Board of Directors - Public

SUMMARY REPORT	Meeting Date:	27 November 2024
	Agenda Item:	20

Report Title:	**Clinical and Social Care Strategy Annual review**	
Author(s):	Linda Wilkinson Director Psychological Services & Chin Maguire Programme Lead	
Accountable Director:	Dr. Helen Crimlisk Executive Medical Director	
Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	Quality Assurance Committee
	Date:	March 2022/ November 2022/April 2023/ /November 2023/ May 2024/ November 2024
Key points/ recommendations from those meetings	Accepted updates and assurance regarding the progress with the implementation of the Clinical and Social Care Strategy.	

Summary of key points in report

The Clinical and Social Care Strategy (2021-2026) is our core five-year plan to increase quality whilst reducing inequalities across SHSC. The strategy was coproduced with extensive involvement from service users, carers, colleagues in SHSC and partners across Sheffield. Through this consultation we developed four work streams: Person-centred, Strengths-based, Trauma-informed, and Evidence-led as principles for care to inform our approach across services, with Coproduction embedded within all the workstreams.

This paper gives an update on the key assurance points and impact of the Clinical and Social Care strategy over the last 5 months. We have attached a slide set which outlines progress.

Summary Table for the Clinical and Social Care Strategy Programme Objectives

This table shows summary progress for the programme overall with **73% of tasks completed or on track.** 12% are no longer needed as they have been progressed in other work plans. 7% of tasks are delayed with 8% not yet started this is largely linked to the Outcomes and Benefits workstream (newly approved August 2024) and changes in leadership of the Strengths based workstream.

TOTAL	Total outputs/ things set out to achieve	Complete based on original plans		On track		Delayed		No longer required/ amended / on hold (n)	% not needed	Activity Not started (n)	% not started
		Complete (n)	% complete	On track (n)	On track (%)	Delayed (n)	Delayed (%)				
	163	78	48	41	25	11	7	20	12	13	8

The Clinical and Social Care Strategy Programme has been rated with an overall status of **Green.** Significant progress has been made with Person Centred and Co-production Workstreams, all tasks are now completed, with work embed and continuing in services as business as usual. We are confident that all the remaining tasks will be complete for the end date of 2026.

Year 3 Objectives 2024/25 Creating Environments for Excellence:

This is largely held in overlapping programmes of work with the Physical Environment: Therapeutic Environment and Creating a Great place to work. All three of these areas have made significant progress in 2023/24 within other strategies & programmes of work e.g. Physical/Therapeutic environment progress through the Estates project e.g. the Longley and MCC Sites.

The People plan, has made significant developments with a recruitment, retain and train strategy: Organisational Development interventions e.g. support for leadership development and work on the National Staff Survey: PDR and Workplace wellbeing including internal Counselling staff service.

Embedding the Strategy as Business-as-Usual 2025- 2026: The key focus for 2025 is to support teams to fully embed the Clinical and Social Care Strategy into existing structures as business as usual. The process for achieving this will be through embedding the frameworks in business planning structures: growing outcome measures within Rio and using QI methodologies. Alongside supporting/developing team cultures to embed care that is Person-centred, Strengths-based, Trauma-informed, and Evidence-led as principles for care.

This process aligns with year 4 and year 5 strategy objectives outlined in the initial plan related to Transforming care in Sheffield and across the system. Work continues with the four key large transformation programmes in our Learning Disabilities Services, Primary and Community mental health, Acute Care Pathways and Older Adult services to ensure delivery of good quality care for people who use our mental health services. Alongside this we have been contributing to the development of the system work through the South Yorkshire Mental Health Learning Disabilities and Autism Provider Collaborative as leading members of the Clinical and Care Professional Assembly.

Recommendation for the Board/Committee to consider:							
Consider for Action		**Approval**		**Assurance**	**x**	**Information**	**x**

The Board are asked to review the programme summary and consider if this report provides sufficient information to describe progress against the key performance areas.

Risks: The Clinical and Social Care Strategy Programme has been rated with an overall status of Green. There have however been delays in developments of Rio which has impacted on our capability to develop systems that support collecting programme outcome data. We have noted the risk of being unable to accurately reflect the impact of our transformation work within the Benefit section of the RAG rating on the Programme Highlight report accordingly.

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:				
Effective Use of Resources	*Yes*	***x***	*No*	
Deliver Outstanding Care	*Yes*	***x***	*No*	
Great Place to Work	*Yes*	***x***	*No*	
Ensuring our services are inclusive	*Yes*	***x***	*No*	

Is this report relevant to compliance with any key standards ?					**State specific standard**
Care Quality Commission Fundamental Standards	*Yes*		*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, Engagement 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

Clinical and Social Care Strategy

Background
The Clinical and Social Care Strategy (2021-2026) is our core five-year plan to increase quality whilst reducing inequalities across Sheffield. The strategy was coproduced with extensive involvement from service users, carers, colleagues in SHSC and partners across Sheffield. Through this consultation we developed four pillars: person-centred, strengths-based, trauma-informed and evidence-led as principles for care to inform our approach across services.

Section 1: Analysis and supporting detail

1.1 Outcomes and Inequalities Workstream

Outcomes and Benefits is a newly created workstream for 2024/25. The focus is to ensure population health and inequalities are at the forefront of the strategy and we can measure the benefits and impact of the clinical and social care strategy through a health inequalities lens. The implementation plan for the workstream has been signed off (August 2024).

An overview of activity is provided below:

Plan approved August 2024	Total outputs/ things set out to achieve	Complete based on original plans		On track		Delayed		No longer required/ amended / on hold (n)	% not needed	Activity Not started (n)	% not started
		Complete (n)	**% complete**	On track (n)	On track (%)	Delayed (n)	Delayed (%)				
Outcomes and inequalities workstream	15	1	6.7	5	33.3	0	0	0	0	9	60

Measurement of success:

Health inequalities indicators outlined from NHSEI include SMI Physical health Checks; Rates of Mental health Act Detention; Rates of Restrictive Practice and the Recovery Rates for NHS Talking Therapies. These are reported to QAC in other reports and will not be repeated here.

The workstream lead has been working with the implementation group to firm up the outcome and impact measures which should be collected by teams to demonstrate the impact of this work. The next phase of this work looks to embed the key outputs across teams with the supporting infrastructure e.g. Rio. Work to progress this will be developed in conjunction with Rio.

1.2 Trauma Informed Workstream

The Trauma Informed Workstream has two additional, associated plans Complex Emotional Needs Pathway Plan and Post Incident Support Plan. For the purposes of this report, we will report the main workstream plan which set out to achieve 38 outputs of which 76.3% are either complete or on track, 13.2% no longer required and 5% not started.

Implementation Plan developed September 2022	Total outputs/ **things set out to achieve**	Complete based on original plans		On track		Delayed		No longer required/ amended / on hold (n)	% not needed	Activity Not started (n)	% not started
		Complete (n)	**% complete**	On track (n)	On track (%)	Delayed (n)	Delayed (%)				
Trauma Informed Workstream	**38**	21	**55.3**	8	21.1	2	5.3	5	13.2	2	5

1.2.1 Staff Training: A significant part of this plan links to Trauma Informed training for staff, which is now an established full day session and ROOTS to SHSC teams. To date around 376 staff have attended the full days Training session with an **expected 400 to have completed this by 31/12/24.** An hour's trauma informed training is also scheduled (on an ongoing basis) to new staff members through SHSC staff induction.

We are looking to co-ordinated the full day training through Business as Usual (BAU), currently there is insufficient capacity in the training team to co-ordinate training package, solutions are being sort.

1.2.2 ROOTS assessments (a measure to understand how trauma informed teams and care is being delivered and how to improve) is actively being worked on in a total of 10 teams. Some of the original Pilot teams (CERT) are embarking on a re-audit. Where there is opportunity to link this to new transformation (e.g. Older Adults) we are actively encouraging this to reduce siloed work.

A Roots Community of Practice has developed this brings teams together to share challenges, barriers, good practice and outcomes for service users and teams.

The linked Complex Emotional Needs (CEN) Pathway plan was developed and signed off in November 2023. Significant progress has been made with 53% of the outputs in the plan set are either achieved or on track. 15.4% are no longer needed and 30.8% of tasks not started.

Implementation Plan developed November 2023	Total outputs/ **things set out to achieve**	Complete based on original plan		On track		Delayed		No longer required/ amended / on hold (n)	% not needed	Activity Not started (n)	% not started
		Complete (n)	**% complete**	On track (n)	On track (%)	Delayed (n)	Delayed (%)				
Complex Emotional Needs	**26**	9	**34.6**	5	19.2	0	0	4	15.4	8	30.8

Key successes of this workstream include a full mapping of service criteria from a number of services who typically see people with CEN to understand pathways, criteria and interventions on offer as well as three co-production and engagement events. Service users, who identify with CEM will help work through starting to think about what CEM means for them and the use of appropriate language. The group will be supporting the development of a communication aid for service users to explain what support is on offer through different teams.

The Post Incident work has been completed resulting in a Post Incident Support Pack for teams and associated documentation which is available on Jarvis. Any further work will be managed through BAU: https://jarvis.shsc.nhs.uk/system/files/2024-09/Post%20Incident%20support%20reference%20pack%20final.pdf

1.3 Person Centred Workstream

The Person Centred Workstream delivered its key outputs; principles of Person-Centred Care and the Framework through which to embed these in Teams through the move from CPA.

Plan developed January 2023	Total outputs/ things set out to achieve	Complete based on original plans		On track		Delayed		No longer required/ amended / on hold (n)	% not needed	Activity Not started (n)	% not started and not required
		Complete (n)	**% complete**	On track (n)	On track - to embed through BAU (%)	Delayed (n)	Delayed (%)				
Person Centred Workstream	**27**	14	**51.9**	6	22.2	2	7.4	5	18.5	0	0

The Framework defines an approach for NHS staff to consider how their local team approaches the move from CPA to be more meaningful for their service users whilst strengthening their person-centred/ evidence led approach to care planning.

In summary, this will be through a combination of:

- directly measuring how person centred their practice is locally through feedback from service users accessing their service, via a person-centred tool
- understanding how and when Patient Reporting Outcome Measures (PROMS) collected from service users, will be managed to support their journey to recovery

This workstream has closed, in terms of developing its outputs but will continue to now embed these through BAU.

1.4 Evidence Led Workstream

Work has been ongoing, since 2022 to implement Year 1 and Year 2 of the Research Innovation and Effectiveness Strategy objectives. These will also be reported to the Quality Assurance committee elsewhere.

Implementation Plan developed September 2022 -	Total outputs/ things set out to achieve	Complete based on original plans		In progress OR Business as Usual (BAU)		Delayed		No longer required/ amended / on hold (n)	% not needed	Activity Not started (n)	% not started
		Complete (n)	**% complete**	On track (n)	On track (%)	Delayed (n)	Delayed (%)				
Priority 1; becoming evidence led	**13**	2	**15.4**	8	61.5	2	15.4	0	0	1	8

Priority 2; developing equipped workforce	**11**	8	**72.7**	3	27.3	0	0	0	0	0	0
Priority 3; being engaged, inclusive and accessible	**12**	6	**50.0**	6	50.0	0	0	0	0	0	0
Priority 4; building partnerships	**7**	5	**71.4**	2	28.6	0	0	0	0	0	0

A significant amount of work has been conducted to develop a comprehensive PROMS training and implementation package across teams. PROMs Training delivered to Urgent and Crisis (Single Point of Access and Out of Hours), Forest Close, Older Adults Crisis and Home Treatment Team and Older Adults Medics with training in progress for Early Intervention Service, Acute Inpatient Wards. Pathway development work is being undertaken with Crisis and Home Treatment Team, Homeless Assessment and Support Team (HAST), Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) Service, Forest Lodge, Perinatal Mental Health Service and Long-Term Neurological Conditions (LTNC).

EBO, the patient facing app, which will allow the completion of PROMS by service users and integrates with Rio will be used at SHSC. Workshops to train staff begin in November 2024. The functionality of this is dependent on the roll out and implementation of Rio across all Trust services (anticipated to commence in March 2025).

PROMS Delivery Overview: a Total of 32 teams appropriate to work with across SHSC		
	N	% of total (32)
Teams approached and engaged with PROMS work	**29**	**90**
Teams who have completed mapping their PROMS to model, agreed PROMS and been Trained in their use	12	38
Teams who have completed mapping their PROMS to model, agreed PROMS	11	34
Teams approached, mapping model/considering interventions and plan of approach agreed	6	19
Teams due training/ training booked	7	22
Teams yet to approach/ no work to date	3	9

A formal Evaluation Implementation Evaluation Report received from Yorkshire Improvement Academy provided useful insights into how to complete a successful implementation. The findings provide the opportunity to inform our learning and shape future approaches, that can be applied to other implementation projects. The full report is available as appendix 2

The **3 PROMS (ReQoL, Goal Based Outcomes and Dialog) are now built into Rio** (including the graphical displays) and ready to use for “go live” which is a significant piece of work which has been completed. A “How to” guides and associated videos to support staff and service users are in development.

A series of PROMS data workshops will commence in November 2024 to continue the further embedding PROMS to allow teams to start to consider the quality of data collected and how to meaningfully interrogate the data which will be collected to support service users.

A video for staff and external partners has been developed to articulate the evidence led workstream and forms another part of the communication archive linked to the strategy

1.5 Strengths based Workstream

The Strengths based workstream was developed in September 2023 once it was separated from the Person Centred workstream but despite this and leadership changes, significant progress has been made to develop key outputs delivering almost 62% of outputs.

Plan developed September 2023	Total outputs/ things set out to achieve	Complete based on original plans		On track		Delayed		No longer required/ amended / on hold (n)	% not needed	Activity Not started (n)	% not started
		Complete (n)	**% complete**	On track (n)	On track (%)	Delayed (n)	Delayed (%)				
Strengths based workstream	**21**	13	**61.9**	3	14.3	1	4.7	4	19.0	0	0

A single page document forming part of the care planning documentation has been developed to support teams in gathering strengths-based information from service users. This will be linked to Rio once it has further been refined to consider any additional questions linked to the other pillars – making these **clearly linked to the actual data collected and therefore make it measurable.**

The strengths based workstream has worked with the evidence led workstream to incorporate strengths-based element into the PROMS training, strengthening the pillars through linkage together.

The workstream has also conducted several pieces of communication through articles and videos, stories which strengthen the reach of the workstream across the organisation. Alongside this, more staff have been recruited to the Steering Group for the workstream.

1.6 Embedding the Strategy as Business-as-Usual 2024- 2026:

The key focus for 2025 is to support teams to fully embed the Clinical and Social Care Strategy into existing structures as business as usual. The process for achieving this will be through embedding the frameworks in business planning structures: growing outcome measures within Rio and using QI methodologies. Alongside supporting/developing team cultures to embed care that is Person-centred, Strengths-based, Trauma-informed, and Evidence-led as principles for care.

This process aligns with year 4 and year 5 strategy objectives outlined in the initial plan related to Transforming care in Sheffield and across the system. Work continues with the four key large transformation programmes in our Learning Disabilities Services, Primary and Community mental health, Acute Care Pathways and Older Adult services to ensure delivery of good quality care for people who use our mental health services. Alongside this we have been contributing to the development of the system work through the South Yorkshire Mental Health Learning Disabilities and Autism Provider Collaborative as leading members of the Clinical and Care Professional Assembly.

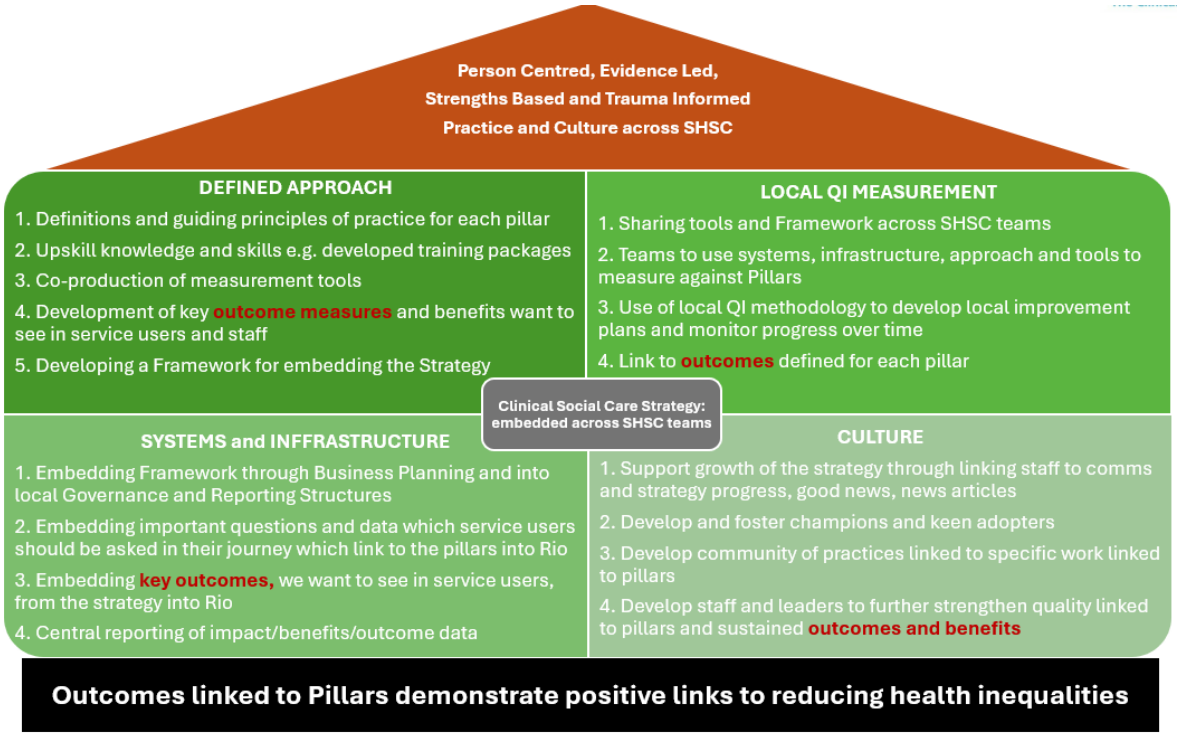
The workstream leads and strategy implementation group have recognised that there are multiple strands of interconnectivity across all the workstreams some of which are highlighted below:

- PROM implementation will deliver evidence led, person centred and strengths-based care
- The person-centred framework and measuring against the principles will support delivery of evidence led and person-centred care through embedding PROMS locally in teams
- There are points of interconnectivity and overlap between ROOTS and the other measurement tools

There has been an acknowledgement that although workstreams initially individually set off to define their pillars, and questionnaires and tools which would support embedding each pillar, there is now a need to pull this together into one, coherent offer for the organisation in its sustained and measurable uptake.

The implementation team is developing a Framework to continue to embed the work conducted, into clinical and operational teams through the Business Planning cycle and this to be monitored through the SHSC Performance Framework and IPQR dataset.

The concepts of embedding the products of the work into BAU and Rio through to working in a culture which supports these ways of thinking can be seen in the diagram below:



A draft of the Framework has been developed and the implementation team are looking to further co-produce appropriate screening tools, readiness checklists, documents, processes and measures to allow us to finalise this next year. Associated with this will be the focus on Rio (data and measures to support teams in working in this way and measuring its impact) as well as the cultural work happening through the people directorate (reported elsewhere).

A final version of the implementation or delivery plan/roadmap will be developed for the remaining 2 years which encompasses the above.

We have worked with the Planning and Performance team in setting objectives for the strategy linked specifically to this work for next years' service objectives. This will support reduced duplication of efforts, reduce siloed working and connect all teams through different channels to the same work.

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 delays in developments of Rio which has impacted on our capability to develop systems that support collecting some programme outcome data. We have noted the risk of being unable to accurately reflect the impact of our transformation work within the Benefit section of the rag rating for the programme.

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.

2.4 An new Issue linked to the roll out of Trauma Informed Training through Business as Usual has been identified and added to the Programme risk register; there is insufficient support available in the organisation to support the coordination of the full days training.

Section 3: Assurance

Take assurance from the progress made, ongoing actions and next steps outlined this report

Section 4: Implications

Strategic Priorities and Board Assurance Framework. The key issues and BAF Risks to be considered are: Digital /IT: Reliance on legacy systems and technology compromising patient safety and clinical effectiveness

Section 5: Recommendations

Trust Board are asked to note in relation to the risks identified:

- The Clinical and Social Care Strategy Programme has been rated with an overall status of Green. There have however been delays in developments of Rio which has impacted on our capability to develop systems that support collecting programme outcome data.
- 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.

Section 6: Appendices

Appendix 1 Slide set
Appendix 2 PROMS Implementation Evaluation Report SHSC 2024

Appendix 1

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Clinical and Social Care Strategy (November 2024 update)

Linda Wilkinson – Director Psychological Services
Chin Maguire – Programme Manager

Proud to care in Sheffield

Our Clinical and Social Care Strategy 2021- 2025/26

Our Vision

To improve the mental, physical and social wellbeing of the people in our communities.

Strategic aims

Deliver outstanding care. **Create a great place to work.** **Effective use of resources.** **Ensure our services are inclusive**

The Clinical and Social Care Strategy

We will give care that is

- Person-Centered /strengths base
- Evidence-Led
- Trauma-Informed
- Coproduced

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 TeamSHSC

Care that is:

Person-centred	Trauma informed	Evidence based	Strength based

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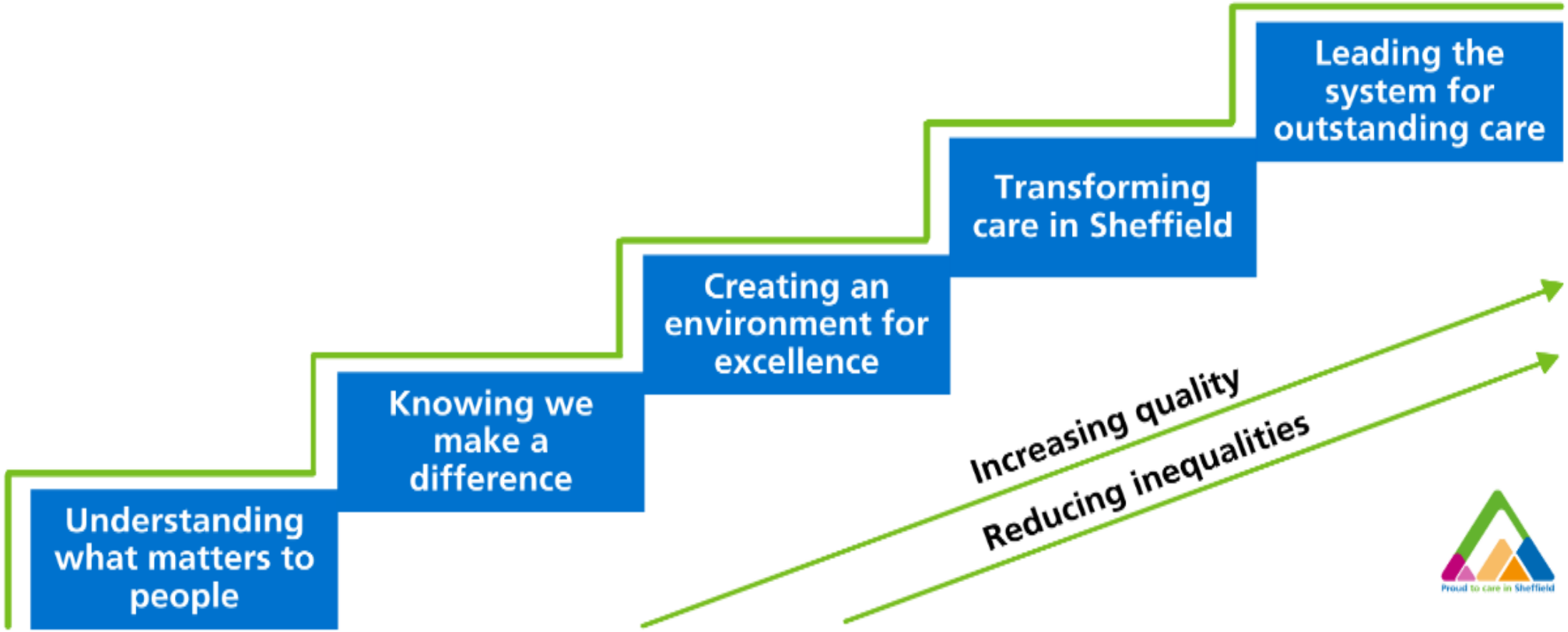
Primary Care	The City	The Wider System



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Key Assurance Points and Impact of the Clinical and Social Care Strategy (CSCS)

Sheffield Health and Social Care NHS Foundation Trust

TOTAL	Total outputs / things set out to achieve	Complete based on original plans		On track		Delayed		No longer required/ amended / on hold (n)	% not needed	Activity Not started (n)	% not started
		Complete (n)	% complete	On track (n)	On track (%)	Delayed (n)	Delayed (%)				
	163	78	48	41	25	11	7	20	12	13	8

- **73% of tasks completed or on track**
- The Clinical and Social Care Strategy Programme has been rated with an overall status of **Green.** Significant progress has been made with Person Centred and Co-production Workstreams, all tasks are now completed, with work embed and continuing in services as business as usual. We are confident that all the remaining tasks will be complete for the end date of 2026.

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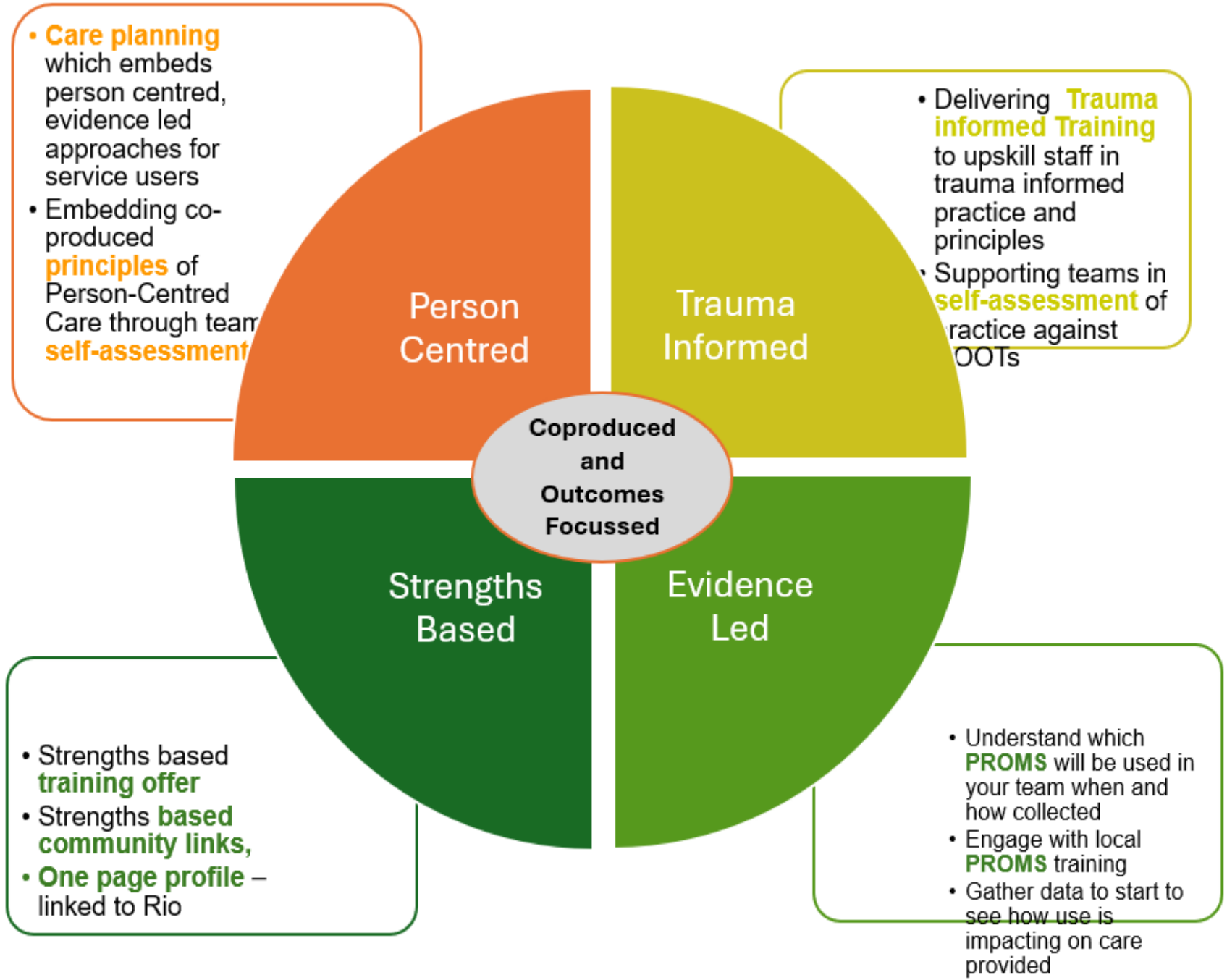
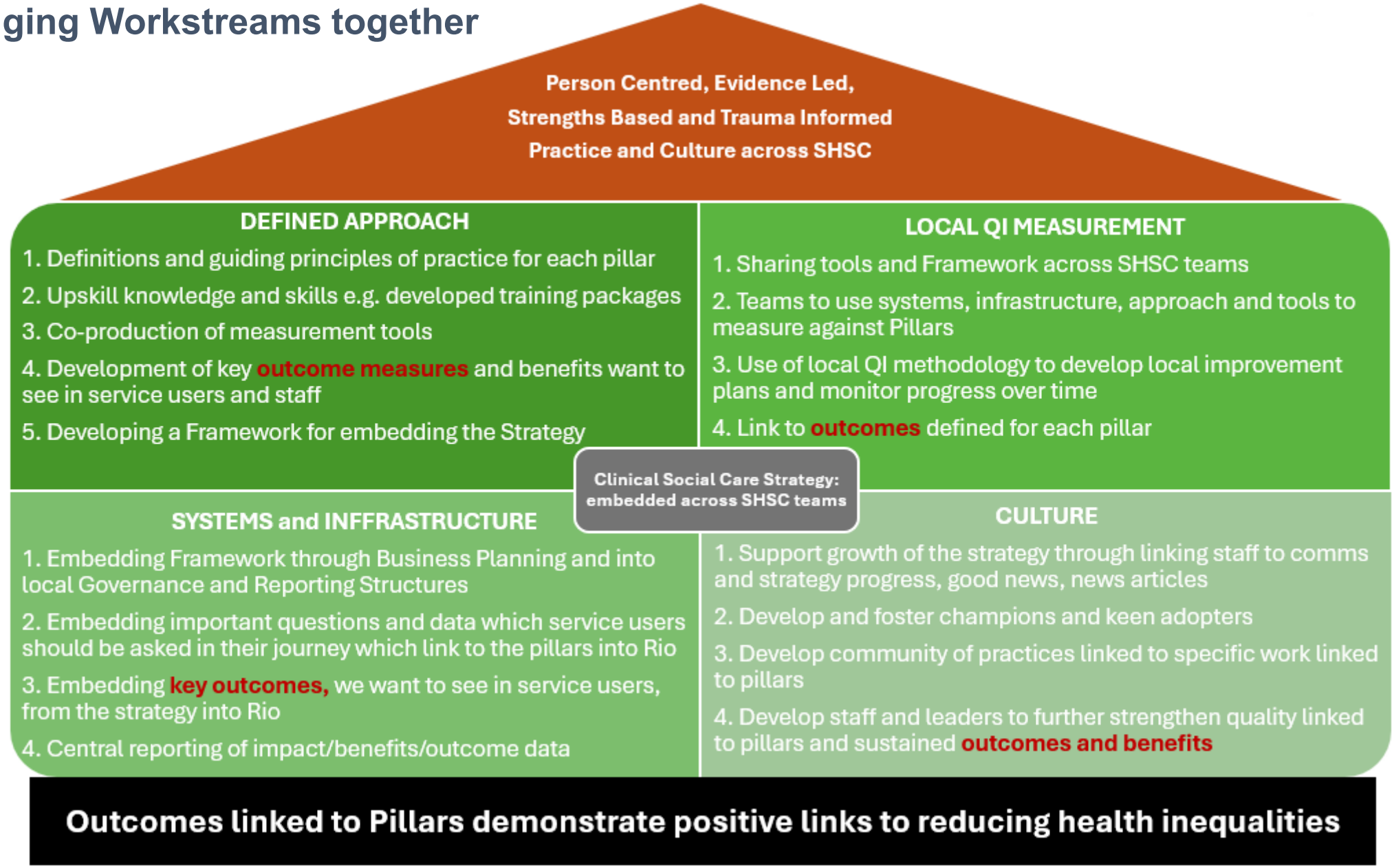
Fully Embedded strategy Business as usual - Locally Embedding Person Centred, Trauma Informed, Evidence led, Strengths based approaches across SHSC Teams



Bringing Workstreams together



One Pager

Sheffield Health and Social Care NHS Foundation Trust

Overview

This is a short document for professionals I come in contact with. It has important information about what is important to me, people who support me and things that I want you to know about me as a person.

This should not contain clinical information and focuses on my strengths.

Name:

Date last updated	Jan 7, 2030
Key Information	**What is most important to me?** Include hobbies, things I enjoy doing, things that keep me well, **Places I go/where I access them:** Faith groups, community hubs, peer groups
People who are important to me	**People who are important in supporting me with my mental health:** **Other people who are important in my life:** Add context
Please Do and Please Don't	**When working with me, please do** think about ways of communicating, things that are helpful to talk about/ask me **Please don't** things that are unhelpful
Also worth knowing about me	**Anything else that I would want you yo know about me as a person**

Relevant Resources

My Toolkit (Sheffield Mental Health Guide)

My Toolkit | My Toolkit (sheffieldmentalhealth.co.uk)

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Updated links to business planning within SHSC 2025

Sheffield Health and Social Care NHS Foundation Trust

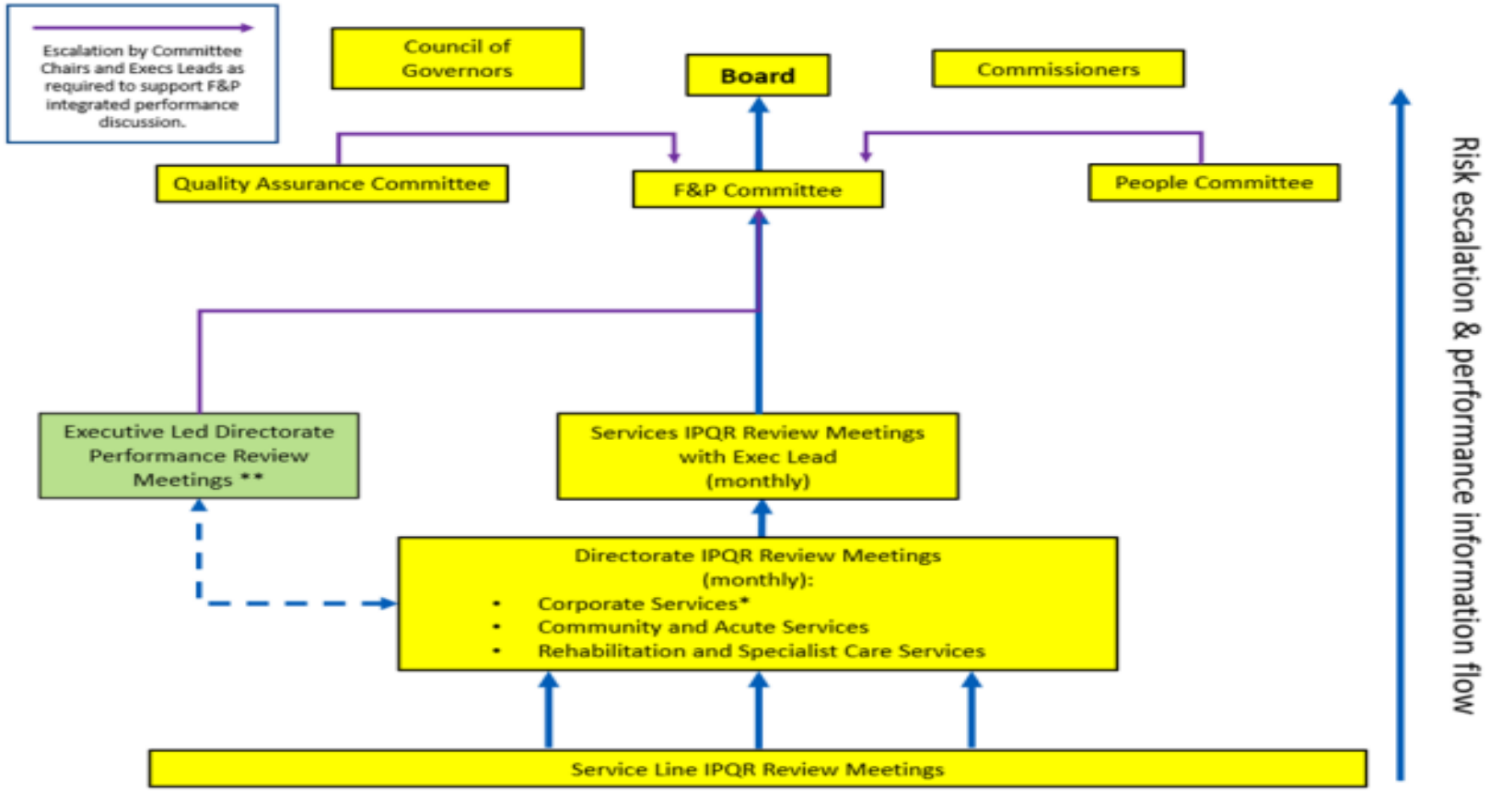
Suggested pick lists for service objectives

Clinical and Social Care Strategy… choose one or two

- Option 1: Becoming more trauma informed through staff attending trauma informed training
- Option 2: Becoming more trauma informed through conducting a ROOTS assessments where service users and (separately) staff assess how trauma informed your team is
- Option 3: Becoming more evidence led through the implementation of patient reported outcome measures (PROMS)
- Option 4: Becoming more person centred through measuring the principles of person-centred care

IPQR accountability and assurance structure for BAU

Sheffield Health and Social Care NHS Foundation Trust



* Less frequently

** Look back at key challenges, achievements, issues, current picture, looking forward so broader than performance review, e.g. strategy, transformation, system integration, showcase achievements and best practice

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Figure 1: Internal governance, reporting and escalation for the Performance Framework

Resourcing CSCS into BAU

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Key Issues to in Focus for 2025

What support will teams need and where will they access it?

How will we support this being embedded into job roles?

Will link to the integrated CHANGE FRAMEWORK –

How do we bring it into other people's roles

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Summary

NHS
Sheffield Health and Social Care

- Embedding the Strategy as Business-as-Usual 2025- 2026- using Business planning cycle to engage teams and offering a coordinated approach from all workstreams
- Aligns with year 4 and year 5 strategy objectives outlined in the initial plan related to Transforming care in Sheffield and across the system.
- Clinical and Social Care Strategy achieved 73% of tasks completed or on track. 12% are no longer needed -progressed in other work plans. 7% of tasks are delayed with 8% not yet started this is largely linked to the Outcomes and Benefits workstream (approved August 2024).
- Significant progress with Person Centred and Co-production Workstreams, all tasks are now completed, with work embed and continuing in services as business as usual.
- We are delivering care that is **Trauma informed**: evidenced in Roots- Complex emotional needs pathway and Post Incident Support Pack
- **Person Centred**: person-centred/ evidence led approach to care planning.
- **Strengths based**: A single page document forming part of the care planning -gather strengths-based information from service users
- **Evidence Led:** 3 PROMS (ReQoL, Goal Based Outcomes and Dialog) are now built into Rio – training for all clinical teams.

Implementation evaluation of Patient Reported Outcome Measures within Sheffield Health and Social Care NHS Trust

Introduction

Community mental health services (CMHSs) in England are undergoing radical change including place-based integration with primary care and voluntary sector services, as set out in the Community Mental Health Framework (CMHF) (1). In 2023, to promote person-centred (2), rights-based (3) and outcomes-led care, NHS England directed all community mental health services (CMHSs) across England to begin using Patient Reported Outcome Measures PROMs as part of routine care. They chose 3 PROMs (ReQoL-10, DIALOG and Goal Based Outcomes) as the ones that all CMHSs should use.

Patient-reported outcome measures (PROMs) are questionnaires designed to record patients' views about issues that matter to them. They may ask about patients' health, their symptoms, or their treatment goals. When they are used regularly, PROMs can help show the effects of the care and treatment patients have received. Because PROMs focus on issues that are important to patients, they can support more equal decision-making, and improved experiences and outcomes of care. PROMs information that is gathered from large, diverse groups of patients can help NHS decision makers learn what is important to patients and take steps to reflect this in delivering care.

If PROMs are to have a positive impact on patient outcomes, they not only need to be effective as an intervention, but also need to be implemented and sustained. There is currently not enough clear evidence on how to implement PROMs successfully and research is needed to inform NHS decision makers about the best way to introduce, deliver and support the use of PROMs.

Implementing PROMs remains a challenge

Many attempts to implement PROMs into routine healthcare services have failed, and even determined efforts have encountered significant obstacles (4-8). Patients and staff can have mixed feelings about using PROMs. There are worries about the impact of some questions, the time needed to complete PROMs and how the information gathered will be used. PROMs remain underused in mental healthcare (8, 9). Barriers to implementation have included challenges of data collection, poorly developed reporting systems and lack of integration with clinical systems (4). These challenges are exacerbated by failure to articulate the aims and benefits of using routine PROM data and by the dearth of evidence about their effectiveness in improving outcomes (10-12). In the NHS, PROMs were collected and reported at provider level in England between 2009 and 2017 for patients undergoing varicose vein, groin hernia and hip and knee replacement surgery. The programme was beset by high rates of missing data (with as few as 19% of patients having pre- and post-operative PROMs data) and was estimated to have cost around £800k pa. There was little evidence of improvement in provider outcomes (9).

Learning more about PROMs implementation

Understanding the practicalities of implementation and achieving implementation plans for innovations such as PROMs is highly complex. The implementation of innovations like PROMs takes place in open systems characterised by dynamically changing relationships and tensions (13). Individuals responsible for the implementation process need to use creativity to generate pragmatic solutions to local contextual challenges that arise during implementation. Over time, circumstances

continue to change, so these individuals will need to continue to adapt what they do (14). Good implementation outcomes rely on this process of innovation development, ongoing adaptation and testing (15, 16), a process referred to here as 'within-system learning'. It seems appropriate then that if we are to understand 'how to' implement PROMs, we should focus our research efforts on learning from those on the ground engaged in 'doing' implementation such as implementation teams, and how they navigate complex health systems and the implementation challenges these present.

This evaluation

Between September 2023 and May 2024, Dr Kristian Hudson, an implementation specialist from the Yorkshire and Humber Improvement Academy carried out a preliminary evaluation of the implementation of PROMs in CMHSs provided by Sheffield Health and Social Care NHS Trust (SHSC). Rather than simply explaining the outcomes resulting from PROMs implementation efforts within SHSC and understanding what contextual factors slowed, halted, or supported their uptake, this evaluation went a step further. It also aimed to capture in detail the ongoing interaction between the components of PROMs, the context of PROMs implementation and how these factors interacted with the approach of the implementation team and what outcomes this led to. This was ensure SHSC would be able to capture important practical implantation learning as it occurred and generate transferable knowledge for future attempts or other Trusts attempting to implement PROMs.

The PROMs implementation team

The implementation of PROMs within SHSC has been supported by an implementation team made up of a programme manager, a clinical effectiveness manager and Clinical Outcomes Lead (COL). The goal of this team has been to oversee, attend to and be accountable for facilitating key activities in the implementation of PROMs. This experienced team was formed to provide a foundation for effective implementation by leveraging members' diverse skill sets and perspectives and ensuring that the context for implementation is ready and supportive of implementation.

The evaluation approach taken

This evaluation drew from learning evaluation principles (17), which encourage the capture and feedback of ongoing learning in an iterative and informative way. It also combined the use of a widely used implementation science framework (CFIR 2.0: Consolidated Framework for Implementation Research) with ongoing rapid qualitative analysis using Stanford Lightning Reports. The approach involved baseline and end-point in-depth interviews with the implementation team, and a series of short contact interviews throughout the implementation process. Lightning reports were produced during the short contact interviews and were shared with the implementation team, thus providing actionable feedback and supporting within-system learning. They are included with this evaluation.

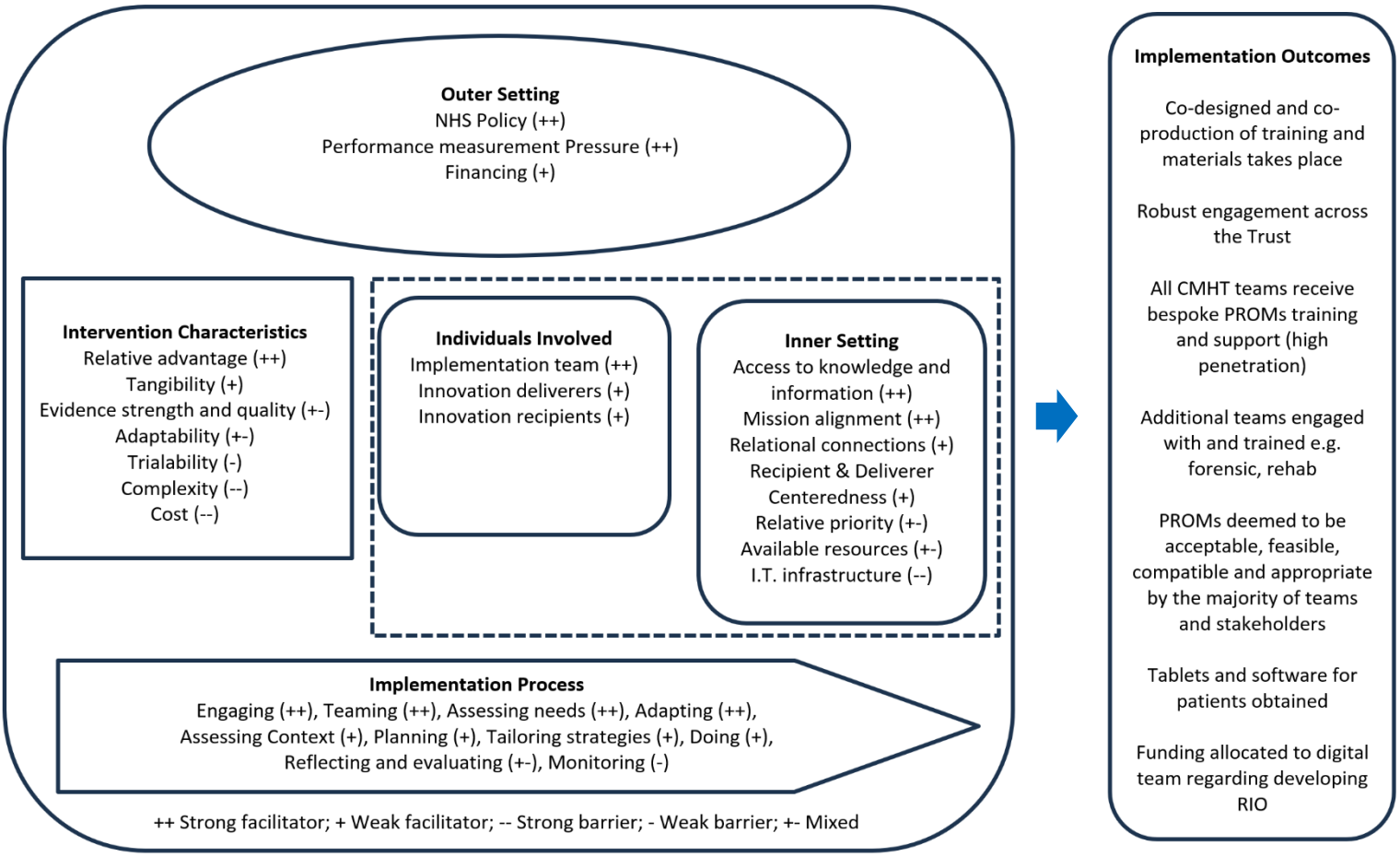
The in-depth interviews asked participants questions around their experiences of implementing PROMs. Each lightning report described what participants perceived to be going well, what was a challenge and any relevant insights in regards to the implementation of the PROMs. Data from the interviews and lightning reports was coded with CFIR 2.0 indicating the most prevalent barriers and facilitators to PROMs. The data was also analysed for what implementation strategies seemed to work best, and how the team saw PROMs implementation being sustained going forward. Implementation outcomes such as adoption, and penetration were also recorded along with acceptability, appropriateness and the feasibility of PROMs. These findings were put together into an

implementation research logic model in order to explain how the context and implementation strategies interacted to result in the final implementation, service and patient, clinical outcomes.

The results

Barriers and facilitators to PROMs implementation were identified across all five CFIR domains and included 30 different implementation constructs. As the figure below shows, the strongest facilitators of implementation were present in all five CFIR domains and included relative advantage, NHS policy, performance measurement pressures, access to knowledge and information, mission alignment, implementation team members, engaging, teaming, assessing needs and adapting. The strongest barriers included cost and complexity in the intervention characteristics domain and IT infrastructure in the inner setting domain. Implementation outcomes are also shown. The implementation team navigated the complex system of SHSC and the complexity of PROMs implementation using various approaches as shown in the process domain leading to outcomes such as PROMs being widely accepted across SHSC and all CHMT teams being trained.

Figure 1: Strong and weak facilitators and barriers to implementation of PROMs by Consolidated Framework for Implementation Research (CFIR) domain as well as their relation to implementation



These findings were analysed further to create a narrative of the implementation effort including what impacted it and what helped. This led to the creation of four main themes as shown in Table 1 below: 1) The characteristics of PROMs; 2) The importance of outer setting support and organisational support 3) Contextual challenges; 4) Drivers of implementation. Each theme is described in detail below.

Table 1: Consolidated Framework for Implementation Research (CFIR) domains and constructs associated with themes

Theme	**CFIR domains**	**Constructs**
1. The characteristics of PROMs	Innovation Characteristics	Relative advantage Tangibility Adaptability Evidence strength and quality Trialability Complexity Cost
2. The importance of outer setting support and organisational support	Outer Setting Inner setting	NHS policy Performance measurement pressure Financing Mission alignment Recipient Centredness
3. Contextual challenges	Inner setting Individuals involved Process	Access to knowledge and information Innovation deliverers Available resources Relative priority IT infrastructure and monitoring
4. Drivers of implementation	Inner setting Individuals involved Process	Engaging Assessing Needs and Context Tailored training and support Co-production, Co-design and PPI Teaming and Implementation team members Relational connections Planning Adapting Doing Reflecting and evaluating

Discussion of themes

1. The characteristics of PROMs

The perceived advantages of PROMs over current measures and approaches aided its implementation. So did its tangibility. The PROMs measures are research validated which also supported their implementation but evidence around effectiveness in real world settings will take time and remains to be seen. There is a rigidity to the measures but the fact teams can adapt and tailor how they are delivered supports their implementation. PROMs are not something that can be trialled, rather the implementation team needed to implement them across the system all at once which makes them a particularly complex intervention to implement.

Relative advantage (++)

The implementation team felt there was a general feeling that PROMs could bring additional value to mental health services as they would be better able to capture and demonstrate the impact of these services. There was a general consensus across the Trust that much of the quality work in mental health services was not adequately captured or quantified. Current qualitative assessments describe what has been done but fail to measure numerical changes. PROMs was therefore something which could help address this gap by providing tools to capture data both on an individual and aggregate level. In theory this should allow clinical teams to identify key points of change and focus on successful practices.

This belief that PROMs represented an improvement over existing measures was a clear facilitator of its implementation. Teams could see value in having consistent measures across the board, though there was some concern about over-reliance on specific tools like ReQoL or The Dialog Scale. Despite this ensuring that the measurement of outcomes was standardized was deemed essential for meaningful analysis and continuous improvement and in comparing data across different teams.

Tangibility (+)

Another facilitator of PROMs was the fact they are straightforward and tangible, making them easier to understand and implement compared to broader, less specific goals like being more evidence-led. Their use can be clearly defined which helps decision makers and implementers easily identify and manage the relevant strategies and evaluations and prevents the message from becoming diluted or lost amid more general objectives. As one of the implementation team stated *“using these outcome measures, you are providing evidence for the value of your service”.*

Evidence strength and quality (+-)

All of the PROMs have been developed through a scientific process and are evidence based which was seen to support their adoption. However, the Trust was not seen to be in a position to thoroughly interrogate PROMs measures to demonstrate their impact on service user journeys, either individually or in aggregate. This meant no one would fully understand what PROMs could do until a large amount of data had been collected. This would likely take years. So although PROMs stems from a scientific process there is still little understanding of their actual effectiveness in wider practice**.**

Adaptability (+-)

The implementation team emphasised having to find the balance between adherence to PROMs, which are research-validated tools, and flexibility in implementation. The questions asked in PROMs cannot be changed but teams could be given significant flexibility in how they planned to implement these tools which clearly aided implementation. For example, decisions on the pathway, timing, and personnel involved in using the PROMs could be tailored to fit their specific context. While the technology requirements and processes could make adaptation challenging, there was an acknowledgment that rigid guidelines may not always be effective. Customizing the implementation to different settings and ensuring collaborative efforts was deemed to improve ownership and outcomes. Tailoring the implementation process collaboratively helped teams take more ownership and ensures the core elements of PROMS was consistently engaged with, despite differences in execution

Trialability (+)

PROMs was not an innovation the team felt could be trialled in one team or setting and then rolled out more broadly which made their implementation all the more challenging. From the implementation teams point of view, implementing PROMs in only one ward or team would only demonstrate its effectiveness in that specific setting, not across the entire trust. More importantly it would not address the broader question of whether PROMs had been properly implemented trust-wide and this was a necessity due to the way PROMs works across pathways. Service users move through multiple teams and services, from A&E to liaison, inpatient units, and various community teams. All these teams need to use PROMs in a coordinated manner. A joined-up implementation approach is therefore necessary for consistency across the entire pathway of care and to learn how to tailor PROMs to different settings. The team's goal was therefore to ensure all CMHT services were familiar with and trained in PROMs rather than just one team or bubble. This made implementation of PROMs all the more challenging but was deemed totally necessary to ensure an understanding of implementation and that the pathway for service users would be consistent.

Complexity (--)

Service users were described as interacting with multiple teams throughout their care journey—such as A&E, assessment units, inpatient care, and community teams. It was crucial that all these teams used PROMs consistently to ensure a cohesive approach to tracking and improving patient outcomes. Of course, integrating PROMs across all of these different teams workflows was highly complex and presented challenges for the training and implementation. While it was reported as fitting well on some levels, there were significant challenges in linking it effectively into systems and training staff, particularly in settings like urgent and crisis care where there was initial resistance to using PROMs. PROMs were felt to be relatively straightforward for both clinicians and patients to use. However, there were concerns about potential misuse of the data, such as making incorrect assumptions based on the information collected. Again, this may be a potential barrier to PROMs effectiveness in the future. It is also unclear how far much needed adaptations (such as translations into other languages) means they lose their effectiveness.

Cost (--)

The implementation team were careful to highlight how costly implementing PROMs can be. For SHSC there were significant time and financial costs involved in setting up and maintaining digital solutions for data collection. These costs included ongoing support and staffing. The team

also had to invest in digital tools, such as tablets for data entry, which proved to be more expensive than anticipated. This expense covered not just the technology itself but also the infrastructure needed to process and manage the data. There was some concern that the high cost of implementing digital solutions might exacerbate existing health inequalities. Issues such as language barriers and access to technology may be worsened by the additional costs and complexities. The implementation team have learnt over the last two years that it's important to thoroughly understand and plan for the financial and resource implications before starting a PROMs project. Costs are often underestimated and can be substantial, including expenses for electronic translations and other support resources. There is also the cost of ensuring the right IT infrastructure, training, ongoing support from an implementation team, and things like language translations.

2. The importance of outer setting support and organisational support

The theme represents the power of the formal systems around SHSC and how they greatly facilitated PROMs implementation to take place. These may be referred to as 'make or break' variables as if they were not present, it would have been a lot less possible for PROMs to be successfully implemented.

NHS policy (++)

One of the implementation team described how they had been pushing at getting PROMs implemented for years but it had never had enough external momentum. Now there was a strategic need for it which was perceived to be driving implementation. The external environment surrounding the services within SHSC was described by the implementation team as being particularly favourable to PROMs implementation. For example, NHS England decided to recommend the use of the PROMs across all mental health community services in the UK. This helped put 'PROMs to the top of the list' and aided a significant organisational push towards their use.

Performance measurement pressure (++)

Another strong facilitator of implementation was that NHS England were requiring CHMTs to start delivering PROMs data by the end of March 2025. There was also consideration of incorporating PROMs into regular trust audits to formalize and sustain their use. The team felt that PROMs was increasingly expected to become a regular part of trust audits, ensuring ongoing monitoring and sustainability. Embedding PROMs into routine practice and demonstrating their effectiveness through performance reviews was seen as a significant implementation facilitator. It could make PROMs an integral part of long-term strategy and transformation efforts in mental health services and increase the motivation of clinicians to adopt and use them.

Financing (+)

Ensuring adequate funding was seen as crucial for sustaining and supporting the use of PROMs in mental health services. NHS England's mandate for PROMs led to increased funding, which allowed the appointment of dedicated roles, such as the COL. This funding supported various aspects of the transformation work, including training and service user involvement, highlighting the importance of financial resources in effectively implementing and maintaining these initiatives. However additional training, venues, and food costs money and the implementation team have had to be very careful what they spend the money they have on. The project will need

the same money again next year and there is uncertainty around that. It's not clear where the cost of further translations of PROMs will come from. Funding was found to make the implementation support practitioners role more permanent, and this had a highly beneficial impact on implementation during the evaluation as it meant engagement and training could continue.

Recipient centredness (+)

Overall, the culture of SHSC and the way the implementation team worked emphasized integrating PROMs meaningfully into patient care, ensuring it was person-centered and balanced, and addressed practical and cultural challenges to avoid worsening existing inequalities. SHSC care strategy supported this by maintaining a focus on patients' strengths instead of their problems, ensuring that care is tailored to the individual rather than a one-size-fits-all. This aligned well with the use of PROMs which the team stressed would only work if it genuinely influences the patient's journey through the service or pathway, rather than being a mere tick box exercise. The implementation team's concern for patient needs stemmed beyond... For example, there were concerns that the implementation of PROMs could exacerbate health inequalities, particularly if it imposes additional burdens or fails to accommodate diverse needs, such as language barriers.

3. Contextual Challenges

This theme represents all of the contextual challenges and facilitators the implementation team had to contend with and how far they impacted implementation positively or negatively.

Availability of knowledge and information (++)

A key strategy of the implementation team was to develop tailored, bottom up, and bespoke training for the teams' implementing PROMs within SHSC Trust. This was a hugely beneficial step towards the initial adoption of PROMs as it meant the teams had access to training around PROMs that worked for them. The training was co-produced and co-designed, also co-led by service users in the delivery. The COL would go and talk to teams and design training for them based on their needs and pathways making it highly collaborative and adaptive. 'How to' guides on the EPR system for how to input the PROMs as well as an intranet page were also created. People were able to download the different measures, in different languages.

The training was well received by teams, demand for it remained high, and there was an ever-growing waiting list of teams across the Trust. The result of this was that all CHMT teams were eventually trained and additional teams started taking it up e.g. forensic and rehab teams.

Innovation deliverers (+)

Most staff found PROMs to be acceptable which aided its implementation but not all the reactions to it were positive. Some staff were enthusiastic and eager to adopt it, while others were sceptical or fatigued by constant changes which could affect receptiveness (e.g. frequent new agendas and transformations). The implementation team felt that some clinicians struggled to see the practical value, viewing it as a checkbox exercise rather than a meaningful tool, but other clinicians were genuinely motivated by the potential benefits. Support workers were keen to have something a little bit more structured to reflect the work they do. Some teams were

proactive and requested additional training, while others needed more encouragement to engage fully. Leadership and the medical director were facilitators for PROMs implementation.

Available resources (+-)

Resources were a significant challenge to the implementation of PROMs. Teams within SHSC faced overwhelming caseloads and competing demands, leading to a lack of time and capacity for additional tasks. Most teams were quite keen to be involved but their main concerns were time and the practical aspects of using PROMS.

As one of the implementation team members said:

"Add an extra couple of years to it. I would say if you're doing it in an NHS setting, just don't underestimate the amount of time it's going to take because of everyone's capacity" (Clinical effectiveness manager).

Relative priority (+-)

Keeping PROMs a consistent priority was also difficult. There were a lot of transformation strategies and change programmes going on simultaneously which meant sites were all having to compete for the same resources and sometimes the same funding. All the people that were expected to feed into PROMS had clinical responsibilities which created additional competing pressure. These issues affected the pace of PROMs but did not stop its implementation as the team felt that the commitment to keeping PROMs a priority despite the challenges remained, with ongoing efforts to integrate it into broader strategies and keep it a focus.

IT infrastructure (--) and Monitoring data (-)

Extracting and processing the right data for the right people was surprisingly costly and difficult for the team. Far from being three paper questionnaires, PROMs needed to link in with care plans, clinical case notes, and be part of the clinical record which was electronic. The plan for the start was for the three PROMs to be available and used through a new EPR known as RIO. The system was in the process of changing from INSIGHT (the old system) to RIO (the new system). The technology needed to link seamlessly with care plans and clinical case notes within this new system to be effective. RIO needed to successfully output results from the measures for clinicians in real time for the project to work and for people to be able to evaluate the service as a whole. The implementation team had meetings with the RIO build team and data performance team to think about how the PROMs data would be captured in RIO. However, Rio was delayed. The system's readiness and functionality remained uncertain throughout the evaluation and there were concerns about the accuracy and usability of data if these systems were not properly aligned. It kept getting pushed back and by the end of the evaluation the RIO team said it was going to take another year.

There was also a need and keen interest to analyze the collected measures to demonstrate changes in the service user journey, both individually and in aggregate. The team had yet to finalize methods for tracking PROMs on the Rio system. Quantitative data and patient feedback were both crucial however the team felt the organization lacked data maturity, and they were working with the information team to specify and collect necessary data. Feeding back data to users, clinicians, and teams would be essential for understanding and utilizing the PROMs. It was thought that the different methods of data collection available (e.g., digital solutions, paper forms, text messages) may affect results.

To tackle this delay the team had initiated refresher training to maintain familiarity with PROMs, ensuring ongoing engagement despite the system issues. However, this delay in RIO's launch risked losing momentum, with no set date for it to go live, complicating the timing of additional training due to staff turnover. In some cases, the team explored using the old Electronic Patient Record (EPR) system, Insight, but this was basic and inadequate for their needs, supporting only one of the three necessary measures and lacking advanced data handling capabilities. Some teams had access to RIO but found it challenging to use PROMs and there were various issues that needed ironing out. Using pen and paper for PROMs was a fallback but the team felt this could undermine previous training efforts and engagement strategies. The team communicated with the CMHTs carefully to avoid demotivating staff, maintaining a positive message despite setbacks.

Overall, while progress was being made, the delay of RIO and the associated technological uncertainties posed significant risks to the successful implementation and use of PROMS. As the team faced hurdles with training, data management, and maintaining morale amid delays, the risk of the project's overall momentum and effectiveness was evident.

4. Drivers of implementation

The characteristics of PROMs, the outer setting, and the contextual challenges the team faced all had an impact on the implementation of PROMs. But what really drove implementation and allowed for a positive interaction between PROMs and their context was the concerted effort of the implementation team. The constructs within this theme and in Table 1 therefore represent all the things the implementation team did to support PROMs implementation.

Engaging (++)

The PROMs training was part of a larger process of engagement and this was the strongest facilitator for the implementation of PROMs across SHSC. The COL had a particular approach to this based on meaningful, flexible, and collaborative implementation of PROMs, ensuring that staff understood and valued their use, thereby fostering sustained adoption and integration into practice. PROMs had to be made important and valuable to practitioners' daily practice rather than just a formality. Past attempts to implement PROMs in SHSC had failed due to a lack of meaningful integration and understanding so the COL ade a point of proactive outreach. They would actively seek feedback, gather ideas, and learn from other trusts to overcome barriers and improve implementation. They would spend much of their time educating teams about the importance and practical benefits of PROMs, aiming to improve understanding and acceptance. The COL would provide teams with the necessary information and resources while encouraging them to tailor the approach to their needs. Regularly check in with teams, identify local champions to maintain momentum, and adjust strategies based on feedback. It was a grassroots approach recognizing that top-down directives are less effective. Her approach gained traction, with positive feedback and increasing demand for her training sessions and support.

Assessing needs (++) Assessing context (++) and Tailoring training and support (+)

The implementation team were excellent at collecting information about the priorities, preferences, and needs of the teams that would be adopting PROMs and taking part in the training. A key role for the COL was to align understanding and motivation with the benefits of PROMs. Some of the implementation team felt there was a lack of comprehensive understanding

within the organization about how to use PROMs effectively. Proper understanding and training was therefore crucial; otherwise, the quality of data collected could be compromised or the use of PROMs could diminish over time.

The COL customized training and support based on each team's needs and preferences. They emphasized a collaborative approach, working closely with different services to understand their unique needs and adapt the implementation plan accordingly. This involved engaging with various levels of the organization, from leadership to front-line staff, to ensure that the process is well-integrated and supportive. The COL preferred to engage with entire teams, not just their managers, to understand their specific needs and challenges. This helped in designing solutions that fit their actual day-to-day realities. Teams were encouraged to adapt the approach to fit their specific contexts, which increased their buy-in and likelihood of successful implementation. Feedback was continuously collected and used to refine the training and implementation process. This iterative approach ensured that the training remained relevant and effective for all teams involved. Overall, the focus was on collaboration, customization, and ongoing improvement to ensure successful implementation and adoption of PROMs across diverse teams. As one of the implementation team said:

"It's about them getting agreement on which ones to use, when and how cause they've all got different ideas".

The ISP outlined a comprehensive, adaptable approach to implementing PROMs across different mental health services and this is shown in Table 1.

Table 1: The implementation teams' approach to implementing PROMS across different mental health services
1. Initial contact: The Clinical Outcomes Lead (COL) starts by explaining what the specific recommendations from NHS England are and the trust wide strategic expectations for using PROMs, why they are needed and how other teams are using them. This helps teams understand the context and gather ideas on how to apply PROMs in their own settings.
2. Initial Diagram Pathway: The teams are presented with a diagram pathway outlining three specific PROMs and the suggested appropriate time points for using them. Teams are asked to think about how they would create a diagram or pathway showing how they will use the PROMs, tailored to their specific needs and service workflows.
3. Collaborative Development: The COL offers assistance in this process, either through direct collaboration or by reviewing their submissions and providing feedback. They might collaborate with the team by using flipcharts, scribbles, and post-it notes to figure out the details, or alternatively, the team can develop a pathway slide and send it for feedback.
4. Feedback and Tweaking: The COL reviews the diagram pathway, provides feedback, and helps the team tweak it until it is ready to be included in the tailored training.
5. Custom Training: Based on the completed diagrams, training is customized for each team. If a team decides not to use all three PROMs, the training focuses only on the

relevant ones. This approach ensures that the training is practical and aligned with the team's needs. During the training, the customized pathway is presented to the team again, highlighting who will complete which PROM, when and how?
6. **Contextual Adaptation**: The training session includes discussions on when certain approaches might not be appropriate and offers problem-solving strategies for adapting to different situations.

Co-production, Co-design, PPI (++)

The COL also engaged the recipients of PROMs and the public. They again adopted a collaborative approach to developing and delivering the PROMs training by co-producing the training package with two service users, who had been actively involved in both designing and facilitating the sessions. These service users shared their personal experiences of using and completing PROMs and emphasized the critical role of the introductory conversation in securing buy-in from participants. This part of the training is highlighted as essential for engagement. Additionally, the COL engaged with service users to gather their priorities, needs, and preferences, ensuring that the training was tailored to meet their requirements. This strong emphasis on co-design and patient and public involvement (PPI) ensures that the training remained relevant and informative.

Teaming (+) and implementation team members (+)

The implementation team also demonstrated a robust ability to work as a team and with other teams across the healthcare system which was also a significant facilitator of implementation. Each member had clear roles that complement each other's strengths. For example, one member exceled in planning and thinking strategically, while another was skilled in engagement and motivation. This diverse skill set has contributed to a well-rounded and effective team dynamic.

There was a shared responsibility for the implementation of PROMs, with various teams and individuals contributing rather than claiming sole ownership. The integration of PROMs was supported by multiple forces, including the digital team, which has helped in selecting appropriate software and provided crucial support. This collaborative approach reassured those involved that they were not isolated in their efforts.

The team worked flexibly across different areas and departments, collaborating with various stakeholders rather than sticking rigidly to departmental boundaries. This inclusive approach helps address issues more comprehensively and ensures that all necessary expertise is leveraged. There was a shared sense of ownership and support across the team, which helps in pushing the PROMs project forward. Having multiple forces and stakeholders involved reassures team members and mitigates concerns about isolation or lack of progress. Overall, the team's ability to integrate diverse skills, collaborate effectively, and engage with various stakeholders has been crucial in advancing the implementation of PROMS.

Relational connections (+)

The implementation team worked closely together with a strong sense of camaraderie and mutual support. They reported genuinely liking each other, sharing a sense of humor, and maintaining a supportive atmosphere even during stressful times. Trust was a key element of

their collaboration, with team members stepping in for each other seamlessly, whether covering meetings or handling tasks. They regularly debriefed and refined their training based on collective observations and feedback, enhancing their collaborative efforts. This strong interpersonal connection, was perceived to be a strong facilitator of a more engaging and effective PROMs implementation effort.

'We have each others backs 100%'.

Planning (+)

Implementation plans are often key facilitators of implementation success and the implementation team had a clear and robust plan from the start. Their approach involved implementing PROMs across various services, including all three CMHTs, specialist services, forensic and rehab services, and Trust-wide. To plan for this, the approach includes visiting each of the 41 teams to discuss PROMS, map out typical service user journeys, and identify key points for collecting PROMs. This involves creating a 'map of opportunities' using flipcharts to show when and which PROMs to use. Although the overall plan has been less formalized and more adaptive, with the team having to adjust as they go, there was a focus on ensuring at least one patient-centred outcome measure was consistently used. There was also an emphasis on sustainability, providing centralized resources, and ongoing support tailored to each team's needs. Feedback mechanisms were established to help teams understand and utilize the PROMs data effectively. Future plans included training other services beyond the CMHTs, assessing their needs, and offering bite-sized training to leaders and managers on how to use and analyse PROMs data for reporting.

Adapting (++) and Doing (+)

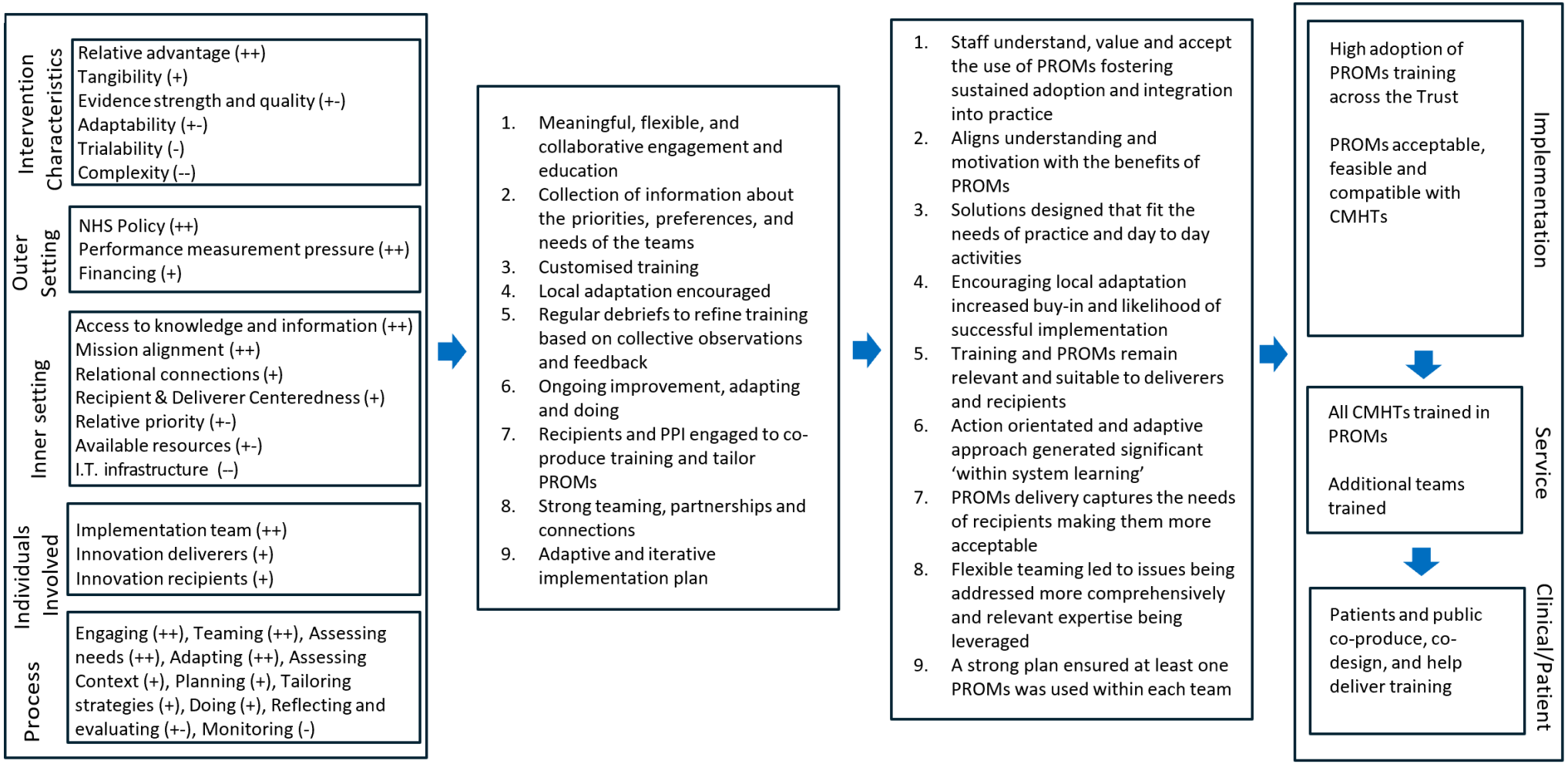
The implementation team's approach to implementation emphasized flexibility and creativity. They advocated for a dynamic process where ineffective strategies were quickly discarded in favour of trying new ones. Unlike the structured nature of clinical audits, this approach was more action-oriented and adaptive. The ISP, had to start immediately, making adjustments on the fly, which means some parts of the original plan became outdated due to the ongoing and responsive nature of their efforts. Examples of this dynamic approach could be seen in the training where teams were actively encouraged to think about how they need to adapt PROMs to fit their specific contexts and client groups and the feedback was used to improve the implementation process.

Reflecting and evaluating (++)

Dedicating time for reflecting or debriefing before, during, and after implementation is a key way to promote shared learning and improvements. These times of reflection help foster a learning climate. one in which successful implementation can flourish. The implementation team would regularly debrief after training sessions to discuss dynamics, share observations, and refine the training process together. They would reflect on individual or group strategies to engage participants and adapt as needed. They focus on overcoming potential resistance from parts of the system to ensure successful implementation.

Implementation Research Logic Model (IRLM)

Project Title: Evaluation of PROMs Implementation across Sheffield Health and Social Care Trust



Conclusion

Although future healthcare services that decide to adopt PROMs are likely to face different or additional contextual challenges to implementation, the implementation strategies shown in the implementation research logic model above are likely to support implementation regardless. This is because they are adaptive and tailored to the needs of the practice setting they are in and can therefore respond to and address complex implementation challenges as they arise in real time. Services may also consider funding an experienced implementation team such as the team in SHSC, ensuring plenty of time for engagement. They may also want to ensure their I.T infrastructure is in place.

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