Sussex Health&Care

Improving Lives Together

Shared Delivery Plan

Year Two

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1. Introduction

Introduction

In 2023, the Sussex Health and Care system published a strategy for the next five years called Improving Lives Together that sets out our ambition and the long-term improvement priorities we will be focusing on across health and care to bring the greatest benefits to local people and our workforce.

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

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. However, 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 long-term ambitious approach.

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.

Achieving our ambition will take time as we cannot do everything we need to do all at once.

In July 2023, health and care partners in Sussex agreed Our Plan for our Population – a shared delivery plan that outlines the agreed actions that will be taken across health and care over the next five years that will help to address many of the issues and challenges we face and improve local people's health, and health and care services now and in the future.

Our Plan for our Population aims to bring together into one place the key strategic, operational and partnership work taking place across our system to improve health and care for our population.Significant action has taken place in 2023-24 in the first year of the Shared Delivery Plan, and now health and care partners are focused on the 12 months ahead for 2024-25.

In line with operational guidance, Sussex Health and Care partners have reviewed and refreshed the delivery aims for year two of Our Plan for our Population. This is to ensure that the plan not only reflects any changes in national guidance, but also addresses opportunities and risks, and ensures that we continue to direct our resources in a way which will maximise benefit for the population which we serve.

This document provides a summary of what has been achieved in year one and the focus for health and care partners for 2024-25 to progress our work in achieving the ambition set out in Improving Lives Together for our population across Sussex.

Read more on our ambitions and how these will be delivered in our full ***Shared Delivery Plan.***

Read more about what we've achieved in year one in our ***Summary of year one.***

2.

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 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.

Our full Shared Delivery Plan sets out how we will do this over the next five years and this document covers 2024-25 (year 2).

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 1)

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 five key areas that need continuous focus and improvement. Four of these were original improvement areas identified, and this year Children and Young People has been agreed as a specific area of focus.

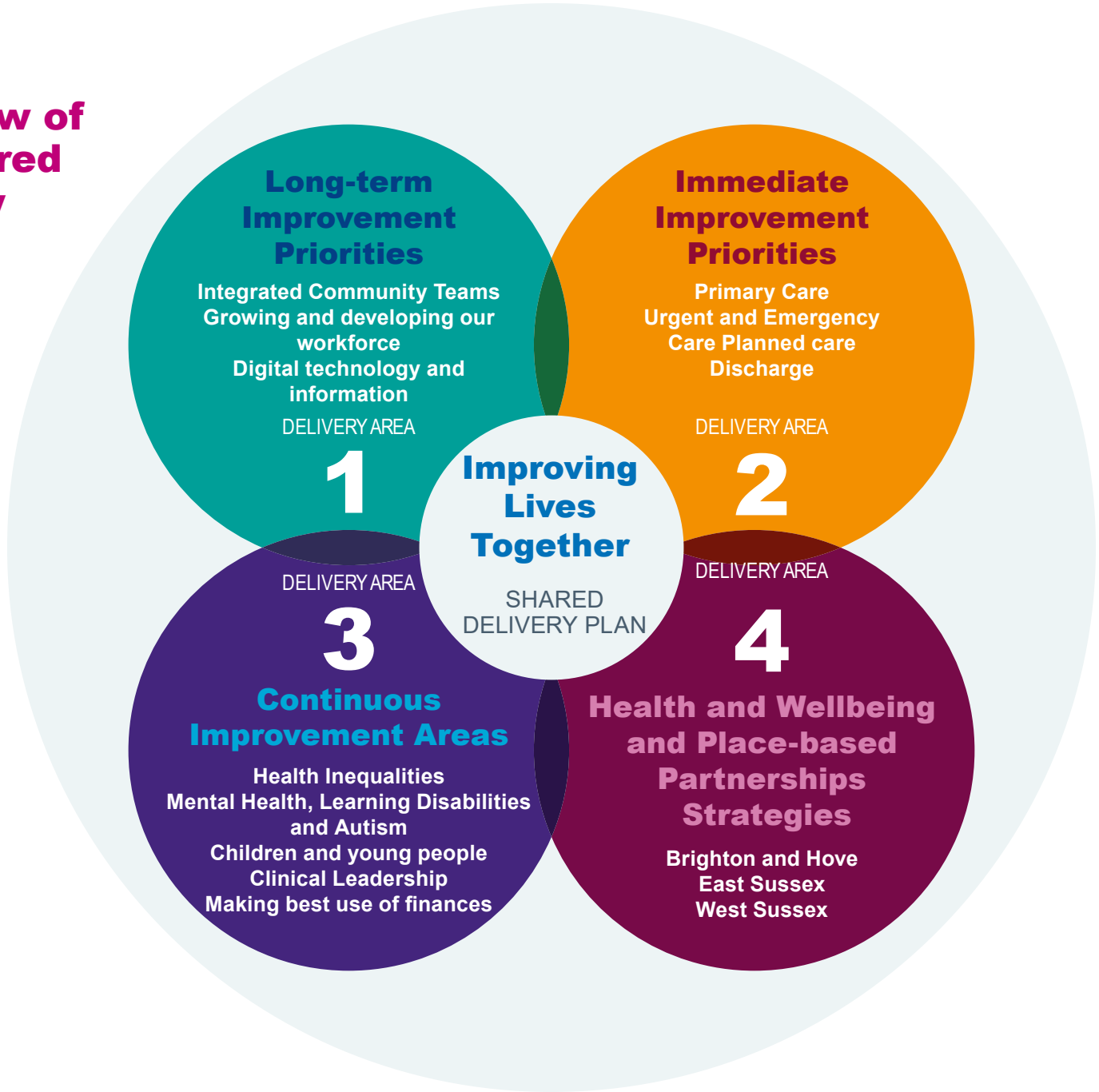
- **Addressing health inequalities that exist across our population to achieve greater equity in the experience, access, and outcomes of our population.** This is a 'golden thread' running through the delivery of all the actions we are taking, and we also have a specific system-wide focus to help bring about short and long-term change.
- **Addressing the mental health, learning disabilities and autism service improvements that we need to make across our system.**
- **Ensuring children and young people have the best start in life.** We will work together to make sure children have the best possible coordinated care throughout childhood.
- **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.

Overview of our Shared Delivery Plan




Long-term Improvement Priorities
Integrated Community Teams
Growing and developing our workforce
Digital technology and information
DELIVERY AREA
1
Immediate Improvement Priorities
Primary Care
Urgent and Emergency Care Planned care
Discharge
DELIVERY AREA
2
Improving Lives Together
SHARED DELIVERY PLAN
DELIVERY AREA
3
Continuous Improvement Areas
Health Inequalities
Mental Health, Learning Disabilities and Autism
Children and young people
Clinical Leadership
Making best use of finances
DELIVERY AREA
4
Health and Wellbeing and Place-based Partnerships Strategies
Brighton and Hove
East Sussex
West Sussex

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

YEAR 2
Immediate Improvement Priorities

- **Long-term Improvement Priorities**
- **Continuous Improvement Priorities**
- **Health and Wellbeing Strategies**

Improving lives of local people

- **Healthier communities:** Starting well, Living well, Ageing well
- **Better access to services**
- **Reduced waits**
- **Better joined-up care**
- **Better staff opportunities and support**

PROGRESS AND IMPROVEMENT
YEARS 2-5

3.

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

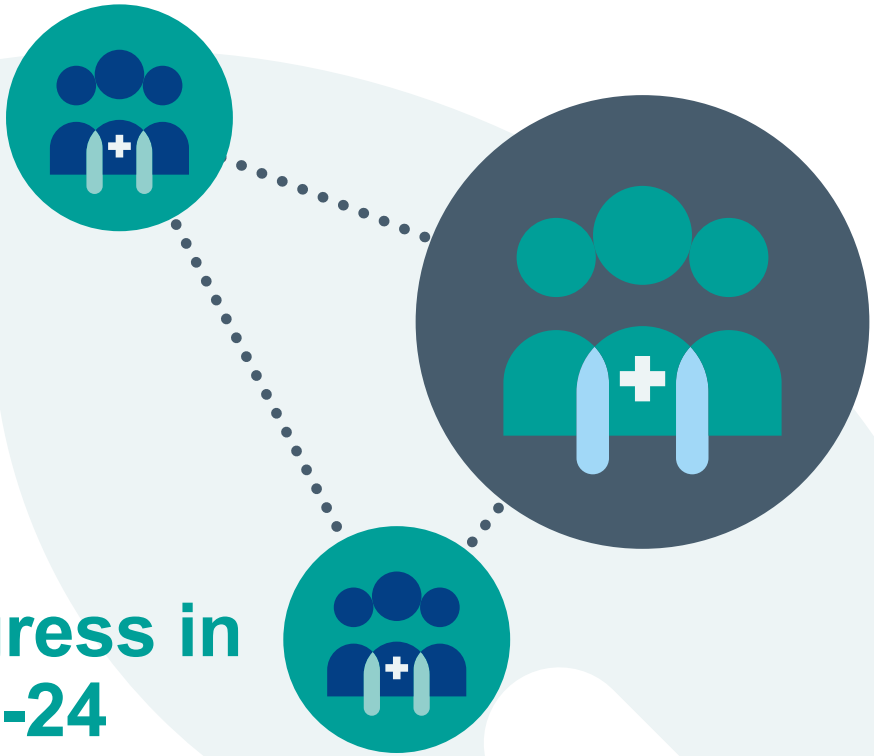
Over the next five years we will be integrating health, social care, and health-related services across local communities in a way that best meets the needs of the local population, improves quality, and reduces inequalities. This will involve us working with local people to build on what works best 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.

A **'core offer'** will be delivered by each Integrated Community Team 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.



Progress in 2023-24

In the first year of the development of Integrated Community Teams (ICTs) across Sussex, we have made significant progress in line with our ambition.

- **We have defined 16 ICT footprints across Sussex.** These are broadly coterminous with District and Borough boundaries in East Sussex and West Sussex, whilst Brighton & Hove have been divided into four locality areas.
- **For each of these footprints we have created community data and insight packs**, which will be used to inform priority areas for each footprint, ensuring a data driven approach to the development of each ICT in Sussex and providing a baseline data set to evaluate the programme against.
- **In addition, we have incorporated learning** from our three frontrunner programmes, Hastings, Crawley and East Brighton, to test and refine our new ways of innovative working.
- **The learning to date has also informed the development of our ICT core offer** which is the health and care model that will be consistently delivered across all 16 ICT footprints. This will be complemented by our local offer which will be uniquely developed and informed by local priorities and inequalities of our ICT communities.

The actions we are taking this year (2024-25) to progress Integrated Community Teams are:

What we will do	What we will achieve	When
We will refocus the development of ICTs to be place-led in Brighton & Hove, East Sussex and West Sussex.	Oversight and delivery from the full range of health and care partners within the three place Health and Care Partnerships.	June 2024
We will complete a mapping of community assets, services and leadership in each ICT area.	Greater understanding of what is currently available and the baseline for development of the ICT.	Sept 2024
We will codesign a service specification for the 'core offer'.	Working through our system collaboratives there will be wide system involvement in the development of the 'core offer'.	Nov 2024
We will implement the 'core offer' with an initial focus on delivering proactive care to the most complex and vulnerable patients.	The aim will be to reduce avoidable exacerbations of ill-health and improving the quality of care for older and frail people. We will start with the coordination of care for people who have regular and ongoing complex care needs by providing support with managing multiple long-term physical and mental health conditions, and frailty.	Dec 2024
We will develop plans for piloting our approaches to the preventative aspect of the 'core offer'.	To provide a clear way forward to address prevention through the ICTs.	March 2025
We will develop the scope for our critical enabling infrastructure which will support delivery of our ICTs, in collaboration with our estate, workforce and digital programmes.	To ensure that ICTs are fully supported by the necessary infrastructure to be successful.	March 2025

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 also want to support our existing staff and enable everyone working in health and care to have a fulfilling and rewarding career in Sussex 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.**

Progress in 2023-24

The publication of the People Plan in 2023 was a significant milestone in our system commitments to collaboratively deliver on a sustainable workforce plan.

- **The plan has a five-year ambition,** which is underpinned by the NHS Long Term Workforce Plan, the NHS Equality, Diversity and Inclusion (EDI) Improvement Plan, the plans for a Social Care Workforce Strategy. Our People Plan will enable staff to work differently, supported by system working to enable access to equal health and wellbeing resources, working closer with our training providers and universities and providing quality of shared services.
- **This year we will go further by developing a digitally enabled workforce, removing slow processes and enabling more innovation to find solutions to workforce gaps.** It also creates a standard baseline of knowledge for all staff across the system, which assists in embedding new ways of working regarding digital. The package of training will be jointly developed and delivered through digital and teams.
- **Developing a pipeline of future clinicians is vital** to keeping our services running effectively. Sussex Partnership Foundation Trust, worked with the University of Brighton to develop a Guaranteed Employment model. The model gave student nurses an offer of employment when they graduated, providing them with certainty of employment and keeping them within Sussex, where data tells us that some of our students do leave Sussex after they have completed their degree. This innovative solution will be spread to other partners across health and social care.
- **Our EDI teams across the system play a pivotal role** in meeting our duties as inclusive employers and ensuring our diverse workforce is representative of the population we serve.
- **The People Delivery Board will oversee the development of the ICT workforce models** and infrastructure, including team development training, health and wellbeing support and ways of working. The People Board's Clinical Reference Group will take a lead role in development of the workforce model.

The actions we are taking this year (2024-25) to better grow and develop our workforce 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 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 support the development of a workforce model for ICTs through clinical leaders in the system	Integrated Community Teams workforce model agreed.	March 2025

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). 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.

We will continue to support those less digitally able, and will continue to offer a non-digital alternative to those members of our communities who do not have access to the internet or digital devices.

Progress in 2023-24

A significant amount has been achieved over the past 12 months to progress the digital elements of the system's strategy.

- **In September 2023, we agreed a system-wide digital and data charter.** The purpose of the charter is to help partners steer their work towards the common ambitions of the ICS Strategy and Shared Delivery Plan and to develop a shared digital and data culture.
- **Three Digital Centres of Excellence were established by the December 2023 target for innovation, infrastructure and data / intelligence.** The development of distributed Centres of Excellence will enable Provider partners to take a leadership role in developing practice, capability, and resourcing for a specific area in line with the development of the Provider Collaboratives.
- **In October 2023, we agreed a system-wide Digital and Data Charter, with sign up from all NHS partners.** This will enable alignment on principles around procurement, managed convergence, user centred design and Digital Transformation, ensuring that NHS Sussex can continue to develop as a leader in digital and data practice.
- **The Sussex Digital Inclusion Framework has been developed** in collaboration with NHS Sussex, the University of Sussex and Health Innovation Kent Surrey Sussex, working with health and care partners and the public, examining digital inclusion based on known barriers and enablers. The Framework will allow us to ensure that future Digital Transformation projects and programmes map and mitigate against digital exclusion in Sussex, and that we can target our efforts in the most impactful areas.
- To reduce inequalities of digital access within our population, **a Digital and Data People's Panel has been established with 17 members from a range of backgrounds and experiences.** They have met 7 times to date. The People's Panel brings value to the digital and data delivery board through ensuring that a population and insight led approach is used to deliver the right digital and data services for our population.
- **Close to one million people in Sussex are now signed up to the NHS App,** and more than 400,000 people are using it each month to request medication or check records. All GP Practices in Sussex now have Cloud Based Telephony, to improve access and experience for people calling into practices. Many of our GP Practices have also implemented advanced Cloud Based Telephony with functions that include call back, call queuing and enhanced telephony data.
- **The number of people using remote monitoring to report their blood pressure results** more than doubled in the year 2023/24, from 13,500 to 32,300.

The actions we are taking this year (2024-25) to improve the use of digital technology and information are:

What we will do	What we will achieve	When
We will develop a strategic case for Digital Innovation Labs approach across Sussex. A Frontrunner Digital Innovation Lab will be established with its learning inputted into the Strategic Case.	A coordinated approach to innovation across the system.	March 2025
We will agree a system-wide Digital Inclusion Strategy including a roadmap of proposed interventions and target metrics for the reduction in the impact of digital exclusion and digital poverty.	We will ensure we have a clear approach to reduce inequalities, especially in relation to digital exclusion and digital poverty.	March 2025
We will increase NHS App utilisation rates to ~1m logins per month, 8k appointments booked or cancelled each month and 65% of the population registered. For My Health and Care Record we will increase monthly logins to 200k and population registrations to 600k.	We will increase access to a range of digital services across our population.	March 2025
We will support the development of ICTs, taking a user centred design approach to understand the digital and data requirements for both our patients and health and care professionals.	ICTs will have clear digital and data infrastructure to support their development.	March 2025
We will develop and agree an ICS cybersecurity strategy by December 2024.	A coordinated strategy across the system.	March 2025

What we will do	What we will achieve	When
Plexus Care Record will be made available in 30% of Care Homes and frontrunner VCSE provision.	Improved information sharing across health and care partners.	March 2025
Kent Medway & Sussex Secure Data Environment for Research and Development will deliver its Minimum Viable Product	There will be an agreed approach across the system.	March 2025
The Digital People's Panel will establish its draft Social License for review and develop the metrics and method for assessing public confidence and trust in digital and data services.	A clear involvement approach will be in place, with work informed by public and patient insight.	March 2025
Following the baseline assessment through the Digital, Data and Technology (DDaT) workforce census a DDaT Workforce Plan will be developed including the business case for delivery of the Digital and Data Science Academy with University and Further Education partners.	Greater integration with university and further education partners.	March 2025
Data, Insight and Intelligence Strategy will be delivered during 2024/25 including a partner-wide Charter agreed by the Assembly.	A strategy will be in place that will allow us to use data, information, and insight better.	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
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.

4. 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 an operational plan for 2024-25 which sets out the key actions that will be taken and how we will ensure best use of finances across our services.

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. During the year, GP services delivered 10.8 million appointments, which is around 900,000 appointments per month, and approximately 30,000 per day across Sussex.

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.

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.

Progress in 2023-24

In 2023/24 we focused on increasing capacity across GP services, improving the quality of services and patient outcomes and supporting general practice services to be more sustainable. This was in recognition of the fact that demand on these services was growing and that people were having mixed, and often frustrating experiences, when trying to book an appointment with their GP.

During this year, GP services delivered 10.8 million appointments, which is 5.6% more appointments than in 2022-23, with 63.7% being on the same day and 78.7% within two weeks. Now, when calling a practice in Sussex, most people will experience new triaging and telephony systems which facilitate quicker advice from the practice on what to do about their symptoms and call-backs if there are multiple people calling the practice simultaneously. This is also giving us a better understanding of demand which will inform future plans.

Other key achievements have been:

- We have made progress in enabling messaging services, appointment booking and repeat prescription ordering **through the NHS App** across 95%, 92% and 97% of practices respectively.
- **1,104 additional staff have been recruited** through the Additional Roles Reimbursement Scheme against a 2023/24 target of 754
- **We launched a new Pharmacy First service,** with over 95% participation rate from Community Pharmacies, which offers support for a range of minor illnesses without requiring referral from a general practitioner.
- **We commissioned an additional 130,589 Units of Dental Activity (UDA's)** in 2023/24 and plan to increase this further by extending the rapid commissioning process, expanding the Urgent Dental Care and Stabilisation pilot and testing new schemes aimed at enhancing services for targeted groups, including children.

Despite these improvements, we recognise that unwarranted variation in how people can access general practice, and the availability of NHS dental appointments, persists.

For this coming year (2024/25), addressing these challenges will be our focus.

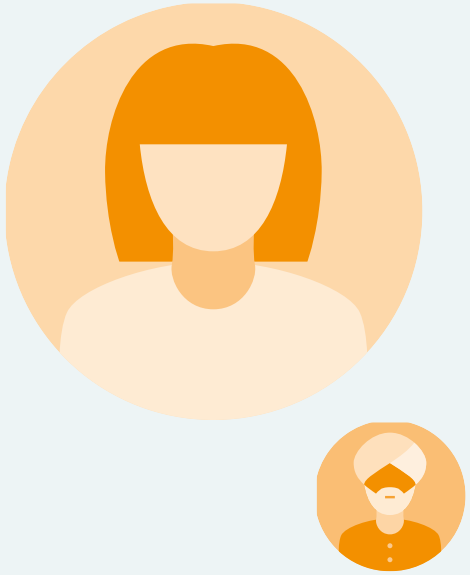
More specifically, we will:

- deliver a 2% increase in the number of general practice appointments
- reverse the current trend and deliver – on average – 85% of all appointments within two weeks.
- improve patient experience by improving on the average score for overall satisfaction of general practice service as being good from that achieved in the 2024 General Practice Patient Survey
- sustain current workforce levels at around 6,200 professionals.
- embed pharmacy first, offering a total of 32,000 consultations.

The actions we are taking this year (2024-25) to increasing access to, and reducing variability, in Primary Care, are:

What we will do	What we will achieve	When
We will support Primary Care Networks (PCNs) to develop clear Capacity and Access Plans that reflect seasonal demands on appointment capacity.	Further increased access to GP practices across our communities.	March 2025
We will review appointment data and develop an improvement plan, with clear actions for some PCNs, to improve the number of people seen on the day and within two weeks (to at least the England average).	More people will be seen on the day and within two weeks at GP practices in Sussex.	October 2025
We will ensure consistent delivery of Units of Dental Activity (UDAs) vs contracted levels.	There will be a target for 95% of all contracted UDAs to be delivered.	March 2025
We will enhance utilisation of Pharmacy First consultations within Sussex.	There will be a target that there are 32,700 completed consultations over the course of the year.	March 2025
We will maintain baseline staffing levels with General Practice. (Target = 5% recruitment levels across various roles, allowing 3.5% for usual attrition rates and sickness leave, to ensure workforce sustainability)	GP practices will have consistent staffing numbers to ensure access for patients.	March 2025

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.
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.**

Progress in 2023-24

Significant progress was made in 2023/24 in improving various aspects of urgent and emergency care services across Sussex, aimed at enhancing patient care and streamlining service delivery.

Work focused on improving response times to 999 calls and reducing A&E waiting times, with initiatives to increase ambulance service capacity, support out-of-hospital care, and implement standardized care for individuals at risk of rapid deterioration. Measures have also been taken to accelerate patient flow and discharge, including the development of improvement plans, proactive discharge planning, economic modelling for discharge, and workforce capacity building, all targeted for completion by March 2024.

During 2023/24:

- **We focused on high users of Emergency Departments** to make sure that there is appropriate support in place more widely.
- **The Sussex Admissions Avoidance Single Point of Access was expanded** through a pilot to provide access to care homes across Sussex. The ambition is to expand this for all health and care professionals in 2024/25.
- **Urgent Community Response services have provided support** to improve ambulance response times within Sussex, by identifying and providing care to those patients who phone 999 but who can be cared for safely and effectively in their own homes by community services. This releases ambulance service capacity and ensures that patients are treated in the most appropriate setting for their needs, avoiding unnecessary conveyance to hospital.
- **Virtual ward capacity increased** over the course of the year and its utilisation increased above 80%. Further work has been undertaken to develop admissions avoidance pathways which utilise virtual wards, in order to maximise the number of individuals who can safely and effectively be cared for in their own homes.
- Advancements in supporting emergency response were delivered through the **implementation of the 111 Starline** providing direct clinical support to healthcare professionals and improving communication channels.

During 2024-25, health and care partners will continue to expand on the work achieved to date. There will also be the development and design of an Urgent and Emergency Care strategy.

The actions we are taking this year (2024-25) 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 design and develop an Urgent and Emergency Care strategy.	To ensure services and pathways going forwards are being developed in a way which meets future demand.	March 2025– pre-mobilisation
We will develop a programme of work to manage high intensity and high-risk patients ahead of winter, inclusive of both physical and mental health conditions.	To ensure that people receive timely and appropriate care in the right place, first time. This will also reduce A&E attendances and improved demand management.	Sept 2024
We will optimise our use of out of hospital alternatives, including further developments of our Virtual Wards, Urgent Community Response, and Admissions Avoidance Single Point of Access.	To increase capacity and improved patient flow, ensuring that people receive timely and appropriate care in the right place, first time.	March 2025
We will optimise pathways to manage lower acuity activity, working with system partners across primary and community services to ensure patients are seen by the most appropriate services for their needs and in a way which enables us to balance demand more effectively.	Reduced A&E attendances and improved demand management Improved access to patient care as well as increased patient satisfaction.	March 2025

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.

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.

Progress in 2023-24

Health and care partners have had a clear focus to reduce the time people are waiting for treatment this year.

- The system delivered improvements in our cancer waiting time standards achieving a compliant position in terms of the Faster Diagnosis Standard (time from referral to diagnosis) and **we have reduced the number of patients waiting over 62 days for definitive treatment.**
- We have also maintained our focus on improving early diagnosis of cancer. One example of this is through the **expansion of the Targeted Lung Health Check screening programme** which identified 61 patients in the early stages of lung cancer.
- **Seven Community Diagnostic Centres are now in place** across the system and in 2023-24 they delivered more than 20% of all diagnostic tests performed in Sussex.
- **We have also rolled out new digital functionality via the My Health and Care + programm**e to support patients along their elective care pathway which means patients are notified when their referral has been accepted, are sent reminders for appointments, and are signposted to self-care and waiting well information.
- Whilst we have made progress in reducing the number of long waiting patients – **we ended the year with 337 patients waiting over 78 weeks and face a significant challenge to deliver a position of zero patients waiting over 65 weeks** and in moving to sustainable delivery of the Referral to Treatment (RTT) standard. The plan in year 2 therefore shifts to how we make best use of our system capacity enabled by mobilisation of the Elective Coordination Centre and a shared waiting list (PTL) and a continued focus on increasing productivity and efficiency and redesigning pathways in challenged specialties e.g. ENT (Ear, Nose and Throat).
- **We also must make improvements in our diagnostic waiting times** – a key enabler for both cancer and elective pathways – and will continue the roll out of Community Diagnostic Centres and transformation of diagnostic pathways.
- **For cancer, our priority will be to continue improvements in early diagnosis** and in achieving a significant increase in the percentage of patients who have a confirmed diagnosis and start their treatment within 62 days.

The actions we are taking this year (2024-25) to reduce diagnostic and planned care waiting lists are:

What we will do	What we will achieve	When
We will continue to realise productivity opportunities though improved theatre utilisation and day case rates and use Further Faster methodology to transform outpatient pathways across the 19 specialties.	We will increase our theatre utilisation rate to a minimum of 85% and continue to 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. We will use Further Faster methodology to transform outpatient pathways across the 19 specialties.	March 2025
We will take a system wide approach to how patients are managed along the elective pathway to harmonise waiting times and making better use of our available capacity.	We will mobilise an elective co-ordination centre during quarter one and make better use of our available capacity via a shared PTL across all provider types (NHS and IS). We will provide enhanced support to GP practices to increase uptake in Advice and Guidance and ensure patients are offered choice at the point of referral.	July 2024
We will ensure a more personalised experience for patients and will digitally transform how patients interact with the NHS whilst on an elective pathway via full roll out E meet and Greet via the NHS App.	Patients will be notified of their appointment, validated every 12 weeks whilst on the waiting list and have access to a personalised library to help waiting well, supported self care and inform choices around treatment and care. We will introduce a system wide early health screening tool for patients who need surgery reducing the need for pre-assessment appointments by 20%.	July 2024

What we will do	What we will achieve	When
We will engage effectively with the ICT workstream to develop a planned care ICT core offer to patients.	Inclusion of planned care within the ICT core offer.	December 2024
We will identify the top five clinical pathways that require a strategic approach to be ensure they are clinically and financially sustainable, and develop clear plans including consideration of service reconfiguration and workforce development where necessary	We will implement our new MSK pathway model in December 2024. We will prioritise the redesign of services in ophthalmology, ENT and dermatology this year.	December 2024
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 that they need.	We will intelligently book CDC capacity, prioritise direct access for primary care and implement new pathways including Non-Specific Symptoms, teledermatology and bleeding on HRT (Hormone Replacement Therapy)	March 2025
To support patients referred on a cancer pathway, we will ensure referrals are made in-line with standardised referral protocols and local pathways are optimised.	We will work with the Surrey and Sussex Cancer Alliance to implement best practice timed pathways to support delivery of Faster Diagnosis and deliver a minimum 2% stage shift in earlier cancer diagnosis (against the 75% target by 2028). We will fully implement new pathways such as FIT (Fecal Immunochemical Test) pathway and Non-Specific Symptoms. We will work with partners to increase uptake and coverage of the NHS screening programmes, including continuing to roll out Targeted Lung Health Checks and uptake of HPV (human papillomavirus) vaccination.	March 2025

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 from September 2024.
We will continue to reduce the number of patients who are waiting too long to start their cancer treatment.	We will ensure that by March 2025 at least 70% of patients receive a diagnosis and start treatment within 62 days of their urgent cancer referral.
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 77% of patients by March 2025 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 8% 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.

Progress in 2023-24

2023/24 has been a challenging year for the discharge programme. Some significant steps forward have been achieved including:

- **Improved sharing of information across system partners** to support earlier discharge of patients, through the development of an Acute and Community Integrated Transfer of Care case management dashboard
- **The development of transfer of care hubs in all three places**
- **Sharing of learning** between our acute providers through peer reviews,
- **The development of an economic model** to support the shift of resources and increase capacity in the right parts of the system to reduce delays which was used to inform the deployment of National Better Care Fund Discharge funding.
- **The development of an acute therapy model and participation in the NHSE Skills for Health Intermediate Care Workforce demand and capacity modelling pilot,** and
- **The securing of Hospital Technology Accelerator funding** to scale up of a small number of digital care solutions including point of care testing in virtual wards

However, we have not seen a translation of these changes into a sustained reduction in the delays experienced by patients at the point of discharge. Consequently, there is a need to deliver a sustainable step change improvement in our discharge pathways and operating model in 2024-25.

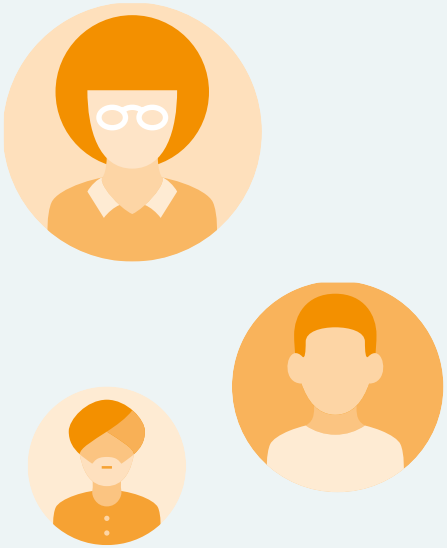
Discharge improvement remains a significant priority for our system and our plans for further improvement to be delivered during 2024-25 have been shaped and informed by our participation in the national discharge front runner programme over the last year and the recommendations following an external review of our discharge arrangements, undertaken by Professor John Bolton as part of an agreed Better Care Fund Support programme support offer to the system.

The actions we are taking this year (2024-25) to accelerate patient flow through, and discharge from, hospitals are:

What we will do	What we will achieve	When
We will complete a review of our pathway 2 intermediate care bedded model to ensure that we optimise the use of our community beds to enable both a step up and step-down responsive model that can meet the needs of a patients with broader range of dependencies.	We will have completed an analysis of our intermediate care services that will help us deliver an improvement plan to provide better outcomes for local people needing community based support and helping people stay as independent as possible.	Sept 2024
We will fully roll out and embed our integrated digital transfer of care discharge planner to ensure that there is single shared understanding of patients discharge needs across health and social care teams.	We will achieve a system oversight of the patient journey so that health and care has a good understanding of people' s needs upon discharge and the transfer of care hub teams across Sussex will be using the digital planner to make better informed decisions about discharge.	Sept 2024
We will further develop and embed our new care transfer data system to enable our care transfer hubs to have visibility of a single integrated dataset at patient level.	We will enable a closer overview of discharges across multiple providers to support joined up planning for a better patient experience.	March 2025

What we will do	What we will achieve	When
We will take action to enable earlier and more consistent mobilisation of patients whilst in hospital, to reduce the risk of deconditioning and to support an increase in the number of patients that can be discharged to their normal place of residence, with little or no support.	We will have fewer people needing enhanced support to help them safely go home from hospital and more people will have targetted input in hospital to help them recover quicker before discharge.	March 2025
We will establish a Homefirst discharge to recover and then assess model and refocus existing hospital assessment resources to support our community pathways. This will require the scaling up of our community homefirst pathway services enabled by a shift in investment from acute escalation capacity into community Urgent Community Response capacity.	We will increase the number of people discharged from hospital to their own place of residence with the right support for their needs. We will reduce the time people wait in hospital before this support is in place.	March 2025

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



Difference for local people and workfore	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).

5. 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 five key areas that need continuous improvement:

- **Addressing health inequalities**
- **Mental health, learning disabilities and autism**
- **Children and young people**
- **Clinical leadership**
- **Getting the best use of the finances available**

When the Shared Delivery Plan was agreed last year, four key areas were agreed, and in the refresh process for the year two document, it was agreed to add Children and young people to this delivery area to recognise the specific needs of this population group and the work underway across the system.

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.

Progress in 2023-24

As a health and care system, we are committed to embedding population health management, prevention, and personalised care approaches to help realise our ambition for all people in Sussex live to a good age in the best possible health and to experience the high-quality care necessary to help them achieve this.

- **We have fully adopted the NHS England Core20PLUS5 approach** to inform the action we are taking to reducing healthcare inequalities and these have been the focus of our year one priorities.
- We have aimed to improve our position against our 2022-23 baseline on 'Hypertension identification and treatment' and 'Lipid lowering therapy (LLT) prescription'. **As of April 2024, there is an improvement in hypertension performance to 65.9%** (England average - 66.8%), and work is underway to reach the SDP target of 77%.
- **We have continued the roll-out of the NHS funded offer of universal smoking tobacco treatment services** and ensure investment at scale and sustainability beyond 2023/24 across adult inpatient services and maternity services. We have successfully increased the proportion of maternity settings offering tobacco dependence services across Sussex – meeting our 5-year target in our first year. We are in the process of increasing the proportion of adult inpatient settings offering tobacco dependence services to 20%.
- **We have developed a defined work programme around the Children and Young people Core20PLUS5 five clinical areas**. Sussex is one of the first ICBs to prioritise baselining the CYP Clinical areas, we continue to work closely with NHSE to help shape this further nationally.
- **We have been measuring our waiting times / people who do not attend / cancellation rates for those with protected characteristics and/ or reside in our deprived geographical areas.** We continue to work closely to ensure mitigating actions are in place to redress any imbalance identified and are developing an evidenced based action plan for 2024/25, building upon our Equality and Health Inequality Impact Assessment.
- **We have invested into projects and programmes through our health inequalities allocation** which are showing impacts in relation to improved outcomes, more accessible information and services and ensuring the voice of those with lived experience are being fed into our governance, strategies and decision making processes.
- **Sussex has achieved its target to improve ethnicity recording,** completeness is now at 94.9%. Further analysis is underway to support data recording quality to reduce the number of 'not stated' or 'not known' coded ethnicity.

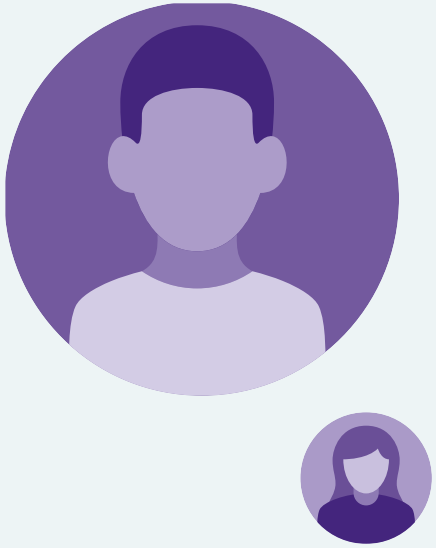
The actions we are taking this year (2024-25) to make progress to address health inequalities are:

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.	March 2025

What we will do	What we will achieve	When
We will deliver a dedicated Adult Programme for Core20PLUS5.	**Hypertension:** We will continue to improve performance and aim to meet the 24/25 national ambition of 80%. **Lipid Lowering** We will continue to improve performance and aim to meet the 24/25 ambition of 65%. **Chronic Respiratory Disease:** We will maintain the exemplary performance of NHS funded offer of universal smoking tobacco treatment services in maternity services and fully embed within 20% of adult inpatient services. **Cancer:** We will begin to measure delivery of the national expectation of 75% cases of cancer being diagnosed at stage one or two by 2028 by deprivation and ethnicity.	March 2025

What we will do	What we will achieve	When
We will improve the quality of recording ethnicity across all providers.	There will be a clear data position to inform work across the system.	March 2025
We will implement the actions agreed in the recently published Sussex Social Prescribing Works Plan and it will inform future commissioning of social prescribing.	Support across our communities and a clear plan for future commissioning.	March 2025

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



Difference for local people	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).

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.

Progress in 2023-24

For Mental Health, Learning Disability and Autism, during 2023/24 we had a key focus on delivering a number of key targets including reducing the number of our of area placements to ensure care is offered closer to home, increasing our perinatal mental health services, increasing dementia diagnosis rates, and increasing the number of people on the Learning Disability Register who have received an annual health check and action plan.

Together this has supported more people accessing services and enabling greater levels of support closer to where people live.

We have also worked to develop plans to transform approaches to how we support children and young people's mental health and well-being and how we plan to better support our neurodiverse communities. This work continues into the year ahead as part of our strategic approach to needs-based integrated community provision. We have more to do in ensuring good community-based access and this is a key focus for our plans for year two, reflected in a key target for us to fully implement community transformation with a clear neighbourhood-based model.

Our year two plans build on the year one deliverables during 2023-24, and there have been some small amendments to the years 2-5 deliverables that were included in the published Improving Lives Together strategy.

It should be noted that the key deliverables as previously set out for 2024-25 have not altered in purpose as these continue to reflect our shared system priorities. However, amendments have been made to recognise the development of the neighbourhood community transformation model and its alignment to the development of Integrated Care Teams. It also recognises the new national requirements for all systems to develop an inpatient improvement strategy and the importance of aligning this to continued work to ensure out of area placements remain at an absolute minimum.

Our adults and children and young people's urgent and emergency care improvement plans remain critical in underpinning our aims for inpatient care and community transformation as part of a whole system pathway. Similarly, there is an ambition regarding Children and Adolescent Mental Health Services that is stated for delivery in 2026. This work is not slowing and for 2024/25 we will finalise this year's plans for transforming CAMHS as well as working towards our longer-term goals into 2025-26.

The actions we are taking this year (2024-25) 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 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
We will fully implement the community transformation plan within Sussex with an agreed and defined model in each neighbourhood, 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
We will develop closer linking of mental and physical health planning and delivery through aligning the community transformation with 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 develop and begin implementation of a 3-year plan to improve the quality of inpatient provision, including maintaining the ambition to reduce out of area placements	Assurance on quality of inpatient care, and patient experience. Continuation of the reduction of out of area placements offering better experiences for those that require admission and maintain a 0% tolerance.	March 2025

What we will do	What we will achieve	When
We will develop a Sussex-wide dementia strategy and plan that meets best practice and local needs, alongside continuing to support diagnostic rates	There will be a coordinated and clear ambition across all partners.	March 2025
We will develop and fully embed physical health checks for people with severe mental illness outreach and health improvement support in Primary Care as part of neighbourhood mental health teams.	There will be a coordinated and clear ambition across all partners.	March 2025

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

Difference for local people	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.

Children and young people

We are committed to working together to achieve the best health and wellbeing outcomes for children and young people. All children deserve the best possible coordinated support through their childhood.

Promoting good health and wellbeing for children and young people is important to minimise poor health in adults. We are also keen to equip and empower children and their families to take maximum responsibility for their health and wellbeing and to manage any long-term conditions they may have in a way which puts them in control while providing them with the best possible support.

Although not one of the original 11 SDP areas, Sussex health and care partners have agreed that children and young people is an ongoing improvement area and consequently we have developed a set of deliverables for 2024/25 which will be taken forward by the Pan-Sussex Children's Board.

Key areas of challenge, that have been highlighted through the Pan-Sussex Children's Board and the Sussex Joint Area Special Educational Needs and Disabilities (SEND) CQC (Care Quality Commission) and Ofsted Inspections include:

- Increasing levels of need and recruitment challenges mean that some children and young people wait too long for some specialist health assessments and treatment.
- Waiting times for speech and language therapy (SaLT), Child and Adolescent Mental Health Services (CAMHS) and the neurodevelopmental (ND) pathway are too long. Arrangements to ensure that families can 'wait well' are inconsistent. This impacts negatively on some children and young people, including school or family breakdown.
- In neurodevelopmental services, demand growth is outstripping available capacity in line with national trends. Referral for Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Condition (ASC) assessment have risen since 2019/20 by between 40% - 700% dependent on provider. As at September 2023, there were over 13,000 children and young people on a waiting list for assessment with average waiting/waited times ranging from 38 to 75 weeks depending on the service across our Child Development Centres and our CAMHS Neurodevelopmental service
- Impacts of delayed access to children's health services can include increased demand on specialist hospital services (such as inpatient beds), increased numbers of children coming into care, reduced school attendance and attainment impacting on children and young people reaching their potential, exacerbating health inequalities.

Building on partnership arrangements and in response to these challenges, the system is committed to delivering against our five key pillars for children and young people:

1. **To help them have the best possible start to life** through integrated health and care support during pregnancy and postnatally for babies, young children, and their families, tailored to meet their specific individual needs.

2. **To promote good understanding of children's emotional needs across communities and services** so that children and young people experiencing distress have the right support at the right time, and to ensure that high quality specialist mental health support is provided to those who need it.

3. **To promote the best possible physical health for children and young people** through effective public health programmes and swift response to physical health needs by primary, secondary and as appropriate tertiary care providers.

4. To ensure that there is clear shared understanding across the county of the current and future needs of children and young people who have **special educational needs and long-term conditions and/or disabilities** and well-planned delivery of effective, jointly commissioned services. We will ensure that all statutory responsibilities for these children are effectively discharged.

5. To develop the best possible shared understanding of the health and care needs of **particularly vulnerable children and young people including children who are looked after, care leavers, young people who are supported by the Youth Offending Teams, asylum seekers and refugees and young carers.** We will ensure there is effective joint working to address the needs of these groups, both at local level and across the county.

The actions we are taking this year (2024-25) to make progress for children and young people are:

What we will do	What we will achieve	When
We will develop a shared S117 process across Sussex	Development of a shared S117 process across Sussex	December 2024
Following the CAMHS stocktake, completed in 23/24, we will develop prioritised plans for implementation.	Have clarity on mental health service offer for CYP (including those that are neuro-divergent), funding & pathways across Sussex	December 2024
We will develop an integrated and seamless pathway of care for young people aged 16-25 to improve transfers of care, outcomes and patient experience, avoiding unnecessary admission	Agree priorities, including potential invest to save proposals	March 2025
We will develop robust and consistent governance around individual funding and complex cases.	Revised governance arrangements for individual funding of complex cases	December 2024
We will develop an integrated model for paediatrics with partners across acute, community and primary care, aligned to virtual ward and paediatric hub models	Agree outline integrated model for paediatrics and establish pilot project	March 2025

What we will do	What we will achieve	When
We will implement the CYP Core20Plus5 framework to address health inequalities in relation to asthma, epilepsy and diabetes	Confirm baseline dataset against the CYP Core20Plus5 framework	March 2025
We will implement national standards for Paediatric End of Life Care to ensure equitable access across Sussex.	Development of a paediatric specialist palliative care team which is in line with adults.	March 2025
Speech & Language Therapy (SaLT) and Special School Nursing (SSN) services will be reviewed across three places, to develop a consistent offer that is proportionate to need	Mapping of Speech & Language Therapy / Special School Nursing offer to inform future commissioning arrangements	March 2025
We will support full engagement of key stakeholders in Sussex Neuro-Development Programme to develop clear CYP pathways of care (with or without a diagnosis) and co-ordinated support for those waiting for an assessment	Standardisation of current NDP assessment and diagnostic (pre and post) pathways	March 2025

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

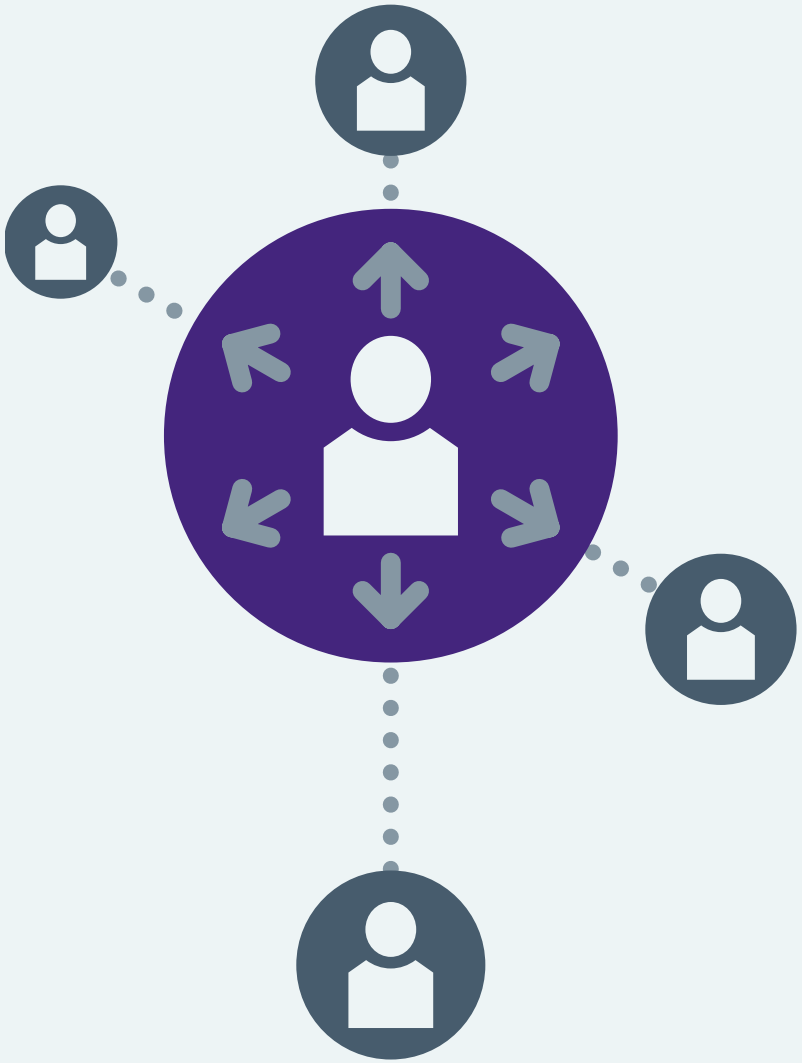
Difference for local people	How will this be measured
More integrated offers of support for children and young people aged 0-25 and their families across education, health and care	Children, young people and parent/carer satisfactions surveys and CQC/Ofsted SEND inspections

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.



Progress in 2023-24

Clinical Leadership is identified in the ***Sussex Shared Delivery Plan (SDP)*** as an area in which Sussex needs to develop and strengthen. The SDP recognises that strong clinical and care professional leadership leads to higher productivity, better organisational performance, and improved outcomes for local people.

- **A clinical leadership delivery board** has been established to oversee the delivery of the year one objectives with clinical leads from all other delivery board being part of the membership.
- Each of the delivery boards has also implemented a **clinical and care professional reference group (CRG)** to provide a strong multi-professional, cross organisational clinical voice. Working with provider training and development leads system wide leadership training offers have been developed to support staff working outside of traditional organisational boundaries; Leading Sussex Together has been launched to provide these opportunities.
- Each delivery board has agreed a **suite of metrics to support the delivery of their objectives,** as part of these, each board has agreed key clinical outcomes.
- Clinical outcomes are measurable changes in health, function or quality of life that result from the care that the person receives. Developing a culture of constant review of clinical outcomes establishes standards against which to continuously improve all aspects of practice and help focus on changes across patient pathways.

The actions we are taking this year (2024-25) to make progress in clinical leadership are:

What we will do	What we will achieve	When
We will ensure clinical leadership support for SDP delivery workstreams, review current function of Clinical Reference Groupsand develop a model to support changes in SDP governance framework.	Ensure clear clinical leadership across the system for the SDP workstreams.	September 2024
We will ensure that the emergent ICTs have strong clinical and care professional leadership in place to enable the delivery of new clinical models or pathways of care, which build on the use of data, digital & technology opportunities. A clinical leadership structure will be identified with appointments in place. Clinical and care professional leads for ICTs will be supported to utilise opportunities identified by data and digital technology.	Ensure that clinical leaders selected for each of the Integrated Community Teams areas are well trained and supported for leadership.	December 2024
We will develop a virtual offer as part of the Sussex Population Health Academy to enable quality improvement and innovation across Sussex which will support opportunities for wider collaboration. Training, webinars and an outline innovation platform will be set up for collaboration. 150 leaders are engaged.	Agree Quality Improvement training and data baseline. Progress training plan in identifed Clinical Leadership Group.	December 2024

What we will do	What we will achieve	When
We will increase the number of clinical and care professionals being offered system-wide leadership development opportunities. With 100 leaders having utilised leadership training and development system-wide offers, we will ensure an ongoing evaluation of these programmes for effectiveness.	100 leaders will have undertaken the programme.	March 2025
We will embed delivery of clinical outcomes as related to each of the SDP Boards, improve the clinical outcomes of greatest importance for the population of Sussex to deliver measurable impacts, and align clinical and care professional focus around the delivery of shared clinical outcomes, including improvements in our wiser population outcomes.	Improve the clinical outcomes of greatest importance for	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
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.

Progress in 2023-24

The Sussex system is financially challenged but needs to be sustainable to deliver our ambitious ***Shared Delivery Plan (SDP).*** Therefore, the focus is on financial recovery and productivity and putting in place the building blocks of the financial framework to support the Improving Lives Together strategy.

In 2023/24 we have:

- **Developed four productivity workstreams** to support the system's drive for financial sustainability.
- **Identified significant cost pressures** in year and so had a far greater drive to improve productivity, reduce costs and target services appropriately. Additional cost control measures have been implemented.
- **Developed a joint system-wide Medium Term Financial Plan** that demonstrates a route to a recurrent breakeven position by 2025/26. It illustrates the scale of the system financial challenges is significant over the next 5 years.
- For 2024/25 the financial challenge is significant, and we will have to make very difficult decisions.

We are working to ensure we have a clear and robust process to considering these decisions and where efficiencies can be made and are committed to working with providers and partners throughout this process.

The actions we are taking this year (2024-25) to get the best from the finances available are:

What we will do	What we will achieve	When
We will optimise our capital allocation through prioritising strategic capital requirements for 2025/26 and 2026/27	We will have a clear approach for capital allocation.	October 2024
A financial recovery plan will be prepared detailing the investment and efficiency plan required to achieve a sustainable financial balance position	We will have a plan across the system.	October 2024
We will agree a programme of productivity and efficiency improvements	A programme will be taken forward led by clinicians.	December 2024
We will model and plan the financial impact of the five-year plan.	We will meet our financial budget at the end of the year.	March 2025
We will ensure Sussex can live within it's financial allocation each year giving us the freedom to implement the SDP	We will meet our financial budget at the end of the year.	March 2025

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

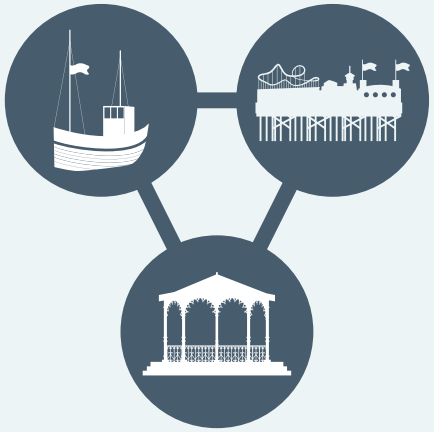
Difference for local people and workforce	How will this be measured
Living within our financial allocation will allow for greater investment in new services and innovation to support and accelerate improvements for local people.	Financial positions across system partners at the end of each financial 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.

6.

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.

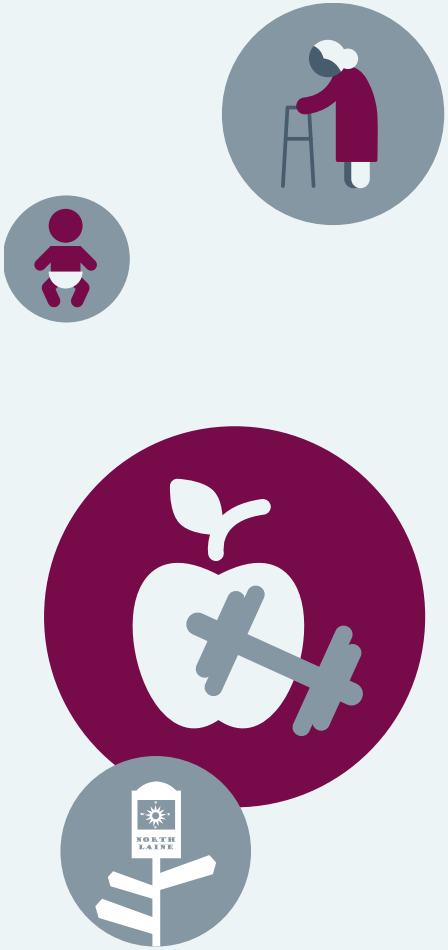
Our ambition for Brighton and Hove in 2030 is that:

- **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.**

Read more on our ambitions and how these will be delivered in our full ***Shared Delivery Plan.***

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.



Progress in 2023-24

The Brighton & Hove Health and Care Partnership brings together key local health and care partner organisations to work collaboratively to deliver the objectives of the Brighton & Hove Health and Wellbeing Strategy and the Sussex wide strategy, Improving Lives Together. The partnership leads on delivering shared population health objectives on behalf of the Health and Wellbeing Board. Together we have developed key transformational priorities to:

- **Address health inequalities** that focus on areas and communities of most need
- **Integrate models of care** to further develop how our services work together to streamline pathways for patients, improve experience and create more integrated approaches.
- **Transform the way we do things** to improve our services where it will have the greatest impact

During Year one we were able to make significant improvements. We have piloted and started an evaluation of a multidisciplinary team model to better integrate services for people with multiple compound needs in the city (one of our five local population health priorities). We have implemented our local community mental health transformation programme aligning with the recommendations from our recent mental health Joint Strategic Needs Assessment. We have completed and evaluated a successful community health inequalities programme aligned with our Core20Plus5. As part of our work on early cancer diagnosis we completed our targeted lung health checks programme.

And as part of our hospital discharge programme, we established our new transfer of care hub in RSCH (Royal Sussex County Hospital).

Our plans for Year 2, build on many of these achievements and reflect the next phase for them. In addition, we have responded to the next phase in the implementation of ICTs through the further development of our multiple compound needs frontrunner programme and the development of an ICT implementation plan to support alignment with our new ICT neighbourhood areas in the city.

The actions we are taking this year (2024-25) to deliver our Brighton and Hove Placed-based priorities are:

What we will do	What we will achieve	When
We will further support people with multiple compound needs.	We will develop a Multiple compound needs (MCN) community frontrunner. As part of our Central ICT we will use the learning from the MCN transformation programme to establish an MCN Integrated Community Team. We will complete the external evaluation of the multidisciplinary team pilot. We will develop the detailed business case for the MCN Integrated Community and Integrated commissioning approach. We will signoff the MCN partners compact agreement.	March 2025
We will progress the development of Integrated Community Teams.	To support the development of our new ICT footprints we will establish a local ICT implementation plan that builds on our community development approach and establishes strong local partnerships. We will map our local ICT community assets across the four ICT footprints. We will align ICT development with our Healthy Communities, Family Hubs and Community Mental Health programmes. We will establish four Health Forums and test two ICT partnership pilots across our four ICT areas.	March 2025

What we will do	What we will achieve	When
We will maintain a focus on reducing health inequalities across the city	We will continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people. We will develop the learning from last year's health inequality programmes as part of our local ICT development. We will implement locally the priorities set out in the new Sussex Health Inclusion Framework.	March 2025
We will ensure support for children and young people	Develop a joint triage for Wellbeing Service, CAMHS and Schools mental health service Develop a joined up approach between Family Hubs and the development of ICTs Deliver the SEND health & care partnership priorities as set out in the city's SEND Strategy 2021-26	March 2025
We will maintain a focus on mental health	We will continue to implement the recommendations of the 2022 B&H Mental Health & Wellbeing JSNA, aligning our local community mental health transformation programme with ICT development. We will test Neighbourhood Mental Health Teams with at least two PCN (primary care networks) populations/ICT partnerships. We will reduce demand on urgent and crisis care, improve system flow and reduce the numbers of inappropriate out of area placements. We will increase the number of people both on SMI (Serious Mental Illness) registers and having a physical health check.	March 2025

What we will do	What we will achieve	When
We will continue our work across the city to support early cancer diagnosis and appropriate support	Cancer - We will continue our work to improve early diagnosis of cancer with a particular focus on Core20 and Health Inclusion groups. We will increase screening rates across our Core 20 communities and health inclusion groups. We will improve performance against the headline 62-day standard. We will improve performance against the 28-day Faster Diagnosis.	March 2025
We will help people with multiple long term conditions	We will develop our cardiovascular disease reduction priorities, including hypertension, and restore the NHS health checks programme through a health inequalities lens. We will develop a cardiovascular disease reduction action plan. We will increase the percentage of patients with hypertension treated according to NICE guidance. We will increase the percentage of patients aged 25–84 years with a CVD risk score greater than 20% on lipid lowering therapies.	March 2025
We will work with our partners to support appropriate and timely hospital discharge	We will implement the 2024-25 Discharge Transformation Plan. We will improve patient waiting times to meet NHSE targets for patients seen within 4 hours (through generating flow, thereby increasing front door capacity). We will roll out a new Care Transfer Hub model. We will improve outcomes for patients through the same day discharge team at front access, preventing admission.	March 2025

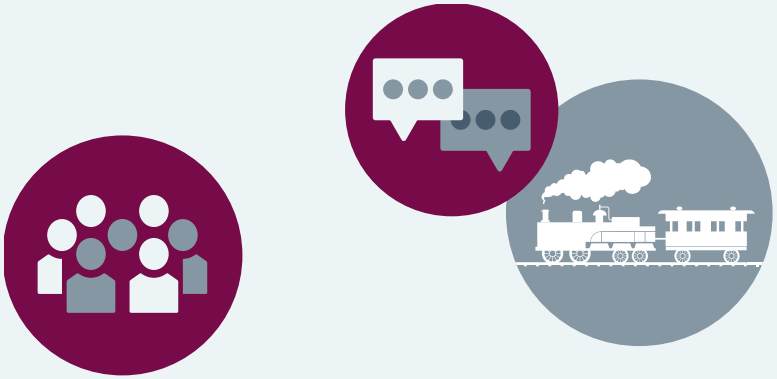
Difference this will make to local people and workforce in Brighton and Hove and how it will be measured

Difference for local people and 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.

Difference for local people and workforce	How will this be measured
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. Improve access by making it easier and quicker to get 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.
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%.

Difference for local people and workforce	How will this be measured
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.

Read more on our ambitions and how these will be delivered in our full ***Shared Delivery Plan.***

Progress in 2023-24

The East Sussex Health and Care Partnership brings together NHS, Local Government and Voluntary, Community and Social Enterprise (VCSE) partner organisations to work collaboratively to deliver shared priorities in the Joint East Sussex Health and Wellbeing Strategy and the Sussex Assembly Improving Lives Together Strategy. On behalf of the Health and Wellbeing Board, the Partnership leads on delivering shared programmes aimed at improving population health outcomes and reducing health inequalities and ensuring a clear focus on increasing levels of prevention and integrated care. Priorities cover children and young people, mental health, community services and health outcomes improvement for people of all ages and align with pan-Sussex SDP plans to ensure a strong focus on the population.

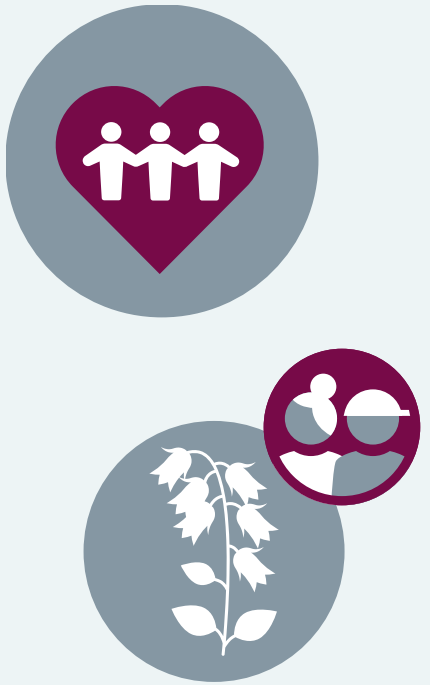
As snapshot, in summary in Year 1 of the SDP we have:

- Delivered and evaluated the proposition phase of our **Hastings Universal Healthcare community frontrunner,** and initiated a further phase of prototypes which will report in October 2024.
- **Held initial sessions with senior executives and key front-line teams and services in Hastings,** to start our Integrated Community Teams (ICT) development and help shape our model and focus for ICTs more widely in East Sussex.
- **Developed and agreed a whole system action plan** focussed on the conditions that significantly contribute to gaps in life expectancy and healthy life expectancy in our population to drive improved health outcomes.
- **Reduced delays** experienced by patients who have been waiting in our hospitals over 21 days by 17%.
- **Opened 11 Family Hubs in East Sussex** which will provide additional support for families with young children and developed a joint Mental Health and Emotional Wellbeing Strategic Plan (2023 – 25) to improve wellbeing and to promote whole school approaches in educational settings.

- **Worked closely with our Primary Care Networks (PCNs)** to establish the foundations of the new integrated community mental health support offer through the delivery of new Emotional Wellbeing Services and increased the supply of supported accommodation for people with mental health needs to 54 units whilst improving integrated working between social care and mental health rehabilitation teams, to improve the success of all supported housing placements.
- **Mapped over 60 infrastructure and community networks** across the county and co-produced a 'Connecting People and Places' programme to combat social isolation and loneliness.

More information about this can be found **here**. Our plans for Year 2 build on many of these achievements and reflect the next phases of implementation.

We will continue with our plans to implement more integrated delivery in neighbourhoods to offer proactive and well-coordinated care to the most vulnerable people in our population, including older people and those who need support with their mental health, as well as enabling opportunities for early intervention and prevention across the whole life course. In addition, we will ensure a strong focus on our partnership actions to help us meet the health, care and housing needs for our population, as a new area in 2024/25.



The actions we are taking this year (2024-25) to deliver our East Sussex Placed-based priorities are:

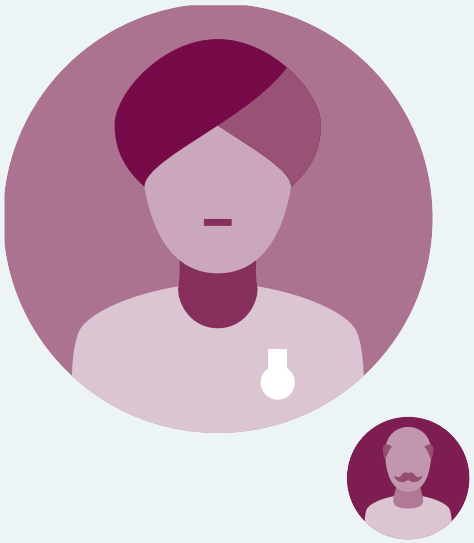
What we will do	What we will achieve	When
We will commence implementation of the approved whole system action plans on cardiovascular disease (CVD), Chronic Respiratory Disease (CRD), healthy ageing and frailty and mental health prevention, and monitor progress on a quarterly basis through the Health Outcomes Improvement Oversight Board, with a deep dive into one priority area each quarter.	Improved outcomes for the population.	March 2025
We will 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
We will strengthen the focus and role of the Health and Wellbeing Board and the East Sussex Health and Care Partnership by strategically aligning partnerships and working to support our shared priorities for delivering a joined-up offer for health, care and wellbeing, including prevention, across NHS, local government and VCSE sector services for our population. We will develop proposals for the Health and Wellbeing Board (HWB) to phase in during 2024/25, focussed on the Joint Strategic Needs Assessments (JSNAs) and needs and assets in East Sussex	A clear focus and approach across all partners.	March 2025

What we will do	What we will achieve	When
We will enhance support to families to enable the best start in life including delivery of an integrated pre and post-natal offer, and implementation of the Early Intervention Partnership Strategy.	Improved experience and increased opportunities to support our most vulnerable families.	March 2025
We will implement integrated delivery of community mental health services and a wider range of earlier mental health support for adults of all ages and people with dementia, through the evolution of neighbourhood mental health teams in line with the Sussex-wide approach, and increased access to supported accommodation.	Reduced reliance on specialist services and improved population health and wellbeing.	March 2025
We will continue to develop our neighbourhood delivery model through the evolution and implementation of our five Integrated Community Teams (ICTs) across East Sussex. In line with the ICTs across Sussex, this will focus on providing proactive, joined up care for the most complex and vulnerable people alongside approaches to improving the health and wellbeing of our communities through an asset-based approach.	In year plan delivered.	March 2025

What we will do	What we will achieve	When
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’.	More people will be able to be discharged safely to a community setting.	March 2025
We will develop and agree a partnership Housing Strategy to set out a shared vision for housing sector in East Sussex, including a strong focus on health, housing and care, and provide the strategic partnership framework to complement the borough and district housing authority strategies.	A clear ambition for all partners.	March 2025

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

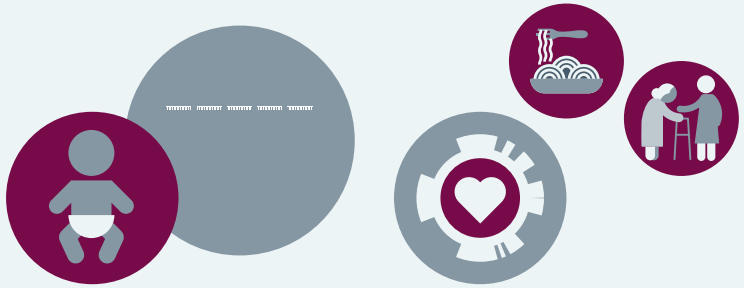
Difference for local people and workforce	How will this be measured
People will be supported to stay healthy for longer and more proactive preventative care will be available for those who need it, across the full range of organisations that can support this.	Reduction in the numbers of people accessing 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.



Difference for local people and workforce	How will this be measured
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.

Difference for local people and workforce	How will this be measured
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.

Read more on our ambitions and how these will be delivered in our full ***Shared Delivery Plan.***

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.

Progress in 2023-24

The West Sussex Health and Care Partnership brings together key local health and care partner organisations to work collaboratively to deliver the objectives of the Joint West Sussex Health and Wellbeing Strategy and the Sussex wide strategy, Improving Lives Together. The partnership leads on delivering shared population health objectives on behalf of the Health and Wellbeing Board.

Together we have developed key transformational priorities to:

- **Address health inequalities** that focus on areas and communities of most need
- **Integrate models of care** to further develop how our services work together to streamline pathways for patients, improve experience and create more integrated approaches.
- **Transform the way we do things** to improve our services where it will have the greatest impact

During Year 1 of the SDP we made significant improvements. We have developed three year service redesign plans to tailor services to the needs of Crawley communities, implemented phase 1 of the Bognor Community Diagnostic Centre, begun to mobilise a new model of stroke services for Coastal West Sussex following the approval of the post consultation business case, agreed a new model for intermediate care services (rehab, reablement and recovery), developed a hospital discharge improvement plan between health and adult social care and begun a review of Section 75 joint arrangements for learning disabilities and mental health.

Our plans for Year 2, build on many of these achievements and reflect the next phase for them. In addition, we have recognised the need to implement local Integrated Community Teams across West Sussex as well as included a focus for children and young people and to implement the West Sussex SEND inspection recommendations.

The actions we are taking this year (2024-25) to deliver our West Sussex Placed-based priorities are:

What we will do	What we will achieve	When
We will develop our Integrated Community Team approach West Sussex, implementing the core offer and developing the wider offers across our ICTs.	We will develop integrated community teams across West Sussex to provide coordinated health and care to our communities.	March 2025
We will finalise Phase 2 Business Case for a new 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.	September 2025
We will implement the first changes agreed to NHS and Adult Social Care community intermediate care services and reprocure new Adult Social Care community-based hospital discharge reablement and recovery service for West Sussex. We will establish system programme governance for partnership delivery of 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 2025

What we will do	What we will achieve	When
We will deliver Adult Social Care improvement actions around assessment and placement and begin first stages of implementing the newly agreed discharge to recover and assess model across all partners.	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 aligned to national best practice and achieving maximum efficiency.	March 2025
We will respond to the recommendation within the West Sussex SEND inspection report to address 'waiting well' arrangements, and gaps in service provision to meet the full range of needs of children and young people with SEND. This includes speech and language provision, neurodevelopmental pathways and CAMHS.	Children and young people will receive further improved care and services.	March 2025
We will undertake a strategic approach to understand and address the housing challenge across West Sussex and develop solutions together	There will be a collective understanding across health and care partners.	March 2025
We will delivery joint S75 review and withdraw from old joint commissioning arrangements and establish new joint commissioning arrangements	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.	March 2025

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, with more service available outside 9-5, Monday to Friday.
Improved access and capacity of diagnostics in Bognor Regis.	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.	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.

Difference for local people and workforce	How will this be measured
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.

Difference for local people and workforce	How will this be measured
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.

7.
Other areas of focus

Helping the NHS support broader social and economic development

The Sussex Health and Care system has set a strategic direction towards the creation of a health and care system moving beyond service delivery to improving the lives of Sussex residents using its statutory levers, including commissioning and procurement, use of assets and employment opportunities, as well as wider policy levers and spheres of influence through local strategic partnerships and planning. The priority is to establish the anchor role of the NHS in Sussex over the next five years, and this has begun with benchmarking anchor related activity happening across the health and care system to ensure we begin by building on the good work already happening.

In Year Two, NHS Sussex has begun development of its plan to outline the anchor role of the integrated care board and the way the NHS can work with partners to deliver improved social and economic wellbeing outcomes. The plan identifies first year priorities for the ICB, including the way it uses the Apprenticeship Levy to benefit local communities, how it includes social value considerations in its procurement contracts and how the NHS participates in local economic planning to support improved health outcomes for communities.

What will we do to help the NHS support broader social and economic development

What we will do	What we will achieve	When
We will develop a Social and Economic Wellbeing Plan, articulating our first-year priorities which align with the anchor role of the NHS, focused on social value in procurement, spending the Apprenticeship Levy and participating in place based economic partnerships.	A clear plan with system agreement and coordination.	November 2024
We will develop a Sussex Anchor Network to share good practice, learning and develop shared priorities in line with the social and economic wellbeing plan.	A positive way to work together across the system to further our aspirations and ambitions in this area.	November 2025
We will develop a communications plan to drive the implementation of our social and economic wellbeing priorities.	Clear, coordinated proactive communications across the system.	January 2025

Find out more

Read more on our ambitions and how these will be delivered in our full ***Shared Delivery Plan.***

Read more about what we've achieved in year one in our ***Summary of year one.***

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To read our full Shared Delivery Plan go to

www.sussex.ics.nhs.uk