Trust Board Report

SUMMARY REPORT	Meeting Date:	23rd November 2022
	Agenda Item:	19

Report Title:	**Clinical and Social Care (2021-2026) Strategy Annual Update**	
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Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	Quality Assurance Committee update report
	Date:	9th November 2022
Key points/ recommendations from those meetings	Accepted updates and reported a high level of assurance of progress with the implementation and delivery of the strategy.	

Summary of key points in report

The paper attached outlines the annual update report on the implementation of the Clinical and Social Care Strategy with progress of key performance areas, deliverables, and updates on risks. In summary the overarching aim of the Clinical and Social Care Strategy is to improve the quality of care received by our service users and to reduce health inequalities. The report outlines key points of progress over the year in relation to fulfilling year one objectives around *what matters to people*:

Programme management: Since the last report we have appointed a Programme Manager and Co-production Consultant (expert by experience) to oversee the delivery of the implementation plan in conjunction with workstream leads. Each of the workstreams have clear plans related to change initiatives and these are outlined within the report.

Improving access to effective services: IAPT has met its first increase in access from 15,783 to 17,183 per year. Alongside this they have maintained good quality and outcomes meeting the IAPT national benchmark recovery rate standard, the service also continues to exceed all national waiting time standards.

Intervene early with an offer of care that's joined up and within people's local Communities: Primary care mental health transformation which integrates community models for adults with serious mental illness, "personality disorders" within primary care have continued to expand to reach people in local communities. The programme is moving into phase 3 with an ambition to bring together multiple teams to provide a whole system approach bridging the gaps service users told us about in service provision.

Providing services that are Trauma Informed/deliver trauma informed care: establishment of Roots a baseline assessments of trauma informed care across the rehabilitation care pathway. QI methodology is being used to implement improvements in care alongside Training and supervision to shape and change practice.

Provide treatments and interventions that are evidence led: Structured Clinical Management as an evidenced based approach to working with people presenting with Complex trauma/personality disorder.

SHSC have invested in team training for the North and South Recovery teams and a small implementation team to deliver this clinical approach. The evaluation within the pilot project has shown that service users' weekly average crisis contacts have reduced by 49% since starting SCM compared with the 18 months prior to the pilot (this includes A&E, OOH, duty, and S136).

Reducing restrictive practice: A number of initiatives have been delivered including all wards now have a relaxation room and de-escalation room (e.g., safe spaces within wards) whilst following the ambition to remove seclusion rooms from the acute wards. Alongside this there have been improvements to systematise support with post incident support for staff and service users. Ensuring teams take up opportunities for discussions around restrictive practice at Huddles, daily handovers, MDT reviews, within reflective practice sessions on the ward or formulation planning sessions supports reduction in restrictive practice.

Ensuring Purposeful admissions for people admitted to inpatient wards: The acute wards are working to implement PIPA which is a range of initiatives aimed to improve the experience of service users and carers and staff : having a clear purpose for each admission and then for the systems and processes to fit around this to enable this purpose to be achieved.

Expand Access to Perinatal Services to support vulnerable women and give the best start in life for children: Perinatal has a focus on expanding access from 5% to 11% of the birth rate in Sheffield and seeing infants up to 24 months. The team are working to increase access and engagement supporting Dads/partners and to reaching higher risk groups including the Roma/Slovak community.

Coproduction is a key factor in the success of the strategy working with service users, carers, and staff from the conception throughout the 5-year implementation plan. We have established a service user reference group and they have adapted a version of Sherry Arnstein's ladder of participation and are using the National Survivor User Network 4Pi principles. The group have formed positive links and partnerships with Sheffield Flourish, Healthwatch, VCSE and Rethink to develop wider networks and partnership working to ensure a broader representation.

Increasing visibility /Comms plan: we have set out a communication and engagement plan including regular updates on Jarvis, alongside wider engagement activities including engagement visits with clinical teams and services (from November through to April 2023) to improve understanding of strategy in line with local initiatives, create communication channels across the programme and develop team SHSC to link into the goals and objectives of the Strategy.

We held a stall at the Annual Members Meeting and used menti.com to gather some feedback on the strategy implementation and how we can make connections with new people and enable more people to get involved.

Creating environments for Excellence: we have started a full programme of work to improve the environment for service users and staff, alongside small change big impact projects eg East Glade recovery team were successful with funding for continuing development of green space meadow within the community garden/grounds. Understanding what makes a good team and place to work and extending the therapeutic offer on the inpatient wards.

Enabling Strategies and Transformation Programmes: Work has been undertaken to understand the interdependencies and linkages across the transformation portfolio. Workstream leads (steering groups and subgroups), enabling strategy and transformation leads, project teams and all staff leading on local projects and quality improvements All have a responsibility to ensure that the outcomes they measure link to the clinical and social care strategy priorities.

Recommendation for the Board/Committee to consider:

Consider for Action		**Approval**		**Assurance**	**x**	**Information**	

The board are asked to consider the Programme Summary and the review of progress to date to consider if this report provides sufficient information to describe progress against the key performance areas.

Risks: the ratings for the programme as a whole relate to BAF risks 0024 and 0029.

The Clinical and Social Care Strategy Programme has been rated with an overall status of Amber; this is due to resources impacting the progress of the programme. This includes workstream leads capacity and changes in the leadership we are aiming for the programme to be rated green in all areas by March 2023.

The other high priority risk currently being managed by the Programme Board pertains to the significant amount of work to deliver per programme objective across all services. There is a risk that the scale of the change required is too large and as a result hinders successful implementation.

The risks associated with the implementation of the strategy are managed by the Programme Board and escalated to the Transformation Board, Finance and Performance Committee and Board of Directors as necessary.

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Recovering effectively	*Yes*	*x*	*No*	
CQC Getting Back to Good – Continuing to improve	*Yes*	*x*	*No*	
Transformation – Changing things that will make a difference	*Yes*	*x*	*No*	
Partnerships – working together to make a bigger impact	*Yes*	*x*	*No*	

Is this report relevant to compliance with any key standards ?					**State specific standard**
Care Quality Commission Fundamental Standards	*Yes*	*x*	*No*		All CQC standards relate to the quality of care
Data Security and Protection Toolkit	*Yes*		*No*	*x*	
Any other specific standard?					

Have these areas been considered? YES/NO					If yes, what are the implications or the impact? If no, please explain why
Service User and Carer Safety and Experience	*Yes*	*x*	*No*		Patient Safety and Experience is a key consideration within the Clinical and Social Care Strategy including a focus on the principles of Person-Centred, Trauma-Informed, Evidence-Led and Strengths-Based care.
Financial (revenue &capital)	*Yes*	*x*	*No*		Finance is a core component of the Clinical and Social care Strategy, ensuring NHS Long Term Plan investment is used to enable evidence led care and demonstrable outcomes
Organisational Development /Workforce	*Yes*	*x*	*No*		OD and workforce considerations are explicitly part of the implementation plan – ensuring the change process is supported throughout the 5-year implementation plan.
Equality, Diversity & Inclusion	*Yes*	*x*	*No*		EDI is referred to in relation to accessibility and workforce development ensuring the workforce is reflective of the Sheffield population.
Legal	*Yes*		*No*	*x*	
Environmental Sustainability	*Yes*	*x*	*No*		The strategic plan around Sustainability and Green plan have been considered in terms of overlapping aims

Name of Report

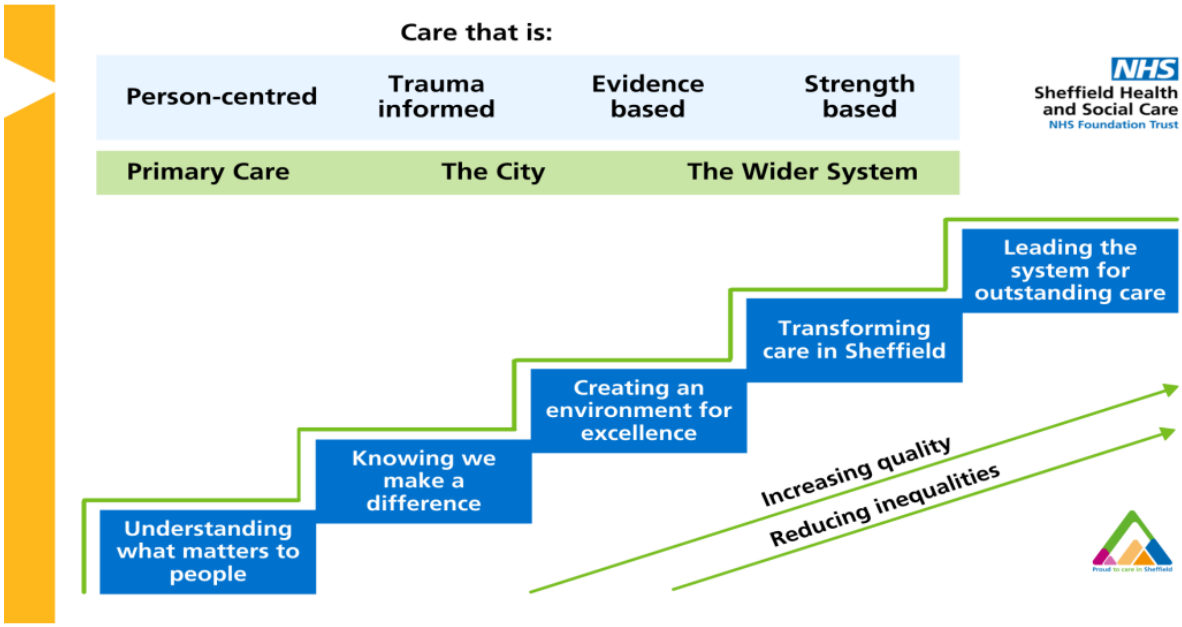
Clinical and Social Care Strategy

Section 1: Analysis and supporting detail

Background

1.1 The Clinical and Social Care Strategy (2021-2026) is our core 5-year strategy to increase quality whilst reducing inequalities across team SHSC. Coproduced through extensive consultation with service users, carers, colleagues in SHSC and partners across Sheffield to we have established Person-Centred, Strengths-Based, Trauma-Informed and Evidence-Led as principles for care that will inform our approach in different contexts, ranging from Primary Care to the Wider System.

The diagram below shows our broad goals for achieving these aims over the 5 years:



In this report we are updating on progress with year one objectives related to understanding what matters to people, through progress with workstreams: work with the enabling strategies (i.e. the strategies which support and drive the delivery of the clinical and social care strategy) alongside some broader themes of change initiatives.

1.2 Programme and workstream set up

Following approval of the Strategy (July 2021), we have made significant progress towards robust Programme set up including Governance arrangements, programme staff recruitment (defining their roles and responsibilities) and developing more detailed delivery plans (also called Project Initiation Documents). Plans outline the approach to be taken, systematically across team SHSC, to embed the principles of care that matter to people i.e. the 4 pillars described within the Strategy.

Delivery has been set up into 4 distinct workstreams to deliver the Pillars as follows:

1. Person centred and strengths-based care
2. Trauma informed approach
3. Evidence led care
4. Coproduction to support delivery of the strategy

The table below described the Objectives or things we want to achieve across the 4 workstreams:

	Person/Strengths	**Trauma Informed**	**Evidence led**	**Coproduction**
Objective 1	To develop and deliver a co-produced road map for the delivery of this workstream by end of December 2022.	To develop an SHSC organisational trauma informed system	To become an evidence Led organisation	To establish Coproduction Groups
Objective 2	To agree the guiding principles of person-centred/ strengths-based approach to meet the outcomes that matter to people	To educate and develop SHSC around Trauma Informed care and practices	To develop an equipped Research, Innovation and Effectiveness workforce	To embed the NSUN 4Pi principles across the programme
Objective 3	To develop and deliver a co-design approach with relevant service lines that agrees what the guiding principles mean for their service delivery and implement an action plan to embed locally	To develop and deliver Trauma Informed training to SHSC staff	To become Engaged, Inclusive and Accessible	To determine gaps in engagement from populations who are underrepresented and develop methods to improve engagement from these groups
Objective 4	To develop and deliver the five principles of mental health care following the abolition of Care Programme Approach, and ensure it aligns with the South Yorkshire initiatives, and is supported by SHSC governance process	To provide support/ supervision to enable Trauma Informed care	To build Partnerships for Improvement	
Objective 5 (for all workstreams)	To ensure that the enabling strategies and all other transformation and change work across SHSC is in line with the Clinical and Social Care Strategy – note: this objective sits across all of the workstreams, and progress is outlined in 6.0 Enabling Strategies			

1.3 **Programme outcomes and benefits**

Achieving incremental outcomes particularly those which are tangible benefits throughout the lifecycle of the programme is important to us.

Following on from the data gathered through coproduction of the strategy, further work continues to refine the **outcomes and benefits profile** for the programme. These will include a combination of patient reported as well as process and delivery metrics which will demonstrate how effectively we have made a real difference to the population we serve as well as positively impact on SHSC staff.

We continue to develop a comprehensive outcome and benefits measurement plan. The plan will be a key reference for articulating the change, over time, the programme achieves in increasing quality and reducing inequalities in relation to the 4 pillars of work.

2.0 Access to IAPT

We said:

Improving access to effective services is key to our service users - we plan to deliver on this through the further expansion of IAPT (Increasing Access to Psychological Therapies) over the next year, providing evidence-led, person-centred therapies for people with mental health problems that include coping with Covid 19, early interventions for anxiety, depression, stress, and trauma.

2.2 Progress so far:

The Sheffield IAPT portion of the NHS Long-Term Plan sets out a trajectory increasing the number of people accessing IAPT each year in Sheffield from 15,783 to 21,351.

The first increase of 15,783 to 17,183 was planned to meet the Sheffield IAPT emerging equality strategy to improve equality of access and outcomes for all and has been achieved.

Table 1 NHS Long-Term Plan Sheffield IAPT Access standard expansion trajectory:

Base line from Five Year Forward View	**15,783**
Access standard increase October 2021	17, 183
Access standard increase October 2023 tbc	18,238
Access standard increase October 2024 tbc	19,909
Access standard increase October 2025 tbc	21,351

The IAPT service has been able to meet the national recovery rate standard of 50% of people entering treatment in IAPT clinically and statistically recovering over the last 12 months. Sheffield IAPT continues to exceed all national waiting time standards.

To meet the ambition of equality of access and outcomes for all, Sheffield IAPT has developed an Equality and Outreach Team to work in partnership with the voluntary and community sector, to 'in-reach' in order to improve equality of access and outcomes. Work is underway with partnerships developed with SOAR and with Mulberry practice to work differently to enable refugee and asylum seekers to access evidence-based interventions as the first cohort of IAPT staff are trained by NHSE in Narrative Exposure Therapy.

In addition to partnership working with primary care and the community and voluntary sector, IAPT has been committed to partnership working with Sheffield Teaching Hospitals (STH) developing the Long-Covid Rehabilitation Hub in STH, ensuring appropriate and timely

access for people with Long-Covid to IAPT. IAPT and STH have also developed a joint administrative process to allow the flow of patients from STH to IAPT and communication flow back to referrers from STH. STH identified a need for IAPT to develop a tinnitus pathway this is now established.

An ethnically diverse staff working groups have been developed within IAPT to focus on implementing positive practice guidance and equality of outcomes, in addition to partnership working with the voluntary and community sector supporting the delivery of courses with bi-lingual staff delivered in Arabic and Urdu.

New working groups for next year include perinatal and LGBTQ+ as well as building relationship with carers centre and scoping out how IAPT will increase access for veterans. To support this work, the service has commissioned cultural competence training and delivered LGBTQ+ awareness training amongst other training and skills development as part of a yearly Continuing Professional Development (CPD) plan.

2.2 Primary and community care transformation

We said:

Primary care transformation - integrated community models for adults with serious mental illness, "personality disorders" with a planned expansion to all 15-care networks. This will support the agenda to intervene early with an offer of care within the communities in which people feel familiar.

Progress so far:

We have identified the links and overlaps with the broader transformation programmes of work being conducted across the Trust to ensure the programmes are inclusive of the key aims of the Clinical & Social care strategy this includes:

• Learning Disabilities Programme

• Primary and Community Mental Health Transformation Programme

Both programmes have a key focus on being evidence led, trauma informed, person centred/strengths based and coproduced.

In October 2019, Sheffield was selected to be one to twelve national early implementer sites for NHS England to pilot new integrated primary and community mental health models of care, which deliver support and treatment linked to the NHS Long Term Plan and the Community Framework for Adults and Older Adults for Serious Mental Illness. New models were initially piloted in 4 Primary Care Networks (PCNs) in Sheffield, comprising of 21 GP practices and approximately one third of Sheffield's population. In April 2021, the model was expanded to a further 2 PCNs.

Work is underway with phase 3 this phase of the transformation which is arguably the most complex of the transformation programme and involves joining together:

- Single Point of Access/Emotional Wellbeing Service
- Short Term Educational Programme
- Former early implementer
- PCN Direct Enhances Services Contract for Mental Health Practitioners hosted through the Additional Reimbursable Roles Scheme (ARRS).

This will support further progress around easy access to the right care in the right place at the right time. With the intention of intervening early with an offer of care that's joined up and within people's local Communities, providing a whole system approach bridging the gaps service users told us about in service provision.

2.3 Perinatal Services

We said:

Further expansion of Perinatal services, including improving access to specialist community care from pre-conception to 24 months after birth, increased availability of evidence-based psychological therapies, access for partners and Maternity Outreach Clinics.

Progress so far:

Rapid expansion (since 2019) of the Perinatal team in-line with the NHS LTP which outlines the understanding of the impact of untreated mental health conditions on women, families and their infants. This research had an economic focus but is supported by a significant body of attachment literature that demonstrates the significance of the early parent infant relationship and the catastrophic effect of untreated mental health conditions on the infant. The team have focused on embedding new models of care in clinical practice this year using for example Video Interaction Guidance (VIG) a case example below illustrates the impact.

Case vignette Ingrid – illustrates new models of care

Ingrid has a history of self-harm and attempted suicide. She experienced emotional abuse as a child and has a family history of mental health difficulties (grandfather died by suicide; grandmother & mother had post-natal depression). During pregnancy she experienced intrusive thoughts about the baby and herself as a mother worried about passing on genetic predisposition of mental ill health and intergenerational transmission of trauma.

Ingrid agreed to engage in parent-infant psychotherapy (PIP) using Video Interaction Guidance (VIG where mother and baby are videoed during the sessions to work on the relationship and interactions). The VIG process helped Ingrid to see and acknowledge the beautiful relationship she had with her baby. This helped ease her high levels of anxiety depression and low mood related to feelings about not being not being a "good enough mother", passing on trauma, or repeating her own parents' neglectful parenting style Ingrid. made good progress over a 6 month period and was discharged.

Over the remainder of this year Perinatal has a focus on supporting Dads/partners and seeing infants up to 24 months expanding access from 5% to 11% of the birth rate. The team are working to increase access and engagement in higher risk groups and have begun to in reach to the Roma/Slovak community.

2.4 Purposeful hospital admission (PIPA)

We said:

We would undertake a multidisciplinary piece of work to develop an improved therapeutic offer known as Purposeful Inpatient Admission for our inpatient wards.

Progress so far:

The acute wards are working to implement PIPA which is a range of initiatives aimed to improve the experience of service users and carers and staff : **having a clear purpose for each admission and then for the systems and processes to fit around this** to enable this purpose to be achieved.

Key learning from work

Define roles and responsibilities throughout the admission process, improving how this work together and complement one another

Formulation reviews with increased awareness of Trauma and risk of re-traumatisation are supporting: Early understanding of triggers and mechanisms which helps to reduce restrictive practice.

Reviews and MDT clinics
Service user and family collaboration in MDT clinics - reduced frustration around not being involved in care
Provides multiple perspectives – supporting holistic approach to care planning
clarification of admission aims and plan critical tasks to support service users early in admission and avoid delayed discharges

2.6 Least Restrictive Practice

We said

We made a commitment to ensure our care is the least restrictive, the most positive and takes account of human rights, choice and engagement, and collaboration. We inspire to reduce our restrictive practices to the least amount, and where we do use them ensure they are safe and positive, are done in collaboration with service users and their families/carers and are supported by best practice, a clinical model and sit within the framework of trauma informed care and human rights

Progress to date (Year 1)

A number of initiatives have been delivered against the short term (Year 1) Least Restrictive Practice implementation plan. Including all wards now have a relaxation room and de-escalation room (e.g., safe spaces within wards) whilst removing seclusion rooms from the acute wards. This has been achieved on Dovedale 2 and plans in place for Stanage ward. The second area of improvement is with **Post Incident Support (inpatient teams)**

A current piece of work ongoing to implement a systemic way to review and debrief service users and staff following incidents (post incident support) that will offer a consistent approach across all inpatient wards. The task and finish group have conducted a piece of process mapping to agree a for routes and access to support New and updated documentation has been designed to support a) immediate debrief b) post incident reviews and c) staff support. This work is currently being implemented as a Pilot on 3 wards (Stanage ward, Forest Close and G1).

Additionally, RESPECT training contains a section on post incident support the RESPECT trainers use service user feedback from live post incident reviews to highlight the difference it can make in service user care. Plans are in place for this update training to 700 staff by August 2023. Formal evaluation in progress.

Post incident review as described above and maintaining support are key for clinical and non-clinical teams. Ensuring teams take up opportunities for discussions around restrictive practice at Huddles, daily handovers, MDT reviews, within reflective practice sessions on the ward or formulation planning sessions supports reduction in restrictive practice.

Overview of key successes with Restrictive Practice

- Partnership working with Flourish, SACHMA, Sheffield Voices, Advocacy and Disability Sheffield
- RESPECT Training; review and implementation with key areas which include race equity, carers, activity and car planning
- Development of current data dashboards and reporting requirements
- Introduction of key roles; Human Rights Officer, Race Equity worker and PCREF
- Embedding de-escalation spaces across SHSC

- Post incident review project (see above)
- Use of force statutory requirement implementation
- Review and implementation of key policies – Use of Force, Seclusion, Segregation and Search

3.0 Workstream successes Year 1

Below is an overview of some of the additional individual successes and progress, in Year 1 towards the individual workstreams

3.1 Coproduction

Coproduction is at the heart of this strategy. The more our coproduction is robust, representative, and meaningful, the greater our independent assurance of the quality of our strategy. We are aligning our approach to national guidelines, developed by service users and carers and the National Survivor User Network.

Development of a National Survivor Network Assessment Template

We are developing a template to assess how well we use coproduction across our programme. Assessing our work against the 4 PIs which relate to Presence, Purpose, Principles, Purpose and Impact. The 4Pi framework has been developed by mental health service users and carers. The involvement of people with lived experience of mental distress and their carers and family members has formed the basis of the work, which will be utilised across team SHSC to add to the knowledge base and "best practice" in coproduction.

3.2 Trauma informed Care: Structured Clinical Management

Within SHSC Recovery teams progress with Structured Clinical Management as an evidenced based approach to working with people presenting with Complex trauma/personality disorder. SHSC have invested in team training for the North and South Recovery teams and in a small implementation team to deliver this clinical approach. We have been carrying out an evaluation to consider the effectiveness of SCM and the impact for service user and staff experience.

The evaluation within the pilot project has shown that service users' weekly average crisis contacts have reduced by 49% since starting SCM compared with the 18 months prior to the pilot (this includes A&E, OOH, duty, and S136). Service users in the SCM pilot who do attend the emergency department are also 41% less likely to re-present to crisis services within 48 hrs of discharge as they are following consistent crisis management plan.

Feedback from service users reflected people finding the SCM pathway helpful for understanding emotions and thinking about change. Feedback included:

…."Excellent! My care coordinator has been an invaluable resource of support and care".

"It has made me start to think about how I react to stuff and why ….and it's helped me start to think about how I could do it differently"

…."I feel more empowered to manage everyday situations. Whilst I still struggle, the intensity and frequency has subsided".

Staff feedback showed that people found having a structure to their work with service users and the additional support and supervision available beneficial.

Over the next year the plan is to expand the offer across South and North Recovery and to offer further training to new care coordinators. Staff already involved in SCM are being given the opportunity to become accredited SCM practitioners through HEE funded training.

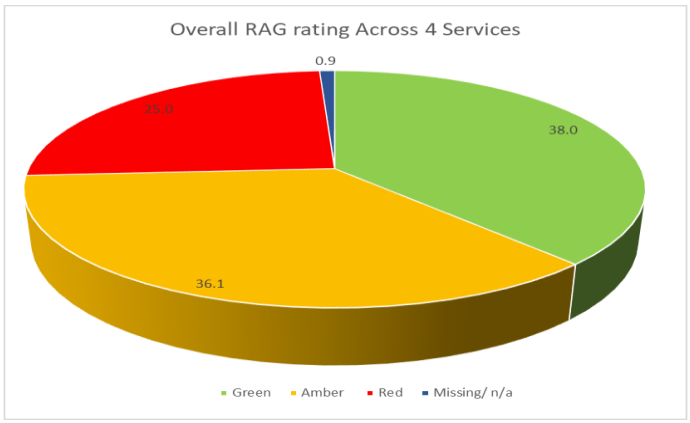
3.3 Initial ROOTs PILOT:

ROOTs is a “real world system capability” methodology developed through a summit in 2019 involving trauma leads across the UK; clinicians, service users and other stakeholders. The framework identified 7 themes as below:

Process	Interpersonal	Structure
Safety	Social	Interventions
Empowerment	Compassionate transformational leadership	Responsive system design
Language		

The framework uses both a staff evaluation and service user evaluation with a facilitator to design a more effective trauma service. This assessment tool will allow us to capture “baseline” measures of self-assessment for longer term evaluation of embedding trauma informed practice across the SHSC.

4 teams (CERT, Community Forensic Team, Forrest Lodge and Forrest Close) have initiated the Pilot for this work which will be used as a baseline to embed self assessment across other SHSC teams. Initial findings indicate that these services rate themselves as being 38% green, 36.1% amber and 25% as red in relation to being trauma informed.



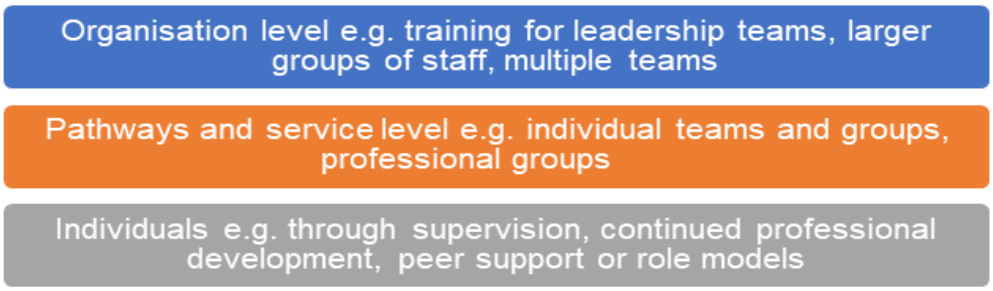
The safety and social domains scored better across teams: staff feel they have a collaborative risk management approach; are able to reflect on safety plans contributing to a positive outcome; staff actively seek to contribute towards functioning an open relationship even when things are difficult.

Areas within the evaluation which considered poorer and with a red rating linked predominantly to the Empowerment and Whole System domains: trauma informed approaches not explicit in commissioning arrangements; lack of monitoring of trauma related outcomes / lack of trauma related interventions for complex trauma to pick a few of the more consistently Red rated items. Teams are currently reviewing the data to consider the next steps in developing quality improvement plans to work on both collectively and as individual teams.

3.4 Trauma informed teaching and training

Delivered to several teams and across multiple forums: a total of approximately 200 people over the last 6 months. Training has allowed identification of teams who will further engage

in trauma informed local evaluation and initiated the development of a comprehensive, mandatory training package for team SHSC.



Training staff and teams across all areas of SHSC is important as:

- It focuses upon the need to prioritise the service user experience
- Acknowledges the need to support staff in working well with trauma.
- Affirms the importance of providing a space to think about the sometimes 'every day' challenges of the trauma faced by staff working across all services.
- The presentation reviews the evidence and introduces the need for evidence based led change and the importance of Senior Operational and Executive Level support.

3.5 Knowing we make a difference: Initiating the systematic collection of outcome measures across SHSC

Appointment of an outcomes lead and Recovery Teams work

We have appointed a 12month post as an outcome led. A key component of this role will be to link together the digital and practical considerations for outcome data collection locally together with ensuring teams are focussing on collecting outcomes which are important to their cohorts of patients and are using the data to drive effective delivery of treatments.

This role will be working closely with the routine collection of outcome measures for the Adult Community/Primary Mental Health Care pathway using Dialogue plus, ReQol and a goal outcome measure through a number of workshops (June – Oct 2022). The next event will consider the principles of implementing outcome measures in the recovery teams. Learning from the recovery teams will be used to systematically embed outcome measures across the Trust.

Below are some examples of evidence led programmes of work that met national evidence-based standards: Memory service took part in a national audit that has allowed them to benchmark various aspects of their service delivery. They are also currently undertaking the work necessary for re-accreditation. Specialist Psychotherapy and IAPT have recently been re-accredited via APPTs Royal College of Psychiatry and Older Adult CMHT received accreditation with ACOMHS Royal College of Psychiatry.

4.0 Creating environments for Excellence:

As part of SHSC's commitment to creating environments for excellence and having therapeutic environments that support care, we developed our practice in 3 key areas:

Physical Environment: TeamSHSC therapeutic environment developments

The Estates Directorate have undertaken a modernisation programme of work that has included co-production with service users and staff in transforming the physical environment TeamSHSC have planned several capital developments e.g. improvements to the acute wards with the removal of dormitories, providing de-escalation spaces, removing fixed

ligature anchor points (LAPs), changing ward flow to reflect a single gender environment, providing modern and therapeutic spaces to aid treatment and recovery.

Other works have been developed based on recommendation from our Back to Good action planning, reducing restrictive practice work and Therapeutic and Great place to work workstream feedback and the broader Clinical and Social Care strategy.

4.1 Small Change Big Impact: an innovation developed by the Therapeutic and Great place to Work group. The idea is a simple one - by enhancing and maximizing use of green spaces, working in parallel with the green plan and connecting with nature, we can significantly impact on the health and wellbeing of service users and staff. Staff were asked to apply for funding and support for small projects that enhanced the physical and therapeutic environments they work in. Alongside funding there was mentorship for each project from a representative of the Therapeutic and Great Place to Work Group. Below are some examples of the work

East Glade recovery team were successful with funding for continuing development of green space meadow within the community garden/grounds. Please follow the link below

https://jarvis.shsc.nhs.uk/team-shsc/green-and-therapeutic-spaces-small-changes-big-impact

Ignite Project Mental Health Recovery teams – Co-produced art for reception waiting areas (project with external company 'Ignite').

Through the small change big impact grant, Arts therapists are working alongside a local arts-based cooperative, 'Ignite imagination', to create workshops for service users to coproduce with an artist, some bespoke prints for the recovery team bases. The workshops informed the artist's design and a film has been commissioned of the project which can be shared on social media. Opposite Is the design the teams chose for their reception area

4.2 Therapeutic Environment

Within the strategy we outlined the ambition to promote the development of therapeutic teams through a well-trained workforce, creating a great place to work. There has been progress with extending Occupational Therapy (OT) provision to include evenings, weekends (Saturdays) and Bank Holidays within the adult acute inpatient wards using first wave MHIS (Mental Health Investment Standard) money. Extending opportunity and flexibility to support service user discharge: functional assessments, home visits, family/carer contact.

4.3 Great Place to Work

A small multidisciplinary focused group looked to develop an understanding of positive working cultures within 6 teams in SHSC. They used an 'appreciative enquiry' approach with over 40 staff with open questions to inform discussions around culture. Themes reported:

1. Mutual Team Support
2. Share Team Vision

3. Proactive leadership
4. Fluid Communication and Feedback
5. Being Valued as a Whole Person
6. Ongoing Learning and Development

A significant thread was the importance of working in a team where people understood one another as 'whole people' within the context of their personal as well as their work lives. Positive teams know one another and can recognise when a team member needs help or support. The significance of a range of skills and characteristic of individual team members that came together to form an effective team. Difference was welcomed and embraced.

In terms of next steps, we plan to generate a questionnaire from the themes that can be used to identify strengths and weaknesses so that a tool kit could be developed to help teams and leaders identify how they can improve team culture becoming a 'great place to work'.

5.0 Managing Dependencies with the Enabling Strategies

To drive the delivery of the Clinical and Social care strategy alongside the enabling strategies, to break down siloes of independent working and to start to create a true SHSC collaborative culture, we held the first Enabling Strategies workshop in June 2022. Strategy leads were invited to briefly share their plans and discuss how we can collaborate effectively across team SHSC to deliver key, joint objectives, to create a collaborative space for strategy teams to work together on interdependencies. The diagram provides and overview of the inter relationships

Key messages from the workshop identified

Time together was valuable and necessary: Sharing strategies was a move away from silo working/ thinking. All agreed that we had not done enough of this and it was important in noting overlaps, connections and dependencies between the strategies. We need to unlock the potential for inclusive working across the strategies.

Scale of the work: Action planning all aspects of change all felt potentially paralysing. There was a view that we need to balance clear focus on thinking and innovating for big impact alongside governance and reporting.

Joint communications**:** Shared / joint communication planning so staff get clear, simple messages that aren't competing with each other. Develop clear unifying messages and broadcast well a few times a year, aligned to Clinical and Social Care Strategy.

Co-production: all agreed that we need to pay attention to who is 'in the room' as we move forward to include cohesion and reach across services. Diversity. Roles. Ensure shared approaches include the service user voice and staff voice.

Shared and joint implementation**:** There were clear benefits of connecting delivery across the strategies – focussed on 1 or 2 themes of change to make delivery (a) manageable, (b) impactful and improve the quality of care and service user and staff experience

The next 2 events have been planned in November and December 2022 to understand the key joint objectives and how we can progress this work collectively.

6.0 Wider Engagement: Team SHSC (Nov – Mar 2023)

To ensure we reach all of our staff, teams and directorates, we are embarking on a Clinical and Social Care strategy "roadshow" to link in with individuals and teams. This will allow us to share our thinking so far (e.g. plans, individual pieces of work) and allow us a space to hear from colleagues to further break down siloes, hear what is important to local teams and consider how other pieces of work link into the overall strategy to realise our goals and achieve benefits. Eleven individual meetings have been scheduled where we will visit teams between November and December 2022.

7.0 Next Steps

The next steps for the strategy are clear to:

- Work over the next 6 months to deliver on the objectives and milestones within the plan set for 2022/23 which includes the focus on Knowing we make a difference through a person-centred outcome framework: Have in place Digital systems to capture clinical outcomes and experience with measurable consistency and continuity of care.
- Deliver on the Comms/engagement plan and ensure service users, carers, staff and our partners continue to feel engaged with the delivery of the strategy
- Work with Enabling leads -focussed on 2 or 3 themes of change to make delivery (a) manageable, (b) impactful and improve the quality of care and service user and staff experience.

Section 2: Risks

2.1 The risks associated with the implementation of the strategy are managed by the Programme Board and escalated to the Transformation Board, Finance and Performance Committee and Board of Directors as necessary.

2.2 The high priority risk currently being managed by the Programme Board pertains to the significant amount of work to deliver per programme objective across all services. There is a risk that the scale of the change required is too large and as a result hinders successful implementation.

2.3 A risk that the initial implementation timeframes will not be achieved based on operational pressures, resource and capacity issues and successful engagement with teams to adopt the four pillars of care (Evidenced led, Trauma Informed, Person Centred/Strengths based and Coproduced).

2.3 Mitigation: Delays in progress are monitored by the Implementation Group and escalated as necessary to the Programme Board. The implementation plan has been developed to support phasing of delivery.

Section 3: Assurance

Benchmarking

3.1 Within the report we have outlined the key objectives and the next steps in the delivery over the coming year.

3.2 The outcomes will be audited against the detailed objectives for each workstream.

3.4 There are several national documents that we have drawn on that set the national direction for services for people with mental health problems, learning disability and autism (MHLDA). These include No Health Without Physical & Mental Health; Longer, Healthier Lives; Zero Suicide; and NICE guidelines for mental health, learning disability and autism. The other key documents are the NHS Long Term Plan 2019, The Community Mental Health Framework for Adults and Older Adults 2019 and the recently published White Papers covering Reform of the Mental Health Act and Innovation and Integration (both 2021).We used this as guidance along with the consultation & feedback of the experience of our stakeholders to devise a strategy based on the values of SHSC and the recovery principle, delivering care that is Person-Centred, Strengths-Based, Evidence-Led and Trauma-Informed.

Triangulation

3.4 We will be triangulating the outcome data across the workstreams and with the enabling strategies as outlined in section 5.0. There were clear benefits of connecting delivery across the strategies – focussed on 2 or 3 themes of change to make delivery (a) manageable, (b) impactful and improve the quality of care and service user and staff experience. A workshop is planned in November 2022 to agree the priorities and programme of work.

We will also triangulate the data with information from change-based programmes of work and the transformation programmes.

Engagement

3.5 We have a coproduction lead (expert by experience) and a project plan in place around coproduction described above with the NSUN 4Pi Assessment.

3.6 We are also expanding the Coproduction Expert Group to collaborate with workstreams to coproduce the content which will deliver the workstreams across the strategy. I.e., giving feedback on the extent to which the plans to be person-centred make sense to service users to work with workstream leads (and others within workstreams) to input into the design of all the elements which relate to change to achieve the programme objectives

3.7 This group will also collaborate with other local VCSE and service user groups Sheffield Flourish, Rethink, Sheffield Mind and SACMA and where appropriate South Yorkshire MHLDA provider collaborative.

Section 4: Implications

Strategic Priorities and Board Assurance Framework

1. CQC – Continuing to improve
2. Transformation - Changing things that will make a difference
3. Partnerships – Working together to have a bigger impact

4.1 The key issues and BAF Risks to be considered are:

Digital /IT: *Reliance on legacy systems and technology compromising patient safety and clinical effectiveness*

STAFFING: *Risk of not retaining staff, not workforce planning effectively, failing to provide effective leadership impacting on quality of care*

4.2 Key risks noted for the programme as a whole include the BAF risks related to Digital/IT. There are key interdependencies with the enabling strategies particularly the Digital and its implementation for example with the evidence led workstream. We are reliant on the use of electronic records to report on the patient reported outcomes measures to evaluate and monitor service delivery and effectiveness i.e., ReQoL,

The implementation of Rio should support evidence-led practice and systems developed to enable easy input of data and extraction and reporting to teams but also to individual service users. There could be delays with recording, reporting and data visualisation capabilities and availability of tools to support an Evidence-Led approach.

4.3 Staffing: within the programme we do not hold a budget for separate allocated staff to lead the workstreams and deliver on the goals within the workplans. The change-based work within the workstreams are reliant upon the staff working within the individual teams and services to deliver the quality improvement changes e.g., Trauma informed work across the rehabilitation services implementing Roots methodology and shaping clinical practice changes. There is a risk that due to operational pressures, staffing resource and capacity issues that successful engagement with teams to adopt the new pillars of care (Evidence led, Person centred/strengths based, and trauma informed) is not achieved.

4.4 A risk that due to staffing shortages staff are not able to be released to attend training or able to access the materials (time/space created through job planning) as they cover over the winter period for staff absence due to seasonal flu/covid and operational pressures increase.

4.5 As the programme requires significant work to deliver each objective across all services, there is a risk that the scale of the change required is too large which will impact the ability to deliver the objectives.

4.6 **Integration and system thinking**

South Yorkshire Mental Health Learning Disabilities and Autism Provider Collaborative is developing a clinical strategy based on the same strategic principles: evidence led, person centred/Strengths based, trauma informed, outcomes focussed, carrying through the golden thread across providers. It also has a focused-on coproduction, holding service users and carers at the centre of change process. It is developing a strategy based on the principles

4.7 These recommendations are supported by SY MHLDA provider collaborative following an engagement event with stakeholder consultation with representation from the five NHS Trusts, SWYFT, SCH, SHSC, RDaSH, place leads, Service user and carer organisations including Healthwatch along with support from SY ICB.

Financial

4.8 Finance: whilst there is no distinct budget for this programme, there are two posts (programme manager and service user representative) who are funded to deliver work. These posts, funded by operational budgets, will incur an operational budget pressure caused by the programme. A business case is being developed for longer term funding of these positions.