Appendix 1

East Sussex Health and Wellbeing Board Shared Delivery Plan (SDP) year 2 deliverables: progress summary September 2024

This report provides a summary of early progress across the eight deliverables for year 2 (2024/25) in the SDP that are specific to the East Sussex Health and Wellbeing Board (HWB). Along with the progress commentary for each deliverable, a rating has been given about progress status relative to expectations. Many deliverables are a continuation of shared priorities for transformational change over the medium term, building on the activity and progress in year 1 (2023/24). The rating is as follows:

G Green: progressing well against delivery objectives and on track

A Amber: plans are progressing but are subject to risk or additional pressure which may impede overall achievement of the objective and/or measurable improvements

R Red: progress is challenging and a review of in-year objectives for 2024/25 may be required

No.	Deliverable	Date	What we will achieve	RAG
1	We will commence implementation of the approved whole system action plans on cardiovascular disease (CVD), Chronic Respiratory Disease (CRD), healthy ageing and frailty and mental health prevention, and monitor progress on a quarterly basis through the Health Outcomes Improvement Oversight Board, with a deep dive into one priority area each quarter.	March 2025	Improved outcomes for the population	**G**
1(a)	**Progress summary** As part of agreed actions focussed on CVD prevention data packs on hypertension and lipids (cholesterol) have been produced to improve understanding of the numbers to meet the national guidance and targets, for sharing with Primary Care Practices. A new 6-month respiratory clinic pilot within substance misuse clinics located in Hastings and Eastbourne to support clients with respiratory issues. A framework has been developed to better understand and prioritise opportunities for promoting good public mental health and preventing mental health difficulties, from a whole life course perspective. This will be piloted in the Autumn to map evidence and good practice against the current service offers, initially focussing on trauma. Initial collaborative improvement work on healthy ageing is focussed on the falls prevention pathway and frailty ahead of the winter season.			
2	We will implement the improvements to cardiology and ophthalmology through reconfigured acute hospital services.	March 2025	Agreed transformation plans fully March 2025 implemented improving efficiency and outcomes for local people.	**G**

2(a)	**Progress summary** The Programme Board continues to meet to provide assurance around the delivery of the cardiology and ophthalmology programmes. Both programmes continue to progress and meet timeframes for delivery. A package of measures has been put in place to assist those patients who travel further for treatment. Further risks will continue to be monitored by the oversight board, along with the effectiveness of agreed mitigations.			
3	We will strengthen the focus and role of the Health and Wellbeing Board and the East Sussex Health and Care Partnership by strategically aligning partnerships and working to support our shared priorities for delivering a joined-up offer for health, care and wellbeing, including prevention, across NHS, local government and VCSE sector services for our population. We will develop proposals for the Health and Wellbeing Board (HWB) to phase in during 2024/25, focussed on the Joint Strategic Needs Assessments (JSNAs) and needs and assets in East Sussex	March 2025	A clear focus and approach across all partners.	**G**
3(a)	**Progress summary** The HWB agreed proposals in July 2024 to strengthen its strategic system stewardship role across the following key areas: • Improving population health and the specific challenges of the county using an evidence-based approach, focussed on the JSNA priorities for our system • Implementing models of care that are proactive and person-centred and emphasis prevention and early intervention • Ensuring we are getting the most benefit out of Integrated Community Teams as a key means to deliver an integrated offer of health, care and wellbeing at a local level A programme of informal deep-dive sessions has now been scheduled based on the priority themes of our East Sussex JSNA, and a clear focus on the objectives above. A first scene-setting session was held on 5 September 2024 which included exploration of the long-term health of our population, and how are local understanding of needs and plans come together, to consider how the HWB can go further with its strategic stewardship role in our current context.			
4	We will enhance support to families to enable the best start in life including delivery of an integrated pre- and post-natal offer, and implementation of the Early Intervention Partnership Strategy.	March 2025	Improved experience and increased opportunities to support our most vulnerable families.	**G**

4(a)	**Progress summary** Collaborative work has taken place to progress enhanced support to children and young people and families across a number of priority areas: • We have enhanced our support for perinatal mental health and infant parent relationships through an increase in Emotional Wellbeing support contacts. Parents in Mind peer support programme for fathers is growing with the addition of two new male practitioners. Universal antenatal education has expanded, and the Screening and Triage Parent Infant Mental Health team is also growing. We are moving forward with the next phase of Infant Mental Health training. • The Supporting Families transformation programme has now been integrated into our Early Help system to support implementation of the Early Intervention Strategy through expanding our partnership with VCSE organisations. The potential for shared assessments is currently being explored which could support a whole system approach and benefits. • To support better communication and information, over 190 services and online sources of information, advice and guidance (IAG) support about support with mental health and emotional wellbeing (MHEW) for children, young, people and families, have been mapped and added as a new search filter to the East Sussex 1Space directory. User testing of 1Space and the ESCC webpage on mental health support for young people will take place in October and November. Further work is also taking place to support early years professionals to feel better equipped to meet the MHEW needs of children and their families. • The development of a draft Pan-Sussex health plan for Sussex children in care and care leavers has been progressed and shared with all three local authorities in Sussex to enable children and young people to give their view alongside other local stakeholders. The plan covers priorities identified by children and young people and their carers, for access to and support with dental care, mental health and Neurodiversity assessments. • A new project has been started aimed at delivering inclusion of Neurodiversity in schools. Health and education specialists and expert parent carers will go into mainstream primary settings to help shape whole school SEND provision, provide early interventions at a school level, upskill school staff, and support the strengthening of partnerships between schools and parent carers. The project will be delivered between September 2024 to March 2025. • Feedback from children, young people and families across a number of partner organisations has been collected and reviewed to help understand how the views and experiences of children and families has informed and impacted service developments, and ensure clear feedback through a future annual report process.			
5	We will implement integrated delivery of community mental health services and a wider range of earlier mental health support for adults of all ages and people with dementia, through the evolution of Neighbourhood Mental Health Teams (NMHTs) in line with the Sussex-wide approach, and improved access and outcomes in supported accommodation.	March 2025	Reduced reliance on specialist services and improved population health and wellbeing.	**G**

5(a)	**Progress summary** Options for Neighbourhood Mental Health Team footprints have been appraised and agreed, and these align with Integrated Community Team footprints in our five borough and districts. The initial NMHT core team make up has been agreed for first phase implementation in October 2024. This is supported by a staff communications plan and a survey to understand experiences of accessing community mental health services, as well as designing a community services demand and utilisation dashboard to build awareness across the system around shared demand and capacity. Linked but separate work to strengthen integrated working practices across mental health, adult social care and housing services is progressing. New multi-agency communities of practice have been established and an audit of current supply and demand across mental health supported housing pathways has also been completed.			
6	We will continue to develop our neighbourhood delivery model through the evolution and implementation of our five Integrated Community Teams (ICTs) across East Sussex. In line with the ICTs across Sussex, this will focus on providing proactive, joined up care for the most complex and vulnerable people alongside approaches to improving the health and wellbeing of our communities through an asset-based approach.	March 2025	In year plan delivered.	**G**
6(a)	**Progress summary** Through collaboration at a pan-Sussex level a description has been developed of the consistent ICT core offer across all sixteen footprints in Sussex, complemented by a flexible local offer based on specific needs, challenges and strengths in each footprint, and ICT Profiles data packs have been produced to support this. In East Sussex teams, services, community assets and leadership infrastructure have now been mapped for all five ICT footprints. This includes leads from primary care, community healthcare, social care, mental health, children's services, housing and homelessness services, and nominated leads for the voluntary and community sector. Two development sessions have been held in each ICT footprint to start to identify, and plan, collaborative action, and relevant tests of change to further integrate service delivery which will start in the latter half of 2024/25. This will be informed by the evaluation of the Hastings Universal Healthcare programme. This is initially focussed on proactive care of frail and older people with complex needs and a wider prevention and wellbeing offer, and includes planning for networking and learning events across our 5 ICT footprints ahead of winter. A survey has also been undertaken to get a snapshot of multi-disciplinary team activity in relation to vulnerable older and frail people in primary care settings, and the findings will be used to inform new ways of working.			
7	We will further develop and implement efficient hospital discharge processes, supported by digital automation, with a long-term funding plan for discharge capacity. We will embed efficiency and process learning from transformation programmes into 'business as usual'.	March 2025	More people will be able to be discharged safely to a community setting.	**A**
7(a)	**Progress summary**			

	The national Government Discharge Fund Grant allocations for 2024/25 were agreed for Q1 2024/25 and rolled forwards for the remainder of the financial year. This has focussed on improving discharge to someone's own home, alongside increased therapy and assessment provision and associated plans to reduce the use of bedded discharge pathways to build additional adult social care and community-based reablement capacity to reduce hospital discharge delays by delivering sustainable improvements to services. In the context of increases in the numbers and complexity of people's onward care needs, collaborative work has continued on our Discharge Transformation work. Six areas of work have been identified to address the increase in the number of patients who no longer meet the Criteria to Reside in an acute hospital bed. Demand and capacity modelling will also be undertaken to inform the capacity requirements for the system going forward and the best use of discharge funding.			
8	We will develop and agree a partnership Housing Strategy to set out a shared vision for housing sector in East Sussex, including a strong focus on health, housing and care, and provide the strategic partnership framework to complement the borough and district housing authority strategies.	March 2025	A clear ambition for all partners.	**G**
8(a)	**Progress summary** Data and insights from across the sector have been used to support the Housing Strategy development. This includes the earlier Annual Report by the East Sussex Director of Public Health on health and housing, as well as broader population trends and the area profiles developed for the integrated community teams. This will continue to be refined in the Autumn ahead of presentation to the HWB. Key areas of work underway, which will also contribute to the Strategy include: • Partners across housing, health, mental health, social care and substance dependency services have been working to create a multi-disciplinary approach to supporting people with 'multiple and compound needs'[1] across the county, and avoid the risk of gaps in provision and further increases in demand for statutory services due to programme funding ending in March 2025. The following priorities have been agreed for our ongoing approach: o Settled and stable housing for people with multiple compound needs o Team around the person approach, with lead professional o Multi-disciplinary working and a focus on prevention o Using data to improve outcomes o Completion of a healthcare needs assessment to better understand the number and profile of people with multiple compound needs in East Sussex by the end of 2024. o Learning and good practice from the existing programmes will also be incorporated within the partnership housing strategy.			

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

	• Collaboration between housing and health to support the identification of people in housing need in hospital settings. This also includes supporting joint training opportunities with housing teams in each area and the newly appointed discharge co-ordinators, as well as improved discharged coding. • A joint project to map assets across the public sector which may be suitable for housing and accommodation development in the future. The initial findings have been shared and the next steps are to develop a pipeline of future developments. The group will also consider opportunities to develop accommodation solutions for individuals with additional health and care needs.