Sheffield Partnership Place Plan
Proposed Priorities
April 2023

healthwatch Sheffield

Primary Care Sheffield

Sheffield City Council

Sheffield Children's NHS Foundation Trust

NHS Sheffield Health and Social Care NHS Foundation Trust

NHS Sheffield Teaching Hospitals NHS Foundation Trust

vas supporting community action

NHS South Yorkshire Integrated Care Board

Introduction and Purpose

Purpose: To provide an overview of the **proposed** key priorities for delivery across Sheffield Place Partnership over the next 18- 24 months.

Introduction and Background

We have come together across Sheffield to review our Partnership governance over recent months. The role and priorities of the following delivery boards have also been reviewed to focus on the needs of our communities across Sheffield.

- 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

In February, we came together to discuss the priorities for each of these groups, and recognised that there was a need to identify our top 5 priorities that the Partnership need to collaborate on over the next 18-24 months.

As we have been developing our plans for Sheffield, we have had the publication of the South Yorkshire Integrated Care Strategy, the launch of the 2023/4 operational planning process and the NHS joint forward plan. The Provider Collaboratives and Alliances Plans will need to be reflected through our work.

The following slides set out the proposed approach for delivering our priorities and a broader view of the work we will continue to deliver. It is acknowledged that accountability for different elements of our Place work is being led by other areas such as the Acute Federation and the Place Partnership would require sight of progress in these work programmes and how they relate to the delivery of the Sheffield Place ambitions.

We are keen that our focus continues to be on the areas which have the greatest impact for the people of Sheffield.

Our partnership vision is *for our* ***health and care services*** *to be* ***integrated****, joined up, and seamless; to* ***reduce and remove inequalities in health outcomes and access*** *to support, by playing 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.*

Our vision

Sheffield Place - Strategy and Planning

Since the establishment of the Integrated Care Board and the Integrated Care Partnership in July 2022, we have been supporting the development of the Integrated Care Strategy across South Yorkshire, which provides us with a significant opportunity to drive forward our ambitions for the people of Sheffield. As we develop our Place Plan, it is important for us to consider the delivery of our broader strategy and plans as we focus our collective efforts on the key priorities, our delivery group work plans and the enablers through our framework.

South Yorkshire Integrated Care Strategy

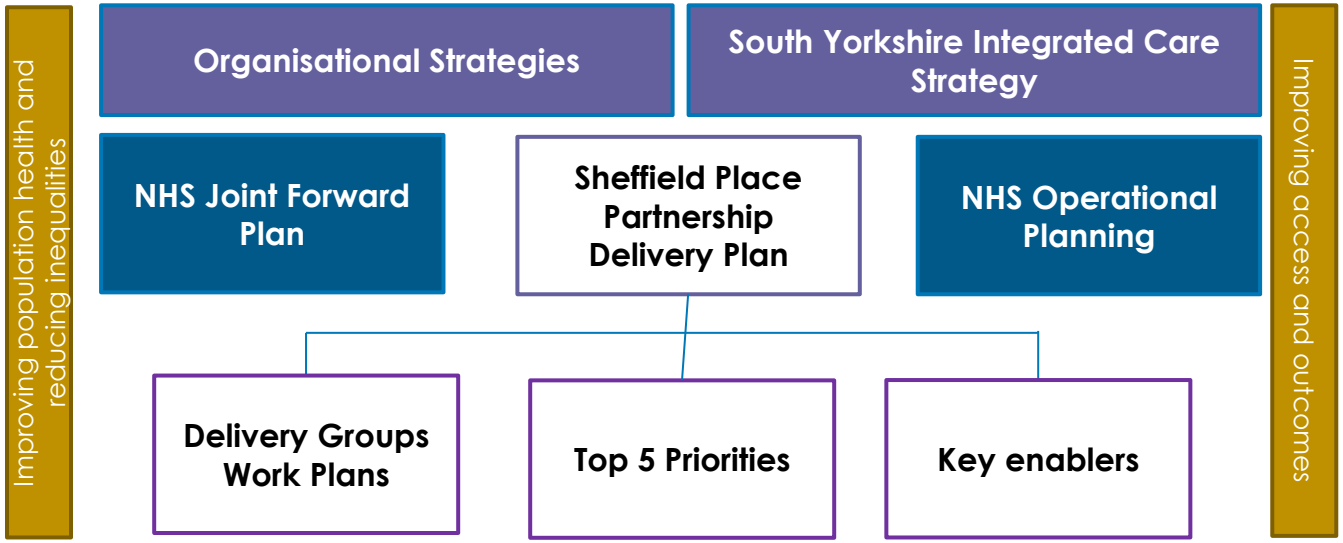
The Integrated Care Partnership, the joint committee of the ICB and Local Authorities in South Yorkshire have developed the Integrated Care Strategy where collectively we have agreed a set of goals, bold ambitions and joint commitments. This builds on our Health and Wellbeing Strategies in each of the four Places. In South Yorkshire we will continue to contribute to the delivery of these through our Place Partnership Plan.

NHS Joint Forward Plan and Operational Planning

The development of the NHS Joint Forward Plan is underway, across the ICB and Trusts across South Yorkshire, this will set out our delivery plans across South Yorkshire for the NHS contribution to the delivery of the Integrated Care Strategy. The first year of this plan will align with the annual operational plan where there is an immediate focus on improving access and quality across services.

Our golden threads

Throughout our strategy and plans we all have a focus on improving the health of our population and reducing inequalities across the city. We have as a partnership focussed on this in the development of our delivery plan, and this will be central to our approach. In developing our priorities it has been key for us to consider how we maximise our impact as a partnership for the benefit of our communities.



We have undertaken a process to develop the priorities of the delivery groups and alongside this have identified proposed 5 key priorities for the partnership. The following slides set out how we have assessed these priorities including an outline of how we would deliver against these and what success would look like.

Sheffield Place Plan - Identifying our Top 5 Priorities

To identity the top 5 priorities, we have undertaken an assessment of our key challenges and our aspirations as a partnership. Through the following lenses, this has enabled us to develop the proposed priorities, linking to a strong evidence base to support us in onward delivery.

Considerations when identifying our Priorities

National requirements and local strategies

- Focus on our role in the delivery of the 31 Operational Planning Objectives
- The development of the NHS Joint Forward Plan
- National strategies and plans for specific sectors
- Provider Collaboratives and Alliances
- Sheffield's Health and Wellbeing Strategy
- Embed the Core20plus 5 to reduce healthcare inequalities and focus on the needs of our most deprived communities

Improving performance and focussing on access and outcomes

- Focus on areas where we have long standing challenges in achieving national performance requirements and identify areas where collectively we have a role
- Specific key areas of challenge include;
  - Discharge from hospital,
  - same day access to care,
  - mental health crisis support and
  - C &YP Neurodiversity

Listening to the needs of our communities

- Focus on what have heard through listening exercise(s) to understand the needs of patients and the public
- Engagement with our diverse communities to inform and shape these priorities
- Need to actively address equality and inclusion in our work
- Help us support patients and public partners to have a meaningful and positive experience

Focus on Health Inequalities

- Assessed the population health needs of our communities
- Utilised health outcomes and wider determinant's of health as an indicator for these priorities
- Ensure we support the most deprived communities across Sheffield, with a focus on the north east of the city
- Focus on the bold ambitions of the ICP
- Embed an approach to co-produce a neighbourhood model with our communities

Partnership working

Where best we can jointly maximise our impact for the benefit of our communities

Proposed Top 5 Priorities

Discharge and Neighbourhood Home First	Same Day Access to Care	Mental Health Crisis Support	C&YP Neurodiversity	Building a Model in North East Sheffield

Sheffield Place Plan - Proposed Priorities

To support discussion, we have set out below the reasons for identifying these priorities, objectives and importantly how this will support our communities along with where we will deliver this work – across our delivery groups in some instances.

	Discharge and Home First	Same Day Access to Care	Mental Health Crisis (all age)	Neurodiversity	Building a model neighbouhood
Why is this a priority	Significant challenges in our discharge pathways which has an impact on hospital flow and patient experience.	Ssignificant challenge in levels of presentation in ED, ambulance handover delays and demand on primary care along with levels of occupied beds.	Challenges in achieving core standards due to increase in demand and presentation in ED for people in crisis that impacts on experience and 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 which has a significant waiting time for patients.	To address the health inequalities experienced by communities residing in the north-east of the city, where we have the highest levels of deprivation and poorer outcomes
Objectives	To work together to reduce delays in discharge ,implement home first principles across the city including roll out of the optimum model for D2A, including 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 patients 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	Improve patient experience and outcomes through appropriate and timely discharge and recovery in patient's own homes.	Will result in shorter stays for patients and unnecessary delays in leaving hospital, this will also support us to improve access in ED and primary care on the day improving flow.	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 children, young people and their families improving experience and outcomes.	Improve health outcomes, patient experience and the overall health and wellbeing for our local people
Delivery Groups	Urgent and Emergency Care Primary Care and Community		Mental Health, Learning Disabilities and Autism		Community Development and Inclusion
	Planned and Elective Care		Children and Young People		
Our golden threads	Improving population health and reducing inequalities Focussing on access and outcomes				

Proposed Priorities: Summary of key deliverables and benefits

The following table sets out the potential deliverables and associated success measures for each of our areas.

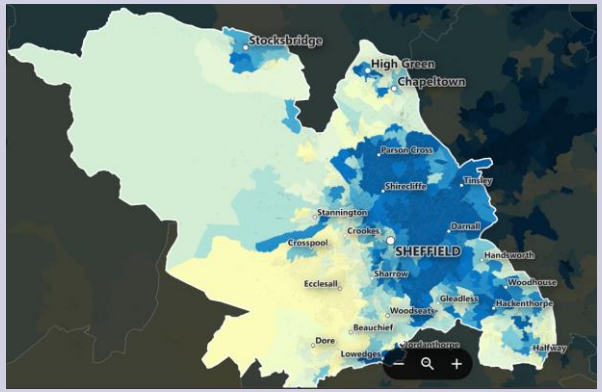
	Deliverables	Measuring success
Discharge and Home First	• Ensure all partners adopt the home first principles • Agree and deliver by November 2023 the optimum model for Discharge to assess across the city • Target investment for discharge at schemes that support and sustain sustainable D2A • Re-procure 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.	• Increase in residents who return to normal place of residence after hospital discharge (BCF) • Increase in older people with reablement support • Reduction in length of stay in hospital (BCF) • Carers satisfaction • Decrease in unplanned admissions for chronic ambulatory care sensitive conditions (BCF).
Same Day Access to Care	• Develop a new model for same day urgent care across the city (Primary Care, Extended Access, Walk In Centre, GP collaborative, ED) • Improve navigation and signposting across the city access • Improve knowledge of urgent care pathways (staff and patient). • Improve ambulance handover processes, reducing handover delays • Work with community services to enhance opportunities to avoid admission, ensure effective use of SDEC and consider future model of SPA for Urgent Care • Ensure high quality local Directory of Service to ensure we Reduce conveyances to ED	• Improved access points to urgent care pathways across the city; • deliver and then maintain the new 2023 (ambulance handover and ED performance) • Reduction in ambulance handover delays • Patient and carer satisfaction • improving patient experience • reducing hospital admissions • Avoiding unplanned and longer than necessary stays in hospitals, resulting in lower risk of infections and de-conditioning for patients • Sustainable model of Primary care
Mental Health Crisis Response (all age)	• 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 local care crisis pathways, cross –sector.	• Improve older adults' experience and access to services • Improve access, in line with NHS standards • Increase in range of complementary services • Decrease in crisis ED attendance • Improved patient experience • Improved outcomes
Neurodiversity	• Designing 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	• We will reduce waiting times for access to diagnostic services • Improved diagnosis rates • Increase in commissioned VCSE services for support to those with a diagnosis • Improved patient outcomes for those with co-morbidities • Improved patient and carer satisfaction
Building a Model Neighbourhood (further information slide 7)	• 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	This will support us to improve health outcomes, satisfaction, experience and improve the overall health and wellbeing for local people alongside addressing the wider determinants of health.

Health and Care Needs – Building a model neighbourhood

We have summarised below elements of the population health and wider determinants of health facing our communities focussing on the most deprived communities in north east Sheffield.

Sheffield Health and Care Needs

- Sheffield is ranked as the 57th most deprived local authority in England, out of 317
- Five (out of 345) lower super output areas in Sheffield are within the 1% most deprived in England, an increase from three in 2015
- Around 19% of the Sheffield population are from a BAME background
- 38% of the 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.**



Our North East Sheffield Communities

93,749 total population	**3,749 unemployed**
Diverse Population	**High Digital Exclusion Index – 35,877.2**
<50% own their own homes	**47,980** receive universal credit
High levels of reported poor health	Young population – **25.6% aged 0-15**
Lower life expectancy	**45,406 economically inactive**

https://sheffield.communityinsight.org/dashboard/

Building a Model Neighbourhood

Our approach

- **We will co-design a model neighborhood**, 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

Embedding an approach of co-production and working together to maximise our approach to addressing the needs of local communities

Enablers to delivering our Place Plan

To support us to achieve our objectives we will require a focus across the following areas to ensure we are able to deliver the plan and the associated benefits.

Embedding a compassionate leadership model

Compassionate leadership involves 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.

The approach helps to promote a culture of learning, where risk-taking (within safe boundaries) is encouraged and where it is accepted that not all innovation will be successful, this will support us to drive innovation through the work of our teams.

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' and will be a focus throughout all of our delivery plans.

Across all of 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

To be able to deliver our ambitions, we will need to address the longstanding challenges on how resources are allocated.

We have identified funding to support the reduction in health inequalities, and we must continue as a partnership to address some of our biggest challenges with the required investment to address needs of local communities.

We will co design a set of principles for how we allocate resources to those areas most in need

Focus on workforce and digital throughout all of our work

We will need to be informed by high quality, current 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.

The longstanding challenges across workforce will require focussed work, and we will embed this through the development of each of our plans.

Summary and areas for discussion

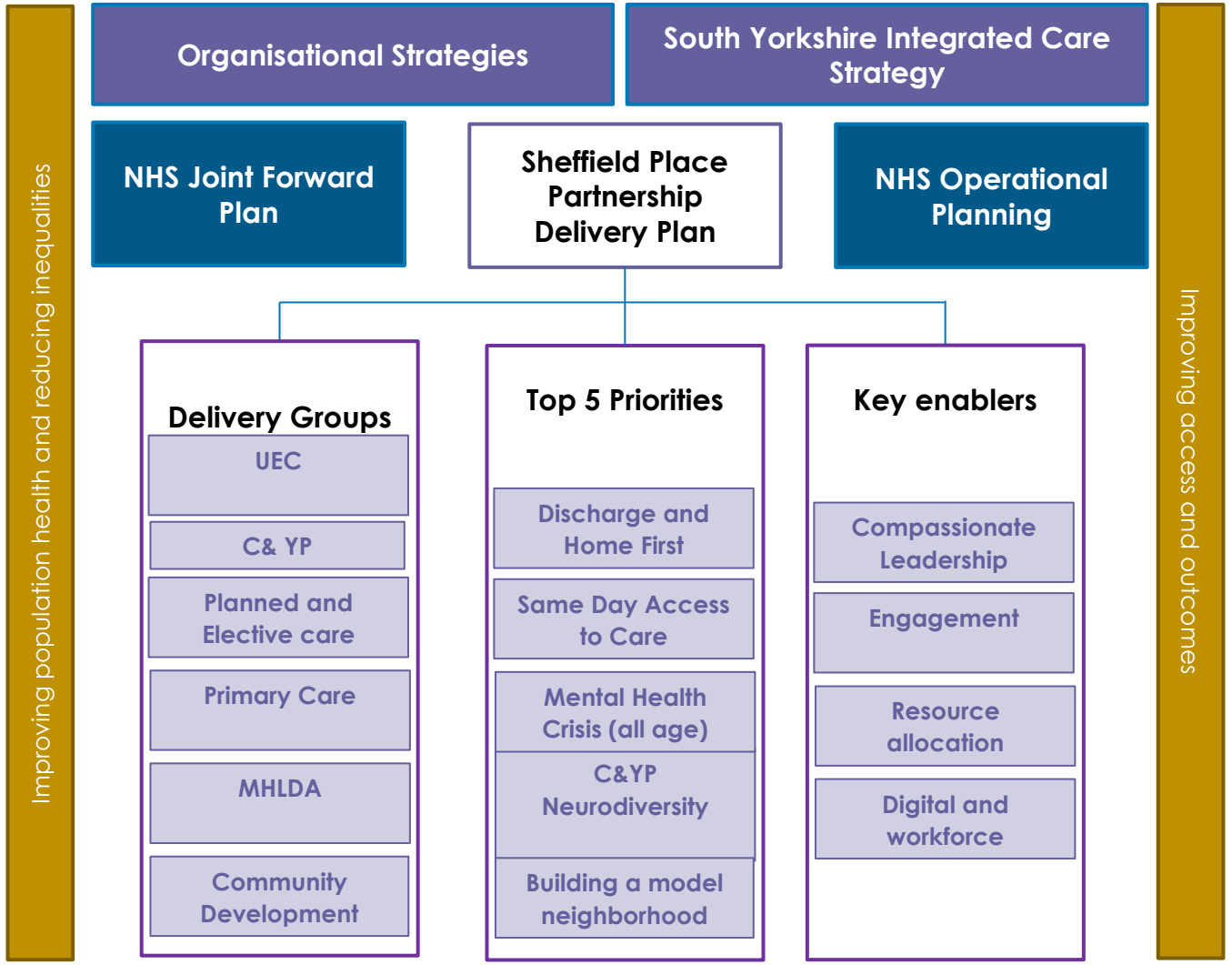
We have set out the key considerations, assessment of priorities and a summary of the areas of focus for the next 18-24 months for the Sheffield Health an Care Partnership.

Proposed next steps:

- To develop the plans aligned to each priority area and create a detailed plan alongside a plan on a page for each area
- Launch work programmes, building on the progress to date within each of the delivery groups.
- Agree periodic reporting to the board

The Partnership Board is requested to discuss the assessment of priorities and discuss:

- Consider the five key priorities and whether these are the right areas of focus for us
- Discuss the deliverables and success measures, and share comments on how we can further develop these
- Discuss the key enablers and consider agreeing to developing a detailed framework to embed these in our partnership approach



Appendix

South Yorkshire Integrated Care Strategy

As part of our role in developing the South Yorkshire Integrated Care Strategy, we have contributed to developing a series of goals, outcomes, bold ambitions and joint commitments, which all drive our collective vision. This is central to developing our Place Plan, ensuring our key deliverables support us to deliver on our ambitions.

Everyone, in our diverse communities, to live happier healthier lives for longer

South Yorkshire Integrated Care Strategy, Vision

South Yorkshire Integrated Care Strategy

Our goals	**Healthier Life for Longer**	**Fairer Outcomes for All**	**Access and Quality**
Shared Outcomes	Children and young people have the **best start in life**	People in **South Yorkshire live longer and healthier lives** and the **physical and mental health and wellbeing** of those with the greatest need improves the fastest	People are supported to live in **safe, strong and vibrant communities**	People are **equipped with the skills**
Bold Ambitions	**Early Years and School Ready**	**Acting Differently on Prevention**	**Fair Inclusive Sustainable Economy**	**Value and Support our entire Workforce**
Joint Commitments	**Bold, visible and collaborative leadership**	**Identifying, recognising and tackling systemic discrimination including a focus on anti racism**	**Reallocation of resources to where there is most need**	**Joined up service delivery and support**	**Listening and co-production with people and communities**	**Create a culture of learning and innovation**

Our **Sheffield Place Plan**, will support us to deliver the above, as part of the **Integrated Care Strategy**, for the **local population of Sheffield**.

The above has been central to the development of our plan.

Operational Planning – Delivery focus

Area	Priority	Where
1. Urgent and emergency care*	(1a) Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25 (1b) Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25 (1c) Reduce adult general and acute (G&A) bed occupancy to 92% or below	UEC Alliance and Places
2. Community health services	(2a) Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard (2b) Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals	UEC Alliance and Places Places and Primary Care Alliance
3. Primary care*	(3a) Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need (3b) Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024 (3c) Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024 (3d) Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels	Primary Care Alliance and Places Primary Care Alliance and Places Primary Care Alliance and Places Primary Care Alliance
4. Elective Care	(4a) Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties) (4b) Deliver the system- specific activity target (agreed through the operational planning process)	Acute Federation
5. Cancer	(5a) Continue to reduce the number of patients waiting over 62 days (5b) Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days (5c) Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	Cancer Alliance
6. Diagnostics	(6a) Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% (6b) Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition	Acute Federation
7. Maternity*	(7a) Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury (7b) Increase fill rates against funded establishment for maternity staff	LNMS
8. Use of Resources	(8a) Deliver a balanced net system financial position for 2023/24	South Yorkshire CFOs
9. Workforce	(9a) Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise	All building blocks
10. Mental Health	(10a) Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019) (10b) Increase the number of adults and older adults accessing IAPT treatment (10c) Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services (10d) Work towards eliminating inappropriate adult acute out of area placements (10e) Recover the dementia diagnosis rate to 66.7% (10f) Improve access to perinatal mental health services	MHLDA
11. People with a learning disability and autistic people	(11a)Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024 (11b) Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit	MHLDA
12. Prevention and health inequalities	(12a) Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024 (12b) Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60% (12c) Continue to address health inequalities and deliver on the Core20PLUS5 approach	Place and Prevention Programme

UEC Alliance
Places
Primary Care Alliance
Acute Fed
Cancer Alliance
LNMS
CFOs
MHLDA
Place and Prevention Programme