



EAST SUSSEX HEALTH AND WELLBEING BOARD

TUESDAY, 10 MARCH 2026

2.00 PM COUNCIL CHAMBER, COUNTY HALL, LEWES

MEMBERSHIP - Councillor Keith Glazier OBE, East Sussex County Council (Chair)
Jayne Black, East Sussex Healthcare NHS Trust (ESHT)
Carolyn Fair, Director of Children's Services
Darrell Gale, Director of Public Health
Councillor Amanda Jobson, Hastings Borough Council
Veronica Kirwan, Healthwatch East Sussex
Dr Stephen Pike, NHS Sussex
Councillor Carl Maynard, East Sussex County Council
Ashley Scarff, NHS Sussex
Mark Stainton, Director of Adult Social Care
Councillor John Ungar, East Sussex County Council
Councillor Trevor Webb, East Sussex County Council
Councillor Kelvin Williams, Wealden District Council
Ian Smith, NHS Sussex

INVITED OBSERVERS WITH SPEAKING RIGHTS Councillor Dr Kathy Ballard, Eastbourne Borough Council
Councillor Paul Davies, Lewes District Council
Duncan Kerr, VCSE Alliance
Councillor Teresa Killeen MBE, Rother District Council
Simon Morris, Sussex Police and Crime Commissioner
Becky Shaw, Chief Executive, ESCC
David Kemp, East Sussex Fire & Rescue Service

AGENDA

1. Minutes of meeting of Health and Wellbeing Board held on 9 December 2025 (*Pages 3 - 8*)
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. Best Start in Life Strategy (*Pages 9 - 60*)
6. East Sussex Health and Social Care Programme - update report (*Pages 61 - 84*)
7. Neighbourhood Health Plan (*Pages 85 - 92*)
8. Alcohol-Related Cognitive Impairment (*Pages 93 - 134*)
9. Work programme (*Pages 135 - 136*)

10. Any other items previously notified under agenda item 4

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2 March 2026

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governance. Vicky detailed the implementation of multidisciplinary teams (MDT) for proactive care, initially targeting people over 65 with frailty and multiple long-term conditions. She emphasised the use of the risk stratification tool to identify high-risk groups and improve integrated care, aiming to reduce emergency admissions.

28.2 The report also outlined early expectations for neighbourhood health plans under the National 10-Year Health Plan, covering health, social care and public health. Vicky commented that although guidance was still awaited, there were indications that this would likely need to progress soon, under the leadership of the Health and Wellbeing Board, and that existing work on the shared delivery plan would be utilised.

28.3 Vicky noted the postponement of the deep dive session on mental health and wellbeing to 7 January.

28.4 Ashley Scarff endorsed the revised Better Care Fund (BCF) metrics and explained that the revised avoidable admissions ambition now aligned with the health and care winter plan for East Sussex, while the discharge metrics reflected ongoing Sussex-wide work under national oversight.

28.5 Mark Stainton praised progress to date, including the rollout of the Risk Stratification Tool, and stressed the importance of focusing on admission avoidance and timely discharges. Mark proposed that work on the Neighbourhood Health Plan be included on the March agenda, although recognised that progress would be contingent on guidance being issued. Vicky responded that a formal item on the Neighbourhood Health Plan could be scheduled for the March meeting but that the development of this work could also be discussed at the January deep dive session.

28.6 The Chair acknowledged the significant work undertaken and expressed hope for positive outcomes during winter pressures.

28.7 The Board RESOLVED to:

1. Note the progress in quarter 2 for the East Sussex HWB Shared Delivery Plan (SDP) priorities and plans in 25/26 as set out in Appendix 1;
2. Endorse the early initiation work that has taken place as part of the Government's National Neighbourhood Health Implementation Programme, focussed on Hastings and Rother;
3. Note the expected content of the new neighbourhood health plan that will be developed under the leadership of HWBs for 26/27, and that guidance is awaited from the Department of Health and Social Care (DHSC); and
4. Note and endorse revised Better Care Fund (BCF) metrics that reflect updated impacts and plans to support delivery of the SDP as set out in Appendix 2.

29. EAST SUSSEX SAFEGUARDING CHILDREN PARTNERSHIP (ESSCP) ANNUAL REPORT 2024-25

29.1 Richard McDonagh presented the annual report for 2024–2025, outlining statutory duties under Working Together guidance, governance changes to strengthen the partnership and the partnership's achievements. Richard commented that the annual report demonstrated appropriate partnerships are in place and effective, promoting a culture of critical thinking and

professional challenge as well as oversight and assurance on multi agency and single safeguarding practice.

29.2 The report set out key learning, including from two multi-agency rapid reviews, one Local Child Safeguarding Practice Review, and ongoing reviews awaiting publication.

29.3 Richard highlighted extensive training and projects on information sharing, online safety, and child sexual abuse. He noted strengthened partnership arrangements, including the formation of an education subgroup and recruitment of independent scrutiny.

29.4 Carolyn Fair commented on the strength of the parentship and the importance of this amid significant reforms in children's services and noted that formal guidance would be updated again to reflect further reforms.

29.5 The Chair commended the continuity and resilience of safeguarding arrangements and welcomed the independent scrutiny arrangements.

29.6 The Board RESOLVED to receive and consider the East Sussex Safeguarding Children Partnership Annual Report for 2024-25.

30. SUSSEX LEARNING FROM LIVES AND DEATHS (LEDER) ANNUAL REPORT 2024/25

30.1 Mandy Catchpole introduced the annual report and accompanying easy-read version, reminding the Board that LeDeR is an NHS Long-Term Plan priority and that adults with a learning disability and autistic people are more likely to have early death than the rest of population. The report outlined 123 deaths were reviewed across Sussex, of which 45 were East Sussex residents, with the respiratory system the most common cause of death. Mandy outlined service improvement learning and actions, including training, resources developed with the Sussex Prevention Programme Board on stop smoking, and sepsis training.

30.2 Priorities for 2025/26 included increasing notifications of deaths of autistic people, ensuring LeDeR is included across commissioned NHS services as integration progresses, and developing further accessible information.

30.3 Mark Stainton welcomed the comprehensive evidence base showing learning from deaths and asked what the Board could do to assist promotion of reporting.

30.4 Mandy confirmed the programme was working with system partners across Sussex and within East Sussex to actively promote notifications within organisations to improve capture and learning.

30.5 The Board RESOLVED to:

1. note the report; and
2. help ensure system partners have a formal approach to utilising the learning from LeDeR to reduce the mortality gap for people with a learning disability and autistic people.

31. JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) UPDATE REPORT

31.1 Darrell Gale presented the annual JSNA update which was commissioned by Public Health and wider system partners. He highlighted 2025 developments including the Director of Public Health annual report, health inequalities audit, Pharmaceutical Needs Assessment, analysis of multiple compound needs, sexual health and substance misuse assessments, Alcohol Care Team evaluation, and the My Health, My School survey.

31.2 Darrell confirmed the JSNA now sat within East Sussex in Figures as a single county data observatory and noted Public Health support for HWB deep-dives and the strategy refresh. Priorities for 2026 included reducing health inequalities, improving healthy life expectancy, and mental health and wellbeing.

31.3 Ian Smith welcomed the JSNA as the platform for changing health and social care delivery. He stressed the scale of change required to shift to population health management, addressing wider determinants and pathways (frailty, mental health, cardiovascular), and getting specialist services out of hospital to reduce admissions and delayed discharges. He noted learning opportunities from pilot programmes in Hastings and Rother and East Surrey.

31.4 Ashley Scarff emphasised the importance of supporting data and intelligence needs of ICTs and considering cross-cutting themes when developing priorities and work plans.

31.5 Darrell confirmed that data analysis was tailored to specific population levels, from ICT groups to smaller units like LSOAs and wards and noted integration of intelligence teams across Sussex (and now Surrey). Darrell commented that work was underway to expand this collaborative approach to better support both strategic priorities and targeted community interventions.

31.6 The Chair endorsed the focus of turning intelligence into action, noting the ongoing changes to wider health delivery, and taking measured risks to do things differently.

31.7 The Board RESOLVED to approve the JSNA priorities and workplan for 2026.

32. WORK PROGRAMME

32.1 Mark Stainton introduced the draft work programme noting the agenda for the March meeting would include items on the Shared Delivery Plan update, Climate Change Health Impact Assessment, and, as agreed earlier in the meeting, the Neighbourhood Health Plan. A BCF item for 2026/27 may also be added, subject to awaited guidance.

33. ANY OTHER ITEMS PREVIOUSLY NOTIFIED UNDER AGENDA ITEM 4

33.1 Mark Stainton briefed the Board on the Government's consultation on local government reorganisation across Sussex including the two proposals for East Sussex: One East Sussex supported by East Sussex County Council and four of the five boroughs/districts, with the Brighton & Hove footprint unchanged; and five unitaries across Sussex proposed by Brighton & Hove City Council, which would divide East Sussex into three and cross the border into West Sussex. Mark expressed that a single council option for East Sussex was preferable on economies of scale, affordability, and system partnerships. He advised that the consultation closed on 11 January and that links to papers setting out both options would be shared with members.

33.2 The Chair encouraged the Board to respond to the consultation.

33.3 Board RESOLVED to note the Government consultation on local government reorganisation proposals for East Sussex.

The meeting ended at 14:47.

Councillor Keith Glazier, OBE (Chair)

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| Report to: | East Sussex Health & Wellbeing Board |
| Date of meeting: | 10 March 2026 |
| By: | Carolyn Fair, Director of Children's Services |
| Title: | Best Start in Life: East Sussex Strategy |
| Purpose: | To inform the Board about the delivery of the Best Start in Life strategy and associated targets |

Recommendations:

East Sussex Health and Wellbeing Board (HWB) is recommended to note:

- 1) The final draft of the East Sussex Best Start in Life Strategy;
 - 2) Governance in place to oversee delivery of the Strategy.
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1 Background

1.1 The East Sussex Best Start in Life Strategy sets out a comprehensive ambition to improve outcomes for children from conception to school entry. It outlines the local authority's commitment to ensuring that every child enters education with confidence, belonging, and an equitable start. The strategy aligns with the national target for 75% of children to achieve a Good Level of Development (GLD) by the end of the 2027/28 academic year.

1.2 National ambitions include improved access to early education, better quality in early years settings, and stronger family support systems. East Sussex has mirrored this ambition by setting out actions to deliver the local target that we have been set for 78% GLD by 2027/28, ensuring disadvantaged children benefit equally.

2 Supporting information

2.1 The strategy is founded on principles including integration of services, reducing inequalities, and evidence-based practice. It relies on shared intelligence and high-quality data to understand need and drive accountability across the early years system.

2.2 Three strategic objectives underpin delivery: (1) better support for families; (2) more accessible early education and childcare; and (3) improving quality in early years, including reception.

2.3 Objective 1 focuses on delivering Family Hubs, integrated services, early identification of needs, improving vaccination uptake, and supporting parental mental health.

2.4 Objective 2 includes increasing childcare places, promoting uptake of funded entitlements, supporting wraparound childcare, ensuring places for disadvantaged two-year-olds, and establishing Early Years Centres of Excellence.

2.5 Objective 3 aims to ensure every nursery has access to a qualified Early Years teacher, strengthen workforce development, and improve partnerships between settings, schools, and health services. It also strengthens reception teaching and moderation.

2.6 Governance is delivered through the Local Best Start Partnership Board and is chaired by the Public Health Consultant lead for Children and Young People. The Board includes representatives from education, children's social care, schools, early years settings, the voluntary, community and social enterprise (VCSE) sector, and health.

2.7 Three operational subgroups will each focus on one of the strategic objectives, developing and implementing detailed action plans. This work will be supported by data and impact frameworks, workforce strategy, community engagement and digital infrastructure. It should be

noted that data for early years sits across a range of data sets and systems, which presents a barrier to tracking children and targeting support. There is limited resource available to develop the data infrastructure required across partners, including health.

2.8 Funding from the Department for Education (DfE) is included in the allocations for Family Hubs delivery, which covers parenting support, infant feeding, perinatal mental health, home learning environment support and parent/carer panels.

2.9 We have also been successful in securing a very small amount of DfE funding (to end March 2026). The Regional Improvement for Standards and Excellence (RISE) bid supports coastal communities through targeted interventions, enhanced Early Years Foundation Stage (EYFS) expertise, and transition support, with evaluation based on GLD outcomes and school readiness.

2.10 The Board is asked to note that the targets set by the DfE for all pupils (78% GLD) and disadvantaged children (59.2% GLD) will be very challenging for us to meet. We have written twice to the DfE to provide this feedback and also met with them at the end of last academic year. Data for the 2024/25 academic year shows that East Sussex performance continues to be strong, with improved GLD outcomes in 2024/25 of 70.4%, outperforming the national rate of 68.3%. Whilst we are ambitious for our children, it needs to be recognised that improvement at this rate is difficult given that we start from a high base already, have seen improvement at a much steadier rate in previous years, and that investment in Best Start is relatively modest. Furthermore, the children who will be in reception in 2027/28 (when the targets are due to be delivered) are already aged 3 and have not benefitted from the additional resource and activity associated with Best Start. Page 8 of the strategy sets out the current gaps in GLD attainment.

3. Conclusion and reasons for recommendations

3.1 The Best Start Strategy provides a strong, evidence-based framework for improving outcomes for children aged 0–5 in East Sussex. Its ambitions, governance, and funding mechanisms support delivery of national and local priorities. The Board is asked to note the strategy and support ongoing governance arrangements.

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Appendix 1: Final Best Start in Life Strategy

Appendix 2: HWBB Best Start Strategy Overview March 2026



Best Start in Life Strategy (2026-2028)

February 2026



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Introduction

Giving every child the best start in life is essential to improving life chances and reducing inequalities. In East Sussex, we have made progress through initiatives such as Family Hubs and Start for Life, yet there remain opportunities to strengthen outcomes for children from conception to age five—particularly for our most vulnerable families.

This strategy aligns with the national ambition of “*Giving every child the best start in life*” and has been co-produced with local communities and partners to reflect East Sussex priorities. It sets out an ambitious plan to improve early child development and health outcomes, with a clear target: to increase the proportion of children achieving a Good Level of Development (GLD) by age five.

The Best Start in Life Strategy is underpinned by the East Sussex Education Strategy: Excellence for All (2024–2030), which aims to create an inclusive education system where every child thrives and has an equitable start. By focusing on the earliest years, we ensure children enter school ready to learn and able to achieve their full potential. Together, these strategies create a seamless pathway of support that fosters belonging, confidence, and success for all families.

We recognise that preparing for parenthood brings both joy and challenges. Our aim is to stand alongside parents—reducing stress and empowering them to provide nurturing, responsive care. Babies are born ready to learn, and the quality of their early experiences shapes their future. By embedding prevention and early intervention across services, we will enable children to thrive and maximise their life chances.

This plan builds on the priorities of the Early Help Partnership Strategy (2023) and reviews current interventions, identifies gaps, and enhances support for families. It reflects a shared commitment across partners to create opportunities for every child and family in East Sussex.

Alignment with National and Local Strategies

This strategy is firmly rooted in national priorities and reflects local ambitions to improve outcomes for children from conception to age five. It aligns with the Department for Education’s ‘[Giving every child the best start in life](#)’ (2025) strategy pillars:

- Better Support for Families
- More Accessible Early Education and Childcare
- Improving Quality in Early Years Including Reception

At a local level, our Best Start in Life Strategy complements and strengthens existing frameworks, including:

- **[East Sussex Education Strategy: Excellence for All \(2024–2030\)](#)** – setting out our vision that by 2030 all children and young people in East Sussex are part of an excellent, inclusive, and equitable education system. The system *fosters* a meaningful sense of belonging from the early years through to post-16 provision, *driven* by outstanding leadership and *supported* by strong governance. Children, young people, and their families *feel* confident, cared for, and ready to reach their full potential.
- **Early Help Partnership Strategy (2023)** – embedding prevention and early intervention across services.
- **[East Sussex SEND Strategy](#)** – promoting inclusion and tailored support for children with additional needs.
- **Neighbourhood Health Plans and NHS ‘Fit for the Future ’** - focusing on improving mental and physical health by embedding mental health expertise within multidisciplinary teams and *bridging* the gap between primary care and children and young people's mental health services.
- **Families First Partnership** – focusing on earlier intervention and providing the right support for children and families at the right time. From January 2027 Family Help teams in East Sussex will bring Early Help and Social Care together into integrated teams to provide seamless support for families.

By aligning these strategies, we create a coherent system that maximises resources, reduces duplication, and delivers joined-up support for families. This approach ensures that national ambitions translate into local action, with clear accountability and measurable impact.

Vision and Principles

Our vision is that every child in East Sussex has the best possible start in life, regardless of background or circumstance. We believe that the earliest years are critical for shaping future health, learning, and wellbeing, and that no child should be left behind.

This strategy sets out a clear ambition for children and families. Together we will ensure that:

- Parents are supported to have good health in pregnancy and into parenthood
- Babies and parent/carers have good early relationships
- Mental health and wellbeing challenges in parents/carers are identified early and supported
- Babies and children have good health outcomes
- Every child enters education with confidence, belonging, and an equitable start.
- We meet the national ambition that 75% of children achieve a Good Level of Development (GLD) by age five by 2028.

Key principles:

- To create a joined-up, inclusive, and high-quality early years system that supports families from conception to school entry.
- To use high-quality data and shared intelligence to understand need, track progress and drive accountability across the whole system.
- To commit to a reduction in inequalities across all outcomes, as well as an overall improvement.
- To centre evidence-based practice and to continue to be responsive to developing policies and practices (e.g. the anticipated revised Healthy Child Programme guidance).

By embedding prevention and early intervention across services, strengthening partnerships, and listening to families, we will build a system that reduces inequalities and maximises life chances for all children.

East Sussex Context Data

Children and young people



111,900 children and young people aged 0-19 years (xxx census)



67,074 in school (January 2025 School Census)



13,013 with SEN (January 2025 School Census)

1,124 children supported on child in need plans (Q2, 2025-26)

532 children supported on child protection plans (Q2, 2025-26)

689 children we care for (including 70 separated migrant children) (Q2, 2025-26)



589 aged 16-17 are NEET (2024/25)

17.5% of school population are BME compared to 38% in England (January 2025 School Census)



3.46% 0-25 yr olds have EHCP

414 19-25 year olds with an Education Health and Care (EHC) plan (Jan 2025)

5,574 Contacts to SPOA CAMHS (Children 0-17) (Q2 2025-26)



Between 1st October 2024 and 30th September 2025 there were **7,000** family referrals into Early Help Services for Emotional Wellbeing Support. This was 22.8% of total referrals into SPOA for that same period.

Early Years Disadvantaged Gap

The early years disadvantage gap in East Sussex remains a significant challenge (*Appendix 4 - East Sussex Funding Futures Data*). In 2022, this gap stood at 3.8 months and has widened steadily over the past three academic years to 4.7 months in 2024, with initial 2025 data indicating that the trend continues. Closing this gap is critical to achieving our ambition that every child enters education with confidence and an equitable start. This reinforces the need for a sustained focus on our most vulnerable children. The data highlights priority areas across health, early education, and childcare, which will be addressed through the high-level actions set out in this strategy to reduce inequalities and improve outcomes for all families.

Early Years Foundation Stage (EYFS)

East Sussex has consistently performed above the national average for the proportion of children achieving a Good Level of Development (GLD) at age five. In 2022/23, East Sussex recorded 69.9% compared to the national figure of 67.2%, and while both dipped slightly in 2023/24, East Sussex remained ahead at 69.0% versus 67.7% nationally. Data for 2024/25 shows East Sussex improving to 70.4%, continuing to outperform the national rate of 68.3%. Looking ahead, East Sussex has set an ambitious target of 78% by 2027/28, exceeding the Department for Education’s national ambition of 75%, reflecting a strong commitment to narrowing gaps and driving early years improvement. Our target for those eligible for free school meals is also ambitious and represents a 9.1% uplift from our 2023/24 outcomes. Improving attainment of our most vulnerable children is therefore a priority.

| Prime areas | | | England | | | | South East East Sussex | | | | Difference between last year | Trend |
|-----------------------------------------------|-------------------------|---------------------------------------------------|---------|---------|---------|---------|---------------------------|---------|---------|---------|------------------------------------|-------|
| | | | 2021/22 | 2022/23 | 2023/24 | 2024/25 | 2021/22 | 2022/23 | 2023/24 | 2024/25 | | |
| Physical Development | Gross motor skills | Percentage of children at expected level | 92.10% | 92.10% | 91.60% | 91.60% | 94.50% | 93.90% | 92.40% | 93.10% | 0.70% | ↑ |
| | Fine motor skills | | 85.80% | 86% | 85.60% | 85.50% | 88% | 88.50% | 86.90% | 87.50% | 0.60% | ↑ |
| Personal, social and emotional development | Building relationships | | 88.60% | 88.40% | 87.90% | 88.10% | 92% | 91.40% | 89.50% | 90.10% | 0.60% | ↑ |
| | Managing self | | 87.10% | 87.20% | 86.80% | 87% | 89.90% | 90.00% | 88.20% | 88.50% | 0.30% | ↑ |
| | Self-regulation | | 85.10% | 85.10% | 84.70% | 84.80% | 88.50% | 88.10% | 86.70% | 87.30% | 0.60% | ↑ |
| Communication and language | Speaking | | 82.60% | 82.80% | 82.30% | 82.80% | 87.00% | 86.90% | 85.30% | 85.70% | 0.40% | ↑ |
| | Listening and attention | | 82.20% | 82.20% | 81.60% | 81.70% | 86.50% | 86.40% | 84.30% | 84.80% | 0.50% | ↑ |
| | Comprehension | | 80.30% | 80.60% | 80.10% | 80.40% | 84.90% | 84.10% | 82.80% | 83.50% | 0.70% | ↑ |
| Literacy | Word reading | | 74.70% | 76.20% | 76.20% | 76.50% | 78.10% | 77.00% | 76.50% | 76.90% | 0.40% | ↑ |
| | Writing | | 69.50% | 71% | 71.40% | 71.80% | 72.60% | 72.70% | 72.00% | 72.70% | 0.70% | ↑ |

Gaps in GLD attainment

An analysis of the GLD data for 2022-2025 has focused on attainment in each EIP area to identify trends within the following categories: GLD, Prime areas of learning, Literacy and Mathematics. The EIP areas are Ashdown, Wealden, Eastbourne and Hastings, Rother and Rye. This analysis included looking at gender patterns of attainment, disadvantaged groups and SEND. The analysis has also provided an initial insight into the uplift required to reach the LA target of 78% by 2028. Currently, the lowest attaining EIP area is Hastings, Rother and Rye with 69.1% of children achieving GLD in comparison to Eastbourne with the highest GLD attainment of 70.2%.

Data shows that three EIPs are currently successful in achieving over 78% of children achieving the ELGs for the prime areas of learning, providing them with a secure foundation on which to build the skills required for the specific areas of learning. For all EIPs, achievement in mathematics is consistently stronger than literacy with a positive gap of between 7.6% and 9.6%.

The gender literacy gap is the largest and most consistent area of learning across all EIPs, suggesting a clear focus for improvement in boys' literacy. In all EIP areas boys' literacy is between 12.3% and 15% below girls. When analysed further by term of birth, girls are attaining higher than boys in all terms. In one EIP, summer born girls are attaining higher than autumn born boys. In Hastings, Rother and Rye, 70% of summer born girls achieved GLD in comparison to 68% of autumn term boys. In three EIPs, summer born girls are attaining higher than spring born boys. Going forward, there will need to be a focus on improving outcomes for all summer born children across all EIPs.

Disadvantaged boys are substantially behind disadvantaged girls (between 12.1 and 20%). The Wealden EIP has the lowest attainment for both girls and boys and Hastings, Rother and Rye has the largest gap between genders at 20%. Attainment in mathematics and literacy are typically the areas of development with the lowest scores.

The data has been used to calculate the additional numbers required to reach the LA target of 78%. To ensure that there is flexibility within the data, calculations have been based on reaching 79% in each EIP area. On average over the last three years, the reception cohort in East Sussex has been approximately 5,063 children. Currently, 3,528 children achieve their GLD. To reach a target of 79%, 4000 pupils in total will need to achieve a good level of development; this is an increase of 472 children.

Using this data East Sussex can identify strategies for ensuring the GLD target of 78% is met. These include micro-targets that are unique to the data set for each EIP to ensure actions are bespoke to maximise impact in the local area. Targets will focus on closing the gap between boys and girls and improving literacy outcomes for disadvantaged boys.

East Sussex take-up of childcare entitlements

East Sussex continues to perform broadly in line with, and in some areas slightly above, national averages for the take-up of funded childcare entitlements. The universal 15-hour offer for 3- and 4-year-olds remains strong, with local uptake consistently above the national figure of around 93.1%. For disadvantaged 2-year-olds, take-up nationally has declined to approximately 65.2%, and East Sussex is prioritising targeted outreach to reverse this trend and ensure eligible families access their entitlement.

The recent expansion of funded hours for working parents of children from nine months has seen rapid growth nationally, with uptake approaching 80% in East Sussex. We continue to actively support providers to meet demand through sufficiency planning and flexible provision.

Continued monitoring via the DfE Early Years Census, local headcount data, and parental surveys will ensure progress is tracked and gaps are addressed, particularly for vulnerable groups and those with SEND.

DfE Early Years Census

- Additional data collections on 2-year-olds and under
- Additional data collections on children with SEND
- EY Census moving to three times a year from April 2026

Early Years Pupil Premium (EYPP)

- Continued promotion of EYPP to families
- Training for EYs Providers on how to use EYPP to support children in their care

EYEE audits

- Continuation of a 'rolling' audit programme
- Targeting EY's settings with an annual EYEE income of more than £500,000
- Audit attendance of vulnerable groups, including those with SEND to ensure full access to their free entitlement

Strategic Objectives

We have articulated our long-term strategic plans for children aged 0-5 under the three delivery pillars set out in the government strategy '[Giving every child the best start in life](#)'. Three detailed Action Plans sit beneath each delivery pillar outlining specific actions, timescales and impact measures.

1. Better Support for Families

We plan to:

- 1.1 Deliver Best Start Family Hubs across East Sussex
- 1.2 Deliver integrated services including health, education, parenting, and enhanced SEND support
- 1.3 Ensure hubs are accessible, inclusive, working together with parent and carers on co-designing and reviewing service provision through parent panels.
- 1.4 Maintain delivery of health services within Family Hubs (e.g. health visitors, infant feeding, mental health)
- 1.5 Promote early identification and support for developmental needs
- 1.6 Improve vaccination uptake and access to mandated reviews
- 1.7 Deliver healthy eating and oral health programmes
- 1.8 Deliver digital resources in line with national digital programme for parents/carers

We will know we are making progress when:

- More families are accessing evidence-based interventions delivered through Family Hubs and integrated services including healthy eating/oral health programmes.
- More parents are accessing support for their mental health to improve parents baby relationships
- We are reaching more disadvantaged families and those with historically lower levels of engagement.
- Parents report improvements in parenting confidence, child development outcomes, or other relevant measures.
- Parents are accessing the Consultation Advice Line to seek support
- Parent's report positive experiences of influencing service design.
- Vaccination uptake and completion of mandated reviews improve.
- Families engage with digital resources
- Developmental needs are identified earlier and supported effectively.

2. More accessible early education and childcare

We plan to:

- 2.1 Increase availability of early years places
- 2.2 Promote uptake of funded childcare entitlements
- 2.3 Support wraparound childcare and flexible provision for working families
- 2.4 Ensure sufficient places for eligible two-year-olds where the family is in receipt of additional support
- 2.5 Track vulnerable children and those who are not in childcare to ensure every effort is made to enable them to access provision
- 2.6 Support the Early Years sector to create an inclusive environment for all children
- 2.7 Create Early Years Centres of Excellence that unite education, health, and community expertise to improve child development and support smooth transitions into school.

We will know we are making progress when:

- The number of early years places available across East Sussex increases.
- Uptake of funded childcare entitlements rises significantly for disadvantaged children.
- Wraparound childcare and flexible provision meet the needs of working families.
- Fewer eligible two-year-olds are missing out on early education.
- Early years settings demonstrate inclusive practice for all children.
- Early Years Centres of Excellence are established and supporting smooth transitions into school.

3. Improving quality in early years including reception

We plan to:

- 3.1 Work with the sector to ensure every nursery setting has a qualified EY teacher with a specific focus initially on our most disadvantaged communities.
- 3.2 Support and grow a skilled early years workforce.
- 3.3 Deliver training & resources for early years educators
- 3.4 Strengthen partnerships between settings, schools, and health services
- 3.5 Improve teaching in the reception year through a universal offer to all our schools.
- 3.6 Expand our Early Years moderation offer to improve pupil outcomes

We will know we are making progress when:

- Every nursery setting has access to a qualified Early Years teacher, especially in disadvantaged communities.
- The early years workforce grows in skill and capacity through training and development.
- Partnerships between nurseries, schools, and health services are strengthened.
- Teaching quality in reception year improves through a universal offer.
- Early Years moderation processes lead to better pupil outcomes.
- GLD attainment at age 5 moves closer to the 75% national ambition.

Delivery Mechanisms

This strategy will be delivered through a coordinated, multi-layered approach that ensures accountability, collaboration, and effective use of resources:

- **Local Best Start Partnership Board:** Provides strategic oversight and leadership, bringing together health, education, social care, voluntary sector partners, and parent representatives to drive system-wide change.
- **Three Operational Subgroups:** Each subgroup will focus on one of the strategic pillars—Better Support for Families, More Accessible Early Education and Childcare, and Improving Quality in Early Years Including Reception—developing and implementing detailed action plans.
- **Community Partnerships and Family Voice:** Working in partnership with the voluntary sector, District and Borough Councils to join up support for families. Embedding parent and carer voices through panels and feedback mechanisms to ensure services are inclusive, responsive, and co-designed.
- **Data and Impact Framework:** A robust monitoring system using local and national data tools to track progress against key indicators such as GLD attainment, service reach, and equity of access. This will include quarterly dashboards and annual reports.
- **Workforce Strategy:** A comprehensive plan for recruitment, retention, and professional development to build a skilled and sustainable early years workforce, aligned with national initiatives and local needs.
- **Funding and Resources:** Leveraging national funding streams (e.g. Family Hubs, EYPP, SEND support) and aligning local budgets to ensure sustainability and targeted investment in areas of greatest need.
- **Digital Infrastructure:** Delivering accessible online resources and tools for families and professionals, in line with the national digital programme, to support information sharing and service navigation.

Monitoring and Evaluation Framework

To ensure accountability and continuous improvement, the impact of the Local Best Start Strategy (2025-2028) will be monitored through a robust framework that combines quantitative data, qualitative feedback, and regular review cycles.

Purpose

The framework will:

- Track progress against strategic objectives
- Identify areas requiring additional focus or resources
- Provide transparency to partners, stakeholders, and families.

Key Components

Indicators and Data Sources

- **Child Development Outcomes:** Percentage of children achieving a Good Level of Development (GLD) at age 5.
- **Family Engagement:** Number of families accessing interventions at Family Hubs; satisfaction levels from parents.
- **Service Reach and Equity:** Uptake of funded childcare entitlements; access for vulnerable groups.
- **Workforce Capacity and Quality:** Recruitment, retention, and training completion rates for early years professionals.

Data Collection and Reporting

- **Quarterly Dashboards:** Summarising progress against key indicators for operational subgroups and the Local Best Start Partnership Board.
- **Annual Impact Report:** Comprehensive review of outcomes, trends, and recommendations for improvement.
- **Qualitative Feedback:** Parent/carer provider surveys, and stakeholder engagement sessions.

Review Points

- **Mid-Point Review (2026):** Assess progress, recalibrate priorities, and address emerging challenges.

- **Annual Strategy Review:** Ensure alignment with national policy changes and local needs.

Governance and Accountability

- Reports will be shared with:
 - Local Best Start Partnership Board.
 - CYP Health Oversight Board.
 - Children's Services Departmental Management Team.
 - Public Health Senior Management Team.
- Subgroups will provide update reports for each Partnership Board meeting.

Continuous Improvement

- Use data insights to inform targeted interventions.
- Highlight and scale best practice across East Sussex.
- Embed co-production with families to ensure services remain responsive and inclusive.

Governance

Strategic oversight of the Best Start Strategy in East Sussex, is overseen by Local Best Start Partnership Board. This group will support the delivery of the government strategy '[Giving every child the best start in life](#)' through the development and delivery of our local Best Start Strategy, which has been co-produced by the local authority together with our community and in response to local needs.

Terms of Reference

The overall purpose of the Local Best Start Partnership Board is to oversee the development and delivery of the Best Start Strategy, and to:

- Set a bold vision for improving child development and health outcomes with local delivery partners across all sectors
- Maximise opportunities for partnership working across the early years, including creating strong networks and building on existing community assets
- Share and use data to understand local need and disparity that informs the targeting of interventions and resources effectively and efficiently
- Highlight areas of best practice in East Sussex and beyond, and to develop and scale innovative practice
- Share insights from families and collaborate on engagement to improve services
- Identify opportunities for prevention at scale, with a focus on reducing inequalities

Operational subgroups

The Local Best Start Strategy Partnership Board will also oversee three operational subgroups who will deliver on the Best Start Strategy Action Plans:

- 1. Better Support for Families**
Strategic Leads: Celia Lamden and Tina Pellini
- 2. More accessible early education and childcare**
Strategic Leads: Jane Spice and Allison Martin
- 3. Improving quality in early years including reception**
Strategic Leads: Nicola Blake and Rowena Dumbrell

Membership

The meeting will be chaired by the Public Health Consultant lead for Children and Young People for the first year.

- Emma King, Public Health Consultant lead for Children and Young People (Chair)
- Kathy Marriott Assistant Director, Early Help and Social Care
- Elizabeth Funge, Assistant Director Education
- Celia Lamden, Head of Early Help Services 0 - 19
- Katie Ridgway, Head of Inclusion and Partnerships

- Alison Amstutz, Strategic Commissioning Manager - Healthy Child Programme
- Kaia Vitler, Divisional Director of Operations (Women & Children's Division)
- Joanna Robertson, ICB MH commissioner (perinatal MH)
- Caroline Tozzi, ICB representative for children and SEND
- Sharon Gardner-Blatch, ICB maternity commissioner
- Dr. Chrysanthos Poullikas, Consultant in Paediatric Neurodisability
- Dr. Patience Okorie, GP representative GP Clinical Director
- Graham Evans, Head of Public Health Intelligence
- Laylee Pocock, Director of School Improvement Provision Aurora Academies
- Katherine Barrellie, Nursery Manager All Saints Nursery
- Angelica McMillan, Fellowship of St Nicholas (FSN)
- Rebecca Harmer, Service Support Officer Education

Frequency of meetings

The Local Best Start Partnership Board will meet bi-monthly to begin with, to be reviewed after no more than 6 months. The meetings will last for 2 hours and will take place virtually on MS Teams. The subgroups will be meet at a frequency to be agreed. Administrative support for the meetings will be provided by Education.

Review

The terms of reference and membership will be reviewed on an annual basis by the Local Best Start Partnership Board.

Key Contacts

Any queries regarding better **support for families** should be directed to:

Celia Lamden

Head of Early Help Services 0 - 19

Celia.Lamden@eastsussex.gov.uk

Julie Powell

Operations Manager Early Years Community 0 – 19 Early Help Service

Any queries regarding **more accessible early education and childcare** should be directed to:

Jane Spice

Early Years Sufficiency and Organisation Manager

jane.spice@eastsussex.gov.uk

Allison Martin

Service Manager: SEND Early Years and CLASS

Allison.Martin@eastsussex.gov.uk

Any queries regarding **early years settings including reception**, should be directed to:

Nicola Blake

Strategic Lead: Intervention and Early Years

nicola.blakecs@eastsussex.gov.uk

Rowena Dumbrell

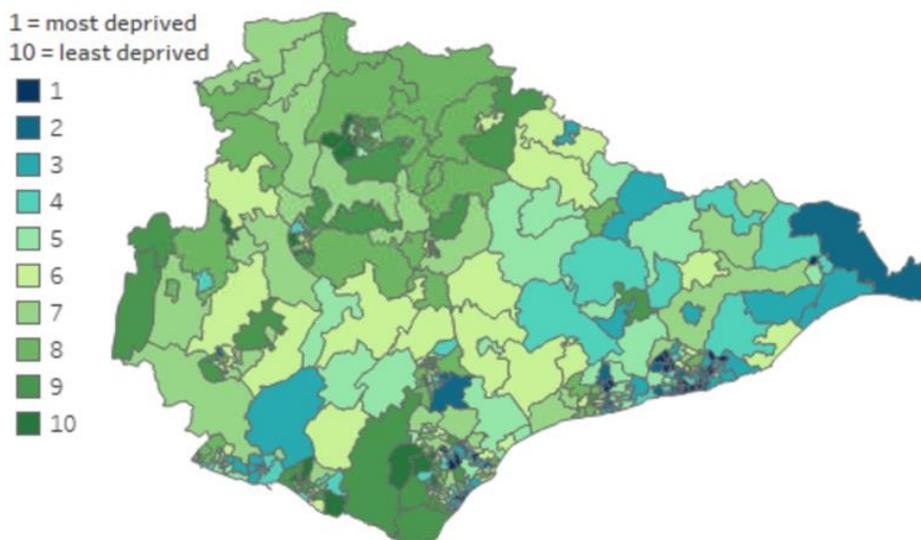
Senior Manager: Early Years

Rowena.Dumbrell@eastsussex.gov.uk

Appendix – East Sussex Context Data

East Sussex Deprivation Data

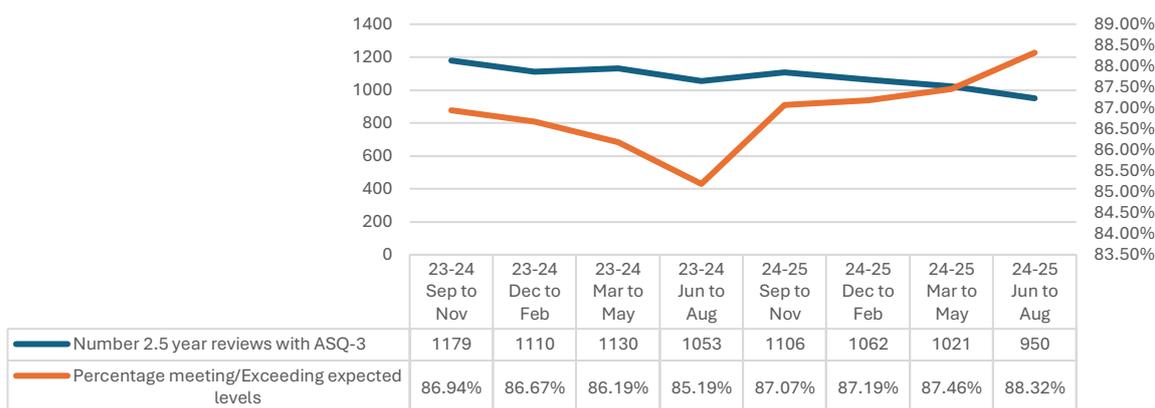
Deprivation: Of 332 LSOAs, 29 in the most deprived 10% nationally. 18 in Hastings, 8 in Eastbourne and 3 in Rother (2025)



Ages and Stages Screening tool (ASQ) – parent led

(Completed at 27 months)

Percentage Achieving all 5 levels on ASQ-3; Trend for 2.5 Year reviews completed using ASQ-3



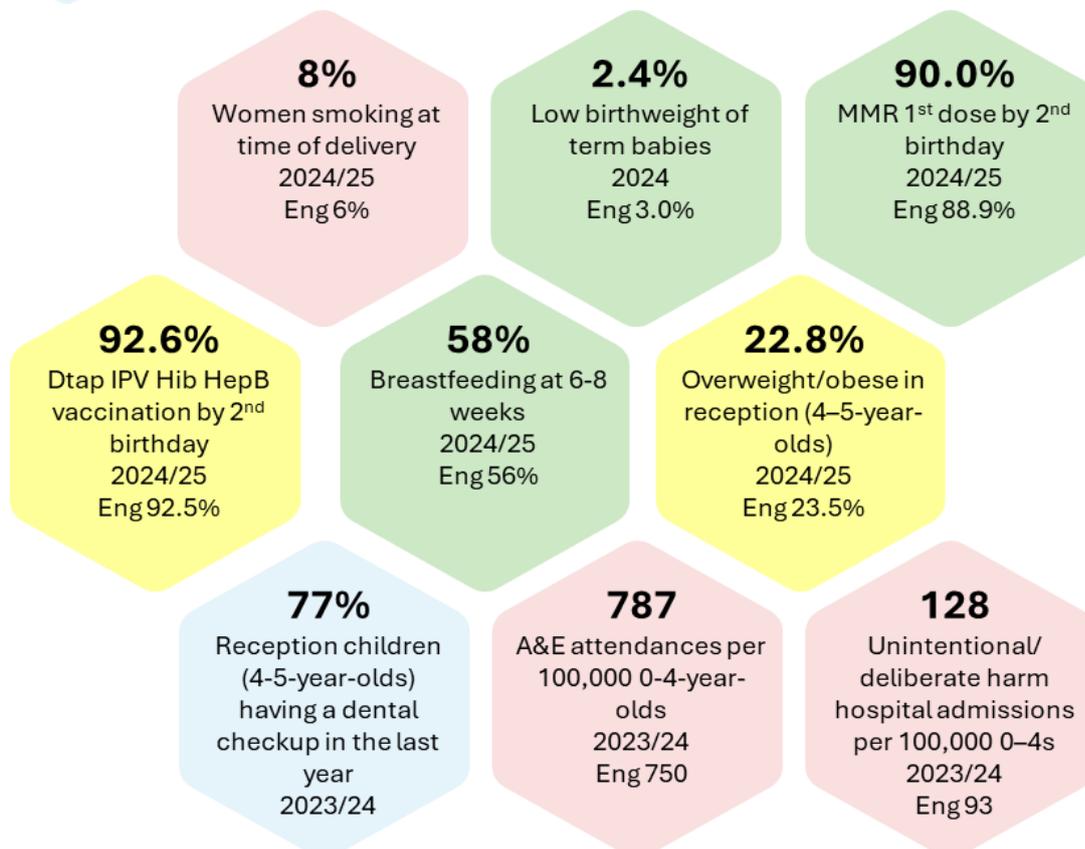
The ASQ data shows a steady decline in the number of 2.5-year reviews completed using ASQ-3, falling from 1,179 in Sept–Nov 2023 to 950 by Jun–Aug 2025—a reduction of around 19%. Despite this drop in coverage, the percentage of children meeting or exceeding expected developmental levels has improved over time. After a dip to 85.19% in mid-2024, outcomes rose consistently, reaching 88.32% by summer 2025, the

highest point in the series. This upward trend suggests that while fewer reviews are being completed, the quality of early development support and interventions is improving. Sustaining this progress while addressing the decline in review numbers will be critical to ensuring equitable access and early identification for all children.

The parent led ASQ at 27 months is the last formal data point that we have for children before they start school.

East Sussex Health Data

Key: East Sussex compared to England



The data above shows some key existing outcomes that can help guide our actions to improve health and wellbeing for children and families.

- Supporting pregnant women and their partners to stop smoking and then remain smoke-free has a positive effect on the health of the whole family. Currently, we have a higher smoking rate at time of delivery (8%) than the England average (6%) and the rate is the highest in the South East. There has been a significant drop over time, but this has slowed and further improvements will require a joined-up approach across services for families.
- East Sussex has a low number of term babies born at low birth weight (2.6%)- this is an indication of infant health that is affected by maternal health and care. This is in line with the regional average (2.6%) and lower than England (3%). There is a variation by area, with Hastings (2.9%) having the highest rate and Wealden being significantly lower (1.7%).
- Childhood vaccinations protect babies and children from diseases that can cause harm. Rates for the combined vaccine 'Dtap/IPV/Hib/HepB' (92.6%) are similar to England (92.5%) but have been dropping over time.
- Although the one dose MMR by 2 years figure (90%) is better than the England average, rates have been dropping since 2019/20 and the goal of 95% has never been reached.
- Breastfeeding has many health benefits for families. Currently breastfeeding prevalence at 6-8 weeks is 57% which is higher than the England average and slowly increasing.
- The number of children in reception measured as overweight or obese (22.8%) is similar to the England average (23.5%) and has remained steady for the last 3 years, compared to an upward trend nationally. However, by the time children reach Year 6 this rises to 32.4%. This varies across the county with Eastbourne (25.4%) the highest and Wealden (20.2%) significantly lower than the others.
- Good oral health in children helps with eating, speaking, sleeping and socialising and can prevent pain and discomfort. Data from the School Health service shows that 77% of parents report taking their child for a dental check up in the last year. The NHS recommends children should attend the dentist at least every year, or more often if recommended.
- A&E attendances and hospital admissions specifically for unintentional injuries remain higher than the national average for 0-4s. More work is being taken to understand this, but the reduction of accidents and injuries in children continues to be a priority and requires multiprofessional input.

In addition to these outcomes, there are many other ways we could seek to measure and improve parental and child health. In 2026, a health needs assessment will be

conducted for children under 5 which will identify further areas for focus, as well as highlight inequalities within our populations.

East Sussex Funding Futures Data

- [Funding Futures Data Dashboard - Mime](#)

East Sussex

Size of the disadvantage gap at early years in 2024: **4.7 months**

Relative ranking:

1st quintile 2nd quintile 3rd quintile 4th quintile 5th quintile

Size of the disadvantage gap in months:

| | 2022 | | 2023 | | 2024 | |
|------|----------|-----------|----------|-----------|----------|-----------|
| | Gap size | % Disadv. | Gap size | % Disadv. | Gap size | % Disadv. |
| EYFS | 3.8 | 19.8% | 4.5 | 18.8% | 4.7 | 17.3% |
| KS2 | 12.8 | 26.5% | 12.6 | 27.5% | 12.2 | 28.3% |
| KS4 | 23.3 | 21.9% | 22.8 | 21.7% | 24 | 22.4% |

| Local Indicators | Category | Eng. avg. | |
|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-----------|----------------------------------------------|
| Proportion of New Birth Visits completed within 14 days | Health services & support | 83 | 70.6% England rank: 119 out of 143 |
| Proportion of 3 and 4 year olds accessing their universal childcare entitlement at a state-provider | Early education & childcare | 56.4 | 47% England rank: 124 out of 150 |
| Per capita total SEN inclusion fund for 3 and 4 year olds | Early education & childcare | 68 | £29 England rank: 122 out of 147 |
| Percentage of women who have their booking appointment with a midwife within 1 completed weeks of their pregnancy | Health services & support | 63.5 | 57.6% England rank: 117 out of 150 |
| Number of children aged 7 and under per accessible childcare place | Early education & childcare | 4 | 4.76 England rank: 113 out of 150 |
| Households with dependent children in temporary accommodation (per 000s of households with dependent children) | Economic support & essential resource | 12 | 11.3 England rank: 100 out of 140 |
| Households with dependent children owed a homelessness prevention or relief duty (per 000s of households with dependent children) | Economic support & essential resource | 15.8 | 16.8 England rank: 85 out of 143 |
| Net expenditure per capita on family support services | Early support services | 68 | £58 England rank: 88 out of 150 |
| Proportion of children who receive their 2 to 2 and a half year health visitor review | Health services & support | 78.4 | 81.2% England rank: 79 out of 143 |
| Proportion of 3 and 4 year olds taking up their universal childcare entitlement | Early education & childcare | 93.1 | 93.3% England rank: 82 out of 150 |
| Net expenditure per capita on Sure Start children's centres and early years fundin. | Early support services | 29 | £24 England rank: 74 out of 136 |
| Proportion of 2 year olds accessing their FRAS childcare entitlement at a state-provider | Early education & childcare | 20.3 | 21.7% England rank: 68 out of 148 |
| Income Deprivation Affecting Children Index (IDAC) average score | Local Context | - | 0.16 England rank: 64 out of 148 |
| Proportion of 2 year olds taking up their FRAS childcare entitlement | Early education & childcare | 65.2 | 66.8% England rank: 64 out of 150 |
| Net expenditure per capita on children's 0-5 public health services | Health services & support | 254 | £271 England rank: 60 out of 139 |
| Indices of Multiple Deprivation (IMD) overall score | Local Context | - | 19.8 England rank: 58 out of 148 |
| Proportion of children achieving a good level of development at EYFSP | Local Context | 67.7 | 69% England rank: 53 out of 150 |
| Proportion of 2 year olds accessing their FRAS childcare entitlement at an Ofsted rated Outstanding provider | Early education & childcare | 12.2 | 17% England rank: 39 out of 150 |
| Proportion of EHCP requests assessed within 20-week timeline | Early support services | 46.4 | 85.1% England rank: 30 out of 149 |
| Proportion of 3 and 4 year olds accessing their universal childcare entitlement at a Ofsted rated Outstanding provider | Early education & childcare | 17.6 | 24.9% England rank: 30 out of 150 |
| Gross expenditure of children & young people's charities (per number of residents under the age of 18) | Social capital/infrastructure | - | £1,468 England rank: 16 out of 145 |
| Food parcels distributed to children (per 10,000 households with dependent children) | Economic support & essential resource | 1235 | 3,145 England rank: 10 out of 127 |

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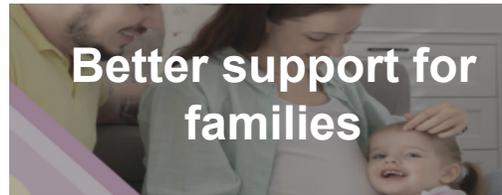
East Sussex Best Start Strategy

Overview March 2026



Giving Every Child the Best Start in Life: strategy overview

In July 2025, the Department for Education (DfE) published its plan to improve family services and early years education. This will support the ambition for 75% of children aged 5 achieving a Good Level of Development (GLD) by 2028.



Additional £500m investment to deliver **Best Start Family Hubs** in every local authority by 2028

- A national **digital service** to bring together the trusted advice and guidance parents need in one place
- **Improved services** for child and maternal health
- **Child outcome targets** for every local authority (LA)

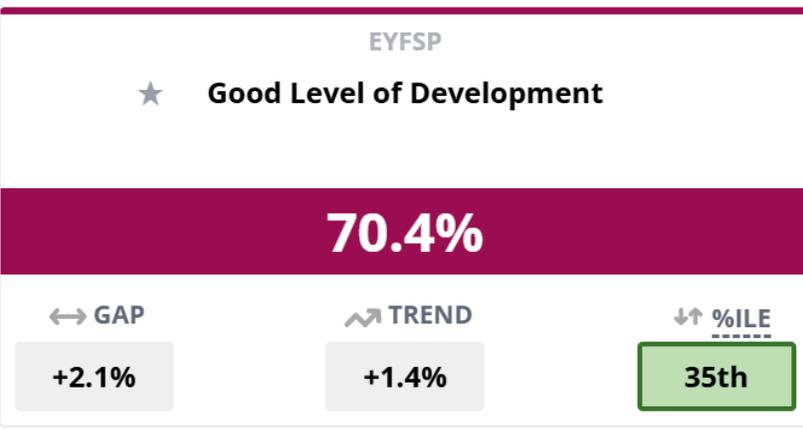
- Continue the **working parent entitlement expansion** to 30hrs free education from 9 months
- **More places in settings**, inc. in school-based nurseries
- **Increased funding to promote inclusion** of children with SEND
- Create a **stronger system** by supporting high-quality providers grow, consider new powers for LAs to shape markets, and more frequent, Ofsted inspections

- **Incentives for early years (EY) teachers** in disadvantaged communities - an ambition for one in every setting
- **Raising the status of EY educators**, through a workforce register and career pathways
- **Raising skill levels** through training and resources, centres of expertise and stronger links between schools and settings
- Universal and targeted support for schools to **improve teaching in reception year**.

East Sussex: Good Level of Development (GLD)

East Sussex Target

- The proportion of children in East Sussex County Council achieving a Good Level of Development at the end of the 2027/28 academic year is at least 78%; and
- Disadvantaged children have benefitted *at least equally* from this improvement; that is, that the proportion of children eligible for Free School Meals (FSM) and achieving a Good Level of Development at the end of the 2027/28 academic year is at least 59.2%.



12 development goals for children
Children’s development is assessed at the end of reception by their teacher through the Early Years Foundation Stage (EYFS) Profile assessment. To meet a ‘Good Level of Development’ (GLD) children must meet 12 development goals:

| | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Personal, social and emotional development | | |
| 1. Self-regulation <ul style="list-style-type: none"> • understand feelings and begin to regulate behaviour • focus, respond and follow instructions • work towards simple goals with patience | 2. Managing self <ul style="list-style-type: none"> • show confidence and independence • understand and follow rules • manage personal needs, like hygiene and dressing | 3. Building relationships <ul style="list-style-type: none"> • form positive attachments • play cooperatively and take turns • show sensitivity to the needs of others |
| Communication and language | | |
| 4. Listening, attention and understanding <ul style="list-style-type: none"> • listen attentively, responding with comments or questions • take part in conversations with teachers and peers | | 5. Speaking <ul style="list-style-type: none"> • participate in discussions using new vocabulary • explain thinking and express ideas and feelings using full sentences |
| Physical development | | |
| 6. Gross motor skills <ul style="list-style-type: none"> • move confidently and safely • show strength, balance and coordination in a range of physical activities | | 7. Fine motor skills <ul style="list-style-type: none"> • hold a pencil effectively in preparation for fluent writing • use other tools such as scissors and cutlery • begin to show accuracy when drawing |
| Literacy | | |
| 8. Comprehension <ul style="list-style-type: none"> • understand and retell stories using own words and new vocabulary • anticipate events and use new vocabulary in discussions | | 9. Word reading <ul style="list-style-type: none"> • say sounds for letters and digraphs • read simple words and sentences aloud, including sound blending |
| 10. Writing <ul style="list-style-type: none"> • write recognisable letters and spell words • write simple phrases and sentences | | |
| Mathematics | | |
| 11. Number <ul style="list-style-type: none"> • understand numbers up to 10 • recognise quantities up to 5 without counting • automatically recall number bonds up to 5 and some to 10 | | 12. Numerical patterns <ul style="list-style-type: none"> • count beyond 20 • compare quantities up to 10 • explore number patterns up to 10 such as odds, evens and doubles |

Vision

This strategy sets out a clear ambition for children and families. Together we will ensure that:

- Parents are supported to have good health in pregnancy and into parenthood
- Babies and parent/carers have good early relationships
- Mental health and wellbeing challenges in parents/carers are identified early and supported
- Babies and children have good health outcomes
- Every child enters education with confidence, belonging, and an equitable start.
- We meet the national ambition that 75% of children achieve a Good Level of Development (GLD) by age five by 2028.



Principles

- To create a joined-up, inclusive, and high-quality early years system that supports families from conception to school entry.
- To use high-quality data and shared intelligence to understand need, track progress and drive accountability across the whole system.
- To commit to a reduction in inequalities across all outcomes, as well as an overall improvement.
- To centre evidence-based practice and to continue to be responsive to developing policies and practices (e.g. the anticipated revised Healthy Child Programme guidance).



Strategy Overview

01

Better support for families

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02

More accessible early education and childcare

03

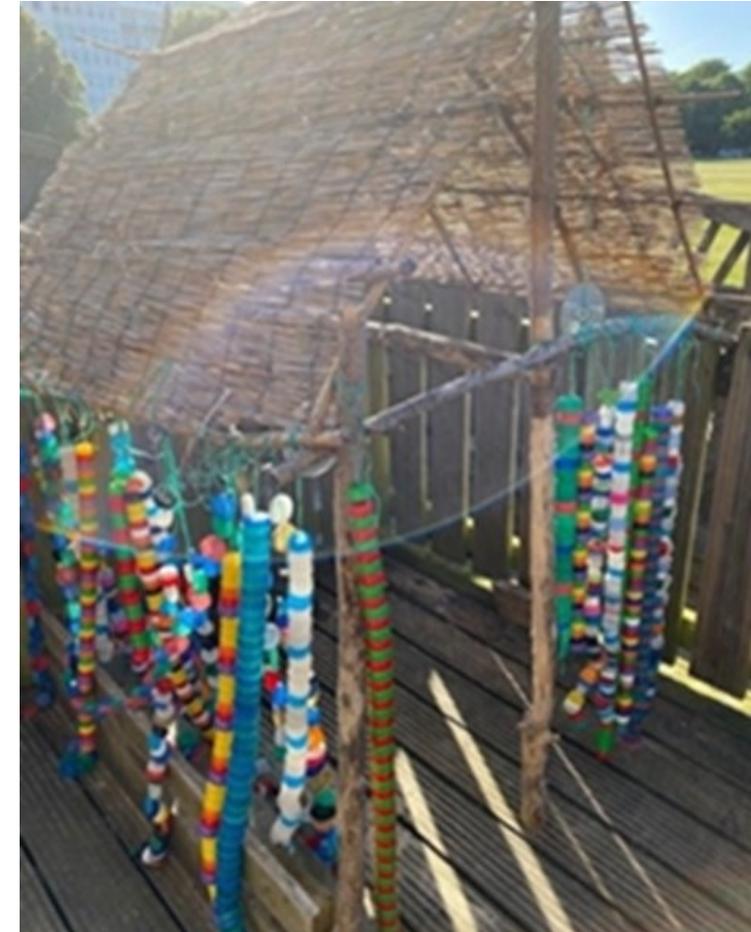
Improving quality in early years including reception



1. Better support for Families

We plan to:

- 1.1 Deliver Best Start Family Hubs across East Sussex
- 1.2 Deliver integrated services including health, education, parenting, and enhanced SEND support
- 1.3 Ensure hubs are accessible, inclusive, working together with parents and carers on co-designing and reviewing service provision through parent panels
- 1.4 Maintain delivery of health services within Family Hubs (e.g. health visitors, infant feeding, mental health)
- 1.5 Promote early identification and support for developmental needs
- 1.6 Improve vaccination uptake and access to mandated reviews
- 1.7 Deliver healthy eating and oral health programmes
- 1.8 Deliver digital resources in line with national digital programme for parents/carers



2. More accessible early education and childcare

We plan to:

2.1 Increase availability of early years places

2.2 Promote uptake of funded childcare entitlements

2.3 Support wraparound childcare and flexible provision for working families

2.4 Ensure sufficient places for eligible two-year-olds where the family is in receipt of additional support

2.5 Track vulnerable children and those who are not in childcare to ensure every effort is made to enable them to access provision

2.6 Support the Early Years sector to create an inclusive environment for all children

2.7 Create Early Years Centres of Excellence that unite education, health, and community expertise to improve child development and support smooth transitions into school.



3. Improving quality in early years including reception

We plan to:

- 3.1 Work with the sector to ensure every nursery setting has a qualified early years teacher with a specific focus initially on our most disadvantaged communities
- 3.2 Support and grow a skilled early years workforce
- 3.3 Deliver training & resources for early years educators
- 3.4 Strengthen partnerships between settings, schools, and health services
- 3.5 Improve teaching in the reception year through a universal offer to all our schools.
- 3.6 Expand our Early Years moderation offer to improve pupil outcomes



Delivery Mechanisms

- Local Best Start Partnership Board
- Three Operational Subgroups
- Community Partnerships and Family Voice
- Data and Impact Framework
- Workforce Strategy
- Funding and Resources
- Digital Infrastructure

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Local Best Start Governance Board



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Terms of Reference

- Set a bold vision for improving child development and health outcomes with local delivery partners across all sectors
- Maximise opportunities for partnership working across the early years, including creating strong networks and building on existing community assets
- Share and use data to understand local need and disparity that informs the targeting of interventions and resources effectively and efficiently
- Highlight areas of best practice in East Sussex and beyond, and to develop and scale innovative practice
- Share insights from families and collaborate on engagement to improve services
- Identify opportunities for prevention at scale, with a focus on reducing inequalities

Operational Sub-Groups

01

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Better support for families

- Leads: Celia Lamden and Julie Powell

02

More accessible early education and childcare

- Leads: Allison Martin and Jane Spice

03

Improving quality in early years including reception

- Leads: Nicola Blake and Rowena Dumbrell

- Each sub-group will include representatives from across Children's Services teams.

Family Hub Funding

| Strand | % | 2026-27 Allocation | 2027-28 Allocation | 2028-29 Allocation |
|----------------------------------------------------------------|-----|--------------------|--------------------|--------------------|
| Best Start Family Hubs delivery grant - programme | 23% | £523,700 | £428,200 | £439,700 |
| Best Start Family Hubs delivery grant - capital | 5% | £104,700 | £106,800 | £108,900 |
| Parenting support | 18% | £364,400 | £369,000 | £385,200 |
| Home learning environment support | 14% | £276,500 | £279,900 | £292,200 |
| Perinatal mental health and parent-infant relationships | 26% | £534,600 | £534,600 | £534,600 |
| Infant feeding support | 13% | £261,400 | £261,400 | £261,400 |
| Healthy babies offers and parent and carer panels | 1% | £26,700 | £26,700 | £26,700 |
| Total | | £2,092,000 | £2,006,600 | £2,048,700 |

Universal RISE Bid

- 1. Strengthening EYFS quality in coastal communities** by seconding experienced EYFS teachers and Special Educational Needs Coordinators (SENCOs) into family hubs to improve early identification, inclusive practice, and transitions for disadvantaged children.
- 2. Embedding cross-sector collaboration** between early years settings, family hubs, and mainstream schools to create shared expertise, aligned pedagogy, and consistent support pathways.
- 3. Targeted transition and family engagement work** to support disadvantaged three-year-olds not accessing childcare, including transition programmes, resource packs, and parental workshops.
- 4. Measuring impact through GLD outcomes, early identification rates, school-readiness indicators, and qualitative feedback**, supported by baseline 2024–25 data and a final evaluation by March 2026.

Picture of 0-5 year olds in East Sussex

- Summary of some key data for East Sussex

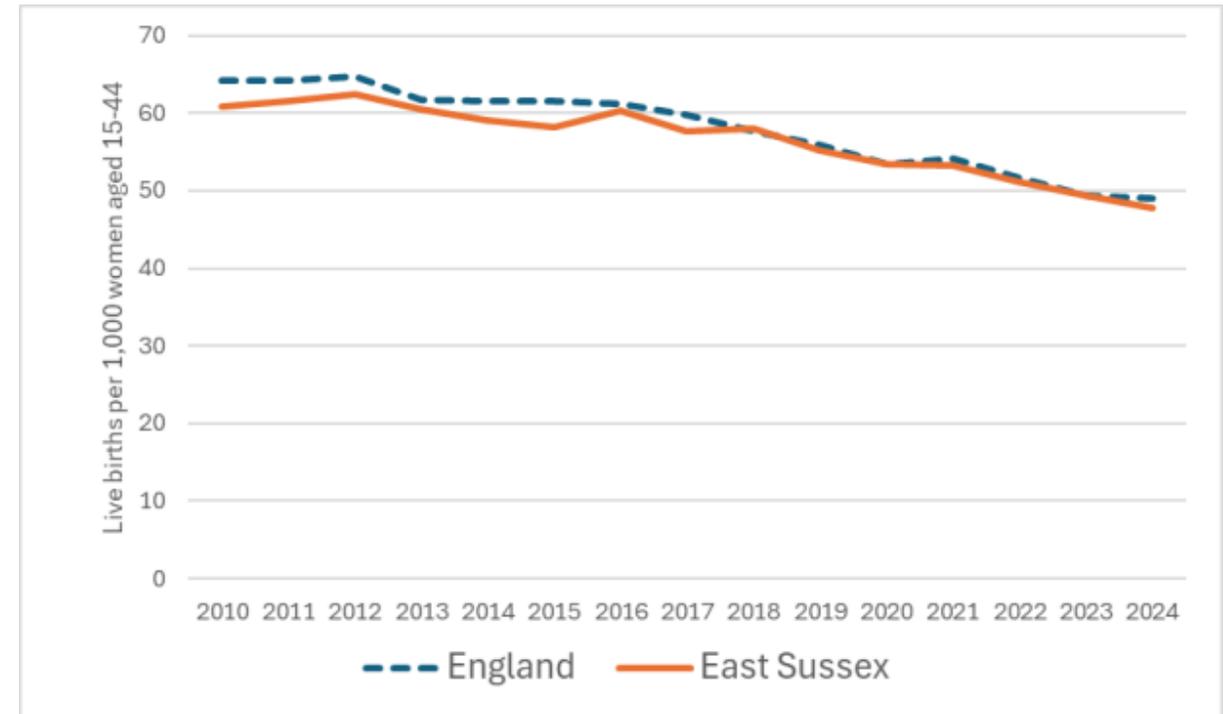
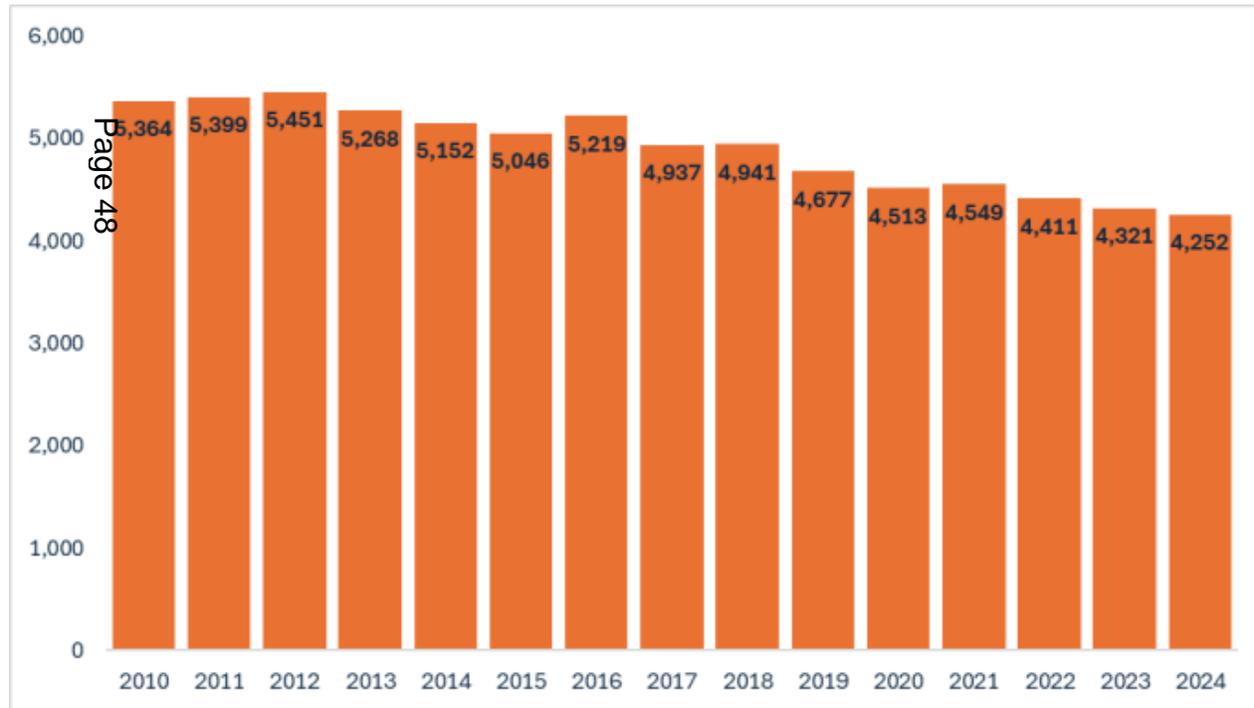
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Picture of 0-5 year olds in East Sussex

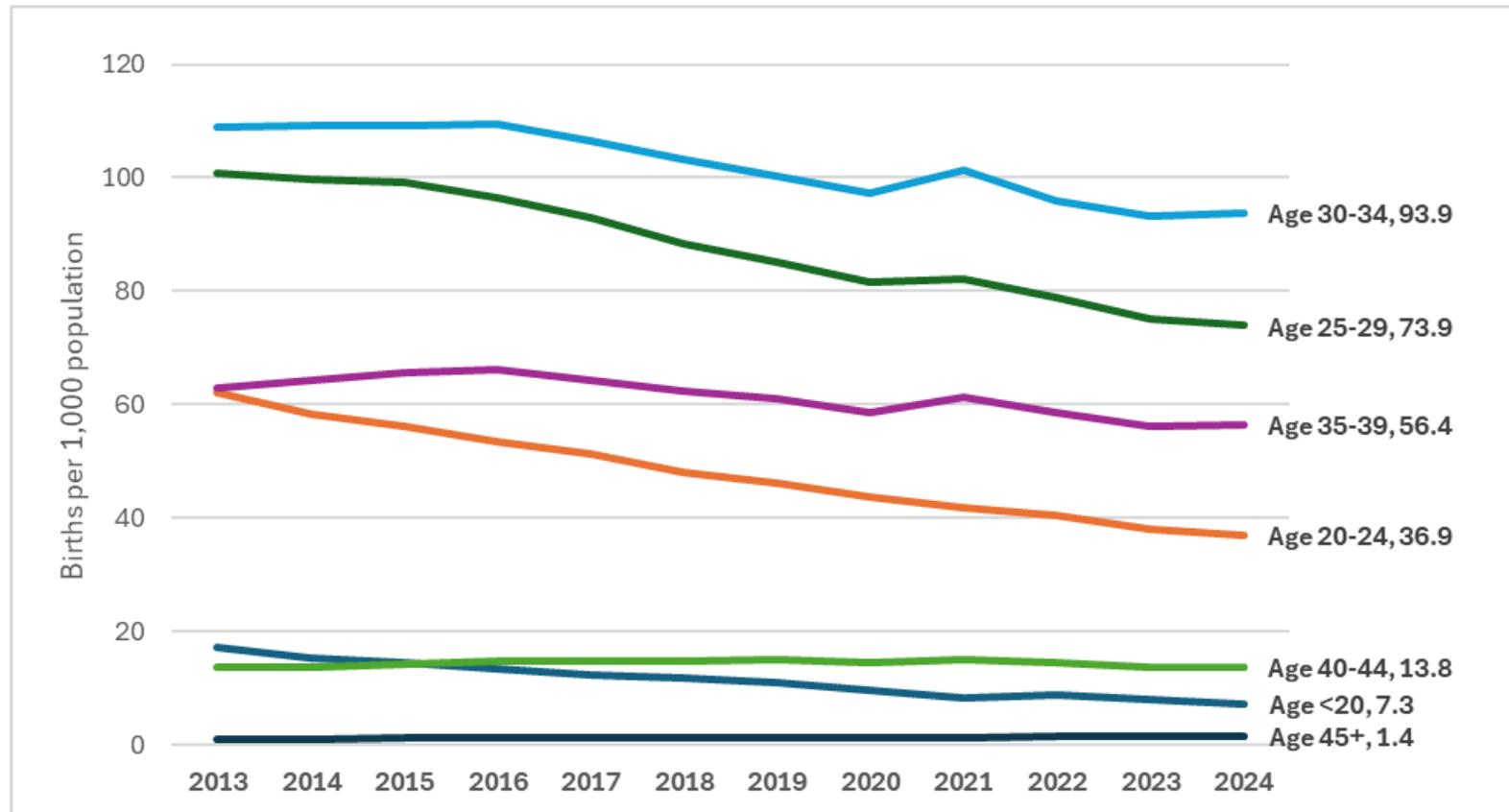
Number of live births in the county continues to reduce

Rates are reducing in line with England



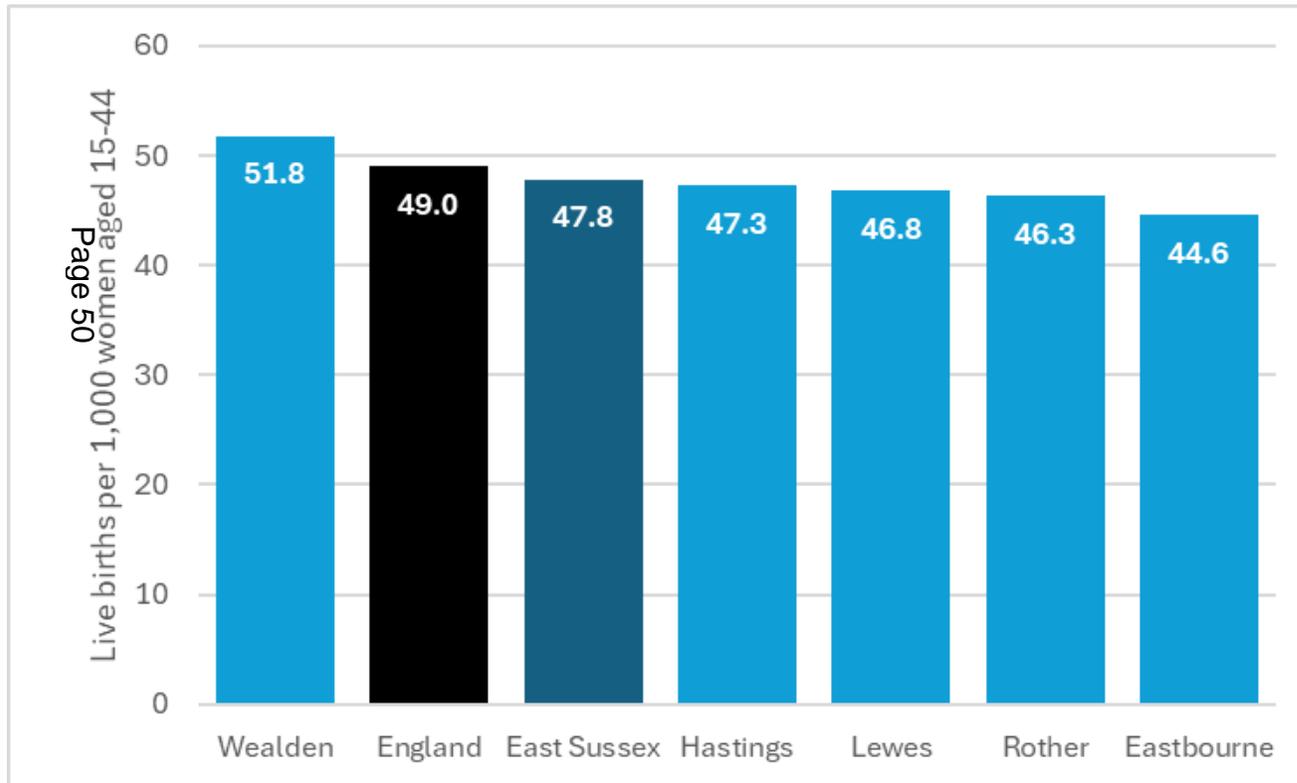
Picture of 0-5 year olds in East Sussex

Age-specific birth rates in East Sussex show biggest reductions for those in their 20s at the time of pregnancy



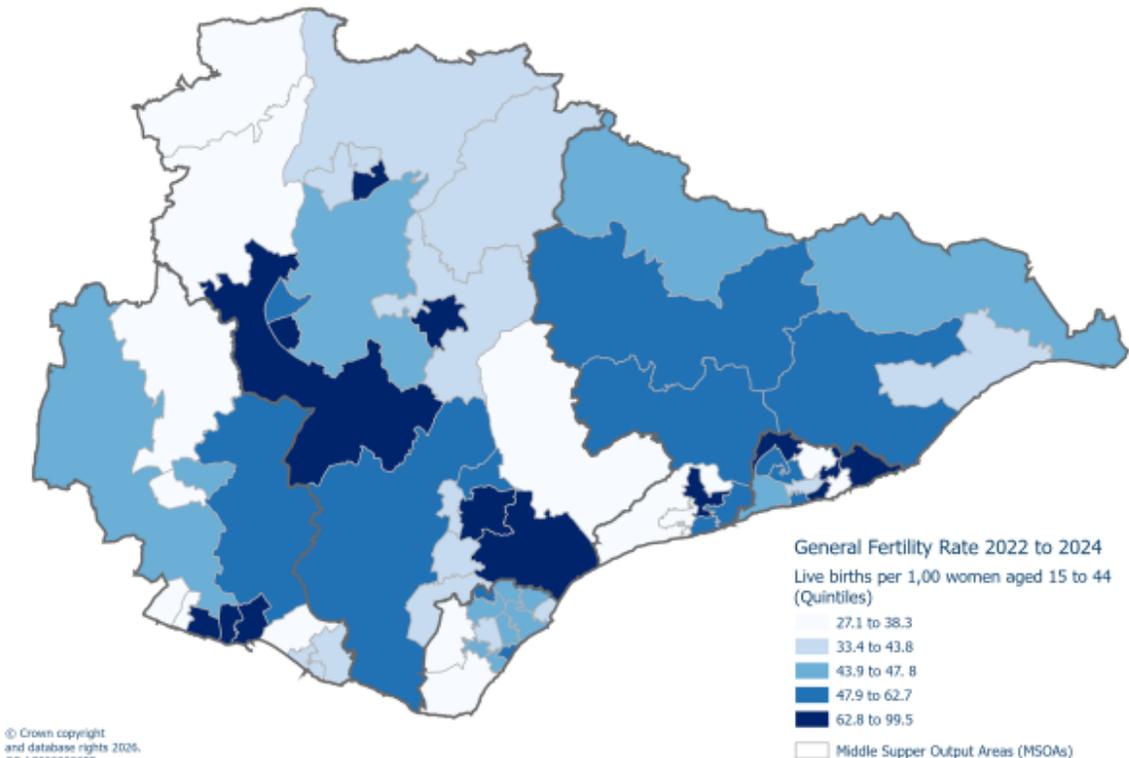
Picture of 0-5 year olds in East Sussex

Rates in 2024 by district/borough



Source: ONS

Rates in 2022-2024 by smaller area



Source: East Sussex Public Health Intelligence Team

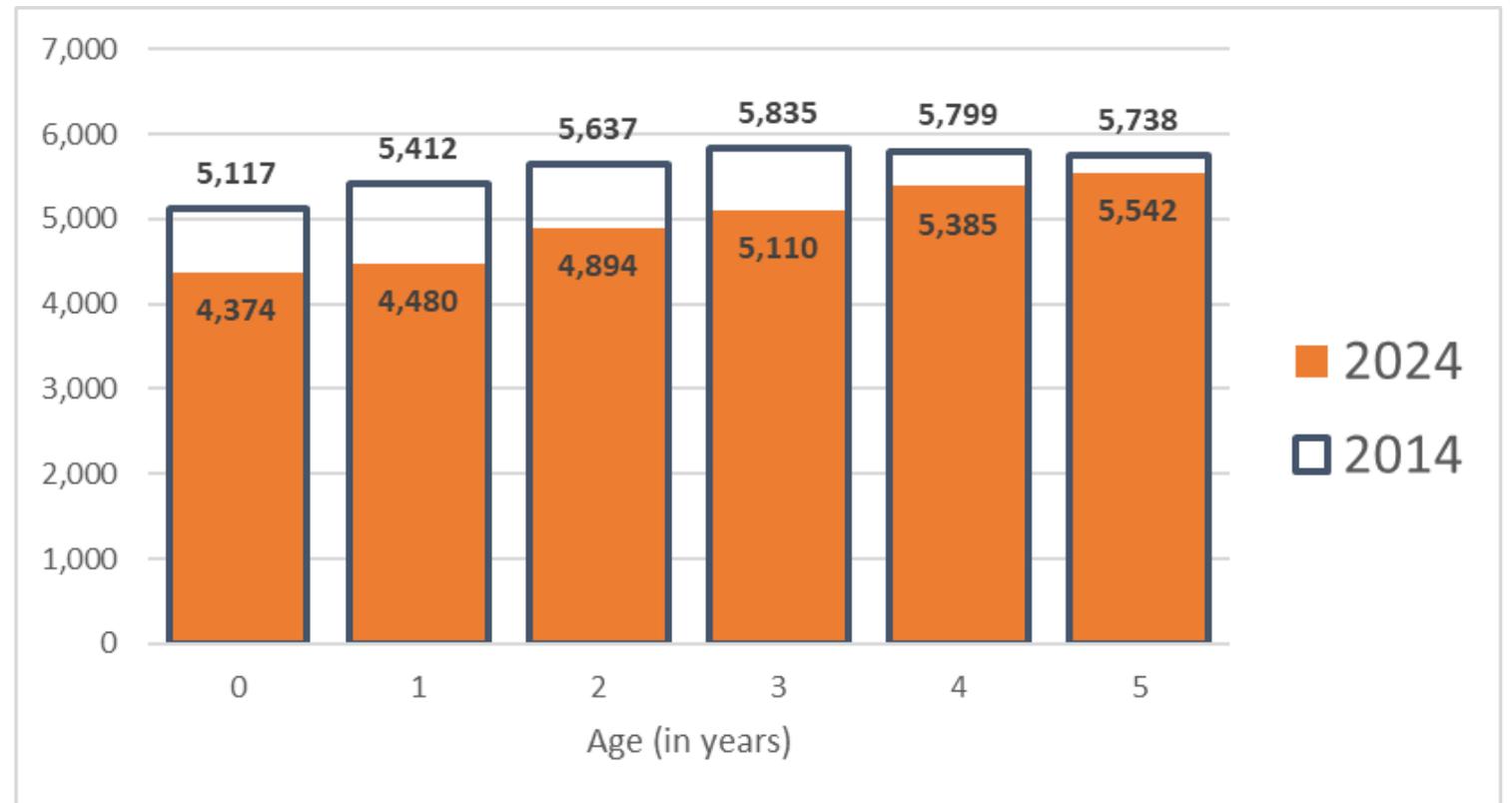
[Further detail in JSNA report: Birth rates in East Sussex between 2001 and 2021](#)

Picture of 0-5 year olds in East Sussex

East Sussex residents aged 0-5 years, comparing 2014 to 2024

- Reduction of 11% in the last 10 years from 33,538 in 2014 to 29,785 in 2024

Page 51

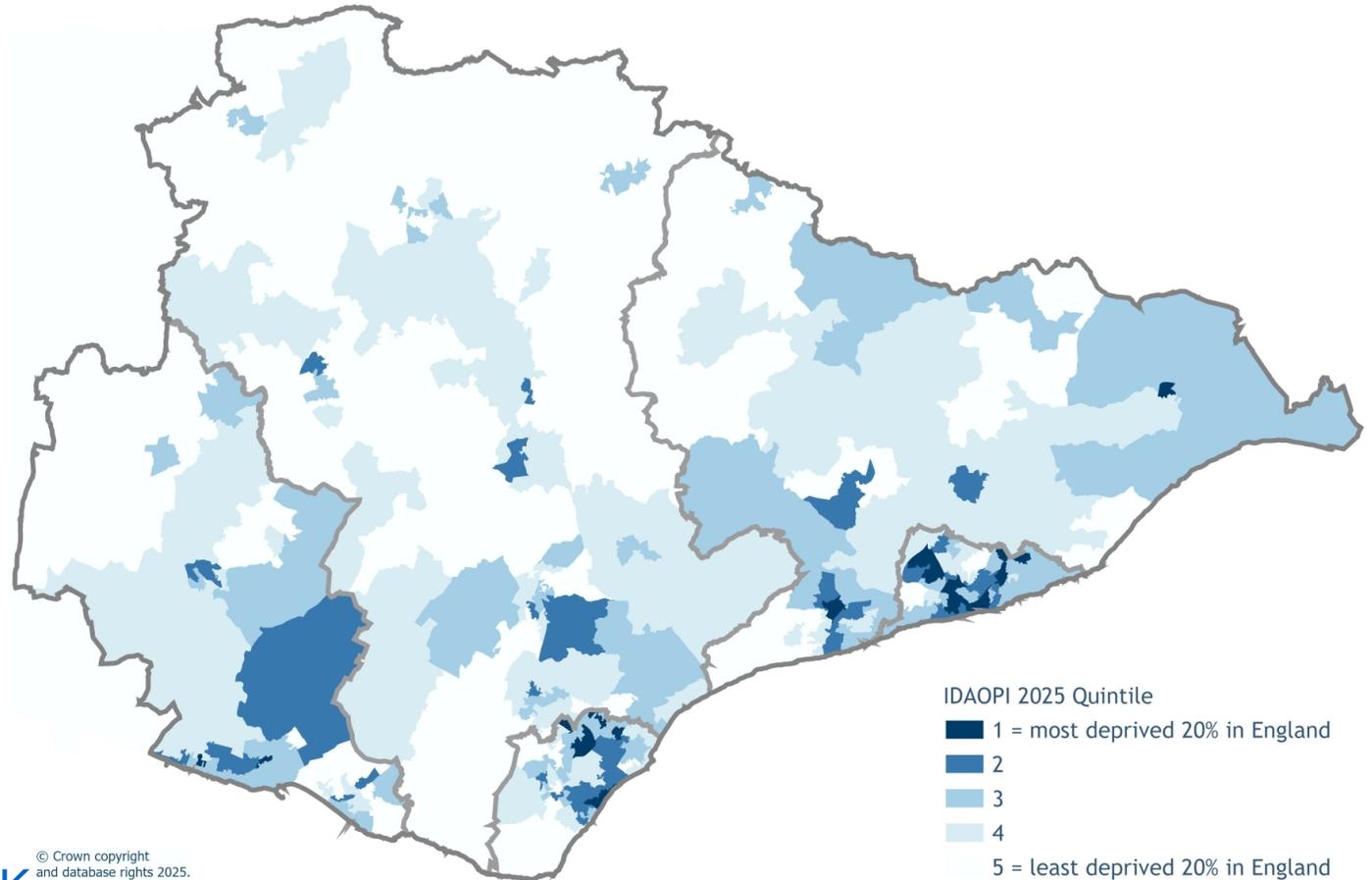


Picture of 0-5 year olds in East Sussex

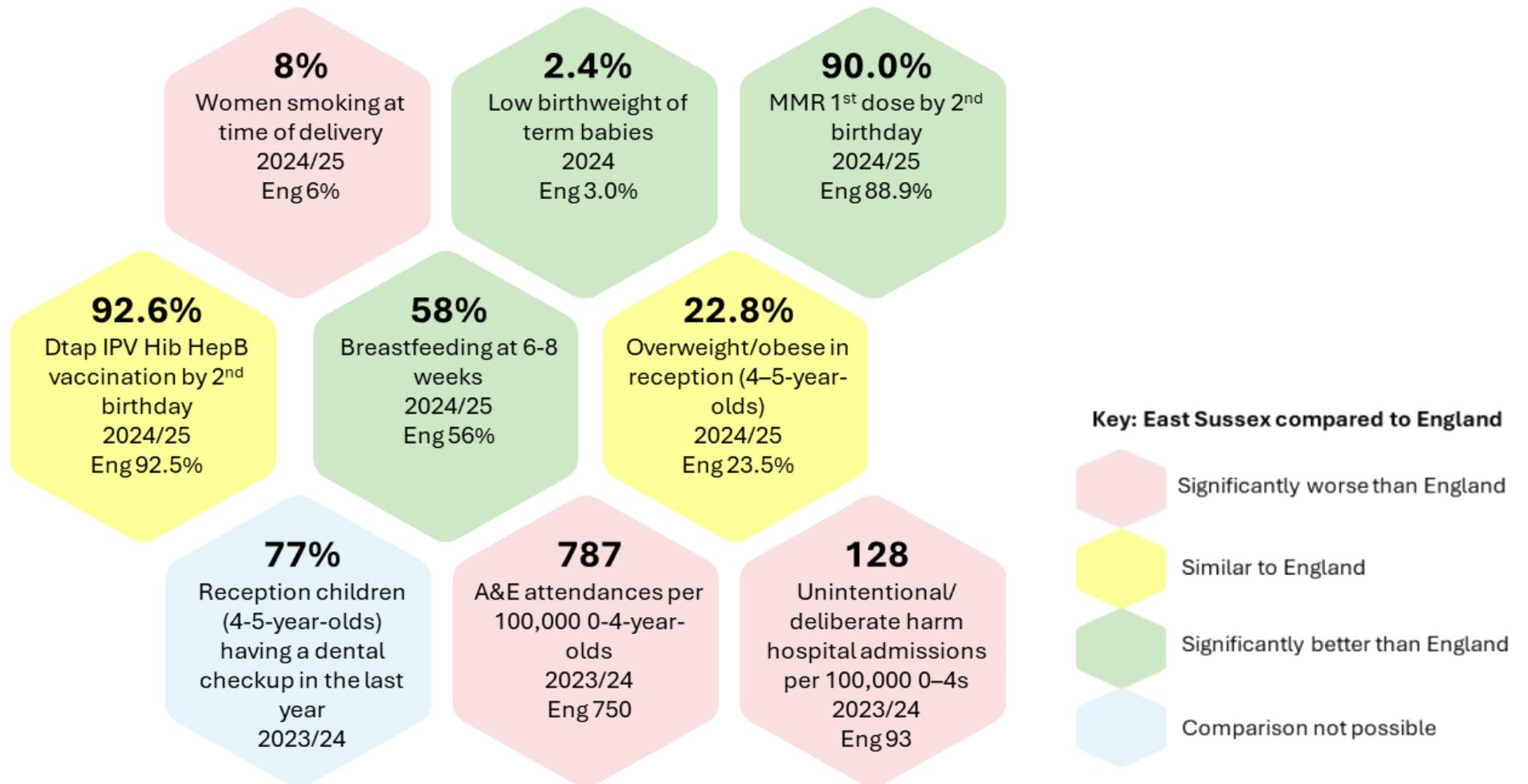
Income Deprivation Affecting Children Index (IDACI) 2025 by LSOA in East Sussex

Measures the proportion of all children aged 0 to 15 living in income deprived families

| Area | Average Score | Rank (out of 296 Local Authorities) | No. of LSOAs amongst worst 20% in England | % of all LSOAs |
|--------------------------|---------------|-------------------------------------|-------------------------------------------|----------------|
| Eastbourne | 42% | 68 | 14 | 23% |
| Hastings | 50% | 26 | 23 | 43% |
| Lewes | 33% | 140 | 4 | 6% |
| Rother | 36% | 118 | 8 | 14% |
| Wealden | 26% | 216 | 3 | 3% |
| East Sussex total | | | 52 | 16% |

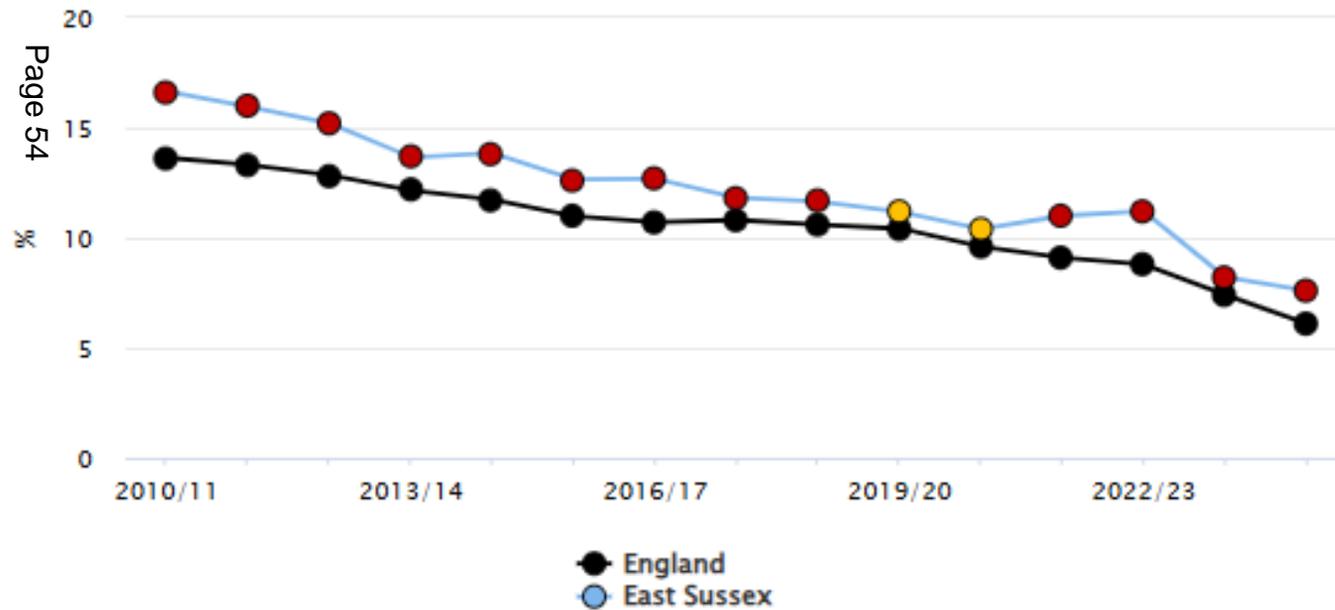


Picture of 0-5 year olds in East Sussex



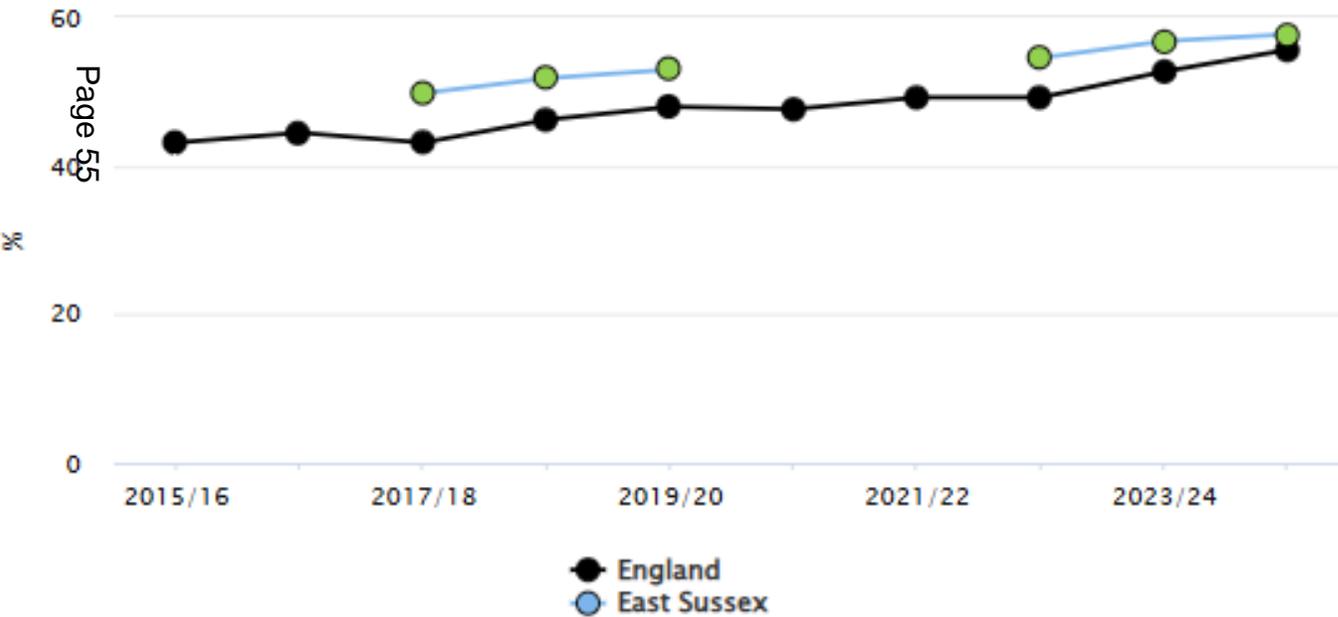
Picture of 0-5 year olds in East Sussex

Mothers who are smoking at the time of delivery, data to 2024/25



Picture of 0-5 year olds in East Sussex

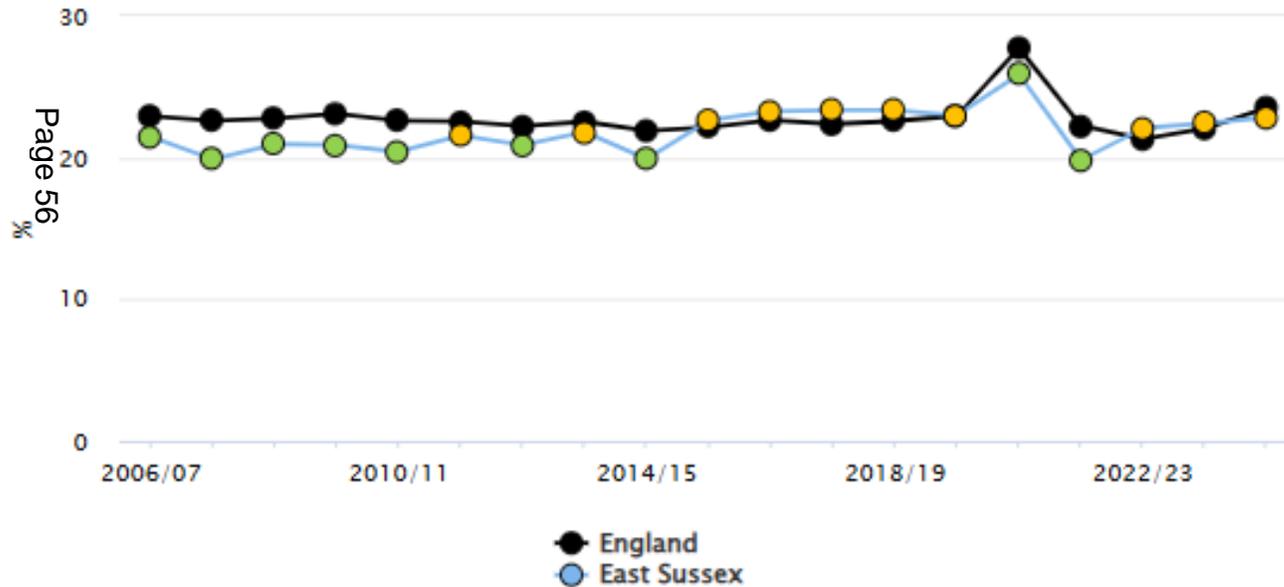
Breastfeeding at 6-8 weeks, data to 2024/25



| | Recent Trend | Count | Value |
|-------------|--------------|---------|-------|
| England | → | 492,132 | 43.5 |
| East Sussex | → | 5,040 | 57.4 |
| Lewes | → | 1,010 | 65.6 |
| Eastbourne | → | 1,060 | 58.8 |
| Wealden | → | 1,460 | 58.6 |
| Rother | → | 735 | 56.3 |
| Hastings | → | 780 | 47.7 |

Picture of 0-5 year olds in East Sussex

Prevalence of overweight (including obesity) in 4–5-year-olds, data to 2024/25

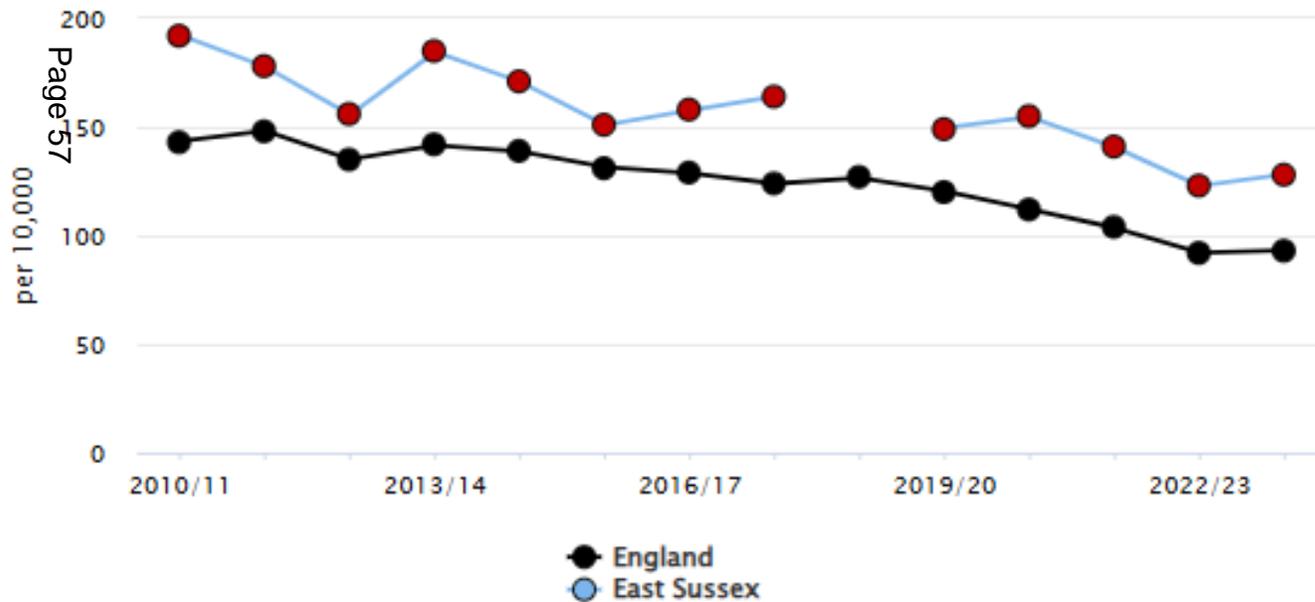


| | Recent Trend | Count | Value |
|-------------|--------------|---------|-------|
| | | ▲▼ | ▲▼ |
| England | → | 128,255 | 23.5 |
| East Sussex | → | 1,040 | 22.8 |
| Eastbourne | - | 225 | 25.4 |
| Hastings | - | 215 | 24.2 |
| Rother | - | 165 | 23.2 |
| Lewes | - | 185 | 22.8 |
| Wealden | - | 255 | 20.2 |

22.8% for 4-5 year olds and 32.4% for 10-11 year olds

Picture of 0-5 year olds in East Sussex

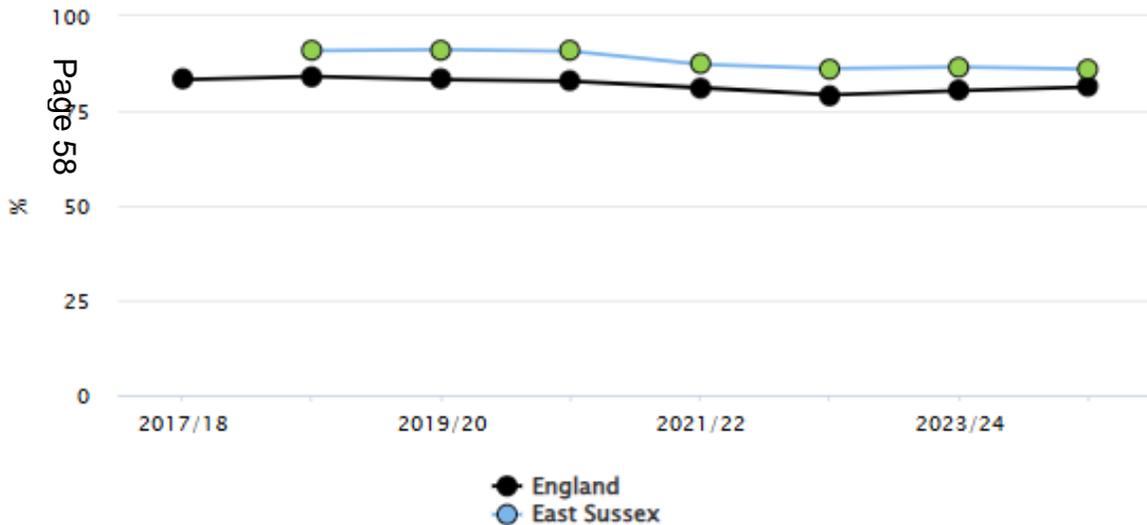
Emergency admissions to hospital caused by unintentional and deliberate injuries, ages 0-4, data to 2023/24



| | Recent Trend | Count ▲▼ | Value ▲▼ | |
|-------------|--------------|-------------|-------------|--|
| England | ↓ | 28,554 | 93.2 | |
| East Sussex | ↓ | 315 | 128.3 | |
| Hastings | → | 80 | 170.6 | |
| Rother | → | 55 | 150.9 | |
| Eastbourne | → | 55 | 121.1 | |
| Lewes | → | 50 | 117.6 | |
| Wealden | → | 75 | 101.0 | |

Picture of 0-5 year olds in East Sussex

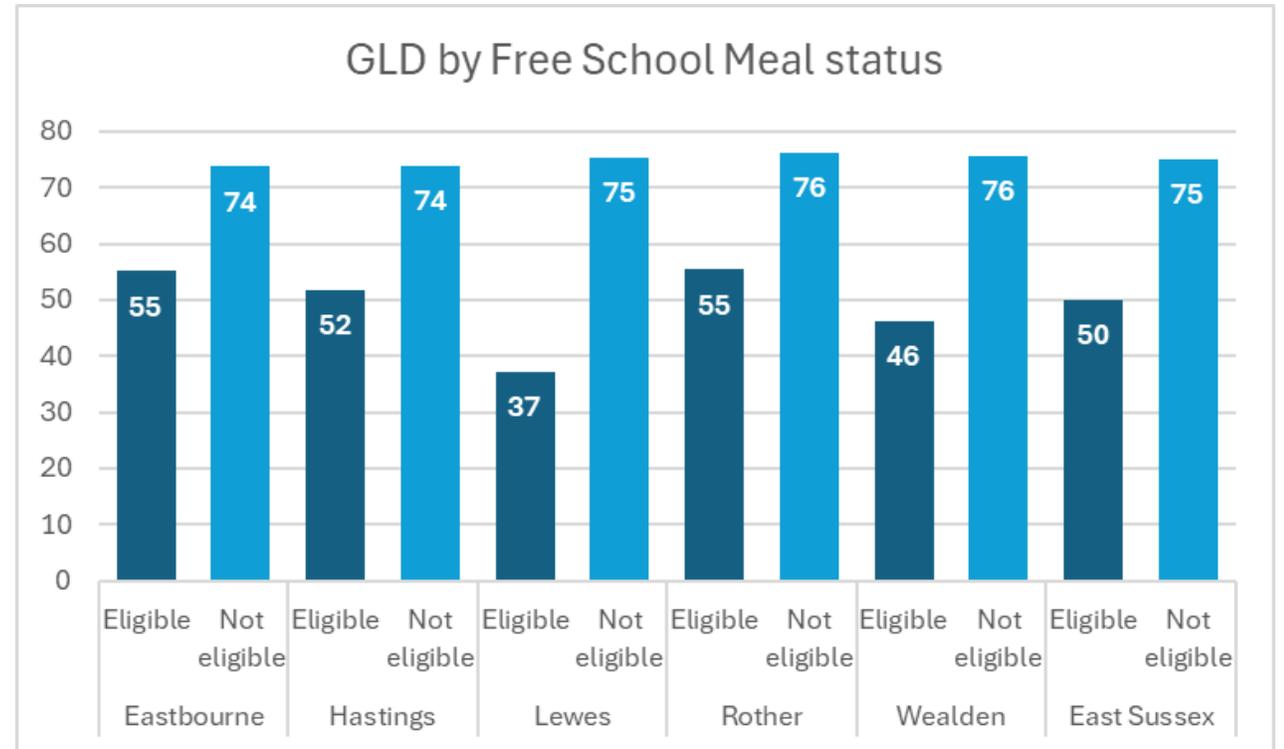
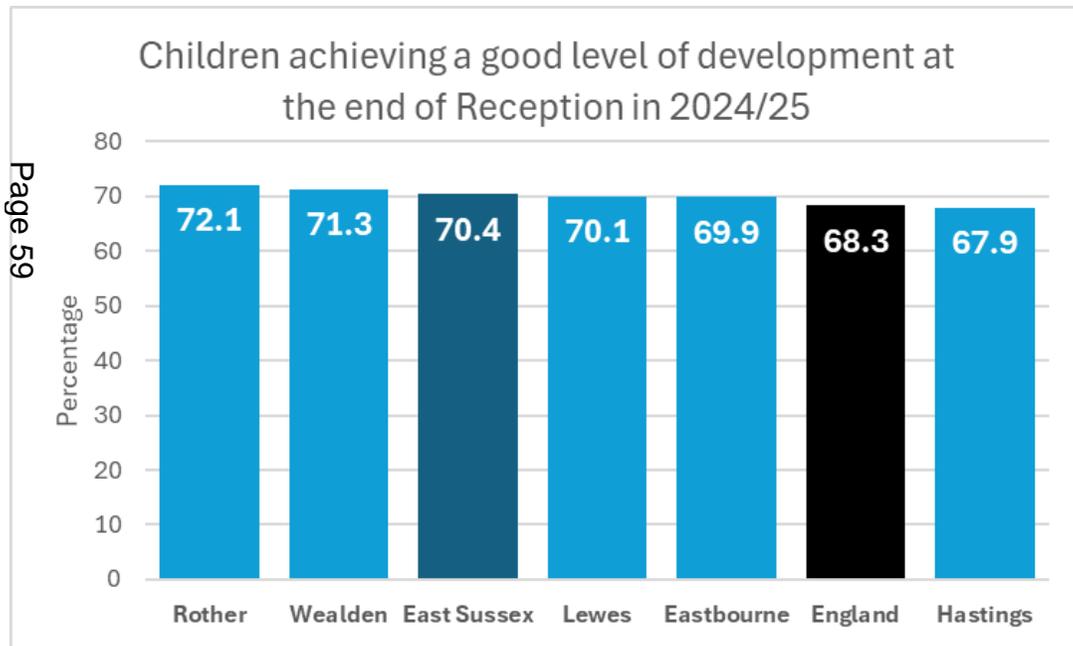
Good Level of Development at age 2 to 2 and a half years, data to 2024/25



| Measure | England | South East Region | East Sussex |
|--------------------------------------------|---------|-------------------|-------------|
| Good level of development | 81.4 | 81.3 | 86.1 |
| - expected level in communication skills | 87.6 | 89.8 | 92.7 |
| - expected level in gross motor skills | 93.6 | 93.7 | 95.5 |
| - expected level in fine motor skills | 93.7 | 91.8 | 97.6 |
| - expected level in problem solving skills | 93.0 | 93.9 | 94.7 |
| - expected level in personal social skills | 91.8 | 92.6 | 93.8 |

Picture of 0-5 year olds in East Sussex

Good Level of Development data at age 5



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Report to: East Sussex Health and Wellbeing Board

Date: 10 March 2026

By: Director of Joint Commissioning and Integrated Community Teams Development (East Sussex), NHS Sussex and Director of Adult Social Care and Health, East Sussex County Council

Title: Integration programme update

Purpose of Report: To provide an update of progress with the East Sussex priorities in the Sussex Shared Delivery Plan in quarter 3 25/26, and plans to use this to inform and shape our Neighbourhood Health Plan in 26/27

Recommendations:

East Sussex Health and Wellbeing Board (HWB) is recommended to:

1. **Note** the progress with East Sussex HWB Shared Delivery Plan (SDP) priorities and plans in quarter 3 25/26, as set out in **Appendix 1**.
 2. **Endorse** the suggested approach to using our SDP progress in 25/26 to inform joint planning and delivery in 2026/27, and the transition to shaping and developing the HWB Neighbourhood Health Plan (set out in paragraph 2.2 of this report).
 3. **Endorse** the briefing note from the informal session of the HWB held on 7 January 2026 in **Appendix 2**.
 4. **Note** the progress on Integrated Community Teams (ICTs) and neighbourhood health and the recent visit by the National Neighbourhood Health Implementation Programme (NHHIP) lead.
-

1. Background

1.1 Our joint vision for a healthier Sussex is currently set out in the 5-year [Sussex Integrated Care Strategy *Improving Lives Together* \(2022\)](#), including the goal of more integrated working in our neighbourhoods and communities through Integrated Community Teams (ICTs). Building on the [East Sussex Health and Wellbeing Board Strategy *Healthy Lives, Healthy People* \(2022 – 2027\)](#) and insights from the East Sussex [Joint Strategic Needs Assessment](#) (JSNA), a single [Shared Delivery Plan](#) (SDP) was agreed by partners in June 2023 and is updated annually to support this vision. The SDP includes our East Sussex 'Place' deliverables overseen by the HWB.

1.2 Published in July 25, the Government's new [10 Year Health Plan for England: fit for the future](#) (10YHP) sets out plans to reinvent the NHS based on three shifts as the core components of a new care model; from hospital to community; from analogue to digital, and; from treating sickness to prevention.

1.3 The shift from hospital to community-based care is driving the development of a 'neighbourhood health service', which aims to bring care into local communities, organise professionals into patient-centred teams, and reduce fragmentation. In Sussex this is being

implemented through Integrated Community Teams (ICTs), aligned to our five borough and district boundaries in East Sussex.

1.4 To accelerate the move away from a hospital-centric model of care, a new National Neighbourhood Health Implementation Programme (NNHIP) was also launched in Autumn 2025. East Sussex was successful in applying to participate in the first wave of the NNHIP - focussed on Hastings and Rother - to support delivery of the shift from hospital to community.

1.5 The 10YHP sets out an expectation that each area will develop a new Neighbourhood Health Plan, led by the Health and Wellbeing Board (HWB), reinforcing the strategic role of HWBs in coordinating partners to deliver integrated health, care and wellbeing services. Aligned with existing responsibilities for the JSNA, HWB Strategy and Better Care Fund (BCF), the plan will form part of the NHS' new multi-year planning framework. National guidance for developing Neighbourhood Health plans is still awaited, and this change and our proposed working arrangements to develop the plan in 2026/27 are covered in more detail in a separate report on the meeting agenda.

1.6 This report provides an update on our progress with our shared delivery plans at Place and outlines the next steps for our joint planning and delivery in 26/27, as we move towards Neighbourhood Health plan development.

2 Supporting information

East Sussex HWB SDP progress in 25/26

2.1 A brief summary of our progress with our year 3 East Sussex HWB SDP objectives during quarter 3 (1 October – 31 December 25) is summarised in **Appendix 1**. In summary it covers the following areas of health and care system collaboration:

- **Health outcomes improvement** – including action on cardiovascular and respiratory disease, healthy ageing, frailty, and mental health.
- **Strengthening the role and vision of the HWB** – growing a deeper shared understanding of population health needs and priorities and a strengthened approach to system stewardship
- **Children and young people** - improving support for families to ensure the best start in life and boosting the health, wellbeing, and life chances of children and young people.
- **Mental health** – improving community and accommodation-based support for adults with mental health problems and enhancing support for people with dementia.
- **Integrated Community Teams (ICTs) and neighbourhood health** - developing and delivering joined up neighbourhood health and care through Integrated Community Teams
- **Improving hospital discharge** - improving hospital discharge processes using digital tools, improved planning, and long-term funding arrangements.
- **Health, housing and care** - creating a partnership Housing Strategy to strengthen collaboration across East Sussex with a clear focus on housing, health, and care.

2.2 In the context of developing the forthcoming ICB 5-year strategic commissioning plans and informing Neighbourhood Health Plan development, during quarter 4 (1 January–31 March 2026) our oversight and partnership boards will start to review 2025/26 SDP progress and shape priorities for 2026/27. Our East Sussex Place Health and Care Partnership governance is also being updated to support this. A key focus will be delivery capacity in light of health system reforms (noted in

earlier reports to the HWB), taking into account the ICB's shift to a smaller, more strategic commissioner across Surrey and Sussex, and the transfer of some former ICB system functions to NHS providers.

Strengthening the role and vision of the HWB

2.3 Previous reports to the HWB have noted that our wider context involves major system change, including health system reforms, increasing demand and complexity of needs across all age groups in our population, and financial constraint. The important role of the HWB as a vehicle for genuine stewardship of our health and care system's vision for our population in this context, has been recognised locally and is now emphasised in the 10YHP.

2.4 To support our SDP objective to further strengthen the role of the HWB, the final two informal HWB development sessions in the current programme took place on 7 January and 12 February 2026. The session on 7 January focussed on the JSNA theme of Mental Health and Wellbeing, and consideration of the new multi-year planning framework for the NHS being introduced under the 10YHP. A briefing note setting out the ground covered in the session is included in **Appendix 2** of this report, and a diagram of the new multi-year planning framework is included in **Appendix 3** of this report.

2.5 The final session on 12 February recapped the JSNA themes covered since September 2024 and explored how they will inform the HWB Strategy refresh. It also considered new expectations for HWBs to develop a Neighbourhood Health Plan as part of the 10YHP and the shift to neighbourhood health at scale. The discussion outcomes and proposed delivery arrangements, under the strategic oversight of the HWB, are set out in more detail in a separate report on the agenda.

Integrated Community Teams (ICTs) and Neighbourhood Health

2.6 As reported at the last HWB meeting, we have continued to develop the infrastructure for shared leadership of neighbourhood level health and care in our 5 ICT footprints (Eastbourne, Hastings, Lewes district, Rother and Wealden). This includes supporting leadership development and agreeing joint ICT workplans that will contribute to neighbourhood health objectives in 26/27.

2.7 Over winter 2025/26 work has progressed to establish neighbourhood-based multi-disciplinary working within ICT footprints to deliver more proactive, coordinated care for people with complex health and social care needs. This uses a risk stratification tool to identify individuals who would benefit most from a proactive, integrated approach – initially older, frail individuals aged over 65 and those with multiple long-term conditions. A growing shared understanding of the identified groups is helping to shape a more coordinated care offer across primary care, community health, social care and partners.

2.8 On 30 January leaders from the Hastings and Rother Integrated Community Teams (ICTs) welcomed Dr Minal Bakhai, NHS England's Director of Primary Care and Community Transformation and national lead for the NNHIP - as part of her national tour of all 43 Wave 1 neighbourhood health sites across England. During her visit, Dr Bakhai met with local team and programme leads involved with the two ICTs, to observe first-hand how neighbourhood health is being delivered in East Sussex. The visit included the following local sites in Hastings and Rother:

- Hub on Rye Hill - an example of a community hub where a range of health, care and wellbeing services are co-located to provide coordinated, multidisciplinary support closer to home.

- Tressell Ward at Conquest Hospital - where a nurse and therapy-led model supports patients awaiting discharge through a strong reablement approach. Delivered in partnership with volunteers and community organisations, the model demonstrates effective integration between acute, community and primary care services to enable a “left shift” in care.
- Station Plaza in Hastings - a site accommodating GP, dental and sexual health services alongside a primary care hub, presenting further opportunities to expand integrated provision and improve joined-up access to services in central Hastings.

2.9 The visit highlighted strong collaboration between primary and secondary care teams, particularly in delivering earlier intervention for people with respiratory conditions and in supporting timely, effective hospital discharge. These initiatives are contributing to improved patient experience, reduced avoidable hospital admissions, and ensuring that individuals receive the right care, in the right place, at the right time.

2.10 The visit provided the opportunity for system partners to explore with Dr Bakhai the opportunities and challenges associated with delivering neighbourhood health at scale and reducing health inequalities. This included improving access to services in rural communities and deprived areas, strengthening partnerships with voluntary and community organisations to support prevention, and addressing practical barriers such as funding, estates and procurement processes.

2.11 Significant local progress was recognised, reinforcing our Sussex-wide commitment to collective leadership in transforming community-based care. Referencing the ICB’s 2026/27 commissioning intentions as key to enabling the spread of neighbourhood health, Dr Bakhai welcomed the strong shared commitment to integrated working and sustainable community-based models, and the solid foundations already in place to deliver neighbourhood health at scale.

3 Conclusion and reasons for recommendations

3.1 *Improving Lives Together* and the SDP has guided our joint work on HWB priorities since 2022, and our in-year delivery in 2025/26. This has included establishing the core leadership infrastructure for our ICTs and developing frontline multidisciplinary teams for proactive care as part of the foundations for a neighbourhood health model. This, alongside our shared priorities aligned to improving population health and care needs – including for children and young people, mental health and housing – should move us away from over reliance on hospital services to a community-based model of care.

3.2 The foundations provided by our SDP progress in 2025/26 and our early learning from participating in the NNHIP will be reviewed to help inform and shape plans for Neighbourhood Health in 26/27. This will need to focus on areas of complex health and care needs alongside early intervention, prevention and wellbeing, and the connections to the wider determinants that will help reduce health inequalities and improve health outcomes for our population.

3.3 The strengthened strategic leadership of the HWB and deeper understanding of our population JSNA will help ensure our health and care system continues to collectively focus on the right shared priorities in this context, including the transition to aligning our BCF Plans and other resources to support Neighbourhood Health delivery where helpful and appropriate.

ASHLEY SCARFF

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Appendix 1: Draft progress summary East Sussex HWB high level SDP quarter 3 (25/26)

Appendix 2: Draft briefing note HWB session 6 – mental health and wellbeing

Appendix 3: Diagram of the new NHS multi-year planning framework

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East Sussex Health and Wellbeing Board (HWB) Shared Delivery Plan (SDP)

Draft progress summary quarter 3 25/26 (1 October – 31 December 2025)

Background

The 5-year Sussex [SDP](#) sets out short, medium, and long-term improvement priorities, including Place delivery priorities for each of the three Health and Wellbeing Boards in Sussex. Delivery is supported through joint work between the County Council, the local NHS, Voluntary, Community and Social Enterprise (VCSE) organisations, Healthwatch, and Borough and District councils - together known as the East Sussex Health and Care Partnership - aimed at improving services and outcomes for the East Sussex population.

Our joint Place delivery priorities for East Sussex were refreshed for 2025/26 (year 3 of the SDP) and endorsed by the HWB in July 25. The refreshed priorities align with the national NHS planning guidance for 25/26, existing pan-Sussex SDP priorities and work aimed at improving health and care outcomes as well as our local HWB priorities.

This paper provides a brief summary of our progress in quarter 3 (Q3) of 2025/26 (1 October – 31 December 2025).

1) Health outcomes improvement

| East Sussex HWB SDP priority | Date | What we will achieve |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|--------------------------------------|
| <p>We will continue to deliver our agreed 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.</p> <p>We will ensure that the health outcomes improvement and learning are used to inform ICT implementation and address variation in outcomes.</p> | March 26 | Improved outcomes for the population |
| <p>Q3 progress summary</p> <p>The Health Outcomes Improvement Programme continues to make strong progress, with all major projects on course to meet their agreed milestones by the end of the year and planning for 2026/27 now underway across our priority areas. This next phase will strengthen alignment with neighbourhood health and wider system plans - including work to improve cardiovascular disease outcomes - while ensuring we are well positioned to respond to potential changes in health and care governance and operate effectively within a more streamlined Integrated Care Board (ICB) structure. A summary of highlights to improve prevention, early diagnosis and community wellbeing across our system in Q3 is as follows:</p> <ul style="list-style-type: none"> • Work to refresh the cardiovascular disease (CVD) prevention plan has strengthened our whole-system approach, bringing together partners from across health and care. A well-attended system workshop, followed by in-depth stakeholder engagement, is helping to shape a more coordinated and impactful prevention strategy. • Prevention activity continues to expand. The vast majority (88%) of GP practices in East Sussex are now signed up to deliver NHS Health Checks in 2025/26, compared to 44% in Q2, supporting earlier identification of risk factors. There has also been measurable improvement in prescribing lipid-lowering therapies for people at high risk of CVD, with prescription rates rising by 4% and East Sussex's comparative ranking improving significantly among peer areas. | | |

- Community engagement has played an important role in supporting **winter resilience focussed on respiratory disease**. Ten winter preparedness events were delivered across the county, reaching 190 people. Feedback was positive, with almost all attendees reporting increased understanding of how to **stay well over winter** and all participants saying they would recommend the sessions.
- Early diagnosis programmes are delivering substantial impact across Surrey and Sussex. Over 111,000 invitations have been issued through the **Lung Cancer Screening** programme, leading to nearly 65,000 lung health checks, more than 30,000 CT scans and 376 lung cancer diagnoses — supporting **earlier detection and improved outcomes**.
- Healthy ageing initiatives have also continued to grow. Following the Stay Strong, Stay Steady, Stay Independent campaign, partners contributed to local **“Full of Life” festival events** in October 25, and developed a **new intergenerational toolkit** to help communities build stronger connections between age groups.
- In addition, a comprehensive review of **mental health peer support** has now been completed. This includes evidence-based recommendations to maximise the preventative benefits of peer support models across East Sussex, helping to strengthen community-based mental health support for the future.

2) Role and vision of the Health and Wellbeing Board

| East Sussex HWB SDP priority | Date | What we will achieve |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-------------------------------------------------|
| <p>We will continue to strengthen the strategic stewardship role and vision of the Health and Wellbeing Board (HWB) through completing our programme of development sessions aimed at growing a deeper shared understanding of our population health and care needs and strengths, and understanding how well we are working together as a system to improve outcomes.</p> <p>Building on the work on system stewardship in 24/25, we will ensure our East Sussex Health and Care Partnership is operating effectively across our system at Place, with accountability to the HWB for our strategic planning and operational collaboration in our local communities.</p> | March 26 | A clear focus and approach across all partners. |
| <p>Q3 progress summary</p> <p>Work to strengthen Health and Wellbeing Board leadership continues to move forward. While there has been a slight delay in the published timetable for informal Health and Wellbeing Board development sessions, the overall programme remains on track for completion by February 2026. Wider national health system reforms are now progressing, with local plans underway to establish the ICB as a more streamlined strategic commissioning organisation operating across a larger Surrey and Sussex footprint.</p> <p>Locally, a review of place-based health and care governance has been launched to ensure arrangements are aligned with the 10-Year Health Plan and wider system reforms. This will help ensure the HWB and local partnerships remain strong, responsive and well-positioned for the future, including the developing the future Neighbourhood Health Plan in 26/27.</p> <ul style="list-style-type: none"> • In addition, partners in Hastings and Rother have now successfully joined the National Neighbourhood Health Implementation Programme, building on existing Integrated Community Teams leadership and governance arrangements (please also see priority 5, below). This marks an important step in strengthening and accelerating neighbourhood-level working and delivering more integrated care closer to home. | | |

3) Children and young people

| East Sussex HWB SDP priority | Date | What we will achieve |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|------------------------------------------------------------------------------------------|
| We will continue to enhance support to parents and carers and families to enable the best start in life and ensure service improvements, including pathway and service redesign, are effectively implemented to improve the health and wellbeing and life chances of children and young people. | March 26 | Improved experience and increased opportunities to support our most vulnerable families. |
| <p>Q3 progress summary</p> <p>Significant progress has been made in strengthening support for children and young people, particularly those with neurodevelopmental needs and emotional wellbeing challenges:</p> <ul style="list-style-type: none"> • The Neurodevelopmental (ND) Pathway Programme continues to evolve, with early evidence demonstrating the positive impact of the needs-led Dimensions tool in improving how children’s needs are understood and supported. Work through the Partnerships for Inclusion of Neurodiversity in Schools (PINS) programme is also helping to improve outcomes for children by promoting earlier, more coordinated intervention. • Collaboration across partners has been strengthened through a dedicated Communications Task and Finish Group, improving the consistency and clarity of information available to families across neurodevelopment and children’s mental health services. • Access to practical support has been expanded through a one-year extension of the Amaze Neurodevelopmental Navigation Service, ensuring more families receive timely guidance and help to navigate services. • The Suicide Prevention Strategy has now been completed, providing a clear framework for coordinated action to reduce risk and strengthen early support. • Improvements have also been made to the accessibility of information and early intervention offers for emotional wellbeing and mental health (EWMH), making it easier for children, young people and families to find help when they need it. • Importantly, the Voice of the Child continues to inform service development, ensuring that lived experience remains central to shaping future improvements. | | |

4) Mental health

| East Sussex HWB SDP priority | Date | What we will achieve |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|--------------------------------------------------------------------------------------|
| 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 delivering functional Neighbourhood Mental Health Teams (NMHTs) and ensuring their alignment with emerging Integrated Community Teams, in line with the Sussex-wide approach, as well as improving access and outcomes in supported accommodation and capitalising on opportunities presented by the planned opening of the new Coombe Valley Hospital. | March 26 | Reduced reliance on specialist services and improved population health and wellbeing |
| <p>Q3 progress summary</p> <p>Neighbourhood Mental Health Teams (NMHTs) are now fully live across East Sussex, with all five local teams successfully completing the preparations needed to begin operating aligned to Integrated Community Teams (ICTs) and borough and district boundaries. This marks an important milestone in improving access to more joined-up, community-based mental health</p> | | |

support. Teams are up and running and supporting local people, with work continuing to strengthen digital integration and the planned shared client record system.

Alongside this, work is also progressing to strengthen support for people living with dementia, mental health needs and those requiring supported housing, helping to build a more responsive and coordinated mental health system for our communities. This includes:

- A feasibility study is underway to explore a potential **dementia support service** in Lewes.
- Partners continue to strengthen **supported living provision** through contract review, re-tender activity and informal engagement with providers potentially interested in developing or expanding mental health housing options.
- Adult Social Care is progressing work to strengthen **trauma-informed practice**, with a trauma self-assessment under consideration and a **Peer Support and Personal Wellbeing** report nearing completion.
- Work on the **Older People’s Mental Health Needs Assessment** is advancing, with partner data secured and the dementia focus agreed to support a robust, evidence-based review.

5) Integrated community teams (ICTs)

| East Sussex HWB SDP priority | Date | What we will achieve |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|--------------------------------|
| <p>We will support the move to a neighbourhood health service that delivers more care at or closer to home through our five Integrated Community Teams (ICTs) across East Sussex. In line with ICTs across Sussex, this will focus on providing proactive, joined-up care for people who require support from multiple services and organisations; improved access to local health and care services and, improving the health and wellbeing of our population through an asset-based approach.</p> | <p>March 26</p> | <p>In year plan delivered.</p> |
| <p>Q3 progress summary</p> <p>Work continues to strengthen shared leadership and integrated care across East Sussex’s five ICT areas (Eastbourne, Hastings, Lewes, Rother, and Wealden). All leadership groups now meet regularly, have nominated Chairs, and are co-producing joint work plans to address local health and care priorities. Groups also use dedicated digital channels and have completed self-assessments to identify development needs, with a Sussex-wide ICT ‘organisational development’ support offer planned for the multi-agency leadership teams in Q4.</p> <p>A key focus is implementing neighbourhood-level multidisciplinary teams (MDTs) to deliver more proactive care for older and frail people and those with multiple long-term conditions. A risk stratification tool is now being used to identify groups where coordinated care can have the greatest impact. Early work is building shared understanding across primary, community, and social care services, with the aim of improving independence, quality of life, and the experience of integrated care, while reducing avoidable unplanned hospital admissions. Insights from this initial phase will inform the expansion of integrated care to wider populations with complex or rising health needs.</p> <p>Voluntary and community sector-led winter resilience initiatives have been actively promoted and supported across the system, helping to strengthen local preparedness and community support.</p> | | |

6) Improving hospital discharge

| East Sussex HWB SDP priority | Date | What we will achieve |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|--------------------------------------------------------------------------|
| We will continue to embed efficiency and process learning from transformation programmes into 'business as usual' to further strengthen efficient hospital discharge processes, supported by digital automation, with a long-term funding plan for discharge capacity | March 26 | More people will be able to be discharged safely to a community setting. |
| <p>Q3 progress summary</p> <p>The system continues to work collaboratively to improve hospital discharge and support patients with complex care needs. Additional winter funding, now fully integrated into the Better Care Fund, has been used to expand discharge-to-recover-and-assess (D2RA) beds, alongside care coordination hubs, deploying social work teams to support discharge pathways, and support for people who self-fund their care. A small portion of funding is also reserved to maintain flexibility and support patient flow over the winter period. Multi-agency Discharge Events (MADE) involving local partners were also put in place ahead of winter – these structured discussions aim to improve the flow of patients through hospital, reduce length of stay and speed up discharge through identifying bottlenecks, challenging complex cases and streamlining processes.</p> | | |

7) Housing, health and care

| East Sussex HWB SDP priority | Date | What we will achieve |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-----------------------------------|
| We will finalise, agree and implement our shared vision for the housing sector in East Sussex set out in the East Sussex Housing Partnership Strategy and mobilisation plan, with a strong focus on health, housing and care as part of a strategic partnership framework that complements the borough and district housing authority strategies. | March 26 | A clear ambition for all partners |
| <p>Q3 progress summary</p> <p>East Sussex continues to make progress in improving housing and preventing homelessness. Having been co-produced across partners in the housing, health and care system, the first East Sussex Housing Partnership Strategy has now been adopted by all six local authorities, providing a shared framework for action and reducing health inequalities linked to housing.</p> <p>National policy developments have been reviewed to shape a local response, including the Plan to End Homelessness and the Social and Affordable Homes Programme 2026–2036. These support earlier identification of people at risk, expanded supported housing, and more accommodation options for older residents. The Plan to End Homelessness includes a new duty to collaborate to help identify people at risk of homelessness earlier, strengthening joint working to prevent people being discharged from hospital becoming homeless, and new guidance for health and care staff linked to the Care Act 2014.</p> <p>Local authorities are preparing for new responsibilities under the Renters' Rights Act 2025 and have already hosted the first East Sussex Landlord Forum to raise awareness of tenant protections. National funding settlements for local housing authorities have also been announced. The funding period runs until March 2029 and combines previous grants to prevent homelessness and support people who are rough sleeping.</p> | | |

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East Sussex Health & Wellbeing Board Development Sessions Summary Briefing

Session #6: Mental Health and Wellbeing

1. Background

Two recent Peer Reviews of the Council have noted that in addition to performing its statutory role as a formal committee of the Council, the Health and Wellbeing Board (HWB) could be further strengthened to become a vehicle for genuine strategic stewardship of our system, focussed on the health, care and wellbeing needs of the population.

This complements 'Place' at upper tier/HWB level being a key point of subsidiarity in our Sussex Integrated Care System (ICS) for collaboration across the local NHS, Local Authorities and the voluntary, community and social enterprise (VCSE) sector – and reflecting the variation in inequalities, needs and context for delivery across Sussex.

Strengthening the focus and role of our HWB and our East Sussex Health and Care Partnership was agreed in July 24 as a local priority in the Shared Delivery Plan (SDP). To support this a programme of 7 informal development sessions was arranged, structured around the priority themes in our [East Sussex Joint Strategic Needs Assessment \(JSNA\)](#), starting in September 24. Both voting HWB members and non-voting members with speaking rights are invited to the sessions, which are aimed at deepening the shared understanding of our population's health and care needs and priorities. The priority has continued in our SDP plans for 25/26, with the current programme of sessions running until February 26. Overall, the sessions are an opportunity to:

- Improve consistency of shared knowledge and understanding about our population
- Generate innovation and ideas
- Inform our in-year plans and co-creation of the Health and Wellbeing Board Strategy refresh in 2 years' time

This briefing note sets out the summary outcomes and key messages from the **sixth** development session, which took place on **7 January 26** in Lewes on the theme of **mental health and wellbeing**. Building on our previous discussions about system stewardship, the main aim of the session was to grow shared understanding of our JSNA theme of mental health and wellbeing - what we mean by this and the collaborative work we do to support and promote mental wellbeing and overall emotional resilience in our population, focussing on prevention and early support. The session explored our work to prevent suicide and self-harm, and our work with children and young people as a key focus in the life course (please also see the briefing for session #4 about the life course).

We also spent time considering the new health and care planning arrangements, including the 5 -year provider delivery plans, and the work to develop ESHT's 5-year delivery plan.

2. Briefing note

2.1 Mental health and wellbeing

The JSNA topic for the session was mental health and wellbeing **with a focus on prevention and early support.**

- Good mental health is a vital asset for dealing with the different stresses (physical and mental) and problems in life
- Good mental health is associated with better physical health, increased productivity in education and at work and better relationships at home and in our community

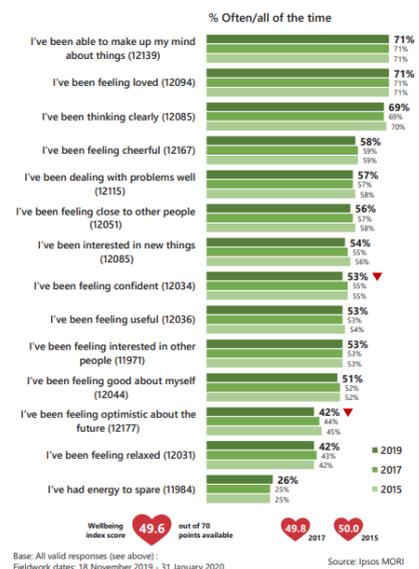
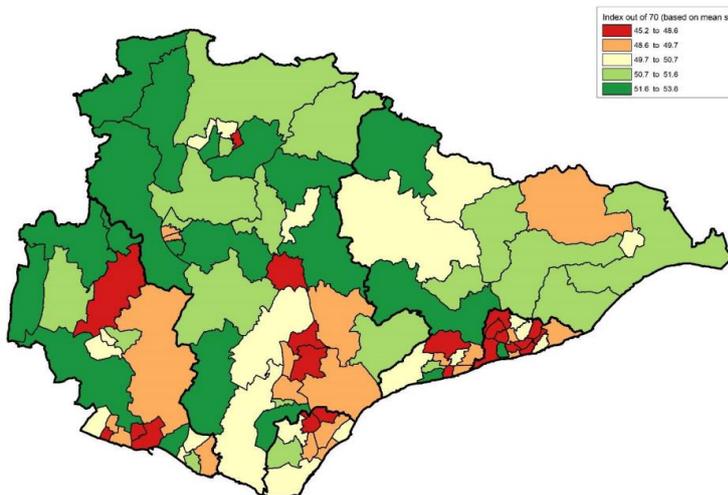
The session explored mental wellbeing and mental health - including the prevalence of different mental health conditions and suicide prevention. The role of schools and mental health services in supporting children and young people with their emotional wellbeing and mental health was also considered, as a priority group.

2.2 Mental wellbeing

Information about the status of **mental wellbeing** in East Sussex can be found in the following

- The East Sussex [My Health My School survey 2023-2024](#)
- National annual population survey data for East Sussex can be found at [Adult mental health and wellbeing - Data | Fingertips | Department of Health and Social Care](#)
- [The East Sussex Community Survey 2019](#) which asked the 14 statements of the Warwick Edinburgh Mental Wellbeing Scale (see the diagram below)

Figure 3.10: Wellbeing index



Undertaken in 2019 the Community Survey shows the following summary information about mental wellbeing in East Sussex:

- Rother (50.6) & Wealden (50.5) both have high mean scores compared to Eastbourne (48.4) & Hastings (48.3)
- Older residents aged 65+ have highest scores (50.6) compared to 18-34's who have the lowest (48.8).
- Owner occupiers have a significantly higher mean score (50.9) than private renters (46.3) and social tenants (42.8).

- Wellbeing scores rise alongside educational level; those with no qualifications score 46.2 in comparison to the highest with level 4/5 qualifications score of 51.3.
- There are also variations in wellbeing scores across other social groups, with lower scores among:
 - people who live alone (47.9) or are a single parent (44.9);
 - people who are finding it difficult to manage financially (43.0);
 - disabled residents (42.6) and those in bad health (36.8); and
 - those who are workless (39.5).
- Lower mental wellbeing scores and dissatisfaction with a local area appear to be interconnected. The score for residents who are dissatisfied with where they live is 44.4, compared to 50.5 for those who are satisfied.
- Similarly, the score for residents who feel they do not belong to their neighbourhood is 46.3, whilst those who feel connected score 51.4

2.3 Prevalence of mental health conditions

The session then explored the prevalence of mental health conditions, outlining the following distinction:

*‘Common mental health conditions’ (CMHCs) which comprise different types of depression and anxiety disorder. They cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. CMHCs are usually less disabling than **major psychiatric disorders** - conditions such as schizophrenia, bipolar disorder or major depression which affect less people overall within the population but can be severe and have the potential to cause long term disability.*

In England there is an increased prevalence evident for some indicators of poor mental health¹:

- 16 to 64-year-olds with a CMHC increased from 17.6% in 2007 and 18.9% in 2014, to 22.6% in 2023/4. The proportion was higher in women than men at each point.
- Lifetime non-suicidal self-harm was reported by 3.8% of 16 to 74-year-olds in 2007, rising to 6.4% in 2014 and 10.3% in 2023/4.
- The proportion of adults screening positive rose for ADHD from 8.2% in 2007 and 9.7% in 2014, to 13.9% in 2023/4.

There is stability in prevalence evident in other conditions:

- Autism (examined using the Autism Diagnostic Observation Schedule) has remained stable in prevalence since 2007, at about one in a hundred adults (0.8%).
- Psychotic disorder (examined using Schedules for Clinical Assessment in Neuropsychiatry) has also remained stable since 2007, identified in less than one in a hundred adults (0.5%).
- One in fifty adults screened positive for bipolar disorder in both 2014 and 2023/4 (using the Mood Disorder Questionnaire).
- Similar stability over time was evident for personality disorders (using both the SCID-II Q and SAPAS).

¹ [Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4 - NHS England Digital](#)

However young adults remain a key group:

- The proportion of 16 to 24 year olds with a common mental health condition rose from 17.5% in 2007 to 25.8% in 2023/4.
- Younger adults were also more likely to report lifetime non-suicidal self-harm and to screen positive for disordered eating symptoms, Post Traumatic Stress Disorder (PTSD) and Attention Deficit Hyperactivity Disorder (ADHD) than older age groups.
- There was a decline in drinking at hazardous levels or above. It halved among 16 to 24 year olds (from 40.7% in 2000 to 18.1% in 2023/4) and also fell among those aged 25 to 34 and 35 to 44.

Socioeconomic inequalities in mental health persist:

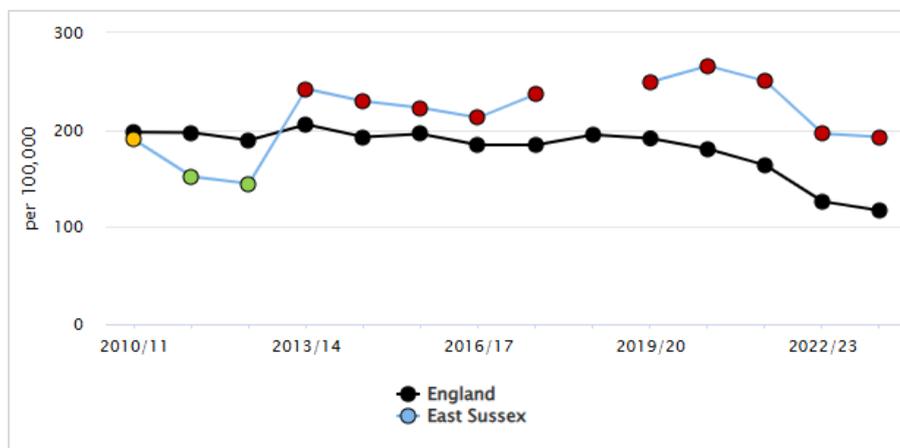
- The proportion of adults with common mental health conditions was higher in those living in the most deprived fifth of areas (26.2%), with problem debt (39.0%) and not in employment (40.0% in unemployed adults and 38.8% in economically inactive adults).
- The proportion of adults with bipolar disorder was higher in those living in the most deprived fifth of areas (3.6%), with problem debt (6.4%) and not in employment (9.0% in unemployed adults and 4.9% in economically inactive adults).
- The proportion of adults with clinically examined psychotic disorder was higher in those living in the most deprived fifth of neighbourhoods (1.0%), with problem debt (1.7%) and varied by employment status (2.6% in economically inactive adults).

Treatment use for common mental health conditions increased in prevalence:

- The proportion of 16 to 74 year olds with common mental health condition symptoms reporting receipt of treatment rose from 24.4% in 2007 and 39.4% in 2014, to 47.7% in 2023/4.
- Receipt of psychological therapies, among those with symptoms, rose from 10.4% in 2007 to 17.9% in 2023/4; and receipt of medication rose from 19.6% in 2007 to 38.4% in 2023/4.

East Sussex is significantly higher than England for emergency hospital admissions due to self-harm. Trends are reducing nationally and locally, particularly in the last two years, with the exception of 10-14 year old females where recent rates have increased.

Emergency admissions due to self-harm, all ages



2.4 Suicide and suicide prevention

| The national suicide prevention strategy priority groups | Risk factors at a population level |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">• Children and young people• Middle-aged men• People who have self-harmed• People in contact with mental health services• People in contact with the justice system• Autistic people• Pregnant women and new mothers | <ul style="list-style-type: none">• Physical illness• Financial difficulty and economic adversity• Gambling• Alcohol and drug misuse• Social isolation and loneliness• Domestic abuse |

East Sussex is part of the Sussex Suicide Prevention Strategy which has the following shared priorities:

- Strengthen collaboration, system wide ownership and commitment
- Improving suicide response and postvention support for people affected by a suicide death
- Training and learning opportunities
- Communications
- Working with people with lived experience
- Self-harm

Recent joint action has included:

- Launching a Support Pack for GPs
- Domestic abuse training
- Transferring bereavement service commissioning to the ICB for a consistent approach across Sussex
- Delivery of the Wellbeing At Work project and evaluation
- Focussed exploration of self-harm by the Sussex Mental Health Learning Disability and Autism Board
- Campaigning supported through the Staying Alive App
- Development of approaches to help gain a clearer understanding of suspected deaths by suicide in local areas in real time, and increasing the ability to identify and implement prevention support in a timely way

In East Sussex recent examples of partnership work focussed on priority groups include:

- Men's mental health – VSCE Men's Mental Health Network, Mr Hastings and St. Leonards (expanding to Rother), and the MIND small grants programme
- Beachy Head – Friends and Family group, Ethics of Suicide Prevention Surveillance Conference
- Online Wellbeing – literature research and focus groups with YMCA Downslink and the Youth Voice Event in February for young people

- The peer support and mental health project (for all ages) and self-harm Toolkit and Guidance [Self-harm | Czone](#) for children and young people
- Whole School Approach to Mental Health (including PSHE suicide guidance)

2.5 What good public mental health looks like

The Association of Directors of Public Health outlined some principles for [What Good Public Mental Health Looks Like \(ADPH 2019\)](#):

- Adopting a system-wide focus on the prevention of the onset of mental health problems, incorporating action across public health and wider organisational strategies and plans.
- Shifting the focus of services towards more structural upstream interventions that enable early help, including action on the wider determinants of health and reducing inequalities.
- Taking proportionate action across the life course that balances population-wide mental health promotion with targeted support where need is greatest.
- Drawing on the lived experiences of people with mental health problems and mental illness, as well as the wider community, to identify solutions and promote equality.
- Building the capacity and capability across our workforces to prevent mental health problems and promote good mental health within their everyday practice.
- Continuing to normalise and lessen the stigma associated with mental health problems.
- Understanding barriers and enablers for change to engage and steer local system leaders from multiple disciplines.

2.6 Key life course focus: mental health service provision for children and young people

Children and young people are key priority group nationally and locally. In summary the key points for children and young people's local access to mental health services and support are as follows:

- The current picture reflects post-pandemic demand and the impact of targeted investment and redesign. 'Nationally, 1 in 6 children aged 7-16 have a probably mental disorder' (*NHS Digital, Mental Health of Children and Young People in England 2023*)
- An estimated 60,000 children and young people in Sussex live with a diagnosable mental health condition.
- 22,035 children and young people in Sussex have accessed the range of NHS Funded Mental Health services in the previous 12 months (April 2025 data); this represents 98% of the national standard for access to services. (September 2025 data indicates 22,450 against a plan of 22, 572).
- This is an increase of 66% from March 2021 where 13,265 children and young people in Sussex accessed NHS Funded Mental Health services.
- Demand for specialist services increased significantly post-pandemic and whilst demand remains high, it is beginning to show signs of stabilisation. In Sussex Child and Adolescent Mental Health Services (CAMHS) referral volumes have fluctuated throughout the year, with monthly numbers ranging from 559 (August 2024) to 1,157 (January 2025) and an average per month of 901 during 2024/25. East Sussex CAMHS currently has 284 children or young people waiting for assessment and a median time to assessment of 45 days

Although some children and young people are waiting longer than we would want to access services, most notably for neurodevelopmental assessment, high level improvement actions and trends include

- Alternatives to inpatient care are expanding with the average number of Tier 4 beds occupied across Sussex has declined from a high of 46.2 (in July 2022) to 28.5 (in October 2024).
- Implementation of the Crisis Outreach Acute Support Team (COAST) that supports alternatives to inpatient care and supports discharge into the community
- Routine system-level review of demand, waits and outcomes across CYP mental health, neurodevelopmental and crisis pathways

There are two main children and young people's community mental health services in East Sussex commissioned by NHS Sussex:

- Mental Health Support Teams (MHSTs) in Schools provided by East Sussex County Council
- Specialist Child and Adolescent Mental Health Service (CAMHS) provided by Sussex Partnership NHS Foundation Trust.

The services work with each other to ensure children and young people access the right service to meet their needs. Children and young people also have access to targeted commissioned offers with voluntary and community sector partners such as Impact Initiatives and Amaze. The aim is to continue to develop and ensure these services operate as part of a single, integrated local pathway rather than in isolation.

MHSTs in schools

- MHSTs are a key mechanism for managing demand into specialist CAMHS by intervening earlier and supporting schools to respond confidently.
- MHSTs operate in 94 educational settings, covering 65% of East Sussex schools, supporting youth mental health. As of Spring 2025, the national average cover of Schools was 52% which puts us in the upper quartile
<https://www.england.nhs.uk/mental-health/cyp/trailblazers/>
- Teams deliver short-term, evidence-based interventions through trained Education Mental Health Practitioners. MHSTs take a whole school approach to promote mental wellbeing through staff training, parent workshops, and student psychoeducation sessions.
- In 2024/25, MHSTs handled 1,359 referrals and delivered 8,830 sessions, focusing on timely support to reduce specialist demand.
- As a system, we have recently submitted our plans to achieve 100% of schools' coverage by the national deadline of 2029 and a stronger alignment between MHSTs, SEND services and pastoral support in schools

CAMHS

- CAMHS currently uses a stepped care model offering specialist interventions for child and adolescent mental health. In the new Sussex-wide clinical model (in line with evidence-base and focus on mod-severe in the specialist service) some of the groups that were running have already been phased out to ensure most efficient use of resource and clinically effective service.

- Specialist CAMHS met the 28-day target with an average wait of 26 days and over 130 assessments monthly 24/25. Waiting times for assessment for Child and Adolescent mental health services (CAMHS) have begun to improve within community CAMHS teams (following targeted changes to assessment capacity and clinical model), falling from 42 weeks (Oct 2023) to 10 weeks (Sept 2025) for initial assessment but waiting times for access to treatment continue to be high.
- Dedicated staff provide ADHD and autism assessments and treatments within the neurodevelopmental service (ND waits are structurally different alongside the models- and note the plan is included in slide 12)
- Increased demand means that children and young people are waiting longer than we would like but when people are seen, satisfaction is high with 100% feeling supported and 95% recommending the service. CAMHS transformation seeks to improve timely access to evidence-based treatment by adopting a model of episodic care that delivers the targeted specialist interventions identified as most effective and tracking progress towards agreed goals.

There is also a focussed approach to improving support for children and young people and their families while they wait to access services:

- Families are encouraged to contact the service if circumstances change.
- A project has recently been completed to contact every young person on the CAMHS treatment waiting list for longer than 6 months, by phone. This is to review risk, offer advice/signposting and update the care plan accordingly.
- Assessment clinics during the week and at weekends have been increased to help to identify risks earlier, agree formulations, and allocate to the correct treatment pathway.
- The neurodevelopmental service also sends regular 'Support while waiting' letters and has worked with experts by experience (EBEs) and families to develop online resources that provide advice and guidance while waiting for assessment.
- The CAMHS Duty team remains available by phone to provide time-limited support for young people in mental health crisis.

Sussex Children and Young People's Mental Health Transformation Programme

A broader Sussex Children and Young People's Mental Health Transformation Programme aims to improve access, reduce waiting times, enhance clinical effectiveness, and achieve consistent, needs-based care across all areas with four key areas of focus:

- Getting Advice and Help – early access, communication, and a consistent Sussex Core Offer.
- Urgent and Emergency Care (UEC) – responsive crisis support and intensive community alternatives.
- Specialist CAMHS Redesign – a unified clinical model improving access and consistency.
- All-Age Neurodevelopmental (ND) Transformation (Focus Sussex) – a triage-led, needs-based ND model across the life span.

These programmes are at different stages of maturity, with benefits being realised incrementally and changes that translate into day-to-day improvements for families.

The overall approach to supporting children's mental health and emotional wellbeing can be summarised in the following way:

- Rising need and pressure: there are more children struggling with anxiety, emotional regulation, neurodivergence and crisis, and families feeling this impact day-to-day.
- Progress is being made: earlier support in schools, improving crisis responses, fewer inpatient admissions, and growing alternatives to hospital care.
- Where we're going is a more joined-up, needs-led system that supports children earlier, responds faster in crisis, and avoids escalation wherever possible.
- Wellbeing first, specialist care when needed: strengthening early help and wellbeing support before CAMHS, while ensuring timely access to specialist mental health services for those who need them.
- More support closer to home: building local, place-based responses that reduce the need for children to travel or enter hospital when community support is safer and more effective.
- Changes to the pathways for neurodivergent children and young people aimed at reducing waits and improving the service offered

The joint Sussex Mental Health, Learning Disability and Autism Board, with strong alignment to the Children's Board, continue to provide strategic direction and oversight, challenge and support — helping the system stay focussed on prevention, equity and long-term outcomes for children and families in East Sussex.

3. New NHS multi-year planning framework

The session finished with a brief introduction to the new multi-year planning framework launched by NHS England in August 25, aligned to the national 10-year Health Plan (10YHP). This requires all NHS organisations to produce 5-year plans for submission in February 2026.

- All NHS Trusts and Foundation Trusts must produce 5-years integrated delivery plans (narrative) and medium-term (3-year) financial, workforce and activity plans, plus a 4-year capital plan.
- ICBs are required to produce overarching 5-year population health improvement strategies in the same timescale. These are intended to replace Joint Forward Plans.
- 5-year neighbourhood health plans should also be developed, led by the Health and Wellbeing Board, integrating public health, social care, the Better Care Fund and VCSE partners (guidance for neighbourhood health plans is still awaited).
- The approach replaces short-term annual business planning cycles with a rolling, annual refresh to maintain long-term focus. Planning over multiple years is intended to create the opportunity to focus on longer-term strategic changes

The discussion focussed on the development of ESHT's five-year integrated delivery plan and the role the HWB will be expected to play in joining up a clear whole health and care system plan for Neighbourhood Health at scale - building on local needs and priorities for their populations based on JSNAs and HWB strategies, including mental health and wellbeing.

It was agreed to come back to the new planning framework, and particularly the Neighbourhood Health Plan, as part of the HWB strategy refresh design conversation at the final HWB development session scheduled for **12 February 2026**.

For more information please contact:

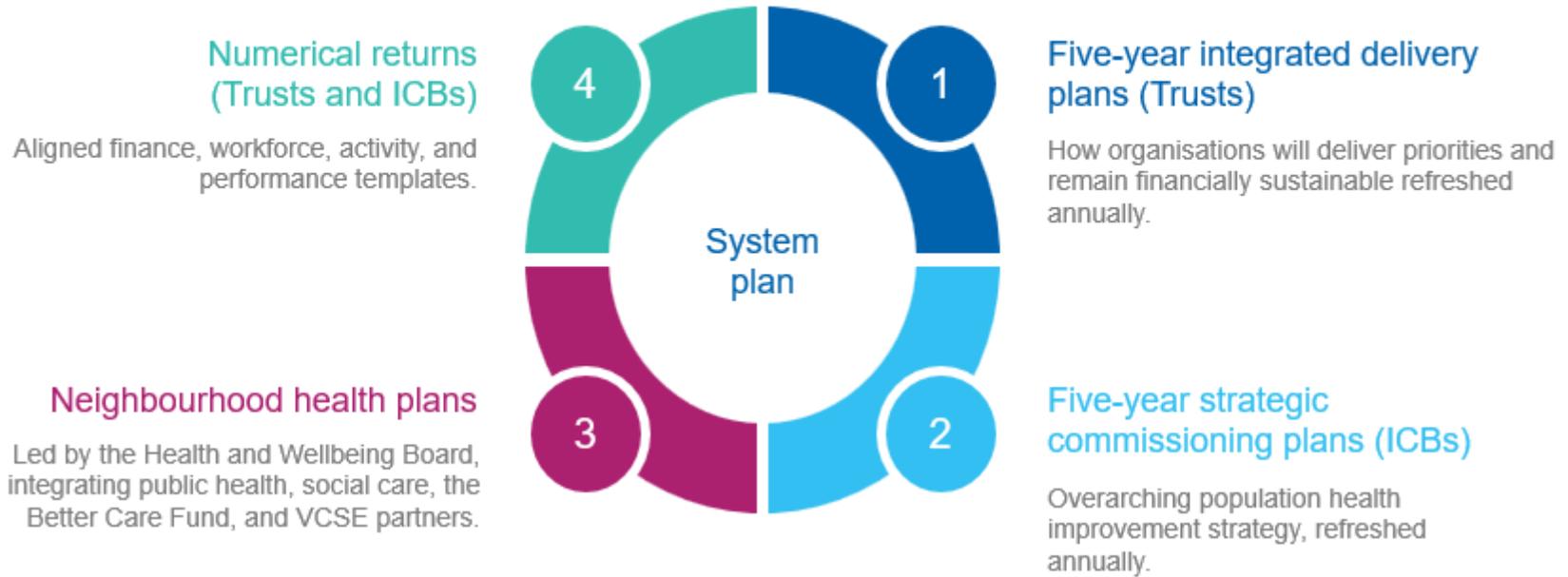
Vicky Smith, Programme Director, East Sussex Health and Care Transformation

East Sussex County Council and NHS Sussex

Contact: vicky.smith@eastsussex.gov.uk

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Organisations should work collaboratively to produce their plans, which taken together, will form an overarching system plan:



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Report to: East Sussex Health and Wellbeing Board

Date: 10 March 2026

By: Director of Joint Commissioning and Integrated Community Teams Development (East Sussex), NHS Sussex and Director of Adult Social Care and Health, East Sussex County Council

Title: Neighbourhood Health Plan development

Purpose of Report: To brief the Health and Wellbeing Board on the implications of the emerging national requirements for neighbourhood health planning, and the proposed approach ahead of national guidance and legislation.

Recommendations:

East Sussex Health and Wellbeing Board (HWB) is recommended to:

1. **Endorse** the expected role of HWBs and Place in the health system reforms and neighbourhood health planning.
2. **Note** the expected content of the new neighbourhood health plan that will be developed under the leadership of HWBs for 2026/27 and that, at the time of writing, guidance is still awaited from the Department of Health and Social Care (DHSC).
3. **Endorse** the proposed working arrangements to support the development the East Sussex Neighbourhood Health Plan with key stakeholders, as set out in paragraphs 2.12 – 2.16 of the report, and the timetable in **Appendix 1**.
4. **Delegate** responsibility to the East Sussex Health and Care Partnership to coordinate the detailed interim Neighbourhood Health Plan development on behalf of the HWB.

1. Background

1.1 Earlier reports to the HWB in 2025/26 have set out some of the implications of health system reform under the Government's [10 Year Health Plan for England: fit for the future](#) (10YHP), which was published in July 2025. In summary, the key points are as follows:

- The reinvention of the NHS based on a new community-based care model which moves away from sickness to prevention and the use of hospitals by default
- The shift from hospital to community driving the development of a 'neighbourhood health service', which aims to bring care into local communities, organise professionals into patient-centred teams, and reduce fragmentation
- The introduction of a new multi-year planning cycle for the NHS which includes five-year integrated delivery plans (Trusts) and five-year strategic commissioning plans to support population health improvement (ICBs). These separate plans are intended to replace the current requirement for Joint Forward Plans¹

¹ In Sussex the Joint Forward Plan is known as the Shared Delivery Plan

- As part of the above, the expectation that a new 'Neighbourhood Health plan' will be drawn up under the leadership of the HWB to support a whole health and care system approach to neighbourhood health, across Local Government, the NHS and Voluntary, Community and Social Enterprise (VCSE) sector
- Building on the new ICB model blueprint, ICBs becoming smaller organisations with an increased focus on strategic commissioning across larger geographies
- New and increasing roles for NHS provider collaboratives which bring together NHS providers across primary, community and mental health and acute services
- A changing relationship between the NHS and Local Authorities as co-commissioners and co-providers of services
- All of these developments are taking place in a broader context of shared challenges being experienced by all partners locally – including rising demand for services, increasing complexity of needs and financial constraint – and as such are part of wider policy development designed to respond to this.

1.2 These elements have been explored further as part of our recent informal HWB development sessions in January and February 2026, to support the HWB's consideration of its refreshed role as part of the reforms, based on the national guidance and information that has been available to date. This report briefly summarises this and brings the proposed working arrangements and suggested timetable for developing the East Sussex Neighbourhood Health Plan in 2026/27 for formal endorsement.

2 Supporting information

Role of HWB and Place in health system reform

2.1 Following the publication of the 10YHP, many of the associated changes to structures and processes are starting to be implemented, for example the move to the NHS Surrey and Sussex ICB from April 2026. The new national [Strategic Commissioning Framework](#) (NHS England, November 2025) sets out the new functions of ICBs in the reformed health system. On the relationship with local government, in summary it notes that:

- Engagement and co-design with local government are essential. ICBs should maintain strong partnerships across adult social care, children's services, housing and public health to understand their populations, reduce inequalities and improve neighbourhood health outcomes.
- As ICBs evolve and local government reforms progress, Health and Wellbeing Boards will be the key forums for joint planning with upper-tier local authorities, complemented at system-level by working in partnership with strategic authorities discharging their new health duties.

2.2 The Strategic Commissioning Framework highlights that Place-based partnerships - bringing together health, social care, local government, the VCSE sector and wider partners - are central to planning and improving services within each ICS, using population health management and coordinated multidisciplinary care to meet local needs. The Framework suggests that these partnerships need to be supported through greater delegation over time and clearer leadership and operating models - including how this interacts with local government - to thrive.

2.3 Our existing East Sussex Health and Care Partnership performs this role to support integrated commissioning and delivery and is reviewing its governance to ensure it can maintain a clear focus on Place delivery in the context of the health system reforms.

2.4 In addition, the 10YHP strengthens the role of place partners through two main mechanisms:

- Planning at Place level: local government, the NHS and its partners at single or upper tier authority level will draw up a neighbourhood health plan under the leadership of the HWB, incorporating public health, social care, VCSE partners and the Better Care Fund (BCF). This will set out shared objectives across Place partners, how the model of care will change based on local need, and how commissioners and providers will reorganise themselves to deliver services in a more integrated way.
- New delivery models: Place partners will work together to define the optimal delivery model for their population and configuration, including the development of single and multi-neighbourhood provision and, in some parts of the country, Integrated Health Organisations (IHOs). ICBs will commission these models and will play a key role in shaping and supporting providers to work collaboratively and develop the necessary capabilities to implement them.

Neighbourhood Health Plan development

2.5 Neighbourhood Health plans are anticipated to set out the next phase of system reform, positioning neighbourhood health as the operating model for health services. Further national guidance is awaited with the HWB potentially being asked to:

- Oversee development of an interim strategic plan for neighbourhood health in early Q1 26/27 (April – June 2026).
- Oversee the development of an interim operational plan for neighbourhood health by Q2 26/27 (July – September 2026)
- Within this agree neighbourhood footprints, priority outcomes and initial scope for services, including integrated neighbourhood teams and the use of the BCF and other resources that apply to neighbourhood health delivery

Health and Wellbeing Board Strategies

2.6 As part of delegated responsibilities the existing statutory functions of HWBs include:

- Leading a shared understanding of local population health and care needs through the production of Joint Strategic Needs Assessments (JSNAs)
- Agreeing a high level HWB Strategy which sets the strategic direction for local service commissioning, integrating NHS, public health and social care, and which partners must have regard to when exercising their functions.

2.7 These statutory duties originated in the Local Government and Public Involvement in Health Act 2007 and the Health and Care Act 2012, and were maintained by the Health and Care Act 2022. Our rolling [East Sussex Health and Wellbeing Board Strategy](#) *Healthy Lives, Healthy People* (2022 – 2027) is informed by insights from the East Sussex [Joint Strategic Needs Assessment](#) (JSNA).

2.8 In Sussex, the three HWB Strategies and JSNAs for East Sussex, West Sussex and Brighton & Hove informed the [Sussex Integrated Care Strategy](#) *Improving Lives Together* (2022). A

single [Shared Delivery Plan](#) (SDP) was agreed by partners in June 2023 and has been updated annually to support this vision. Progress with the HWB objectives in the SDP is the subject of a separate, regular report on the HWB meeting agenda.

2.9 A key objective in the SDP has been to strengthen the HWB's role as the system's primary strategic stewardship forum for health, care and wellbeing. To support this, seven informal JSNA-themed development sessions have been delivered between September 2024 and February 2026, aimed at building a shared understanding of population health and care needs and strengthening the partnership relationships necessary for system stewardship. Session briefings are published on the JSNA website [JSNA: Health and Wellbeing Board briefing notes 2025](#)

2.10 It is anticipated that 2026/27 will be a transitional year, pending a new Health and Care Bill. As such Neighbourhood Health Plans will potentially be an addendum to the HWB Strategy. Further Guidance is anticipated about the long-term expectations for HWB Strategies, including whether the Neighbourhood Health Plan will in effect replace the need for a HWB Strategy.

Approach to neighbourhood health in Sussex

2.11 Discussions at our most recent informal HWB development session on 12 February 2026 have acknowledged that our early work to implement Integrated Community Teams (ICTs), as part of the Sussex-wide approach set out in *Improving Lives Together*, provides a strong foundation on which to build our interim strategic neighbourhood health plan. The core features of this include:

- 13 defined footprints for ICTs (five in East Sussex) aligned to district and borough and unitary footprints in Sussex, and leadership groups in place to take plans and work forward, supported by team building and development
- Population health outcomes data and performance indicators at ICT footprint level
- An agreed specification for neighbourhood health, moving to provider-led delivery supported by clear ICB commissioning intentions, and agreement of a core offer of neighbourhood multi-disciplinary team working based on populations of 30-50,000 (generally the Primary Care Network (PCN) footprints)
- Use of the Johns Hopkins risk stratification tool in conjunction with the Sussex Integrated Dataset to identify groups of people – initially frail people over-65 years of age - with similar needs where we can have the greatest impact through a better coordinated proactive approach. The aim is to establish more holistic closer multi-disciplinary team-working around these groups for the services in scope, and over time less reliance on urgent and unplanned care and more specialist services.
- Formation of the Sussex NHS Neighbourhood Alliance to take forward the specification, and further strengthen the integration and partnership working needed within the NHS to support delivery and local targeted projects

Proposed working arrangements for 26/27

2.12 Acknowledging this will be further informed by national Guidance when it is published, the following next steps will need to be taken to fulfil HWB statutory duties and new expectations under the 10YHP:

- Agree BCF plans for 26/27 as a transitional year
- Agree the initial high level interim strategic neighbourhood health plan – in part based on

work already in train

- Start the process of developing the interim operational Neighbourhood Health plan, giving it a central focus as part of the HWB Strategy refresh exercise
- Delegate leadership of the detailed operational Neighbourhood Health Plan development to the East Sussex Health and Care Partnership Place Delivery Board, with accountability to the HWB
- Ensure strong links with the Sussex NHS Neighbourhood Alliance and alignment with plans to deliver the ICB commissioning intentions in 26/27

2.13 To enable health and care system stewardship and accountability through the HWB, it is proposed that a further four informal HWB development sessions are scheduled to take place 6 weeks ahead of the formal HWB meetings in July, September, November 2026 and March 2027. The aim of this next programme of development sessions would be to oversee and support the co-production and agreement of our East Sussex Neighbourhood Health Plan and HWB strategy refresh.

2.14 To build on and further develop the successful model, it is suggested that these sessions use a two-part agenda model:

- Part 1 – for voting HWB members and non-voting HWB members with speaking rights
- Part 2 – HWB members and wider East Sussex Health and Care Partnership Leads across the NHS, Councils and the VCSE sector – with members to be drawn from the existing Health and Care Partnership Executive Board, which would no longer meet separately, and some additional representation to ensure a whole system approach.

2.15 The anticipated activity and timetable to support neighbourhood health plan development in 26/27 is set out in **Appendix 1**.

2.16 The proposed approach was agreed in principle at the informal HWB development session on 12 February 2026, with the following suggestions to support the development of a shared Neighbourhood Health Plan based on local priorities, needs and strengths:

- Reviewing and updating NHS HWB membership arrangements in light of the new Sussex NHS Neighbourhood Alliance and the ICB role as strategic commissioner to ensure a strong relationship and alignment
- Reviewing HWB elected member membership arrangements to ensure this reflects the important role they play and can support effective feedback loops
- Ensuring that the wider Part B meeting of the informal HWB development sessions includes Borough and District Council lead officers and independent care sector representatives alongside NHS, Social Care, Public Health and VCSE leads
- Ensuring that the outcomes of the East Sussex Health and Care Partnership governance review enables a clear focus on Neighbourhood Health Plan development and delivery, including the transformation to ICTs as part of the Sussex-wide approach.
- A clear focus on children and young people is adopted to support a whole life course approach, including working with schools and alignment with Government reforms including early intervention and family support, and Best Start in Life.

3 Conclusion and reasons for recommendations

3.1 The 10YHP and national Strategic Commissioning Framework reaffirm the role of HWBs and Place as the key forum for political, clinical, professional and community leaders to improve health, tackle wider determinants and reduce inequalities. They also confirm HWBs and Place health and care partnerships as central to integrating health, care and wellbeing, including oversight of pooled and aligned budgets such as the BCF.

3.2 Developing a Neighbourhood Health plan as a central part of our HWB strategy refresh exercise will allow the HWB to build on the insights, themes and strategic priorities driven by our JSNA, and the work already being progressed through *Improving Lives Together* and our SDP. Over time, this will help support a sustainable, neighbourhood-based model of integrated care and reduce reliance on more costly services.

3.3 The plan will support a more joined-up approach to health, care and wellbeing by better aligning our collective vision, ambition and resources for our population. The proposed arrangements for 2026/27 build on the strong partnership working across health and care in East Sussex, and our earlier work to strengthen the HWB's strategic leadership of our system - maintaining this in the context of the wider system reforms and at the same time streamlining meetings and strengthening oversight and stewardship.

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Appendix 1: Potential Neighbourhood Health plan development timetable

Potential Neighbourhood Health Plan development timetable

NB timings and milestones are anticipated and may change subject to national guidance when it is published

| Anticipated timescale | Anticipated milestone / activity | Informal HWB session suggested date | Formal HWB meeting date |
|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------|
| April – June 2026 | <ul style="list-style-type: none"> Agree interim strategic Neighbourhood Plan Finalise the scope of interim operational Neighbourhood Health Plan and the connection to the HWB Strategy refresh | 11 June 2026 | 21 July 2026 |
| July – September 2026 | <ul style="list-style-type: none"> Finalise draft interim operational Neighbourhood Health Plan for formal agreement Undertake wider engagement on the draft interim operational Neighbourhood Health Plan and further evolution | 20 August 2026 | 29 September 2026 |
| October – November 2026 | <ul style="list-style-type: none"> Review and adjust interim Neighbourhood Health Plans in light of feedback and commissioning plans for 27/28 Align with HWB Strategy refresh post Health and Care Bill clarification | 15 October 2026 | 24 November 2026 |
| December 2026 – March 2027 | <ul style="list-style-type: none"> Agree finalised Neighbourhood Health Plans for delivery in 27/28 | 28 January 2027 | 9 March 2027 |

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Report to: East Sussex Health and Wellbeing Board

Date: 10 March 2026

By: Director of Public Health

Title: Alcohol-Related Cognitive Impairment

Purpose of Report: To provide the Health and Wellbeing Board (HWB) with an overview of Alcohol-Related Cognitive Impairment (ARCI) in East Sussex and the emerging evidence of its impact on individuals and the wider system.

Recommendations:

East Sussex Health and Wellbeing Board is recommended to:

- 1. note the health and wellbeing concerns outlined in this report and appendix 1 for this cohort and the emerging evidence on Alcohol-Related Cognitive Impairment in East Sussex; and**
 - 2. support the development of an ARCI pathway, delegating the governance around this to the Multiple Compound Needs (MCN) Board.**
-

1 Background

1.1 Alcohol-Related Cognitive Impairment (ARCI) refers to a spectrum of cognitive impairment resulting from prolonged alcohol use, characterised by persistent difficulties with memory, executive functioning, judgement and decision-making. These impairments significantly affect an individual's ability to engage with services, sustain recovery and maintain stable accommodation. ARCI is frequently closely associated with multiple compound needs, including mental ill health, homelessness and repeated contact with emergency, criminal justice and safeguarding services, leading to consistently poor outcomes and high system demand.

1.2 This work emerged through the Alcohol Harm Alliance's Seamless Treatment and Recovery Pathway workstream, which identified ARCI as a recurring system gap where existing alcohol, mental health, housing and social care pathways do not align with need. In response, Public Health, through Priority Three of the Alcohol Harm Reduction Strategy, established an ARCI Steering Group to bring together national evidence, local data and frontline service intelligence. This report and appendix 1 summarises that work and sets out the case for a coordinated, whole-system response aligned to MCN governance, safeguarding arrangements and health inequality priorities.

2 Supporting Information

2.1 National evidence indicates that ARCI is common amongst people with long-term harmful drinking and is frequently under diagnosed. Around 0.5% of the UK population are estimated to be affected, rising substantially among very heavy drinkers. Evidence also suggests that around 10% of dementia cases, and up to 12.5% of dementia cases in people under 65, may be alcohol related. Where ARCI is identified and appropriately supported,

outcomes can improve, with substantial or partial recovery possible for a significant proportion of individuals.

2.2 Local intelligence shows that ARCI represents a high-impact cohort in East Sussex. Between 2015/16 and 2024/25, there were 660 hospital admissions with an ARCI-related diagnosis, the majority of which were emergency admissions. Rates are strongly patterned by deprivation, with higher recorded prevalence in Hastings and Eastbourne, aligning with wider patterns of alcohol harm, homelessness and Multiple Compound Needs.

2.3 ARCI is closely associated with Multiple Compound Needs, including alcohol dependence, mental ill health, homelessness and safeguarding concerns. Cognitive impairment within this group undermines engagement, recovery and accommodation stability, reinforcing cycles of crisis and repeated service contact.

2.4 The system gap for people with ARCI is a structural deadlock between abstinence, diagnosis and access to funded accommodation. In the current system, a formal diagnosis is required to unlock funding and specialist accommodation. However, diagnostic assessment typically requires a period of abstinence and stability.

2.5 For people with advanced ARCI, abstinence is only achievable within a structured and supportive environment. Because accommodation and funding cannot be accessed without a diagnosis, and diagnosis cannot be achieved without abstinence, individuals are unable to progress through the system at any point. This results in repeated hospital admissions, safeguarding concerns and housing instability despite ongoing contact with services.

3 Conclusion

3.1 Alcohol-Related Cognitive Impairment represents an important health and wellbeing concern for a cohort of people in East Sussex experiencing multiple disadvantages, including alcohol dependence, poor mental health, housing instability and safeguarding risks. Recognising ARCI within existing partnerships and governance arrangements provides an opportunity to improve understanding, reduce avoidable harm and support better outcomes for this group, while also reducing reliance on crisis management, repeated hospital admissions and avoidable bed days.

DARRELL GALE

Director of Public Health

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Appendix 1: Alcohol-Related Cognitive Impairment: Prevalence, Impact, and Service Implications

Alcohol-Related Cognitive Impairment: Prevalence, Impact, and Service Implications

East Sussex County Council

Public Health

Monday, 02 February 2026

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Definitions

| Term | Description |
|----------------|------------------------------------------------------------------------------------------------------------------------------------|
| 6-CIT | Six-Item Cognitive Impairment Test - brief cognitive screening tool. |
| ACE-III | Addenbrooke's Cognitive Examination III - detailed cognitive screening assessment. |
| ACT | Alcohol Care Team - hospital-based team providing care for patients with alcohol-related problems. |
| ARBD | Alcohol-Related Brain Damage - cognitive impairment caused by long-term heavy alcohol use. |
| ARBI | Alcohol-Related Brain Injury - injury to the brain associated with alcohol use, sometimes used interchangeably with ARBD. |
| ARD | Alcohol-Related Dementia - dementia caused or exacerbated by alcohol use. |
| CGL | Change Grow Live - UK-based substance misuse treatment and recovery organisation. |
| HES | Hospital Episode Statistics - administrative data on hospital admissions, outpatient appointments, and A&E attendances in England. |
| KS | Korsakoff's Syndrome - chronic memory disorder, typically following untreated Wernicke's Encephalopathy. |
| MCN | Multiple Compound Needs - co-occurring social, health, or economic disadvantages. |
| MMSE | Mini-Mental State Examination - commonly used cognitive assessment tool. |
| MoCA | Montreal Cognitive Assessment - cognitive screening tool sensitive to mild impairments. |
| PHOF | Public Health Outcomes Framework - tool to measure public health outcomes in England. |
| PWYLL | Potential Working Years of Life Lost - measure of premature mortality impact on workforce. |

| | |
|-------------|----------------------------------------------------------------------------------------------------------------------------------|
| SID | Sussex Integrated Data - linked health and social care data for Sussex. |
| SMR | Standardized Mortality Ratio - ratio of observed to expected deaths in a population. |
| SPFT | Sussex Partnership Foundation Trust - mental health and learning disability NHS trust in Sussex. |
| UK | United Kingdom - country comprising England, Scotland, Wales, and Northern Ireland. |
| WE | Wernicke's Encephalopathy - acute neurological condition caused by thiamine deficiency; can progress to WKS if untreated. |
| WKS | Wernicke-Korsakoff Syndrome - severe neurological disorder due to thiamine deficiency, often associated with alcohol dependence. |
| ARCI | Alcohol Related Cognitive Impairment |

Purpose of Review

This evidence review synthesises local and national datasets, service intelligence, and case-based learning to illuminate the scale of need, the extent of under-detection, and the consequences of delayed or inaccessible diagnosis and support. It also identifies the structural and pathway-related barriers that contribute to unmet need, including fragmented access to assessment and inconsistency in recording and referral routes. Taken together, these findings provide a robust foundation for defining strategic opportunities for earlier identification, integrated care pathways, and coordinated multi-agency responses to reduce harm and improve outcomes for people living with alcohol-related cognitive impairment in East Sussex.

1. **Review of Local Needs Assessment:** Examined the Multiple Compound Health Needs Assessment to identify data and insights relevant to cognitive impairment and Alcohol-Related Brain Damage, extracting all pertinent aspects.
2. **National Data Review:** Explored available national datasets and publications to understand the broader prevalence and context of ARBD and cognitive impairment.
3. **Benchmarking with Other Local Authorities:** Investigated approaches and data from peer local authorities to identify potential benchmarks.
4. **Hospital Data Analysis:** Accessed local hospital data via the Hospital Episode Statistics database to identify patterns and prevalence of ARBD-related admissions.
5. **Primary Care Data Review:** Examined the Sussex Integrated Dataset for relevant primary care information, including GP records, to understand ARBD and cognitive impairment at the community level.
6. **Public Health Outcomes Framework Review:** Checked PHOF indicators for any relevant metrics on alcohol related brain damage, cognitive impairment, and related health outcomes.
7. **Local Service Data Collection:** Engaged with local services, including the Alcohol Care Team, Sussex Partnership NHS Foundation Trust, and Change Grow Live, to gather relevant service-level data if possible.
8. **Case Studies:** Requested anonymised case studies from ACT and CGL to illustrate real-life experiences, highlight the complexity of support needs, and demonstrate how cognitive impairment and ARBD impact both individuals and service provision.

Literature Review: Alcohol-Related Cognitive Impairment and Alcohol-Related Brain Damage

Introduction

Alcohol-Related Brain Damage (ARBD), increasingly understood within the broader concept of Alcohol-Related Cognitive Impairment (ARCI), refers to a spectrum of cognitive and neurological impairments resulting from prolonged heavy alcohol consumption. These impairments arise through a combination of alcohol neurotoxicity, thiamine deficiency, malnutrition, repeated withdrawal episodes, and associated physical and mental health conditions^{1, 2}.

ARCI encompasses a range of clinical presentations, including Wernicke's encephalopathy (WE), Korsakoff's syndrome (KS), alcohol-related dementia, alcohol-induced cerebellar degeneration, and peripheral neuropathy. Importantly, ARBD is not a single diagnostic entity within ICD-10, and cases are therefore recorded across multiple diagnostic codes. This contributes to under-recognition within routine datasets and limits accurate assessment of prevalence and service need³.

This review synthesises national and international evidence on prevalence, clinical characteristics, outcomes, system impacts, and service responses to ARCI, with a focus on implications for identification, diagnosis and care pathways.

Prevalence and Population Impact

Estimates suggest that approximately 0.5% of the UK population experience alcohol-related brain changes, with prevalence increasing substantially among people with heavy or dependent drinking patterns⁴. Among very heavy drinkers, ARCI prevalence has been estimated at 30-35%, highlighting the strong dose-response relationship between alcohol exposure and cognitive harm.

ARCI represents a significant proportion of dementia diagnoses. Evidence indicates that 10-24% of all dementia cases may be alcohol-related, rising to 12-12.5% among people with young-onset dementia (<65 years)^{5, 6}. This has implications for

¹ Thomson AD, Guerrini I, Bell D, Drummond C, Duka T, Field M, Kopelman M, Lingford-Hughes A, Smith I, Wilson K, Marshall EJ. Alcohol-related brain damage: report from a Medical Council on Alcohol Symposium, June 2010. *Alcohol Alcohol*. 2012 Mar-Apr;47(2):84-91. doi: 10.1093/alcalc/ags009. Epub 2012 Feb 16. PMID: 22343345.

² Royal College of Psychiatrists. (2014). *Alcohol and brain damage in adults: With reference to high-risk groups* (College Report CR185). Royal College of Psychiatrists. Retrieved from https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr185.pdf?sfvrsn=66534d91_2

³ Ward R, Roderique-Davies G, Hughes H, Heirene R, Newstead S, John B. Alcohol-related brain damage: A mixed-method evaluation of an online awareness-raising programme for frontline care and support practitioners. *Drug Alcohol Rev*. 2023 Jan;42(1):46-58. doi: 10.1111/dar.13545. Epub 2022 Sep 12. PMID: 36097437; PMCID: PMC10087889.

⁴ Schölin, L., Rhyas, S., Holloway, A., & Jepson, R. (2019). *Dual diagnosis, double stigma: A rapid review of experiences of living with alcohol-related brain damage (ARBD)*. Alcohol Change UK / The University of Edinburgh. Retrieved from <https://s3.eu-west-2.amazonaws.com/sr-acuk-craft/documents/Dual-diagnosis-double-stigma-a-rapid-review-of-experiences-of-living-with-alcohol-related-brain-damage-Final-Report.pdf>

⁵ Alzheimer's Society. (2021). *Alcohol-related brain damage (ARBD)*. Alzheimer's Society. Retrieved from <https://www.alzheimers.org.uk/about-dementia/types-dementia/alcohol-related-brain-damage-arbd>

⁶ Dementia UK. (n.d.). *Alcohol-related brain damage*. Dementia UK. Retrieved from <https://www.dementiauk.org/information-and-support/types-of-dementia/alcohol-related-brain-damage/>

working-age populations and long-term dependency on health and social care services.

International registry data reinforce the scale of the issue. A nationwide Finnish study reported incidence rates of 2.4 per 100,000 for Wernicke-Korsakoff syndrome and 5 per 100,000 for alcohol-related dementia, alongside extremely high crude mortality rates⁷. Population-based studies in Scotland and Wales similarly suggest prevalence ranging from 0.07% to 0.14%, with acknowledged underestimation due to diagnostic and recording limitations^{8, 9}.

Clinical Characteristics and Course

ARCI is characterised by impairments across multiple cognitive domains, including memory, attention, executive functioning, visuospatial skills and social cognition (Smith et al., 2025; Ramey, 2018). These impairments significantly affect functional ability, including treatment engagement, adherence, independent living and service navigation.

Wernicke's encephalopathy represents an acute neurological emergency associated with thiamine deficiency. Although potentially reversible, WE is widely underdiagnosed; post-mortem studies suggest that only 5-20% of cases are identified during life¹⁰. Untreated WE carries a 10-20% mortality risk, and approximately 75-85% of survivors develop Korsakoff's syndrome, which is associated with persistent memory impairment and functional decline.

ARCI is considered non-progressive if abstinence is achieved and maintained. Recovery trajectories vary, with evidence suggesting that approximately 25% of individuals experience substantial or complete recovery, 50% partial improvement, and 25% minimal or no recovery, often requiring long-term care¹¹. Most cognitive recovery occurs within the first three months of abstinence, with further improvement possible over 1-2 years.

Mortality, Morbidity and Health System Impact

ARCI is associated with significantly elevated mortality and morbidity. The Finnish register study reported standardised mortality ratios exceeding five times that of the general population for both Wernicke-Korsakoff syndrome and alcohol-related dementia. Even where treatment is initiated, individuals experience high rates of hospital admission, prolonged length of stay, and repeated readmissions.

⁷ Palm A, Vataja R, Talaslahti T, et al. Incidence and mortality of alcohol-related dementia and Wernicke-Korsakoff syndrome: a nationwide register study. *Int J Geriatr Psychiatry*. 2022; 1-9. <https://doi.org/10.1002/gps.5775>

⁸ Quelch D, Roderique-Davies G, John B. Alcohol-related brain damage: an umbrella (term) for the approaching post-COVID monsoon. *Future Healthc J*. 2023 Nov;10(3):313-320. doi: 10.7861/fhj.2023-0022. PMID: 38162212; PMCID: PMC10753228.

⁹ Welsh Government. (2021). *Substance misuse treatment framework: Prevention, diagnosis, treatment and support for alcohol-related brain damage* (WG43872). Cardiff: Welsh Government. Retrieved from <https://www.gov.wales/sites/default/files/publications/2021-11/substance-misuse-treatment-framework-prevention-diagnosis-treatment-and-support-for-alcohol-related-brain-damage.pdf>

¹⁰ Isenberg-Grzeda E, Chabon B, Nicolson SE. Prescribing thiamine to inpatients with alcohol use disorders: how well are we doing? *J Addict Med*. 2014 Jan-Feb;8(1):1-5. doi: 10.1097/01.ADM.0000435320.72857.c8. PMID: 24343128.

¹¹ Royal College of Psychiatrists. (2014). *Alcohol and brain damage in adults: With reference to high-risk groups* (College Report CR185). Royal College of Psychiatrists. Retrieved from https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr185.pdf?sfvrsn=66534d91_4

Evidence from Northern Ireland indicates substantial system costs associated with ARCI. One analysis estimated annual hospital costs approaching £1 million for 105 patients, driven largely by delayed discharges and lack of appropriate post-acute pathways¹². Similar findings are reported across UK and international settings, with ARCI frequently contributing to bed blocking, repeated crisis presentations and long-term dependency.

ARCI, Multiple Disadvantage and Service Engagement

ARCI disproportionately affects individuals experiencing severe and multiple disadvantage, including homelessness, substance dependence, mental ill health and criminal justice involvement¹³. Studies in homeless populations report ARCI prevalence of up to 21%, with broader cognitive impairment affecting over 80% of individuals in some settings¹⁴.

Cognitive impairment is also prevalent across substance use treatment populations more broadly. Evidence suggests that 60-70% of individuals in substance use treatment exhibit moderate to severe cognitive deficits, particularly in executive functioning and working memory¹⁵. These impairments are associated with poorer engagement, reduced retention, and weaker outcomes, reinforcing cycles of relapse and crisis-driven care.

Diagnosis, Pathways and Workforce Capability

Across the literature, ARCI is consistently described as underdiagnosed and poorly integrated within care pathways. Barriers include fragmented referral routes, inconsistent use of diagnostic criteria, limited access to neuropsychological assessment, and insufficient workforce training¹⁶.

Many rehabilitation and residential services require a minimum level of cognitive functioning and capacity to engage in structured programmes, rendering them inaccessible to individuals with more advanced impairment¹⁷. This contributes to a structural gap in which individuals with the highest levels of need are least able to access appropriate care.

Training and awareness interventions have demonstrated effectiveness. A mixed-methods evaluation of an online ARCI training programme reported significant

¹² Craig, D. V. (2018). *Alcohol-related brain damage in Northern Ireland: Treatment, not just care* (College Report CR212, Apr 2018). Royal College of Psychiatrists. Retrieved from <https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2018-college-reports/alcohol-related-brain-damage-in-northern-ireland-cr212-apr-2018>

¹³ Fisher, G. (2015). *The Complexity of Severe and Multiple Disadvantage*. Lankelly Chase Foundation. Retrieved from <https://lankellychase.org.uk/wp-content/uploads/2015/09/SMD-and-Complexity.pdf>

¹⁴ Gilchrist G, Morrison DS. Prevalence of alcohol related brain damage among homeless hostel dwellers in Glasgow. *Eur J Public Health*. 2005 Dec;15(6):587-8. doi: 10.1093/eurpub/cki036. Epub 2005 Sep 14. PMID: 16162595.

¹⁵ Bruijnen CJWH, Dijkstra BAG, Walvoort SJW, Markus W, VanDerNagel JEL, Kessels RPC, DE Jong CAJ. Prevalence of cognitive impairment in patients with substance use disorder. *Drug Alcohol Rev*. 2019 May;38(4):435-442. doi: 10.1111/dar.12922. Epub 2019 Mar 27. PMID: 30916448; PMCID: PMC6593747.

¹⁶ Quelch, Darren & Davies, Nyle & John, Bev & Taylor, Rachel & Fishleigh, Lucy & Bowers, Dan & Lewis, Julia & Gwyn, Sue & Bevan, Janet & Ward, Rebecca & Thorkildsen, Elin & Cassley, Harriet & Roderique-Davies, Gareth. (2025). Outcomes from a National Consensus Event Targeting Service Development Strategies for Alcohol Related Brain Damage. *Alcoholism Treatment Quarterly*. 44. 1-14. 10.1080/07347324.2025.2579313.

¹⁷ Wade DT. Selection criteria for rehabilitation services. *Clin Rehabil*. 2003 Mar;17(2):115-8. doi: 10.1191/0269215503cr591ed. PMID: 12625650.

improvements in staff confidence, recognition and practice, sustained over time. National guidance consistently recommends integrated, multi-agency pathways, embedding ARCI expertise within existing services rather than creating parallel systems¹⁸.

Models of Practice and Service Responses

Evidence from the UK and internationally demonstrates that specialist, integrated ARCI services can improve outcomes. Case studies from Scotland, Kent and Devon highlight reductions in hospital bed days, improvements in cognitive functioning and greater stability when multidisciplinary approaches are employed^{19, 20}.

Effective models typically include early identification, nutritional and thiamine supplementation, abstinence or alcohol management support, occupational therapy, and coordinated discharge planning. Innovations such as recovery passports and named care coordinators have been shown to improve continuity and service engagement²¹.

Multiple Compound Needs Review

Multiple Compound Needs Health Needs Assessment

The East Sussex Multiple Compound Needs (MCN) Health Needs Assessment draws on national and local evidence to characterise complexity and associated health risks. In the Changing Futures national evaluation (April 2023) involving 1,250 participants, 85% reported lifetime substance misuse and 92% reported mental health issues, highlighting the high prevalence of co-occurring needs that may intersect with cognitive impairment.

People experiencing Multiple Compound Needs (MCN) often face overlapping challenges, including homelessness, substance dependence, offending behaviour and mental ill health. These experiences are frequently underpinned by trauma, poverty and social isolation, and are associated with poorer health outcomes and increased risk of premature mortality²². Within this population, alcohol dependence is common. Sustained heavy drinking, combined with poor nutrition, repeated detoxification, head injury and limited access to health care, significantly increases the risk of cognitive impairment²³.

¹⁸ UK Government. (2023). *Draft UK clinical guidelines for alcohol treatment: Specific settings and populations* (Consultation). Department of Health and Social Care / Office for Health Improvement and Disparities. Retrieved from <https://www.gov.uk/government/consultations/uk-clinical-guidelines-for-alcohol-treatment/uk-clinical-guidelines-for-alcohol-treatment-specific-settings-and-populations>

¹⁹ Care Inspectorate (Scotland). (2024). *Inspection report: Penumbra Supported Accommodation (ARBD) Care Home* (Service No. CS2006130024). Care Inspectorate. Retrieved from <https://www.careinspectorate.com/berengCareservices/html/reports/getPdfBlob.php?id=318723>

²⁰ A.D. Thomson, I. Guerrini, D. Bell, C. Drummond, T. Duka, M. Field, M. Kopelman, A. Lingford-Hughes, I. Smith, K. Wilson, E.J. Marshall, Alcohol-Related Brain Damage: Report from a Medical Council on Alcohol Symposium, June 2010, *Alcohol and Alcoholism*, Volume 47, Issue 2, March/April 2012, Pages 84-91, <https://doi.org/10.1093/alcalc/ags009>

²¹ Glasgow City Health and Social Care Partnership (HSCP). (2023). *Alcohol Related Brain Damage Recovery Passport*. Glasgow City HSCP. Retrieved from <https://glasgowcity.hscp.scot/news/alcohol-related-brain-damage-recovery-passport>

²² East Sussex Joint Strategic Needs Assessment. *Multiple compound needs health needs assessment*. 2025. Available from: <https://www.eastsussexjsna.org.uk/resources/multiple-compound-needs-health-needs-assessment/>

²³ Bramley G, Fitzpatrick S, Edwards J, Ford D, Johnsen S, Sosenko F, et al. *Hard Edges: Mapping Severe and Multiple Disadvantage in England*. London: Lankelly Chase Foundation; 2015. Available from: <https://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf>

Cognitive impairment is increasingly recognised as both a cause and a consequence of MCN. Impairments in memory, concentration and executive functioning can reduce an individual's ability to engage with services, maintain stable housing, adhere to treatment plans, or manage daily living tasks. In turn, chaotic lifestyles, continued substance use, repeated withdrawal episodes, nutritional deficiencies and exposure to trauma further exacerbate cognitive decline. This interaction creates a reinforcing cycle in which cognitive impairment both contributes to, and is worsened by, social and health inequalities^{24, 25, 26}.

The evaluation also found that 83% had experienced three or more disadvantages and 62% had experienced four or more, indicating a level of cumulative adversity associated with poorer outcomes and heightened vulnerability to substance-related harm. Locally, service data from East Sussex providers (including Change Grow Live) contributed to a linked dataset identifying individuals where substance misuse is recorded as a primary need, supporting estimation of prevalence and characteristics of people who may be at risk of alcohol-related cognitive impairment.

Among individuals experiencing four MCNs, substance misuse was the most common need, suggesting a strong association between higher complexity and substance-related harm. The assessment further reports that people with MCN experience poor health outcomes, including avoidable deaths, and identifies key barriers to accessing support, such as difficulty navigating fragmented systems, limited trauma-informed practice, and capacity constraints in specialist services, which may contribute to delayed identification and support for conditions such as alcohol-related cognitive impairment.

The report notes evidence from the Fulfilling Lives programme indicating that service users can cost the public sector £28,800 per person per year, largely driven by crisis use (including emergency healthcare), reinforcing the case for more integrated provision and earlier identification of need.

Within this broader landscape, Alcohol-Related Brain Damage (ARBD) represents a spectrum of acquired brain injury associated with prolonged alcohol use and thiamine deficiency. Presentation ranges from subtle cognitive changes to more severe conditions such as Wernicke-Korsakoff syndrome. Evidence suggests that many individuals within the MCN cohort display symptoms consistent with ARBD; however, diagnosis is frequently missed or delayed. Contributing factors include fragmented service engagement, inconsistent recording within health systems, limited workforce awareness, and diagnostic pathways that are poorly aligned to the realities of alcohol dependence^{27, 28}.

²⁴ Public Health England. *Better care for people with co-occurring mental health and alcohol/drug use conditions: a guide for commissioners and service providers*. London: Public Health England; 2017. Available from: https://assets.publishing.service.gov.uk/media/5a75b781ed915d6faf2b5276/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

²⁵ Ramey T. Cognitive impairment in substance use disorders. *Addiction Science & Clinical Practice*. 2018;13(1):1. Available from: <https://pubmed.ncbi.nlm.nih.gov/articles/PMC6599555/>

²⁶ Erga AH. Patients with cognitive deficits and substance use disorders: a clinical population in need of focused attention. *Front Psychiatry*. 2023;14:10613487. Available from: <https://pubmed.ncbi.nlm.nih.gov/articles/PMC10613487/>

²⁷ Isenberg-Grzeda E, Kutner HE, Nicolson SE. Wernicke-Korsakoff syndrome: under-recognized and under-treated. *Psychosomatics*. 2012;53(6):507-16. Available from: <https://pubmed.ncbi.nlm.nih.gov/23157990/>

²⁸ Royal College of Psychiatrists. *Alcohol-related brain damage in Northern Ireland: treatment not just care*. College Report CR212. London: Royal College of Psychiatrists; 2018. Available from: <https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr2121829213d17e3461785bcb073c1529334.pdf>

The relationship between MCN and alcohol-related cognitive impairment is mutually reinforcing. Individuals experiencing MCN are at heightened risk of developing cognitive impairment due to prolonged alcohol use, poor nutrition, repeated detoxification and barriers to accessing care, including stigma and service fragmentation. Cognitive impairment, in turn, undermines recovery by reducing an individual's ability to sustain abstinence or reduced drinking, manage accommodation, engage with support services, or navigate complex systems. This deepens disadvantage and increases the likelihood of repeated crisis presentations, hospital admissions and homelessness. This cycle highlights the need for coordinated, multi-agency approaches that integrate substance use treatment, healthcare, social care and housing, with a focus on early identification and effective support for cognitive impairment.²⁹.

To better reflect the spectrum of harm and reduce diagnostic silos, the preferred terminology moving forward is Alcohol-Related Cognitive Impairment (ARCI), encompassing both ARBD and broader alcohol-associated cognitive decline.

Economic Evidence

Most economic evidence comes from broader studies of alcohol use disorder (AUD) and alcohol-related cognitive impairment rather than ARBD specifically.

Available evidence suggests that individuals with alcohol-related cognitive impairment have higher healthcare utilisation and costs prior to assessment and diagnosis. A Norwegian cohort study examining healthcare use before and after specialist cognitive assessment reported median annual healthcare costs of approximately €2,226 in the year prior to assessment, with substantial variation between individuals. Participants with AUD incurred around 50% higher healthcare costs than those without AUD (median €3,286 compared with €2,190), indicating increased use of healthcare services prior to recognition of cognitive impairment. This pattern is consistent with wider literature showing that people with alcohol-related cognitive challenges often experience fragmented care, repeated crisis presentations, and frequent use of emergency and acute services.

Following assessment and diagnostic recognition, the same study found that the difference in healthcare costs between individuals with and without AUD became negligible. This suggests that identification of cognitive impairment and access to appropriate post-diagnostic care may reduce excess healthcare utilisation, likely through improved care coordination, more appropriate service responses, and reduced reliance on crisis-led care. This finding aligns with evidence from alcohol harm and dementia-related literature, which indicates that early identification and structured support can reduce unplanned admissions, emergency department attendances, and avoidable hospital stays.

However, the current evidence base has significant limitations. There are no UK-specific cost-of-illness studies focused solely on ARBD or ARCI, and most studies report median costs, which may underestimate the financial impact of individuals with complex needs

²⁹ Schölin L, Rhynas S, Holloway A, Jepson R. Dual diagnosis, double stigma: a rapid review of experiences of living with alcohol-related brain damage. Alcohol Change UK; 2019 Jul 31. Available from: <https://s3.eu-west-2.amazonaws.com/sr-acuk-craft/documents/Dual-diagnosis-double-stigma-a-rapid-review-of-experiences-of-living-with-alcohol-related-brain-damage-Final-Report.pdf>

who experience repeated hospital admissions, prolonged lengths of stay, delayed discharges, or safeguarding involvement. ARBD is also frequently under-coded or misclassified as alcohol dependence alone, limiting the ability of routine data to capture true prevalence and associated costs. In addition, wider system costs related to housing instability, social care involvement, and delayed discharge are often excluded from healthcare-focused analyses.

Overall, the literature indicates that alcohol-related cognitive impairment is associated with increased healthcare costs prior to diagnosis, but that these excess costs may reduce following assessment and appropriate care. While published estimates suggest annual healthcare costs in the low thousands of euros for managed cases, real-world experience and broader alcohol harm evidence indicate that unrecognised or unmanaged ARBD can drive substantially higher costs through repeated crisis presentations and inefficient use of acute services. This supports the case for earlier identification, improved diagnostic coding, and targeted interventions to reduce avoidable healthcare utilisation.

Local Context

Local intelligence from the East Sussex Multiple Compound Needs Assessment (2025), while not explicitly diagnosing cognitive impairment, strongly supports the association between MCN, alcohol dependence and likely ARCI. The assessment identifies a cohort with high levels of alcohol dependence, poor mental health and unstable housing, with concentrations of need in Hastings and Eastbourne. These areas also experience the highest rates of alcohol-specific mortality and alcohol-related hospital admissions, indicating long-term, high-risk drinking patterns that increase susceptibility to cognitive impairment.

Frontline intelligence from the Alcohol Care Team (ACT) and Change Grow Live (CGL) further evidences this issue. Clinicians and practitioners report frequent presentations of individuals with memory loss, disorientation and impaired executive functioning, often without a formal diagnosis of ARCI. Many of these individuals experience repeated hospital admissions, difficulties adhering to care plans, and challenges securing or sustaining accommodation. Patterns consistent with findings from the MCN Needs Assessment.

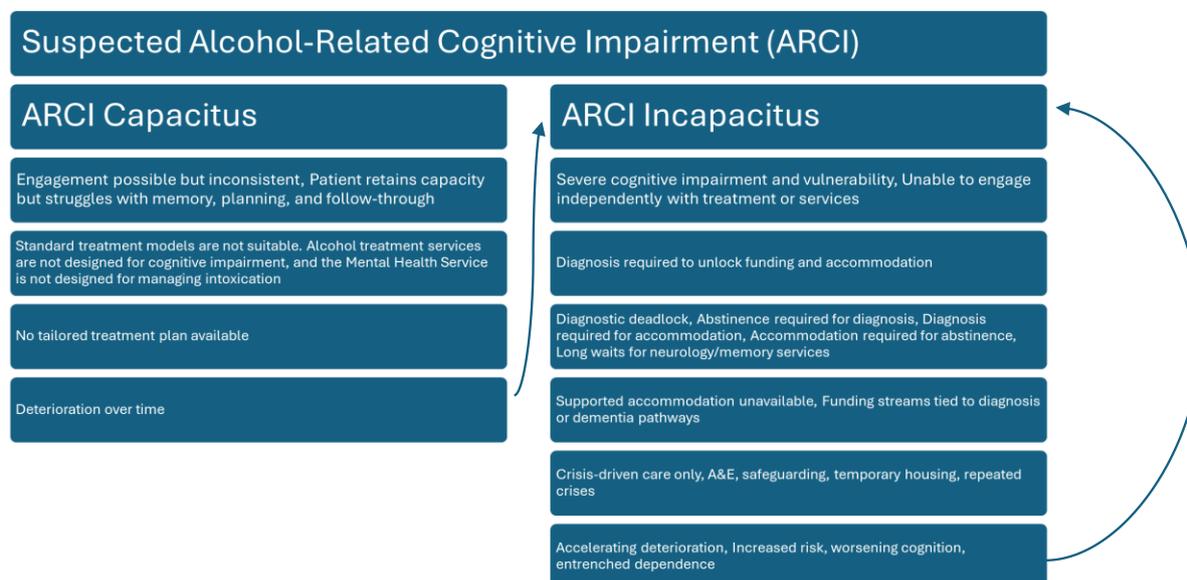
Hospital Episode Statistics (HES) and local treatment data suggest significant under-recording of ARCI, with relatively few coded diagnoses despite a clinical picture indicating a substantially higher underlying prevalence.

The Gap

There is a group of individuals living with Alcohol-Related Cognitive Impairment (ARCI) for whom current diagnostic and support pathways are inaccessible or ineffective. This group sits at the intersection of alcohol dependence, cognitive decline and multiple compound needs, and experiences persistently poor outcomes despite repeated contact with health and social care services.

Current System for People with ARCI

Present Pathway that has been observed:



Formal diagnosis of ARCI typically requires referral to Memory Clinics or Neurology services. However, access to these pathways is constrained by several structural limitations:

- Memory Clinics are unable to undertake assessments where an individual is intoxicated at the time of appointment.
- General Practitioners are not able to diagnose ARCI within primary care.
- Neurology referrals often involve waiting times of up to three years, during which time individuals may experience significant cognitive and functional deterioration.

A central barrier across these pathways is the requirement for abstinence at the point of assessment. For individuals who are alcohol-dependent, achieving and sustaining abstinence without appropriate support is extremely challenging. This is further compounded by the widespread availability of alcohol and the absence of consistent alcohol policies within supported accommodation. While many settings operate clear restrictions in relation to illicit substances, there is no equivalent, standardised approach to alcohol, enabling continued access and use.

Differentiation within the ARCI Population

It is important to recognise that ARCI does not present uniformly, and that barriers to diagnosis and support vary by severity.

For individuals with emerging or mild-moderate cognitive impairment, stabilisation or abstinence at the time of assessment can often be achieved through existing specialist alcohol treatment services, including community-based provision

delivered by Change Grow Live (CGL). For this group, engagement with cognitive assessment and onward support may be feasible without specialist accommodation, and current pathways may be sufficient.

However, there exists a smaller but highly vulnerable cohort whose cognitive impairment has progressed to a level where memory, executive functioning and decision-making capacity are significantly compromised. In this group, the expectation of abstinence at the point of assessment becomes unrealistic without a higher level of structured support. Cognitive impairment itself undermines the ability to plan, self-regulate, adhere to detoxification regimes, or sustain abstinence for long enough to access diagnostic services.

This cohort is disproportionately affected by repeated hospital admissions, failed discharges, homelessness and disengagement from services. Fluctuating or declining mental capacity further complicates engagement with standard treatment models and increases the likelihood of crisis-driven care.

Dependence on Diagnosis-Led Support

For individuals with advanced ARCI, access to diagnosis and effective care is structurally dependent on specialist support and accommodation capable of providing stability, nutritional support and either managed alcohol or abstinence-focused environments. Yet access to such provision frequently relies on the presence of a confirmed diagnosis and the diagnosis confirms the funding stream.

This creates a **systemic catch-22** where individuals cannot access the environments required to achieve abstinence without a diagnosis but cannot obtain a diagnosis without achieving abstinence.

This gap affects a small but high-impact population whose needs cannot be met through existing community-based alcohol treatment services alone.

Limitations of Residential Rehabilitation

It is also important to note that this cohort is not typically able to access residential rehabilitation services. Most rehabilitation settings require a minimum level of cognitive functioning, insight and capacity to engage in structured therapeutic programmes. For individuals with advanced ARCI, these thresholds are often unattainable until a degree of cognitive and physical recovery has already occurred, further narrowing available pathways and reinforcing exclusion from care.

Abstinence as Treatment

Abstinence from alcohol is the primary intervention for improving cognitive function in ARCI. Evidence indicates that, with sustained abstinence, nutritional support and appropriate care, cognitive functioning can stabilise and partially recover.

However, for individuals with advanced cognitive impairment, the deficits caused by ARCI, particularly impaired memory, reduced executive functioning and

diminished capacity, significantly limit the ability to achieve and maintain abstinence independently.

In these cases, abstinence is not simply a treatment goal but a treatment outcome that depends on the availability of the right environment and support.

For this cohort, achieving abstinence often requires specialist accommodation and integrated care, rather than standard community-based treatment alone. Without this, individuals remain trapped in a cycle of continued alcohol use, cognitive deterioration and repeated crisis presentations, despite abstinence being the key therapeutic intervention.

Implications for the System

This systemic gap leaves individuals without appropriate assessment, treatment or care and places sustained pressure on treatment and recovery services, which are forced to manage deterioration rather than enable recovery for this cohort.

The data gathered through this project will provide robust evidence of unmet need and the structural barriers embedded within the current system. This evidence will be used to demonstrate the necessity for system change, including:

- Earlier identification of alcohol-related cognitive impairment
- Alternative and pragmatic diagnostic approaches
- Workforce development and training
- The development of appropriate supported accommodation pathways for people living with ARCI

Collectively, these changes are essential to breaking cycles of repeated crisis, improving outcomes for individuals with Multiple Compound Needs, and enabling more stable recovery and independent living.

Coding and Recording of Alcohol-Related Cognitive Impairment

ARCI is not recognised as a single diagnostic category within ICD-10. As a result, individuals living with alcohol-related cognitive impairment are recorded across a range of diagnostic codes that reflect specific clinical presentations rather than the underlying, alcohol-related aetiology. This fragmentation limits the visibility of ARCI within routine datasets and contributes to significant under-identification at both local and national levels.

To address this limitation, an agreed proxy definition of Alcohol-Related Cognitive Impairment (ARCI) has been applied for the purposes of this analysis. This definition draws together the relevant ICD-10 codes that collectively capture alcohol-related cognitive and neurological harm within Hospital Episode Statistics (HES) and Sussex Integrated Dataset (SID). These codes reflect conditions commonly associated with prolonged alcohol use and thiamine deficiency and are consistent with clinical descriptions of ARCI and ARBD.

ICD-10 codes identified within HES include:

- E51.2 - Wernicke's encephalopathy
- F10.6 - Alcohol amnesic syndrome
- F10.7 - Alcohol-related residual and late-onset psychotic disorder
- G31.2 - Degeneration of nervous system due to alcohol (including cerebellar atrophy)
- G62.1 - Alcoholic polyneuropathy

ICD-10 codes identified within SID include:

- E512 - Wernicke's disease
- F106 - Korsakoff's psychosis
- F107 - Dementia associated with alcoholism
- G312 - Alcohol-induced cerebellar ataxia
- G621 - Chronic alcoholic brain syndrome

The necessity to use multiple ICD-10 codes as proxies highlights a key data and system challenge. ARCI is likely to be substantially under-recorded, as cognitive impairment may be coded under acute presentations, mental health diagnoses, or alcohol dependence alone, without capturing the associated neurological harm. This limits the ability to quantify prevalence, track pathways, and plan services effectively.

Improving recognition, recording and consistent use of ARCI-related codes, alongside workforce training and clearer diagnostic pathways, will be essential to strengthening local intelligence and ensuring that individuals with alcohol-related cognitive impairment are identified earlier and supported more appropriately across the system.

Drug and Alcohol Specialist Service versus ARBD specific service findings

Evidence from local service intelligence and frontline practice indicates that the challenge is not a lack of existing drug and alcohol treatment provision, but a mismatch between current service models and the needs of a small cohort of individuals with more advanced Alcohol-Related Cognitive Impairment (ARCI). Community-based alcohol treatment services are effective for the majority of people with alcohol dependence, including those with emerging or mild-moderate cognitive impairment, and remain a critical component of the local system.

The primary gap identified relates to workforce awareness, confidence and capability in recognising alcohol-related cognitive impairment. While cognitive

difficulties are frequently observed in practice, they are not consistently identified, recorded or escalated as a distinct clinical concern. Upskilling the workforce in ARCI awareness, screening and functional recognition would support earlier identification and more appropriate referral, reducing reliance on crisis-driven responses.

A further gap relates to clarity of diagnostic referral pathways. Current routes to diagnosis are complex, fragmented and poorly aligned to the needs of people with alcohol dependence, resulting in delays or missed diagnoses. Clear, pragmatic referral pathways, supported by shared understanding across health, social care and substance use services, are required to ensure timely assessment and to define clinical responsibility at each stage.

Finally, where community-based treatment is insufficient, particularly for individuals with advanced cognitive impairment, there is a lack of clarity around commissioning and funding responsibility for enhanced support, including specialist supported accommodation. The absence of defined pathways creates uncertainty over who holds responsibility for funding and coordinating care, contributing to service drift and unmet need. Addressing this requires system-level agreement on thresholds, responsibilities and funding mechanisms, rather than changes to existing drug and alcohol services themselves.

Hospital Episode Statistics Data

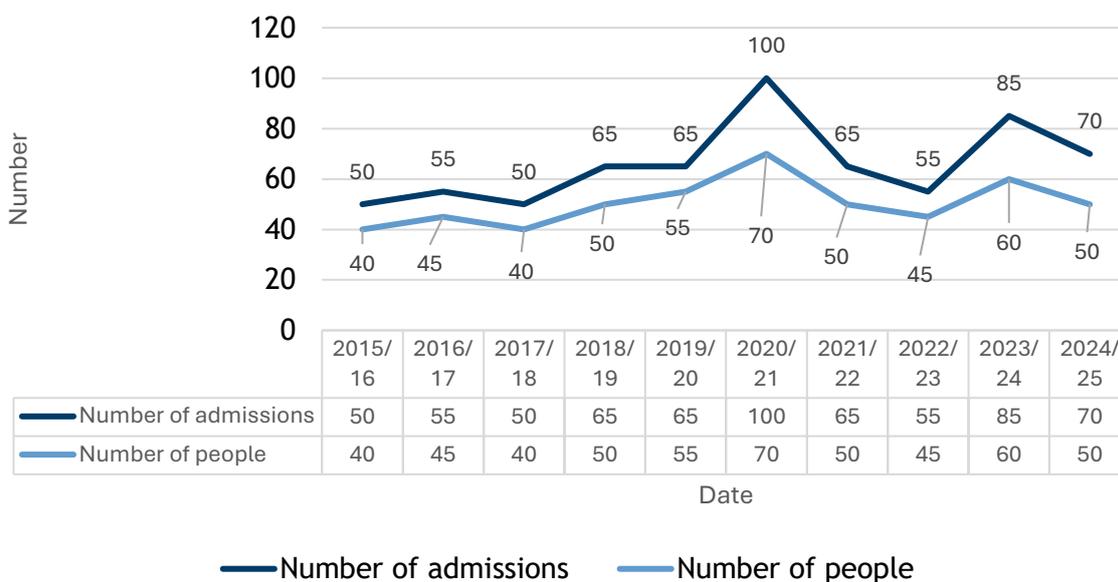
Hospital Episode Statistics (HES) is a national administrative dataset that records all NHS hospital admissions in England. In this analysis, HES inpatient data were used to examine hospital activity related to alcohol-related cognitive impairment (ARCI) among residents of East Sussex, providing insight into acute presentations and demand on hospital services.

Hospital admissions for ARCI were defined as first finished admission episodes among patients resident in East Sussex with any recorded mention of an ARCI-related diagnosis. Diagnoses were identified using the following ICD-10 codes: E51.2, F10.6, F10.7, G31.2, and G62.1. Admissions occurring at any point during the ten-year period from 2015/16 to 2024/25 were included.

In line with HES data governance requirements, all sub-national counts of admissions and patients were rounded to the nearest five and counts between one and seven were suppressed. Proportions were calculated using rounded counts, while directly age-standardised rates were calculated using unrounded counts to ensure statistical accuracy.

Hospital admission episodes do not represent unique individuals; the same person may have multiple admissions within or across years, meaning admission counts may exceed the number of people affected. All data was sourced from Hospital Episode Statistics, NHS England, and accessed by East Sussex Public Health.

Number of hospital admissions, East Sussex, 2015/16 to 2024/25

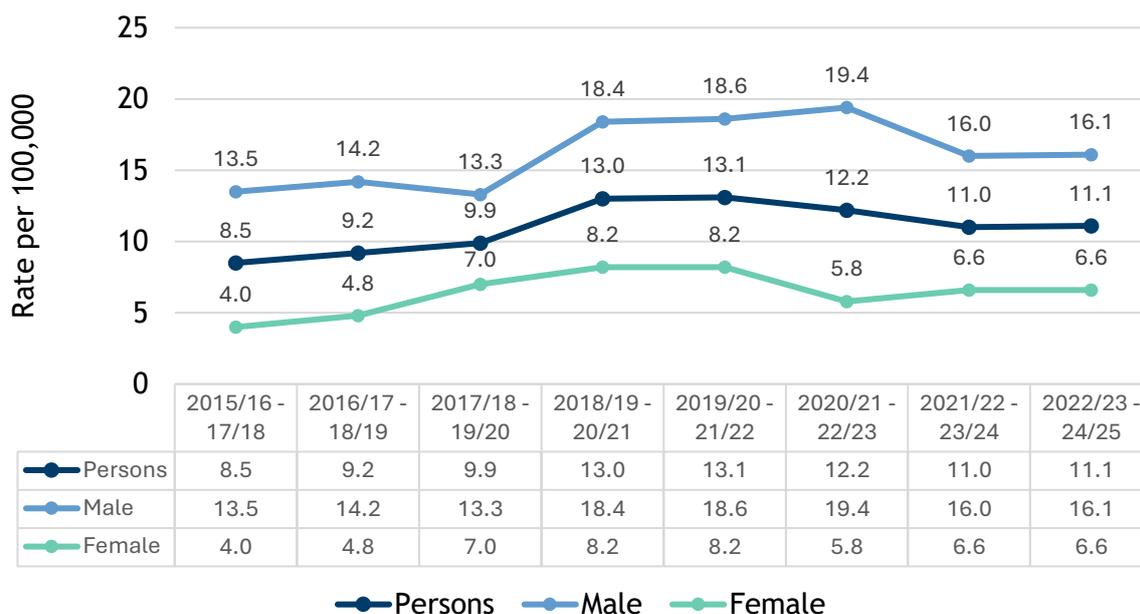


In the past 10 years, there were 660 hospital admissions with a mention of ARCI (in any diagnostic field) in East Sussex. There was a yearly average of 66 admissions and on average, 50 patients were admitted each year with ARBD.

| Year | Number of admissions | | | Year | Number of people | | |
|--------------|----------------------|------------|------------|--------------|------------------|------------|------------|
| | Males | Females | Total | | Males | Females | Total |
| 2015/16 | 35 | 10 | 50 | 2015/16 | 25 | 10 | 40 |
| 2016/17 | 40 | 10 | 55 | 2016/17 | 35 | 10 | 45 |
| 2017/18 | 35 | 15 | 50 | 2017/18 | 30 | 15 | 40 |
| 2018/19 | 45 | 20 | 65 | 2018/19 | 35 | 15 | 50 |
| 2019/20 | 35 | 30 | 65 | 2019/20 | 25 | 30 | 55 |
| 2020/21 | 75 | 25 | 100 | 2020/21 | 50 | 15 | 70 |
| 2021/22 | 45 | 20 | 65 | 2021/22 | 35 | 15 | 50 |
| 2022/23 | 45 | 10 | 55 | 2022/23 | 35 | 10 | 45 |
| 2023/24 | 50 | 35 | 85 | 2023/24 | 35 | 25 | 60 |
| 2024/25 | 50 | 20 | 70 | 2024/25 | 40 | 10 | 50 |
| Total | 460 | 200 | 660 | Total | 340 | 160 | 505 |

Across, the 10-year period, 70% of admissions were males. The average age of ARBD admissions was 61.4 years (females = 62.3 years Males = 61 years).

Directly age standardised rate (per 100,000 population) of admissions, East Sussex



Readmissions, 2015/16 to 2024/25

Number of ARCI (any mention) admissions per patient 2015/16 to 2024/25

| Number of admissions | Number of patients | Percentage of patients |
|----------------------|--------------------|------------------------|
| 1 admission | 265 | 68% |
| 2 admissions | 65 | 17% |
| 3 admissions | 30 | 8% |
| 4 admissions | 10 | 3% |
| 5 or more admissions | 20 | 5% |

| | | |
|--------------|------------|-------------|
| Total | 390 | 100% |
|--------------|------------|-------------|

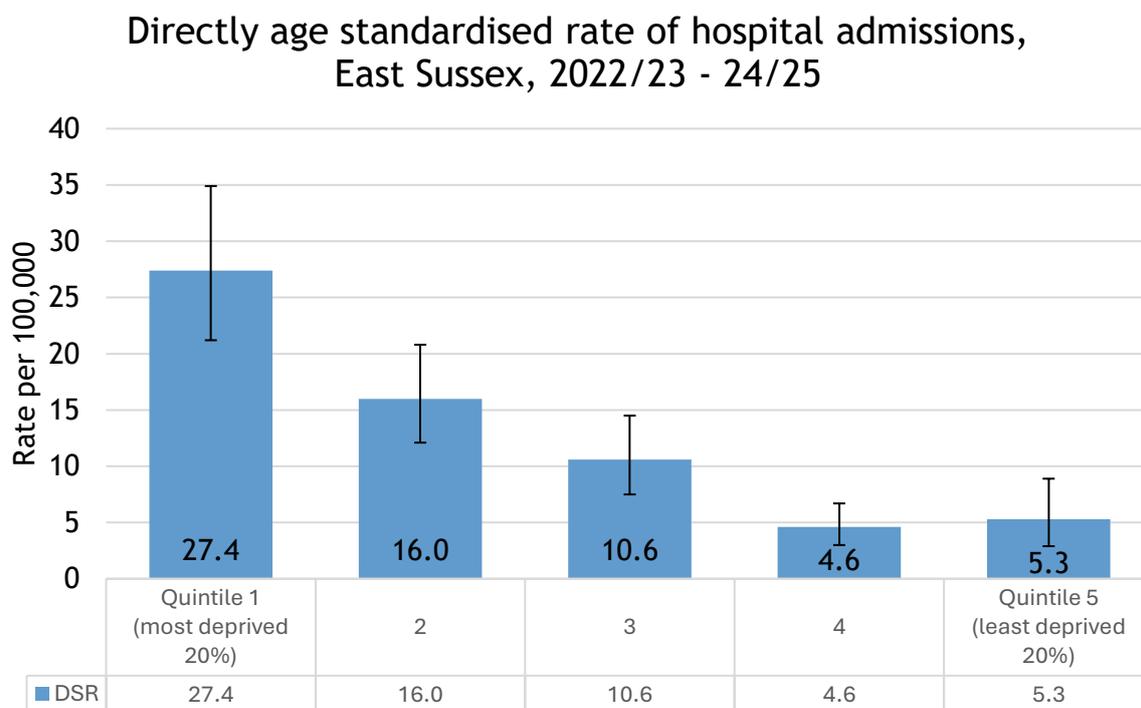
Types of admission

The majority of the 660 ARCI admissions were emergency admissions (87%, 575 admissions). The site with the most admissions was the Conquest Hospital in Hastings (310 admissions, 47%).

| Trust | Number of admissions | Percentage of Admissions |
|-----------------|----------------------|--------------------------|
| Conquest | 310 | 47% |
| EDGH | 210 | 32% |
| Total | 660 | |

7.2 Deprivation

Directly age standardised rate of hospital admissions for ARBD (any mention) in East Sussex by national Index of Multiple Deprivation (2025) quintiles.



Sussex Integrated Data

Sussex Integrated Data (SID) is a locally linked, person-level dataset that brings together health and care records across Sussex, including primary care, secondary care, and community services. SID was used in this analysis to identify unique individual residents in East Sussex with a recorded diagnosis sitting under the umbrella term of alcohol-related cognitive impairment, providing a broader view of diagnosed prevalence beyond hospital admissions.

ARCI cases were identified using ICD-10-aligned diagnostic codes recorded within SID: E512 (Wernicke’s disease), F106 (Korsakoff’s psychosis), F107 (Dementia associated with alcoholism), G312 (Alcohol-induced cerebellar ataxia), and G621 (Chronic alcoholic brain syndrome). Any individual with a recorded diagnosis at any point within the period analysed was included (2015/16 to 2024/25).

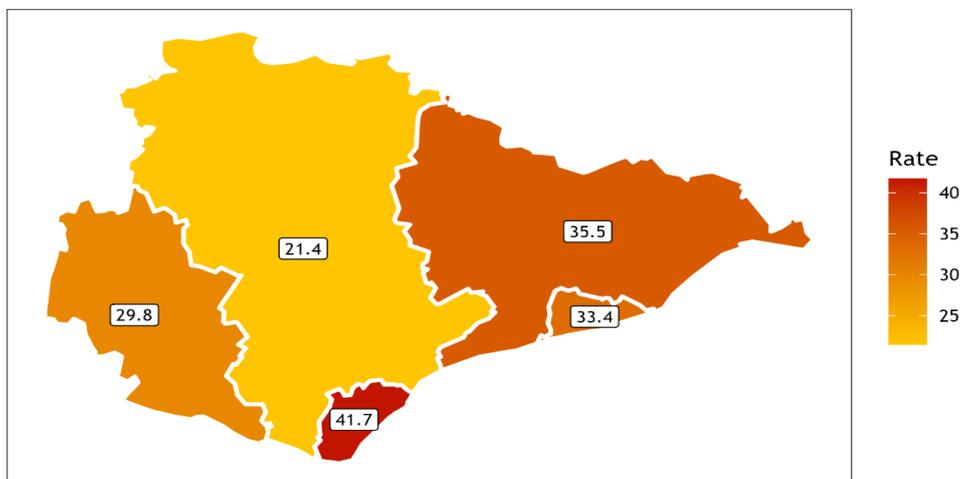
Counts derived from SID represent people rather than admission episodes, allowing identification of individuals who may not appear in hospital data. Data was accessed and analysed by East Sussex Public Health in line with local information governance requirements.

ARCI by location

Rates of alcohol-related cognitive brain damage vary across East Sussex, with clear differences between local authority areas. Higher rates are concentrated in more urban parts of the county, while lower rates are observed in more rural districts. This geographic pattern suggests that alcohol-related cognitive harm is shaped by place and local context, rather than being evenly distributed across the county.

In the below figures, “Persons” represents the age-standardised rate for the total population, calculated using all recorded cases and the combined population. It is included to show the overall burden of alcohol-related cognitive impairment, rather than an average of male and female rates.

Alcohol-Related Cognitive Impairment in East Sussex, Persons,
by Lower Tier Local Authority - Rate per 100,000
Resident/Registered Population



Source: SID

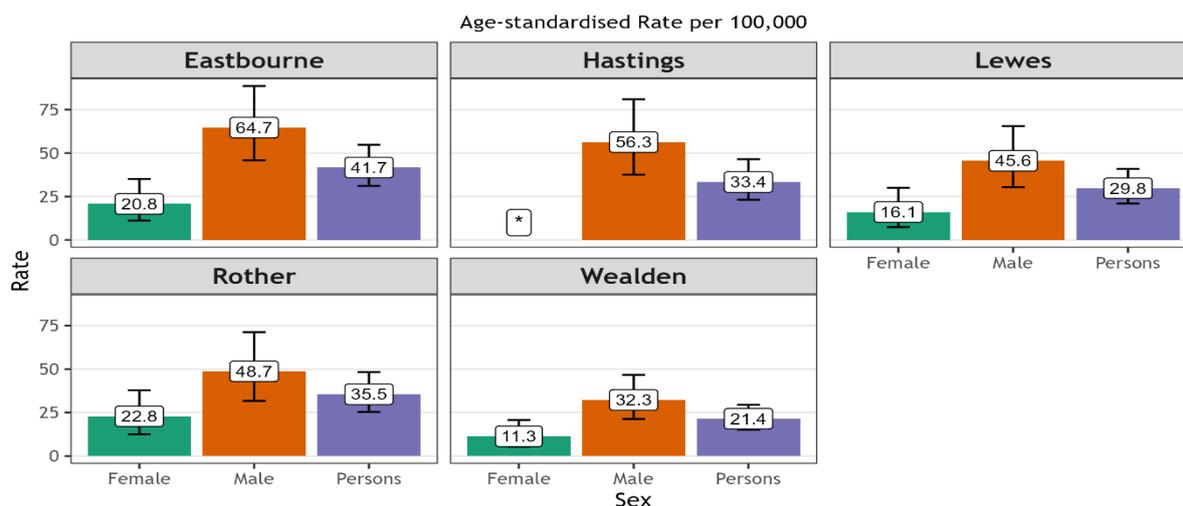
Examining age-standardised rates by sex adds important nuance to the geographic picture, Examining age-standardised rates by sex provides important insight into how alcohol-related cognitive impairment is distributed across local authority areas.

Across all local authority areas, rates are substantially higher among males than females, indicating a consistent male predominance. As a result, male prevalence contributes disproportionately to the overall population rate and drives much of the variation observed between areas.

However, the geographic distribution of recorded prevalence does not fully align with expected deprivation patterns. In particular, Eastbourne records higher male and overall rates than Hastings, despite Hastings having higher levels of deprivation; a similar pattern is also observed among females.

This suggests that recorded prevalence reflects not only underlying need, but also variation in identification, diagnostic pathways, engagement with services, and local population characteristics.

Alcohol-Related Cognitive Impairment in East Sussex, by LTLA

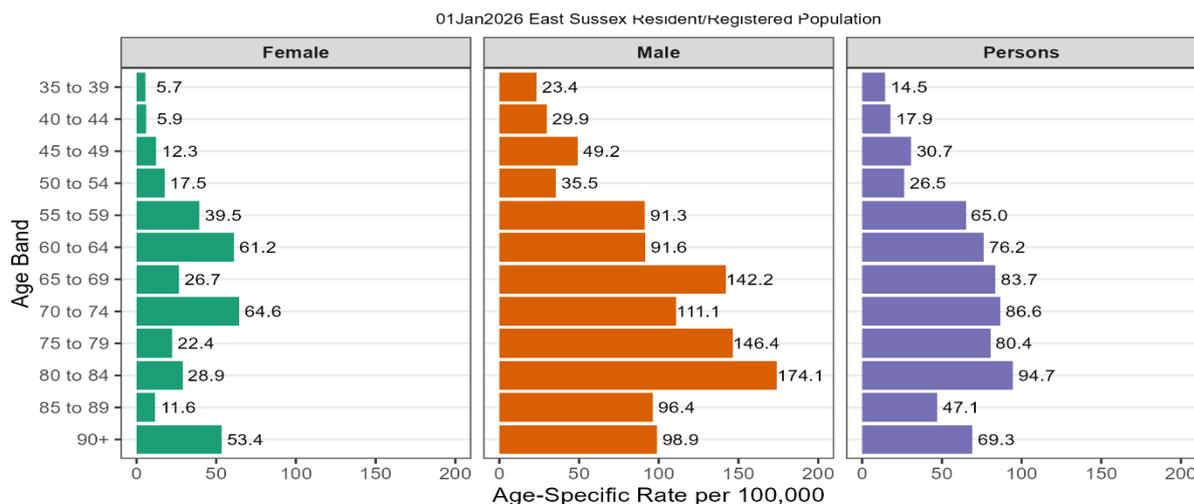


* n < 10 - cannot be calculated
Any res/reg patient ever having had a diagnosis

ARCI by Age and Sex

Age-specific rates of alcohol-related cognitive impairment show that harm is evident from mid-adulthood, with recorded prevalence present from as early as ages 35-39 for both males and females. Rates increase through the 40s followed by a more pronounced increase from the mid-50s onwards. Rates peak in the 80-84 age group before declining in the oldest age bands, likely reflecting increased mortality and survivorship effects at older ages rather than a true reduction in underlying risk. Overall, the pattern reflects the cumulative impact of long-term alcohol-related harm across the life course.

Alcohol-Related Cognitive Impairment in East Sussex by Age-Specific Rates



Source: SID
Any res/reg patient ever having had a diagnosis

Public Health Outcomes Framework Data

[Fingertips | Department of Health and Social Care](#)

The alcohol-specific hospital admissions (narrow definition) indicator from Public Health Fingertips is the most appropriate proxy for the ICD-10 codes associated with (ARBD, such as E51.2 (Wernicke’s encephalopathy), F10.6 (Alcohol amnesic syndrome), F10.7 (Alcohol-related residual and late-onset psychotic disorder), G31.2 (Degeneration of nervous system due to alcohol), and G62.1 (Alcoholic polyneuropathy)). This is because the indicator includes conditions that are wholly attributable to alcohol, which covers these neurological and psychiatric conditions. While Fingertips does not report each ICD-10 code individually, the alcohol-specific definition encompasses these codes, making it the closest available population-level measure for ARBD-related harm via this Database.

We are not including under-18s data because the neurological and psychiatric conditions associated with ARBD (e.g., Wernicke’s encephalopathy, alcoholic polyneuropathy) typically develop after prolonged, heavy alcohol use, which is unlikely to occur in younger age groups.

| Code | Description |
|-------|-------------------------------------------------------------------------|
| E24.4 | Alcohol-induced pseudo-Cushing’s syndrome |
| E51.2 | Wernicke’s encephalopathy |
| F10 | Mental and behavioural disorders due to alcohol (includes F10.6, F10.7) |
| G31.2 | Degeneration of nervous system due to alcohol |
| G62.1 | Alcoholic polyneuropathy |
| G72.1 | Alcoholic myopathy |
| I42.6 | Alcoholic cardiomyopathy |
| K29.2 | Alcoholic gastritis |
| K70 | Alcoholic liver disease |

| | |
|---------------|------------------------------------------------------------------------------|
| K85.2 | Alcohol-induced acute pancreatitis |
| K86.0 | Alcohol-induced chronic pancreatitis |
| Q86.0 | Foetal alcohol syndrome |
| R78.0 | Excess alcohol blood levels |
| T51.* | Toxic effects of alcohol (ethanol, methanol, unspecified) |
| X45, X65, Y15 | Poisoning by and exposure to alcohol (accidental, intentional, undetermined) |
| Y90, Y91 | Evidence of alcohol involvement |

(*Some codes apply to hospital admissions but not mortality measures.)

Of the measure available on Public Health Fingertips, we identified four potentially relevant indicators.

1. Admission episodes for alcohol-specific conditions (persons) (2023/24)
2. Admission episodes for mental and behavioural disorders due to alcohol (narrow) (persons) (2023/24)
3. Admission episodes for alcohol liver disease (broad) (persons) (2023/24)
4. The proportion of clients entering alcohol treatment identified as having a mental health treatment need, who were receiving treatment for their mental health (2023/24)

Admission episodes for alcohol-specific conditions (persons) (2023/24)

Within East Sussex, there is significant variation in alcohol-specific hospital admission rates. Hastings have rates that are significantly worse than the England average, indicating a high burden of alcohol specific harm. Eastbourne, Lewes and Rother are similar to the national average, while Wealden performs significantly better, suggesting comparatively lower levels of harm. Although most districts show a decreasing trend, Eastbourne and Hastings remain priority areas for targeted interventions.

Better 95% **Similar** **Worse 95%** **Not compared**

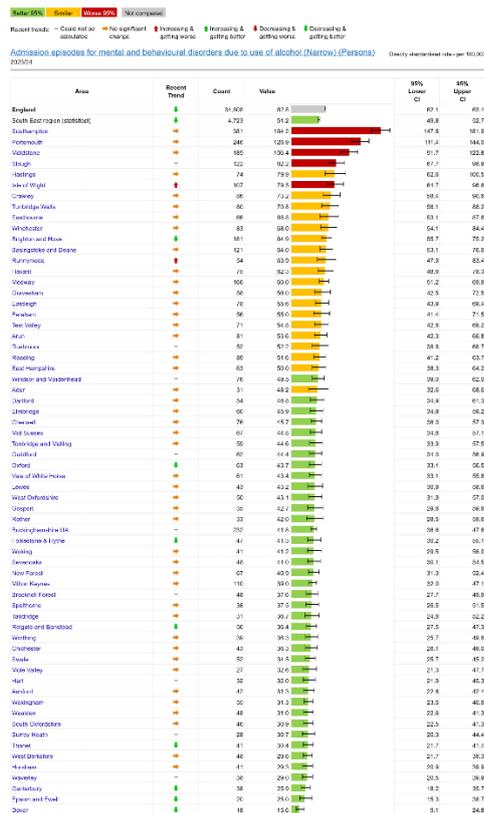
Recent trend: → Could not be calculated ↔ No significant change ↑ Increasing & getting worse ↓ Increasing & getting better ↘ Decreasing & getting worse ↙ Decreasing & getting better

Admission episodes for alcohol-specific conditions (Persons) 2023/24 Directly standardised rate - per 100,000

| Area | Recent Trend | Count | Value | 95% Lower CI | 95% Upper CI |
|---------------------------------|--------------|---------|-------|--------------|--------------|
| England | → | 339,916 | 612 | 610 | 614 |
| South East region (statistical) | ↓ | 48,649 | 521 | 516 | 526 |
| Southampton | ↓ | 3,645 | 1,713 | 1,657 | 1,770 |
| Portsmouth | ↓ | 1,727 | 932 | 888 | 978 |
| Eastleigh | ↓ | 1,087 | 778 | 733 | 828 |
| New Forest | ↓ | 1,547 | 756 | 717 | 797 |
| Hastings | ↔ | 666 | 754 | 669 | 813 |
| Spelthorne | ↔ | 730 | 719 | 667 | 773 |
| Gravesham | ↔ | 705 | 700 | 649 | 753 |
| Test Valley | ↓ | 968 | 696 | 653 | 742 |
| Winchester | ↔ | 889 | 677 | 633 | 723 |
| Runnymede | ↓ | 566 | 676 | 621 | 735 |
| Gosport | ↔ | 546 | 650 | 596 | 708 |
| Basingstoke and Deane | ↓ | 1,185 | 638 | 602 | 675 |
| Dartford | ↔ | 650 | 633 | 585 | 685 |
| Isle of Wight | ↔ | 944 | 628 | 588 | 671 |
| Crawley | ↔ | 647 | 618 | 570 | 668 |
| Malden | ↔ | 1,088 | 611 | 575 | 648 |
| Rushmoor | ↔ | 586 | 609 | 560 | 661 |
| Woking | ↔ | 565 | 584 | 537 | 635 |
| Anan | ↓ | 1,035 | 582 | 546 | 620 |
| Slough | ↔ | 777 | 580 | 538 | 625 |
| Brighton and Hove | ↔ | 1,518 | 579 | 549 | 600 |
| Eastbourne | ↔ | 583 | 597 | 521 | 615 |
| Guildford | ↔ | 768 | 561 | 522 | 602 |
| Oxford | ↓ | 685 | 524 | 484 | 566 |
| Turbridge Walls | ↓ | 594 | 522 | 480 | 566 |
| Havant | ↓ | 682 | 522 | 482 | 563 |
| East Hampshire | ↔ | 704 | 509 | 471 | 549 |
| Chichester | ↓ | 708 | 504 | 467 | 544 |
| Windsor and Maidenhead | ↔ | 765 | 499 | 464 | 536 |
| Adur | ↔ | 340 | 499 | 446 | 555 |
| Epsom | ↔ | 675 | 495 | 458 | 534 |
| Wokingham | ↔ | 564 | 489 | 449 | 531 |
| Surrey Heath | ↔ | 452 | 486 | 442 | 533 |
| Fareham | ↓ | 585 | 481 | 442 | 523 |
| Cherwell | ↔ | 759 | 469 | 436 | 503 |
| Torbridge and Malling | ↔ | 600 | 454 | 419 | 492 |
| Thanet | ↓ | 656 | 449 | 414 | 485 |
| Reading | ↓ | 672 | 446 | 412 | 482 |
| Rother | ↔ | 427 | 443 | 400 | 490 |
| Lewes | ↔ | 479 | 437 | 388 | 479 |
| Buckinghamshire UK | ↔ | 2,379 | 428 | 411 | 448 |
| Sevenoaks | ↔ | 523 | 425 | 389 | 464 |
| Wealden | ↔ | 758 | 415 | 385 | 446 |
| West Oxfordshire | ↔ | 502 | 410 | 374 | 447 |
| Folkestone & Hythe | ↓ | 477 | 407 | 371 | 446 |
| Mid Sussex | ↔ | 636 | 404 | 373 | 437 |
| Dover | ↔ | 511 | 403 | 368 | 440 |
| Medway | ↔ | 1,085 | 401 | 377 | 425 |
| Vale of White Horse | ↔ | 559 | 397 | 364 | 431 |
| Bracknell Forest | ↔ | 472 | 393 | 358 | 430 |
| Regate and Binstead | ↓ | 563 | 391 | 360 | 424 |
| South Oxfordshire | ↔ | 583 | 382 | 351 | 414 |
| Tandridge | ↔ | 348 | 381 | 342 | 424 |
| Waverley | ↔ | 511 | 380 | 348 | 415 |
| Canterbury | ↓ | 584 | 380 | 350 | 413 |
| Milton Keynes | ↓ | 684 | 365 | 342 | 389 |
| Mole Valley | ↓ | 334 | 357 | 319 | 398 |
| Swale | ↔ | 531 | 351 | 322 | 383 |
| Hart | ↔ | 358 | 349 | 314 | 387 |
| Horsham | ↔ | 513 | 334 | 305 | 364 |
| West Berkshire | ↔ | 549 | 333 | 308 | 363 |
| Ashford | ↔ | 427 | 317 | 288 | 349 |
| Epsom and Ewell | ↓ | 200 | 259 | 224 | 298 |
| Wokingham | ↓ | 442 | 255 | 232 | 281 |

Admission episodes for mental and behavioural disorders due to the use of alcohol (Narrow) (Persons) (2023/24)

Admission rates for mental and behavioural disorders due to alcohol (narrow definition) show East Sussex districts performing differently across the county. Hastings and have the highest rates locally, with Hastings significantly above the England average and Eastbourne similar to the national level. Lewes, Rother, and Wealden are all significantly better than the England average, indicating lower levels of alcohol-related psychiatric harm. Most districts show no significant recent trend, suggesting stable patterns over time. Hastings remains a clear outlier and priority for targeted mental health and alcohol interventions.



Admission episodes for alcoholic liver disease (Broad) (Persons) (2023/24)

People with conditions recorded under ICD-10 codes associated with ARBD (such as Wernicke’s encephalopathy, alcoholic polyneuropathy, and alcohol-related psychotic disorders) are more likely to develop alcoholic liver disease because both share the same underlying cause: prolonged, heavy alcohol consumption. Chronic alcohol use affects multiple organ systems simultaneously, so neurological damage and liver disease often co-occur in individuals with long-term harmful drinking patterns.

Although alcoholic liver disease is not a direct measure of ARBD, it serves as a useful proxy for the level of chronic alcohol harm in a population. High rates of alcoholic liver disease admissions indicate sustained heavy drinking patterns, which are strongly associated with the development of ARBD-related conditions

Admission rates for alcoholic liver disease (broad definition) in East Sussex districts show a mixed picture. Eastbourne and Hastings are similar to the England average indicating a substantial burden of liver-related harm. Lewes and Rother are slightly better, while Wealden performs significantly better than the national average. Most districts show no significant recent trend. The data reinforces that Eastbourne and Hastings remain priority areas for reducing alcohol-related harm, particularly liver disease.

Additional information for alcohol flow classes (2023/24) (2023/24)

| Area | Count | Value | 95% Lower CI | 95% Upper CI |
|---------------------------------|--------|-------|--------------|--------------|
| England | 38,971 | 83.4 | 83.1 | 83.8 |
| South East region (statistical) | 5,064 | 82.5 | 81.5 | 83.4 |
| Portsmouth | 92 | 48.9 | 41.9 | 56.0 |
| Brighton and Hove | 191 | 70.7 | 65.1 | 75.8 |
| Medway | 118 | 70.7 | 63.4 | 77.0 |
| Wokingham | 82 | 71.3 | 61.0 | 79.7 |
| Isle of Wight | 125 | 74.4 | 67.3 | 80.4 |
| Southampton | 174 | 78.0 | 72.1 | 83.0 |
| Kent | 800 | 78.9 | 76.3 | 81.3 |
| Windsor and Maidenhead | 84 | 80.0 | 71.4 | 86.5 |
| Slough | 65 | 80.2 | 70.3 | 87.5 |
| Buckinghamshire UA | 304 | 81.5 | 77.2 | 85.1 |
| West Berkshire | 82 | 81.6 | 71.4 | 88.7 |
| Milton Keynes | 121 | 82.3 | 75.3 | 87.6 |
| Bracknell Forest | 44 | 83.0 | 70.8 | 90.8 |
| West Sussex | 482 | 84.9 | 81.7 | 87.7 |
| East Sussex | 346 | 85.4 | 81.7 | 88.5 |
| Hampshire | 550 | 86.3 | 83.5 | 88.8 |
| Surrey | 942 | 89.7 | 87.7 | 91.4 |
| Reading | 102 | 90.3 | 83.4 | 94.5 |
| Oxfordshire | 420 | 95.5 | 93.1 | 97.0 |

The proportion of clients entering alcohol treatment identified as having a mental health treatment need, who were receiving treatment for their mental health (2023/24)

In 2023/24, 85.4% of clients entering alcohol treatment in East Sussex who had a mental health need were receiving treatment for their mental health. This is slightly above both the Southeast regional average (82.5%) and the England average (83.4%). East Sussex falls within the “similar” (yellow) band, meaning its performance is not significantly different from the regional average.

Better 95% Similar Worse 95% Not compared

Recent trends: — Could not be calculated — No significant change ↑ Increasing & getting worse ↓ Decreasing & getting better ↕ Increasing & getting better ↘ Decreasing & getting worse ↙ Decreasing & getting better

The proportion of clients entering alcohol treatment identified as having a mental health treatment need, who were receiving treatment for their mental health, 2023/24

Proportion - %

| Area | Recent Trend | Count | Value | 95% Lower CI | 95% Upper CI |
|---------------------------------|--------------|--------|-------|--------------|--------------|
| England | — | 38,971 | 83.4 | 83.1 | 83.8 |
| South East region (statistical) | — | 5,064 | 82.5 | 81.5 | 83.4 |
| Portsmouth | — | 92 | 48.9 | 41.9 | 56.0 |
| Brighton and Hove | — | 191 | 70.7 | 65.1 | 75.8 |
| Medway | — | 118 | 70.7 | 63.4 | 77.0 |
| Wokingham | — | 82 | 71.3 | 61.0 | 79.7 |
| Isle of Wight | — | 125 | 74.4 | 67.3 | 80.4 |
| Southampton | — | 174 | 78.0 | 72.1 | 83.0 |
| Kent | — | 800 | 78.9 | 76.3 | 81.3 |
| Windsor and Maidenhead | — | 84 | 80.0 | 71.4 | 86.5 |
| Slough | — | 65 | 80.2 | 70.3 | 87.5 |
| Buckinghamshire UA | — | 304 | 81.5 | 77.2 | 85.1 |
| West Berkshire | — | 82 | 81.6 | 71.4 | 88.7 |
| Milton Keynes | — | 121 | 82.3 | 75.3 | 87.6 |
| Bracknell Forest | — | 44 | 83.0 | 70.8 | 90.8 |
| West Sussex | — | 482 | 84.9 | 81.7 | 87.7 |
| East Sussex | — | 346 | 85.4 | 81.7 | 88.5 |
| Hampshire | — | 550 | 86.3 | 83.5 | 88.8 |
| Surrey | — | 942 | 89.7 | 87.7 | 91.4 |
| Reading | — | 102 | 90.3 | 83.4 | 94.5 |
| Oxfordshire | — | 420 | 95.5 | 93.1 | 97.0 |

East Sussex Services Data

In October 2025, East Sussex County Council reached out to service providers in East Sussex, to build an understanding of what data already exists about ARBD in a local context. Responses were received from the following services: East Sussex Memory Clinics, Sussex Partnership NHS Foundation Trust, East Sussex Healthcare NHS Trust, Change Grow Live and Drug and Alcohol Related Deaths.

These services could not provide any data relating to ARBD, for a number of reasons:

- Data on ARBD is not recorded.
- There is not a formal pathway for ARBD, and therefore data relating to it is not collected.
- CGL complete a cognitive screening which is not integrated or reliable so cannot be used for an ARBD diagnosis. Once referred to a GP there is no follow up pathway for a person with suspected ARBD.
- Active intoxication is an exclusion for assessment at East Sussex Memory Clinics.

However, following service mapping from the 3rd of November 2025, CGL will record 6CIT for all clients. A tracker has been put in place to monitor all those scoring over 8. If a client reaches a score over 10, CGL complete a MOCA and assessment for Wernicke's risk: get IM thiamine prescribed if required. GP to be informed and a repeat 6CIT/MOCA to be undertaken at post detox so a review 2 weeks after alcohol detox occurs.

Case Studies

Case Study 1:

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| <p>Background</p> | <ul style="list-style-type: none"> • Age bracket: 25-34 • Substance Use: Up to 300 units of alcohol/week; crack cocaine use; cannabis; benzodiazepines (non-prescribed). • Presenting Issues: Severe alcohol dependency (~300 units/week), epilepsy, suspected neurodivergence (ASD/ADHD), acquired brain injury (frontal lobe), and complex trauma history. • Diagnosis: MRI confirmed frontal lobe trauma and cerebellar damage (Aug 2024), consistent with ARBD and possible Korsakoff's Syndrome. • Mental Health: PTSD, suicidal ideation, hallucinations, cognitive decline, suspected ARBD. |
| <p>Clinical Indicators of ARBD</p> | <ul style="list-style-type: none"> • Cognitive Impairment: <ul style="list-style-type: none"> ○ Memory loss, poor executive functioning, disinhibition. ○ 6CIT score: 10 (mild impairment); AQ10 and ASD screening completed. ○ MCA concluded lack of capacity regarding alcohol use and care decisions. • Neurological Findings: <ul style="list-style-type: none"> ○ MRI: Bilateral frontal cortical/subcortical encephalomalacia, gliosis, cerebellar atrophy. ○ Neurologist (Dr Ali) confirmed ARBD and advised abstinence and structured risk assessment. • Behavioural Presentation: <ul style="list-style-type: none"> ○ Repeated hospital admissions for seizures and intoxication. ○ Aggression, inappropriate public behaviour, and self-neglect. ○ Frequent absconding from placements and hospital. |
| <p>Hospital Liaison and Clinical Pathway</p> | <ul style="list-style-type: none"> • Detox Attempts: <ul style="list-style-type: none"> ○ Declined by Bridge House and Birchwood due to forensic history. |

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| | <ul style="list-style-type: none"> ○ Conquest Hospital provided unplanned inpatient detox (Aug 2024); Librium-based protocol. ○ Acamprosate initiated post-detox, adherence inconsistent. ● Hospital Coordination: <ul style="list-style-type: none"> ○ Alcohol Care Team led inpatient management. ○ Safeguarding Nurses coordinated risk reviews. ○ MHLT were involved for psychiatric assessment; DOLS applied and later revoked. ● Post-Detox Planning: <ul style="list-style-type: none"> ○ MDT agreed on structured discharge with neuropsychiatric follow-up. ○ Referral for executive functioning assessment (CGL-funded). <p>Fibroscan scheduled to assess liver damage.</p> |
| <p>Safeguarding and Risk Management</p> | <ul style="list-style-type: none"> ● Safeguarding Status: Persistent concerns flagged under Section 42 (self-neglect). ● Community Protection Warning (CPW): Issued to restrict public intoxication and aggression. ● Risk Factors: <ul style="list-style-type: none"> ○ Vulnerability to exploitation. ○ Assaults on staff and emergency workers. ○ Incontinence, poor hygiene, and refusal of medication. |
| <p>Multi-Agency Coordination</p> | <ul style="list-style-type: none"> ● Key Stakeholders: <ul style="list-style-type: none"> ○ CGL ○ Social Care ○ Healthcare: ESHT (Alcohol Care Team, Neurology, Safeguarding), SPFT (Psychiatry) ○ Probation ● Meetings & Forums: <ul style="list-style-type: none"> ○ COSUMH, MDTs, safeguarding panels, clinical reviews. ○ Coordinated planning for detox, rehab, and neurodiversity assessment. |

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| <p>Housing Instability</p> | <ul style="list-style-type: none"> • Multiple placements in 18 months: Little Acorns → Kingswood NH → The Hurst. • Frequent absconding, non-compliance, and behavioural issues. • Concerns raised about care quality and safeguarding at The Hurst. • Awaiting placement at Elizabeth House or High View. |
| <p>Outcomes and Next Steps</p> | <ul style="list-style-type: none"> • Rehab: Kenward Trust admission (Nov 2024); self-discharged after 9 days. • Placement: Accepted by Elizabeth House (Upstreet Project); awaiting bed. • Legal: Court dates pending; forensic history complicates care planning. • Clinical: Awaiting neuropsychiatric assessment and autism diagnosis. • Monitoring: Continued hospital liaison, safeguarding oversight, and structured engagement via STAR Recovery Service. |
| <p>Conclusion</p> | <p>This case illustrates the clinical complexity of ARBD, the importance of hospital-based detox, and the critical role of multi-agency coordination in managing high-risk individuals with overlapping neuropsychiatric, forensic, and safeguarding needs.</p> |

Case Study 2:

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| <p>Background</p> | <ul style="list-style-type: none"> • Age bracket: 55 - 64 • Presenting Issues: Severe alcohol dependency and potential EUPD. Client B characterised by street drinking, and putting themselves in highly vulnerable situations, necessitating the public calling ambulances. • Diagnosis: Executive Function Assessment completed, and the patient was found to have capacity. • Client B has had 47 presentations to ED in 2025. • Client B lives in a care home, where they were dispensed alcohol in an attempt to modify their drinking. We worked |
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| | <p>closely with the Care Home and CGL, both of whom tried everything in their disposal.</p> |
| <p>Clinical Indicators of ARBD</p> | <ul style="list-style-type: none"> • Cognitive Impairment: <ul style="list-style-type: none"> ○ Variable. There are issues in correctly conducting assessments for ARBD and there is no current pathway, but it was suspected that Client B had ARBD due to their presentation. However, after having a detox, Client B appeared to have capacity. ○ Assessed Client B for a referral to neuropsychiatry assessment. ○ Client B was put on a DOLS for the duration of one of their detoxes, but this was relinquished when Client B was deemed to have capacity, whereupon they immediately discharged. • Neurological Findings: <ul style="list-style-type: none"> ○ 5 x CT head due to concerns of head injury following a fall. My understanding is that they did not reveal abnormalities. • Behavioural Presentation: <ul style="list-style-type: none"> ○ Repeated hospital admissions for intoxication. ○ Presented with sunburn and poor personal hygiene - self-neglect. ○ They would take discharge against medical advice as soon as they could. |
| <p>Safeguarding and Risk Management</p> | <ul style="list-style-type: none"> • Safeguarding Status: <ul style="list-style-type: none"> ○ Persistent concerns flagged under Section 42 (self-neglect). • Risk Factors: <ul style="list-style-type: none"> ○ Vulnerability to exploitation. ○ Theft of alcohol. ○ Aspirating whilst intoxicated. |
| <p>Multi-Agency Coordination</p> | <ul style="list-style-type: none"> • Key Stakeholders: <ul style="list-style-type: none"> ○ CGL ○ Social Care Healthcare: ESHT (Alcohol Care Team, Safeguarding) and SPFT (Psychiatry) ○ Arden House • Meetings & Forums: <ul style="list-style-type: none"> ○ MDTs, safeguarding panels and clinical reviews. |

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| <p>Outcomes and Next Steps</p> | <ul style="list-style-type: none"> • Patient Outcomes: <ul style="list-style-type: none"> ○ Client B would like to re-engage with CGL to manage his alcohol use. ○ Client B would like to access counselling. ○ Client B would like to get back into volunteering. ○ Client B would like to keep the current alcohol plan at Arden in place as a backup. ○ Client B would like to attend some groups at Thrift House, possibly including acupuncture. • Outcomes and Next Steps: <ul style="list-style-type: none"> ○ Monitoring: Continued hospital liaison, safeguarding oversight, and structured engagement via STAR Recovery Service. ○ Patient has not attended ED since a safeguarding meeting held in 2025. |
| <p>Conclusion</p> | <p>This case illustrates the importance of joint working across the borough, with careful planning and jointly agreed outcomes. It also highlights the borough’s need for an adequately resourced care pathway specifically for ARBD.</p> |

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East Sussex Health and Wellbeing Board Work Programme

| Date of Meeting | Report |
|--------------------------|-----------------------------------------------------------------------------------------|
| 21 July 2026 | East Sussex Health and Social Care Shared Delivery Plan (SDP) Programme - update report |
| | East Sussex Climate Change Health Impact assessment |
| | The Director of Public Health Annual Report |
| | Making it Happen: learning and wider synergies |
| | Better Care Fund 2026/27 |
| | |
| 29 September 2026 | East Sussex Health and Social Care Shared Delivery Plan (SDP) Programme - update report |
| | East Sussex All Age Autism Action Plan |
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| 24 November 2026 | East Sussex Health and Social Care Shared Delivery Plan (SDP) Programme - update report |
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