Sussex Health&Care

Improving Lives Together

Ambition to Reality: Our Shared Delivery Plan

Contents

1. Delivering Improving Lives Together

Our ambition is to improve the lives of everyone living across Sussex now and in the future. We want local people to thrive to be the best they can be; to be healthier and feel supported; and have the best possible services available to them when and where they need them.

Our Integrated Care Strategy, *Improving Lives Together* represents this ambition and sets out the agreed long-term improvement priorities we will be focusing on across health and care in Sussex that will bring the greatest benefits to local people and our workforce.

We are committed to making our ambition a reality over the next five years and beyond, and this Shared Delivery Plan sets out the actions we are taking in Year One to make it happen. This will involve:

- **Progressing our long-term improvement priorities**

We will be building on work that is already taking place and taking new actions to progress the long-term improvement priorities that have been agreed across our health and care system. These are:

- A new joined-up community approach, through the development of Integrated Community Teams;
- Growing and developing our workforce;
- Improving our use of digital technology and information.

We have set out the Year One actions we will be taking to progress our priorities, what we plan to achieve and when, as well as outlining the actions we are planning for subsequent years.

- **Making immediate improvements to health and care services**

We recognise there are immediate improvements that need to be made to health and care services. This winter has been extremely challenging for our health and care system, due to high numbers of people needing support and care from services, and this has meant not everyone is always getting the right care, at the right time and in the right place for their needs. This has had an impact of some people's experience of services and their outcomes and has put intense pressure on our hard-working workforce.

A lot of work is taking place to give people better access to, and experience of, services and we are giving specific focus to four areas that need the most improvement:

- Increasing access to and reducing variability in Primary Care;
- Improving response times to 999 calls and reduce A&E waiting times;
- Reducing diagnostic and planned care waiting lists;
- Accelerating patient flow through, and discharge from, hospitals.

- **Progressing areas that need continuous focus and improvement**

To bring about the improvements we want to make to achieve our ambition, there are four key areas that need continuous focus and improvement:

- **Addressing health inequalities** that exist across our population. This will be achieved through the delivery of all the actions we are taking but there is also a specific system-wide focus to help bring about the biggest short and long-term change.
- **Addressing the mental health, learning disabilities and autism** service improvements that we need to make across our system.
- **Strong clinical leadership** is crucial to enable us to make improvements to both health and care services and the health outcomes of local people.
- **Getting the best use of the finances available**. We will need to get the most out of the money we have available to invest in services and make sure we are working in the most effective and efficient way.

- **Delivering our Health and Wellbeing Strategies**

Improving Lives Together is built on the Health and Wellbeing Strategies across our three 'places' of Brighton and Hove, East Sussex, and West Sussex. These set out the local priority areas of work taking place to best meet the needs of our diverse populations. Health and care organisations are working together to deliver these strategies, as well as the long-term, immediate, and continuous improvements that need to be made to achieve our ambition.

We are developing a Five-Year Shared Delivery Plan to be published in July 2023, that will build on the work that is already taking place and outline the steps we will be taking to *Improve Lives Together* for our Sussex population, in future years. This draft version (March 2023) sets out our progress to date in developing our Plan.

2. Our ambition for a healthier future

We know that currently people across Sussex are not always getting the support and care they need to live the healthiest life possible.

Our Case for Change outlines the issues we face as a health and care system and why health and care services are not always able to meet the needs of our population. This includes population factors such as our growing and ageing population that means that more people need more care more often; the wider determinants of health, such as society and economic environment and conditions our local communities are living within; and people's lifestyles. There is also the lasting impact the Covid-19 pandemic has had on both services and health, and the current cost of living crisis that is negatively affecting people's health and wellbeing.

We also have long-standing health inequalities, with communities and groups of people having worse health than other people because of who they are or where they live, particularly those who are most disadvantaged.

In addition, individuals, communities and our workforce have told us that people are not always getting what they need, when they need it due to difficulties accessing services, support and information, and the disjointed and confusing way the 'system' works.

A lot of work has already taken place across health and care over recent years to improve the support, care, and treatment available, and the timeliness of how people access services, and progress has been made that has brought real benefits to local people. However, we recognise this has not always gone far enough in many areas and a lot of the issues we face can only be resolved through a more ambitious approach.

We have an ambition to achieve four aims:

- To improve health and health outcomes for local people and communities, especially those who are most disadvantaged.
- To tackle the health inequalities we have.
- To work better and smarter, getting the most value out of funding we have.
- To do more to support our communities to develop socially and economically.

We will do this through organisations working closer together and differently with and within our communities to support people through each stage of their lives. We want to:

- **Help local people start their lives well** by doing more to support and protect children, young people, and their families.
- **Help local people to live their lives well** by doing more to support people to stay well, to look after their own health and wellbeing.
- **Help local people to age well** by doing more to support older people to live independently for longer.

- **Help local people get the treatment, care, and support they need** when they do become ill by doing more to get them to the right service first time.
- **Help our staff to do the best job they can** in the best possible working environment by doing more to support their own health and wellbeing and to promote opportunities which ensure people want to work in health and care services.

We want to achieve our ambition over the next five years and beyond and recognise that we will not be able to do everything at once, with some things taking longer than others to get up and running, so we need to be focused on what we can do and when. We also need to do it in a realistic way, using the money, workforce, and facilities we have available as a health and care system.

However, by working together across all system partners, and with local people and communities, we now have an opportunity to combine our collective energy, resource, and expertise to make our ambition a reality.

3. Making our ambition a reality – Our Shared Delivery Plan

To make our ambition a reality, throughout 2023/24 and beyond, we will be making progress and improvement across the four key delivery areas set out below:

Delivery Area 1

Delivering our Long-term Improvement Priorities

Achieving our ambition is centred on three agreed long-term priorities **– a new joined-up communities approach; growing and developing our workforce; and improving our use of digital technology and information.** We will be taking action in Year One to progress these priorities and have agreed the key milestones we want to achieve over the following two to five years.

A Joined-up Community Approach: Integrated Community Teams

Over the next five years we will be integrating health, social care, and health-related services across local communities in a way that best meets the needs of the local population, improves quality and reduces inequalities. This will involve us working with local people to build on what works best already, and to create a multi-disciplinary workforce, tailored to the health and care needs of the community. We will do this by developing **Integrated Community Teams**, that are made up of professionals working together across different organisations within local communities. This will involve integration across primary care, community, mental health, local authority partners, VCSE and other local partners.

We will develop a **'core offer'** that each Integrated Community Team delivers to everyone, in addition to the individual support and services available to meet the specific needs of different communities. This new service model will be enabled by the delivery of our digital and workforce priorities, meaning our workforce has more time for direct care and to focus on population health management, prevention, and community engagement.

To progress this priority over the next year, we will build on the work already detailed in our respective Health and Wellbeing Strategies and test new ways of working through three innovative programmes in each of our three places – Brighton and Hove, East Sussex, and West Sussex. The learning from these **'Integrated Community Frontrunners'** will be used to shape and inform roll-out of the Integrated Community Team model across our system.

Our Year One actions to progress Integrated Community Teams:

What we will do	What we will achieve	When we will achieve it
We will define our Integrated Community Teams across Sussex.	We will have a clear model for Integrated Community Teams informed by our Joint Strategic Needs Assessments, Health and Wellbeing Strategies, and local population data and insights.	June 2023

We will agree our core offer for communities.	We will define and agree the health and care needs, outcomes and 'core offer' that each Integrated Community Team will deliver to its population.	March 2024
We will have data and information in place to support our Integrated Community Teams.	We will be able to measure outcomes that have been agreed at a local level, using a consistent outcomes framework which can be utilised at local level and be shared across the Sussex system.	December 2023
We will test and refine our new ways of working through our three Integrated Community Frontrunners.	We will have learning documented and shared across to inform further rollouts and our approach to clinical leadership, workforce and the use of technology and data.	March 2024

We will further progress our Integrated Community Teams approach from Year Two by:

- Agreeing our model of care and service specification for our 'core offer', working with system partners to agree the delivery form for this.
- Using data, insights, and evidence, develop a flexible local service offer for each Integrated Community Team for delivery alongside the core offer.
- Rolling out our Integrated Community Team model across Sussex, in a series of agreed 'waves'.
- Implementing a continuous improvement and evaluation approach to improve and refine the way we deliver services at a community level.

Our Integrated Community Frontrunners

We have selected three programmes at each of our respective Places, to be tests of change for our new ways of working. Within each of these, we will test and adapt our approach to clinical leadership, multi-disciplinary working, and the way in which we use technology and data.

Brighton and Hove: ***Improving Brighton and Hove Lives Together***

Across Brighton and Hove, we are working to improve and join-up services to better support people with multiple compound needs. These are among the most marginalised and vulnerable members of society and face significant health inequalities. There is a 34-year life expectancy gap for people with multiple compound need compared to the general population and they are likely to be living in the most deprived area and specifically Central and East of Brighton.

The aim is for multidisciplinary teams will be working together to better co-ordinated services that are preventative, proactive, responsive, and empowering; enabling individuals to maximise control over their lives. Team members pool their skills, professional experience, and knowledge to provide a rounded response to the people they are supporting.

East Sussex: ***Improving Hastings Lives Together***

Partners across health and care are currently working with community and voluntary organisations and local people in Hastings to design and develop health and care services and support in the future. Hastings has some of the most deprived wards in the country, so is the focus of the initial testing and development phase of the new model to enhance and integrate our joined-up offer of health, care and wellbeing in communities and neighbourhoods. There are many existing projects and funding streams focussed on reducing the gap in health inequalities, including the gap in life expectancy and the needs of specific groups within this. The programme of work is intended to build on this to establish a framework for planning and delivering joined up health, care and wellbeing services to get the best benefit for the local population.
A project called ‘Universal Healthcare’ has been underway since June 2022 with a number of community engagement workshops taking place to understand the needs of local people and help shape how they can be better supported in the long term.

West Sussex: ***Improving Crawley Lives Together***

Crawley is one of the most culturally diverse communities in West Sussex and has significant pockets of deprivation where people have poorer health outcomes than other areas of the county.

We have been running a programme of work since 2021 that is an innovative approach to tackling health inequalities and poor outcomes at a borough level. Its aim is to tailor health services and service models in Crawley to meet the needs of the population with a focus on the most disadvantaged communities.

Phase One of the programme set out to understand what health service developments were required to address the health inequalities and improve the poor outcomes. We took a local approach to looking at the needs of the population and engaged with local people to understand what barriers they are facing, and what is a priority to help support their health and wellbeing. A range of service developments are being undertaken to ensure they can meet the needs of the local communities.
By April 2024, we will have developed key service business cases and plans and developed the estates strategic outline case.

Growing and developing our workforce

We want to support our staff and volunteers to do the best job they can by growing and developing our workforce. The number of people working in health and care has grown and we need to carry on increasing staff numbers but recruiting more is not the only answer. We need to also get the best out of the staff we already have. There are five objectives we want to achieve:

- Developing a ‘one team’ approach across health and care so they can work together and across different areas to help local people get the support and care they need.
- We will support staff to develop new skills and expand the skills they have to allow them to work across different disciplines and areas and help staff to have more opportunities to progress in their careers.
- We want to create a more inclusive working environment that recognises diversity and has a workforce that better represents the population they care for.
- We will encourage, and make it easier for, more young people, students, and people who have never considered a career in health and care, to work with us.
- We want to create a culture where people feel valued and supported to develop their skills and expertise. We want to take a ‘lifelong learning’ approach where people never stop developing their skills throughout their career.

Our Year One actions to progress growing and developing our workforce:

What we will do	What we will achieve	When we will achieve it
We will agree the model for a single workforce support package across the system.	We will have an agreed single workforce support package in place.	December 2023
We will develop a People Plan with a three-year delivery roadmap.	We will agree one approach to workforce across our system and how this will be implemented.	September 2023
We will launch an innovative guaranteed employment scheme, in conjunction with Brighton University and Sussex Partnership NHS Foundation Trust (SPFT).	We will have supported SPFT to achieve an agreed reduction (subject to operational plan) in their registered mental health nurse vacancy rate.	June 2023
We will identify initial communities to test our one workforce approach.	We will begin to roll-out our one workforce approach.	March 2024

We will further progress our Workforce approach from Year Two by:

- Launching our system-wide digital and data training scheme.
- Agreeing and implementing one approach across the system, to talent management, succession planning and equality, diversity, and inclusion.
- Adapting and further rolling out our guaranteed employment scheme.
- Launching our system-wide organisational development and culture framework.
- Developing a compelling offer for multi-skilled professionals, in partnership with the education sector.
- Implementing a single system recruitment framework.
- Expanding our single workforce offering to include a collaborative bank function, wellbeing offerings, a single transactional service for employers and workforce.

Improving the use of digital technology and information

We need to do much more to harness the potential for the use of digital technology and information. in doing so, we can improve access and join-up our services in a way that will fundamentally transform the experience for our local population and workforce.

We currently have too many disjointed systems, and data that is not shared and available at the point of need and we will be working with our communities and workforce to co-design and deliver long-term improvements.

For our Integrated Community Teams to succeed, we will need to ensure that information can be shared effectively across teams from multiple organisations, in a simple, timely way. We also need to simplify and democratise digital access to services for our population.

To do this, we will need to **Digitise**, **Connect**, and **Transform** our services.

- We need to **digitise** to put the right foundational technology, tools, leadership, and capability in place across our system, and in the hands of our population and workforce. We need to do this in a way that will improve and simplify access for all and reduce the variation we see that leads to inequality and digital exclusion impacting some people and communities more.

- We need to **connect** our population, partners and communities through digital and data services that enable them to play their part in tackling the challenges the system faces and in building trust in the data that informs care, population health management, research, and innovation.

- With the right digital and data foundations in place across our system, we need to then **transform** our services through co-design of more integrated ways of working within our Integrated Community Teams (via our Frontrunners), and across our system; use trusted data and insights to improve, innovate and explore new technologies.

People and communities will be able to choose high quality digital and data services, information, and technologies they have co-designed and can trust; information that supports them to live healthier lives; technologies to help manage their conditions and treatments and services to communicate and plan with those involved in their treatment and care.

Our Year One actions to progress the use of digital technology and information

What we will do	What we will achieve	When we will achieve it
We will progress the work to **digitise** our services by evaluating our baseline position.	A system and provider digital maturity assessment will be completed and nationally benchmarked.	September 2023
We will agree a system-wide digital and data charter, setting out clear design principles and national benchmarking.	We will have 100% partners formally signed up to the charter.	September 2023

We will map unwarranted variation of inequality of digital access within our population and create a plan to address it; we will establish a People's Panel for Digital and Data and embed our Digital Inclusion Framework.	We will establish where we have inequality of digital access within our population and better ensure a population-led design approach of digital and data services.	March 2024
We will agree a system-wide data, information, and insight strategy.	A strategy will be in place.	March 2024
We will extend access and enrich services offered through the My Health and Care patient app (integrated with the NHS app).	We will have 65% of patients registered with the NHS App and 33% patients registered with My Health and Care.	March 2024
We will establish Digital Centres of Excellence in three providers to lead system improvements and innovation.	We will improve the quality and standard for Infrastructure, Data Intelligence, and Innovation across the system.	December 2023
We will extend our digital service offering including virtual care technologies, care planning, self-referral, primary care accessibility and other capabilities	We will have an enhanced range of digital service provision and integration across the system.	March 2024

We will further progress our Digital and Data approach from Year Two by:

- Expanding our work to connect community teams and share information to our wider system partners including social care and the voluntary sector.
- Delivering a single electronic staff record and rota system across Sussex to support our workforce in delivering health and care across providers and within community teams.
- Implementing a shared, single point of access, population health management data platform and Data and Analytics team to support the work of our Integrated Community Teams, building on the work undertaken through our Integrated Community Frontrunners.
- Removing system interface issues, enabling data sharing across complex health and care settings.
- Embedding and supporting population and community-led digital innovation.

Delivery Area 2

Delivering our Immediate Improvement Priorities

Alongside the Long-term Improvement Priorities, there are immediate improvements that need to be made across our health and care services. We have developed and submitted an operational plan for 2023/24 [link will be added here] which sets out the key actions that will be taken and how we will ensure best use of finances across our services.

We recognise that all service provision is vital for individuals and communities and work will continue to give people the best possible care and treatment they need in all areas. However, there is a need for us to make greater improvement across four key areas, to improve access to services and reduce the backlog in waiting lists that increased during the pandemic:

We need to:

- Increase access to and reduce variability in Primary Care;
- Improve response times to 999 calls, and reduce A&E waiting times;
- Reduce diagnostic and planned care waiting lists;
- Accelerate patient flow through, and discharge from, hospitals.

Increasing access to and reducing variability in Primary Care*

GP practices across Sussex work extremely hard to ensure their patients get the timely support, treatment and care they need in the best possible way. In January 2023 alone, there were over 900,000 appointments offered by Sussex practices, which was 97,000 more than the previous month and over 120,000 more than the same time last year.

The increasing number of people accessing GP services means it is increasingly becoming difficult for everyone to always get an appointment when the patient wants it. In addition, because each practice works differently, there is variation in how appointments are managed and accessed. This means some people trying to get an appointment can find some systems frustrating and the variation can exacerbate inequalities in access and outcomes.

Throughout Year One, we will be focusing on increasing capacity across GP services, improving the quality of services and patient outcomes and supporting general practice services to be more sustainable. At the end of Year One, we expect patient satisfaction and experience to have significantly improved, with patients having increased choice in access to same day and two weekly appointments via a range of methods.

Our Year One actions to improve Primary Care access and reduce variability:

What we will do	What we will achieve	When we will achieve it
Increased coverage of the cloud telephony system to improve service access	95% of practices will be signed up.	September 2023
Increased practice staff able to provide direct patient care	245 more staff recruited	March 2024
Increase referrals to our Community Pharmacist	We will increase referrals to 17,574	March 2024

The difference this will make to local people and how it will be measured:

Difference for local people	How will this be measured
It will be easier for patients to contact practices	Patient satisfaction scores will improve by 5%
Patients will be able to access more appointments	There will be a 2% increase in appointments from previous year.
Patients will be able to access an appointment within two weeks if they needed	The number of people obtaining an appointment within two-weeks if they need it, will increase by (X% tbc subject to operational plan)

* Note that the priorities and milestones might change in light of the forthcoming publication of the GP Access Recovery Plan.

Improving response times to 999 calls and reduce A&E waiting times

Like many systems across the country, we have seen increasing numbers of people using urgent and emergency care services over recent years and this is putting significant strain on our workforce and has impacted the timeliness for people accessing the care they need. Rather than seeing peaks and troughs throughout the year, services are now constantly busy and as a result too many people are routinely experiencing delays in care and staff are under ever increasing pressure.

A lot of work has taken place to continuously look at ways the system can improve responsiveness, quality of care and patient satisfaction. This will be built on, expanded, and taken even further during Year One and we will be focusing four key areas to make the biggest improvements:

- **Improving and standardising care** to give giving more of our population access to care which aligns with best practice.
- **Improving discharge** to free up more capacity to allow more people to be cared for in a more timely way.
- **Expanding care outside hospital** to ensure people's needs are meet sooner and they do not have to end up going to acute hospitals for treatment and care.
- **Expanding our use of virtual wards** to allow more people to be cared for in their own homes when they would otherwise have gone into hospital for care.

Our Year One actions to improve response times to 999 calls and reduce A&E waiting times:

What we will do	What we will achieve	When we will achieve it
We will undertake a full review of same-day emergency services in Sussex alongside an analysis of the different needs of our population.	We will have a clear understanding of the changes we need to make to ensure all our citizens have timely access to same day emergency care.	June 2023.
We will increase capacity in our ambulance service, including the roll out of Mental Health ambulances, 111 clinical advisory service, virtual wards, non-injured falls service, Mental Health same day urgent care services, Acute respiratory hubs, urgent community response services and Alternative to Admission Single Point of Access.	A greater number of people will receive rapid assessment and care for physical or mental health conditions in their own home or in the community and therefore avoid a hospital admission	December 2023
We will roll-out clear standardised pathways of care for individuals in Sussex who are at risk of a rapid deterioration in their health, including patients with respiratory illnesses or suffering from frailty.	Vulnerable individuals will spend more of their time in good health and receive rapid, early intervention through joined up primary, community, and secondary care services when support is required.	March 2024

We will support each of our acute hospital sites to undertaken improvement work within their emergency departments, including a focus on rapidly streaming patients to the right service.	There will be improved flow of patients through emergency departments, enabling ambulances to be offloaded and minimising the time that patients spend in departments before being discharged or admitted.	December 2023

The difference this will make to local people and how it will be measured:

Difference for local people	How will this be measured
More patients will experience shorter waits for treatment in A&E, Urgent Treatment Centres, and Minor Injury Units across Sussex.	We will achieve a minimum of 76% of patients attending A&E being seen within four hours.
Patients who call 999 with a time critical condition will receive a faster response from the ambulance service.	We will achieve the category 1 response time (90% of calls responded to within 15 minutes) and a better response rate of less than 30 minutes for category 2 (90% of calls responded to within 40 minutes).
More patients will receive medical care closer to home, with admission to an inpatient bed only occurring when absolutely necessary, enabling patients to cared for in a familiar environment with the support of friends and family.	We will increase the number of virtual ward beds to 40 per 100,000 population, reduce the number of ambulance conveyances to hospital (achieving better than the national average), expand 24/7 Mental Health Crisis resolution and home treatment services, increase the number of referrals to urgent community response services and deliver the two hour urgent community response target of 75%. Our Sussex Admission Avoidance Single Point of Access will play a significant role in coordinating this.
Patients at high risk of hospital admission or who are frequent users of healthcare services will be provided with more proactive care and support to enable them to stay well.	We will see a reduction in the number of high intensity service users and a reduction in the number of admissions and length of stay for patients identified as high risk.
Patients waiting for or undergoing emergency treatment or awaiting admission will be cared for in appropriate clinical settings at all times and will either be admitted or discharged more quickly, spending less time in the Emergency Department.	No patients will be cared for in corridors within Emergency Departments while awaiting treatment or admission. The number of patients waiting in Emergency departments for more than 12 hours will reduce to below 2%.

Reducing diagnostic and planned care waiting lists

There are currently large numbers of people waiting too long for diagnostic services and planned care, which can cause a deterioration in their condition, impact on their day-to-day lifestyle, and affect their general health and wellbeing. The lockdown restrictions that were put in place during the pandemic meant waiting times in these areas significantly increased and system partners have been working hard to reduce these as quickly as possible.

We will be maintaining and continuing this work in Year One and over the longer term will transform the way planned care and cancer services are delivered with that aim that no one waits over a year and we see movement towards achievement of the 18-week standard for elective care and 75% of cancers are diagnosed at stage 1 or 2.

Our Year One actions to reduce diagnostic and planned care waiting lists:

What we will do	What we will achieve	When we will achieve it
We will continue to realise productivity opportunities to make the best use of our resources, to provide greater access for patients.	We will increase our theatre utilisation rate to a minimum of 85% across all services. We will deliver at least 85% of surgery as a day case procedure. We will reduce the length of stay for key pathways such as hip and knee replacement surgery in line with best practice rates	March 2024
We will enhance patient choice and access to treatment through our system capacity strategy for key specialties including ENT and T&O. We will establish clinically led workstreams to develop patient pathways that are productive and standardised across Sussex.	we will have in place agreed clinical pathways across all acute services for our key specialties. This will provide greater choice and access to patients and reduce waiting time variation across the system.	September 2023
We will focus on outpatient transformation to improve earlier access to hospital services with a focus on reducing the number of patients that do not attend (DNA) their appointment, continuing to provide virtual clinics to reduce the need for patients to attend the hospital, and to provide greater flexibility to patients by increasing the number of 'Patient initiated Follow Up' (PIFU) appointments	We will reduce our DNA rate across Sussex by at least 2% over the course of the year. We will reduce the number of follow Up appointments generated by increasing our PIFU rate from 0.5% to 5% across Sussex. We will ensure that at least 25% of outpatient activity is undertaken virtually	March 2024
We will make further use of our Community Diagnostics Centres (CDCs) across Sussex, providing greater access to patients who need a	We will prioritise direct access for primary care for CT, ultrasound and MRI.	December 2023

test in order to support a decision for the care that they need.	We will have as a minimum six day working across our CDCs providing greater flexibility for patients. Reduced pressure within hospitals, to support their backlog reduction plans	
To support patients referred on a cancer pathway we will ensure referrals are made in line with standardised referral protocols and local pathways are optimised enabled by the Ardens Pro system which is in place across all practices in Sussex. We will continue to increase the number of patients referred with a Faecal Immunochemical Test (FIT) result at point of referral for a suspected colorectal cancer.	We will ensure that patients are referred into the most appropriate service based on their referral and clinical information, as an example, we will implement our bleeding while on HRT pathway, which will reduce 2 week wait demand by 30%. With a full compliance of colorectal referrals with a FIT test completed, we will reduce the number of colonoscopies required by up to 40%	September 2023

The difference this will make to local people and how it will be measured:

Difference for local people	How will this be measured
We will continue to reduce our waiting times with a commitment to deliver a maximum wait for treatment for patients referred for elective care.	No patient will wait more than 65 weeks for their elective care treatment
We will continue to reduce the number of patients waiting over 62 days for cancer treatment.	As a maximum no more than 548 patients will be waiting over 62 days for cancer treatment by March 2024
We will enhance access to diagnostics for patients across Sussex with our CDC capacity, improved diagnostics pathway and capital investment in services	We will ensure that at least 75% of patients by March 2024 referred on a cancer pathway will be diagnosed within 28 days. we will continue to reduce our waiting times across 15 diagnostic modalities with no more than 10% of patients waiting more than six weeks

Accelerating patient flow through, and discharge from, hospitals

There are currently too many patients who are being cared for in an inpatient hospital bed when there is no longer a health-related need for them to do so. This results in a lack of available beds across the system that can cause risks to both the patient, as they can deteriorate in hospital and be exposed to infection risks, and those waiting for inpatient care.

We have a good track record of system partnership working to improving discharge and we will be building on this and accelerating existing and new initiatives. Sussex is one of six national sites selected as Discharge Frontrunners, which involves health

and social care partners locally working together rapidly to find innovative solutions and new approaches which have the potential to make a substantial difference. Discharge Frontrunners will use tried and tested improvement tools to find what works, how and why and will make recommendations for how their approaches can be adopted across the country. The objective of our programme is to develop, design and test new approaches and service models for discharge across all settings by focusing on integrated workforce models, deploying new technologies, developing shared business intelligence, and developing an economic and financial model to underpin this sustainably.

Our goal will be to bring together a comprehensive model of integrated hospital discharge that meet the needs of our three places. It will support good system flow with reduced lengths of stay, admission avoidance, and better long-term outcomes for our population.

Our Year One actions to accelerating patient flow through, and discharge from, hospitals:

What we will do	What we will achieve	When we will achieve it
We will develop and mobilise a multi-agency workforce plan based on agreed discharge demand and capacity requirements.	We will right-size our health and care workforce to enable us to build the right capacity in home care or post-hospital bedded care to meet the needs of our population.	March 2024
We will evaluate and select a small number of digital innovations which will best support improvements in the discharge pathways, alongside the development of a shared data architecture to provide visibility of patient flow and capacity.	We will support more efficient use of our workforce, improved patient experience and seamless working between health and care colleagues.	September 2023 to select innovations; and March 2024 to roll it out.
We will develop an economic model for Discharge in Sussex which enables us to make best use of available funding on behalf of Sussex residents and supports the care market to expand in a sustainable way.	We will have a clear and affordable plan for the future to ensure we understand where best to invest available funds to grow discharge capacity which will meet the needs of our population now and into the future.	December 2023

We will undertake a comprehensive review of discharge pathways to identify and put in place improvement plans for the changes which need to be made to reduce delays to patients being discharged from inpatient and community services.	Health and care partners will have a more proactive approach to discharge planning, minimising delays at each part of the pathway (across pathways 0 to 3) and utilising virtual wards for early supported discharge, with a more seamless interface between health and care.	June 2023

The difference this will make to local people and how it will be measured:

Difference for local people	**How will this be measured**
Patients will be involved in planning for their discharge from early in their inpatient stay and will be discharged without significant delay as soon as they are declared medically fit to do so into the most appropriate bed for their needs.	There will be a reduction in the number of patients who no longer meet the criteria to reside who are not discharged (no nationally defined reduction – to be determined locally)
Patients will be admitted to an inpatient bed (acute, community or mental health) in the most appropriate department for their condition, without significant delay.	We will reduce bed occupancy to 92%.
Patients will be discharged earlier but receive ongoing clinical oversight where required through the use of digital innovations such as remote monitoring.	There will be a reduction in Length of Stay (Need to quantify based on experience of exemplars).

Delivery Area 3

Delivering our Continuous Improvement Areas

To successfully deliver the ambitions set out in our Shared Delivery Plan, there are four key areas that need continuous improvement – **addressing health inequalities; mental health, learning disabilities and autism; clinical leadership; and getting the best use of the finances available.**

These areas are part of and are critical success factors in all the actions and improvements we are making in our Shared Delivery Plan and, therefore, need constant focus across everything we do.

Addressing health inequalities

There are currently avoidable and inequitable differences in health between different groups of people across Sussex. There are many reasons for this, including disability, employment, where someone lives, income, housing, education, their ethnicity and their personal situation. We know these health inequalities are particularly seen among our most disadvantaged communities, with people living in deprived areas having worse health and outcomes.

Addressing health inequalities is a core aim of *Improving Lives Together* and is a key part of all the work we will do over Year One.

We will embed a focus on inequalities that people experience impacting on their health and adopt the following overarching commitments:

- **Co-production** – we will work with those with lived experience to design and delivering change.
- **Interventions** – we will invest in prevention, personalised care and other activities to drive reductions in heath inequalities.
- **Funding** – we will focus a greater amount of funding based on need.
- **Design of services** – we will undertake Equality and Health Inequalities Impact Assessments for all service changes.
- **Visibility** – we will ensure every decision we make considers the impact of proposals or decisions.
- **Outcomes and performance** –we will always consider the differences across geographical areas, population groups and other factors in how we set and monitor outcomes and performance.
- **Workforce** – we will actively recruit, develop and support people from our diverse communities.
- **Net Zero and social value** – we will use our resources and assets to help address wider social, economic or environmental factors.
- **Data Quality and Reporting** – we will drive work to both improve and increase the recording and reporting of data by key characteristics.

Understanding the causes and drivers of health inequalities and identifying opportunities for action across Sussex is crucial and a significant amount of work has already taken place to do this. Core20PLUS5 is an NHS England national approach to help systems reduce health inequalities (link). Our local health and wellbeing strategies are using this approach to identify populations in Sussex, using local population health management data to identify areas of focus for targeted interventions.

The system-wide actions we are taking are themed around five priority areas:

- Restoring NHS services inclusively.
- Mitigating against digital exclusion.
- Ensuring datasets are complete and timely.
- Accelerating preventative programmes that proactively engage those at greatest risk of poor health outcomes.
- Strengthening leadership and accountability.

Alongside the five priority areas above are a range of actions that we plan to take to tackle health inequalities.

Our Year One actions to make progress to address health inequalities:

What we will do	What we will achieve	When we will achieve it
Improved position against 22/23 baseline on 1. hypertension identification/ treatment to target 2. lipid lowering therapy prescription >QRISK 20%	77% for Hypertension 60% lipid lowering	March 2024
Marked improvements against 22/23 Health Inequality provider maturity matrix baseline, culture to address HI embedded and fruitful.	Reduced waiting times by 10%.	March 2024
Address inequalities and improve outcomes in priority clinical pathways, deprived geographical areas and vulnerable/protected characteristics and population groups which are known to have worse outcomes and experience.	Investment and capacity secured which improves secondary prevention and CORE20Plus5 priorities for adults, children and young people.	March 2024
Focus on reducing waiting times for those from our most deprived areas	We will reduce waiting times in these areas by 10%, with a plan to reduce by a further 10% in years two and three	March 2024
Focus on reducing DNA and cancellation rates in our most deprived areas	We will reduce DNA and cancellation rates in these areas by 5%	March 2024
Dedicated Children and Young Persons (CYP) programme for Core20PLUS5	CYP Core20PLUS5 baseline and improvement trajectory	December 2023

Mental Health, Learning Disabilities and Autism

Additional MH narrative to be added here (subject to operational plan)

Over the past two years we have transformed the Sussex LDA function to meet our system and Long-Term Plan targets.
As we progress with our ambitious LDA discharge plans we are facing several challenges marked by frequent LDA hospital closures across the country alongside the market availability of community/placement accommodation to meet the higher complexity needs of our population. This complexity is further accentuated by the relatively higher number of patients in Sussex who have a forensic background which means there is an increased complexity of packages of care.
To respond to these challenges, we are currently working on initiatives that will help us to increase in-area capacity and respond to urgent needs, such as crisis resolution.

Our Year One actions to make progress in Mental Health, LD, and Autism:

What we will do	What we will achieve	When we will achieve it
Increase the numbers of adults accessing IAPT services	We will increase access by 5%	March 2024
Increase the number of adults and older people supported by the community mental health team	We will increase support by 5%	March 2024
We will ensure care is offered close to home	We will eliminate out of area placements	From June 2023
We will develop a locally commissioned service to improve our dementia diagnosis rate	We will increase the dementia diagnosis rate by (tbc subject to operational plan)	Tbc subject to operational plan
We will improve access to perinatal mental health services	We will increase access by 1%	March 2024
We will improve services for those with a learning disability or autism through increased investment in community and forensic support	We will reduce demand on inpatient care by (tbc subject to operational plan)	Tbc subject to operational plan
We will increase the number of people on the Learning Disability Register who have received an annual health check and action plan	We will increase this to 75%	March 2024

Clinical Leadership

There is clear evidence that strong clinical and care professional leadership is associated with higher productivity, better organisational performance, and improved health outcomes for local people. The delivery of our ambition will only be successful with strong clinical leadership, and it is recognised that this is something in Sussex that needs to be developed and strengthened at every level within the system.

We want to create a culture that systematically embraces shared learning, based on outcome data, to support clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities. The aim is for patients to have a better quality of joined-up care, better clinical outcomes, and better experience. This will require close working across system partners, including social care, housing, education, and other Local Authority colleagues, as well as the NHS.

Our Year One actions to make progress in clinical leadership:

What we will do	What we will achieve	When we will achieve it
Establish multi-professional Clinical Reference Groups (CRG) for each of our Shared Delivery Plan priority areas.	Governance structure confirmed and implemented for CRG	June 2023
Put in place a multi-professional Leadership Academy to develop our clinical leaders across the system.	100 Leaders undertaken programme	September 2023
Agree an organisational development approach to quality improvement and use of data.	Agree QI training and data baseline. Progress training plan in identified CL Group.	September 2023
Formally appoint a clinical leader for each of the three Integrated Community Team Frontrunner programmes.	Clinical leadership structure identified with appointments in place.	June 2023
Set out benchmarks for improvements in clinical outcomes.	Governance structure and resource identified with programme plan. Agree reduction plan in unwarranted variation.	September 2023

Getting the best from the finances available

Financial sustainability is integral to delivering our ambition as it is a key part of enabling our health and care system to drive improvements to services for local people. We must live within the finances available and, to do so, it is crucial that all organisations across our system manages resources effectively, ensuring value for money and patient benefit from every pound that is spent.

Currently, the NHS across the Sussex system is challenged financially and has a recurrent deficit, which means it is spending more than its national allocation. We must therefore work collaboratively across the system to make efficiencies in how we work to get the most out of the money we have available. It also means we must be targeted in our investments, to ensure we are getting most value for local people. In addition to this, NHS Sussex is required to make running cost reductions of 20% from 2024/25, with a further 10% reduction from 2025/26.

A key area of focus for us in improving our finances in Year One is productivity, which is the amount of activity we do compared to what it costs. Currently, we are not getting the best use of the money we spend is some areas, such as our acute

hospitals, where current productivity is significantly lower than before the pandemic. To improve our productivity, we will be focusing on a number of areas including:

- Getting the most out of the money we spend on workforce, ensuring we can deliver the necessary clinical activity within the resources available.
- Making services as efficient as possible.
- Improving productivity across operating theatres.
- Getting value for money across medicines.
- Getting the most out of the buildings and facilities we use.
- Reducing waste and reusing resources.

Our Year One actions to get the best from the finances available:

What we will do	What we will achieve	When we will achieve it
We will deliver our 2023/24 system financial plan.	We will meet our financial budget at the end of the year.	March 2024
We will create a comprehensive and resourced system productivity plan, with individual workstream targets and milestones and measurable cost reductions demonstrated.	We will have a plan for improving system productivity.	September 2023
We will implement initiatives to improve productivity.	We will see productivity improvement compared to 2019/20 of 10 percentage points, to 7% below 2019/20 for Acute trusts	March 2024
We will agree a methodology for assessing productivity output for Community, Mental Health, and Primary Care services.	We will have key performance indicators and methodology for productivity across services outside of acute hospitals.	March 2024
We will develop a clinically-led process for optimising some of our clinical models or services, to reduce cost.	Three services or models will be taken forward led by clinicians.	December 2023

Delivery Area 4

Delivering our Health and Wellbeing Strategies and developing Place-based Partnerships

Improving Lives Together supports and builds on the three Health and Wellbeing Board Strategies in place across Sussex. The Health and Wellbeing Boards in Brighton and Hove, East Sussex and West Sussex have a statutory role to bring together representation from local government, local NHS organisations, Healthwatch and voluntary, community, social enterprise organisations, and other key public services to assess needs and agree plans, focussed on improving health, care and the overall social and economic wellbeing of their populations.

The Health and Wellbeing Board Strategies use local evidence, data, and insight to set out the priorities for improving health and wellbeing of their populations, responding to the distinct issues and challenges in these places. There are three Health and Care Partnerships that support the Health and Wellbeing Boards to deliver these strategies.

Alongside the delivery of the Health and Wellbeing Board Strategies, one of the key priorities of *Improving Lives Together* is 'maximising the power of partnerships' and during Year One we will be strengthening how partners can work together across our populations in Brighton and Hove, East Sussex and West Sussex, focussing on the distinct needs and challenges in our local areas. We call this working at "place" and it is where the local NHS, local government and a wide range of local partners come together to shape and transform health and care and make the most of the collective resources available. We will do this by working in our three Health and Care Partnerships, whose work is overseen by the Health and Wellbeing Boards.

The ways of working and priorities for each of our 'places' are as follows:

Brighton and Hove

Our 2019-30 Health and Wellbeing Strategy (link) focuses on improving health and wellbeing outcomes for the city and across the key life stages of local residents: starting well, living well, ageing well and dying well. Our ambition for Brighton and Hove in 2030 is that:

- People will live more years in good health (reversing the current falling trend in healthy life expectancy).
- The gap in healthy life expectancy between people living in the most and least disadvantaged areas of the city will be reduced.

Eight principles guide the delivery of our strategy with a focus on health being everyone's business; supporting communities to be more resilient; reducing health inequalities; and making sure that health and care services will provide high quality care, feel more joined up and will be delivered in the most appropriate place.

The establishment of the Health and Care Partnership Executive Board in January 2020 enables us to continue and build upon the work already started and is now becoming formalised with the development of *Improving Lives Together*. The firm foundations of the Board enable us to develop and mature service design, delivery, and governance over the coming years.

Our ambitions for improving lives at place

The ambitions set out in our Health and Wellbeing Strategy are:

- Brighton and Hove will be a place which helps people to be healthy.
- The health and wellbeing of young people will be improved – we will have a focus on early years encouraging immunisation; we will address risks to good emotional health and wellbeing; and provide high quality joined-up services which consider the whole family.
- The health and wellbeing of working age adults will be improved - information, advice and support will be provided to help people to eat well, move more, drink less and stop smoking to reduce their risk of developing long-term health conditions. There will be easier access to mental health and wellbeing services; sexual health will be improved; and people with disabilities and long-term conditions, and the long-term unemployed, will be supported into work.
- Brighton and Hove will be a place where people can age well - people will be supported to reduce loneliness and social isolation and to reduce their risk of falls and more people will be helped to live independently by services that connect them with their communities.
- The experiences of those at the end of their life, whatever their age, will be improved – we will improve health and wellbeing at the end of life and help communities to develop their own approaches to death, dying, loss and caring. More people will die at home or in the place that they choose and support for families, carers and the bereaved will be enhanced.

How we will deliver our ambition

The Health and Wellbeing Strategy identifies five priority areas for Brighton and Hove:

- **Children and Young People** - We will improve and expand access and existing support to children and young people and their families for mental health, emotional wellbeing, autism, ADHD and other neurodevelopmental conditions. We will improve early diagnosis and outcomes for children and young people and increase the identification of, and support for Young Carers.
- **Mental Health -** We will implement the key recommendations of our 2022 Mental health JSNA, expanding our support for people with mental health needs and further developing integrated community mental health services,

connecting mental health services with community assets. We will do this at local neighbourhood level and develop integrated systems and increase the provision of supported accommodation and support for people with mental health needs, co-occurring disease, and substance misuse services.

- **Multiple Long-Term conditions -** We will improve services to people with long-term conditions to deliver personalised care, tailored to individual needs, strengths, and capabilities. We will aim to better understand the interaction of mental and physical health conditions as a factor to improve outcomes and we will proactively identify and/or support and meet the needs of those at risk of or living with long term conditions.
- **Cancer -** We will complete the recovery of cancer services affected by the pandemic, improve performance against cancer waiting times standards and deliver the ambitions of the NHS Long Term Plan to diagnose more people with cancer at an earlier stage, with a particular focus on disadvantaged areas and underserved communities where rates of early diagnosis and screening uptake are lower.
- **Multiple Compound Needs** - We will improve and join up services to better support people with multiple compound needs by delivering a joined up, integrated service model, co-produced for and by people with lived experience. We will do this through our **Integrated Community Frontrunner** programme.

Our Year One actions to deliver our Brighton and Hove placed-based priorities:

What we will do	What we will achieve	When we will achieve it
Agree success measures for the overall programme	Success measures agreed by Place leadership Board	September 2023
Agree monitoring, evaluation and learning framework	Framework agreed by Place leadership Board	September 2023
Gain consensus on the service model, supported by a compact agreement with all partners	Service model agreed with all partners	December 2023
Agree a roadmap for delivering the workforce plan for the identified cohort	Roadmap agreed	March 2024

East Sussex

Improving Lives Together and our East Sussex Health and Wellbeing Board Strategy to 2027 (link) align around a shared vision where in the future, health and care organisations will work in a more joined-up way with and within communities to better understand and respond to their specific needs. Support and services will be shaped around local people, rather than expect them to fit into the 'system'.

Delivering this requires a collaborative approach across all our organisations to improve health, reduce health inequalities and deliver integrated care for our population. In East Sussex, we have committed to some shared priorities and work

based on the needs and assets in our population and the factors that influence people's overall health and ability to stay healthy, in addition to improving outcomes through integrated health and care. The focus of our shared work is aimed at increasing prevention and early intervention and delivering personalised, integrated care.

Our East Sussex Health and Care Partnership brings together the full spectrum of local partners responsible for planning and delivering health and care to our communities. We have comprehensive governance arrangements that support collective accountability between partner organisations for whole-system delivery and performance. The governance arrangements facilitate transparent decision-making and foster the culture and behaviours that enable system working.

Our ambitions for improving lives at place

We will build on our existing work to expand the integrated community model for our population that will better enable health, care and wellbeing for people and families across the whole of life. This will mean designing a model that best enables:

- Working together in our communities across primary care, community healthcare, education, social care, mental health, and the full range of local voluntary and community and housing organisations, and using our collective resources driven by a deeper shared understanding of local needs
- Strengthening our offer of integrated care. For children and young people this will involve working with whole families and linking more closely with early years settings, schools and colleges. For adults this includes further developing Trusted Assessor roles, rapid crisis response and support with discharges from hospital, as well as exploring ways to build more integrated leadership and roles to deliver better coordinated care.
- A clear focus on improving population health overall and therefore the years of life people spend in good health. This includes leisure, housing and environment services provided by borough and district councils and others.

How we will deliver our ambition

Our partnership plans to embed hubs in communities to help coordinate access to local sources of practical support and activities will be a key part of this model. We also want to develop our plans for using our power as employers and buyers of services to stimulate economic and social wellbeing in our communities. This model will bring:

- Greater capacity in communities to promote mutual support, and deeper levels of joined up and personalised care, building on the strengths and assets of individuals, families, and communities.
- Greater levels of prevention, early intervention, and ways to proactively respond to prevent situations getting worse.
- New ways to remove the barriers that prevent staff and volunteers working in different teams from working together on the ground.

With accountability through to the Health and Wellbeing Board and strong links into Sussex-wide programmes, this is intended to enable a clear focus to be retained at Place on our key priority integration programmes across health improvement and reducing health inequalities, and integrated care for children and young people, mental health, and community services.

Our Year One actions to deliver our East Sussex place-based priorities:

What we will do	What we will achieve	When we will achieve it
We will have a joined-up approach to planning and delivering health, care and wellbeing in Hastings with clear evidence of integrated approaches to improving outcomes for local communities	A planning and delivery approach agreed by Place leadership board.	March 2024
Service models will be developed and approved for scaling up across the county and an implementation timetable with key milestones agreed.	Service models will be approved by Place leadership board.	March 2024
A comprehensive stakeholder engagement process will take place to help us explore how we can improve health outcomes in cardiovascular disease (CVD) respiratory disease, mental health and frailty/ageing as significant drivers of poor health and early death in our population.	Stakeholder engagement process approved by Place leadership board.	March 2024
A strategy will be developed setting out how we will help people get the best start in life, focused on improving support to children and young people.	Strategy approved by Place leadership board.	March 2024
Hubs will be developed in communities to help coordinate access to local sources of practical support and activities, to boost emotional wellbeing and help with loneliness and isolation.	Hubs will be in place.	March 2024

A strategy shaping our approach as an "anchor" system in East Sussex will be agreed, developing our plans for using our power as employers and buyers of services to stimulate sustainable economic and social wellbeing in our communities.	Strategy approved by Place leadership board.	March 2024

West Sussex

Our West Sussex Health and Wellbeing Board has a Joint Health and Wellbeing Strategy 2019-2024 called "Start Well, Live Well, Age Well" (link). It sets out the Health and Wellbeing Board's vision, goals and ways in which we will work to improve health and wellbeing for all residents in West Sussex. It was developed in consultation and collaboration with local residents, service users, multi-disciplinary professionals and partners. It draws on evidence of West Sussex's health and wellbeing needs from the joint strategic needs assessment.

The strategy adopts a life course approach, identifying our priorities across three themes - Starting Well, Living and Working Well and Ageing well. It consists of a few carefully selected priorities that can significantly contribute towards achieving its vision with a focus on:

- A whole system approach to prioritise prevention, deliver person centred care, and tackle health inequalities.
- Harnessing the assets and strengths of local communities to improve health and wellbeing, creating safe, sustainable environments that promote healthy living.

The West Sussex Health and Care Partnership was formed in 2020, bringing together key local health and care partner organisations to work collaboratively to deliver the objectives of the Joint Health and Wellbeing Strategy and the Sussex-wide strategy through a place-based plan. The partnership leads on delivering shared population health objectives on behalf of the Health and Wellbeing Board.

We have developed a model of collaboration that brings changes to people directly within their community, through our Local Community Networks. These are co-located with district and borough footprints and are empowering communities to deliver change through collaborative working between primary care, district and borough councils, local Public Health, and voluntary sector enterprises. We will maintain our focus in Year One on how Local Community Networks can continue to make the positive changes for people who live in West Sussex.

Our ambitions for improving lives at place

Our West Sussex Health and Care Partnership responds to the challenges faced collaboratively as a group of organisations and deliver on the priorities set out in *Improving Lives Together*.

- **Address health inequalities** – There are stark inequalities in outcomes, access, and experience of care for maternity and neonatal service user's and the opportunities and experience of staff from minority backgrounds and we will tailor our services to target the needs of our local populations and offer a personalised maternity journey that wraps around the individual and their family. We will prioritise the improvement of healthy life expectancy through tackling the key health inequality related conditions and ill health relating to CVD, respiratory and cancer. We will utilise approaches such as tobacco control, cancer screening and health checks and work together with key stakeholders across the area to target our activity and resources where it is needed most based-on need and evidence of what works. We will make care more personalised so that people can access health and care services that are more tailored to their needs, make sense to them and focus on what really matters in their lives.
- **Integrate models of care** - We have opportunities to further develop how our services work together to streamline pathways for patients, improve experience and create more integrated approaches. Through integrated services we will remove the unnecessary barriers between our services that are all working to support the same local people and create more sustainable models of care.
- **Transform the way we do things** – We will continue to improve our services where it will have the greatest impact, taking the opportunity to address health inequalities and strengthen our integrated approach. We will continually review our joint transformation priorities year on year, systematically improving our services.

How we will deliver our ambition

The West Sussex Health and Care Partnership Place-based Plan uses evidence from the Joint Health and Wellbeing Strategy to determine local priorities and key areas for change agreed across our partners and within the framework of the ambitions outlined above. In addition to our Sussex-wide priorities, there are six specific priority areas for change that have been identified from the Health and Wellbeing Strategy for West Sussex:

- **Tackling the wider determinants of health** – we will work together to influence the many determinants of healthy living, such as how services are accessed and how communities can be empowered to support healthy living for their residents.
- **Addressing health inequalities** - we will have a targeted and focused approach for those with most need and who need additional support.
- **Adults Services** – we want to help people 'live the life they want to lead', by remaining independent for as long as possible and maintaining a high quality of life.
- **Children and Young People -** we will improve the existing support to children and young people so they can have the best possible start to life, through our West Sussex Children First programme.
- **Mental Health** - we will expand our support for people with mental health needs to address the growing need, delivering the best standard of physical

health checks for people with mental illness, and developing sustainable housing solutions for people living with long-term mental illness.

- **Learning Disabilities and Neurodevelopmental Needs** - we will provide greater focus and support for those with a learning disability and neurodevelopmental needs, by reforming our children's and young people's neurodevelopmental diagnosis and care pathway, including social support.

Our Year One actions to deliver our West Sussex place-based priorities:

What we will do	What we will achieve	When we will achieve it
In Crawley, we will develop new models of care for our priority services and a strategic outline case for improvement to our estates.	Four service business cases with implementation plans and an estates Strategic outline case that will improve access to our services for the most disadvantaged communities.	March 2024
We will develop and agree a business case for a new Bognor Diagnostics Academic Centre	Business case approved for improvements to prevention services which will reduce incidences of stroke and improve patient outcomes for those that are due to have a stroke.	September 2023
We will begin to mobilise a new model for stroke services in Coastal West Sussex,	New model mobilised that will be designed to be fully compliant with national standards and achieving the highest levels of performance.	December 2023
We will develop a new model for integrated intermediate care	New model of care business case and implementation plan to ensure people receive care in a timely manner and have improved long-term outcomes following discharge from hospital, retaining more independence in the community.	March 2024
We will improve our hospital discharge model to ensure people who no longer need inpatient care can go home or in a community setting (such as a care home) to continue recovery.	Hospital occupancy will be reduced to less than 92%.	March 2024
We will improve the support and interventions for children and young people (CYP) with autism and or mental health issues.	New pathway focused on ensuring that the best outcomes are achieved for and with the young person, as well as embedded training at point of induction for social workers and annual refreshers thereafter.	March 2024

We will review our joint commissioning arrangements for learning disabilities, mental health and neurodevelopmental services.	Robust and transparent Section 75 agreement which sets outs the pooled commissioning and provider arrangements between West Sussex Adult Social Care and NHS West Sussex Place.	March 2024

4. Other areas of focus

To support the delivery of our ambition, there are areas that will require continued focus, either within the delivery of our improvement priorities or as distinct pieces of work. These are:

Prevention

Prevention is a key principle that underpins the delivery of our ambition. This includes supporting: good physical health; people to be socially connected; emotional wellness and positive mental wellbeing; people to feel safe; and a clean and sustainable environment.

The work being undertaken at place to deliver our Health and Wellbeing Strategies has prevention as a core focus and this will be taken further with the development of our Integrated Community Teams.

We will measure the success of our prevention work through:

- An increase in healthy life expectancy for males and females and a reduction in the social gradient in healthy life expectancy.
- A reduction in the prevalence of overweight children in reception and year six of primary school.
- An increase in the percentage of children and adults meeting the recommended levels of physical activity.
- A reduction in rates of emergency admissions and subsequent loss of independence due to falls.
- More adult social care users and adult carers have as much social contact as they would like.
- More people aged 40-74 offered and taking up an NHS Health Check.

Climate change commitments

Since 2010, the NHS has reduced its emissions by 30%, exceeding its commitments under the Climate Change Act. In doing so, we have learnt that many of the actions needed to tackle climate change will directly improve patient care and health and wellbeing. This is because many of the drivers of climate change are also the drivers of ill health and health inequalities.

Together to Zero is our plan for a greener NHS in Sussex. The plan sets out how we will work together as partner organisations across our system to reduce carbon emissions and build an NHS more resilient to the effects of climate change. It also sets out a number of key areas for action on climate change that pose the most significant co-benefits for health, and which drive at greater efficiency and productivity. The actions we are taking in our plan can be read here (link).

Supporting social and economic development

Supporting local social and economic development across Sussex is one of the core aims of achieving our ambition. This will be done through our focus to the wider determinants of health across local people and communities, including access to education and skills, good employment and quality, affordable and sustainable homes – all the things that can help people and communities to thrive and prevent the need for medical intervention and give people the best opportunities for improving their lives.

We want to develop our health and care organisations into 'anchor institutions', where they will use their sizeable assets and ways of working to support the health and wellbeing of local communities and help address health inequalities.

To support this, in Year One we will establish a baseline understanding of current work happening across the system. This will include:

- Procurement activity which promotes local supply chains and local employment opportunities with a living wage.
- Employment initiatives that can assist with recruitment and retention of staff, as well as supporting the wider economy of Sussex.

Children and young people

Supporting children and young people is a specific focus in *Improving Lives Together* and is a key area for improvement across our Health and Wellbeing Strategies.

We have a system-wide plan for children and young people's physical health services that sets out five priorities:

- Integrated models of care.
- Joined up working across mental health, learning disabilities and autism and physical health.
- A focus on long term conditions (asthma; diabetes; epilepsy and tier three obesity services).
- Children and young people with complex medical / health and care needs in the community.
- Transitions from children's health services to independence and / or adult services.

We also have plans to improve children and young people's emotional wellbeing and mental health. These focus on three main areas: prevention, improving support and improving ways of working. The specific actions we will be taking are:

- Implement the THRIVE Framework across Sussex.
- Mobilise and extend the Single Point of Access.
- Further develop and expand our Mental Health Support Teams in Schools.
- Early intervention in psychosis.
- Develop a system-wide and expanded eating disorder pathway.
- Improve urgent and emergency support.
- Strengthen the system-wide approach to suicide prevention and self-harm reduction.
- Support children and young people with complex needs.
- Young People being better supported to transition to adulthood.

Safeguarding

We want to ensure all children, adults, families, and communities across Sussex are safe and free from all forms of abuse and harm. This involves a whole system multi-agency approach that crosses all ages, places where people live and work, communities, and systems.

NHS Sussex has an agreed strategic approach (link) to maintain safe and effective safeguarding and Looked After Children services and to strengthen arrangements for safeguarding children and adults at risk from abuse and neglect across Sussex. We are required to demonstrate how our strategic and assurance arrangements enable us to carry out the duties and functions specified under the Care Act (2014) and the Children and Social Work Act (2017).

We have an extensive and wide-reaching approach which includes:

- Clear systems to train staff to recognise and report safeguarding issues;
- A clear line of accountability for safeguarding and Looked After Children, reflected in our governance arrangements and overseen by NHS England;
- Arrangements to work with local authorities through our Safeguarding Children Partnerships and Safeguarding Adult Boards;
- Arrangements to share information between service providers, agencies and commissioners;
- Designated doctors and nurses who are responsible for safeguarding adults, children and looked after children;
- A child death review team, who are responsible for reviewing deaths in childhood, including nurses and a designated doctor.

Quality

NHS Sussex has a statutory duty to ensure quality of care is maintained across services and meets the Care Quality Commission minimum standards for quality and safety, and that our health and care organisations have systems in place to check

the quality and safety of care provided. Our quality assurance and improvement frameworks support our workforce in ensuring that our populations experience the best possible care.

We will know that we are making a difference because:

- People that inspect our health services will agree that they are safe and the measures for rating our services, such as those set out by the Care Quality Commission (CQC) will have improved.
- Our people will tell us that our services are improving in quality. By April 2024 we will have co-produced meaningful measures of quality and safety with our people and communities as well as an improvement target for the subsequent five years.
- People will report a better experience of contacting our primary care services.
- Our staff will be able to talk about and report quality and safety concerns freely without fear of speaking up or being criticised.
- There will be evidence that we are working more closely and better together to improve quality, responding to complaints more quickly, and running educational events to teach people how to create better quality and safety in our integrated services.

5. Developing and Delivering our Shared Delivery Plan

Our Shared Delivery Plan meets national guidance and takes account of key national, regional, and local strategies and policies. In line with guidance, we will review and update the plan before the start of each financial year. We may also revise the plan in-year if considered necessary.

Planning approach and principles

Three principles describing the Shared Delivery Plan's nature and function have been co-developed with systems across the country, trusts and national organisations representing local authorities and other system partners. These are:

- Principle 1: Fully aligned with the wider system partnership's ambitions.
- Principle 2: Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments.
- Principle 3: Delivery focused, including specific objectives, trajectories and milestones as appropriate.

Governance and leadership

Subject to final approval, the Shared Delivery Plan governance is set out in Appendix One.

The current System Leadership Forum will be accountable to the NHS Sussex Board for delivery. Each delivery workstream will be led by an accountable provider Chief Executive, and a clinical lead will be appointed for each.

Performance and Scrutiny

NHS Sussex Integrated Care Board

The NHS Sussex Integrated Care Board (ICB) has established committees to assist it with the discharge of its functions, including the delivery of the key priorities and goals set out in Shared Delivery Plan. Our governance framework is described here (link).

Sussex Health and Care Assembly

The **Assembly** (link) is the Integrated Care Partnership for Sussex, jointly established by NHS Sussex, Brighton and Hove City Council, East Sussex County Council and West Sussex County Council (the three Local Authorities) in accordance with the Constitutions of each body.

The purpose of the Assembly is to support co-ordinate the strategic direction for meeting the broader health, public health and social care needs of the population.

Health and Wellbeing Boards

NHS Sussex and partner trusts must send a draft of the Shared Delivery Plan to each Health and Wellbeing Board and consult on whether the draft takes proper account of each joint local health and wellbeing strategy.

A Health and Wellbeing Board must respond with its opinion and may also send that opinion to NHS England.

NHS Sussex and partner trusts should expect to be held to account for its delivery – including by the population, patients and carers or representatives and through the Sussex Health and Care Assembly, Healthwatch and the local authorities' Health Overview and Scrutiny Committees.

Engagement and Partnerships

Our Shared Delivery Plan has been developed across system partners and is informed by national, regional, and local evidence, guidance and insight. To support the co-development process, we have established an engagement working group, working with:

- The Sussex Health and Care Assembly members
- Primary care providers
- Local authorities and each relevant Health and Wellbeing Boards
- Other systems in respect of providers whose operating boundary spans multiple systems.
- NHS providers.

- The voluntary, community, and social enterprise sector
- People and communities that will be affected by specific parts of the proposed plan, or who are likely to have a significant interest in any of its objectives, in accordance with the requirement to consult.

Insight from engagement with people and communities across Sussex over a two-year period underpinned the development process of the Improving Lives Together, and thematic analysis of this insight has now informed the creation of the Shared Delivery Plan. Enhanced engagement opportunities were also offered via three online sessions for Foundation Trust Governors and two public virtual sessions with the NHS Sussex Chair, an online discussion with members of the Sussex VCSE sector, discussion with Healthwatch in Sussex, and with other key partners.

Extensive workforce engagement was also undertaken with insight collated from the national NHS staff survey results and from NHS organisation and Local Authority "pulse" surveys.

As we deliver the actions outlined in our Shared Delivery Plan, we are committed to making sure we continue to reach and hear from as many people as possible across Sussex, and ensuring their experiences, views and suggestions shape and influence our work. Our Working with People and Communities Strategy (link) outlines our approach to public engagement and how we meet the legal duties around involvement.

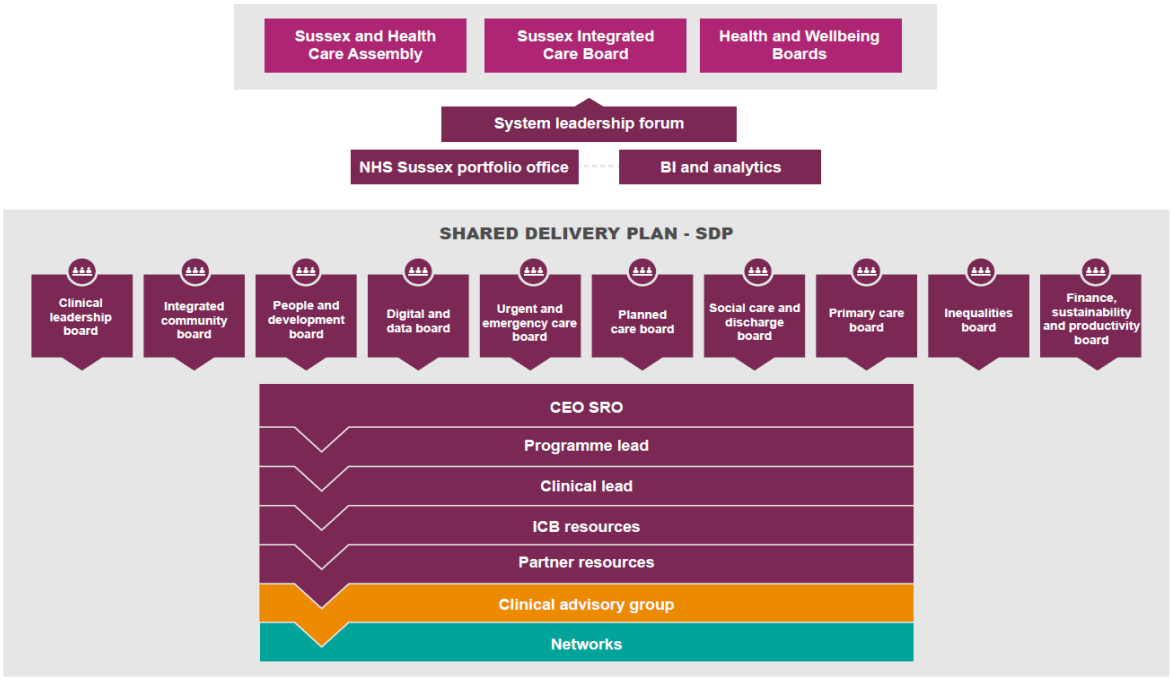
Evidence, research and change methodology

We want to be driven by the best evidence and be at the forefront of improving health and care in our communities. To do this we will generate and use research evidence and create a culture of innovation to bring the best new approaches to Sussex. A new group is being developed called the Innovation and Research Hub, which will aim for the first time to bring together a Sussex-wide approach to Innovation, Research and Evaluation.

The Innovation and Research Hub will hold the relationships with academic and research networks, national bodies, universities, local economic groups and national and local industry groups.

The introduction of the Innovation and Research Hub will bring the most progressive approaches in healthcare into Sussex. Having a streamlined approach to evidence finding, impact analysis and introduction will reduce the time lost through the current fragmented approaches but also accelerate the introduction or spread of useful technologies, medicines, or practices.

Appendix 1: Outline Delivery Governance



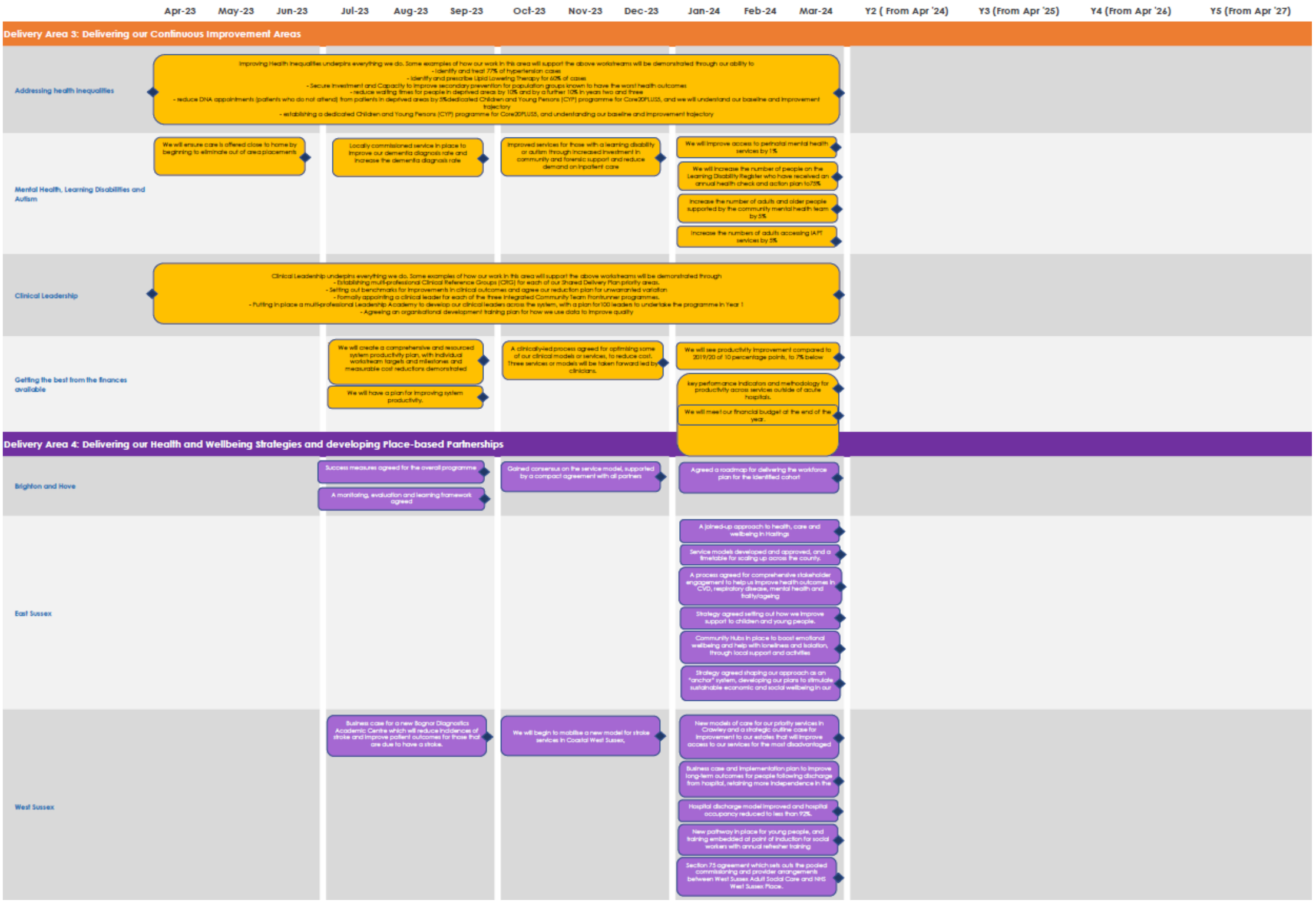
Appendix 2: Key Points in our Shared Delivery Plan

Delivery Area 1: Delivering our Long Term Improvement Priorities

A Joined-up Community Approach: Integrated Community Teams	Model for Integrated Community Teams		Measurable Outcomes Framework	Outcomes and Core Offer Agreed Lessons Learned Shared	**We will further progress our strategic delivery areas from Year Two by:** **Integrated Community Teams** • Agreeing our model of care and service specification for our 'core offer', working with system partners to agree the delivery form for our Integrated Community Teams. • Using data, insights, and evidence, develop a flexible local service offer for each Integrated Community Team for delivery alongside the core offer. • Rolling out our Integrated Community Team model across Sussex, in a series of agreed 'waves'. • Implementing a continuous improvement and evaluation approach to improve and refine the way we deliver services at a community level. **Growing and Developing our Workforce** • Launching our system-wide digital and data training scheme. • Agreeing and implementing one approach across the system, to talent management, succession planning and equality, diversity, and inclusion. • Adapting and further rolling out our guaranteed employment scheme. • Launching our system-wide organisational development and culture framework. • Developing a compelling offer for multi-skilled professionals, in partnership with the education sector. • Implementing a single system recruitment framework. **Improving the use of Digital Technology and Information** • Expanding our work to connect community teams and share information to our wider system partners including social care and the voluntary sector. • Delivering a single electronic staff record and rota system across Sussex to support our workforce in delivering health and care across providers and within community teams. • Implementing a shared, single point of access, population health management data platform and Data and Analytics team to support the work of our Integrated Community Teams, building on the work undertaken through our Integrated Community Frontrunners. • Removing system interface issues, enabling data sharing across complex health and care settings. • Embedding and supporting population and community-led digital innovation.
Growing and Developing our Workforce	Guaranteed Employment Scheme Launched	People Plan & 3 Year Roadmap Published	Sussex Workforce Support Package in place	One-Workforce approach begins to roll out	
Improving the use of digital technology and information		Sussex digital maturity assessment completed 100% signup to digital and data charter	Improved Quality & Standard for Infrastructure, Data Intelligence and Innovation across the system	Inequalities-driven and population-led approach established for digital and data services Systemwide data, information and insight strategy 65% of patients registered with the NHS App and 33% patients registered with My Health and Care Digital Centres of Excellence established across three providers Extended digital service offering including virtual care technologies, care planning, self-referral, primary care accessibility and other capabilities	

Delivery Area 2: Delivering our Immediate Improvement Priorities

Increasing access to and reducing variability in Primary Care		95% of practices will be signed up to the cloud		245 more General Practice staff recruited to provide Referrals to our Community Pharmacists increased	
Improving response times to 999 calls and reduce A&E waiting times	Same Day Emergency Services review and		Increased number of at-home or community based Improvements in flow begins to impact ambulance handovers and patient discharges or admittances	Standardised Pathways for patients with rapid deterioration, including respiratory and Frailty	
Reducing diagnostic and planned care waiting lists		Patients are referred into the most appropriate 2 week wait demand is reduced by 30% The number of colonoscopies required will be Agreed clinical pathways in place for key specialties, improved access and choice, and reduced variation in waiting times.	We will prioritise direct access for primary care for We will have as a minimum six day working across our Community Diagnostic Hubs providing greater flexibility for patients. Reduced pressure within hospitals, to support their backlog reduction plans	Theatre Utilisation Rate increased to a minimum of At least 85% of surgery is being delivered as a day Length of stay for key pathways such as Hip and Knee replacement surgery will be reduced in line with best practice rates. DNA Rates reduced across Sussex by at least 2% over the course of the year Patient Initiated Follow-ups increased from 0.5% to 5% across Sussex At least 25% of outpatient activity is undertaken virtually	
Accelerating patient flow through, and discharge from, hospitals	Discharge Pathways reviewed and Improvement Plans in place to reduce delays to patients be discharged from inpatient and community	Digital innovations evaluated and selected to best support improvements in discharge pathways We will develop a shared data architecture to provide visibility of patient flow and capacity	Economic model for Discharge in Sussex has been developed	Digital improvements rolled out to support more efficient use of our workforce, improved patient experience and seamless working between health Our health and care workforce has been right-sized to enable us to build the right capacity in home care or post-hospital bedded care to meet the needs of our population.	


Apr-23
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Nov-23
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Mar-24
Y2 (From Apr '24)
Y3 (From Apr '25)
Y4 (From Apr '26)
Y5 (From Apr '27)
Delivery Area 3: Delivering our Continuous Improvement Areas
Addressing health inequalities
Improving Health Inequalities underpins everything we do. Some examples of how our work in this area will support the above workstreams will be demonstrated through our ability to
- Identify and treat 77% of hypertension cases
- Identify and prescribe Lipid Lowering Therapy for 60% of cases
- Secure investment and Capacity to improve secondary prevention for population groups known to have the worst health outcomes
- reduce waiting times for people in deprived areas by 10% and by a further 10% in years two and three
- reduce DNA appointments (patients who do not attend) from patients in deprived areas by 5%dedicated Children and Young Persons (CYP) programme for Core20PLUS5, and we will understand our baseline and improvement trajectory
- establishing a dedicated Children and Young Persons (CYP) programme for Core20PLUS5, and understanding our baseline and improvement trajectory
Mental Health, Learning Disabilities and Autism
We will ensure care is offered close to home by beginning to eliminate out of area placements
Locally commissioned service in place to improve our dementia diagnosis rate and increase the dementia diagnosis rate
Improved services for those with a learning disability or autism through increased investment in community and forensic support and reduce demand on inpatient care
We will improve access to perinatal mental health services by 1%
We will increase the number of people on the Learning Disability Register who have received an annual health check and action plan to75%
Increase the number of adults and older people supported by the community mental health team by 5%
Increase the numbers of adults accessing IAPT services by 5%
Clinical Leadership
Clinical Leadership underpins everything we do. Some examples of how our work in this area will support the above workstreams will be demonstrated through
- Establishing multi-professional Clinical Reference Groups (CRG) for each of our Shared Delivery Plan priority areas.
- Setting out benchmarks for improvements in clinical outcomes and agree our reduction plan for unwarranted variation
- Formally appointing a clinical leader for each of the three Integrated Community Team frontrunner programmes.
- Putting in place a multi-professional Leadership Academy to develop our clinical leaders across the system, with a plan for100 leaders to undertake the programme in Year 1
- Agreeing an organisational development training plan for how we use data to improve quality
Getting the best from the finances available
We will create a comprehensive and resourced system productivity plan, with individual workstream targets and milestones and measurable cost reductions demonstrated
We will have a plan for improving system productivity.
A clinically-led process agreed for optimising some of our clinical models or services, to reduce cost. Three services or models will be taken forward led by clinicians.
We will see productivity improvement compared to 2019/20 of 10 percentage points, to 7% below
key performance indicators and methodology for productivity across services outside of acute hospitals.
We will meet our financial budget at the end of the year.
Delivery Area 4: Delivering our Health and Wellbeing Strategies and developing Place-based Partnerships
Brighton and Hove
Success measures agreed for the overall programme
A monitoring, evaluation and learning framework agreed
Gained consensus on the service model, supported by a compact agreement with all partners
Agreed a roadmap for delivering the workforce plan for the identified cohort
East Sussex
A joined-up approach to health, care and wellbeing in Hastings
Service models developed and approved, and a timetable for scaling up across the county.
A process agreed for comprehensive stakeholder engagement to help us improve health outcomes in CVD, respiratory disease, mental health and frailty/ageing
Strategy agreed setting out how we improve support to children and young people.
Community Hubs in place to boost emotional wellbeing and help with loneliness and isolation, through local support and activities
Strategy agreed shaping our approach as an "anchor" system, developing our plans to stimulate sustainable economic and social wellbeing in our
West Sussex
Business case for a new Bognor Diagnostics Academic Centre which will reduce incidences of stroke and improve patient outcomes for those that are due to have a stroke.
We will begin to mobilise a new model for stroke services in Coastal West Sussex,
New models of care for our priority services in Crawley and a strategic outline case for improvement to our estates that will improve access to our services for the most disadvantaged
Business case and implementation plan to improve long-term outcomes for people following discharge from hospital, retaining more independence in the
Hospital discharge model improved and hospital occupancy reduced to less than 92%.
New pathway in place for young people, and training embedded at point of induction for social workers with annual refresher training
Section 75 agreement which sets outs the pooled commissioning and provider arrangements between West Sussex Adult Social Care and NHS West Sussex Place.