Sheffield Health and Social Care NHS Foundation Trust

Board of Directors - Public

Date:	26 May 2021	Item Ref:	13

TITLE OF PAPER	**Clinical and Social Care Strategy – Final Draft**
TO BE PRESENTED BY	Dr Mike Hunter, Medical Director Dr Linda Wilkinson, Director Psychological Services
ACTION REQUIRED	For Approval of the Final Draft for final consultation

OUTCOME	For the Board to approve the Final Draft of the Strategy for a final round of consultation with stakeholders who contributed to its development.
TIMETABLE FOR DECISION	May 2021 Board Meeting.
LINKS TO OTHER KEY REPORTS / DECISIONS	Quality Strategy People Plan Transformation Programme
STRATEGIC AIM **STRATEGIC OBJECTIVE** **BAF RISK NUMBER & DESCRIPTION**	Delivering Outstanding Care Creating a Great Place to Work Improving Use of Resources CQC – Getting Back to Good Transformation – Changing things that will make a difference BAF 0007. Inability to deliver our transformation plans resulting in a failure to deliver our objectives. BAF 0004: There is a risk that the Trust is unable to improve the quality of patient care, resulting in a failure to comply with CQC requirements and achieve necessary improvements
LINKS TO NHS CONSTITUTION /OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	NHS Long Term Plan (2019) NHS Mental Health Implementation Plan (July 2019) Integrating Care: Next steps to building strong and effective integrated care systems across England (October 2020) White Paper : Integration & Innovation: Working together to improve health and social care for all (February 2021)
IMPLICATIONS FOR SERVICE DELIVERY & FINANCIAL IMPACT	The Clinical and Social Care Strategy will inform plans for service development and delivery, including the resources necessary for such development.

Proud to care in Sheffield

CONSIDERATION OF LEGAL ISSUES	Health and Social Care Act 2008 Integration & Innovation White Paper 2021

Author of Report	Dr Linda Wilkinson
Designation	Director Psychological services
Date of Report	19th May 2021

Sheffield Health and Social Care NHS Foundation Trust

Clinical and Social Care Strategy – Final Draft

1. Purpose

For approval	For assurance	For collective decision	To seek input	To report progress	For information	Other (Please state)
X				X		

2. Summary

The paper outlines a final draft Clinical and Social Care Strategy for SHSC with a 5 year development plan based on key principles developed with service users and carers, staff and partners during the engagement process. This includes care based on principles of **Person-Centred, Trauma-Informed, Evidence-Led and Strengths-Based** approaches**.**

The overarching aim of the strategy is to improve the quality of care received by our service users and to reduce health inequalities.

We have outlined a context that focuses on the delivery of mental health and social care in Primary Care, the City and the Wider System, and that develops over a 5 year period, building on strategic priorities below:

1. **What matters to people**: accessible primary and secondary care services, purposeful hospital admissions and minimal restrictive practice.
2. **Knowing we make a difference**: person centred outcome frameworks, digital systems to capture experiences and outcomes, measurable consistency and continuity of care.
3. **Creating environments for excellence**: therapeutic built environments that support care models, accredited teams across services, quality networks throughout SHSC.
4. **Transforming care in Sheffield**: community partnerships for clinical, social care & academic excellence, all age integration of physical & mental health and social care, zero suicide Sheffield
5. **Leading the system for outstanding care**: developing SYB quality networks for mental health, learning disability and autism; an equitable mental health and social care system; integrated care from neighbourhoods to system

We have run 20 workshops with a range of stakeholders including service users and carers, SHSC staff from a range of teams and services, partners including VCSE, commissioners, representatives from Sheffield Teaching Hospitals, Sheffield Children's, Universities, Public Health and Sheffield City Council with good engagement. We have also worked with Healthwatch Sheffield and Sheffield Flourish triangulating service user feedback about SHSC from surveys and detailed case reviews.

3 Next Steps

This is the final draft of the Strategy, which, subject to Board approval, will go back to the stakeholders involved in its development for final consultation before returning to Board for approval.

4 Required Actions

For the Board to approve the final draft for final consultation with stakeholders.

5 Monitoring Arrangements

Monitored by the Clinical and Social Care Strategy Steering Group, chaired by the Medical Director, and by reporting to Board.

6 Contact Details

Dr. Mike Hunter Executive Medical Director
Mike.Hunter@shsc.nhs.uk

Dr Linda Wilkinson Director Psychological Services
Linda.Wilkinson@shsc.nhs.uk

0114 2718933

NHS
Sheffield Health and Social Care
NHS Foundation Trust

Clinical and Social Care Strategy

2021-2026

Proud to care in Sheffield

Welcome to the Strategy

Welcome to our Clinical and Social Care Strategy 2021-2026. This is the first time that Sheffield Health and Social Care (SHSC) has had a Clinical and Social Care Strategy, and the reason for developing the Strategy now is simple. In TeamSHSC we want everything we do to be led by providing the best specialist care to all the people we work with.

In bringing the Strategy together, we have involved service users and colleagues across SHSC and beyond, including in the Council, CCG, Healthwatch, Voluntary Care Sector and other health and social care providers in Sheffield. Working together to develop the Strategy is particularly important because Sheffield is an unequal city. We are amongst the most deprived local authorities in the country. People living in the most affluent parts of our city can typically expect to live eight years longer than those in the poorest areas. For people with mental health problems, learning disability and autism, inequalities are even more pronounced and often affect multiple aspects of their lives.

Our Strategy is focussed on reducing health inequalities, and we are committed to working with partners across the City to make Sheffield a healthier place for all to live.

As the Clinical and Social Care Strategy has grown, some key principles have become clear. We believe care should be **Person-Centred, Trauma-Informed, Evidence-Led and Strengths-Based.** This means that we will always consider all of what matters to people, understand what has happened in their lives, provide the best therapeutic interventions and fundamentally see people as “whole”.

To implement the Strategy, we will work in partnership and value co-production. We will create the environments for great care and continuous improvement. Most of all, we will always remember what a privilege it is to work with people and help to make a difference in their lives.

The Clinical and Social Care Strategy Steering Group

Proud to care in Sheffield

NHS
Sheffield Health and Social Care
NHS Foundation Trust

The Clinical and Social Care Strategy

We will give care that is

- Person-Centred
- Evidence-Based
- Trauma-Informed
- Strength-Based

We will work with

- Primary Care
- The City
- The Wider System

What are we going to do?

- Develop Care Models that promote recovery

How will we do it?

- Design services to meet people's needs
- Develop Team SHSC

Sheffield and the Wider Mental Health Context

At SHSC we provide a wide range of specialist health and social care services to improve the mental, physical and social wellbeing of the people living in our communities. We want people to live fulfilled lives and aim to help them achieve this by providing services which work closely alongside primary care and services based within the community (e.g., voluntary sector, housing providers and local leaders) to meet people's health and social care needs, support their recovery and improve their health and wellbeing.

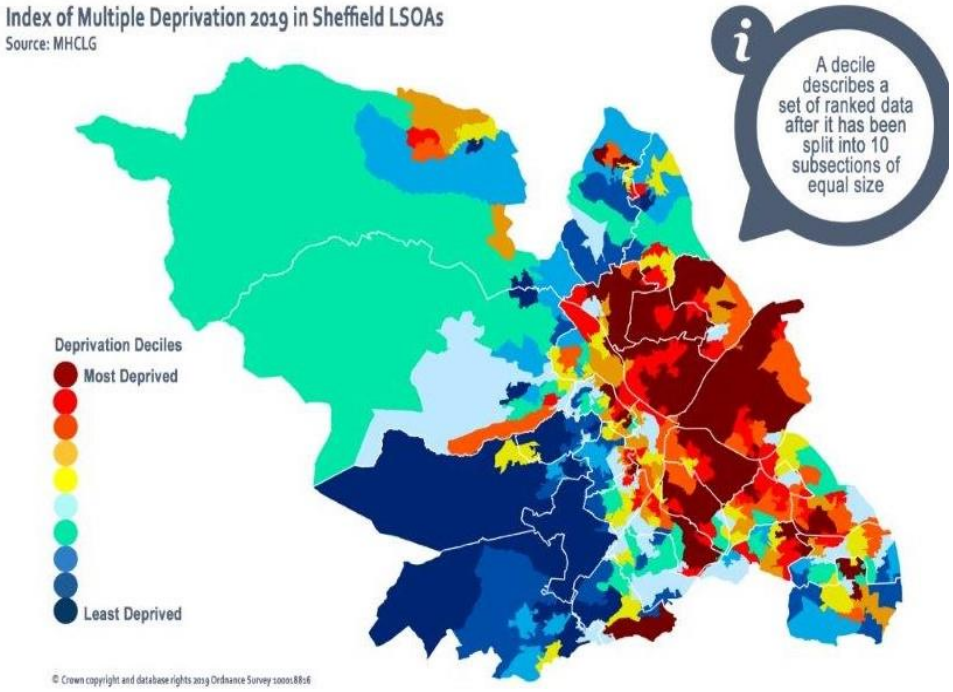
We recognise that learning disability and autism (LDA) and severe mental illness (SMI) such as psychosis, bipolar disorder, and complex trauma and "personality disorder" are closely associated with many forms of inequality including reduced life expectancy of up to 20 years when compared to the general population. Evidence suggests that the mortality gap is continuing to widen nationally. These inequalities are largely driven by complex and interrelated factors, including:

- Social and environmental determinants of poor health, including poverty, unemployment and homelessness
- Stigma, discrimination, social isolation and exclusion
- Increased levels of addictions including smoking, alcohol and street drugs
- Lack of support to access health and preventative care
- Diagnostic overshadowing – seeing physical health symptoms as part of an existing mental health diagnosis, rather than as another physical health problem requiring treatment

Our Population

We know that people in poorer parts of Sheffield live shorter lives and have worse health than those in more affluent areas. We also see similar disparities affecting groups with specific shared characteristics, such as people from BAME backgrounds, or people with learning disabilities. These differences and disparities are the health inequalities that exist in our city, which we see as unacceptable.

Sheffield is an unequal city with an 8-10 year life expectancy gap between areas that fall within the 10% most deprived in the country (Burngreave, Firth Park, Southey, Manor Castle, and Park and Arbourthorne) and areas amongst the 1% most affluent in the UK (Fulwood, Ranmoor and Dore). We have a high concentration of people seeking asylum and refugee status living in the North of the city; a high population of people over the age of 65 years living in the South West of the city; and a high population of students living in the City centre. We recognise that "one size doesn't fit all" and our population requires different things of our services.



Sheffield is the seventh most deprived of England's eight core cities, with nearly a quarter of Sheffield's areas in the most deprived 10% nationally. Five areas in Sheffield are within the 1% most deprived in England, which is an increase from three in 2015 (Joint Strategic Needs Assessment 2019)

People with SMI and LDA experience a greater burden of physical health conditions, often driven by the inequalities that they face. It is estimated that two in three deaths for people with SMI are due to physical illnesses such as cardiovascular disease, which can be prevented.

In our current strategy we have been working to reduce inequalities through collaboration and integration of physical, mental health and social care. For example, by targeting improvements in the monitoring of physical health for our service users, running a Quit from smoking programme on our wards and implementing our Smokefree policy. We have expanded Early Intervention for Psychosis services and developed our Perinatal Mental Health service in line with the every child matters/giving the best start in life programmes. We recognise that we need to do more over the next five years to better meet the needs of people who use our services.

What has informed our Strategic thinking?

National Policy and key documents

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).

The NHS Long-Term Plan sets out a number of actions to improve detection and care for people with a range of physical and mental health problems, seeking to address health inequalities through the emphasis on early intervention, prevention and transformation of mental health care to be closer to communities with the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care.

The Community Mental Health Framework describes how the Long-Term Plan's vision for a place-based community mental health model can be realised, and how community services should modernise to offer whole-person, whole-population health approaches, aligned with the new Primary Care Networks. The paper highlights how services have been fragmented over many years and must re-establish the original principles of community-based care with accessible services ('no wrong door'), integrated within the local communities.

The White Paper "Integration and innovation: working together to improve health and social care for all" sets out proposals for strategic commissioning at the level of the South Yorkshire and Bassetlaw Integrated Care System (ICS), with system oversight of locally services equipped to meet the needs of the people of Sheffield.

What is clear is that the future direction will require us to work in different contexts: at the level of primary care networks, at the level of the City and at the level of the wider system in South Yorkshire and Bassetlaw.

Key Priorities

Within our Clinical and Social Care Strategy, we have drawn on the above principles of transformation around partnership working to define a 5-year plan covering key priorities listed below.

- **Understanding What Matters to People:** Improving the experience, safety and quality of care for service users, carers and families through understanding what matters to people and co-producing systems and models of care.

- **Knowing We Make a Difference:** Seeking to help people to live well and reducing the inequalities associated with mental health problems and learning disability through early intervention, prevention and transformation of mental health care to be closer to communities and capturing impact and outcomes.

- **Creating Environments for Excellence:** Promoting the development of therapeutic teams through a well-trained workforce, working within with healing built environments.

- **Transforming Care in Sheffield:** Building further and faster the partnerships and transformation with other organisations to become a more integrated health and social care system with improved outcomes, including a Zero Suicide ambition.

- **Leading the System for Outstanding Care:** Developing system quality networks for MHLDA and building an equitable system in South Yorkshire and Bassetlaw.

We will be developing more of our services within the local community, working in partnership with Primary Care, Local Authority and Voluntary Care Services, and re-establishing a Recovery College in order to deliver population based mental healthcare.

We want to offer more mental and social care in the least restrictive ways outside of a hospital care setting by building on the Primary Care Transformation project we started last year. There will be further expansion of IAPT services for anxiety and depression alongside 10 specific physical health conditions including cancer, respiratory and cardiac conditions. The “At Risk Mental State” pathway is being established within the Early Intervention Services and the Assertive Outreach pathway is being re-established in the community services. Further development of the Complex Trauma / “Personality Disorder” pathways is being undertaken using the evidence-led Structured Clinical Management approach across teams. Crisis Services are being enhanced to 24/7 capacity.

Over the next two years we will see core Primary Care SMI mental health teams forming in each of the 15 Primary Care Networks that will function as multiagency, multidisciplinary teams being responsible for the mental healthcare for that population. As we start to increase the provision of care in the community, we are anticipating a reduction in the pressures on the hospital inpatient care due to the more robust provision in the community, early intervention and the growing capacity to manage higher levels of acuity through the redesign and expansion of Core 24 crisis services and utilisation of the Crisis House and the Decision Unit.

Consultation with Stakeholders

How and whom we have consulted in relation to the Clinical and Social Care Strategy

The approach we took in creating this clinical strategy was to engage as widely as possible with service users, carers, staff and partners to listen to experiences, gather ideas about improvements and priorities and bring people on board. Due to Covid restrictions much of the feedback was gathered through workshops led by experts by experience with senior leaders working with service users, carers, and staff working within SHSC and partner organisations.

We had an oversight group led by the Medical Director, consisting of an Expert by Experience, Clinical Directors from SHSC and Primary Care, Director of Strategy, Executive Director of Nursing and Professions/Chief Operating Officer and Heads of Professions, who all brought different expertise and experience.

In terms of engagement and coproduction, we held two workshops with service users and carers. Alongside this we met with Healthwatch Sheffield, whose role is to collect consumer feedback about health services in the city, and Sheffield Flourish, a charity that works collaboratively on innovative digital and community projects recognising the untapped strengths of people who have experienced mental health challenges. They work with service users to enable them to tell their stories.

We triangulated the feedback from a report written by Healthwatch Sheffield and Sheffield Flourish outlining the in-depth mental health journey for nine services users, with the noted findings and recommendations. We also triangulated feedback with the results of a questionnaire sent by Heathwatch to users of community mental health services in Sheffield .

We held 20 workshops, 14 of these were attended by approximately 400 staff who work across the 80 different teams within SHSC. We held a further six workshops with our partner organisations including representatives from 15 VCSE organisations, local Commissioners, Sheffield City Council, Sheffield Teaching and Sheffield Children's Hospital, Sheffield University, Sheffield Hallam University, Healthwatch, Sheffield Flourish and Public Health reaching over 90 stakeholders.

What is important to service users and carers?

Key messages from our services users and carers:
Access: they want services to have easy access, be based within the communities where people live, be responsive, coordinated and tailored to individual needs with a focus on overall wellbeing. The inclusion criteria for some services are too high. "*I felt I didn't have the right illness or are not ill enough"*

Early intervention: they want services to focus on early intervention support and signposting to stay well. "*I have to wait until I'm in a crisis before I get a response".*

When people need to come back into services following discharge, they want to *"find a way back into services without repeated assessments"*

Consistent Care: Sometimes there is discontinuity of care often due to staff turnover. *" [they] said they would hand my case over to the new person … But it didn't happen because of the covid and staffing"*

Service users and carers want continuity of care from clinicians and teams who they get to know and, if admitted to the inpatient wards, they want to spend as short a time as necessary in hospital with the least restrictive care, in therapeutic environments that support healing and recovery.

They want a skilled workforce that is representative of the community and able to provide culturally appropriate treatments. *"the white people's behaviour on the ward was passed off as passion and anxiety … I was labelled as angry, threatening, and aggressive".*

Partnership working: Service users want services to be delivered in good quality environments and have good partnerships with other services that can provide wrap around care with good communication between and within teams.

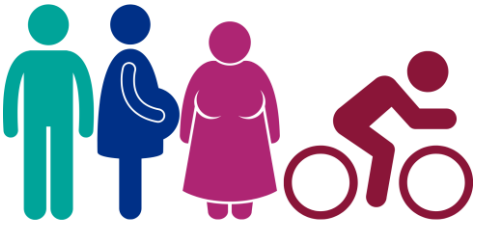
"I don't have to keep telling my story over and over again to different workers and different teams …"

Falling between the gaps: *"Difficulties being dropped in gaps and this is extremely detrimental to mental health as you feel you are being let down"*

Listen to me as an equal whole person: Service users and carers want to have an active role in their care, "feel fully informed and have a choice of treatments" and some people want to be involved in the delivery and running of the organisation.

Feedback indicates that service users want mental health services that understand inequality and the impacts of poverty on mental health. *"Services that can recognise the economic impacts of mental health problems offer additional support to those in financial hardship and have a role in connecting with community safety and cohesion".*

There were 173 responses to the Healthwatch survey, with the take home messages being that people who use services wanted an experience of care that was more caring, effective and responsive.



What is important to staff?

Triangulating feedback from staff in the latest staff survey results, with feedback in the engagement sessions as well as other key pieces of staff feedback from across the organisation, there are three key aspects that are important to staff that can be summarised as autonomy, belonging and contribution.

Providing excellent quality care to service users and their families is of paramount importance to staff. This inevitably draws on many aspects of organisational working. Innovation is key. Being able to initiate and follow through with quality improvements is essential, as well as having the opportunity to be able to participate in and influence decision making, at a local team level as well as more organisationally wide.

Staff felt: "Community teams are too small to effectively manage the increasing demand and the rising acuity levels which makes work stressful especially when managing clinical risk."

Being able to fully utilise skills and expertise, and receiving recognition for this, is fundamental. Staff feel strongly about maximising their contribution, as well as their associated personal development to deliver excellence.

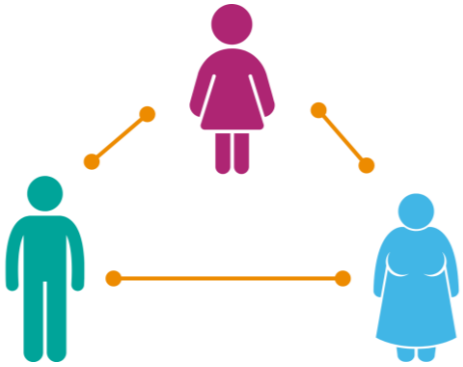
Staff felt "*Across teams the scope of what teams are expected to manage is increasing, this means that it feels difficult to fully utilise skills and expertise …lack of time to care…"*

Having good, respectful and supportive relationships, within teams and more widely across the Trust is not only valued but considered essential. Good connections between staff are recognised as often being the means by which high quality care is delivered, and complex problems managed or solved.

"inconsistent workforce on the wards … bank and agency staff are helpful but not the same as a consistent team".

Good relationships across the organisation are fundamentally important: *"feeling listened to and getting feedback "*

Having the opportunity, support and resources to develop, transform and deliver high quality services is fundamental to staff feeling valued, working optimally, and being fully engaged within the organisation. Devolved leadership is key, as is instilling a sense of optimism and hope.



What is important to our partners?

All organisations welcomed the opportunity to work in partnership to develop shared thinking about the strategy with more integrated work across mental health and social care *"Great to be asked and be involved from the beginning of the journey ... from conceptualisation of strategy to practical implementation of it rather than coming with the finished product."*

Our partners spoke about "handovers rather that handoffs", recognising that warm handovers with teams & systems where they come together to maintain shared responsibility across team and services until service users had settled into a new system was helpful to manage risk and safety for both service users and staff. "*It is often difficult to find the right person to speak to about access to mental health services."*

The workshops for some organisations provided the opportunity to "*heal past hurts … and the difficulties from the breakdown in relationships providing the platform for collaboration rather than competition*" working together to find ways of collaborating on bidding for funds, pooling and sharing knowledge and expertise to achieve better care for Sheffield citizens.

The VCSE sector reported experiencing some very good partnerships through the Primary Care Mental Health transformation programme of work and the Sheffield Psychology Board where "*SHSC services did not just parachute in and out of voluntary services but were building equal partnerships"* and developing long term relationships through shared contracts. This is working well through shared values, principles and models of working, and changing the language and the skill sets of teams to improve the offer of services for people with complex problems. Although there are still reports of *"difficulties in communication because of pressure on time and incompatible digital systems."*

The junctions between internal teams and external partners can adversely affect the quality of experience for service users, result in disengagement, poor outcomes and at times harm. *"Clinical problems arise from teams not working in the interest of the [whole] pathway, sending people on the wrong path"*

Continuity of care: *"We have lost some aspects of continuity of care, for many of our service users their single experience of on-going or crisis mental health presentation is carved up by us into segments."*

Our service users often need groups of teams, statutory, voluntary and peer-led, to work, prioritise, operationalize, care and treat in unison across systems. *"Access to support can depend on where you are, which bit of the city. We need to be more consistent."*

The Foundations of Care

The bedrock of our strategy is based on the values of SHSC and the principle of delivering care that is Person-Centred, Strengths-Based, Evidence-Led and Trauma-Informed

Person-Centred

By being person-centred, we mean:

- Recognising that we are all unique, worthwhile individuals with equally unique experiences, personalities, beliefs, and values.
- Ensuring that people are given choices and supported to make informed decisions about what is important to them.
- Working with a core assumption of what is important to you is important to us.
- Empowering people so they can make as many decisions for themselves and to do as much for themselves, for as long as possible.
- Making sure that the needs of the individual come first.
- Accepting that we all need our own private space and time – and that services will respect this.
- Recognising that each person has human rights and that we will help ensure those rights are met and protected.
- Making decisions 'with' people, not 'for' people

Strengths-Based

By being strengths-based, SHSC:

- Will provide care and support in a holistic, multidisciplinary, proportionate way.
- Will work with individuals in a way, which explores the person's abilities and circumstances rather than just focusing on 'what's wrong'.
- Will recognise that risk is part of everyday life for everyone. Risk will be looked at as an enabler and not as a barrier.
- Will help to reduce risks whilst at the same time supporting individuals to manage their own risks.
- Will support, and work with, people to identify how they can use their personal strengths and resources to move closer to how they want their life to be.
- Will provide the right amount of help, the right advice, at the right time.
- Will listen to how a person's illness, disability, social and personal situation impacts upon them.
- Will ask what matters to you, what is strong, and what is good?
- Will support you to be more engaged and involved in your local community.

Evidence-Led

By being Evidence-Led, SHSC will:

- Provide services which are based upon the best evidence available and best practice.
- Support and develop Team SHSC by ensuring there is ready access to a range of resources where research and best practice can be found.
- Recognise that whilst evidence-based services are important, we will still value and respect each person as a unique individual. This means staff will be empowered to make decisions, guided by research and evidence but in a person-centred way.
- Acknowledge that evidence-based interventions are not only obtained from academics. We will seek out and listen to the views of service users, their family/carers about what has worked, and not worked, for them in the past.

Trauma-Informed

By being trauma-informed SHSC will:

- Work to develop a trauma-informed system that asks about and understands the impacts of experiences including sexual, physical and emotional abuse, and other trauma that impacts on mental health.
- Ask people who use our service “what happened to you?” rather than “what’s wrong with you?”
- Train staff in trauma specific treatments with training that is coproduced by experts by experience and build a trauma-informed workforce.
- Prevent secondary trauma within staff by offering good support through supervision and reflective practice.
- Create safe physical and emotional healing environments where service users, carers, families, and staff receive and deliver care, and where there is least restrictive practice.
- Work to engage partner organisations to develop a city-wide trauma-informed system.

How will we know the strategy has had an impact?

We know having spoken to our service users, staff, partner agencies and commissioners that we are connected by a single aim of seeking to “improve the mental, physical and social wellbeing of the people in our communities.” Our Clinical and Social Care Strategy has at its heart a stepped approach to delivering this vision together with those that use and provide our services.

How will we know if this has an impact?

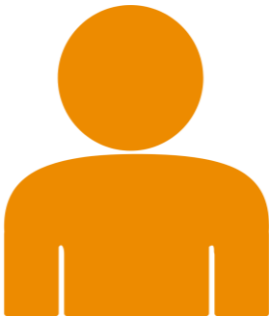
Across our organisation, every day that passes in every service we provide, there exists a rich tapestry of experiences of care received and delivered. We believe that there is learning form the experiences from our services users, staff and carers gives essential insight into the good care that is provided but also the gaps that sometimes exists between care as intended and care as experienced.

The following case-vignettes presented in this strategy cannot represent the rich and diverse set of experiences of all service users but are intended to tether the strategic aim with the lived experience of our service users, staff and partners.

Case vignettes

There can be no single case vignette that reflects the experience of all our service users. We will work with teams to help them understand the experiences of people who use services, learning from excellence, incidents and near misses.

The cases below are composite and do not relate to specific service users, although the do illustrate key themes.



Vignette 1: Person-Centred

T is a 57-year-old man with a long history of mental health problems associated with bipolar affective disorder and alcohol dependency. T often presents in crisis following difficulties when he feels very low - at those times it is noted that he uses alcohol to manage distress and difficult feelings, which further exacerbates the crisis.

T is offered support during the crisis episodes; the team liaises regularly with family members and those supporting T during these periods. T’s alcohol use is responded to appropriately by specialist services, and when presenting in crisis there is evidence of liaison with emergency services.

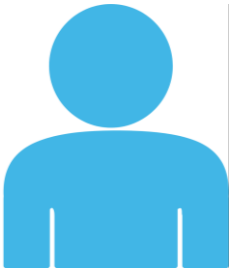
How would implementation of the core principles of the Strategy improve the care received by T?

Person-centred

There are up to four teams involved in T’s care, and while each team works well with T, family members experience what for them appears uncoordinated care. The structure of services makes it harder to meet T’s need from a person-centred point of view - the sum is not greater than the parts.

True person-centred care requires services to rethink the way in which care is accessed and provided. By beginning to re-design and deliver care through the person-centred lens, this Strategy provides us

with an opportunity to better understand the potential gaps between services and embed approaches to organising care around the person at the centre, and their specific needs.



Vignette 2: Strengths-Based

Y is a 70-year-old and had been admitted to an older adult psychiatric ward following a serious suicide attempt. Y was treated for depression with medication but was still an in-patient some months later. Attempts to discharge Y were associated with serious self-harm. Although previously a highly sociable person, Y was in a state of withdrawal and frozen watchfulness.

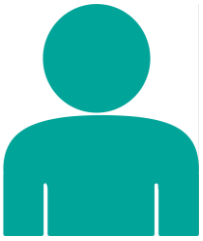
One-to-one communication was difficult as Y offered monosyllabic answers, repetition of 'I don't know' and tendency to terminate interviews. Anxiety management and graded exposure to improve social skills proved ineffective because of difficulties in engaging Y meaningfully in the work. There were at times outbursts of anger and frustration if there were changes to ward routine.

Staff on the ward were finding it difficult to manage Y's needs to move forward with a care plan.

Strengths-Based

Therapy staff were introduced to working on the ward and the Staff team worked together to develop a broader understanding of Y, build up a strengths-based model and learn more of Y's interests and motivations. Behavioural observations with an assistant psychologist gave insight into an understanding of triggers for points of distress. Staff learned that Y would often behave in ways that brought particular interactions with the staff team. Through supervision staff were able to reflect on the interactions that they had with Y that initiated more of Y's strengths and interests rather than self-harm.

Y began to take more independent steps with self-care, feeling confident about leaving the ward for walks and periods of leave with family members, joining in with ward-based activities Y was interested in, Y's mood and motivation improved, and they were successfully discharged.



Vignette 3: Trauma-Informed

J is 35-year-old woman who frequently requires crisis intervention following self-harm.

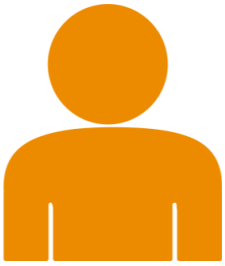
J's childhood background was characterised by abuse, including neglect, verbal abuse, and physical assault over many years. As a child she tried to cope with the impact of the abuse by going through rituals such as counting and placing things in an order to get a sense of control and safety. These rituals carried through into teenage years and J would feel very distressed if unable to complete these behaviours. This led to J being bullied at school and further problems developed around self-esteem and J began self-harming.

Trauma-Informed

The delivery of care in a trauma-informed way focuses on "what's happened to you" and less on "what's wrong with you ". It explains how trauma affects people's lives, their care needs and use of services.

Caring in a trauma-informed way supports a model of care that focuses on the development of collaborative and trusting relationships, and the importance of consistency across teams and services that leads to a whole system trauma-informed approach.

Trauma-informed care is defined as practices that promote a culture of safety, empowerment, and healing. Services and systems can understand about trauma and how it can affect people and groups, recognize the signs of trauma, and have a system that can respond to trauma. By achieving a trauma-informed approach to care, services can avoid re-traumatisation (e.g., restrictive practices) and provide improved outcomes for service users.



Vignette 4: Evidence-Led

B is a 24-year-old woman who gave birth to her daughter M two months ago. The health visitor is concerned about B who is reporting thoughts about death and dying. B had for the first 6-8 weeks been breastfeeding M but stopped when she started having thoughts that her breast milk was contaminated by substances and turning M into an alien.

B is becoming increasingly anxious and preoccupied about M's development and her safety, and constantly checking M, for example waking her to check she is breathing. The health visitor has noted that M has lost weight and has stopped crying.

It is noted that B's self-care is poor, she has not been getting dressed and she reports she is not sleeping. B feels that she has to hold M all the time, so that she feels safe and doesn't cry.

In terms of the background, B is a single parent; her ex-partner did not want any involvement with the baby and has had no contact with B. In terms of support, B has distanced herself from family and friends, as she feels unable to share her thoughts and feelings, fearing that they would see her as a bad mother. It is clear that she has become very isolated.

Evidence-Led

There is overwhelming evidence that B requires specialist care from a specialist, multidisciplinary perinatal mental health team. She requires input from a range of professionals including psychologists, psychiatrists, and specialist nurses.

The team involved with B's care will come together to look at an evidence-led approach. Elements of her care will include consideration of pharmacological treatments (noting risks around breast feeding) and interpersonal talking treatment, sitting alongside practical support from a parent-infant worker including baby massage and peer support to make progress.

The team will also use a new evidence-led treatment using video recordings of B with M to illustrate attachment and inform discussions around the mother/baby relationships with a parent/infant psychotherapist. Information from this will be utilised by the whole team to support B to recover from severe post-natal mental illness and form warm attachments with M that help to give her the best start in life.

Five-year strategic plan

We recognise that the changes we will implement need to follow the key deliverables outlined within the NHS LTP, meet the needs of service users and carers, commissioners and partners to deliver on the goal of improving quality and reducing health inequalities.

The figure below gives a high-level representation of the strategy, describing a summary of the five-year plan to build on each year a staircase platform of improvement in care that service users, carers and staff want to see. The fundamental principle is of care that is informed by the four pillars of person-centred, strengths-based, trauma-informed and evidence-led care, working in partnership across Primary Care, the City and the wider South Yorkshire Integrated Care System to increase quality and reduce inequalities.

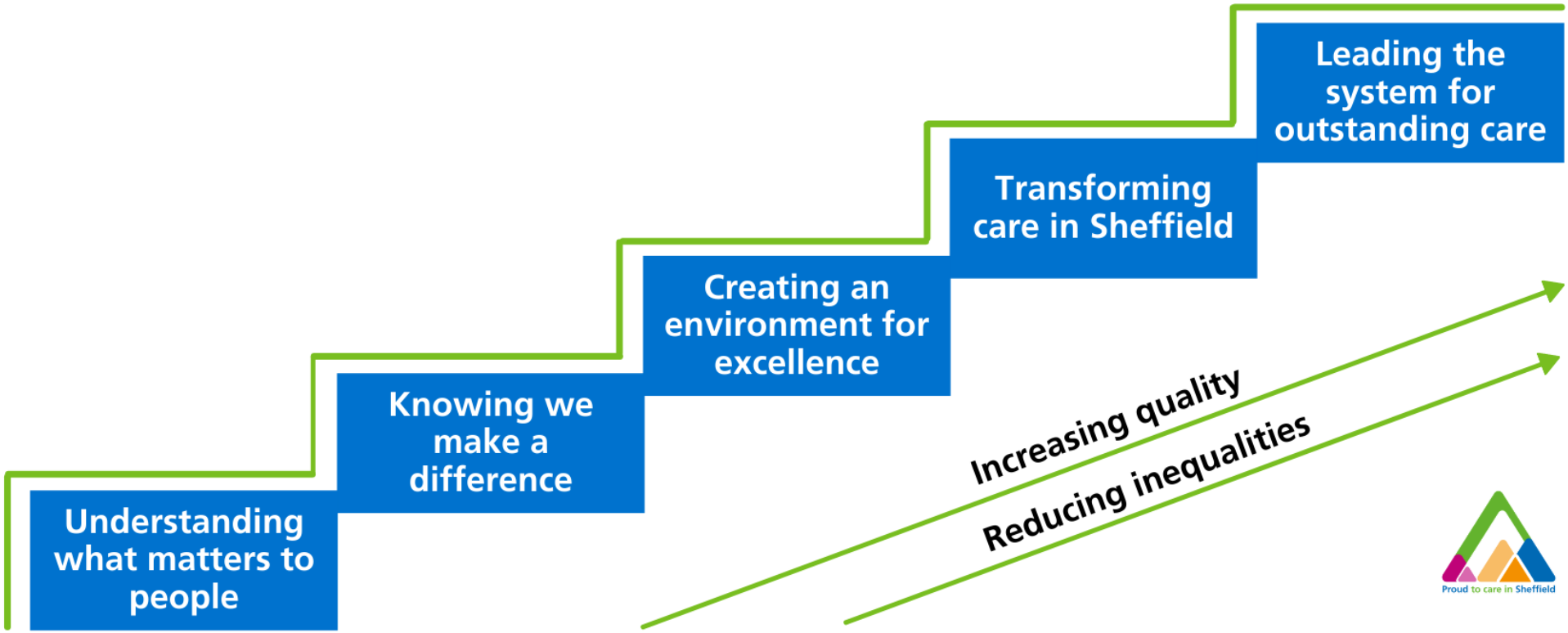
Clinical and Social Care Strategy: Five-Year Plan on a Page

Care that is:

Person-centred	Trauma informed	Evidence based	Strength based

NHS
Sheffield Health and Social Care
NHS Foundation Trust

Primary Care	The City	The Wider System



Proud to care in Sheffield

Populating the Staircase

NHS
Sheffield Health and Social Care
NHS Foundation Trust

Understanding What Matters to People	Knowing We Make a Difference	Creating Environments for Excellence	Transforming Care in Sheffield	Leading the System for Outstanding Care
Minimal Restrictive Practice	A Person-Centred Outcomes Framework	Therapeutic Built Environments that Support Care Models	Community Partnership for Clinical, Social Care & Academic Excellence	Outstanding SHSC at the Forefront of SYB Quality Network
Meaningful Hospital Admission	Digital Systems to Capture Experience & Outcomes	Accredited Teams Across All Services	All Age Integration of Physical & Mental Health and Social Care	An Equitable Mental Health and Social Care System
Accessible Primary & Secondary Mental Health and Social Care	Measurable Consistency & Continuity in Care	Quality Networks Throughout SHSC	Zero Suicide Sheffield	Integrated Care from Neighbourhoods to System

Increasing Quality and Reducing Inequality

Proud to care in Sheffield

What are the Key Deliverables?

Understanding what matters to people

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.

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.

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.

The crisis service is undergoing transformation to improve access by going to 24/7 care to provide alternatives to hospital inpatient admission.

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

We are mobilising a range of interventions, including the Safe Wards programme, to reduce restrictive interventions.

We aim to end out-of-area placements in 2021, subject to establishing a viable bed base during significant inpatient building works required on the grounds of patient safety.

Knowing we make a difference

We are committed to developing the required levels of digitisation and achieve data quality maturity within and across our clinical services that support clinical teams to deliver care that is based on real time and up to date information. We are developing a new Electronic Patient Record. We recognise that a strong digital infrastructure and capability will enable us to deliver high quality, safe service user care and the ability for our staff to work in a flexible and agile way.

We will develop a person-centred outcomes framework, building on existing measures such as the Health of the Nation Outcomes Scale (HoNOS), adding service user reported outcomes including Recovering Quality of Life (ReQoL). We will link outcomes with the aims of Collaborative Care Plans and ensure that outcomes are tailored to what matters to people.

We will track key indicators of wider impact, for example:

- Deaths by suspected suicide
- People with SMI in stable and appropriate accommodation
- Recovery targets in IAPT
- Rates of detention under the Mental Health Act, including according to ethnicity
- Smoking rates in people with a serious mental illness
- Homelessness
- Dementia recorded prevalence and place of death

In summary, we will know that we are succeeding if we are collecting and achieving good clinical outcomes for our service users and carers which they report as meaningful and achieved within services that are accessible and effective.

Creating environments for excellence

As part of SHSC's commitment to creating environments for excellence and having therapeutic environments that support care, we will develop environments that are safe, therapeutic, compassionate, enable best practice and provide the best for service users. These will be environments where people feel valued and listened to, and staff enjoy coming to work because they are supported to learn and develop together. This work will cover three main areas:

Physical Environment

There is an agreement with the Estates Directorate that all modernisation work to the physical estate will include co-production with service users and staff working into that area, as well as staff who are experts in transforming the physical environment via a creative approach, for example Arts In Health being a main contributor.

We will develop the Small Change – Big Impact approach to ask service users and staff what small changes they would like to make to the physical environment that could potentially have a big impact. For example, planted areas and artwork in reception/welcome areas.

Therapeutic Environment

We will lead on a range of developments that strengthen the therapeutic offer. This includes inpatient services having Allied Health Professional staff working flexibly to include evening and weekends, and supporting the Therapeutic Activities Development Group to offer a range of meaningful activities across inpatient areas. We will support ideas into innovation, including developing a new, dedicated Recovery College that fits with existing activities at Sheffield Flourish and other community groups. We will engage Peer Support Workers as part of developing the therapeutic environment.

Great Place to Work

We will develop a positive workplace culture, working with Organisational Development to ask, 'What makes a great team?' and widely share learning. We will continue to develop the 'Health and Wellbeing' festival as well as the 'Joy at Work' initiative.

Transforming care in Sheffield

The Primary Care Mental Health Framework for Sheffield launched in July 2020 and within weeks they had seen and supported 600 people who would have neither accessed IAPT or secondary care mental health services (nearly 40% of whom were from BAME backgrounds).

- We have tested new models within four Primary Care Networks in Sheffield, accounting for 33% of Sheffield's population
- We have recruited around 30 staff into roles ranging from clinical psychologists/psychotherapists; mental health nurses; occupational therapists; community connectors and health coaches. We have also piloted new NHS roles such as Clinical Associate Psychologists (CAPs) and Mental Health Pharmacists.
- Over 1600 individuals have been seen to date within the new models of mental health support, working to a 4 week waiting time target that is locally developed. (This is already significantly ahead of the planned trajectory of 855 patients being seen between June 2020 - March 2021).
- We are also working to support citywide work to improve access to, uptake of and behaviour change related support relating to SMI Physical Health Checks
- We have been successful in investing with VCSE organisations to support wider social needs through social prescribing.

As part of the Clinical and Social Care Strategy we plan over the next 2 -3 years to build on the success of the 4 primary care networks and role this out to the remaining 11 primary care networks across Sheffield covering all 15 networks with the NHS LTP stipulating 50% matched funding from primary and secondary care.

What we expect to see in terms of specifics and measurable by 2025 are matched funded posts between primary and secondary care, integrated ways of working across the 15 primary care networks, and well-developed partnerships and integrated work with VCSE. We also expect a reduction in difficulties in reported access to mental health services, early intervention for people from BAME communities, reduction in health inequalities and improvements in reported quality and service user experience. We aim to align SHSC and its partners to a Zero Suicide Sheffield ambition and enabling programme.

The Primary Care Mental Health Programme is currently focussed on working age adults and older; our aim is to achieve all age working as part of delivering this Strategy.

Leading the system for outstanding care

We will adopt a stepped approach to developing quality networks for MHLDA. Firstly, within SHSC as part of our overall improvement plan. Secondly, within Sheffield, creating place-based quality networks for MHLDA and working with partners to improve outcomes across the City. Using this experience, we will build towards a system level MHLDA quality network, bringing benefits to the wider system and providing the quality platforms for system level programmes such as Provider Collaboratives.

We will work with the system to develop measures of experience and outcomes from neighbourhood to system level. We will also develop measures of assurance of equity for MHLDA in the system.

We will use our academic identity to facilitate Research and Innovation for MHLDA within the system. We are one of only three MHLDA Trusts in the Country to be members of the University Hospital Association. We are the only MHLDA Trust in Yorkshire and the Humber to achieve all our Key Performance Indicators for research set by the Clinical Research Network. We are the largest local recruiter of patients to interventional studies. We will use our experience to bring the same success in the wider system.

In summary

Person-Centred, Strengths-Based, Trauma-Informed and Evidence-Led. We have worked with service users, carers, colleagues in SHSC and partners across Sheffield to coproduce the Clinical and Social Care Strategy. In doing so, we have established these foundation principles for care that will inform our approach in different contexts, ranging from Primary Care to the Wider System. Throughout, the aim is simple, which is to improve the quality of care that our service users receive at the same time as reducing health inequalities that adversely impact on many.

The Clinical and Social Care Strategy sets out a five-year map to use the foundation principles of care to support strategic priorities ranging from Understanding What Matters to People, to Leading the System for Outstanding Care. The Strategy will inform other strategic developments and be supported by enabling strategies, including the Quality Strategy.

The range of influence in the Clinical and Social Care Strategy is broad and sets high standards. If we were to sum up the Clinical and Social Strategy in a single phrase, then perhaps we should borrow from the values of the NHS Constitution and simply say ‘everyone counts’.