Sussex Health&Care

Improving Lives Together

Ambition to Reality: Our Shared Delivery Plan

Improving Lives Together

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SECTION 1
Making our ambition a reality

Our ambition

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 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 more people need more care more often; the wider determinants of health, such as the social and economic environment 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 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.

Improving Lives Together represents that ambition and has 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 to get the most value out of the 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 and 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 the 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.

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.

This Shared Delivery Plan sets out how we will do this over the next five years.

Our Shared Delivery Plan

Our Shared Delivery Plan brings together into one place the strategic, operational and partnership work that will take place across our system to improve health and care for our population over both the short and long term. It reflects and responds to national policy and guidance and aims to provide one single vehicle for delivery and focus for our system. It incorporates four delivery areas:

Delivery Area 1: Long-term improvement priorities [Section 2]

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.

Delivery Area 2: Immediate improvement priorities [Section 3]

We recognise there are immediate improvements that need to be made to health and care services. Our health and care system is continually extremely challenged, due to high numbers of people needing support and care from services, and this means 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 on 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 these are set out in our 2023-24 Operational Plan. From this plan, 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 reducing A&E waiting times;
- Reducing diagnostic and planned care waiting lists;
- Accelerating patient flow through, and discharge from, hospitals.

Delivery Area 3: Continuous Improvement Areas [Section 4]

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 to achieve greater equity in the experience, access, and outcomes of our population. This is a 'golden thread' running through the delivery of all the actions we are taking, and we also have a specific system-wide focus to help bring about 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.

Delivery Area 4: Health and Wellbeing Strategies and Place-based Partnerships [Section 5]

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.

Figure 1: Overview of our Shared Delivery Plan

Alongside the four delivery areas, we have other areas of focus **[Section 6]** that will be part of, and cut across, all the work we do. This includes a focus on prevention, climate change commitments, supporting social and economic development, maternity and neonatal care, safeguarding and quality of services.

To support the delivery of our Shared Delivery Plan, our statutory organisations responsible for health and care will work together in a new way across four different levels – System level, NHS provider level, Place level, and Local Community Level **[Section 7].**

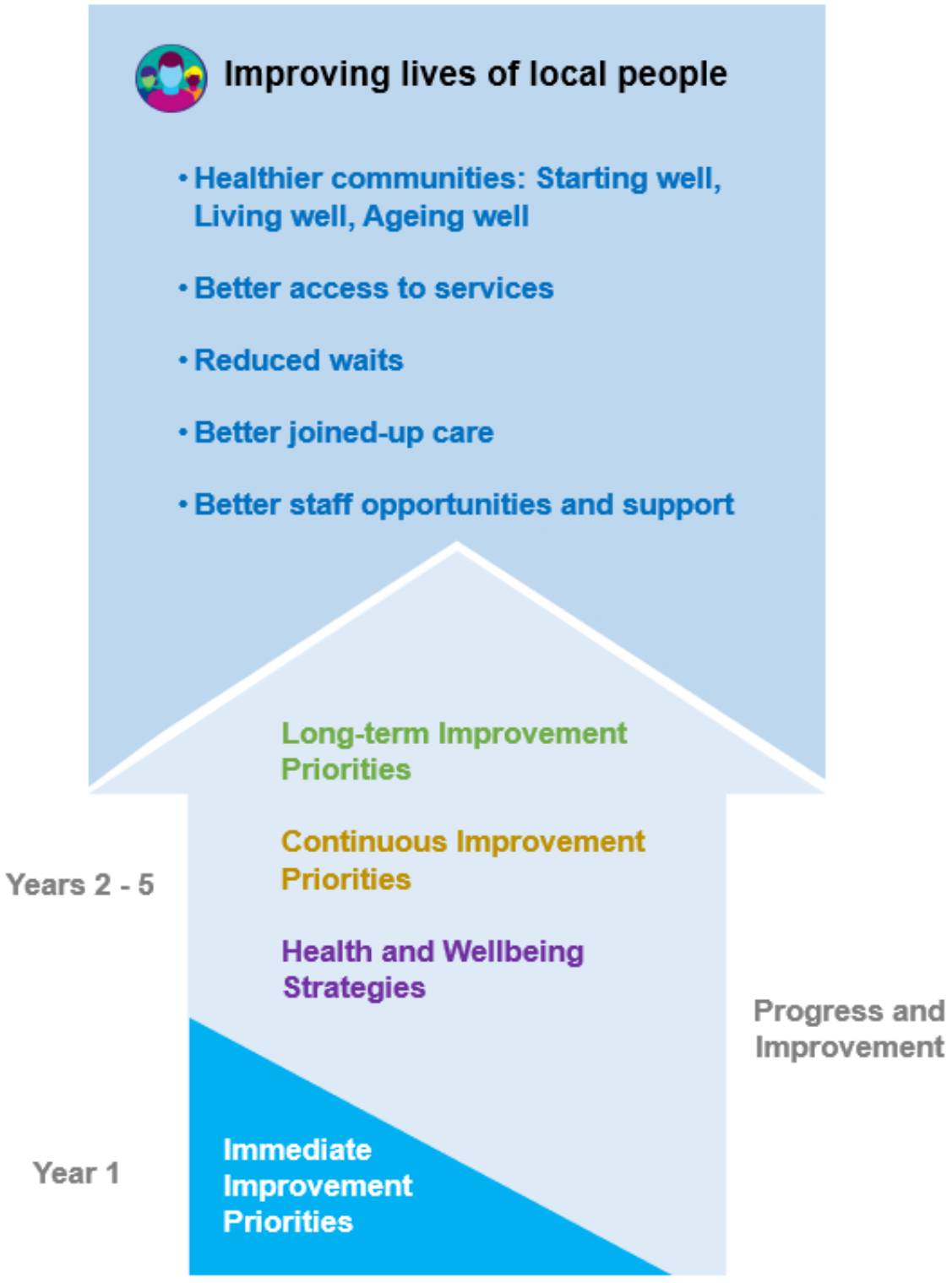
Each of the Long-term Improvement Priorities (Delivery Area 1), Immediate Improvement Priorities (Delivery Area 2) and Continuous Improvement Areas (Delivery Area 3) will be led by a Delivery Board, chaired by a system Chief Executive Officer, and they will have a workstream that will be resourced from across system partners. The work of these Boards and workstreams will be overseen by a System Oversight Board Chaired by the Chief Executive Officer of NHS Sussex. The Boards will address the needs of the whole population of Sussex. To ensure we deliver the focus we are committed to on the needs of children and young people, the system Children and Young People Board will contribute to and advise the work of each of the Delivery Boards to ensure that those needs are addressed.

How improvements will be made

The four delivery areas are not mutually exclusive; they support and interrelate with each other with the collective aim of making improvements over the next five years.

The actions taken across our Immediate Improvement Priorities (Delivery Area 2) aim to address issues that can be resolved in the short-term this year and make changes that give people better access to services and reduce waiting times. These will be supported and built on both this year and over the next five years across the Long-term Improvement Priorities (Delivery Area 1), the Continuous Improvement Areas (Delivery Area 3) and the actions in our Health and Wellbeing Strategies (Delivery Area 4) to address some of the deep-rooted and long-standing issues we face. Collectively, this will support longer-term improvement, change and transformation to the way services are delivered, the way organisations are organised and run and the health and wellbeing of local people.

Figure 2: Each of our Delivery Areas combine to make improvements for local people.



SECTION 2
Delivery Area 1: Long-term Improvement Priorities

Achieving our ambition is centred on three agreed long-term priorities – a new joined-up communities approach through Integrated Community Teams; growing and developing our workforce; and improving our use of digital technology and information.

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 with local communities, individuals, and their carers. This will involve integration across Primary Care, community, mental health, local authority partners, voluntary, community and social enterprise organisations 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.

Our Integrated Community Teams will have specific focus on addressing health inequalities, taking preventative and proactive action, and working with local partners that support the wider determinants of health, including housing.

The initial work to progress this priority will build on what is already detailed in our respective Health and Wellbeing Strategies and test new ways of working through 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 Integrated Community Frontrunners

We have selected three programmes at each of our respective Places to be our Integrated Community Frontrunners. These will be tests of change for our new ways of working and our approach to clinical leadership, multi-disciplinary working, the way we use technology and data, and how we will work with local communities to better meet their needs.

Brighton and Hove frontrunner

Across Brighton and Hove, we are working to improve and join-up services to better support people with multiple compound needs and their carers. 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 to be working together to better co-ordinate services that are preventative, proactive, responsive, and empowering; enabling individuals to maximise control over their lives. Team members will pool their skills, professional experience, and knowledge to provide a rounded response to the people they are supporting.

The proof of concept started in November 2022 and is benefitting from an independently-led evaluation, monitoring, and learning framework that enables the model to be flexed through an action learning approach. By April 2024, it is planned there will be a reported improvement in the baseline performance metrics for the identified cohort.

East Sussex frontrunner

Hastings has some of the most deprived wards in the country and partners across health and care are currently working with community and voluntary organisations and local people to design and develop services and support in the future. The focus of the initial testing and development phase of the new model is 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 is intended to build on this to establish a framework for planning and delivering joined-up health, care, and wellbeing services to bring about the most 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.

Throughout year one, we will be co-designing a proof of concept and identify early ‘quick wins’ that can be implemented immediately. By April 2024, we will have an evaluation to support further delivery and improvement and a plan in place to roll-out the approach across other areas of East Sussex.

West Sussex frontrunner

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 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 health inequalities and improve 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.

The actions we are taking this year (2023-24) to progress Integrated Community Teams are:

What we will do	What we will achieve	When
We will define our Integrated Community Teams across Sussex.	We will have a clear footprint 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 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 used at a local level and be shared across the Sussex system.	December 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 test and refine our new ways of working through our three Integrated Community Frontrunners.	We will have learning documented to inform further roll-outs and our approach to clinical leadership, workforce and the use of technology and data.	March 2024

The actions we will take over years 2-5 to deliver Integrated Community Teams are:

What we will do	What we will achieve	When
We will undertake a stocktake and evaluation of year one.	We will understand what is important to local communities, supported by data, and a proposal for the new ways of working.	April 2024
We will further test and refine our new ways of working through our Integrated Community Frontrunners	We will have learning documented to inform further roll-outs and our approach to clinical leadership, workforce and the use of technology and data.	March 2025
Implement a continuous improvement and evaluation approach to improve and refine the way we deliver services within different local footprints.	We will have a continuous learning and improvement approach for Sussex Integrated Community Teams.	March 2027
Rolling out our Integrated Community Team model across Sussex in a series of agreed 'waves'.	We will have a sequential roll-out of Integrated Community teams across Sussex. We will see a steady improvement in patient access, more services delivered locally within different communities, improving patient experience, satisfaction, and outcomes.	March 2027

Difference this will make to local people and how it will be measured

Difference for local people	How it will be measured
Seamless delivery of Proactive Personalised Care.	Reduction in avoidable admissions and increased system capacity and resilience. Patient, carers and stakeholder feedback, qualitative and quantitative datasets, measuring patient journey through the lens of individual patients. Access, waiting time, experience, carer registration and outcome data. Service delivery and efficiency standards.
Tangible reduction in health inequalities, through a focus on prevention and addressing root causes of ill health.	Population Health Management - metrics to be defined to suit local need.
Increased provider resilience with significantly improved collaboration across different organisation boundaries within a patient pathway.	Staff survey results. Workforce evaluation and feedback. Reduced staff turnover. Patient satisfaction surveys.
Increased job satisfaction, career progression and resilience for our workforce.	Workforce evaluation and feedback. Reduced staff turnover.

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 want to support staff to develop new skills and expand the skills they have to allow them to work across different disciplines and areas. We also want to 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 want to 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.

The actions we are taking this year (2023-24) to better grow and develop our workforce are:

What we will do	What we will achieve	When
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 develop a People Plan with a delivery roadmap for Years 2 to 5. Our approach to ensuring an inclusive culture will be informed by our Workforce Race Equality Standard and Workforce Disability Equality Standard and gender pay gap data.	We will agree one approach to workforce across our system and how this will be implemented.	September 2023

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 identify initial communities to test our one workforce approach.	We will begin to roll-out our one workforce approach.	March 2024

The actions we will take over years 2-5 to deliver our workforce aims are:

What we will do	What we will achieve	When
We will develop a digital training programme for Sussex.	Our staff will be better digitally trained.	March 2025
Based on the success of the SPFT and Guaranteed Employment model, we will adapt and adopt this process for an extended number of professions.	Guaranteed employment model will be adapted and adopted to create a pipeline of future workforce.	March 2025
We will review our Equality, Diversity, and Inclusion (EDI) offer across our system to strengthen our consistent approach in tackling inequalities, building on the success of our system Workforce Race Equality Strategy and Statement.	One approach to EDI support in place, taking account of individual organisations or professional context and needs.	March 2025
Build on the work to be undertaken in year one with our pilot Health Care Assistant collaborative bank and our South East regional collaborative with other systems.	Collaborative Bank process established.	March 2025
We will develop a workforce model for Integrated Community Teams.	Integrated Community Teams workforce model agreed.	March 2025
Start transition to new ways of working and provider form.	Colleagues can work in Integrated Community Teams with the same conditions, support inclusive of technology.	March 2026
Review transactional services.	Having a consistent approach to recruitment, payroll and Electronic Staff Record services.	April 2026 – March 2027

Difference this will make to local people and workforce and how it will be measured

Difference for our workforce and local people	How it will be measured
Improved working environment, opportunities, and development.	For all: Vacancy rates. Staff survey results. Retention rates. Workforce availability (inclusive of absence rates). EDI metrics such as WRES, WDES and Gender Pay. Temporary staffing usage Carer registrations among employees
Staff will connect better and form relationships with the community.	
Greater opportunities for people to work and have impact in the place they live, with flexible options.	
Better use of technology.	
Inclusive recruitment, with workforce that reflects its community.	
Opportunities for innovation and research.	

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 **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 in future 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 that communicate and plan with those involved in their treatment and care.

The actions we are taking this year (2023-24) to improve the use of digital technology and information are:

What we will do	What we will achieve	When
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 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 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 that will allow us to use data, information, and insight better.	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 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

The actions we will take over years 2-5 to deliver improvements to the use of digital technology and information are:

What we will do	What we will achieve	When
Digitise: We will drive improvement across all partners of their digital maturity, cyber security and the commitments agreed in the digital and data charter. We will also work to embed strong digital inclusion practice and reduce unwarranted variation in access and equity of digital services.	Core Electronic Patient Records (EPRs) implemented in all providers. All Trusts will be consistently good in digital maturity across EPR and cyber security areas of digital maturity. Quantifiable progress in reducing impacts of digital exclusion and improving design of digital services.	April 2025 April 2025 April 2026

Connect: We will co-design, develop and deliver common digital and data platforms and products to enable our population, communities, workforce, researchers, and innovators to have access to the tools and insight they need to improve lives together. Our People's Panel will develop and publish the social rules under which we will operate.	Integrated Community Teams will connect and share data, including with patients, carers and VCSE partners, with 90% of care providers using shared care (Plexus) care record. NHS App and My Health and Care will be embedded as the "digital front door" in Sussex. Data platform for research and innovation will be fully developed. People's Panel will be publishing a Social Agreement for how we use Digital and Data tools to support their care.	April 2026
Transform: We will deliver our digital services through a sustainable model with provider Centres of Excellence; enabling co-design and innovation with our communities; developing our workforce, working in partnership with communities, academia, and industry.	Frontrunner Digital Innovation Lab will be developed. Digital and Data Science Academy will be launched to tackle long-term. recruitment, development, and retention issues. Provider Centres of Excellence will be developed in all partner providers across Sussex underpinned by sustainable environmental and financial model. Digital Innovation Labs will be operating across Sussex.	April 2025 April 2026 April 2026 April 2027

Difference this will make to local people and workforce and how it will be measured

Difference for local people and workforce	How will this be measured
Digitise: We will improve and simplify access to digital technology and services for all and reduce the variation we see that leads to inequality and digital exclusion impacting some people and communities more.	All providers will have consistently good digital maturity across Sussex and across What Good Looks Like domains. Key intervention programmes to tackle digital exclusion and inequity of service have been developed and are having measurable impact. Our population and workforce feel supported to use technology in the best way to suit them and their needs.
Connect: Our population, partners and communities will be connected through digital and data services that informs care, population health management, research, and innovation.	Digital health and care tools and support are established as an everyday service for significant cohorts of patients including those at risk of digital exclusion. People involved with the care and support of an individual (including the individual) share a common view of information and plans and can communicate across the Integrated Community Team.
Transform: Services will be transformed through co-design of more integrated ways of working within our Integrated Community Teams and across our system.	Citizen confidence and trust in digital and data services in Sussex will be improved with strong user experience measures across digital and data services. All providers have achieved core Minimum Digital Foundations safely, through clinically and patient-led implementations with sustainable infrastructure and resourcing in place to continuously improve services.

SECTION 3
Delivery Area 2: 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 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. Specifically, we need to:

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

The actions taken to make improvements in these areas will be carried out this year (2023-24) and will be reviewed, adapted, and built on in the years ahead, according to the effectiveness of the improvements and the needs of local people. The actions will also be supported by the Long-term Improvement Priorities that aim to address many of the issues faced across these areas over time.

Increasing access to, and reducing variability, in Primary Care

GP practices across Sussex work extremely hard to ensure their patients and carers 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 growing 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.

While general patient satisfaction remains relatively high with GP services, it has declined over recent years and there are some areas where local people find it more difficult than others to access services.

Throughout this year, 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. This includes maximising the benefits of virtual consultations, continuing to improve access to face-to-face appointments and reducing bureaucracy to free-up clinical time. At the end of the year, we expect patient satisfaction and experience to have improved, with patients having increased choice in access to same-day and two weekly appointments via a range of methods.

In addition to GP services, we are also focusing on improving access to NHS dentists. Over the last year we have heard significant feedback from local people and Healthwatch around issues with access to dentists across Sussex. This is something that is being experienced across the whole country. Responsibility for dentistry transferred from NHS England to NHS Sussex from April 2022 and we are working locally to make improvements where possible.

This work to improve access will also allow us to deliver continuity of care which is important for people managing multiple long-term conditions. This will be achieved by developing partnerships with the voluntary sector and expanding the roles within the general practice team to include social prescribers, pharmacists, physiotherapists, health and wellbeing coaches and others, to provide people seeking care and support the right contact first time. We will also focus on helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention, building on lessons learnt through the Covid-19 vaccination programme which is an example of how we can develop an Integrated Community Team response to vaccination.

The actions we are taking this year (2023-24) to improve Primary Care access and reduce variability are:

What we will do	What we will achieve	When
Increase people's ability to manage their own health through the NHS App, including booking an appointment.	Target, to be determined once baseline is known (July).	March 2024
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

Increased levels of dental activity to improve access. This will include more opportunities for outreach into communities and those living in the most deprived quintiles and making every contact count by aligning the development of dental pathways across the public sector, including early years, health visiting and dental services.	Agree and establish an agreed approach for reporting on all relevant Public Health outcome indicators. Aligned NHS Sussex and Local Authority oral health promotion campaign and commissioning strategy. Improved units of dental activity (UDAs) to 95% of the contract.	September 2023 September 2023 March 2024

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 the previous year.
Patients will be able to access an appointment within two weeks if they need it.	The number of people obtaining an appointment within two-weeks if they need it will increase by (3.1%) with an additional c.340,188 appointments delivered within two weeks, resulting in an increase from 81.9% during 22/23 to 85% during 23/24.
It will be easier to access a dental appointment.	The number of UDAs delivered compared to pre-pandemic levels (target 100%). UDAs delivered as a proportion of all UDAs contracted (target 95%). This relates to the ambition to improve delivery of contracted activity. Proportion of the Sussex population accessing NHS dental services (provisional target of 47%).

Improving response times to 999 calls and reducing 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 on the timeliness for people accessing the care they need.

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 this year and we will be focusing on four key areas to make the biggest improvements:

- Improving and standardising care to give more of our population access to care which aligns with best practice.
- Expanding care outside hospital to ensure people's needs are met 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.

The actions we are taking this year (2023-24) to improve response times to 999 calls and reduce A&E waiting times are:

What we will do	What we will achieve	When
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 local people 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 support each of our acute hospital sites to undertake improvement work within their emergency departments, including a focus on rapidly streaming patients to the right service.	There will be improved flow of patients and their carers through emergency departments, enabling ambulances to be offloaded and minimising the time that patients spend in departments before being discharged or admitted.	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

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 and their carers 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 be cared for in a familiar environment with their carers and the support of friends and family.	We will increase the number of virtual ward beds, 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%.

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 Emergency Departments.	No patients will be cared for in corridors within Emergency Departments while awaiting treatment or admission. The number of patients and their carers 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 this year and over the longer term will transform the way planned care and cancer services are delivered with the 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 diagnosed at stage 1 or 2.

The actions we are taking this year (2023-24) to reduce diagnostic and planned care waiting lists are:

What we will do	What we will achieve	When
We will enhance patient and carers choice and access to treatment for key specialties including Ear, Nose and Throat and Trauma and Orthopaedic. We will establish clinically led workstreams to develop patient pathways that are productive and standardised across Sussex.	We will have agreed clinical pathways across all acute services for our key specialties to provide greater choice and access to patients and reduce waiting time variation across the system.	September 2023

To support patients and their carers who are 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 patients are referred into the most appropriate service based on their referral and clinical information. With full compliance of colorectal referrals with a FIT test completed, we will reduce the number of colonoscopies required by up to 40%.	September 2023
We will make further use of our Community Diagnostics Centres (CDCs) across Sussex, providing greater access to patients who need a test to support a decision for the care they need.	We will prioritise direct access for primary care for computerised tomography (CT), ultrasound and Magnetic Resonance Imaging (MRI). We will have as a minimum six day working across our CDCs providing greater flexibility for patients.	December 2023
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 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 provide greater flexibility to patients by increasing the number of 'Patient initiated Follow Up' (PIFU) appointments.	We will reduce our DNA rates 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 at least 25% of outpatient activity is undertaken virtually.	March 2024

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 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 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 discharges and we will be building on this and accelerating existing and new initiatives. Sussex is one of six national systems selected as Discharge Frontrunners, which involves health and social care partners locally working together, and with carers and wider partners, to rapidly find innovative solutions and new approaches which have the potential to make a substantial difference. Discharge Frontrunners 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 discharges 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 to support good system patient flow with reduced lengths of hospital stay, admission avoidance, and better long-term outcomes for local people.

The actions we are taking this year (2023-24) to accelerate patient flow through, and discharge from, hospitals are:

What we will do	What we will achieve	When
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
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 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.	December 2023
We will develop and mobilise a multi-agency workforce plan based on agreed discharge demand and capacity requirements.	We will develop our model for the 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

Difference this will make to local people and how it will be measured

Difference for local people and workforce	How will this be measured
Patients and their carers 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 in hospital who are not discharged.
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 and their carers will be discharged earlier but receive ongoing clinical oversight where required using digital innovations such as remote monitoring.	There will be a reduction in hospital length of stay (quantified based on experience of exemplars).

SECTION 4
Delivery Area 3: Continuous Improvement Areas

To support the successful delivery of the actions set out across our Long-term and Immediate Improvement Priorities, and our Health and Wellbeing Strategies, there are four key areas that need continuous improvement:

- Addressing health inequalities
- Mental health, learning disabilities and autism
- Clinical leadership
- 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 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 the driving purpose of developing Integrated Community Teams that better meet the needs of our diverse local communities. Health inequalities is a key priority of all our Health and Wellbeing Strategies and is a key element of all the workstreams of our Shared Delivery Plan and will be embedded within many of the actions outlined. This will be done with the following 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.

In addition to, and to support, the work across our workstreams and the Health and Wellbeing Strategies, we are taking the following actions to address health inequalities.

The actions we are taking this year (2023-24) to make progress to address health inequalities are:

What we will do	What we will achieve	When
Working with children and young people (CYP), partners, and young carers to develop a defined work programme around the CYP Core20PLUS5 similar to the adults' Core20PLUS5. This will include: • Address over-reliance on asthma reliever medication and decrease in number of asthma attacks. • Increase access to real time continuous glucose monitoring, and insulin pumps, in the most deprived areas, and from ethnic minority backgrounds. • Increase access to epilepsy specialist nurses within the first year for those with learning disabilities or autism • Address backlog for tooth extractions for under-10's. Improve Mental Health access rates for 0–17-year-olds from ethnic minorities and children in greatest areas of deprivation.	Develop CYP Core20PLUS5 baseline and improvement trajectory across each of the five clinical areas.	December 2023

Improve position against 2022-23 baseline on hypertension identification and treatment and increase lipid lowering therapy (LLT) prescription.	Hypertension: We will improve from the September 2022 position performance of 57% to 77%. Lipid lowering: We will increase from September 2022 position of 53% to 60%.	March 2024
Continue the roll-out of the NHS funded offer of universal smoking tobacco treatment services, across inpatient, maternity, and mental health services and ensure investment at scale and sustainability beyond 2023/24.	Increase proportion of adult inpatient settings offering tobacco dependence services from 0% baseline to 20%. Increase proportion of maternity settings offering tobacco dependence services from 50% to 80%.	March 2024
Address inequalities and improve outcomes in priority clinical pathways for those in deprived geographical areas and with vulnerable or protected characteristics. This includes: • Reducing waiting times, DNA, and cancellation rates in our most deprived areas and those with protected characteristics. • Establishing an inclusion health programme, identify gaps in provision and develop associated commissioning plans. • Improve recording of ethnicity recording across all providers. • Commissioned baselining of LGBTQ+ and Learning Disability data recording.	Reduced waiting times, DNA, and cancellation rates for those in deprived geographical areas and protected characteristic groups by 5%. Commissioned dedicated inclusion health network - 60% of providers signed up. Ethnicity recording moved from 65% to 90% data completeness. Data recording baseline achieved for LGBTQ+ and Learning Disability.	March 2024

The actions we will take over years 2-5 to further reduce health inequalities are:

What we will do	What we will achieve	When
Improve position against 2022/23 baseline on hypertension identification and treatment, and lipid lowering therapy prescription.	Hypertension: We will continue to improve performance to 80%. Lipid lowering: We will continue to improve performance to 70%.	March 2028
Continued support for the roll-out of the NHS funded offer of universal smoking tobacco treatment services, across inpatient, maternity, and mental health services and ensure investment at scale and sustainability beyond 2023/24.	Increase proportion of adult inpatient settings offering tobacco dependence services from 20% to 50% year two and to 80% by year five. Increase proportion of maternity settings offering tobacco dependence services from 80% to 100% by year five.	March 2028
Continue to address inequalities and improve outcomes in priority clinical pathways for those in deprived geographical areas and with vulnerable/protected characteristics.	Build on reducing waiting times, DNA, and cancellation rates in our most deprived areas and those with protected characteristics by reducing further on year one by 5% in years two and three. Dedicated inclusion health network established with 90% of providers signed up by year five. Identified gaps in services commissioned during years two to five. Ethnicity data completeness moving from 90% to 100% data completeness. Data completeness of 50% by year two and 75% by year five for LGBTQ+ and Learning Disability.	March 2028
Dedicated Children and Young Persons (CYP) programme for Core20PLUS5.	5% increase on year one baseline figures by year two and 20% increase on baseline year one figures by year five.	March 2028

Difference this will make to local people and how it will be measured

Difference for local people and workforce	How will this be measured
Improved and equitable access to health care for the population, particularly those in our deprived areas and those with protected characteristics.	Improvement in waiting times and access to treatment times for those from our most deprived areas and with protected characteristics.
Reduced inequalities, and variation in population outcomes.	Reduction in the number of avoidable stroke and cardiac events for adults. Improved access rates to mental health services from areas of deprivation, CYP, males and certain ethnic groups. Improved healthy life expectancy and life expectancy for people with severe mental illness and learning disabilities. Fewer CYP asthma events requiring emergency admissions, improved access to specialist nurse for those with epilepsy, learning disabilities and autism and fewer dental extractions for 0-10 years.
Reduced inequalities in delivery of services, service developments, commissioning, and employment.	Reduction in gaps for health inclusion groups in community service provision, which will reduce requirements for emergency and urgent care and fewer GP appointments.
Inclusive digital pathways.	Focused and reasonable adjustments will be applied to digital pathways to support population groups at risk of digital exclusion.

Mental Health, Learning Disabilities and Autism

Supporting people with mental health, learning disabilities and autism is a key priority across system partners. Although we are working across these areas in one workstream, they are separate areas of focus and will require differing approaches and actions.

Our aim is to ensure those who are suffering from emotional distress and mental ill health get the support, care, and treatment they need as quickly as possible and can live fulfilled lives within their communities. A lot of work has taken place to improve mental health services, including establishing the specialist perinatal mental health community service, increased physical health checks for those with serious mental illness, and recruitment of additional clinical staff in the eating disorder service. This has been done through consistent delivery of the Mental Health Investment Standard (MHIS) and this will be achieved again in 2023-24 at a level of 7.1%.

Despite funding and staffing levels increasing, the need for mental health services has grown exponentially in recent years, with the pandemic contributing to a rapid rise in emotional distress, depression and anxiety, and many individuals are still facing lengthy waits for assessment and treatment.

We are taking action in response to this growing need through our operational plan this year (2023-24) and over the longer term:

- We will improve care for those facing mental health crisis through rapid access to crisis services, such as NHS 111 links to the crisis line, Crisis Houses, Safe Havens, and specialist teams that will support the emergency services where an individual with mental health needs is being detained.
- We will continue to improve access to support for children and young people, access to talking therapy services for adults and perinatal services.
- We will eliminate out of area placements to provide care closer to home.
- We will work to increase dementia diagnosis through schemes such as the locally commissioned services in Primary Care.
- We will continue to deliver and work towards meeting the commitments detailed within the NHS Mental Health Plan 2019/20-2023/24 across the range of services.

These key commitments sit within the context of a comprehensive programme of transformation focused on population health and wellbeing and addressing health inequalities.

Alongside our focus on mental health, we are working to improve the care and outcomes for those with learning disabilities and autism. This includes:

- Working to ensure those with learning disabilities receive an annual health check and action plan.
- Reducing reliance on inpatient care, and improving the quality of inpatient care, for those with a learning disability and who are autistic through providing services in the community.

- Working with the NHS England South East Regional team on the regional delivery plan which includes special educational needs and disabilities (SEND) to improve outcomes.

The actions we are taking this year (2023-24) to make progress for those with mental health issues, learning disabilities, and autism are:

What we will do	What we will achieve	When
We will ensure care is offered close to home.	We will eliminate out of area placements.	From June 2023
Increase the numbers of adults accessing talking therapies (formerly known as 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 develop a locally commissioned service to improve our dementia diagnosis rate.	We will increase the dementia diagnosis rate by 0.3% as a minimum from 22/23.	March 2024
We will improve access to perinatal mental health services.	We will increase access by 1%.	March 2024
We will commence a Child and Adolescent Mental Health Service (CAMHS)/acute pathway programme involving all partners.	We will agree and develop a system approach to children and young people requiring an acute response from CAMHS services as part of the wider support network.	March 2024
We will maintain a strong commitment to reducing reliance on inpatient care for both adults and children with a learning disability and/or who are autistic, consistent with the ambition set out in the NHS Long Term Plan, and to develop community services to	30 adult and 15 CYP inpatients per million population,	March 2024

support admission avoidance and timely discharge.		
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 the uptake of annual health checks for those on the Learning Disability Register to 75%.	March 2024

The actions we will take over years 2-5 to further improve the experience of those with mental health issues, learning disabilities and autism are:

What we will do	What we will achieve	When
We will develop a strategy that strengthens commissioning aligned to a collaborative delivery of outcomes; enabling increased lead provider arrangements that deliver whole pathway approaches.	Reduced pathway fragmentation, increased provider sustainability and productivity and improved patient and carer outcomes and experience.	March 2025
Fully implement the community transformation plan within Sussex with an agreed and defined model in each place, including a functional single point of access and developed specialist pathways.	A consistent approach to supporting all people that present with mental health problems at primary care level and more cohesive service offer within Primary Care and secondary care mental health services.	March 2025
Develop closer linking of mental and physical health planning and delivery through the Integrated Community Teams approach.	Increased integrated community-based access to support, reducing reliance on more specialist care and delivering improved health outcomes for local people.	March 2025
We will review the existing successful plans for reducing out of area placements and embed practice as business as usual with continuous review and evaluation.	Continuation of the recent reduction of out of area placements offering better experiences for those that require admission and maintain a 0% tolerance.	March 2025
Agree and formalise a dementia model and strategy for each place that is consistent and meets national best practice with the	The memory services will offer a clearer and timelier assessment and diagnostic service that will support the existing pre and post diagnostic support for people with dementia. It	March 2025

implementation of locally commissioned Primary Care services to support diagnostic rates.	will also support wider system strategies.	
Develop and fully embed physical health checks for people with severe mental illness outreach and health improvement support in Primary Care as part of Emotional Wellbeing Service and mental health transformation objectives.	We will maintain completed annual comprehensive physical health checks to 75% of GP severe mental illness (SMI) registers.	March 2025
Implement the recommendations of the CAMHS review project.	We will improve timeliness of flow through CAMHS services with a consistent offer for children and young people. It will offer improved patient experience and achieve better outcomes for individuals and improve the offer and links to support education and social care processes.	March 2026
We will review the profile of mental health investment to ensure a balanced approach across children and adult services that reflects population demographic and need.	An enhanced focus on early intervention and wellbeing support that reduces reliance on specialist and bed-based services and addresses inequalities in access and provision.	March 2026
We will support the NHS regional plan to offer a cohesive service within our area and engage within the planning process.	This will allow a wider range of interventions across the region to be provided more consistently and will allow us to maximise our resources better on a larger geographical footprint.	October 2026

Difference this will make to local people and how it will be measured

Difference for local people and workforce	How will this be measured
We will undertake a system-wide participation and co-production strategy review, with local authority, experts by experience and VCSE partners, that will be embedded within all work programmes consistently and at all levels of development, review, and evaluation throughout mental health services.	Development of the participation matrix has been agreed with milestones being reported monthly to the Performance and Assurance Group and to the system multi-stakeholder mental health board.
We will have a mental health workforce that is consistent and suitably trained who feel supported and offered opportunities to develop best practice.	Annual staff surveys with a robust audit of issues raised, with associated recommendations and actions that may impact on this commitment led by chief officers.
We will have health and care services working as one team to provide a holistic offer of support to people with mental health and learning disabilities in the community in which they live.	Increase in the uptake of annual physical health checks. Increase in access to preventative and timely access to treatment services, same level as those without mental health or learning disabilities.

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.

The actions we are taking this year (2023-24) to make progress in clinical leadership are:

What we will do	What we will achieve	When
We will formally appoint a clinical leader for each of the three Integrated Community Team Frontrunner programmes.	The development of Integrated Community Teams will be clinically led.	June 2023
Establish multi-professional Clinical Reference Groups (CRG) for each of our Shared Delivery Plan priority areas.	Governance structure confirmed and implemented for the Clinical Reference Groups.	June 2023
Set out benchmarks for improvements in clinical outcomes.	Agree reduction plan in unwarranted variation.	September 2023
Agree an organisational development approach to quality improvement and use of data.	Agree Quality Improvement training and data baseline. Progress training plan in identified Clinical Leadership Group.	September 2023
Put in place a multi-professional Leadership Academy to develop our clinical leaders across the system.	100 leaders will have undertaken the programme.	March 2024

The actions we will take over years 2-5 to further develop, improve, and progress clinical leadership are:

What we will do	What we will achieve	When
Agreement on clinical support for delivery workstreams.	Review function of Clinical Reference Group support for year one delivery priorities for effectiveness.	March 2025
Review the 100 leaders who have undertaken the Clinical Leadership Academy programmes and work on lessons learned and ways to improve.	Ensure that clinical leaders selected for each of the Integrated Community Teams areas are well trained and supported for leadership.	March 2025

Embed delivery of clinical outcomes as related to each Delivery Board.	Improve the clinical outcomes of greatest importance for the population of Sussex to deliver measurable impacts.	March 2027
Develop the model of clinical delivery within our ICTs year-on-year and build on the use of digital and data within our pathways.	Clinicians are able to use the opportunities of digital, data and technology.	March 2027
Clinical leadership to ensure clinical interventions and transformation are being delivered using the highest quality evidence, though multi-professional teams using continuous improvement cycles.	Review of outcomes of Integrated Community Teams across Sussex to ensure impact of clinical leadership for delivering high quality care and evidence by using agreed metrics.	March 2028
Clinician leaders demonstrating their proficiency in using digital, data and technology as a means of improving the clinical interventions.	Clinical leaders will be using clinical interventions and research data to demonstrate the effectiveness of interventions in clinical pathways.	March 2028
Clinical ownership of population outcomes.	Clinical leaders will be able to demonstrate improvements in agreed clinical outcomes in the pathway of care for the community.	March 2028

Difference this will make to local people and workforce and how it will be measured

Difference for local people and workforce	How will this be measured
There will be integrated working within Integrated Community Teams and networking across the system partners, with a greater focus on preventing ill health and on evidence-based impacts of personalised care.	Public satisfaction with services survey.
Sussex will be an attractive place to work for clinicians, attracting and retaining talent who are able to see they are making a positive difference to local people.	Staff survey on satisfaction and engagement for Trusts.

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 we have available and, to do so, it is crucial that all organisations across our system manages resources effectively, ensuring value for money from every pound spent.

Currently, the NHS across the Sussex system is challenged financially and has a recurrent deficit, which means it is spending more than its 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, NHS Sussex is required to make running cost reductions of 20% from 2024/25, with a further 10% reduction from 2025/26.

The Sussex system receives a capital allocation, used to upgrade estates and equipment, and must prioritise all the capital requirements to make sure the funding available is spent in the most effective way. In addition, we receive national capital funding for specific programmes and projects. Over the next five years we will invest in some significant developments which will radically improve patient experience and our productivity. Examples include a new Emergency Department in Brighton, a programme which will eradicate mental health dormitory accommodation, the development of community diagnostic centres and new facilities to deliver elective activity.

A key area of focus for us in improving our finances 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 in some areas, such as in our acute hospitals, where current productivity is significantly lower than before the pandemic. To improve our productivity, we have agreed a set of principles and actions across four areas, overseen by a system Productivity Steering Group. These aim to ensure the system is maximising value for money from use of its public funding, expertise, technology, and estates to deliver services. These are:

- System-led workstreams: To develop a joined-up Sussex approach and reduce variations across providers across areas such as workforce, procurement, and discharge.

- Provider-centric workstreams: To share best practice across providers and identify system opportunities across areas such as theatre productivity, outpatient opportunities and A&E.

- Integrated approach: Focusing on productivity opportunities that may impact on both primary and secondary care and potentially areas that impact multiple services/ pathways, including medicine optimisation.

- Non-pay saving opportunities: To explore medium-term opportunities in areas like estate optimisation and corporate service.

The actions we are taking this year (2023-24) to get the best from the finances available are:

What we will do	What we will achieve	When
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 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
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 deliver our 2023/24 system financial plan.	We will meet our financial budget at the end of the year.	March 2024

The actions we will take over years 2-5 to continue to get the best from the finances available are:

What we will do	What we will achieve	When
Model the medium-term financial position of the system including the improvements we would expect as a result of the productivity improvements.	A medium-term financial plan owned by the system.	March 2025

Build a longer-term plan for productivity improvements.	A rolling programme of productivity and efficiency improvements.	March 2025
Review and consider national and international financial frameworks which would support delivery of the Shared Delivery Plan.	A revised financial framework which supports the strategy.	March 2026
Make clinical leadership the natural driver of the productivity improvement programme.	Build enduring clinical leadership into the productivity programme, linking with the Clinical Leadership workstream.	March 2028
Ensure Sussex can live within its financial allocation each year, giving us the freedom to implement our Shared Delivery Plan.	Deliver the annual financial plans.	March 2028
Optimise our capital allocation through prioritising strategic capital requirements.	A prioritised capital plan for 2025/26 onwards (2023/24 and 2024/25 already done).	March 2028
Model and plan the financial impact of all the elements of the five-year plan.	A detailed investment and efficiency plan showing where cost and income will change.	March 2025

Difference this will make to local people and workforce and how it will be measured

Difference for local people and workforce	How will this be measured
Living within our financial allocation will allow for greater investment in new services and innovation to support and accelerate improvements for local people.	Financial positions across system partners at the end of each financial year.
Greater productivity and efficiency will help people to be seen and treated quicker.	Productivity improvement across the system.
Significant major capital developments which will provide improved facilities and better patient experience.	Capital programmes delivered to time and budget.

SECTION 5

Delivery Area 4: Health and Wellbeing Strategies and developing Place-based Partnerships

Improving Lives Together supports and builds on the three Health and Wellbeing 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; 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 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.

Alongside the delivery of the Health and Wellbeing 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. Further details of how these partnerships fit into the way of working across our system is in **Section 7****.**

The ways of working and priorities across each of our places are set out below.

Brighton and Hove

Our 2019-30 Health and Wellbeing Strategy 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 build upon the work already started and is now becoming formalised. 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, Attention Deficit Hyperactivity Disorder (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 Joint Strategic Needs Assessment, 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 community 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 under-served 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 an integrated service model, co-produced for and by people with lived experience. We will do this through our Integrated Community Frontrunner programme.

The actions we are taking this year (2023-24) to deliver our Brighton and Hove Placed-based priorities are:

What we will do	What we will achieve	When
Integrated Community Teams frontrunner: Through our multi-disciplinary team pilot we will trial and develop a new integrated model of care and support for people with multiple compound needs and their carers. This will be supported by a clear set of programme objectives, a compact agreement between system partners and an independent evaluation of our pilot project.	We will develop a clear set of programme objectives that supports our aim of increasing life expectancy for people with multiple compound needs. We will establish a compact agreement, across system partners that supports a new integrated model of care and support. We will get an independent evaluation of our pilot project to inform future service design and commissioning.	March 2024
Health inequalities: We will build on the work with Public Health to reduce the spread of blood borne viruses. We will deliver the aims of our current commissioned health inequalities	We will build on HIV ED opt-out testing and commence the opt-out blood borne testing.	March 2024

services working with the local population, VCSE and our providers to responds to known areas of health inequalities.	We will improve experience, access, and outcomes for the most disadvantaged communities in Brighton and Hove.	
Children and young people (CYP): We will implement year one emotional wellbeing action plan priorities for the Foundations for Our Future Place-based Plan. This will include a new emotional wellbeing pathway for CYP and embed training at point of induction for social workers and annual refreshers thereafter.	We will improve the support and interventions for children and young people who are neurodiverse and for children and young people with mental health needs and their carers.	March 2024
Mental health: We will implement the recommendations of the 2022 Mental Health and Wellbeing JSNA ensuring that progress is made across all seven delivery areas - extend and expand the range of emotional wellbeing services to Primary Care Networks, physical health checks for people with severe mental illness, develop suicide and self-harm prevention action plan.	Increase access to community mental health services. Reduce demand on acute and crisis care. Increase the number of people on severe mental illness registers.	March 2024
Cancer: We will build on the work with Public Health, the local population, VCSE and our providers to help to detect cancer at an early stage through promoting uptake of screening programmes, including expanding the targeted lung health checks programme, Faecal Immunochemical Test (FIT) testing and continuing the fibro scanning outreach service (to check for liver inflammation). The programme will ensure it responds to known areas of health inequalities.	Increased screening rates including in areas of deprivation and communities, including BAME communities, people experiencing homelessness, Trans people, and people with learning disabilities.	March 2024
Multiple long-term conditions: We will develop our cardiovascular disease reduction priorities in Brighton and Hove including hypertension case finding and treatment, and the restoration of the NHS health checks programme with health inequalities lens.	The cardiovascular disease reduction action plan will be developed and monitored at the Brighton and Hove Community Oversight Group.	March 2024

Hospital discharge: We will develop our integrated model, implement the 2023-24 hospital discharge transformation plan, and deliver the improvements aligned with the discharge frontrunner programme. Our place-based discharge transformation work will happen to ensure efficiency within current processes.	This will enable us to ensure people who no longer need acute inpatient care can go home or to a community setting to continue recovery with appropriate support for any unpaid family/friend carers who help that patient.	March 2024

The actions we will take over years 2-5 to continue to deliver our Brighton and Hove Place-based priorities are:

What we will do	What we will achieve	When
Integrated Community Teams frontrunner: We will evaluate the impact and results of our multi-disciplinary team pilot project, including the independent evaluation report. This will inform our longer-term redesign of services for people with multiple compound needs.	We will develop a long-term integrated model of service, where partner organisations from across the public and community sector will work together as a multidisciplinary team. Service-users and their carers will experience a joined-up service that best meets their multiple health and social care needs.	March 2028
Health inequalities: We will further develop our prevention programmes, in-line with our Health and Wellbeing Strategy priorities, with an increased focus on reducing health inequalities in identified populations and locations across the city.	We will reduce barriers, increase service use, and improve health outcomes for the most disadvantaged communities in the city.	March 2028
Children and young people: We will implement Year 2-5 action plan priorities for Foundations for Our Future Place-based Plan.	We will improve the support and interventions for children and young people who are neurodiverse and for children and young people with mental health needs.	March 2028

Mental health: We will transform the community mental health system, improving access though provision of holistic care, shifting investment to increasingly focus on CYP as well as prevention. Improve access to stable and secure housing and accommodation-related support for people with serious long term mental health conditions.	We will improve access to community mental health services – both numbers of people accessing and reduction in waiting lists. We will improve access to CYP mental health services - both numbers of people accessing and reduction in waiting lists. We will increase the number of people on the severe mental illness register. We will deliver a reduction in use of avoidable crisis and acute care.	March 2028
Cancer: In-line with the Brighton and Hove wellbeing strategy, we will expand cancer diagnostic and treatment service capacity, enabling earlier diagnosis of cancers through use of community diagnostic centres.	We will achieve the 28 day faster diagnosis standard (75%). We will increase the number of cancers diagnosed at stages 1 and 2. We will reduce under 75 mortality from cancer considered preventable.	March 2028
Hospital discharge: We will further develop and implement efficient admission avoidance and hospital discharge processes, supported by digital automation and engagement with patients and their carers. We will put in place a long-term funding plan for discharge capacity. We will embed efficiency and process learning from transformation programmes into 'business as usual'.	We will have quicker and more effective discharge processes, reducing the length of the time people wait to be discharged and maximise reablement and independence after discharge. We will ensure that more patients are able to return to their usual place of residence following discharge, increasing Home First capacity, and decreasing reliance on bedded capacity. We will ensure discharge pathways allow for greater personalisation to meet the individual need of the patient and their carer.	March 2028
Multiple long-term conditions: We will implement a new integrated intermediate care model for rehabilitation and reablement services including a quality outcomes framework to demonstrate benefits.	We will improve the support for a short time to help more people and their carers to remain in their own home while they recover from a hospital stay.	March 2028

Difference this will make to local people and workforce in Brighton and Hove and how it will be measured

Difference for local people or workforce	How will this be measured
Multiple compound needs: Life expectancy will improve for people with multiple compound needs, reducing the current 34-year gap in life expectancy between this group and the general population. Services for people with multiple compound needs will be integrated and all service-users will have access to a lead professional who coordinates their care and support.	Through a clear outcomes framework, that is consistent across all partner organisations. Through a successful redesign and commissioning of services for people with multiple compound needs.
Health inequalities: Models of health, care and support that focus on prevention, greater independence and choice, self and proactive care including social prescribing through a locality-based integrated neighbourhood team model. This will be tailored to the individual needs within local neighbourhoods and our communities of interest.	Reduction in the numbers of people accessing hospital services in an unplanned way. Reduction in the gap in life expectancy and healthy life expectancy for communities with health inequalities. Reduction in new cases of HIV, with the aim to achieve zero transmission.
Children and young people: We will see a reduction in waiting times for emotional wellbeing treatment and support, with a greater focus on prevention and early intervention.	Reduced waiting times to access services. Reduction in referrals to specialist CAMHS services.
Mental Health: Life expectancy will improve for people with serious mental illness. Improved experience of people using services by reducing barriers between services and the need to re-tell their story, reducing the potential for re-traumatisation. Increase in availability of preventative support including suicide prevention.	Life expectancy data. Patient Reported Outcome Measures (PROMS). Measurement of suicide rate. Reduction in waiting times. Increase in number of people accessing services.

Improve access by making it easier and quicker to get support.	
Cancer: Improved take-up rates of FIT testing, including groups with low participation, particularly men, people from minority ethnic backgrounds and people from deprived areas. Targeted lung health checks will lead to an increase in lung cancers being diagnosed at an earlier stage.	Public Health Screening Data. Cancer Action Group Dashboard. Increase take-up rates of FIT testing by 7%. Increase lung cancer stage 1 diagnosis by 47%.
Multiple long-term conditions: Lower levels of mortality and disability due and cardiovascular disease. People will be better supported to remain at home and retain more independence in the community.	Increased levels of independence. 90% of the expected prevalence of Atrial Fibrillation is diagnosed. Reduced time waiting to receive reablement/intermediate care intervention. Reductions in people unnecessarily needing long term care. Reductions in need for care home placements. Increased proportion of care provided at home. Greater personalisation of discharge care and increase in number of personal health budgets and increase in proportion of people living independently at home for longer.
Hospital discharge: Improved discharge process to ensure people return home as appropriately as possible.	Reduction in the length of time between someone being ready to leave hospital and when they do. Maximise the proportion of people who can return home after leaving hospital.

East Sussex

Improving Lives Together and our East Sussex Health and Wellbeing Board Strategy to 2027 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

Aligned to our system ambitions to develop Integrated Community Teams, 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 co-ordinated 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 within our integrated communities to help co-ordinate access to local sources of practical support and activities. 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.

Accountability through to our Health and Wellbeing Board and strong links into Sussex-wide programmes will 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.

The actions we are taking this year (2023-24) to deliver our East Sussex Place-based priorities are:

What we will do	What we will achieve	When
Building on the Universal Healthcare initiative and other local programmes, 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.	Improvement plans approved by Place leadership board.	March 2024
Aligned to our discharge workstream, we will develop our integrated hospital discharge model, implement the 2023-24 hospital discharge capacity plan, and deliver the improvements aligned with the discharge frontrunner programme.	More people will be able to be discharged safely to a community setting.	March 2024

Our place-based discharge transformation work will happen to ensure efficiency within current processes.		
Deliver our children and young people's programme plan with a key focus on priority workstreams to support getting the best start in life; promoting emotional wellbeing and mental health; physical health, needs of children with SEND, and our most vulnerable young people.	Family hubs with additional support for families with young children; strengthened support for long term conditions (Core20PLUS5 for CYP); clearer and improved pathway for mental health support and support for parent carers.	March 2024
We will deliver initial stages of integrated models of community mental health care within local communities, through Primary Care Network based offers and developing plans to support more people who need housing-based support due to their mental health.	In-year plan delivered.	March 2024
Networks will be developed in communities to help co-ordinate access to local sources of practical support and activities, to boost emotional wellbeing and help with loneliness and isolation.	Consolidation of networks providing access and support to local people.	March 2024
Develop our approach as an "anchor" system in East Sussex, including our plans for using our power as employers and buyers of services to stimulate sustainable economic and social wellbeing in our communities.	Approach approved by Place leadership board.	March 2024

The actions we will take over years 2-5 to continue to deliver our East Sussex Place-based priorities are:

What we will do	What we will achieve	When
Refresh and implement further actions in targeted areas to support population health improvement and integrated care in our four target conditions.	Continuation of measurable plans to improve life expectancy and healthy life expectancy and reduce unplanned use of hospital services.	March 2025

Implement the improvements to cardiology and ophthalmology through reconfigured acute hospital services.	Agreed transformation plans fully implemented improving efficiency and outcomes for local people.	March 2025
Appraise and jointly respond to forthcoming national guidance and tools and system opportunities designed to support a joined-up offer of care at Place across Primary Care, community health, adult social care, mental health, public health, and housing services which relate to health and social care.	An agreed plan to further evolve our provider collaboration at Place to support delegated responsibility for services in scope, to deliver shared population priorities for improved population health and integrated care.	March 2025
Develop a reprofiling of resource application to support a widening of emotional wellbeing services for children and young people.	Improved access to emotional health and wellbeing services that support improved experience for children and young people and reduce the need for more specialist care.	March 2026
Enhance support to families to enable the best start in life including continued development of an integrated pre and post-natal offer.	Improved experience and increased opportunities to support our most vulnerable families.	March 2026
Implement integrated community-based approaches for mental health and a wider range of early support for mental health, in-line with Sussex-wide approaches.	Reduced reliance on specialist services and improved population health and wellbeing.	March 2026
Continue phased implementation and evolution of locality-based Integrated Community Teams model.	An approach and model supported by comprehensive engagement and fully owned and embedded with communities that delivers integrated support in local communities.	March 2028

Aligned to the discharge workstream, we will further develop and implement efficient hospital discharge processes, supported by digital automation, with a long-term funding plan for discharge capacity. We will embed efficiency and process learning from transformation programmes into 'business as usual'.	We will have quicker and more effective discharge processes, reducing the length of the time people wait to be discharged and maximise reablement and independence after discharge, ensuring more patients are able to return to their usual place of residence following discharge, increasing Home First capacity, and decreasing reliance on bedded capacity. We will also ensure discharge pathways allow for greater personalisation to meet the needs of individuals and carers.	March 2028

Difference this will make to local people and workforce in East Sussex and how it will be measured

Difference for local people and workforce	How will this be measured
People will be supported to stay healthy for longer and more proactive preventative care will be available for those who need it, across the full range of organisations that can support this.	Reduction in the numbers of people accessing hospital services in an unplanned way. Reduction in the gap in life expectancy and healthy life expectancy.
More children and young people will be accessing assessment and treatment more quickly and will be supported to live healthier lives.	Improvements in health outcomes. Increase in the proportion of children and young people with a diagnosable mental health condition who receive treatment from an NHS-funded community mental health service.
More people will be able to access support with their mental health needs more quickly and closer to home and there will be more intensive bespoke housing-based options for people who need it to ensure people can leave hospital more quickly when they are ready. Staff roles will become more manageable and more enjoyable.	Reduction in the number of inappropriate referrals to mental health secondary services, and an increase in appropriate referrals to secondary mental health services improving outcomes, reducing waiting times and preventing issues from worsening.

Community care and support will be better co-ordinated to enable people to stay independent for longer, have better onward care after a spell in hospital, and ensure access to local sources of practical support and activities, boost emotional wellbeing, and help with loneliness and isolation.	Increase in the number of people seen within the waiting time target for reablement services. Number of people living at home and accessing support in their communities. Proportion of people with support needs who are in paid employment. Proportion of people who regain independence after using services. Proportion of people and carers who report feeling safe. Reduction in the numbers of people accessing hospital services in an unplanned way. Reduction in the average length of stay in community beds. Reduction in the average length of stay in Discharge to Assess (D2A) commissioned beds and increased use of D2A bed capacity utilisation.
People have access to timely and responsive care, including access to emergency hospital services when they need them.	Reduction in waiting times for GP services, community support and care services. Referral times for health treatment. Reduction in the length of time between somebody being ready to leave hospital and when they do.
Digital services and innovation are used to help make best use of resources.	Proportion of people and staff in all health and care settings able to retrieve relevant information about an individual's care from their local system.

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". 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 (JSNA).

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, as we develop our Integrated Community Team model across 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 the delivery of the priorities set out in *Improving Lives Together*. Our strategic goals are:

- **Address health inequalities**: There are stark inequalities in outcomes, access, and experience of care for maternity and neonatal service users 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. To support the delivery of the system-wide priorities and our strategic goals, 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.

The actions we are taking this year (2023-24) to deliver our West Sussex Place-based priorities are:

What we will do	What we will achieve	When
We will develop and agree a business case and implementation plan for a new Bognor Diagnostics Academic Centre. We will develop education, training and develop courses to support local people in gaining employment in this sector.	We will be able to provide additional capacity for diagnostic tests.	September 2023 March 2024
We will complete a public consultation, produce, and agree a business case and start to mobilise a new model for stroke services in the coastal area of West Sussex subject to the outcomes of the public consultation. We will develop our cardiovascular disease reduction priorities in West Sussex including hypertension case finding and treatment, and the restoration of the NHS health checks programme.	We will be able to become fully compliant with national standards for acute stroke services. The West Sussex Cardiovascular Disease Reduction action plan will be developed and monitored at the West Sussex Cardiovascular Disease Reduction group.	December 2023 March 2024
Aligned to the Integrated Community Frontrunner programme, we will develop new models of care for our priority services in Crawley, produce and agree the business cases (including impact measures) and implementation plans for our four priority service areas and a strategic outline case for improvement to our estates.	We will be able to tailor our services and improve access for the most disadvantaged communities in Crawley. This includes the development of a new Community Diagnostics Centre at Crawley Hospital, and new improved facilities for the Child Development Centre at Crawley Hospital.	March 2024
Aligned to the discharge workstream, we will develop our integrated hospital discharge model, implement the 2023-24 hospital discharge capacity plan, and deliver the improvements aligned with the discharge frontrunner programme.	We will be able to ensure people who no longer need acute inpatient care can go home or to a community setting to continue recovery. We will also ensure Place-based discharge pathways are	March 2024

Our Place-based discharge transformation work will happen to ensure efficiency within current processes.	aligned to national best practice and achieving maximum efficiency.	
We will develop a new integrated intermediate care model for rehabilitation and reablement services and a business case and implementation plan for the new model.	We will be able to ensure people receive rehabilitation and reablement care in a timely manner, through teams working together in reducing unnecessary duplication and handovers.	March 2024
We will create an emotional wellbeing pathway focused on ensuring that the best outcomes are achieved for children and young people and embed training at point of induction for social workers and annual refreshers thereafter.	We will be able to improve the support and interventions for children and young people with autism and or mental health issues.	March 2024
We will review our joint commissioning arrangements for learning disabilities, mental health, and neurodevelopmental services.	A robust and transparent Section 75 agreement which sets outs the joint and pooled commissioning and provider arrangements between West Sussex Adult Social Care and NHS Sussex West Place to meet the needs of residents. This will enable the introduction of new clinical governance measures on Case Review Process to ensure best practice and compliance to new regulations.	March 2024

The actions we will take over years 2-5 to continue to deliver our West Sussex Place-based priorities are:

What we will do	What we will achieve	When
We will implement tailored health services and service models for our priority service areas in Crawley to meet the needs of the population with a focus on the most disadvantaged communities.	We will increase service use by the most disadvantaged communities in Crawley. We will have improved health outcomes for the most disadvantaged communities.	March 2028

	We will have co-ordinated utilisation of estates and assets across health and social care.	
We will deliver the Bognor Diagnostics Academic Centre.	We will contribute to the West Sussex diagnostic programme to enhance access to diagnostics for patients across Sussex with our CDC capacity, improved diagnostics pathway, and capital investment in services. We will increase in numbers of physiological and imaging workforce being trained or being employed.	March 2028
We will create access to 24/7 acute stroke centres for the coastal area of West Sussex, subject to the outcome of public consultation. We will further develop and implement seamless rehabilitation pathways to ensure people can return home as soon as their acute episode is resolved. We will implement our cardiovascular disease reduction priorities.	We will have a fully compliant stroke pathway from prevention through to hyper-acute care to rehabilitation in place for the population. We will have better long-term outcomes for patients and their carers and reduced mortality/ disability due to stroke and cardiovascular disease.	March 2028
We will further develop and implement efficient hospital discharge processes, supported by digital automation. We will put in place a long-term funding plan for discharge capacity. We will embed efficiency and process learning from transformation programmes into 'business as usual'.	We will have quicker and more effective discharge processes, reducing the length of the time people wait to be discharged and maximise reablement and independence after discharge. We will ensure more patients are able to return to their usual place of residence following discharge, increasing Home First capacity, and decreasing reliance on bedded capacity. We will ensure discharge pathways allow for greater personalisation to meet the needs of the individual and their carer.	March 2028

We will implement a new integrated intermediate care model for rehabilitation and reablement services including a quality outcomes framework to demonstrate benefits.	We will improve the support for a short time to help more people remain in their own home while they recover from a hospital stay.	March 2028
We will implement a new emotional wellbeing pathway to further support and interventions for children and young people with autism and or mental health issues.	We will ensure that within 24 hours of admittance to a paediatric ward due to autism, learning disabilities or mental health concerns, there is a multi-disciplinary plan to ensure a discharge in-line with their best interest.	March 2028
We will continue with our Joint Commissioning Review in West Sussex to further enable delivery of the priorities set out in *Improving Lives Together*, the Adult Social Care Strategy, and the Children First Strategy.	We will reform our joint commissioning governance to support the continued development of integrated health and care partnership working at system, Place and local community level. We will realign our strategic and financial joint commissioning arrangements to match our local population health priorities, and the priorities set out in our health and care strategic plans.	March 2028

Difference this will make to local people and workforce in West Sussex and how it will be measured

Difference for local people and workforce	How will this be measured
Improved health outcomes for the most disadvantaged communities in Crawley.	Improved health outcomes across a number of areas including maternity, mental health, and long-term conditions. Improved access across a range of services for our most disadvantaged communities. Increase uptake of translation services, more services available outside 9-5, Monday to Friday.
Improved access and capacity of diagnostics in Bognor	People will have access to their diagnostics at more convenient times. Reduced waiting times for diagnostics. Local residents in local university diagnostics related courses. Increased workforce supply, skills mix and new roles across imaging workforce.
Lower levels of mortality and disability due to stroke and cardiovascular disease.	Increased number admitted to stroke ward within four hours and spend 90% of their time there. More lives saved 90 days post discharge. Increased levels of independence. 90% of the expected prevalence of Atrial Fibrillation is diagnosed in every practice in West Sussex. 90% of people already known to be at high risk of stroke are adequately anticoagulated.

Improved discharge process to ensure people return home as appropriately as possible.	Reduction in the length of time between someone being ready to leave hospital and when they do. Reduction in overall number of patients who are ready to leave hospital but cannot. Maximise the proportion of people who can return home after leaving hospital.
People will be better supported to remain at home and retain more independence in the community.	Reduced time waiting to receive reablement/intermediate care intervention. Reductions in people unnecessarily needing long-term care. Reductions in need for care home placements. Increased proportion of care provided at home. Greater personalisation of discharge care and increase in number of personal health budgets. Increase in proportion of people living independently at home for longer.
Improved outcomes for children and young people with autism and mental health issues	Within 24 hours of admittance to a paediatric ward due to autism, learning disabilities or mental health concerns there is a multi-disciplinary plan to ensure a discharge in line with their best interest. Mental health, autism and learning disability module for social workers at university.
A shared set of strategic priorities and plans with integrated and streamlined commissioning arrangements and use of resources supporting delivery.	By streamlining and strategically aligning the West Sussex Joint Commissioning activities between local government and the NHS to population health priorities for children and young people, people living with a learning disability or neurodiversity or long-term mental illness, we will aim to deliver:

- Care models that enable greater independence, choice, and self-care.
- Greater technology enabled care to support more people to live independently at home.
- Better long-term health outcomes by tacking health inequalities experienced by people with learning disabilities, or mental illness.

SECTION 6
Other areas of focus

To support the delivery of our ambition and the four delivery areas, there are other areas that will require continued focus, either within the actions of our improvement priorities or as distinct pieces of work. These are set out below.

Prevention

Prevention is a key principle that underpins the delivery of our ambition. This includes supporting good physical health, supporting people to be socially connected, supporting emotional wellness and positive mental wellbeing, supporting people to feel safe in a clean and sustainable environment. The work being undertaken 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 are committed to the delivery of our Sussex Improving Population Health Strategy and the key priorities in the Sussex Strategic Framework for Health Inequalities. We continue to embed Population Health Management methods to identify target populations for health conditions, prevention programmes, racial health disparities and focussed personalised care interventions. We also have a series of programmes of work to address Core20PLUS5 for children, young people, and adults.

Increasing our focus on addressing the needs of children and young people is also an important element of our commitment to prevention. Using the system Children and Young People's Board to ensure that the work of all our Delivery Boards address the needs of children and young people will help us to identify and take opportunities, where we can, increasingly to shift the profile of our investment into prevention while still continuing to provide the health and care needed across our population.

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 inequalities 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.
- Meeting national targets for vaccinations and immunisations.
- 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.

Maternity and Neonatal Care

Maternity service reviews undertaken across England identified the need to proactively identify Trusts that require support before serious issues arise. To safeguard Sussex residents using our perinatal services, we must ensure we can identify adverse outcomes early and act swiftly whilst we embed learning from these national investigation reports. The processes and ways of working we have developed across our local maternity and neonatal system (LMNS) partners will continue to support our response to key national reports, Ockenden and Reading the Signals.

NHS England published the three-year Maternity and Neonatal Delivery Plan which details the national ambition of ensuring that care is safer, more personalised, and equitable and based around the themes below. NHS Sussex is collaborating with the LNMS to develop provider and system plans to respond to these recommendations.

- Listening to, and working with, women/people and their families with compassion.
- Growing, retaining, and supporting the workforce.
- Developing and sustaining a culture of safety, learning and support.
- Standards and structures that underpin safer, more personalised, and more equitable care.

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 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.
- Child Protection Information Sharing (CP-IS) will continue to be rolled out across Sussex.

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 workforce 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.

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 on 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. NHS Sussex is committed to using its evolving anchor role to explore and develop new networks across the region with the intention of establishing a greater understanding of the cross-sector impacts of health inequalities in Sussex and enabling policymakers from the system and wider sectors to come together to share ideas

and develop health focused solutions. A growing socioeconomic challenge in the region and a significant determinant of a healthy and happy life is housing, from quality and accessibility to affordability, NHS Sussex will work with established and new partners to explore strategic options to tackle housing challenges.

This represents a new way of working for our system and it is recognised that it will take time to establish how partners can achieve this ambition most effectively together. To support this, in year one we will establish a baseline understanding of current work happening across the system that we can build on over years 2-5. 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.

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 plan supports the individual organisational plans of our NHS providers and will support the effective delivery of our Integrated Community Teams and Health and Wellbeing Strategies.

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 implementation will reduce the time lost through the current fragmented approaches but also accelerate the introduction or spread of useful technologies, medicines, or practice.

SECTION 7
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.

Maximising the power of partnerships

Improving Lives Together outlines a commitment to maximising the power of partnerships to ensure organisations responsible for health and care work together in the best possible way for local people.

To enable the most effective delivery of our Shared Delivery Plan, it has been agreed that organisations will work together across four different levels:

- System level – across the whole of Sussex
- NHS provider level - across NHS organisations.
- Place level - across the footprints of our three local authorities.
- Local community level – to support the development and delivery of the Integrated Community Teams

This way of working will enable better integration of services, use of resources, co-ordination, planning, and decision-making that will lead to better joined-up care for local people and better ways of working for our staff. It also supports national policy and guidance. To enable this to happen, we are developing a new operating model across the system that will have a 'golden thread' of all organisations working in the best possible way for local people and patients. In doing so, we will respect the statutory and corporate accountabilities and responsibilities of all organisations.

This will require every statutory organisation to start to work in a new way across the four different levels from April 2024.

System level

We will continue to work at a Sussex-wide system level through the existing statutory architecture that was established with the formal formation of our Integrated Care System.

The Sussex Health and Care Assembly is the Integrated Care Partnership for Sussex, which is a joint committee established by NHS Sussex, Brighton and Hove City Council, East Sussex County Council and West Sussex County Council in accordance with the constitutions of each body. The membership of the Assembly includes wider partners, including our three Universities, further education, the housing sector, the local enterprise sector, Healthwatch, and the Voluntary Community and Social Enterprise sector. The purpose of the Assembly is to bring a broad section of system partners together to approve and facilitate the strategic direction for meeting the broader health, public health, and social care needs of the population. This allows for partnership and collaborative working to take place across wider partners.

NHS Sussex Integrated Care Board (ICB) is the statutory NHS organisation responsible for the oversight of performance, quality, and resource allocation of NHS services across Sussex. This is done by working with NHS providers and a legal obligation to work with Local Authority partners. The NHS Sussex Board is made up of independent Non-executive Directors, partner members from NHS providers, local authorities, and Primary Care, as well as Executives. The future function of NHS Sussex will change to be predominantly focused on the strategy and planning for the system to achieve improved outcomes for the population. A new operating model will be developed during 2023-24 and will be in place from 2024-25.

NHS provider level

A Provider Collaborative will be established, which will involve NHS providers working together in a more formal, effective, and joined-up way for the benefit of patients and staff. The collaborative will design the service transformation models to deliver the strategic priorities, in co-production with partners, at Place and local community level. The provider collaborative will include Primary Care as part of the membership.

Place level

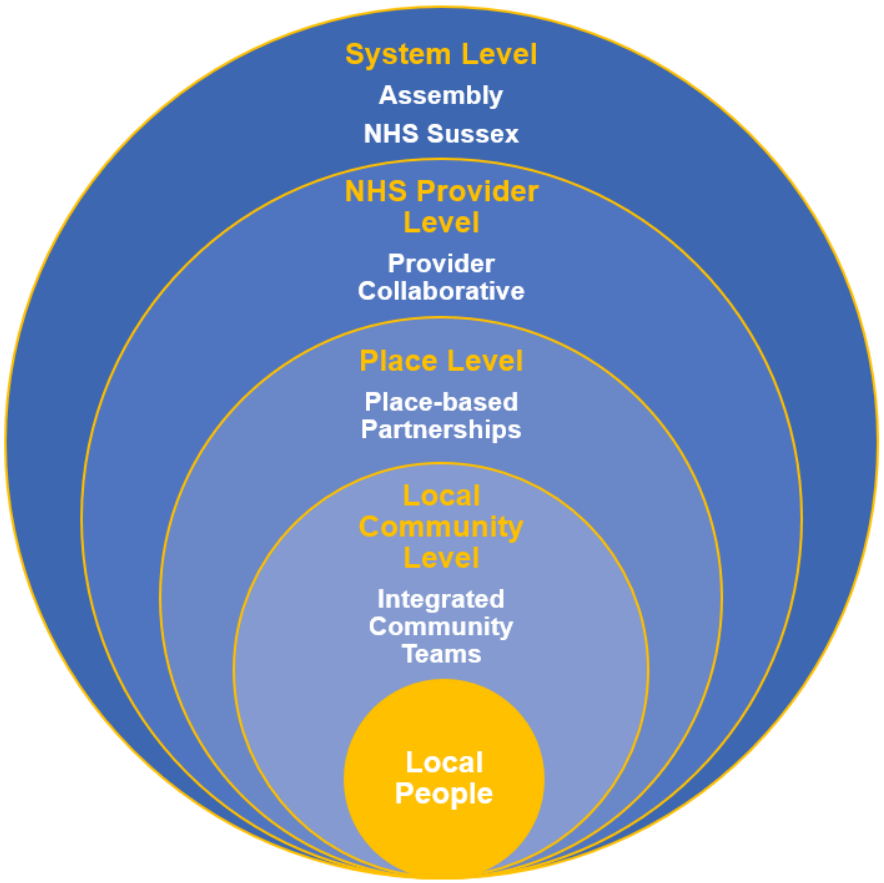
We will strengthen how our organisations work together across our populations in Brighton and Hove, East Sussex and West Sussex through Health and Care Partnerships and delivery of the Place-based Health and Wellbeing Strategies. Place will be the intermediary tier for the NHS and the primary tier for the Local Authority to discharge its statutory responsibilities to meet residents' needs in their council area. It will oversee and provide leadership for the delivery of services at community level and fulfilment of legal duties in respect of Place-based partnerships including with Health and Wellbeing Boards.

Local community level

We will integrate services and ways of working at a local community level through the formation of Integrated Community Teams. We are consciously using the term ‘community’, rather than ‘neighbourhood’ which is also often used to represent integration at a very local level, as we will have a broader focus on people’s individual needs that will stretch beyond simply the geographical location they live. By community, we mean both the recognised local area someone lives and communities that people identify with, such as those with the same interest, beliefs or ways of life.

Integrated Community Teams will be the focus for prevention, self-care, and providing support to help people make choices about their care and look after their own health priorities, enabled by strengthened Primary Care and assets-based approaches with communities. They will be supported to develop new approaches across Sussex which will be based on empowering our communities, the promotion of local leadership, equality of partnership between participating organisations, a permission to innovate for local people and for staff, and a different approach to working with people. As our communities across Sussex are all unique, partner organisations will have to work in a pragmatic and flexible way at this level and will be supported to do so. This will involve changes to how partners have worked in the past to ensure they are able to work in an integrated way at a local level.

Figure 3: Strategic levels of joined-up working:



Governance and leadership

Governance for delivery

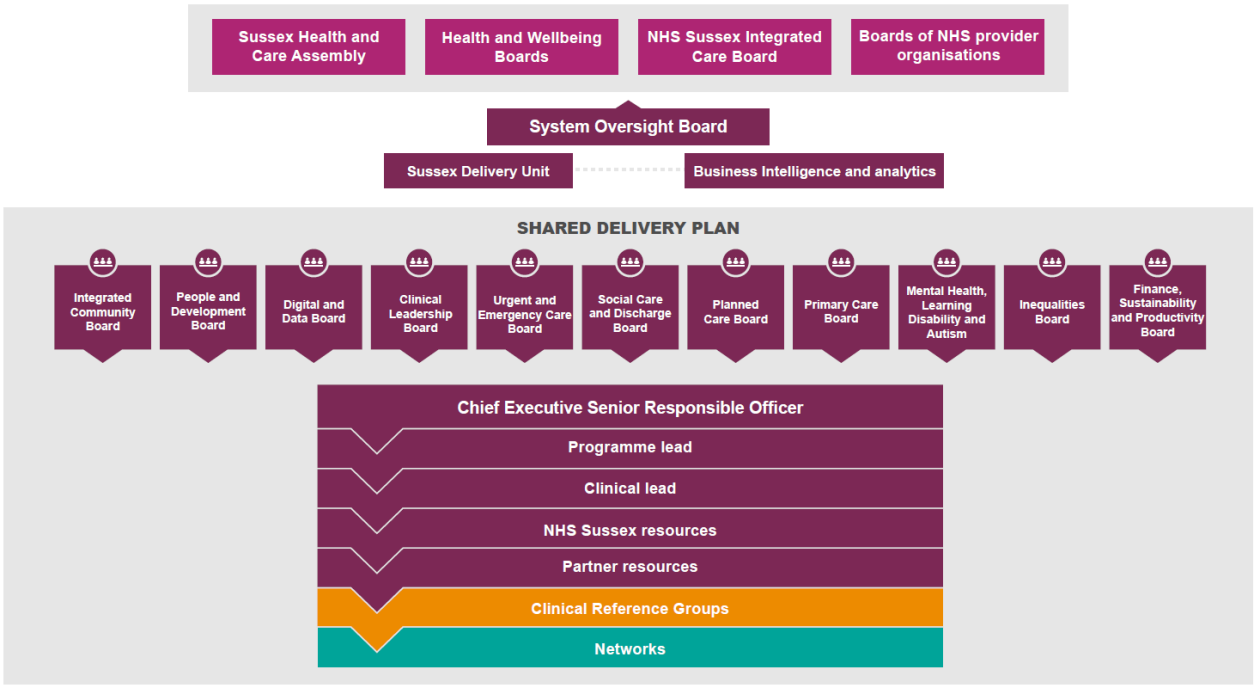
The delivery structure for the Shared Delivery Plan is outlined below. This involves each of our Long-term Improvement Priorities (Delivery Area 1), Immediate Improvement Priorities (Delivery Area 2) and Continuous Improvement Areas (Delivery Area 3) having a Delivery Board to lead the delivery of the agreed actions, chaired by a system Chief Executive Officer. Each will have a workstream that will be resourced from across system partners. The work of these Boards and workstreams will be overseen by a System Oversight Board.

Each workstream across Delivery Area 1 and 2 will give due regard to the continuous improvement areas and ensure they are embedded within the work taking place and all will ensure they are supporting the aims and ambitions of *Improving Lives Together* in:

- Improving health and health outcomes for local people across the life course, with particular focus on children and young people;
- Tackling health inequalities;
- Working better and smarter; and
- Supporting communities to develop socially and economically, including sustainability.

The delivery Boards will develop detailed workplans and milestones for each workstream and will use insight and data to create outcome frameworks.

Figure 4: Governance structure for delivery:



System Oversight Board

The core functions of the System Oversight Board (SOB) will be to oversee the implementation of the Shared Delivery Plan and to provide leadership with regards to strategy, and resolution of system risk.

SOB will report into the NHS Sussex Executive Committee and onwards to the NHS Sussex Board. Members will be required to report back from SOB through to their respective organisational boards and leadership forums to ensure system alignment. The new SOB replaces the former System Leadership Forum and is made up of Chief Executive Officers from the statutory NHS organisations, GP Federations, and senior representatives from the Local Authorities. This includes the leadership of Surrey and Sussex Healthcare NHS Trust.

Financial strategy and delivery plan

Work has taken place across the system to co-produce a plan to deliver our long-term strategic ambitions. However, it is important to recognise public sector financial constraints over a number of years, which therefore means delivery of this plan is subject to an underpinning financial strategy which will be developed by September 2023. As a result of this there may be further strategic and operational change required to underpin delivery over the next five years, the size and impact of which will need to be captured.

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
- Healthwatch
- 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 *Improving Lives Together*, and thematic analysis of this insight has informed the creation of the Shared Delivery Plan. Enhanced engagement opportunities were also offered via online sessions for Foundation Trust Governors and the public, discussions with members of the Sussex VCSE sector, Healthwatch 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. Each Delivery workstream will set out how the public and patients will be involved and engaged as part of their workplans for the delivery of the agreed actions. Our Working with People and Communities Strategy outlines our approach to public engagement and how we meet the legal duties around involvement.