Information supplement

DRAFT East Sussex Health and Wellbeing Board (HWB) Shared Delivery Plan (SDP) objectives – 2024/25 progress summary

Launched in September 2019, the East Sussex Health and Care Partnership is accountable to our East Sussex Health and Wellbeing Board (HWB), which oversees how well we work together as a system in East Sussex and feeds into our Sussex Integrated Care System (ICS). The membership of the Partnership includes East Sussex Healthcare NHS Trust (ESHT), Sussex Community NHS Foundation Trust (SCFT), Sussex Partnership NHS Foundation Trust (SPFT), representation from East Sussex borough and district councils, Healthwatch, the East Sussex Voluntary, Community and Social Enterprise (VCSE) Alliance and our 12 Primary Care Networks in East Sussex, alongside NHS Sussex Integrated Care Board (ICB) and East Sussex County Council (ESCC).

Through aligning organisational plans and collaborative action across health, social care and wellbeing at Place (East Sussex) within our ICS, a key responsibility of the Partnership is delivering the shared priorities of the East Sussex HWB set out in the 5-year Sussex Shared Delivery Plan (SDP). This report provides a summary overview of joint work on the 8 HWB objectives in year 2 (2024/25) of the SDP. Noting that some of the objectives form part of a medium to long-term delivery process, as well as an accompanying commentary for each deliverable, a rating has been given about progress status[1] relative to our expectations in July 2024 when the SDP plans for year 2 were agreed, and the need to continue with delivery over a multi-year time-frame. The rating is as follows:

R	Red: progress is challenging and a review and/or acceleration of in-year delivery objectives for 25/26 is required if this has not already been started.
A	Amber: plans are progressing but maybe subject to adjustment in 25/26, for example they are subject to risk or additional pressure which may impede overall achievement of the objective and/or measurable improvements by the end of the SDP 5-year timeframe
G	Green: progressing well against our in-year delivery objectives and on track for completion and/or being built on in 25/26
C	Grey: complete - planned work has reached a conclusion and service change has become business as usual or delivered its objectives

Our 8 East Sussex HWB SDP objectives, together with in-year milestones, are also currently being reviewed by lead oversight and partnership boards ahead of 25/26 to ensure they still make sense as appropriate priorities and focus for our joint working. We have given an indication in the commentary of the expected next steps and deliverables in 25/26. Where helpful and relevant this will also align with the national NHS planning guidance published on 28 January and alignment with pan-Sussex ICS priorities and work aimed at improving health and care outcomes.

[1] This draft (26/02/25) represents expectations of planned achievements by year end (31/03/25) remaining on track

The publication of the 10 Year Health Plan is expected in spring 25, and this will require a broader system review and response by partners in the Sussex Integrated Care System, including any implications for our SDP. The refreshed and updated account of our East Sussex HWB SDP priorities will inform that process.

No.	Deliverable	Date	What we will achieve	RAG
1	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.	March 2025	Improved outcomes for the population	**G**
1(a)	**24/25 progress summary** Good progress has been made across the majority of our HWB SDP objectives for Health Outcomes Improvement in 24/25, through joint working across the full range of partners in East Sussex, including the local NHS, social care, public health, VCSE organisations and borough and district councils. Implementation has commenced of the CVD and CRD action plans agreed in 24/25. The CVD action plan 2024-27 highlights the importance of addressing the variation in primary and secondary CVD prevention, and priorities are embedded in Integrated Community Teams as they evolve to ensure strengthened joint-delivery of both universal and targeted approaches to improve CVD outcomes. To improve outcomes for CRD, alongside the additional venue secured in Hastings to deliver increased capacity for face-to-face Pulmonary Rehabilitation support, the virtual Pulmonary Rehabilitation service has commenced delivery and is receiving referrals from primary care and community respiratory teams. A Healthy Ageing Partnership Group (HAPG) has been established and in advance of winter 24/25 supported local partners' staff and volunteers to be more aware of local services that support healthy ageing and wellbeing during winter. The HAPG is currently developing a falls prevention action plan, as well as actions to support age-friendly communities and models. This will align with the updated NICE guideline on Falls: *assessment and prevention in older people and people 50 and over at higher risk (update)* which is due to be published on 15 April 2025, as well as other evidence and good practice. Plans for mental health and prevention are being finalised for implementation in 25/26, building on the agreement of a shared definition for prevention in the context of mental health and wellbeing, and a framework approach to support understanding of needs and gaps across the key domains of wellbeing. The focus of initial plans is reducing the impact of trauma and personal resilience, including how peer support can potentially add value in supporting recovery for people with mental health difficulties and good overall mental health and wellbeing for people with other long terms conditions.			

	Additionally in 24/25 HOIOB has received reports, and agreed actions to support our existing partnership plans and work to reduce the harms caused by tobacco, improve health outcomes for women and address health inequalities, for example through East Sussex Healthcare NHS Trust's (ESHT's) Alcohol Care Team. The evaluation of the Hastings Universal Healthcare programme has also been reviewed to ensure full adoption of action and recommendations by our system. In 25/26 we will maintain focus on our priority objectives and delivering our plans to support improved outcomes in CVD, CRD, Healthy ageing and frailty and mental health as areas where we want to see improved life expectancy and healthy life expectancy. This will be informed by the outcomes from the recent HWB development session on improving healthy life expectancy, alongside the national NHS planning guidance and alignment with pan-Sussex priorities aimed at improving health outcomes, including any additional priorities identified, for example through the Sussex Health and Care Population Health Outcomes Framework, where we can have positive impacts for the East Sussex population. As part of this we will double-down on the next phase of implementation plans in the following areas: • The need to continue to focus on actions on three key partnership prevention priorities for our system; reducing tobacco dependency, reducing falls and improving CVD outcomes following the system report and recommendations • The need to continue our focus on joint work on mental health and wellbeing, including action to prevent situations from getting worse and where possible linking this with other long-term condition pathways to provide a holistic person-centred offer of health, care and wellbeing			
2	We will implement the improvements to cardiology and ophthalmology through reconfigured acute hospital services.	March 2025	Agreed transformation plans fully implemented improving efficiency and outcomes for local people.	**C**
2(a)	**24/25 progress summary** The implementation phase for the redesigned cardiology and ophthalmology services has been delivered in line with the programme and planned timescales for 24/25. This includes operation of ophthalmology services from sites in Bexhill and Eastbourne which are in the process of bedding in to become 'business as usual' in 25/26.			
3	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.	March 2025	A clear focus and approach across all partners.	**G**

	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			
3(a)	**24/25 progress summary** Delivery of the programme of HWB development sessions agreed in July 24 has progressed well in 24/25. Three of the 7 scheduled sessions have now taken place and have been highly valued by HWB members, these were: • 5 September 24: exploration of the long-term health outlook for our population, and how our local understanding of needs and plans come together, and consideration of how the HWB can go further with its strategic stewardship role in our current context • 14 November 24: improving healthy life expectancy • 6 February 25: the building blocks of health; a decent home, education, work and good social connections and community and climate change, and how we can strengthen a joined-up approach to the building blocks and climate change through developing the unique system stewardship role of the HWB Each session has been aimed at deepening the shared understanding of our population's health and care needs and priorities based on our East Sussex Joint Strategic Needs Assessment (JSNA), generating ideas and innovation, and informing in-year SDP refresh plans as well as the co-creation of the next refresh of the rolling East Sussex Health and Wellbeing Strategy *Healthy Lives, Healthy People* due in 26/27. The informal 'in person' nature of the discussions has also started to help strengthen the relationships and mutual accountability needed for whole system collaboration, particularly in the challenging financial context being experienced by our organisations, and shaping a shared vision for the HWB's unique leadership and stewardship role for our health and care system. The briefing notes and outcomes from each session have been shared at the formal meetings of the HWB for agreement and subsequent sharing and awareness-raising across partner organisations and teams. Publication of the growing set of HWB development session briefings will also be explored, to ensure they are widely accessible to inform plans and action. The remaining 4 development sessions based on the JSNA themes will be delivered in 25/26. The work to deepen how the HWB and the East Sussex Health and Care Partnership applies a stewardship approach to system leadership in practice will also be further shaped, and the next phase in 25/26 will be to embed this new way of working in our work as a system to improve health and care outcomes. Work is also underway on developing our approach to understanding measurable impacts through the HWB's Shared Outcomes Framework. The East Sussex Population Health and Care Intelligence Group has supported the development of a proposal for review by the East Sussex Health and Care Partnership to pilot use the HWB Shared Outcomes Framework, to help us understand how we might collectively measure the impact of our whole system working, for adoption in 25/26.			

4	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.	March 2025	Improved experience and increased opportunities to support our most vulnerable families.	**G**
4(a)	**24/25 progress summary** We have continued to make progress with our shared priorities for children and young people, however, there is still work to do and this is reflected in our refreshed planning for 25/26. In summary our achievements in 24/25 are as follows: **Family Hubs** We have enhanced our support for perinatal mental health and infant-parent relationships through an increase in Emotional Wellbeing support contacts. Parents in Mind peer support programme for fathers has seen the benefit of two new additional male practitioners. Universal antenatal education has expanded, and the Screening and Triage Parent Infant Mental Health team also continues to grow. Family Hubs will continue to be developed as part of the transformation work in 25/26, in line with the Families First Partnership Programme published Dec 2024 and as part of the nationally driven social care reforms. **Emotional Wellbeing and Mental Health** The focus in 24/25 has been on improving the information and advice and guidance (IAG) offer. This has resulted in over 190 services and online sources of IAG support with mental health and emotional wellbeing (MHEW) for children, young, people and families being added to East Sussex 1Space directory leading to better communication and access to information. The usability of the East Sussex 1Space directory and the ESCC webpage on mental health support for young people has been tested through a comprehensive exercise involving young people from the Youth Cabinet, the Children in Care Council, and NHS and VCSE sector youth voice groups. Parents, carers and professionals working directly with young people were also involved, and updates are being made based on the feedback from both exercises. This complements ongoing work to ensure consistency in messaging and signposting for children and young people's Mental Health and Emotional Wellbeing (MHEW) across the health and care system, as well as supporting Early Years professionals to feel better equipped to meet the MHEW needs of children and their families. This has included adapting existing training for schools for an Early Years audience, and creating resource packs on Early Years MHEW information, advice and guidance **Neurodiversity** The focus in 24/25 has been widening access to support through partnership working with schools. Following the initial conference with parent carer forums and health and education partners in October, the Partnerships for Inclusion of Neurodiversity in Schools (PINS) project continues to grow and is now being delivered in 16 East Sussex primary schools. We continue to work with the schools who have now completed their self-assessments. Parent/carers have also completed questionnaires which have informed the bespoke support for each school, including place-based and pan-Sussex support on topics identified through the self-evaluations.			

	Schools have also been supported to create their own communication strategy through 'Communicating Well with Parent/Carers' workshops and the production of webinars. Particular themes identified are engagement with parent/carers, supporting the mental health needs of neurodiverse children, and supporting emotional regulation in neurodiverse children. This support is being delivered by a range of people across health, education, VCSE and those with lived experience. The draft pan-Sussex health plan for Looked After Children and Care Leavers is being finalised after feedback from children and young people and will be shared for final review in early 25/26. The views of children and young people and their carers, alongside other local stakeholders, have contributed to the identified priorities including access to and support with dental care, mental health and Neurodiversity assessments. As part of a refreshed approach in 25/26 after early review of progress against shared objectives in 24/25, the Children and Young People's Health Oversight Board has agreed five key shared priorities, four of which are aligned to the Sussex ICS Children's Board and an additional priority for physical health. A focus on best start in life would be maintained through work on all five key priorities. The four aligned priorities are: • Neurodevelopmental Pathway (NDP) • Children's Emotional and Mental Health • Special Educational Needs and Disabilities (SEND) • Children in Care and Care Leavers The physical health priority could be helpfully approached through the work on the children and young people's Core20PLUS5 and picking up 4 of the 5 key areas: asthma, diabetes, epilepsy, oral health, noting that mental health would be picked up through the Children's Emotional and Mental Health priority. Collaborative projects to support delivery will now be shaped for 25/26 to enhance support to children and young people and families based on these priorities.			
5	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 (NMHTs) in line with the	March 2025	Reduced reliance on specialist services and	**G**

	Sussex-wide approach, and improved access and outcomes in supported accommodation.		improved population health and wellbeing.	
5(a)	**24/25 progress summary** By the end of March 25 progress will have been made towards our SDP objective for mental health, with the following key elements expected to be delivered to help reduce reliance on specialist services and improve outcomes: • New community-based offers for people living with dementia; dementia virtual wards and intensive community support offers will be expected to positively impact admission rates following initial pilot schemes that are currently underway • After agreement of footprints (aligned with Integrated Community Teams) and alignment of initial core team membership and resources, the foundational elements of NMHTs are on track to be in place, with partners utilising multi-agency forums to facilitate more joined up offers of care from early 25/26 • Partnership actions as a result of our review of the evidence, gaps and opportunities for delivering improved preventative approaches to trauma are on track to begin in early 25/26, and plans to take forward actions designed to increase personal resilience and peer support will be shaped • A Community Services Utilisation Dashboard tool has been designed and set up to help partners understand and respond to issues related to current demand and capacity • Work to deliver an Older Person's Mental Health Needs Assessment has begun which will shape our response in 25/26 across commissioning and delivery of services • The supply of Supported Accommodation has increased by over 40 new places, focussing on more rural areas where we know there is limited supply. This, alongside an audit of current supply and demand across mental health supported housing pathways, will contribute to improved access and integrated working practices across mental health, adult social care and housing services through new multi-agency communities of practice in 25/26 In 25/26, working within the Sussex-wide framework we will build on these strong foundations in the following ways: • Work to better integrate existing community-based offers for people living with Dementia will be taken forward through identifying which services can most easily work more closely and with the most impact, and planning transition processes to allow closer working. This will include work to explore in detail the feasibility of establishing potential one stop shop approaches to dementia services • NMHTs will be further developed through the inclusion within the offer of a wider range of existing services, and through developing key enablers such as shared patient record systems and single care planning and risk management processes • The older people's mental health needs assessment will be completed and will be utilised to begin work aimed at future proofing our mental health services in response to our growing older population over coming years			

	• Ways of continuing to drive up the quality and integration within our mental health supported housing offers will continue to be explored and pursued in line with our current 18-month Mental Health and Housing plan			
6	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.	March 2025	In year plan delivered.	**G**
6(a)	**24/25 progress summary** Engagement has taken place with over 600 people to support the development of Integrated Community Teams in five footprints aligned with our borough and district boundaries. This builds on the success of our Hastings community frontrunner and the Universal Healthcare programme which brought people together to understand how the NHS could design services so that everyone has a fair chance of access and care. In spring 24, initial development sessions took place across each of our 5 ICT footprints (Eastbourne, Hastings, Lewes District, Rother and Wealden) with service and team leads from system partners including NHS providers, PCNs and general practice, community pharmacy, social care, VCSE, Public Health and district/borough local authorities. The initial development sessions brought people together to introduce the concept of ICTs and discuss how they might develop locally to add value to the current ways of working. Partners reiterated their commitment to working differently and in a more joined-up way, emphasising the need for the System to support greater integration through removing barriers such as digital and information governance. Follow up sessions took place in summer 24 and explored how we can improve multi-disciplinary team (MDT) working and communication across services and teams. A short online survey was also shared across system partners to help us better understand what is currently happening with MDT working. Over 100 people responded enabling us to understand areas of good practice as well as areas of development to ensure a level of consistency across footprints. Alongside this, some small-scale tests of change were identified and progressed to test out new approaches and ways of working including: • Developing and piloting the use of a digital falls prevention tool utilising data from the Sussex Integrated Dataset • Exploration of VCSE partners being co-located in our hospital discharge hubs • Asthma clinics co-located with energy advice and fuel poverty support • Targeting the use of a personalised hydration plans to reduce the risk of Urinary Tract Infections (UTIs) in people over 65 • Identifying people who are experiencing loneliness and signposting them to VCSE services and support • ESHT pilot of community rehabilitation clinics bringing together multiple services in a local community setting			

- Holding 5 ‘winter preparedness’ events to bring together people working in frontline roles within that ICT footprint and give them key information around services and support available to people in crisis this winter, as well as the opportunity to network and learn together.

Some of the early outcomes of these tests of change are as follows:

- Over the 3 PDSA cycles 114 people have participated in the hydration programme across Bexhill PCN practices. 60% of participants at risk of developing UTIs and falls were drinking more after completing the hydration plan. 75% of participants completed their drink diary for all 4 weeks. Participants scored higher on their Quality-of-Life scores after completing the hydration plan. Participants told us the hydration plan was easy to complete, beneficial for their health and informative. Initial data suggests falls in reported UTIs and falls having started the hydration plan.
- The pilot of offering community rehabilitation and frailty services on an outreach basis took place in Uckfield, and extended beyond the initial pilot period (January 2024 - July 2024). Evaluated in October 24, as of 19 September 24, there were 269 referrals received from Musculoskeletal (MSK - 16.4%) Joint Community Reablement (JCR - 40%) and Neuro outpatients (NOP - 43%) with a caseload of 184 patients. 100% of patients who completed feedback felt they had a very good experience of the service or were extremely satisfied with the support they received. All patients said the support they received improved their confidence to manage their own health (50% yes significantly, 50% yes moderately). 75% of staff reported being very satisfied with the model and service available. A reduction in waiting lists and times was also seen, for example the neuro outpatient waiting time reduced from 76 weeks to 25 weeks. Similar reductions have been seen across the other specialities.
- 269 frontline staff and volunteers from across our system attended our 5 ‘supporting people through winter and beyond’ networking and learning events in November in each ICT footprint. Delivered in partnership with Citizens Advice, the events were aimed at improving understanding of the wide range of support available to people this winter and to provide an opportunity for teams across the system to come together, get to know each other and learn together. The evaluation from these events show that they resulted in people having a much better understanding of what is available in their community (increase of 20%). Attendees also reported feeling much more connected to those working across the footprint (increase of 20%) as a result of the events, contributing to strengthened relationships and the forming of a team identity in the ICT footprints.

In 25/26, working within the Sussex-wide framework we will build on these strong foundations in the following ways:

- Putting in place the formal local leadership arrangements for management and planning in each ICT footprint across the resources in scope
- Develop, agree and start to deliver a joint action plan in each ICT footprint building on the tests of change and supporting strategic and local priorities aligned to the population health challenges and local opportunities in each footprint

	• Continue to build strong relationships across the wider networks of support available in each footprint through working with VCSE partners • Co-designing a consistent approach to MDT-working for people with complex needs across East Sussex, based on good practice and the recommendations from the MDT survey, including agreement of standards, coordination of meetings and working culture • Work with NHS Sussex on a draft specification for core ICT related services and how we can jointly enable system partners to respond to this.			
7	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'.	March 2025	More people will be able to be discharged safely to a community setting.	**R**
7(a)	**24/25 progress summary** Whole system collaboration to improve hospital discharge has taken place in 24/25. Prior to Christmas this saw a sustained 10% reduction in the number of people delayed in hospital who no longer met the medical criteria to be there (classed as having No Criteria to Reside[2] - NCTR). In addition to weekly multi-agency senior operational management meetings, our collaboration has included: • Adult Social Care staff participating in daily meetings and contribute to discussions about patients classed as NCTR. There has also been involvement in regular multi-agency discharge events ('MADE' events) which look to review patient level detail and opportunities to try and expedite early discharge • Adult Social Care therapy staff have been deployed in hospital discharge settings to try and optimise individual patients' independence, with a focus on returning people home with fewer needs • People being supported to stay active whilst in hospital to minimise deterioration in health and wellbeing • Hubs have been put in place to better coordinate and standardise the transfer of care across the different discharge pathways, and meeting national the national guidelines for care transfer hubs by the end of March • A clear system escalation framework has been instigated to enable a focus on our most complex patients who have been waiting a very long time in an acute hospital bed			

[2] *Delayed hospital discharges are now described as patients who have 'No Criteria To Reside' (NCTR). This is a clinical decision, rather than a multi-agency, multi-disciplinary team decision, to describe when a patient no longer has a medical reason to be in an acute hospital. This occurs much earlier in an individual's recovery journey, compared to the previous method of counting delayed transfers of care.*

- A common data set with agreed definitions covering NHS and social care information about discharge has been set up, alongside a Sussex-wide dashboard to capture assessments across all hospital sites and impact
- A needs-based demand and capacity model has informed plans to help us get the right type of support in place to respond to people's needs appropriately after being in hospital. ESCC and NHS Sussex agreed an additional £1m joint investment to reopen 42 additional 'Discharge to Recover and Assess' (D2RA) beds to support 'step down' and intermediate care as part of the Sussex System Winter Plan which runs to March 25
- A strong focus on mental health housing-related delays enabled through our mental health and housing strategy, and supported tenancy schemes
- The Sussex System Winter Plan (November 2024 to March 2025) was developed and agreed to help alleviate the impact of winter and seasonally driven increases in illness, such as acute respiratory illness, flu, Covid-19, and norovirus, and increased demand seen across services generally during this period

In 24/25 we have seen growing numbers of people presenting in our acute hospitals across Sussex, whose discharges are delayed due to increasingly complex onward care needs and situations. This is particularly challenging in East Sussex where we have proportionately high numbers of people aged over-85 in our population, often with more than one long term condition alongside other complexities due to ageing and being frail. Through our joint work across Sussex, there has been improvement across mental health, community, and acute sites with reductions in the numbers of patients no longer having a medical reason to be in hospital, however we will not be able to meet our overall planned Sussex system target to achieve a one-third reduction in NCTR overall.

Maintaining an improving trajectory in our system work to improve hospital discharge has also been challenging over the winter, a time when we naturally see an increase in demand for services. In East Sussex our joint work has led to some notable improvements which has been acknowledged by the Department of Health & Social Care Discharge Support and Oversight Group, particularly efforts made to help reduce avoidable admissions in ESHT, including a joint Urgent Community Response and Virtual Ward team in EDs. For example, although emergency admissions rates for ESHT have reduced since summer 2024, the NCTR rate has remained high (>23% of adult General and Acute beds against a national average of 12-15%).

Delays are not attributed to individual agencies as it is acknowledged that all but the most simple discharges (for example back to the person's own home or usual place of residence with no new or additional health and/or social care needs or onward need for care), require a multi-disciplinary or whole system approach. In light of the red rating for this objective looking forward to 25/26 and as part of an enhanced oversight approach within the updated Better Care Fund (BCF) framework for 25/26, including regular reporting into ministers on plans and progress, our plans will continue to be focussed on this system priority in the following areas:

	• Ensuring a system-wide single version of the truth on data, building on progress with the Care Transfer Hub dashboards, with regular monitoring of length of delay between a patient's discharge ready date and their date of discharge, by pathway. This would also include:
	  ○ A clear focus on those patients with the most complex needs, including frailty and dementia, understanding reasons for delay, and planning for increased demand
	  ○ Implementing site-level improvement plans and addressing variation across the system
	• Accelerating efforts to optimise the Care Transfer Hubs building on progress made, particularly 'describe not prescribe'. This will enable more consistent assessments and tackling the potential overprescription of care, and build on our progress in mental health facilities to agree and embed standards (e.g. for assessment times) to cover acute sites.
	• Broadening our successful work on mental health housing-related delays into our acute hospital settings, and a focus on improved working with partners on housing.
	
	The absence of stable long-term funding to sustainably resolve bed-capacity issues within our system will continue to be a compounding factor that will need to be managed by system partners in 25/26.			

8	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.	March 2025	A clear ambition for all partners.	**G**
8(a)	**24/25 progress summary** Partners across housing, health and care have been collaborating throughout the year to identify priority areas of work and are now refining the draft strategy. Our agreed partnership vision is for *"healthy, safe and affordable homes for all, with a focus on preventing homelessness and ending rough sleeping, with priority on accelerating housing delivery and increasing infrastructure. For the partnership to drive innovation, through strong links to our communities, enabling partners to achieve more than they could alone"*. The draft strategy is supported by data and insights from across the sector, including the previous Annual Report by the East Sussex Director of Public Health on health and housing, broader population trends and the area profiles developed for the integrated community teams. This has driven the strategy's key themes of collaboration, evidence-based decision making, and workforce, and priority areas of homelessness prevention, housing and health, supply of housing, improving standards, reducing carbon emissions and the private rented sector. The final draft strategy will be shared with the Health and Wellbeing Board for endorsement in early 25/26, and the aims of the priority for health, housing and care integration are as follows: • Housing is embedded in work across health, mental health, social care and community sector partners to reduce health inequalities. • Housing is an enabler for people to live healthy, independent lives for as long as possible.			

	• Housing is integrated in community-based models across health, mental health and care services. • A whole system approach to supporting people with multiple compound needs, with a dedicated multi-disciplinary team. At the end of 24, national Government confirmed that grant funding for existing programmes supporting people with 'multiple and compound needs'[3] (MCN) would continue for a further year. Since then, work has been underway with partners across housing, health, social care, substance dependency and mental health services to design an ongoing approach which will embed learning from the Rough Sleeping Initiative and Changing Futures programmes over the coming year. The model will be informed by the findings of a needs assessment recently carried out by Public Health and the following priorities identified through our existing activities: • Settled and stable housing for people with multiple compound needs • 'Team around the person' approach, with lead professional • Multi-disciplinary working and a focus on prevention • Using data to improve outcomes Learning and good practice from the existing programmes will also be incorporated within the partnership housing strategy. In 25/26 plans will set out how we implement the agreed Housing Strategy and will include: • Developing an initial implementation plan for the partnership housing strategy, including maintaining and strengthening collaboration across housing, health and care during devolution and local government reorganisation • Identifying housing specialisms as part of the core offer for integrated community teams and neighbourhood mental health teams, and sharing learning and good practice from local teams through the housing partnership • Supporting the development of refreshed housing and homelessness strategies in district and borough areas • Implementing a system wide approach to supporting people with multiple compound needs, including sharing insights and recommendations from the needs assessment carried out by Public Health

[3] Multiple Compound Needs (MCN) relates to the experience of having several support needs linked to social exclusion and disadvantage, and the multiplying effects of these needs in combination i.e. housing, substance misuse, mental health issues, engagement with the criminal justice system (specifically probation) and experience of domestic abuse

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