (e.g., low-income families) in relation to inpatient mental health services.

3.40 Some of these groups are described as "seldom-heard" or "hard-to-reach", requiring specific targeted activities to be undertaken which require planning and time. While feedback has already been received in relation to some of these groups, further opportunities to engage with and involve protected characteristics and other groups and individuals will continue in 2021. The findings from these will be added to subsequent reports and shared with the RIS:ES Programme Team.

3.41 Without providing specific feedback, two questionnaire respondents highlighted the gypsy and traveller community, and people who are homeless or rough sleeping, as groups who might be impacted by changes and improvements to inpatient mental health services. Deprivation was also mentioned, with concerns expressed about the impact of moving services on those with low incomes.

3.42 ORS conducted an interview with a BAME service user who, as someone whose first language is not English, often relies on translation services. They reported challenges in understanding and accessing community services in East Sussex, as well as difficulties in communicating their feelings and needs which were *"lost in translation"* - a fact that had become clear when the service user had read reports following interactions with clinicians and community support workers. Being unable to communicate with nuance made benefitting from counselling difficult.

> *If you don't feel you are going to benefit from where you're going or get treatment, then there's no point in you going there. (Translated interview - BAME service user)*

3.43 While the interviewee had not been admitted to an inpatient mental health ward in East Sussex, previous experience in a secure unit elsewhere in the UK had resulted in feelings of isolation and anxiety as a result of language barriers and a lack of understanding of their cultural and religious background.

> *I believe people need to feel safe when they are getting treatment so they can be open. (Translated interview - BAME service user)*

3.44 A carer/family member responding to the early-involvement questionnaire suggested that the needs of younger adults (those under the age of 25 years) who are admitted to adult inpatient wards need to be considered, stating that, *"an immature 18-year-old"* might find an adult ward very difficult.

3.45 As mentioned above, the specific needs of inpatient service users with children - and in particular nursing mothers and those with very young children - were raised several times. This included a suggestion that additional perinatal beds be made available as part of future plans.

3.46 An informal discussion with a representative of an organisation working with d/Deaf people highlighted the importance of ensuring the needs of service users with sensory disabilities are understood and addressed when planning services and designing inpatient mental health buildings and facilities. Further work will be undertaken as part of the ongoing engagement programme to ensure that the views and concerns of people with disabilities are given due consideration.

3.47 The importance of considering issues such as lighting, not only for service users with sensory differences (e.g., Sensory Processing Disorder) but for all service users and staff members, was raised in relation to a Sussex Partnership inpatient mental health ward in a neighbouring area, alongside a specific request that the issue be considered as part of the RIS:ES programme.

> *Several service users / staff members have commented that the lighting on the ward is too bright… This leads to them often being switched off to avoid headaches, which then affects the atmosphere of the ward and also the perception of time of day. This can be detrimental for circadian rhythm, especially for our patient group who are often not oriented to time of day. Ideally, we would like to be able to dim the lights to create a more therapeutic and less clinical environment. We believe this would help to settle the ward by virtue of improving the overall atmosphere [and] patient experience. [Email feedback received via Sussex Partnership Trust]*

3.48 Other comments around the needs of, and suitability of service provision for, people with learning and sensory disabilities and ASD included suggestions for measures which might be introduced to improve patient

care, from provision of ear defenders for people with Sensory Processing Disorder (SPD), to ensuring specific communication and wellbeing needs are understood and met:

> *As one of my sons has ASD […] this should be thought about, to reduce stress on impatient stay. There should be ear defenders for any patient that needs them and more privacy. (Questionnaire respondent - Carer/family member)*
>
> *There seemed to be limited understanding of [our son's] repetitive communication needs in the community provision [and] if he had been admitted or were to be admitted in future, we believe the clinical needs of other patients and witnessing potentially distressing incidents which could occur would cause him additional anxiety and place him at further risk. (Written submission - Carer/family member)*

Balancing prioritising local access and maximising scope for improvements to services and facilities

3.49 During qualitative activities and in the early-involvement questionnaire, participants and respondents were asked to consider the possibility that not all services would remain at existing sites, given a combination of factors including:

- East Sussex CCG and Sussex Partnership's view that it may be impossible to achieve their clinical vision and priorities at these sites;
- The cost of maintaining old buildings;
- Some sites are not owned by Sussex Partnership and may need to be vacated at some point in the future (including the DoP building at Eastbourne District General Hospital, which is likely to play an important part in East Sussex Healthcare NHS Trust's (ESHT) future plans); and
- The current site of the DoP is not flexible enough to meet the future needs of mental health inpatients.

3.50 Respondents to the questionnaire were specifically requested to consider the possibility that inpatient mental health service provision might be delivered from fewer hospitals, meaning that some service users, carers and families could have to travel further within East Sussex in future to access those improved services and facilities. Respondents used a nine-point-scale to answer the question, and for ease of reporting have been divided into three groups:

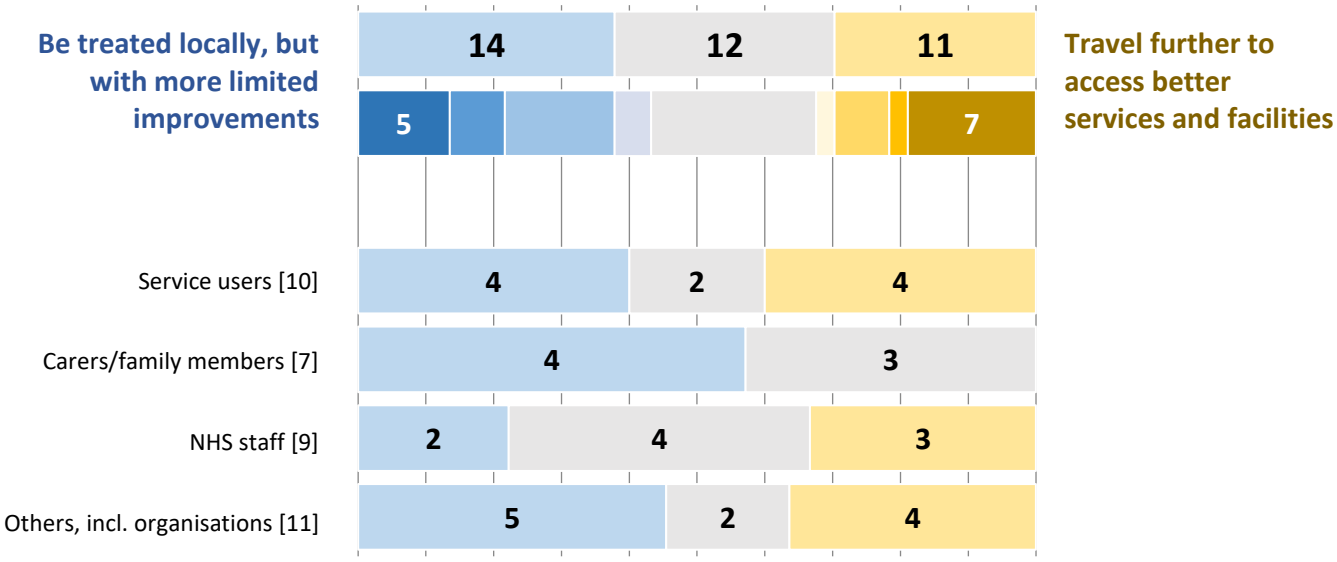
- Those who scored 1-3 on the scale, indicating that they tended to favour prioritising local hospital treatment over maximising potential improvements;
- Those who scored 4-6, indicating a preference for a balanced approach; and
- Those who scored 7-9, indicating a willingness to strive for maximum improvement to services and facilities, even if some people have to travel further within East Sussex to access them.

3.51 Overall, views were fairly evenly balanced (

3.52 Figure 3), with a similar proportion of respondents overall, and among each respondent type, falling into each of the three groups – with the exception of those responding as carers or family members of service users. It should be noted, however, that carers who engaged through other activities (e.g., group discussions)

spoke about the importance of quality of care and issues such as staffing and resources being *greater* than the specific location of services.

Figure 3: Questionnaire respondents views on how they might prioritise between local access to inpatient services, or traveling further within East Sussex to access more improved services and facilities [Base:37]



3.53 Of those questionnaire respondents who provided a reason for prioritising local or existing services, one specifically expressed a concern that low-income groups would *"suffer enormously"* if required to travel further to visit family members, while another called for services to be localised even more than at present. In fact, travel and access were the most common concerns overall, although it should be noted that some comments suggested that these concerns were as much about *out-of-area transfers* as they were about travelling within East Sussex.

> *Patients & staff like to be as near to home as possible. Moving out of the local area to a new hospital may place staff under strain in terms of travel to/from work & childcare responsibilities. Patients & their visitors will not want to have to travel too far… (Questionnaire respondent - NHS staff member)*

3.54 One respondent expressed concern at the idea of a need to "compromise" quality of care, and the feedback overall implied a widely held view that whatever improvements or extensions are made to existing buildings, or wherever new sites or buildings might be located, that a much broader and far-reaching programme of improvements would be required in the coming years to ensure that inpatient and community-based mental health services meet the needs of those who depend upon them.

> *You should not have to compromise on excellent service & facilities available to you locally or travel to a different hospital to get "better" treatment. The Trust should have the same standards across the sites... there should not be compromise on inpatient care and treatment. (Questionnaire respondent - NHS staff member)*
>
> *I feel that the services provided ACROSS THE WHOLE RANGE of services must be considered a priority for updating and improving care for all patients with mental health issues. (Questionnaire respondent)*

3.55 By contrast, those service users and other stakeholders who prioritised maximising scope for improvements, even if it meant travelling further to access inpatient services, tended to highlight the potential benefits of new buildings on new sites. This was particularly the case in relation to the DoP, which many respondents felt needed to be replaced completely (particularly in the light of the site not being owned by Sussex Partnership and the likelihood that it would need to be vacated in the near future).

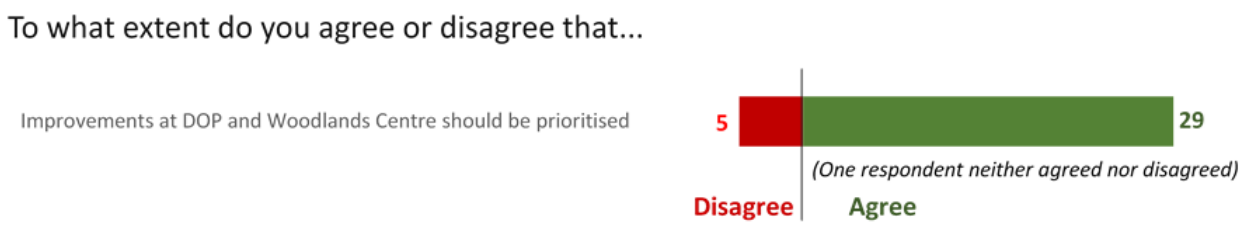
> *Because the Dept of Psychiatry is operated by a different body to the general hospital it may as well be moved to another site and the general hospital could use the building. (Questionnaire respondent - Service user)*
>
> *The current facilities at Eastbourne are appalling. Everything possible should be done to provide a new start and improve the service to an acceptable level where patient compassion is a priority. (Questionnaire respondent - service user)*
>
> *There is no possibility of refurbishing Eastbourne DoP as it is not owned by the Trust. (Questionnaire respondent - NHS staff member)*

Prioritising acute inpatient services at Eastbourne and Hastings hospitals

3.56 Questionnaire respondents were then asked to what extent they agreed or disagreed with the possibility of prioritising improvements to inpatient and out-of-hours mental health facilities currently delivered from the two acute hospitals in Eastbourne and Hastings. East Sussex CCG and Sussex Partnership might then be able to consider improvements to rehabilitation and dementia facilities and services, but only after the immediate priorities have been met.

3.57 While participants were somewhat more divided in their views than in relation to the challenges and priorities covered above, the majority did agree with this approach (Figure 4). Those who disagreed raised concerns about the possibility of shortcomings in inpatient services for people with dementia being neglected, or added comments such as, *"It feels unfair to disadvantage service users living with dementia and those needing rehabilitation as they are equally deserving of a gold standard service. You should be aiming higher to provide appropriate care for all service users, they are all precious."*

Figure 4: Questionnaire respondents views on East Sussex CCG and Sussex Partnership's suggestion to prioritise improvements to acute inpatient mental health facilities, currently delivered from DoP and Woodlands Centre [Base: 35]



3.58 Some questionnaire respondents, while in agreement with the idea of prioritising those services and facilities at DoP and Woodlands, were keen to emphasise that dementia and rehabilitation services ought not to be, *"kicked into the long grass"*, but also needed to be addressed as soon as possible. Thus, the message reported above - that improvements to inpatient services, even if they are to start with acute adult services, need ultimately to encompass all inpatient and community-based care - was reiterated.

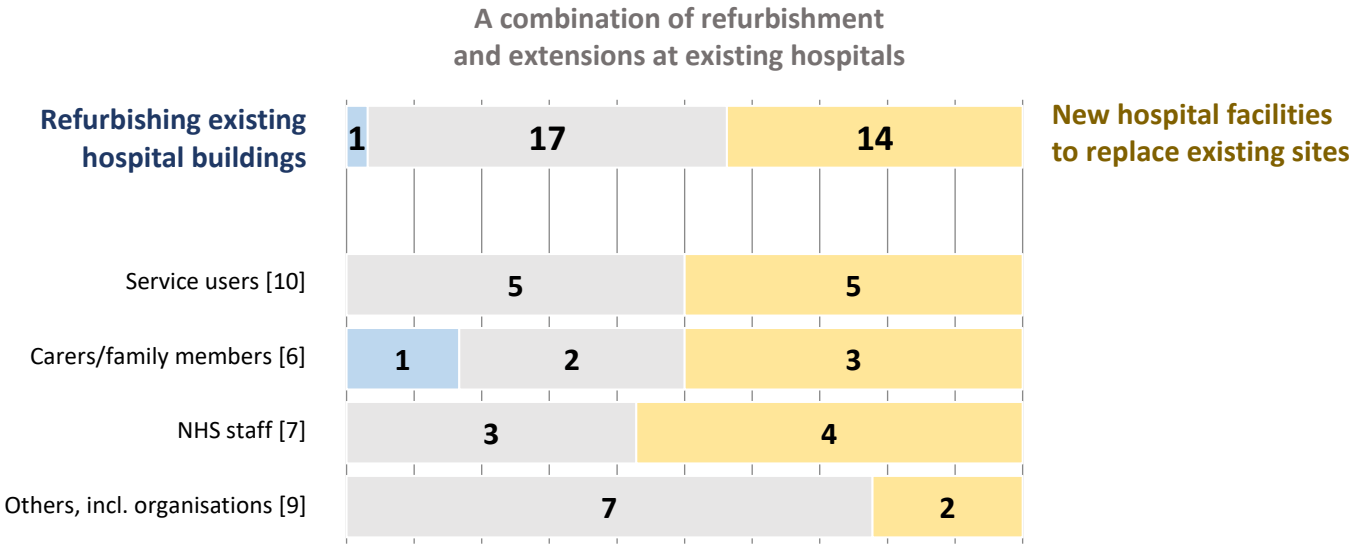
I have a vested interest in acute inpatient services because that is what my son needs but it feels unfair to disadvantage patients living with dementia and those needing rehabilitation as they are equally deserving of a gold standard service. You should be aiming higher to provide appropriate care for all service users, they are all precious. (Questionnaire respondent - service user)

I think that priority should be given equally to both acute inpatient mental health facilities AND improvements to rehabilitation and dementia facilities and services. Improving rehabilitation and community-based support will lessen the need for acute inpatient facilities. (Questionnaire respondent - service user)

Possible approaches to redesign

3.59 Questionnaire respondents, when asked to give their views on approaches to redesigning and improving inpatient mental health services, were first asked to consider three possibilities and choose just one of them (Figure 5), although they also had the option of suggesting an alternative approach instead.

Figure 5: Questionnaire respondents views on three possible approaches to inpatient mental health services and facilities [Base: 32]



3.60 Of the 32 respondents who chose to select one of the three options, only one favoured an approach based solely on refurbishments to existing buildings, while another declined to choose on the basis that much more detailed proposals would be required so that people could, *"weigh up the pros and cons"* of each.

3.61 Questionnaire respondents who favoured a combination of refurbishment and new extensions to existing buildings cited a number of different reasons, including the belief that this might be the cheapest and most cost-effective option, as well as being the least disruptive as staff and service users would continue to be based at the current sites.

Unless there was huge budget available the most cost-effective way of improving the facilities would be to reconfigure and add to the existing buildings. (Questionnaire respondent - Carer/family member)

> *Existing facilities have a team of staff who want disruption to be kept to a minimum. Providing them with new extensions, then refurbishing the older wards, will provide continuity and an improved workplace without the inconvenience of their having to start travelling to a new location, or the expense of building a completely new set of wards somewhere else. (Questionnaire respondent - Service user)*

3.62 Some others felt that keeping inpatient services on the same site as other types of hospital services was important for meeting both physical and mental healthcare needs. This view was echoed by the one respondent who chose to suggest an alternative approach to improvements, advocating the construction of new buildings for inpatient mental health services - but on the sites at Eastbourne District General Hospital and Conquest Hospital, specifically in order to keep them co-located with other ESHT services.

> *Refurbishing alone will not meet the standards [required] as more space is needed as well. Site should be as close as possible to original and incorporate original so inpatients can be transferred from A&E etc easily with minimised stress. (Questionnaire respondent)*

3.63 The similar proportion of questionnaire respondents who preferred the approach of building new hospital facilities on new sites tended to provide similar reasons to favouring refurbishment and extensions – but this time feeling that brand new buildings would provide better value for money than refurbishments, and that it would be stressful and disruptive to try to complete refurbishments or build extensions on sites that are already in use.

> *It makes little sense to refurbish the DoP if the Sussex Partnership will need to vacate at some point in the future, whilst it would cost more money to refurbish the Woodlands site than 'completely start from scratch'. [Engagement workshop participant]*
>
> *Trying to refurbish and extend current wards might be very stressful for staff and patents. I feel it's best to build new wards that are separate from existing wards and can have state of the art facilities rather than adapting what is already there. [Questionnaire respondent - Carer/family member)*

3.64 For other advocates of new buildings, the fact that the DoP is on land owned by ESHT, rather than by Sussex Partnership, was a good reason to relocate to an entirely new sight; as reported above, others simply viewed the DoP as *"appalling"* and viewed a fresh start as being the best approach to take.

3.65 Finally, there were some questionnaire respondents who specifically raised the prospect of bringing some or all of the other inpatient mental health services onto a single site, arguing that doing so would maximise benefits for staff, service users, carers and relatives by allowing for co-location of inpatient and community services, the addition of staff accommodation, and providing the best opportunity to achieve excellence.

Support for a new single-site 'campus' approach

3.66 Stakeholders who participated in the Engagement Workshop were presented with two possible scenarios: refurbishment of existing sites versus a single-site 'campus' approach. They were asked to consider both the benefits and drawbacks to both, along with their balance of opinion and any additional or alternative suggestions, which are outlined below.

3.67 Some participants – especially among one of the 'breakout rooms' - expressed very clear support for a new campus site and strong opposition to refurbishment of existing sites on the basis that:

» The 'refurbishment scenario' lacks sustainability and fails to adequately address some of the key challenges because…

- *Travel and access would remain an issue insofar as the current sites are situated reasonably far away from each other and that public transport networks make it difficult to travel across East Sussex.*
- *It is not congruent with the clinical strategy as it only provides temporary solutions which will not have the 'stamina' to improve and maintain good quality services.*

» The 'campus scenario' is better placed to foster sustainable, consistent, good quality, holistic, and integrated care because it would…

- *Provide longevity and 'outlast' simply refurbishing current sites.*
- *Provide a site that's suitable both for now but is also "flexible for the future." Specifically, some stakeholders felt that it would enable inpatient services to grow and transform with and around community services insofar as it can be built to suit services (rather than the other way around), which will be a key opportunity for joined-up working.*
- *Provide an ideal opportunity for mental and physical health services to be co-located (the Mill View site in Brighton was offered as an example of where such co-location currently works well). It was also argued that this would help in reducing mental health stigma and increase understanding, especially around holistic approaches to treating people.*
- *Enable allow co-location of integrative, holistic services beyond medical care, for example: art therapy, music therapy and other creative activities, prayer rooms, and movement classes. It was felt that providing such services would not be possible within the current or refurbished infrastructure due to the lack of space.*
- *Provide consistency of care in terms of staffing. For example, if a ward is short-staffed, there will be more support and resilience on hand. It was also highlighted that a new state-of-the-art site could potentially act as an 'employer' by attracting highly skilled staff.*
- *Cause less disruption than trying to refurbish existing site which are trying to also provide mental health services.*

3.68 Ultimately, those who supported the single-site 'campus' approach believed that quality of care is more important than access – and felt confident that this scenario would be able the provide the former. They also argued that improved public transport networks and parking access would mitigate for increased travel (as well as acknowledgement that existing sites are not always easy to access, with some services only available on a single site already).

3.69 However, although everyone who supported this scenario agreed that a phased implementation would be the correct approach to take, reassurances were sought around funding. Specifically, there was concern that the available investment could be reduced or removed over time, before the campus is finished and *'leaving services even more fragmented than before.'* Therefore, stakeholders said they would expect there be a '*clear plan set out from the start and a funding commitment'* for it.

Support for the 'refurbishment' approach

3.70 However, others preferred an approach which maintained existing services on current sites, citing:

- The 'campus scenario' would reduce local care and may not address all of the current challenges – many of which are not directly related to bricks and mortar…
    - Concerns about impacts on travel, and loss of local provision (with some advocating more local inpatient mental health services or multiple but smaller campuses); and
    - Concerns about the huge capital costs involved in building a campus site, which may not necessarily address current issues insofar as, "throwing money at a shiny new building may not get to root issues".
- The 'refurbishment scenario' provides better accessibility which is key for recovery…
    - The importance of accessibility for family and carers of service users, particularly as a key part of any treatment and discharge plan (although some others felt that service users sometimes need to "escape" their local situations to improve their chances of recovery and rehabilitation); and
    - This scenario would ultimately provide more local care, which is most important in enabling recovery – and that focusing on providing inpatient care in local communities is key.

Other suggested approaches

3.71 These included:

- Building a 'campus site', but also transforming the existing inpatient buildings onto community-run services, such 'one stop shops' which provide holistic care. These community hubs would very much be part of the larger plan for service redesign, rather than a silo project;
- Building several new *"mini-campuses"* might balance the benefits of proximity to population centres and the need for improved facilities; and
- Offering more local inpatient services through refurbishment of both current sites and currently unused NHS buildings.

Balance of opinion on approaches to redesign

3.72 Overall views around refurbishment versus a brand-new campus site were mixed, with most stakeholders and EBEs acknowledging the pros and cons of both. However, there was *slightly* more support for building a new campus site. That said, stakeholders emphasised the need for any changes – no matter which route they take – should be "*patient-outcome focused*."

Appendix I - Summary of additional early-involvement activities in 2021

Following the formal period of early engagement from October to December 2020, several ad-hoc opportunities for further engagement arose in spring 2021. These comprised two one-to-one telephone interviews - conducted by ORS - with service users from diverse ethnic and/or religious protected characteristics groups, and an opportunity for an ORS staff member to attend a Working Together Group at which the RIS:ES programme was discussed.

The interviews were used to explore the service users' experiences in relation to the challenges and priorities identified by East Sussex CCG and Sussex Partnership, and their views on possible approaches to address them. The Working Together Group, which took place in early May 2021, was primarily used to explore ideas about how best to engage with service users and other stakeholder during the forthcoming public consultation, although there was also a brief opportunity to discuss the programme and the draft shortlist of options being considered.

Summary of key feedback

Challenges and priorities

- Further feedback regarding negative experiences of dormitory accommodation in DoP and Conquest Hospital, although it was also recognised by one service users as providing opportunities for "camaraderie" with fellow patients;
- Some concerns about patient safety in both dormitory accommodation (due to threatening behaviour and upset or disturbed patients) and single rooms (risk of self-harm or suicide), with a need to balance privacy and safety concerns; and
- The need for private spaces for meetings with advocates, family members and carers, friends and supporters etc.

The needs of diverse service users

- Finding appropriate food (e.g., halal options) can be difficult and sometimes mean that family members have to provide food;
- "Spiritual spaces" for service users who benefit from being able to observe religious practices or similar reflective activities, without disturbing other patients, would be beneficial;
- Language barriers create challenges when communicating with staff and service users, and provision of translation services is vital for meetings and appointments, and would be helpful at other times;
- "Patients' Councils" can have a helpful role in representing all service users' interests, particularly in relation to therapeutic spaces and activities; and
- Employing staff members from more diverse backgrounds who might "better understand" cultural and language differences would be helpful.

Possible approaches to improvements

- Some concerns about services currently at DoP being moved further from Eastbourne, with suggestions that impacts could be mitigated by a commitment to provide transport links (i.e., shuttle buses);
- One service user was positive about Amberstone Hospital as a beautiful location and "healing environment", but also expressed concern that it is "out in the sticks", making it hard for inpatients to access community amenities or support groups, and that inpatient mental health hospitals should not be "tucked away";
- Sufficient space is needed for creative and other therapeutic activities at inpatient mental health hospitals;
- There is a need for mental health services to act as a "bridge" between inpatient and community care, including access to community networks as inpatients, supported/sheltered housing with easy access to key workers and therapeutic activities, and peer-support networks; and
- Increasing bed numbers and avoiding out-of-area transfers as much as possible is important, particularly to locations which may be several hours from home and difficult for family and carers to visit.

Engagement and public consultation

- The opportunity to be involved in pre-consultation engagement since autumn 2020 was described as positive and appreciated by stakeholders, even those who may have concerns about the final proposals;
- Recommendations that a mixture of consultation activities be used to allow as many people as possible to engage in ways that are comfortable and suitable for their needs, e.g.:
    - Questionnaires;
    - Group discussions; and
    - One-to-one conversations.
- Suggestions for groups and organisations which could be invited to participate in the public consultation, including:
    - Patients and staff, including bank staff and volunteers;
    - Residents who might be affected by changes in their areas;
    - Service users, carers and family members;
    - Support groups and charities, e.g., Autism Sussex, Diversity Resource International (DRI), Age UK and POhWER; and
    - Other mental health services, e.g., CAHMS, Assessment and Treatment Services (ATSs), Sussex Armed Forces Network, Assertive Outreach Teams (AOTs) and private mental healthcare providers.