DRAFT
Sussex Shared Delivery Plan:
East Sussex priorities

Health outcomes improvement
Children and young people
Mental health
Community

East Sussex Health and Care Partnership

Draft East Sussex delivery priorities: Year 1

What we will do	What we will achieve	When
Building on the Universal Healthcare Proposition 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
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. Our place based discharge transformation work will happen to ensure efficiency within current processes.	More people able to be discharged safely to a community setting	March 2024
Deliver 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 (core 20 plus 5 for CYP); clearer and wherever possible improved pathway for mental health support	March 2024
We will deliver initial stages of integrated models of community mental health care within local communities, through PCN 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 coordinate 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

Draft East Sussex delivery priorities: Year 2 – 5 (proposed roadmap)

East Sussex

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 LE and HLE 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
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 earlier support for mental health, in line with Sussex wide approach	Reduced reliance on specialist services and improved population health and well being	March 2026
Continue phased implementation and evolution of locality-based integrated neighbourhood teams model	An approach and model supported by comprehensive engagement and fully owned and embedded with communities that delivers integrated support in neighbourhoods	March 2028
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 ensure discharge pathways allow for greater personalisation per individual patient need.	March 2028
Appraise and jointly respond to forthcoming national Guidance and tools and ICS 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

Draft Outcomes and measures

Difference for local people or workforce	How will this be measured (suggested: measures to be confirmed)
People will be supported to stay healthy for longer and more proactive preventative care will be available for those that 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 LE and HLE
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 coordinated 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 access hospital services in an unplanned way • Reduction in the average length of stay in Community Beds • Reduction in the average length of stay in D2A commissioned beds • 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 primary care 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

East Sussex County Council

NHS

DRAFT New areas of focus: Health Outcomes Improvement

East Sussex Health and Care Partnership

Ongoing aims and objectives in 2023/24

Continue to strengthen the way we work together to coordinate our joint work to:

- Address the physiological causes of ill health to prevent premature death and the overall prevalence of disease
- Support individuals and populations to adopt healthy behaviours
- Address psychosocial factors and the wider determinants of health in our communities
- Strengthen our capability as a system to support delivery

New delivery opportunities in 2023/24

- Opportunity to strengthen our focus on **improving health outcomes and inequalities**, to achieve measurable pathway improvements to health in four priority areas that our preliminary analysis suggests are leading causes early death, poor health, and less years of life lived in good health overall in our population:

  - **Cardiovascular disease (CVD)**
  - **Respiratory disease**
  - **Mental health (all ages)**
  - **Frailty/healthy ageing**

- The evidence suggests that **outcomes can be influenced** through the contribution of the full range of services across the NHS and social care, VCSE and wider county, district and borough council services
- Opportunities range from **primary prevention** and **early intervention**, through to meeting clinical and complex care needs
- The approach needs to take in the **full span of activity, services and support** that helps .e.g. relationships, resilience, personal and community assets, self support, sense of belonging and ability to manage health conditions, through to clinical/care pathway and service improvements

2023/24 high level milestones

East Sussex County Council

Aim: Improve health outcomes in the following areas: CVD, respiratory disease, mental health and frailty/aging well		
Actions		
Co-design and deliver whole system and pathway action plans for CVD, respiratory disease, mental health and frailty/ageing well	**Q1**	Design and hold stakeholder workshops to map and understand the opportunities and key areas of focus
	Q2	Agree whole system 'plan on a page' for each area and implement identified immediate improvements to support Winter planning, and approaches to capturing and measuring impacts
	Q3	Mobilise implementation of rapid cycle improvement activity
	Q4	Evaluate and review progress and impacts, and plan for 2024/25

High level time line

Nº	Milestone	When	RAG
1	Confirm delivery priorities for the East Sussex Place and align work and resources to support delivery	May 2023	G
2	Design a template for the four workshops covering format, supporting information and key areas of enquiry/opportunities and identify key stakeholders to participate	May 2023	G
3	Invite stakeholders to workshops *NB clinicians need 6 week lead-in time*	May 2023	A
4	Convene workshops	June 2023	A
5	Agree whole system 'plan on a page' for each area and implement identified immediate rapid cycle improvements to support Winter planning, and approach to capturing and measuring impacts	July 2023	G
6	Plan and deliver small-scale rapid cycle/'PDSA' exercises to test different ways of working and further inform what is needed to enable teams to better work together	Sept 2023	G
7	Use rapid cycle/'PDSA' outcomes to understand further functional changes and resource requirements to support BAU delivery	Dec 2023	G
8	Evaluate and review progress and impacts to support further phases of implementation in 2024/25	March 2024	G

East Sussex
County Council

DRAFT New areas of focus: Community

Ongoing aims in 2023/24

Continue to strengthen our target operating model for integrated health, care and wellbeing to:

- Increase opportunities for prevention and early intervention across the wide range of local services that can improve health, wellbeing and care, and reduce health inequalities in our communities
- Better support people with long-term complex care needs and their carers in their own homes, care homes and other community settings through embedding proactive and seamless wraparound care, including when people are at the end of their lives
- Further develop Trusted Assessor roles, rapid crisis response and support with discharges from hospital, as well as exploring ways to build more integrated leadership and roles to deliver better coordinated care

New delivery priorities 2023/24

- Opportunity to expand and enhance our model for the way all our teams can work together in communities and neighbourhoods, and removing the barriers between our organisations to enable them to do this.
- Use a specific site to test and develop a 'proof of concept' model:
  - Test and develop our approach together; focussing on Hastings initially, followed by further phases of similar activity to roll the model out across the county
  - Build on the existing related services and projects
  - Build on our original target operating model for community services to ensure primary care, mental health and services that impact on the wider determinants of health and wellbeing are fully a part of the model

Hastings 'proof of concept' exercise

Codesign and deliver rapid cycle improvements covering the following functional elements:

- Multi-disciplinary working and coordinated care across primary care, community health and social care, housing, mental health and key voluntary sector services
- Strengthened links with community networks - an enhanced offer with VCSE sector, wider District, Borough and County Council services, and very local activity to enable access to a wide range of wellbeing support
- Underpinning locality focussed planning and delivery framework
- Workforce and integrated role design e.g. Integrated Support Worker

2023/24 high level milestones

East Sussex

Aim: Enhance our offer of joined up health, care and wellbeing in communities and neighbourhoods

By March 2024	Milestone	Actions
1. Deliver a ‘proof of concept’ exercise for delivering joined up health, care and wellbeing initially focussed on the Hastings area, building on existing partnership projects and activity there 2. Co-design and identify early quick wins and develop a phased plan to support wider roll out for the whole County	**Q1**	Map the existing projects and funding streams focussed on Hastings. Convene a meeting with a range of local frontline teams to explore what is working well currently, and agree the areas of focus for a strengthened joined up offer that can adapt where appropriate to local population needs
	Q2	Plan and deliver small-scale rapid cycle/’PDSA’ exercises to test different ways of working and further inform what is needed to enable teams to better work together
	Q3	Use ‘PDSA’ outcomes to model functional and resource requirements to support BAU delivery
	Q4	Evaluate and review progress and impacts to support further phases of implementation in 2024/25

High level time line

Nº	Milestone	When	RAG
1	Confirm priorities for the East Sussex Place and align work and resources to support delivery	May 2023	G
2	Agree footprints for integrated planning and delivery in neighbourhoods	May 2023	G
3	Map the existing projects and funding streams focussed on Hastings	June 2023	A
4	Convene a meeting with a range of local frontline teams to explore what is working well currently, and agree the areas of focus for rapid cycle improvements	June 2023	A
5	Plan and deliver small-scale rapid cycle/'PDSA' exercises to test different ways of working and further inform what is needed to enable teams to better work together	Sept 2023	G
6	Use 'PDSA' outcomes to model functional and resource requirements to support BAU delivery	Dec 2023	G
7	Evaluate and review progress and impacts to support further phases of implementation in 2024/25	March 2024	G