Brighton & Hove City Council

HEALTH OVERVIEW & SCRUTINY COMMITTEE ADDENDUM

4.00PM, WEDNESDAY, 22 APRIL 2026

COUNCIL CHAMBER, HOVE TOWN HALL

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ADDENDUM

Brighton & Hove City Council

Scrutiny Report Template

Overview & Scrutiny

Agenda Item 32

Subject: **Improving urgent care pathways for homelessness and drugs & alcohol**

Date of meeting: **22 July 2026**

Report of: **Chair, Health Overview & Scrutiny Committee**

Contact Officer: **Name: Giles Rossington, Scrutiny Manager**

Email: giles.rossington@brighton-hove.gov.uk

Ward(s) affected: (All Wards);

Key Decision: No

For general release

1. Purpose of the report and policy context

1 This paper sets out how the Brighton & Hove health and care system is strengthening urgent care pathways for people experiencing homelessness and/or drug and alcohol dependency, with a focus on admission avoidance, timely discharge and sustained community engagement. It describes current arrangements, identifies shared system challenges and sets out agreed actions to improve coordination, outcomes and flow across community, mental health and housing services.

2. Recommendations

2.1 Health Overview & Scrutiny notes the contents of this report.

3. Context and background information

3.1 Urgent care in Brighton & Hove continues to experience significant pressures, including long waits at A&E and delays in discharging people from hospital. Some vulnerable groups are, due to the nature of their vulnerabilities, more likely than average to seek urgent health care, more likely to require admission to hospital, and more difficult to discharge. This is

especially the case for the group of people with multiple and overlapping needs, particularly homelessness, substance misuse and mental ill-health.

3.2 This is a national issue, but of particular relevance to Brighton & Hove because the city has unusually high numbers of people with multiple needs: for example, the local Multiple Compound Needs (MCN) programme identified 704 people in the city experiencing homelessness who had 3 or more compounding disadvantages. The highest compounding needs associated with homelessness are mental health with 88% of the 704 having mental health support needs and 77% substance misuse support needs (more details in the appended slide deck). Brighton & Hove is an outlier in terms of emergency department attendances associated with drug & alcohol needs and wider multiple compound needs. The city is in the top quartile of local authorities for drug related deaths and our 2020 MCNs Joint Strategic Needs Assessment identified that people with three or more MCNs have 34 years less life expectancy than the average person. These data themes of the increasing prevalence of substance use and mental health care and support needs amongst people who are homeless are also captured in the city council's new homeless & rough sleeping strategy (see appended slide deck), with one of its three strategic priorities being to *provide joined-up support with partners for people who most need help.*

3.3 Following the publication of the 2020 MCNs Joint Strategic Needs Assessment, the city's Joint Health & Wellbeing Board agreed to make homelessness and multiple compound needs (H&MCNs) one of its five population health priorities. This also aligned with the three upper tier Sussex local authorities being awarded national Changing Futures Funding to tackle MCNs through integrated and proactive care models of delivery. For the past three years Brighton & Hove has had national funding for a multidisciplinary team to deliver intensive proactive care to people with MCNs. The team is known locally as the Changing Futures Team.

3.4 **Current Services.** In order both to better support vulnerable people with MCN and to reduce pressure on the urgent care system, additional support for people with complex needs is required. This is recognised by the local health and care system and supported through specialist health inclusion teams in our primary and secondary care health services. An important contribution to the costs of these teams is made through the allocation of circa £1m of the city's health & care partnerships Better Care Fund. Specialist services specific to urgent care pathways include:

Hospital In-Reach and Discharge Support
People experiencing homelessness who attend the Royal Sussex County Hospital (RSCH) are supported through a multi-agency in-reach model commissioned by NHS Surrey and Sussex and Brighton & Hove City Council (BHCC). This includes ARCH Primary Care, NHS Inclusion Health and Mental Health teams, housing officers, hospital social work, and substance recovery leads. The pathway focuses on early identification, coordinated discharge planning and connection to housing and community services. (see flow chart in appended slide deck for more detail)

Brighton & Hove Public Health commissions a drug and alcohol community treatment system through Change Grow Live (CGL), including recovery nurses providing emergency department (ED) and inpatient in-reach, harm reduction, rapid assessment and onward referral into structured treatment and community support.

As part of the specialist hospital in-reach & discharge service there are 7 intermediate care beds known as the homeless stepdown beds. These beds are situated in the Councils New Steine Mews Hostel. Arch Healthcare are commissioned to provide clinical nursing support and the hostel team provide intensive housing related support around attending health appointments and accessing services relevant to their MCNs.

Community Intervention via Multiple Compound Needs (MCN) / Inclusion Health Model

The Homelessness & MCN Integrated Community Team (H&MCN ICT) brings together NHS, local authority and VCSE partners to provide intensive, multidisciplinary care coordination and proactive community follow-up. Some of the core objectives of the H&MCNs ICT are to reduce preventable presentations at A&E, and support safe and timely discharge, through further development of integrated pro-active community care for this population group. This model is a core enabler for urgent care improvement and admission avoidance for people with the highest needs (see H&MCNs ICT structure chart in in appended slide deck for more detail).

3.4 **Challenges.** Despite these existing assets, system partners consistently identify challenges:

- **Repeat ED attendances** linked to substance use, mental distress and unstable housing, often resulting in treat-and-discharge
- **Variable clarity at front door** on which pathway or team holds responsibility, particularly out of hours
- **Complex discharge planning**, where housing availability, substance use risk and mental health needs intersect
- **Post-discharge follow up**, community support may not feel sufficiently intensive or coordinated
- **Lack of flow through specialist homeless intermediate care beds,** the seven beds are often not available as there are long-term challenges of getting people successfully moved on from these beds when they no longer need the intermediate clinical care
- **Reducing stigma and improving knowledge of the specific needs of this population group,** there is evidence that in an under-pressure hospital system that people with MCNs sometimes experience poorer levels of service associated with stigma around perceived ‘lifestyle’ choices. This has been reported by Common Ambition lived experience group and through community health professionals. The result is often that people with MCNs are discharged without receiving additional consideration for their needs, which often results in repeat presentations to the hospital.

3.5 **Strategic Direction.** To address these challenges, system partners have agreed on an improvement goal to to reduce avoidable urgent care use and improve outcomes for people experiencing homelessness and/or substance

use by strengthening integrated health, care and housing pathways. Key improvement themes are:

1. Admission Avoidance

- As part of the new national neighbourhood health reform and its 'left shift' focus from hospital to community. Building on the learning from the national Changing Futures Programme through the further development of the new Multiple Compound Needs Integrated Community Team. This includes doubling the capacity of the Changing Futures Multidisciplinary Team to support up to 200 people a year. Focus on reducing avoidable hospital presentations. As a partnership reviewing the current multidisciplinary hospital in-reach model and agreeing where improvements can be made.
- Earlier identification of homelessness, drug and alcohol needs at ED front door preventing unnecessary detoxing in A&E
- Rapid in-reach from ARCH, CGL and MCN teams to stabilise risk and divert where safe.
- As part of the city's Combatting Drugs Partnership, work has started to improve the way Mental Health & Substance Use Services work together to support people with co-occurring mental health and substance use care and support needs. This will include a formal protocol to ensure the right services are available and that eligibility criteria don't prevent people receiving the care and support they need. The protocol will be supported through joint commissioning of specialist co-occurring condition services
- Consideration to be given to reinstating the lived experience training that Common Ambition has delivered to junior hospital doctors to improve their understanding of the specific needs of people who are homeless and/or have multiple compound needs

2. Improved Discharge and Flow

- Clear ownership of discharge coordination for people with no fixed abode
- Stronger alignment between hospital teams and Homelessness and MCN ICT (Housing, Changing Futures and community and mental health inclusion services.)
- Further development of the intermediate care beds at New Steine Mews Hostel to improve flow through the beds
- Access to Housing support-Hospital HPO

4. Analysis and consideration of alternative options

4.1 Not applicable to this report for information.

5. Community engagement and consultation

5.1 None for this information report.

6. Financial implications

6.1 None identified for this information report.

Name of finance officer consulted: Ishemupenya Chagonda Date consulted: 13/04/26

7. Legal implications

7.1 No direct legal implications have been identified as arising from this for-noting report.

Name of lawyer consulted: Victoria Simpson Date consulted: 13/04/26

8. Risk implications

8.1 A dysfunctional urgent care system poses significant risks for the health of local residents as well as potentially impacting on the city's economy and reputation. Measures being taken to reduce pressure on the urgent care system by providing additional support for groups of people with complex needs are a key mechanism for managing this risk.

9. Equalities implications

9.1 None directly for this information report. Members may wish to explore the degree to which people with protected characteristics are more likely than average to present for urgent care or require specific support in order to move smoothly along the urgent care pathway, and the degree to which this is recognised and addressed in current services and improvement planning.

10. Sustainability implications

10.1 None identified.

10. Health and Wellbeing Implications:

10.1 The report describes initiatives which are designed to improve the health and wellbeing of some of our most vulnerable people in addition to reducing general pressures on urgent care.

Other Implications

11. Procurement implications

11.1 none identified.

12. Crime & disorder implications:

12.1 None identified.

13. Conclusion

13.1 Members are asked to note the work being done across the health and care system to reduce pressures on urgent care by identifying and providing additional support to people with complex needs.

Appendices

1. Slides on urgent care pathways for homelessness and for drugs and alcohol

Brighton & Hove Health Overview & Scrutiny Committee

Improving Urgent Care Pathways for Homelessness and Drugs & Alcohol

Report Appendix

Improving Lives Together

Brighton & Hove Multiple Compound Needs Mapping- this mapping is compiled across all homeless services in the city to provide an evidence base for the prevalence of Multiple Compound Needs. To access the full report use this link [Brighton & Hove Q4 MNA 2024/25]

MCN Overview

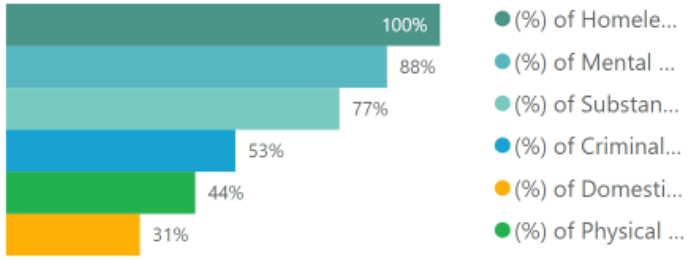
1909 total clients in this return

37% of total experiencing MCN

704 are experiencing MCN

This page shows the demographics around the Multiple Compound Needs (MCN) of those clients who are experiencing MCN, as well as contrasting those scores with those in the return who are not experiencing MCN. the following pages show more detail regarding the categories which contribute to MCN. All clients are experiencing homelessness.

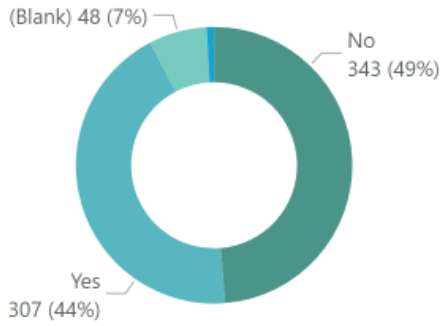
Total Experiencing MCN by Need



Needs Profile of those experiencing MCN

Areas of MCN	#	%
3	417	59.23%
4	234	33.24%
5	53	7.53%
Total	**704**	**100.00%**

Total Experiencing MCN by Physical Health Need



88% Registered with GP Services

6% Are known to be in Target Priority Group

516 individuals (excluding BHCC data)

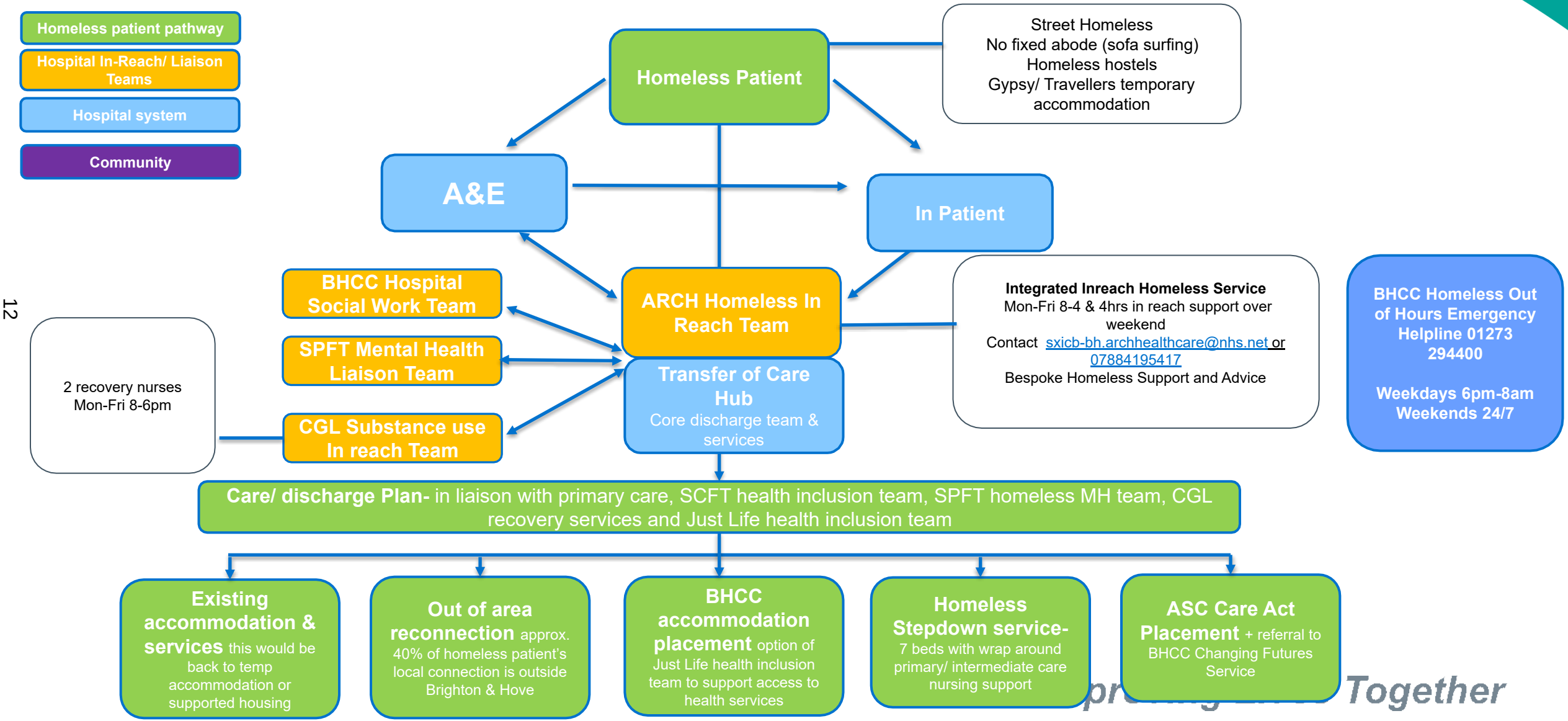
	Of those experiencing MCN...	Of those not experiencing MCN...
Are rough sleeping	11%	18%
Are known to MH Services	36%	10%
Are known to SU Services	50%	4%
Are known to Probation	19%	1%
experienced Care	8%	7%

Brighton & Hove City Council Homelessness & Rough Sleeping Strategy Support needs of homeless applicants to council 2020 to 2024

Support needs (overlapping categories)	Prevention duty owed	Relief duty owed
Access to education, employment or training	87	96
Alcohol dependency needs	100	574
At risk of/has experienced abuse (non-domestic abuse)	53	224
At risk of/has experienced domestic abuse	170	707
At risk of/has experienced sexual abuse/exploitation	51	199
Care leaver aged 18-20 years	8	72
Care leaver aged 21+ years (Retired)	8	74
Difficulties budgeting	187	133
Drug dependency needs	115	717
Former asylum seeker	58	163
History of mental health problems	737	2,020
History of repeat homelessness	81	515
History of rough sleeping	46	500
Learning disability	109	266
Offending history	73	605
Old age	95	74
Physical ill health and disability	628	1,238
Served in HM Forces	3	18
Victim of modern slavery	8	21
Young parent requiring support to manage independently	20	47
Young person aged 16-17 years	8	14
Young person aged 18-25 years requiring support to manage independently	74	278

RSCH Homeless Care Co-ordination Pathway-

Arch Healthcare are commissioned to provide a care-coordination service for people who are homeless that enter RSCH Hospital. They work in an integrated way with many partners and the service works closely with the TOCH, A&E and departments across the hospital



Brighton & Hove

Homeless & Multiple Compound Needs Integrated Community Team

One vision for Brighton & Hove

For people experiencing multiple compound needs to lead healthy independent lives with value and purpose and access to the right care

The ICT is bound by a Compact Agreement to which all partners are committed.