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NHS Leeds and York Partnership NHS Foundation Trust

Pathway Development Service (PDS)

Annual Review Report

April 2022 – March 2023

Faye Cox
Assistant Psychologist

Jouko Koecher
Principal Psychotherapist

The service is responsive and flexible, their work and reports are comprehensive and valued as supporting evidence for next steps for service users who are stuck. **Case Manager**

This in-depth report will be of support to professionals currently supporting the patient in the community / generic non-secure services and has redirected a patient with clear advice from an inpatient secure care direction. **Case Manager**

We have found the meetings with your team supportive and insightful. We have valued the team's knowledge of our patients which we have used to further guide our treatment and care plans. **Psychologist**

[The PDS] helped to facilitate a constructive discussion between all services involved. **Case Manager**

This has been very useful. **Case Manager**

I am very grateful for your thorough information gathering from various agencies, comprehensive report of my patient's complex history, psychosocial formulation and proposals for future consideration. **Responsible Clinician**

I learnt lots of new concepts and it gave me a deeper understanding into personality disorders such as how small changes in behaviour could give deeper insights into how a team is working together. **Training Participant**

Executive Summary

This report on *Pathway Development Service* provision between the 1st of April 2022 and the 30th of March 2023 is organised along three key narratives and the six domains of healthcare quality.*

Pathway Development Service (PDS) 2022/23 key narratives:

- **Transition**: operationalising a new service specification and outcomes.
- **Re-teaming**: recruitment, training, supervision, and reflective practice structures.
- **Networking**: relationships with legacy and new providers across the region.

Six domains of healthcare quality *

Safe: avoiding harm to people from the care or service that is intended to help them.

Timely: access and service delivery in timely and geographically equitable ways.

Effective: the ways in which the PDS has a meaningful effect on systems of care.

Efficient: avoiding waste, including waste of equipment, supplies, ideas, and energy.

Equitable: PDS delivery does not vary in quality because of personal characteristics.

Person-centred: respectful of and responsive to individual preferences, needs, and values.

PDS delivery in this reporting period was focussed on:

- the completion of independent reviews of a service user's care and treatment in hospital, including the suitability of their current placement and prospective pathways, considering where care can be provided within the least restrictive environment in relation to identified needs and safety considerations.
- Assessments of housing and resettlement needs where required, to enable the clinical team and commissioners to develop effective planning towards the goal of community discharge, which may include brokering of housing and resettlement packages and consultation to locality-based housing providers, to support resettlement into the community.
- Facilitation of the Knowledge and Understanding (KUF) Awareness training for multi-agency groups of staff across the region, as well as two groups for carers.

From 2023/24, the PDS will therefore only work with clinical teams in the event of:

- A new referral to and/or admission to a secure service.
- Where there is concern about the management of primary risk towards others within the community.
- A situation in which a team/parts of the system would like to consult on a particular question in working with a service user.
- To assist with planning for transitions into or out of secure care.
- To support planning when a pathway is obstructed or contested (including circumstances in which the source is linked to appropriate accommodation).

* Institute of Medicine & Committee on Quality of Health Care in America. (2001). *Crossing the quality chasm a new health system for the 21st century*. National Academies Press. https://doi.org/10.17226/10027

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Introduction

The regional *Pathway Development Service* (PDS) is based in Leeds and part of the Leeds and York Partnership NHS Foundation Trust. It is a blended service co-delivered by lived and occupational experts, with a focus on enabling progressive and trauma-informed journeys through secure care. It aims to improve the experience and outcomes for individuals who have been given the diagnostic label of a 'personality disorder' and the services working with them.

The PDS team work alongside inpatient and community pathways for adults and young people (16+) across the region. Changes following the introduction of Integrated Care Services (ICS) mean that the service operates across the region covered by the three provider collaboratives (PCs) that serve the population of West Yorkshire, South Yorkshire, and Humber & North Yorkshire ICS.

The work of the PDS is informed by overarching clinical model principles for Personality Disorder specialist services. This model guides services tasked with providing interventions in the lives of people who have difficulties associated with a 'personality disorder' diagnosis to:

- **Increase 'mentalising' capacity. The term 'mentalisation' refers to an ability to notice and think about one's own and others' mental states, their thoughts, and feelings. Through the provision of reflective spaces, training, joint working, and team formulation the service will support teams to use psychological formulation to inform practical, trauma-informed interventions designed to increase mentalisation.**
- **Facilitate access to social capital. 'Social capital' refers to the effective functioning of social groups and networks through interpersonal relationships. Working with teams over time and in different contexts, the service will seek a holistic view of the individual, which identifies strengths, resources, and sources of pro-social power.**
- **Foster learning from and with each other within the social network of PCs and alongside persons with lived experience (both service users and peer-workers).**

The overarching aim of the PDS is to support systems striving to deliver trauma-informed, integrated care for people who (have) experience(d) the world as profoundly unsafe (often associated with the diagnostic label of a 'personality disorder'). The PDS work alongside community and inpatient teams whose service users are either at risk of entering secure hospital provision or are currently within secure care, focussing on those with a primary risk towards others (see also the PDS Primary Task, Position Statement and Values in Appendix 1).

PDS delivery in this financial year has been both impacted and shaped by a new service specification, alongside a change in leadership and staffing. The consequent re-teaming efforts (e.g. recruitment, training, supervision, and reflective practice structures), as well as the operationalisation of the new service specification and outcome framework, have thus absorbed much time and energy, which will be evident in some of the data that follows. – Nevertheless, the team have been able to adapt, develop and thrive under difficult circumstances, helping to co-create thinking spaces wherever possible.

Safe (avoiding harm to people from the care or service that is intended to help them)

There were no reported incidents in this Annual Review reporting period, 2022-2023.

The PDS works alongside teams to utilise their knowledge of and therapeutic relationship with persons at the centre of concern. Aiming to enhance the capacity of those systems of care to notice and manage processes which interfere with compassionate, trauma-informed care delivery and with effective pathways, this approach requires the PDS to maintain and foster **psychological safety**, in turn.

Changes in the Pathways Development Service specification and staffing were identified as factors potentially impacting psychological safety and staff morale. In order to establish a baseline, and given that PDS team size was not sufficient to extract team-level results from NHS staff survey data, a tailored questionnaire† was offered to all PDS staff twice. Average total scores were above the target of ≥75% on each occasion (≈82%), and themes emerging from responses were explored during a team development session, with a view to supporting personal-professional self-care.

With a view to further developing and supporting the PDS team's psychological safety and ability to model relational security to other teams, in turn, a reflective practice group and more focussed clinical supervision were introduced. Individual clinical supervision meetings replaced a group previously introduced as an interim measure (in the temporary absence of a Principal Psychological Practitioner), with a reflective practice group every other week offering a space to contain and think about dynamics of the work.

Training and development were also integral to and underpinning safe PDS delivery, particularly in light of the service having been re-commissioned to focus exclusively on working with individuals on secure pathways. – A team development day in April 2022 considered proposed changes in the service and key priorities, followed by monthly team development afternoons from July that year, covering the following topics: '*Overview of secure pathways*' (including MHA legislation, levels of security, types of provision, access assessments, gender differences in pathways); '*Healthy teams and showcasing strengths within the PDS team*' (skills/ strengths analysis); '*Overview of the PDS Housing and Resettlement function*'; '*Team diagnostic consultation*' with Jina Barrett, external consultant (whole day in October 2022, including a focus on the team's primary task and service developments); '*PDS work and clinical risk management– developing a shared understanding*' (risk assessment tools and processes, positive risk taking)'; '*Formulations*' (with reference to mentalisation); '*Dilemmatic spaces*' (intro to thinking about consultation); '*Team building and consultation work*'.

Furthermore, individual PDS team members completed the following courses in 2022/23: two caseworkers completed the MSc module on '*Formulation & Therapeutic Approaches to Personality Disorder (PD)*' and a third completed a masterclass on '*Assessment and Management of PD*' as well as a 'Group Relations Conference'. The Assistant Psychologist completed an MSc module on '*Enhancing capability for working with personality disorder*' and the *Knowledge and Understanding Framework (KuF) Awareness training*. The Practice Development Lead commenced the NHS Leadership Academy's Mary Seacole Programme.

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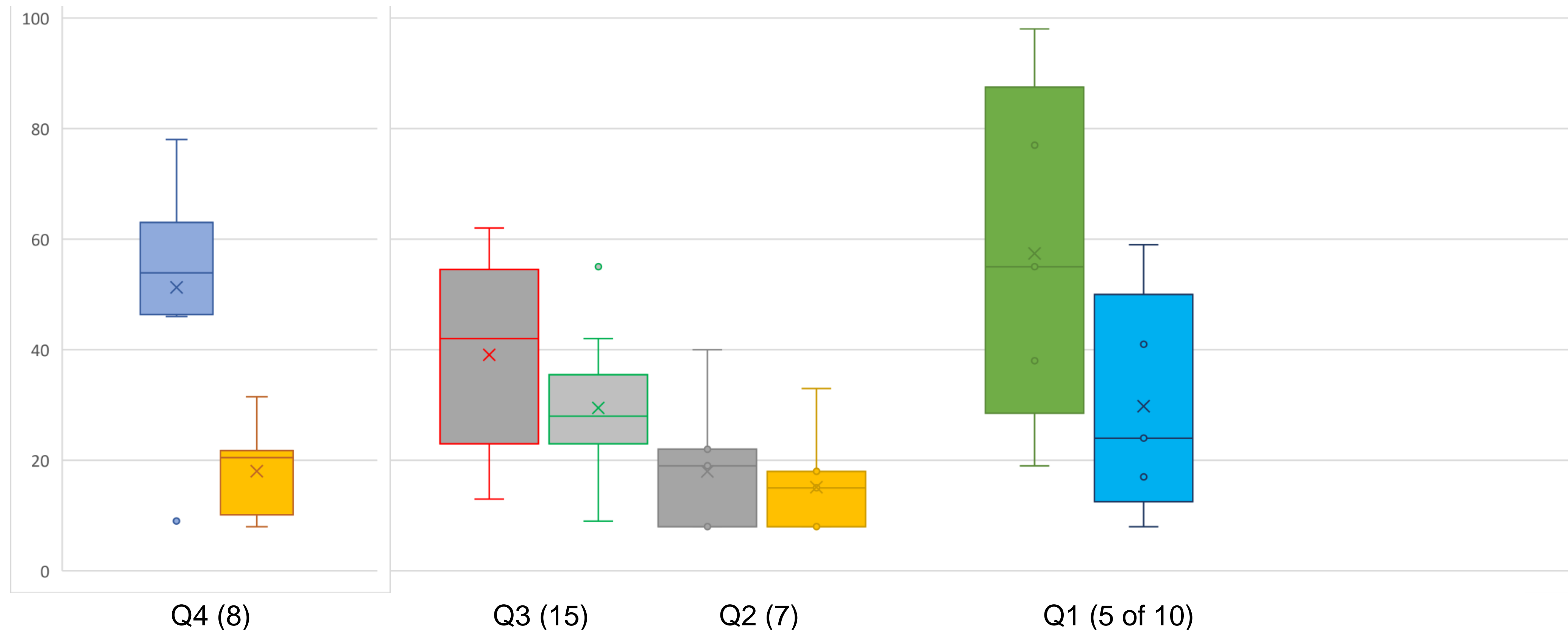
† Edmondson, A. (1999). Psychological safety and learning behavior in work teams. *Administrative science quarterly*, *44*(2), 350-383. Also including items from a questionnaire by Dr Ramesh Mehay (2010) adapted from 'The Assessment of Work Environment Schedule' (AWES), which was developed originally by Nolan (1998) at Sheffield University, e.g. Nolan, M., Grant, G., Brown, J., & Nolan, J. (1998). Assessing nurses' work environment: old dilemmas, new solutions. *Clinical Effectiveness in Nursing*, *2*(3), 145-154.

Timely (access and service delivery in timely and geographically equitable ways)

The average number of days between **receipt of referrals** and their processing was 2.75 days, and together with a median value of two days and a mode of one, this would seem sufficiently responsive in practice yet greater than the new target of two days. Indeed, the maximum time interval was seven days, which would be in line with the service's weekly referrals meeting for cases that required further discussion by the whole MDT.

The distribution of **waiting time** data points was skewed, which was partially accounted for by the variable number of days cases remained on the waiting list (see Figure below). Indeed, the average time on the waiting was between 0 and 60 days, with a median of 14 days, and this may be accounted for by the relatively variable rate of incoming referrals across the year, in conjunction with a temporarily reduced staff resources and redirection of team resources in the preparation for the service transition.

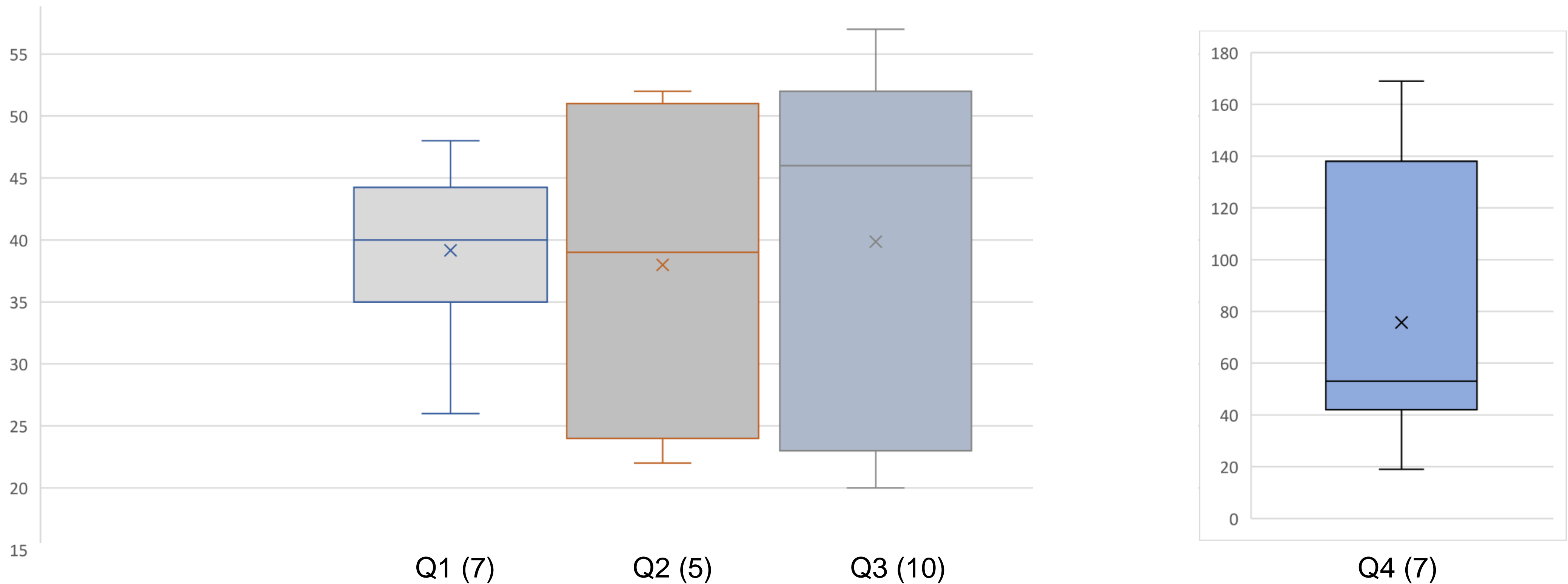


Pairs of Box-and-Whisker Plots of time elapsed in days (vertical axis), between date of referral and first visit (left-hand B-a-W plot in each pair) and the same time interval with time on waiting list subtracted (right-hand side B-a-W plot), per quarter (Q) in the financial year 2022/23, with number of accepted referrals in parentheses.

Key: X indicates the mean average value; horizontal lines on each box are the 75th, 50th (median) and 25th percentiles, respectively; top/bottom lines indicate maximum and minimum data values, respectively. The latter are calculated as 1.5 x the Interquartile Range (IQR), which is the difference between the first quartile (25th percentile; Q1) and third quartile (75th percentile; Q3). Outliers are indicated by circles and include values greater than the maximum value (i.e., greater than 1.5 x IQR + Q3).

Whilst the average **time to PDS review report completion** remained relatively stable in the first three quarters of the year, the variability of time to completion increased progressively, culminating in an almost doubled average completion time in quarter four. As this final quarter also saw the introduction of a new service specification and continued changes in the team, this may account for some of the increased variability. Other potential sources of variability included delays due to referring teams not being able to meet and the PDS staff team regrouping (i.e., due to staff absence, team development and changes or use of resources to operationalise the new service specification). However, the service did not collect data to systematically identify the respective sources of delay.

One **key area of development** will therefore focus on the capturing of additional data points that aim to identify patterns and sources of delays, with a view to allowing the PDS to become more effective in responding to enquiries from all three provider collaboratives. This will also be important to allow the service to accommodate to a variety of different responses from the new PDS menu of options, which require varying lengths and intensities of PDS team involvement (i.e., a less homogenous pattern of service provision that was on offer previously).



Box-and-Whisker Plot of time elapsed, in days (vertical axis), between first PDS contact with referrer and report completion, between 1st of April 2022 (quarter one; Q1) and 31st of March 2023 (quarter four; Q4), with number of cases per quarter in parentheses. Data for Q4 plotted separately, given longer timescales.

Key: X indicates the mean average value; horizontal lines on each box are the 75th, 50th (median) and 25th percentiles, respectively; top/bottom lines indicate maximum and minimum data values, respectively. The latter are calculated as 1.5 x the Interquartile Range (IQR), which is the difference between the first quartile (25th percentile; Q1) and third quartile (75th percentile; Q3). Outliers are indicated by circles and include values greater than the maximum value (i.e., greater than 1.5 x IQR + Q3).

Effective (the ways in which the PDS has a meaningful effect on systems of care)

As in previous years, the PDS has mainly relied on feedback questionnaires to ascertain experiences of service provision and its putative effects. Given the historically poor return rate of feedback questionnaires, in conjunction with a commonly found bias towards positive feedback in those returned, a need for alternative approaches was identified, and is due to be piloted in the next financial year.

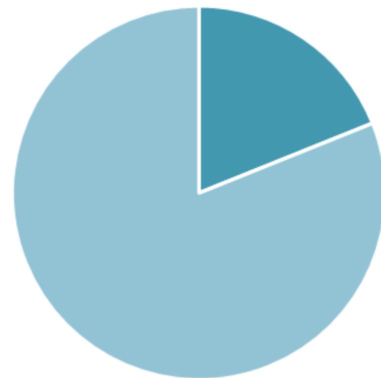
Based on a conceptual distinction between any particular person's pathway (e.g. helping to pave the way by way of housing and resettlement packages) and pathways more generally (cf. 'natural clinical flow'), PDS activity will, in future, be measured by way of contacts with teams and services ('the system' coalescing around a service user), with potential effects ascertained by experiences of both service users and the teams working with them over time. The latter could thus include a team or service having contact with different 'service users' over time (i.e., the team are part of 'the pathway'), and as the PDS interface with the team, the aim will be to measure possible effects over time as well.

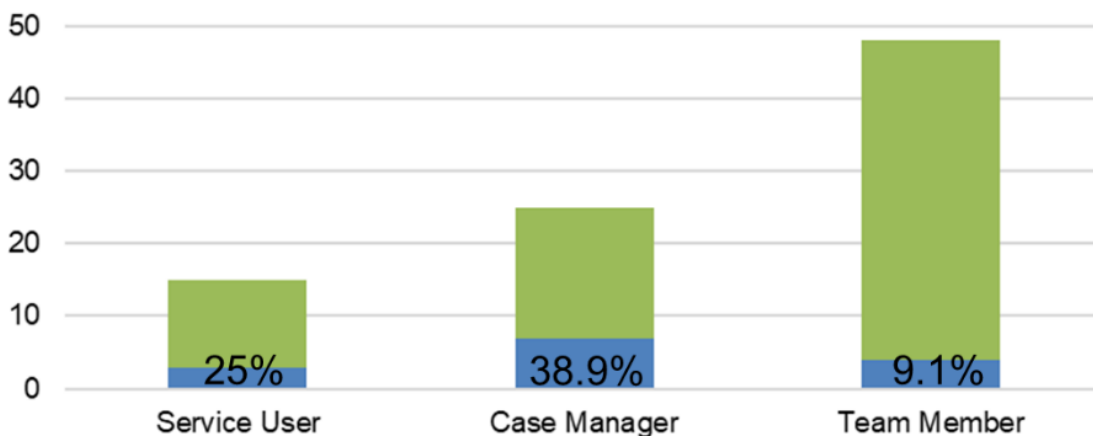
One assumption, based on the PDS operating over several years with a different service specification, is that it may not generally be possible to show direct or immediate causality between PDS involvement and the subsequent 'journey' of any particular service user. Because of the aforementioned heterogeneity and consequent non-linear effects over a longer period of time, it would seem unlikely to show a causal effect on aspects such as length of stay, incidents or levels of subjective wellbeing, for example. Similarly, the previously employed service experience questionnaires do not allow for inferences on effectiveness or generalisability. – Notwithstanding these challenges, a retrospective analysis (e.g. over a period of three to five years) or case studies of different individuals over time may have utility.

For this financial year, for purposes of continuity and completeness, a thematic analysis of questionnaire responses is included below.

As in previous years, response rates to feedback questionnaires have been low. A total of 74 feedback questionnaires were sent out, with a total of 14 responses received (see chart to the right), yielding an overall response rate of 18.9 percent. Response rates from case managers were highest, followed by service users and team members (see below).

Proportion of Feedback Forms Completed





Bar chart of the number of questionnaires received (blue) as a proportion (percentage) of questionnaires sent out (possible responses; green bar).

Questionnaire Responses from Service Users

On the three questionnaires returned by service users, all respondents indicated that they felt understood 'a little' (alternative response options were 'not at all' and 'a lot') and that most of their questions were answered. Asked about the clarity of PDS review report recommendations, all service users responded with 'a little,' whilst three different responses were received on the question of whether their needs were understood (i.e., 'not sure,' 'a little,' 'a lot'). One respondent added that the "[caseworker] was really nice," whilst another commented, "I don't really understand what's going on." It is unclear whether this related to their care on the ward, or their subsequent care in response to PDS recommendations.

Questionnaire Responses from Case Managers

Of the seven case managers that responded, most indicated that PDS attendance at clinical reviews helped their role and that the report would influence management of the case 'a great deal'. Respondents added that this "helped to ensure the service user did not return to an inappropriate package of care." Although two emerging themes in respondents' comments centred on service users moving to a different setting or their presentation changing during PDS involvement, case managers still noted the PDS "offer [of] guidance and clear evidence-based rationale."

Several case managers stated that PDS involvement had contributed to pathway improvement for their cases, citing one service user having 'no further referrals into secure care' and that another 'avoided residential or inpatient settings'. A further theme centred on the PDS providing support for staff and new ways of thinking. One case manager stated the PDS provided "a 'new look'" to a group of staff who "had become jaded". The PDS "facilitate[d] a constructive discussion between all services involved."

Case managers described how services had really valued the depth of information and recommendations provided by the PDS, with many considering the PDS work in terms of a legacy, likely influencing future care of service users on their subsequent pathway (e.g. "community services are utilising the approaches suggested in the report").

Whilst most feedback from case managers was positive, there were some comments on a theme of the PDS involvement taking too long to be completed. One case manager noted that some delays due to staff absence "caused stress to the client" and another shared that "the ward were really struggling at the point of referral, and it took too long to get support and a new look at the situation."

Questionnaire Responses from Team Members

The four responding team members considered PDS reports to be clear, anticipating that they would influence care of service users 'a great deal'. Another theme highlighted the ability of the PDS to bring opinions of various professionals together, by way of providing space to share their views "effectively to meet the best outcome for the patient". There was a sense of team members valuing the feedback and recommendations given by the PDS. However, in line with feedback from case managers, there were other comments on a theme of PDS involvement taking too long to complete (e.g. "[the patient's] behaviours were already assessed by the psychologist and the team, and the recommendations were made already").

Efficient (avoiding waste of equipment, supplies, ideas, and energy)

Whilst the PDS aims to be as helpful as possible to those referring, PDS resources were limited and referral criteria applied. Some referrals were thus declined or closed as follows.

Context/history of Declined/Closed Referrals

1. Referral from an adult acute ward regarding a service user who had had four previous PDS reviews and two housing and resettlement interventions. The referral was closed with an outline of previous recommendations.
2. Further discussion with the discharge coordinator revealed that a referred service user had since been accepted by a locked rehabilitation placement, so a review being no longer required.
3. Whilst awaiting confirmation from a Single Point of Access team regarding a required decision on an access assessment, the referred service user had given no further concern to referrers, so the inpatient team no longer required PDS input.
4. A referral was received from an adult acute ward, but the patient was subsequently no longer detained under the Mental Health Act. A pathway planning meeting was arranged, the pathway was found to be no longer blocked, so there was no role for PDS.
5. When contacting the originator of an incomplete referral, they informed the PDS that the service user would be moving to a different setting. The case manager therefore intended to advise the new placement to re-refer, if required.
6. A referral received from a PICU ward was initially accepted with two sessions of consultation work offered by the PDS. Despite multiple attempts to contact the team to offer this, no response was received, so the case was closed.
7. A referral with no information on the pathway/mental health history, staff or service issues. Telephoned ward to discuss criteria, but the referrer was not available and did not respond after further email contact. Closed with new referral criteria given.
8. An initially incomplete referral was subsequently resubmitted (with prompting).
9. Having followed up a referral twice over the course of month, both by email and telephone, a letter was sent, advising that the PDS would close the case, if no response had been received by a certain date (closed thereafter).

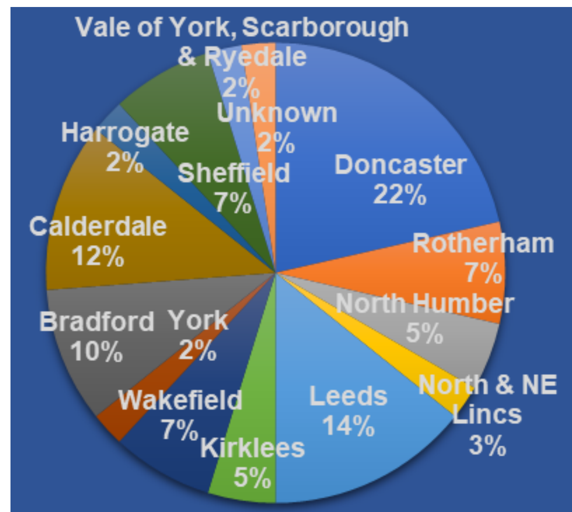
These examples illustrate the way most referrals were closed due to the PDS not being able to reach referrers (or those familiar with the situation) or a change of circumstances. In preparation for a changed service specification and consequently different referral criteria, the PDS have begun to explore different ways of engaging with services, with the aim of increasing responsiveness and engagement of the system of care around a referred service user, in the current context of frequently increased pressures on the wider system.

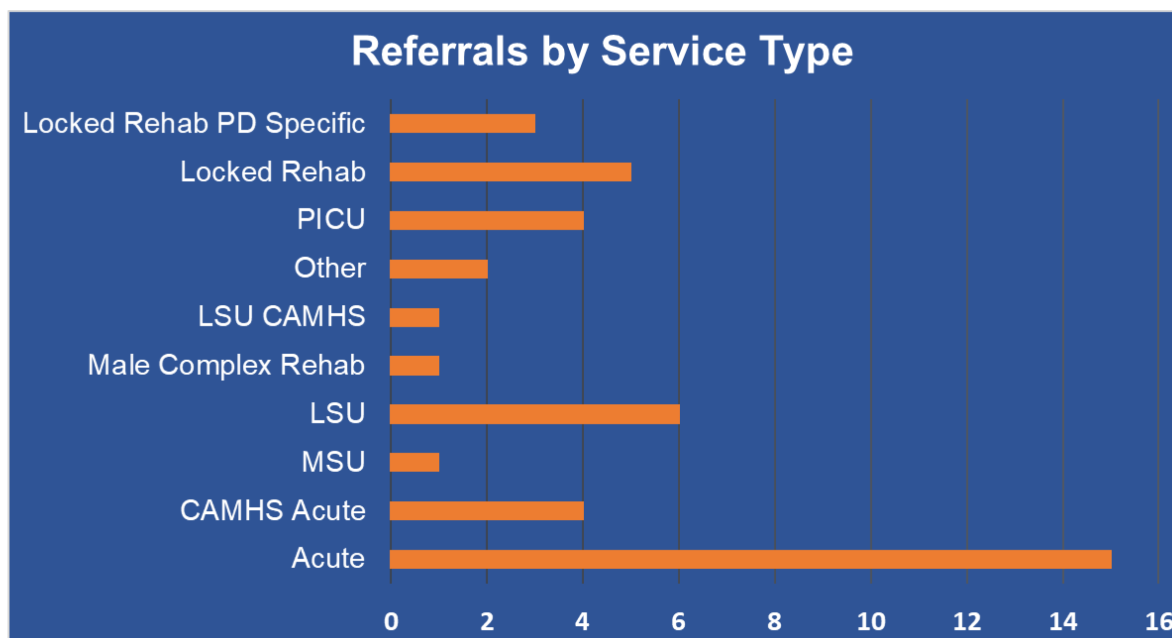
Equitable (PDS delivery does not vary in quality because of personal characteristics)

As in previous years and similar to comparable services nationally, there was again a lack of diversity with respect to gender, age and ethnicity (see table on page 12). In order to improve the analysis of demographics data, the PDS have introduced an enhanced demographics questionnaire with their initial enquiry form, which was adapted from that used by the Leeds Gender Identity Service. This has also invited further discussion and thinking within the PDS team, on topics of gender identity. Furthermore, the PDS plans to continue conversations on diversity with partners across the region, co-produced ways of engagement and methods, such as the Cultural Formulation Interview (American Psychiatric Association, 2013; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7011218).

Gender	**Female**	n=27	(64.29%)
	Male	n=12	(28.57%)
	Other	n=3	(7.14%)
Age	**Mean**	29 years	
	Age Range	15-56 years	
Ethnicity	**White British**	n=34	(80.95%)
	Mixed White and Black Caribbean	n=2	(4.76%)
	White Irish	n=1	(2.38%)
	(British) Asian Pakistani	n=1	(2.38%)
	(British) Black Caribbean	n=1	(2.38%)
	Not Stated	n=3	(7.14%)

The majority of referrals originated from within the West Yorkshire and South Yorkshire & Bassetlaw Provider Collaboratives (46 and 40 percent, respectively), with a smaller proportion from within the Humber, Coast and Vale Provider Collaborative (14 percent). Most of these referrals were of service users detained on adult acute mental health wards, followed by low secure units and locked rehabilitation wards. The pattern of referrals was similar to those received in the previous year.





Person-centred (responsive to individual preferences, needs, and values)

Service user involvement has continued by way of the PDS aligning with and joining activities organised by the *Yorkshire and Humberside Involvement Network*, which was formed in 2006 with the aim of bringing 15 different secure services together to network and share best practice. Equally, the South Yorkshire & Bassetlaw Provider Collaborative Involvement Coordinator has been a valued collaborator and offers a link to service user (experience) networks in that region.

The co-produced *'Horizon Inequalities Service Evaluation in Adult Secure Services'* project, commissioned by the South Yorkshire & Bassetlaw Provider Collaborative, is one example of person-centred practice that will inform future PDS collaborations on service evaluation (with anticipated learning on the other domains of healthcare quality as well). As might be expected, based on similar person-centred projects, their work with service users across inpatient settings revealed that autonomy, choice and being heard, feeling safe and comfortable, and representation and respect of all backgrounds are particularly important to service users. The project enlisted the help of staff members on secure wards to complete questionnaires with service users. Similarly, the Yorkshire and Humber Service User Involvement Network have developed a Secure Quality Involvement Tool (SeQuIn; McKeown, Byrne, Cade, Harris, and Wright (2023); https://doi.org/10.1108/JFP-01-2022-0001), which is used to evaluate service user involvement across the region. The tool focuses on evaluating services' approaches to involvement, reducing restrictive practice and technology. An online portal allows services to submit data via an accessible platform. The measures were created using service user language and are available in easy read format.

Furthermore, the previously reported intention of creating a new job role within the PDS, with a 'service user peer support' or 'expert by experience' function was operationalised in this financial year. A job description and person specification for a *Senior Lived Experience Practitioner* was co-created by the PDS and 'lived experience' post holders across the region, and on the basis of an NHS England template for 'Lived Experience' roles in the Knowledge and Understanding Framework programme.

Upon commencement of their post, this new colleague will work alongside PDS team members in an advisory, quality improvement and networking capacity. In the way that all members of the PDS bring their own perspective of a person's journey through secure care services, they will contribute their own lived experience to support the PDS in thinking with other teams, to develop an understanding of complex situations and questions (advisory function). Helping the PDS challenge their thinking and practice, as all aim to learn from and with each other (quality improvement), which will include becoming involved in PDS service evaluation and training. The postholder will also join the team in continuing to build on their existing networks of support throughout the region, with a focus on making connections with involvement leads and lived experience practitioners across the region.

Conclusion

Pathway Development Service delivery was characterised by multiple internal and external changes in this reporting period, offering much opportunity for learning and continued improvements, in turn. In addition to a changed commissioning landscape, PDS team and service specification, a new strategic direction focussed on lived experience / involvement and service evaluation.

Pathway Development Service feedback forms offered only sparse information and thus an opportunity to revisit service evaluation methodology. Some of the feedback highlighted the predominantly indirect provision of Pathway Development Services and raised a broader question about the 'users' of this service (i.e., 'service users' as traditionally defined and/or the systems of care around them). Whilst the service has begun to engage systems of care, to parallel contextual changes introduced by way of *Integrated Care Services* (ICSs) and their *Provider Collaboratives* (PCs), this also raised challenges of how to maintain responsiveness and demonstrate effectiveness of a systemic approach.

With a view to addressing these challenges, the PDS have begun to operationalise brief case reviews and consultation work, alongside the pre-existing offer of case reviews (e.g. in the context of an access assessment to secure care). Working alongside teams by way of consultation, for example, will not only support colleagues in thinking about those they are working with (i.e., supporting both reflective practice and practice-based learning), but also aims to help develop culture and care approaches of pathways as a whole. Another intention is to learn from feedback, whereby respondents indicated that PDS work took "too long" to complete and thus, at times, appeared to become redundant when not 'keeping up with' fast-moving developments in the context of 'high acuity' and 'natural clinical flow'.

The feedback questionnaires also did not offer much indication of what the services and service users were initially hoping for from PDS involvement, reducing the explanatory power of existing evaluation methods in terms of effectiveness. Learning from this, the PDS will trial gathering information on respondents' hopes for and expectations from PDS involvement in the early stages of the work (see Appendix 2, for an example of an early draft of a new evaluation form). Further learning from feedback received included a preference for something less structured (e.g. brief conversations), which would also afford capturing more qualitative, experiential data.

Implementing a revised service evaluation plan going forward, the PDS will draw on information from existing projects (see, for example, those outlined on page 13 above). In addition to articulating a mixed methods approach to answering a series of key questions on which meaningful measures to employ, how and with whom, to demonstrate safe, timely, effective, efficient, equitable and person-centred PDS delivery, the evaluation plan also draws on existing evidence-based methods, such as the **C**hart of **I**nterpersonal **R**eactions in **C**losed **L**iving **E**nvironment (CIRCLE; Blackburn and Renwick, 1996), **P**ersonality **D**isorder – **K**nowledge **A**ttitude and **S**kills **Q**uestionnaire (PD-KASQ; Lamph et al., 2014), and the **C**limate **E**valuation **S**chema (CES; Schalast et al., 2008).[‡]

This service evaluation plan will initially be trialled with collaborators in some of the local Provider Collaborative services. A co-produced approach will thus seek to foster the kind of distributed agency to support service users and learn from/with them that the PDS aspires to model. This will be based in the continued development of a network of relationships, both by way of joint working and forums for complex case work and learning, which aims to enhance a more collaborative, efficient and effective referral process, in turn.

[‡] Blackburn, R., & Renwick, S. J. (1996). Rating scales for measuring the interpersonal circle in forensic psychiatric patients. *Psychological Assessment*, *8*(1), 76.

Lamph, G., Latham, C., Smith, D., Brown, A., Doyle, J., & Sampson, M. (2014). Evaluating the impact of a nationally recognised training programme that aims to raise the awareness and challenge attitudes of personality disorder in multi-agency partners. *The Journal of Mental Health Training, Education and Practice, 9*(2), 89-100.

Schalast, N., Redies, M., Collins, M., Stacey, J., & Howells, K. (2008). EssenCES, a short questionnaire for assessing the social climate of forensic psychiatric wards. *Criminal behaviour and mental health: CBMH, 18*(1), 49–58.

Appendix 1 – Primary Task, Position Statement and Values

The Pathway Development Service (PDS) primary task is *to work alongside teams to learn about what has happened within a system to obstruct pathways, by way of co-created thinking spaces that foster the conditions for something different to happen.*

All our ways of working help us achieve our primary task because they are focussed on helping people to trust and foster effective, meaningful, and important relationships. We work like this as a team, too, by way of reflective practice and continued learning from and with each other and the people we work with.

Pathway Development Service (PDS) Position Statement – staff within the PDS recognise that:

- Even with extensive training and experience, working with people who (have) experience(d) the world as profoundly unsafe can generate high levels of emotion in staff. This does not mean that staff are failing in their roles, nor does it mean that staff are incompetent, uncaring, or 'unprofessional'. Our team understand that intense feelings are normal in this work, and that they can be an important source of information about the experiences of a person at the centre of concern.
- The importance of working in genuine collaboration, with involvement and co-production at heart of our approach, we continue to learn from people with different lived experiences and from different cultures and communities.
- We approach our work alongside teams with curiosity about what 'recovery' and 'improvement' mean to different people. Signs of change may vary and what seems 'better' to whom may be difficult to tell. We approach our work with these realities in mind, and with a sense of optimism about the potential for people to find their preferred future and way in life.
- Therapeutic relationships are important to us, with psychological theory informing our approach, in particular Attachment Theory, which highlights the role of early relationships in later ways of relating with others. We aim to mentalise (in) these relationships. 'Mentalising' refers to our capacity to notice, think about and explore thoughts and feelings (mental states).
- We understand that difficult or 'challenging' behaviours are often means of communicating and surviving; that service users and staff make use of whatever skills are available to them and which seem most effective when distress is high. Here, our stance is informed by Dialectical Behaviour Therapy (DBT): we accept that people are doing their best to cope, whilst also recognising the need for change.
- The foundation for our strong emphasis on therapeutic risk-taking and working towards the least restrictive conditions close to home, is built on thinking spaces for teams that feel as safe as possible. We model relational security that aims to foster the free expression of thoughts and feelings, however complicated or frightening the situation may seem at times.

PDS Team Values and Practices:

⇨ Relating to others as human beings, not as diagnoses or labels, we model self-compassion.
⇨ Noticing and valuing each other's differences, we aim to let each other know what we need to fulfil our primary task.
⇨ We understand that the primary task may change –for unconscious reasons– and a team may not notice. We are then concerned to ensure there are ways of noticing practice and how it might change built into team functioning.
⇨ In mentalising, we practise and model to others:
  - being curious about other people's experiences, thoughts, and feelings.
  - not knowing (not being certain).
  - being open to different points of view.
  - simply noticing.
  - being able to doubt ourselves and reflect on own thoughts and feelings.
  - allowing feelings to happen without trying to get rid of them.

⇨ Paying attention to thoughts and feelings arising from the work, we aim to link these to the dynamics in the work.
⇨ Instead of telling others what to think, we help create opportunities for understanding to grow / develop / emerge.

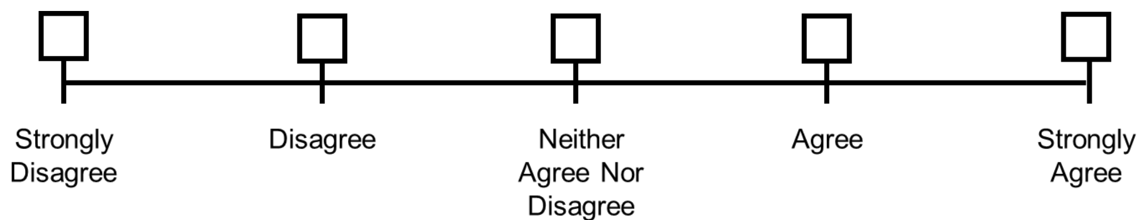
Appendix 2 – Example of a revised PDS Feedback Form

Leeds and York Partnership
NHS Foundation Trust

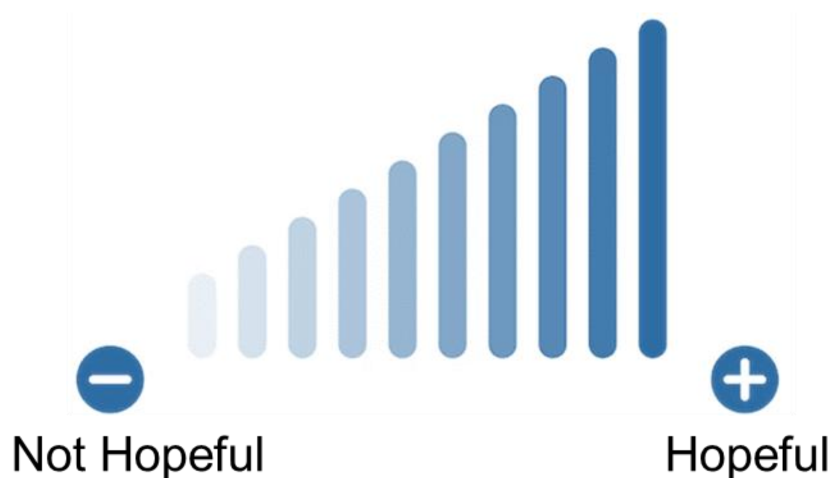
Pathway Development Service Feedback

What is your best hope in working with us (Pathway Development Service)?

I felt heard / listened to during the discussion today (please tick).



How hopeful do you feel that something different can happen in your situation?



Any other thoughts/suggestions/ideas after today's conversation?

https://www.leedsandyorkpft.nhs.uk/our-services/pathway-development-service-yorkshire-humberside