Work in progress

Strengthening the way we work together in our communities

DRAFT Strategic Development Framework 2021/22

East Sussex Health and Social Care System Partnership Board
11th June 2021

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Shared East Sussex Outcomes

Population health and wellbeing

The impact of services on the health of the population such as preventing premature death and overall prevalence of disease.

Ambition	Outcome
Improve and protect mental and physical health and wellbeing for local people	• Children have a good start in life • People are able to live well • People age well • People have a good end of life
Reduce health inequalities for local people	• The gap in health outcomes is improved

East Sussex County Council

NHS

Sussex Vision 2025

Our Outcomes	Measured by
People will live more years in good health	Healthy and disability-free life expectancy at birth and at age 65
The gap in healthy life expectancy between people living in the most and least disadvantaged communities of Sussex will be reduced	Inequality in healthy life expectancy at birth
People's experience of using services will be better. Our staff will be working in a way that really makes the most of their dedication, skills and professionalism	Access to health and care, quality of care, and experience of health and care
The cost of care will have been made affordable and sustainable	Cost per capita of health and care

East Sussex Key Population Data & Indicators

Key Population Data	Key Metrics
• The population is predicted to grow by around 19,000 people between 2020 and 2024 to around 580,000 with over 50% of the increase in people aged 65 and older • Ageing population: 2nd highest proportion of over 85-year olds in England . Over 65's unevenly distributed around the county. 20% of Hastings population over 65 compared to 31.2% in Rother • Of the 8% describing themselves as being from a BAME group, other white is the largest single category at 4.4%. • Life expectancy (LE) for both men and women is 0.7 years longer than England average but this masks significant variation within the county • LE for people living in the most deprived quintile in each district and borough is below England average: 7 years lower in Hastings males, 2.5 years for both sexes in Eastbourne, and 1-2 years in Rother. • Most people can expect to reach their mid-sixties in good health, however on average men in Hastings will only reach 59.3 years and women 61.2 years in good health • 732 fewer men and 532 fewer women would have died between 2015 and 2017 if the mortality rate in the most deprived areas was the same as least deprived areas	• Overall the biggest causes of inequality in life expectancy are circulatory disease, cancer, respiratory disease and digestive disease, much of which is preventable or modifiable. • Causes vary by district and borough: external causes (injury, poisoning and suicide) is the biggest contributor to inequality in male LE in Hastings. • 13% of the population estimated to have undiagnosed hypertension • Almost 300,000 adults are estimated to be overweight or obese (63% overall – ranging from 59% in Lewes to 66% in Eastbourne) • The no of people living with LTCs is estimated to increase by 20,700 from 160,300 in 2018 to 181,000 by 2028 • 6% of children live-in low-income families and 13% of older people live in poverty • Children and young people's mental health is significantly worse than England. • Educational achievement is variable across the county and absences and exclusion from school is above the England average. • The suicide rate is higher than England. • Dementia is the leading cause of death for women in the county and 1 in 3 cases of dementia could be prevented through lifestyle and social changes

East Sussex: achievements in 2020/21

- ✓ **An existing health inequalities programme established in 2014 to target the eight most deprived wards in the county**. The Healthy Hastings and Rother programme delivers a broad range of commissioned projects co-designed with partners aimed at reducing health inequalities by improving the health and wellbeing of people in most disadvantaged communities.

- ✓ Statutory and voluntary sector partners have worked together to **ensure that people affected by the pandemic who need extra support to cope, including people registered as clinically extremely vulnerable** to coronavirus get the help they need such as help shopping for food and essentials.

- ✓ Supported the development of the **Rough Sleepers Initiative (RSI) and multi-disciplinary team** to improve access to health care and delivered the national 'Care and Protect' model to make sure we can care for people with symptoms and provide the greatest level of protection for those at the highest risk, including mobile dental outreach.

- ✓ Free, confidential support and advice available through our **East Sussex Welfare Benefits Helpline** for people who are facing financial difficulty, struggling to pay bills or concerned about growing debt, whether this is due to the Covid-19 pandemic or otherwise.

- ✓ Strong progress with the roll out of **Mental Health Support Teams** to enable access to mental health and emotional wellbeing for school pupils, so far covering 45 schools and 24,000 pupils

- ✓ Joint working between the acute hospitals and voluntary and community sector organisations to enable support from local volunteers **to extend the Hastings HEART to current hospital discharge pathways into the community** and take pressure off health and care systems.

- ✓ **Completed the first phase of a hospital discharge wellbeing checks pilot commissioned from Healthwatch East Sussex.** 1,441 follow-up wellbeing checks were completed in a four-month period identifying people who needed additional support need and providing signposting to appropriate health, care and community organisations.

East Sussex

Key highlights:

- ❖ Development of COVID-19 community hubs in each district and borough to ensure that no one is left without support.
- ❖ Secured £3,208,194 in annual benefit payments for people from April to December 2020 with 75% of people living in the most deprived wards in the county and 79% of people surveyed reporting improved mental wellbeing.

- ✓ Worked collaboratively with the Police and Crime Commissioner, East Sussex Healthcare Trust and CGL to **fund a hospital-based Independent Adviser for Domestic violence and Abuse since September 2020.**
- ✓ Adapted the **parenting support programme delivery model in response to the pandemic and extended its reach to support parents across East Sussex.**
- ✓ **Developed a scheme for GP practices to deliver health checks to BAME patients, those with a serious mental illness or learning disability, and current smokers.**
- ✓ Supported a **range of programmes led by system partners which aim to address the wider determinants of health**. For example CHART (Connecting Hastings and Rother Together) which aims to stimulate local economic growth and improve employability skills and job opportunities, and the Hastings Opportunity Area which is focused on improving social mobility amongst young people and protecting their emotional wellbeing and mental health.

Priorities in 2021/22 – slide 1/2

- East Sussex Health and Care Partnership is developing its roadmap for integration which incorporates a refreshed focus on how we approach health and wellbeing and health inequalities in our work, and working together to further develop and deliver our agreed shared outcomes.
- We have committed to strengthening the way we work in East Sussex to promote more integrated working across the health and social care system and the full range of services that impact on the broader determinants of health, including housing, employment, welfare, transport, environment and leisure and voluntary, community and social enterprise sector (VCSE) services and support, through:
  - *Coordinated and integrated models of personalised care and support, 'wrapped around' high risk vulnerable people who have long term conditions and complex care needs*
  - *Developing a more targeted approach to populations to enable more anticipatory, preventative models of care to impact on health inequalities in the medium term*
  - *Supporting broader social and economic development in our diverse communities in the long term*
- We will develop and deliver this agenda in collaboration with local people and our key partners, to support prevention and promote health wellbeing in communities in East Sussex.

Priorities in 2021/22 - slide 2/2

Areas of focus in 2021/22 will include:

- Developing a sustainable model for community hubs (developing partnership approaches to community wellbeing)
- Social isolation, and developing a systems approach to tackling loneliness and social isolation
- Supporting ICS-wide programmes and working with primary care to ensure prevention, early identification and management of risk factors to reduce inequalities (and tackle the inverse care law)
- Developing a longer term vision of adopting a whole systems approach to changing life opportunities and expectations for our population.

Other current developments that support this agenda:

- Learning from the Making it Happen programme and our asset based approach to working with communities
- Learning from the Healthy Hastings and Rother programme to target areas of deprivation and health inequalities in other parts of the county
- Extending the reach of the vaccination programme and continuing to promote vaccine take up within BAME communities
- Further developing the East Sussex social prescribing model
- Multi-agency partnership working to improve health outcomes and reduce health inequalities for example Project Adder, which over the next three years in Hastings aims to achieve a reduction in drug related deaths, a reduction in drug related offending and a reduction in drug use

The role of systems in the three main causes of health inequalities

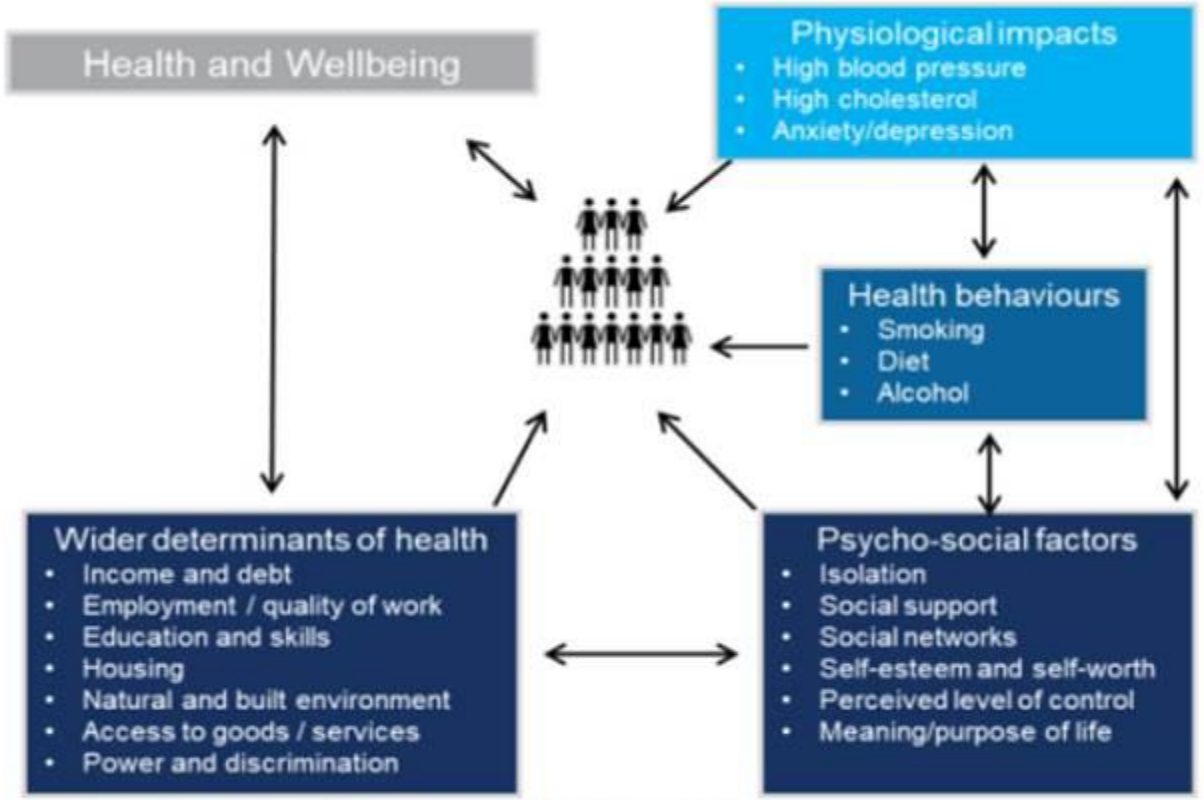


Figure 4. System map of the causes of health inequalities.

The causes of health inequalities can be grouped into three main causes (the Labonte model):

- Physiological
- Health behaviours
- Psycho-social factors and wider determinants of health

This gives you three main areas of partnership action and ways of thinking about interventions required at each level from a systems perspective.

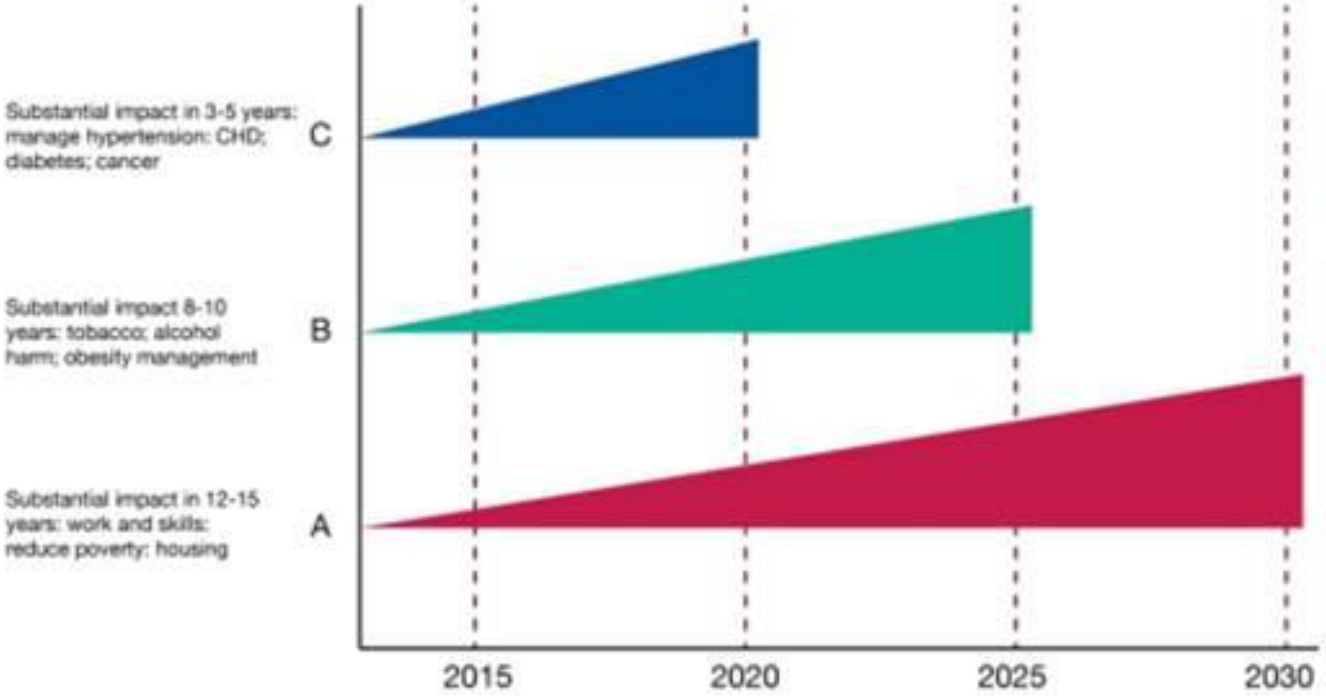
The model moves from the very individual (physiological impacts) through to actions that impact on whole groups and segments within populations.

Different stakeholders have influence at different levels, and we need to increase our collective capability to have an impact at all three levels.

Individuals may experience challenges with all three causes of health inequality. For example some people might need support with the darker boxes to tackle physiological risk factors through personalised and coordinated care approaches that link them to wider sources of support in communities, and housing and employment opportunities.

Improving outcomes

Figure 3: Time needed to deliver outcomes from different intervention types



The time it takes to see a measurable impact is different across each of the three types of partnership interventions.

Medical interventions to reduce physiological causes of ill health can have an impact on increasing life expectancy in a small number of years.

Interventions related to psychosocial factors and the wider determinants of health will make a difference to people's wellbeing in the short term as well as produce long term improvements in overall population health.

Strategic Development Framework

East Sussex County Council

Ambitions	• **Improve and protect mental and physical health and wellbeing for local people** • **Reduce health inequalities for local people**
Aims	• **Strengthen the way we work together in our communities in East Sussex to improve health and wellbeing and reduce health inequalities**

	Objectives	Role and purpose of East Sussex Health and Care Partnership
1	Address the physiological causes of ill health to prevent premature death and the overall prevalence of disease	• In-depth **understanding of our local communities** – needs, assets and a focus on health inequalities, including oversight of key indicators to ensure actions reduce health inequalities, including access to services • New approaches to **working in partnership**, including working with VCSE organisations in reaching out to disadvantaged groups • **Coordinating high quality service delivery across multiple agencies**; community and acute providers, PCNs, social care providers, housing, employment and welfare services • **Transformation** – agreeing the strategic vision in partnership with communities, including **new models of support** which promote wellbeing, deliver high quality care and support prevention • **Mobilising** the local community and **building leadership capacity** • **Understanding and making use of local assets** to improve population health • **Enabling local organisations to use their resources** to support health and socio-economic development (e.g. anchor institutions)
2	Support individuals and populations to adopt healthy behaviours	
3	Address psychosocial factors and the wider determinants of health in our communities	
4	Further developing our capability as a system	

Objective 1: Address the physiological causes of ill health to prevent premature death and the overall prevalence of disease

Action	2021/22			
	Q1	Q2	Q3	Q4
Implement shared ICS and East Sussex place actions on the main causes of reduced Life Expectancy and reduced Healthy Life Expectancy: • Circulatory disease • Cancer • Respiratory disease • Digestive disease	Restart East Sussex Cancer Action Group and agree priorities Ensure a focus on the physical health of • People with Mental Health problems • People with Learning Disabilities	Establish East Sussex NHS health checks steering group	Implementation and monitoring	Implementation and monitoring
Ensure our programme of shared service transformation priorities builds in appropriate opportunities to reduce health inequalities as part of pathway and service redesign	Review and refresh our shared transformation priorities across the five programmes	Review opportunities to impact on health inequalities Agree measures and KPIs Begin implementation	Implementation and monitoring	Implementation Review and refresh priorities for 20222/23

Objective 2: Support individuals and populations to adopt healthy behaviours

Action	2021/22			
	Q1	Q2	Q3	Q4
Alcohol harm reduction plan	Take refreshed plan to the HWB for endorsement	Implementation	Implementation	Implementation
Healthy Weight Plan	Take refreshed plan to the HWB for endorsement	Implementation Agree indicators to monitor impact on inequalities	Implementation	Implementation
Tobacco		Begin development of multi-agency East Sussex tobacco strategy	Use CLeaR improvement tool to review local system with stakeholders, identify gaps and make recommendations	Complete multi-agency strategy development and begin implementation

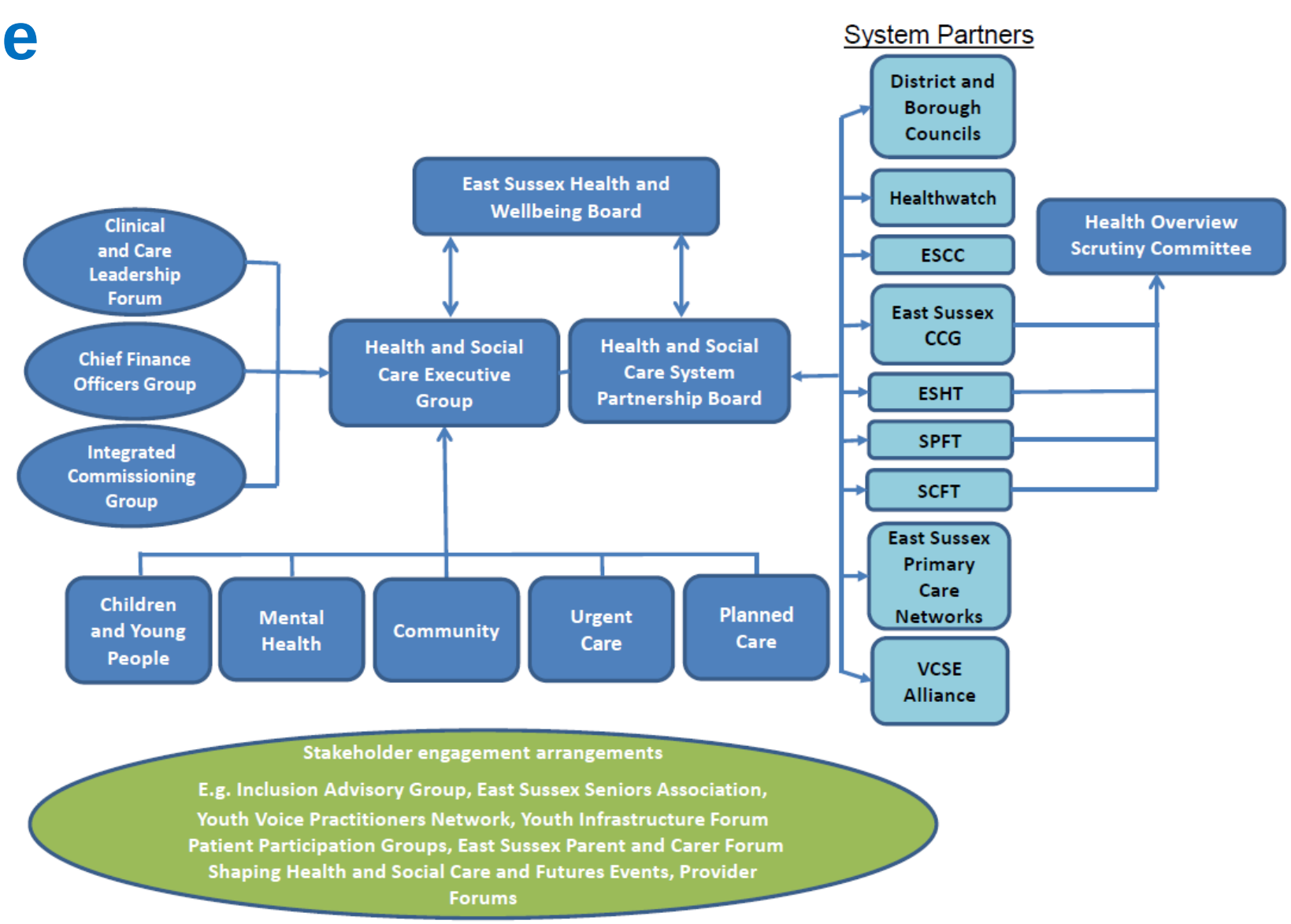
Objective 3: Address psychosocial factors and the wider determinants of health in our communities

Action	2021/22			
	Q1	Q2	Q3	Q4
Develop partnership approaches to community wellbeing (sustainable community hubs)	Appoint delivery partner and commence project	Draft stage 1 outputs	Draft reports	Presentation of reports and agreement of plans for 2022/23. Begin detailed business case development
Develop a systems approach to tackling loneliness and social isolation	Appoint delivery partner and commence project		Draft reports	Presentation of reports and agreement of further plans for 2022/23
Explore the wider role of our organisations in supporting social and economic wellbeing	Develop understanding of concept and possibilities of Anchor institutions	Agree and set out next steps for exploring and developing a shared approach	Initial steps implementation phase (to be determined)	Further develop and agree plans for 2022/23

Objective 4: Further develop our capability as a system

Action	2021/22			
	Q1	Q2	Q3	Q4
Set measures, indicators and long term trajectories for reducing the life expectancy (LE) gap and healthy life expectancy gap (HLE)	Agree baseline measures and caveats	Scope business case development for real time measures of HLE	Set trajectories and further work to be determined based on business case	
Set out our understanding of population health at a more granular level within East Sussex	Agree approach and defined geographical area	Develop profiles	Ensure programmes and plans are informed by understanding	
Implement new Population Health Management (PHM) Capability at scale to stratify population risk	Conclude ICS-wide accelerator pilot programme final phase	Receive and review reports from the accelerator pilot programme	Agree next phase developments to increase scale and spread of PHM capability at place (to be determined)	Begin implementation phase (to be determined) and agree plans for 2022/23
Further align relevant wider commissioning plans where appropriate			To be determined based on service and procurement timetable	To be determined based on service and procurement timetable

Governance



East Sussex Health and Social Care System Partnership Board

East Sussex Health and Social Care System Partnership Board

Launched in September 2019, the East Sussex Health and Social Care System Partnership Board (SPB) is accountable to our East Sussex Health and Wellbeing Board which oversees how well we work together as a system in East Sussex. Our SPB also feeds into our Sussex Health and Care Partnership (SHCP) Integrated Care System (ICS). Through aligning organisational plans across our health, social care and wellbeing system, the focus for the System Partnership Board is to shape and oversee the following developments:

- Our East Sussex Health and Social Care Plan, which sets out **what** we need to do to drive the developments required to meet the health and care needs of our population. This is done through agreeing our local priorities for collaboration and our contribution to wider Sussex Health and Care Partnership strategies and plans to help achieve NHS Long Term Plan ambitions
- Our proposals for **how** our organisations can best organise ourselves to deliver our plans as place-based partnership in 2021/22 and beyond
- Further developing our approach to population health and social care commissioning in East Sussex to deliver improved health **outcomes** and reduce health inequalities

The membership embraces broader representation to help impact on the wider determinants of health. This includes East Sussex Healthcare NHS Trust, Sussex Community NHS Foundation Trust, Sussex Partnership NHS Foundation Trust, District and Borough Councils, Healthwatch and the East Sussex Voluntary, Community and Social Enterprise (VCSE) Alliance and the Primary Care Networks in East Sussex, alongside East Sussex Clinical Commissioning Group and East Sussex County Council as statutory health and social care commissioners. Everyone on the System Partnership Board (SPB) feeds back to a broader constituency, and we have agreed to capture the key messages from each meeting to support this.

Appendices

- Partnership Approaches to Community Wellbeing
- Systems approach to loneliness and isolation
- Sussex Population Health Management (PHM) Pilot Programme
- What can be done differently using PHM
- NHS White Paper: Anchor Institutions
- Other linked areas of work

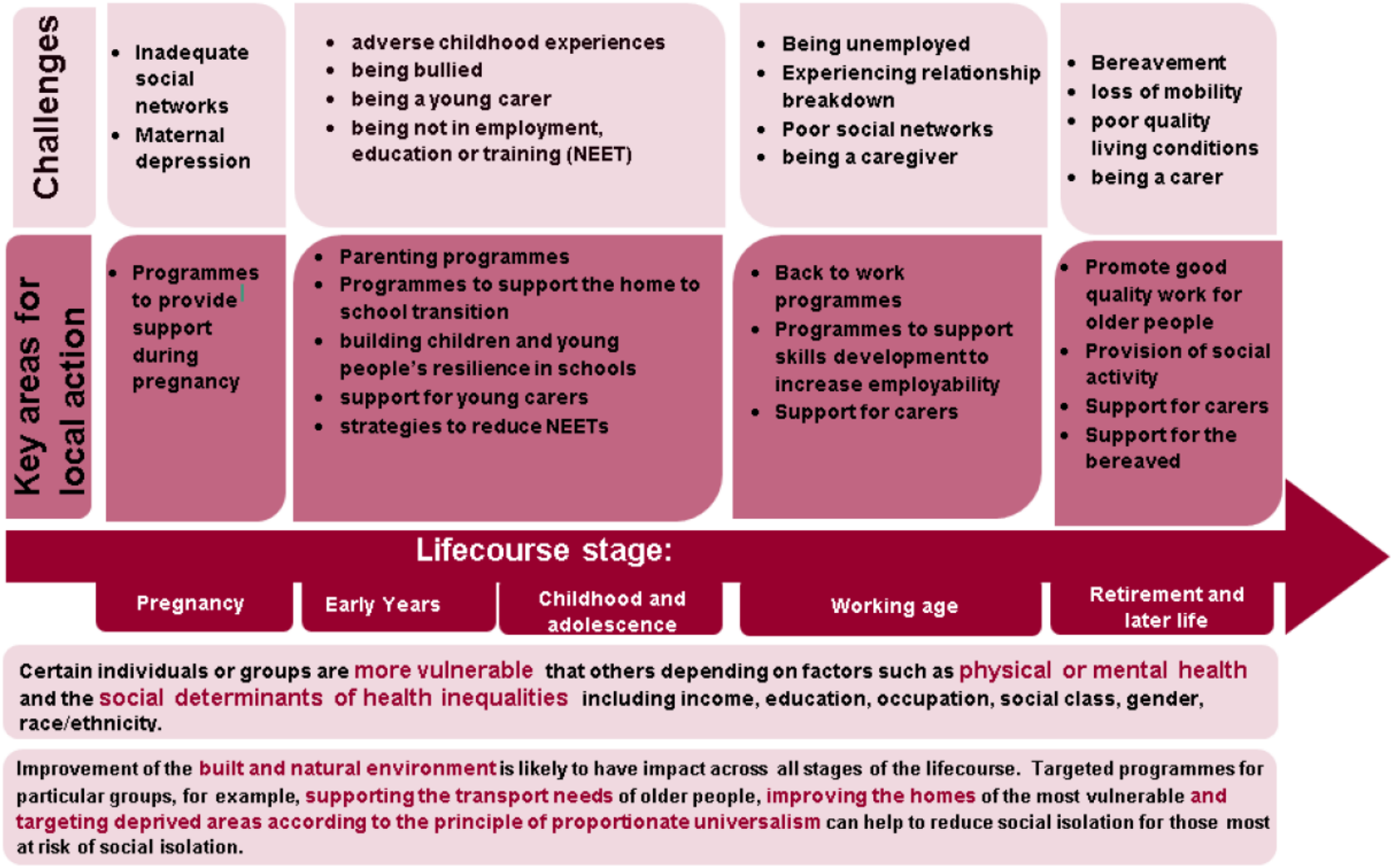
Partnership approaches to community wellbeing in East Sussex

Creating a preventative community based service through building on the ethos of the five Community Hubs that were mobilised as part of the pandemic response, by Councils at Borough, District and County level, CCG, VCSE partners and other community-based organisations, to meet essential food, medicine and social isolation needs.

Project aims

- **Phase 1**: Engage key stakeholders involved in meeting the needs of vulnerable people in East Sussex during the pandemic to collectively develop and agree a vision and scope for community hubs, acting as a key part of the integration of health and social care, and specifically developing a preventative offer grounded in the VCSE
- **Phase 2**: Once the vision is agreed by the key partners, developing a robust business case to take forward the first permanent model for community hubs

Systems approach to loneliness and isolation



Source: PHE and UCK Institute of health Inequality

Project aims:

Gain a better understanding of the nature and impact of loneliness on people living in East Sussex, and to identify future opportunities and approaches to mitigate its worst effects, through shaping existing provision and local resources.

This graphic shows examples of opportunities for interventions to address the impact of loneliness and social isolation across key stages of the life course.

Sussex Population Health Management Pilot Programme

PHM is the enabler for systems and local teams to look for the best solutions to people's needs. This is achieved through:

- the use of digital technology to reimagine care pathways
- joining up care across boundaries and improving outcomes
- cross-system data and intelligence to improve decision-making at every level.

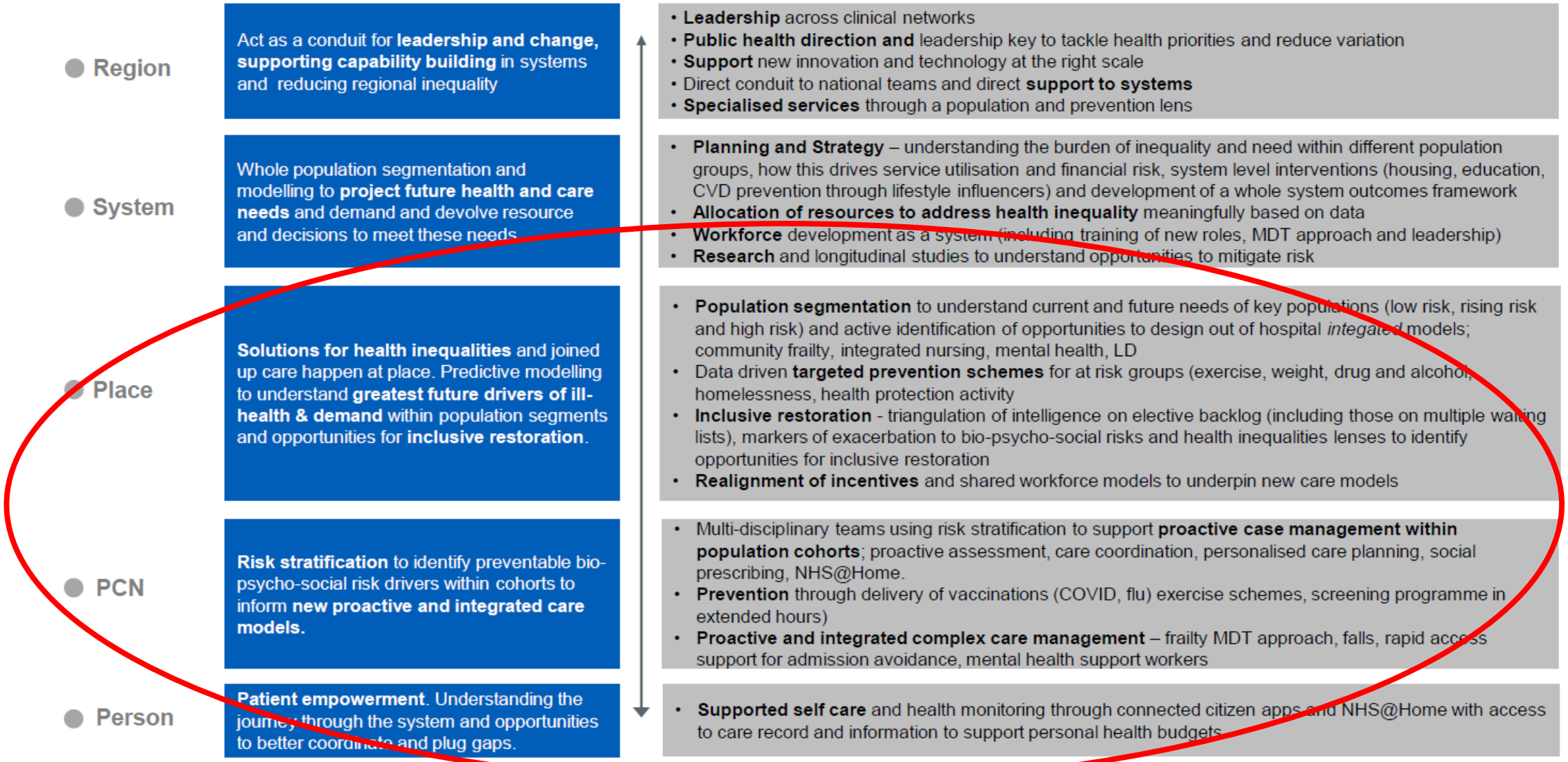
PHM Provides the toolkit:

- Data (needs/spend/processes/outcomes/evaluation)
- Guided by our population's needs (JSNA etc) to inform designing and targeting of interventions at each level of our system.
- Modelling – what if?
- Reducing risk - whole population (/segmented) & system-wide approaches not just services for the most ill
- Strategy (& culture…..)

The overall aim is to embed Population Health Management (PHM) across the Sussex Integrated Care System (ICS) = delivering increased capability at all tiers of the ICS

Source: Sussex Population Health Management Development Programme Restart Workshop 24 March 2021

What can be done differently using PHM



Source: Sussex Population Health Management Development Programme Restart Workshop 24 March 2021

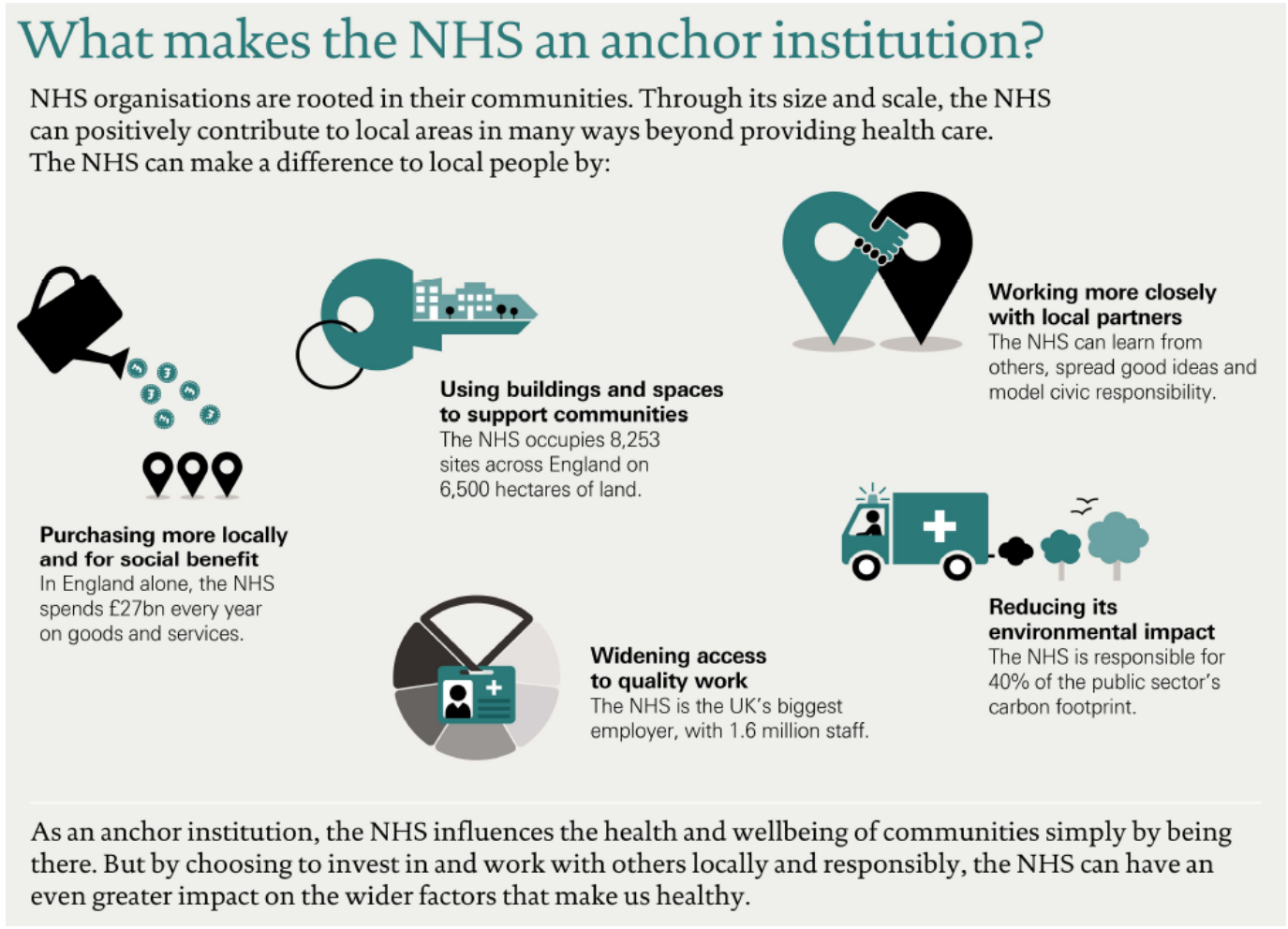
Timescales

East Sussex: Developing partnership approaches to community wellbeing (sustainable community hubs)	
Commences	May 2021
Draft Stage 1 outputs	July 2021
Draft reporting	October 2021
Final reporting	December 2021
Presentations	December 2021/January 2022

East Sussex: Systems approach to loneliness and isolation	
Commences	May 2021
Interim progress report	October 2021
Final reporting	December 2021/January 2022

Sussex ICS: Population Health Management Development Programme	
Initial accelerator pilot programme	Concludes August 2021
Scale and spread of PHM capabilities	From August 2021, subject to further planning

White Paper: Anchor institutions



Developing NHS organisations as Anchor Institutions to support broader social and economic development

Source: The Health Foundation

[Building healthier communities: the role of the NHS as an anchor institution | The Health Foundation]

Other linked areas of work…

- Local work to reset and recover NHS services and the eight urgent actions on health inequalities
- PCN developments e.g. Additional Roles Reimbursement Scheme – Mental Health Practitioners, Health Coaches and Social prescribing and targeted work on PHM
- Primary care and mental health developments - Emotional Wellbeing Services and PCN resource mapping
- Existing/new work being taken forward by the East Sussex Healthy Weight, Alcohol and Smoking Partnerships
- Existing integration programme objectives across the five areas aimed at supporting independence, early intervention and prevention and reducing health inequalities, for example end to end pathways in planned care
- Integrated and jointly commissioned services aimed at improving population health, supporting independence, early intervention and prevention and reducing health inequalities
- Learning from existing and recent work e.g. Health Hastings and Rother Programme, our Pandemic response
- Sussex ICS Population Health and Prevention Programme
- Sussex Integrated Dataset (SID) and SID-East Sussex developments
- East Sussex Outcomes Framework Population Health and Wellbeing Domain – and work to set baselines, indicators and trajectories and aligning this with Sussex Vision 2025, along with a coherent set of actions to ensure impact
- Sussex Vision 2025 and reducing gaps in health inequalities
- *Other……*

…..coordination, alignment, visibility at place level