EAST SUSSEX HEALTH AND WELLBEING BOARD

TUESDAY, 16 JULY 2024

2.30 PM COUNCIL CHAMBER, COUNTY HALL, LEWES

MEMBERSHIP -	Councillor Keith Glazier, East Sussex County Council (Chair) Councillor Carl Maynard, East Sussex County Council Councillor John Ungar, East Sussex County Council Councillor Trevor Webb, East Sussex County Council Stephen Lightfoot, NHS Sussex Dr Stephen Pike, NHS Sussex Ashley Scarff, NHS Sussex Mark Stainton, Director of Adult Social Care Darrell Gale, Director of Public Health Carolyn Fair, Director of Children's Services Veronica Kirwan, Healthwatch East Sussex Joanne Chadwick-Bell, East Sussex Healthcare NHS Trust Councillor Dr Kathy Ballard, Eastbourne Borough Council Councillor Paul Davies, Lewes District Council
INVITED OBSERVERS WITH SPEAKING RIGHTS	Councillor Billie Barnes, Hastings Borough Council Councillor Paul Coleshill, Wealden District Council Councillor Teresa Killeen MBE, Rother District Council Becky Shaw, Chief Executive, ESCC Mark Matthews, East Sussex Fire and Rescue Service Duncan Kerr, VCSE Alliance Simon Morris, Sussex Police and Crime Commissioner

A G E N D A

1. Minutes of meeting of Health and Wellbeing Board held on 5 March 2024 *(Pages 3 - 10)*

2. Apologies for absence

3. Disclosure by all members present of personal interests in matters on the agenda

4. Urgent items

   Notification of items which the Chair considers to be urgent and proposes to take at the end of the agenda. Any members who wish to raise urgent items are asked, wherever possible, to notify the Chair before the start of the meeting. In so doing, they must state the special circumstances which they consider justify the matter being considered urgently

5. NHS Sussex Shared Delivery Plan (SDP) Year 2 Refresh *(Pages 11 - 126)*

6. Proposals for strengthening our East Sussex Health and Wellbeing Board *(Pages 127 - 138)*

7. Better Care Fund Plans 2024/25 *(Pages 139 - 198)*

8. Healthwatch East Sussex Annual Report 2023/24 *(Pages 199 - 228)*

9. Director of Public Health Annual Report 2023/24 *(Pages 229 - 280)*

10. Work programme *(Pages 281 - 282)*

11. Any other items previously notified under agenda item 4

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8 July 2024

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EAST SUSSEX HEALTH AND WELLBEING BOARD

MINUTES of a meeting of the East Sussex Health and Wellbeing Board held at Council Chamber, County Hall, Lewes on 5 March 2024.

MEMBERS PRESENT	Councillor Keith Glazier (Chair) Councillor Carl Maynard, Councillor Trevor Webb, Councillor Teresa Killeen MBE, Jessica Britton, Stephen Lightfoot, Dr Stephen Pike, Mark Stainton, Darrell Gale, Alison Jeffery, Veronica Kirwan and Richard Milner
INVITED OBSERVERS PRESENT	Councillor Dr Kathy Ballard and Duncan Kerr
PRESENTING OFFICERS	Alexandra Hawkins, Healthwatch East Sussex. Sarah Speedie, Strategic Lead Education Improvement Vicky Smith, Programme Director East Sussex Health and Care Transformation
ALSO IN ATTENDANCE	Councillor Bob Bowdler (in attendance virtually)

33. MINUTES OF MEETING OF HEALTH AND WELLBEING BOARD HELD ON 12 DECEMBER 2023

33.1 The minutes of the meeting held on 12 December 2023 were agreed as a correct record.

34. APOLOGIES FOR ABSENCE

34.1 The following apologies for absence were received from members of the Board:

- Joe Chadwick-Bell, East Sussex Healthcare Trust.
- Councillor John Ungar.

34.2 The following apologies for absence were received from invited observers with speaking rights:

- Becky Shaw, East Sussex County Council
- Councillor Paul Davies, Lewes Distract Council
- Councillor Glenn Haffenden, Hastings Borough Council
- Councillor Julia Hilton, Hastings Borough Council (substituting for Councillor Glenn Haffenden)

34.3 The following substitutions were made for members of the Board:

- Richard Milner, East Sussex Healthcare Trust substituted for Joe Chadwick-Bell.

34.4 The following substitutions were made for invited observers with speaking rights:

- Councillor Julia Hilton, Hastings Borough Council substituted for Councillor Glenn Haffenden.

35. DISCLOSURE BY ALL MEMBERS PRESENT OF PERSONAL INTERESTS IN MATTERS ON THE AGENDA

35.1 Councillor Carl Maynard declared a personal, non-prejudicial interest under item 6, School Attendance as a Public Health Outcome, as he is a father of three school age children. Cllr Trevor Webb declared a personal, non-prejudicial interest under item 7, Focus on Men's Mental Health in East Sussex, as he is a trustee of His Place voluntary organisation which provides a meeting venue for some of the groups listed in the report.

36. URGENT ITEMS

36.1 The were no urgent items.

37. RYE LISTENING TOUR - HEALTHWATCH EAST SUSSEX

37.1 The Board considered a report from Healthwatch East Sussex on the Rye Listening Tour that was undertaken in Rye and the surrounding area in September 2023. The report was introduced by Veronica Kirwan, Executive Director and Alexandra Hawkins, Communications Officer, who outlined the key findings and recommendations of the report.

37.2 Members of the Board thanked Healthwatch for a valuable and insightful report and commented that the richness of the report which is very helpful. The Board noted the post Covid experiences in accessing health services and the role that transport and the cost of living crisis is playing in accessing health services in more rural areas such as Camber and Icklesham. Jessica Britton, Executive Managing Director NHS Sussex commented that the cost of living issues mentioned in the report link to the financial inclusion work that is taking place and will be picked up by the Health and Care Partnership.

37.3 Mark Stainton, Director of Adult Social Care and Health commented that the 'Enter and View' work undertaken as part of the Listening Tour was really valuable, as well as the level of insight the report provides. He added that the three recommendations for East Sussex County Council (ESCC) that are included in the report have been shared with the Director of Communities, Economy and Transport where they relate to the Local Transport Plan and bus services.

37.4 Dr Stephen Pike, Deputy Medical Director NHS Sussex, outlined that there are national programmes to improve access to GP practices and more locally conversations are taking place with the Primary Care Network (PCN) Director to try and put in place some outreach services in the areas covered by the report. There is also a piece of work underway in the South East Region on GP websites to review website accessibility and the Healthwatch work will feed in well into this piece of work.

37.5 Members of the Board asked if there is anything more to report from the work Young Healthwatch undertook, and whether there are any recommendations around social isolation. Veronica Kirwan outlined that that Young Healthwatch will provide more feedback from their work. Alexandra Hawkins commented that one of the key outcomes was that more networking type events could help if people are socially isolated. There are a lot of village halls in the area with events and activities, so one of the key issues for people is how do they know what is on and where to go for help.

37.6 Councillor Kathy Ballard commented that it is very important to include access to healthcare in the Local Transport Plan (LTP) for the whole of East Sussex and supports the approach that includes access to healthcare in the LTP as it is a key issue across the county.

37.7 The Board RESOLVED to note the findings and recommendations in the report.

38. SCHOOL ATTENDANCE AS A PUBLIC HEALTH OUTCOME

38.1 The Board considered a report on School Attendance as a Public Health Outcome. The report was introduced by Alison Jeffery, Director of Children's Services and Sarah Speedie, Strategic Lead for Education Improvement. School attendance is listed as one of the Public Health outcomes on the Public Health Outcomes Framework and is vitally important for attainment and the life chances of children and young people. The Covid pandemic has had a huge impact on school attendance and the report outlines the work that is being undertaken to tackle this issue and the other factors that contribute to poor attendance.

38.2 Board members commented that it was a useful and timely report, and it was good to have a clear information on school attendance in the county. Board members considered the development of an attendance delivery plan and single point of contact for schools as very positive and were be interested to see the impact of the proposals contained in the report. Sarah Speedie outlined that East Sussex is one of the first local authorities to develop a single point of contact for attendance and this mirrors the emerging statutory guidance from the Department for Education.

38.3 Councillor Maynard commented that it was important to embed the expectation that all children should attend school and to encourage children to want to attend school especially at primary level. It is also important to ensure that home educated children get a good quality education as the numbers of children being home educated are rising.

38.4 Dr Stehen Pike commented that there is an opportunity for schools to be involved with the new Integrated Care Teams (ICTs). For example, secondary schools working with GP surgeries, and ICTs could also establish more community relationships with health services and schools. This could include working with primary and early years settings to establish good behaviours early on.

38.5 Darrell Gale, Director of Public Health commented that it was an excellent report which bench marked current school attendance, establishes what we need to do and what is being done to tackle attendance. Although some parental attitudes persist from lockdown, schools are places of protection and opportunities for life courses and should not be seen merely as places of infection.

38.6 Stephen Lightfoot, Chair of NHS Sussex asked if it was possible to interrogate the 3% to 4% of absences that were attributed to illness to explore any themes that emerge and cross check with health programmes such as those for vaccinations. Sarah Speedie responded that the information was provided via a coded system and would have to go away and see how far it would be possible to drill down into the data to look patterns and trends.

38.7 Dr Stephen Pike asked if children's mental health is an issue. Alison Jeffery responded that there is a lot of emotional school avoidance. She added that the Education Division has been shaped to support vulnerable children and has a team passionate about their work to support children. The school attendance links to public health also helps to increase the authority of the Council when speaking to schools and parents about attendance.

38.8 The Chair thanked officers for the report and commented that there was more work to do to recover from the impact of Covid and the effect on attendance and the life chances of children.

38.9 The Board RESOLVED to note the report, the areas of challenge and the proposed course of action.

39. FOCUS ON MEN'S MENTAL HEALTH IN EAST SUSSEX

39.1 The Board considered a report on Men's Mental Health in East Sussex, introduced by Darrell Gale, Director of Public Health. The report outlined the work carried out by Public Health on men's mental health. Work in this area has prioritised middle aged men who are the highest risk age group of men, who overall account for around three quarters of suicides in East Sussex and those with physical and mental health issues where there is a combination of risk factors including financial issues, bereavement and caring responsibilities.

39.2 Members of the Board thanked Darrell for the very positive report and case studies. The Board noted that the issues of physical and mental health are interlinked issues with people's feelings of worth and purpose being important factors. This makes opportunities to re-train and gain new skills important. Often people face a combination of issues such as losing parents, financial issues, increasing isolation. The Board made a number of comments on the report which are summarised below.

39.3 Councillor Maynard commented on the positive impact of Men's Sheds project and noted that there are similar services for ex-servicemen in Westfield. He also noted the importance of opportunities to re-train and gain new skills. Councillor Webb commented on the impact of the 2007/8 economic downturn on suicide rates and whether the Covid pandemic and cost of living crisis would have a similar impact on suicide rates.

39.4 Jessica Britton noted the positive impact of community based projects on men's mental health and asked if links were being explored and made with front line, primary care mental health services so there are two way links with community based support. There may be opportunities for Public Health to encourage and support two way access between community based support and more formal mental health services such as talking therapies.

39.5 Mark Stainton commented that the report illustrates how projects with small pieces of investment can have a significant impact on demand. The projects can also be useful local resources for ICTs where they are available. There is a good offer of support in East Sussex and there may be a need to bring all the services and support available under an over-arching Prevention Strategy, which could be used to signpost people to services.

39.6 Stephen Lightfoot agreed and commented on the importance of suicide prevention. He observed that the beauty of the projects is that they are small scale at around £1,500 each and provide a powerful model of projects and schemes. This prompts the question of how to scale up this type of activity across East Sussex, and how to signpost people to services. There is an opportunity to achieve a marked impact on mental health issues with a small amount of funding, and there may also be a need for a central resource for services and support.

39.7 Darrell Gale commented that in terms of scaling up the projects, the majority of the cost of each project is the infrastructure cost and there was a need to fund an umbrella community organisation to help with setting up the projects. However, compared with other services they are good value. There are other examples through the Making it Happen scheme where other community needs, not just for men, are being addressed. The five year funding for the men's mental health projects is coming to an end and the Public Health team will have to work

creatively to co-produce these projects in the future. This is something that the Integrated Care Board (ICB) may be able to help with to take this work forward in the future.

39.8 Veronica Kirwan outlined that in respect to loneliness and isolation, Healthwatch East Sussex is just starting a project which links to the work the Public Health have been doing. The project will look at what work in this area is already taking place and what more could be done. A reference group for this project is being established and will include someone from the Public Health team.

39.9 Darrell Gale responded to an earlier point regarding re-training and there has been some success with the Estar scheme in Eastbourne that was run during Covid with street homeless men. This scheme provided support and training opportunities and has led to number of men securing jobs and being able to maintain tenancies. The Public Health team is always looking for opportunities to support this type of work which provides people with purpose and feelings of self-worth.

39.10 Darrell Gale also commented that all the men's mental health projects and programmes are relatively new, and the groups have been developed from the community up. As such they do not necessarily see themselves as services or as meeting health outcomes, and care will need to be exercised not to impose expectations upon them. However, the Public Health team do want to maximise links to other services.

39.11 It was noted that suicide rates rose after 2007/8 financial crisis. The data in the report on suicide rates is local county data and national data and it is hoped that the work outlined in the Suicide Prevention Strategy will help contain any rise in suicide rates linked to the current cost of living crisis. The work that is being undertaken is definitely making individual impacts and it is hoped that the work will have a positive impact on future suicide rates.

39.12 The Board RESOLVED to note the recent and ongoing work commissioned by Public Health to support men's mental health in East Sussex.

40. EAST SUSSEX SHARED DELIVERY PLAN (SDP) PROGRAMME UPDATE

40.1 The Board considered an update report on the East Sussex Shared Delivery Plan (SDP) programme. The report was introduced by Vicky Smith, Programme Director East Sussex Health and Care Transformation. The report covered a review of progress against the eight key milestones for year one of the SDP; the latest progress on the development of the Integrated Care Teams (ICTs); and proposals for moving forward with the Health and Care Partnership and the HWB statutory role.

40.2 Jessica Britton outlined that the report sets out the strategic approach and the progress towards greater integration. It also sets out the progress on the areas of focus on the ground where partners are starting to work differently such as in Family Hubs, emotional and wellbeing support services, as well as the development of ICTs. This is through an asset based approach to local shared priorities to improve the offer and services available to people locally.

40.3 Mark Stainton added that the partners had worked well together to deliver the eight key milestones during the first year of the SDP. Going forward it will be important when looking at the key milestones to get the right balance between strategic priorities and development of services on the ground. There had been really good progress on the development of the ICTs with the development of the core offer, establishment of the footprint for each ICT and an intelligence base for each of the neighbourhoods. It will be important to articulate what this means for staff and residents, highlighting which teams form part of the ICT and how residents will access them and what is different. In terms of governance arrangements for the East

Sussex 'place', some proposals will be brought to the next HWB in July. There is a role to develop for the HWB around challenge, accountability as well as stewardship of the Health and Care system. Developing a whole system Preventative Strategy, including approaches to men's mental health is one example where the HWB could pull together and steer the collective energies of the health, care and VCSE partners.

40.4 The Chair commented that he thought the direction of travel for the work on the SDP is exactly right, and recent work on the LGA Peer Review of Adult Social Care and Health highlighted the role and opportunities that the HWB has to co-ordinate the work of all the partners. This will need serious consideration to focus on the areas of work that are important to residents.

40.5 Alison Jeffery outlined that although the progress on the work on the children's programme is marked as green, and good foundations have been laid for future work, there is still not much impact on services on the ground on the mental health and neurodiversity pathways. There is a need to make sure the work over the last year makes a difference. Going forward the incoming Director of Children's Services will continue to raise the case for involving children and young people in this work.

40.6 Veronica Kirwan commented that good progress had been made, but going forward it will be important to look at how the Partnership continues to focus on strategic and system wide issues but reflect this at the local level, whilst communicating this to members of the public. It will also be important to see how better use of metrics can used to challenge each other and to hold each other to account on things like the development of a preventative strategy.

40.7 Stephen Lightfoot commented that a good place to start with monitoring measurable improvement, would be to use the shared outcomes framework that is contained in the current HWB Strategy as it set's out a clear framework across four elements that are important to the population.

40.8 The Board RESOLVED to note the content of the progress report and the forthcoming changes to aspects of the partnership working within the Sussex Integrated Care System (ICS), and:

- The proposed review to ensure our HWB is empowered to undertake its leadership role across the broader range of stakeholders working together at Place; and
- That further reports that will be brought to the July meeting of the HWB on delivery plans for 2024/25 and the outcomes of the review.

41. WORK PROGRAMME

41.1 The Board considered the HWB work programme and Mark Stainton highlighted the forthcoming reports that are on the work programme for the next HWB meetings. Stephen Lightfoot commented that it might be helpful to include something in the future work programme on the shared outcomes framework in the HWB Strategy, once the ICTs are up and running, to provide a framework for the measurement and demonstration of the impacts across the four elements that are important to the population of East Sussex.

41.2 The Board RESOLVED to agree the work programme.

42. CHAIR'S ANNOUNCEMENTS

42.1 The Chair noted that this will be Alison Jeffery's last Board meeting as she is soon to retire from her role. The Chair thanked Alison on behalf of the HWB for all her work on the Board, and the inclusion and involvement of children and young people in the work of the HWB.

42.2 Alison responded that she was hugely grateful for all the support she had received in her role as Director of Children's Services and thanked everyone for their support.

43. ANY OTHER ITEMS PREVIOUSLY NOTIFIED UNDER AGENDA ITEM 4

43.1 There were none.

The meeting ended at 4.20 pm.

Councillor Keith Glazier (Chair)

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Report to:	**East Sussex Health and Wellbeing Board**
Date:	**16 July 2024**
By:	**Chief Integration and Primary Care Officer, NHS Sussex and Director of Adult Social Care and Health, East Sussex County Council**
Title:	**Sussex Integrated Care Strategy Shared Delivery Plan (SDP) year 2 refresh**
Purpose of Report:	**To enable consideration and endorsement of the year 2 refresh plans for the Sussex SDP.**

Recommendations:

East Sussex Health and Wellbeing Board is recommended to:

1. **Endorse the update for year 2 of the 5-year SDP, and provide any further feedback to the NHS Sussex Integrated Care Board (ICB), to strengthen the SDP update and the collaborative arrangements to support delivery;**
2. **Approve the continuation of the East Sussex Health and Wellbeing Board (HWB) population and Place priorities as set out in Appendix 1 (pages 86 – 94) of this report, and;**
3. **Note the changes to our Place partnership governance to support delivery of the HWB priorities.**

1 Background

1.1 The 5-year Sussex Integrated Care Strategy *Improving Lives Together* was approved by the Sussex Health and Care Assembly on 14 December 2022, following agreement by the County Council's Leader and Lead member for Strategic Management and Economic Development on 29 November 2022, and endorsement by the East Sussex Health and Wellbeing Board (HWB) at its meeting on 13 December 2022. The Strategy builds on our East Sussex Health and Wellbeing Strategy *Health Lives, Healthy People* (2022 – 2027), and sets out our ambition for a healthier future for everyone in Sussex over the next 5 years.

1.2 Improving Lives Together sets out our shared ambition for a healthier future for everyone in Sussex over the next 5 years, and 3 overarching strategic priorities:

- A new joined-up community approach, through the development of Integrated Community Teams (ICTs)
- Growing and supporting our Sussex health and care workforce
- Improving the use of digital technology and information

1.3 In keeping with national policy and guidance, a core principle for this joint work is that the primary building blocks are the three "Places" (East Sussex, West Sussex and Brighton and Hove). At the inception of the Sussex ICS there was local agreement that "Place" is key to strategic leadership, local commissioning and delivery within the ICS, in order to get the best value out of the full range of collective resources available to meet needs and improve the health, care and wellbeing of populations.

1.4 In line with the NHS England Joint Forward Plan guidance, the supporting 5-year delivery plan was developed and agreed by all system partners, including the HWB, in June 2023. In Sussex this is known as the Shared Delivery Plan (SDP). It is written as a single plan that incorporates the local NHS response to the annual national NHS priorities and

operational planning guidance, the delivery plan for the Improving Lives Together strategy and each of the three Health and Wellbeing Board strategies in Sussex. It covers areas for immediate, continuous and long-term improvement, as well as shared priorities specific to each of the three Health and Wellbeing Boards in Sussex and their populations.

1.5 Joint Forward Plans (JFPs) must be refreshed each year and ICBs and their partner Trusts and NHS Foundation Trusts must involve each relevant Health and Wellbeing Board (HWB) in preparing or revising their forward plans. The SDP refresh will also be considered by East Sussex County Council (ESCC) as a joint statutory partner in the Sussex Health and Care Assembly and Integrated Care Strategy, and partner member on the NHS Sussex ICB. This will take place at the Leader and Lead Member for Strategic Management and Economic Development meeting on 19 July 2025.

1.6 This report provides an update on the progress made with the 5-year SDP in year 1 (2023/24), and the refresh plans for year 2 of the SDP (2024/25). This will include content as it relates to delivering the specific priorities for the population of East Sussex previously agreed by the East Sussex HWB. It covers governance arrangements to support delivery, including the work of the East Sussex Health and Care Partnership which is accountable to the HWB for delivering the East Sussex focussed elements in the SDP.

2 Supporting information

SDP year 2 refresh

2.1 To provide the opportunity to reflect the national NHS priorities and operational planning guidance for 2024/25 (published on 27 March 2024), NHS England initially set 30 June 2024 as the date for ICBs to publish and share their refreshed plans. Following the announcement of the election and the immediate start of the pre-election period, NHS England confirmed that systems should publish their JFPs as soon as possible after 4 July, in line with published pre-election guidance. Local authorities in Sussex are also ensuring the SDP is taken through their individual governance arrangements as an opportunity for comment and agreement.

2.2 A summary progress review of year 1 of the full SDP (2023/24) was produced for the Assembly meeting on 10 April 2024: Shared-Delivery-Plan-Progress. A paper setting out the draft year 2 refresh plans covering the full SDP prepared by NHS Sussex is contained in **Appendix 1** and includes:

- Long-term improvement priorities
- Immediate improvement priorities
- Continuous improvement areas
- Health and Wellbeing and Place-based Partnerships strategies

2.3 The proposed updates for year 2 have been developed and signed off by each of the 11 pan-Sussex delivery boards. As well as a continuation of improvement plans from year 1, the SDP year 2 refresh contains new ‘stand-alone’ pan-Sussex workstreams for children and young people (pages 61– 65, Appendix 1) and helping the NHS support broader social and economic development (pages 103 – 104, Appendix 1).

2.4 Both the Integrated Care Strategy and the SDP are built on our understanding of population health needs in East Sussex, and the East Sussex Health and Wellbeing Strategy. The County Council participates in joint work with the NHS on both a pan-Sussex and Place (East Sussex) level which contributes to a range of service improvement objectives for the benefit of the East Sussex population. As well as the new pan-Sussex workstream for children and young people, work on a pan-Sussex level includes improvements to hospital discharge arrangements and aspects of mental health, learning disability and autism services for children and adults.

East Sussex Health and Wellbeing Board (HWB) priorities

2.5 Alongside the pan-Sussex SDP deliverables, the year 2 SDP includes the East Sussex HWB priorities in pages 86 – 94 of Appendix 1. This represents shared work specifically focussed on the population Joint Strategic Needs Assessments (JSNAs) and Health and Wellbeing Strategy for East Sussex.

2.6 The refresh builds on the summary of progress and achievements in year 1 of the SDP which was presented to the HWB at its meeting on 5 March 2024: SDP milestones progress summary 23/24. Highlights are also included in section pages 87 - 88 of Appendix 1.

2.7 Most of the year 2 deliverables reflect a continuation of previously stated plans, with some further refinements or updates to reflect the status and expectations for year 2 and any changes after delivery of the SDP in year 1. This has been agreed via the programme leads and Oversight Boards in the relevant area. Delivery plans reflect our continuing shared priority programmes covering children and young people, mental health, community (and integrated community teams) and improving health outcomes.

2.8 Some specific changes to note for year 2 are as follows:

- Specialist Childhood and Adolescent Mental Health Services (CAMHS) pathway transformation is now led through the pan-Sussex CAMHS Transformation Operational Group. This includes the stock take of specialist CAMHS and exploration of options for investment (including any resource reprofiling if appropriate), and improvement of accessibility of self-help and information, advice and guidance on mental health and emotional wellbeing. Our East Sussex SDP deliverables have been updated to reflect this partnership work is now taking place on a pan-Sussex basis. Support to families to enable the best start in life continues to be the ongoing focus of partnership delivery at Place.

- A new deliverable has been added to ensure a strong focus on health, care and housing as a shared priority for HWB oversight in 2024/25, in line with the East Sussex Health and Wellbeing Strategy and previous agreement by the East Sussex Health and Care Partnership in 2023/24. This has been agreed by our East Sussex Housing Partnership Board and members include Borough and District Councils, Voluntary, Community and Social Enterprise (VCSE) and County Council housing and public health leads.

Supporting governance

2.9 As reported to the HWB meeting on 5 March 2024, the overall ICS architecture in Sussex is evolving to include:

- A new operating model in 2024/25 to carry out ICB core functions as a strategic commissioning organisation.
- Plans to establish a new committee in common between the ICB and NHS providers to focus on increasing productivity and efficiency, and the overall sustainability of healthcare services in Sussex focussing on NHS elements of Improving Lives Together and the SDP.
- Developing new pan-Sussex NHS provider collaboratives focusing on acute and community pathways to better enable improvements to healthcare services, supported by the outcomes-based strategic commissioning role of the ICB.

2.10 In light of this, the existing pan-Sussex partnership governance of 11 delivery boards to support the SDP set up in year 1 is currently being reviewed to better align with the new arrangements described above, and support effective delivery in year 2. The amended approach to oversight and grip on delivery of the Sussex-wide SDP workstreams is expected to be streamlined as a result. There will still be oversight needed for delivery of some our shared long term shared strategic areas of improvement, as set out in *Improving Lives*

Together, including the implementation of Integrated Community Teams.

2.11 The pan-Sussex System changes noted in paragraph 2.10 above primarily involve new working arrangements within or between NHS organisations to focus on improvements to healthcare delivery. There will be a need for the County Council to engage with them appropriately, to support alignment across health, social care and public health.

2.12 Consideration has also been given to the role of Place within this newly evolving system architecture. The continuing pivotal role of the three Place Health and Care Partnerships within the Sussex ICS is to bring together the contribution of the Voluntary, Community and Social Enterprise (VCSE) sector, Borough and District Councils, NHS providers, the NHS Sussex ICB, County Council and others to deliver an integrated offer of health, care and wellbeing for their population.

2.13 Tailored to the JSNAs, differing population health and care needs and the system of partnership planning and delivery that exist in East Sussex, Brighton & Hove and West Sussex, it has been agreed that the purpose of the NHS and Local Authorities coming together to jointly facilitate wider partnership work at Place within the ICS is two-fold:

- To drive health and care improvement through joint commissioning of services
- To develop and oversee the implementation of Integrated Community Teams

2.14 In the SDP this is framed around the specific priorities shared across the NHS and the County Council for our Place, driven by the HWB strategy and the role of the East Sussex Health and Care Partnership. We have undertaken an early review of our jointly facilitated partnership and programme governance, to ensure it is best aligning our capacity to monitor and deliver the East Sussex specific plans in the SDP, and reduce any potential duplication with pan-Sussex arrangements. This has included formally incorporating our East Sussex Housing Partnership Board into our health and care governance structure to enable monitoring of delivery.

2.15 A summary of the background and changes to our East Sussex Health and Care Partnership programme governance in 2024/25 is contained in **Appendix 2**. This also links to a broader review of the vision, focus and role of our East Sussex HWB as the key stewardship group for our system at Place. To support this, proposals have been developed aimed at strengthening strategic oversight and mutual accountability of our collective work at Place to improve health, care and wellbeing outcomes for our population. This is covered under a separate report on the meeting agenda.

2.16 A critical next step will be to ensure our borough and district council partners are able to engage effectively in this refreshed governance, both from the perspective of mutual accountability to the HWB through the Health and Care Partnership Board, and also in the key areas of shared priorities for change, for example Housing and Integrated Community Teams development.

Patient and public engagement

2.17 As part of the development of the Sussex Integrated Care Strategy, *Improving Lives Together*, the engagement approach successfully delivered direct feedback from 18,000 people, face to face and virtual workshops with 420 people, 500 interviews and direct feedback through partners, 1,440 survey responses on our ambition priorities, 800 individual conversations in public engagement events and online communication that has reached more than 200,000 people.

2.18 The original SDP was informed by this feedback from patients, the public and workforce as well as existing insight and feedback available to the ICS. The SDP refresh builds upon this engagement. Recognising that this is a refresh of commitments rather than a full restatement of our strategy and intended areas of focus, a short period of engagement with bodies reflecting the patient voice is planned. Wider engagement with the public will

take place when the refreshed SDP is published, led by NHS Sussex and supported by accessible material which clearly articulates our shared areas of focus in 2024/25 and what this means for our population.

2.19 There will be ongoing and strong engagement with people with lived experience and patients, clients, carers and communities tailored to the discrete SDP deliverables, including those captured in our Place-based plans. This would include assessments of equality and health inequalities impacts, as appropriate and necessary to support accountability and decision-making by the relevant lead organisations and in line with their polices.

3 Conclusion and reasons for recommendations

3.1 The year 2 refresh of the 5-year SDP reflects the continuing priorities for change that are thought will improve the system working to achieve better health and care outcomes across Sussex. This includes the areas of change related to the East Sussex system and population specifically.

3.2 Deliverables are being carried out within existing resources, and as a single shared plan the SDP will support alignment of resources and capacity to enable delivery at both a Place and System level. As such, programme delivery arrangements at a pan-Sussex and Place level are being aligned with new System and Place-Partnership governance arrangements described in paragraphs 2.9 – 2.16 above.

3.3 Within this there are no changes to organisations' statutory roles and responsibilities for services and budgets. The refreshed SDP contains high level milestones and serves as a roadmap covering the next 4 years. The approach outlined in the Integrated Care Strategy and SDP adds value through helping partner organisations focus on the things that can only be achieved well by working together.

3.4 The unique statutory role of the East Sussex HWB and the underpinning Place partnership governance will be critical to maintaining oversight and mutual accountability for how well we work in partnership at Place to deliver our SDP and improve outcomes for our population. Proposals to further strengthen the way the HWB carries out the 'stewardship' role for partners in our East Sussex system are covered separately on the meeting agenda for HWB consideration.

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Appendix 1: Draft SDP Year 2 refresh paper
Appendix 2: East Sussex Health and Care Partnership programme governance

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Sussex Health&Care

Improving Lives Together

Shared Delivery Plan

Year Two

Contents

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.

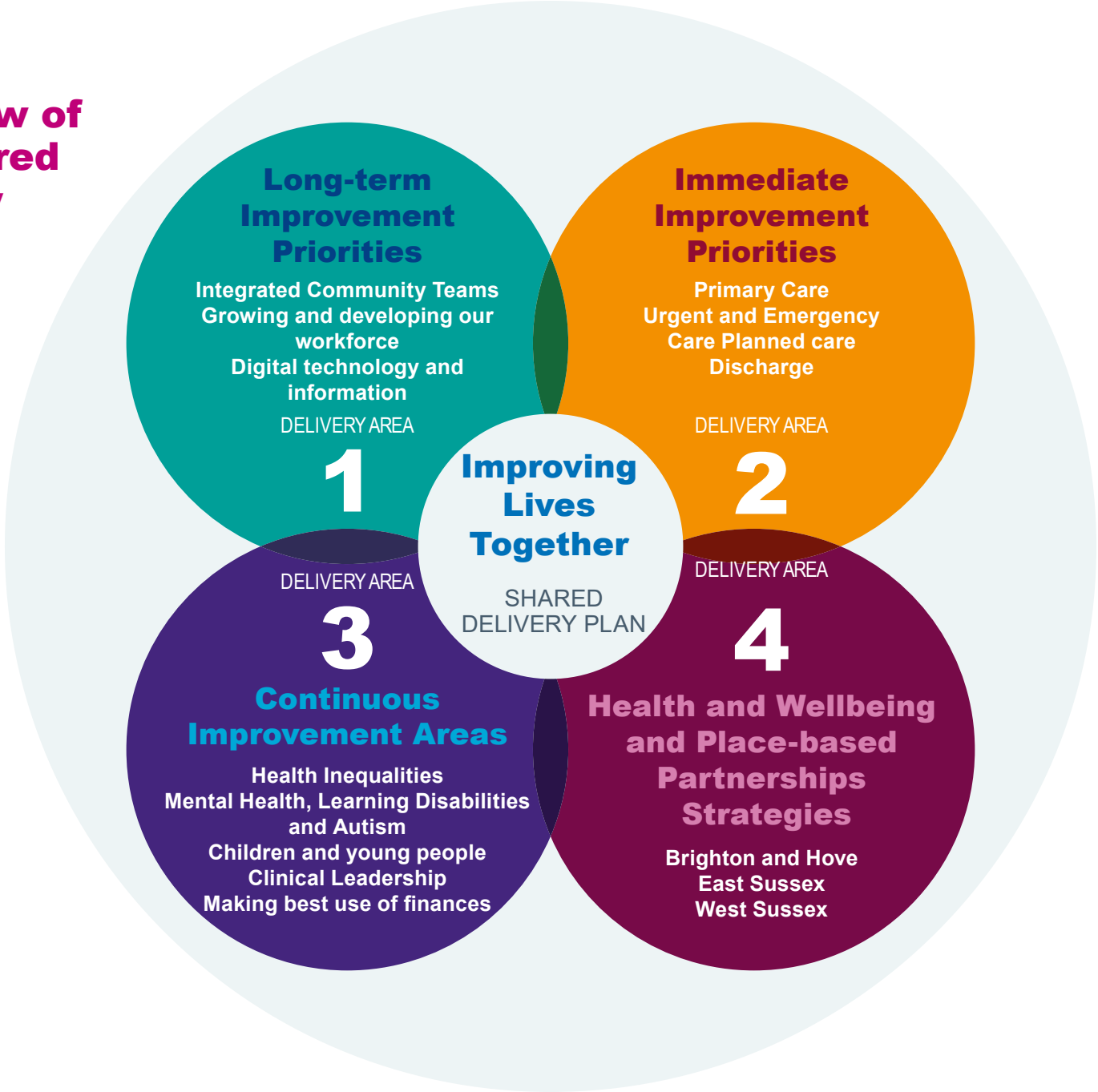
- **Addressing health inequalities that exist across our population to achieve greater equity in the experience, access, and outcomes of our population.** This is a 'golden thread' running through the delivery of all the actions we are taking, and we also have a specific system-wide focus to help bring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

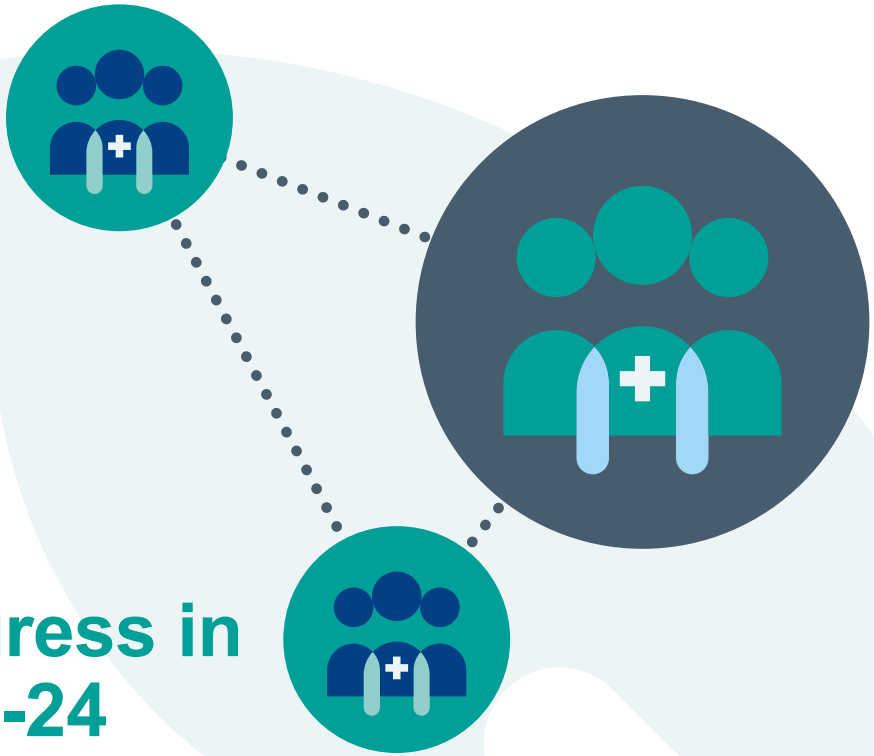
Over the next five years we will be integrating health, social care, and health-related services across local communities in a way that best meets the needs of the local population, improves quality, and reduces inequalities. This will involve us working with local people to build on what works best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

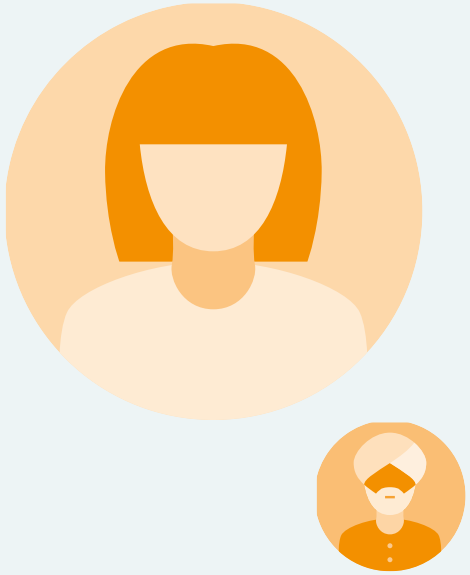
- deliver a 2% increase in the number of general practice appointments
- reverse the current trend and deliver – on average – 85% of all appointments within two weeks.
- improve patient experience by improving on the average score for overall satisfaction of general practice service as being good from 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.

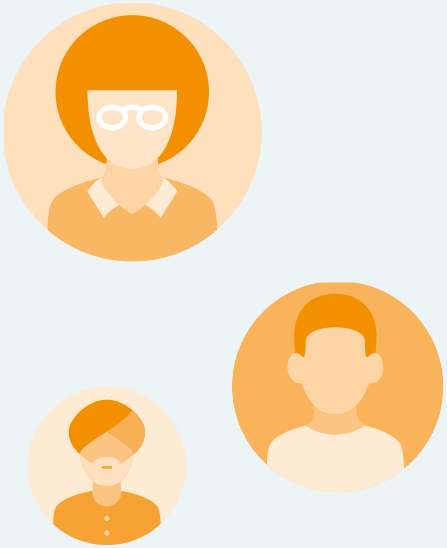
Discharge improvement remains a significant priority for our system and our plans for further improvement to be delivered during 2024-25 have been shaped and informed by our participation in the national discharge front runner programme over the last year and the recommendations following an external 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.

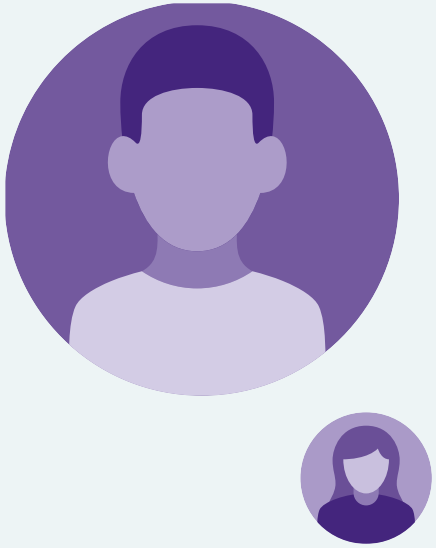
The actions we are taking this year (2024-25) to make progress to address health inequalities are:

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

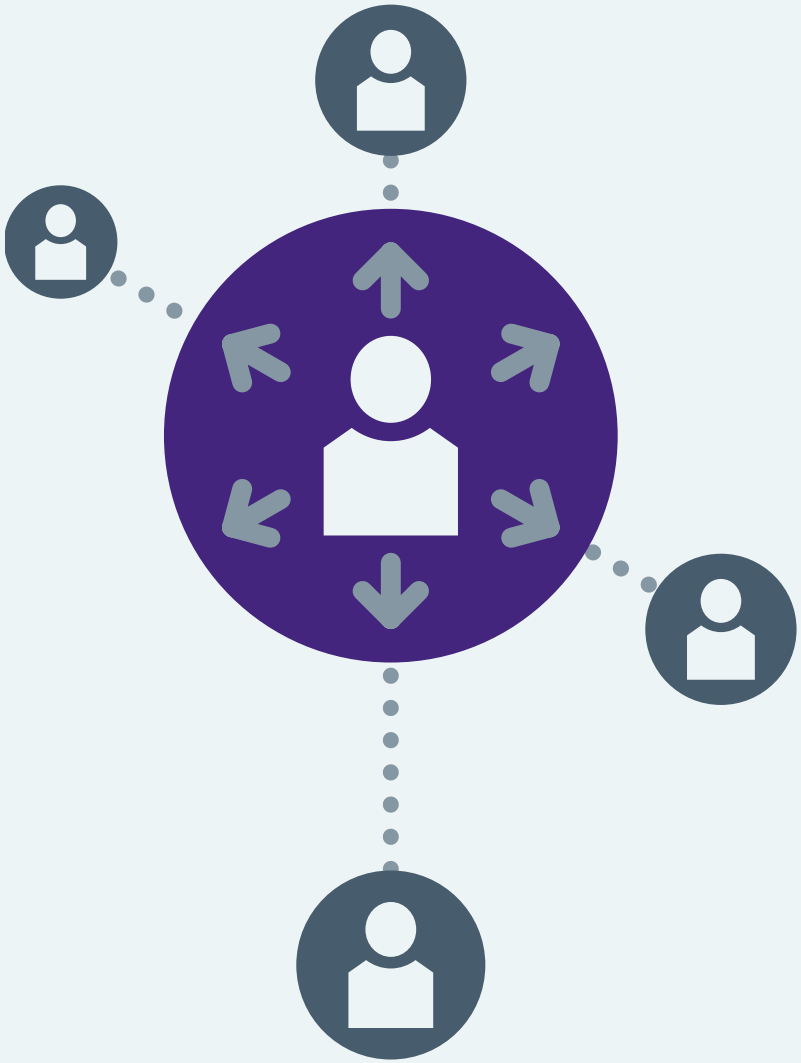
Difference for local people	How will this be measured
More integrated offers of support for children and young people aged 0-25 and their families across education, health and care	Children, young people and parent/carer satisfactions surveys and CQC/Ofsted SEND inspections

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

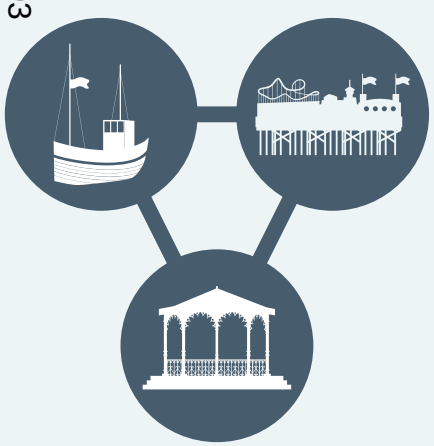
Difference for local people and workforce	How will this be measured
Living within our financial allocation will allow for greater investment in new services and innovation to support and accelerate improvements for local people.	Financial positions across system partners at the end of each financial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

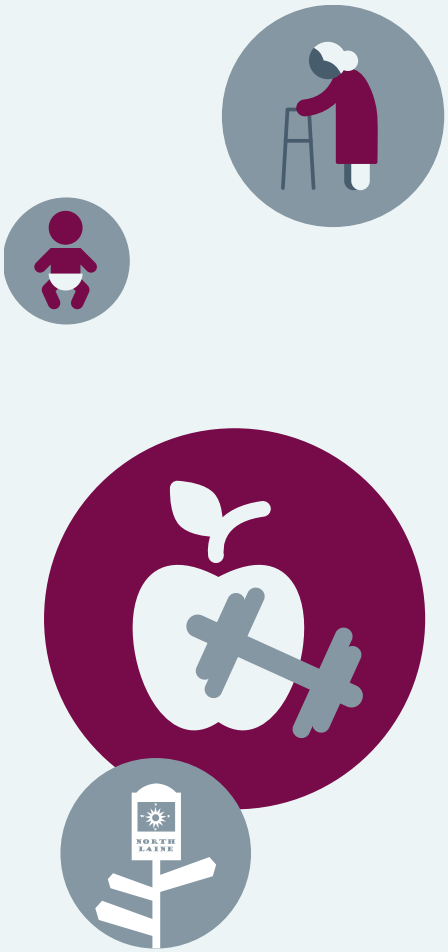
Our ambition for Brighton and Hove in 2030 is that:

- **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

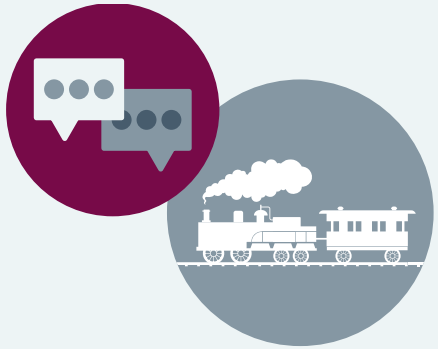
Difference this will make to local people and workforce in Brighton and Hove and how it will be measured

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.

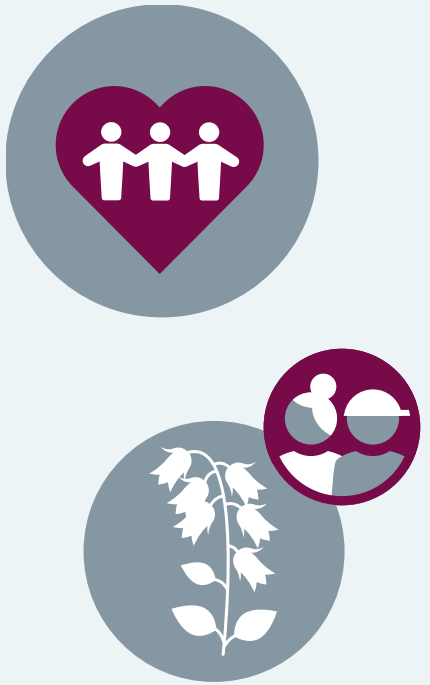
As snapshot, in summary in Year 1 of the SDP we have:

- 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:

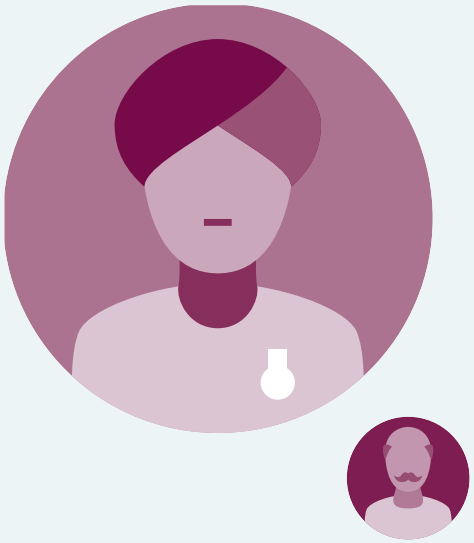
What we will do	What we will achieve	When
We will commence implementation of the approved whole system action plans on cardiovascular disease (CVD), Chronic Respiratory Disease (CRD), healthy ageing and frailty and mental health prevention, and monitor progress on a quarterly basis through the Health 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

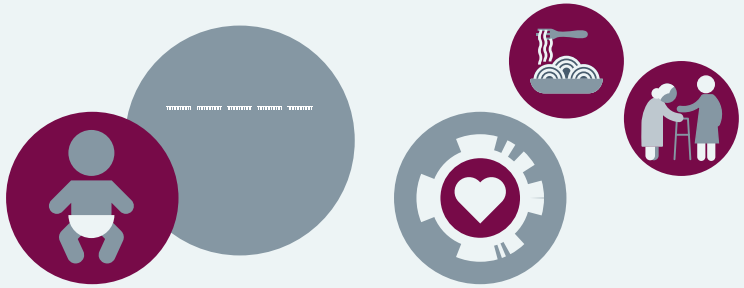
Difference for local people and workforce	How will this be measured
People will be supported to stay healthy for longer and more proactive preventative care will be available for those who need it, across the full range of organisations that can support this.	Reduction in the numbers of people accessing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

Sussex
Health&Care

To read our full Shared Delivery Plan go to

www.sussex.ics.nhs.uk

Appendix 2

Summary of changes to the East Sussex Health and Care Partnership Governance

The East Sussex Health and Care Partnership brings together NHS, Local Government (County, Borough and District Councils), Healthwatch 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 *Healthy Lives, Healthy People*, 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, with a clear focus on reducing health inequalities and increasing levels of prevention and integrated care. Priorities cover children and young people, mental health, community services, health outcomes improvement and housing for people of all ages and align with pan-Sussex SDP plans to ensure a strong focus on the population.

The work of our Sussex Integrated Care System (ICS) is taking place in an environment of almost constant pressure, which is felt by all parts of our health and care system. Changes being implemented to our ICS system architecture which are intended to help with the challenges include:

- A new operating model in 2024/25 to carry out NHS Sussex ICB core functions as a strategic commissioning organisation
- Plans to establish a new committee in common between the NHS ICB and NHS providers to focus on increasing productivity and efficiency, and the overall sustainability of healthcare services in Sussex focussing on NHS elements of Improving Lives Together and the SDP
- Developing pan-Sussex NHS provider collaboratives to better enable improvements to healthcare services, supported by the outcomes-based strategic commissioning role of the ICB.

These changes primarily involve new working arrangements within or between NHS organisations and focus on healthcare on a Sussex-scale. There will also be a need for County Council services to engage with these arrangements as they evolve to ensure joint commissioning and delivery is aligned within the system across health, social care and public health.

In light of this, in the new Sussex system architecture the continuing pivotal role of the three Place Health and Care Partnerships is to bring together the contribution of the Voluntary, Community and Social Enterprise (VCSE) Sector and Local Authorities with NHS providers, the ICB and others to deliver an integrated offer of health, care and wellbeing to their population. This is tailored to the JSNA for the population and the complex ecosystems of planning and delivery that exist in East Sussex, Brighton & Hove and West Sussex, accountable to the Health and Wellbeing Being Boards.

The role of the East Sussex Health and Care Partnership is framed around the specific deliverables contained in the 'East Sussex' section of the Sussex Shared Delivery Plan (SDP), and the priorities shared across the NHS and East Sussex County Council (ESCC) for our Place. These are driven through our robust understanding of our population needs in the JSNA and annual State of the County report, and ambitions set out nationally in the NHS Long Term Plan, the joint Sussex Improving Lives Together Strategy and the East Sussex Health and Wellbeing Board Strategy.

As part of early consideration of the focus and role of the East Sussex Health and Wellbeing Board (HWB) and Health and Care Partnership, at its meeting on 28 March 2024, the East Sussex Health and Social Care Executive Delivery Group agreed some initial proposals to ensure our Place partnership is fit for purpose in 2024/25. These changes are aimed at:

- Streamlining our formal Place Health and Care Partnership governance, in light of the changes to our system architecture and the need to retain a clear strategic focus on population needs driven by the statutory JSNA and HWB Strategy.

- Responding to changes in expectations about increased delegation of resources to Places within our ICS, lessening the immediate need for system executive leadership and grip across local NHS and Local Authority activity, finance and performance, which our longstanding East Sussex Health and Care Partnership had originally been designed around.

- Better aligning existing capacity and roles to support our Place Health and Care Partnership to enable us to deliver our SDP and the expectations of our HWB effectively.

The following changes to our formal partnership and programme governance initially agreed as of April 2024 are:

- Merging our Executive Delivery Group with our Health and Care Partnership Board and having a **strengthened single quarterly Partnership Executive Board meeting**, potentially with a broader breadth of membership from Borough and District Councils. This acknowledges that Executive leads at Place will still meet informally to discuss and manage shared system issues at Place level.

- Ensuring grip on delivery of shared SDP priority programmes of change for our population across the collective resources of the NHS, ESCC and wider partners, through facilitating the following **thematic boards** which will report directly into the East Sussex Health and Care Partnership Board:

    - Children and Young People Health Oversight Board
    - Mental Health Oversight Board
    - Community Oversight Board
    - Health Outcomes Improvement Oversight Board
    - Housing Strategic Partnership Board

- These Boards will each be responsible for agreeing **SDP milestones for their area and leading programmes of work** aimed at progressing them in-year, as well as tracking the delivery of outcomes and KPIs that will be reported through to the Partnership Board.

- Refreshing our approach to **enabling** joint planning and transformation at Place to reflect new arrangements for leadership at pan-Sussex level. This acknowledges that pan-Sussex enabling programmes can still connect with non-NHS partners via the appropriate Place governance, and through individual organisations and networks, to support successful implementation and integration at Place level. In light of this, agreement has been reached to stand down the following groups:

    - East Sussex Chief Finance Officers Group
    - East Sussex Strategic Workforce Group
    - East Sussex Digital Board

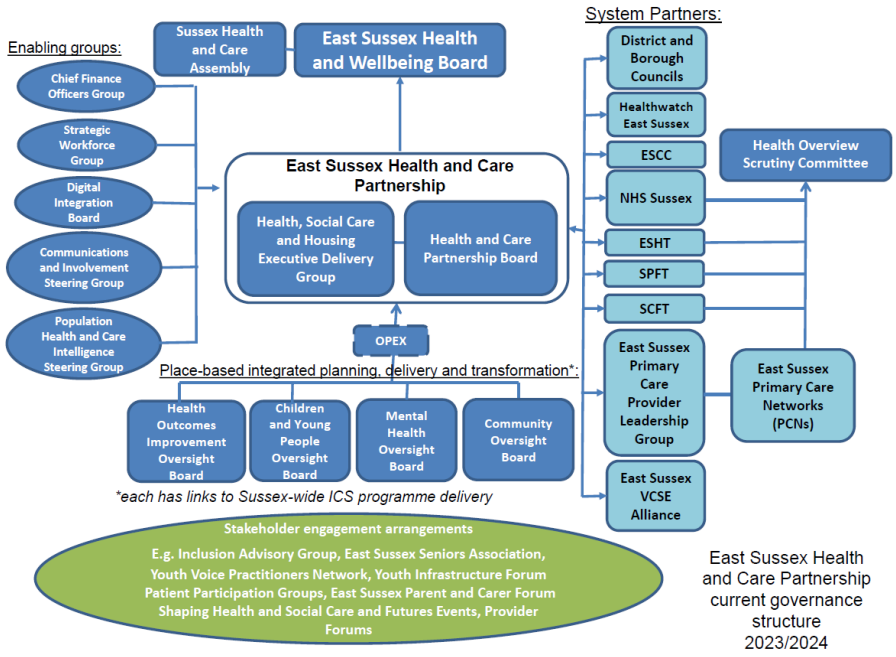
- The joint steering groups for **Communications and Involvement** and **Population Health and Care Intelligence** will be retained. As ‘communities of practice’ in these functional areas these groups will help actively progress priority programmes of work aligned to SDP delivery, including better understanding our communities and working with their strengths and assets to support neighbourhood delivery.

NHS Sussex have also been considering the additional impact of the adjustments to staffing levels in the context of the new ICB organisational operating model across Sussex. This extends to both the Place joint health and care governance and wider Local Government-led partnership work, and is intended to further ensure reduced duplication of work at system and Place, and well aligned capacity at all levels within our ICS. This is connected to work to review the pan-Sussex SDP system delivery arrangements. The priority focus and next steps for Place-based partnership

governance may need to be further reviewed in light of the outcomes of this review.

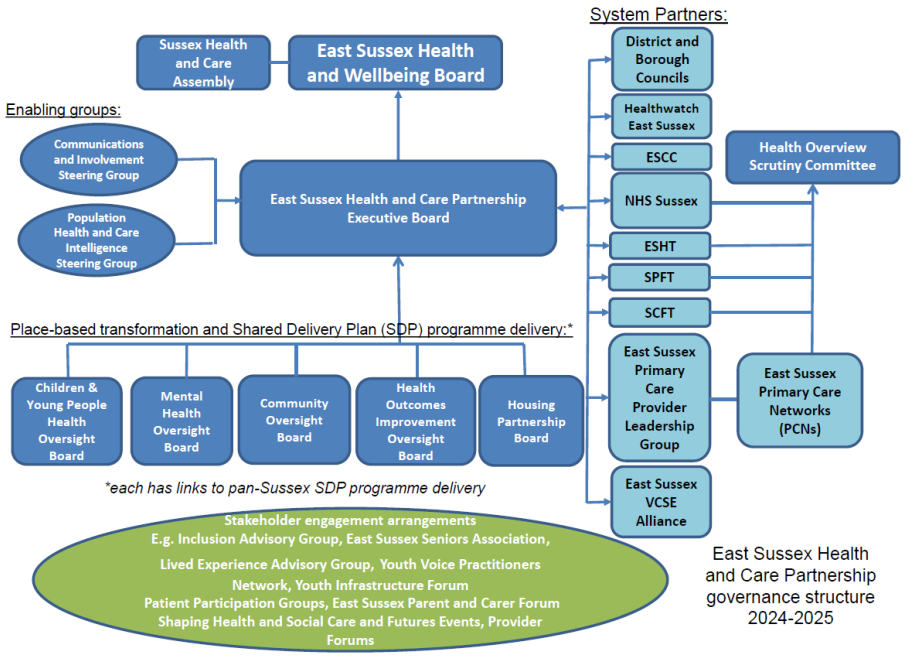
The following diagrams show the changes to our Health and Care Partnership Board structure.

Diagram 1: East Sussex Health and Care Partnership governance structure in 2023/24



East Sussex Health and Care Partnership current governance structure 2023/2024

Diagram 2: East Sussex Health and Care Partnership governance structure in 2024/25



East Sussex Health and Care Partnership governance structure 2024-2025

This refreshed partnership and programme governance will support delivery of our SDP milestones and will underpin our East Sussex Health and Wellbeing Board's (HWB) strategic leadership of the health and care system in East Sussex, aligned to the Sussex ICS. Our review and proposals to further strengthen our HWB's vision and stewardship role will focus on the full breadth of partnership activity to improve health, care and wellbeing outcomes for our population, and ensure this is aligned with the wider ambition of the Sussex Health and Care Assembly.

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Report to:	**East Sussex Health and Wellbeing Board**
Date:	**16 July 2024**
By:	**Director of Adult Social Care and Health, East Sussex County Council**
Title:	**Proposals for strengthening our East Sussex Health and Wellbeing Board**
Purpose of Report:	**To enable consideration of the vision, focus and role of the East Sussex Health and Wellbeing Board (HWB)**

Recommendations:

East Sussex Health and Wellbeing Board is recommended to:

1. **Agree the suggested future vision, role and focus of the HWB, as outlined in paragraphs 2.11 – 2.14 of the report, and;**
2. **Agree the proposed new way of working, set out in paragraphs 2.15 – 2.17 and Appendix 3 of the report, to strengthen the HWB's statutory role as the key strategic stewardship group for the health and care system in East Sussex**

1 Background

1.1 The joint 5-year Sussex Integrated Care Strategy *'Improving Lives Together'* was approved by the Sussex Health and Care Assembly in December 2022. The Strategy builds on the East Sussex Health and Wellbeing Strategy '*Healthy lives, healthy people'* (2022 – 2027)', and our compelling understanding of population health needs and assets and strong history of partnership working in East Sussex. It sets out our shared ambition for a healthier future for everyone in Sussex over the next five years, and three overarching strategic priorities of developing a new joined-up community approach through the development of Integrated Community Teams; growing and supporting our Sussex health and care workforce; and improving the use of digital technology.

1.2 In line with the NHS England Joint Forward Plan guidance, the supporting 5-year Sussex *Shared Delivery Plan* (SDP) was developed and agreed by all system partners in July 2023, and covers areas for immediate, continuous and long term improvement, as well as shared priorities specific to each of the three Health and Wellbeing Boards and their populations in Sussex. The year 2 refresh of the SDP is covered separately on the meeting agenda.

1.3 Both the Sussex Strategy and the SDP build on our understanding of population health needs in East Sussex set out in our population Joint Strategic Needs Assessments (JSNA) and other evidence such as the annual State of the County report. Joint work takes place between the County Council, the NHS and partners at a pan-Sussex and Place (East Sussex) level which contributes to a range of service improvement objectives for the benefit of the East Sussex population. Our specific Place priorities are delivered through transformation programmes overseen by the East Sussex Health and Care Partnership covering, children and young people, mental health, community (including integrated community teams implementation), housing and improving health outcomes.

1.4 A core principle for this joint work is that the primary building blocks in Sussex are the three 'Places' (East Sussex, West Sussex and Brighton and Hove). East Sussex is clear that 'Place' is key to strategic leadership, local commissioning and delivery in order to achieve the best health, care and wellbeing outcome for our population.

1.5 Informed by feedback from recent County Council Peer and LGA reviews, at the meeting of the HWB on 5 March 2024 it was agreed to develop proposals for strengthening the vision, focus and role of the HWB, to ensure that this can best support strategic leadership and mutual accountability for delivering our agreed shared priorities for the population of East Sussex, in the context of the wider Sussex Integrated Care System (ICS). Proposals will be informed by national guidance and good practice, and take into account recent developments in the System architecture at a Sussex-scale designed to better enable improvements to healthcare delivery for the population.

1.6 This report brings for consideration suggestions for strengthening the way our Health and Wellbeing Board operates to serve as the key stewardship group for strategic leadership and oversight of our health, care and wellbeing system at Place, and suggested priority areas of focus.

1.7 This will support County Council priorities to keep vulnerable people safe, help people help themselves and make the best use of resources. It will also contribute to a key East Sussex Health and Care Partnership Plan deliverable in the joint Shared Delivery Plan (SDP) for year 2 refresh as follows:

"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".

2 Supporting information

Integrated care systems and the role of 'Place'

2.1 The following White Papers, reports, guidance and good practice outline expectations in relation to HWBs and the role of Place and Place-based partnerships in Integrated Care Systems in England:

- Developing Place-based Partnerships: the foundation of effective integrated care systems (The King's Fund, April 2021).
- Health and Care Act 2022, Health and wellbeing boards – guidance (Department of Health and Social Care (DHSC), November 2022)
- Thriving Places: Guidance on the development of place-based partnerships as part of statutory integrated care systems (NHS England, September 2021)
- White Paper, Health and social care integration: joining up care for people, places and populations (DHSC, February 2022)
- Next steps for integrating primary care: Fuller stocktake report (NHS England, May 2022)
- Working in partnership with people and communities: statutory guidance (NHS England, July 2022, updated May 2023)
- Shared outcomes toolkit for integrated care systems (DHSC, October 2023)
- Integrated care systems (NHS England)

2.2 A light-touch review[1] of the themes suggests some core design principles for the critical role of Place within Integrated Care Systems:

[1] *Pre-publication draft: Place Development toolkit (NHS England, June 2024)*

- Shared outcomes based on the holistic needs of local people and communities
- Joint vision for population health, prevention and health inequalities
- NHS, Local Government and wider partners should agree the ICS responsibilities and functions to be carried out at place level.
- Leadership reflective of local responsibilities and functions
- Mutual accountability
- Development of Integrated Neighbourhood/Community Teams
- Appropriate resource, capability and delegated decision making to support subsidiarity
- Digital levelling up across care settings and population health data capability
- Enablers - workforce development, estates, integrated data and population health analytics, contractual, commissioning and funding frameworks for new care models.

2.3 There is flexibility in how arrangements can be adopted and supported by each of the 42 ICSs in England and their constituent Places, as this is dependent on geography, population size, and local government structures as well as existing relationships and shared priorities. At the inception of our Sussex Integrated Care System (ICS), it was agreed that 'Place' is key to strategic leadership, commissioning and delivery to enable a clear focus on population needs. Sussex is made up of three Places – Brighton & Hove, East Sussex and West Sussex. The purpose of the NHS and Local Authorities coming together to jointly facilitate wider partnership work at Place within the ICS is two-fold:

- To drive health and care improvement through joint commissioning of services
- To develop and oversee the implementation of Integrated Community Teams

System and Place in the Sussex Integrated Care System (ICS)

2.4 The NHS Sussex ICB has recently led work to strengthen integrated working between NHS organisations. This is taking place on a pan-Sussex scale and involves developments in the System architecture aimed at improving delivery of healthcare services**.** Changes include:

- Two new pan-Sussex NHS provider collaboratives for acute and community health services (including mental health)
- A committee-in-common between the ICB, Trust and Foundation Trust Boards in Sussex

2.5 The ongoing role of the Place-based health and care partnerships in Sussex is being considered alongside these changes. East Sussex has a longstanding and relatively mature Health and Care Partnership which is responsible for delivering shared HWB 'Place' priorities captured in the SDP, reporting into the HWB. The refreshed high-level list of proposed Year 2 deliverables is included in **Appendix 1** of this report for ease of reference. More detail about the deliverables, the broader SDP and the supporting East Sussex Health and Care Partnership governance arrangements can be found in the separate report about this on the agenda.

Statutory role of HWBs

2.6 The Health and Social Care Act 2012 introduced HWBs, which became operational on 1 April 2013 in all 152 local authorities in England with social care and public health responsibilities. The purpose of HWBs is threefold:

- provide a strong focus on establishing a sense of place
- instil a mechanism for joint working and improving the wellbeing of their local population

- set strategic direction to improve health and wellbeing

2.7 Since 2013 other legislation and statutory guidance has built on this, including for example the need to involve HWBs in receiving specific annual reports about safeguarding children and adults, and learning from the lives and deaths of people with a learning disability and autistic people.

2.8 The Health and Care Act 2022 did not change the statutory duties of HWBs as set out by the 2012 Act, but established new NHS bodies known as Integrated Care Boards (ICBs) and required the creation of Integrated Care Partnerships (ICPs) in each local system area. This empowers local health and care leaders to join up planning and provision of services, both within the NHS and with local authorities, and help deliver more person-centred and preventative care.

2.9 New Health and Wellbeing Boards guidance published as a result of the Health and Care Act 2022 underlined the roles and duties of HWBs and clarified their purpose within the new system architecture. A summary of the statutory role and functions of HWBs and how this relates to the new statutory arrangements for the ICS is included in **Appendix 2** of this report.

2.10 In summary HWBs are critical to ensuring there is a 'joining up' of ICB work to improve healthcare for populations and the work of the Place-based Health and Care Partnership, which is rooted in Place and populations across all the services that impact on health, care and wellbeing.

Proposed future role of the East Sussex Health and Wellbeing Board

2.11 In light of the new elements of NHS System architecture on a Sussex scale (described in paragraphs 2.4 – 2.5 above), there is an opportunity to further strengthen the role of our HWB as the key strategic stewardship group for partnership working across the wider range of system partners that contribute to the health, care and wellbeing of our population. This would both complement and augment the collaborative working at a pan-Sussex level, ensuring it is tailored to local populations and Place across the collective resources available to meet needs and challenges.

2.12 The vision for our HWB is set out in our HWB Strategy *Healthy Lives, Healthy People 2022 – 2027.* The HWB is responsible for ensuring the organisations that make up the health, care and wellbeing system in East Sussex work in an integrated way together, to deliver shared strategic priorities for change set out in the Strategy. As an overarching rolling 3+2 year strategy, it covers a 5-year period with the next refresh due no later than 2027. This will also inform the refresh of the broader Sussex Integrated Care Strategy Improving Lives Together which covers the same 5-year time-frame.

2.13 At Place level our HWB's role is to ensure we can be mutually accountable for working as a system in the following ways:

- Aligning partnership plans and activity across statutory, voluntary and civic sectors and the contributions different partners make to the health, care and wellbeing of our population, and building the case for the further action we can take together to add maximum value.
- Using the resources and assets we have collectively available in innovative ways to deliver the ambitions we share, and the best possible outcomes for our population.

2.14 In keeping with the discussion at the HWB meeting on 5 March 2024, and our commitment in the SDP, it is suggested that this will focus on holding organisations collectively to account for undertaking collaborative action in following key areas:

- Improving **population health** and the specific challenges faced in the county using an evidence-based approach. This will be focussed on the JSNA priorities for our system that were agreed at the HWB meeting on 12 December 2023:
    - **Building blocks of good health** – decent home, education and employment alongside good social connections and community.
    - **Importance of the Life course approach** – good start in life, living well, ageing well, and a good end of life.
    - **Improving Healthy Life Expectancy** – extending years in good health by enabling healthy behaviours and reducing risk and impact of chronic disease and ill-health.
    - **Reducing Health Inequalities** – underpinning everything we do. Gaps are always changing and not always in the direction we want them to.
    - **Mental Health and Wellbeing** - focussing on prevention and early support.
- Embedding **prevention and early intervention** and proactive, person-centred models of care as part of delivering the following HWB priorities in the SDP:
    - Health outcomes improvement
    - Children and young people
    - Mental health
    - Community and ICT implementation
    - Housing
- Ensuring that our new **Integrated Community Teams (ICTs)** model is best enabled in East Sussex, as a key mechanism to strengthen our partnership working across a number of strategies and services, to deliver an integrated offer of health, care and wellbeing in our neighbourhoods and communities.

2.15 To support this it is suggested that the HWB adopts the following arrangements to carry out its role effectively and drive expectations to address the above three areas of focus:

- Continuation of the minimum of four formal meetings a year to be held in public to carry out statutory functions and receive update reports, based on the forward plan, to include our SDP integration programme progress reports
- Measuring impact: agreement of the overarching measures and indicators in our East Sussex Health and Wellbeing Strategy Shared Outcomes Framework, and an annual review process, to ensure a clear focus on population and Place in line with the recommendation at the 5 March HWB meeting and the Shared outcomes toolkit (DHSC, October 2023) good practice
- Holding additional informal ‘strategy’ workshop sessions focussed on specific challenges faced by our population and system, informed by JSNA priority themes. Workshops would be data-driven and facilitated through the following format:
    - A description of the priority, what it is and why it is important
    - How is East Sussex doing; an exploration of the data and performance
    - What should East Sussex be doing; the evidence base and what ‘good’ looks like
    - What is East Sussex doing; current strategies and services
    - What else could East Sussex be doing; collective whole system action planning to enable improvement, and where appropriate looking to align

opportunities for prevention, early intervention and integrated care in the SDP and implementation of our Integrated Community Teams model in East Sussex

2.16 The informal Strategy workshop sessions would link to the existing work plans of key strategic leadership partnerships and groups, to enable the actions identified to be taken forward at the earliest opportunity. At the same time the sessions will support the refresh of the rolling HWB Strategy which will need to start from 2025, and ensure a fully up to date position that is owned across our Place in time for the refresh of the *Sussex Improving Lives Together Strategy* in 2027.

2.17 **Appendix 3** sets out a draft possible timetable showing how the combined informal and formal meetings, measurement of impacts and overall HWB Strategy refresh process would look in practice. An important step will be to ensure all partners, including our East Sussex VCSE Alliance and borough and district councils can engage effectively in these proposals, including mutual accountability to the HWB through the East Sussex Health and Care Partnership Board, and arrangements to support ICT implementation in East Sussex.

3 Conclusion and recommendations

3.1 In England, HWBs have been a key mechanism for driving joined up working at a local level since they were established in 2013. In the new landscape introduced by the Health and Care Act 2022, HWBs were, and are, expected to continue to play an important statutory role in instilling mechanisms for joint working across health and care organisations, and setting strategic direction to improve the health and wellbeing of people locally.

3.2 The East Sussex HWB is uniquely positioned to provide the strategic stewardship of collaboration across health, care and the wider system that impacts on the health and wellbeing of people and communities in East Sussex, to improve outcomes for our population. If accepted by the HWB these proposals will strengthen the HWB's ability to:

- Meet expectations set out in national guidance, good practice and principles for partnership working at Place within our Sussex ICS, and respond to the recent Peer and LGA Reviews of the County Council about strategic leadership of our Place;
- Ensure our East Sussex Health and Care Partnership is fit for purpose to carry out its functions within our Sussex ICS;
- Better align and drive our broader local strategic partnership plans and collaboration at Place to achieve our shared aims to improve population health and care outcomes;
- Ensure the HWB Strategy is both informed by our population JSNA priority themes, and owned across our system at Place, and in doing this;
- Align and support the wider work of the Sussex Health and Care Assembly alongside the other two HWBs in Sussex, to deliver the long-term shared ambitions for our population set out in *Improving Lives Together*, and the Sussex Shared Delivery Plan.

3.3 There are no changes to the statutory role and function of our HWB as a result of these proposals, and they are within the existing terms of reference for the HWB.

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Appendix 1 Draft East Sussex HWB Shared Delivery Plan year 2 priorities (excerpt)
Appendix 2 Summary of HWB statutory role and functions
Appendix 3 Draft proposal timetable

Appendix 1

DRAFT Year 2 HWB Shared Delivery Plan priorities - excerpt from the Sussex Shared Delivery Plan (SDP) Year 2 refresh (2024/25)

SDP Refresh: Year 2 Deliverables		
	Deliverable	**Date**
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
2	We will implement the improvements to cardiology and ophthalmology through reconfigured acute hospital services.	March 2025
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. 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	March 2025
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
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 in line with the Sussex-wide approach, and improved access and outcomes in supported accommodation.	March 2025
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
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
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

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Appendix 2

Summary of the statutory role and functions of Health and Wellbeing Boards

In England, Health and wellbeing boards (HWBs) have been a key mechanism for driving joined up working at a local level since they were established in 2013. The Health and Care Act 2022 introduced new architecture to the health and care system, specifically the establishment of Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs – locally this is known as the Sussex Health and Care Assembly).

In keeping with this, the County Council is a statutory partner in the Sussex Health and Care Assembly, which is the integrated care partnership in Sussex, alongside the NHS Sussex ICB, West Sussex County Council and Brighton & Hove City Council. The Leader and Chair of the HWB represents the County Council on the Assembly. The County Council is also represented as a partner on the ICB which is responsible for planning and commissioning healthcare services for the population of Sussex. Taken together this makes up the Sussex integrated care system (ICS).

To support an aligned approach, in the Sussex ICS all three Chairs of HWBs in Sussex are the representatives of the three Local Authorities on the joint Sussex Health and Care Assembly, alongside the Chair of the NHS Sussex ICB. The Chair of the NHS Sussex ICB is also one of the NHS Sussex members of the HWB.

In this new landscape, HWBs continue to play an important statutory role in instilling mechanisms for joint working across health and care organisations and setting strategic direction to improve the health and wellbeing of people locally. The new guidance published as a result of the Health and Care Act 2022 Health and wellbeing boards – guidance - GOV.UK (www.gov.uk) sets out the roles and duties of HWBs and clarifies their purpose within the new system architecture. It accompanies previously published statutory guidance on joint strategic needs assessments (JSNAs) and joint local health and wellbeing strategies (JLHWSs). The Health and Care Act 2022 amends section 116A of the Local Government and Public Involvement in Health Act 2007, renaming 'joint health and wellbeing strategies' to 'joint local health and wellbeing strategies'. Statutory guidance on JSNAs and JLHWSs currently remains unchanged.

The new guidance emphasises the role of HWBs which "remain a formal statutory committee of the local authority, and will continue to provide a forum where political, clinical, professional and community leaders from across the health and care system come together to improve the health and wellbeing of their local population and reduce health inequalities".

Statutory Functions

The statutory functions of HWBs include:

- Producing and publishing a Joint Strategic Needs Assessment (JSNA).
- Producing and publishing a Joint Local Health & Wellbeing Strategy (JLHWS).
- Producing and publishing a Pharmaceutical Needs Assessment (PNA).
- Responsibility for signing-off the Better Care Fund plan for the local area and providing governance for the pooled fund.

HWBs should also be involved in the production of Joint Forward Plans, known locally as the Shared Delivery Plan (SDP). The guidance lists the following involvement of the HWB:

Joint forward plans (replacing CCG commissioning plans)

Before the start of each financial year, an ICB, with its partner NHS trusts and NHS foundation trusts, must prepare a 5-year joint forward plan, to be refreshed each year. ICBs must involve HWBs as follows:

- Joint forward plans for the ICB and its partner NHS trusts and NHS foundation trusts must set out any steps that the ICB proposes to take to implement any JLHWS.

- ICBs and their partner NHS trusts and NHS foundation trusts must involve each relevant HWB in preparing or revising their forward plans.
- In particular, the HWB must be provided with a draft of the forward plan, and the ICB must consult with the HWB on whether the draft takes proper account of each relevant JLHWS.
- Following consultation, any HWB within the ICB's area has the right to respond to the ICB and may give its opinion to NHS England.
- Within the ICB's forward plan, it must include a statement from the HWB as to whether the JLHWS has been taken proper account of within the forward plan.
- With the establishment of ICBs and the abolishment of CCGs, the former requirement for CCGs to share their commissioning plans with HWBs has been removed.

ICB Annual reports
ICBs are required as part of their annual reports to review any steps they have taken to implement any JLHWS to which they are required to have regard. In preparing this review, the ICB must consult each relevant HWB.

ICB Performance assessments
In undertaking its annual performance assessment of an ICB, NHS England must include an assessment of how well the ICB has met the duty to have regard to the relevant JSNAs and JLHWSs within its area. In conducting the performance assessment, NHS England must consult each relevant HWB for their views on the ICB's contribution to the delivery of any JLHWS to which it was required to have regard.

Other annual reports and regular reports
The HWB should receive the following annual reports and reports:

- Director of Public Health annual report
- Safeguarding Adults Board (SAB) Annual Report
- East Sussex Safeguarding Children Partnership (ESSCP) Annual Report
- Sussex learning from lives and deaths – People with a learning disability and autistic people (LeDeR) annual report
- Healthwatch Annual Report
- An annual update on the JSNA
- East Sussex Health and Social Care Shared Delivery Plan (SDP) Programme - update report (at each meeting)
- Any significant changes to Pharmacy provision and agreement of any action that needs to be taken.

Relationship with local democratic scrutiny processes for health and social care

Scrutiny is carried out by elected County Councillors who understand and promote the concerns of the local residents who elected them, in a process that looks to connect decision makers to local residents. The HWB does not hold commissioning budgets and is not a mechanism for local democratic scrutiny of health and social care services. In East Sussex the role of the East Sussex County Council Health Overview and Scrutiny Committee (HOSC) is to look at the work of local NHS organisations by acting as a 'critical friend' suggesting ways that health related services might be improved through commissioning and delivery.

HOSC also looks at the way the health service interacts with our social care services, the voluntary sector, independent providers and other council services to jointly provide better health services to meet the diverse needs of East Sussex residents and improve their wellbeing.

The East Sussex County Council People Scrutiny Committee looks specifically at the commissioning and delivery of County Council social care services for children and young people and adults of all ages, and the full range of other services across children, young people and adults of all ages. There is a specific People Scrutiny Reference Group: Health and Social Care Integration Programme which looks at the County Council's work on health and care integration, currently set out in the Shared Delivery Plan.

Appendix 3

Draft: suggested informal HWB Strategy sessions timetable

Suggested date (3-4 weeks prior to the HWB meeting)	**Informal HWB strategy session** • Face-to-face session, no longer than 3 hours • Rotating venues on the east and west of the county to enable all HWB members to attend	**Statutory deadline for publication of HWB papers**	**HWB formal meeting date**	**Suggested partnership leadership group (examples)**
		8 July 2024	Tuesday 16 July 2024 • Present the suggested approach for agreement • Endorse Shared Delivery Plan (SDP) refresh Year 2 (2024/25)	
Thursday 5 September 2024	**Scene-setting session** • Priority JSNA themes • Shared delivery plan priorities: prevention, early intervention and proactive care • Integrated Community Teams: the opportunity • East Sussex HWB Shared Outcomes Framework measuring impacts	18 September 2024	Thursday 26 September 2024 • Forward plan agenda • Review of workshop outcomes	• East Sussex Health and Care Partnership Board • East Sussex Community Oversight Board
Thursday 14 November 2024	**Improving Healthy Life Expectancy** Extending years in good health by enabling healthy behaviours and reducing risk and impact of chronic disease and ill-health.	2 December 2024	Tuesday 10 December 2024 • Forward plan agenda • Review of workshop outcomes	• East Sussex Health Outcomes Improvement Oversight Board • East Sussex Healthy Weight partnership • East Sussex Tobacco Control Partnership • East Sussex Reducing Alcohol Dependency Partnership
Thursday 6 February 2025	**Building blocks of good health** – Decent Home, Education and Employment alongside Good Social Connections and Community.	24 February 2025	Tuesday 4 March 2025 • Forward plan agenda	• Team East Sussex • Skills East Sussex • East Sussex Housing Partnership Board

			• Review of workshop outcomes	• East Sussex Loneliness and Social Isolation Stewardship Group • *Local Strategic Partnerships and Town Boards?*
Annual Shared Delivery Plan Refresh (Year 3: 2025/26)				
Thursday 19 June 2025	**Importance of the Life course approach** – Good Start in Life, Living Well, Ageing Well, A Good End in Life	7 July 2025	Tuesday 15 July 2025 • Forward plan agenda • Review of workshop outcomes • Endorse SDP Year 3 refresh (2025/26)	• Early Intervention Partnership Board • Children and Young People's Oversight Board • Mental Health Oversight Board • Health Outcomes Improvement Oversight Board • Community Oversight Board
East Sussex HWB Shared Outcomes Framework: annual review				
Thursday 4 September 2025	• **Reducing Health Inequalities** – Underpinning everything we do. Gaps are always changing and not always in the direction we want them to • **Annual review:** East Sussex HWB Shared Outcomes Framework measures	15 September 2025	Tuesday 23 September 2025 • Forward plan agenda • Review of workshop outcomes	• East Sussex Health Outcomes Improvement Oversight Board
Thursday 13 November 2025	**Mental Health and Wellbeing** - focusing on prevention and early support.	1 December 2025	Tuesday 9 December 2025 • Forward plan agenda • Review of workshop outcomes	• Mental Health Oversight Board • Health Outcomes Improvement Oversight Board
Thursday 12 February	**HWB strategy refresh approach -** reviewing outputs and progress from the previous five sessions, and agreeing the broad structure to refresh the Strategy	2 March 2026	Tuesday 10 March 2026 • Forward plan agenda • Review of workshop outcomes	• East Sussex Health and Care Partnership Board
Annual Shared Delivery Plan Refresh (Year 4: 2026/27)				
			Further meeting dates to be confirmed	

Report to: **East Sussex Health and Wellbeing Board (HWB)**

Date: **16th July 2024**

By: **Director of Adult Social Care and Health**

Title: **Better Care Fund Plans 2024-25**

Purpose of Report: **To provide a summary of the Better Care Fund (BCF) requirements for 2024 - 2025 and to seek approval of the East Sussex BCF plans.**

Recommendations:

The East Sussex Health and Wellbeing Board is recommended to:

1. **Note the Better Care Fund requirements for 2024-25.**
2. **Approve the East Sussex Better Care Fund Plans for 2024-25 recognising these represent an update on 2023-25 plans approved by the Board in June 2023.**

---

1 Background

1.1 Since 2014 the Better Care Fund (BCF) has provided a mechanism for joint health, housing and social care planning and commissioning, focusing on personalised, integrated approaches to health and care that support people to remain independent at home or to return to independence after an episode in hospital. It brings together ring-fenced budgets from NHS Integrated Care Board (ICB) allocations, and funding paid directly to Local Government, including the Disabled Facilities Grant (DFG) and the improved Better Care Fund (iBCF).

1.2 The continuation of national conditions and requirements of the BCF in recent years has provided opportunities for health and care partners to build on their plans to embed joint working and integrated care further. This includes working collaboratively to bring together funding streams and maximise the impact on outcomes for communities whilst sustaining vital community provision.

1.3 Since last year, the Additional Discharge Funding to enhance community and social care capacity is also required to be included in the BCF pooled budget arrangements.

1.4 Following approval by the Board in June 2023, East Sussex's two-year BCF plans were nationally assured and approved for 2023-25. A copy of the East Sussex HWB Better Care Fund Narrative Plan 2023-2025 is contained in appendix 2 of the report.

2 National BCF Planning Guidance and Requirements for 2024-25

2.1 The Addendum to the BCF 2023-25 Policy Framework was published on 28th March 2024. This provided a refreshed planning template to update on income, expenditure,

setting outputs and new metric targets, capacity, and demand planning for 2024-25 alongside updated narrative to provide assurance of meeting the national conditions for the year ahead. A copy of the Better Care Fund 2024-25 update template is contained in appendix 1 of the report.

2.2 The Addendum also confirms the overarching approach to, and the funding conditions for the Discharge Fund for 2024 to 2025 to which expenditure is to be outlined within the plan and monitored quarterly.

2.3 Further information relating to the Addendum can be found on the external web link below.

Addendum to the 2023 to 2025 Better Care Fund policy framework and planning requirements - GOV.UK (www.gov.uk)

3 East Sussex updated Better Care Plans 2024-25

3.1 The contributions to the BCF Pooled budget for 2024-25 are outlined below.

Funding Source	**Lead Org**	**2024/25 Contributions**
NHS Minimum Contribution	NHS Sussex ICB	£52,426,847
Carers	ESCC	£694,000
Disabled Facilities Grant	ESCC	£8,860,833
Improved Better Care Fund	ESCC	£21,776,611
Discharge Funding	ESCC	£5,088,412
Discharge Funding	NHS Sussex ICB	£5,024,117
Total BCF Resources		**£93,870,820**

3.2 The NHS minimum contribution has risen by 5.66% for 2024/25 as in previous years.

3.3 The additional Discharge funding for 2024-25 has been allocated to Local Authorities (LAs) and the ICB to be included in the BCF. The ICB is required to agree with local Health and Wellbeing Boards how the ICB element of Discharge funding will be allocated at HWB level rather than being set as part of overall BCF allocations, this being based on allocations proportionate to local area need.

3.4 Improved Better Care Fund (iBCF) and Disabled Facilities Grant (DFG) conditions remain as previous years and the allocations for 2024-25 remain at the 2023-24 rate for these plans.

3.5 Adult Social Care contribution and NHS commissioned out of Hospital services ringfences have increased in line with the overall increase i.e., 5.66%.

3.6 Many of the schemes and services previously funded through the Better Care Fund have continued into this year.

3.7 Modelling of the Capacity and Demand on community services to support avoidance of admission to and reduction in length of stay in bedded care have been reviewed for 2024-25. It is anticipated a further review of this will be required in October.

3.8 Metrics targets for 2024-25 have been reviewed for the following measures:

Metric	Detail
Avoidable admissions	Unplanned Admissions for chronic ambulatory care sensitive conditions (NHS OF 2.3i)
Falls Admissions	Emergency hospital admissions due to falls in people over 65
Residential care admissions	Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes. (ASCOF 2A part 2)
Discharge destination	Percentage of discharges to a person's usual place of residence (SUS data)

There is one measure which is has been removed from BCF reporting for 2024-25.

Effectiveness of reablement	People over 65 still at home 91 days after discharge from hospital with reablement (ASCOF 2B part 1)

4 Assurance Timetable

4.1 Following submission of our plans on 10th June and pending approval by the Board, a proportionate regional assurance process is being undertaken to approve updates to plans for 2024 to 2025.

Assurance milestone	**Date**
Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation	10 June 2024 to 15 July 2024

Regionally moderated assurance outcomes sent to BCF team	15 July 2024
Cross-regional calibration	Mid-July 2024 (date to be confirmed)
Commence issuing of approvals letters giving formal permission to spend (NHS minimum)	31 July 2024
All section 75 agreements to be signed and in place	30 September 2024

5 Conclusion and reasons for recommendations

5.1 This paper summarises the Better Care Fund requirements for this year and sets out the East Sussex revised plans for 2024-25 (appendix 1) confirming their alignment with the national conditions.

5.2 The Health and Wellbeing Board is asked to:

1. Note the Better Care Fund requirements for 2024-25.

2. Approve the East Sussex Better Care Fund Plans for 2024-25 recognising these represent an update on 2023-25 plans approved by the Board in June 2023.

MARK STAINTON
Director of Adult Social Care and Health
East Sussex County Council

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Sally Reed, Joint Commissioning Manager
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Appendix 1: East Sussex HWB Better Care Fund Planning Template 2024-2025.
Appendix 2: East Sussex HWB Better Care Fund Narrative Plan 2023-2025.

HM Government

NHS England

Better Care Fund 2024-25 Update Template

2. Cover

Version 1.3.0

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	East Sussex	
Completed by:	Sally Reed	
E-mail:	sally.reed@eastsussex.gov.uk	
Contact number:	01273 481912	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no please indicate when the HWB is expected to sign off the plan:	Tue 16/07/2024	<< Please enter using the format, DD/MM/YYYY

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Keith	Glazier	cllr.keith.glazier@eastsussex.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Hannah Claudia	Hamilton Griffith	hannah.hamilton2@nhs.net claudia.griffiths@nhs.net
	Additional ICB(s) contacts if relevant		Ashley	Scarff	ashley.scarff@nhs.net
	Local Authority Chief Executive		Becky	Shaw	becky.shaw@eastsussex.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Mark	Stainton	mark.stainton@eastsussex.gov.uk
	Better Care Fund Lead Official		Sally	Reed	sally.reed@eastsussex.gov.uk
	LA Section 151 Officer		Ian	Gutsell	ian.gutsell@eastsussex.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4.2 C&D Hospital Discharge	Yes
4.3 C&D Community	Yes
5. Income	Yes
6a. Expenditure	No
7. Narrative updates	Yes
8. Metrics	Yes
9. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2024-25 Update Template

3. Summary

Selected Health and Wellbeing Board: East Sussex

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£8,860,833	£8,860,833	£0
Minimum NHS Contribution	£52,426,847	£52,426,847	£0
iBCF	£21,776,611	£21,776,611	£0
Additional LA Contribution	£694,000	£694,000	£0
Additional ICB Contribution	£0	£0	£0
Local Authority Discharge Funding	£5,088,412	£5,088,412	£0
ICB Discharge Funding	£5,024,117	£5,024,117	£0
Total	**£93,870,820**	**£93,870,820**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	2024-25
Minimum required spend	£14,898,223
Planned spend	£20,860,699

Adult Social Care services spend from the minimum ICB allocations

	2024-25
Minimum required spend	£26,092,688
Planned spend	£26,098,655

Metrics >>

Avoidable admissions

	2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	182.1	180.7	179.3	178.0

Falls

		2023-24 estimated	2024-25 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,421.8	2,313.1
	Count	3720	3657
	Population	143415	147175

Discharge to normal place of residence

	2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	93.0%	93.5%	93.5%	93.5%

Residential Admissions

		2022-23 Actual	2024-25 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	489	348

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	0
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	0
NC4: Implementing the BCF policy objectives	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

Better Care Fund 2024-25 Update Template

4. Capacity & Demand

Selected Health and Wellbeing Board: East Sussex

Hospital Discharge

Capacity - Demand (positive is Surplus)	Capacity surplus. Not including spot purchasing												Capacity surplus (including spot puchasing)											
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Reablement & Rehabilitation at home (pathway 1)	99	50	60	66	48	61	43	50	32	26	73	52	99	50	60	66	48	61	43	50	32	26	73	52
Short term domiciliary care (pathway 1)	-103	-121	-118	-114	-124	-118	-124	-123	-128	-131	-112	-120	-14	-32	-29	13	3	9	3	4	-1	-4	15	7
Reablement & Rehabilitation in a bedded setting (pathway 2)	15	-14	-15	13	9	-3	8	2	7	8	27	-21	16	-12	-14	15	11	-2	10	4	9	10	28	-19
Other short term bedded care (pathway 2)	-59	-65	-61	-33	-33	-41	-53	-47	-36	-32	-28	-50	-48	-54	-50	-28	-28	-36	-48	-42	-31	-27	-23	-45
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Average LoS/Contact Hours per episode of care	
Full Year	Units
23	Contact Hours per package
78	Contact Hours per package
25	Average LoS (days)
28	Average LoS (days)
0	Average LoS (days)

Please briefly describe the support you are providing to people for less complex discharges that do not require formal reablement or rehabilitation – e.g. social support from the voluntary sector, blitz cleans. You should also include an estimate of the number of people who will receive this type of service during the year.

Between 650 and 700 less complex patient per month (8,000 per year) will be supported through our expanded Urgent Community Response service (70%) and a range of voluntary services (30%) including 'take and home and settle' and 'carer support' services primarily provided by the Bristish Red Cross and the provision of a limited number of Personal Health Grants providing practical support to facilitate a patients return home.

Capacity - Hospital Discharge

Service Area	Metric	Refreshed planned capacity (not including spot purchased capacity												Capacity that you expect to secure through spot purchasing											
		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new packages commenced.	407	407	407	407	407	407	407	407	407	407	407	407	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home (pathway 1)	Estimated average time from referral to commencement of service (days). All packages (planned and spot purchased)	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8												
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	89	89	89	127	127	127	127	127	127	127	127	127
Short term domiciliary care (pathway 1)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8												
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new packages commenced.	133	133	133	133	133	133	133	133	133	133	133	133	1	2	1	2	2	1	2	2	2	2	1	2
Reablement & Rehabilitation in a bedded setting (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7												
Other short term bedded care (pathway 2)	Monthly capacity. Number of new packages commenced.	57	57	57	42	42	42	42	42	52	52	52	42	11	11	11	5	5	5	5	5	5	5	5	5
Other short term bedded care (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	37.6	37.6	37.6	37.6	37.6	37.6	37.6	37.6	37.6	37.6	37.6	37.6												
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0	0	0	0	0	0	0												

Demand - Hospital Discharge

Please enter refreshed expected no. of referrals:

Pathway	Trust Referral Source	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Total Expected Discharges:	Total Discharges	**4288**	**4657**	**4739**	**4549**	**4721**	**4604**	**4501**	**4616**	**4588**	**4875**	**4315**	**4717**
Reablement & Rehabilitation at home (pathway 1)	Total	**308**	**357**	**347**	**341**	**359**	**346**	**364**	**357**	**375**	**381**	**334**	**355**
	EAST SUSSEX HEALTHCARE NHS TRUST	170	202	196	193	205	197	209	205	217	220	192	202
	QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	1	1	1	1	1	1	1	1	1	1	1	1
	SURREY AND SUSSEX HEALTHCARE NHS TRUST	3	3	3	3	3	3	3	3	3	3	3	3
	UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST	56	67	65	61	65	63	66	65	68	70	60	64
	OTHER	78	84	82	83	85	82	85	83	86	87	78	85
Short term domiciliary care (pathway 1)	Total	**103**	**121**	**118**	**114**	**124**	**118**	**124**	**123**	**128**	**131**	**112**	**120**
	EAST SUSSEX HEALTHCARE NHS TRUST	70	82	80	78	84	81	85	84	88	90	78	82
	QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0
	SURREY AND SUSSEX HEALTHCARE NHS TRUST	1	2	2	1	2	1	2	2	1	1	1	2
	UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST	23	27	26	25	27	26	27	26	28	29	24	26
	OTHER	9	10	10	10	11	10	10	11	11	11	9	10
Reablement & Rehabilitation in a bedded setting (pathway 2)	Total	**118**	**147**	**148**	**120**	**124**	**136**	**125**	**131**	**126**	**125**	**106**	**154**
	EAST SUSSEX HEALTHCARE NHS TRUST	75	93	94	76	78	86	79	83	80	79	68	98
	QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0
	SURREY AND SUSSEX HEALTHCARE NHS TRUST	2	2	2	2	2	2	2	2	2	2	1	2
	UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST	32	40	40	33	34	37	34	36	34	34	29	42
	OTHER	9	12	12	9	10	11	10	10	10	10	8	12
Other short term bedded care (pathway 2)	Total	**116**	**122**	**118**	**75**	**75**	**83**	**95**	**89**	**88**	**84**	**80**	**92**
	EAST SUSSEX HEALTHCARE NHS TRUST	87	92	89	56	56	62	71	67	66	63	60	69
	QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0
	SURREY AND SUSSEX HEALTHCARE NHS TRUST	1	1	1	1	1	1	1	1	1	1	1	1
	UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST	17	18	17	11	11	12	14	13	13	12	12	13
	OTHER	11	11	11	7	7	8	9	8	8	8	7	9
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	EAST SUSSEX HEALTHCARE NHS TRUST	0	0	0	0	0	0	0	0	0	0	0	0
	QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0
	SURREY AND SUSSEX HEALTHCARE NHS TRUST	0	0	0	0	0	0	0	0	0	0	0	0
	UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0
	OTHER	0	0	0	0	0	0	0	0	0	0	0	0

Better Care Fund 2024-25 Update Template

4. Capacity & Demand

Selected Health and Wellbeing Board: East Sussex

Community — **Refreshed capacity surplus:**

Capacity - Demand (positive is Surplus)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting	-4	-4	-4	-4	-4	-4	-4	-4	-4	-4	-4	-4
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

Average LoS/Contact Hours

Full Year	Units
10	Contact Hours
10	Contact Hours
23	Contact Hours
21	Average LoS
0	Contact Hours

Please enter refreshed expected capacity:

Capacity - Community													
Service Area	Metric	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Social support (including VCS)	Monthly capacity. Number of new clients.	17	17	17	17	17	17	17	17	17	17	17	17
Urgent Community Response	Monthly capacity. Number of new clients.	1530	1530	1530	1530	1530	1530	1530	1530	1530	1530	1530	1530
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	755	755	755	755	755	755	755	755	755	755	755	755
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	15	15	15	15	15	15	15	15	15	15	15	15
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0

Please enter refreshed expected no. of referrals:

Demand - Community	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Service Type												
Social support (including VCS)	17	17	17	17	17	17	17	17	17	17	17	17
Urgent Community Response	1530	1530	1530	1530	1530	1530	1530	1530	1530	1530	1530	1530
Reablement & Rehabilitation at home	755	755	755	755	755	755	755	755	755	755	755	755
Reablement & Rehabilitation in a bedded setting	19	19	19	19	19	19	19	19	19	19	19	19
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

Better Care Fund 2024-25 Update Template

5. Income

Selected Health and Wellbeing Board: East Sussex

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
East Sussex	£8,860,833
DFG breakdown for two-tier areas only (where applicable)	
Eastbourne	£1,914,512
Hastings	£2,243,297
Lewes	£1,337,135
Rother	£2,012,223
Wealden	£1,353,666
Total Minimum LA Contribution (exc iBCF)	**£8,860,833**

Local Authority Discharge Funding	Contribution
East Sussex	£5,088,412

ICB Discharge Funding	Previously entered	Updated	Comments - Please use this box to clarify any specific uses or sources of funding
NHS Sussex ICB	£5,024,117	£5,024,117	
Total ICB Discharge Fund Contribution	£5,024,117	£5,024,117	

iBCF Contribution	Contribution
East Sussex	£21,776,611
Total iBCF Contribution	**£21,776,611**

Local Authority Additional Contribution	Previously entered	Updated	Comments - Please use this box to clarify any specific uses or sources of funding
East Sussex	£694,000	£694,000	
Total Additional Local Authority Contribution	**£694,000**	**£694,000**	

NHS Minimum Contribution	Contribution
NHS Sussex ICB	£52,426,847
Total NHS Minimum Contribution	**£52,426,847**

Additional ICB Contribution	Previously entered	Updated	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	**£0**	
Total NHS Contribution	**£52,426,847**	**£52,426,847**	

	2024-25
Total BCF Pooled Budget	**£93,870,820**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2024-25 Update Template

6. Expenditure

To Add New Schemes

Selected Health and Wellbeing Board: East Sussex

<< Link to summary sheet

Running Balances	2024-25 Income	Expenditure	Balance
DFG	£8,860,833	£8,860,833	£0
Minimum NHS Contribution	£52,426,847	£52,426,847	£0
iBCF	£21,776,611	£21,776,611	£0
Additional LA Contribution	£694,000	£694,000	£0
Additional NHS Contribution	£0	£0	£0
Local Authority Discharge Funding	£5,088,412	£5,088,412	£0
ICB Discharge Funding	£5,024,117	£5,024,117	£0
Total	**£93,870,820**	**£93,870,820**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2024-25 Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£14,898,223	£20,860,699	£0
Adult Social Care services spend from the minimum ICB allocations	£26,092,688	£26,098,655	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

>> Incomplete fields on row number(s):

298, 299, 300, 301, 302, 303, 304

									Planned Expenditure											
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Previously entered Outputs for 2024-25**	Updated Outputs for 2024-25	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Previously entered Expenditure for 2024-25	Updated Expenditure for 2024-25 (£)	% of Overall Spend (Average)
1	Protecting ASC services which benefit health	A range of social care services which benefit health	Community Based Schemes	Integrated neighbourhood services			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£6,936,579	£7,423,000	9%
2	Protecting ASC services which support hosptial	A range of social care services to support hospital discharge	Community Based Schemes	Integrated neighbourhood services			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£5,386,547	£5,764,000	7%
3	Protecting ASC services in line with iBCF criteria	A range of social care services to meet iBCF criteria	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	iBCF	Existing	£21,776,611		27%
4	Milton Grange - Community Bed Based	ESCC provision of Intermediate Care beds in Eastbourne	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step		149	148	Number of placements	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,683,500	£1,734,500	47%
4	Milton Grange - Community Bed Based	ESCC provision of Intermediate Care beds in Eastbourne	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step		149	148	Number of placements	Community Health		LA			Local Authority	Minimum NHS Contribution	Existing	£1,683,500	£1,734,500	47%
5	Community Bed Based Intermediate Care	Funding towards Independent Sector Commissioned Intermediate	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		10	9	Number of placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£89,000	£95,000	3%
5	Community Bed Based Intermediate Care	Funding towards Independent Sector Commissioned Intermediate	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		10	9	Number of placements	Community Health		LA			Private Sector	Minimum NHS Contribution	Existing	£89,000	£95,000	3%
6	Joint Community Rehabilitation Services	Funding to support provision of 7 day service	Home-based intermediate care services	Joint reablement and rehabilitation service (accepting step up and step		77	0	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£433,500	£0	0%
6	Joint Community Rehabilitation Services	Funding to support provision of 7 day service	Home-based intermediate care services	Joint reablement and rehabilitation service (accepting step up and step		155	0	Packages	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£433,500	£0	0%
7	Carers Servcies	A range of carers support services commissioned by ESCC.	Carers Services	Respite services		6586	0	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£1,982,153	£0	0%
7	Carers Services	A range of carers support services commissioned by ESCC.	Carers Services	Respite services		61	0	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£22,000	£0	0%

7	Carers Services	A range of carers support services commissioned by ESCC.	Carers Services	Respite services		10	0	Beneficiaries	Community Health		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£4,000	£0	0%
8	Carers Services	A range of carers support services commissioned by ESCC.	Carers Services	Carer advice and support related to Care Act duties		13344	0	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£1,463,355	£0	0%
8	Carers Services	A range of carers support services commissioned by ESCC.	Carers Services	Carer advice and support related to Care Act duties		2671	0	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£672,000	£0	0%
9	Disabled Facilities Grant	DFG and housing support services	DFG Related Schemes	Adaptations, including statutory DFG grants		1367	253	Number of adaptations funded/people	Other	Adaptations, including statutory DFG	LA			Local Authority	DFG	Existing	£4,061,806	£6,645,625	75%
10	Disabled Facilities Grant	DFG and housing support services	DFG Related Schemes	Discretionary use of DFG		600	59	Number of adaptations funded/people	Other	Discretionary use of DFG	LA			Local Authority	DFG	Existing	£4,061,806	£2,215,208	25%
12	Carers Services	Carers commissioning team	Carers Services	Other	Carers commissioning team	0	0	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£175,100	£0	0%
13	Care Act Implementation	Care Act Duties, including info/advice, safeguarding, advocacy and reviewing.	Care Act Implementation Related Duties	Other	Care Act Duties, including info/advice,		0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,617,000	£1,680,000	92%
14	Frailty	Multi-discplinary frailty services in HWLH area	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£491,000		3%
15	Diabetes	Diabetes Support in HWLH area	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£1,216,000		8%
16	Lewes UTC	Ad Av pathways	Urgent Community Response						Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£474,000		100%
17	Intermediate Care Services	Joint Community Rehab servcies in HWLH area	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		4414	4221	Packages	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£888,000	£888,000	46%
18	IAPT	Access to Psycholgical Therapies in HWLH	Prevention / Early Intervention	Other	Psycholgical Therapies in HWLH				Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution	Existing	£352,000		6%
19	Enhanced Health in Care Homes	Enhanced Health in Care Homes	Personalised Care at Home	Other	Physical health and mental health well-being				Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£1,188,000		8%
20	Enhanced HIT - scheme continuing	Addtional ASC capacity to cover extended hours	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning			0		Social Care		NHS			Local Authority	Minimum NHS Contribution	Existing	£205,000	£211,000	29%
21	SCT Medicines Optimisation in Care Homes	Medicines Optimisation in Care Homes	Other				0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£529,000	£0	0%
22	ESHT Community Programme	Additional community services including crisis response, frailty	Community Based Schemes	Integrated neighbourhood services			0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£7,809,000	£8,086,000	10%
23	HSCC Overnight Service	Funding for HSCC cover 22.00-08.00hrs	Enablers for Integration	Integrated models of provision			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£132,500	£153,000	6%
23	HSCC Overnight Service	Funding for HSCC cover 22.00-08.00hrs	Enablers for Integration	Integrated models of provision			0		Community Health		NHS			Local Authority	Minimum NHS Contribution	Existing	£132,500	£153,000	6%
24	Consultant pharmacist in diabetes	Consultant pharmacist in diabetes	Other						Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£76,000		3%
25	Dieticians in Meds Management team (2)	Dieticians in Meds Management team (2)	Other						Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£95,000		4%
26	Medicines Optimisation in LD Care Homes	Medicines Optimisation in Care Homes	Other				0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£98,000	£0	0%
27	Home First Pathway 3	D2A beds	Residential Placements	Short-term residential/nursing care for someone likely to require a			7	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£2,132,329	£588,500	1%
27	Home First Pathway 3	D2A beds	Residential Placements	Short-term residential/nursing care for someone likely to require a			7	Number of beds	Community Health		LA			Private Sector	Minimum NHS Contribution	Existing	£2,132,328	£588,500	1%
28	Staff - Programme and Project support	A range of joint posts	Other				0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£786,721	£354,000	33%

28	Staff - Programme and Project support	A range of joint posts	Other				0		Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£277,475	£292,500	12%
29	Health and Social Care Connect	Funding for health hub within HSCC (Single Point of Access)	Enablers for Integration	Integrated models of provision			0		Community Health		NHS			Local Authority	Minimum NHS Contribution	Existing	£630,000	£844,000	29%
30	High Intensity User Service	High Intensity Users - case management	Personalised Care at Home	Mental health /wellbeing					Community Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution	Existing	£181,000		1%
31	ICES Pooled Budget	NHS contribution to Community Equipment Pooled budget	Assistive Technologies and Equipment	Community based equipment		129142	0	Number of beneficiaries	Community Health		LA			Private Sector	Minimum NHS Contribution	Existing	£2,900,000	£0	0%
32	VCSE services	NHS contibution to VCSE services commissioned by ESCC.	Prevention / Early Intervention	Other	A range of services provided by VCSE		0		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£1,892,084	£349,000	33%
32	VCS services	NHS contribution to VCS services commissioned by ESCC.	Prevention / Early Intervention	Other	A range of services provided by VCSE		0		Community Health		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£946,042	£349,000	16%
32	VCS servcies	NHS contribution to VCS services commissioned by ESCC.	Prevention / Early Intervention	Other	A range of services provided by VCSE		0		Mental Health		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£946,042	£0	0%
33	Healthy Hastings and Rother	VCSE services commissioned by NHS.	Prevention / Early Intervention	Other	A range of services provided by VCSE		0		Community Health		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£862,817	£0	0%
34	Domiciliary care capacity	Additional investment in home care provision to support hospital discharge	Home Care or Domiciliary Care	Domiciliary care packages		42540	0	Hours of care (Unless short-term in which	Social Care		NHS			Private Sector	Minimum NHS Contribution	Existing	£1,418,000	£0	0%
35	Dementia Post Diagnostic Support Services:	Dementia Post Diagnostic Support Services	Prevention / Early Intervention	Other	Dementia Post Diagnostic Support Services		0		Mental Health		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£784,000	£1,092,000	14%
36	BCF Reserve	Contingency for service pressures	Other				0		Social Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	New	£123,997	£0	0%
37	BCF Reserve	Pending uplift and application agreements	Other				0		Community Health		NHS			NHS	Minimum NHS Contribution	New	£751,278	£458,195	16%
38	Domiciliary Home care capacity	Additional investment in home care provision to support hospital discharge	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		87108	161494	Hours of care (Unless short-term in which	Social Care		LA			Private Sector	Local Authority Discharge	New	£2,873,047	£3,541,484	16%
39	Weekend Discharge Team	Additional capacity to support hospial discharges at weekends	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Acute		NHS			NHS Acute Provider	ICB Discharge Funding	New	£342,408		48%
40	High Intensity Users/Mental Heath Discharge	Discharge Co-ordination	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge			0		Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding	New	£170,004	£148,152	24%
41	Additional ASC assessment	Additional ASC assessment capacity	Workforce recruitment and retention				0	WTE's gained	Social Care		LA			Local Authority	Local Authority Discharge	New	£500,000	£0	0%
42	Personal Health Grants	Small grants issued to support hospital discharge	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess			0		Social Care		NHS			Charity / Voluntary Sector	ICB Discharge Funding	New	£62,400	£64,400	1000%
43	Additional D2A Beds	Additional D2A Beds	Residential Placements	Short-term residential/nursing care for someone likely to require a			31	Number of beds	Social Care		NHS			Private Sector	ICB Discharge Funding	New	£3,439,836	£1,966,757	2%
44	Assisted Discharge Home - BRC	Home from Hospital support form the British Red Cross	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess			0		Social Care		LA			Charity / Voluntary Sector	ICB Discharge Funding	New	£171,516	£125,256	2500%
45	Domiciliary Home care capacity	Additional investment in home care provision to support hospital discharge	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		922	0	Hours of care (Unless short-term in which	Social Care		LA			Private Sector	ICB Discharge Funding	New	£837,953	£0	0%
46	Block beds for clients with complex care	Block beds for clients with complex care needs	Residential Placements	Short-term residential/nursing care for someone likely to require a			0	Number of beds	Social Care		LA			Private Sector	Local Authority Discharge	New	£1,040,000	£0	1%
47	OT in-reach to D2A beds	OT in-reach to D2A beds	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as			0		Social Care		LA			Local Authority	Local Authority Discharge	New	£655,011	£187,500	100%

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Adding New Schemes:

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'		Outputs for 2024-25	Units (auto-populate)	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner) (auto-populate)	Provider	Source of Funding	New/ Existing Scheme		Expenditure for 2024-25 (£)	% of Overall Spend
48	Carers Services - Independent Sector Respite	A range of carers support services commissioned by ESCC.	Carers Services	Respite services			626	Beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing		£1,873,000	100%
49	Carers Services - Contracts	A range of carers support services commissioned by ESCC.	Carers Services	Carer advice and support related to Care Act duties			11312	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing		£694,000	32%
48	Carers Services - Staffing	A range of carers support services commissioned by ESCC.	Carers Services	Other	Staff		0	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing		£45,000	85%
48	Carers Services - Staffing	A range of carers support services commissioned by ESCC.	Carers Services	Other	Staff		0	Beneficiaries	Community Health		LA			Local Authority	Minimum NHS Contribution	Existing		£135,000	15%
48	Carers Services - Contracts	A range of carers support services commissioned by ESCC.	Carers Services	Carer advice and support related to Care Act duties			5827	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing		£552,500	25%
48	Carers Services - Contracts	A range of carers support services commissioned by ESCC.	Carers Services	Carer advice and support related to Care Act duties			1027	Beneficiaries	Community Health		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing		£97,500	5%
48	Carers Services - Carers Personal Budgets	A range of carers support services commissioned by ESCC.	Carers Services	Carer advice and support related to Care Act duties			1732	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing		£678,300	32%
48	Carers Services - Carers Personal Budgets	A range of carers support services commissioned by ESCC.	Carers Services	Carer advice and support related to Care Act duties			306	Beneficiaries	Community Health		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing		£119,700	6%
21	Medicines Optimisation in Care Homes	Medicines Optimisation in Care Homes	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing		£627,000	100%
28	Staff - Programme and Project support	A range of joint posts	Enablers for Integration	Joint commissioning infrastructure					Community Health		LA			Local Authority	Minimum NHS Contribution	Existing		£421,500	100%
31	ICES Pooled Budget	NHS contribution to Community Equipment Pooled budget	Assistive Technologies and Equipment	Community based equipment			60108	Number of beneficiaries	Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing		£3,045,000	50%
32	Mental Health VCSE services	NHS contibution to VCSE services commissioned by ESCC.	Prevention / Early Intervention	Other	A range of services provided by VCSE				Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing		£989,200	33%
32	Mental Health VCSE services	NHS contibution to VCSE services commissioned by ESCC.	Prevention / Early Intervention	Other	A range of services provided by VCSE				Mental Health		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing		£1,483,800	50%
32	Mental Health VCSE services	NHS contibution to VCSE services commissioned by ESCC.	Prevention / Early Intervention	Other	A range of services provided by VCSE				Social Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing		£204,220	7%
32	Mental Health VCSE services	NHS contibution to VCSE services commissioned by ESCC.	Prevention / Early Intervention	Other	A range of services provided by VCSE				Mental Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing		£306,329	10%
50	Lewes Foundry Project	Population Health Collaboration Pilot	Community Based Schemes	Integrated neighbourhood services					Social Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	New		£30,000	50%
50	Lewes Foundry Project	Population Health Collaboration Pilot	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	New		£30,000	50%
51	Transfer of Care Hub (TOCH)	Hospital Discharges	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		NHS			NHS Community Provider	Minimum NHS Contribution	New		£500,000	50%
51	Transfer of Care Hub (TOCH)	Hospital Discharges	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	New		£500,000	50%
33	Healthy Hastings and Rother	VCSE services commissioned by LA.	Prevention / Early Intervention	Other	A range of services provided by VCSE				Community Health		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing		£296,213	33%
33	Healthy Hastings and Rother	VCSE services commissioned by LA.	Prevention / Early Intervention	Other	A range of services provided by VCSE				Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing		£437,740	49%
33	Healthy Hastings and Rother	VCSE services commissioned by NHS.	Prevention / Early Intervention	Other	A range of services provided by VCSE				Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing		£150,955	17%
34	Domiciliary care capacity	Additional investment in home care provision to support hospital discharge	Home Care or Domiciliary Care	Domiciliary care packages			56057	Hours of care (Unless short-term in which	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing		£1,517,000	8%

36	BCF Reserve	Contingency for service pressures	Other		Contingency for service pressures				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing		£458,195	100%
6	Joint Community Rehabilitation Services	A range of additional staff to ensure 7 day cover	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing		£461,500	22%
6	Joint Community Rehabilitation Services	A range of additional staff to ensure 7 day cover	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing		£461,500	22%
41	Additional ASC assessment	Additional ASC assessment capacity	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Private Sector	Local Authority Discharge	Existing		£480,000	11%
52	JCR In-reach	Intermediate care in-reach to acute	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Local Authority Discharge	New		£120,000	100%
53	Tail/Transition Costs/MH Hub	Tail/Transition Costs/MH Hub	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Community Health		NHS			Private Sector	ICB Discharge Funding	New		£472,792	100%
54	HWLH UCR Medical Cover	HWLH UCR Medical Cover	Urgent Community Response						Community Health		NHS			NHS	ICB Discharge Funding	New		£313,571	100%
55	Contribution to PMO	Contribution to PMO	Enablers for Integration	Programme management					Community Health		NHS			NHS	ICB Discharge Funding	New		£120,000	33%
56	Discharge Transformation	Discharge Transformation	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Community Health		NHS			NHS	ICB Discharge Funding	New		£1,470,781	100%
57	Additional D2A beds	Additional D2A Beds	Residential Placements	Short-term residential/nursing care for someone likely to require a			9	Number of beds	Community Health		NHS			Private Sector	Local Authority Discharge	Existing		£759,428	19%

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.

12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care or Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed based intermediate Care Services	Number of placements
Home-based intermediate care services	Packages
Residential Placements	Number of beds
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2024-25 Update Template

7. Narrative updates

Selected Health and Wellbeing Board: East Sussex

Please set out answers to the questions below. No other narrative plans are required for 2024-25 BCF updates. Answers should be brief (no more than 250 words) and should address the questions and Key lines of enquiry clearly.

2024-25 capacity and demand plan

Please describe how you've taken analysis of 2023-24 capacity and demand actuals into account in setting your current assumptions.

Working in conjunction across the 3 Sussex places and in engagement with our discharge hub leads, we analysed the discharge pathways based on the latest available 2023/24 demand data, as influenced by the John Bolton Theoretical Optimal Model, to establish more accurate splits and update our capacity model in alignment with the ICB's operational planning submission.
Assumptions for 24/25 have been set based on the analysis of the 23/24 actuals. Summary of key points:
- There is variable access to Pathway 1 Home First Urgent Community Response (UCR) services due to geographical areas of challenge in respect of the availability of onward care capacity.
- The current processes for referral to Discharge to Assess (D2A) pathways are complex and there is a need to simplify the existing pathway.
- Assessment capacity to meet all demands including timely assessments to support discharge was a challenge over the winter period.
- Complex cases remain a key issue, where clients' clinical needs are high requiring specialist input from a range of professionals and services.
- The care market faces a continuing challenge to recruit and retain sufficient staff to meet demand both in the community and for hospital discharge.

Have there been any changes to commissioned intermediate care to address any gaps and issues identified in your C&D plan? What mitigations are in place to address any gaps in capacity?

Significant consideration has been given to the intermediate care requirements for 24/25 across all pathways within the East Sussex system. To address this, the Discharge Funding will be utilised to provide additional home and bed based care along with social support for those on pathway 0. These include:
- Home care: additional block hours to support hospital discharge.
- High Intensity Users/Mental Health Discharge Co-ordinators
- Additional Adult Social Care assessment capacity
- Personal Health Grants: small grants to support low level hospital discharges.
- Additional D2A Beds and therapy in-reach support
- Assisted Discharge Home: additional capacity for this service provided by the British Red Cross to support low level hospital discharges.

What impacts do you anticipate as a result of these changes for:

i. Preventing admissions to hospital or long term residential care?

The transformation programme, service redesign schemes and developments in East Sussex are significantly wider than those funded by the Better Care Fund however the BCF plans for 2023/25 seek to support people to stay well safe and independent at home for longer through:
1. Enhanced prevention, personalisation and reducing health inequalities.
2. Support for people with mental health needs by ensuring access to a full range of services.
3. Continue to integrate health and social care services and work with our Primary Care Networks to embed proactive anticipatory care, and seamless wrap around care to people with long term care needs and conditions and those in care homes.
4. Improving services that deliver planned care for local people including voluntary sector support for carers and people with mental health needs.

ii. Improving hospital discharges (preventing delays and ensuring people get the most appropriate support)?

A key priority for improving discharge continues to be the Home First (HF) pathway, ensuring as many people as possible are discharged home from a stay in an acute hospital or community bedded setting. HF underpins our delivery of a Discharge to Assess (D2A) approach, enabling people to come home as soon as they are medically ready, with support wrapped around them by joint Health and Social Care service. This will include:
- Implementing a strategic approach to our enhanced Discharge to Assess (D2A) services to improve outcomes for patients, including linking this to other services such as rehabilitation and reablement and pharmacy support.
- Reviewing the urgent community response model across acute, community health and social care. This will support people to avoid going into hospital where there is a better alternative service and enable them to get home quickly when they are ready to leave hospital.
- Identifying and implementing Trusted Assessor opportunities, for example NHS staff being able to commission simple social care packages and telecare.

Please explain how assumptions for intermediate care demand and required capacity have been developed between local authority, trusts and ICB and reflected in BCF and NHS capacity and demand plans.

East Sussex system partners have undertaken a significant amount of modelling to understand the demand and capacity for different parts of the system. Much of the data has been derived from tracking discharge hub activity and reviewing unmet community demand both within the NHS and local authority.
Demand Assumptions
- Underpinned by Trust Discharge Sitreps for four core providers, providing analysis by Pathway.
- Growth: net neutral
- Phased by month by days in month with limited adjustments for seasonal variation.
- Pan Sussex assessment that 2% of Pathway 0 activity requires Social Support
- A limited amount of Pathway 2 activity transferred to Pathway 1 – Domiciliary care – in line with pan Sussex agreed focus on 'Home First' and evidence from East Sussex service leads.

Have expected demand for admissions avoidance and discharge support in NHS UEC demand, capacity and flow plans, and expected demand for long term social care (domiciliary and residential) in Market Sustainability and Improvement Plans, been taken into account in you BCF plan?	**Yes**

Please explain how shared data across NHS UEC Demand capacity and flow has been used to understand demand and capacity for different types of intermediate care.

The hospital discharge demand estimate is derived using the Operational Planning submission for Sussex ICB with common assumptions regarding transformation of discharge pathways for example underpinning the modelling, and with engagement with discharge hub leads.

Approach to using Additional Discharge Funding to improve

Briefly describe how you are using Additional Discharge Funding to reduce discharge delays and improve outcomes for people.

Linked KLOEs (For information)

Checklist Complete:	
Yes	Does the HWB show that analysis of demand and capacity secured during 2023-24 has been considered when calculating their capacity and demand assumptions?
Yes	Does the plan describe any changes to commissioned intermediate care to address gaps and issues? Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the capacity needed for additional services?
Yes	Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service?
Yes	Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service?
Yes	Does the plan set out how demand and capacity assumptions have been agreed between local authority, trusts and ICB and reflected these changes in UEC activity templates and BCF capacity and demand plans?
Yes	
Yes	Has the area described how shared data has been used to understand demand and capacity for different types of intermediate care?

Significant consideration has been given to the intermediate care requirements for 24/25 across all pathways within the East Sussex system. To address this, the Discharge Funding will be utilised to provide additional home and bed based care along with social support for those on pathway 0. These include: • Home care: additional block hours to support hospital discharge. • Weekend Discharge Team: additional capacity to facilitate hospital discharge at weekends. • High Intensity Users/Mental Health Discharge Co-ordinators • Additional Adult Social Care assessment capacity • Personal Health Grants: small grants to support low level hospital discharges. • Additional D2A Beds and therapy in-reach support	Yes	Does this plan contribute to addressing local performance issues and gaps identified in the areas capacity and demand plan? Is the plan for spending the additional discharge grant in line with grant conditions?
Please describe any changes to your Additional discharge fund plans, as a result from **o Local learning from 23-24** **o the national evaluation of the 2022-23 Additional Discharge Funding (Rapid evaluation of the 2022 to 2023 discharge funds - GOV.UK (www.gov.uk)**		
Throughout 23/24, Sussex made progress implementing the agreed SDP transformation priorities of the short-term system discharge improvement plan at system, place and provider level, supported by the system's participation in the national Discharge Front Runner Programme. Following initial improvements in discharge delays in 23/24, the number of acute discharge delays increased during Autumn following admission demand pressure and the impact of industrial action on improvement and transformation. Despite the challenges, significant progress was made ahead of Winter with a notable reduction in the number of acute delays ahead of Christmas/New year. However a rise in admissions over Q4, not matched by an equivalent increase in discharges, has eroded some of the positive gains in NCTR and LoS made earlier in 2023/24. The challenge remains to translate the improvements into sustained operational improvements in respect of NCTR as benchmarked against peers.	Yes	Does the plan take into account learning from the impact of previous years of ADF funding and the national evaluation of 2022/23 funding?"
Ensuring that BCF funding achieves impact		
What is the approach locally to ensuring that BCF plans across all funding sources are used to maximise impact and value for money, with reference to BCF objectives and metrics?		
How the application of the Better Care Fund, including the Discharge Funds, supports the delivery of the Sussex Shared Delivery Plan, is captured through the Sussex system oversight governance arrangements. East Sussex governance arrangements link to the Shared Delivery Plan and System Oversight governance that encompasses health and social care, to ensure alignment of plans and benefits realisation through the current and future deployment of the BCF.	Yes	Does the BCF plan (covering all mandatory funding streams) provide reassurance that funding is being used in a way that supports the objectives of the Fund and contributes to making progress against the fund's metric?

Better Care Fund 2024-25 Update Template

7. Metrics for 2024-25

Selected Health and Wellbeing Board: East Sussex

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Plan	2023-24 Q4 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	195.7	182.6	172.7	173.3	Demographic change across all age groups is assumed to be minimal (<1%) derived from East Sussex JSNA report (Feb 24). Review of most up to date nationally and locally derived indicator values showed planned indicator values for Q3/Q4 (as quoted in this template) were not achieved, with 'actuals' very similar to Q1/Q2 values, respectively. A stretch target of 2% reduction in avoidable admissions each quarter for 24/25 compared with 23/24 actual levels has been modelled in alignment with system delivery plans, to be delivered through continued development of	The East Sussex Urgent Community Response service is supported by BCF funding primarily to ensure full geographical coverage. The expansion of this service has also included development of a direct ambulance clinician to clinician decision making call via an admission avoidance single point of access enabling faster clinical decision making. This service - together with Virtual Wards expansion - supports a wide range of community need including chronic ambulatory care sensitive conditions and targets frailty, respiratory and heart failure in particular.
	Number of Admissions	1,474	1,375	-	-		
	Population	546,924	546,924	-	-		
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan		
	Indicator value	182.1	180.7	179.3	178		

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2023-24 Plan	2023-24 estimated	2024-25 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,134.6	2,421.8	2,313.1	Demographic change for Ages 65+ 23/24 to 24/25 (2.6%) derived from East Sussex JSNA report (Feb 24); Target reduction based on stabilising UCR activity supporting 'Falls' in 24/25 and translating that expanded service activity into a reduction in admissions due to 'Falls' (based on Feb 24 admissions activity - 'best' performing month in 23/24 post UCR expansion)	The East Sussex Urgent Community Response service is supported by BCF funding primarily to ensure full geographical coverage. The expansion of this service has also included development of a direct ambulance clinician to clinician decision making call via an admission avoidance single point of access enabling faster clinical decision making. This service - together with Virtual Wards expansion - supports a wide range of community need including falls related conditions. The expansion of this service is anticipated to have a 'full year' impact
	Count	3,278	3720	3657		
	Population	143,415	143,415	147,175		

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Actual	2023-24 Q4 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.
	Quarter (%)	92.5%	92.6%	93.0%	94.0%	Applied 2% activity growth 23/24 to 24/25 (as per national	All Sussex places are committed to developing a discharge model

Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Numerator	10,712	10,999	10,370	10,198	guidance): Q4 actual achievement was lower than plan. Given current pressures on the system, 24/25 Q1 Plan: set to improve on average level achieved in 23/24 based on introduction of revised Home First policy, diverting 30% of patients on 'D2A' bedded care pathway to 'D2A' Home Care pathway	with a principle of Home First. East Sussex BCF and national discharge investment plans for 24/25 support the increase of 'discharge' capacity in the home including support for onward assessment capability and wrap around services. Together with the implementation of an interactive intermediate care workforce planning tool, a Transfer of Care Hub and system improvement plans including a full review of the discharge model supported by Professor John Bolton, these initiatives are anticipated to deliver system 'shifts' from Q2 24/25.
	Denominator	11,585	11,883	11,154	10,848		
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan		
	Quarter (%)	93.0%	93.5%	93.5%	93.5%		
	Numerator	10,947	11,283	11,122	11,048		
	Denominator	11,775	12,067	11,894	11,816		

8.4 Residential Admissions

		2022-23 Actual	2023-24 Plan	2023-24 estimated	2024-25 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	488.8	450.4	302.9	347.5	The target variance for 24/25 against 23/24 out-turn is due to the change of data source from the SALT to the CLD.	Continued investment in Joint Community Rehab and other community based services, maximising opportunity for people to remain living in their own homes. Maximising use of seven Extra Care Schemes across the East Sussex, providing accommodation with on-site support. Continued investment in D2A beds and other discharge support services including community equipment and
	Numerator	701	696	468	547		
	Denominator	143,415	154,515	154,515	157,406		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

Please note, actuals for Cumberland and Westmorland and Furness are using the Cumbria combined figure for the Residential Admissions metrics since a split was not available; Please use comments box to advise.

Better Care Fund 2024-25 Update Template

8. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: East Sussex

	Code	2023-25 Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR) to be confirmed for 2024-25 plan updates	Confirmed through
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated (in line with the Health and Wellbeing Board's formal governance arrangements) approval? **Paragraph 11 as stated in BCF Planning Requirements 2023-25* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Have all elements of the Planning template been completed? *Paragraph 11*	Cover sheet Cover sheet Cover sheet Cover sheet
	Not covered in plan update - please do not use	**A clear narrative for the integration of health, social care and housing**	Not covered in plan update	

	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils?	Cover sheet Planning Requirements
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4 & PR6**	**A demonstration of how the services the area commissions will support the BCF policy objectives to:** **- Support people to remain independent for longer, and where possible support them to remain in their own home** **- Deliver the right care in the right place at the right time?**	Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service? Has the area described how shared data has been used to understand demand and capacity for different types of intermediate care? Have gaps and issues in current provision been identified? Does the plan describe any changes to commissioned intermediate care to address these gaps and issues? Does the plan set out how demand and capacity assumptions have been agreed between local authority, trusts and ICB and reflected these changes in UEC demand, capacity and flow estimates in NHS activity operational plans and BCF capacity and demand plans? Does the HWB show that analysis of demand and capacity secured during 2023-24 has been considered when calculating their capacity and demand assumptions?	
Additional discharge funding	**PR5**	**A strategic, joined up plan for use of the Additional Discharge Fund**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? Does this plan contribute to addressing local performance issues and gaps identified in the areas capacity and demand plan? Does the plan take into account learning from the impact of previous years of ADF funding and the national evaluation of 2022/23 funding?	
NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	PR 4 and PR6 are dealt with together (see above)	

NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services and NHS commissioned out of hospital services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? Does the total spend from the NHS minimum contribution on NHS commissioned out of hospital services match or exceed the minimum required contribution?	

Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? Where there have been significant changes to planned expenditure, does the plan continue to support the BCF objectives? Has the area included estimated amounts of activity that will be delivered/funded through BCF funded schemes? (where applicable) Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? Is there confirmation that the use of grant funding is in line with the relevant grant conditions? Has the Integrated Care Board confirmed distribution of its allocation of Additional Discharge Fund to individual HWBs in its area? Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? Paragraph 12	
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Is there a clear narrative for each metric setting out: - supporting rationales that describes how these ambitions are stretching in the context of current performance? - plans for achieving these ambitions, and - how BCF funded services will support this?	

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Better Care Fund Narrative Plan

2023-2025

East Sussex Health & Wellbeing Board

June 2023

Contents

1. Stakeholder Engagement

In East Sussex, an integrated approach across the NHS, local government and wider voluntary and independent sector services plays a key role in developing all our local plans which align to the Better Care Fund (BCF) plans. At a local level this integration is managed through the East Sussex Health and Care Partnership which brings together:

East Sussex County Council (ESCC)
NHS Sussex Integrated Care Board (ICB)
East Sussex Healthcare NHS Trust (ESHT)
Sussex Community NHS Foundation Trust (SCFT) and Sussex Partnership NHS Foundation Trust (SPFT)
Primary Care Networks (PCNs)
District and Borough Councils (including Housing)
Healthwatch
Voluntary, Community and Social Enterprise (VCSE) Alliance
East Sussex Fire and Rescue Service
South East Coast Ambulance Service
Education Providers, Registered Landlords, and a wide range of public and private organisations.

The overall purpose of the East Sussex Health and Care Partnership is to support delivery of our locally agreed plans and programmes of transformation for the recovery, stabilisation and future sustainability of our health and care system. Our aim is to work together as a system to ensure a focus on prevention and deliver high quality, effective care, and improved health outcomes, and the operational models that enable this, for the population in East Sussex.

Through a partnership approach the East Sussex Health and Care Partnership has the following key roles:

1. Supporting the ongoing development and implementation of a 5-year integrated local East Sussex Plan which forms part of the Sussex-wide Integrated Care Strategy ***Improving Lives Together***.

2. Supporting the delivery of initial agreed priority programmes of transformation in three core areas of urgent care, planned care and community services, and

3. Ensuring engagement with the delivery of the plans and collectively tackling the issues and challenges we face as a system.

We work with our citizens in a range of ways to ensure that the way our priorities are delivered fits with what people have told us is important about their health and care. This includes Healthwatch and Young Healthwatch, Youth Infrastructure Forum, the Mental Health Action Group, East Sussex Seniors Association, and patient participation groups. Meetings have also been held with partners to discuss specific aspects of the East Sussex BCF plans and ensure a collaborative and cohesive approach to their development.

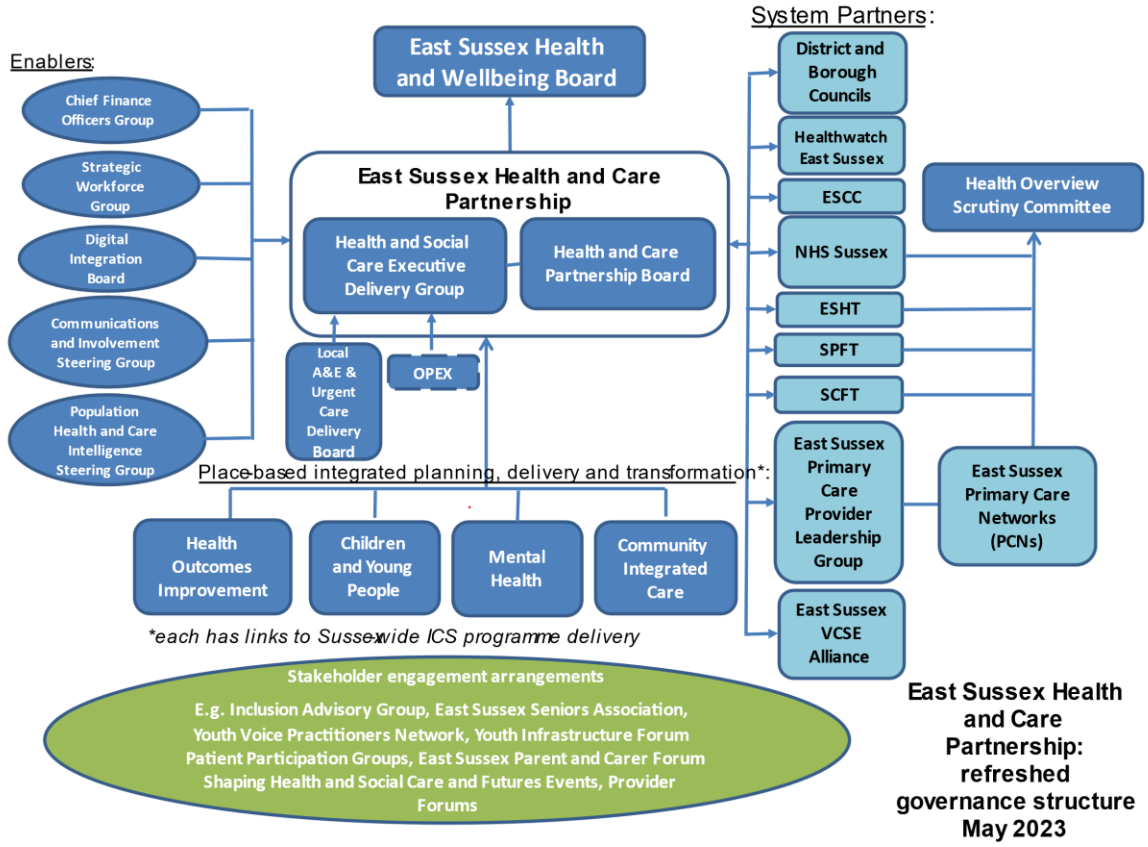
In addition to approval of the plan there is ongoing and regular stakeholder engagement via established forums. For example, with our providers in respect of discharge planning and

monitoring, system performance, capacity and demand planning, and at individual scheme level with NHS providers, social care providers, VCSE providers, and housing authorities.

2. Governance

East Sussex is one of three places in our Sussex ICS (alongside West Sussex and Brighton and Hove) that are working together to deliver our shared priorities through a shared plan. The East Sussex Health and Wellbeing Strategy provides an overall framework for our partnership work in East Sussex, and with the public, aimed at improving the health and wellbeing of local people and transforming the way we provide health and care.

Our established place-based system partnership governance has evolved over four years since its inception in 2019. During that time core membership across the range of system partners has remained relatively stable, and programme governance has been used to support delivery of shared priorities originally set out in our East Sussex Health and Social Care Plan (March 2020), which brought together County Council priorities and NHS Long Term Plan commitments.



The East Sussex Better Care Fund plan is developed and delivered within the context set by the:

- Healthy lives, healthy people: East Sussex Health and Wellbeing Board Strategy 2022-2027

Healthy lives, healthy people: East Sussex Health and Wellbeing Board Strategy | East Sussex County Council

- Improving Lives Together: Our ambition for a healthier future in Sussex - built upon the Health and Wellbeing Strategies of the three Sussex 'places':

  https://www.sussex.ics.nhs.uk/wp-content/uploads/sites/9/2023/01/0438-NHS-Sussex-VF4-4.pdf

- Improving Lives Together: Sussex Integrated Care Board Shared Delivery Plan – five-year Shared Delivery Plan including specific East Sussex ambitions and actions.

How the application of the Better Care Fund, including the Discharge Funds, supports the delivery of the Sussex Shared Delivery Plan, is captured through the Sussex system oversight governance arrangements. East Sussex governance arrangements link to the Shared Delivery Plan and System Oversight governance that encompasses health and social care, to ensure alignment of plans and benefits realisation through the current and future deployment of the BCF.

3. Executive summary

The vision of the East Sussex Health and Wellbeing Board is to protect and improve health and wellbeing and reduce health inequalities in East Sussex, so that everyone has the opportunity to have a life that is as safe, healthy, happy, and fulfilling as possible.
For health and care services, our aim is to work towards a fully integrated health and care system and by doing this we will ensure people receive high quality, coordinated care, enabling them to live good lives.

Priorities for 2023-25

There are common themes throughout all the East Sussex priorities which will be a part of everything we deliver over the next three to five years. These are:

- improving health and reducing health inequalities
- improved access to local services
- bringing together health and social care
- urgent and emergency care.

The Better Care Fund will continue to play a significant role in the driving improvement in all of these areas through the integration and pooling of resources to support delivery of our shared priorities.

Key changes since previous BCF plan.

The Sussex-wide Integrated Care Strategy ***Improving Lives Together*** was launched late in 2022/23 providing a strategic approach for ensuring the Better Care Fund across all parts of Sussex is focused on delivery of the key priority delivery areas via a Shared Delivery Plan.

To support these delivery areas, the BCF funded schemes are carried forward from the previous year with the following additions:

- Discharge Fund: Local Authority (LA) Grant and ICB Allocation. The schemes funded by the Discharge Fund fall fully within the BCF plan following the initial roll-out in Quarter 4 (January – March) 2022/23.
- For 2023/24, the ICB will fund additional hospital discharge schemes via the BCF.

4. National Condition 1: BCF plan and approach to integration

The vision of the East Sussex Health and Wellbeing Board is to protect and improve health and wellbeing and reduce health inequalities in East Sussex, so that everyone has the opportunity to have a life that is as safe, healthy, happy and fulfilling as possible.

For health and care services, our aim is to work towards a fully integrated health and care system and by doing this we will ensure people receive high quality, coordinated care, enabling them to live good lives.

East Sussex joint priorities for 2023-25

Through our partnership work, we will focus on a small number of shared priorities where we can achieve better results if we work together to offer more integrated care.
There are common themes throughout all the East Sussex priorities which will be a part of everything we deliver over the next three to five years. These are:

1. Improving health and reducing health inequalities by building on our existing progress to:
    - empower people to stay healthy and well for as long as possible.
    - reduce health inequalities and the gap in life expectancy and healthy life expectancy in the county.
2. Improved access to local services by improving the range of services available in the community.
3. Bringing together health and social care by removing barriers between our health and social care teams to support very frail and vulnerable people with long-term complex care needs and conditions.
4. Urgent and emergency care by making sure people get seen in the right place, at the right time by the right healthcare professional.

All the schemes within our BCF plans contribute to delivering these priorities and themes, and there are a range of wider commissioning and delivery plans which cover specific services and objectives in more detail.

The East Sussex approaches to joint/collaborative commissioning.

Our East Sussex Health and Care Partnership brings together the contributions of a range of partners to deliver this strategy, including the NHS, county, district, and borough councils, the voluntary, community and social enterprise sector, and Healthwatch East Sussex.
Together, we continue to explore the opportunities joining up care for people, places and populations and as part of our ICS to further strengthen collaboration on our priorities. These include more formal arrangements to plan services and share resources such as within the Better Care Fund, aimed at increasing integrated care and responding better to the needs of our population.

In delivering the vision and our priorities we recognise that:

- Working with people, carers, families, and communities is crucial to designing services and support that works. We will continue to build on the strengths of our communities, involving people in ways that suit them through a wide range of existing arrangements and new approaches.

- Healthwatch will continue to play a role at both a local and national level, ensuring that the views of the public and people of all ages who use health, care and other related public services are taken into account.
- Health and care services can offer joined-up high quality care that anticipates needs and intervenes as soon as possible, to have a positive impact on people's day-to-day life and deliver better outcomes.
- District and borough council actions have a positive effect on public health, and an enabling role in the health of their populations and communities through innovation in service delivery.
- Voluntary, community and social enterprise (VCSE) organisations play a key role in mobilising local social action that can bring communities together, both in times of need and more generally, as well as being a part of health and care delivery that supports people's health and wellbeing.
- Working together at a local and neighbourhood level with our partners will give a strong platform to deliver initiatives which improve health, wellbeing and services.

We continue to develop how we jointly commission and provide services, based on our knowledge of population's health and care needs and with a renewed focus on reducing health inequalities at the centre of everything we do, including:

- Proportionally targeting our resource to match the needs of individuals and communities to reduce the gap in life expectancy and to increase the quality of life.
- Having robust mechanisms to reach, hear from and better understand people and communities' experiences.
- Ensuring services are informed by both peoples' and communities' needs and assets.
- Connecting out knowledge of local health inequalities with front line service delivery.
- Taking action for people from pre-conception to after-death.
- Developing key performance indicators for addressing inequalities and supporting improved outcomes.

How BCF funded services are supporting our approach to continued integration of health and social care.

The services funded from the BCF in 2022/23 will continue to be funded for the next 2 years as they remain critical components of the system, by way of prevention or supporting system flow. All jointly funded and jointly commissioned BCF funded services contribute to delivery of the East Sussex plans for integration outlined above and support avoidance of admission to and reduced length of stay in bedded care, either directly or indirectly.

Alongside this, the Discharge Funding will be used to ensure people are transferred to an appropriate setting after an acute episode in order to maximise their outcomes and opportunities to return to independent living.

5. National Condition 2: Enabling people to stay well, safe, and independent at home for longer.

The East Sussex Better Care Fund Plans support the delivery of the East Sussex Health and Social care plans which address the local needs identified, the vision for integrating health and social care and to enable people to stay well, safe, and independent at home for longer whilst providing the right care in the right place at the right time.

Our steps to personalise care and deliver asset-based approaches.

The focus of our shared work on health and care services is aimed at increasing prevention and early intervention and delivering personalised, integrated care across services.

Through the BCF and wider programmes, we will continue to enhance community services and strengthen our overall model for integrated community health and social care services in our neighbourhoods and localities. Working with our Primary Care Networks and local VCSE organisations we will use information about local populations to better understand and target the needs and risks of particular groups, aimed at:

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

A project called ‘Universal Healthcare’ is already underway in Hastings with a number of community engagement workshops having taken place to understand the needs of local people and help shape how they can be better supported in the long term. We intend to be able to start new ways of working and this is a good example of the way we want to work with our communities in future.

Our approaches to population health management, and proactive care, and how our schemes commissioned through the BCF support these approaches.

Our East Sussex Health and Care Partnership has a set of shared priorities drawn from the East Sussex HWB Strategy which are set out as four programmes all aimed at delivering improved health, care and wellbeing and reduced health inequalities based on the needs of our population. The overall focus of our shared work on health and care services is aimed at changing the way we make access to services and support available for people locally, increasing prevention and early intervention and delivering personalised, integrated care.

Population health management, prevention and health Inequalities are key areas of focus within the East Sussex delivery plan. Our shared priorities are to:

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

Through services funded via the BCF, we work closely with local VCSE organisations to support these approaches through ensuring that everyone is able to access:

- Clear advice on staying well.
- A range of preventative services
- Simple, joined up care and treatment when this is needed.
- Digital services (with non-digital alternatives) that put the citizen at the heart of their own care.
- Proactive support that keeps people as well as possible, where they are vulnerable or at high risk.

These BCF funded services in East Sussex include community hubs, community connectors, benefits advice, and access to community-based support for people with sensory and mental health needs.

Our development of multidisciplinary teams at place or neighbourhood level

In East Sussex, we will take the opportunity to expand and enhance our model for the way all our teams can work together in communities and neighbourhoods and removing the barriers between our organisations to enable them to do this.

- Use a specific site to test and develop a 'proof of concept' model:
- Test and develop our approach together; the suggestion is to focus on Hastings initially, followed by further phases of similar activity to roll the model out across the county.
- Build on the existing related services and projects.
- Build on our original target operating model for community services to ensure primary care, mental health and services that impact on the wider determinants of health and wellbeing are fully a part of the model.

Our work to support unpaid carers and deliver housing adaptations on delivering this objective.

A wide range of services to support unpaid carers are funded through the BCF including:

- ASC undertakes Carers assessments and reviews with allocation of a Carers Personal Budget as required to meet identified eligible needs.
- Carers reviews also offered by Care for the Carers – pilot project.
- Young Carers assessments/reviews undertaken by commissioned young carers provider.
- Carers assessments/reviews for carers of people living with dementia included in Dementia Support Service
- Carer respite allocated as a service to the cared for person.

- East Sussex Carers Centre offers information, advice, support, peer support groups, engagement opportunities, counselling, Carers Card (emergency plan, discounts), respite funding for healthcare appointments and training.
- Targeted support for carers of people with severe mental illness
- Carer identification and targeted support through primary care in Hastings and the Havens
- Short breaks provided through a volunteer respite service.
- Carer crisis service - short term interventions to meet agreed outcomes.
- Range of services provided through small grants – dementia training, cookery & arts activities, targeted support for BAME carers, carer support in hospices, digital support, lunch & supper clubs.
- Telephone befriending

Adapting the home can increase the usability of the home environment and enable people to maintain their independence for as long as possible. This has been shown to reduce the risk of falls and other accidents, relieve pressures on accident and emergency services, speed hospital discharge and reduce the need for residential care. Provision of home adaptations is likely to alleviate pressure on unpaid carers and enable disabled people to assess the wider community.

Secondment of specialist Adult Social Care Occupational therapy housing teams into District and Borough Councils in 2019 has allowed for provision of integrated, co-located housing related services including housing adaptations and a move away from the more traditional non-integrated two-tier approach that was previously employed in East Sussex.

This joining up at an operational level as recommended in the DFG review 2018 has enabled a single point of referral, simplification and speeding up of the client journey and an increase in the number of major and minor adaptations, where adaptations are not possible the Occupational Therapist can assist with exploring options available to them and advise about the most appropriate housing solution to meet their needs.

The team use prevention and personalisation to reduce health inequalities, supporting people to live as independently as possible through a greater focus on outcomes and the wider determinants of health in our community, and enabling more people to access more adaptations at the right time for them.

Five unqualified Occupational Therapy (OT) staff have received training to enable them to carry out a Trusted Assessor role allowing the assessment and recommendation from simple Disabled Facilities Grant (DFG) adaptations such as stairlifts and level access showers, enabling qualified OT staff to focus on the more complex assessments.

Referral routes have been streamlined and are accepted from a wide variety of sources, preventing delays in accessing services, consistency of approaches across areas provides greater equality. Closer working between organisations has meant more timely access to the service and an ability to resolve problems as they occur and with minimal impact on the tenants.

Referrals are screened and triaged based upon a priority and those where risks are highest or requiring support to be discharged are prioritised.

The team can access the full suite of Adult Social Care support by completing Care Act Assessments and are trained in assessing equipment, adaptations, telecare, carers

assessments, mental capacity, and safeguarding, they can provide daily living equipment and minor adaptations via the local Integrated Community Equipment service.

They work collaboratively with colleagues from Social Care, Wheelchair services, Health, Voluntary and Housing sectors to consider options to meet individuals' needs.

An innovative example is accessing funds for a 'third party top-up' towards a wheelchair provided by the wheelchair services to enable an additional rise and fall element to be fitted to the seat of the chair, allowing the individual to access higher shelves within their kitchen but also assisting them to access shelves within their local supermarket and have conversations at eye level.

Support is provided with rehousing; either via accessing discretionary assistance to finance moving costs, part-buy schemes to purchase an adaptable property (recently cited as an example of Best Practice by Foundations) or local housing registers. Options are fully explained and referrals to organisations such as Brighton Housing trust or internal Housing Solutions workers made. Assessments of temporary accommodation and adaptations and equipment in alternative housing are also carried out. Interim risk management measures are also provided.

Assessments are undertaken for individuals regardless of whether they live in public or private sector housing. For individuals who are identified as self-funding adaptations are offered information and advice to ensure their needs are appropriately met.

This service has successfully won the DFG team of the year award by Foundations in 2022.

Innovative applications of Housing Assistance Policies across the District and Borough Councils in East Sussex have enabled a larger number of residents to access home adaptations via support such as:

- Flexible application of financial means testing
- Addition of adaptations outside of the mandatory DFG framework (ie Dementia assistance grants to support people with dementia to retain independence at home for longer)
- Additional funding over the mandatory £30,000 mandatory limit
- Identifying high risk situations – such as falls accessing stairs and speeding up processes for accessing solutions to reduce risks.
- Hospital discharge grants including assistance with deep clean/decluttering.
- Support to relocate where existing property is not suitable for adaptations.

Our rationale for our estimates of demand and capacity for intermediate care to support people in the community.

Learning from 2022-23

- There is variable access to Pathway 1 services due to geographical areas of challenge in respect of the availability of onward care capacity.
- The current processes for referral to Discharge to Assess (D2A) are complex and there is a need to simplify the existing pathway.
- These will be forward as part of Hospital Discharge transformation and Discharge Front Runner programme.

Our approach

Demand Assumptions:

- Demand for 'Urgent Community Response' is based on referrals received in 22/23, excluding those received from acute services.
- Demand for other services arising from community sources is based on best estimates and analysis of supporting Hospital Discharge estimates.

Capacity Assumptions

- Reablement and Rehabilitation at Home and in a bedded setting are as for Hospital Discharge
- Capacity is linked to demand as the best current indicator of capacity.

Significant Demand and Capacity Gaps

- Rehabilitation in a bedded setting: As for Hospital Discharge, demand exceeds capacity, primarily in the south and east of the County. This is a focus of Discharge transformation and use of discharge capacity.

Further work to refine the data is being undertaken as part of the Discharge Front Runner programme, this will include data for Mental Health pathways.

How East Sussex HWB is using the Better Care Fund to Enable people to stay well, safe, and independent at home for longer.

The transformation programme, service redesign schemes and developments are significantly wider than those funded by the Better Care Fund however the BCF plans for 2023/25 seek to support people to stay well safe and independent at home for longer through:

1. Enhanced prevention, personalisation and reducing health inequalities.
    - Falls and Fracture Prevention Programme as part of the ESHT community programme.
    - A range of services provided by the Voluntary, Community and Social Enterprise sector.

2. Support for people with mental health needs by ensuring access to a full range of services including:
    - Improved access to psychological therapies
    - Dementia services

3. Continue to integrate health and social care services and work with our Primary Care Networks to embed proactive anticipatory care, and seamless wrap around care to people with long term care needs and conditions and those in care homes.
    - Frailty services
    - Carers Services
    - Health and Social Care Connect (Single point of Access)
    - Housing support and adaptations

- Maintaining social care services
- Community Equipment services

4. Improve services that deliver planned care for local people.
    - Diabetes self-management and pharmacy support
    - Medicines Optimisation in Care Homes
    - Dietician support to medicines management

These BCF schemes support the delivery of the BCF metrics with many of these schemes being jointly commissioned and jointly provided by Adult Social Care and local NHS Trusts. The schemes support the development of integrated local service delivery and the move towards planning and designing services around local communities as a cornerstone of our vision for integrating care and support.

Although attribution at scheme level can be difficult, the funded services together with the overall approach to supporting this policy objective are expected to have a positive impact on unplanned admissions to hospital for chronic ambulatory care sensitive conditions, emergency hospital admissions following a fall for people over the age of 65, and the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

6. National Condition 3: Provide the right care in the right place at the right time.

Our ongoing arrangements to embed a Home First approach.

A key priority for improving discharge continues to be the Home First (HF) pathway, ensuring as many people as possible are discharged home from a stay in an acute hospital or community bedded setting. HF underpins our delivery of a Discharge to Assess (D2A) approach, enabling people to come home as soon as they are medically ready, with support wrapped around them by joint Health and Social Care service. This will include:

- Implementing a strategic approach to our enhanced Discharge to Assess (D2A) services to improve outcomes for patients, including linking this to other services such as rehabilitation and reablement and pharmacy support.
- Reviewing our proposed integrated urgent community response model across acute, community health and social care. This will support people to avoid going into hospital where there is a better alternative service and enable them to get home quickly when they are ready to leave hospital.
- Identifying and implementing Trusted Assessor opportunities, for example NHS staff being able to commission simple social care packages and telecare.
- Supporting the local implementation of 'virtual wards' to increase proactive care coordination at home for very frail people with complex care needs.

Our approach to improving discharge.

Our discharge improvement and transformation programme is being delivered within our SDP Discharge and Social Care Board, supported by our participation in the national Discharge Front Runner programme.

The selection of Sussex as a Discharge Front Runner will enable the existing initiatives to be built on and taken further to make greater improvements for local people.

Discharge Front Runners will involve local health and social care partners being supported to work together to rapidly find innovative solutions and new approaches, which have the potential to make a substantial difference to improving discharge across the country. They will specifically look at how workforce, data and digital, and intermediate care, can be better used to speed up discharges.

As part of the Discharge Front Runner programme our system is undertaking a comprehensive hospital discharge patient needs analysis, building on the work completed last year, which will be the underlying evidence base for our transition and future models.

Place-based initiatives are enabled through our system wide prioritised approach to developing the following to underpin our agreed model:

- A joint workforce planning framework across health and social care including the care provider market.

- Widen our scope of digital innovations.
- Business intelligence management tools: working towards a live tracking system to support demand modelling, performance improvement and operational oversight.
- Move to more innovative funding approaches as part of the total economic model to achieve more sustainable contracting, delivery, and better value for money.
- Delivery of a programme of discharge improvement at system, place, and provider level.

What we achieved last Winter

- Co-ordinated the identification and delivery of place-based schemes and associated prioritisation for capacity investment in relation to the £300m National Adult Social Care Fund and £200m Discharge Fund.

- Rolled out 100 Day Challenge High Impact Actions to Community and Mental Health providers building upon internal discharge improvement work undertaken within our community and mental health providers.

- Improved system visibility of data with the development of a system discharge dashboard covering a wide range of key performance indicators.

- Developed a new system Choice Policy based upon best practice, which has been agreed by all stakeholders and is being implemented in Q1 of 2023/24 supported by the provision of training for staff involved in discharge.

- Completed a review of the three Sussex discharge hubs against nationally published best practice guidance to inform the Transfer of Care Hub development for 2023/24

- Maintained the number of Medically Ready for Discharge (MRDs) at Quarter 1 (April–June) 2022/23 baseline levels over the Winter period with improvements in East Sussex.

- In Q4 of 2022/23 delivered an improvement in weekend discharges across the acute hospital sites.

What we learnt over Winter

- That there is a need to consider the cultural changes required to deliver and embed systemic improvements and to ensure that there is sufficient change capacity and capability in place to support implementation.

- That the short notice, non-recurrent nature of additional discharge funding made available for Winter resulted in the purchase of additional capacity, limited to the care market's ability to respond, which could not always be fully aligned to the strategic needs of the system, e.g. Interim care home beds for short-term placements with constrained onward care capacity and stretched assessment resources.

- It is important to ensure consistency around data and flow so performance management and strategic direction setting can be more closely aligned.

- It was identified that there is a significant opportunity to utilise Personal Health Budgets going forward learning from the use of Personal Health Grants over the Winter Period.

Feedback from the national system discharge visit to East Sussex on 31st May 2023.

We will receive a letter setting out the areas that are recommended to be addressed. This is expected to include further work on the system ambition for improvement and plans to address unwarranted variation in processes. This will be reflected in further development of this plan and overseen by the Discharge Front Runner Programme, linking back to local BCF governance.

Additional discharge funding: How we will use the to deliver investment in social care and community capacity to support discharge and free up beds.

A number of schemes have been agreed following review of the schemes funded from the additional discharge funding in Q4 2022/23 where there is confidence they can be fully utilised in line with the capacity and demand modelling for 2023/24. These include:

- Home care: additional block hours to support hospital discharge.
- Weekend Discharge Team: additional capacity to facilitate hospital discharge at weekends.
- High Intensity Users/Mental Health Discharge Co-ordinators
- Additional Adult Social Care assessment capacity
- Personal Health Grants: small grants to support low level hospital discharges.
- Additional D2A Beds
- Assisted Discharge Home: additional capacity for this service provided by the British Red Cross to support low level hospital discharges.

Early plans for 2024/25 will continue to ensure the required capacity is available to support Home First pathways however this will be subject to review of the demand for and efficacy of each later in 2023/24. These plans also include therapy support to the additional beds to maximise people's independence and opportunities to return home.

Our rationale for our estimates of demand and capacity for intermediate care to support discharge from hospital.

Learning from 2022/23

- There is variable access to Pathway 1 Home First Urgent Community Response (UCR) services due to geographical areas of challenge in respect of the availability of onward care capacity.
- The current processes for referral to Discharge to Assess (D2A) pathways are complex and there is a need to simplify the existing pathway.
- Assessment capacity to meet all demands including timely assessments to support discharge was a challenge over the winter period.
- Complex cases remain a key issue, where clients' clinical needs are high requiring specialist input from a range of professionals and services.
- The care market faces a continuing challenge to recruit and retain sufficient staff to meet demand both in the community and for hospital discharge.
- Challenges in the availability of onward supported accommodation capacity for adult, older people, dementia, and rehab patients with mental health related conditions.

What we have been doing

- December 2022 restart of length of stay reviews for longest waits.
- Zero tolerance to bedding of same day emergency care areas from December 2023
- Gap analysis on processes and understanding of discharge and pathways at ward level January to March 2023
- April 2023 move to protect clinical decision unit for use only by the Emergency department.
- April 2023 Created a new Discharge Lounge at Eastbourne DGH and prevented bedding of lounge at Conquest Hospital.
- May 2023 Full audit of all patients not meeting criteria to reside (NCTR) on both acute sites with support of clinical team from the national Emergency Care Intensive Support Team.
- Development of full back to basics for discharge training programme – commenced delivery to Train the Trainer for all wards May to June 2023
- Revision of on call training support to support on call teams with best practice for patient flow.
- Review of oversight and management arrangements for discharge – new discharge lead May 2023 and improvement plan development April onwards
- Joint work between Trust managed UCR and ASC to allow patients to be supported home prior to ASC picking up so reducing length of stay.

Our Approach

East Sussex system partners have undertaken a significant amount of modelling to understand the demand and capacity for different parts of the system. Much of the data has been derived from tracking discharge hub activity and reviewing unmet community demand both within the NHS and local authority.

Demand Assumptions

- Underpinned by Trust Discharge Sitreps for 2022/23 for four core providers, providing analysis by Pathway.
- Growth 2022/23 to 2023/24: net neutral
- Phased by month by days in month with limited adjustments for seasonal variation.
- Pan Sussex assessment that 2% of Pathway 0 activity requires Social Support
- A limited amount of Pathway 3 activity transferred to Pathway 1 – Domiciliary care – in line with pan Sussex agreed focus on ‘Home First’ and evidence from East Sussex service leads.
- Analysis by ‘sub pathway’ (%) derived from review of patterns of referral 2021/22 and 2022/23; this analysis will be subject to further development as part of the Discharge Front Runner Programme

Capacity Assumptions

Performance (Utilisation factors) and Care Profiles (length of stay and resource use) derived from:

- Routinely produced performance dashboards for Pathway 2 and Pathway 3 services (Pathway 3 care profiles feature length of stay in line with pan Sussex strategy)

- Reviews with service managers were also undertaken to validate Pathway 1 services and available data sources.

Significant Demand and Capacity Gaps

- Social Support: capacity exceeds demand to meet periodic fluctuations – optimisation of Pathway 0 to be addressed via pan Sussex 'Home First' strategy.
- Short term domiciliary care: capacity currently exceeds demand; the plan has been modelled to match demand as patients transferred from Pathway 3 (see note above) as part of discharge transformation plans.
- Rehabilitation at Home: capacity shown exceed demand, this allows for the number of Pathway 1 patients requiring multiple services (based on review of service use 2021/22)
- Rehabilitation in a bedded setting: demand exceeds capacity as some Pathway 2 patients will require bespoke capacity provision due to complex/End of Life Care (EOLC)/All Age Continuing Care needs but is also reflective of known shortfall in the system evidenced by waiting lists for these facilities together with unmet demand from the community. This is a focus of Discharge transformation within the Discharge Front Runner programme.
- Pathway 3 capacity meets current demand assuming the 'Home First' strategy is mobilised and supported by additional assessment capacity.

How East Sussex HWB is using the Better Care Fund to provide the right care in the right place at the right time.

The transformation programme, service redesign schemes and developments are significantly wider than those funded by the Better Care Fund however the BCF plans for 2023-25 seek to provide the right care in the right place at the right time through:

1. Continue to integrate health and social care services and work with our Primary Care Networks to embed proactive care, and seamless wrap around care to people with long term care needs and conditions and those in care homes.
    - Frailty services
    - Carers Services
    - Health and Social Care Connect (Single point of Access)
    - Housing support and adaptations
    - Maintaining social care services
    - Community Equipment services

2. Improve support for people with urgent care needs including targeted support for vulnerable people – by way of admission avoidance and supporting hospital discharge pathways:
    - Community based Intermediate Care and Reablement, by way of both domiciliary and bed-based care and support.
    - Urgent Community Response services
    - Hospital Intervention team based in A&E
    - Discharge to Assess - bed-based capacity.

- Domiciliary Care capacity
- Hospital discharge support provided by the Red Cross.
- 24/7 Health and Social Care Connect (Single point of Access)

These BCF schemes support the delivery of the BCF metrics with many of these schemes being jointly commissioned and jointly provided by Adult Social Care and local NHS Trusts. The schemes support the development of integrated local service delivery and the move towards planning and designing services around local communities as a cornerstone of our vision for integrating care and support.

A commitment from operational teams to collaborate and improve services by taking a whole system approach, reviewing pathways and processes to identify barriers and improve patient journeys, examples of this include:

- Developing direct referral pathways from hospital discharge teams into housing adaptations teams (on occasions using the District and Boroughs powers under their RRO Housing Assistance policy) to provide swift adaptations to enable safe and timely discharge.
- Prioritisation of hospital discharge referrals
- Attendance of housing teams at hospital multi-disciplinary meetings where the discharge is complex and potential housing issues are identified to improve outcomes and system flow.

Our progress in implementing the High Impact Change Model for managing transfers of care.

East Sussex system partners recognise and agree the impact and importance of system flow on patient experience, quality and safeguarding, costs and efficiencies and elective care recovery. The Sussex ICS approach is aligned to our strategic system wide work that incorporates a whole system approach across improved efficiency, admission avoidance, hospital discharges, developing enhanced community responses and growing our virtual wards.

This has patient experience and outcomes at the heart of our work and has been informed by quality and equality impact assessments, the high impact change actions along with hospital flow and discharge pathways as part of the Discharge Front Runner programme.

East Sussex Healthcare NHS Trust, supported by the Emergency Care Intensive Support Unit have reviewed patient flow and identified actions aligned to the High Impact Change Model along with other plans outlined in the East Sussex BCF Plans.

Impact Change	**East Sussex Actions**
Early Discharge Planning	Review Ward and Board round processes, moving from sequential of patient actions, to actions in parallel.
Monitoring and responding to system demand and capacity	Ongoing review of bottlenecks.
Multi-Disciplinary Working	Build on “Frailty Ward” to develop short stay frailty unit with enhanced therapy input.

	Review use of Therapy resources with a more proactive approach
Home First /Discharge to Assess	Work with discharge hub to ensure better feedback and further optimising all pathways.
Flexible Working Patterns	Improve Weekend and Monday discharges, Improved use of discharge lounge
Trusted Assessment	Identifying and implementing Trusted Assessor opportunities
Engagement and Choice	Continued implementation of the new system Choice Policy based upon best practice
Improved Discharge to Care Homes	Increased capacity within Discharge to Assess pathways for bed-based capacity.
Housing and Related Services	Understand and act on current delays for equipment and adaptations

BCF schemes supporting improvements in hospital discharge pathways.

Housing adaptations have been utilised to enable residents to be discharged to usual place of residence via the use of discretionary policies to support with fast tracking works, developing pathways with hospital discharge teams to enable hospital discharge referrals to be prioritised and, where the existing place of residence is not suitable for adaptations, support with options for identifying and relocating to alternative accommodation.

Assisted Discharge Service provided by British Red Cross with additional capacity through the Discharge funding.

Introduction of Personal Health Grant to provide low level support which facilitates hospital discharge.

Community based Intermediate Care and Reablement, by way of both domiciliary and bed-based care and support.

Increased capacity within Discharge to Assess for both Domiciliary Care and bed-based capacity.

How East Sussex HWB have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered

Through services funded via the BCF, we work closely with local VCSE organisations to support everyone to be able to access:

- Clear advice on staying well.
- A range of preventative services
- Simple, joined up care and treatment when this is needed.
- Digital services (with non-digital alternatives) that put the citizen at the heart of their own care.
- Proactive support that keeps people as well as possible, where they are vulnerable or at high risk.

These BCF funded services in East Sussex include community hubs, community connectors, benefits advice, and access to community-based support for people with sensory and mental health needs.
In East Sussex, much of the BCF funding is used to provide services which support the delivery of duties under the Care Act:

Health and Social Care Connect (HSCC) is the East Sussex Single Point of Access to community services and also provides a single point for internal staff and external partners to raise safeguarding concerns.

Support for unpaid carers including young carers, carers who are working and older age carers - further details can be found in the next section.

7. Supporting unpaid carers:

Through the BCF, a wide range of services are jointly funded and commissioned to support unpaid carers including:

Carers Centre provided by Care for the Carers to:

- Raise awareness with service providers & within communities to identify & reach carers
- Information & advice
- Targeted support both to assist with accessing appropriate support for carers & cared for and for carers' own emotional and physical wellbeing.
- Act as "one stop shop" with referral pathways to a range of carers' services
- Provide a range of universal services provided directly by Care for the Carers and commissioned through small grants*
- Provide peer support, carer engagement, wellbeing support and training, Carers Card (contingency planning and discounts)
- Targeted services including one to one casework and emotional support, counselling, Health Care Appointments Respite Grant,
- Targeted support for carers of people with severe mental illness and for young adult carers
- Working with Primary Care practices in the most deprived areas of Hastings and the Havens to reach carers with the most complex needs/caring roles.
- Undertaking carers' reviews on behalf of ASC
- New NHS funded services for 23/24 – the Havens (above) plus carer identification, awareness, and direct support in the acute trust to assist with hospital discharge.

Outcomes for unpaid carers:

- Carers identified early in caring role.
- Reduction in carers reaching crisis point.
- Carers referred to Single Access Point
- Carers recognised as expert partners in care through the health and social care systems.
- Increase in carer friendly communities.
- Identification of carers from communities that are hard to engage, those who have additional vulnerabilities and those at key transition points.
- Carers recognise themselves as carers and are enabled to access the information, advice and support that they need.
- Carers have access to information and advice in a range of formats including by phone and online.
- Carers are signposted/referred on and/or provided with appropriate support/services.
- Carers are supported and enabled to find their own solutions without the need for ongoing support.
- Single referral route for both carer and professional referrals
- Carers can access peer support e.g., through groups or online fora.
- Carers have access to engagement opportunities such as consultation.
- Carers have access to health and wellbeing opportunities.
- Carers can access universal services which reduce the need for access to targeted services

- Carers can access emotional and practical support including face to face, counselling, short-term and crisis interventions that enable carers to look after their own health and wellbeing and sustain their caring role.
- Carers can access training, e.g., condition specific, building resilience, stress management and digital inclusion that will inform their caring role and enable them to care without negatively impacting on their own health and wellbeing.
- Services are inclusive of carers caring at end of life and experiencing bereavement; carers from communities that are hard to engage; those who have additional vulnerabilities and those at key transition points.
- Improved outcomes for carers in primary care
- Evening support group and targets mental health support group reach working age carers.

Care Act services

- Carers Personal Budgets – direct payments to carers to meet Care Act eligible outcomes following a carers assessment or review.
- Carers Reviews Pilot – carers' reviews allocated to Care for the Carer to undertake on behalf of ASC.
- Funded Respite for ASC clients to give carers a break.
- Volunteer Respite services - short home-based breaks (sitting service) where the cared for person is at risk if left alone.
- Carers Break and Engagement Service – undertake carers assessments and reviews for carers of people living with dementia in addition to the NHS funded Dementia Support Service
- Young Carers – a separately commissioned service to provide young carers assessments, individual and family support, workshops and in-school support groups which seek to reduce levels of inappropriate caring and their social, emotional, health and educational needs.

Small Grants (funding now held and allocated by Care for the Carers)

A range of grant funded services including:

- Carer support at all 3 hospices
- Outreach to identify & support BAME carers in Hastings & Eastbourne
- Dementia training
- Digital inclusion
- Short breaks – lunch/supper clubs, creative & social activities, cookery
- Targeted support – Motor Neurone Disease, parent carers of young people with SEND (16-25)
- WRAP (Wellness Recovery Action Planning)

8. Disabled Facilities Grant (DFG) and wider services:

The 2019/20 Annual Report of the Director of Public Health focuses on Health and Housing in East Sussex. Annual Public Health Report 2019/20 - Health and Housing | East Sussex: Joint Strategic Needs Assessment (eastsussexjsna.org.uk) This included the following statements of intent considering opportunities to improve housing in East Sussex.

- **TO MAKE ALL HOUSING AND NEIGHBOURHOODS HEALTHY**: East Sussex County Council and the District and Borough Councils will work more collaboratively on each of the Local Plans through the existing groups - Local Plan Managers and the East Sussex Housing Partnerships Board , sharing data and intelligence to fully understand housing needs and population distribution and hardwiring the principles of "Putting health into place" to ensure health is central to place making, and the design and delivery of homes and neighbourhoods.
- **TO MAKE ALL HOMES HEALTHY**: East Sussex County Council, the District and Borough Councils and the NHS will support and promote initiatives that improve the health and safety of homes, including adaptations that improve environmental sustainability, and promote independent living.
- **TO MAKE PEOPLE HEALTHIER IN THEIR HOMES**: East Sussex County Council, the District and Borough Councils, the NHS and the voluntary and community sector in East Sussex will collaborate to integrate the planning and delivery of care and support in housing, ensuring that specific homelessness and rough sleeping support is continued.

Healthy lives, healthy people: East Sussex Health and Wellbeing Board Strategy | East Sussex County Council sets out the overarching vision supporting the residents of East Sussex and highlights the importance of high-quality safe housing and its impact on health and wellbeing

Whilst the DFG funding is passed down in its entirety, deployment of the DFG funding within the BCF is overseen by the East Sussex Housing Partnerships Board with representation from East Sussex County Council and the Housing departments within local District and Borough Councils as well as health commissioners and wider housing sector partners.

The East Sussex Housing Partnerships Board provides a countywide strategic approach to housing and support issues and oversees effective use of the funding available, including use of adaptations to support independent living and any cross-county projects.

Secondment of specialist Adult Social Care Occupational therapy housing teams into District and Borough Councils in 2019 has allowed for provision of integrated, co-located housing related services including housing adaptations and a move away from the more traditional non-integrated two-tier approach that was previously employed in East Sussex.

This joining up at an operational level as recommended in the DFG review 2018 has enabled a single point of referral, simplification and speeding up of the client journey and an increase in the number of major and minor adaptations, where adaptations are not possible the Occupational Therapist can assist with exploring options available to them and advise about the most appropriate housing solution to meet their needs.

The team use prevention and personalisation to reduce health inequalities, supporting people to live as independently as possible through a greater focus on outcomes and the wider determinants of health in our community, and enabling more people to access more adaptations at the right time for them.

Five unqualified OT staff have received training to enable them to carry out a Trusted Assessor role allowing the assessment and recommendation from simple DFG adaptations such as stairlifts and level access showers, enabling qualified OT staff to focus on the more complex assessments.

Referral routes have been streamlined and are accepted from a wide variety of sources, preventing delays in accessing services, consistency of approaches across areas provides greater equality. Closer working between organisations has meant more timely access to the service and an ability to resolve problems as they occur and with minimal impact on the tenants.

Referrals are screened and triaged based upon a priority and those where risks are highest or requiring support to be discharged are prioritised.

The team can access the full suite of Adult Social Care support by completing Care Act Assessments and are trained in assessing equipment, adaptations, telecare, carers assessments, mental capacity, and safeguarding, they can provide daily living equipment and minor adaptations via the local Integrated Community Equipment service.

They work collaboratively with colleagues from Social Care, Wheelchair services, Health, Voluntary and Housing sectors to consider options to meet individuals' needs.

An innovative example is accessing funds for a 'third party top-up' towards a wheelchair provided by the wheelchair services to enable an additional rise and fall element to be fitted to the seat of the chair, allowing the individual to access higher shelves within their kitchen but also assisting them to access shelves within their local supermarket and have conversations at eye level.

Support is provided with rehousing; either via accessing discretionary assistance to finance moving costs, part-buy schemes to purchase an adaptable property (recently cited as an example of Best Practice by Foundations) or local housing registers. Options are fully explained and referrals to organisations such as Brighton Housing trust or internal Housing Solutions workers made. Assessments of temporary accommodation and adaptations and equipment in alternative housing are also carried out. Interim risk management measures are also provided.

Assessments are undertaken for individuals regardless of whether they live in public or private sector housing. For individuals who are identified as self-funding adaptations are offered information and advice to ensure their needs are appropriately met.

This service has successfully won the DFG team of the year award by Foundations in 2022.

The following services have been or are in the process of being developed to use housing support, including DFG funding, to support independence at home:

- Integration and co-location of Housing OT Service into DFG teams
- Review and updating of discretionary DFG policies, using the joint strategic needs assessments to identify gaps in service provision and focus on place-based provision of

services tailored to the needs of the specific communities within district or borough areas aiming to address health inequalities.
- Development and adaptation of temporary accommodation that supports independence for users who are disabled.
- Working with housing development teams to ensure requirements for accessible and adaptable new build housing is tailored to the needs of the local population and addresses current shortfalls.

In addition to BCF funded Housing support there are a range of other Housing Support services across East Sussex including:

- Extra-care facilities
- Shared lives/ Supported accommodation: a number of planned developments for supported living and potential shared lives placements over the next 3 years.
- Floating support services
- Homelessness and Rough Sleeper initiatives
- Telecare and Telecheck services
- Warm homes teams
- Mental health services links with housing
- ESCC pilot of assistive technology (Alexa)
- Linked smoke alarms, jointly funded with East Sussex Fire and Rescue services

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? **Yes**

The amount allocated for these discretionary uses is £4,061,806 per annum. Further information can be found at:

Disabled Facilities Grants in Hastings

Eastbourne Housing Strategy 2020-2024 - Lewes and Eastbourne Councils (lewes-eastbourne.gov.uk)

Housing Financial Assistance Policy 2021-2025 – Rother District Council

Discretionary Assistance for Disabled Occupants - Wealden District Council - Wealden District Council

9. Equality and health inequalities

The East Sussex partners continue to work together guided by the council's priorities under the Equality Act, NHS equalities duties and the NHS Core20PLUS5 approach to reducing healthcare inequalities.

We'll build on our existing progress to:

- empower people to stay healthy and well for as long as possible.
- reduce health inequalities and the gap in life expectancy and healthy life expectancy in the county.

We will do this by working with all the services that influence health, like housing, employment and leisure as described in the wider determinants of health section. We believe that collectively our organisations can make a real difference to our population's economic and social wellbeing.

East Sussex is a county with a growing and ageing population. By 2026, almost one in four people here (24%) will be aged 65 to 84. For England as a whole, that figure is nearer one in six (17%). More than 4% of our population will be over 85. This compares to less than 3% for England as a whole.

With more older people, which includes those who are frail and have multiple conditions, East Sussex is likely to have higher health and care needs than other areas of our size. This rise in demand is just one part of our health and care for the whole population.

By 2028, around 20,000 more people in East Sussex will be living with two or more long-term health conditions than was the case a decade earlier.

The number of children in need of help and protection is rising locally and nationally, linked to the increase in families with financial difficulties. There is also a rise in the number of children with statements of special educational needs and disability (SEND), some of whom will have complex medical and care needs.

East Sussex is both rural and urban, which brings challenges in ensuring the right access to services and at the right quality. Our coastal communities reflect the patterns of inequality and poverty highlighted nationally in the Chief Medical Officer's report from 2021 and there is also hidden poverty in our rural areas.

On average, our population's health is similar to England's but there are wide variations within East Sussex. People in deprived areas tend to be affected by poorer health. The gap in life expectancy between our most and least-deprived areas is more than 11 years for men and almost 10 years for women.

A person's chance of enjoying good health and a longer life is influenced by the social and economic conditions in which they are born, grow, work, live and age. These affect the way people look after their own health and use services throughout their life. The poorer your circumstances, the more likely you are to have poor health and wellbeing, spend more of your days with life-limiting illness and die prematurely. This requires joining up NHS and social care with other services provided by the County Council, district, and borough councils, the voluntary, community and social enterprise sector and other services and businesses that affect people's lives, health, and social or economic wellbeing.

The Covid-19 pandemic also further highlighted how a combination of structural inequalities in our society (for example, income and housing) and inequalities experienced due to ethnic background and other characteristics, led to increased risks for some groups.

We want to reduce health inequalities for our population. This will be measured by inequality in healthy life expectancy at birth. It will require us to work differently on how resources are used, how we assess the impact of the decisions we make and look at new ways in which everyone can have equal access to appropriate services. This includes identifying where some groups may require more intensive support and additional help to access services. Health and care also needs to be delivered with an awareness of the differences between groups and within our population and tailored to each individual's strengths and potential vulnerabilities. Every opportunity will be explored to make sure we improve our ability to do this.

We are monitoring our progress with delivery of our priorities across the four areas below to make sure we are having the most impact:

Addressing the causes of ill health to prevent premature death and the overall prevalence of disease. The Core20Plus5 approach sets out a model to support integrated care systems to focus on health inequalities by identifying local areas of focus linked to deprivation and outlining the 5 key clinical areas for health inequalities:

- early cancer diagnosis
- chronic respiratory disease
- hypertension case finding to minimise risks of heart attacks and strokes.
- continuity of maternity care
- annual health checks for people living with serious mental illness and learning disabilities.

We will also focus on identified and prioritised population groups that are experiencing health inequality and disadvantage. In East Sussex these are identified as:

- Carers.

- LGBTQ+ groups

One overarching recommendation is that the East Sussex Health and Care system prioritises the improvement recording and monitoring of protected characteristics. Although Carers are not a protected group under legislation, it is recommended that within the East Sussex health and care system that they are treated in this way. In terms of making change – there are two approaches – top down- SROs for Health inequalities champion the importance of data recording and monitoring within their organisation; and practically - to link up with the ICS programme to improve ethnicity recording and include LGBTQ+ and carers at the same time when reviewing data systems and considering staff training.

We will prioritise the improvement of healthy life expectancy tackling the key health inequality related conditions and ill health through:

- Supporting individuals and populations to adopt healthy behaviours, including promoting and supporting healthy weight, and action to reduce harm from alcohol and tobacco.
- Addressing the social and emotional factors that influence health in our communities, including the economic wellbeing of our population.

- Further developing our capability as a system, including through locality and neighbourhood working and a 'Population Health Management' approach. This is a way of working supported by data and insight, to help frontline teams understand current health and care needs and what factors are driving poor outcomes in different population groups. This will result in more proactive models of care which will improve health and wellbeing today and in future years.

The BCF in East Sussex funds a wide range of services provided by the VCSE sector. These services include community hubs, community connectors, benefits advice, and access to community-based support for people with sensory and mental health needs.

The East Sussex BCF schemes are subject to the requirements of the commissioning partner organisations in respect of Equality Impact Assessments. Consideration is given to the level of the schemes' impacts on the wider determinants of health and Core20+5 priorities to reduce health inequalities.

The East Sussex BCF is embedded in the local health and social care economy and broader plans and as with wider health and care, services funded via the BCF need to ensure they are accessible for people with protected characteristics and / or experience health inequalities.

To support shared accountability for delivering the vision and the outcomes, our Health and Wellbeing Board has brought together a small number of strategic outcomes that we all share and have agreed we will work together to measure and improve. We are continuing to make sure that these align with our developing ICS strategy and framework.

The outcomes are based on what local people have told us is important about their health and care services and other areas. These have been used to inform this strategy as well as our East Sussex Health and Care Plan and programme and the other strategies and plans that will support delivery of this strategy.

Outcomes are set out under four headings:

- Population health and wellbeing
- The experience of care
- The quality of care
- Transforming services for sustainability

As we develop at place into 2023-24 and beyond, any review and restructuring of our BCF programme, including new schemes, will require new or refreshed Equality Impact Assessments.

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Report to:	**East Sussex Health and Wellbeing Board**
Date:	**16th July 2024**
By:	**Healthwatch East Sussex**
Title:	**Healthwatch East Sussex Annual Report 2023-24: The value of listening**
Purpose of Report:	**To provide an overview of the Healthwatch Annual Report 23/24**

Recommendations: East Sussex Health and Wellbeing Board is recommended to:

1) Consider and note the Healthwatch East Sussex Annual Report 2023-24

1 Background

1.1 Each local Healthwatch in England is required to publish an annual report providing an overview of its activity and statutory functions. The Healthwatch East Sussex Annual Report 2023-24 is titled 'The value of listening' and is attached as appendix 1.

2 Supporting Information

2.1 The Annual report sets out, amongst other things, highlights of work over the course of the year; work on engagement; ways in which a difference has been made; information about volunteers; financial details; and details of Healthwatch's priorities for 2024/25.

3 Conclusion and reasons for recommendations

3.1 The East Sussex Health and Wellbeing Board is recommended to consider and note the report.

Veronica Kirwan
Chief Executive, East Sussex Community Voice, delivering Healthwatch in East Sussex

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Appendix 1: *Healthwatch East Sussex Annual Report 2023-24: The value of listening*

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The value of listening

Healthwatch East Sussex
Annual Report 2023-2024

healthwatch
East Sussex

Contents

"Over the last year, local Healthwatch have shown what happens when people speak up about their care, and services listen. They are helping the NHS unlock the power of people's views and experiences, especially those facing the most serious health inequalities."

Louise Ansari, Chief Executive at Healthwatch England

Message from our Chair

Last year when I highlighted Healthwatch's tenth anniversary and the activity undertaken to date, I had not appreciated the further changes that would occur as we moved into our second decade, which have seen us appoint a new Chief Executive and several new staff. We have also moved to offices that better cater for our needs, so we are best-placed to continue our important work during 2024-25.

Our health and care sector has continued to face pressures, and we have worked hard to ensure feedback is heard and acted on by commissioners and providers. We believe this is more important now than ever before, especially for less heard groups in our communities.

Healthwatch East Sussex championed the patient-voice in approximately 40 different fora during 2023-24, including the Sussex Health and Care Assembly, East Sussex Health and Wellbeing Board and Health Overview Scrutiny Committee, as well as with the Care Quality Commission, Safeguarding Adults Board, NHS Trusts, County Council departments and individual service providers such as GPs and pharmacies.

We continued our wide-ranging engagement activities, including Enter and Views of care homes and community diagnostic centres, exploration of long COVID, and mystery shopping of GP websites. Our Rye and rural Rother Listening Tour enhanced links with local communities, and we continue to raise the issues around access to primary care and the provision of transport for isolated communities in discussions around the new local transport plan and creation of Integrated Community Teams.

Like our NHS, social care and voluntary sector colleagues, we have seen increasing volumes of public enquiries compared to previous years. Our Information & Signposting service supported 578 people to navigate health and social services, including asylum seekers, prison residents and users of food banks.

Young Healthwatch has grown by leaps and bounds, recruited more members and progressed its activities, including the development of an accreditation of GP practices for children and young people.

I am proud that we achieved 'Investors in Volunteers' accreditation which reflects the hard work of our staff and volunteers in developing volunteer policies, procedures and ways of working. This has supported the recruitment of more volunteers enabling us to undertake core activities such as Enter and View visits, as well as build further links with our local communities.

As always, can I finish with a big thank you to my fellow non-executive board members, the management team, our wonderful staff and of course our volunteers of all ages for making it possible.

"Our continued collaboration with other Healthwatch, the Sussex Health & Care Assembly and East Sussex Health & Wellbeing Board has enabled us to ensure the profile of Healthwatch and the patient voice is kept at the forefront of decision making."

Keith Stevens, Chair of East Sussex Community Voice, delivering Healthwatch East Sussex

About us

Healthwatch East Sussex is your local health and social care champion.

We make sure NHS leaders and decision-makers hear your voice and use your feedback to improve care. We can also help you to find reliable and trustworthy information and advice.

Our vision

A world where we can all get the health and care we need.

Our mission

To make sure people's experiences help make health and care better.

Our values are:

- **Listening** to people and making sure their voices are heard.
- **Including** everyone in the conversation – especially those who don't always have their voice heard.
- **Analysing** different people's experiences to learn how to improve care.
- **Acting** on feedback and driving change.
- **Partnering** with care providers, government, and the voluntary sector – serving as the public's independent advocate.

Year in review

Reaching out:

1,367 people

shared their experiences of health and social care services with us, helping to raise awareness of issues and improve care.

578 people directly and 23,840 virtually

came to us for clear advice and information about topics such as access to dentistry, social care, vaccinations, complaints and cost-of-living.

Making a difference to care:

We published

36 reports

about the improvements people would like to see in health and social care services.

Our most popular report was

What we heard in our 2022 Listening Tour

which highlighted the health and care experiences of people living in and around Eastbourne.

Health and social care that works for you:

We are lucky to have

21 adult and 12 Young Healthwatch

outstanding volunteers who gave up 125 days of their time to make care better for our community.

We are funded by our local authority.
In 2023 - 24 we received

£364,470

which is the same as the previous year.

We currently employ

13 staff

who help us carry out our work.

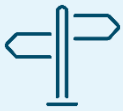
How we have made a difference this year

Spring

We published our 'guide to complaints' to help people understand how and when to make a complaint to health and care services. It also explained advocacy support and how to access it.

We contributed to the East Sussex Adult Social Care Strategy Action Plan, encouraging activity to raise public awareness of social care services and how to access them appropriately.

Summer



Our roadshow events held across East Sussex helped us capture and understand the health and care experiences of local people from a range of different communities.

We undertook audits at GP practices in Eastbourne to support them in assessing their physical accessibility for patients and the public and shared recommendations for improvements.

Autumn

Our staff and volunteers undertook 16 Patient-Led Assessments of the Care Environment (PLACE) to review local services settings and ensure they are fit for purpose.

We highlighted the impact of increased cost of living on people's wellbeing, including changes in their use of health and care services, with the East Sussex Financial Inclusion Steering Group.

Winter

We contributed to a Health Overview and Scrutiny Review of changes to paediatric services at Eastbourne District General Hospital, helping ensure the patient voice was captured and heard.

Our host organisation received 'Investors in Volunteers' accreditation which reflects the importance we place on supporting our volunteers in delivering programmes such as Healthwatch.

Feedback from our partners

East Sussex County Council

"Healthwatch East Sussex continues to gather and promote important insights into residents' experiences of health and care services (as well as playing a valuable role with the VCSE Alliance for our county via East Sussex Community Voice). The Rye and rural Rother Listening Tour was a great example of Healthwatch's work, providing a wide range of feedback from all parts of the community, and building a stronger understanding of local developments across the health and care system.

I am also delighted that the national profile of Healthwatch East Sussex received a well-deserved boost in 2023, after presenting the 'Putting a face to Unmet Need' report to the Healthwatch England Committee. I am pleased that Young Healthwatch has grown so much in the last year - with young people volunteering to audit health settings, design surveys, and create artwork. On behalf of East Sussex County Council, I look forward to continuing to work closely with Healthwatch East Sussex in improving the experiences and outcomes for residents across the county."

Mark Stainton
Director of Adult Social Care and Health, East Sussex County Council

Sussex Integrated Care Board (NHS Sussex)

"Over the past year, work with Healthwatch has continued to support NHS Sussex in ensuring that the voices and experiences of people and communities in East Sussex are heard and responded to.

Collaborative work to develop support for NHS Sussex volunteers, to develop ways for Children and Young people to share views and be involved in decision making and to produce a toolkit to support patient engagement in GP practices has highlighted the value of working with Healthwatch as a trusted partner.

Healthwatch continues to support NHS Sussex to ensure that the focus remains firmly on putting people and communities at the heart of all we do.

I have valued the positive working relationship with Healthwatch over the past year and look forward to continuing this into the next year and beyond".

Jane Lodge
Deputy Director, Working with People and Communities, NHS Sussex

Feedback from our partners

East Sussex Healthcare NHS Trust

"Healthwatch East Sussex has continued to support East Sussex Healthcare NHS Trust during 2023/24 ensuring that all feedback received regarding the experiences of patients, carers, relatives and local communities is shared directly back with our patient experience team, to enable them to use this information to shape and develop services which we provide.

Enter and view activities were undertaken in our Emergency Departments, Paediatric Services (Conquest) and Bexhill Community Diagnostic Centre. The feedback Healthwatch gained as part of these activities has made a positive impact for these areas.

We look forward to delivering further activities during 2024/25 in collaboration with Healthwatch East Sussex."

East Sussex Healthcare NHS Trust

Healthwatch in Sussex

"Three local Healthwatch (Brighton & Hove, East Sussex and West Sussex) cover Sussex.

Over the past year, the three Healthwatch teams have collaborated as 'Healthwatch in Sussex' to capture and share feedback on the transformation of outpatient services, and experiences of long COVID, dentistry, NHS complaints, Patient Advice and Liaison Services (PALS) and Memory Assessment Services.

Partnership working has enhanced our ability to champion public and patient voices on these and other health and care themes at a Sussex-wide level.

Our collaborative working has been recognised and acknowledged as good practice by our national body Healthwatch England and NHS Sussex, and we will continue to work together to ensure that people sit at the heart of health and care services over the next 12 months and beyond."

Chief Officers
Healthwatch Brighton & Hove, East Sussex and West Sussex

Your voice heard at a wider level

We collaborate with other Healthwatch to ensure the experiences and views of people in East Sussex influence decisions made about services at Sussex Integrated Care System (ICS) level.

This year we've worked with Healthwatch in Brighton & Hove and Healthwatch West Sussex to deliver:

Achievement one: We delivered four workshops with diverse participants to support the transformation of local outpatient services. This helped the NHS to understand how best to deliver Advice and Guidance, Patient Choice, Patient Initiated Follow-Up (PIFU) and reduce Did Not Attends (DNA) whilst improving the patient experience. NHS Sussex are now progressing these changes using the feedback from local people.

Achievement two: We regularly shared people's experiences of dentistry with NHS decision-makers and dentists to ensure barriers to access and impacts were understood. NHS Sussex have improved advice on their website, clarifying how and where emergency and routine services can be accessed. Pilots are being launched to explore the expansion of local NHS dental capacity and enhance oral health in care homes.

Achievement three: We supported the Sussex Integrated Care Board (NHS Sussex) in surveying Sussex residents' views on the priorities of our Shared Delivery Plan, the use of patient data within the NHS, and their satisfaction with local NHS services. Healthwatch used its reach and links with local networks to maximise contributions from diverse communities, helping to amplify people's experiences and views.

Achievement four: We gathered qualitative experiences of long COVID from across Sussex, using people's stories to highlight the wide range and often significant scale of impacts on their lives. We shared our insight with the NHS, including the Post-COVID Assessment and Support Service (PCASS), to help them adapt and diversify their activities to best meet the needs of those experiencing ongoing symptoms.

Improving the patient experience of using the Non-Emergency Patient Transport Service (NEPTS)

Since 2016, the three Sussex Healthwatch teams have collated nearly 600 patient experiences of NEPTS across four separate reviews, our latest in 2020. Since then, we have worked with NHS Sussex Commissioners to ensure that improvements patients wanted were acted on. We also wanted to make sure that the new provider could deliver the service and avoid past mistakes.

NEPTS is for people whose condition means they need support to and from hospital and other medical appointments. This year, Healthwatch contributed to the commissioning and delivery of NEPTS by:

- **Being part of a Sussex Communications and Engagement Group** where we influenced the final wording and requirements for the new NEPTS contract being delivered in Sussex from 2025.
- **Evaluated bids to deliver the new NEPTS contract**, focusing on what patients told us mattered most to them: focusing on patient communications, timeliness, assessment of eligibility, continuous service improvements and accessibility of the service.

Previously, local Healthwatch in Sussex have supported the current provider of NEPTS to deliver patient forums, so user voice is captured and used to inform service delivery. We also fed into a national review of NEPTS to ensure that the views of Sussex residents and patients were heard in the process.

What difference did we make to the Sussex NEPTS service?

Using people's feedback and our independent review of the NEPTS service, we developed several recommendations. Those commissioning the new service acted on these, including:

We recommended the new provider should invest in delivering improved communications including clearer patient guidance around eligibility and how to apply. The service provider should also provide information about alternatives to the service. There is a new requirement for the provider to develop a Single Point of Coordination which will refer patients who meet the eligibility criteria to an expanded and more responsive patient transport service, and signpost ineligible patients to alternative transport options.

We recommended the new provider should use innovative technological solutions such as mobile phone tracking apps and a patient online account facility to help patients track their vehicles. There is a new requirement for the NEPTS provider to embed modern technology such as apps and web-based portals to ensure patients, their carers, and hospital staff are kept informed of the location of their transport so that they are ready on time for its arrival.

We recommended that the new provider should establish fully accessible patient forums for patients. The new transport provider is required to establish and support patient groups across Sussex to assist in the ongoing cycle of service monitoring and improvement, so it will always have patients working with it to plan for a better service.

"As someone whose role it is to make sure patient concerns are central to decision-making, I can honestly say that I have never seen a more meticulous, patient-centric contribution." Feedback on Healthwatch

Listening to your experiences

Services cannot make improvements without hearing your views. That's why, over the last year, we have made listening to feedback from all areas of the community a priority. This allows us to understand the full picture, and feed this back to services and help them improve.

Listening Tour 2023:
Rye and the surrounding villages

Each year we focus on one area in East Sussex to gather in-depth feedback and hear about local people's health and care needs and aspirations.

Our 2023/24 Listening Tour visited Rye and the surrounding villages and engaged with over 300 people as well as community groups, services providers and commissioners. Throughout the tour we:

- Held a networking event with representatives from 13 local voluntary organisations
- Conducted mystery shopping of websites at 6 GP practices to assess information provision
- Had six pop up stands at community locations to capture people's views
- Ran two focus groups and visited three local community groups for one-to-one conversations
- Conducted Enter and Views at 19 care homes to assess experiences of care settings
- Distributed our Listening Tour survey, available online and in hard copy, to capture people's experiences of local health and care services, impacts of cost of living and priorities for change.

24.3%
of survey respondents told us the greatest barrier to accessing services were the challenges associated with using public transport

Our recommendations called for:

- East Sussex County Council to ensure development of the forthcoming local transport plan appropriately considers enabling access to health and care services across the county.
- Adult Social Care services to deliver on their engagement strategy and ensure communities in Rye and surrounding villages are aware of the support that is available and how they can access it.
- NHS Sussex and local primary care networks to ensure reasonable adjustments are provided to patients with additional communication needs when engaging with GPs and other services.
- Services to investigate opportunities for delivering into rural communities, rather than expecting residents to travel, especially for key activities such as health screening and outreach surgeries.

What difference will this make?

Our Rye Listening Tour helped us raise public and organisational awareness of Healthwatch and what we do in a predominantly rural part of our county. It has provided us with a starting point for developing our relationships with local community groups and service providers, helping us to amplify the voices of people we haven't previously reached.

We have already begun working with local groups, providers, and commissioners to progress our recommendations, and used what we learnt to shape our work plan and further explore the issues raised.

With the support of the Health and Wellbeing Board, we have already begun work with our local authority to address concerns about local transport links to health and care services.

Listening Tour 2023:
Rye and the surrounding villages.

What has the Listening Tour achieved so far?

- Through our face-to-face engagement and promotion via local and social media, we created a greater awareness of Healthwatch amongst Rye residents, groups and service providers.
- We raised the profile of health and care issues in Rye and the surrounding villages with the East Sussex Health & Wellbeing Board through our reports and by presenting our findings.
- We highlighted the challenges faced by patients in accessing GP services with NHS Sussex and the Clinical Director of the Primary Care Network, and work to address these is ongoing.
- We are responding to the feedback we received from our Enter and Views by collaborating with NHS Sussex to explore oral health and access to dentistry in care homes in 2024/25.
- We liaised with the local Primary Care Network and a voluntary group to explore improvements for clients with learning difficulties in accessing cervical screening and holistic health and wellbeing support on a rolling basis.

Next Steps

- Healthwatch will continue to share our reports and what we heard with key partners including local health and care commissioners and providers and the wider public.
- We will feed the learning from this Listening Tour into our priority setting and project planning for 2024/25, and into initiatives such as the creation of the Integrated Community Team for Rother.
- We will produce a 'One Year On' report to update partners and residents on the progress that has been made since the tour during 2024.
- We will work with Primary Care colleagues to explore options for improving access to services within the rural communities surrounding Rye, especially GP provision, and screening services.
- We will sustain relationships with key partners and communities across Rye and rural Rother to ensure patient and public voices are fed into the design and delivery of local services.
- We will work with Adult Social Care and the NHS to explore experiences of oral health and access to dentistry in care homes, and the implementation of Modern General Practice amongst GPs.

"Need a medical hub in the Rye area as we are quite rural. Somewhere where we can get X rays, check ups, blood tests, basic treatments etc. quickly without travelling to Hastings or further."

Local resident surveyed by Healthwatch East Sussex

Bexhill Community Diagnostic Centre

The NHS is struggling to meet key diagnostic targets. Since February 2017, the NHS has not met its target for 99% of patients waiting for less than 6 weeks for a diagnostic test at a national level. Demand for diagnostic tests is increasing.

Setting up Community Diagnostic Centres (CDCs) is a flagship policy for the NHS and crucial part of the elective care recovery plan. CDCs aim to transform diagnostics in England by reducing the pressure on acute services, ringfencing resources for elective diagnostics, and increasing diagnostic capacity. In response to this, in early 2024 we asked people about their experiences of Bexhill CDC, which had opened in March 2023.

94%

of respondents using Bexhill CDC reported that they waited less than 6 weeks for their test or scan.

What did you tell us about care?

- 85% of patients were either satisfied or very satisfied with their overall experience of their test or scan at Bexhill CDC. The quality of facilities and adjacent free parking were highly valued by patients.
- 55% of respondents reported being offered a choice about the date and time of their appointment, which was highlighted as a positive in the patient feedback.
- 89% of respondents travel to Bexhill CDC by car. There are limited public transport options for patients and staff. There is a need for disabled parking bays and a drop off-pick up zone for taxis and non-emergency patient transport.
- The environment is accessible for people with dementia and there is good use of pictorial signage. Further improvements could be made with signage and patient information in reception.

What difference did this make?

- We reported patient and user feedback to NHS Sussex, who will combine our findings with their Experienced Based Design to implement our recommendations on further improving the patient experience of Community Diagnostic Centres.
- We shared our findings with Healthwatch England, contributing to a national report on Community Diagnostic Centres which will evaluate their impact on tackling waiting times for diagnostic testing.

"Very happy with the staff and they made a difficult situation so easy … staff at this centre are obviously experts in the field. Clean building and friendly staff. I was very impressed " Patient who responded to Healthwatch survey

Hastings Children and Young People GP Accreditation Project

Young Healthwatch East Sussex is made up volunteers between the ages of 12 and 21 who work to shine a spotlight on issues that affect young people in health and social care. Our young volunteers come from a wide range of backgrounds and are vital in ensuring that the voice of young people is represented and acted upon.

In 2023, we were commissioned by Hastings Universal Healthcare to co-design an accreditation for GP practices in Hastings and St Leonards. The project aimed to improve young people's confidence in GP services by enabling practices to demonstrate that they consider and support the needs of children and young people (CYP).

Our activity has focused on building knowledge of practices' current provision, and exploring what young people feel could help practices to be more welcoming. To date our volunteers have:

- Collaborated to co-design the accreditation criteria based on what makes practices children and young people friendly
- Taken part in 'mystery shopping' of GP practice websites to assess their suitability for children and young people
- Undertaken pilot audits of GP practices in Hastings and St Leonards to test the criteria, providing feedback and recommendations directly to practice staff during their visits

The accreditation criteria cover a range of themes: information about things that affect young people; anxiety, neurodiversity, and the practice environment; booking appointments; and welcoming and listening to young people.

We will soon be arranging visits to GP practices by our young volunteers, who will assess which are children and young people friendly.

All participating practices will receive feedback to help them identify actions that respond to any identified areas for improvement. It is hoped the process may be rolled out more widely in the future.

What difference did this make?

- Feedback from young people has been shared with GP practices to enable practices to have a greater understanding of what is important to young people, and how best to support them.
- Volunteers involved in the project are reporting greater confidence in accessing their GP compared to the beginning of the project.
- An accreditation has been designed which focuses on what is important to young people, ensuring that GP practices who receive the accreditation are taking the steps needed to give young people the confidence to access services when required.

"I have enjoyed working with everyone and working on very essential skills like communication, teamwork and understanding the standards in the NHS."

Young Healthwatch East Sussex volunteer

Three ways we have made a difference in the community

Throughout our work we gather information about health inequalities by speaking to people whose experiences are not often heard.

Creating empathy by bringing experiences to life

It's important for services to see the bigger picture. Hearing personal experiences and the impact on people's lives provides them with a better understanding of the problems.

People may experience a range of long COVID symptoms, with the severity also varying from person to person. Healthwatch in Sussex collated 15 case studies to illustrate how long COVID can affect people's physical and mental health, as well as impact on people's education, employment, housing and quality of life. These were shared with NHS Sussex to help inform delivery of the Post COVID Assessment and Support Service (PCASS) in tailoring support that responds to these needs.

Getting services to involve the public

Services need to understand the benefits of involving local people to help improve care for everyone.

Healthwatch East Sussex collaborated with Bexhill Primary Care Network to develop a new website for one of its GP practices. Our volunteers undertook 'mystery shopping' of the design, content and navigability of the site before it went live, sharing feedback with PCN staff and the website developer. This helped ensure it was accessible to the public and patients and would support local people in identifying how, when and where to access services from their practice.

Improving care over time

Change takes time. We often work behind the scenes with services to consistently raise issues and bring about change.

Attending health appointments often incurs costs, especially for travel. Similarly, medication and prescriptions may also have charges attached. The NHS has schemes that provide support with healthcare costs to those on low incomes or eligible to receive them, but public and patient awareness of them is often low. Healthwatch East Sussex has pro-actively shared our guidance to raise awareness of them, as well as offering information and signposting support at food banks and other locations.

Hearing from all communities

Over the past year, we have worked hard to make sure we hear from everyone within our local area. We consider it important to reach out to the communities we hear from less frequently to gather their feedback, make sure their voice is heard, and ensure services meet their needs.

This year we have reached different communities by:

- Working with Diversity Resource International (DRI) to deliver health and wellbeing drop-in sessions to support people from ethnically diverse communities and listen to their experiences.
- Attending food banks to hear from individuals struggling with daily life and sharing insight on the impacts of changes in the cost of living with the East Sussex Financial Inclusion Steering Group.
- Attending the Ethnically Diverse Engagement Forum and community initiatives to gather insight from migrants and asylum seekers and feed this into the new East Sussex Migration Partnership.
- Holding discussion groups with parent carers to listen to their experiences of working with multiple services, including the NHS and Adult Social Care and Health.
- Attending networks, meetings and groups across East Sussex to hear from different communities.

Supporting the fishing community

Healthwatch East Sussex attended a health and wellbeing event organised by the Fishermen's Mission, aimed at providing support to the fishing community.

We heard from fishermen who were concerned about new legislation which required them to have a signed medical certificate (ML5) from their GP deeming them medically fit to go to sea. This was an optional service for GPs to provide with a cost implication for the fishermen.

As a result of what we heard, we:

- Liaised with the Fishermen's Mission to understand the potential impact of the new legislation on fishermen, who already face health inequalities and are sporadic users of health services.
- Raised the issue with the Integrated Care Board, who provided information to GP practices via primary care networks to plan for the increase in requests for GP appointments from fishermen.
- Ensured arrangements were in place at PCN level for appointments to be available at neighbouring practices for those whose own GP practice opted out of the scheme.
- Shared information with the Fishermen's Mission so they could promote this arrangement with individuals from the fishing community, so they were informed about how to access services.

Hearing from residents at HMP Lewes

Healthwatch East Sussex delivered monthly drop-in sessions for residents of HMP Lewes to hear about their experiences of accessing healthcare services and provide information and signposting to help them access services to meet their needs.

This included:

- Hearing about the barriers and challenges residents face when trying to access health and care services within and outside of the prison.
- Liaising with the HMP Lewes Patient Engagement Lead, to identify areas for improvement and making suggestions to make positive changes that enhance residents' experiences.
- Providing drop-in sessions alongside colleagues from The Advocacy People so that residents could access advocacy support to make a complaint about health services if required.
- Meeting with the Independent Monitoring Board and the Care Quality Commission Regional Manager for Prisons to ensure residents' voices were being heard.

Healthwatch East Sussex plan to further explore the key themes that have emerged from the drop-in sessions at HMP Lewes, by holding focus groups with residents.

It is hoped that by undertaking further engagement with people from this closed community, we will:

- Gain greater understanding of the issues faced by residents when accessing healthcare services.
- Identify improvements made to date.
- Identify areas where work is still required.
- Share learning and best practice so others may learn from these experiences.

Advice and information

If you feel lost and don't know where to turn, Healthwatch is here for you. In times of worry or stress, we can provide confidential support and free information to help you understand your options and get the help you need. Whether it's finding an NHS dentist, making a complaint or choosing a good care home for a loved one – you can count on us.

This year we've helped people by:

- Publishing guidance on topics including how to complain about health or care services, accessing cost of living support, navigating social care, and accessing home adaptations and equipment.
- Offering Information and Signposting drop-in sessions to less-heard groups, including food bank attendees, ethnically diverse communities and residents at HMP Lewes.
- Meeting regularly with NHS Sussex, Adult Social Care and Health, and Care Quality Commission colleagues to share patient and public experiences and contribute to service development.
- Developing our monthly 'You Said - We Did' publication to highlight what we've heard and the actions we've taken.

Responding to the cost-of-living crisis

We listened to how the cost-of-living crisis is impacting on people's wellbeing and their ability to access services.

We delivered regular Information and Signposting drop-in sessions at local food banks and cost-of-living support sessions, to offer advice to people who were struggling to access health and social care and to raise awareness of available help with health costs. People told us:

- They had stopped using prescribed medicine due to lack of affordability.
- They struggled to make and attend appointments for a variety of reasons, including lacking a reliable phone, inability to afford transport costs, and lack of locally accessible services.
- Ill health, coupled with challenges in knowing how and where to access appropriate support, was often a cause of people's financial struggles.

Through event attendance, our newsletter and website, we let people know about sources of help with healthcare/travel costs, where they could access local health and care services, and what further forms of support, including for carers and home adaptations, they could apply for.

We published a 'Help with Healthcare Costs' article and shared people's experiences with NHS Sussex at regular meetings, also advocating for flexibility in the appointment times for working people.

We shared public and patient feedback on the cost barriers of dentistry services, prescriptions, and medication charges with the East Sussex Financial Inclusion Steering Group.

Improving equality of access to services

We work in collaboration with local health and social care staff and decision-makers to share people's experiences of using services and to support improvements in patient experience.

An East Sussex resident contacted our Information and Signposting service to complain that they had not received reasonable adjustments from their GP practice for their sensory impairment. This affected their ability to access services. We raised this with NHS Sussex, who passed the patient's concerns on to the surgery and received a positive response, including assurance that the patient will receive communications in a format suitable for them. The surgery recognised the need for staff training around the Accessible Information Standard, identifying potential for the Royal National Institute for the Blind (RNIB) to support the surgery in embedding adjustments that will appropriately support people with a visual impairment.

Support to provide feedback and complain

We regularly receive enquiries from individuals requesting information, advice, and guidance on how to make a complaint regarding NHS or social care services. People often report finding information on complaints confusing, not knowing who to contact to make a complaint or the process to follow.

In response we:

- Produced a Healthwatch 'Guide to complaints about health and care services', which is available on our website. It explains the complaint options and support available.
- Contributed to the development and roll-out of the Sussex Integrated Care Board's (ICB) Complaints Policy and supporting information and processes, to ensure a consistent approach to complaints locally.

Volunteering

We are supported by a team of amazing volunteers who are at the heart of what we do. Thanks to their efforts in the community, we are able to understand what is working and what needs improving.

This year our volunteers:

- Undertook mystery shopping of six GP websites in Rother District to assess how user-friendly they are for patients and users in terms of content, design, accessibility and navigability.
- Designed, led, and delivered an Enter and View of care homes in Rye and Rural Rother, visiting 19 homes to capture the experiences of residents and staff and identify recommendations for change.
- Represented us at meetings, working groups and boards including NHS Sussex Virtual Wards – Patient and Carers Reference Group, East Sussex Care Homes Group, East Sussex Healthcare NHS Trust Nutrition and Hydration Steering Group, and Cardiology and Ophthalmology Joint Steering Board.
- Young Healthwatch undertook an Enter and View of the Paediatrics department at the Conquest Hospital. They completed the 15 Steps Challenge and spoke with staff, patients and carers about their experiences, identifying how the service and space could be improved for parents and children.

"I started volunteering with Healthwatch in September 2020 after 30 years working in the care sector. It has enabled me to remain active, gather feedback, give people a voice – especially vulnerable individuals in our community, and make change happen in the health sector we all use.

I have so enjoyed my time as a volunteer; learned lots about the problems faced by the community and have been supported by managers and staff at ESCV to improve my interactions with others, work with a great team of volunteers and remain committed to improving for everyone the health and care services we use or may use in the future."

Jan

"My name is Robert. I joined Healthwatch East Sussex in 2015 with very little healthcare experience but had to curtail my Healthwatch activities for personal reasons and re-established my commitment to the Healthwatch family in 2023.

Being an authorised representative for Healthwatch I have participated in announced visits to varied healthcare facilities in the Healthwatch catchment area. These have included 'Enter and View' of nursing, care and rest homes. Visits also undertaken have been to hospitals with other Healthwatch team members.
I am now looking forward to a rewarding association with all team members of Healthwatch and being part of the family again."

Robert

Do you feel inspired?

We are always on the lookout for new volunteers, so please get in touch today.

www.healthwatcheastsussex.co.uk
0333 101 4007
enquiries@healthwatcheastsussex.co.uk

Finance and future priorities

To help us carry out our work we receive funding from our local authority under the Health and Social Care Act 2012.

Our income and expenditure in 2023/24

Income		**Expenditure**	
Funding from our local authority	£364,470	Expenditure on pay	£292,171
Additional income (including Independent Health Complaints Advocacy Service – IHCAS)	£118,530	Commissioned services (including Independent Health Complaints Advocacy – IHCAS)	£114,000
		Operational costs	£76,443
Total income	**£483,000**	**Total expenditure**	**£482,614**

Additional income included:

- £10,000 from NHS Sussex to resource our contribution to the Sussex Integrated Care System (ICS).
- £895 from Healthwatch England to capture feedback on Community Diagnostic Centres.

ICS funding

The three local Healthwatch in Sussex received funding to support our input into the Sussex Integrated Care System (ICS), which is not covered by our funding at place (East Sussex).

During 2023-24, the three Healthwatch pooled two years of funding from our Integrated Care Board (NHS Sussex) totalling £60,000, to fund a Healthwatch Strategic Liaison Lead post and to resource local Healthwatch staff to participate at system-level, including contributing to the Sussex Health and Care Assembly.

Our Strategic Liaison Lead co-ordinated the monthly collation and sharing of Sussex-wide Healthwatch insight with NHS Sussex, represented Healthwatch at system meetings, provided a single point of contact for ICS colleagues, and chaired a task and finish group progressing primary care communications with the public and patients.

The funding also supported Healthwatch in contributing to the Sussex-wide Patient Experience Committee, Quality Governance Improvement Group, and a range of other boards and partnerships.

Next steps

Over the next year, we will keep reaching out to every part of society, especially people in less-heard communities and deprived areas, so that those in power hear their views and experiences.

We will also work together with partners and our local integrated care system to help develop an NHS culture where, at every level, staff strive to listen and learn from patients to make care better.

Our top four priorities for the next year are:

1. **Listen and engage with people**
2. **Understand the impact of pressures on health and care services**
3. **Embed a focus on equality and diversity in our projects and increase the voice of seldom heard communities**
4. **Explore the effects of social determinants on health and wellbeing**

Statutory statements

Healthwatch East Sussex is delivered by East Sussex Community Voice CIC, Unit 31, The Old Printworks, 1 Commercial Road, Eastbourne, East Sussex, BN21 3XQ.

Healthwatch East Sussex uses the Healthwatch Trademark when undertaking our statutory activities as covered by the licence agreement.

The way we work

Involvement of volunteers and lay people in our governance and decision-making

Our Healthwatch Board consists of five members who provide direction, oversight and scrutiny of our activities. Our board ensures that decisions about priority areas of work reflect the concerns and interests of our diverse local community.

Throughout 2023/24, our board met five times and made decisions on matters such as:

- Embedding our Business Development and Prioritisation Sub-Committee which meets quarterly to review our projects and set our priorities.
- Adopting a revised Prioritisation and Decision-making Policy so that the process for setting Healthwatch priorities is clear, transparent and accessible to all.

We ensure that there is wider public involvement in deciding our priorities by:

- Using insight gathered via Information & Signposting enquiries and Feedback Centre reviews.
- Gathering input from our multi-agency Healthwatch Advisory Group which meets quarterly.
- Undertaking engagement virtually and face-to-face so that we hear from as many voices as possible.

Methods and systems used to obtain people's experiences

We use a wide range of approaches to ensure that as many people as possible can provide us with insight about their experience of health and care services. During 2023/24 we have been available by phone, email, LiveChat, and via social media, as well as face-to-face at a wide range of settings, such as community networks, health and care events, food banks, migrant drop-ins and Lewes Prison.

We ensure that this annual report is made widely available to the public and our partners. We publish it on our website, promote it to our partners and mailing list, share it with East Sussex County Council as our commissioner, the East Sussex Health and Wellbeing Board, and Healthwatch England as our national body. Hard copies are available on request.

Responses to recommendations

In 2023-24, no providers failed to respond to requests for information or recommendations. There were no issues or recommendations escalated by us to the Healthwatch England Committee, so no resulting reviews or investigations.

Taking people's experiences to decision-makers

We ensure that the people who can make decisions about services hear about the insights and experiences shared with us. In East Sussex, we take information to the Health & Wellbeing Board, Health & Care Partnership, and Health Overview & Scrutiny Committee to support local decisions.

We take insight and experiences to decision makers in the Sussex Integrated Care System (Sussex Health and Care). We are members of the Sussex Health & Care Assembly and alongside other Sussex Healthwatch sit on a range of thematic pan-Sussex boards and groups to champion patients' voices.

We share our data with Healthwatch England to help address health and care issues at a national level.

Enter and view

This year, we made four Enter and View visits to services in East Sussex and made 29 recommendations as a result of these activities.

Location	Reason for visit	What we did as a result
Paediatric services at Eastbourne District General Hospital (EDGH)	Gathering experiences of the service from children and young people and carers/parents.	Shared a report/recommendations – supporting the service to explore changes to the décor/environment.
19 Care Homes in Rye and rural Rother	Capturing staff and residents' experiences of care settings as part of Rye 2023 Listening Tour.	Provided feedback to each care home and shared findings/recommendations with East Sussex Care Home group.
Conquest Hospital and Eastbourne District General Hospital Emergency Departments	Gathering patient feedback of visits to emergency departments/urgent treatment centres in East Sussex.	Shared a report/recommendations – supporting East Sussex Healthcare NHS Trust to explore changes to the décor, patient sign-in and communications.
Bexhill Community Diagnostic Centre	Assessing the effectiveness of community diagnostic centres.	Shared a report with recommendations – supporting exploration of improved access, signage and patient follow-up.

Healthwatch representatives

East Sussex Health and Wellbeing Board

Healthwatch East Sussex is represented on the East Sussex Health and Wellbeing Board by our Chief Executive. During 2023/24 our representative has effectively carried out this role by championing the voice of the public and patients in the key health and care issues that have come before the board:

- Sharing findings and recommendations from our 2023 Rye and rural Rother Listening Tour and collaborating with partners to identify responses and next steps.
- Monitoring the Shared Delivery Plan (SDP) which is guiding implementation of the Sussex Integrated Care Strategy 'Improving Lives Together'.
- Contributing to programme planning and discussions related to service development and delivery, including winter pressures, pharmacy services, and mental health provision.

Sussex Health and Care Assembly

Healthwatch East Sussex is represented on the Sussex Integrated Care Partnership (Sussex Health and Care Assembly) by our Chief Executive. Contributions over the last 12 months included:

- Sharing patient and public feedback on health and care received by Healthwatch East Sussex.
- Asking that assembly ambitions and activity are communicated in plain English and in a form that allows the public and patients to understand and monitor them.
- Requesting that patient-centric metrics and measures (including patient experience) are embedded in the mechanisms used to review health and care performance across Sussex.
- Contributing to an annual review of the assembly, offering feedback on its effectiveness, and sharing areas for potential change and development.

healthwatch East Sussex

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Report to:	**East Sussex Health and Wellbeing Board.**
Date of meeting:	**16 July 2024**
By:	**Darrell Gale, Director of Public Health.**
Title:	**Annual Report of the Director of Public Health in East Sussex - Creativity for Healthier Lives.**
Purpose:	**To share the Annual Report of the Director of Public Health in East Sussex - Creativity for Healthier Lives and an update on previous and future reports.**

RECOMMENDATIONS:

The Health and Wellbeing Board is recommended to review and champion the 2023-24 Annual report of the Director of Public Health in East Sussex - Creativity for Healthier Lives, ahead of wider dissemination and publication.

1. Background

1.1 Appendix 1 contains the 2023-24 Annual Report of the Director of Public Health in East Sussex - Creativity for Healthier Lives.

1.2 This report highlights how creative health, creative approaches, and creative activities have benefits for our health and wellbeing. These activities can include visual and performing arts, crafts, film, literature, cooking, and creative activities in nature, such as gardening. Approaches may involve creative and innovative ways to approach health and care services. Creative health can be applied in homes, communities, cultural institutions and heritage sites or healthcare settings. It can contribute to prevention of ill health, promotion of healthy behaviours, management of long-term conditions, and treatment and recovery across the life course.[1]

1.3 The Board should note that the 2023-24 Creativity for Healthier Lives report forms part of a series of Annual Director of Public Health reports. The reports have been developed to highlight and increase our impact on health and wellbeing locally by focusing on the wider determinants of health, the factors that create and sustain the health and wellbeing of our population, beyond the provision of universal free NHS healthcare. These include:

1. The 2019-20 Health and Housing report that focuses on health and housing in East Sussex.
2. The 2021-22 Work, Skills and Health report that considers the relationship between work, skills, and health.
3. The 2022-23 Connecting People and Places report on social connections and multi-agency work to tackle loneliness.

The previous COVID-19 related report 2020: A Year of COVID-19 in East Sussex, interrupted our planned series of reports focusing on the wider determinants.

[1] National Centre for Creative Health (ncch.org.uk)

1.4 The 2023-24 report will be disseminated widely and published on the Joint Strategic Needs Assessment website at JSNA - Annual Public Health Reports (eastsussexjsna.org.uk)

2. Supporting information

2.1 This year's report builds upon the East Sussex Creative Health Position Paper - September 2023 and the Creativity and Health Evidence Review 2022.

2.2 The report includes contributions from key national and local figures from the creative health sphere and case studies from local agencies and projects.

2.3 The report is a key resource in making East Sussex a 'creative health county' and it outlines the key creative assets the county has that contribute to the health and wellbeing of our population.

2.4 The recommendations made in the report set out how we will work with new and existing partners. This will be through the strengthening of existing structures to focus on creative health, connecting local partners, and weaving it into existing public health programmes, whilst building collaboration beyond the county in research and external funding opportunities.

2.5 The report also includes a brief update on the previous report, Connecting people and places, and our progress against its recommendations.

2.6 The 2024-25 report will be on the health and wellbeing of coastal communities in East Sussex which will build on the Chief Medical Officer's Annual Report 2021 Health in Coastal Communities in which Hastings was a case study.

3. Conclusion and Recommendations

3.1 The 2023-24 Annual Report of the Director of Public Health in East Sussex - Creativity for Healthier Lives is now available to be reviewed by the Health and Wellbeing Board.

3.2 The Board is recommended to review and champion the 2023-24 Annual Report of the Director of Public Health in East Sussex - Creativity for Healthier Lives, ahead of wider dissemination and publication.

DARRELL GALE

Director of Public Health

Darrell.Gale@eastsussex.gov.uk

Appendix 1 - 2023-24 Annual Report of the Director of Public Health in East Sussex - Creativity for Healthier Lives.

Creativity for Healthier Lives

East Sussex
County Council

Contents

Section four

Section five

Section Six

> I have prescribed many things, dogs, books, roller-skating, rambling, crochet and choirs alongside standard medical treatments.
>
> A holistic approach to health is often a creative one - people need joy to get better as much as they need all the other things that medicine can offer.

Dr Sarah Andersen, Herstmonceux Integrative Health Centre

Foreword

I am delighted to introduce this annual report for 2023/24 which focusses on Creativity for Healthier Lives. Creativity is a fundamental aspect of humanity, and it is a pleasure to be able to focus on the essential role creativity has in supporting us all to be fulfilled, connected, healthy and expressive individuals.

Darrell Gale
Director of Public Health

One of the core tasks of a Director of Public Health comes from the statutory requirement that they publish an annual report on a theme of their choosing that speaks to a key issue or area of concern and focus. I am pleased to be able to use this year's Annual Director of Public Health Report to highlight the wide range of creative health activities and opportunities already in place across the county.

This years Creativity for Healthier Lives report forms part of a series of Annual Director of Public Health reports. These reports have been developed to highlight and increase our impact on health and wellbeing locally by focusing on the wider determinants of health, the factors that create and sustain the health and wellbeing of our population, beyond the provision of universal free NHS healthcare. These include the 2019/20 Health and Housing report that focused on health and housing in East Sussex. The 2021/22 Work, Skills and Health report that considers the relationship between work, skills, and health. Whilst last years, Connecting People and Places report covered social connections and multi-agency work to tackle loneliness.

A lot of arts in health and care work happens at grass root levels, in community based organisations and programmes that address both the clinical and social determinants of health. With this in mind, it's a great time to look in detail at creative health and the many contributions it makes at improving the health of our communities.

Health improvement projects and programmes that have featured creative health elements are not a new thing in the county. We have been making steady progress to establish East Sussex as a creative health county. We have done this with a wide range of partners, including those from the cultural, heritage, tourism, artistic and health and care sectors. When it comes to using creative health approaches we are slowly moving from 'nice to have' to 'must do!'.

This report builds on the Creativity and Health Evidence Review 2022 [Endnote 1]. The East Sussex Creative Health Position Paper - September 2023 [Endnote 2] and the Creative Healthier Lives - Arts in Public Health Delivery Action Plan [Endnote 3]. With contributions from

key national and local figures in the creative health sphere. This report aims to be a key resource in making East Sussex a creative health county and highlights the creative health assets and organisations involved.

There is a vast range of creative activities and opportunities across the county including the recent exhibition of the Turner Prize to Eastbourne [Endnote 4] and the Towner Eastbourne Gallery's centenary [Endnote 5].

This report sets out the benefits and evidence base for using creative health approaches across the life course. Recommendations are included to show how creative health approaches contribute to the local economy and health improvement, enhancing individual and communal opportunities to engage in creative activities that bring joy, connection and personal expression.

Furthermore the recommendations set out how we will work, without contributing additional financial resources, with new and existing partners. This will be through the strengthening of established structures to focus on creative health, connecting local partners, and weaving it into existing public health programmes. We shall also be building collaboration beyond the county using research and external funding opportunities to support our creative health ambitions.

My thanks are extended to everyone across East Sussex who, in ways great and small, are making East Sussex a creatively healthier place to live in.

Darrell Gale

Director of Public Health

Executive summary

Creativity, artistic, heritage and cultural activities have an enormous potential to help improve our experience of life. They can help improve our health, connect with others and most importantly, they give us joy. Joyful experiences are at the heart of a healthy life well lived.

From pre-conception to end of life care, creativity can help to support the needs of our communities. With just two hours of structured creative activity a week [Endnote 6] we can all improve our own health and wellbeing and of those around us.

Many organisations contribute to the range of work that uses creativity to help connect, support, and inspire people to live joyfully, making East Sussex a special place to live, work and play in. This includes, East Sussex County Council (ESCC), district and borough councils, the NHS, artistic, cultural and heritage organisations.

The public health department, within ESCC, has actively explored the use of creativity to understand how it can improve health and wellbeing for our communities. Since 2021, a programme has been in place to explore how East Sussex might become a creative health county.

A creative health county actively encourages all of its residents, communities and visitors to be involved in a range of activities that can support self-care, prevent ill health and strengthen connection between people. Creativity can have a real, measurable, positive, and lasting effect on individuals and communities. It should be seen as one of the foundations for good health and wellbeing.

In this report we shine a spot light on the organisations, activities and projects that provide a range of creative opportunities across the county [Endnote 7].

We want to ensure that the opportunities to take part, express ourselves and enjoy creativity are available to everyone across East Sussex.

Local creative opportunities include activities such as music, drama, dance, painting, drawing, collage, sculpture, cultural exchanges, celebrations, heritage, and tourism activities. They can also include ‘everyday creativity’ from home baking, crafts, hobbies, alongside outdoor and natural pursuits like gardening [Endnote 8], conservation [Endnote 9], and other nature-based [Endnote 10] or outdoor activities [Endnote 11].

Collaborative work to explore how East Sussex can become a creative health county has informed this report and a series of recommendations which are listed below.

Recommendations: Creativity for Healthier Lives

1. We will work with the wide range of existing partners in East Sussex – including the district and borough councils, the NHS, voluntary, community and creative sectors, and use established collaborative groups such as Culture East Sussex to promote and embed creative health approaches for everyone.
2. We will embrace the new opportunities in tourism promotion provided by 'Experience Sussex' to support economic development that builds on the vast array of creative action within the county.
3. We will continue to develop and refine the Creative Health Support Collaborative and ensure that it evolves to meet the needs of the wide range of stakeholders, organisations and communities that are contributing to East Sussex becoming a creative health county.
4. We will 'connect the creatives' by understanding the current practices and future opportunities for service commissioners across East Sussex to benefit from embedding creative health approaches into existing or new areas of work.
5. We will use the Creative Health Charter Mark as a complimentary addition to the existing Wellbeing at Work East Sussex Programme.
6. We will work with system partners across the South East to understand and secure opportunities for research, collaboration, integrated programme support, delivery, and funding of creative health works across the region.

Section one

An introduction to creative health

Creative health activities are not a ‘cure all’ but can have a positive, lasting effect across a range of conditions and health support needs.

Creative health has been shown to have beneficial effects to support those experiencing numerous physical and mental health conditions. These include non communicable diseases such as cancer, heart and other cardio-vascular conditions. Creative health approaches have shown to have positive impacts to support child development, healthy ageing, end of life care and bereavement. Sometimes creative health approaches support medical interventions and sometimes can be a replacement for such interventions [Endnote 12].

What is creative health?

There is no single definition of creative health but there is a consensus that it refers to the use of creative, artistic, cultural or heritage assets to positively improve the health and wellbeing of individuals and communities.

If we can embed the arts, creativity, culture, heritage and the natural environment alongside other community and non-clinical approaches to health and social care (such as social prescribing) into the everyday life of individuals, and their communities, we can help everyone to experience good health.

‘Good health’ is not only concerned with a person’s level of physical and mental health and wellbeing. It also describes the extent to which individuals in a community or wider society are enabled and encouraged to live healthy, flourishing, and joyful lives.

The World Health Organisation definition of ‘wellbeing’ [Endnote 13] includes quality of life and the ability of people and societies to contribute meaningfully to the world around them.

“The arts can be seen as the glue that binds all parts of society.”

Cllr Keith Glazer ESCC Health & Wellbeing Board

Imagine this: not just pills and prescriptions, but a vibrant tapestry of music, dance, storytelling, and nature woven into the fabric of our communities. This is the essence of creative health, a powerful tool that goes beyond symptom management, delving into the very essence of human connection, expression, and resilience.

Professor Kevin Fenton CBE, President, Faculty of Public Health

Why is creativity important to health and wellbeing?

There is growing evidence that arts and creative activity can lead to improved health wellbeing and social connectivity. Getting involved in creative activities throughout our lives helps reduces loneliness, supports our physical and mental wellbeing, and helps to strengthen the social ties we need to live happily [Endnote 14].

Group arts, creativity, culture, heritage, and the natural environment form the components of a creative health programme. Similarly, engagement in a wide range of activities across these five areas has comparable beneficial physical and mental health impacts on individuals.

Turning to the New Economics Foundation's Five Ways to Wellbeing [Endnote 15] we can see the underlying health improvement actions proposed [Endnote 16] include the following:
Connect, Be Active, Take Notice, Keep Learning and Give

Fig 2. The 5 Ways to Wellbeing Summary [Endnote 17]

Central to the Five Ways to Wellbeing, and creative health, is the idea that '...people will, to some extent, already be involved in specific activities under the overarching themes of

connecting, being active, learning etc. Rather than encouraging a completely novel set of behaviours, the outcomes of a campaign of this kind are, therefore, more concerned with increasing the time people spend in activities known to enhance wellbeing [Endnote 18].

If we build on the foundations and health benefits of activities that people already enjoy, we are much more likely to help them to live healthier, happier lives.

> The arts are less about curing our conditions and more about curating our lives, giving events meaning and in so doing, transforming ourselves and often those around us. Creative expression is a health behaviour, like nutrition and exercise. It helps us live to our fullest potential throughout the life course.
>
> Christopher Bailey, Arts and Health Lead at the World Health Organisation (WHO)

Creative health as a 'building block' for health

All of us need some basic things to grow, learn, develop, and thrive. Evidence tells us that engagement with the arts and creativity can mitigate against some of the negative effects that individuals may experience caused by wider health determinants of health.

Many factors or building blocks, sometimes called the wider or social determinants of health, combine together to affect the health of individuals and communities. Whether people are healthy or not, is determined by their circumstances and environment. To a large extent, factors such as where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family all have considerable impacts on health, whereas the more commonly considered factors such as access and use of health care services often have less of an impact [Endnote 19].

The East Sussex Creative Health Position Paper [Endnote 20] states that access to the opportunities presented by creative health is one of the building blocks [Endnote 21], and a key element of delivery for services.

This year's report seeks to show just how access to creative, cultural, artistic, heritage, environmental and community activities form part of the foundations for individual and community health and wellbeing.

The Creative Healthier Lives - Arts in Public Health Delivery Action Plan [Endnote 22] explains how individuals, communities, and the systems in East Sussex, can all benefit from creative health approaches to help support them to live fulfilled, healthier, and joyful lives.

Joyful, fulfilling and happy lives, getting a bit more than the bare necessities

Creativity, artistic, heritage and cultural activities have an enormous potential to help improve our experience of life. They can help improve our health, connect with others and most importantly, they give us joy.

We all deserve joy in our lives. Joyful experiences are at the heart of a healthy life well lived.

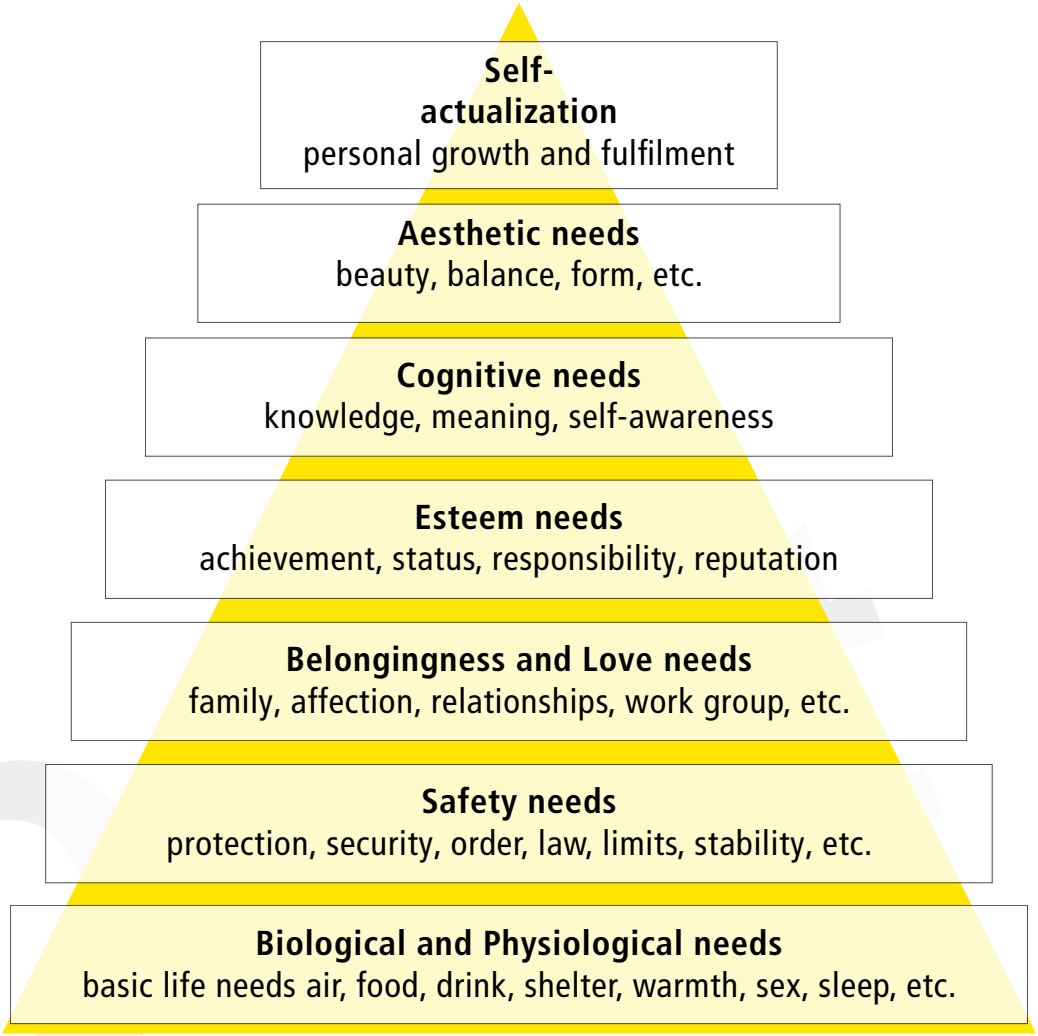
We all deserve the basics such as safety, food, water, shelter, education, employment, people we can share our lives with. We also all deserve the opportunity to grow, explore and experience the world around us.

In the 1950's, Maslow came up with a way to describe these basics, the original model for the 'Hierarchy of Needs' [Endnote 23]. This was updated in the 1970's to include [Endnote 24] a larger and more specific range of definitions for the needs of individuals and communities. Ranging from the basic physical need to sustain basic life support (food, water, air, shelter, safety) at its basic level to 'cognitive' or intellectual stimulation, 'aesthetic' or cultural opportunities and experience, and 'self-actualisation' or personal fulfilment needs at its top.

Sometimes we forget that we need a bit more than the basics, and the bare essentials to keep ourselves happy and well. Therefore we should make real efforts to nourish our psychological, emotional, and intellectual needs as much our physical selves.

In a nutshell, 'One must live well to know what living is!' [Endnote 25].

Fig 1 The 7-level version of the Hierarchy of Needs based on Maslow [Endnote 26]



Source: Design Alan Chapman 2001-7-adapted by Ward, David & Lasen, Marta. (2009).

We need to be able to communicate what we are feeling, and have meaningful connections with others, if we want to stay healthy.

One example of a local project is Mr. Hastings and St Leonards. This uses drama and film making to look at the issues around communication, connection, mental health and suicide prevention.

Mr Hastings and St Leonards is a project for local men that has been making important contributions to the local discussion around mens health. The project, run by a group of local men, with assistance from Hastings Voluntary Action [Endnote 27] it seeks to support men to develop coping strategies, resilience and peer support networks that enables them to live happier and healthier lives.

The Monologues of Men [Endnote 28] was developed and delivered by the Mr Hastings and St Leonards project [Endnote 29] and looks at communication around men's mental health and wellbeing. The Monologues of Men was a community theatre project that tackled a range of key subjects including childhood experiences, mental and physical health, self imposed limitations, negative expectations and pressures men can face.

The project highlights that men are often uncomfortable with communication, sometimes lacking experience or the chance to talk about their personal issues and challenges. The wider social pressure to 'man up' and not share anxieties, weakness, fears and uncertainty can lead to some men bottling up their feelings.

This can lead to deterioration in relationships, worsening mental health, and sometimes self harming behaviours or suicidal thoughts and feelings. The project provides spaces and connections that can support them to get used to communicating their experience, develop relationships and links with others who can help build personal resilience. Through this they can live happier, more fulfilled, less lonely and isolated lives.

Monologues of Men builds upon the work highlighted in the short film 'Men Don't Talk' [Endnote 30]. The film, made by the Mr Hastings and St Leonards project to help tackle male mental health issues and high levels of suicide and self harming behaviours in men, looked at the difficulties faced by men in Hastings and St Leonards. The film highlights the need for open communication, sharing of experiences and feelings. With an insightful depiction of male mental health and wellbeing, it is an important creative output from a grassroots community project.

Another Hastings based project used music and a 'rave style' event to help highlight community mental health issues and challenge stigma during the 2024 Mental Health Awareness Week (MHAW). The MHAW Musical Extravaganza [Endnote 31] that ran on the 17 May used a wide range of musicians and dance acts to tackle some of the stigma that surrounds mental health.

This festival, a collaboration between ESCC, Hastings Borough Council, Hastings Voluntary Action, Mr. Hastings & St Leonards, Love Hastings and Hastings Commons. Included the Hastings Punk Choir and a wide range of DJ sets and musicians. Local mental health advocates and 'experts by experience' were also in attendance.

Both of these projects highlight the sort of activities that are already happening in East Sussex and show local people getting involved in organising creative experiences and activities that give their communities a bit more than the bare necessities.

Still from the [Men Don't Talk - Mr Hastings and St Leonards | youtube.com] film project.

Hastings Punk Choir at the MHAW Hastings event.

You can find more information about Mr. Hastings and St Leonards in the links below.

- [Mr Hastings & St Leonards, BBC South East News 26/04/24 | youtube.com]
- [Men's Room Hastings & St Leonards | Youtube.com]
- [#MentalHealthAwarenessWeek2024 | TikTok]
- [Mental Health Awareness Week 2024 | hastingsonlinetimes.co.uk]

East Sussex, local assets and creative riches

East Sussex has a rich and diverse range of arts, creativity, culture, heritage and tourism activities.

These include concert halls, galleries, libraries, theatres, and museums. We also have some of the most beautiful countryside and coastline. Our assets include a wide range of education, health and social care environments, community settings, and our places of work, and of course our own homes.

There are many local opportunities for creative activity, reflection and connection on our doorstep. As individuals we are often consumers of creativity, however we can also be active participants and creatives in our own right. We all have the ability and the opportunity to make something that nurtures and supports our creative expression, wellbeing, and health. Its important that we can find the help we need to do this, near to where we live, study, work or play.

In order to really make people's lives better, it is necessary to understand the whole system and to be person-centred. That's where arts, culture, museums, libraries, and other community assets can play a key role. When people are isolated and disconnected from their communities, there is an automatic correlation with poor health' [Endnote 32].

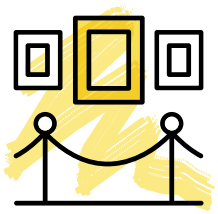
Across the county we have an impressive range of opportunities to engage with creative activities. The following list represents a sample of countywide creative assets.

Music venues and concert halls

- Trading Boundaries | tradingboundaries.com
- Glyndebourne opera | glyndebourne.com
- The White Rock | whiterocktheatre.org.uk
- Blackbox Hastings | blackboxhastings.com

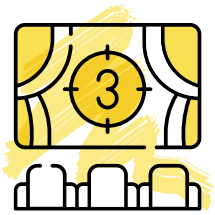
Museums and heritage sites

- Anne of Cleves House | Sussex Past
- Hastings Museum and Art Gallery | hmag.org.uk
- Seaford museum | seafordmuseum.co.uk



Art galleries, cultural centres

- De La Warr Pavilion | dlwp.com
- Hastings Contemporary | hastingscontemporary.org
- Ditchling Museum of Art + Craft | ditchlingmuseumartcraft.org.uk
- Attenborough Centre for the Creative Arts | attenboroughcentre.com
- the blackShed gallery | theblackshedgallery.org.uk
- Project Art Works | projectartworks.org
- Devonshire Collective | devonshirecollective.co.uk
- Towner Eastbourne | townereastbourne.org.uk

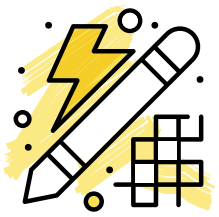


Cinemas

- Cineworld Eastbourne | cineworld.co.uk
- Depot Lewes | lewesdepot.org
- Duke's at Komedia Picturehouse | picturehouses.com
- Kino Rye | kinodigital.co.uk
- Kino-Teatr | kinodigital.co.uk
- Odeon Cinema Hastings | odeon.co.uk
- Pavilion Hailsham | hailshampavilion.co.uk
- Picturehouse Uckfield | picturehouseuckfield.com
- Sussex Exchange Cinema | thesussexexchange.co.uk
- Towner Eastbourne Cinema | townereastbourne.org.uk
- Seaford Community Cinema Seaford Community Cinema | escis.org.uk

Theatres

- Devonshire Park Theatre | Eastbourne Theatres
- Royal Hippodrome Theatre
- Congress Theatre | Eastbourne Theatres
- Winter Garden | Eastbourne Theatres
- Opus Theatre | Hastings
- Stables Theatre & Art | stablestheatre.co.uk
- Chequer Mead Theatre | chequermead.co.uk
- Printers Playhouse | Eastbourne

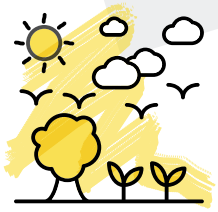


Creative, cultural organisations

- Hospitable Environment | hospitable-environment.com
- Culture Shift | cultureshift.org.uk
- Make (Good) Trouble | makegoodtrouble.co.uk

Community activities, pastimes and support

- The Sussex Stitchers | escis.org.uk
- The Links Project East Sussex | escis.org.uk
- The Hastings Library of Things | escis.org.uk
- The Hastings Local History Group | escis.org.uk
- The Dallington Art Club – Rother | escis.org.uk
- The Lewes Singing Circle | escis.org.uk
- Lewes Live Literature Group | escis.org.uk
- Meridian Lacemakers in Seaford | escis.org.uk
- Bexhill Art Society | Sussex Modern
- Projects | Sussex Wildlife Trust
- Home - South Downs National Park Authority



Outdoor, environmental or natural settings

- Allotments, Lewes and Eastbourne Councils | lewes-eastbourne.gov.uk
- England Coast Path | East Sussex County Council
- The Coastal Trail - South Downs National Park Authority
- Great Dixter Charitable Trust

National forums and agencies about creative health

- National Centre for Creative Health Round table on Health Inequalities Dec 2022 | youtube.com
- CHWA Seminar Health Inequalities Panel 2021 | youtube.com

Inequality and creative health opportunities

Many East Sussex residents already enjoy a wide range of arts, creativity, and cultural experiences, from everyday creative activities within their homes, activities held within local organisations to large events hosted by internationally renowned venues. However we have to recognise that some people and communities face barriers in accessing creative health activities. These can include.

- Disposable income, where you or your family or your ancestors come from, the colour of your skin, your accent and attitudes, if you have physical and or intellectual disabilities.
- The way you think, express yourself, communicate with and understand the world, the way you worship or choose not to.
- The way you feel love and who you love, your identity and the way you choose to dress and name yourself.
- How young or old, how thin or fat you are and how you think and feel.

Across the county, in coastal, urban, and rural communities, there are a wide range of organisations and individuals increasing access to creative health activities to support local people, many examples are highlighted throughout this report.

> There is clear evidence that cognitive stimulation, a sense of purpose, engagement in your community and a fulfilling social life are as important as diet, exercise and medical care when it comes to living a long and healthy life. This 'creative health' approach to public health is a vital component to tackling prevention and addressing major health inequalities. To this end I am delighted that East Sussex County Council is a partner in a newly funded Coastal Communities research consortium supported by United Kingdom Research and Innovation's mobilising community assets to tackle health inequalities research programme. This important research project will bring together the NHS, local authorities, researchers, voluntary and community organisations and residents together to tackle health inequalities including young people's mental health, substance misuse and life-limiting illness.
>
> Professor Helen Chatterjee, Professor of Human & Ecological Health, UCL and AHRC/UKRI Programme Director for Health Inequalities.

Section two

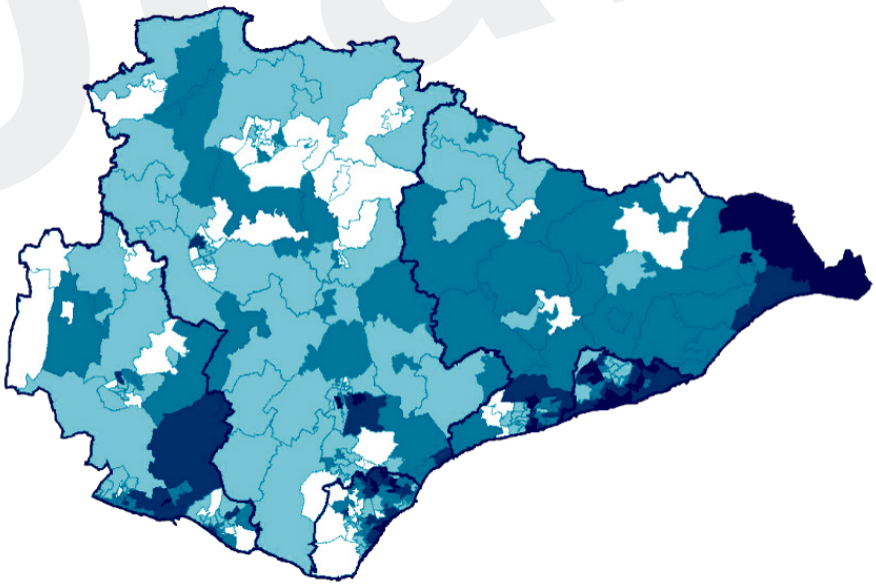
Setting the scene

Our place

East Sussex is a diverse and contrasting county, with a rich cultural heritage. It features the coastal urban boroughs of Eastbourne and Hastings, and mixed coastal and rural districts of Lewes, Rother, and Wealden. Although over three-quarters of residents live in urban areas, the county is predominantly rural with almost two-thirds falling within the High Weald Area of Outstanding Natural Beauty or the South Downs National Park. This mix of rural and urban brings challenges for people's health and wellbeing, and access to creative cultural, heritage and tourist activities.

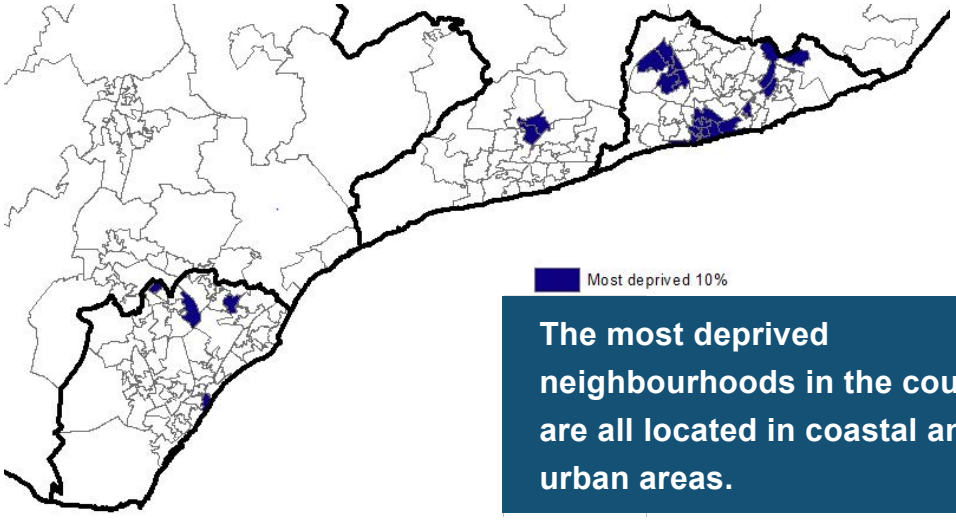
The latest Index of Multiple Deprivation (IMD) | gov.uk, suggests that relative multiple deprivation has risen in East Sussex in all district and borough councils since 2015, although there is variation across the County.

Map of areas of deprivation in East Sussex, 2019



Source: JSNA Life Course Summary East Sussex 2023 | eastsussexjsna.org.uk

Deprivation is a significant driver of health inequalities and is notable along the coastal strip, particularly in Hastings which is the most deprived local authority in the Southeast.



Source: Indices of deprivation 2019 | eastsussexjsna.org.uk

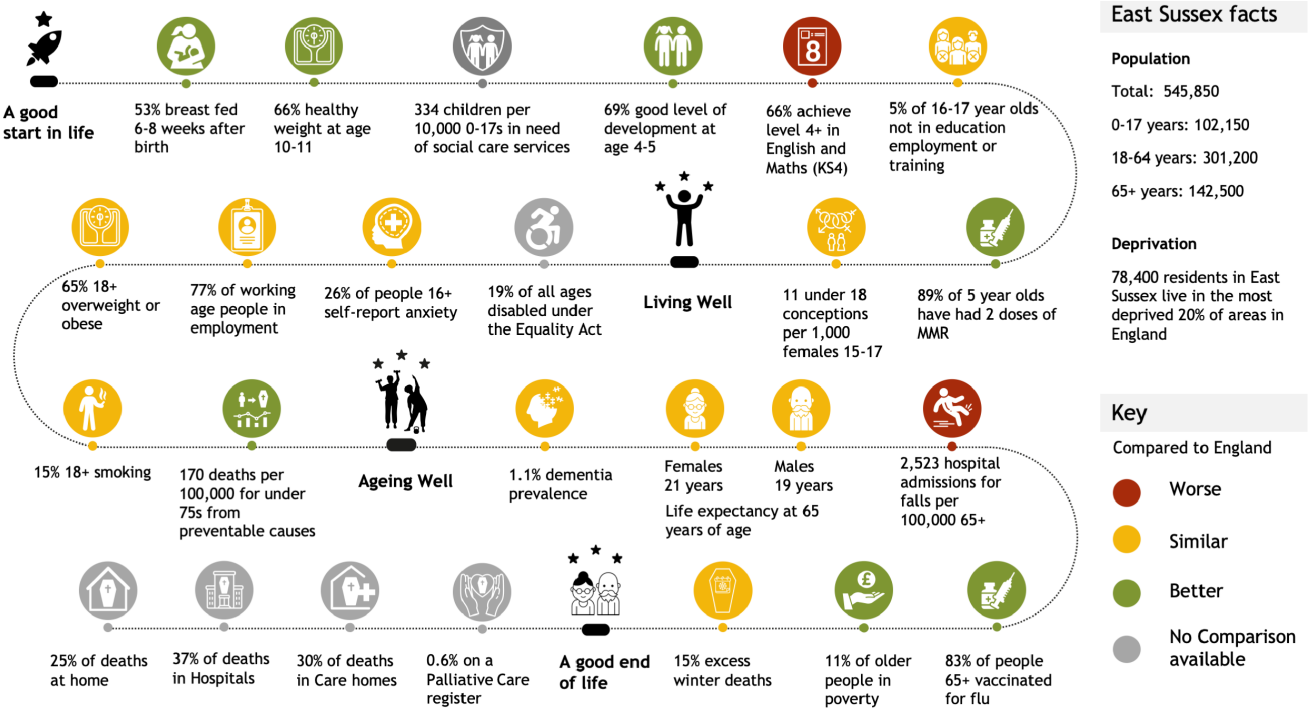
Our residents

Compared to England, East Sussex has:

- a much older age profile with an increasingly ageing population,
- a less ethnically diverse population,
- a higher proportion of people with a long-term limiting illness or disability (20% vs 18%).

Whilst there are many indicators that can be measured, figure 3 sets out a few key facts to paint a picture of the East Sussex population.

Fig 3 The East Sussex Joint Strategic Needs Assessment Life Course Summary [Endnote 33]



The East Sussex population is projected to grow by nearly 66,000 people by 2037, from 550,700 in 2022 to 616,300. Over a quarter (26%) of our residents are aged 65 years or over, a much older age profile compared to England (18% aged 65 years and over). This is projected to increase to a third of our population by 2037, which presents unique challenges to supporting the health and wellbeing of East Sussex residents.

This underlines the importance of initiatives to support self-care, resilience, prevention of ill health and promotion of activities, for all ages, that foster creative activity and connection with others to tackle isolation. Creative opportunities and interpersonal and community connection are key elements required to be a creatively healthy county.

You can find more local data and information:

- East Sussex Joint Strategic Needs Assessment | eastsussexjsna.org.uk
- East Sussex In Figures | eastsussexinfigures.org.uk
- East Sussex Life Course Summary | eastsussexjsna.org.uk
- NHS England Towards integrated care, the Sussex and East Surrey journey | youtube.com
- Our Plan for our Population | youtube.com
- Healthwatch East Sussex | youtube.com

East Sussex – A rich artistic heritage and a bright cultural future

East Sussex is a county with a diverse creative and cultural legacy. This is showcased through its many historic landmarks, buildings, landscapes, creative centres, organisations and historic individuals. From prehistoric Britons, through to the Romans, including the Beachy Head lady, a well to do Black Roman woman whose buried remains were found in Eastbourne. This continued with the Normans, to Anne of Cleves to Winnie the Pooh. With our Medieval castles to the Turner prize and beyond, East Sussex has so much to offer in terms of culture, art, heritage, history, and landscape.

Outside of physical cultural infrastructure, East Sussex continues to play a role in developing and nurturing creativity through hubs and networks such as Hastings Creatives or the Rye Creative Centre. Many of the institutions mentioned in this section have strong links to the community in which they are situated, working to increase access to, and enjoyment of, the creative world as well as enhancing the wellbeing of participants.

History

- Pevensey Castle | english-heritage.org.uk
- Lewes Castle | sussexpast.co.uk
- Wealden Hall House | sussexpast.co.uk
- Bodiam Castle | nationaltrust.org.uk
- Herstmonceux Castle
- Long Man of Wilmington
- Litlington White Horse

Events

- Jack in the Green Lewes
- Bonfire Night Bonfire Night

Authors

- The Bloomsbury Group Bloomsbury Group
- Thomas Paine A.A. Milne author of Winnie the Pooh and the illustrations by Rev E H Shepard Pooh Corner Hartfield Homepage - Pooh Corner Hartfield

Nature

- Ashdown Forest South Downs Beachy Head Beachy Head - Visit Eastbourne
- The mystery of Beachy Head Lady – Museum Crush

Gallery and artists

- Hastings Pier, Stirling Prize RIBA Stirling Prize
- Turner Prize 2023 Turner Prize 2023 | Towner Eastbourne
- Jesse Darling Wins Turner Prize 2023 – Press Release | Tate IMAGE TBC
- Towner: Eastbourne Alive
- De La Warr Pavilion
- Hastings Contemporary
- Eric Ravilious
- Edward Burra

Museums

- Ditchling Museum of Art and Craft
- Farleys House and Gallery

Music

- Glyndebourne Opera
- Lewes Folk Club
- Music: Hastings Punk Choir
- Love Supreme Festival – 5-7th July 2024
- Festival: Rye International Jazz & Blues Festival
- ryecreativecentre.co.uk/

TBC Map to be added

Culture East Sussex

Culture East Sussex (CES) is a network of public bodies, cultural organisations, and individuals that is hosted by ESCC. It works across four main areas, all of which are essential for the creative, and programmes across the county. CES has four key responsibilities:

- as a collective voice for culture across East Sussex.
- as a supports and develops the skills of all people working in the cultural sector in East Sussex.
- to promote the diversity of the sector and ensures equality of access to culture in East Sussex.
- to encourage collaboration and mutual support within the cultural sector and works with its partners across a range of themes of mutual interest.

The priorities of CES are linked to the East Sussex Cultural Strategy (2013-25) | eastsussex.gov.uk which has three key priorities:

Priority 1 Create an environment where great cultural experiences are available to everyone to enhance their quality of life.

Priority 2 Create an environment which enables the cultural and creative economy to expand and enhances the ability to attract and retain other businesses.

Priority 3 Develop and promote well packaged cultural tourism offers which celebrate the identity of East Sussex, raises its profile and attracts more visitors and businesses to the County.

The role of the voluntary, community and social enterprise sector

The voluntary, community and social enterprise (VCSE) sector continues to make an essential contribution to the cultural life and vitality of East Sussex. The sector facilitates and leads a wide range of creative projects giving communities much needed support and activities, that contribute to health.

Compass Arts

Based in Eastbourne, Compass Arts is an intergenerational, co-creative, artist led organisation for anyone vulnerable to social isolation, lived trauma, mental illness and hidden disabilities

Mental health services are constricted by the time they can spend with clients. Escalating demand means that staff can only focus on the bare minimum of alleviating suffering.

Through the provision of spaces that are dedicated to developing art practices, patients can experience the potential of art and its enhancement and contribution to a quality of life. Art supports healing by reaching the plasticity of the brain. It is beneficial for everyone.

Fenya Sharkey, Artistic Director, Compass Community Arts.

Lewes Death Cafe

A Death Cafe is a group directed discussion of death with no agenda, objectives or themes. It is a discussion group rather than a grief support or counselling session

At a Death Cafe people, often strangers, gather to eat cake, drink tea and discuss death. Our objective is 'to increase awareness of death with a view to helping people make the most of their (finite) lives'.

deathcafe.com

Hospitable Environment

Is a socially engaged arts & wellbeing organisation based in Newhaven, East Sussex. We bring people together using creativity and food to explore what it takes to build safe, connected and sustainable communities.

A small sample of the organisations involved in co-ordinating creative health and linked programmes includes wellbeing.

hospitable-environment.com

Hastings Voluntary Action

Hastings Voluntary Action - a charity that helps other charities, community groups and social enterprises to start, survive and thrive in Hastings, East Sussex.

- Social Prescribing for older people pilot
- The Hastings & Rother Food Network
- Links Project
- Shorelink Writers
- hastingsvoluntaryaction.org.uk

Sussex Community Development Association

Sussex Community Development Association works across East Sussex, supporting community based projects aimed at tackling loneliness and social isolation, improving health and wellbeing and increasing economic stability.

- Our Stories
- sussexcommunity.org.uk

Rother Voluntary Action

Support and champion Rother's voluntary, community and social enterprise (VCSE) sector to make positive change, challenge issues and develop new ideas to strengthen communities.

- Rother Food Partnership | rva.uk.com
- Rye Community Garden | rva.uk.com
- Age-Friendly Rother | rva.uk.com
- Ukraine Crisis | Rother Voluntary Action | rva.uk.com

3VA

Voluntary Action organisation for the three districts of Wealden, Eastbourne and Lewes in East Sussex.

3va.org.uk

"For me, a truly creative approach to health would seek to remove more of the psychological and physical barriers to engaging with the natural world and invest in the natural and human assets that exist there. We have many innovative volunteer-led community projects across the county that create meaningful opportunities for individuals to connect with nature and each other. Being free to play, create and learn in wild places brings health and wellbeing benefits and early intervention across the spectrum of public health concerns.

It promotes physical and mindful activity, raises confidence, reduces anxiety and isolation, encourages mindfulness, self-care and create opportunities to find peace and joy, ourselves, and with each other, all of which makes us more resilient to life's challenges"

Kim Richards, CEO, Rother Voluntary Action

For more information visit:

- East Sussex Community Information System | escis.org.uk
- The Tribe Project | East Sussex County Council

Section three

East Sussex creative health, across the life course

From preconception to the end of our lives, our needs change. When we move from childhood into adulthood there are different opportunities for creative health to help individuals and communities explore, experience, reflect upon, and actively participate in the world.

Pablo Picasso once said “Every child is an artist. The problem is how to remain an artist once he grows up”. It is startling just how resonant this quip seems when we look at how many of us do not think of ourselves as having creative abilities, interests, or outlets. A recent report from a member of the Eastbourne Alive team shows the power of remembering how we played and can play again.

The member of the team recalled how a woman, who was visiting the Eve De Haan artwork ‘Its nicer to be nice*’,* sat on the swing which was a central element of the artwork and began weeping openly. When asked why she was crying she explained that she had not sat on a swing since she was a very small child and was simply moved by the joyful experience and the interaction with the artwork. She explained that she hadn’t realised that, as an adult, it was ok to play and think creatively. Her interaction with the De Haan artwork had in a powerful and poignant way helped her rediscover a simple forgotten pleasure, a playful and creative experience after many years that had moved her to joyful tears.

The Eve De Haan artwork was made available as part of Turner Wraparound events [Endnote 34].

A small selection of case study summaries set out below give an indication of the wide range of projects and organisations using creative health approaches. Each summary has a link to a larger more detailed summary with contact details for the organisations leading on the projects involved.

Starting well

So much of human development relies on the arts, culture, heritage, and the environment to support experimentation, education, play and growth.

Babies, children and young people need to access opportunities that support cognitive and social development, reasoning, critical thinking, self-expression, self-regulation, connection and a range of experiences across different artistic, cultural and heritage domains and the natural world [Endnote 35]. This access to varied, vibrant encounters and connections is important to support healthy development, growth, independence, and maturity. It is in short 'how we learn to be human'.

It is essential that we give every child and young person the opportunity to develop and grow with a wide range of opportunities and experiences. There is a range of creative activities including for children and young people with Special Educational Needs and Disabilities (SEND).

The Catalyst

Delivered by Making Good Trouble

A children and young people's creativity focussed project looking to widen access to the creative sector and creative skills.

- The Catalyst: A creators' collective | Make Good Trouble

The Devonshire Collective

Devonshire Collective is a cultural and community organisation operating across a network of ex-retail sites in the Devonshire West ward, Eastbourne – a vibrant area with a long-standing community.

- Devonshire Collective | devonshirecollective.co.uk

Holiday Activities and Food (HAF) Programme

Delivered by more than 100 East Sussex

The HAF is a Department for Education funded programme that provides free healthy meals and enriching holiday activities to eligible young people. Activities include arts, music, drama, and other creative sessions across the county. During 2023, more than 36,000 sessions were attended by children in receipt of benefits-related free school meals.

One example of HAF delivery is The All Aboard Bus: This is an art and foreign language-based activity provider that takes young people (aged 5-11 years) on 'journeys' to different places, cultures, languages, and food. Sessions include a range of arts activities as well as daily opportunities for young people to prepare meals and try new foods.

- Welcome to Holiday food and fun | East Sussex County Council

Social Prescribing for Children and Young People

Delivered by Imago and Sussex Community Development Associate (SCDA)

NHS Sussex and ESCC are currently funding and supporting Imago and SCDA to deliver two pilot social prescribing projects. These projects provide early intervention support to young people with mild to moderate mental health and wellbeing needs by giving them access to a social prescriber. The pilot has two strands:

- Children in four primary schools in the High Weald area, as a pilot project for the Primary Care Network area.
- Ukrainian children and young people who are fleeing war and conflict in Ukraine.
- Children and young people's social prescribing | socialprescribingacademy.org.uk
- Imago Community
- Webinar for launch of the CYP Social Prescribing Tender Opportunity in East Sussex (youtube.com) December 2022
- SCDA • Making A Difference In Our Community (sussexcommunity.org.uk)

Theatre in Schools

Delivered by various Theatre in Education providers

Since 2021, ESCC has developed and supported the delivery of Theatre in Education packages for state funded secondary schools in East Sussex (including special schools). Key issues addressed include county lines, harmful sexual behaviours and drug, alcohol and tobacco education.

- Embracing Arts, East Sussex | 1Space
- Head2Head Sensory Theatre | East Sussex 1Space
- HAF Easter Musical Theatre Workshops | eequ.org

Living well

The focus on living well seeks to build upon the creative activities we enjoyed in the past, perhaps continue to enjoy, and expand them to support health benefits and health seeking behaviours, and we hope, joyful experiences.

We have an opportunity to ensure that we bring creativity into the workplace and throughout our adult lives. If we become parents or carers there is another key opportunity to ensure that the creativity, we value for ourselves, is maintained with those creative elements we treasure, and 'handed down' or inherited by the next generation.

Wellbeing at Work Programme

The Wellbeing at Work Programme aims to provide support to East Sussex employers with improving employee health and wellbeing in their workplace.

The programme:

- Offers workplace health resources, training, events and a signposting service to those working in East Sussex.
- Operates a free Accreditation Scheme for East Sussex employers, providing a framework to improve employee health and wellbeing, whilst rewarding organisations who are actively working to do so.

Is funded and delivered by Public Health at East Sussex County Council.

Existing creative support opportunities offered by the programme have been added to with a new Creative Health Charter Mark, aimed at promoting two hours of creative activity before, during or after work.

- Website | East Sussex Wellbeing At Work

The Creative Health Charter Mark

Aimed at encouraging workplaces across the county to include creative health in their workplace health offer and support the take up of two hours of creative activity within or outside the working week

- Wellbeing at Work, Factsheets | cipd.org
- Creativity and wellbeing, What Works Wellbeing | whatworkswellbeing.org
- Wellbeing In The Arts | wellbeinginthearts.org.uk

Pottery Project Pilot

Macmillan, ESHT NHS Trust, ESCC Public Health Eastbourne Pottery Studio

A project using pottery and peer support as part of the cancer pathway in East Sussex, initially working with people with breast cancer.

> A diagnosis of cancer changes a person's world and knocks it off its axis, as they are plunged into treatment, recovery and all the physical effects and anxieties that accompany it. People affected by cancer tell us that they often lose a sense of control. We have found that the creative arts are a way back for people to regain some new control within their lives and find outlets for the emotional upheavals of cancer. I have been pleased to work with patients who have used poetry, theatre, painting, sculpture and even someone who created music from the electrical signals of the plants originally used to make chemotherapy. These all have been evidence to me of the benefits of creative arts in health.
>
> Professor Richard Simcock, Consultant Clinical Oncologist, Chief Medical Officer, Macmillan Cancer Support

Arts on Prescription

Arts on Prescription (AOP) has been running creative programs for people who have issues impacting on their mental health and experience challenges accessing groups in the wider community since 2018.Their programs support people to maintain mental health wellbeing and reduce loneliness and isolation through activities proven to build confidence, learn new skills, access training, education, volunteering and employment.

In 2022 AOP took on a disused building in Alexandra Park in Hastings and set up a peer-led wellbeing hub. People who have been through the program are invited to join the steering group and to be actively involved in the running of the space.

- Arts on prescription | artsonprescription.org

Ageing well

From retirement and into older age it is important that we maintain our social connections, our physical health and mental wellbeing. We need to ensure that we support ourselves, and those around us to age healthily, remain physically and mentally active, connected and engaged with the world around us. Creativity offers us shared languages, and opportunities to make lasting contacts with others. As we age we must recognise the need for connection and community and the possibilities that engagement with creative activities can bring.

Our Songs, Our Stories

Our Songs our Stories is a creative health project which is founded on the body of evidence around the impact of music-based activity on people living with Dementia and those who care for them to:

- Improve physical and mental health
- Improve connections and relationships
- Combat loneliness and isolation
- Culture Shift CIO | cultureshift.org.uk

Grow Your Own Health

Herstmonceux Integrative Care Centre, ESCC and Sussex LMC

The Grow your own health project was started by Dr Sarah Andersen, a Sussex GP, and Julia Behrens, a medical herbalist and published author. This project used the simple act of giving away small packets of seeds as a method for people across Sussex to grow and share with others around them.

- Grow Your Own | hmxihc.co.uk
- Introduction to Grow Your Own Health | You Tube

Life Transitions – HAIRE Project

ESCC and Rother Voluntary Action

Healthy Ageing through Innovation in Rural Europe (HAIRE) ran until March 2023 and used community and creative projects to promote healthy ageing activities.

Since then, the Life Transitions project has been established to carry on the work with a renewed focus on connection and local opportunities for creativity.

- Life Transitions | East Sussex County Council
- Transitions Service - Innovate UK Business Connect | ktn-uk.org
- East Sussex Conference: Innovations in Healthy Ageing | exeter.ac.uk

Wellbeing Support at the De La Warr Pavilion

A multi-stranded wellbeing support programme designed to encourage and assist access to creative arts practice and experiences for people with a range of complexities and challenges. De La Warr is a Dementia Friendly venue and has specifically works with the Bexhill Dementia Action Alliance to develop its support offer.

- Wellbeing The De La Warr Pavilion | dlwp.com

‘One of the founding principles of De La Warr Pavilion when it opened in 1935 was to promote health in mind, body and soul. We continue with that ethos today, providing creative and cultural experiences to help boost the health and wellbeing of our local community. Our packed programme includes free fortnightly making sessions, creative holiday clubs for children eligible for benefits-related free school meals, art and craft workshops for people living with dementia and their carers, and creative groups for young people experiencing social, emotional or mental health challenges and from asylum seeker, refugee and migrant backgrounds. We host shows by local dance and drama groups and work with organisations including Create Music and Bexhill Festival of Music to give young people hugely valuable professional performance experience. This is in addition to our year round programme of uplifting and inspiring gigs, performances, comedy shows, talks and free exhibitions.

Stewart Drew, Director & CEO, De La Warr Pavilion

Compass Arts

An intergenerational, artist-led organisation providing arts opportunities for those vulnerable to social isolation, lived trauma, mental illness, and hidden disabilities.

Specific contributions include work with the Eastbourne ALIVE programme of Turner wraparound events and the Big Conversation in the Beacon Shopping Centre.

- Compass Arts | compasscommunityarts.co.uk

blackShed Gallery

Is a well respected gallery in the heart of Rural Sussex with a reputation as a distinctive, diverse contemporary art space with a focus on artist lead projects and exhibitions. The gallery has a strong and established relationship with a number of highly regarded partners, such as Hastings Museum, Hasting Contemporary, De La Warr Pavilion, Project Artworks and the Towner Gallery, and more recently the Talent Accelerator, which helps drive our work towards supporting community projects, and young people as they look for experience within the cultural sector.

At its core, the blackShed aims to develop and support the regional artist based community, bringing high quality artwork, through direct inclusion, to a rural audience where social-economic inequalities preclude and prejudice participation in the visual arts. The environment surrounding the blackShed is set in a beautiful location giving artists the opportunity to explore their practice within the immediate environment, taking art beyond the gallery, often creating informal opportunities with the public and local visitors.

- theblackshedgallery.org.uk

Dying well

Death can occur at all stages of life and central to this is the support for end-of-life care, a 'good death' and care for the bereaved. Death is a central aspect of human existence, and we could all be doing more to understand the experiences of both those who have died or are nearing death alongside those that will be bereaved by their death.

Child Bereavement UK

Child Bereavement UK helps families to rebuild their lives when a child grieves or when a child dies with confidential bereavement support for individuals, couples, children, young people, and families.

They routinely utilise creative techniques to explore and support the experiences of the bereaved.

- BBC Radio 4 - Four Thought, Facing Death Creatively
- British Association for Music Therapy: Facing Death Creatively | bamt.org
- Creative connections made at a conference | stchristophers.org.uk
- Sussex to host the inaugural Death Festival | University of Sussex

Dragonflies Bereavement Project

Dragonflies provides creative therapeutic activities and group discussions delivered by trained staff and volunteers and a range of support options.

- Dragonflies Bereavement Project | East Sussex 1Space

Willow Tree Children's Support

Willow Tree Children's Support provide group & individual support in school settings for children and young people impacted by family illness and bereavement.

- Willow Tree Children's Support, Hastings | willowtreechildrenssupport.com

Death Café Lewes

The Lewes Death café gives attendees an opportunity to discuss issues related to death and dying in a directed group discussion. Death Cafés are run on a not-for-profit basis, and provide an accessible, respectful, and confidential space with no intention of leading people to any conclusion, product, or course of action. Frequently referencing artistic and cultural practices from different cultural traditions the Death Cafes provide a safe space to discuss death and enjoy a nice cup of tea and some great cake.

- Lewes Death Cafe | deathcafe.com
- Encouraging death communication in a death-avoidant society | biomedcentral.com
- Can the 'death café' concept be adapted for use in healthcare professional learning and development? | BMJ Supportive & Palliative Care
- Death cafés as a strategy to foster compassionate communities: Contributions for death and grief literacy | nih.gov
- The Global Spread of Death Café: A Cultural Intervention Relevant to Policy? | Cambridge Core
- Death doulas: helping people at the end of their life | open.ac.uk
- Death doula Alua Arthur on letting grief transform the creative process of your life | The Creative Independent
- Creative Engagement in Public Health Interventions | Rosetta Life

Section four

Key creative health programmes

With the Turner Prize's arrival in East Sussex in 2023 and the Towner Gallery's centenary, a programme of work was developed to promote, sustain, and share the creative opportunities presented to Eastbourne.

Eastbourne ALIVE

Eastbourne ALIVE, a town-wide partnership project celebrating local art scene, creatives, and businesses, developed an ambitious wraparound partnership programme of public art, exhibitions, movement, music and workshops. The programme was designed to ensure that all of Eastbourne could participate in the creative opportunities the Turner prize coming to Eastbourne presented.

Public Health worked extensively with the Eastbourne ALIVE team from the early days of the project's design to ensure that activities could be evaluated to understand the difference the programme has made to the local economy and to the attitudes and outlook of Eastbourne residents and visitors.

Making it Happen

Making it Happen (MiH) takes an asset-based community development (ABCD) approach to building the confidence and capability of people to come together in their neighbourhoods to make change for themselves and create positive health outcomes. It seeks to support people to make connections, initiate projects and activities, feel more connected to their local place, and bring local community assets into use.

It is delivered with the support of a wide range of partners to ensure that it can work with local organisations across East Sussex and works with the core voluntary sector alliance members to ensure local reach.

Action in Rural Sussex is delivering Making it Happen in the following areas in Wealden District: Uckfield North, Polegate, Crowborough East, Hailsham East.

Hastings Voluntary Action is delivering Making it Happen in the following areas of Hastings Borough: Greater Hollington, Castle Ward.

Rother Voluntary Action is delivering Making it Happen in the following areas in Rother District: Central & Sackville, Eastern Rother, St Michaels, Sidley.

Sussex Community Development Association is delivering Making it Happen in the following areas in Lewes District: Newhaven Valley, Newhaven Meeching, Peacehaven West, Peacehaven North.

3VA is delivering Making it Happen in the following areas of Eastbourne Borough: Shinewater, Willingdon Trees, Hampden Park East.

MiH supported activities are built from the community-up rather than trying to create activities for a particular cohort or need. The focus is instead about what gives someone purpose, enjoyment and belonging. Creative, cultural, artistic heritage and natural environment-based approaches and settings are used throughout the wide range of projects MiH supports.

The stage two report | making it happen.org.uk has found that without question MiH is deploying ABCD effectively to support people to make connections, initiate projects and activities, feel more connected to their local place, and bring local community assets into use. The report identified that one of MiH's greatest aspects is its ability to recognise individuals and communities for their strengths and create change by building on these. The findings show no shortage of ideas and passions from people for change they'd like to see in their communities.

From the ideas that have been nurtured, explored, and developed to come to fruition, it is evident that East Sussex is abundant with creativity, and individuals and community have taken forward their own ideas. Almost a quarter of the grants awarded to community projects were for arts related projects, with activities ranging from crochet to choirs, as well as the development of new arts spaces, to applying arts and creativity to placemaking to community research. Just a few of the brilliant groups and projects across the county are showcased in the TV Series Phenomenal Happenings | making it happen.org.uk

The programme, recognised nationally as good practice, includes many projects across the Life Course.

Newhaven Wood Creatives

Formed originally as a Woodcarving Club we have grown to enhance all creative aspects of working with wood. The Wood Creatives meets at the Hillcrest Centre, where we rent a large workshop behind the main building for adults to learn, practice and hopefully improve our woodcarving, woodturning and the other general wood related skills.

- Wood Creatives – Hillcrest

Take Action Man

Take Action Man offers local men the opportunity to get outside in the town's wonderful natural spaces, get active, learn new skills and spend time together talking, supporting and helping one another.

- Take Action Man — Project Rewild

Compass Arts

An intergenerational, artist-led organisation providing arts opportunities for those vulnerable to social isolation, lived trauma, mental illness, and hidden disabilities.

- Compasscommunityarts.co.uk

Bexhill Men's Shed

Men's Sheds (or Sheds) are similar to garden sheds – a place to pursue practical interests at leisure, to practice skills and enjoy making and mending. The difference is that garden sheds and their activities are often solitary in nature while Men's Sheds are the opposite. They're about social connections and friendship building, sharing skills and knowledge, and of course a lot of laughter.

- Bexhill Men's Shed | bexhillmensshed.org.uk

Section five

Local area transformation through creative health

The East Sussex Creative Health Position Paper was published in 2023. It was developed to set out the key features and opportunities for using creativity across of East Sussex to promote the connective, cognitive, physical activity and engagement benefits that creative health can bring. At its heart is the idea that creativity can have a real, measurable, positive, and lasting effect on individuals and communities.

Creativity should be seen as one of the building blocks for good health and wellbeing. The Creative Healthier Lives - Arts in Public Health Delivery Action Plan provides a roadmap and central strategy in the use of the arts, culture, heritage, and creativity to support the health and wellbeing of residents.

The 'Local Area Transformation through Creative Health' (LATCH) concept aims to support population level health improvement using creative health approaches. It will drive increased activity, resilience, connection and participation in creatively healthier activities and health promoting behaviours such as the Five Ways to Wellbeing. It also uses The COM-B model of behaviour. The COM-B model [Endnote 36] is a behavior change framework that proposes three necessary components for any behavior (B) to occur. Through assessing capability (C), opportunity (O), and motivation (M), leaders, policymakers, and behavioral scientists can understand why a specific behavior occurs and how to create targeted interventions that lead to effective change.

Key resources for the creative health programme include:

- creativity-and-health-evidence-review-2022 | jsnaeastsussex.gov.uk
- Evaluation - Everyday Creativity Programme
- The East Sussex Creative Health Position Paper which sets out the strategic high-level case and evidence base to support the roll out of a creative health Approach.
- The Creative Healthier Lives - Arts in Public Health Delivery Action Plan which sets out the details for how each priority area will be addressed across each life course stage.
- A life course approach from Starting Well, into Living Well Ageing Well and Dying Well.
- A Creative Health Charter Mark Aimed at encouraging workplaces across the county to include creative health in their workplace Health offer and support the take up of two hours of creative activity within or outside the working week.
- A focus on research evaluation and local evidence to inform practice and help establish

more localised evidence of what works for the Eat Sussex context.

- The quantification of creative health (the ‘arts dose’).
- A creative health support collaborative aimed at supporting dialogue, understanding and collaboration between creative, cultural, artistic, heritage and health and social care practitioners, groups and organisations.
- A range of practice support resources aimed at supporting the creative sector.

Recommendations

Following on from the initial consultation events that began in 2021 and the publication of the East Sussex Creative Health Position Paper in 2023. Public Health have been working to capture recommendations, activities and priorities suggested by creative and health and social care practitioners across the statutory and VCSE sectors. Many of these are already using creative health approaches to their work. These conversations have informed both the Position Paper, the Delivery Action Plan that supports it, and this report.

The recommendations are mostly focussed on enabling the sharing of creative health approaches, tools, techniques and opportunities across East Sussex.

System level partners include the ESCC service areas fora adults, children and community services, the local district and borough councils, NHS Sussex Integrated Care system, Sussex Partnership Foundation Trust, East Sussex Foundation Trust, Culture East Sussex partners, voluntary and community sector organisations including HVA, 3VA, RVA and wider VCSE alliance.

The Creative Health Support Collaborative is a community of practitioners from across the different sectors and places in the county to access resources, evidence and insights that can help them to either recognise where they are already contributing to creative health projects or support them to include new approaches into their existing services.

Recommendations: Creativity for Healthier Lives

We will work with the wide range of existing partners in East Sussex, including the District and Borough Councils, NHS and voluntary and community and creative sector to establish a system level creative health operational group reporting to the Public Health Board and Culture East Sussex Board. This will help to focus collaboration and leadership across the county to aid promotion and embedding of creative health approaches for everyone.

1. We will work with the wide range of existing partners in East Sussex – including the district and borough councils, the NHS, and voluntary, community and creative sectors, and use established collaborative groups such as Culture East Sussex to promote and embed creative health approaches for everyone.
2. We will embrace the new opportunities in tourism promotion provided by 'Experience Sussex' to support economic development that builds on the vast array of creative action within the county.
3. We will 'Connect the Creatives' by understanding the current practices and future opportunities for service commissioners across East Sussex to benefit from embedding creative health approaches into existing or new areas of work.
4. We will use the Creative Health Charter Mark as a complimentary addition to the existing workplace health offer for East Sussex (Wellbeing at Work).
5. Work with system partners across the Southeast to understand and secure opportunities for research, collaboration, integrated programme support, delivery, and funding of creative health works across the region.

Conclusion

It is clear that creative health activities are effective in promoting lasting and sustainable health improvement across our lifetimes. With the wealth of creative assets, opportunities and expertise across East Sussex, it is vital that we build upon these assets and that anchor institutions collaborate with the VCSE and all partners involved, to maximise the impact that creative health can have in East Sussex.

Section Six

Update on the Director of Public Health Report 2022/23

Recommendations

For the report please visit Connecting people and places 2022/23

For previous reports focusing on housing, employment and the recovery from the pandemic please visit: Annual public health reports| eastsussexjsna.org.uk

Below is a summary of key elements of progress against last year's report. You will see that there are a wide range of achievements against the ambitions set out in last year's report and much work already underway. Crucially you will see how the focus of this year's report can add to the works set out in the previous years and how we have sought in this year's report to contribute to and support existing works and issues identified in the report on Connection People and Places.

Recommendations

1. Establish a System Stewardship Group to build and maintain the required collaborative leadership across the system.
2. Create a 'connection test' to apply a loneliness perspective to the policy making process.
3. Develop an action plan for developing social infrastructure rooted in the principles of ABCD (asset-based community development) and harnessing the potential of community ownership and community businesses.
4. 'Connect the connectors' by creating learning communities that learn and test ideas together and model and incentivise ongoing learning.
5. Mobilise and equip a movement of connectors stretching across all public facing roles, businesses and communities.

Latest updates from 2023

1. A series of workshops have been held with partners to identify how system leaders and interested parties could be best supported to drive future actions across the system through this stewardship approach. East Sussex County Council has then worked in partnership with the East Sussex Voluntary, Community and Social Enterprise (VCSE) Sector Alliance to develop proposals and appoint a host organisation within the VCSE sector to support the development of this collaborative stewardship group and approach.

2. A two-year grant agreement has been in put place with the host organisation, Sussex Community Development Association (SCDA), who will be involving many other partners in this work. East Sussex Community Voice will be providing evaluation, data and monitoring capacity, and other VSCE organisations such as 3VA, Age UK East Sussex, Care for the Carers and Possibility People will help reach target communities and support identification of other East Sussex organisations to be involved as the programme develops.

3. The programme facilitator and reference group are working to establish a broad coalition of partners to join the collaborative stewardship group, define what success looks like and agree the vision for the programme. The collaborative group will then be developing ways of working together, reaching and engaging those with lived experience of loneliness, providing learning opportunities, raising awareness of loneliness, and agreeing how to make further progress on other recommendations of the 2022/23 report, which include:

    - create a ‘connection test’ to apply a loneliness perspective to the policy making process.
    - develop an action plan for developing social infrastructure rooted in the principles of ABCD (asset-based community development) and harnessing the potential of community ownership and community businesses.
    - ‘connect the connectors’ by creating learning communities that learn and test ideas together and model and incentivise ongoing learning.
    - mobilise and equip a movement of connectors stretching across all public facing roles, businesses and communities.

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Tracey Houston, Business Manager, ESCC

Along with contributions from many other members of the team

The Schools Art Competition

Following a competition among schools to design the front and back covers of this report, two were chosen out of the incredible entries. A full gallery is online for you to see the amazing entries.

TBC link on essc website to follow

A full list of contributors is available here TBC

Thanks are extended to everyone in Childrens services and the schools the children attend and of course the children themselves.

Note of Thanks to Compass Arts and other contributors - illustration numbers etc

Resources and references

Key organisations and resources for creative health

Links to Resources to follow

1 https://www.eastsussexjsna.org.uk/resources/creativity-and-health-evidence-review-2022/
2 the-east-sussex-creative-health-position-paper-september-2023 | eastsussexjsna.org.uk
3 See **TO BE ADDED**
4 Turner Prize — Towner Eastbourne
5 Towner 100 Celebration — Towner Eastbourne
6 Study reveals the art of ageing well (uwa.edu.au)
7 Creative_Health_The_Short_Report.pdf (culturehealthandwellbeing.org.uk)
8 Cultivating resilience: community gardening can benefit all ages | (ageing-better.org.uk)
9 The impact different species and their traits have on human wellbeing | University of Leeds
10 Linking the natural environment, human wellbeing & poverty | Conservation Research Institute (cam.ac.uk)
11 committees.parliament.uk/written evidence/117836/pdf/
12 9789289054553-eng.pdf (who.int)
13 Promoting wellbeing (who.int)
14 Outcomes | Arts Council England
15 Five ways to wellbeing | New Economics Foundation
16 Five_ways_to_wellbeing the evidence.doc (neweconomics.org)
17 https://wellbeinginfo.org/self-help/wellbeing/5-ways-to-wellbeing/
18 Five ways to wellbeing | New Economics Foundation
19 https://www.who.int/news-room/questions-and-answers/item/determinants-of-health
20 The East Sussex Creative Health Position Paper - September 2023 | (eastsussexjsna.org.uk)
21 Wider Determinants of Health - OHID (phe.org.uk)
22 **LINK TO FOLLOW WHEN AGREED**
23 An Overview of Needs Theories behind Consumerism | researchgate.net
24 Ward et al ibid ResearchGate
25 Bertold Brecht and Kurt Weil the Threepenny Opera, The Ballad of Gracious Living
26 Ward Ibid
27 Hastings and St Leonards Men's Health and Wellbeing Project | Hastings Voluntary Action
28 The Monologues Of Men – Stables Theatre
29 Hastings and St Leonards Men's Health and Wellbeing Project | Hastings Voluntary Action
30 Men Don't Talk (You Tube)
31 Hastings Online Times – Mental Health Awareness Week 2024
32 Museums: Sites of history, culture – and wellbeing? | European Voices - UCL – University College London
33 JSNA Life Course Summary East Sussex 2023 | (eastsussexjsna.org.uk)
34 Eve De Haan It's nicer to be nice — Towner Eastbourne
35 Children and young people | Arts Council England
36 Behaviour-change-guide-for-local-government-and-partners | /www.gov.uk

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St Anne's Crescent
Lewes BN7 1UE
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Website: eastsussex.gov.uk

East Sussex Health and Wellbeing Board Work Programme

Date of Meeting	Report
26 September 2024	East Sussex Health and Social Care Shared Delivery Plan (SDP) Programme - update report
	Public Health Outcomes Framework (PHOF)
	Safeguarding Adults Board (SAB) Annual Report 2023-24
	Social and Economic Wellbeing Plan (Sophie Greenwood, NHS)
	Mental Health Teams in Schools and stock take of Specialist CAMHS Service (Lizzie Izzard/Steve Murphy, NHS)
10 December 2024	East Sussex Health and Social Care Shared Delivery Plan (SDP) Programme - update report
	Public Health Outcomes Framework (PHOF)
	East Sussex Safeguarding Children Partnership (ESSCP) Annual Report 2023-24
	Joint Strategic Needs Assessment (JSNA) Update report
	Sussex learning from lives and deaths (LeDeR) Annual report 2023/24
04 March 2025	East Sussex Health and Social Care Shared Delivery Plan (SDP) Programme - update report
	Public Health Outcomes Framework (PHOF)
	Housing Strategy report

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