Theme 1: address the wider determinants of health

Action	Update on progress	Delivery priorities for next year
Improve awareness in the wider population and workforce to support good emotional health and wellbeing and reduce stigma, including through approaches which recognise the trauma some people have experienced	• A new public health lead has been recruited who will lead in this area over the coming year.	• Workplan to be created and shared with partners.
Enable employment and training opportunities for people with mental health conditions and help employers look after the wellbeing people who are in work	• There are a range of projects in Sheffield supporting people with health conditions and learning disabilities to get a job, retain their job and stay healthy at work. This includes, for example, Employment Advisors supporting people who have been referred to Talking Therapies for Mental Health Support and SOHAS (Sheffield Occupational Health Advisory Service) who support people with health conditions to stay in work and take referrals from GPs, voluntary sector organisations and self-referrals. • We recognise that the system is complex with projects under a range of funding systems and with different criteria.	• The Sheffield Employment and Skills Advisory Board has established a subgroup to bring together partners to map the work and health support system and support cross working. • The ICB and the SY Mayoral Combined Authority have bid for additional funding from the national Work Well Partnership Programme to support integration of the local system so that it becomes easier to navigate and the gaps in the system can be identified and filled.

Connect to wider programmes and public policy which tackle poverty and inequality, such as housing, education and skills	• Sheffield City Council have re-commissioned and mobilised new substance misuse service in Sheffield. The new service, 'Likewise', is contracted to Humankind and launched in August 2023. Likewise offers a range of free, confidential and non-judgmental services for adults aged 18+ and their families whose lives are affected by drugs and/or alcohol. Their aim is to support people to stay safe and live happier, healthy lives, free from drugs and alcohol. As part of their offer, they can provide the following:
	  ○ One-to-one support
	  ○ Structured group therapy work
	  ○ Support to family members, involving them as part of recovery plans wherever possible
	• A health and wellbeing check, health screenings, blood testing and vaccinations
	  ○ Help to achieve a balanced approach to life through therapeutic intervention
	  ○ Support to reduce harm and prevent overdose
	  ○ Substitute medication is available for some drugs
	  ○ Detox from alcohol and/or drugs.
	  ○ Early Intervention and Prevention, including brief intervention, harm reduction, outreach and training
	  ○ With their partner, Project 6, Likewise offers a diverse programme of recovery and aftercare support
	• Changing Futures has been a joint initiative by the Department for Levelling Up, Housing and Communities (DLUHC) and The National Lottery Community Fund. The fund is for local organisations to work in partnership to better support people who experience multiple disadvantage: those who are experiencing three or more of homelessness, substance misuse, mental health issues, domestic abuse and contact with the criminal justice system. In Sheffield, this programme has had a significant impact on local people – **see case study 1**
	• In early 2023 Sheffield ICB and Doncaster ICB worked together to prepare a bid to NHSE to fund a 'test and learn' programme covering the two areas which focused on Mental Health and Rough Sleepers. They worked collaboratively to test and learn from the approaches with a focus on cross boundary learning and information exchange. Not only did the programme thrive as a result of the cross-boundary collaboration, it was able to produce an insightful final report providing conclusions and observations for future commissioning across the two areas.
		• Continue to embed learning from the Changing Futures Programme, including in homeless mental health provision.
		• Development of a Prevention and Early Intervention Leadership Group and a change programme, to coordinate services at first point of contact with people across partners.

Action	Update on progress	Delivery priorities for next year

Work closely with the voluntary, community, social enterprise sector and faith and community groups to see community-based support which combats isolation and supports connection and recovery	• One of Health and Care Partnership's 5 priorities is to develop new approaches to supporting the north-east of Sheffield. The programme's aim is to empower communities in the north-east to live happier and healthier lives. This is a new approach to tackle the wider determinants of health by investing in communities to improve their own lives; it isn't about commissioning or delivering health services – **see case study 2**
	• The Mental Health Collaborative has been launched, which aims to:
	  ○ Set up, facilitate and support a Steering Group of experts by experience to contribute to mental health transformation and delivery in Sheffield.
	  ○ Coproduce a shared view of NHS priorities for the city to improve individuals' experiences and outcomes.
	  ○ Connect with other lived experience groups in Sheffield to maximise further opportunities to collaborate and reach different communities.
		• Continue to embed the approach in the north-east of Sheffield
		• Take learning from Sheffield people to improve services (via the Mental Health Collaborative)
		• Deliver a micro-commissioning approach with Synergy Mental Health Alliance on strategic mental health priorities

Case study 1: the impact of the Changing Futures Programme

A video about the impact of the programme can be viewed here: https://www.youtube.com/watch?v=ma9UabVWe8c.

Case study 2: model neighbourhood plan in the north-east of Sheffield

- *We have a five-year plan. In year one, we are investing £800,000 into the north-east to connect people via small grants, to help sustain the VCS, building capacity and infrastructure of VCS, and co-production of community plans.*
- *Albeit small, the grants may have a big impact on people's lives. Take, for example, Hani, a Somali woman who lives alone in Burngreave. She's socially isolated which is affecting her mental health. She loves to sew but doesn't have the money for a sewing machine or material. Hani would like to form a sewing group of like-minded women, to form friendships and make culturally appropriate clothes for women in Burngreave. Not only could it help improve her loneliness and mental health, but it may also reduce her chances of getting CVD, dementia and early death. The mutual aid may help women who can't afford to buy dresses. Perhaps, with the right support it might build into an enterprise taking Hani and other women out of poverty.*
- *This isn't a one-year programme; it's a multi-layered complex piece of work to create health and help improve people's lives. We hope to embed this approach for the long term due to the scale of the challenge. Impacts will only be fully realised over years, if not decades. We want to change Sheffield, one neighbourhood at a time.*

Theme 2: support the emotional and mental health and wellbeing of our children and young people

Action	Update on progress	Delivery priorities for next year
Develop support for infant mental health and peri/prenatal services to give children a great start in life and support their attachment, attunement and attainment	• The Infant Mental Health Programme fully integrated with Start for Life Programme, and a new strategy is being developed • Recruitment of specialist staff in Parent and Infant Relationship Service (PAIRS) team and 5 specialist health visitor posts recruited to as part of the expanded offer around early intervention and prevention for child development/Early Years offer **– see case study 3** • Work on a developmental trauma pathway for early years perinatal has started, linking with all-age developmental; trauma work being developed with system colleagues	Priorities will be aligned with the THRIVE Framework for system change. This is an integrated, person centred and needs led approach to delivering mental health services for children and young people. It conceptualises need in five categories; Thriving, Getting Advice and Signposting,

Action	Update on progress	Delivery priorities for next year
Increase early intervention for school-age children and give schools and other professionals the tools they need to support to children's emotional health, wellbeing and resilience	• The Youth Information and Counselling Service (YIACS) is to be reprocured in 2024, having been remodelled during summer 2023 to focus on meeting need in communities and centrally. Kooth is also available as an online tool, alongside various voluntary sector groups offering tailored support • Mental Health Support Teams are in 50% of schools (mainstream secondary and primary) • 15 schools are now working under the Autism in Schools pilot. The Sheffield Parent Carer Forum are also running peer support groups for parents of children with autism • We re-launched the Sheffield Mental Health Guide, co-produced with young people in Sheffield, focussing more on accessibility and information provision for emotional wellbeing and mental health early help for young people alongside the existing adults information.	Getting Help, Getting More Help and Getting Risk Support.
Provide early intervention, targeted support, intensive outreach and home treatment services, and better, earlier crisis care including safe space alternatives to A&E and approaches to support suicide prevention and awareness	• The Dynamic Support Register is now functioning and regularly reviewed within Sheffield for those children with Autism and/or a Learning Disability that may be at increased risk of hospital admission or mental health crisis • Senior Navigators work closely with young people with a Learning Disability and/or autism to support them to access education and health services that they need, with support, with the additional goal of trying to avoid hospital admissions unless they are completely necessary. In the first three quarters of 23/24, 46 young people had received support from the navigators—23 aged 0-17 and 23 aged 18-25 – **see case study 4** • The 16-17 Safe Space was reviewed, and while it has not been recommissioned, there is significant learning from it to inform work in this space • A review of the section 136 offer is underway	

Work in partnership with the provider collaborative to reduce avoidable admission to inpatient care and ensure children and young people can access beds when required	• The Provider Collaborative for this area is overseen by the South Yorkshire and Bassetlaw Specialised Commissioning Hub. Together, with the support of partners, their staff, and those with lived experience we are seeking to transform services and improve experiences and outcomes for patients and their families by:
	  ○ Delivering high-quality services in line with best practices
	  ○ Streamlining referral and assessment pathways
	  ○ Reducing the length of time that people need to stay in specialist inpatient services
	  ○ Keeping people closer to home and avoiding out-of-area placements where appropriate
	  ○ Reducing health inequalities
	  ○ Ensuring services are led by clinicians and 'experts by experience'
	  ○ Reinvesting into local provision and supporting community alternatives	

Support young people to receive developmentally appropriate care as they grow into young adults and ensure clear service pathways are in place that work for them especially for those aged 18-25	• We are looking to revise and optimise the support available for children looked after, aiming for it to be more flexible and responsive. Development work is a joint approach between SCFT, SY ICB, SCC Children's social care and residential services • A model is being finalised for a newly funded 18-25 service in SHSC, focussing on support for young adult mental health and transitions between children's and adults' services	
Protect and safeguard children and young people from exploitation and abuse	• Children affected by domestic abuse has been agreed as a priority for the Safeguarding Children Partnership. The Safe and Together model, which promotes partnering with the non abusing parent and holding perpetrators to account has been agreed as central to safeguarding children affected by domestic abuse • Sheffield Rape and Sexual Abuse Centre is developing a service to offer counselling to children affected by sexual abuse	

Action	Update on progress	Delivery priorities for next year
	• Domestic Abuse Act funding will continue to be invested in the YIACs contract to enable counselling to be offered to children and young people recovering from the impact of domestic abuse who are living in safety • A working group of the Safeguarding Partnership is considering the impact of the legal change in the Domestic Abuse Act that recognised children living with domestic abuse as victims in their own right • Youth services are developing sessions for boys / young men on gender equality to prevent Violence Against Women and Girls • A successful conference was held in October for schools on preventing and responding to Violence Against Women and Girls	

Case study 3 – family supported by the Parent And Infant Relationship Service (PAIRS) team

- The initial referral to PAIRS made by the Health Visitor. The mother had taken time to express to her health visitor that she was struggling with her mental health and relationship with her infant, due to the fear that her children would be removed.
- The initial phase of PAIRS' intervention saw the mother and the PAIRS clinician spending time talking about the circumstances surrounding the conception and difficulties in pregnancy, which led to immense guilt and fear of losing her baby throughout. The mother also experienced postnatal depression and spoke about how the recent concerns about her infant's developmental delay had left her feeling further guilt and decline in her mental health. These sessions offered an opportunity for the mother to understand and work through the guilt she was feeling, identifying how this and her difficult pregnancy had impacted on her relationship with her infant. During these sessions the mother was also able to make important links between her own difficult childhood experiences and impact on her anxiety as a parent.
- The mother agreed to Video Interactive Guidance intervention (VIG) with the aim to build confidence in her parenting and focus on how she was supporting her infant's development. The mother and the PAIRS clinician had identified that her negative thinking patterns were a barrier to her noticing any positive moments with her infant. Through VIG the mother was able to see her sensitive and attuned responses towards her infant and recognise, and believe, that she was supporting her infant's development. Following VIG mum reported that she was making a conscious effort to notice positive interactions with her infant daily. The mother also reported significant improvements in her mental health. She felt more confident and happier in her relationship with her infant. The mother went on to access her own mental health support as well as signing up to various college courses due to identifying that she wanted to work on her own personal development.

Case study 4 – story of a young person helped by a senior navigator

The young person in question was supported for 20 months by a senior navigator. Some of the goals achieved included:

- *Accessing education with a tutor four times a week*
- *Engagement with CAMHS*
- *An Autism Alert Card for the Police*
- *Learning to discuss thoughts and feelings*
- *Writing and recording a song/track*
- *Leaving Care PA provided who supports regularly*
- *GP visits decreased to bimonthly from every six weeks*
- *Strong friendship group and identification with the local community*

Theme 3: provide earlier help to people who need it

Action	Update on progress	Delivery priorities for next year

Transform community based and primary care mental health provision to make it easier to get help	• A new model was launched in April 2024 which saw increased investment in mental health care, support and treatment to remove the barriers and join up provision that many people currently experience – **see case study 5**. For example:
	  • Repeated assessments.
	  • Being referred to different parts of the mental health system.
	  • Reducing multiple patient administration systems to have shared views or joined up records.
	  • Physical health needs not being viewed alongside mental health needs.
	  • Gap in service offer that exists where some people are classed as being too complex for NHS-Talking Therapies yet not complex enough for the community mental health teams.
	  • Need for better involvement between NHS services and the voluntary sector.
	  • Need for care, support and treatment closer to where service users live and their local communities.
		• Successfully implement new primary and community mental health transformation models
		• Implement integrated models across adults health and social care, primary care and acute care to enable joined up delivery in communities.

Expand access to talking therapies and increase the range of different therapies available	• The NHS Talking Therapies Service have a new equalities strategy, which aims:
	  • To increase access for people from BAME communities
	  • To increase access for Older Adults
	  • To improve recovery rates for BAME communities in line with White British
	  • To go beyond the scope of improving equality of access and outcomes for BAME groups and Older Adults to addressing further inequalities and focusing on improving access in populations Talking Therapies can help (For example, Improving access for men, rapid access for women in the perinatal period, Carers, Students)
	  • To have dedicated & tailored promotion and marketing to diverse populations to improve access
	  • To support staff through supervision, reflective practice, CPD, engagement events and co-location with voluntary and community sector to provide culturally sensitive, inclusive practice, actively reduce barriers and encouraging access and effective treatment in Talking Therapies
	• **See case study 6**
		• Review progress with Talking Therapies equalities strategy

Provide better, more joined up, support to carers and families	• A Carers Delivery Plan was approved at Committee in December 2022 and regular updates provided to Committee as to progress with delivery, including impact using ASCOF outcomes and I statements. • In October 2023, Sheffield had its first ever ‘Carers Roadshow’. This saw an exciting programme of events and over 30 organisations there from health, social care and the VCS, alongside health checks to unpaid carers	• Continue to embed the Carers Delivery Plan. • Continue to embed positive working practices with unpaid carers

Action	Update on progress	Delivery priorities for next year
	• The Carers' Centre provide support to adult carers in Sheffield. At times it is appropriate to enable carers to have a Carers' Assessment, and for Carer Support Plans to be created which include different kinds of support to help with carer wellbeing and sustainability of caring role • In 2022 a small additional investment was provided, which enabled a 44.8% increase in mental health carer referrals to the Carers' Centre. In addition, Sheffield Health and Social Care Trust (SHSC) is the second largest source of referrals to Carers Centre (after Adult Care and Wellbeing) with an average of 76 referrals per quarter in 2023 • In early 2023 a pilot was launched between the Carers Centre and Sheffield Talking Therapies (STT, then IAPT). This enabled referrals for carers to be made to a named worker within STT who could then potentially support carers at the Centre (a possibly less-formal, more comfortable environment for them). This arrangement is ongoing and has involved close co-working between the Centre and STT when appropriate and agreed with the carer. • Sheffield Carers Centre continues to hold an appointed governor seat on the SHSC Council of Governors. This has, for example, helped maintain a carer perspective at Council meetings and has helped carer views and experience to be put forward. • **See case study 7**	
Intervene and promote resilience for our children, young people and adults at an early stage	• The Youth Information and Counselling Service (YIACS) was recommissioned, having been remodelled during summer 2023 and received extra funding from Government to focus on meeting need in communities and centrally. Kooth is also available as an online tool, alongside various voluntary sector groups offering tailored support • Mental Health Support Teams are in 50% of schools (mainstream secondary and primary) • 15 schools are now working under the Autism in Schools pilot. The Sheffield Parent Carer Forum are also running peer support groups for parents of children with autism • We re-launched the Sheffield Mental Health Guide, co-produced with young people in Sheffield, focussing more on accessibility and information provision for emotional wellbeing and mental health early help for young people alongside the existing adults information	• The Prevention and Early Intervention Leadership Group is creating a number of workstreams, including an aligned front door with partner, enablement provision prior to long-term planning, embedding Sheffield Directory across our partners, and developing a commissioning strategy for optimising the use of VCSE contracts

Case study 5 – the new kinds of support available through the Primary and Community Mental Health Programme

Case Study – John

Issues

- Outstanding SMI health check
- Decline in Mental Health
- Recurring health problems e.g. infections, cysts
- Social difficulties since COVID: maintenance of 3 bedroom house, lack of emotional support / meaningful relationships
- Lack of faith / motivation to contact GP

Person's Goals

- Support with mental health
- Appointment to be made with Doctor regarding current infection
- Flu jab arranged
- Extra support in housing and socialising

Outcomes

- Appointments made with GP for same week regarding MH and infections
- Completed annual SMI Physical Health Check
- Identified high BP and education surrounding nutrition and exercise in relation to Overweight BMI
- Contact made with council for housing
- Flu Jab booked for day after SMI check
- Tasking GP to be aware of Johns physical health including BP
- Would like help in the future regarding stopping smoking and weight loss – documented on S1

Case study 6 – a patient talks of the value of NHS Talking Therapies

"Having become a carer unexpectedly, after a while I began to flounder and reached out to anybody I could think of. Thankfully a call to the carers service proved vital to helping me get back on track.

I was seamlessly referred to Talking Therapies who called back much faster than I expected and were able to offer a range of services, from which I chose face to face sessions. The sessions were really focused and provided very practical, hands-on advice and exercises which [the staff] explained with great skill and was able to break down the underpinning ideas so I could understand the rationale for them. This meant I was able to engage with them independently at home and get the most out of them.

[The staff] provided a very professional and caring sounding board to explore the issues I was encountering. The advice I received in the sessions and the maintenance plan have allowed me to overcome many of the issues and negative thought patterns I was experiencing and carry this on now sessions are finished.

I will be forever thankful that I made that one call to the carers service lead quickly and simply to sessions with Talking Therapies. It has contributed to me regaining a positive outlook on life and the future."

Case study 7 – short case studies to illustrate co-working between the Carers Centre and SHSC

- A referral was received from Early Intervention Team in December 2023. Following discussion with the referrer it was agreed this referral would be prioritised. An appointment was held at the Carers Centre using the support needs identified in the referral as a starting point. The carer is being referred to Sheffield Talking Therapies and being supported with grant applications for carer respite (Time for a Break) and hardship.

Theme 4: provide effective and good quality care and treatment services

Action	Update on progress	Delivery priorities for next year
Transform our crisis response services including home treatment, earlier support, and alternatives to A&E such as crisis cafes and safe spaces	• The crisis programme is being relaunched and is part of the Urgent and Emergency Care (UEC) Delivery Group of the Sheffield Health and Care Partnership • The Sheffield Support Hub is operational, providing people with a place to go which is not A&E or calling 999/111 if they find themselves in a crisis with their mental health. Support needs can include simply wanting help for low mood and depression, to being suicidal. The service also frequently supports people with their loneliness. Many who attended the service created an action or safety plan and reported that the contact had reduced anxiety and distress, and that they felt listened to. Service data suggests city wide coverage, and over 200 people received support in November 2023—a number expected to increase as the service opens its doors more frequently going forward • *See section 2 for update on CYP crisis work* • **See case study 8**	• Commission learning disability/autism crisis safe space with regional partners • Crisis transformation programme relaunch as part of Health and Care Partnership priorities • Carry out self-assessment with the AMHPs service and create an improvement plan
Improve inpatient care and our inpatient facilities	• SHSC continue with their work to refurbish their inpatient wards to create a more modern, compliant and therapeutic environment to help service users recover and live with their mental health. The new improvements have removed ligature anchor points from adult acute wards, and refurbished wards to provide a homely, therapeutic feel, and are designed to help people get better quicker and learn techniques to help them stay well for longer. Improvements include safer outdoor spaces which are accessible without supervision, refurbished bedrooms, including provision of appropriate accessible bedrooms, provision of high level de-escalation facilities, a service user gym and the provision of separate clinic and treatment rooms.	• Discharge and flow workstream as part of the Adults Policy Committee and Health and Care Partnership's objectives, which includes regular discharge meetings between partners, new social care discharge teams and new commissioning arrangements for interim placements • Therapeutic Environment Programme to continue to transform SHSC hospital wards including completion of the final adult acute ward refurbishment.
Invest in training and workforce	• Learning needs across adult mental health care have been reviewed, with new training plan in place. A Memorandum of Understanding concerning a shared training plan between partners has also been agreed. • An adult Health and Care Workforce Strategy was approved in March 2023 with latest updates provided in January 2024. A Care Academy is due to be launched in October 2024 which will support and enable provision of learning and development across the care sector.	• Launch and implementation of Care Academy in 2025. • Ongoing implementation of the Adults Health and Care Workforce Strategy. • Ongoing delivery of training plan and identification of resources to deliver bespoke training needs
Provide effective and purposeful reviews of care to support people in their journey of recovery and independence	• Additional investment into staffing and the retention of staff has meant teams are now increasing the review work they are able to complete and reducing waiting times for assessments, re-assessments, and reviews. These teams also support with discharges from inpatient facilities and into appropriate accommodation, employment and education support. • From March 2025 all social care teams will be meeting targets and managing review workloads as part of their day-to-day caseloads.	• Complete reviews via agency teams • Complete recruitment to new posts and implementation of a learning and development plan so that mental health social work teams are supported to deliver strength-based approaches to care and delivery.
Continue to review presenting priorities within the Sheffield population and invest to meet this need	• The Mental Health, Learning Disabilities, Dementia and Autism Delivery Group carries out an exercise, usually annually, to coproduce with partners and local people the areas where we most need to prioritise our time and activity. • One recent piece of work in response to need has been an antidepressant deprescribing project; another is to continue to look at improving services for all ages with an eating disorder	• Organise a conference and workshop sessions to involve and engage individuals, carers, partners in agreeing priorities for 2025 – 2027 and promoting understanding of emotional and mental health.

Action	Update on progress	Delivery priorities for next year

Work in concert with the provider collaboratives to ensure clear areas of responsibility and service pathways	• The MHLDA provider collaborative in South Yorkshire ICB is working on a range of pieces of working, including:
	  • Looking at the neurodiversity pathway – including assessment, post-diagnosis support, and support for ADHD and autism
	  • Considering the best way to ensure access to a Health-Based Place of Safety
	  • Coordinating the South Yorkshire eating disorders system and parity of provision across the region
		• Continued working with provider collaboratives and identification of clear governance structures
		• Seek synergies between provider collaboratives, VCSE and Social Care Providers.

Ensure that the accommodation services we commission help people to live as independently as possible in the community	• A Personal Independence Programme was implemented as a partnership with South Yorkshire Housing Association. This is successfully supporting people to move from residential to community based independent living. • Development of an Enhanced Care Framework was agreed at Committee in June 2024. This along with a partnership with housing supports development of accommodation with care, emergency overnight short breaks and aims to reduce need for out of area placements. • In January 2024 providers were contracted to deliver three new interim beds designed for people awaiting a provider placement or further support planning on discharge from hospital.	• Deliver Personal Independence Programme throughout 2025 • Deliver and develop Enhanced Care Framework and with that deliver commissioning arrangements which will reduce need for out of area placements. • Ongoing interim beds scheme – to be evaluated throughout the year • New discharge pathways to be clarified for when people are ready to leave hospital and need accommodation

Case study 8 – experiencing the Sheffield Support Hub

- *This client accessed the hub to gain emotional support following some recent life events that have been causing them distress. The client uses the hub when they feel they need someone to talk to/offload their feelings. We have helped the client achieve these goals when accessing our service by offering them someone to talk to about how they are feeling. Furthermore, we have worked with the client to create a safety plan, which they have said they find useful.*
- *The client reported finding the safety plan to be useful in preventing self-harm and always thanks staff for the conversations they have with us. We also make sure to accommodate to the client's needs by offering to see them during the day, as this time often works best for them. The client has not reported any new instances of self-harm since they have been using the service.*

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