Paper D

Sheffield Health and Care Partnership

Sheffield Partnership Place Plan

2023-2025

Population
622,455
3 NHS Provider
Trusts
1 Local
Authority
Member of
South Yorkshire
Integrated
Care
Sheffield
Health and Care
Partnership
Voluntary and
Community
Sector Alliance
76 GP
Practices
Working with
Sheffield local
communities
1 Integrated
Care Board

1. Introduction and Context

The Sheffield Health and Care Partnership have jointly developed five key priorities for delivery over the course of 2023 - 2025. The priorities draw together our collective ambition as set out in our vision statement.

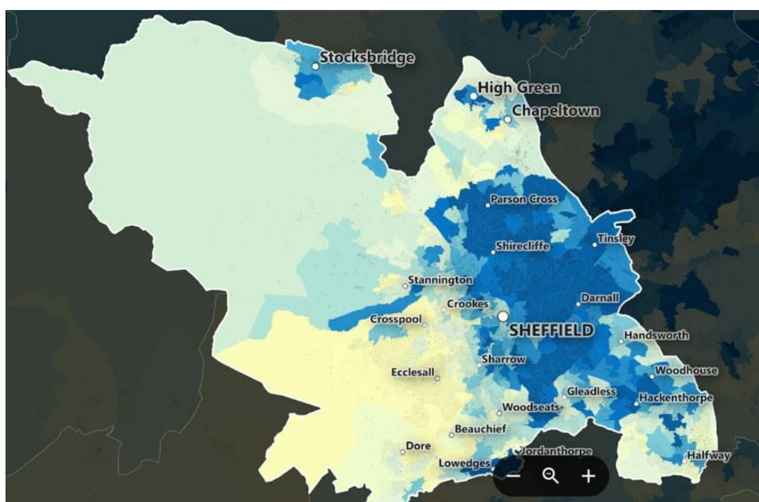
For *our health and care services to be integrated, joined up, and seamless; to reduce inequalities in health outcomes and access to support, to play our full role as anchor organisations in our city, and to do all this in a way that involves people, their experiences, and our communities at the centre of our work*.

2. Focusing on the Health and Care needs of Sheffield People

Sheffield is ranked as **the 57th (out of 317) most deprived local authority in England**, with **five (out of 345)** of its lower super output areas **within the 1% most deprived** in England. This is an increase from three in 2015, demonstrating the increasing levels of deprivation being experienced across the city.

People in Sheffield have an average life expectancy in line with the national average, **however, they are living a greater proportion of their lives in poorer health,** with healthy life expectancy for men at 60.8 years and for women at 60.3 years.

Across the north-east of the city, we have **the highest levels of deprivation.** This is **impacting on healthy life expectancy**, educational attainment, skill-levels and the overall health and wellbeing of our communities.



38% of the Black and Minority Ethnic (BAME) population live in the 10% most deprived areas in Sheffield, which is above the citywide average of 23%. The map demonstrates the **differences in deprivation across the city,** with the most deprived communities in **the east.**

Health Inequalities are unfair and avoidable differences experienced across the population, and between different groups within society. They are a combination of factors which contribute to an individual's experience, including where we are born, grow, live, work and age. Reducing health inequalities and targeting interventions based on need is fundamental to tackling the injustice of health inequalities.

As part of establishing our arrangements across the Sheffield Health and Care Partnership throughout 2022/23, we have highlighted the key priority of reducing in

health inequalities and improving population health, aligning our work with the development of the South Yorkshire Integrated Care Strategy and the Sheffield Joint Health and Wellbeing Strategy.

In developing our priorities, it has been key to identify the areas where we have longstanding challenges and variable access to these services that are largely dependent on where you live in the city. We also need to ensure we start to transfer power into the hands of our local communities.

The following sections set out our key five priorities, where we will initially focus our partnership work in Sheffield. This will be done alongside our continued role in the implementation of the South Yorkshire Integrated Care Strategy and Joint Forward Plan.

3. South Yorkshire Integrated Care Partnership

The South Yorkshire Integrated Care Partnership, the joint committee of the Integrated Care Board and the four Local Authorities in South Yorkshire have developed the Integrated Care Strategy[1], where collectively we have agreed a set of goals, bold ambitions, and joint commitments. This builds on our Health and Wellbeing Strategies in each of the four Places.

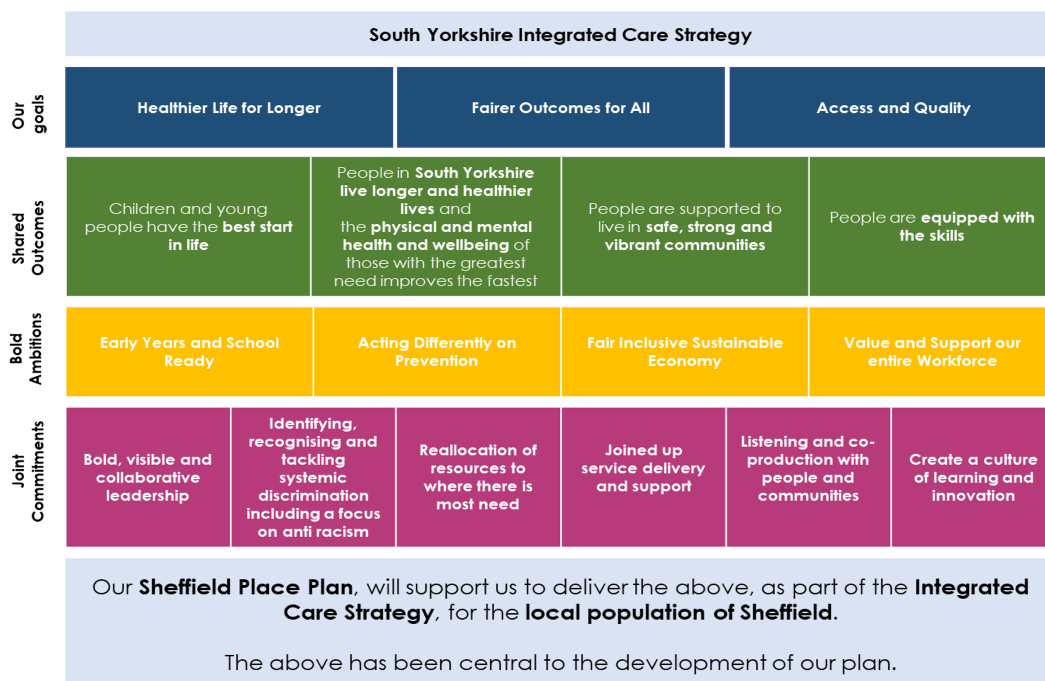
3.1 Integrated Care Strategy

South Yorkshire Integrated Care Partnership's (ICP) vision is for "everyone in our diverse communities to live a happy, healthier life for longer." The goals are:

- Healthier and longer life
- Fairer outcomes for all
- Access to quality health and wellbeing support and care.

We have been part of developing the vision, goals, bold ambitions and joint commitments, which provides us with a key opportunity to drive forwards our vision for the people of Sheffield.

[1] South Yorkshire Integrated Care Strategy, 2023



4. Developing our priorities

To develop our priorities, we analysed the evidence base to identify our challenges and aspirations, including the strategic context, our performance against national requirements, and our focus on the reduction in health inequalities. The priorities we identified draw on our collective challenges and focus on areas in which a partnership approach would maximise the impact and benefits for our communities.

- **Aligning to national requirements and local strategies:** Our priorities align to the national strategic context, including the Operational Planning Objectives, and the CORE20PLUS5[2] framework, as well as our local system's Health and Wellbeing Strategy, Integrated Care Strategy, and the Joint Forward Plan. The Provider Collaboratives' and Alliances' plans have also been incorporated into the development process.
- **Improving performance and focusing on access and outcomes:** There are several areas that face longstanding challenges in achieving national performance requirements, including:
    - discharge from hospital,
    - same day care,
    - mental health crisis support, and
    - neurodiversity

  Taking a system approach to these challenges provides an opportunity to make a bigger difference to our local population.

[2] NHS CORE20PLUS5 Framework, 2022

- **Listening to the needs of our communities:** In line with our Partnership's vision of involving people and our communities, we conducted listening exercise(s) to understand the needs of patients and the public. We shaped our priorities through proactive engagement with Sheffield's diverse communities, focusing on a need to address equality and inclusion, and improve our support to patients and public partners to have a meaningful and positive experience.
- **Focusing on health inequalities:** Reducing health inequalities is a core component of our Integrated Care Strategy and Sheffield's Health and Wellbeing Strategy. We reviewed population health data, including health outcomes and wider determinants, to focus our partnership's efforts in the most deprived areas of the city.

Our analysis process identified five key priorities for the Partnership over the next 18 – 24 months. The following section describes each proposed priority in further detail, including how we could deliver against them and what success could look like.

We acknowledge that to deliver our key five priorities each of our delivery groups will have a subset of additional priority areas of work, where at a partnership level we know we can add value. The oversight of these additional priorities is managed through our Transformation and Oversight governance with the Place Partnership.

4.1 Discharge and Home First

We have experienced significant challenges in our discharge pathways in recent months, which impact on hospital flow and patient experience. The collective approach[3] to developing a discharge model is significantly supported through networks of service that place more emphasis on a person's needs rather than on organisational boundaries. Evidence suggests a Home First approach can reduce deconditioning, improve patient experience, and enhance working relationships between health, social care and housing sectors.[3] Addressing our discharge challenges jointly across the partnership will support us in continuing to deliver an integrated discharge model that focuses on appropriate discharge from an acute setting, where a patient is supported to be at home first, or in another community setting if the patient is unable to go home.

Through this priority, we will work together to reduce delays in discharge, implement home first principles across the city including roll out of the optimum model for Discharge to Assess (D2A), across acute, community and adult social care. This will support us to improve patient experience and outcomes through appropriate and timely discharge and support patients to recover in their own homes.

[3] Discharge to Assess, TRANSFORMING URGENT AND EMERGENCY CARE SERVICES IN ENGLAND

Discharge and Home First – Deliverables

- Ensure all partners adopt the **home first principles**
- Agree and deliver the **optimum model for D2A** across the city by November 2023
- **Target investment** for discharge at schemes that support and sustain a sustainable D2A
- **Re-procure Domiciliary Care** provision that supports ‘independence’ not ‘dependence’
- Increase **virtual ward capacity** to support discharge and avoidable admission
- Evaluate and invest in **voluntary sector support** for discharge where value is demonstrated

Alongside the development of key deliverables, we have developed outline measures which will support us in measing our success. These focus on reducing length of stay and discharging our patients with appropriate support.

Discharge and Home First – How will we measure success?

- Increased number of residents who return to normal place of residence after hospital discharge (BCF)
- Increased number of older people with re-ablement support
- Reduced length of stay in hospital (BCF)
- Increased carers’ satisfaction
- Decreased unplanned admissions for chronic ambulatory care sensitive conditions (BCF)

4.2 Same Day Care

In line with the Fuller Stocktake report, Sheffield HCP has a vision for integrating primary care. At the heart of which is the need to improve the access for our communities. Access to care needs to be timely and streamlined for those requiring immediate or urgent care but also needs to be more proactive and person centred for those with multiple long-term conditions or complex needs. The public, patients, carers and staff have told us that they value continuity of care, particularly when people have complex needs. Primary Care’s ability to manage complexity and hold risk or uncertainty is built around enduring relationships between patients and their multi-disciplinary teams. For many people though, especially those normally in good health, timely access is more important for them than seeing a clinician they know.

We will therefore work to develop access models that preserve continuity of care where it is most important (for example for people with multiple long term conditions, requiring palliative care, or have serious mental illness and complex social circumstances) whilst providing alternative options for rapid access for those with relatively minor, or acute problems.

In addition to the challenges faced in primary care, Sheffield has also seen increased numbers of people coming into our emergency departments (ED), ambulance handover delays and high levels of bed occupancy within our hospitals. Our focus on Same Day Care (SDC) will support us to provide patients with the right care in the right place at the right time, and support patients to be assessed, diagnosed and start treatment on the same day, improving patient experience and reducing hospital admissions.[4] The cross-organisational impact of this and the potential to improve patient experience will support all our communities, and improve capacity for hospitals to deliver elective care.

Increased use of digital technology and improved access to information and education will ensure people are empowered to manage their own health whilst at a neighbourhood level we will work with our communities to proactively manage chronic illness early, increasing patient activation through coaching and peer support.

We will develop a new model for same day care that delivers the national ambitions and enables our communities to access the right service based on need. This will result in shorter stays for patients and unnecessary delays in leaving hospital and support us to improve access to primary care, patient flow and reduced waits in ED.

Same Day Care – Key deliverables

- Develop a **new model for same day care** across the city (Primary Care, Extended Access, Walk-in Centre, GP collaborative, ED
- **Improve navigation** and signposting across the city
- **Improve knowledge** of urgent care pathways (staff and patients)
- Protected **Continuity of Care** for those who needs it.
- **Improve ambulance handover** processes, reducing handover delays
- Work with community services to **enhance opportunities to avoid admission**, ensure effective use of SDC and consider future model of Single point of Access for Urgent Care
- Ensure **high quality local Directory of Service** to ensure we reduce conveyances to ED

Our measures of success consider the various impacts of implementing a new model for SDC, which supports patients to access care on the same day and increases the potential to avoid an emergency hospital admission.

[4] Same day emergency care: clinical definition, patient selection and metrics, NHS England

Same Day Care – How will we measure success?

- Improved access points to urgent care pathways across the city
- Sustainable delivery of ambulance handover and ED performance metrics
- Reduced ambulance handover delays
- Improved patient and carer satisfaction
- Improved patient experience
- Reduced hospital admissions
- Reduced unplanned and longer than necessary stays in hospitals, resulting in lower risk of infections and de-conditioning for patients
- Sustainable model of Primary care
- Exploration of non-medical pathways to support our populations health and wellbeing

4.3 Mental Health Crisis (All Ages)

The increase in demand has had a direct impact on our ability to meet our populations needs and achieve our national standards for access, waiting times have been challenging across the city. This affects patients' experience, outcomes and the opportunity to access timely treatment and support. Moreover, there is a clear correlation between poor mental health and socioeconomic deprivation,[5] meaning delays to diagnosis and treatment further exacerbate health inequalities for those facing the greatest barriers to accessing care.

[5] Poverty and mental health: policy, practice and research implications, 2020

The NHS Long Term Plan[6] set out key objectives for improving access to crisis support across all ages, including the implementation of access to crisis support for all ages via 111, ensuring implementation of appropriate series for children and young people and appropriate support in ED from specialist liaison psychiatry teams. More recently, the Department of Health's 2021 – 2031 Mental Health Strategy[7] highlighted the importance of providing the right support at the right time through the creation of clear and regionally consistent urgent, emergency and crisis services for children and young people that will work together with crisis services for adult mental health.

Through this priority, we will ensure there is 24/7 access to mental health crisis support for children, young people and adults. This will lead to the delivery of a more person-centered, responsive and supportive service, whilst improving the response times to age-appropriate services to those in mental health crisis.

Mental Health Crisis (All age) – Key Deliverables

- Reduce inequalities in access, experience and outcomes of crisis care amongst different groups, and to co-design alternative provision which is tailored to their needs and preferences
- Staffing models for these types of services must include peer support workers and will require partnership with voluntary sector providers of all sizes
- Development of cross-sector local care crisis pathways

To support us to further develop our model across Sheffield, and focus on the needs of local people, we have been keen to identify success measures that relate to age groups and ensure a focus on national requirements.

Mental Health Crisis (All age) – How will we measure success?

- Improved older adults' experience and access to services
- Improved access, in line with NHS standards
- Increased in range of complementary services
- Decreased crisis ED attendance
- Improved patient experience
- Improved outcomes

4.4 Neurodiversity

Neurodiversity is a collective term to describe the differences and variation of cognitive functioning within the population, and encompasses conditions including Autism, Dyslexia, ADHD and Dyspraxia. Sheffield's neurodiversity service has

[6] NHS Long Term Plan, Crisis and Mental Health Support, 2019
[7] DoH Mental Health Strategy 2021-2031, 2021

received more than double the number of referrals compared to 18/19 and 19/20, and this increasing demand significantly impacts waiting times for patients.

Whilst there isn't a national strategy for neurodiversity, the 2021 National Strategy for Autistic Children Young People and Adults[8] committed to delivering timely access to diagnosis and improved assessment pathways by 2026. The Framework for Delivery[9] highlights the importance of developing a holistic, accessible and person-centred service that supports patient choice, and proactively takes action to reduce known sources of health inequality in access to, or experiences of assessments. We will work to improve waiting times to access our neurodiversity services as well as ensuring we have a variety of support offers for patients post diagnosis. Faster diagnosis and better support for people and their families will improve patient experience and outcomes.

Neurodiversity – Key Deliverables

- Design an approach to identify and assess neurodivergent people's needs in a **more holistic way** focussed on the whole person and **embedding a personalised care model**
- Implement the national objective to **reduce reliance on inpatient care**, while improving the quality of inpatient care
- Focus on **developing preventative programmes** of work, by co-designing with those with lived experiences and their carers
- **Identify alternative community support provision**, building on the progress to date

Alongside our key deliverables, we have developed outline measures to support us in measing our success. These are focused on improving access to diagnostic tests and providing post-diagnosis support.

Neurodiversity – How we measure success

- Reduced waiting times for access to diagnostic services
- Improved diagnosis rates
- Increased commissioning of VCSE services for support to those with a diagnosis
- Improved patient outcomes for those with co-morbidities
- Improved patient and carer satisfaction
- Holistic model of care working across all partners that supports prevention

[8] National strategy for autistic children, young people and adults: 2021 to 2026, 2021
[9] A national framework to deliver improved outcomes in all-age autism assessment pathways: guidance for integrated care boards, 2023

4.5 Building a Model Neighbourhood

The north-east of Sheffield has a diverse and young population but experiences the highest levels of deprivation in the city. This includes, but is not limited to the following:[10]

- Higher levels of poor reported health
- Young population (25.7% aged 0-15 years)
- Lower household income of £33,456 average (£40,688 for Sheffield and national average of £43,966)
- Less than 50% of the population own their own homes
- Higher levels of digital exclusion (38%)
- 13.7% estimated levels of obesity prevalence

We have an ambition to support communities to lead happy and healthier lives, and we understand that this will mean we need to be innovative in our approach to tackle this. We will focus our priorities on addressing the needs of our communities experiencing health inequalities in the north-east of the city as well as a core focus on the needs of inclusion groups and those experiencing poorer outcomes.

Action on health inequalities requires action across all the social determinants of health, including education, occupation, income, home, and community.[11] We will need to embed this through joint working with our communities. To support us to do this, the Community Development and Inclusion Group has developed proposed principles, building on the joint commitments:

- We will **prioritise resources** in the north-east of Sheffield and bring partners from multiple sectors together with communities to overcome the social determinants, to improve health outcomes
- The model will **be co-designed with our local communities**, ensuring we are embedding their views in designing the key elements of the neighbourhood with all agencies
- Initial design to be developed and continued co-design approach to be identified

[10] Local Insight (communityinsight.org) – North East Local Area Committee Indicators
[11] HEALTH EQUITY IN ENGLAND: THE MARMOT REVIEW 10 YEARS ON

4.6 Enablers

Our approach

- **We will co-design a model neighbourhood, working across health and care partners, to address the needs of our communities living in north-east Sheffield**
- Develop a plan with associated resource allocation to drive forward our ambitions in partnership with our communities.

What Does Success Look Like?

- Improved health and wellbeing
- Happy healthy people
- Strengths based approach to co-design
- Increased levels of employment
- Supporting people to achieve educational attainment
- Supporting local businesses and drive forwards social value
- Personalised service models addressing health needs of individuals

There are five key enablers that will support delivery of our five priorities.

- **Embedding a compassionate leadership model:** A focus on relationships through careful listening to, understanding, empathising with and supporting other people, enabling those we lead to feel valued, respected and cared for, so they can reach their potential and do their best work.
- **Listening to the needs of our communities:** As part of the Compassionate Leadership Model and through our local approach, we will build in continuous engagement and involvement with our communities to best support our work. This will include co-production of building a 'Model Neighbourhood'. Across all our priorities we have included a measure of improved patient experience, this will be key for us alongside embedding further detailed listening exercises.
- **Allocating resources:** We will address the longstanding challenges on how resources are allocated to deliver our ambitions. We have identified funding to support a reduction in health inequalities, and we will co-design a set of principles for how we allocate resources to those areas most in need.
- **Focusing on workforce and digital throughout all our work:** We will be informed by high quality, information for each of the key areas as well as across our partnership. This includes information we hold individually as organisations being shared across the partnership, where this is helpful, along with collectively measuring our approach. Our longstanding workforce challenges will require focussed work, and we will embed this through the development of each of our plans.

- **Allocative efficiency –** to work in partnership to deliver the 1.8% efficiency target at Place, including working innovatively and implementing key schemes in collaboration.

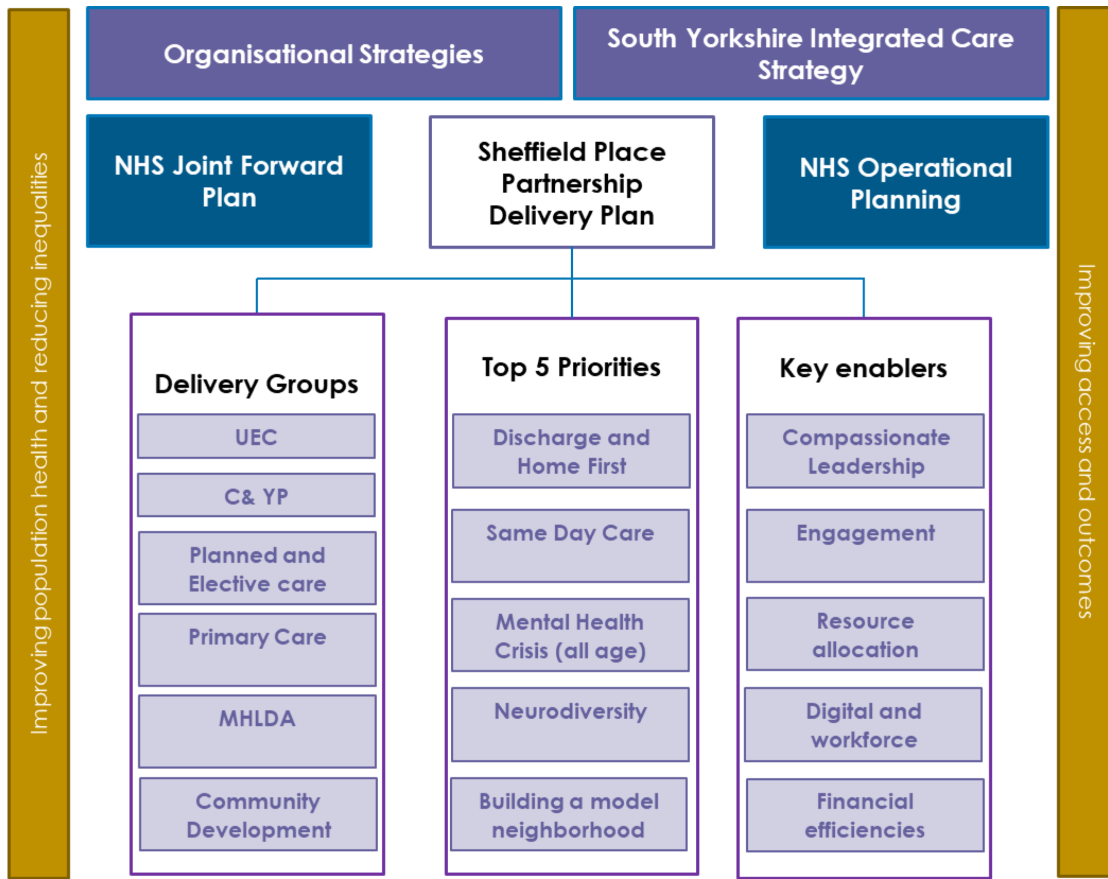
5. How we will deliver this together

Over recent months, we have collectively reviewed our partnership's governance, and the role and priorities of our six Delivery Boards to focus on the needs of our communities across Sheffield. The Delivery Boards include:

- Urgent and Emergency Care
- Children and Young People
- Mental, Health, Learning Disabilities and Autism
- Community Development and Inclusion
- Primary and Community Care
- Planned and Elective Care

It is acknowledged that different elements of our work are being led by other areas such as the South Yorkshire Acute Care Federation. The Place Partnership would require sight of progress in these work programmes and how they relate to the delivery of the Sheffield Place ambitions, this includes a core focus on the 31 national operational planning objectives along with our joint work towards the NHS Joint Forward Plan.

We are committed to delivering South Yorkshire Integrated Care Strategy's vision, goals, and shared outcomes by working with our system partners to maximise our impact at both Place and System level. We will continue to work across all of our delivery groups, with a focus on the five priorities we have identified, to drive forward our vision for the people of Sheffield.



We have initiated the development of a Framework for delivery to plan our outputs for 2023/24. For each priority, we will collectively agree an approach to regular reporting, risk management, and allocation of resources. In line with our vision as a Partnership and South Yorkshire's Integrated Care Strategy, reducing and removing inequalities in health outcomes is a central component of our vision for Sheffield. Therefore, the allocation of resources will reflect the needs of our local communities.

Appendix 1 – Sheffield Partnership's Five Priorities –Framework

	Discharge and Home First	Same Day Care	Mental Health Crisis (all age)	Neurodiversity	Building a model neighbouhood
Why is this a priority	Significant challenges in discharge pathways which impacts on hospital flow and patient experience.	Significant challenges in ED presentation, ambulance handover delays and demand on primary care along with levels of occupied beds.	Challenges in achieving core standards due to increased demand and presentation in ED. This impacts on experience, outcomes and an opportunity to deliver alternative models of support.	The neurodiversity service has received more than double the number of referrals compared to 18/19 and 19/20. Increasing demand has a significant impact on waiting times.	Communities residing in the north-east of the city experience health inequalities, have the highest levels of deprivation and poorer outcomes
Objectives	To work together to reduce delays in discharge, implement home first principles, including roll out of the optimum model for D2A in acute, community and adult social care.	To develop a new model for same day care that delivers the national ambitions and enables our communities to access the right service based on need	To ensure there is 24/7 access to mental health crisis support for children, young people and adults	To work jointly to improve waiting times to access services as well as ensuring we have a variety of support offers for post-diagnosis	To work with our local communities in the north-east of the city to develop a neighborhood model which best supports their needs
How will this support our communities	Improved patient experience and outcomes through appropriate and timely discharge and recovery in patients' own homes.	Reduced length of stay and unnecessary delays in leaving hospital. This will also support us to improve flow, access in ED and primary care on the day.	Delivery of a more person-centred, responsive and supportive service whilst improving the response times to age-appropriate services to those in mental health crisis	Faster diagnosis and support for people and their families, leading to improved experience and outcomes.	Improved health outcomes, patient experience and the overall health and wellbeing of our local people
23/24	• Achieve the national requirements by winter 2024 • Embed the National D2A model to enable Trusts to have a robust winter plan • Reduce occupancy for No R2R • Reduce G&A bed occupancy to 92%	• Achieve and sustain ambulance handover requirements by winter 2024 • Identify an agreed Single Point of Access model for urgent care • Develop a campaign to improve knowledge of urgent care pathways in Sheffield	• Implement the 24/7 response line for all ages • Develop a triage pathway to ensure patients can access an appropriate care setting during a mental health crisis • Increase the number of adults being supported by community mental health services by 5%	• Reduce waiting times • Ensure 75% of people over 14 on GP registers receive an annual health check by March 2024 • Develop post-diagnosis support options to reduce reliance on inpatient care	• Identify a Proof-of-Concept study to embed Community Power, allocating an agreed budget to communities to develop a service (health or non-health related) • Agree a social value framework for measuring the system's impact as an Anchor