Appendix 1

East Sussex Health and Wellbeing Board Shared Delivery Plan (SDP) year 2 deliverables: progress summary November 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 a medium-term time frame, 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** • A draft East Sussex CVD prevention action plan has now been signed off by the East Sussex CVD prevention group. • An additional venue in Hastings has been secured to deliver Pulmonary Rehabilitation support. This will ensure that there is increased capacity to meet local needs for people with Chronic Respiratory Disease (CRD). • A shared definition for prevention in the context of mental health and wellbeing, together with a framework approach to support understanding of needs and gaps, has been agreed. This is initially being used to explore collaborative action to reduce the impact of trauma with a review of the evidence-base undertaken to support recommendations, and a potential focus on self-help and personal resilience including the role of peer support in supporting good mental health and wellbeing. • A new Healthy Ageing Partnership Group with has been established to take forward collaborative action with a focus on age-friendly communities and models, falls prevention and frailty. This work complements and aligns with the ESCC Healthy Ageing Scrutiny Review exercise and recommendations, which was positively received and agreed by ESCC Cabinet in November 24, ahead of its final stage of review with Full Council in February 25.			

2	We will implement the improvements to cardiology and ophthalmology through reconfigured acute hospital services.	March 2025	Agreed transformation plans fully implemented improving efficiency and outcomes for local people.	**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. Further risks will continue to be monitored by the programme 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** Building on the proposals agreed in July 2024 to enhance the strategic system stewardship role of the HWB, the programme of 7 informal 'deep dive' sessions is underway. Sessions are aimed at deepening the shared understanding of our population's health and care needs and priorities based on our East Sussex JSNA. The informal 'in person' nature of the discussions will also help strengthen the relationships and mutual accountability needed for whole system collaboration, particularly in the challenging financial context being experienced by our organisations. A first scene-setting session was held in Battle on 5 September 2024 which included exploration of the long-term health outlook for our population, and how our local understanding of needs and plans come together, and considered how the HWB can go further with its strategic stewardship role in our current context. Resulting action is being progressed by the East Sussex Health and Care Partnership working with organisations' communications leads to develop a shared narrative vision, values and principles which will inform HWB Strategy refresh. The second session took place on 14 November 2024 focussed on improving healthy life expectancy and the outcomes will contribute to informing the SDP refresh for 25/26, the draft briefing note describing the session and outcomes will be brought to the HWB for			

	agreement at its meeting on 10 December 24 and onward sharing. Work is also underway on developing our approach to understanding measurable impacts through the HWB's Shared Outcomes Framework.			
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 continued to take 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 continues to grow 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. • 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. We are awaiting further information on funding for children's social care and future investment in preventative services in the upcoming local government finance settlement, which will include funding for the Supporting Families and Family Hub programmes. • As previously reported over 190 services and online sources of information, advice and guidance (IAG) about support with mental health and emotional wellbeing (MHEW) for children, young, people and families have been added to the East Sussex 1Space directory to support better communication and access to information. In November, young people from the Youth Cabinet, the Children in Care Council, and NHS and VCSE sector youth voice groups tested the usability of the East Sussex 1Space directory and the ESCC webpage on mental health support for young people. Parents, carers and professionals have also tested the usability, and updates are being made based on the feedback from both exercises. An NHS Sussex pan-Sussex communications working group has been set up and will focus on ensuring consistency in messaging and signposting for children and young people's Mental Health and Emotional Wellbeing (MHEW) across the system. Work is ongoing to support Early Years professionals to feel better equipped to meet the MHEW needs of children and their families, which includes adapting existing training for schools for an Early Years audience and creating resource packs on Early Years MHEW information, advice and guidance. • The draft Pan-Sussex health plan for Sussex children in care and care leavers has now been finalised for review by senior managers in all the three local authorities in Sussex in December 24. Children and young people were able to give their views alongside other local			

	stakeholders the draft plan which covers priorities identified by children and young people and their carers, including access to and support with dental care, mental health and Neurodiversity assessments. • Support through the PINS (Partnership for Inclusion of Neurodiversity in Schools) Project is now being delivered in 14 East Sussex primary schools (38 across Sussex). An initial conference took place in October, with speakers from the parent carer forums, Health and Education. The rest of the support is being delivered both at place level and at pan Sussex level, covering topics identified by the schools through their self-evaluations. Particular themes identified are engagement with parent/carers, supporting the mental health needs of neurodiverse children, and supporting emotional regulation in neurodiverse children. This support is being delivered by a range of people across health, education, VCSE and those with lived experience. • Feedback from children, young people and families across a number of partner organisations has been collected and reviewed to help understand how their views and experiences have informed and influenced 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** Neighbourhood Mental Health Team (NMHT) footprints have now been agreed and aligned with our five borough and district based Integrated Community Team footprints, and the initial make-up of the core NMHT team has been agreed. Sussex Partnership NHS Foundation Trust (SPFT) is in the process of exploring alignment of resources to the new footprints and implementation is expected to start in January 25. A recent survey aimed at understanding public experiences of accessing mental health services has been completed and the results are currently being reviewed to support this. Communications describing the planned changes over the coming months have also been circulated to existing patients, the staff in scope and primary care colleagues. A community services demand and utilisation dashboard to build awareness across the system around shared demand and capacity is being designed for review and initiation. Work to strengthen integrated working practices across mental health, adult social care and housing services continues to be progressed through establishing new multi-agency communities of practice, and an audit of current supply and demand across mental health supported housing pathways.			
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** Following the two development sessions that took place in each ICT footprint over the summer with key service and team leads across primary care, community health and social care, mental health, housing, VCSE and others, actions are being taken forward to build a community network, embed multi-disciplinary team (MDT) working and support effective management and planning across our 5 ICT footprints in East Sussex. Tests of change are being progressed to test out new approaches and ways of working including: • Development of a digital falls prevention tool utilising data from the Sussex Integrated Dataset • Exploration of VCSE partners being co-located in our hospital discharge hubs • Community rehabilitation clinics bringing together multiple services in a local community setting • Asthma clinics co-located with energy advice and fuel poverty support • The use of a personalised hydration plan to reduce UTIs in people over 65 • Identifying people who are experiencing loneliness and signposting them to VCSE services and support Five 'Supporting people through winter and beyond' networking and learning events were held in each ICT footprint in November for people working or volunteering in our communities. In collaboration with our Integrated Community Teams (ICTs) programme, Citizens Advice funded the events as part of their fuel poverty and energy efficiency work, with the events aiming to equip people in understanding the range of services and support available locally as well as what advice to offer someone struggling this winter. They also provided an opportunity for ICT 'team identities' to be formed and the further strengthening of relationships across system partners.			
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** As reported in the September progress update, an increase the numbers of patients who need support with multiple and complex onward care after a spell in an acute hospital bed has resulted in an increase in the numbers of patients who have been classed as having No Criteria to Reside (NCTR) in our acute hospitals who are awaiting discharge from hospital. Whole system improvement action has taken place on hospital discharge, involving parts of the NHS, Adult Social Care, Borough and District Councils and the VCSE, to seek to remedy this. As a result, we are starting to see significant improvements in Mental Health delayed discharges across Sussex and more recently an improvement in delayed discharges from our acute hospitals in East Sussex. Examples of the collaborative work leading to improved performance includes: • Schemes to support timely discharge and admission avoidance • Regular place based OPEX (Operational Executive) meetings • Our Transfers of Care Hub (TOCH) to standardise decisions about the different discharge pathways available for patients coming out of hospital • Developing a common data set and definitions covering NHS and social care information about discharge			

	• The development of a Sussex-wide dashboard to capture assessments across all hospital sites and impact • A clear system escalation framework related to complex patients who have been waiting a very long time in an acute hospital bed • Modelling to inform the capacity requirements for the system going forward, and the best use of discharge funding • Adult Social Care staff participate in daily meetings and contribute to discussions about patients classed as 'NCTR'. There is engagement at regular multi-agency discharge events ('MADE' events) which look to review patient level detail and opportunities to try and expedite early discharge • A pilot programme has recently started to deploy Adult Social Care therapy staff in hospital discharge settings to try and optimise individual patients' independence, with a focus on returning people home with fewer needs This area is still challenging for our system and may mean overall achievement of the objectives and measurable improvements in 24/25 are at risk, despite the effort being put in by our whole system. There will now be a need to sustain the trajectory of improving performance as we head into winter, when we would naturally expect to see an increase in pressure across the system, and beyond. In keeping with this, through the work to model and jointly agree system discharge capacity requirements for 'step down' and intermediate care, the ICB and ESCC are jointly investing funds to create additional 'Discharge to Recover and Assess' (D2RA) bedded capacity to maintain and improve hospital discharge flow throughout the winter period.			
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** Progress on Housing Strategy development continues well supported by data and insights from across the sector, including the previous Annual Report by the East Sussex Director of Public Health on health and housing, broader population trends and the area profiles developed for the integrated community teams. The strategy will include key themes of collaboration, evidence-based decision making, and workforce. Priority areas will include homelessness prevention, housing and health, supply of housing, improving standards, reducing carbon emissions and the private rented sector. This will continue to be refined ahead of presentation of the finalised strategy to the HWB. Work is also underway by partners across housing, health, mental health, social care and substance dependency services working with a focus on creating a multi-disciplinary approach to supporting people with 'multiple and compound needs'[1] (MCN) across the county. This is aimed at avoiding the risk of gaps in provision and further increases in demand for statutory services due to programme funding ending in March 2025, based on the following agreed priorities:			

[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

	• Settled and stable housing for people with multiple compound needs • 'Team around the person' approach, with lead professional • Multi-disciplinary working and a focus on prevention • Using data to improve outcomes • 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 24. • Learning and good practice from the existing programmes will also be incorporated within the partnership housing strategy.