Who are we?

The Health & Wellbeing Board is the forum where representatives of the City Council, NHS and Third Sector hold discussions and make decisions on the health and wellbeing of the people of Brighton & Hove.

Meetings are open to the public and everyone is welcome.

Where and when is the Board meeting?

This next meeting will be held in the Council Chamber at Hove Town Hall on Tuesday 8 November 2022 starting at 2.00pm.

Health & Wellbeing Board

Date: **8 November 2022**

Time: **2.00pm**

Venue: **Council Chamber, Hove Town Hall**

Who is invited:

B&HCC members: Councillors: Shanks (Chair), Nield (Deputy Chair), Robins (Opposition Spokesperson), Brown (Group Spokesperson) and Appich

NHS members: Lola Banjoko, Ashley Scarff, Siobhan Melia (SCFT), Dr Jane Padmore (SPFT) and Dr Andy Heeps (UHS)

Non-voting members: Joanna Martindale (Community Works), Tom Lambert (Carers Centre), Geoff Raw (CE - BHCC), Deb Austin (Statutory Director of Children's Services), Rob Persey (Statutory Director for Adult Care), Alistair Hill (Director of Public Health), David Liley (Healthwatch) and Annie Callahan (SAB)

Contact: **Penny Jennings**
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Date of Publication - Monday, 31 October 2022

AGENDA

Formal matters of procedure

This short formal part of the meeting is a statutory requirement of the Board

Part One **Page**

17 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

The Chair of the Board will formally ask if anyone is attending to represent another member, and if anyone has a personal and/or financial interest in anything being discussed at the meeting. The Board will then consider whether any of the discussions to be held need to be in private.

18 MINUTES **9 - 32**

(a) Minutes of the meeting the Board held on 12 July 2022 (copy attached);

(b) Minutes of the special meeting of the Board held on 13 September 2022 (copy attached);

(c) Minutes of the meeting of the Adult Social Care and Public Health Sub Committee meeting held on 14 June 2022 (copy attached for information only)

19 CHAIR'S COMMUNICATIONS

The Chair of the Board will start the meeting with a short update on recent developments on health and wellbeing.

20 FORMAL PUBLIC INVOLVEMENT **33 - 34**

To consider the following:

(a) Petitions – to consider any petitions received by noon on 3 November 2022;

(b) Written Questions – to consider any written questions received by noon o November 2022 (copy attached);

(c) Deputations – to consider any Deputations received including any received f full council.

21 FORMAL MEMBER INVOLVEMENT

To consider the following :

(a) Petitions;

(b) Written Questions ;

(c). Letters;

(d) Notices of Motion

22 ITEMS REFERRED FROM COUNCIL

Items referred from Full Council (if any)

23 MENTAL HEALTH JOINT STRATEGIC NEEDS ASSESSMENT **35 - 240**

Report of the Director of Public Health (copy attached)

Contact Officer: *Kate Gilchrist* *Tel: 01273 290457*
Ward Affected: *All Wards*

24 BRIGHTON & HOVE MENTAL HEALTH & HOUSING PLACE BASED PLAN **241 - 426**

Report of the Executive Director, Health and Adult Social Care (copy attached)

Contact Officer: *Jenny Knight* *Tel: 01273 293081*
Ward Affected: *All Wards*

25 FAST FOOD & ENERGY DRINK ADVERTISING: OFFICER RESPONSE TO NOTICE OF MOTION **427 - 438**

Report of the Executive Director, Adult Health and Social Care (copy attached)

Contact Officer: *Kathleen Cuming*
Ward Affected: *All Wards*

26 BETTER CARE FUND **439 - 464**

Report of the Executive Director, Health & Adult Social Care, and the Deputy Managing Director, Brighton & Hove, NHS Sussex (copy attached)

Contact Officer: *Andy Witham* *Tel: 01273 291498*
Ward Affected: *All Wards*

27 TOWARDS ZERO HIV TASKFORCE: UPDATE **465 - 480**

Report of the Executive Director, Adult Health and Social Care (copy attached)

Contact Officer: *Stephen Nicholson* *Tel: 01273 296554*
Ward Affected: *All Wards*

28 BRIGHTON & HOVE COLD WEATHER PLAN 2022-23 **481 - 526**

Report of the Director of Public Health (copy attached)

Contact Officer: *Becky Woodiwiss* *Tel: 01273 296575*
Ward Affected: *All Wards*

29 JOINT HEALTH & WELLBEING STRATEGY (JHWS) OUTCOME MEASURES: UPDATE **527 - 556**

Report of the Director of Public Health (copy attached)

Contact Officer: *Kate Gilchrist* *Tel: 01273 290457*
Ward Affected: *All Wards*

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Further information

For further details and general enquiries about this meeting contact Penny Jennings, (01273 291065, email penny.jennings@brighton-hove.gov.uk) or email democratic.services@brighton-hove.gov.uk

HEALTH & WELLBEING BOARD Agenda Item 18(a)

BRIGHTON & HOVE CITY COUNCIL

HEALTH & WELLBEING BOARD

2.00pm 12 JULY 2022

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Shanks (Chair)

Also in attendance: Councillor Nield (Deputy Chair), Robins (Opposition Spokesperson), Appich, Bagaeen and Hugh-Jones

Other Members present: Lola Banjoko, Ash Scarff (NHS Commissioners); Dr Jane Padmore (Sussex Partnership NHS Foundation Trust); Andy Heeps (University Hospitals Sussex NHS Foundation Trust); David Liley (Healthwatch Brighton & Hove); Annie Callahan (Brighton & Hove Safeguarding Adults Partnership); Tom Lambert, Joanna Martindale (Community & Voluntary Sector representatives); Geoff Raw (BHCC Chief Executive); Deb Austin (BHCC Director of Children's Services); Rob Persey (BHCC Director of Adult Social Services)

PART ONE

1 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

1.1 Apologies were received from Siobhan Melia (Sussex Community NHS Foundation Trust).

1.2 Cllr Hugh-Jones attended as substitute for Cllr Nield
Cllr Bagaeen attended as substitute for Cllr Brown.

1.3 There were no declarations of interest.

1.4 **RESOLVED –** that the press & pubic be not excluded from the meeting.

2 MINUTES

2.1 **RESOLVED –** that the minutes of the 08 March 2022 committee meeting be agreed as an accurate record.

3 CHAIR'S COMMUNICATIONS

3.1 The Chair gave the following communications:

Masks reintroduced in health and care settings due to rising COVID-19 cases
Unfortunately the number of positive COVID-19 cases and the number of hospital admissions with COVID-19 is rising.
Last week NHS Sussex reintroduced mask wearing in all clinical healthcare settings to prevent the spread and protect those who are most vulnerable. This applies to patients, visitors and staff, including at GP practices, consulting rooms, outpatient departments, clinics and wards.
We now recommend that visitors and staff in all care settings should wear masks. This includes care homes, supported living, home care and offices in care settings.
Masks will be made available for visitors to use, and exemptions will be respected.

COVID-19 vaccinations
The COVID-19 vaccination centre at Churchill Square has now closed but vaccinations remain available at mobile sites in the city for people aged 16+. Many of these are now regular slots – including at Hove Tesco on a Wednesday, Hove Polyclinic on a Thursday and St Peter's Church on a Friday. Other locations vary each week.
For children aged 5-15, appointments are available to book at the racecourse through the national booking system.
For the latest information, please check the new Sussex Health and Care website.

Bird Flu
Sadly, cases of bird flu have been found in the city and are spreading in our wild bird populations – particularly gulls. The risk to humans is very low, but please do not touch any dead or sick birds that you find and keep any pets away.
If you find a dead bird on public land please report it to Cityclean for them to safely clear it. And if you find it on private land, including in your garden please let DEFRA know.
If you find a sick bird, please don't try to handle it. You should contact the RSPCA for advice.

Level 3 heat-health alert
A level 3 heat-health alert is currently in place in the South East until Friday. With such hot weather expected for a prolonged period of time please check in on elderly or vulnerable friends or neighbours to make sure they are keeping cool and hydrated, and watch out for signs of heat stroke. Encourage them to stay in the shade, close curtains, drink plenty of fluids, and check that any medicines are being stored at the correct temperature.

4 FORMAL PUBLIC INVOLVEMENT

4(a) petitions

4.1 The baby box petitioners were not in attendance at the meeting to present their petition. The Chair noted that the subject of premature mortality was a very important one, and that there would be a focus on reducing rates of infant mortality in general, and inequalities in terms of mortality rates specifically, as part of the review of the city Joint Health & Wellbeing Strategy Starting Well commitments.

4.2 **RESOLVED –** that the petition be noted.

4(b) Public Questions

4.3 The Chair asked Daniel Harris to put his question. Mr Harris asked:

The museum of homelessness an organisation who monitor nationwide homeless deaths finally after a struggle to get an FOI response on homeless deaths in which Cllrs and myself had to intervene, have told me the following:

"the council has told us of 31 deaths in 2021, all of which took place in supported or emergency accommodation. This is not dissimilar to the number they provided us in 2020, which was 30."

This is very high. Would the council consider commissioning a report into these by BH Healthwatch in order to fully understand how this happened?

4.4 The Chair responded by noting that it was unfortunately the case that the mean age of death for homeless people is in their mid-forties, compared with around 80 for the general population, with a particularly high prevalence of deaths associated with drug poisoning, alcohol-specific causes or suicide. Brighton & Hove is developing a new Drug Strategy and is refreshing the Suicide Prevention Strategy. The needs of homeless people will be addressed in both.

4.5 In response, Mr Harris noted the complexity of the support needs of many homeless people, where there may be multiple vulnerabilities in play, and asked again if the Board would consider commissioning Healthwatch to obtain more information about this very vulnerable group. The Chair responded that she would consult with housing colleagues and with the Chair of Housing Committee about this (Cllr Hugh-Jones, Chair of Housing Committee, was in attendance at the Board in any case).

5 MEMBER INVOLVEMENT

5.1 David Liley, Healthwatch Brighton & Hove member, asked a member question:

Healthwatch notes that following the removal of NHS funding it has been forced to close HOPs, the hospital discharge phone support project, from the end of June 2022. Healthwatch volunteers helped approximately 2,700 local people over the COVID period. What plans does the NHS have in place to continue to support people, in the City, post hospital discharge, with proactive telephone support? Are these plans restricted to older people and do they include support for younger people with emotional and wellbeing issues, particularly those who are at risk of self-harm and suicide?

5.2 The Chair responded:

The HOPs service was commissioned with Healthwatch at the very beginning of the COVID-19 pandemic, using national emergency procurement regulations. The aim was to support people, post discharge, by providing a check on them, and the opportunity to signpost those requiring local services to appropriate local support.

We want to thank Healthwatch for mobilising the service so quickly at the time of the pandemic and for working alongside other commissioned Voluntary Community Service (VCS) providers in supporting people being discharged from hospital.

As we are now working to restore and recover from the pandemic, all additional services commissioned by the NHS to support hospital discharge at the height of COVID-19 have been evaluated to determine whether they are still required and if so, how each can sustainably and effectively be best delivered.

Healthwatch's Report of the HOPs service covered a 21-month period from the start in April 2020 to January 2022. The report showed that, Healthwatch contacted 63% of the 6,530 people referred. Of those contacted (equivalent to the 2,700 highlighted in the question raised by Healthwatch), 77% needed no assistance or were simply made aware of other commissioned support services in B&H.

542 people (8% of the referred cohort) required further input and were actively referred onto other organisations to provide active support (commissioned VCS providers, primary care, mental health services etc).
Healthwatch have spent time to go through their detailed evaluation report with the NHS and we thank them for this time and for highlighting areas for improvement.

We have taken forward the learning from this service, and the help that it provided. Firstly we have absorbed post-discharge calls into the contract of an existing commissioned VCS provider who were already providing direct home support in the city. This means that post-discharge checks and direct care, where applicable, are managed by a single organisation, which reduces the risk of delays in people receiving the direct support they need.

For those requiring emotional and wellbeing support including patients at risk of self-harm and suicide, the NHS and the Council commission a wide range of services across both the NHS and voluntary sector and these are all available to the post-discharge check providers to signpost or refer to.
Therefore, we thank again Healthwatch for their support with this service during the pandemic and are confident that we have taken the learning from this service as we continue to support people now post discharge.

5.3 Mr Liley asked a supplementary question, noting that the commissioning change would mean that a valuable service had been lost. Whilst other services were excellent, and would pick up some of the work that Healthwatch had undertaken, he feared that there would be gaps, with not everyone who needed support receiving the help and advise that they needed. The Chair responded by noting that the Sussex Health & Care Partnership (ICS) was prioritising work to improve hospital discharge, so hopefully this work would address some of the gaps that Mr Liley had identified.

6 PHARMACEUTICAL NEEDS ASSESSMENT

6.1 This item was introduced by Nicola Rosenberg, Consultant in Public Health. Ms Rosenberg told the Board that public satisfaction with local pharmacies is high, and that pharmacies are relatively well-spread across the city, with all residents within 20 minutes of a pharmacy. Although some areas are less well provided for than others, there is no gap in provision requiring an additional pharmacy to be established. However, not all pharmacies provide a full range of services; and there are issues with evening and weekend opening, with limited access across the city. The draft Pharmaceutical Needs Assessment (PNA) has recommendations to address these issues.

6.2 Ms Rosenberg noted that the final PNA needs to be submitted by 01 October 2022. A special meeting of the HWB will be called in September to agree the final draft . Board members will also be asked to comment on the West Sussex and East Sussex PNAs, and these will be circulated to members outside the meeting.

6.3 The Chair noted that the report was comprehensive. She also queried how well additional pharmaceutical services were advertised in chemists and whether the links between pharmacies and GP practices were as robust as they could be. Ms Rosenberg agreed that both were valid points; the draft PNA recommendations include measures to improve public awareness of additional services provided by city pharmacies and to strengthen links with GP practices.

6.4 Cllr Appich noted that some pharmacies had seen reduced funding, and that taking on additional services would presumably help make up any shortfall. Ms Rosenberg agreed that payment for additional services could help pharmacies maintain their profits, although they do have to be mindful of their capacity to deliver additional services.

6.5 Cllr Appich told members that she was especially concerned about the impact on women of restricted evening and weekend opening, particularly in terms of being able to access emergency contraception. Ms Rosenberg agreed that this was a concern and she would ensure that this was emphasised in the final draft.

6.6 Cllr Appich also noted that she would like to see pharmacies do more to promote healthy living and that she was happy to see the increased availability of hepatitis C testing in pharmacies. Ms Rosenberg agreed with encouraging the promotion of healthy living and said that this would receive more emphasis in the final draft. With regard to hepatitis C testing, there was more work to do in the city.

6.7 Cllr Appich noted that there is substantial housing being built in the city, particularly around Hove Station, and there may be an impact here on pharmacy capacity. Ms Rosenberg responded that the full draft PNA details new housing developments, and that there has been engagement with pharmacies sited near new developments to check that they are confident managing increased demand, with almost all pharmacies currently expressing confidence.

6.8 Cllr Hugh-Jones asked how resilient local pharmacies were. Ms Rosenberg responded that there were 60 city pharmacies in 2015, 56 in 2018 and 53 in 2022. There is a

decline, which is mirrored in other parts of the country. However, the decline is not precipitate which suggests that the market is fairly resilient.

6.9 Cllr Hugh-Jones noted that three of the most deprived areas of the city had no pharmacy. Ms Rosenberg agreed that this was a concern; the local health system needs to think about the under-provision of a range of health services in the most deprived parts of the city and the conglomerative impact this may have.

6.10 In response to queries from Cllr Hugh-Jones, Ms Rosenberg agreed to amend the draft report to include the dates of the user survey and more information on how additional evening and weekend opening hours will be advertised.

6.11 Cllr Robins pointed out that the car ownership data cited in the report may be misleading as the actual level of ownership varies considerably between the city centre and the suburbs, making citywide averages of little use. Ms Rosenberg agreed to address this issue in the final draft.

6.12 In response to a query from Cllr Robins about the use of jargon and acronyms in the report, Ms Rosenberg noted that the PNA report had to be written to a closely prescribed format, requiring a good deal of technical information which required to use of the appropriate terminology. The final draft would be as accessible as possible within these significant restrictions.

6.13 Cllr Robins noted that a pharmacy had previously been sited at West Hove Sainsburys, but had subsequently closed. This location had been very convenient as the supermarket is easily accessible and opens late. Ms Rosenberg agreed that this could be suggested as a potential location for any new pharmacy.

6.14 The Chair asked whether there was a shortage of pharmacists in the city. Ms Rosenberg responded that this was not easy to quantify as the PNA measures pharmacies rather than individual pharmacists. However, since a number of services can only be delivered by a qualified pharmacist, this is a valid point.

6.15 Cllr Bagaeen noted that a disappointingly low number of city GPs responded to the PNA consultation . Ms Rosenberg agreed, noting that the PNA includes recommendations to strengthen links with GPs.

6.16 Cllr Bagaeen asked whether the draft PNA had taken account of recently published census date. Ms Rosenberg responded that it did not, but that the census data will be used to inform the final PNA. Rob Persey noted that the accuracy of the 2021 census is questionable, given that it was undertaken when Covid restrictions were in place which may have resulted in a large number of city residents, particularly younger people, temporarily living elsewhere.

6.17 RESOLVED – that the Board notes the draft Pharmaceutical Needs Assessment.

7 UPDATE ON FUEL POVERTY & AFFORDABLE WARMTH SUPPORT AND MEASURES AVAILABLE AND PLANNED

7.1 This item was presented by Sarah Podmore, Health Promotion Specialist (Public Health); and by Miles Davidson, Sustainability and Energy Manager (Housing). Ms Podmore explained to the Board the work of the steering group and engagement with community & voluntary sector organisations.

7.2 Cllr Robins noted that homes were rated in terms of energy efficiency, but queried how easy it was for residents to access this information. Mr Davidson replied that whenever a home is sold or rented, an Energy Performance Certificate is required. This means that many, although not all, home sin the city have certification already.

7.3 In response to a question from Cllr Robins on older people at risk of hypothermia, Ms Podmore confirmed that older people are a priority for fuel poverty work and will be a focus of the upcoming Equality Impact Assessment.

7.4 Cllr Robins noted that some measures to insulate or retain heat in a home could lead to increased condensation and the risk of damp. Mr Davidson agreed that this was an issue, and it was important that works should be undertaken with care and following a proper survey. Advice to residents recognises that there is a balance to be struck between minimising condensation (e.g. by opening windows) and retaining heat in the home; so for instance people may be recommended not to air their homes when they have heating on.

7.5 In response to a question from the Chair on the energy efficiency of council-owned housing stock, Mr Davidson told members that the average for council housing was currently just below C. There are plans to improve this rating in order to reduce carbon emissions and to help residents with their fuel consumption.

7.6 Cllr Hugh-Jones asked for details of the LAD (Local Authority Delivery) Scheme 3. Mr Davidson responded that the scheme has only recently been launched and all the details are not yet available. There is £30M available across a number of local authority areas, and eligibility criteria will include household income and the property energy efficiency rating.

7.7 Tom Lambert asked whether the council was confident that it would be able to allocate all of our Household Support Fund (HSF) monies, particularly given the requirement to target a percentage of the funding to people of pensionable age. Ms Podmore told the Board that colleagues in BHCC Revenues & Benefits had confirmed that plans are in place to allocate all the HSF.

7.8 RESOLVED – that the Board notes the update on Fuel Poverty & Affordable Warmth.

8 JOINT STRATEGIC NEEDS ASSESSMENT ANNUAL UPDATE: 2022-23

8.1 This item was presented by Caroline Vaas, Consultant in Public Health. Ms Vaas explained that the Joint Strategic Needs Assessment (JSNA) is used as an evidence-base to develop strategies and inform commissioning decisions, identifying gaps and under or over provision of services. The JSNA consists of a number of individual Needs Assessments, which vary considerably in size and complexity. The current JSNA format has served the city well, but in light of major developments in health and care systems (e.g. the launch of Integrated Care Systems: ICS), the way that the JSNA is delivered

needs to be reviewed. To this end, there is a proposal to reconvene the City Needs Assessment Steering Group to review the JSNA and to agree a long-term (3 year) programme of needs assessments.

8.2 Responding to a question from Cllr Bagaeen on census data, Ms Vaas told the Board that needs assessments would be reviewed to reflect emerging data from the 2021 census.

8.3 In response to a question from Cllr Robins on why this was largely a report to note, Rob Persey told members that there is a lengthy process to follow in the creation of strategies or complex assessments of need. In order to keep the Board up to date on the progress of these matters, and to enable members to inform their development via comments, the Board is periodically asked to note recent developments or plans for further work. The current JSNA report is to note, but a future report will ask the Board to approve a needs assessment programme.

8.4 Cllr Hugh-Jones asked a question on the contribution of wood-burning stoves to the negative health impacts of poor air quality. Ms Vaas did not have this information available at the meeting, but agreed to provide a written response. The following response was subsequently received: The council's draft Air Quality Action Plan has recently been out to consultation
https://www.brighton-hove.gov.uk/sites/default/files/2022-05/7434%20Air%20Quality%20Action%20Plan%20pages%20and%20doc%20combined%20r3.pdf
and the results will be reported to September ETS Committee.

The plan refers to airborne pollution being a strong contributor to the 170 early deaths that occur each year in Brighton & Hove and be a factor in the onset of certain diseases or conditions. This is often linked to long-term exposure. There is a section on air quality and health and one of the plan's priority areas is to reduce smoke/emissions from buildings, and this includes wood burning in stoves or fireplaces. Pages 33 and 34 refer to domestic burning. Further work would be required to determine the contribution domestic burning has on local air quality.

The council's webpages include clear advice about woodburning:-
https://www.brighton-hove.gov.uk/environment/noise-pollution-and-air-quality/using-solid-fuels-safely-and-legally
It is a seasonal activity and therefore increases in winter months.

Media reports can also highlight the impacts of woodburning from time to time, including the impacts on indoor air quality:-
https://www.theguardian.com/environment/2021/jan/01/avoid-using-wood-burning-stoves-if-possible-warn-health-experts

8.5 In response to a question from Cllr Hugh-Jones on smoking, Ms Vaas told members that city smoking rates were falling, but remained higher than the national average; in some part this links to deprivation and to city demographics. Some vape products are now being used for harm reduction in smoking cessation services. There is also work ongoing to discourage general vape use, particularly amongst younger people.

8.6 Cllr Hugh-Jones asked a question about relatively low vaccination take-up in the city. Ms Vass responded that is a priority area, and that learning from the success of the Covid vaccination programme is being used to inform the development of the Child Immunisation Programme to be launched in November 2022.

8.7 In response to a question from the Chair on suicide and self-harm, Ms Vaas told members that there was a good deal of work ongoing in these areas: suicide and self-harm feature in the Mental Health Needs Assessment work, and also have links to work on homelessness and on substance misuse. The Sussex Suicide Prevention Strategy is also being developed currently. The Mental Health Needs Assessment will be presented to the HWB, potentially at the November 2022 Board meeting.

8.8 RESOLVED – that (1) the Board notes the annual JSNA update; and (2) that the Board agrees to the re-establishment of a Steering Group to review and develop the JSNA structure and the proposed three year programme of in-depth needs assessments for 2023-24 and 2025-26.

9 HEALTHWATCH BRIGHTON & HOVE: ANNUAL REPORT

9.1 This item was presented by David Liley, Chief Officer of Healthwatch Brighton & Hove. Mr Liley told the Board that Healthwatch had a small number of employed staff, but over 70 volunteers, and together they produced a good deal of work, publishing 20 reports and 70 newsletters and bulletins over the past year as well as attending more than 1000 meetings to hold decision-makers to account. Healthwatch receives £178K per year from the local authority, and receives no routine NHS funding, other than for specifically commissioned pieces of work. Of particular note in the past 12 months were:

- The work of Young Healthwatch (in partnership with the YMCA), especially initiatives focusing on access to mental health services, digital barriers to access, and encouraging vaccination uptake.
- The HOPS initiative which had seen Healthwatch commissioned to contact people after discharge from hospital to check they are okay etc.
- Work on access to dental services
- Work on access to GP services.

9.2 In response to a question from the Chair on funding, Mr Liley confirmed that Healthwatch's funding comes ultimately from a Government grant which is passported by the local authority. Healthwatch is not asking for more general funding, but is eager to be commissioned to deliver specific pieces of work.

9.3 In response to a question from Cllr Robins on dentistry, Mr Liley told members that many dentists were excellent. However, there are real recruitment problems, and website information is not always clear. Ultimately, significant improvements to dental services will only be delivered via a new dental contract. Mr Liley noted that, in the future, the ICS will have responsibility for commissioning dental services (rather than

regional NHS England commissioners), and it will be interesting to see what NHS Sussex's plans are to improve access locally.

9.4 Cllr Hugh-Jones commended the work of Healthwatch and asked a question about cancer screening. Mr Liley suggested that Lola Banjoko would be best able to answer this, and Ms Banjoko told the Board that the key factor in improving screening was to get better community uptake in communities where screening rates are poor. This may involve the use of mobile units or targeting specific communities such as homeless people.

9.5 Mr Liley also told the Board that he particularly wished to thank Frances McCabe, who had chaired Healthwatch for a number of years with great energy, humour and effectiveness. Fran has now retired from this post, and is a Governor at University Hospitals Sussex, where she is leading work on patient participation. The Chair echoed this thanks on behalf of the Board.

9.6 RESOLVED – that the Healthwatch Brighton & Hove annual report be noted.

10 BRIGHTON & HOVE SAFEGUARDING ADULTS BOARD (SAB) ANNUAL REPORT 2021-22

10.1 This item was presented by Annie Callahan, Independent Chair of the Safeguarding Adults Board (SAB). Ms Callahan explained the role of the SAB, listed the organisations involved in the partnership and outlined SAB priorities. Members were informed that a new independent Chair has been appointed in recent months.

10.2 The Chair thanked the SAB for all their work in the past year, and asked a question about how the balance is drawn between intervening in cases of self-neglect and respecting the autonomy of individuals. Ms Callahan responded that recent years had seen a move away from always respecting individuals' 'lifestyle choices' to a greater recognition of the importance of tackling really damaging behaviours.

10.3 In response to a query from Cllr Hugh-Jones on statistics in the report on DASH (domestic violence) referrals, Ms Callahan agreed to check the quoted data. She confirmed that a rise in referrals was likely to indicate better understanding of the referrals process, rather than necessarily a rise in incidents.

10.4 RESOLVED – that the SAB annual report be noted.

11 INTEGRATED CARE SYSTEM (ICS)

11.1 The Chair told members that there was relatively little to report at this stage, although Sussex Health & Care Assembly members have begun to meet together. Rob Persey added that there would be more to report at the November Board meeting, particularly about the development of 'place' arrangements and about the role of HWBs in the local and regional ICS systems.

11.2 Tom lambert asked a question about local mapping of the most deprived population groups. Lola Banjoko agreed to provide an update on this.

The meeting concluded at Time Not Specified

Signed Chair

Dated this day of

HEALTH & WELBEING BOARD Agenda Item 18((b)

BRIGHTON & HOVE CITY COUNCIL

HEALTH & WELLBEING BOARD

3.00pm 13 SEPTEMBER 2022

COUNCIL CHAMBER, BRIGHTON TOWN HALL

MINUTES

Present: Councillors Shanks (Chair) Councillor Nield (Deputy Chair), Robins (Opposition Spokesperson), Brown (Group Spokesperson) and Appich

NHS Members present: Lola Banjoko and Andy Jones

Non Voting Members : Alistair Hill, Statutory Director for Adult Social Care; Alistair Hill, Director of Public Health; Deb Austin, Statutory Director of Children's Services, David Liley, Healthwatch

PART ONE

12 DECLARATIONS OF SUBSTITUTES AND INTERESTS AND EXCLUSIONS

12(a) Apologies & Declaration of Substitutes

12.1 It was noted that, Siobhan Melia (SCFT), Dr Jane Padmore (SPFT) and Dr Andy Heeps (UHS), voting members had sent their apologies. Also, Geoff Raw (Chief Executive, Brighton & Hove City Council), Joanna Martindale (Community Works), Tom Lambert (Carers Centre) and Annie Callanan had sent their apologies.

1.2 Andy Jones was present in substitution for Ashley Scarff.

12(b) Declarations of Interests

12.3 There were none.

12(c) Exclusion of Press and Public

12.4 In accordance with Section 100A of the Local Government Act 1972 ("the Act"), the Health and Wellbeing Board considered whether the public should be excluded from the meeting during consideration of any item of business on the grounds that it is likely in

view of the business to be transacted or the nature of the proceedings, that if members of the public were present during it, there would be disclosure to them of confidential information as defined in Section 100A (3) of the Act.

12.5 **RESOLVED -** That the public be not excluded during consideration of any item of business set out on the agenda.

13 CHAIR'S COMMUNICATIONS

13.1 The Chair gave the following communications:

Briefing – Mental Health Supported Accommodation for H&WBB

13.2 "Brighton & Hove City Council in partnership with NHS Sussex commission three Supported Accommodation services for people with mental health needs. These services form part of the Mental Health Supported Accommodation Pathway and offer high, medium and low support and accommodation to people in the city. The contracts for these services are due to end and following committee approval and extensive consultation with service users, referrers and other stakeholders the council and NHS Sussex have been through a procurement process for two new supported accommodation services and a discharge to assess service which offers short term accommodation and support for those leaving hospital.

The newly commissioned services offer

- High quality accommodation with support
- An increased level of self-contained accommodation with specific provision for women with complex needs and vulnerable individuals.
- A flexible level of support within the services which can increase and decrease to meet client needs without individuals having to move accommodation.
- Therapeutic interventions and trauma informed support through well trained staff.

The contracts for the services have been awarded to:

SJOG (Saint John of God Hospitaller Services) for the high and medium supported accommodation service BHT Sussex for the medium to low supported accommodation service. BHT Sussex are the existing provider of this service and to Southdowns Housing Association for low support accommodation and the discharge to assess service

The new services are being mobilised and council and NHS Sussex Staff are working closely with both the current and new services to ensure that both service users and staff are supported in the transition period.

We would like to extend our sincere thanks to the outgoing service providers of high and medium support BHT Sussex and Sanctuary Housing for providing good quality accommodation and support services to people with mental health needs over many years. We look forward to supporting SJOG, BHT Sussex and Southdown with the new services.

Boosting your immunity with your flu vaccine and Covid booster this winter

NHS is offering an additional Autumn booster to people who are more vulnerable to COVID-19. The rollout began last week with care home residents and that's now been expanded to people aged 65 and over, those who are immunocompromised, carers and frontline health and care workers. Anyone who is eligible should book through the national booking service online or over the phone. Others will be invited in the coming weeks.

The local flu vaccine rollout has also begun. Those who been invited should book an appointment with their GP or pharmacy as soon as possible.

13.3 **RESOLVED –** That the Chair's Communications be noted and received.

14 FORMAL PUBLIC INVOLVEMENT

It was noted that a public question had been received but that the member of

14(a) Petitions

14.1 There were none.

14(b) Written Questions

14.2 It was noted that one question had been received and that the member concerned had been unable to attend the meeting. It was agreed that a written response would be sent.

14(c) Deputations

14.3 There were none.

15 FORMAL MEMBER INVOLVEMENT

15.1 There were no items.

16 PHARMACEUTICAL NEEDS ASSESSMENT REPORT 2022

16.1 The Board considered a report of the Brighton and Hove Pharmaceutical Needs Assessment Steering Group presenting the Pharmaceutical Needs Assessment Report 2022.

16.2 It was noted that The Health and Wellbeing Board (HWB) had a statutory responsibility to publish a revised Pharmaceutical Needs Assessment (PNA) every three years. However, as a result of Covid19 the regulations were amended to allow for the PNA to be published within four years, by October 2022. The PNA mapped current pharmaceutical services, identifying gaps and exploring possible future needs. It was used by NHS England and Sussex Integrated Care Board to decide upon applications to open new pharmacies and informed the commissioning of pharmaceutical services. The draft PNA report had been discussed at the Brighton & Hove Health & Wellbeing Board

meeting in July 2022 and feedback from those discussions had also informed amendments to the final report.

16.3 Councillor Appich enquired regarding measures to be put into place to publicise opening hours of pharmacies across the city. It appeared that in some areas of the city pharmacies were under used. Councillor Appich went on to ask what arrangements were being put into place by exploring with NHS colleagues how this work could be carried forward, commending the report as a comprehensive document.

16.4 Councillor Robins referred to the late-night contraception service, currently available until 8.00pm, stating that he considered that it would be helpful if this facility could be made available until a later hour.

16.5 Councillor Brown referred to the poor response rate to the consultation also to the lack of evening provision across the city. It appeared that there was a need for a greater degree of communication between pharmacists and GP's in order to publicise the services available.

16.6 The Director of Public Health thanked Board Members for their contributions which had been picked up in the recommendations. Work would be carried forward through work with NHS Sussex where the key issues which had been highlighted would be picked up.

16.7 The Chair, Councillor Shanks was pleased to note that issues raised would be carried forward with NHS colleagues via NHS Sussex. The Chief Executive of Brighton Healthwatch, David Liley, explained that Healthwatch had statutory responsibility for overseeing this. He explained that discussions were taking place to ensure that targeted use of the media took place through use of social media to ensure that information got to where it needed to be, for example in relation to contraception services.

16.8 The Executive Director, Health and Adult Social Care, explained that in the longer term the issues highlighted would be taken up in the appropriate action plans to ensure that that they were reflected in those too.

16.9 **RESOLVED –** That the Health and Wellbeing Board gives its formal approval to the Pharmaceutical Needs Assessment report 2022 and to the recommendations contained within it.

The meeting concluded at 4.00pm

Signed Chair

Dated this day of

ADULT SOCIAL CARE & PUBLIC HEALTH SUB COMMITTEE

Agenda Item 18 (c)

Brighton & Hove City Council

Adult Social Care & Public Health Sub-Committee

4.00pm 14 June 2022

Hove Town Hall - Council Chamber

Minutes

Present: Councillor Nield (Chair) Shanks, Robins (Opposition Spokesperson), Barnett (Group Spokesperson) and Appich

Part One

1 PROCEDURAL BUSINESS

1.1 There were no apologies or substitutes for the meeting.

1.2 There were no declarations of interest.

1.3 RESOLVED – that the press & public be not excluded from the meeting.

2 MINUTES

2.1 RESOLVED – that the minutes of the 11 January 2022 committee meeting be agreed as an accurate record.

3 CHAIR'S COMMUNICATIONS

3.1 The Chair gave the following communications:

"**The opening times of the vaccination centre at Churchill Square have changed.** It's now open:

- Monday and Wednesday, 10am – 6pm
- Saturday and Sunday, 9am – 5pm

1st, 2nd and booster doses are available for all ages 5+.
Appointments can be booked online or by calling 119. Or you can walk-in, no appointment needed.

Vaccinations are also still available every day across the city at mobile sessions.

For the latest info please check www.sussexhealthandcare.uk/get-my-jab

Have your say on physical activity, sport and exercise opportunities in the city

We've launched a citywide consultation to find out how we can better support people in the city to move more and enjoy being active for life. We want to find out people's attitudes, the types of opportunities you would like to see and what support you need to become more active. Your views will create a Sport & Physical Activity Strategy.

- Complete the survey by Sunday 31 July at www.brighton-hove.gov.uk/active-for-life

There's also opportunities to talk to the Healthy Lifestyles team at events across the city.

New members. Finally, I'd like to welcome two new members to the sub-committee: Cllrs Alan Robins and Dawn Barnett. Alan and Dawn replace Theresa Fowler and Mary Mears on the sub-committee, and I'd like to thank Theresa and Mary for their contributions.

RESOLVED – That the Chair's Communications be noted and received.

4 CALL-OVER

4.1 Items 7 (Fast Food & Energy Drink Advertising: Response to Notice of Motion) and 8 (Adult Social Care Budget Position) were called for debate.

5 PUBLIC INVOLVEMENT

5.1 There were no public involvement items.

6 MEMBER INVOLVEMENT

6.1 There were no member involvement items.

7 ITEMS REFERRED FROM COUNCIL

7.1 This item was introduced by Giles Rossington, Senior Policy, Partnerships & Scrutiny Officer. Alistair Hill, Director of Public Health; and Katie Cuming, Consultant in Public Health, also answered member questions.

7.2 Mr Rossington told sub-committee members that the report before them included information on the public health impact of obesity and the links between obesity and the advertising of fast food. The report also included limited information about the extent and nature of advertising on city council-owned properties. However, more information would be needed in order to review the Council's policy on fast food advertising; and it was consequently proposed that an officer project group be established, to undertake this work and to report back to the January 2023 sub-committee meeting with policy proposals.

7.3 In response to a question from Cllr Shanks on ways to combat child obesity, Ms Cuming told members that direct support to families is important, as is ensuring that healthy

eating options are available at school etc. and encouraging physical activity. However, there is abundant evidence to show that the advertising of fast food has a significant impact on behaviour.

7.4 In answer to a query from Cllr Nield on actions being taken in other cities, Ms Cuming told the sub-committee that Transport for London (TfL) has banned the advertising of high fat, salt and sugar foods on the London transport network. Evaluation of this shows that this has resulted in lower energy consumption. TfL has seen no loss in advertising revenue as a result of this move. Councils in Bristol and in Barnsley have also moved to restrict the advertising of certain foods. There are no findings available from these areas yet, but council officers will contact them to talk through their experiences.

7.5 Cllr Robins asked why the report referenced the potential for advertising revenue to be lost, when reducing obesity is a health imperative. Mr Hill responded that it is important for all impacts to be thoroughly explored when considering making changes to policy.

7.6 Cllr Appich stated that obesity can be as dangerous as smoking, and fast food advertising as damaging as tobacco advertising. It was disappointing that the Government's recently published Food Strategy rows back on previous commitments to restrict this type of advertising, but positive that steps to intervene locally will be explored.

7.7 Cllr Barnett noted that advertising was only one cause of childhood obesity, with other important factors including the decline of competitive sports; children spending less time playing outside and less time exercising; and the increasing availability of unhealthy takeaways.

7.8 Cllr Robins added that deprivation was also a key factor: it is much easier for people living comfortable lives to make healthy eating choices than for people in stressful situations with little time or money to spare.

7.9 Cllr Robins queried why the proposal was to bring a report to January 2023 ASCPH. Mr Hill responded that the next scheduled ASCPH meeting will be in September 2022, which would be too soon to report back, and that January 2023 is the next meeting following this. However, the project group will have finished its work well before January 2023.

7.10 Cllr Shanks noted that there is a Health & Wellbeing Board meeting scheduled for November 2022, and proposed an amendment to report recommendation (3): "Agrees that the project group will report back to the January 2023 ASCPH meeting" to be changed to: "Agrees that the project group will report back to the ***November 2022 HWB*** meeting". The amendment was unanimously agreed.

7.11 **RESOLVED –** that the Adult Social Care & Public Health Sub-Committee:

(1) notes the information provided in the report.

(2) Agrees that an officer project group be established, with representation from BHCC Public Health, Property & Design and Transport, and potentially other relevant services, to further explore the issue of fast food & energy drink advertising.

(3) Agrees that the project group will report back to the November 2022 Health & Wellbeing Board meeting with a paper which will include:

- Detailed information on the extent of fast food & energy drink advertising on BHCC estates
- An evaluation of the success of initiatives in other cities to restrict fast food advertising (e.g. Bristol/Transport for London)
- A proposal to refresh the Council's policy on advertising, including updating or extending restrictions, specifically including energy drinks in restrictions etc.

8 PRESENTATION - HEALTH AND ADULT SOCIAL CARE BUDGET POSITION

8.1 This item was presented by Rob Persey, Executive Director, Health & Adult Social Care; Michelle Jenkins, Assistant Director, Resources, Safeguarding & Performance (HASC); and Andy Witham, Assistant Direct, Commissioning (HASC).

8.2 Mr Persey told members that this presentation was in response to a request from Cllr Mears for ASCPH to be better sighted on the use of the HASC budget.

8.3 Mr Persey outlined HASC's priorities and explained that the Joint Health & Wellbeing Strategy was the main strategic document for the directorate. Ms Jenkins added that the HASC net budget 22-23 is £71.7M. This does not include adult Learning Disability funding, which is included in the Families, Children & Learning (FCL) directorate budget rather than HASC's. The HASC budget pays for a range of services across adult social care, mental health (via a Section 75 arrangement with Sussex Partnership NHS Foundation Trust), and integrated commissioning.

8.4 The majority of the HASC budget (69%) is used to fund externally provided services, such as residential care beds and domiciliary care packages. Around 21% is used for staffing (e.g. social workers); and around 10% for in-house services.

8.5 Residential care accounts for around 32% of the HASC budget, nursing care 31%, homecare 16%, and direct payments 12%.

8.6 Mr Persey outlined challenges and pressures, including:

- Increased life expectancy coupled with lower healthy life expectancy, meaning people are living longer with multiple health conditions, and potentially with a need for social care.
- Health system capacity (in particular the reduced number of beds available at the Royal Sussex County Hospital whilst the 3Ts revamp is ongoing).
- The continuing impacts of Covid.
- Workforce shortages.
- Increased acuity of need in people receiving services.
- Forthcoming statutory changes, including the cost of care cap, which will fundamentally change the relationship between the council and self-funders.
- The development of the ICS.

- The need to fund more prevention, while at the same time continuing to meet statutory duties to support people with acute care needs.

8.7 In response to a question from Cllr Appich about the Section 75 agreement with Sussex Partnership NHS Foundation Trust (SPFT), Mr Persey responded that this was currently being rewritten and would come for decision soon. The new model will be less medicalised than the current one, and will recognise that there are a range of providers other than SPFT in the city. Ms Jenkins added that the S75 budget has grown in recent years in response to increasing demand. It is important to view this increase in the broad context of health and care funding: e.g. CCG contributions to Section 117 funding.

8.8 In answer to a query from Cllr Appich about young people's mental health, Mr Persey told members that there was a good deal of work in this area, with the HWB and the Brighton & Hove Health & Care Partnership set to assume oversight of city services under new ICS arrangements. A focus will be on more preventative work and on targeting particular cohorts for support, such as young people struggling post-Covid.

8.9 Cllr Shanks asked when the council would receive Government funding to support the coming changes in care. Mr Persey responded that the Government has announced a series of funds which local areas can bid for, although guidance in a number of areas has yet to be released. The council has been allocated £800K over three years to support transition to the new care arrangements, although 75% of this must be passported to providers (details of this are included in the Fair Cost of Care report also on the June 2022 ASCPH agenda). There is potentially a large funding gap in terms of paying for increased assessment activity, although there may be some potential here to charge self-funders for their care assessments. In the near future, the rates paid by self-funders for their care will need to match rates charged to local authorities. This is likely to lead to providers increasing their rates for local authorities.

8.10 In response to a question from Cllr Robins on plans to reduce the carbon impact of homecare services, Mr Persey told members that this was something being explored as part of the homecare procurement process. The council is looking at innovative ways to reduce carbon emissions from car use, e.g. by more use of electric vehicles, or by requiring providers to focus on serving specific geographies in order to reduce the distance carers are required to travel between calls. Mr Witham added that the current inflationary pressures being felt by homecare workers (e.g. rising petrol prices) were being addressed through additional Fair Cost of Care funding.

9 FAIR COST OF CARE AND FEE UPLIFT IMPLICATIONS REPORT 2022/23

9.1 This item was agreed without discussion.

9.2 **RESOLVED -** That the Adult Social Care & Public Health Sub Committee agrees to the recommended fee increase of an additional 5% to Home Care providers hourly Set Rates and an additional 2% to Care Home providers charging Set Rates by making use of the Council's allocation of the 'Market Sustainability and Fair Cost of Care Fund' for 2022-23. The underpinning background to this proposed fee change is contained in the main body of the report. These increases will apply from 4 July 2022.

10 ITEMS REFERRED FOR COUNCIL

The meeting concluded at Time Not Specified

Signed Chair

Dated this day of

HEALTH & WELLLBEING BOARD Agenda Item 20(b)

Subject: **Public Involvement – Written Questions**

Date of meeting: **8 November 2022**

WRITTEN QUESTIONS

A period of not more than fifteen minutes shall be allowed at each ordinary meeting for questions submitted by a member of the public.

The question will be answered without discussion. The person who asked the question may ask one relevant supplementary question, which shall be put and answered without discussion. The person to whom a question, or supplementary question, has been put may decline to answer it.

The following written questions have been received from members of the public:

(1) **Women's Health -** Ms Jean Calder:

"There are widespread concerns about women's health, nationally and locally. These include low take-up of smear tests, dangerous maternity provision, cuts to female-only services and a failure to address female illnesses such as endometriosis. The Government's recent consultation on women's health released a tsunami of dissatisfaction from many thousands of women who reported widespread sexism within health services and arrogant indifference to women's needs. In response, the Women's Health Ambassador, Professor Lesley Regan has called for Women's Health Hubs across the country. Will you support this initiative, ensuring that if government money becomes available, we bid for it?"

Item

Although a formal committee of Brighton & Hove City Council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults and Healthwatch.

Title:	**Brighton & Hove Mental Health Joint Strategic Needs Assessment**
Date of Meeting:	8 November 2022
Report of:	Director of Public Health
Contact:	Bernadette Alves and Anne Foster Tel: 01273
Email:	Bernadette.alves@brighton-hove.gov.uk and anne.foster5@nhs.net
Wards Affected:	All

FOR GENERAL RELEASE

Executive Summary

The Health and Wellbeing Board approved the undertaking of an all-ages mental health and wellbeing joint strategic needs assessment (JSNA) for Brighton & Hove in July 2021. As a result of Covid19 pandemic, this needs assessment was undertaken in 2022.

The aim of the JSNA is to provide evidence to increase population resilience, improve the range and quality of support for those with mental health problems and address inequalities.

The needs assessment describes current and future mental health needs of the Brighton & Hove population, with consideration of inequalities and the impacts of the wider national and global crises on mental health need.

It describes the impact on mental health and wellbeing of the building blocks of health such as education, income, housing, and other socio economic factors; protective and risk factors that affect mental health and wellbeing and focuses on groups facing greater risks and higher levels of mental health needs.

The needs assessment takes a life course approach, following the approach in the

city's Joint Health and Wellbeing Strategy.

The JSNA was overseen by a steering group made up of commissioners, providers, community and voluntary sector organisations and academic experts.

The voices of those with lived experience were sought through established engagement and co-production forums, review of recent consultation events, reports and JSNAs.

The steering group reported to the Mental Health Oversight Board and Children and Young Person's Health Oversight Board. Delivery of the recommendations will be overseen by the Brighton and Hove Health and Care Partnership with actions specific to Children and Young People or Adults directed through the relevant place based oversight board.

This paper presents the final draft version of the needs assessment to the Health and Wellbeing Board. It has seven recommendation areas.

The reports will be proof read and checked to meet the accessibility standard before being published. In addition, a four page designed summary version will be produced which can be disseminated widely.

1. Decisions, recommendations and any options

1.1. That the Board note the report and its findings.

2. Relevant information

2.1. The JSNA aims and governance

2.1.1. This JSNA is a snap shot in time and pulls together the big picture. Some of the issues will be already known to some or all parts of the system, others will be new. The JSNA provides the opportunity to work with partners to develop a shared understanding of the city's challenges and assets. And based on that shared picture, to identify strategic actions and recommendations.

2.1.2. Taking account of what the system is already doing to improve outcomes and reduce inequalities, the recommendations are intended to have the greatest additional impact.

2.1.3. The aim of this JSNA is to provide evidence to:

- Increase the resilience of the whole population of Brighton & Hove
- Improve the range and quality of support for those with mental health problems
- Address inequalities.

2.1.4. This needs assessment will shape:

- City wide approaches to mental health and wellbeing including commissioning, prevention, and mental health and wellbeing promotion;
- NHS Sussex and Brighton & Hove City Council commissioning plans and investment decisions.

2.1.5. A Steering Group, comprised of the City Council, NHS commissioners and providers, Community and Voluntary Sector organisations and academic experts oversaw the needs assessment, agreed the key findings and recommendations. A small project group produced the JSNA.

2.2. The findings of the JSNA

2.3. The key findings are set out in the Executive Summary and full report of the JSNA. There is also a data profile, which will be updated annually to give an up to date picture of mental health and wellbeing in the city.

2.4. Mental health problems are common – almost two thirds of us will experience a mental health problem during our lives, and 1 in 6 of us is managing fluctuating levels of distress each week. Mental health problems can shorten lives, are subject to stigmatisation and may be kept hidden. They affect, and are affected by, our relationships with family, friends and communities. They are costly and are both a cause and a consequence of inequalities.

2.5. The mental health of each individual is influenced by multiple factors past and present - by the environment in which we are born, grow, live, work and age, by our family relationships especially when we are a child, life experiences, trauma, and our genetics. Differences in these factors can lead to unfair and avoidable differences in mental health within and between populations. Brighton & Hove faces significant risks for poor mental health in terms of housing, unemployment and areas of the city and groups facing poverty. But, as a city we also have protective factors (assets) around access to parks and open spaces, strong arts and cultural opportunities, social capital and a large community and voluntary sector supporting individuals and communities.

2.6. There are several crises unfolding at national and global level that impact on mental health and wellbeing and/or the ability to help those with mental health needs, including:

- The COVID-19 pandemic
- Cost of living crisis
- Climate change

They all increase the risk of mental ill health and deepen inequalities, with more vulnerable groups being disproportionately affected. These are compounded by ongoing national challenges around recruitment and retention of workforces that impact on quality, capacity and ability to address the unmet need in the B&H population. The data in this document does not fully reflect the impact of these crises and may therefore underestimate both current and future need and the extent of inequalities.

2.7. Some groups are more exposed to the unfavourable social, economic and environmental circumstances which lead to higher risk of mental health problems. These groups, interrelated with gender and age, are at higher risk of mental health problems: black and minority ethnic groups; LGB+ (lesbian, gay, bisexual) people; transgender people; people living with physical disabilities; people living with learning disabilities; people with sensory impairment, neurodiverse people, children in care and care leavers, carers; people experiencing homelessness; people with harmful alcohol and/or drug use; people with multiple complex needs; refugees, asylum seekers and stateless person; prison population, offenders and victims of crime; In Brighton & Hove many of the groups identified as being at greater risk of poor mental health make up a greater proportion of the population than elsewhere.

2.8. The number of people who would benefit from support can be very much higher than the number of people known to services.

2.9. Brighton & Hove has higher estimated overall need than England with 1 in 5 of the adult population estimated to have a common mental health condition in the city compared to 1 in 6 for England – equating to over 46,000 adults.

2.10. As part of the needs assessment, we commissioned a summary of effective preventative interventions across the life course, that have the potential to promote good mental health or wellbeing, prevent mental illness and reduce the impact of mental ill-health for those with mental health problems. A summary is included within each life course.

2.11. The JSNA makes recommendations across seven key areas. Recommendations under these areas are presented in the Executive summary and full report:

- Area 1: Population prevention. Develop and promote a population wellbeing approach encompassing the building blocks of health
- Area 2: Communities. Co-production and co-design of mental health services with people with lived experience, community development and VCSE sector provision
- Area 3: Whole System working. Develop pathways that encompass all levels of mental health need with a focus on early intervention. Develop trauma-informed pathways that support individuals in a holistic way
- Area 4: Transform mental health services to take account of current unmet need and predicted growing future need and to improve accessibility (in context of Area 4 – Whole System Working)
- Area 5: Children and Young people. Improve the care and support offer for young people ensuring that they and their families are at the heart of an integrated service approach
- Area 6: Information sharing. Improve monitoring and information sharing across the system to improve quality of care, planning and decision making.
- Area 7: Inequalities, influence and implementation

3. Important considerations and implications

Legal: The Health and Social Care Act 2012 (s196) requires the function of preparing a JSNA to be discharged by the Health and Wellbeing Board. Specifically, from April 2013, local authorities and Clinical Commissioning Groups have equal and explicit obligations to prepare a Joint Strategic Needs Assessment (JSNA) which provides a comprehensive analysis of current and future needs of local people to inform commissioning of services that will improve outcomes and reduce inequalities. The Health and Care Act 2022 replaces CCG's with Integrated Care Boards. S26 of the 2022 Act inserts new provisions into the 2012 Act requiring the formation of an integrated care partnership [comprising the Local Authority and Integrated Care Board] and for that partnership to develop and review its own integrated care strategy in light of local needs assessments, including the JSNA.

Lawyer consulted: Sandra O'Brien Date: 11/10/2022

Finance: The resources required to support the production of the Joint Strategic Needs Assessment are funded by public health ring-fenced grant. This Joint Strategic Needs Assessment provides the mental health needs assessment for the city. Future commissioning plans and the integrated care strategy will need to reflect on these recommendations.

Finance Officer consulted: Sophie Warburton Date: 07/10/2022

Equalities:

The JSNA has taken into consideration protected characteristics and vulnerable groups at each stage of the process and details relating to needs of different groups are detailed in the main report, as are gaps in evidence and recommendations to improve evidence for vulnerable groups. The voices of those with lived experience were sought through established engagement forums, reviews of recent consultation events and views expressed in recent reports and JSNAs.

Supporting documents and information

Appendix1: Brighton & Hove Mental health Joint Strategic Needs Assessment Executive Summary

Appendix2: Brighton & Hove Mental health Joint Strategic Needs Assessment Full Report

Appendix3: Brighton & Hove Mental health JSNA data profile (online) Mental health JSNA profile - Infogram

Mental health and wellbeing in Brighton & Hove

2022

Part of the Joint Strategic Needs Assessment programme

DRAFT Executive summary

NHS Sussex

Brighton & Hove City Council

The needs assessment

This joint strategic needs assessment (JSNA) pulls together the big picture as a snapshot in time. Some of the issues will be known already to some or all parts of the system, others will be new. It provides the opportunity to develop a shared understanding of the city's challenges and assets. Based on this shared picture, it makes recommendations for action.

The aim of this needs assessment is to provide evidence to increase population resilience, improve the range and quality of support for those with mental health problems and address inequalities.

It will shape city wide approaches to mental health and wellbeing commissioning, prevention, and promotion. NHS Sussex and Brighton & Hove City Council should ensure commissioning is informed by the findings of this needs assessment; providers should ensure their delivery is informed by it.

The JSNA was overseen by a steering group made up of commissioners, providers, community and voluntary sector organisations and academic experts. It reported to the Mental Health Oversight Board and Children and Young Person's Health Oversight Board.

Delivery of the recommendations will be overseen by the Brighton and Hove Health and Care Partnership with actions specific to Children and Young People or Adults directed through the relevant place based oversight board.

The voices of those with lived experience were sought through established engagement and co-production forums, reviews of recent consultation events, reports and JSNAs. A review of the evidence of what works and is cost effective were commissioned to inform the recommendations.

Within the summary we provide a high-level overview of the findings of the needs assessment, along with the following recommendations:

Area 1: Population prevention. Develop and promote a population wellbeing approach encompassing the building blocks of health

Area 2: Communities. Co-production and co-design of mental health services with people with lived experience, community development and VCSE sector provision

Area 3: Whole System working. Develop pathways that encompass all levels of mental health need with a focus on early intervention. Develop trauma-informed pathways that support individuals in a holistic way

Area 4: Transform mental health services to take account of current unmet need and predicted growing future need and to improve accessibility (in context of Area 4 – Whole System Working)

Area 5: Children and Young people. Improve the care and support offer for young people ensuring that they and their families are at the heart of an integrated service approach

Area 6: Information sharing. Improve monitoring and information sharing across the system to improve quality of care, planning and decision making

Area 7: Inequalities, influence and implementation

We sought to take account of what is already happening to improve outcomes and reduce inequalities so that recommendations are focussed on areas that have the greatest additional impact. Some of the strategies and programmes that this work can inform are listed in recommendation Area 7.

Wider national and international crises impacting mental health and mental health support services

There are several crises unfolding at national and global level that impact on mental health and wellbeing and/or the ability to help those with mental health needs, including:

- The COVID-19 pandemic
- Cost of living crisis
- Climate change

They all increase the risk of mental ill health and deepen inequalities, with more vulnerable groups being disproportionately affected. These are compounded by ongoing national challenges around recruitment and retention of workforces that impact on quality, capacity and ability to address the unmet need in the B&H population. The data in this document does not fully reflect the impact of these crises and may therefore underestimate both current and future need and the extent of inequalities.

Prevention and the building blocks of mental health

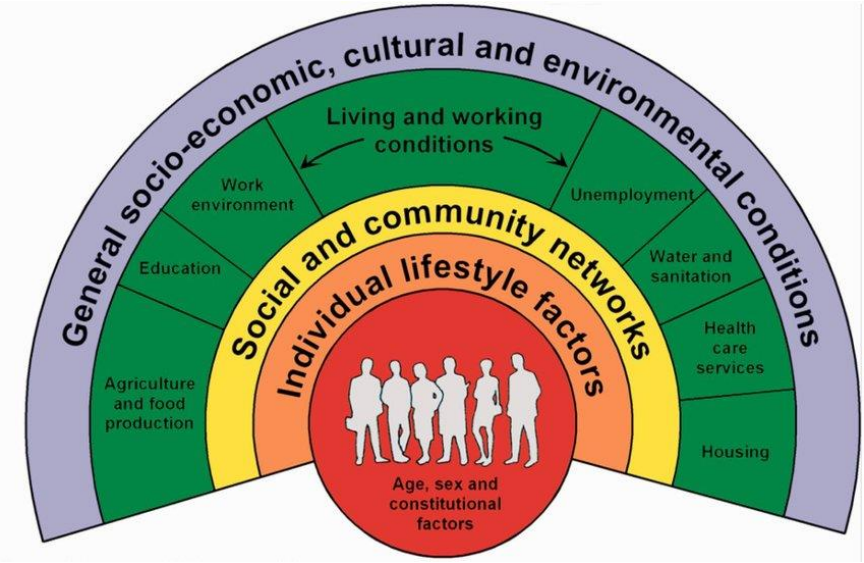
Mental health problems are common affecting almost two thirds of us. Mental and physical health are fundamentally linked and mental health problems can shorten lives. Mental health problems are subject to stigmatisation and may be kept hidden. They affect, and are affected by, our relationships with family, friends and communities. They are costly and are both a cause and a consequence of social inequalities.

The building blocks of mental health

The risk of developing a diagnosable mental illness, and of having low levels of mental wellbeing, varies across people and communities and over time. It is strongly influenced by multiple factors past and present - by the environment in which we are born, grow, live, work and age, by our family relationships especially when we are a child, life experiences, trauma, and our genetics. Some factors increase the likelihood of having mental health problems (risk factors) and other reduce it (protective factors).

Evidence shows that the largest determinant of our health is our wider socio-economic circumstances such as income, wealth, education, employment and community cohesion. These are the building blocks of health and are illustrated here.

The factors are complex and often cluster. For example, a person who has financial insecurity is more likely to live in poorer quality housing, have difficulties in keeping their home warm and have worse access to green spaces. Factors can be inter-generational eg poor parental mental health is a key risk factor for their child's mental health. Risks accumulate over time, for example if a person experiences parental conflict as a child, and/or discrimination as a young adult, those factors may impact on mental health not only at the time, but also in later life.



Source: Dahlgren & Whitehead (1991)

Common risk and protective factors for mental wellbeing at individual and family/community level

	Individual level	Family and community level
Risk factors	Adversity in early life Weak or difficult relationships with impact on attachment Adverse life events (ACEs) Healthy lifestyles Financial worries or debt Traumatic events Violence / abuse Natural disasters Serious illness or disability Bereavement	Poverty / deprivation Poor housing Homelessness Lack of employment Insecure or low paid employment Working conditions that create stress Crime and safety Poor quality neighbourhood environment Low social capital Social isolation
Protective factors	Includes factors that support or increase the development of individual level attributes such as: • Coping abilities, • Self-efficacy and resilience, and • The ability to learn and to develop social skills all of which may encourage healthy behaviours and mental health and wellbeing.	Protective family and community level factors include social support and protective influences organised in schools, neighbourhoods and workplaces. • Feeling part of a community • Access to green and open spaces • Shared public spaces • Sustainable local economy • Arts and creativity

Source: Office for Health Improvement and Disparities Mental health JSNA toolkit, prototype Mental Health tool and The Mental Health Wellbeing Impact Assessment Toolkit

The government defines prevention as “helping people stay healthy, happy and independent for as long as possible. This means reducing the chances of problems from arising in the first place and, when they do, supporting people to manage them as effectively as possible.” Prevention works and is cost effective, however, there are several challenges:

- Many of the actions to prevent mental health problems sit in the wider sector and are about improving the building blocks of health such as income and debt, education, employment, housing, parks and green spaces
- Decision makers can be daunted by the challenge of “fixing” the wider system and actions often focus on the role of individual choices and behaviours
- Investment in one part of the system can lead to savings in another - creating barriers to joint working
- Most NHS targets are about services, few are focused on prevention
- Whilst the evidence of effectiveness of prevention is strong, there are gaps which can create uncertainty about actions
- Impact of interventions on outcomes can be difficult to measure and take years to be fully realised
- Resources are often directed at acute need rather than prevention and financial pressures can reduce investment in prevention

Whilst the building blocks of health play the largest role in determining health, the actions and behaviour of individuals also make a difference. These include the evidence based six ways to wellbeing: Be Active, Keep Learning, Give, Connect, Take Notice, Be curious, Care for the Planet.

Population and place – risk and protective factors

In 2020, the city had an estimated 291,700 residents. Compared to the South East and England, the city has a younger population with more young adults, fewer children and older people.

Environmental risk and protective factors

For many of the environmental factors that influence wellbeing, the city has high need:

- There are areas in the city which are some of the most deprived in England
- A large number of children live in poverty particularly after housing costs
- House prices are higher compared to earnings than for England
- Overall education levels are similar to England but disadvantaged pupils fair worse
- Smoking rates are significantly higher among both young people and adults than England
- Although the population is more physically active and more people have a healthy weight than in England, but there are still high numbers of people who are physically inactive and/or do not have a healthy weight. Inequalities exist across the city and recent trends are going in the wrong direction.

There are also many assets

- There is a strong sense of community (eg feeling of belonging) and high levels of volunteering
- There are many festivals celebrating our diverse communities
- Brighton & Hove has a large and active voluntary, community and social enterprise sector
- We have a strong arts and culture sector and access to green and blue spaces.

Population risk and protective factors

There is strong national evidence that some communities and groups are more exposed and vulnerable to unfavourable social, economic, and environmental circumstances. For many of these groups, Brighton and Hove has high or very high need:

People with alcohol and/or drug dependence: Compared to England, drinking and substance misuse are significantly higher amongst both children and young people and adults.

People experiencing homelessness: Brighton & Hove has the second highest rate of statutory homelessness (households in temporary accommodation) of all local authorities in England outside of London (18th highest in England including London).

People with complex needs and multiple disadvantage: Brighton & Hove, has a higher estimated rate of people with multiple disadvantage than England. The majority have mental health needs.

Other population groups with increased risk include:

- Ethnic minority groups
- Lesbian, gay, bi, trans, queer, questioning, asexual (LGBTQ+) people
- People with long-term physical health conditions
- People living with physical disabilities
- People living with learning disabilities
- People with sensory impairment
- Carers
- Neurodiverse people
- Migrants, refugees, asylum seekers and stateless persons
- Gypsy, Roma and Travellers
- Children in care and care leavers
- Mothers of children taken into care
- Students
- Armed forces personnel and veterans
- Prison population, offenders and victims of crime.

Prevalence of mental health conditions

The number of people who could benefit from support can be very much higher than the number of people known to services. For a severe and life-long mental illness such as schizophrenia, the need in the population is likely to be similar to the number of people known by their GP to have a diagnosis. However, for a condition such as depression, a person with symptoms may not seek help, and even if they do, they may not be diagnosed and therefore, the need in the population is likely to be very much higher than the number of people known to services. The national Adult Psychiatric Morbidity survey and the national Mental Health of Children and Young People survey provide the best estimates of population need at a national level. It is important to note that they underestimate need for Brighton & Hove because the city has higher overall need than England.

The national adults survey estimates that 1 in 6 people in England have a common mental health problem. However, the Office for Health Improvement and Disparities (OHID) estimate that the equivalent figure for the city is 1 in 5 people. This equates to one in ten more adults (a total of

46,000 people) in Brighton & Hove with a common mental health disorder such as anxiety, depression or a mix of these.

The national survey for adults aged 16+, found the most frequently identified issues were common mental health disorders, having experienced at least one major trauma and suicidal thoughts.

The national Children and Young People's survey found:

- Rates of mental health disorders increase with age. Patterns differ for boys and girls
- Young women aged 17 to 19 have the highest prevalence, with a quarter having a mental health condition and almost half of those having self-harmed or attempted suicide
- LGBTQ individuals were more than 2.5 times more likely to have a mental health disorder
- Mental disorders tended to be more common in children living in lower income households
- Eating problems were seven times more common in girls than boys.

A national survey in March 2021, that followed up children and young people who participated in the 2017 survey, found rates of poor mental health had increased. The proportion of children and young people with possible eating problems had almost doubled in those aged 11 to 16 years old. Almost two thirds (58%) of people aged 17 to 19 had a possible eating disorder.

Perinatal mental health

Perinatal mental health is the term for mental health during pregnancy and the first year after birth. It includes both existing mental health issues and conditions that arise during pregnancy or related to pregnancy. The physical and mental health of the mother, and the family environment during pregnancy, infancy and childhood is of fundamental importance to the lifelong mental health of the baby and child. The mental health of fathers and other caregivers also has an impact.

Risk and protective factors

Many of the risk and protective factors associated with mental health problems during pregnancy and after childbirth reflect those associated with mental illness in the general population, however factors which can have a particular impact at this life stage include:

- The birth of a child with a disability has an impact on the family, leading to possible depression, anxiety, health problems, or other psychological distress
- There are distinct challenges for LGBTQ+ parents, linked to stigma, marginalisation, assisted reproduction and /social and legal recognition as parents
- Foetal alcohol spectrum disorder will impact a baby's lifelong mental health risk. It is caused by the baby being exposed to alcohol during pregnancy.

Perinatal mental illness is estimated to affect 10-20% of new and expectant mothers. This equates to an estimated 225 to 450 women in Brighton & Hove in 2020.

Quality and outcomes

Nationally, poor mental health remains one of the leading causes of maternal death during pregnancy and the first postnatal year.

Voices in the perinatal period

We did not identify any recent local engagement reports with pregnant women or new mothers for Brighton & Hove that provide insight into local mental health needs and experiences.

In 2021, some fathers across Sussex were interviewed about their experience of becoming a father, their needs and what works to support them. They identified a need for non-stigmatised support provided by men and for services to think about more ways to increase confidence of fathers to engage with antenatal and postnatal services.

Children, young people and families

This life stage covers conception to age 25 years.

The foundations of life-long wellbeing are laid down in infancy and childhood. The first 1,000 days, from conception to age 2, is a critical phase and secure baby and infant attachment is paramount. The needs of infants differ from primary school aged children and differ again from young people of secondary school age and above. Schools are important and whole school approaches to reducing mental ill health and improving population resilience have a strong evidence base.

Until the age of 18, services for people with mental health needs are provided by child health services. From 18, they are usually provided by adult services, with this transition process starting from age 16. Some people meet the criteria for child mental health services but not for adult services. For these people, support can reduce sharply at the age of 17-18, even though their level of need has not changed.

Early adulthood for young people (between 16 to 25) is a key life stage:

- Half of lifetime mental health problems are established by age 14 and three quarters by age 24
- Young people are making important transitions in their lives and becoming more independent
- Ages 15 to 23 is a period of significant development of capabilities such as planning, self-control, flexibility, awareness which help adults to manage life and work effectively.

Risk and protective factors

Many of the risk and protective factors associated with mental health problems for children and young people are similar to those associated with mental illness in the general population, however there are factors which can have a particular impact at this life stage:

- Nurturing families, nurturing education settings from nurseries to universities and nurturing peer groups are strongly linked to positive wellbeing
- Use of social media can be a risk factor for some children and young people. It is associated with increased rates of anxiety, depression, and poor sleep. Cyber bullying and exposure to images of “ideal” body shapes may have a profound negative effect. However, children and young people also report a positive effect and social media can provide an opportunity to find like-minded communities
- Adverse Childhood experiences (ACEs) are on-going stressful events and situations occurring in childhood including abuse, neglect and family dysfunction. They have been shown to increase the risk of developing mental ill health in childhood and adulthood, as well as increasing the likelihood of developing health harming behaviours such as sexual risk-taking, problematic alcohol use and substance misuse or violence, each of which in turn is linked to poor mental and physical wellbeing
- The impact of complex trauma such as multiple, long-lasting, repeated or continuous exposure to abuse, neglect or family conflict is more severe if it happened in childhood.

Level of need in Brighton & Hove

Compared to England, Brighton and Hove has high need:

- Higher rates of children in care and significantly higher rates of care leavers
- Significantly higher rate of children in need due to family stress due to dysfunction or absent parenting and children subject to child protection plans with initial categories of abuse/neglect
- Significantly higher percentage of school pupils with social, emotional and mental health needs. This proportion is increasing
- More unhealthy behaviours, such as smoking, alcohol use, drugs use
- It has a higher proportion of pupils with an Education, Health & Care Plan and higher number receiving support for special educational needs.

We have a very rich picture of need in Brighton & Hove from the Safe & Well at School Survey (SAWSS) of pupils in primary and secondary schools in the city. This local survey confirms the findings of the national data. The most recent survey in November 2021 shows that young people's emotional wellbeing has seen a significant deterioration compared with previous surveys, particularly for secondary school pupils, including an increase in self-harm and in suicidal thoughts. Struggles with issues related to food and body image were also significant for young people. Some groups are disproportionately affected with consistently lower levels of wellbeing: girls; older pupils; pupils who do not identify with the gender given at birth; LGB+ pupils; young carers; those who receive extra help at school; children in care.

Voices of children & young people

Views were gathered from a review of 11 recent engagement projects lead by children and young people. The engagement projects span 2020-2022 and involve hundreds of young people in primary and secondary schools and older young people aged up to 25. Key themes included:

Equity and equality of inclusion

Work with young people whose voices are less often heard; recognise the impact of racism, take a gender sensitive approach to support the needs of young men.

Getting help early

Ensure there is timely and tailored support; increase awareness of services in children and young people and parents; provide relatable self-care strategies; address the stigma around youth loneliness and social isolation; increase understanding of the impact of a death of a parent and going into care; expand "friends with training" to support those with eating difficulties

Co-design and co-production and meaningful engagement

Expand involvement of peers and people with lived experience in designing and commissioning services; expand development of peer support

The importance of the education setting

Ensure a whole school approach to mental health; staff to reflect diversity of the communities they serve; train more people to be Wellbeing Ambassadors; recognise importance of transition support (primary to secondary)

Outcomes

Compared to England, Brighton & Hove has areas of poorer outcomes with a much higher rate of young people in contact with secondary mental health services, with rates rising. There is a significantly higher rate of both hospital admission due to self-harm in those aged 10-24 years and of hospital admissions for mental or behavioural disorders for those aged under 18. There were 44 deaths by suicide and undetermined injury between 2016 and 2019 in children and young people aged under 25 who were resident in the city. As for England, three quarters were male, and in line with England, deaths by suicide in those aged under 25 made up almost one in ten of all suicides.

Working age adults

Working age is often a time where people experience maximum independence and control over their life. Some of the common markers of adulthood include: starting work; moving out of the parental home; becoming a parent; moving in with a partner; buying a house; cohabiting, forming civil partnerships or getting married; becoming a carer. In this life stage people can influence the mental wellbeing of others through their various roles as partner, co-worker, parent and carer.

This section draws on the findings of other recent JSNAs undertaken in the city.

Risk and protective factors

Many of the risk and protective factors that increase and decrease the likelihood of developing mental health problems for working age adults are covered in the common risk and protective factors section, however there are factors which can have a particular impact at this life stage:

- Work, or lack of it, matters greatly as does the quality of the work. Workplace mental health interventions have a strong evidence base
- Quality of relationships in the home eg with partners and children
- Taking on the role of caring for someone who is ill or has a disability
- Friendship networks, facilities for children, opportunities for exercise, the quality of the environment and social inequity, stigma and discrimination impact on adult mental health.

Level of need in Brighton & Hove

Compared to England, Brighton & Hove has:

- A higher estimated prevalence of common mental disorders and more people self-reporting having a mental health problem
- More adults reporting a high anxiety score
- A lower proportion of the population who feel that the things they do in life are worthwhile
- More people reporting depression and anxiety
- Higher proportion of social care users reporting depression and anxiety among
- A greater proportion of people diagnosed with a severe mental illness
- More Employment Support Allowance (ESA) claimants for mental/behavioural disorders.

Needs assessments for adults with multiple long-term conditions, adults with multiple complex needs, international migrants and trans people found high needs in these groups. The Brighton & Hove Health Counts survey in 2012 found that being at risk of major depression was higher for women, those living in the most deprived areas, respondents who classified themselves as LGB or unsure, those with a limiting long-term illness or disability and others.

Voice of working age adults

Common issues highlighted through the review of recent local needs assessments and other reports include the need for:

- More accessible support and services, and support promoted more widely - using different promotion routes and increasing awareness of support services available amongst primary care and other general access services
- Simplify referral processes, including for self-referral
- Consider all needs, not just mental health (thresholds often on single issues) eg dual diagnosis
- More joined up services, working better together. Better information sharing between services, especially between primary care and specialist services
- When asked for their views, adults with lived experience said they wanted to see more involvement of peers and people with lived experience in developing and commissioning services and more support for the development of peer support
- Taking a more trauma informed approach.
- More mental health awareness and suicide prevention training across NHS frontline services
- Waiting times reduced and more support for those on waiting lists/who don't meet thresholds
- Higher levels of / more accessible support for those who were recently discharged from an in-patient stay
- More support to families and carers and within schools.

Outcomes

Compared to England, Brighton & Hove has areas of poorer mental health outcomes. Brighton & Hove has the greatest disability adjusted life years due to mental health ill health of any local authority in the South East, for both males and females.

Brighton & Hove has significantly worse rates than England of premature mortality of adults with severe mental illness, Detentions under the Mental Health Act 1983 and emergency hospital admissions for self-harm. The city has had one of the highest rates of suicide in England, with rates significantly higher for several years. Our rates remain higher in both men and women.

Older adults

Much of the evidence in the working age adults section will also apply to older people.

Ageing presents both challenges and opportunities: the rate at which people age is influenced by the accumulation of lifelong experiences, past and present socio-economic circumstances. Whilst mental health conditions are prevalent in later life, they are not an inevitable part of ageing and older people are often less dissatisfied than younger people. Poor physical health is a risk factor for mental health problems, with older people more likely to have physical health needs.

Risk and protective factors

Many of the risk and protective factors associated with mental health problems for older people are similar to those in the general population. There are factors which can have a particular impact at this life stage including: bereavement, being a carer, living alone, retirement, low income, having recently experienced or developed a health problem and falls.

For many indicators, Brighton & Hove has similar need to England, however for some, the city has greater risk: older people living in poverty, estimated fuel poverty, older people living alone and

emergency hospital admissions due to falls. Older people are especially vulnerable to being lonely or isolated. Age UK has estimated that the number of older people living alone will continue to increase up to 2033.

There are factors which are better for older people than working age adults. Those aged 55+ are more likely to be satisfied with their local area, feel that they belong in their immediate neighbourhood, agree people pull together to improve the neighbourhood and to volunteer.

Level of need in Brighton & Hove

The estimated prevalence of common mental disorders, such as depression or anxiety, in those aged 65 year or over is higher than the South East and England, and is the third highest in the South East. National evidence is that mental health problems in older people are more common in settings such as hospitals and care homes.

The prevalence of mental and physical long-term conditions increases with age up to around age 70 and then is fairly stable. From ages 65 to 95 years, approximately 15% of women and 10% of men have both physical and mental health problems.

Voice of older people

We did not identify recent local views of older people on mental health services.

Outcomes

From the last published data for the period 2013-2017, males aged 65 years or over in Brighton & Hove had a significantly higher rate of suicide and undetermined injury deaths than England. However, there has been a reduction in suicide deaths of older people in the city.

Recommendations

Delivery of the seven recommendation areas will be overseen by the Brighton and Hove Health and Care Partnership, with actions specific to Children and Young People or Adults directed through the relevant place based oversight board. The Brighton and Hove Health and Care Partnership is a place-based partnership bringing together NHS Sussex (Brighton and Hove), University Hospitals Sussex NHS Trust, Brighton & Hove City Council, Sussex Community Foundation Trust, and Sussex Partnership Foundation NHS Trust, Community Works (Representing the Voluntary and Community Sector), Primary Care Networks (PCNs) - General Practice, patients and the public.

Reducing inequalities needs to be at the heart of tackling and improving the mental health of the population of Brighton & Hove and this is embedded in each of the recommendation areas. There are tools that can assist in assessing impact of proposals on health inequalities.

Area 1: Population prevention. Develop and promote a population wellbeing approach encompassing the building blocks of health

No.	Recommendation
1.1	Strengthen our city-wide prevention-focused approach to improving population wellbeing and reducing inequalities. The Brighton & Hove Health and Care Partnership, linking with cross sector city organisations, should consider options for achieving this, for example utilising the national Prevention Concordat for Better Mental Health. The approach to include: • Increasing awareness that experiences in childhood, particularly the first 1,000 days from conception to 2 years, lay down the foundations of life-long wellbeing • Increasing awareness that mental health is everyone's responsibility and that the key building blocks of health are the social determinants such as employment, debt, income, education, housing, community cohesion, access to green spaces • Increasing awareness of what people can do to make a difference to population mental health and wellbeing • Strengthening whole system approaches to reducing stigma.

Context

- An individuals' mental health is determined by past and present experiences and the circumstances of their daily life such as housing, income, education, access to green spaces etc. These are the building blocks of health
- Adopting a prevention approach that focuses on the building blocks of health is cost effective.
- In the city, there is high need and inequalities, and these have been exacerbated by the impacts of Covid, the cost of living crisis and climate change. Workforce challenges make it difficult to meet current and future need
- Decision makers are not always fully aware of what works and how they can bring about desired change and there are challenges in taking a prevention approach
- Commissioning often focuses on treatment and acute care in part because many of the NHS targets are about treatments. A greater focus on prevention is needed
- The Prevention Concordat is a national evidence-based prevention-focused framework.
- Commitment to, and championing of, a population prevention approach, with tools for system leaders, commissioners, and planners to understand and implement prevention measures could lead to large improvements in mental health and reduce health inequalities.

Area 2: Communities. Co-production and co-design of mental health services with people with lived experience, community development and VCSE sector provision

No	Recommendation
2.1	Commissioners and providers to ensure co-production with experts by experience, including parents and carers, is a fundamental part of all redesigned/transformed mental health pathways working as equal partners from the beginning. Seek to engage with marginalised communities and seldom heard voices including care leavers and children in care
2.2	Ensure co-production best practice is embedded in all aspects of mental health commissioning (both NHS and Local Authority). Start by mapping co-production across the system
2.3	Ensure more peer support opportunities are built into commissioning and delivery.
2.4	Promote community development. Support communities to build on their assets and strengths so that they can improve their local mental health outcomes or the factors that affect their mental health. Consider geographical communities and communities whose voices are less often heard.
2.5	Strengthen VCSE sector provision, including support for smaller organisations. Commission and develop VCSE sector as essential providers in mental health and wellbeing pathways, as equal partners with statutory services and as trusted advocates for their communities.

Context

- Co-production with people with lived experience of services, their families and carers is a key principle of the national Five Year Forward View for Mental Health and improves outcomes
- Co-production is when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered.
- When asked for their views, children and young people and adults with lived experience said they wanted to see more involvement of peers and people with lived experience in developing and commissioning services and more peer support
- Whilst the JSNA found some examples of co-production, it was patchy and far from universal. For some services there was no routine engagement. Some communities had little or no opportunities to express their views
- Children and young who are looked after or are care leavers are at greater risk of developing mental health problems and need strong advocacy - the CIC (children in Care) council and the care leavers forum are opportunities to engage with this group.
- When there was engagement, people with lived experience were not always included from the outset of new commissioning proposals.
- The voluntary, community and social enterprise (VCSE) sector is broad and encompasses independent organisations working with a social purpose. They range from small community based groups or schemes through to larger charities and organisations that may operate locally, regionally or nationally. The city has a strong and vibrant VCSE sector.
- The VCSE sectors plays a key role in improving health, wellbeing and care outcomes and tackling health inequalities. They do this not only by delivering services but also by shaping their design and advocating for, representing and amplifying the voice of service users, patients and carers. Their input is essential to a vibrant local health economy.

Area 3: Whole System working. Develop pathways that encompass all levels of mental health need with a focus on early intervention. Develop trauma-informed pathways that support individuals in a holistic way

No.	Recommendation
3.1	New mental health service developments, transformation work and reviews of existing services and pathways should take a trauma-informed whole systems approach. To be modelled by senior leaders and at all levels of organisational delivery. • Co-production with people with lived experience and their families and carers • Consider differing levels of need: universal support, early help, and specialist services. • Consider other needs eg substance misuse, physical health, social care, homelessness, criminal justice, healthy lifestyles. • Consider role of different sectors in providing mental health support including community groups and the voluntary, community and social enterprise (VCSE) sector • Consider role of different settings eg schools, colleges, and workplaces
3.2	Commissioners and providers to ensure that there is good communication between mental health and other services eg substance misuse, physical health, social care, homelessness, criminal justice to ensure care is provided holistically, takes account of all needs, and considers mental health in the context of what has happened to an individual (possible trauma history or adverse childhood experiences) and their whole needs.
3.3	Organisations, commissioners and providers to ensure that staff wellbeing is a priority - there are evidence based whole workplace approaches in place to promote wellbeing
3.4	Commissioners and providers to ensure universal and specialist services such as substance misuse, physical health, healthy child programme, social care, homelessness, criminal justice etc. routinely identify mental health need and where appropriate, offer brief interventions, and/or refer onwards.
3.5	Through training, increase the mental health and trauma-informed knowledge, skills and confidence of workforces both in mental health services in other sectors for example physical health services, substance misuse services, social care, housing, education etc. consider, for example, Mental Health First Aid training, suicide prevention, trauma informed approaches etc
3.6	Support the continued embedding of Trauma Informed Care, Practice and Values across the Brighton and Hove Health and Care Partnership and extend the Sussex wide Trauma Informed Care (TIC) programme to wider workforces for example blue light services, housing, education

Context

- Commitment to whole systems working is required at all levels within organisations: at a strategic level, modelled by senior managers, by team managers and team members
- An individual's mental health and wellbeing changes over time and the level and intensity of support needed varies. Early intervention can prevent problems from getting worse. Good and sustained support after a period of intense need can help a person to stay well
- Promoting population wellbeing and preventing mental illness is complex and requires a dynamic way of working in partnership with a broad range of stakeholders
- Many people with mental health conditions have experienced trauma which can impact on their ability to access and engage with services. Taking a trauma informed approach to care and

practice can help improve patient engagement, treatment adherence and health outcomes, as well as provider and staff wellness.

- Many people with mental health conditions have other needs. Their needs may impact on their family and friends. For example, a parent with severe mental illness who has a housing problem and whose child is having difficulties at school may need support not only from mental health but also potentially housing, social care, the school
- Outcomes are improved if a persons' multiple needs are considered holistically and where there is a diverse and varied offer of support
- Trauma informed care can help reduce burnout among health and social care providers, potentially reducing staff turnover. Trauma Informed care seeks to:
    - **Realise** the widespread impact of trauma and understand paths for recovery
    - **Recognise** the signs and symptoms of trauma in patients, families and staff
    - **Respond** through integrating knowledge about trauma into policies, procedures and practices and
    - Actively avoid **Re-traumatisation**.

  Trauma informed services are also **Reflective** in their practice, which involves curiosity about ourselves in the work we do. With a fundamental focus on **Relationships** at the heart of our work.
- Better join up is needed across eg: Mental health and physical health; Substance misuse and mental health; People with multiple disadvantage (homelessness / domestic violence / criminal justice / mental health).

Area 4: Transform mental health services to take account of current unmet need and predicted growing future need and to improve accessibility (in context of Area 3 – Whole System Working)

No.	Recommendation
4.1	Brighton & Hove City Council and NHS Sussex commissioners to strengthen their use of intelligence (data, stakeholder views, and evidence of what works) to inform the development of services in order to make best use of resources in responding to current and emerging needs and focusing on early intervention and prevention.
4.2	Commissioners and providers to raise awareness of existing services and pathways so that those referring to and those needing services know where to go and how to access them. Promote via channels that are relevant to different communities. Promote to groups with higher need or poorer access, including: • LGBTQ+ • Ethnic Minority groups • Young people and young adults • Children in care and care leavers • Those less digitally literate eg people with learning disability, older people.
4.3	Shift the balance of investment to increase support for children and young people with mental health and wellbeing problems to bring a lifetime of benefits to young people, their families, communities and the economy.
4.4	Agree priorities for health and care commissioners and providers to work together to address areas where there is significant potential to improve performance. For example: • Long waiting lists for some services • Excess deaths in people with SMI under 75 years old. • People newly diagnosed with depression have lower rates of review by their GP 10-56 days after diagnosis. • Gaps between services for example between primary and second mental health services for adults.

Context

- The needs assessment provides evidence of very high need in the city – both in terms of the numbers of people affected, but also relative to England – and this need is growing.
- It is estimated that in Brighton and Hove, 1 in 5 adults have common mental health disorders, higher than the national average of 1 in 6
- Several crises are unfolding that increase need and increase inequalities including Covid, the cost of living crisis and climate change. Workforce challenges continue to put pressure on service capacity and quality
- The needs assessment highlighted service challenges including long waiting lists, unclear referral pathways, need for comprehensive information and support for greater advocacy
- Some services were highlighted as having very long waiting lists: assessment for neurodivergence such as ASC (autistic spectrum conditions) and ADHD (attention deficit hyperactivity disorder), eating disorder and complex trauma
- There is a lot of work underway to transform services – much of it under the umbrella of the Adult Community Transformation Programme
    - Crisis care; Complex trauma
    - All ages Sussex Eating Disorder
    - Physical health checks for those with serious mental illness
    - Trauma Informed Care (TIC).

Area 5: Children and Young people. Improve the care and support offer for young people ensuring that they and their families are at the heart of an integrated service approach

No.	Recommendation
5.1	Adult and children mental health services should have a dedicated transition function to ensure there is continuity of care for young people.
5.2	Ensure that mental health services are tailored to needs of young people particularly those aged 16 to 25.
5.3	Commissioners and providers to ensure adult and children's mental health services take a whole family approach to mental health. For example, adults' services to take account of the potential impact of poor parental mental health on children and vice versa.
5.4	Expand capacity to meet unmet need in children and young people. In particular in areas where there are rapidly growing needs or large unmet need such as substance use, eating disorder, neurodivergence assessment, self-harm, body image.

Context

- The needs assessment provides evidence of very high risk factors and need in the city – both in terms of the numbers of people affected, but also relative to England. It also provides evidence of increases in need.
- The first 1,000 days (from conception through to age 2) are crucial in laying down foundations for lifelong wellbeing. Support to families in this period is paramount
- Around half of lifetime mental health problems are established by age 14 and three quarters by age 24
- Young adulthood (age 16 to 25) is a key age: Mental health problems often arise for the first time; the service offer changes as people turn 18 (25 for people with SEND); capabilities such as planning, self-control, flexibility, awareness, continue to develop significantly up to the mid-twenties; adult and child service criteria differences mean that some people are no longer able to access services.
- The Safe & Well at School Survey shows some groups are more likely to experience negative impacts on their mental health and wellbeing. This includes girls, older pupils and pupils and students who identify as LGB+, Trans and Non-Binary; those who need additional help in school, Young Carers and those who identify as Black or Black British.
- In childhood, living in a difficult situation (parental conflict, domestic violence, parents with mental health and/or substance misuse issues etc.) can be very harmful and sometimes leads to complex trauma which can have lifelong impacts
- There are high waiting times for specialist CAMHS services, in particular for neurodivergence assessment and diagnosis and eating disorder.

Area 6: Information sharing. Improve monitoring and information sharing across the system to improve quality of care, planning and decision making

No	Recommendation
6.1	All contract monitoring should routinely monitor activity by • protected characteristics • whether people are or were in council care • whether people are neurodivergent. • whether adults are parents / carers for children and young people This should include information on referrals, access and outcomes to be able to assess if services are effectively meeting the higher needs of groups more at risk of poor mental health.
6.2	Information held by organisations on their clients and patients with mental health needs should be comprehensive, up to date and shared appropriately and in a timely manner between care providers when it needs to be.
6.3	Locally commissioned Brighton & Hove health surveys should take account of the JSNA findings to better capture the needs of groups identified as more vulnerable to poorer mental health.
6.4	Collection, collation, reporting and analysis of population level data should be improved to maximise opportunities to improve prevention. • Analysis should be conducted of the anonymised Sussex Integrated Dataset to provide a better picture of the mental health needs of the local population and how people are currently accessing services. The inclusion of data from drug and alcohol treatment services in this dataset should be explored • Annual update of mental health profile to be published

Context

- There is a lack of routine service data to be able to clearly identify trends or to be able to compare service access and quality
- For the most part, we were not able to use routine service data to look at access and outcomes by protected characteristics beyond age and gender
- We are very fortunate to have the Safe and Well at School Survey to give us clear evidence around trends and vulnerable groups of children and young people
- Voice evidence from children and young people, and from other recent JSNAs of adults with physical and mental health conditions and adults with multiple complex needs cited the lack of information sharing across services as a key barrier to good care.
- The Sussex Integrated Dataset provides linked anonymised data to be able to look at all the contacts those with mental health conditions have with services (eg in Primary Care, hospitals and with Specialist Mental Health Services) for the first time.

Area 7: Inequalities, influence and implementation

No	Recommendation
7.1	The Brighton and Hove Health and Care Partnership to oversee the system response to the recommendations by: • developing and monitoring an action plan that identifies which team/ board/organisation/ partnership leads on each action and with goals that are SMART - Specific, Measurable, Achievable, Realistic, and Timely. • Actions specific to Children and Young People or Adults to be directed through the relevant place based oversight boards.
7.2	The findings and recommendations from this JSNA are used by commissioners, providers and decision makers to • improve outcomes and reduce inequalities. • inform relevant strategies, programmes and action plans. At the time of writing these include but are not limited to: ○ Foundations for our Future - Sussex Children and Young Peoples' Emotional Wellbeing and Mental Health Strategy 2022 – 2027 ○ Implementation of the national Mental Health Long Term Plan 2019/20 – 2023/24, including the Adult & Older Adult Community Mental Health Transformation programme ○ Sussex and Brighton and Hove Suicide and Self-harm Prevntion Strategy ○ Brighton and Hove Drug Strategy ○ Relevant Brighton & Hove city council corporate and directorate strategies ○ Place Based Plans developed by the Health & Care Partnership ○ Family Hubs Transformation Programme ○ Multiple disadvantage programme
7.3	Commissioners, providers and decision makers across Brighton and Hove Health and Care partnership to ensure appropriate impact assessments are undertaken when commissioning, developing and reviewing programmes, plans, services and policies. Tools include: Equality and Health Inequalities Impact Assessments (EHIAs)/ Equality Impact assessments (EIA) and quality impact assessments (QIAs).

Mental health and wellbeing in Brighton & Hove

2022

Part of the Joint Strategic Needs Assessment programme

Final draft

NHS Sussex

Brighton & Hove City Council

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1 Summary

The Executive Summary is available at (ADD LINK WHEN PUBLISHED)

2 Background

"**A state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community**".[1] The World Health Organization (WHO) definition of mental health

Nearly 2 in 3 of us will experience a mental health problem during our lives, and 1 in 6 of us is managing fluctuating levels of distress each week. This means that mental health problems commonly affect our lives, our families, workplaces, and communities, impacting everyone.[2]

None of us will lead a long life without having felt limited by our mental health at some point, for a shorter or longer period. We need to nurture and protect everyone's mental health.

Mental Health is a wide-ranging concept

The Mental Health Foundation and the Faculty of Public Health define mental health as a spectrum "from mental health problems, conditions, illnesses and disorders, through to mental wellbeing or positive mental health."[3]

Mental health and wellbeing are often seen as distinct from mental illness (**Figure 1**).[4] A person with a diagnosable mental health condition may have high levels of wellbeing and conversely a person without a diagnosable condition may have low wellbeing.

Figure 1: Mental wellbeing and mental illness



Source: State of Queensland Department of Child Safety, Youth and Women[5]

Mental ill health accounts for a significant disease burden

Together with substance misuse, mental illness accounts for 21% of the total burden of disease in England.[6] This is likely to be an underestimate for several reasons, including the overlap with neurological disorders and the grouping of self-harm as a separate category. It is likely to have increased because of the COVID-19 pandemic.

The cost to the UK economy is large

The cost to the UK economy of mental health problems excluding dementia and alcohol and substance misuse is conservatively estimated to be £117.9 billion annually by the Mental Health Foundation and London School of Economics and Political Science. Most of this (72%) is due to the lost productivity of people living with mental health conditions as well as costs incurred by unpaid informal carers.[7]

Problems are often hidden, stigma is still widespread

And many people are not receiving support to access services.

Most lifelong mental health problems start early in life

Half of all mental health problems begin by the age of 14, rising to 75% by age 24.[8] Our mental health is shaped by our genes, our personal experiences and the social circumstances we find ourselves in such as income, poverty, employment, discrimination, education, and community. The foundations of mental health are laid down in infancy in the context of family relationships.[9]

Mental health is mutually and intrinsically linked with physical health

People with a physical disability or physical health problem are more likely to experience a mental health problem, while people with a mental health problem are more likely to experience a physical health problem.[10] Through neuroscience and other disciplines, our understanding is growing of the mechanisms and pathways through which mind and body are connected.

Those with mental health problems have shorter lives

People with severe mental illness such as bipolar disorder or schizophrenia, die on average 15 to 20 years earlier than those without.[11]

Population factors

Mental health problems are associated with higher rates of alcohol and drug abuse, smoking, lower educational outcomes, poorer employment prospects and social disadvantage. These in turn increase risks of mental and physical health problems.[12]

Poor mental health is both a cause and a consequence of inequalities

Those at greater risk of having poor mental health are often more likely to have difficulties in accessing support.

There is an ever-growing evidence base of what works and what is cost effective

Cost-effective public health and intersectoral strategies and interventions exist to promote, protect and restore mental health, many evaluated in a UK context.[13]

3 About this needs assessment

This Joint Strategic Needs Assessment (JSNA) pulls together the big picture as a snapshot in time. Some of the issues will be known already to some or all parts of the system, others will be new. The needs assessment provides the opportunity to develop an understanding, developed and shared by partners, of the city's challenges and assets. Based on that shared picture, it seeks to identify strategic actions and recommendations. The data within the needs assessment was data available up to end July 2022. A key source of national evidence is the Office for Health Improvement and Disparities Mental Health JSNA toolkit. Appendix 1 has a list of local reports and documents included in the review. There was no primary data collection of quantitative or qualitative data for this review.

3.1 Aim of the JSNA (Joint Strategic Needs Assessment)

This Brighton & Hove all-ages mental health and wellbeing needs assessment is conducted as part of the programme of Joint Strategic Needs Assessments overseen by the Brighton & Hove Health & Wellbeing Board.

The aim is to provide evidence to:

- Increase population resilience
- Improve outcomes through improving the quality and range of support for those with mental health problems
- Address inequalities through a whole systems approach

To do this by:

- Describing the current and future mental health needs of the Brighton & Hove population, both children and young people and adults and older people, with particular consideration of inequalities and the impacts of the COVID-19 pandemic on mental health needs
- Describing protective and risk factors that affect mental health and wellbeing, such as neighbourhoods, education, employment, community safety, housing and homelessness
- Considering future population projected needs to cover the period up until 2030 to bring it in line with the Joint Health and Wellbeing strategy
- Making recommendations based on evidence of what works and what is cost effective at both individual and place level
- Co-producing with stakeholders, including services users, carers, and services provided by voluntary and statutory organisations.

The findings will:

- Shape city wide approaches to mental health and wellbeing including commissioning, prevention, and improvement
- Inform future NHS and local authority commissioning plans and investment decisions from 22/23 onwards

- Be used to inform our readiness for signing up to the Prevention Concordat (See Section 5.2.3)
- Be shared with Sussex partners and will inform mental health and inequalities work at both Place and Sussex work
- Will feed into relevant strategies and action plans, including but not limited to:
  - Foundations for our Future - Sussex Children and Young Peoples' Emotional Wellbeing and Mental Health Strategy 2022 – 2027
  - Implementation of the national Mental Health Long Term Plan 2019/20 – 2023/24, including the Adult & Older Adult Community Mental Health Transformation programme
  - Sussex and Brighton and Hove Suicide and Self-harm Prevention Strategy
  - Brighton and Hove Drug Strategy
  - Relevant Brighton & Hove city council corporate and directorate strategies
  - Place Based Plans developed by the Health & Care Partnership
  - Family Hubs Transformation Programme
  - Multiple disadvantage programme
  - Fairer Brighton and Hove Framework
  - Brighton and Hove Joint Health and Wellbeing strategy 2019-2030
  - The Mental Health Collaborative Programme for 2021/22 strategy
  - Sussex Mental Health and Housing Strategy
  - Best Start for Life Strategy
  - Perinatal Equity and Equality of Access Plan for Sussex 2022-2025
  - Sussex-wide All Age Eating Disorder Pathway review
  - Autistic Spectrum Conditions (ASC) / Attention Deficit Hyperactivity Disorder (ADHD) pathway review
  - Crisis pathway review
  - Complex Trauma pathway

3.2 Governance

The development of the JSNA was overseen by a steering group (See Appendix 2). See also the acknowledgements section.

The steering group was made up of commissioners, providers, community and voluntary sector organisations and academic experts. It reported to the Mental Health Oversight Board and the Children Health Oversight Board.

Delivery of the recommendations will be overseen by the Brighton and Hove Health and Care Partnership with actions specific to Children and Young People or Adults directed through the relevant place based oversight board.

The voices of those with lived experience were sought through established engagement and co-production forums, reviews of recent consultation events and views expressed in recent reports and JSNAs.

3.3 Acknowledgements

We would like to thank the Steering Group for advising on and guiding this needs assessment. The needs assessment was produced by a working group including:

- Bernadette Alves, Public Health Consultant
- Kate Gilchrist, Head of Public Health Intelligence
- Elpida Sideri, Public Health Intelligence Specialist
- Sarah Colombo, Public Health Programme Manager for Starting Well
- Anne Foster, Head of Mental Health Commissioning, Brighton and Hove NHS Sussex
- Lizzie Izzard, Head of Children and Young Peoples Mental Health Commissioning, Brighton and Hove NHS Sussex

In addition, we would like to thank all of those who provided evidence for and gave feedback on the needs assessment.

3.4 Life course

The JSNA takes a life course approach. It considers the critical stages, transitions, and settings where large differences can be made in promoting or restoring health and wellbeing. The approach is in line with that taken by the city's Joint Health and Wellbeing Strategy. Where there are areas of overlap across the stages, we have taken a pragmatic approach to reduce repetition and signpost to other sections.

3.5 Evidence of what works for prevention

A report was commissioned to examine evidence, mainly sourced from reviews and meta-analyses, to identify public health interventions that can promote good mental health or wellbeing and prevent mental illness. The summaries appear in the boxes entitled "**what works for prevention**" in the life course sections. Appendix 3 lists the documents that were used in this review. The summaries cover six areas:

1. In the perinatal period / infant mental health
2. In the early years
3. Among parents and school-aged children
4. In workplaces
5. Among older people facing loneliness
6. Among older people facing long-term conditions

3.6 Interpreting national and local data

A key source of evidence for this JSNA is national and local data. Each have their strengths and limitations:

- **Nationally available data:** (eg proportion of people claiming Employment Support Allowance because of their mental health problems) where we can compare the city with other areas. This kind of data allows us to benchmark, ie to know whether Brighton & Hove is better or worse, higher or lower, than other areas. However, it tends to be older, and the content will be determined at a national level.

- **Local data:** eg the Safe and Well at School Survey. This data is usually more up to date, richer and provides more detail but usually cannot be compared to other areas.

3.7 Comparators

Where meaningful, we compare the city to other geographies: England; the South East and CIPFA comparators. CIPFA comparators are areas with similar population demographics to Brighton & Hove which allows for more meaningful comparisons of outcomes and performance. The comparator local authorities for Brighton & Hove are Bournemouth, Bristol, Coventry, Leeds, Medway, Newcastle upon Tyne, North Tyneside, Nottingham, Plymouth, Portsmouth, Sheffield, Southampton, Southend-on-Sea, Swindon, and York.

Throughout the needs assessment, the colours used for comparison to England are based upon whether Brighton & Hove is statistically significantly lower / higher or better / worse than England (where this judgement can be made). See the key in Appendix 4.

3.8 The structure of the JSNA

- Executive summary
- Background
- About the JSNA
- Wider national and international crises
- Prevention and the determinants of mental health
- Risk and protective factors: environmental and population
- Prevalence (from key national surveys for children and young people and adults)
- Life course stages (these sections do overlap):
- Perinatal – conception to 1 year of age
- Children and young people and families – aged 0 to 25 years
- Working age adults – aged 18 to 65 years
- Older adults – aged 65 years or over
- Recommendations

Each of the life course sections has the following subsections:

- Introduction
- Risk and protective factors
- Level of need
- Voice
- Quality and outcomes
- What we know about the offer of support
- Opportunities to learn more
- What works for prevention

4 Wider national and international crises

Here we briefly cover impacts of the following on mental health and wellbeing:

- The COVID-19 pandemic
- The cost of living crisis
- Climate change
- Workforce

The first three of these crises increase the numbers of people with mental health needs and deepen inequalities. More vulnerable groups have been and are being disproportionately affected. The data in this document does not fully reflect the impact of these crises and may therefore underestimate both current and future need and the extent of inequalities. Challenges around workforce recruitment and retention impact on quality and capacity of support.

4.1 Impact of the Coronavirus (COVID-19) pandemic

The COVID-19 pandemic deepened existing inequalities including mental health inequalities.[14] Some groups were disproportionately affected by the pandemic and this includes those with existing mental health and physical health problems, learning disabilities, younger people, women, BME communities, deprived communities, frontline health and care staff, and those facing financial hardship. The medium and long impact of both the infection and the measures taken to control it, such as lockdown, are ongoing. The negative mental health effects of the pandemic are expected to last longer than its physical health impacts.[15] As we move into recovery, there is an opportunity to create a healthier, more resilient society and redress these inequalities.[16]

Demand for mental health support is predicted to increase. The Centre for Mental Health has estimated an increase of 8.5 million adults and 1.5 million children and young people requiring mental health support as a direct impact of the pandemic during the next three to five years.[17]

Routine and local data in this document may not fully reflect the impact of COVID-19 and may underestimate both current and future need and the size of inequalities.

The population may have experienced and may continue to experience short- or medium to long-term effects from:

- Direct infection: Mental health impact of short- or medium-term morbidity associated with having the virus, receiving treatment or developing Long Covid.
- Control measures like lockdown: The direct effects such as increases in domestic violence, isolation, reduced support from family and friends, loneliness, on-line schooling etc. and indirect effects on the wider determinants of health such as financial insecurity, unemployment, educational achievement and food insecurity. The cumulative effect of repeated pandemic waves and lockdowns may have led to an increased and prolonged negative effect on the mental health and wellbeing of some groups within the population.

- Reduced access to healthcare and wider support: Impaired access to or quality from healthcare for non-COVID-19 related conditions, fewer opportunities to identify safeguarding issues or to pick up developing problems at an early stage. This disruption continues as workforces are stretched, ambulance waiting times increase and there is a backlog of people waiting for treatment.
- Bereavement: Experience of losing loved ones at a time when people could not always visit at the end of their life and grieving processes were disrupted eg funeral arrangements.

Short or medium-term effects include mortality, morbidity, physical and mental health and wellbeing (WHO,2020). Appendix 5 summarises some key impacts by life course.

4.2 Cost of living crisis

The 'cost of living crisis' refers to the fall in real disposable income that the UK has experienced since late 2021.[18] The cost of living has risen steadily for at least 12 months and at the time of writing (autumn 2022) is predicted to increase further. It is driven by various factors including increases in the cost of consumer goods and increasing energy prices.[19] According to the Office for National Statistics, 89% of adults in Great Britain reported an increase in their cost of living in August 2022. The crisis will disproportionately affect low-income households, many of these are the same communities who have been disproportionately affected by COVID-19.

The crisis will have a profound negative impact on population mental health and increase demand for services. This has been highlighted by several organisations and agencies including The Royal College of Psychiatry.[20] It should be noted that because the crisis is evolving so rapidly, the estimates in this needs assessment do not take account of the impact of the cost of living crisis because data was not available. It means that need is likely higher and inequality gaps greater than presented in this report.

4.3 Climate change

Climate change has been recognised as a health emergency, but predominantly as a physical health emergency. Both the drivers and consequences of climate change can lead to mental health disorders and threaten emotional wellbeing.

Climate change is expected to have adverse impacts on well-being and to further threaten mental health. Climate change increases existing inequalities: children and adolescents, particularly girls, elderly people, and people with existing mental, physical and medical challenges are particularly at risk in addition to those with lower socioeconomic status. Mental health impacts are expected to arise from exposure to high temperatures, extreme weather events, displacement, malnutrition, conflict, climate-related economic and social losses, and anxiety and distress associated with worry about climate change.[21]

There are new terms to describe climatic events and the impact on individuals' mental health; ecoanxiety, eco-guilt, ecopsychology, ecological grief, solastalgia, biosphere concern.[22]

4.4 Workforce

Workforce shortages were the single biggest challenge facing the NHS well before COVID-19. But the pandemic has driven increased demand for health care, growing waiting lists and a substantial elective care backlog, while impacting negatively on staff wellbeing and absence.[23]

High level analysis points to an overall workforce supply-demand gap across the NHS Hospital and Community Health Service (HCHS) and general practice in 2021/22 of around 7% of estimated workforce demand and increasing to a peak gap in 2024/25 of around 9% of projected demand. There are particular issues in the GP workforce.[24]

The Covid-19 pandemic exacerbated long-term issues such as chronic excessive workload, burnout and inequalities experienced by staff from ethnic minority backgrounds.[25,26] People across all professions, and carers and volunteers, worked tirelessly to help those who needed care during the pandemic. The negative impact of working under this sustained pressure, including anxiety, stress and burnout, cannot be underestimated.[27]

Workforce shortages are having a direct impact on the quality of people's care.[28]

5 Prevention and the building blocks of mental health

This section provides an overview of what works to improve population wellbeing, prevent mental ill health and the need to intervene as early as possible to reduce impact and deterioration. It begins by describing factors that influence mental health and wellbeing.

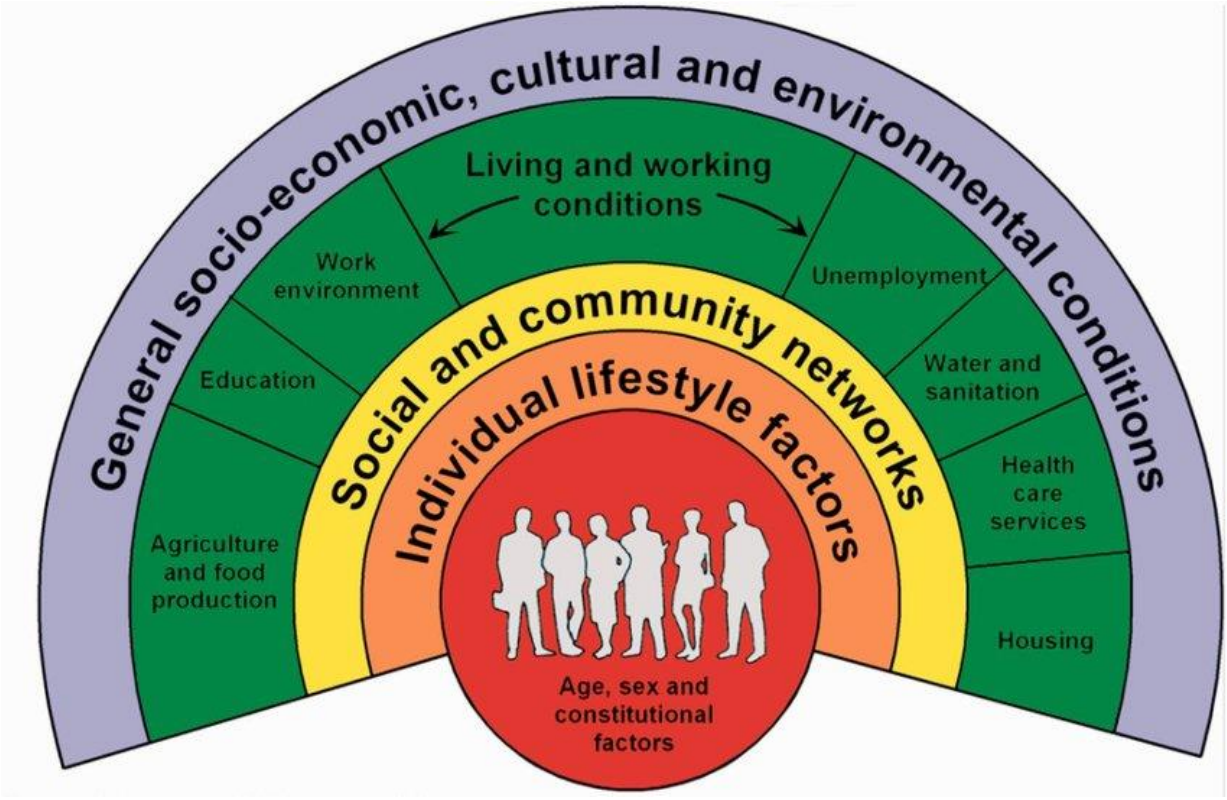
5.1 The building blocks of mental health

The risk of developing a mental health problem, such as a diagnosable mental illness, and the risk of having low levels of mental wellbeing, varies across people and communities and over time. It is strongly influenced by multiple factors past and present - by the environment in which we are born, grow, live, work and age, by our family relationships especially when we are a child, life experiences, trauma, and our biology.

Some factors increase the likelihood of having mental health problems (risk factors) and other reduce it (protective factors). Protective factors contribute to the ability to have control over one's life. Risk factors can undermine the development of individual level attributes and reduce the capability to flourish. Some risk and protective factors operate at an individual level, others at family and some within a community or setting.

Biological, psychological, and environmental factors combine to both protect from and increase the risk of developing mental health problems.

Figure 2: The determinants of health and wellbeing in neighbourhoods



Source: Dahlgren & Whitehead (1991)[29]

Although some mental health problems are partly influenced by genetics, it is important to look at the wide range of environmental, social, economic, community, family, and emotional factors, and health behaviours, that interact with biology (**Figure 2**).

Figure 3 summarises common risk and protective factors for mental wellbeing.

Figure 3: Common risk and protective factors for mental wellbeing at individual and family/community level





	Individual level	Family and community level
Risk factors	Adversity in early life Weak or difficult relationships with impact on attachment Adverse life events (ACEs) Healthy lifestyles Financial worries or debt Traumatic events Violence / abuse Natural disasters Serious illness or disability Bereavement	Poverty / deprivation Poor housing Homelessness Lack of employment Insecure or low paid employment Working conditions that create stress Crime and safety Poor quality neighbourhood environment Low social capital Social isolation
Protective factors	Includes factors that support or increase the development of individual level attributes such as: • Coping abilities, • Self-efficacy and resilience, and • The ability to learn and to develop social skills all of which may encourage healthy behaviours and mental health and wellbeing.	Protective family and community level factors include social support and protective influences organised in schools, neighbourhoods and workplaces. • Feeling part of a community • Access to green and open spaces • Shared public spaces • Sustainable local economy • Arts and creativity

Source: Office for Health Improvement and Disparities Mental health JSNA toolkit, prototype Mental Health tool and The Mental Health Wellbeing Impact Assessment Toolkit

Evidence shows that the largest determinant of our health is not health services or personal behaviour but the wider socio-economic circumstances of our life such as income, educational attainment, transport, employment, community cohesion.[30] These are the building blocks of health.

The factors are complex and often cluster eg a person who has financial insecurity is more likely to live in poorer quality housing, have difficulties in keeping their room warm and have worse access to green spaces. Factors can be inter-generational eg poor parental mental health is a key risk factor for their child's mental health. A parent with poor mental health means the family is more likely to be experiencing one or of more

disadvantage eg poor housing, job insecurity etc. Furthermore, they may have episodes where they have a lower ability and desire to connect with other family members and their baby/child in a warm, responsive way.

Risks accumulate over time, for example if a person experiences parental conflict as a child, and/or discrimination as a young adult, risks will grow and impact on mental health not only at the time, but also in later life.

5.2 Prevention

> ***Prevention is about helping people stay healthy, happy and independent for as long as possible. This means reducing the chances of problems from arising in the first place and, when they do, supporting people to manage them as effectively as possible.***
>
> Department of Health and Social Care: Prevention is better than cure [31]

The government vision for "putting prevention at the heart of our nation's heath" highlights that:[32]

- Many causes of ill health are preventable: Over half of the attributed burden of poor health and early death can be linked to factors that can be modified
- Prevention works and is cost effective: A review of international studies suggests past investments in prevention have had a significant long-term social return on investment and this is estimated to be around £14 of social benefit for every £1 spent.

Prevention is a strand of national mental health policy:

- NHS Long Term Plan
- NHS Five Year Forward View
- Prevention Green Paper: Advancing our health: prevention in the 2020s.

However, it is widely acknowledged that there are challenges to implementing a prevention approach. Some of the wider system challenges are:

- Actions to prevent mental health problems sit for the most part in the wider system – the largest determinants of mental health are the building blocks of health such as income, education, occupation, employment, housing, community cohesion, early childhood development[33]
- Decision makers can be daunted by the challenge of "fixing" the wider system and actions often focus on the role of individual choices and behaviours[34]
- Most NHS targets are about services, few are focused on prevention
- Impact on outcomes can be difficult to measure and it may take years for the full impact to be realised

- Investment in one part of the system leads to savings in another part which can be a barrier to joint working
- The evidence base has gaps which creates uncertainty about future actions
- Cuts to public sector spend, eg NHS and local government funding, mean resources are directed at acute need rather than prevention approaches.

Commitment to, and championing of, a population prevention approach, with tools for system leaders, commissioners and planners to understand and implement prevention measures, could lead to large improvements in mental health and reduce health inequalities. There are toolkits that can help in developing a different, more evidence-based narrative that takes a social model approach and can help promote a sense of efficacy, the sense that the system has the ability to produce the desired change.[35]

This section covers:

- A definition of prevention
- Prevention frameworks
- Outline of the Prevention Concordat
- Individual behaviours

5.2.1 Prevention – definition

Widely accepted models define prevention at three stages:[36]

Primary (before problems emerge)

- Initiatives and strategies to prevent the onset or development of mental ill-health. These interventions may target: The whole community (universal); Particular groups known to be at higher risk (selected); or Individuals at very high risk who may be showing early signs of mental ill-health (indicated).

Secondary (as problems emerge)

- Initiatives and strategies to lower the severity and duration of an illness through early intervention, including early detection and early treatment. These interventions can occur at any stage of life, from childhood to old age and are targeted at risk individuals and those showing early signs and symptoms of mental ill-health.

Tertiary (when problems already exist)

- Interventions and strategies to reduce the impact of mental ill-health on a person's life through approaches such as rehabilitation and relapse prevention. It also includes actions to ensure people have access to supports within the community, such as housing, employment, physical health care and social engagement.

Actions to address each stage aim to mitigate the associated risks and safeguard the known protective factors (**Figure 4**).

Early intervention is a form of prevention activity and overlaps with both primary and secondary prevention. Early intervention can be: 1. Prevention focused - targeting individuals beginning to show the early signs and symptoms of a problem (indicated primary prevention); and 2. Treatment focused - targeting individuals experiencing a first episode of mental illness (secondary prevention).

Figure 4: Summary of types of prevention, target groups and aims

Prevention is often considered in terms of three types at difference stages:

	Type of prevention	Stage	Target group	Aim
○	Promotion and prevention (primary)	No mental health problems	Whole population (universal) and at-risk groups (targeted and specialist)	Prevent mental health problems happening
○	Early detection (secondary)	Early stage of mental health problems	At risk groups (targeted and specialist) and those displaying early signs and symptoms	Detect signs of mental health problems early and timely help
○	Recovery (tertiary)	Later stage of mental health problems	Those with mental health problems (targeted and specialist)	Reduce complications of mental health problems and support recovery and wellbeing

Source: Adapted from Beaglehole, R., Bonita, R., and Kjellstrom, T., (1993). Basic Epidemiology. Geneva: World Health Organisation)[37]

Universal, targeted and specialist prevention activity

Prevention activity may be undertaken on different levels:

- **Universal** – actions focused to everyone regardless of risk. Often primary prevention work is 'universal' in that it targets and benefits everyone in a community.

- **Targeted** (or selective)– focused on those regarded at increased risk either by category eg young parents, middle-aged men or by geography eg living in an area of high deprivation.
- **Specialist** (or indicated)– focused on an even more select group who are at particularly high risk or already exhibiting concerning symptoms.

5.2.2 Mental health prevention frameworks

There are several national evidence-based documents that set out frameworks for preventing mental ill-health and promoting mental wellbeing – some are focused on cost effectiveness, others on effectiveness of specific interventions, others focus on factors that influence health without specifying interventions. Appendix 3 provides a list of some of the key ones.

There is no one framework which reflects well the needs and areas of focus for mental health prevention relevant for Brighton & Hove.

5.2.3 The Prevention Concordat

The Prevention Concordat for Better Mental Health is a national evidence-based prevention-focused framework for improving the public's mental health and reducing health inequalities. It includes tried and tested approaches that impact on the wider upstream determinants of mental health.[38] It was refreshed in 2020 to take account of COVID-19 and has over 250 signatories across the country. Prevention Concordat for Better Mental Health - GOV.UK (www.gov.uk)

The government encourages local authorities, Health and Wellbeing Boards, ICSs, and other health and care partnerships to sign up to the Concordat. It:

1. Focuses on prevention and the wider determinants of mental health to impact positively on the NHS and social care system by enabling early help through the use of upstream interventions
2. Supports joint cross-sectoral action to deliver an increased focus on the prevention of mental health problems and the promotion of good mental health at the local level drawing on the expertise of people with lived experience of mental health problems, and the wider community
3. Encourages collaborative work across organisational boundaries and disciplines to secure place-based improvements tailored to local needs and assets
4. Builds capacity and capability across our workforce to prevent mental health problems.



5.2.4 Individual behaviors

Whilst the building blocks of health such as income, education and housing, play the largest role in determining health, the actions and behaviour of individuals also make a difference.

Connect

Reach out to your local community, neighbourhood, colleagues, family and friends.

Learn

Learning new things can be fun and can improve your confidence. Set a challenge you will enjoy achieving. Share what you have done with others.

Be Active

Exercising makes us feel good. If you can get outside, try and go for a walk every day. Discover a physical activity you enjoy and that suits your level of mobility and fitness.

Take Notice

Look out as well as in. Notice your senses and what's around you. Pay attention to the present moment. Some people call this awareness "mindfulness".

Give

Acts of giving and kindness can help improve your wellbeing by creating positive feelings and a sense of reward, purpose and self-worth. They also help you connect with other people.

Care for the Planet

Look after your community and the world. Make small changes to your life that will reduce your energy use, recycle more, leave the car at home, use low energy light bulbs, small steps to a greener life can make a difference.

6 Brighton & Hove population and place – risk and protective factors

This section summarises some of the characteristics of the city – the population, the place and the wider determinants - that are associated with increased risks of, or greater protection from, developing mental health problems.

Appendix 6 shows the full list of indicators relevant to mental health where a comparison can be made between Brighton & Hove and England and its CIPFA comparators. This section highlights areas where Brighton & Hove has a potentially greater or smaller need or has risk or protective factors that are higher or lower than England, the South East or its CIPFA comparators. It has the following sections:

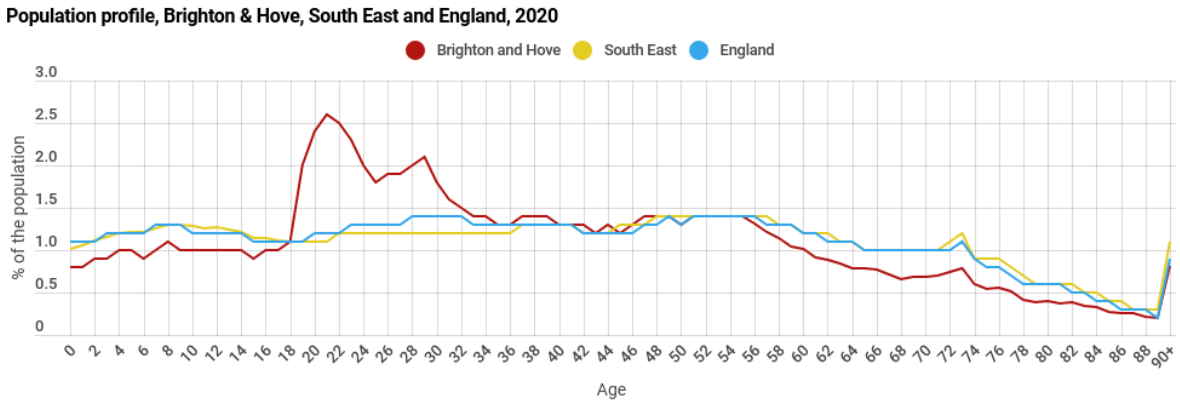
- Current population structure (age and gender) and population projections for 2030
- Environmental risk and protective factors
- Groups and communities at higher risk who are more exposed to, and more vulnerable to, unfavourable social, economic, and environmental circumstances.

6.1 The population of Brighton & Hove

The age and gender structure of the local population is an important driver of need and demand for mental health services.

In 2020, Brighton & Hove had an estimated 291,700 residents. It is estimated that 44,800 people (15%) are aged 0 to 15 years, more than two thirds (71%, 208,000 people) are aged 16 to 64 years, and just over one in ten (11%, 33,100 people) are aged 65 to 84 years and 5,900 people (2%) are aged 85 years or older (**Figure 5**).[39]

Figure 5: Population profile, Brighton & Hove, South East and England, 2020



Source: Brighton & Hove Population JSNA 2021 - Infogram

The population of Brighton & Hove differs from the South East and England (as shown in **Figure 5**):

- The city has a much higher proportion of people aged 19–38 years (37%, 106,800 people) compared to only 24% in the South East and 26% in England

- The difference is most pronounced between the ages 19 to 28. A fifth of Brighton & Hove's total population (21%, 62,300 people) is aged 19 to 28 compared to only 11% in the South East and 13% in England
- Brighton & Hove has a lower proportion of children aged 0 to 17 years (17%, 50,300 people) compared to 22% in the South East and 21% in England
- There are fewer people across all ages from the age of 56. In Brighton & Hove less than a quarter of the total population (23%, 65,700 people) is aged 56 or older compared to 31% in the South East and 29% in England.

Based on population estimates in 2020, Brighton & Hove has a relatively even gender distribution of males and females across all ages up until the age of 75 years. Beyond the age of 75 years, the proportion of female residents increases. There were an estimated 18,300 residents aged 75 or older, of whom 57% (10,400 people) were female and 43% (7,800 people) were male. By the age of 90 years or older the difference is almost two to one with 1,600 female (66%) and 800 male (34%) residents.

Population growth between 2019 and 2020 is mainly the result of inward international migration. There were 150 more births than deaths. Net international migration (from outside the UK) over this period was 2,200 more people, while net internal migration (between Brighton & Hove and the rest of the UK) was 1,500 fewer people (1,500 more people left than moved to the city). Most people moving from within the UK to Brighton & Hove do so from other parts Sussex or London. More people left for Sussex than arrive, but more people arrived from London than leave.[40]

6.1.1 Births

There are around 67,850 women of childbearing age resident in the city, that is defined as aged 15 to 44 years. This is 24% of the female population, higher than our CIPFA comparators (22%) and England (19%).[41]

Brighton & Hove had a general fertility rate of 34.8 live births for every 1,000 women aged 15-44 years in 2019, with 2,395 live births. This was the lowest general fertility rate of any upper tier local authority in England in this year. The rate has been falling; in 2010 it was 50 live births for every 1,000 women aged 15 to 44 years.

In 2020, 29% of all live births in England and Wales were to women born outside the UK; this is the highest since records began in 1969, continuing the general long-term increase. In Brighton & Hove in 2020, 28% of births were to non-UK born parents, an increase from 23% in 2007.[42]

The percentage of births in the city to mothers aged under 20 years was 1.5% in 2020 (2.5% England). The percentage of births to mothers aged 40+ was 9.9% which is more than double our CIPFA comparator areas (4.6%) and England (4.9%).

6.1.2 Future population change

There are projected to be 11,300 more people living in the city by 2030 (compared with 2020, a 4% increase to 303,000 people).

The city's population is predicted to get older, with the greatest projected increases by 2030 by broad age band in the 60-69 years (34%, 7,700 extra people) and 80-84 years (34%, 1,800 extra people). There are projected to be 400 (11%) more 85–89-year-olds and 300 (12%) more 90+ year olds.

6.2 Environmental risk and protective factors

See Appendix 6: Indicators of common risk and protective factors for mental wellbeing, Brighton & Hove, CIPFA comparators and England.

6.2.1 Introduction

This section describes some of the wider determinants of health in Brighton & Hove and considers social and contextual factors that affect mental health, such as employment, crime, safety and housing. The mental health of each individual is influenced by their social setting, such as having the ability to earn enough money and feeling part of a community. This section considers these determinants which lead to unfair and avoidable differences in health within and between populations and to shorter lives.

For each key factor, we have a short overview of national evidence and then present evidence for how Brighton & Hove compared with England.

We cover:

- Deprivation
- Poverty and financial insecurity
- Housing (the homeless population is covered in the next section)
- Education
- Employment
- Crime, safety and violence
- Community wellbeing and social capital
- Healthy lifestyles

Unless otherwise stated, the national evidence sections are taken from the Office for Health Improvement and Disparities Mental Health JSNA Toolkit Mental health and wellbeing: JSNA toolkit - GOV.UK (www.gov.uk)

6.2.2 Deprivation

National evidence

It is well established that deprivation (a lack of money, resources and access to life opportunities) or being in a position of relative disadvantage (having significantly less resource than others) is associated with poorer health, including mental health. The prevalence of psychotic disorders among the lowest fifth of household income is 9 times

higher than in the highest and double the level of common mental health problems between the same groups.

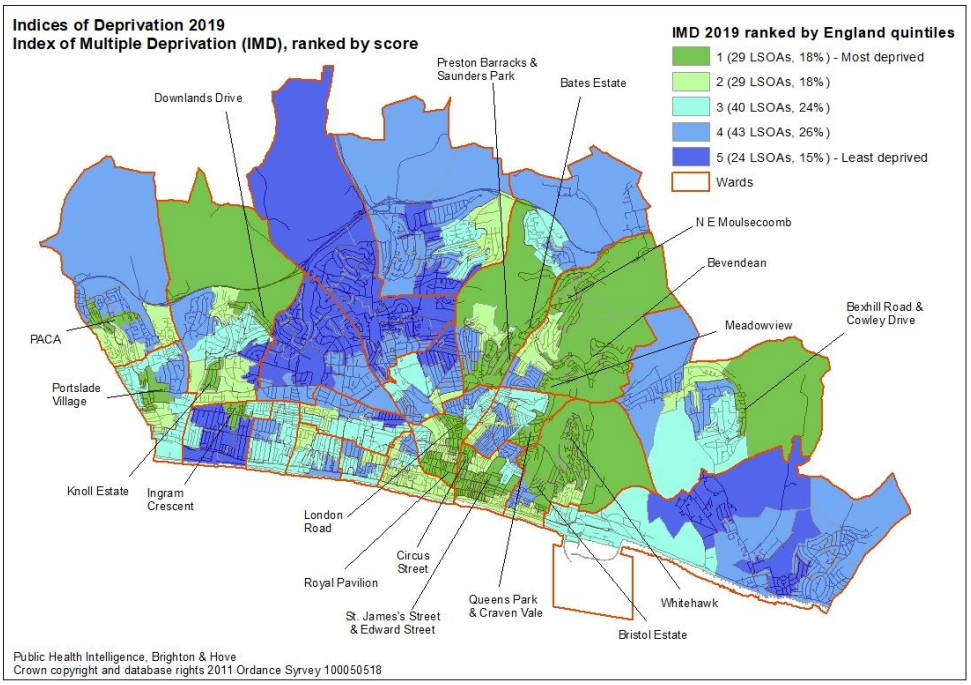
Explaining the relationship between deprivation and mental health is complex and it is hard to unpick cause and effect. Experiencing disadvantage can increase the risk of mental health problems. People with mental health problems can be affected by a 'spiral of adversity' where factors such as employment, income and relationships are affected by their condition. People who live in deprived areas are more likely to need mental healthcare but less likely to access support and to recover following treatment. This compounds and worsens mental health problems.

Brighton & Hove

According to the 2019 Index of Multiple Deprivation, Brighton & Hove is the 131st most deprived local authority in England (of 317), with 17% of the population of the city living in the 20% most deprived areas in England and 13% in the 20% least deprived areas. This means there are fewer people in both the most deprived and least deprived quintiles than in England – which may indicate lower levels of deprivation inequality. There are however some areas of very high deprivation.

The highest concentration of deprivation is in the Whitehawk, Moulsecoomb, and Hollingbury areas. Along the coast, to the west of the city and in Woodingdean there are also pockets of deprivation. All these areas are in the 20% most deprived areas in England (Figure 6).

Figure 6: Index of Multiple Deprivation (IMD), ranked by score, Lower Super Output Area (LSOA) in Brighton & Hove 2019



Source: Ministry of Housing, Communities and Local Government. IMD 2019 English indices of deprivation 2019 - GOV.UK (www.gov.uk)

Deprivation within the city is summarised in Table 1. Brighton & Hove has a greater proportion of older people affected by income deprivation than in England.

Brighton & Hove has a similar proportion of children in low-income families compared to England. There are almost 7,900 children in low-income families before housing costs, but if housing costs are taken into account, then in 2019/20 there are almost 13,000 children in the city living in poverty.[43]

Table 1: Summary of Index of Multiple Deprivation (IMD), Income Deprivation Affecting Children Index (IDACI) and Income Deprivation Affecting Older People Index (IDAOPI), Brighton & Hove, 2019

Measure	Rank*	Quintile	Of 165 LSOAs, % in most deprived quintile	Of 165 LSOAs, % in least deprived	Size of affected pop
Index of Multiple Deprivation (IMD)	131	Third	18%	15%	17% (50,400 people) live in the 20% most deprived areas in England
Income Deprivation Affecting Children Index (IDACI)	145	Third	17%	15%	More than one in ten children aged under 16 (15%, 6,900 children) live in income deprivation
Income Deprivation Affecting Older People Index (IDAOPI)	53	First	25%	5%	One in five residents aged 60 or over (19%, 9,500 people) live in income deprivation

Source: Brighton & Hove City Council. English Indices of Deprivation 2019: Brighton & Hove Briefing. Available at REPORTS | BH Connected and Office for National Statistics Mid Year Population Estimates 2020 Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)
*(of 317 LAs in England)

6.2.3 Poverty and financial insecurity

National evidence

Poverty can be both a causal factor and a consequence of mental ill health. Across the UK, both men and women in the poorest fifth of the population are twice as likely to be at risk of developing mental health problems as those on an average income. The cumulative effects of poverty are present throughout the life course, starting before birth and continuing into older age.

Unmanageable financial debt is associated with poorer mental health. A quarter of people experiencing common mental health conditions also have financial problems, three times more than the general population. Half of adults with a debt problem also have a common mental health condition.

Brighton & Hove

In Brighton & Hove median house prices are 12 times annual residence-based earnings, significantly higher than England (9 times) - 28th highest of 151 local authorities in England, and the third highest in the South East.

In Brighton & Hove 12% of all households (15,800 households) are estimated to be living in fuel poverty compared to 13% in England.

Tourism continues to be an important driver of the Brighton & Hove economy: the sector supports around 1 in 5 jobs in the city. Seasonal jobs and casual employment can create financial insecurity.[44]

6.2.4 Housing (see also population section for people experiencing homelessness)

National evidence

Insecure, poor quality and overcrowded housing causes stress, anxiety, and depression, and exacerbates existing mental health conditions. One in five (19%) adults living in poor quality housing in England have poor mental health outcomes.

Brighton & Hove

In 2020, 16.2% of homes across England did not meet the decent homes standard. Using the English rate and the latest ONS household projections this would mean there are in the region of 20,000 homes in the city that do not meet the decent homes standard.

At the time of the 2011 Census, 7% of homes in Brighton & Hove were classed as overcrowded, significantly higher than England (5%) and 35th highest of 151 local authorities in England.

6.2.5 Education

National evidence

Education is an important determinant of later health and wellbeing. It improves peoples' life chances, increases their ability to access health services and enables people to live healthier lives. A high level of educational attainment at school can lead to higher qualifications and in later life, more secure jobs and housing that can in turn lead to better health.

Brighton & Hove

The city has similar school readiness at the end of reception to England and has seen an improving trend in recent years and a higher average attainment 8 score than

England. There is also a lower rate of 16–17-year-olds not in education, employment or training in Brighton & Hove than England.

6.2.6 Employment and work

National evidence

Stable and rewarding employment is a protective factor for mental health and can be a vital element of recovery from mental health problems. Unemployment and unstable employment are risk factors for mental health problems.

People who are unemployed are between 4 and 10 times more likely to report anxiety and depression and to complete suicide.

Being in work is beneficial to health and well-being. However, it is important to distinguish between 'good work' (characterised by fair treatment, autonomy, security and reward), and 'bad work' in which individuals feel unsupported, undervalued and demotivated.

Brighton & Hove

The city has significantly lower rates of long-term claimants of Jobseeker's Allowance, with 260 people in 2021 (1.3 per 1,000 working age adults compared to 2.1 in England). In 2021, the unemployment rate in Brighton & Hove was 4.8% compared to 4.4% across Great Britain and higher than the South East (3.8%).

6.2.7 Crime, safety, and violence

National evidence

The relationship between crime and mental health problems is complex. It can also be controversial, as public perception about the relationship can contribute to stigma, discrimination and social exclusion. While there is public perception that people with mental health problems are offenders, the vast majority of these individuals are not violent, and most crimes are committed by people who do not have mental health problems. People with mental health problems are three times more likely to be a victim of crime than the general population and five times more likely to be a victim of assault (rising to 10 times more likely for women).

People in contact with the criminal justice system have substantially more risk factors for suicide (increased prevalence of mental health conditions, substance misuse and socioeconomic deprivation).

Being a victim of crime, or exposure to violent or unsafe environments can increase the risk of developing a mental health problem.

Being a victim of intimate partner violence or domestic abuse increases the risk of mental health problems. The relationship between domestic violence and mental health is bidirectional, with research suggesting that women experiencing abuse are at a

greater risk of mental health conditions and that having a mental health condition makes one more vulnerable to abuse.

Brighton & Hove

In 2020/21 there was a similar rate of violent crime offences per 1,000 population in Brighton & Hove compared to England (29.5 and 27.8 respectively) with 8,593 offences within that year.

The rate of domestic abuse-related incidents across Sussex (not available below this level) is lower than England (22.1 compared to 25.9 per 1,000 people), however this may be due to differences in reporting to the Police.

There were 315 first time offenders in 2020 in Brighton & Hove, a lower rate than England (120 and 160 per 100,000 respectively). There is no prison in Brighton & Hove, but one located in nearby Lewes.

6.2.8 Community wellbeing and social capital

National evidence

The mental wellbeing of individuals is influenced by factors at a community level such as social networks, sense of local identify, levels of trust and reciprocity and civic engagement. The benefit of this "social capital" can be felt at an individual level (for example, through family support) or at a wider collective level (for example, through volunteering).

Whilst disadvantaged communities have higher health need, they may also have assets within the community that can improve health and build resilience.

Community assets improve the health and the quality of the community. They include physical assets such as public green space, play areas and community buildings and social assets such as volunteer and charity groups, social networks and the knowledge and experiences of local residents. These assets have potential to protect and increase community wellbeing and thus strengthen resilience.

Brighton & Hove

Brighton & Hove is fortunate to have access to the sea, the South Downs National Park and have many parks and open spaces in the city. More people use outdoor spaces for exercise/health reasons in Brighton & Hove than England (18.3% compared with 17.9%) and more people are physically active. Brighton & Hove also has a strong arts and culture sector, with lots of opportunities for residents to participate in arts and culture activities.

The city has significant community assets with higher rates compared to England of:

- Belonging (76% of Brighton & Hove respondents agree compared to 62% for England)

- Pulling together (76% of Brighton & Hove respondents agree compared to 59% for England)
- Formal volunteering (44% of Brighton & Hove respondents compared to 38% for England)
- Feeling that people from different backgrounds get on (94% of Brighton & Hove respondents compared to 82% for England)
- Satisfied with their local area as a place to live (89% of Brighton & Hove respondents compared to 78% for England).

However, according to the 2012 Brighton & Hove Health Counts survey, 68% of respondents see or speak to their neighbours at least once or twice a week. This is a large decrease from 2003, when 80% of respondents said they saw or spoke to their neighbours at least once or twice a week.

Brighton & Hove has a large community and voluntary sector who support individuals, groups and communities. The voluntary, community and social enterprise (VCSE) sector is broad encompassing independent organisations working with a social purpose. They range from small community based groups or schemes through to larger charities and organisations that may operate locally, regionally or nationally. The city has a strong and vibrant VCSE sector. The VCSE sectors plays a key role in improving health, wellbeing and care outcomes and tackling health inequalities. They do this not only by delivering services but also by shaping their design and advocating for, representing and amplifying the voice of service users, patients and carers. Their input is essential to a vibrant local health economy.

In the last Taking Account report in 2019 there were 2,330 third sector organisations in the city with an estimated 4.5 million volunteer hours per year with an estimated £37million in volunteer time (based upon the minimum wage).[45] The most frequently reported activities relate to health and wellbeing (15%), environment, sustainability and conservation (10%) and community development (9%) - all crucial for improving mental wellbeing. Improving mental health and wellbeing was an additional aim for one in five organisations.

6.2.9 Healthy lifestyles

National evidence

Positive health behaviours, such as not smoking, eating healthy food, healthy sleep routines and engaging in physical activity, can encourage psychological wellbeing, improve physical health, prevent mental health problems, and support recovery among people who are unwell. In addition to supporting individuals to make healthy choices, interventions should focus on providing environments which support adopting healthy behaviours.

Brighton & Hove

Smoking rates are significantly higher amongst both children and young people and amongst adults (17.5% compared to 13.9% for England), including those with a long-term mental health condition.

Physical activity and inactivity, and obesity: 69% of adults in Brighton & Hove are physically active (England 66%), but we have seen a worsening rate which used to be significantly better than England. One in 5 (22%) are physically inactive (England 23%) – conversely, we have seen an increasing (worsening) rate which used to be significantly better than England. In 2019/20, 28% of 10-11 years were overweight or obese in the city, significantly better than England (35%). Local data suggests that this has increased during the pandemic both within the city and nationally. In 2020/21, 33% of 10-11 years were overweight or obese in the city, a 5% increase on the previous year. However, rates are still significantly better than England (41%). For adults, it is estimated that 59% are overweight or obese compared to 64% for England (2020/21).

6.3 Population risk and protective factors

See Appendix 6: Indicators of common risk and protective factors for mental wellbeing.

6.3.1 Introduction

This section describes some of the communities and subgroups who are more exposed and vulnerable to unfavourable social, economic, and environmental circumstances. It includes information on people with characteristics protected under the Equality Act 2010 where it is against the law to discriminate.

For each group, we have a short overview of national evidence and then present evidence for how Brighton & Hove compares with England.

We cover the following groups – many are identified as being of high risk of mental health problems:[46],[47]

- People with alcohol and/or drug dependence
- People experiencing homelessness
- Prison population, offenders and victims of crime (covered in environmental factors)
- People with complex needs and multiple disadvantage
- Ethnic minority groups
- Migrants, refugees, asylum seekers and stateless person
- Gypsy, Roma and Travellers
- Children in care and care leavers
- Students
- Lesbian, gay, bi, trans, queer, questioning and ace (LGBTQ+) people
- Transgender people
- Carers
- People with long-term physical health conditions

- People living with physical disabilities
- People living with learning disabilities
- Neurodiverse people
- People with sensory impairment
- Relationship status
- Armed forces personnel

Unless otherwise stated, the national evidence sections are taken from the Office for Health Improvement and Disparities Mental Health JSNA Toolkit Mental health and wellbeing: JSNA toolkit - GOV.UK (www.gov.uk)

Local evidence on the mental health needs of these groups is covered within the appropriate life stage of the report where possible.

6.3.2 People with alcohol and/or drug dependence

National evidence

Drinking more than the low-risk guidelines can harm mental and physical health. Regular consumption of alcohol has been shown to cause mental ill health including depression, anxiety, and a connection to higher levels of self-harm and suicide in people with alcohol problems. Regular heavy drinking can also lead to alcohol dependence. The relationship between mental health problems and alcohol is a vicious cycle. Mental health problems can cause people to drink more, particularly as people often drink alcohol as a form of 'self-medication'.

Research shows that mental health problems are experienced by the majority of drug (70%) and alcohol (86%) users in community substance misuse treatment, 41% of people entering community alcohol and drug treatment in 2017-2018 reported a co-occurring mental health treatment need. There are many factors associated with harmful alcohol and drug use. Drug misuse can cause social disadvantage, and social disadvantage may lead to drug use and dependence. Many are social factors, such as deprivation.

Brighton & Hove

Drinking and substance misuse are significantly higher amongst both children and young people and amongst adults, including those with a long-term mental health condition.

Brighton & Hove has the 9th highest rate of deaths related to drug misuse at upper tier local authority level in England (2018-2020).

6.3.3 People experiencing homelessness

National evidence

Everybody who experiences homelessness will feel stress and anxiety, and many report depression. Mental health problems among people experiencing homelessness are

more prevalent than in the general population, particularly among people caught in the 'revolving door', between hostels, prison, hospitals and the streets. Compared with the general population, homeless people are twice as likely to have a common mental health condition, and psychosis is up to 15 times more prevalent. They are also over 9 times more likely to complete suicide. People experiencing homelessness find it difficult to access health services, including mental health care.[48]

Brighton & Hove

Brighton & Hove has a higher rate of homelessness, with 37 rough sleepers in the last Street Count (autumn 2021), and the second highest rate of statutory homelessness (households in temporary accommodation) of all local authorities in England outside of London (18th highest in England including London).

According to research carried out by Shelter, 1 in every 78 people in Brighton & Hove are homeless, compared to an average of one in every 206 people across England. London is the worst hit city for homelessness, outside the capital, Luton is the area with the highest rate of homelessness, followed by Brighton & Hove.

6.3.4 People with complex needs and multiple disadvantage

National evidence

There is a huge overlap between the offender, substance misusing and homeless populations. For example, in any given year, two thirds of people using homeless services are either in the criminal justice system or in drug treatment services. It is estimated that, in England, there are 58,000 people who experience the multiple disadvantages of offending, substance misuse and homelessness; and 55% of these individuals have a diagnosed mental health problem.[49]

Brighton & Hove

In Brighton & Hove, 20 per 1,000 working age adults were estimated to receive services across homelessness, substance misuse or offending. The 2020 Brighton & Hove JSNA of Adults with Multiple Complex Needs showed that in 2010/11, there were a total figure of 1,500 adults with two or more needs (420 with all three). Brighton & Hove ranked 61st highest (worst) of 151 local authorities in England. With population growth, this gave an estimated 1,670 people in 2018 with two or more needs.

The JSNA also estimated the number of adults receiving support for at least one of these issues, who also have mental health problems, estimated at 52% of those with severe and multiple disadvantage. The authors note however, that the incidence of mental health problems may be significantly greater than is recorded in the data used. Thus, these figures may underestimate the overlap between mental health problems and severe and multiple disadvantage.

6.3.5 Ethnicity

National evidence

Racial discrimination is recognised as a determinant of racial and ethnic health inequalities and evidence shows strong associations between racial discrimination and adult health outcomes. A systematic review considered the effects of racial discrimination on child and youth health and found that experiencing racial discrimination can impact:

- Positive mental health (eg self-esteem, resilience)
- Behaviour problems
- Wellbeing
- Pregnancy/birth outcomes.[50]

People from Black and Minority Ethnic groups living in the UK are more likely to:[51]

- Be diagnosed with a mental health problem
- Defer seeking help until a in a crisis situation, and access that help via A&E
- Be admitted to hospital with a mental health problem
- Experience a poor outcome from treatment
- Disengage from mainstream mental health services.

People from Black African and Caribbean backgrounds are disproportionately seen in the 'hard end' of services and are more likely to receive harsher more coercive treatments. Some research has found the concept of 'eurocentricity' of service design resulting in people from some Black and Minority Ethnic group communities struggle to access services in ways meaningful to them.[52]

Following the referendum vote to leave the European Union, some experts have suggested that a culture of extremism and intolerance has become more visible in political debate. Stigma, prejudice and discrimination appear to be on the rise, with examples of racism and assault against migrants and religious and ethnic minorities.[53] A study based in south east London found that discrimination was associated with higher rates of common mental health conditions, and this effect was strongest for individuals who had recently migrated to the UK.[54]

Brighton & Hove

The 2011 census (**Table 2**) showed that one in five Brighton & Hove residents (53,351, 19.5%) is from a BME background, higher than the South East (14.8%) but similar to England (20.2%).

The largest BME community is White Other, making up one third (37%) of the BME population. It is 7.1% of the total population, very much higher than in the South East (4.4%) and England (4.6%).

Brighton & Hove has a higher proportion of people of Mixed ethnicity (3.8%) than England (2.3%), with the proportion of people of Mixed White and Asian (1.2%) and

other Mixed ethnicity (1.0%) double the value found in England. Other ethnicities that are more prevalent in Brighton & Hove than across England include White Irish (1.4%), Chinese (1.1%) and Arab (0.8%).

By contrast, the proportion of Asian people (4.1%) is below that for the South East (5.2%) and England (7.8%), with particularly low numbers of people of Pakistani ethnicity (0.2%) compared with England as a whole (2.1%). The proportion of Black people in Brighton & Hove (1.5%) is also less than half that for England (3.5%) but similar to the South East (1.6%).

Table 2: Ethnicity in Brighton & Hove, South East, England, 2011 Census

	Brighton & Hove		South East	England
	Number	%	%	%
All usual residents	**273,369**			
White	**243,512**	**89.1%**	**90.7%**	**85.4%**
English/Welsh/Scottish/Northern Irish/British	220,018	80.5%	85.2%	79.8%
Irish	3,772	1.4%	0.9%	1.0%
Gypsy or Irish Traveller	198	0.1%	0.2%	0.1%
White Other	19,524	7.1%	4.4%	4.6%
Mixed / multiple ethnic group	**10,408**	**3.8%**	**1.9%**	**2.3%**
White and Black Caribbean	2,182	0.8%	0.5%	0.8%
White and Black African	2,019	0.7%	0.3%	0.3%
White and Asian	3,351	1.2%	0.7%	0.6%
Other Mixed	2,856	1.0%	0.5%	0.5%
Asian / Asian British	**11,278**	**4.1%**	**5.2%**	**7.8%**
Indian	2,996	1.1%	1.8%	2.6%
Pakistani	649	0.2%	1.1%	2.1%
Bangladeshi	1,367	0.5%	0.3%	0.8%
Chinese	2,999	1.1%	0.6%	0.7%
Other Asian	3,267	1.2%	1.4%	1.5%
Black/African/Caribbean/Black British	**4,188**	**1.5%**	**1.6%**	**3.5%**
African	2,893	1.1%	1.0%	1.8%
Caribbean	879	0.3%	0.4%	1.1%
Other Black	416	0.2%	0.2%	0.5%
Arab	**2,184**	**0.8%**	**0.2%**	**0.4%**
Any other ethnic group	**1,799**	**0.7%**	**0.4%**	**0.6%**
Black & Minority Ethnic (BME)	**53,351**	**19.5%**	**14.8%**	**20.2%**

Note: Black & Minority Ethnic (BME) is defined as all ethnic groups other than White English / Welsh / Scottish / Northern Irish / British.

Source: ONS, 2011 Census, table KS201EW

The overall age structure of the Black and Minority Ethnic (BME) population is younger than the city's White British population (see Table 3). The 2011 Census data shows that 22% of the city's population are aged 19 or younger, but this proportion is higher for many ethnic groups: mixed ethnic background (50%), Asian (26%), Black (24%) and Arab (30%). The Census data also shows that while people aged 65 or older make up 13% of the city's population, the proportion is very much lower in all other high level ethnic groups (6% or less), aside from White UK/British and White Irish.

Table 3. Age profile by high level ethnic group, Brighton & Hove, 2011 Census

Ethnic group	Age group (%)			
	0 to 19 years	20 to 44 years	45 to 64 years	65 years and older
All persons (n=273,369)	22%	43%	22%	13%
White UK/British (n=220,018)	21%	40%	24%	15%
White Irish (n=3,772)	7%	45%	28%	21%
White Other (n=19,524)	13%	66%	15%	5%
Mixed / multiple ethnic group (n=10,408)	50%	38%	9%	2%
Asian/Asian British (n=11,278)	26%	55%	15%	5%
Black/Black British (n=4,188)	24%	57%	17%	3%
Arab (n=2,184)	30%	49%	16%	5%
Other ethnic group (n=1,799)	20%	53%	22%	6%
All BME (n=53,351)	24%	55%	15%	5%

Source: ONS 2011 census, table DC210EW

6.3.6 Migrants, refugees, and asylum seekers

National evidence

High rates of people moving home within and between areas can disrupt social ties and community networks and is related to higher levels of stress and mental health problems.[55]

People who have recently arrived from abroad to live in an area may face barriers to accessing mental health services. Refugees are more likely to have experienced trauma and have a higher prevalence of mental health conditions such as post-traumatic stress disorder (PTSD), depression and anxiety and these experiences and conditions require skilful engagement in order to minimise the risk of being re-traumatised. Additionally, people who do not speak English well might need specific help to enable them to access the mental health services. [56]

Brighton & Hove

The city is a destination for migrants (people living or intending to live in the city for 12 months or more) from outside the UK. The latest ONS figures (2020) estimates that 55,000 residents (19%) were born outside of the UK. This is similar to 2019 (53,000 people, 18%) and similar to what is seen in the South East (14%) and England (16%). ONS migration statistics at the local authority level are subject to large confidence intervals. For Brighton & Hove the figure is +/- 13,000 people, therefore the true number of migrants in the city will be between 42,000 and 68,000 people (14% - 23%).

As of December 2021, in Brighton & Hove, there were thought to be:

- 100 adult asylum seekers and a further 70 in contingency hotels
- Circa 45 unaccompanied asylum-seeking children (under 18) and 78 care leavers aged 18 to 25
- Circa 69 people on the vulnerable person's resettlement scheme
- Using national estimates at the local level would mean there were circa 300 undocumented people. These are likely to be overstayers and refused asylum seekers.

As of 13 June 2022, Brighton & Hove is expecting 570 individuals from Ukraine, with 295 already arrived, of whom 113 are children.

6.3.7 Gypsies, Roma and Travellers

National evidence

Gypsies, Roma and Travellers (GRT) are amongst the most deprived communities in England; they continue to suffer from poorer health and lower life expectancy, which is ten years lower than the general population.[57] Gypsies, Roma and Travellers are approximately three times more likely to be anxious than the general population and twice as likely to be depressed.[58]

GRT are more likely to lack access to opportunities such as income, education, employment and housing which leads to them being at higher risk of mental illness.[59]

Gypsy and Traveller mothers are 20 times more likely than the rest of the population to have experienced the death of a child.[60]

GRT youth, due to exclusion and discrimination within the educational system, have poorer outcomes in terms of school achievement, unemployment and housing problems, which are all factors associated with psychological distress and depression.[61]

Brighton & Hove

There is no definitive data on the number of Gypsies, Roma and Travellers in Brighton & Hove. Within the city there are a range of locations where families reside. Some locations are short term (12 weeks), others permanent, some are authorised by the council, others are not. According to the 2011 Census, 198 people in the city identified themselves as Gypsies and Travellers.[62]

6.3.8 Religion or belief

More than two out of five residents (117,276 people, 42.9%) are Christian, significantly lower than can be found in England (59.4%) and the South East (59.8%). The Muslim community is the largest non-Christian faith group in the city with 6,095 people (2.2%) (Table 4).

More than two out of five city residents (115,954 people, 42.4%) stated that they had no religion, significantly higher than in the South East (27.7%) and England (24.7%). Older people are most likely to say they have a religion with only 13% not having one. Nearly a half of 0 to 15 year-olds (47%) and 16 to 64 year-olds (47%) don't have a religion.

Table 4: Religion or belief, Brighton & Hove, 2011 Census

	Brighton & Hove		South East	England
	number	%	%	%
All Persons	273,369			
Christian	117,276	42.9%	59.8%	59.4%
Muslim	6,095	2.2%	2.3%	5.0%
Buddhist	2,742	1.0%	0.5%	0.5%
Jewish	2,670	1.0%	0.2%	0.5%
Hindu	1,792	0.7%	1.1%	1.5%
Sikh	342	0.1%	0.6%	0.8%
Other religion	2,409	0.9%	0.5%	0.4%
No religion	115,954	42.4%	27.7%	24.7%
Religion not stated	24,089	8.8%	7.4%	7.2%

Source: ONS 2011 census, table KS209EW

6.3.9 Children in care and care leavers

National evidence

Care experienced children and young people have consistently been found to have much higher rates of mental health difficulties than the general population, including a significant proportion who have more than one condition.[63] They are approximately four times more likely to have a mental disorder than children living in their birth families. Almost half (rising to three quarters in residential homes) meet the criteria for a psychiatric disorder[64,65] compared to 10% of the general population.[66]

The latest measure of the emotional and behavioural health of looked after children using the Strengths and Difficulties Questionnaire (SDQ) found that 37% had scores considered a cause for concern, compared to 12% of children in the general population.[67]

Care leavers are an especially vulnerable group of young people, who have an increased risk of experiencing mental health difficulties and substance abuse issues.[68] Barnardo's surveyed care leavers and found that 46% were identified as

having mental health needs, with 65% of them not receiving any form of statutory support and are between four and five times more likely than their peers to attempt suicide https://www.nyas.net/wp-content/uploads/NYAS-looked-after-mind-report.pdf.[69]

Brighton & Hove

There were 373 Brighton & Hove children in care in 2021, a rate of 74 per 10,000 people which is higher than the rates in England (67 per 10,000) and the South East (53 per 100,000). There were 153 children leaving care in 2021 in Brighton & Hove. With a rate of 30 per 100,000 under 18-year-olds, this is significantly higher than England and the South East (23 and 22 per 100,000 respectively).

6.3.10 Students

National evidence

Research suggests that prevalence and severity of mental illness in university students is increasing and that students have poorer health than the non-student population.[70]

Students' life transitions, including moving home within and between areas can disrupt social ties and community networks and is related to higher levels of stress and mental health problems.[71]

Brighton & Hove

For the academic year 2019/20 there were 38,380 students at the University of Sussex and University of Brighton. 58% of students were female (22,315 people) compared to 42% male (16,005 people). There were also in the region of 1,700 students at other Higher Education Institutes in the city. It should be noted that not all students at universities in Brighton & Hove live in Brighton & Hove. There are also 9,100 Brighton & Hove residents who are students enrolled at a UK higher education institute.

According to the 2011 Census, there were 32,294 full time students aged 16 or over in the city, 14.1% of residents aged 16 or over. This is significantly higher than the South East (7.5%) and England (8.2%).

6.3.11 Lesbian, gay, bi, trans, queer, questioning and ace (LGBTQ+)

National evidence

Evidence suggests that people who identify as lesbian, gay, bisexual and/or trans (LGB&/T) or ace (asexual) are at a higher risk of experiencing poor mental health. This includes a higher risk of a range of mental health problems, including depression, suicidal thoughts and self-harm, and alcohol and substance misuse. This higher prevalence can be related to a wide range of factors, including discrimination, isolation and homophobia or transphobia.[72]

Where possible within the needs assessment, we look at sexual orientation and gender identity separately, as risks/assets, needs and experiences do differ, however some

literature and evidence presents LGBTQ+ populations combined and where this is the case we have referred to the groups referenced in the evidence.

Brighton & Hove

Brighton & Hove has large LGBTQ+ populations. Our best estimate from large scale surveys (including Count Me In Too) is 11% to 15% of the population aged 16 years or more are LGBQ+.

According to the 2011 UK Census, 6,425 people aged 16 and over (and living in a household) were living as part of a same sex couple (in a civil partnership or cohabiting). This represents 2.9% of all residents aged 16 and over, three times higher than the rate for both the South East (0.9%) and England (0.9%).

Trans: It is estimated that between 1,500 (0.6%) and 2,500 (1%) adults living in Brighton & Hove are trans. The true figure is probably greater than this because a significant proportion of trans people do not disclose their gender identity in surveys. In addition, as Brighton & Hove is seen as inclusive, many people who are trans and live elsewhere, visit Brighton & Hove to socialise study and/or work.[73]

Data suggest that people who are trans and live in Brighton & Hove:[74]

- have a younger population distribution than the overall population, although they are represented in all age groups
- have diverse gender identities, including non-binary identities
- are more likely to have a limiting long-term illness or disability than the overall population
- come from a diverse range of ethnic backgrounds
- have diverse sexual orientations
- live across the city, with no concentration in any geographical area
- are more likely to live in private sector rented housing than the overall population.

6.3.12 People with long-term physical conditions

National evidence

Mental and physical health are intertwined. Poor mental and physical health are both determinants and consequences of each other. Long-term physical conditions are those which cannot currently be cured but can be managed with medication or other treatments. They are also known as chronic conditions. Examples include diabetes, asthma, arthritis, epilepsy, chronic fatigue, and high blood pressure. Long-term physical conditions affect the mental health and wellbeing among all age groups, including children and young people. [75]

People with SMI (Severe Mental Illness), such as schizophrenia or bi-polar disorder, on average, have 15 to 20 years shorter life expectancy than the general population. Most of this reduced life expectancy is due to a higher rate of physical conditions such as

cardiovascular disease. Some of the drugs used to treat SMI can cause obesity and thus increase cardiovascular risk.

Some of the burden of poor physical health among those with mental health problems can be explained by health behaviours such as smoking and alcohol.[76] Other factors also play a part such as barriers to receiving adequate physical healthcare; less than a third of people with schizophrenia in hospital received the recommended assessment of cardiovascular risk in the previous 12 months.[77]

It is important to also consider the mental health needs of people with long-term physical health problems. Integrated care for physical health should include provision of psychological support, as failure to do so is associated with poorer outcomes and faster disease progression.[78] People with long term chronic conditions should receive psychological therapy support to improve their recovery.[79]

Brighton & Hove

According to the 2011 Census the day-to-day activity of more than one in twenty Brighton & Hove residents (20,445 people, 7.5%) is 'limited a lot' due to a long-term health problem or disability. For a further 24,124 residents (8.8%) their day-to-day activity is 'limited a little'. This is similar to the proportions found in the South East and England.

In Brighton & Hove and seen in the South East and England, limiting illness increases with age. 4% in those under 20, 13% among 20- to 64-year-olds, rising to nearly a half (47%) of 65- to 84-year-olds and four out of five (81%) of those aged 85 or older.

6.3.13 People with physical disabilities or impairments

National evidence

People living with physical disabilities are at least three times more likely to experience depression compared to the general population. The reasons for this are complex and often related to societal constraints rather than the physical disability itself. People with physical disability experience multiple risk factors for depressive symptoms, including facing negative stereotypic social and personal attitudes; abuse; loss of roles; and stressors related to poverty, environmental barriers, and/ or lack of access to appropriate health care.[80]

Brighton & Hove

See section on physical health problems above as population estimates include both long-term health problems and disability.

6.3.14 People with a learning disability

National evidence

There is strong evidence that individuals with a learning disability are more likely to experience mental ill-health and poor emotional wellbeing. Adults[81] and children and

adolescents with a learning disability have higher prevalence of psychiatric disorder symptoms[82] and mental health problems.[83]

Risk factors are physical ill health, psychological stress, poor social relationships, lack of employment and poverty. Although children with a learning disability had a 6.5 fold increased risk of mental health conditions, 20-50% of this increased risk was accounted for by low socio-economic status.[84]

Mental health problems among people with a learning disability are often overlooked, underdiagnosed, and left untreated as a result of poor understanding, awareness, evidence in this area and symptoms mistakenly being attributed as the person's learning disability.

According to the Adult Psychiatric Morbidity Survey (APMS, 2014), people with lower intellectual ability had higher rates of symptoms of common mental health problems (25%) compared to those with average (17.2%) or above average (13.4%) intellectual functioning.[85]

Brighton & Hove

Using national prevalence rates of learning disability and the ONS 2020 Population Estimates, it is estimated that there are 5,861 adults (2.4%) aged 18 or older in the city who have a learning disability. This includes 5,052 adults aged 18 to 64 (2.4%) and 819 adults (2.1%) aged 65 or older. This includes 1,260 adults (0.5%) aged 18 or over with a moderate or severe learning disability (1,150 adults aged 18 to 64 (0.6%) and 110 adults (0.3%) aged 65 or older).

6.3.15 Neurodiverse people (including those with Autistic Spectrum Conditions (ASC) and attention deficit hyperactivity disorder (ADHD))

National evidence

There is strong evidence that individuals with a neurodevelopmental condition are more likely to experience mental ill-health and poor emotional wellbeing.

Just like everyone, neurodiverse people (including those with ASC and ADHD) can have good mental health.

However, according to the autism research charity Autistica, eight out of ten autistic people have mental health issues during their lives.[86] There is little research into why this is, but the Mental Health Foundation suggests it may be because autistic people:

- can struggle to try to fit into or make sense of the world, which can lead to feelings of depression and anxiety
- may face delays in getting their mental health problems diagnosed
- are more likely to face stigma and discrimination

- are less likely to have appropriate support available. For example, group therapy might not be suitable for some autistic people, or therapists might not know how to adapt their approach to helping an autistic person.[87]

People with attention deficit hyperactivity disorder (ADHD) are more likely to experience a mental health problem. These include anxiety, depression, sleep problems, conduct disorder (showing aggressive or antisocial behaviour) and substance abuse.[88] Half of adults aged 20-39 years with ADHD have had a substance use disorder (SUD) in their lifetime according to new research. young adults with ADHD were still 69% more likely to have had a substance use disorder when compared to their peers without ADHD.[89]

Brighton & Hove

It is estimated that there are just over 1,700 adults aged 16 or over in the city with Autistic Spectrum Conditions (ASC) and 23,958 with attention deficit hyperactivity disorder (ADHD) (Table 5).

Estimates for children and young people are given in that section.

Table 5: Summary of common conditions, prevalence and estimated number of people in Brighton & Hove aged 16+, 2020 and 2030 (based on England prevalence rates from the 2014 Adult Psychiatric Morbidity Survey)

	Sub-conditions	England % (2014)	Estimate Brighton & Hove 2020	Estimate Brighton & Hove 2030
Neurodevelopmental conditions	ASC	0.7%	1,729	1,815
	ADHD	9.7%	23,958	25,155

Source: Adult Psychiatric Morbidity Survey 2014 South East regional estimates applied to Brighton & Hove population from Office for National Statistics 2020 Mid Year Estimates and Office for National Statistics Subnational Population Projections

6.3.16 Sensory impairment

National evidence

Individuals experiencing sensory impairments have been found to be at a higher risk of having mental health problems across the life course; however, this can be overlooked when considering the needs of this group.[90]

A 2011 survey, carried out by the University of Cambridge and Deafblind UK, found that, among 439 deaf and blind people in the UK, 61% reported psychological distress. A 2015 study including 298 people from England, Scotland and Wales found that individuals who are deaf have high levels of depression, with 31% of women and 14% of men self-reporting levels of depression.[91] It should also be recognised that deaf and blind children and young people are also at a higher risk of having mental health problems.

Brighton & Hove

There are an estimated 1,200 adults aged 18 years or over with visual impairments and 7,500 with some hearing loss (1,000 with severe hearing loss).

6.3.17Carers

National evidence

The mental health of carers is often neglected despite many carers having poor mental health. This is also true for young carers, whose long-term outcomes in education, employment and training can be significantly impacted by the caring role that they take on. Looking after a family member with a mental health problem can have a significant impact on carers' own mental health. The review found that the mental health problems of carers included emotional stress, depressive symptoms and, in some cases, clinical depression.[92]

Brighton & Hove

Nearly one in ten of the city's residents (23,967 people, 8.8%) provide unpaid care to a family member, friend or neighbour who has either a long-term illness or disability or problems related to old age. Two thirds of those providing unpaid care (16,401 people, 68%) do so for 1 to 19 hours a week. However, 4,716 people, nearly 20%, provide more than 50 hours a week of unpaid care. The proportion of residents providing unpaid care (8.8%) is slightly lower than the South East (9.8%) and England (10.2%).

As seen in the South East and England, people in Brighton & Hove aged 50 to 64 provide the most unpaid care with one in five (20%) providing at least one hour a week of unpaid care. More than one in ten of those aged 65 or older (13%) and 35 to 49 year-olds (11%) also provide at least 1 hour a week of unpaid care a week. Among younger people 1% of 0 to 15 year-olds provide unpaid care and nearly one in 20 (4.5%) of 16 to 34 year-olds also providing at least one hour of unpaid care.

Parent carers of children and young people with special educational needs and disabilities are not always recognised as carers; it is important to remember parent carers are also similarly at a higher risk of mental health problems.

6.3.18 Relationship status

National evidence

Being happily married or in a stable relationship is linked to both physical and mental health benefits, including lower morbidity and mortality. People in a stable relationship have greater life satisfaction, lower stress levels, lower blood pressure and better heart health than individuals who are single.[93]

Brighton & Hove

According to the 2011 Census, less than a half of Brighton & Hove's 16+ population (48%) live in a couple. Significantly lower than seen in the South East (61%) and

England (58%). In Brighton & Hove, two thirds of residents (67%) living in a couple are married or in a registered civil partnership with a third (33%) cohabiting.

6.3.19 Armed forces personnel

National evidence[94]:

Most British military personnel do not experience mental health problems while they are in service, or afterwards in civilian life. However, they face unique risks in service and, if they do experience mental health problems, they may require particular treatments and particular mental health services.

Experiences during service and the transition to civilian life mean that their mental ill health may be triggered by different factors. Post Traumatic Stress Disorder (PTSD), depression, anxiety, homelessness and substance abuse affect a significant minority of service personnel and veterans.

A study of 10,000 serving personnel (83% regulars; 27% reservists) found lower than expected levels of PTSD. Common mental disorders and alcohol misuse were the most frequently reported mental health problems among UK armed forces personnel. In particular, levels of alcohol misuse overall were substantially higher than in the general population.[95]

Brighton & Hove

Brighton & Hove is not home to any military installations and therefore does not house a substantial community of armed forces personnel. At the time of the 2011 Census there were 147 residents employed by the armed forces in the city, less than 0.1% of the total population. As of March 2020, 532 veterans in Brighton & Hove were in receipt of a pension or compensation under the Armed Forces Pension Scheme. This is a rate of 2.2 per 1,000 people aged 18+, much lower than the South East (8.7 per 1,000) or England (6.9 per 1,000).

7 Prevalence of mental health conditions

This section describes the scale and pattern of mental health need in children and young people and in adults based on national surveys. It describes the prevalence of conditions, how they vary by age, sex, ethnicity and other factors. It also provides estimates of population need in Brighton & Hove based on these national surveys. It is important to note, however, that these estimates will underestimate need in Brighton & Hove because the city has higher overall need than England.

The "need" in a population is defined as the capacity to benefit from health care. Need is often different to the number of people known to services and depends on many factors including the type of condition. For example, for a severe and life-long mental illness such as schizophrenia, the "need" in the population is likely to be similar to the number of people known by their GP to have a diagnosis.

However, for a condition such as depression, a person with symptoms may not seek help, and even if they do, they may not be diagnosed. For depression, therefore the "need" in the population is likely to be very much higher than the number of people known to services.

Two national surveys: Adult psychiatric morbidity survey (2014) and the Mental Health of Children and Young People survey (2017) are seen as the gold standard in terms of estimation of population need. Using these surveys, this section estimates population need in the city and how it varies by age, sex, ethnicity and other characteristics.

- Mental Health of Children and Young People in England 2017 – a large survey of 9,117 children and young people aged 2 to 19
- Mental Health of Children and Young People in England (Wave 2) - a smaller follow up survey of 3,667 children and young people who took part in the 2017 survey aged 6 to 23. It explored the mental health of children and young people in February/March 2021, during the Coronavirus (COVID-19) pandemic and changes since 2017
- Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 of 7,546 adults aged 16 or over.

7.1 Children and young people

7.1.1 Children and young people 2017 survey[96]

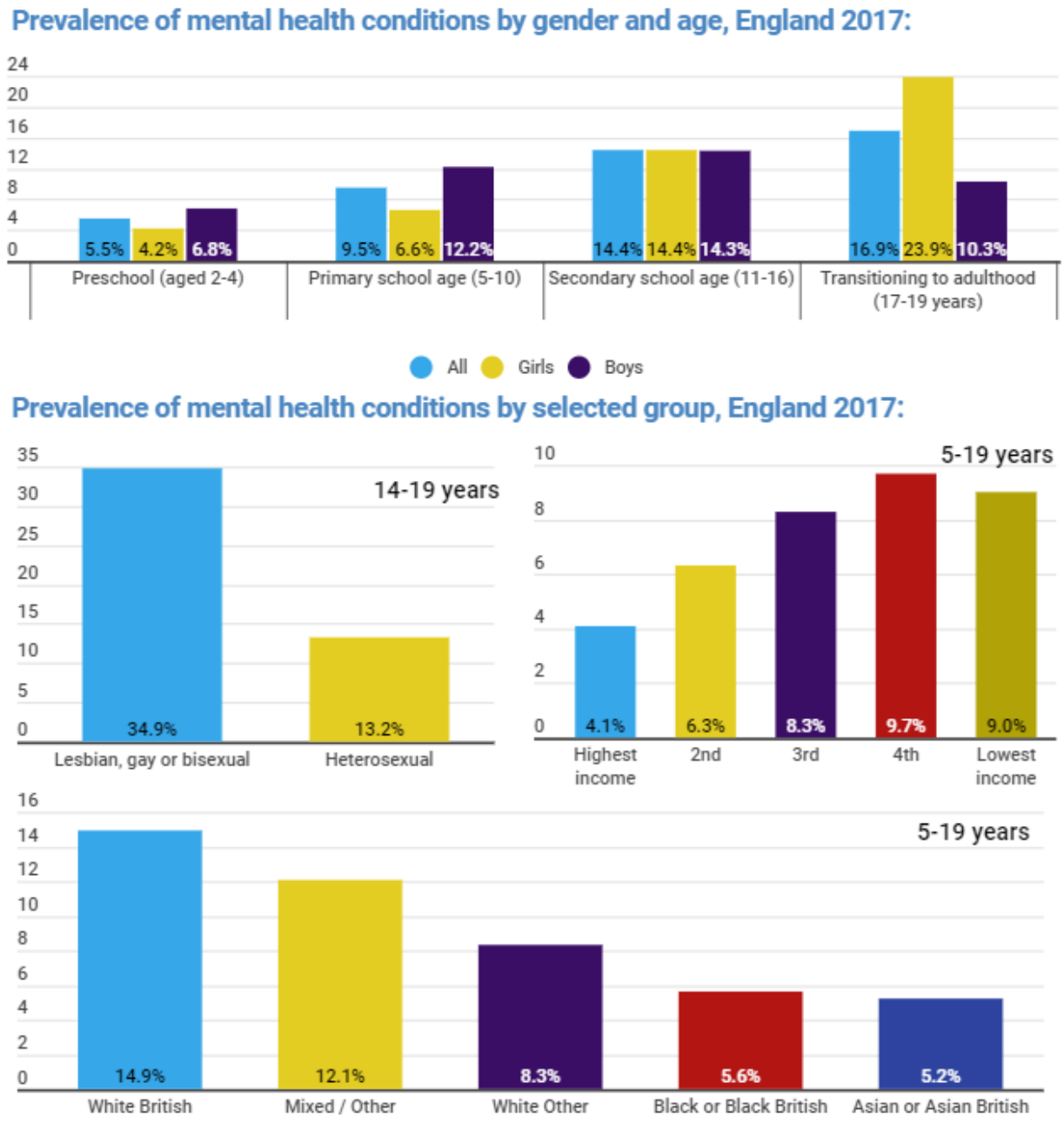
Major surveys of the mental health of children and young people in England were carried out in 1999, 2004, and 2017. Trend data is available for those aged 5 to 15 year-olds – because this age group was covered in all three surveys. The 2017 survey for the first time provides findings on the prevalence of mental disorder in 2- to 4-year-olds and in 17- to 19-year-olds.

The 2017 survey found (Figure 7):

- One in eight (12.8%) 5 to 19 year-olds had at least one mental disorder

- Specific mental disorders were grouped into four broad categories: emotional, behavioural, hyperactivity and other less common disorders
- Emotional disorders were the most prevalent type of disorder experienced by 5 to 19 year-olds in 2017 (8.1%)
- Rates of mental disorders increased with age: 5.5% of 2 to 4 year-old children experienced a mental disorder, compared to 16.9% of 17 to 19 year-olds
- Data from this survey series reveal a slight increase over time in the prevalence of mental disorder in 5 to 15 year-olds. Rising from 9.7% in 1999 and 10.1% in 2004, to 11.2% in 2017
- Young women aged 17 to 19 have the highest prevalence, with 23.9% having a mental health condition
- Emotional disorders have become more common in 5 to 15 year-olds – going from 4.3% in 1999 and 3.9% in 2004 to 5.8% in 2017. All other types of disorder, such as behavioural, hyperactivity and other less common disorders, have remained similar in prevalence for this age group since 1999
- The pattern of association between age and disorder was different for boys and girls. In girls the association was pronounced. Among 5 to 10 year-olds, boys were almost twice as likely as girls to have a disorder (boys 12.2%, girls 6.6%). While in 17 to 19 year-olds, girls were more than twice as likely as boys to have a disorder (boys, 10.3%, girls 23.9%)
- The differences in likelihood of having a disorder by gender and age is due in part to differences in the types of disorder boys and girls had (eg more behavioural disorders in young children which are more prevalent in boys and more emotional and anxiety disorders in 17 to19 year-olds which are more prevalent in girls)
- Those who identified as LGBTQ individuals were more than 2.5 times more likely to have a mental health disorder
- Mental disorders tended to be more common in children living in lower income households.

Figure 7: Prevalence of mental health conditions by various demographic factors, England, 2017



Source: Mental Health of Children and Young People in England 2017

Table 6 gives a breakdown of the estimates of the numbers of people with mental disorders in children and young people in Brighton & Hove based on the percentages reported in the national 2017 survey.

There are an estimated 6,650 children and young people aged 2 to 19 years with a mental health condition. With population projections, this would increase to around 6,900 by 2030.

These are likely to be underestimates given the overall estimate of common mental health disorders for Brighton & Hove, adjusted for population factors, is significantly higher than that for England.

Table 6: Summary of common conditions, prevalence and estimated number of people in Brighton & Hove aged 2-19 years, 2020 and 2030 (based on England prevalence rates from the 2017 Mental Health of Children and Young People in England Survey)

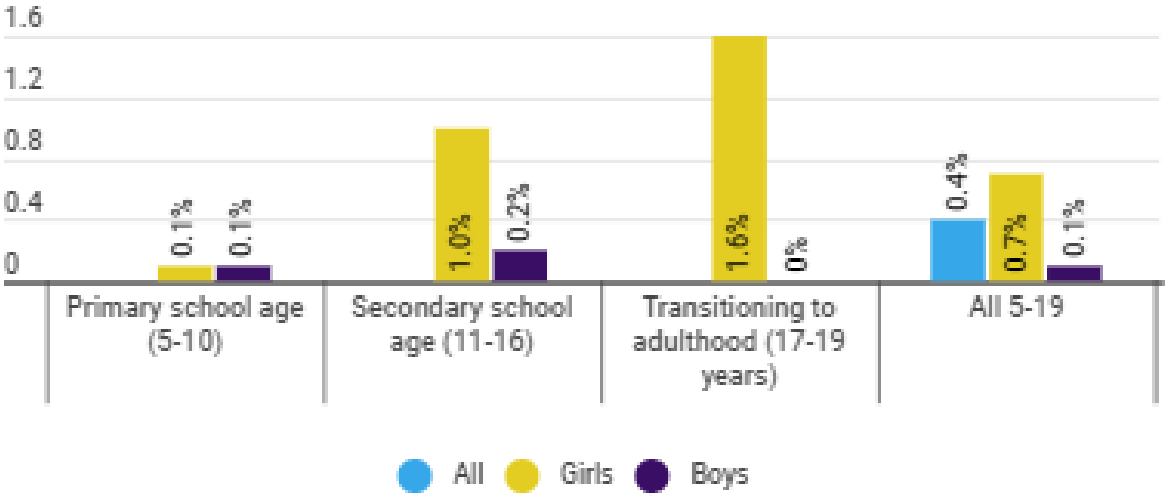
Age and gender		England % (2014)	Estimate Brighton & Hove 2020	Estimate Brighton & Hove 2030
Any disorder (boys and girls)	2–4 yrs	5.5%	457	436
	5–10 yrs	9.5%	1,645	1,451
	11–16 yrs	14.4%	2,463	2,370
	17–19 yrs	16.9%	2,081	2,619
Any disorder (girls)	2–4 yrs	4.2%	169	163
	5–10 yrs	6.6%	562	495
	11–16 yrs	14.4%	1,200	1,159
	17–19 yrs	23.9%	1,484	1,906
Any disorder (boys)	2–4 yrs	6.8%	288	273
	5–10 yrs	12.2%	1,083	956
	11–16 yrs	14.3%	1,263	1,211
	17–19 yrs	10.3%	597	713

Source: NHS Digital Mental Health of Children and Young People in England 2017 Mental Health of Children and Young People in England, 2017 [PAS] - NHS Digital and ONS Population Estimates MYE2: Persons by single year of age and sex for local authorities in the UK, mid-2020.

Body dysmorphia and eating disorders

- 1 in 18 (5.6%) young women were identified with body dysmorphic disorder (an anxiety disorder characterised by the obsessive idea that some aspect of one's body part or appearance is severely flawed and warrants exceptional measures to fix it)
- Eating disorders were identified in 0.4% of all 5- to 19-year-olds (Figure 8)
- They were more common in girls (0.7%) than boys (0.1%); and in older age groups than younger ones (0.1% of 5 to 10 year-olds; 0.6% of 11 to 16 year-olds; 0.8% of 17 to 19 year-olds). Rates of eating disorder were higher in girls aged 17 to 19 (1.6%) than in other demographic groups
- Numbers were too small for a breakdown by ethnic group.

Figure 8: Prevalence of eating disorders by gender and age, England, 2017



Source: NHS Digital Mental Health of Children and Young People in England 2017 [Mental Health of Children and Young People in England, 2017 [PAS] - NHS Digital]

Self-harm or suicide attempt

Self-harm or suicide attempt in one in four 11 to 16 year olds with a disorder

Ever self-harmed or attempted suicide
11 to 16 year olds with a mental disorder were more likely to have self-harmed or attempted suicide at some point (25.5%) than those without a disorder (3.0%). The association with mental disorder was clear in both boys and girls. In 17 to 19 year olds with a disorder, nearly half (46.8%) had self-harmed or made a suicide attempt.

Recent self-harm or suicide attempt
11 to 16 year olds with a disorder were more likely to have self-harmed or attempted suicide in the past four weeks (13.0%) than those without a disorder (0.3%). They were also more likely to have spoken about self-harm or suicide (16.5% compared with 1.4%).

Variation by type of disorder
Rates of having ever self-harmed or attempted suicide varied by the type of disorder present, and at one in three (34.0%) this was highest in children with an emotional disorder.

25.5%
of 11 to 16 year olds with a disorder reported self-harm or suicide attempt

3.0%
of 11 to 16 year olds without a disorder reported self-harm or suicide attempt

7.1.2 Children and young people 2021 survey[97]

A follow up survey of over 3,500 children and young people who took part in the 2017 survey was undertaken in Feb/March 2021. It looked at several areas including:

- How mental health had changed between 2017 (before the pandemic) and 2021
- Covid19 related experiences in Feb/March21 and the preceding months

It found:

- Rates of probable mental disorders increased from the 2017 to 2021 survey: in 6 to 16 year-olds from one in nine (11.6%) to one in six (17.4%), and in 17 to 19 year-olds from one in ten (10.1%) to one in six (17.4%).



- Many more people experienced a deterioration than an improvement in mental health. Four in ten (39.2%) 6 to 16 year-olds had experienced deterioration in mental health since 2017, and two in ten (21.8%) experienced improvement. Among 17 to 23 year-olds, 52.5% experienced deterioration, and 15.2% experienced improvement
- The proportion of children and young people with possible eating problems increased since 2017; almost doubling from 6.7% to 13.0% in 11 to 16 year-olds and increasing from 44.6% to 58.2% in 17 to 19 year-olds
- Sleep problems were common and were more common in older age groups: In 2021, problems with sleep on three or more nights of the previous seven affected over a quarter (28.7%) of 6 to 10 year-olds, over a third (38.4%) of 11 to 16 year-olds, and over half (57.1%) of 17 to 23 year-olds. Across all age groups figures were much higher in those with a probable mental disorder (59.5%, 74.2%, 86.7% respectively)
- Children with a probable mental disorder were twice as likely to have missed 15 or more days at school in the 2020 autumn term (18.2%) than those unlikely to have a mental disorder (8.8%).

Estimates for Brighton & Hove for children and young people with a mental disorder with Figures based on the 2021 update to the survey are given in Table 7.

This estimates that there would be around 5,550 children and young people aged 6 to 16 years in the city with mental disorders, if we experienced the same prevalence as England. Applying the prevalence to population projections, which for this age group show a reduction in the number of children, suggests that there could be 5,100 children

and young people aged 6 to 16 years with mental disorders in 2030. For 17 to 23 year-olds, the estimates for 2021 suggest there are around 7,050 young people with mental health disorders, rising to 8,300 by 2030 based on population projections.

Table 7: Estimated number of children and young people with a mental disorder, Brighton & Hove, 2021

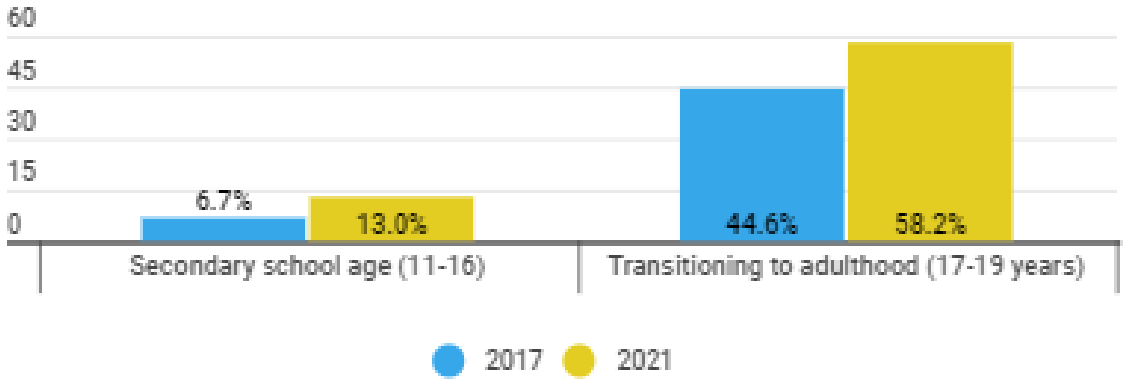
Age and gender		England % (2014)	Estimate Brighton & Hove 2020	Estimate Brighton & Hove 2030
Any disorder (boys and girls)	6–10 yrs	17.1	2,500	2,200
	11–16 yrs	17.7	3,050	2,900
	17–23 yrs	16.9	7,050	8,300
Any disorder (girls)	6–10 yrs	12.0	850	750
	11–16 yrs	19.8	1,650	1,600
	17–23 yrs	23.5	4,950	5,850
Any disorder (boys)	6–10 yrs	21.9	1,650	1,450
	11–16 yrs	15.6	1,400	1,300
	17–23 yrs	10.7	2,100	2,450

Source: Based on Mental Health of Children and Young People in England, 2021 Wave 2 follow up to the 2017 survey Published 30 September 2021, and ONS Population Estimates MYE2: Persons by single year of age and sex for local authorities in the UK, mid-2020 and population projections 2030.[98]

Possible eating problems

The proportion of children and young people with possible eating problems almost doubled between 2017 and 2021 from 6.7% to 13.0% in 11 to 16 year-olds and increased from 44.6% to 58.2% in 17 to 19 year-olds (Figure 9). Applying these to Brighton & Hove, we would expect almost a further 1,600 people with a potential eating problem (from around 9,200 to 10,800 young people) (Table 8).

Figure 9: Percentage of children and young people with a possible eating problem, England 2017 and 2021



Source: Mental Health of Children and Young People in England, 2017 and 2021 Wave 2

Table 8: Estimated number of children and young people with a possible eating problem in Brighton & Hove, 2020 and 2030

Disorder	Age	England % (2021)	Estimate Brighton & Hove 2020	Estimate Brighton & Hove 2030
Possible eating problems	11-16	13.0%	2,232	2,147
Possible eating problems	17-19	58.2%	6,986	8,667

Source: Based on Mental Health of Children and Young People in England, 2021 Wave 2 follow up to the 2017 survey Published 30 September 2021, and ONS Population Estimates MYE2: Persons by single year of age and sex for local authorities in the UK, mid-2020 and population projections 2030.[99]

7.2 Adults

Major surveys of the mental health of adults in England were carried out in 1993, 2000, 2007 and 2014 (Adult Psychiatric Morbidity Survey). The 2014 survey looked at adults aged 16 years or over. It had no upper age limit for participation. The report has chapters on:

1. common mental disorders (CMD)
2. post-traumatic stress disorder
3. psychotic disorder
4. autism
5. personality disorder
6. attention-deficit/hyperactivity disorder
7. bipolar disorder
8. alcohol
9. drugs
10. suicidal thoughts, suicide attempts and self-harm
11. comorbidity

The full report and executive summary of the Adult Psychiatric Morbidity Survey 2014 are available on-line.

It found that:

- One adult in six (17%) had a common mental disorder (CMD): one in five women and one in eight men
- Young women have become a key high-risk group. The gender gap in mental illness had become most pronounced in young people, and there is evidence that this gap has widened in recent years. Young women have high rates of CMD, self-harm, and positive screens for post-traumatic stress disorder (PTSD) and bipolar disorder
- Reported rates of self-harming increased in men and women and across age groups since 2007

- Rates of mental illness increased in men and women aged 55 to 64. Men in this age-group have some of the highest rates of registered suicide, and have been identified as a priority group in England's National Suicide Prevention Strategy
- Most mental disorders were more common in people living alone, in poor physical health, and not employed. Claimants of Employment and Support Allowance (ESA), a benefit aimed at those unable to work due to poor health or disability, experienced particularly high rates of all the disorders assessed
- There was comorbidity with chronic physical conditions, low mental wellbeing and intellectual impairment. For five chronic physical conditions: asthma, cancer, diabetes, epilepsy, and high blood pressure, all had some association with at least one mental disorder.

Figure 10 and Table 9 give estimates for Brighton & Hove for common conditions and presenting needs based upon prevalence estimates for England from the 2014 Adult Psychiatric Morbidity Survey for adults aged 16 years or over, applied to Brighton & Hove population estimates and projections for 2020 and 2030. In 2020 there are an estimated 42,000 adults with a common mental health disorder and by 2030 just over 44,000 adults. The classifications in this section reflect the wording used in the 2014 survey and may not reflect currently used terms. The 2014 survey included ASC, ADHD and comorbidities, these are included within the life course sections.

These are likely to be underestimates given the overall estimate of common mental health disorders for Brighton & Hove, adjusted for population factors, is significantly higher than that for England – at 1 in 5 adults rather than 1 in 6. This would equate to approximately over 46,000 adults in Brighton & Hove and could increase to over 48,400 by 2030.[100]

Figure 10: Summary of common conditions, prevalence and estimated number of people in Brighton & Hove aged 16+, 2020 and 2030 (based on England prevalence rates from the 2014 Adult Psychiatric Morbidity Survey)

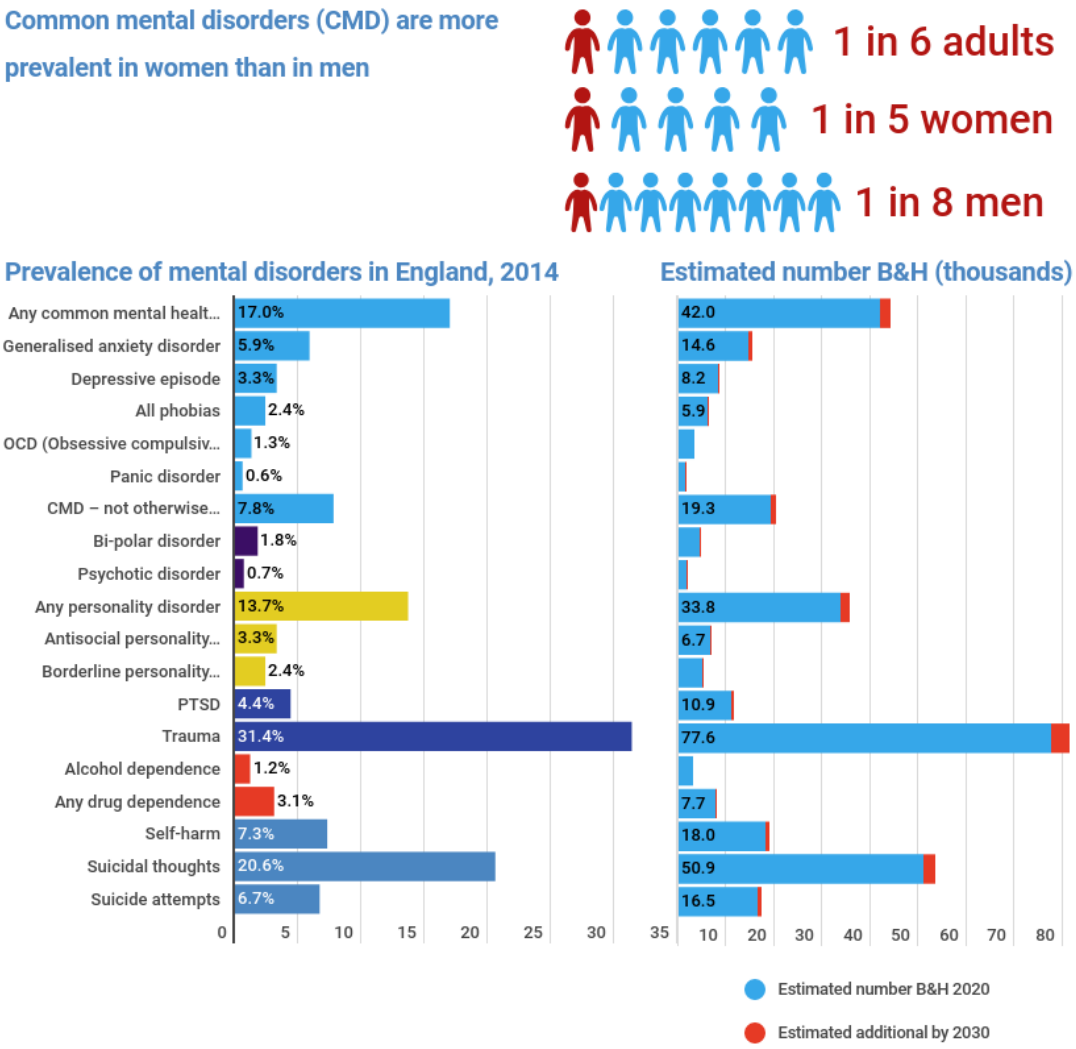


Table 9: Summary of common conditions, prevalence and estimated number of people in Brighton & Hove aged 16+, 2020 and 2030 (based on England prevalence rates from the 2014 Adult Psychiatric Morbidity Survey)

	Sub-conditions	England % (2014)	Estimate Brighton & Hove 2020	Estimate Brighton & Hove 2030
Common MH disorders (CMD)	Any CMD	17.0%	41,988	44,085
	Generalised anxiety disorder	5.9%	14,572	15,300
	Depressive episode	3.3%	8,151	8,558
	All phobias	2.4%	5,928	6,224
	Obsessive compulsive disorder	1.3%	3,211	3,371
	Panic disorder	0.6%	1,482	1,556
	CMD – not otherwise specified	7.8%	19,265	20,227
Severe Mental Illness	Bi-polar disorder	1.8%	4,446	4,668
	Psychotic disorder	0.7%	1,729	1,815
Personality disorders	Any personality disorder	13.7%	33,837	35,695
	Antisocial personality disorder*	3.3%	6,679	6,752
	Borderline personality disorder**	2.4%	4,991	5,109
Trauma	Post traumatic stress disorder (PTSD)	4.4%	10,867	11,410
	Trauma	31.4%	77,554	81,428
Dependence	Alcohol dependence	1.2%	2,964	3,112
	Any drug dependence	3.1%	7,657	8,039
Self-harm and suicide	Self-harm	7.3%	18,030	18,931
	Suicidal thoughts	20.6%	50,880	53,421
	Suicide attempts	6.7%	16,548	17,375

Source: Adult Psychiatric Morbidity Survey 2014 South East regional estimates applied to Brighton & Hove population from Office for National Statistics 2020 Mid Year Estimates and Office for National Statistics Subnational Population Projections

Note: many people may have more than one condition

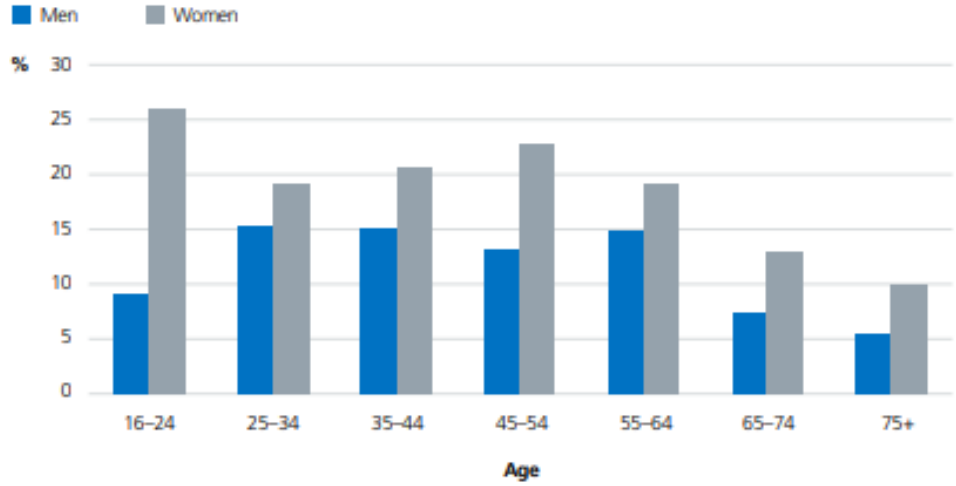
* 18-64 years, ** 16-64 years

7.2.1 Common mental health disorders (CMD)

One in six adults (17%) had a CMD: one in five women and one in eight men. CMDs were about three times more common in women of aged 16 to 24 (26%) than men the same age (9%).

CMDs were more prevalent in certain groups of the population. These included Black women, adults under the age of 60 who lived alone, women who lived in large households, adults not in employment, those in receipt of benefits and those who smoked cigarettes (Figure 11).

Figure 11: Common mental disorders (CIS-R score of 12 or more), by age and sex, England, 2014



Source: Adult Psychiatric Morbidity Survey 2014

7.2.2 Trauma

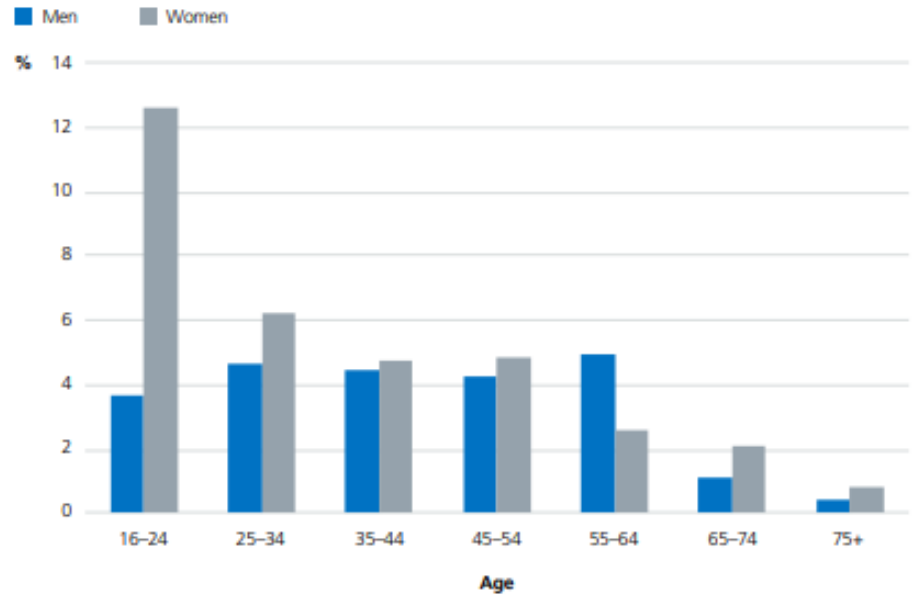
Overall, about one participant in twenty (4.4%) screened positive for Post Traumatic Stress Disorder (PTSD) in the past month, with similar rates for men and women.

Among women, the likelihood of screening positive for PTSD was particularly high among 16–24-year-olds (12.6%) and then declined sharply with age. In men, the rate remained quite stable between the ages of 16 and 64, only declining in much later life (Figure 12).

About a third of all adults (31.4%) reported having experienced at least one major trauma in their lifetime. Trauma in the study was defined as “a major natural disaster, a serious automobile accident, being raped, seeing someone killed or seriously injured, having a loved one die by murder or suicide, or any other experience that either put you or someone close to you at risk of serious harm or death.”

The national 2014 survey did not ask about complex trauma. Complex trauma is defined as traumatic experiences involving multiple events with interpersonal threats during childhood or adolescence. These events may include, for example, abuse, neglect, interpersonal violence, community violence, racism, discrimination, and war.[101]

Figure 12: Screen positive for Post Traumatic Stress Disorder (PTSD), by age and sex, England, 2014



Source: Adult Psychiatric Morbidity Survey 2014

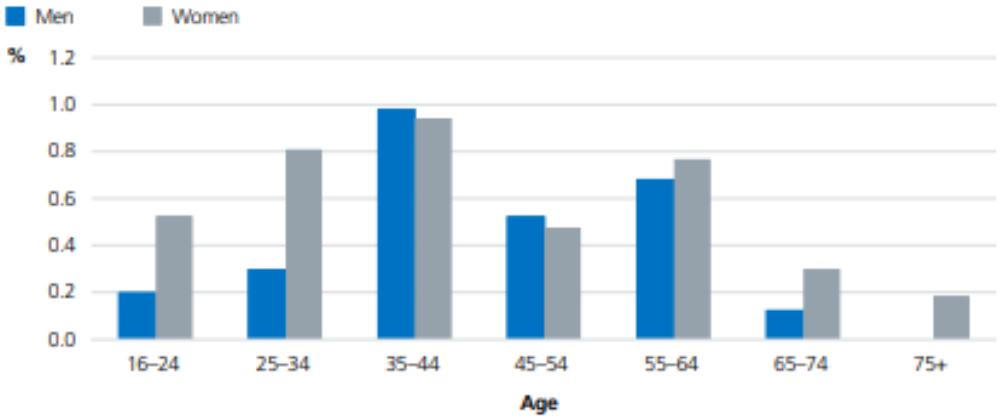
7.2.3 Psychotic disorder

Less than one adult in a hundred was identified with a psychotic disorder in the past year. The estimate for 2007 was 0.4% and for 2014 it was 0.7%. Prevalence is highest in those aged 35-44 years (Figure 13). It is higher for women than men in all age groups except those aged 35-54 years).

The prevalence of psychotic disorder in the past year (using combined 2007 and 2014 data) was 10 times higher among black men (3.2%) than white men (0.3%).

Psychotic disorder was more common in people who live alone, a finding consistent with wider evidence on links between mental illness, social isolation, and the challenges that people with psychotic disorder may face with maintenance of relationships.

Figure 13: Psychotic disorder in the past year (2007 and 2014 combined), by age and sex, England, 2014



Source: Adult Psychiatric Morbidity Survey 2014

7.2.4 Bi-polar disorder

Table 10: Screen positive for bipolar disorder (lifetime), by age and sex, England, 2014

	16-24	25-34	35-44	45-54	55-64	65-74	75+	All
Men (%)	3.1	3.1	2.9	2.1	1.6	0.4	-	2.1
Women (%)	3.7	3.1	1.9	1.2	1.3	0.4	-	1.8
All adults (%)	3.4	3.1	2.4	1.6	1.5	0.4	-	2.0

Source: Adult Psychiatric Morbidity Survey 2014

There was no significant difference in the rates for men and women (2.1% for men and 1.8% for women) (Table 10). However, the proportion screening positive for bipolar disorder did vary by age, being more common in younger age-groups: 3.4% of 16- to 24-year-olds screened positive compared with 0.4% of those aged 65-74 years. None of the participants aged 75 years or over screened positive for bipolar disorder.

Table 11: Screen positive for bipolar disorder (age-standardised), by ethnic group and sex, England, 2014

	White British	White other	Black/ Black British	Asian/ Asian British	Mixed/ multiple/ other
Men (%)	2.3	3.1	2.9	2.0	1.6
Women (%)	1.8	1.1	4.0	0.7	2.0
All adults (%)	2.0	2.0	3.5	1.4	1.8

Source: Adult Psychiatric Morbidity Survey 2014

Positive screening for bipolar disorder did not vary significantly by ethnic group, but was highest among Black/Black British women (Table 11). Rates of positive screening for bipolar disorder were higher in non-employed people, in those receiving particular benefits, and in people living alone.

7.2.5 Personality disorder

3.3% of people aged 18–64 screened positive for antisocial personality disorder (ASPD). It was more common in men (4.9%) than women (1.8%). Screening positive for ASPD decreased with age. Positive screens for ASPD were more common in men aged 18 to 24 (6.4%) and 25 to 34 (6.6%) than in men in older age groups (4.1% of men aged 55 to 64). A similar pattern was observed among women: 3.3% of women aged 18 to 24 screened positive for ASPD, compared with 0.4% of women aged 55 to 64 (Table 12).

2.4% of people aged 16 to 64 screened positive for borderline personality disorder (BPD), differences between men and women did not reach statistical significance. Younger people were more likely to screen positive for BPD than older people, this pattern was more evident in women than men (Table 12). There was no significant association between any measure of BPD and ethnicity (Table 13).

Table 12: Screen positive for antisocial and borderline personality disorder (SCID-II), percentage by age and sex, England, 2014

	16/18-24	25-34	35-54	55-64	All
Men					
Antisocial (%)	6.4	6.6	3.6	4.1	4.9
Borderline (%)	4.2	0.9	1.7	1.1	1.9
Women					
Antisocial (%)	3.3	2.7	1.3	0.4	1.8
Borderline (%)	7.3	3.7	1.4	0.8	2.9
All adults					
Antisocial (%)	4.9	4.6	2.4	2.2	3.3
Borderline (%)	5.7	2.3	1.5	1.0	2.4

Source: Adult Psychiatric Morbidity Survey 2014

Table 13: Screen positive for any personality disorder (age-standardised), percentage by ethnic group and sex, England, 2014

	White British	White other	Black/ Black British	Asian/ Asian British	Mixed/ multiple/ other
Men (%)	13.0	16.8	16.1	22.7	10.2
Women (%)	14.9	11.7	17.7	10.8	21.9
All adults (%)	13.9	14.2	17.0	17.3	16.7

Source: Adult Psychiatric Morbidity Survey 2014

7.2.6 Self-harm and suicidal thoughts

Table 14 shows that a fifth of adults (20.6%) reported that they had thought of taking their own life at some point. This was more common in women (22.4%) than men (18.7%), and in people of working-age than those aged 65 or more. As for suicidal thoughts, lifetime suicide attempts were more likely in working-age adults than in those who were older. While the overall pattern by age was not significantly different in men and women, the rate of suicide attempts reported by young women (aged 16 to 24) was notably high.

The age gradient for self-harm was more pronounced, particularly in women. One in four women aged 16-24 report having self-harmed, compared with one in a hundred women aged 75 or over. Young women were much more likely than young men to self-harm: 26% of women aged 16-24, 10% of men.

Lifetime suicidal thoughts, attempts and self-harm were evident across all ethnic groups, but rates did not differ significantly after age-standardising (Table 15). People under 60 who lived on their own were more likely to have suicidal thoughts than those living with others, also the case for having made a suicide attempt and having self-harmed.

Table 14: Prevalence (%) of lifetime suicidal thoughts, suicide attempts and self-harm, by age and sex, England, 2014

%	16-24	25-34	35-44	45-54	55-64	65-74	75+	All
Men								
Suicidal thoughts	19.3	21.1	21.1	20.7	22.5	11.9	7.1	18.7
Suicidal attempts	5.4	8.0	6.5	5.4	5.4	3.5	1.0	5.4
Self-harm	9.7	10.9	6.6	3.3	3.3	2.0	-	5.7
Women								
Suicidal thoughts	34.6	24.1	22.8	26.6	22.9	11.7	8.8	22.4
Suicidal attempts	12.7	9.1	9.5	8.2	8.6	3.7	2.1	8.0
Self-harm	25.7	13.2	9.2	5.0	5.0	1.8	0.6	8.9
All adults								
Suicidal thoughts	26.8	22.6	21.9	23.7	22.7	11.8	8.1	20.6
Suicidal attempts	9.0	8.5	8.0	6.8	7.0	3.6	1.7	6.7
Self-harm	17.5	12.1	7.9	4.1	4.1	1.9	0.3	7.3

Source: Adult Psychiatric Morbidity Survey 2014

Table 15: Lifetime suicidal thoughts, suicide attempts and self-harm (age-standardised), by ethnic group and sex, England, 2014

%	White British	White other	Black/ Black British	Asian/ Asian British	Mixed/ multiple/ other
Men					
Suicidal thoughts	19.6	23.3	21.4	12.0	9.5
Suicidal attempts	5.3	6.0	8.9	5.1	1.5
Self-harm	5.8	8.3	5.5	6.1	1.9
Women					
Suicidal thoughts	23.5	18.6	20.3	14.3	26.6
Suicidal attempts	8.5	6.2	3.9	5.6	10.0
Self-harm	10.3	4.3	4.2	4.7	6.6
All adults					
Suicidal thoughts	21.6	20.8	20.7	13.1	17.9
Suicidal attempts	6.9	6.1	6.1	5.3	5.7
Self-harm	8.1	6.1	4.8	5.5	4.2

Source: Adult Psychiatric Morbidity Survey 2014

8 Perinatal mental health

8.1 Introduction

Perinatal mental health is the term for mental health during pregnancy and the first year after birth. It includes both existing mental health issues and conditions that arise during pregnancy or related to pregnancy.

The perinatal period is a time of enormous change and transition. Having existing or past mental health problems can increase the risk of becoming unwell, particularly after birth. New problems may develop for the first time. Good support can prevent many problems from arising or from becoming worse.

The physical and mental health of the mother, and the family environment during pregnancy, infancy and childhood is of fundamental importance to the lifelong mental health of the baby and child. While the relationship between mother and child is particularly important, the mental health of fathers and other caregivers should also be considered. A parent's ability to bond with and care for their baby, their parenting style and the development of a positive relationship can predict a number of physical, social, emotional and cognitive outcomes for their child from babyhood through to adulthood.[102]

The impact of poor mental health during the perinatal period, particularly if left untreated, can lead to long lasting effects on women and their families.[103] Paternal and maternal depression is shown to have a negative impact on how parents interact with children[104] and can have long-term consequences if left untreated.[105]

Evidence suggests perinatal mental health issues are associated with an increased risk of pre-term birth, low birth weight[106] and a negative impact on breastfeeding duration.[107]

In addition to the direct impact on families, it is estimated that perinatal mental health problems cost the NHS and social services around £1.2 billion annually.[108] A significant proportion of this cost relates to impact on the child.

Mental health problems occurring during the perinatal period can range from symptoms that do not meet the threshold for clinical diagnosis to severe mental illness and include depression, anxiety, post-traumatic stress disorder, postpartum psychosis, adjustment disorders and distress, eating disorders and drug and alcohol-use disorders.[109]

The confidential Enquiry into Maternal Deaths shows that suicide remains one of the leading causes of maternal mortality in the UK.[110]

8.2 Risk and protective factors

Many of the risk and protective factors associated with mental health problems during pregnancy and after childbirth reflect those associated with mental illness in the general population,[111,112] however there are factors which can have a particular impact at this life stage.

Appendix 6 gives the available data on the prevalence of identified risk factors for maternal mental ill health issues locally, along with how we compare to England and similar local authorities. The table shows that, where we have data, Brighton & Hove is similar to England in the level of risk. However, there are many factors where data is not available and we do not know the scale of the challenge in the city nor how it compares with England and the South East. These include:

- Having a poor relationship with a partner.[113]
- Inadequate social support[114]
- Extreme stress
- History of mental health problems[115,116,117,118,119]
- Childhood abuse and neglect
- Unplanned or unwanted pregnancy
- Emergency situations and natural disasters (including public health emergency such as pandemics)
- Trauma.

The birth of a child with a disability has an impact on the family, leading to possible depression, anxiety, health problems, or other psychological distress.[120] In addition, research has found that parents of premature babies are more likely to experience mental health problems than parents whose babies arrived full term.[121]

The perinatal mental health of fathers, other co-parents and other partners is less well researched. A 2021 systematic review showed that 10% of the fathers experience perinatal depression and 5-15% perinatal anxiety. Non-birthing partners including fathers, co-mothers, and stepparents may themselves experience perinatal mental health difficulties.

Fathers may also experience post-traumatic stress symptoms following the birth of a child. Paternal deaths are not recorded; however, fathers face an increased risk of suicide in the perinatal period.[122] The review found that there was a lack of evidence of the prevalence of perinatal mental health disorders in stepparents, co-mothers, trans and gender-diverse parents. But suggested that there may be distinct challenges for LGBT+ parents, linked to heteronormative systems, stigma, marginalisation, assisted reproduction, and invisibility/social and legal recognition as parents.

8.3 Level of need in Brighton & Hove

See demographics of births and mothers

8.3.1 Prevalence of perinatal mental health issues

Perinatal mental illness is estimated to affect 10-20% of new and expectant mothers. Based on Office for National Statistics birth estimates for 2020 between 225 and 450 women in Brighton & Hove could be affected by perinatal mental illness. With births predicted to increase, by 2030 this could increase to between 280 and 560 mothers.

There are no registers for perinatal mental illness. However, the Office for Health Improvement and Disparities (previously Public Health England) Perinatal Mental Health Profiles[123] provide estimates of the prevalence of maternal mental illness by Local Authority based on national survey data (Table 16).

Adjustment disorders (an unhealthy or excessive emotional or behavioural reaction to a stressful event or change in a person's life) and distress are estimated to be the most common maternity related mental illness (between 1 in 6 and 1 in 3 deliveries), followed by mild-moderate depressive episodes (between 1 in 10 and 1 in 6 deliveries). It is important to note that the estimates **do not** take account of socio-economic or demographic differences which are likely to cause variation across areas.

Table 16: Estimated number of pregnant women with specific mental health issues in the perinatal period, Brighton & Hove, 2017/18 and estimates for 2030

	National estimated prevalence (pregnant women)	Brighton & Hove 2017/18	Brighton & Hove 2030
Mild-moderate depressive illness and anxiety in perinatal period (lower -upper estimate)	100 - 150 in 1,000	207-311	283-424
Severe depressive illness in perinatal period	30 in 1,000	62	86
Chronic serious mental illness in perinatal period	2 in 1,000	4	6
Adjustment disorders and distress in perinatal period (lower – upper estimate)	150 – 300 in 1,000	311-621	424-848
PTSD in perinatal period	30 in 1,000	62	85
Postpartum psychosis	2 in 1,000	4	6

Source: Office for Health Improvement and Disparities. Perinatal mental health profile. Available at: **Perinatal Mental Health - OHID (phe.org.uk)** and Office for National Statistics Subnational Population Projections 2030 for births https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/subnationalpopulationprojectionsforengland/2018based

Fetal Alcohol Spectrum Disorder (FASD) is a lifelong condition caused by alcohol exposure to the developing fetus. The first national effort to quantify FASD in the UK was published late 2018. The study found a screening prevalence range in the UK of 6% to 17%.[124]

The neuro-developmental problems associated with FASD can create great difficulties for individuals in childhood that persist throughout life. Impaired ability to learn, remember, make judgements, and forward plan make day-to-day life challenging.[125]

In 2021/22 there were 11 pregnant women in substance misuse services, 25 women with children under one year and 24 men with children under one year.[126] This appears low given the evidence on risk factors and Brighton & Hove's population. We need to know if this due to recording or access to the service.

8.4 Voices in the perinatal period

We did not identify any recent local engagement reports with pregnant women or new mothers for Brighton & Hove that provide insight into local needs and experiences.

According to the Care Quality Commission 2021 Maternity Survey, across England:[127]

- 69% of women said that during their antenatal check-ups, the midwife asked them about their mental health. Most women (83%) said that if needed, they were given enough support for their mental health during their pregnancy.
- 95% of women said that a midwife or health visitor asked them about their mental health postnatally when they were visited at home or seen in a clinic.
- Respondents felt that information about mental health postnatally could be improved. 56% were 'definitely' given information about changes they might experience in their mental health after having their baby, from 63% in 2019
- Most respondents (79%) were told who to contact if they needed advice about any changes to their mental health after the birth
- 10% of women who responded to the survey said they had a mental health condition. Women with a mental health condition reported more negative experiences, compared to the average experience, in most areas of care.

In Sussex wide engagement (2021), fathers were interviewed about their experience of becoming a father, their needs and what works to support them. They identified a need for non-stigmatised support provided by men and for services to think about more ways to increase confidence of fathers to engage with antenatal and postnatal services.[128]

8.5 Quality and outcomes

There are no local figures, but the UK and Ireland 2021 Confidential Enquiry into Maternal Deaths[129] found that mental health remains one of the leading causes of maternal death during pregnancy and the first postnatal year:

- Maternal suicide is still the leading cause of direct (pregnancy-related) death in the year after pregnancy
- Almost a quarter of all deaths of women during pregnancy or up to a year after the end of pregnancy were from mental health-related causes
- Improvements in care might have made a difference in outcome for two thirds of women who died by suicide.

8.6 What we know about the local perinatal mental health offer

Support for mild to moderate perinatal mental health is provided through primary and secondary care mental health services.

8.6.1 Primary Care

GPs can provide information, advice and treatment and can refer individuals to a mental health or psychological therapies service if needed.

8.6.2 Midwifery service

The Midwifery service offers support to all pregnant women from the moment they are booked into the NHS, usually early on in pregnancy, up until health visiting makes the New Birth Visit around 10 days after birth. For the antenatal period where there is an identified mental health and emotional wellbeing need, there is a focus on signposting to primary, secondary care and private sector organisations, with a specialist direct offer to those who are at higher risk of poor mental health. The pandemic and the subsequent increase in mental health referrals has limited the capacity to meet need.

8.6.3 Health visiting Service

The health visiting services supports women from 28 weeks into pregnancy until their baby is 5 years old. In Brighton & Hove (as is the case nationally) the key universal intervention for all mothers and new babies are the five checks provided by the health visiting service at 28 weeks into the pregnancy, the New Birth Visit, 6-8 week check, 12 month review and 2-2.5years review. Health visitors will ask about the mother's mental health at these checks and provide support and signpost as required.

The Healthy Futures Team within the Health visiting service provides additional support for families with additional vulnerabilities. This service includes a Specialist Health visitor for Perinatal Maternal and Infant Mental Health who provides peer support groups for mothers and a group for fathers alongside 1:1 support and referrals to the specialist perinatal mental health service.

8.6.4 Specialist Perinatal Mental Health Service

The specialist perinatal mental health service is a community-based service providing specialist support to mothers who are experiencing, or who have previously experienced, severe and complex mental health difficulties during the perinatal period.

8.6.5 Inpatient care

Mother and baby units (MBUs) provide inpatient care for mothers experiencing severe mental illness. There is no MBU in Brighton and Hove but there are a number in the greater London and South East area.

8.6.6 Community and Voluntary Sector organisations

Support to improve mental health and wellbeing is provided by many local Community and Voluntary Sector (CVS) organisations. In addition to support and services that are

open to all adults there are also a small number of CVS organisations that provide support for mental health and emotional wellbeing needs to birthing and non-birthing parents and their infants.

8.7 Opportunities to learn more

There is work already planned that will enable us to develop a more detailed view of parents' experiences of the mental health offer in the perinatal period:

- Perinatal Equity and Equality of Access Plan for Sussex 2022-2025 – Mental health peer support is a focus in this 3-year plan lead by the Local Maternity and Neonatal System team. The plan involved consulting with a wide range of stakeholders including the Maternity Voices Partnership
- Recommissioning of the Health Visiting and School Nursing service – the process of recommissioning will include undertaking a JSNA and service review to understand how the services meet need and identify potential gaps. There will be a consultation with families to inform the specification for the service
- Development of Family Hubs – Brighton & Hove has been awarded funding to develop Family Hubs from June 2022 to March 2024. It will involve transforming the current Children's Centres and Early Help Services in the city into Family Hubs which have a wider remit and cover an extended age range – from 0-19 yrs (and up to 25 for CYP with SEND). Consultation with families, communities and service partners will include some relevant services eg Community Midwifery and the Health visiting services which are provided from Children's Centres.

8.8 What works for prevention

Box 1: What works for prevention: perinatal period / infant mental health

Opportunities:

- The perinatal period provides a significant opportunity to improve mental health outcomes for families
- There is strong evidence for perinatal interventions targeting parent tobacco, alcohol and substance use during pregnancy; interventions during pregnancy and immediately after birth to prevent child mental health issues; and home visiting and parenting programmes to improve child-parent attachment and prevent child adversity.

Improving systems:

- There is a need to develop Integrated Care Pathway approaches across local areas that take in to account the physical needs of pregnancy and child development alongside the potential challenges to mental health
- Establish a Maternal Mental Health Pathway (eg by strengthening consistent and seamless support). This will set out guidance for healthcare professionals supporting mothers during pregnancy and after birth to prevent the development or worsening of mental health problems during this period and to manage existing conditions
- Mother and baby units and community perinatal mental health teams should aim to be accredited by the Royal College of Psychiatrists' Centre for Quality

Improvement (CCQI). This accreditation, through ongoing review, will assess staff training and support and positive feedback from parents and carers.

What works:

- Universal infant programmes, which include those offered in the context of antenatal care and programmes offered at birth to help all parents develop sensitivity to their infants, have been shown to be effective in improving parental mental health as well as that of the infant
- Universal infant programmes help parents identify temperamental differences, provide them with knowledge of child development, and help them manage infant behaviours like sleep and crying. More progressive, targeted interventions to address specific needs among more vulnerable and at risk groups can complement these universal programmes where necessary
- Ensure that perinatal and infant mental health pathways include opportunities, for those that need it, to access appropriate support prior to conception and that every woman (where clinically appropriate) has access to mother and baby units
- Health visitors are well placed to identify mothers suffering from postnatal depression and to provide preventative screening and early interventions
- Promotional interviewing, an approach which focuses on the positive and aims to empower and support parents as well as to identify needs, is recommended in the English Child Health Promotion Programme during pregnancy and the postnatal period
- Implement national improvement initiatives locally, including:
  - developing local Health Visitor Champions;
  - implementing the Family Nurse Partnership Programme for young first-time mothers;
  - ensuring that midwives have access to Perinatal Mental Health Training; and
  - implementing guidelines for GPs and primary care from NICE and the Royal College of General Practitioners.
- Effective programmes to address both antenatal and postnatal depression cover prevention in high-risk groups and intervention in mothers with established depression. They include cognitive behavioural and person-based counselling, both of which are equally effective if the practitioner can establish a trusting relationship with the mother
- Produce prevention plans that address suicide within the perinatal period following the Joint Commissioning Panel for Mental Health's three steps, including identifying those at increased risk and developing a personalised care plan for each woman at increased risk.

More evidence needed:

Compared to mothers, there are less interventions specifically for fathers, and other non-birthing fathers, during the perinatal period and the evidence of effectiveness is limited.

9 Children, young people and families

9.1 Introduction

This life stage runs from conception to age 25 years. Until the age of 18, services for children and young people with long-term health conditions are provided by child health and social care services. From 18, they are usually provided by adult services, with this transition process starting from age 16.

Early adulthood for young people (between 16 to 25) is a key life stage:

- Around half of lifetime mental health problems are established by age 14 and three quarters by age 24[130]
- Young people are making important transitions in their lives and becoming more independent
- Between the ages of 16 and 18, young people are more susceptible to mental illness[131]
- Adult and child service criteria differences mean that some people are no longer able to access services as they turn 18. For these people, support can reduce sharply at age 17 /18 even though need has not changed
- Capabilities such as planning, self-control, flexibility, awareness help adults to manage life and work effectively. Ages 15 to 23 years is a period of significant development of these executive function capabilities.[132] Early life adversity directs the brain away from planning and impulse control.

Services for children and young people do not all have the same upper age limit for those receiving a service. National policy is to extend current service models to create a comprehensive offer for 0 to 25 year-olds that reaches across mental health services for children, young people and adults.[133] The Special Education Needs (SEN) code of practice covers the 0 to 25 age range. Between the ages of 16-25 years, children who were looked after by the local authority become care leavers. Local authorities have a statutory duty to provide Personal Adviser (PA) support to all care leavers up to age 25, if they want this support.

Where relevant, we pull out information about young people aged up to 25 years in this life stage, but some will be covered in the next section on working age adults where this breakdown is not possible.

The foundations of life-long wellbeing are laid down in infancy and childhood. It is a time of rapid development, and the needs of infants differ from primary school aged children and differ again from young people of secondary school age and above.

Nurturing families are paramount in supporting the mental health and wellbeing of children and young people. Nurturing education settings from nurseries to universities support life chances and are important in identifying mental health needs.

The first 1,000 days refers to a child's life from the moment they are conceived until they reach 2 years of age (24 months). This is a crucial time when a child's brain, body and immune system grows and develops significantly.

9.2 Risk and protective factors

Many of the risk and protective factors associated with mental health problems for CYP are similar to those associated with mental illness in the general population, for example socio-economic status, housing, access to nature etc,[134,135] however, there are factors which can have a particular impact at this life stage.

During infanthood, secure attachment is paramount in shaping lifelong wellbeing. A growing body of evidence indicates that peer and family relationships, alongside their wider school and neighbourhood environment, have the strongest links to children and young people's wellbeing.[136]

Use of social media can be a risk factor for some children and young people. Social media has been linked to increased rates of anxiety, depression and poor sleep.[137] Cyber bullying and exposure to damaging normative messaging around ideal body shapes may have a profound negative effect on children and young people. Online groups associated with self-harm and suicide are extremely risky spaces for vulnerable children and young people. Children and young people also report a positive effect – finding likeminded communities on-line can be empowering. In the Brighton & Hove Safe and Well at School Survey conducted in late 2021, some groups including LGBTQ+, Young Carer and BME pupil cohorts were more likely to say that social media made them feel better about themselves, happier and more connected than all pupils.[138]

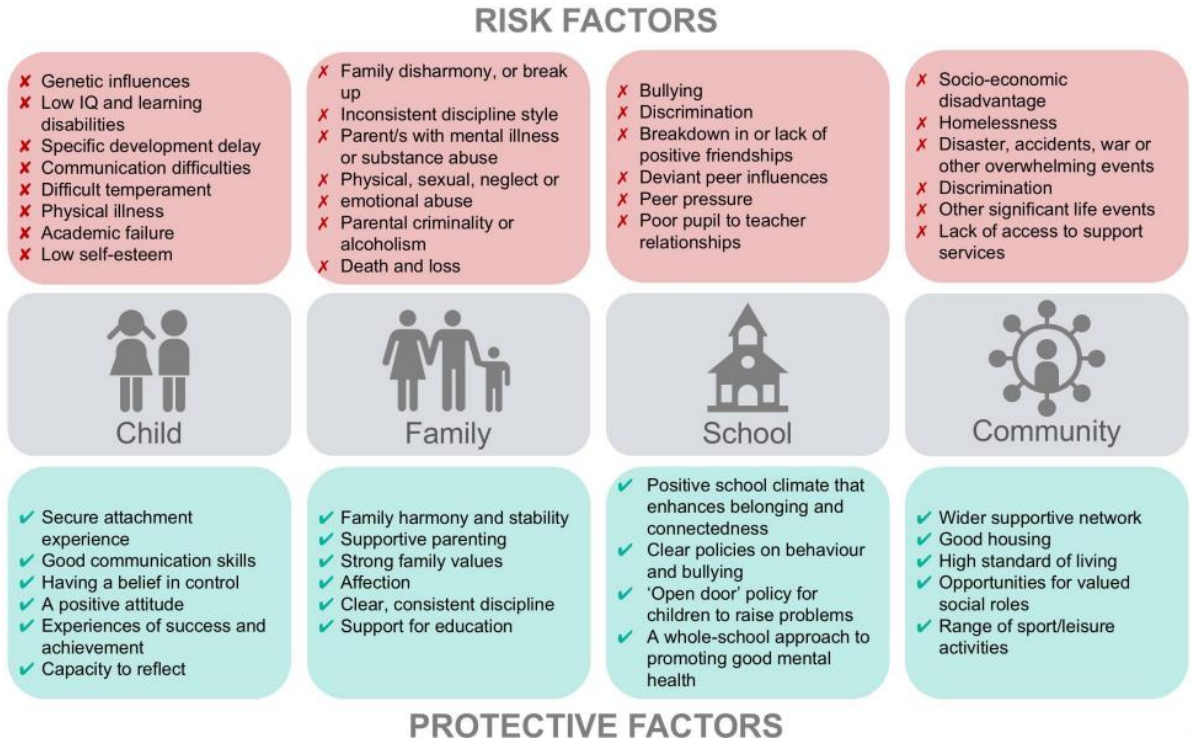
Risk and protective factors are shown in **Figure 13**.

Appendix 6 summarises risk factors associated with reduced mental health and wellbeing where comparisons can be made between Brighton & Hove and England and similar local authorities. The table shows that:

- Whilst Brighton & Hove compares relatively well to England for proportion of children in low-income families before housing costs, there are very high numbers with almost 7,900 children in low-income families. However, if housing costs are taken into account, this figure rises by over 60% with almost 13,000 children in the city living in poverty in 2019/20[139]
- Brighton & Hove has higher rates for both children in care and care leavers than both England and the South East. The proportions of care leavers are statistically significantly higher than both England and the South East)
- It has a significantly higher rate of children in need due to family stress due to dysfunction or absent parenting and children subject to child protection plans with initial categories of abuse or neglect

- Brighton & Hove has a statistically significantly higher percentage of school pupils with social, emotional and mental health needs than England and this proportion is increasing
- Although a few years out of date, in 2015, of all upper tier local authorities in the South East Brighton & Hove had the highest percentage of 15-year-olds with three or more risky behaviours, such as current smokers, alcohol use, cannabis use, use of other drugs, poor diet; or physical inactivity than any upper tier local authority in the South East and significantly higher than the South East and England. Although there is no more recent comparative data, we include local data from the Safe and Well at School Survey (2021) later in this section which gives a more recent picture
- Brighton & Hove has similar school readiness at the end of reception to England and has seen an improving trend in recent years. Brighton & Hove has a higher average attainment 8 score than England, however the attainment for children in care in comparison to the all-pupil average attainment is very poor
- Brighton & Hove had 457 children and young people registered as home educated in the academic year 2021/22 which is an increase on 380 for 2020/21 and 394 for 2019/20. There are a wide range of reasons why children and young people are home educated. We do not have evidence of the mental health needs of this group.

Figure 13: Overview of risk and protective factors for CYP's mental health



Source: The Mental Health of Children in England, 2016

9.2.1 Adverse Childhood Experiences (ACEs) and trauma

Trauma

Traumatic events are those that put you or someone close to you at risk of serious harm or death. Our usual ways of coping are overwhelmed, leaving us feeling frightened and unsafe. We can be traumatised through one-off events or ongoing stress, eg:[140]

- one-off events such as an accident, violent attack or natural disaster
- ongoing stress such as childhood or intimate partner abuse, bullying, long-term illness or a pandemic such as COVID-19
- living in an unstable or unsafe environment
- parental mental illness
- seeing someone else get hurt.

Multiple, long-lasting, repeated or continuous trauma is commonly referred to as complex trauma.[141] The impact of complex trauma is thought to be more severe if it happened in childhood.[142] ACEs can be a measure of childhood on-going stress or trauma.

Adverse Childhood experiences (ACEs)

ACEs are on-going stressful events and situations occurring in childhood including abuse, neglect and family dysfunction (**Figure 14**). They have been shown to increase the risk of developing mental ill health in childhood and adulthood, as well as increasing the likelihood of developing health harming behaviours such as sexual risk-taking, problematic alcohol use and substance misuse or violence, each of which in turn is linked to poor mental and physical wellbeing. Almost two thirds (an estimated 61%) of the adult population have had at least one ACE, however ACEs frequently co-occur and it is estimated that 1 in 6 adults (16%) have experienced 4 or more ACEs.[143] Compared to those with no ACEs, people with 4+ ACEs are:

2 times more likely (currently) to binge drink and have a poor diet

3 times more likely to be a current smoker

6 times more likely to have had, or caused, an unplanned teenage pregnancy

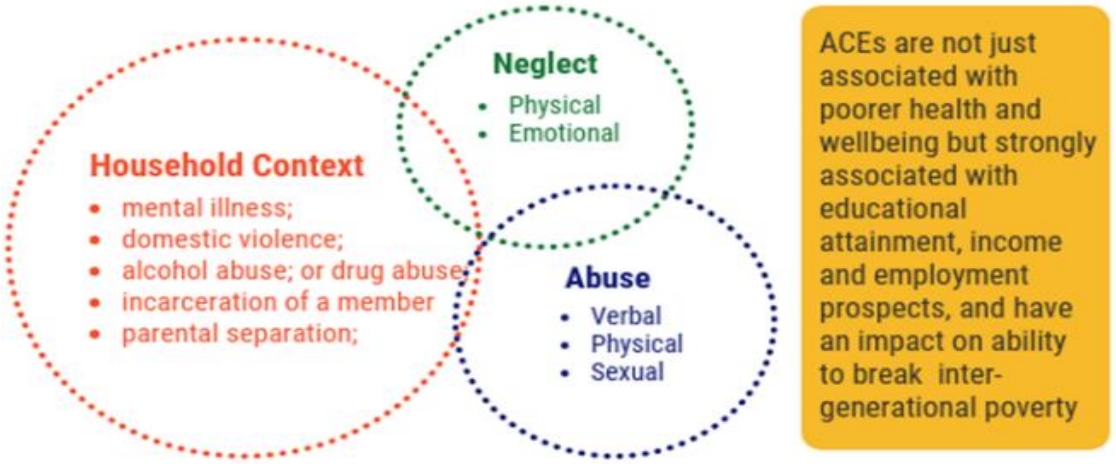
7 times more likely to have been involved in violence in the previous year

10 times more likely to have felt suicidal or self-harmed

11 times more likely to have used heroin/crack[144]

The outcomes most strongly associated with multiple ACEs represent ACEs risks for the next generation.[145]

Figure 14: Adverse childhood experiences[146]



Estimated prevalence (based on national research of adults retrospectively reporting their childhood).

- verbal (18%)
- physical (15%)
- sexual (6%)
- mental illness (12%)
- domestic violence (13%)
- alcohol abuse (10%) or drug abuse (4%)
- incarceration of a member (4%)
- Parental separation (24%)

9.2.2 Parental mental ill health

Poor maternal and paternal mental health has been associated with poor outcomes in children but not all children of parents who have mental health problems are at risk. A number of biological dispositions, sociocultural contexts and psychological processes are likely to interact and can serve as protective factors or risk factors for both parents' and children's mental health.[147] This is covered further in the perinatal mental health section.

9.2.3 Children in Care and Care leavers

Children in care and care leavers have much higher rates of mental health problems than the general population. They have been identified within Future in Mind and the NHS Long Term Plan as one of the most vulnerable groups in terms of emotional wellbeing and mental health. It is estimated that nearly 50 per cent of looked after children will meet the criteria for a diagnosable mental health disorder.[148]

Research has shown that children in care are more likely to have a mental health difficulty compared to their peers and this can be as a result of the abuse or neglect they experienced, an over-exposure to isolation and loneliness or living in socioeconomic hardship, all of which increases their likelihood to develop a mental health issue. The Commission on Young Lives warns that children's mental health services are buckling under pressure post-Covid.[149]

There are too many young people leaving care with diagnosed mental health conditions, but an even larger population of young people in care who have mental health needs but do not meet the threshold for CAMHS or adult mental health services. Whilst these

needs may not meet clinical thresholds, they often have a very significant impact on their quality of life, can lead to multiple moves whilst in care, and poor education and employment outcomes when leaving care.[150]

Most children and young people are taken into care following abuse and neglect, both of which are major ACEs, and all will have experienced trauma. They are more likely to self-harm and are at great risk of attempting suicide in adulthood. Referrals and subsequent wait times for mental health services further disadvantage young people that are brought into care in adolescence. Once in care children and young people who experience placement changes may find their wait time for a mental health service is lengthened as they re-enter a new wait list.

Brighton & Hove has higher rates for both children in care (not statistically significantly higher) and care leavers (statistically significantly higher) than England and the South East. See the population groups section for figures on children in care and care leavers.

9.2.4 Mothers of children taken into care

When children are taken into care, the safety and well-being of the child are the highest priority. This process often overlooks the health and wellbeing of the mother. We refer to mothers here, because most children are not living with their fathers when they go into care.[151]

Studies have found that mothers who had a child taken into care often have more health issues and social instability than mothers in the general population; these challenges worsen after their child is taken into care alongside higher rates of mental illness.[152,153,154] Mothers who had a child taken into care have higher rates of suicide attempts and death by suicide.[155]

See the population groups section for figures on children in care.

9.2.5 Children with Special Educational Needs and Disability (SEND)

Children with Special Educational Needs (SEN) do not necessarily have a disability or a mental health need, and some disabled children and young people do not have special educational needs. However, in comparison to children without special education needs and without Disability, children and young people with SEN and/or with disabilities are more likely to live in poverty and experience material deprivation; have higher rates of mental health issues; be excluded permanently or for a fixed period from school; not be in education, employment or training (NEET); experience social exclusion and discrimination, and live in unsuitable housing and have more difficulty accessing outdoor space for play[156]; all factors which are associated with reduced mental wellbeing.

Nationally, the percentage of children in schools with SEN has increased from 14.9% in 2019 to 16.3% in 2022. In January 2021, 3.7% of all pupils had an Education, Health and Care Plan (EHCP); and 12.21% of all pupils had SEN support.[157] The most common type of need for those with an EHCP is Autistic Spectrum Disorders and for those with SEN support, Speech, Language and Communication needs.[158]

In January 2022:

- 19.1% (6,061) of pupils attending Brighton and Hove schools, were recorded on school special educational needs registers. This is above the England SEN figure of 16.3%
- 4.3% (1,352) of Brighton & Hove pupils have an Education, Health & Care Plan. The national figure is 3.9%
- 14.9% (4,709) of Brighton & Hove pupils were receiving SEN Support (on their school's SEN register, but do not have an EHCP). The national figure is 12.4%
- The most common type of need for those with an EHCP in Brighton and Hove and nationally, is Autistic Spectrum Condition.

9.2.6 Neurodiverse people (including those with ASC, Autistic Spectrum Condition, and ADHD, Attention Deficit Hyperactivity disorder)

People with autistic spectrum conditions (ASC) are at increased risk of anxiety and Obsessive-Compulsive Disorder (OCD). Evidence from combined studies showed that in children and adolescents, 40% of young people with ASC had at least one comorbid anxiety disorder, the most frequently specific phobia (30%), OCD (17%) and social anxiety disorder (17%).[159]

There is no local data available of the number of children and young people with ASC in the city. It is estimated from studies that 1% of the population has ASC,[160] this would equate to almost 1,000 children and young people aged 0-25 in Brighton & Hove.

Attention-deficit hyperactivity disorder (ADHD) is a common childhood behavioural disorder. Systematic reviews indicate that the community prevalence globally is between 2% and 7%, with an average of around 5%. At least a further 5% of children have substantial difficulties with overactivity, inattention, and impulsivity that are just under the threshold to meet full diagnostic criteria for ADHD. Estimates of the administrative prevalence (clinically diagnosed or recorded) vary worldwide and have been increasing over time. However, ADHD is still relatively under-recognised and underdiagnosed in most countries, particularly in girls and older children.[161]

There is no local data available of the number of children and young people with ASC or ADHD in the city. Applying the above estimate of 2-7% to the Brighton & Hove population aged 0-25 years (99,411 children and young people) would give an estimate of between 2,000 and 7,000 children and young people.

9.3 Level of need in Brighton & Hove

This section looks at need from the following sources:

- Emotional wellbeing – local survey in schools and further education – Safe and Well at School Survey (SAWSS)
- Prevalence of mental health disorders – national estimates of local prevalence
- Pupils with identified social, emotional and mental health needs in schools
- Percentage of children in contact with secondary MH services and trends in that measure.

9.3.1 Emotional wellbeing

We have a very rich picture of need in Brighton & Hove from the Safe & Well at School Survey (SAWSS) which takes place every two years. The survey is an anonymous online survey conducted by Brighton & Hove City Council Public Health team, in partnership with the University of Sussex, across primary and secondary schools in the city. Results from the survey are presented in this section and on the section on outcomes. We thank Brighton & Hove schools for their active participation in this important survey.

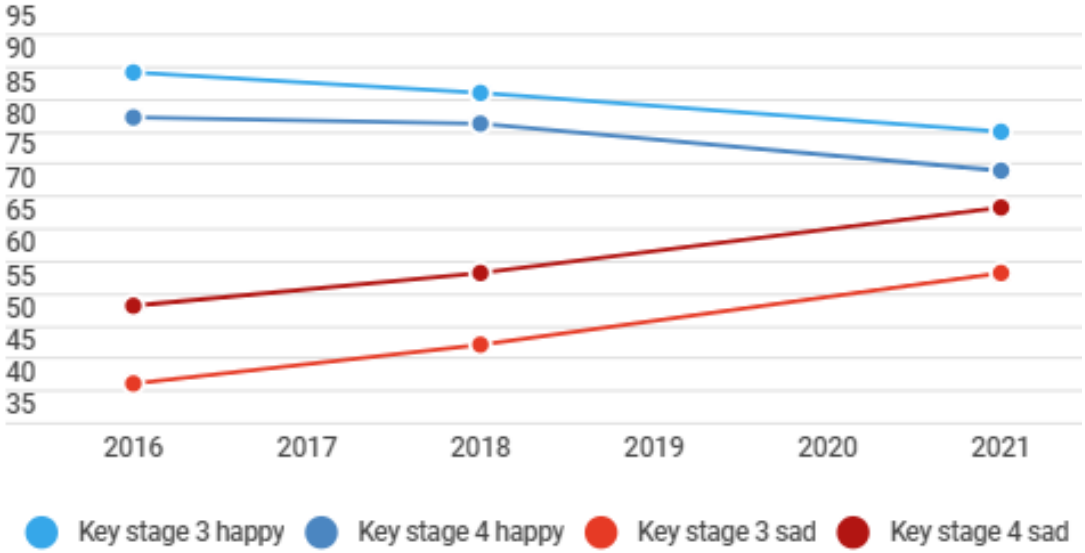
The most recent survey is based on data collected in November 2021, this was at a time when schools had returned to face to face teaching after the Covid lockdowns and restrictions. A total of 7,190 young people aged 11-16 took part from the 10 secondary schools across the city (59% of pupils). 5,322 primary school children aged 8-11 years took part (70%). The high participation in the survey from schools gives us valuable information which can be used to support communities. It helps us and the participating schools to understand and better meet the needs of children and young people in the city.

The survey shows that young people's emotional wellbeing has seen a significant deterioration in 2021 compared with previous surveys (**Figure 15**).

There was less change for primary school pupils, but for secondary school pupils:

- 78% often feel happy, down from 84% in 2018
- 61% often feel sad, up from 51% in 2018
- 63% worry about their future, up from 58% in 2018
- 56% often or sometimes struggle to sleep at night, up from 50% in 2018.

Figure 15: Percentage of pupils who strongly agree or agree that they have often felt happy or sad in the last few weeks, Brighton & Hove, 2016 to 2021



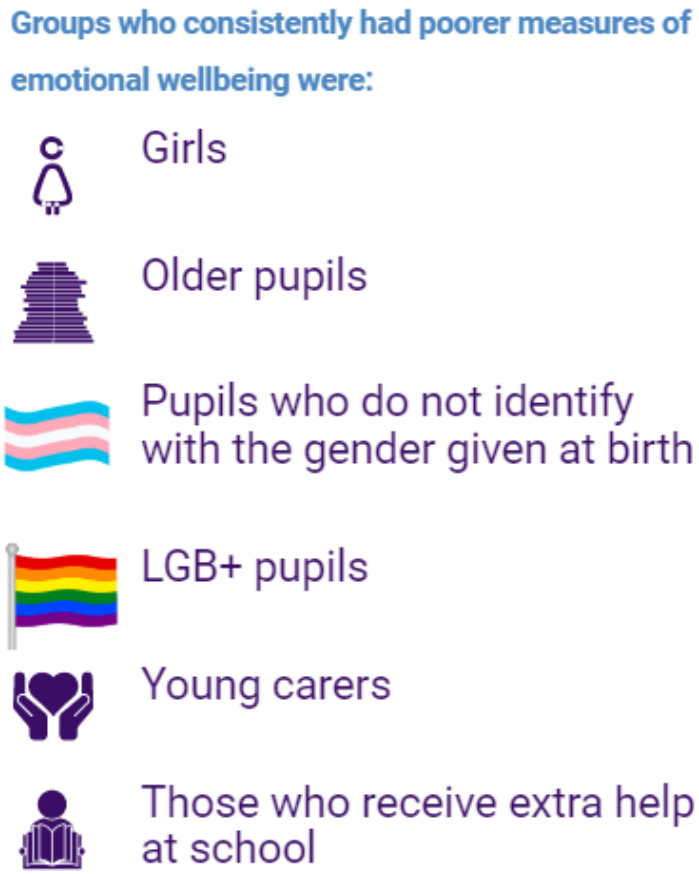
Source: Safe and Well at School Survey, Brighton & Hove City Council and University of Sussex

Some groups were disproportionately affected, **Figure 16** shows the groups who consistently had lower levels of wellbeing.

We do not have trend data, but the 2021 survey also shows:

- 32% often or sometimes have issues with food
- 51% often or sometime struggle with their body image and
- 62% often or sometimes feel angry.

When asked if they had asked for help with worries or feelings, around a third (34%) of pupils said that they had asked for help and 40% said that there was an adult at school that they could speak to about worries or feelings.



Whilst only 31 pupils who identified as children in care completed the survey, they were significantly less likely to be happy (59%) compared to 79% of those not in care; more likely to feel sad often (70% compared to 61%); significantly more likely to have self-harmed (46% compared to 18%) and; more likely to have had suicidal thoughts (36% compared to 23% of children not in care).

9.3.2 Pupils with social, emotional, and mental health needs

Table 18: Percentage of school pupils with social, emotional and mental health needs, Brighton & Hove, and England, 2021

Indicator	Period	Count	Trend	Rate		
		B&H	B&H	B&H	Eng.	CIPFA
Primary school age	2021	518	↑	2.8%	2.4%	-
Secondary school age	2021	508	↑	4.0%	2.9%	-
All school age	2021	1,076	↑	3.4%	2.8%	-

Source: Public Health England Children and Young People's Mental Health and Wellbeing Profile Children and Young People's Mental Health and Wellbeing - OHID (phe.org.uk)

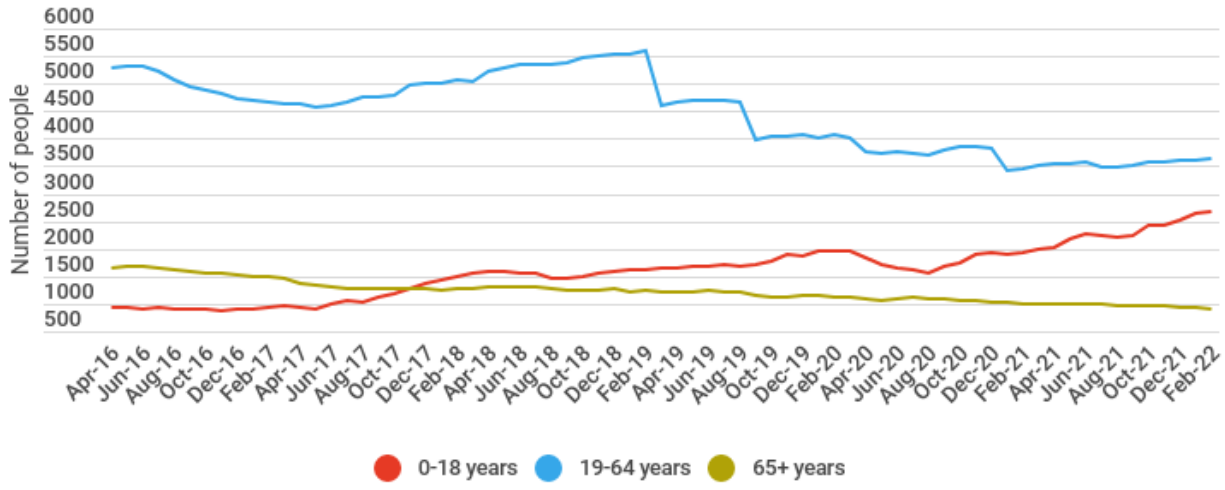
In Brighton & Hove, 1,076 school pupils are identified as having social, emotional and mental health needs, expressed as a primary need under Special Education Needs (518 primary school age and 508 secondary school age) in 2021 (**Table 18**). Rates have increased over the last five years in the city, as well as across England.[162]

9.3.3 Contact with secondary mental health services

As of February 2022, there were 5,560 people in Brighton & Hove using NHS funded secondary mental health services including learning disabilities and autism services (**Figure 17**). Comparison between age groups is shown here and referenced to from the other life stages in the report. The number of people in contact with contact with secondary mental health services:[163]

- aged under 19 years has been rising and is 2.8 times higher than it was in April 2016 (from 945 people to 2,685)
- aged 19-64 years has seen a large fall since 2019, but numbers have started to rise since mid-2021
- aged 65 years or over has fallen steadily over recent years with 910 people in contact in February 2022 compared with 1,645 in April 2016.

Figure 17: Number of people in contact with secondary mental health services by age, Brighton & Hove CCG, April 2016 to February 2022



Source: NHS Digital, Mental health services monthly statistics. Mental health services monthly statistics - NHS Digital

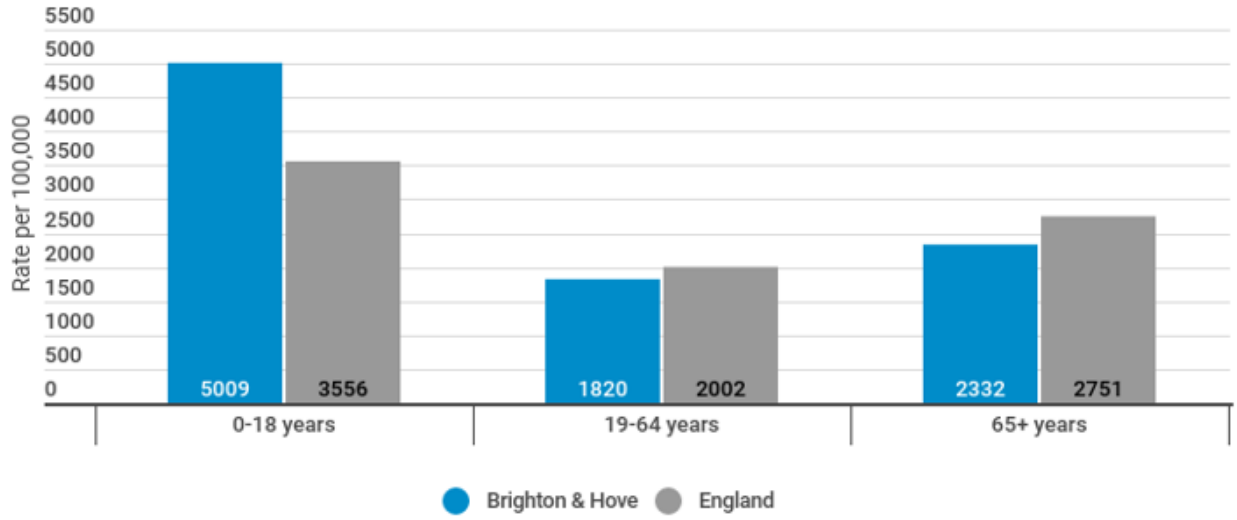
Figure 18 shows the rate per 100,000 population of people using NHS funded secondary mental health services including learning disabilities and autism in Brighton and Hove and England. It shows that:

- Brighton & Hove has a much higher rate of young people in contact with mental health services than England (5,009 people per 100,000 compared to 3,556).

This is in contrast to the rates for working age and older adults:

- Brighton and Hove has a slightly lower rate for those aged 19-64 years than England (1,820 people per 100,000 compared to 2,002) and a lower rate than those aged 65 years or over (2,332 people per 100,000 compared to 2,751)
- Older people have a higher rate of contact with secondary mental health services compared with working age adults in both Brighton & Hove and England.

Figure 18: People in contact with secondary mental health services by age, rate per 100,000, Brighton & Hove CCG, February 2022



Source: NHS Digital, Mental health services monthly statistics. Mental health services monthly statistics - NHS Digital and ONS Mid-Year Population Estimates 2020

9.3.4 Safeguarding concerns related to mental health

The YMCA have identified an increase in safeguarding concerns related to mental health across the services they provide in the city for young people.

9.4 Children and young people's voice

No primary qualitative evidence has been gathered for this rapid review. In practice there is limited routine collection of children and young people's or parents' voices by services. This assessment is informed by a review of the key findings from 11 recent engagement projects lead by children and young people to gain their experiences and voice around mental health and wellbeing.

The engagement projects span 2020-2022 and involved hundreds of young people in primary and secondary schools and older young people aged up to 25.

The list of these projects can be seen at Appendix 7 and the summary report is available alongside this report.

Across the range of engagement projects some key themes emerge:

Equity and equality of access

- Equality of inclusion matters. Engage all young people from all walks of life. Don't take the easy road. Don't work only with the same often heard voices
- A recognition and understanding of the impact of racism on children and young peoples' sense of identity and belonging in schools
- The need to take a gender sensitive approach to supporting the mental health needs of young men and to recruit more male mental health practitioners to support young men.

Getting help early enough

- Ensure children and young people gain timely support for their mental health and that this support is tailored and appropriate to their mental health needs as well as other access/financial barriers
- Make children and young people much more aware of services in their communities regardless of their mental health need and create services to fill the gaps where needed. Also make sure parents know about these services and how to make appropriate referrals to them
- Provide more relatable self-care strategies that reflect our experiences to support our mental health and avoid 'toxic positivity'
- Address the stigma around youth loneliness and social isolation
- More understanding following the death of a parent and going into care and the impact on emotional wellbeing
- We need 'friends with training' to be able to notice, advise and support those with eating difficulties but also know who to turn to for support if they get worried.

Co-design and co-production and meaningful engagement

- When asked for their views, children and young people said they wanted to see more involvement of peers and people with lived experience in designing and commissioning services and more support for the development of peer support
- For some services there was no routine engagement opportunities. Some populations had little or no opportunities to express their views.

The importance of the education setting

- Ensure a whole school approach to mental health
- School staff, Mental Health Support Teams and other support services must reflect the diversity of the communities they serve and support
- Train those with lived experience of mental health and ex-service users to become Wellbeing Ambassadors
- Primary schools need to recognise the importance of offering transition support throughout Year 6 to enable early identification of those who might struggle and plan appropriately, not leaving it until after the SATs.

Co-production is when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered.

Co-production with people with lived experience of services, their families and carers is a key principle of the national Five Year Forward View for Mental Health and improves outcomes. It was included in the Care Act 2014 that Local Authorities should, where possible, actively promote participation in providing interventions that are co-produced with individuals, families, friends, carers and the community. NHS organisations have a duty under Section 14Z2 of the Health and Social Care Act 2012 and the NHS Act 2006 to 'make arrangements' to inform, involve and consult with the public.

Brighton & Hove Citizens UK – Commission into Mental Health

Brighton & Hove Citizens brings together a range of institutions including schools, colleges, faith institutions, universities, unions and community groups across the city. Following a large and intensive listening exercise focused on people's experience of mental health, Brighton & Hove Citizen published a manifesto. The link is given below: https://drive.google.com/file/d/1IkR6QOS9A85Twk90mR2MVwoPKhK2zcuk/view?usp=sharing

The manifesto has asks grouped into six workstreams:

1) Mental Health Charter
2) Community Isolation
3) Mental Health as a Stigma
4) Access to Support
5) Waiting Lists
6) Transition between Children's Services and Adult Services

9.5 Quality and outcomes

This section shows outcomes across the following areas:

- Thoughts of self-harm
- Hospital admissions for self-harm
- Suicide and suicidal thoughts.

The comparative data on outcomes is presented in Appendix 8.

9.5.1 Self-harm

According to the 2021 Safe and Well at School Survey, 18% of 14–16-year-olds in Brighton & Hove said that they often or sometimes hurt or harm themselves, an increase from 10% in 2018.[164]

Groups who had higher rates of self-harm were:

- Girls (24% compared to 7% of boys)
- Pupils who do not identify with the gender given at birth (46% compared to 15% for those who do identify with the gender assigned at birth)
- Those born in the UK (19% compared with 12% of those born outside the UK)
- LGB+ pupils and those unsure of their sexual orientation (43% compared to 10% of heterosexual/straight pupils)
- Young carers (29% compared with 18% of those not a young carer)

- Those who receive extra help at school (30% compared to 17% of those who do not receive extra help.

There were no statistically significant differences by ethnicity.

Brighton & Hove has significantly higher rates of hospital admission as a result of self-harm for young people than England. In 2020/21, for Brighton & Hove residents there were 405 hospital admissions of children and young people aged 10-24 as a result of self-harm (**Table 19**). Whilst hospital admissions for self-harm provide a helpful indicator, they represent only a fraction of the actual self-harming behaviours in children and young people as the majority will not and may never present at hospital with self-harm. Furthermore, the type of self-harm that leads to an admission, may differ from the types that leads to attendance at A&E without admission.

Table 19: Hospital admissions as a result of self-harm, 10–24-year-olds, rate per 100,000, Brighton & Hove residents, 2020/21

Indicator	Period	Count	Trend	Rate		
		B&H	B&H	B&H	Eng.	CIPFA
Hospital admissions for mental health conditions (<18 years)	2020/21	70	→	139.1	87.5	-
Hospital admissions as a result of self-harm (10-24 years)	2020/21	405	→	594.7	421.9	-
Hospital admissions as a result of self-harm (10-14 years)	2020/21	35	→	239.6	213.0	-
Hospital admissions as a result of self-harm (15-19 years)	2020/21	170	→	971.5	652.6	-
Hospital admissions as a result of self-harm (20-24 years)	2020/21	200	→	578.6	401.8	-

Source: Public Health England Children and Young People's Mental Health and Wellbeing Profile
Children and Young People's Mental Health and Wellbeing - OHID (phe.org.uk)

Across Sussex, in 2019/20 and 2020/21 there were more repeat self-harm incidents requiring hospital admission compared to 2018/19. Some people experience multiple episodes of self-harm with 10% of individuals having had three admissions or more. The majority of admissions were of 18- to 24-year-olds, with four out of five admissions in 2020/21 were female.[165]

9.5.2 Hospital admissions for mental health conditions

In 2020/21 there were 70 admissions to hospital of Brighton & Hove residents aged under 18 years for mental or behavioural disorders as the primary diagnosis, up from 40 in 2019/20. This is a rate of 139 per 100,000, significantly higher than England (87.5 per 100,000) and the highest of our CIPFA comparators. There has not been a significant change in this rate over the last decade, although the local rate is the highest it has been since 2010/11 when data is first available.

9.5.3 Suicide and suicidal thoughts

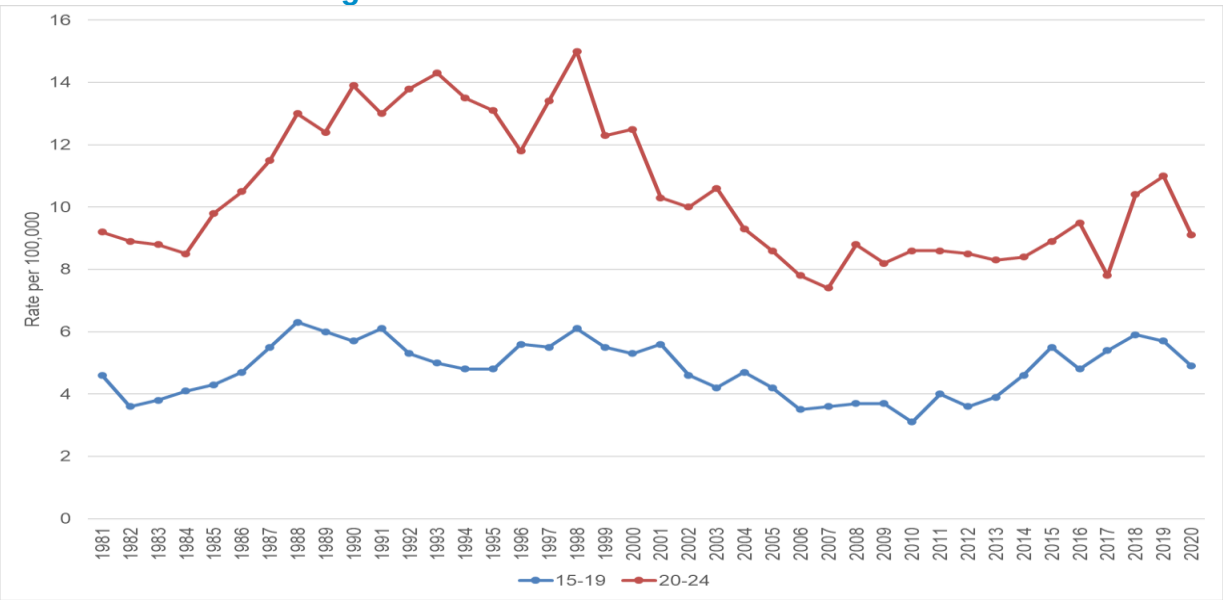
According to the 2021 Safe and Well at School Survey, 24% of 14–16-year-olds in the city said that they often or sometimes have suicidal thoughts, an increase from 17% in 2018.[166] Groups who had higher rates of suicidal thoughts were:

- Girls (28% compared to 14% of boys)
- Pupils who do not identify with the gender given at birth (59% compared to 20% for those who do identify with the gender assigned at birth)
- LGB+ pupils and those unsure of their sexual orientation (54% for LGB+, 39% of those unsure compared to 14% of heterosexual/straight pupils)
- Young carers (35% compared with 23% of those not a young carer)
- Those who receive extra help at school (39% compared to 22% of those who do not receive extra help
- Pupils from Black and Minority Ethnic groups (27% compared to 22% for White British Pupils). Rates were highest for White non-British and Chinese pupils.

For suicide and undetermined injury deaths between 2016 and 2019, almost one in ten (9%) deaths in Brighton & Hove were children and young people aged under 25 years, similar to England (10%). There were 44 deaths in this age group in the four years, 33 male deaths and 11 female deaths.

Across England and Wales the rates of suicide and undetermined injury deaths in those aged 15-19 and 20-24 have been increasing in recent years (Figure 19). Whilst numbers of suicides are too low for a yearly trend for Brighton & Hove, Table 20 shows that there has been an increase in suicide and undetermined injury deaths of Brighton & Hove residents aged under 25 years.

Figure 19: Age-specific suicide rates: by five-year age group, England and Wales, 1981 to 2020 annual registrations



Source: Office for National Statistics, Suicides in England and Wales: 2020 registrations. Available at Suicides in England and Wales - Office for National Statistics (ons.gov.uk)

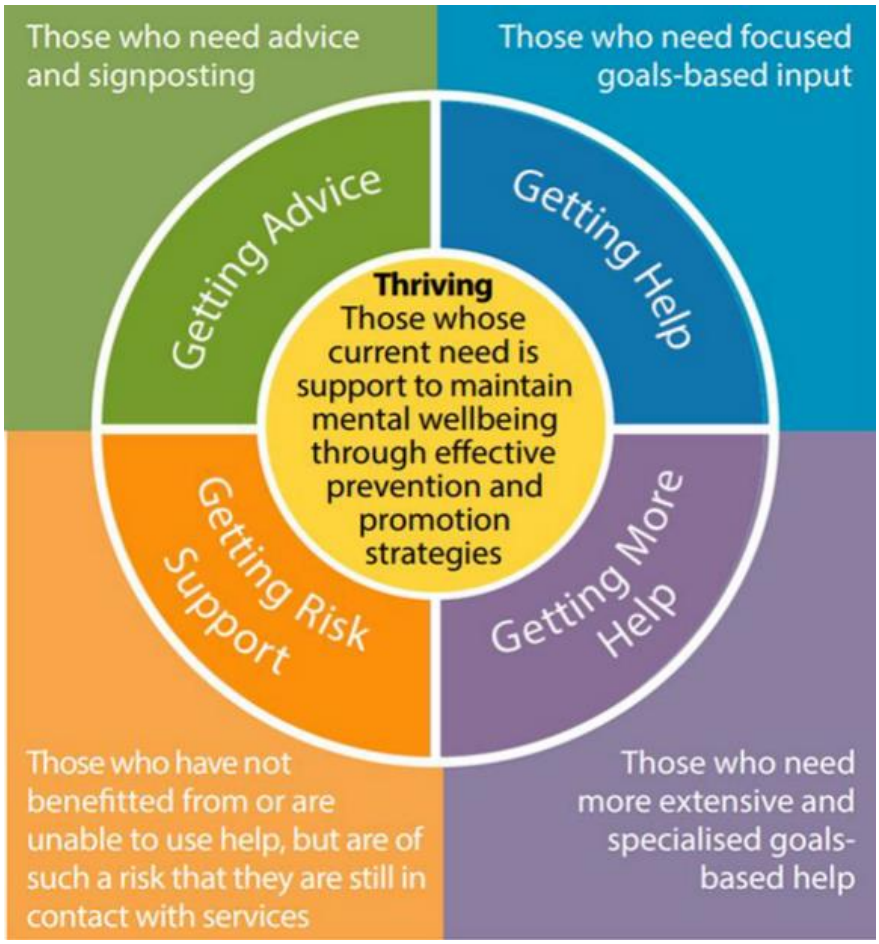
Table 20: Number of suicide and undetermined injury deaths for those aged under 25, Brighton & Hove, three-year periods from 2006-2008 to 2018-2020

Years of death (occurrence)	2006-2008	2009-2011	2012-2014	2015-2017	2018-2020
Number	<6	8	11	8	17

Source: Brighton & Hove City Council Public Health team from death registration data

9.6 What we know about the local mental health offer for children and young people

There are a wide range of services available across Brighton & Hove which are commissioned either by health, the local authority or by schools and colleges and University. In addition, there are local charity and national services which can be accessed. The core services commissioned by health and the local authority are summarised below and Appendix 9 gives a list of more services in the city mapped against the Thrive model shown below:



Source: THRIVE Framework (annafreud.org)

9.6.1 Primary Care

GPs can provide information, advice and treatment and can refer individuals to a mental health or psychological therapies service if needed.

9.6.2 Schools Wellbeing Service

The BHISS (Brighton & Hove Inclusion Service) Schools Wellbeing service works to promote mental wellbeing in schools and reduce stigma around mental health. The service is embedded in all secondary schools and further education (FE) colleges, and it reaches in to Primary schools. The Department for Education (DFE) funded Mental health in schools programme is housed within the Schools Well-being Service. This is a targeted service for the areas of highest need and includes Cognitive Behavioural Therapy (CBT) informed interventions to support children.

The most common presenting issues for the Schools Wellbeing Service in the Autumn and spring terms of the 2021/22 academic year were generalised anxiety; family or peer relationship difficulties; social anxiety/phobia and attendance difficulties.

9.6.3 Children and Young Peoples Wellbeing Service - Primary care mental health service for children and young people.

The Brighton & Hove Wellbeing Service is delivered in partnership by Sussex Partnership Foundation Trust and YMCA Downslink Group. It offers a range of support and NICE compliant psychological therapies, information advice and guidance for those aged 4 to 25. It includes an online offer (E-Wellbeing).

9.6.4 Specialist Children and Adolescent Mental Health Service (CAMHS)

Specialist NICE compliant support commissioned from Sussex Partnership Foundation Trusts which offers assessment and treatment to children and young people who have moderate to severe emotional, behavioural or mental health problems. This includes intensive and crisis services, and A&E liaison services for young people who present at crisis.

There has been significant additional investment in CAMHS services over the last year to respond to the significant increases in demand. These have to date focused on urgent and crisis support and admission avoidance, duty and liaison services and additional investment in services targeted at supporting the neurodevelopmental pathway.

9.6.5 Sussex Family Eating Disorder Service (SFEDS)

The Sussex Family Eating Disorder Service provides specialist assessment and treatment for children and young people with an eating disorder. In line with national trends, demand for this service has significantly increased and the number of young people accessing the service has increased. However, numbers of young people being treated by the specialist service are low compared to the numbers of people estimated to have an eating disorder. In addition, a lower proportion of young people who are seen by the specialist eating disorder service as urgent cases, are seen within a week than for England.

The has been significant investment into the service to increase capacity to meet the rising demand but workforce availability has impacted on the expansion of the service. An All Age Eating Disorder Pathway is currently under development in Sussex to better meet the needs, and improve outcomes, for children, young people and adults with an eating disorder. It is expected that the pathway will be agreed in Autumn 2022.

Inpatient services are provided by Sussex Partnership Foundation Trust.

9.6.6 Parenting programs

Brighton & Hove has an established Reducing Parental Conflict programme of practitioner training, interventions and guidance and tools for parents with a lead Parental Relationships Coordinator role based in the Council's Parenting Team.

There are a number of interventions focused on improving parental relationships available to parents in the city alongside regular opportunities for practitioner training to increase frontline expertise and understanding of the impact on children and young people of persistent and poorly resolved parental conflict.

Parental relationships interventions comprise the following evidence based groupwork interventions: Triple P Transitions for separated parents; Parents as Partners for couples and Family Foundations for expectant parents. The Council's Parenting Team also provides a range of online tools for parents including the Getting on Better Pack; Arguing Better guide; Getting it Right for Children guidance and Baby, You and Me Too.

9.6.7 Suicide prevention

Any death in a child or young person aged up to 18 will trigger statutory Child Death Review processes. For deaths by suspected suicide, there is also a wider system response aimed at identifying those who may have been bereaved or affected by the death and offering support to these individuals. A toolkit has been developed locally to support schools and colleges in Brighton and Hove to respond to an unexpected death.

9.7 Opportunities to learn more

Planned work that will enable a more detailed view of population need and children, young people and their parents and carers experience of the mental health offer:

- Development of a Single Point of Access (SPOA) will provide a gateway to all mental health services for children and young people and an opportunity to monitor the needs of children and young people and their characteristics. Data collected from this initiative will create a significant opportunity to understand more about demand, referral methods and patient journey
- Foundations for our Future – youth participation. As part of the delivery of Foundations for our Future, there is a plan to strengthen the youth voice through deliberate engagement, agreed by children and young people. This includes the mapping of Sussex youth voice groups with a lead for mental health and emotional wellbeing

- The views of the young people will be heard through participation work that is being developed within SPFT and already well embedded within YMCA.
- Development of an All Age Eating Disorder Pathway for Sussex is underway in which young people and their families will share their experience and co-design the pathway.
- Development and improvement of service performance reporting.

9.8 What works for prevention

See Section X for more on how these were identified.

9.8.1 Early Years

Box 2: What works for prevention: Early years

Parenting programmes and mental health:

- There is a strong evidence base for the effectiveness of how parenting and home visiting programmes can prevent child mental health issues, antisocial behaviours and unintentional injury and improve child behavioural outcomes, parenting and parental mental health
- The evidence-base for (strengths-based) parenting programmes is substantial and demonstrates an impact on a wide range of outcomes including child conduct disorder and parental mental health
- Home visiting programmes can also improve attachment-related outcomes in preschool children including among children with existing severe attachment problems
- Universal parenting programmes for all the relevant population, as well as targeted programmes for parents and their children at risk of mental health problems, or for those already experiencing behavioural difficulties, have been shown to be effective
- Examples of programmes to help parents, children and parenting in families where a parent has a mental health problem include: The William Beardslee programme (a family-based approach for prevention in children at risk); Let's Talk About Children (a manual for a two-session discussion with parents who are living with a mental health problem); and Parenting under Pressure (a programme for supporting parenting in families where parents abuse drugs or alcohol).

Specific parenting and family-based programmes and mental health

- Ensure families at greater risk of poor mental health can access evidence-based support, including:
  - Triple P; the Solihull Approach; Mellow Parenting; Strengthening Families Strengthening Communities; and Incredible Years
  - A family-systems approach to consider the care giving relationship between the parent and the child as well as the relationship between parents.
- Video Interaction Guidance (VIG), as this is currently considered to be the best evidenced therapy for developing mother-child interactions

Delivery of parenting programmes:

- Parenting programmes are often delivered within or around school settings, with teachers and teaching assistants trained to deliver the programmes.

More evidence needed:

- Access to and the provision of parenting programmes are not universal and is considered a 'postcode lottery'.

9.8.2 School age children, young people, and their parents

Box 3: What works for prevention: School age children, young people and their parents

Whole-school approach:

- A whole-school approach to mental health is widely acknowledged to have the biggest impact. Supporting your local schools to adopt this approach will boost children's mental health and school achievement
- Key elements of a 'whole-school approach' are:
  - Promoting leadership and commitment to the 'whole-school approach' by ensuring that head teachers and teachers can access mental health literacy support and training
  - Creating a mentally healthy school environment through, for example, providing teacher-led mental health education and providing school nursing services
  - Implementing evidence-based bullying prevention programmes
  - Providing parent training at the secondary school level in the implementation of interventions to promote pro-social behaviours
  - Creating self-management opportunities and access to resources for students and teachers
  - Taking a progressive approach to 'whole-school' work to reduce stigma and promote help-seeking behaviours for children and young people
  - Creating clear and supportive pathways through stepped care (the most appropriate treatment based on assessment).
- Implement whole settings-based programmes within local colleges and universities informed by the work of the English Healthy Universities Network, Student Minds and the World Health Organisation's Health Promoting Universities Programme.

Guidance and local initiatives:

- Promote and implement the Healthy Child Programme through a multi-agency approach including, as examples, primary mental health workers, safeguarding, youth workers, counsellors, and public health specialists
- Collaborate with NHS England to support the local implementation of the Early Intervention in Psychosis (EIP) model - to reduce treatment delays at the onset of psychosis and promote recovery by reducing the probability of relapse following a first episode of psychosis
- Implement NICE guidance on preventing psychosis, such as access to pre-emptive CBT for people considered to be at increased risk
- There are significant effects in favour of Wraparound care in improving young people's mental health (wraparound invests in a care coordinator with low caseloads who convenes a team that includes the family's friends and natural supports, as well as professionals)

- Early Support Hubs offer a speedy, easy-to-access and non-stigmatising way of getting mental health support for young people. See #FundTheHubs campaign
- There is a strong evidence-base for the effectiveness of 'school-based' interventions:
    - To help reduce the incidence of bullying and have positive benefits for mental health. These interventions can also lead to better outcomes for the perpetrators of bullying
    - To prevent mental health issues and alcohol/tobacco/drug use, reduce child adversity, promote mental wellbeing and resilience, and improve social-emotional skills.
- Adopt a range of prevention strategies for eating disorders:
    - Universal media literacy and using the media to critically look at body ideals
    - Prevention interventions aimed at children at risk using body image focused cognitive behavioural activities in schools
    - Cognitive dissonance activities that engage young people in conversation on body image.
- Tackle racism and discrimination. Racial injustice is toxic to young people's mental health
- To implement brief psychological interventions to prevent mental health issues in young people (eg group-based CBT resilience and protective factors; coping skills; mindfulness; emotion recognition and management; empathic relationships; self-awareness and efficacy; and help-seeking behaviour)
- There is an evidence-base for the effectiveness of school based Social and Emotional Learning (SEL) programmes that help children and young people to recognise and manage emotions; set and achieve positive goals; appreciate the perspectives of others; establish and maintain positive relationships; make responsible decisions and handle interpersonal situations constructively
- Promote and implement preschool programmes to support school readiness, communication and the development of social and emotional skills
- Target support to children who are out / or at risk of being out of school and who have greater exposure to factors that negatively impact mental health, for example, children who are homeless or those in the criminal justice system
- Consider using digital interventions which have been shown to be effective to reduce depression in young people (eg MoodGym)
- Reducing Parental Conflict (RPC) has become a government priority through the Department for Work and Pensions, given the detrimental impact this can have on children's mental health. The evidence shows some positive changes in children's mental health from the RPC programme.

More evidence needed:

- There is guidance on Mental Health First Aid (MHFA) training to help individuals recognise risks for poor mental health – however, the evidence of effectiveness is limited
- Further evidence is needed about which interventions are most effective for bullying, and whether their impact is sustained over the long-term.

10Working age adults

10.1 Introduction

The working age population is defined as those aged 18 to 64. Some information cannot be broken down into working age (18 to 64) and older people (65+) so is relevant for all adults.

Working age is often a time where people experience maximum independence and control over their life. Some of the common markers of adulthood include:[167]

- Starting full time work
- Moving out of the parental home
- Having a baby
- Moving in with a partner
- Buying a house
- Getting married
- Becoming a carer.

Each of these changes has potential mental health and wellbeing risk and protective elements. As highlighted in the section on children and young people, young adulthood from aged 16 to 24 is seen as a time of very great risk and transition.

In this life stage adults can have strong influence on the mental wellbeing of others through their various roles as partner, co-worker, parent and carer.

10.2Risk and protective factors

Many of the risk and protective factors for working age adults are similar as for other life stages. However, for working age adults, low educational attainment, material disadvantage and unemployment are particularly strong factors affecting mental health and wellbeing. Work, or lack of it, matters greatly as well as the quality of the working environment. People in Great Britain who are unemployed are between four and ten times more likely to develop anxiety and depression. Cost-effective interventions exist to promote and protect employee mental health.

Many people become parents and the quality of relationships in the home with partners, if present, and children has a very strong influence on parents' mental health. Family relationships matter to adults as well as children. Being in a stable relationship is more strongly associated with both physical and mental health benefits.

Many adults take on the role of caring for a partner, spouse or family member who is ill or has a disability. This can have a negative impact on their mental wellbeing, due to feeling increasingly isolated and unsupported.

Access to community resources, such as friendship networks, facilities for children, opportunities for exercise, the quality of the environment and social inequity, stigma and

discrimination, all impact on adult mental health. The neighbourhood environment is an important factor in the health and functioning of adults.

The Section on Common risk and protective factors summarises key risk and protective factors for Brighton & Hove

10.3 Level of need in Brighton & Hove

The earlier section on prevalence sets out the estimates for mental health conditions for adults based on the England Adult Psychiatric Morbidity Survey.

The Office for Health Improvement and Disparities (previously Public Health England) produces estimates for local authorities which take account of the different demographics of the population. It is estimated that there are over 46,000 adults (19%) in Brighton & Hove with a common mental health disorder, this is almost 10% higher than the estimates based on the England survey prevalence (42,000, 17%). The numbers of people with mental health conditions in the city could increase by over 2,400 people to over 48,400 by 2030, based upon expected population growth.

Brighton & Hove has higher prevalence across most of the indicators for mental health issues (See Table 21) available at local authority level, including:

- High anxiety score (8th highest upper tier local authority in England)
- A lower proportion of the population who feel that the things they do in life are worthwhile
- Depression and anxiety according to the GP patient survey
- Depression and anxiety among social care users
- Estimated new incidents of psychosis
- Severe mental illness diagnosis in Primary Care (12th highest upper tier local authority in England)
- Employment Support Allowance (ESA) claimants for mental and behavioural disorders
- Self-reported mental health problem in the GP Patient Survey (highest in England).

Need may be greater, where these indicators represent diagnosed mental health conditions, as individuals may not seek support or have a specific diagnosis.

Table 21: Estimated prevalence of mental health conditions, Brighton & Hove, CIPFA comparators and England, various dates

Indicator	Period	Count	Trend	Rate		
				B&H	Eng.	CIPFA
Self-reported wellbeing						
People with a high anxiety score	2020/21	-		30.8%	24.2%	-

People with a low satisfaction score	2019/20	-		4.7%	4.7%	-
People with a low worthwhile score	2018/19	-		6.3%	3.6%	
People with a low happiness score	2020/21	-		10.2%	9.2%	
People reporting a mental health problem (GP Patient survey)	2021			17.1%	11.0%	
Common mental health disorders						
Estimated prevalence of common mental disorders: % of population aged 16+	2017	46,244		19.0%	16.9%	-
Depression: Recorded prevalence (18+ yrs)	2020/21	34,150	↑	12.5%	12.3%	12.4%
Depression: QOF incidence (18+) - new diagnosis	2020/21	4,609	→	1.7%	1.4%	1.5%
Depression and anxiety prevalence (GP patient survey): % 18+	2016/17	-		18.5%	13.7%	-
Depression and anxiety among social care users: % of social care users	2018/19	-		63.6%	50.5%	-
Severe mental illness						
New cases of psychosis: estimated incidence rate per 100,000 population aged 16-64 yrs	2011	48		24.9	24.2	25.8
Mental health: QOF prevalence (all ages). Adults on Severe Mental Illness register	2020/21	4,201	→	1.29%	0.95%	0.98%
Mental health						
Employment Support Allowance (ESA) claimants for mental and behavioural disorders: rate per 1,000 working age population	2018	6,440		32.1%	27.3%	31.8%

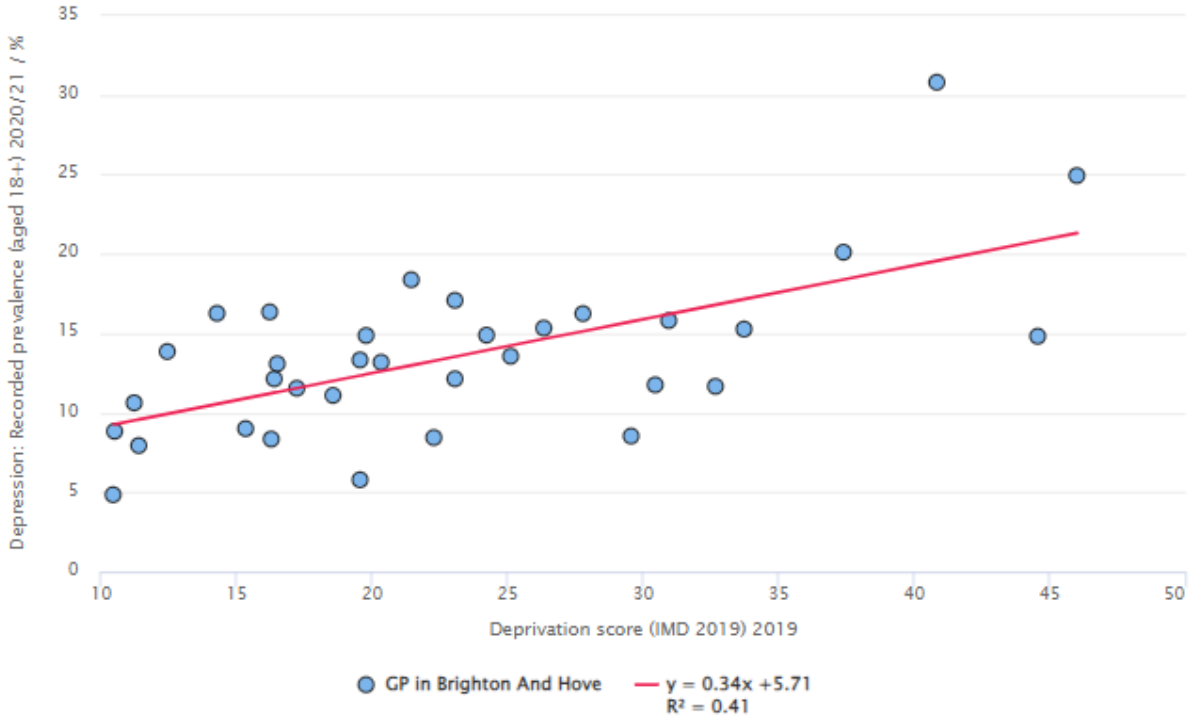
Source: Office for Health Improvement & Disparities. Mental health and Wellbeing JSNA. Available at: Mental Health and Wellbeing JSNA - OHID (phe.org.uk)

10.3.1Depression

There were 34,150 adults on GP practice registers for depression as of March 2021 (12.5% of adults compared with 12.3% for England), with 4,609 new diagnoses within the last year.

This varies considerably by GP practice, from 5% to 25% (aside from the specialist homeless GP practice Arch (31%) which has a different population profile). There is an association with deprivation, with practices having a higher level of deprivation tending to have more patients on depression registers (Figure 20).

Figure 20: Association between Index of Multiple Deprivation (IMD) 2019 and recorded depression prevalence (aged 18+) 2020/21, GP practices in Brighton & Hove



Source: Office for Health Improvement and Disparities. National GP Practice Profiles available at National General Practice Profiles - Data - OHID (phe.org.uk)

10.3.2 Severe mental illness

There were 4,201 adults on GP registers for severe mental illness, 1.3% of adult patients compared with 0.95% for England.

10.3.3 Mental health and physical health conditions

The relationship between physical and mental health is complex. There are high rates of mental health problems among people with long-term physical conditions. Almost half (46%) of people with a mental health problem have a long-term physical condition and almost one third (30%) of people with long-term physical conditions have a mental health problem.[168]

There is a two-way causal relationship; people with long-term physical condition are two to three times more likely to experience mental health problems than the general population.[169] The likelihood of having a mental health condition increases as the number of physical conditions increase. Co-existing physical and mental health problems can lead to:

- increased hospitalisation rates
- increased outpatient service use
- less effective self-management.

Physical and mental health problems should be supported in an integrated way across all aspects of the health system, from public health and prevention initiatives to the care provided by GPs, hospitals and the social care sector.[170] Cost-effective interventions which protect the mental health of people with long term conditions are available.[171]

The Brighton & Hove Adults with Multiple Long Term Conditions JSNA is available at B&H MLTCs JSNA 2018 full report FINAL.pdf (bhconnected.org.uk) (Summary available at B&H MLTC JSNA 2018 Exec Summary FINAL.pdf (bhconnected.org.uk)).

The needs assessment showed that in Brighton & Hove, in 2018:

- Just over 19,000 adults have both mental and physical health long-term conditions (8%)
- This increases to 35,000 (15%) if mild depression is included
- The likelihood of having a mental health condition increases with age and as the number of physical health conditions increases and is much greater in people living in more deprived areas
- The majority (63%) of adults with multiple long-term conditions under 65 have a recorded mental health condition and / or recorded substance misuse (alcohol or drugs misuse). However, in adults aged 65 or over, the majority (77%) do not.

10.3.4 Contact with secondary mental health services

See earlier section

10.3.5 Inequalities

This section presents local needs based on the Health Counts survey (of 2000 adults aged 18+ living in the city), the Count me in Too survey (of LGBT people in Brighton and Hove) some service data and recent local needs assessments. Local routine data was limited, and this is a potential gap in our understanding of population need. It would require further local work to gather and analyse local data where it is being collected.

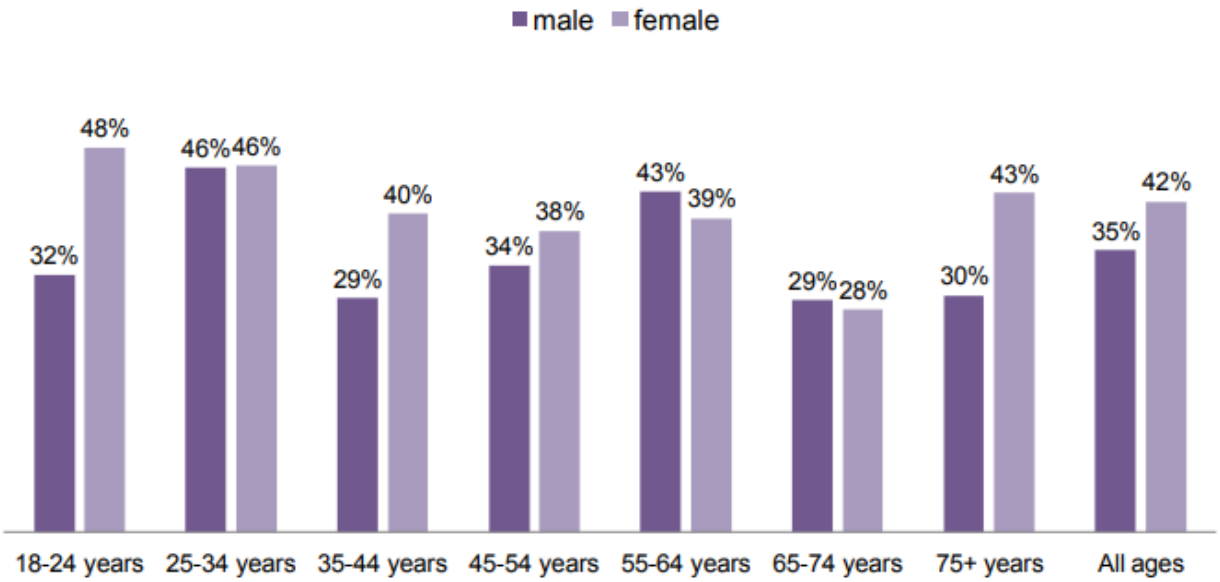
Risk of major depression

Every ten years, since 1992, there has been a Brighton & Hove health and wellbeing survey of adults aged 18+ called Health Counts. The most recent survey was undertaken in 2012[172] and found that 38% of respondents were at risk of major depression (screen for depression from the SF-36 validated tool). This proportion has

changed little over the last twenty years (surveys in 1992 and 2003). Using the latest ONS estimates and projections this would mean that in 2020, 91,700 adults in Brighton & Hove could be at risk of major depression rising to 96,700 by 2030.

Being at risk of major depression was significantly higher for females (42%) than males (36%), but there is no consistent pattern with age (Figure 21).

Figure 21: Risk of major depression (%) by age group and gender, Brighton & Hove, 2012



Source: Brighton & Hove Health Counts Survey 2012

There was a significant association between being at risk of major depression and deprivation. In 2012, in the most deprived quintile of deprivation, 51% of respondents are at risk of major depression, compared to 32% of the least deprived.

In line with national evidence, risk of major depression was higher for the following population groups (38% for all respondents):[173]

- LGB and unsure respondents (46%) are more likely to be at risk of major depression than heterosexuals (37%), though neither group is statistically significantly different to all respondents
- BME respondents (43%) are more likely to be at risk of major depression than White British respondents (37%), but again the difference to all respondents is not statistically significant
- Those who are married, in a civil partnership or living as a couple are significantly less likely to be at risk (31%) than all respondents, with those who were separated or divorced (51%) or single (48%) significantly more likely
- Those with a limiting long-term illness or disability are significantly more likely to be at risk of depression (57%) than all respondents
- Carers (42%) are more likely to be at risk of major depression than all respondents, but not significantly so

- Respondents with a religion other than Christian are statistically significantly more likely to be at risk of major depression (49%) than all respondents
- Those who rent from a private landlord (48%) and those who rent from a housing association or local authority (59%) are significantly more likely to be at risk of major depression. There is a significantly lower risk of major depression for those who own their own homes (29%)
- Respondents who are unemployed and looking for work, unable to work or are caring for home and family (67%) are significantly more likely to be at risk of major depression
- Respondents with a degree level qualification or higher are significantly less likely to be at major risk of depression (33%) than all respondents
- Students did not have a significantly different level of risk to all adults. However, students had a significantly lower feeling of belonging to their immediate neighbourhood (41%) than all survey respondents (58%).

Sexual orientation

Sexual orientation (Count me in Too (CMIT) 2006 and Health Counts 2012): Almost one in five CMIT respondents described their mental and emotional health as poor or very poor over the last year, and only one fifth of respondents had not experienced difficulties in the past five years. Almost a quarter of respondents say that they have had serious suicidal thoughts, with 7% attempting suicide in the past five years. In the Health Counts survey 2012, LGB respondents and respondents unsure of their sexual identity (20%) were more likely to say that they had ever self-harmed than heterosexuals (9%), this was highest for lesbian/gay women (39%) and bisexuals (41%).

Trans

As part of the Trans needs assessment 2015, a trans community survey found high levels of mental health need (including stress, depression, self-harm, suicidal ideation), which participants related to gender dysphoria but more commonly to factors such as discrimination and NHS treatment delays.

10.4Voice of working age adults

The views of adults presented in this section come primarily from a review of recent Brighton & Hove JSNAs (See Appendix 1). Many of the city's JSNAs undertook consultation and engagement with communities and some of the views were about mental health and wellbeing support.

One of the recommendations of the Five Year Forward View for Mental Health is 'to develop evidence-based approaches to co-production in commissioning.' Co-production is defined by the National Collaborating Centre for Mental Health as "an ongoing partnership between people who design, deliver and commission services, people who use the services and people who need them".

There was some routine involvement of people with lived experience and commissioners report that co-production is growing, for some services there are no routine engagement opportunities. Service users and their parents and carers said they wanted to see more involvement of peers and people with lived experience in developing and commissioning services.

Common issues highlighted through the review of recent JSNAs, about services include the need for:

- More accessible support and services, and support promoted more widely - using different promotion routes and increasing awareness of support services available amongst primary care and other general access services
- Simplify referral processes, including for self-referral
- Consider all needs, not just mental health (thresholds often on single issues) for example dual diagnosis
- More joined up services, working better together. Better information sharing between services, especially between primary care and specialist services
- When asked for their views, adults with lived experience said they wanted to see more involvement of peers and people with lived experience in developing and commissioning services and more support for the development of peer support (see Children and young people voice section for more on co-production)
- Taking a more trauma informed approach. More mental health awareness and suicide prevention training across NHS frontline services
- Waiting times reduced. More support for those on waiting lists or who do not meet service thresholds
- Higher levels of support/ more accessible support for those who have come out of in-patient facilities
- More support to families and carers and within schools.

Below is a summary of views expressed in specific JSNAs or studies:

The International migrants needs assessment 2018

Mental health is widely described as the most important health problem for migrant populations, particularly asylum seekers and refugees. The need to manage issues linked to immigration status may further impact on mental health. Migrants may not necessarily understand the concept of mental ill health as being something they were experiencing, or it may be difficult to talk about. Language and cultural barriers and stigma mean that it may be difficult to communicate feelings and ‘open up’ in counselling sessions. The needs assessment found that there is insufficient specialist mental health support to meet the needs of migrants, especially asylum seekers and refugees. Limits to the number of sessions for mental health treatment were felt to be insufficient to meet the level of need of some patients.

A qualitative study of BME mental health and wellbeing in Brighton & Hove (2012)

with the University of Brighton found the following identified obstacles to maintaining good mental health in Brighton & Hove: experience of racism; poverty; poor education;

and acculturation difficulties. 81% of respondents in this study reported experiencing barriers to getting help, most commonly stigma, which was particularly prevalent amongst less acculturated members of BME communities.[174]

Trans needs assessment 2015

As part of the needs assessment, some community research participants described negative experiences of NHS mental health services. Many found community and voluntary sector services more supportive but were aware of their limitations. The most frequently suggested action for improving healthcare for people who are trans was an increase in training.

Adults with multiple long-term conditions (MLTCs) needs assessment 2018

Within the needs assessment those with MLTCs and professionals working with them identified the following key issues: Links between mental and physical health services and more joined up care and care coordination is needed for those with mental illness for their physical conditions; Focus on the person rather than single conditions; More focus on mental health for those with physical health conditions and training / education.

JSNA for adults with multiple complex needs 2020

The needs assessment looked at people with two or more of: mental health needs; homelessness; substance misuse; domestic violence or; offending. Key issues identified by individuals with MCNs and professionals working with them included: Can't access services due to other complex needs i.e. drugs and alcohol use; Long waits for referrals; Lack of staff with skills in dual diagnosis; Mental health eligibility thresholds make it hard for clients with multiple complex needs to access services; More outreach support needed; Information sharing; Siloed working and service coordination; Insufficient housing options (mental health and housing needs are not aligned). It was felt many crises could be de-escalated with a more trauma informed approach.

Switchboard, NHS, impact of COVID-19 on LGBTQ communities of Brighton & Hove, Brighton & Hove City Council

Findings showed that 74% of the respondents felt depressed with 68% of 18–24-year-olds and 41% of people of colour considering suicide. 68% of LGBTQ people felt lonely or isolated as a result of the impacts of pandemic. LGBTQ people said they could not access support when they needed it. Some trans and non-binary respondents had enjoyed not having to navigate spaces where they felt uncomfortable or unsafe because of their identities.

10.5 Quality and outcomes

Here we consider key outcome measures for mental health in Brighton & Hove compared to England.

Brighton & Hove has greater Disability Adjusted Life Years (Burden of disease) due to mental health than England.

Brighton & Hove has significantly worse rates than England of:

- Premature mortality of adults with severe mental illness (in contact with mental health services in the last five years)
- Detentions under the Mental Health Act 1983
- Emergency hospital admissions for self-harm

Suicide and undetermined injury deaths:

- Brighton & Hove has had one of the highest rates of suicide in England, with rates significantly higher than England for several years. Our rates remain higher than for England in both men and women.

Brighton & Hove has significantly better rates than England of:

- Adults in contact with secondary mental health services who live in stable and appropriate accommodation
- Employment of people with mental illness or learning disability.

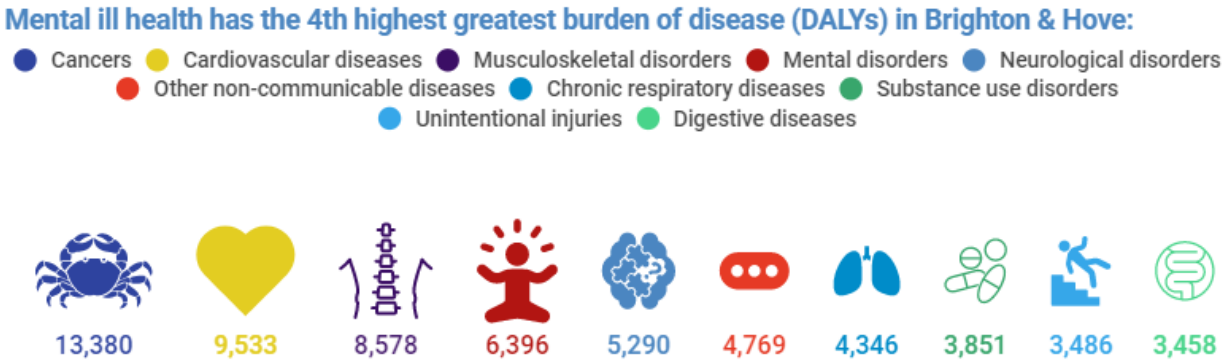
Appendix 8 provides a summary of these outcome measures, and they are considered further below.

10.5.1Disability Adjusted Life Years (Burden of disease)

Brighton & Hove has the greatest disability adjusted life years due to mental health ill health of any local authority in the South East, for both males and females.

Disability-adjusted life years (DALYs) are a measure of disease burden (see Box 4). In Brighton & Hove, mental ill health contributes 8.3% of disability-adjusted life years, greater than both the South East and England (7.4% and 7.3% respectively) (Figure 22). Mental Ill health has the 4th highest burden of disease. The contribution of mental disorders to the overall burden has grown across both the South East and England but has grown at a greater rate in Brighton & Hove.[175]

Figure 22: Global burden of disease: Leading causes of DALYs, Brighton & Hove, 2019



Source: Institute for Health Metrics and Evaluation. Global Burden of Disease 2019 Available at Global Burden of Disease Visualisations: Compare (thelancet.com)

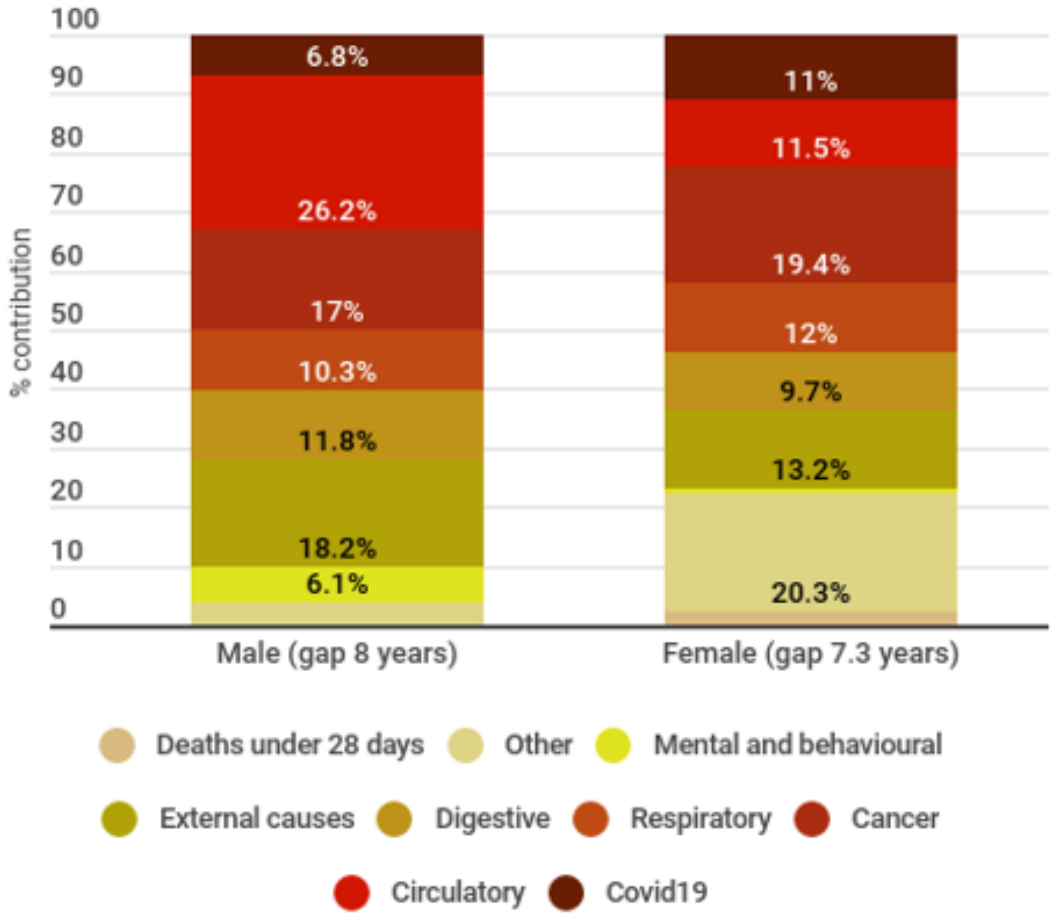
Box 4: Disability adjusted life years

Mortality does not give a complete picture of the burden of disease borne by individuals in different populations. The overall burden of disease is assessed using the disability-adjusted life year (DALY), a time-based measure that combines years of life lost due to premature mortality (YLLs) and years of life lost due to time lived in states of less than full health, or years of healthy life lost due to disability (YLDs). One DALY represents the loss of the equivalent of one year of full health. Using DALYs, the burden of diseases that cause premature death but little disability (such as drowning or measles) can be compared to that of diseases that do not cause death but do cause disability (such as cataract causing blindness).

10.5.2 Life expectancy inequality gap

Mental and behavioural conditions contribute 6.1% to the life expectancy gap in the city for males and 0.8% for females, compared with 3.8% and 6.1% respectively for England (Figure 23). However, external causes which includes suicide and undetermined injury deaths but also include deaths from poisoning and injury, contribute another 18.2% to the life expectancy gap for males and 13.2% for females in Brighton & Hove, compared to 10.3% and 5.4% respectively for England.[176]

Figure 23: Breakdown of causes contributing to the life expectancy gap between the most and least deprived quintiles of Brighton & Hove by cause of death, 2020 to 2021 (Provisional)



Source: Office for Health Improvement and Disparities based on ONS death registration data (provisional for 2021) and 2020 mid year population estimates, and Department for Levelling Up, Housing and Communities Index of Multiple Deprivation, 2019
Footnote: Data are provisional. Circulatory includes heart disease and stroke. Respiratory includes flu, pneumonia, and chronic lower respiratory disease. Digestive includes alcohol-related conditions such as chronic liver disease and cirrhosis. External includes deaths from injury, poisoning and suicide. Mental and behavioural includes dementia and Alzheimer's disease. Percentages may not sum to 100 due to rounding.

10.5.3 Premature mortality in those with severe mental illness (SMI)

People with a long-standing mental health problem are twice as likely to smoke, with the highest rates among people with psychosis or bipolar disorder. Compared with the general patient population, patients with SMI are at substantially higher risk of obesity, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and cardiovascular disease. People with SMI make more use of secondary urgent and emergency care, and experience higher premature mortality rates.[177]

Between 2018 and 2020, 610 people in Brighton & Hove died aged 18-74 years who had had a referral to mental health services in the preceding five years. To compare to other area, a directly age standardised rate of deaths of adults, aged 18 - 74, with SMI, per 100,000 population is calculated.[178]

Brighton & Hove has a significantly higher rate of premature death of those referred to mental health services in the preceding five years (120 per 100,000 people aged 18-74 years) than England (104 per 100,000). In the city adults with SMI can be considered to have 434% higher risk of premature mortality than adults without SMI, compared to a 390% higher risk across England.

The rate in the city is significantly higher for males (150 per 100,000) than for females (91 per 100,000), for England the figures are 124 and 84 per 100,000, respectively. Whilst we do not have a comparison within Brighton & Hove, for England rates are highest for those living in the most deprived areas.

10.5.4 Detentions under the Mental Health Act 1983

In 2020/21, 375 people in Brighton & Hove were detained under the Mental Health Act 1983. This is a crude rate of 128.9 per 100,000 population, higher than the rate for England (94.6 per 100,000) and 16th highest of 135 CCGs in England. This was similar to the rate in 2019/20.[179]

The breakdown of these detentions is not available by CCG, but across England:

- Known detention rates were higher for males (94.8 per 100,000 population) than females (87.9 per 100,000 population)
- Amongst adults, detention rates tend to decline with age. Known detention rates for the 18 to 34 age group (142.5 detentions per 100,000 population) were around 56% higher than for those aged 65+ (91.6 per 100,000 population)

- Amongst the five broad ethnic groups, known rates of detention for the 'Black or Black British' group (343.5 detentions per 100,000 population) were over four times those of the White group (74.7 per 100,000 population).

10.5.5 Self-harm

Self-harm rates for working age adults in Brighton & Hove is higher than for England. Evidence for this comes from estimates of DALYs, the Health Counts survey and hospital admissions.

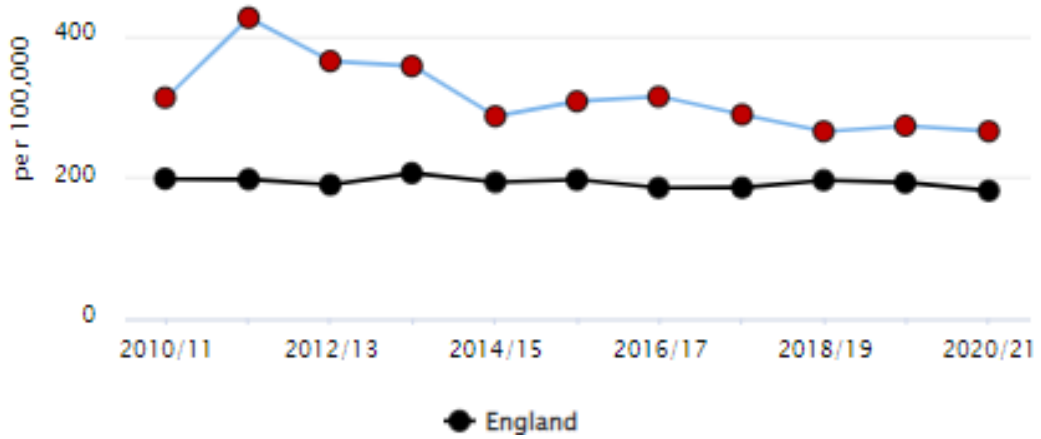
DALYs: Self-harm contributes 1.9% to Brighton & Hove's total disability adjusted life years, higher than South East (1.1%) and England (1.2%) (Figure Y). Whilst across the South East, the contribution of self-harm to the overall burden of disease has reduced, in Brighton & Hove it has increased. For self-harm, Brighton & Hove is the highest for all people, and for females but is ranked 2nd behind Southampton for males.

The 2012 Health Counts survey found that:

- One in ten respondents said that they had ever deliberately self-harmed, but not with the intention of killing themselves
- Self-harm was significantly higher in females (13%) than males (8%)
- There was a significant association with age – from 19% of 18–24-year-olds to 2% of 75+ year olds
- Self-harm has a significant association with deprivation, increasing in each quintile of deprivation: 14% of those living in the most deprived 20% of areas in the City said that they have ever self-harmed compared to 6% of those living in the least deprived 20% of areas
- LGB respondents and those unsure of their sexual orientation (20%) were more likely to say that they had ever self-harmed than heterosexuals (9%), and statistically significantly more likely than all respondents to have self-harmed. The highest percentages were for lesbian/gay women (39%) and bisexuals (41%). The figure for gay men is 9%
- Those who are single were significantly more likely to have self-harmed (17%) than all respondents
- There was little difference between BAME (10%) and White British respondents.

Whilst there has been a reduction in emergency hospital admissions for intentional self-harm for Brighton & Hove, in 2020/21 there were 900 admissions of residents of Brighton & Hove. This is a rate of 265 per 100,000 population (directly age standardised to allow comparison) and remains significantly higher than England (181 per 100,000) (Figure 24).

Figure 24: Emergency hospital admissions for intentional self-harm, directly age standardised rate per 100,000, Brighton & Hove and England, 2010/11-2020/21



Source: Office for Health Improvement and Disparities Mental Health and Wellbeing JSNA - OHID (phe.org.uk)

In most wards in the city, admissions to hospital for self-harm are significantly higher than England (Figure 25). They are highest in two of the most deprived wards, East Brighton & Queens Park and there is a relationship with deprivation (Figures 25 & 26).

Figure 25: Hospital admissions for self-harm, indirectly age-standardised rate (England = 100), Brighton & Hove wards, 2015/16 to 2019/20

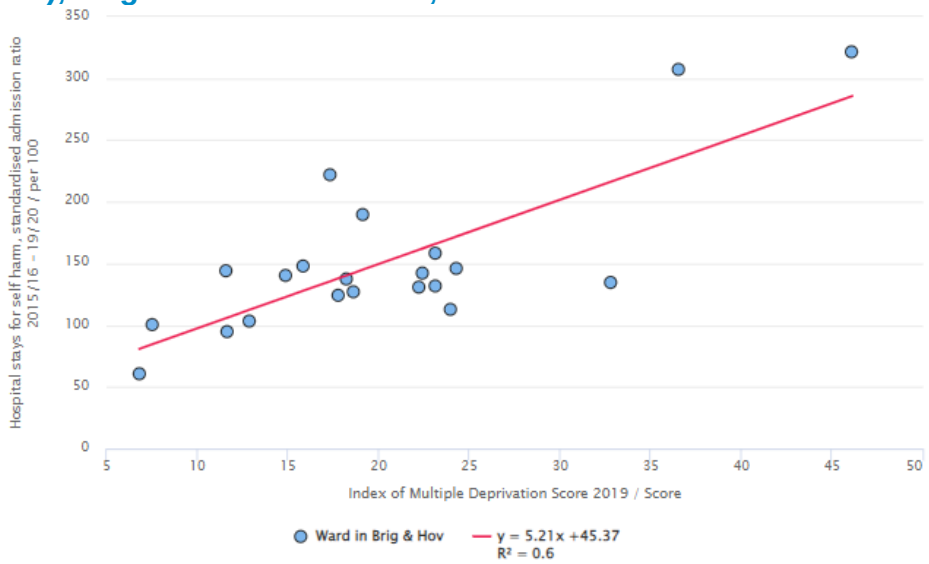
Better 95% | Similar | Worse 95% | Not compared | Data quality concerns

Areas: All in Brighton and Hove | Display: Table | Table and chart

Area	Count	Value	95% Lower CI	95% Upper CI
England	-	100.0	99.7	100.3
Brighton and Hove	-	149.5	145.3	153.9
East Brighton	-	321.4	292.7	352.1
Queen's Park	-	307.4	282.3	334.1
Westbourne	-	222.2	193.7	253.7
Central Hove	-	189.6	163.3	219.0
South Portslade	-	158.2	133.8	185.8
Goldsmid	-	147.6	129.6	167.3
Hangleton and Knoll	-	145.6	126.5	166.9
Rottingdean Coastal	-	144.6	124.7	166.9
North Portslade	-	142.4	119.5	168.3
Wish	-	140.2	117.1	166.6
Woodingdean	-	137.5	114.3	164.0
Moulsecoomb and Bevendean	-	134.9	121.3	149.7
Regency	-	131.7	113.5	151.9
St. Peter's and North Laine	-	131.3	117.9	145.7
Hanover and Elm Grove	-	126.9	112.8	142.4
Brunswick and Adelaide	-	124.0	105.5	144.7
Hollingdean and Stanmer	-	112.7	100.2	126.5
Patcham	-	103.5	87.1	122.1
Withdean	-	100.8	85.3	118.2
Preston Park	-	94.9	80.6	111.1
Hove Park	-	60.7	46.4	78.0

Source: Office for Health Improvement and Disparities. Local Health https://fingertips.phe.org.uk/profile/local-health

Figure 26: Association between hospital admissions for self-harm, indirectly age-standardised rate (England = 100), and Index of Multiple Deprivation Score (IMD 2019), Brighton & Hove wards, 2015/16 to 2019/20

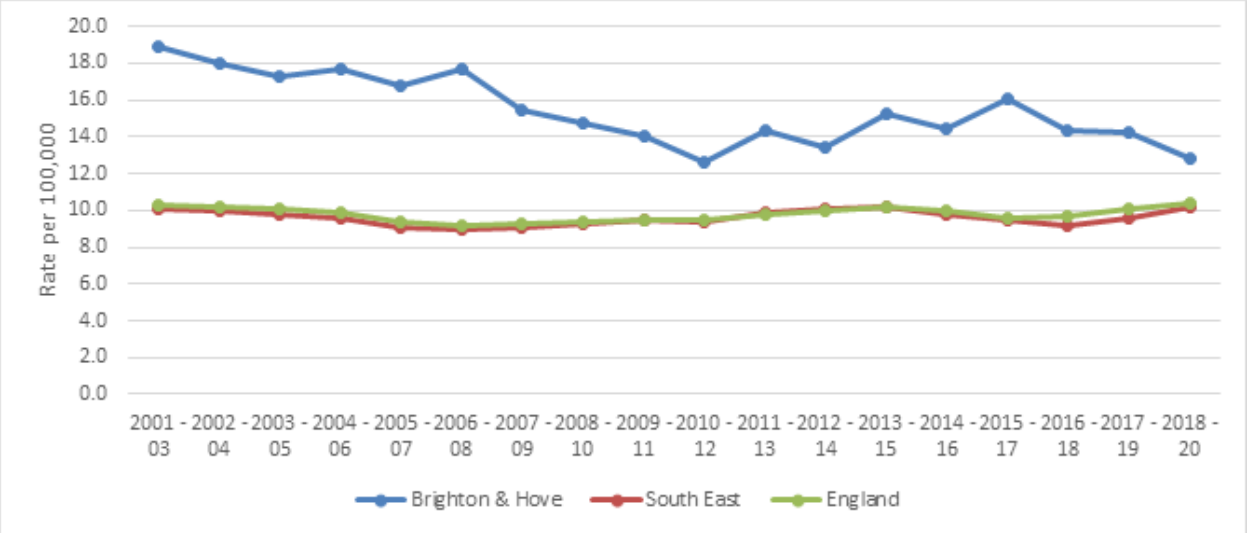


Source: Office for Health Improvement and Disparities. Local Health https://fingertips.phe.org.uk/profile/local-health

10.5.6 Suicide and undetermined injury deaths

Historically, Brighton & Hove has had one of the highest rates of suicide in England, with rates significantly higher than England for several years. However, this is no longer the case: for the most recent period (2018-2020) there was no statistically significant difference between Brighton & Hove and England (Figure 27).

Figure 27: Suicide and undetermined injury deaths: rate per 100,000 population for Brighton & Hove, South East and England, 2001-03 to 2018-2020



Source: Office for Health Improvement and Disparities. Public Health Profiles **Public health profiles - OHID (phe.org.uk)**

Nationally, there is approximately a 10-fold increase in risk of suicide for people under secondary mental health care,[180] however the majority of deaths by suicide are in those

who are not using secondary mental health services. Nearly three quarters of suicides occur in the non-mental-health patient population.[181]

There were 34 deaths per year (on average) in the last three years, 2018 to 2020 and Brighton & Hove remains in the 25 upper tier or unitary local authorities with the highest suicide rates.

As is seen nationally, the majority of deaths continue to be amongst males (2018-20, 69%), although the male suicide rate is no longer significantly higher than England. We have however seen an increase in deaths amongst females from 2013 onwards. The rate in females locally (7.8 per 100,000) is significantly higher than England (5 per 100,000) and the highest rate in the South East.

The age distribution of suicide deaths in Brighton & Hove is similar to England. Whilst the most common age-group was 40 to 54 years (34%), similar to England, almost 1 in 10 (9%) were children and young people aged 10 to 24 years. The age distribution of male deaths is younger than that of females, both in Brighton & Hove and England.

Around three quarters of Brighton & Hove residents who died from suicide or undetermined injury had a mental health diagnosis although they were not necessarily in contact with mental health services. Around one in five of suicide deaths were also recorded as drug related deaths. Over a quarter had been in contact with a support service within a week of their death. Other factors included physical health conditions, drugs and alcohol, relationship breakdown, bereavement, financial difficulties, debt, unemployment or job insecurity, homelessness and housing difficulties.

10.5.7 Employment

It was estimated that in 2018 (Quarter 4) that 63% of those with mental illness or learning disability[a] are in employment in Brighton & Hove compared to 48% for England.

However, the estimated percentage point gap in the employment rate of those in contact with secondary mental health services, and the overall employment rate is 67 percentage points for Brighton & Hove (77 for England).

10.6 What we know about the local working age adults mental health community offer

There are a wide range of community services available for across Brighton & Hove which are commissioned either by health, or jointly with the Local Authority. In addition, there are local charity and national services which can be accessed. Core commissioned services include:

[a] This is based upon data from the Labour Force Survey who report that they have a mental illness and are in employment as a percentage of all respondents who report that they have a mental illness. The definition of "mental illness" used is survey respondents who report having depression, bad nerves or anxiety, severe or specific learning difficulties (mental handicap), mental illness, or suffer from phobia, panics or other nervous disorders.

10.6.1Primary Care

GPs can provide information, advice and treatment and can refer individuals to a mental health or psychological therapies service if needed.

10.6.2 UOK (formerly Community Roots)

UOK is a network of local community-based services working together to support good mental health and wellbeing in Brighton & Hove. The network brings together 16 separate organisations to strengthen, develop and integrate mental health support for different levels of need. The lead provider is Southdown. Service offers include:

- Central Access Point
- Preston Park Wellbeing Centre
- Recovery College
- Lighthouse Personality Disorder Service (non-clinical element of service)
- Employment Support services
- Staying Well (crisis café)
- Screen & Intervene
- Mental Health Promotion Specialist
- Mental Health Support Coordinators in primary care and secondary care
- Mental Health Awareness and Suicide Prevention training
- Bereavement support (including suicide bereavement)
- Debt and welfare benefit advice
- Specialist psychosocial support for communities; people with Asperger's Syndrome and high functioning Autism, men, women, LGBTQ community, ethnically & culturally diverse communities, offenders & ex-offenders, Gypsy, Traveller and Roma communities.

10.6.3 Brighton & Hove Wellbeing Service (Primary Care Mental Health Service)

The Brighton & Hove Wellbeing Service is delivered in partnership by Sussex Partnership Foundation Trust, YMCA Dialogue and Brighton & Hove Mind.

They offer a variety of support and NICE compliant psychological therapies for Adults with mild to moderate mental health needs. Service offers include:

- Improved Access to Psychological Therapy (IAPT)
- Adult Wellbeing - Primary Care Mental Health Practitioner support
- Employment Support
- Wellbeing College courses.

10.6.4 Primary Care Network Mental Health Teams (Emotional Wellbeing Service)

Mental Health Practitioners and Mental Health Support Coordinators (part of UOK) embedded into Primary Care Networks (PCNs)[b] delivering triage, assessment and support for mental health needs within general practice. New initiative as part of the developing Emotional Wellbeing Service, currently in place in three of the six PCNs within Brighton & Hove (North and Central Brighton, East and Central Brighton, West Hove). Provided by Sussex Partnership NHS Foundation Trust and Southdown Housing Association.

10.6.5 The Community Transformation Programme

The Community Transformation Programme aims to develop integrated care that connects clinical mental health services with support offers that address wider determinants of mental health. Services will be developed at a neighbourhood level of a Primary Care Network (PCN) population. The first step towards developing this vision has been to develop embryonic teams in three PCN Accelerator sites.

10.6.6 Specialist Mental Health Services

Specialist mental health services (secondary mental health care) in Brighton & Hove are provided by Sussex Partnership Foundation Trust. The independent sector also provides inpatient care when SPFT inpatient units have reached capacity and for more specialised inpatient care. Table 22 gives a brief overview of the community services provided.

Table 22: Specialist Mental Health Services provided by Sussex Partnership Foundation Trust

Service	Description of the service
Assertive Outreach	People who have used mental health services before and may have a higher risk of being admitted to mental health hospital more frequently. The services works with individuals to create a care plan that allows them to feel supported in their community.
Adult Community Mental Health – Assessment and Treatment Services (ATS)	Specialist mental health assessment, treatment and care that provides specialist assessment and support to people who have more complex mental health needs than cannot be supported by their GP or the Wellbeing Service alone.
Eating Disorders	Specialist assessment and treatment service for adults with an eating disorder.

[b] PCNs are made up from groups of neighbouring general practices. Funding for PCNs means that they can deliver services to patients across the member practices.

Mental Health Homeless Team (MHHT)	The MHHT provides support to people with coexisting severe mental illness and substance misuse. This includes multiple needs (including physical health problems, homelessness or unstable housing). The service supports clients directly through outreach and in-reach sessions on the streets, day centres and emergency/temporary accommodation as well as referrals.
Neurodevelopmental	Diagnostic assessments of neurodevelopmental conditions. This includes autism spectrum conditions, ADHD and Tourette's Syndrome.
The Lighthouse – provided in partnership with Southdown and Brighton & Hove Mind	The Lighthouse is a specialist service for people over the age of 18, living in Brighton & Hove who are experiencing Personality Disorder and Emotional Intensity.
Early Intervention in Psychosis	Early intervention community-based support to people who are experiencing their first episode of psychosis.
Rehabilitation	The Community Rehabilitation Team provides high quality, safe and effective rehabilitation for adults with psychosis and complex mental disorder within Brighton and Hove. The team works collaboratively with service users to deliver personalised rehabilitation in their local area to: • Support a personally meaningful recovery • Improve subjective quality of life • Enable social inclusion and participation in the wider community to achieve personal recovery goals.
SMILES	Clinical Nurse Liaison Service provided by Sussex Partnership NHS Foundation Trust. The team provides step down care from secondary care (ATS) to primary care (GP). The service includes supporting primary care in the delivery of annual physical health checks for those with Serious Mental Illness who are known to secondary care.
Urgent and Crisis Care	
Mental Health Rapid Response Service (MHRRS)	Urgent response service for people when they feel they are in a mental health crisis and are at immediate risk of harming themselves or others.
Crisis Resolution and Home Treatment Team (CRHT)	Designed to provide safe and effective care in your own home if you experience a mental health crisis and would otherwise need to be admitted to hospital.

Psychiatric Liaison	Psychiatric liaison services provide mental health assessment and treatment for people who are inpatients in general hospitals or for those who may go to an A&E department and are in need of a mental health assessment.
The Haven	The Haven at Mill View is a dedicated, mental health crisis assessment facility

10.6.7 Complex Trauma Pathway

The Brighton & Hove Complex Trauma pathway is an integrated pathway, providing support to those who have who have been a victim of a (recent or historical), sexual or domestic violence incident.

A range of therapeutic interventions are delivered to those who present with trauma reactions and trauma related symptoms and experiences, including PTSD and complex PTSD. The pathway is a partnership approach streamlining provision between SPFT and community and voluntary sector partners. SPFT has overall clinical leadership for the pathway. Services are provided by:

- Sussex Partnership NHS Foundation Trust (SPFT)
- Survivors' Network (sexual violence)
- Mankind (sexual violence) and
- RISE (domestic violence and abuse).

The pathway is currently being reviewed which will inform the re-procurement of the pathway in Autumn 2022.

There are very long wait lists in Brighton & Hove for the complex trauma pathway, these waiting lists are now growing to nearly three years. There is insufficient capacity to meet demand and the pathway does not provide a service to all sections of the Brighton & Hove population that have experienced complex trauma. The pathway is currently being reviewed to address this.

Inpatient services are provided by Sussex Partnership Foundation Trust.

10.6.8 Trauma Informed Care (TIC)

The evidence on the impacts of trauma, including adverse childhood experiences (ACEs), on mental health is set out in the Children and young people section of the report. The impact of trauma is increasingly being recognised, along with the benefits of taking a trauma informed approach to care and practice. It can help improve patient engagement, treatment adherence and health outcomes, as well as provider and staff wellness. Trauma informed care can help reduce burnout among health and social care providers, potentially reducing staff turnover.

The Brighton & Hove JSNA for adults with multiple complex needs recommended that services should practice a trauma informed approach. Training staff in a trauma

informed approach is an effective way of supporting adults with trauma as a result of ACEs. It builds knowledge and awareness about the consequences of ACEs amongst professionals; as well as collaborative approaches across sectors and organisations. Staff across a wide range of agencies should be supported to understand the impact people's Adverse Childhood Experiences and adverse adult experiences can have on behaviours, health and wellbeing and enable staff to respond appropriately. This will require training at all levels across all services to develop a shared learning and understanding of the local approach to trauma.

Sussex Health and Care Partnership are implementing a Trauma Informed Care (TIC) programme across Sussex. Trauma Informed care seeks to:

- **Realise** the widespread impact of trauma and understand paths for recovery
- **Recognise** the signs and symptoms of trauma in patients, families and staff
- **Respond** through integrate knowledge about trauma into policies, procedures and practices and
- Actively avoid **Re-traumatisation**.

Trauma informed services are also **Reflective** in their practice, which involves curiosity about ourselves in the work we do. With a fundamental focus on **Relationships** at the heart of our work. The five key principles of trauma informed care are trustworthiness, safety (psychological and physical), choice, collaboration and empowerment.

Training on trauma informed reflective practice has been provided to a number of organisations across the city. There is a small team in place to allow more effective sharing of learning and development of initiatives.

Whilst good progress is being made, there is potential to widen the training offer across the city.

10.6.9 Mental Health Supported Accommodation and short stay accommodation

NHS Sussex (Brighton and Hove) (previously Brighton & Hove CCG) and Brighton & Hove City Council jointly commission supported accommodation to adults (18+) for individuals with support needs around mental health. The pathway consists of high support, medium support and low support. Discharge to Assess provision is also commissioned providing a short-term package of tailored support and accommodation to people ready to leave mental health inpatient settings.

Mental Health Supported Accommodation, Discharge to Assess provision has recently been reprocured and the new contracts will begin in Autumn 2022. As part of the procurement a new seven bed Crisis House for people needing short stay accommodation was procured. The Crisis House will provide a short term (average length will be seven days), non-medical and caring space for people to prevent an escalation of mental health crisis.

10.6.10 Suicide prevention

There are multiple actions taken by the city to reduce deaths by suicide and to reduce rates of self-harm. The local strategic suicide and self-harm prevention group steers our local response and is working on priorities that include:

- Strengthening and improving our response to deaths and possible clusters and our Sussex and city wide surveillance.
- Increasing uptake of suicide prevention training, tailored to different workforces, to improve the skills of confidence of our wider workforce
- Expanding our whole schools approaches to suicide and self-harm prevention
- Wider promotion of information and national and local resources
- Collaboration with partners across Sussex on developing pan-Sussex approaches.

In 2023, there will be a Sussex suicide and self-harm strategy and a new city wide action plan. The Brighton and Hove plan will align strategic intentions and actions with those held at Sussex level and be based on the seven national priority areas.[182]

10.7 Opportunities to learn more

A number of programmes are already underway to transform the way people access and receive mental health support. Integral to this work is understanding the experience of people with mental health issues. There will be opportunities through:

- The Adult Community Mental Health Transformation Programme –NHS England » The community mental health framework for adults and older adults - this is a three year programme from March 2021 to March 2024 and is central to the plans to develop services for this age group. The programme vision is: A new community-based offer that will include access to psychological therapies; improved physical health care; employment support; personalised and trauma-informed care; medicines management and support for self-harm and coexisting substance use; and proactive work to address inequalities based around neighbourhood populations
- Mental Health Supported Accommodation and Hospital Discharge Pathway procurement
- Review and re procurement of the complex trauma pathway
- Sussex wide report to review and optimise the housing-based services that support patients to be safely discharged from hospital or provide an alternative to admission to mental health hospitals
- Supplementary Substance Misuse Grant for Treatment and Recovery – a three year programme of service development as part of the 10 year national drug strategy (Public Health)
- Drug Strategy for Brighton and Hove – under development.
- Changing Futures - a pan Sussex system change programme focusing on improving the system for people experiencing multiple disadvantage. It is funded by Department for Levelling Up, Housing and Communities (DLUHC) until March 2024

- Improving the percentage of annual health checks carried out for people living with Severe Mental Illness as part of the national Core20plus5 approach to reducing health inequalities
- The Brighton & Hove Common Ambition project will work with people with lived experience of homelessness, frontline providers and commissioners to develop a new approach to co-production within homeless health services, in order to improve health services and outcomes for people experiencing homelessness in Brighton & Hove
- Brighton & Hove Health Counts survey of adults planned for 2023. It will give valuable information on the emotional and mental health of the adult population and include questions on protected characteristics and other vulnerable groups.
- Review of the crisis pathway
- Neurodevelopmental pathway work, including tackling the challenges around undiagnosed neurodivergence.

10.8What works for prevention

See Prevention section for more on how these were identified.

Box 5: What works for prevention: workplace based interventions

Workplace-based interventions to reduce employee mental health issues, increase wellbeing and promote recovery from mental ill-health is an intervention area 'with the strongest evidence base'.

Guidance on the workplace and mental health:

- NICE (2022) guidance on mental wellbeing at work; the Public Health England (PHE) Healthy Workplace Charter; The Public Health England Local Healthy Workplace Accreditation Guidance; and the Workplace Wellbeing Charter all offer guidance to promote mental health in the workplace
- Support local organisations to help employ people with mental health challenges through the Individual Placement and Support (IPS) scheme, and support those currently facing mental health issues at work through programmes such as Access to Work
- Look for opportunities to work in partnership with local business leaders and employers to apply a whole workplace approach (to protect and improve mental health at the individual, collective and organisational levels).

Prevention of mental illness and promotion of good mental health or wellbeing among those of working age:

The government commissioned 'Thriving at Work' review created six 'mental health core standards' to be implemented in all organisations.

- Produce, implement and communicate a mental health at work plan
- Develop mental health awareness among employees
- Encourage open conversations about mental health and the support available when employees are struggling
- Provide employees with good working conditions and ensure they have a healthy work life balance and opportunities for development

- Promote effective people management through line managers and supervisors
- Routinely monitor employee mental health and wellbeing.

The ‘Thriving at Work’ reviews also identified four more ambitious ‘enhanced’ standards for employers, to:

- Increase transparency and accountability through internal and external reporting
- Demonstrate accountability
- Improve the disclosure process
- Ensure provision of tailored in-house mental health support and signposting to clinical help.

Reviews indicate that effective workplace-based policies to promote mental wellbeing and prevent mental health issues include:

- Workplace resources which can improve employee wellbeing and organisational performance
- Increasing employee control via flexible working
- Workplace-based physical activity promotion
- Mindfulness and yoga
- To cope with work pressures, preventative mental health measures include the resources of autonomy, strong work relationships, opportunities for advancement, coaching and mentoring, and learning and development
- Additional measures targeted at wellbeing at work can include access to gyms, exercise and sports opportunities and changes to food options
- Explicitly address stigma and discrimination, guided by approaches developed in national programmes such as Time to Change (to help open up discussions around mental health in the workplace)
- There is evidence showing the effectiveness of online interventions at work such as online mindfulness.

11 Older adults

11.1 Introduction

Older age is generally considered to be 65 years and above and this is the age considered within this section, unless otherwise specified.

Ageing presents both challenges and opportunities and intensifies the need for physical and social environments to be made more age friendly. Societies that adapt to this changing demographic and invest in healthy ageing can enable individuals to live both longer and healthier.[183]

The rate at which people age is influenced by the accumulation of lifelong experiences, and their past and present socio-economic circumstances. Ageing is often associated with life transitions such as retirement, relocation to more appropriate housing and the death of friends, family and partners. Changes in physical and mental capacity are neither linear nor consistent and they are only loosely associated with a person's age in years.

Older people are particularly vulnerable to factors that lead to depression such as bereavement, physical disability and illness and loneliness. They are disproportionately affected by loneliness and social isolation and the effects on health that accompany them. Some are caring for partners and spouses, and this can also increase the risk of poor mental health.[184]

Poor physical health is a risk factor for mental health problems and older people may have more physical health needs. At a national level, male life expectancy is 79.5 years, however, on average 16 years (20.3%) are spent in poor health. Female life expectancy is 83.1 years, however on average 19 years (22.9%) are spent in poor health.[185] This varies by socio-economic status.

Whilst mental health conditions are prevalent in later life, they are not an inevitable part of ageing. Most older people are not depressed and often are less dissatisfied than younger people.

However, when mental health problems arise in older people, they tend not to have the same level of priority compared to problems in their younger counterparts. Mental health problems in older people are as treatable as mental health problems in younger people.[186]

We do not focus on dementia within this needs assessment.

11.2 Risk and protective factors

Many risk factors for working age adults, set out in the common risk and protective factors section, are also risk factors for older people. Here we cover risk and protective factors which are particular to older people.

Older people experience complex social, psychological and physical factors that influence the pattern, cause, diagnosis, treatment and prognosis of mental health conditions.[187] Older people who have experienced any of the following are at a greater risk of a decline in their independence and wellbeing:[188,189,190]

- Their partner died in the past two years
- They are a carer
- They live alone and have little opportunity to socialise
- Recently separated or divorced
- Recently retired (particularly if involuntarily)
- Unemployed later in life
- On low income
- Have recently experienced or developed a health problem
- Have had to give up driving
- Have an age-related disability
- Frailty
- Falls
- Are aged 80 or older
- If they are subject to different levels of discrimination
- Have dementia
- Have delirium
- They have been subject to abuse
- They have experienced alcohol and substance misuse
- If they are taking multiple prescribed medications (polypharmacy).

See Appendix 6 for the full breakdown of risk and protective factor indicators for Brighton & Hove, Compared with CIPFA comparators and England.

For most of the risk/protective factors where we have data, Brighton & Hove compares similarly or better to England. However, in the following important areas Brighton & Hove does not compare well:[191]

- 18.7% of older people were estimated to be living in poverty in 2019 (9,271 people). This is a significantly higher proportion than England (14.2%) and the second highest of South East Upper Tier Local Authorities (4th highest of the CIPFA nearest neighbours comparator local authorities)
- A higher estimated rate of fuel poverty, with 11% of all households estimated to be living in fuel poverty
- According to the 2011 Census, 41% of people aged 65 year or over in Brighton & Hove were living alone. This is the highest proportion in the South East and significantly higher than England (32%). This equated to 14,468 people and is the highest proportion among the CIPFA comparator group for Brighton & Hove
- A significantly higher rate of emergency hospital admissions due to falls injuries in those aged 65+ with 1,010 emergency hospital admissions in 2019/20.

Whilst similar to England, less than half of adult social care users aged 65+ have as much social contact as they would like (41%) and adult carers aged 65+ (42%).

According to the 2011 Census 12.7% of people aged 65 or over in the city were an unpaid carer (at that time just over 4,500 older people).

There are some risk and protective factors where we do not have comparative data for Brighton & Hove.

The 2012 Health Counts Survey in Brighton & Hove showed that:[192]

- Sense of belonging increases with age for both males and females, with 78% of those aged over 75 years feeling very/fairly strongly that they belong compared to 46% of those aged 18-24 years
- Those aged 75 or over were least like to use parks and open spaces in the city at least once a week (36% for males and 23% for females compared with 54% of all adults)
- Likelihood of seeing or speaking to a neighbour at least once or twice a week is similar for males and females (69% males, 67% females) and increases with age for both males and females
- Males aged 65-74 year had the highest percentage in doing the recommended physical activity
- Males aged 65-74 years had the highest rate of higher risk drinking.

According to the 2018 Brighton & Hove City Tracker Survey,[193] those aged 55+ are significantly more likely, than those aged under 55, in the city to be:

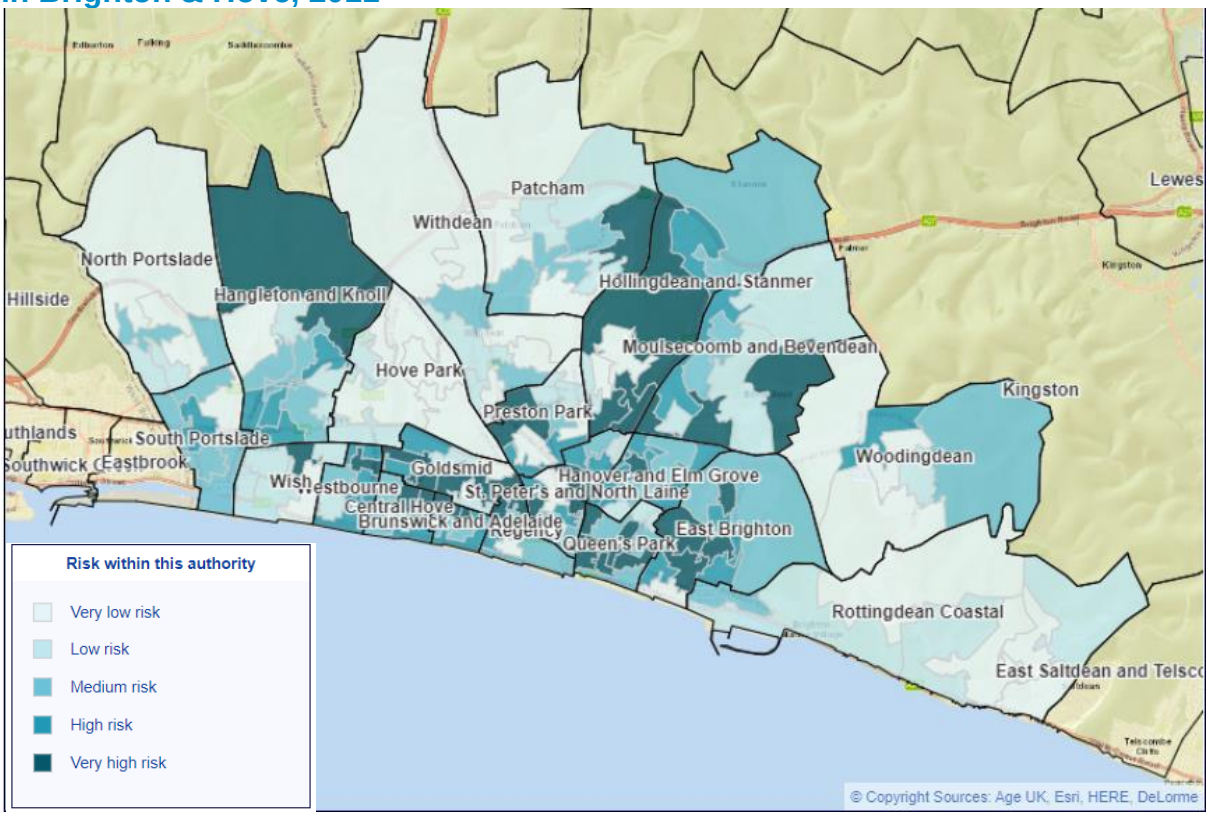
- Satisfied with their local area as a place to live
- Feel that they belong in their immediate neighbourhood
- Agree that people in their neighbourhood pull together to improve the neighbourhood
- Take part in formal volunteering.

Although linked, loneliness and social isolation are not the same. People can be isolated yet not feel lonely, equally they can be surrounded by others and feel lonely.[194,195] While loneliness and social isolation can affect all ages, older people are especially vulnerable. Being lonely or isolated can lead to deterioration in health and wellbeing and is a symptom of common mental disorders.[196]

Age UK has estimated that between 2008 and 2033 there will be a 44% increase in the number of 65–74 year-olds living alone, a 38% increase in those aged 75-85 and a 145% increase in those aged 85+. They produced small area level estimates based on the population characteristics of local areas which are related to loneliness.

There are areas of the city with high and very high levels of risk of loneliness for those aged 65+ within many city centre wards, Moulsecoomb and Bevendean, Hollingdean and Stanmer, and Hangleton and Knoll (Figure 28).

Figure 28: Risk of loneliness for those aged 65 or over, Lower Super Output Area in Brighton & Hove, 2011



Source: AgeUK (Age UK Loneliness maps)

We do not have local data, but national evidence shows that mental health problems in older people are common in settings such as hospitals and care homes. For example, in a 500-bed general hospital on an average day, estimates suggest that 330 beds will be occupied by older people, of whom 220 will have a mental disorder, 100 will have dementia and depression, and 66 will have delirium.[197] Depression affects four in ten people living in care homes[198] and in nursing homes around one in ten residents have psychotic symptoms such as delusions and hallucinations.[199]

In 2022, there were 2,150 registered care home beds in the city.

11.3 Level of need in Brighton & Hove

The earlier section on prevalence sets out the estimates for mental health conditions for all adults based on the England Adult Psychiatric Morbidity Survey.

The Office for Health Improvement and Disparities (previously Public Health England) produces estimates for local authorities which take account of the different demographics of the population and these are presented below.

11.3.1 Prevalence

The estimated prevalence of common mental disorders, defined as any type of depression or anxiety, in those aged 65 year or over in Brighton & Hove is 11.4% (4,450 people) (Table 23). This is based upon the Adult Psychiatric Morbidity Survey, with local authority estimates produced by the Office for Health Disparities (OHID), adjusting for the demographics of local areas.

This is higher, but not statistically significantly higher than the South East (9.2%) and England (10.2%). The estimate for Brighton & Hove is the third highest of Upper Tier Local Authorities in the South East.[200]

By 2030, it is estimated that 5,300 adults aged 65 or over in the city will have a common mental disorder due to the growing number of older adults.

Table 23: Estimated prevalence of common mental health conditions in those aged 65+, Brighton & Hove, 2020 and 2030

	England % (2014)	Estimate Brighton & Hove 2020	Estimate Brighton & Hove 2030
Common MH disorders (CMD) – population aged 65+	11.4%	4,450	5,300

Source: Office for Health Improvement & Disparities. Mental health and Wellbeing JSNA. Available at: Mental Health and Wellbeing JSNA - OHID (phe.org.uk) estimates applied to Brighton & Hove population from Office for National Statistics 2020 Mid Year Estimates and Office for National Statistics Subnational Population Projections

As shown in Table 24, taking national estimates for the prevalence of various conditions by age and gender, and applying to Office for National Statistics population projections for local areas we see that by 2030 we might expect:

- To have almost 600 more adults aged 65+ with depression, a 17% increase to almost 4,000 people (from 3,370 people in 2020)
- To have around 200 more older people with severe depression, a 19% increase to almost 1,300 people (from 1,073 people in 2020)
- The prevalence is higher in females than males in most 65+ age groups (with the exception of those aged 80-84 years).

Table 24: Estimated number of people aged 65+ with depression and severe depression, Brighton & Hove, 2020 and 2030

Condition and age group	England prevalence estimate			Brighton & Hove	
	Male	Female	All	2020	2030
Depression[i] – 65+				3,370	3,968

65-69	5.8%	10.9%		890	1,196
70-74	6.9%	9.5%		846	858
75-79	5.9%	10.7%		595	678
80-84	9.7%	9.2%		499	660
85+	5.1%	11.1%		539	576
Severe depression[ii] – 65+				1,073	1,276
65-69			2.5%	263	355
70-74			1.6%	165	166
75-79			3.5%	249	284
80-84			3.0%	159	210
85+			3.9%	238	261

Source: Oxford Brookes University and Institute of Public Care. Projecting Older People Population Information System (POPPI). Accessed 17/03/2022. Available at: https://poppi.org.uk/ (registration required)

The 2012 Health Counts Survey in Brighton & Hove showed that:[201]

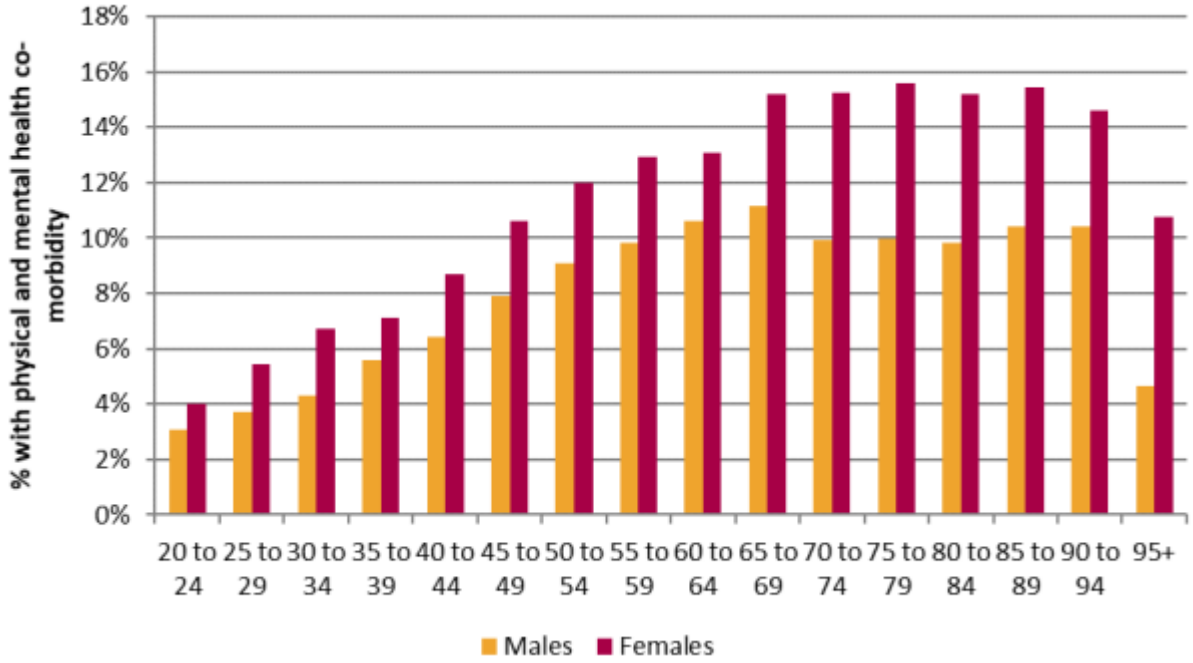
- Risk of major depression was low compared to other age groups for those aged 64-74 years (29% of males and 28% of females aged 65-74 compared to 35% and 42% of all adults aged 18 or over). However, for those aged 75 years or over, risk was higher for females, with 43% at risk of major depression, compared to 30% of males
- Respondents aged over 75 years were least likely to feel that things in their life are worthwhile (65% compared to 74% for all adults)
- Respondents aged 65-74 year were most happy, 78% for men and 77% for women compared to 71% and 72% respectively for all adults).

11.3.2 Mental health and physical long-term conditions in older people

See Section 8.3.3 in the working age adult section on multiple long-term physical and mental health conditions.

The prevalence of mental and physical long-term conditions increases with age up to around age 70 and then is fairly stable (Figure 29). From ages 65 to 95 approximately 15% of women and 10% of men have both physical and mental health problems. However, those who reach 95 years or over are less likely to have physical and mental health conditions than younger older age adults. Physical and mental health comorbidity tends to be higher in females than males.

Figure 29: Percentage of people with physical and mental health conditions by gender and age, Brighton & Hove, March 2017



Source: Brighton & Hove City Council. Adults with multiple long-term conditions needs assessment

11.4 Voice of older people

No information was readily available on the voice of all older adults aside from a consultation in 2018 by Mindout. It looked at the experiences of people who identify as LGBTQ and are over 50. The consultation included 80 survey respondents from LGBTQ people in Brighton & Hove, 131 members of Opening Doors London responding to their annual survey, two focus groups of 12 MindOut service users and volunteers, members of Brighton & Hove Switchboard Older People's Project and members of Older and Out, a Brighton based social group.

Key findings:[202]

- Respondents suggested that all older people's service providers should receive LGBTQ affirmative practice training, that LGBTQ 'kite marks' for older people's services should be developed and that LGBTQ groups should go into older people's services on a regular basis.
- Many LGBTQ people report high levels of loneliness and lack of social and community engagement. Approximately half of respondents to the MindOut surveys use social media to support their mental health. 70% were keen to increase their digital confidence to use existing online support as well as to explore developing online services.
- Older LGBTQ people report high levels of suicidal distress. Last year 80% of MindOut service users talked about suicidal distress, 90% of MindOut Trans clients were at risk of suicide.

Many respondents spoke of the need for, and positive experiences of, LGBTQ groups, services, events and opportunities for older people.

11.5 Quality and outcomes

Most outcomes indicators are published for all adults and are covered in the working age section of this report, with comparative data on outcomes in Appendix 8.

From the last published data for the period 2013-2017, males aged 65 years or over in Brighton & Hove had a significantly higher rate of suicide and undetermined injury deaths England (Table 25).

Table 25: Suicide and undetermined injury rate in those aged 65+, Males, Brighton & Hove, 2013-17

Indicator	Period	Count	Trend	Rate		
		B&H	B&H	B&H	Eng.	CIPFA
Suicide crude rate 65+ years: per 100,000 (5 year average) (Male)	2013-17	20		23.1	12.4	12.8

Source: Office for Health Improvement and Disparities. Productive Health Ageing Profile Productive Healthy Ageing Profile - Data - OHID (phe.org.uk)

Note: rate for females not published as numbers too low at local authority level

However, there have been a reduction in suicide deaths of older people in the city, with 7 deaths of those aged 65+ in Brighton & Hove in the three-year period from 2018 and 2020 compared to 23 deaths in the preceding three year period (this is for males and females combined) (Table 26).

Table 26: Number of suicide and undetermined injury deaths for those aged 65 or over, Brighton & Hove, three-year periods from 2006-2008 to 2018-2020

Year of death (occurrence)	2006-2008	2009-2011	2012-2014	2015-2017	2018-2020
Number	17	16	11	23	7

Source: Brighton & Hove Public Health Intelligence team from death registration data

11.6 What we know about the local older adults mental health offer

11.6.1 Primary Care

GPs can provide information, advice and treatment and can refer individuals to a mental health or psychological therapies service if needed.

11.6.2 Social prescribing

Social prescribing enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services to support their health and wellbeing. It improves outcomes for people by giving more choice and control over their lives and an improved sense of belonging. It is also effective at targeting the causes of health inequalities and is an important facet of community and neighbourhood centred practice.

In Brighton & Hove Social Prescribing within Primary Care Networks (PCNs) is provided by link worker provided by Community and Voluntary Sector organisations or directly employed by the PCN. In addition to this, Together Co deliver a City Wide Social Prescribing service which aims to reduce health inequality and improve outcomes for people who may not traditionally access services via their GP practice.

The social prescribing service provides support to people who may have 'falling through the gaps' and 'not feeling heard' by existing services and feedback suggests this a valued form of support. People receive support on a range of problems they are facing which include money, housing, mental health and loneliness. The service is a key form of support and can help problems escalating from needing more formal support from mental health services.

11.6.3 Specialist Older Adults Mental Health (SOAMHS)

Specialist support and treatment with both health and social care needs by Sussex Partnership Foundation Trust (SPFT) for:

- older adults experiencing moderate to severe mental health problems
- people who have a diagnosis of Dementia who have complex and challenging needs relating to this.

11.6.4 Ageing Well B&H

A programme of services & activities for people aged 50+ delivered by a partnership of providers lead by Impact Initiatives. It provides activities, including peer support, befriending, cognitive stimulation therapy, cafes and centres, groups and activities, befriending, information and advice, multi-cultural activities, LGBTQ+ specific activities, and access to resources.

11.6.5 Carers Hub

Is a partnership of three local charities and local authority assessment staff, who have been commissioned to create a central point for unpaid carers, to get the information and support they need. Carers Hub aims to improve the quality of life of carers in Brighton & Hove by offering a wide range of services and comprehensive local resources for carers of all ages.

11.6.6 Contact with secondary mental health services

See earlier section

11.7 Opportunities to learn more

- Adult and Older Adult Community Mental Health Transformation Programme
- Development of the Brighton & Hove Dementia and Ageing Friendly City Action Plan being led by Brighton & Hove City Council Public Health team.

11.8 What works for prevention

See Prevention section for more on how these were identified.

Box 6: What works for prevention: older people facing loneliness

There is a need to understand that loneliness applies to some older people but also affects other age groups too such as those who are unemployed, living alone, carers and those who are LGBTQ+.

There is a growing evidence base suggesting that interventions tackling loneliness and isolation in older people can also be protective of both their physical and mental health.

A connected society: A Strategy for tackling loneliness – laying the foundations for change: This strategy is an important first step; government is also committed to long-lasting action to tackle the problem of loneliness.
To tackle loneliness and support people's social connections, we all need to act. This includes government, local authorities, businesses, and the voluntary sector, where there is an opportunity to embed loneliness as a consideration across their work. Alongside this, it is also the responsibility of communities, families, and the individual. By working together, we can help to create a more socially connected society.
Campaigns and awareness raising:

- The Campaign to End Loneliness provides Adult Social Care, Clinical Commissioning Groups, and public health teams with guidance on developing strategies to address loneliness amongst older people in their local populations
- NICE guidance (2015 - see below) outlines principles of good practice to promote older people's independence and wellbeing. Much of which relates to reducing loneliness.

Prevention of mental illness and promotion of good mental health or wellbeing among those facing loneliness:

- The Mental Health Foundation suggest the following to prevent loneliness:
  - Try to do some enjoyable things that will keep you busy
  - Think about doing a physical activity
  - Try to engage with the people you meet in your daily life
  - Find people that 'get you'
  - Spend time with pets
  - Try to use social media in a positive way
  - Talking therapies can help.

- NICE guidance (2015) outlines principles of good practice to promote older people's independence and wellbeing. Consider providing a range of group, one-to-one and volunteering activities that meet the needs and interests of local older people and ensure these:
  - Include a clear description of what is on offer
  - Take place at regular times and in a regular location
  - Provide the opportunity to socialise
  - Complement other activities that may support different aspects of older people's independence and mental wellbeing, such as their physical health.

- Community approaches to reduce isolation in older people that have been found to be effective include befriending and mentoring and social group schemes which incorporate self-help support and peer involvement. One example is the 'Standing Together' peer support service delivered by the Mental Health Foundation. This includes self-help groups to improve the emotional health and reduce loneliness among older people living in supported housing
- Befriending initiatives are potentially of value both to the person being befriended and the befriender
- Additional recommendations to reduce loneliness include building a greener living environment that supports social contact and ensuring that everyone has access to digital communication technology. Also, staying in touch with friends and family, volunteering, visiting a senior centre, and joining a group are useful strategies
- There is evidence that psychological therapies delivered to at risk populations such as the bereaved can be cost-effective and protect mental health
- Involve new technologies such as assistive technology (eg Alexa), games consoles and internet-based communication.

More evidence needed:

- Volunteering is beneficial although there is less evidence of its effects on reducing isolation among older people.

Box 7: what works for prevention: older people with long term conditions

System recommendations:

- Promote better integration between mental health support and primary care and chronic disease management programmes, with closer working between mental health specialists and other professionals
- Improve collaborative care arrangements between primary care and mental health specialists
- Clinical Commissioning Groups integrating mental and physical health care more closely as a key part of their strategies to improve quality and productivity in health care
- Create Dementia Friendly Communities and then adopt the Dementia Friends initiative which aims to change people's perceptions of dementia and to change the way the nation thinks, talks, and acts about the condition.

Prevention of mental illness and promotion of good mental health or wellbeing among those with long-term conditions:

- Protecting the mental health of people living with long-term health conditions shows promising evidence from brief psychological support such as CBT or mindfulness-based therapy
- Provide access to evidence-based interventions to prevent depression developing in older people, by:

- Providing Mental Health First Aid training to enable services in contact with older people to respond to distress
- Providing brief intervention approaches for people with physical health problems who are experiencing depressive symptoms
- Creating local service pathways for older people who often encounter significant barriers in accessing help to ensure that they have timely access to stepped care approaches, including CBT and psychotherapy
- Developing initiatives that aim to improve mood and social connectedness including for those with dementia
- Promoting the development of dementia friendly communities.

- Adopt integrated approaches to health and mental health for older people who can experience higher rates of co-morbid mental and physical health problems, including by providing reminiscence therapy for older people in health care settings and developing physical activity programmes.

12 Recommendations

Delivery of the seven recommendation areas will be overseen by the Brighton and Hove Health and Care Partnership, with actions specific to Children and Young People or Adults directed through the relevant place based oversight board. The Brighton and Hove Health and Care Partnership is a place-based partnership bringing together NHS Sussex (Brighton and Hove), University Hospitals Sussex NHS Trust, Brighton & Hove City Council, Sussex Community Foundation Trust, and Sussex Partnership Foundation NHS Trust, Community Works (Representing the Voluntary and Community Sector), Primary Care Networks (PCNs) - General Practice, patients and the public.

Reducing inequalities needs to be at the heart of tackling and improving the mental health of the population of Brighton & Hove and this is embedded in each of the recommendation areas. There are tools that can assist in assessing impact of proposals on health inequalities.

Area 1: Population prevention. Develop and promote a population wellbeing approach encompassing the building blocks of health

Area 2: Communities. Co-production and co-design of mental health services with people with lived experience, community development and VCSE sector provision

Area 3: Whole System working. Develop pathways that encompass all levels of mental health need with a focus on early intervention. Develop trauma-informed pathways that support individuals in a holistic way

Area 4: Transform mental health services to take account of current unmet need and predicted growing future need and to improve accessibility (in context of Area 4 – Whole System Working)

Area 5: Children and Young people. Improve the care and support offer for young people ensuring that they and their families are at the heart of an integrated service approach

Area 6: Information sharing. Improve monitoring and information sharing across the system to improve quality of care, planning and decision making

Area 7: Inequalities, influence and implementation

We sought to take account of what is already happening to improve outcomes and reduce inequalities so that recommendations are focussed on areas that have the greatest additional impact.

Area 1: Population prevention. Develop and promote a population wellbeing approach encompassing the building blocks of health

No.	Recommendation
1.1	Strengthen our city-wide prevention-focused approach to improving population wellbeing and reducing inequalities. The Brighton & Hove Health and Care Partnership, linking with cross sector city organisations, should consider options for achieving this, for example utilising the national Prevention Concordat for Better Mental Health. The approach to include: • Increasing awareness that experiences in childhood, particularly the first 1,000 days from conception to 2 years, lay down the foundations of life-long wellbeing • Increasing awareness that mental health is everyone's responsibility and that the key building blocks of health are the social determinants such as employment, debt, income, education, housing, community cohesion, access to green spaces etc • Increasing awareness of what people can do to make a difference to population mental health and wellbeing • Strengthening whole system approaches to reducing stigma.

Context

- An individuals' mental health is determined by past and present experiences and the circumstances of their daily life such as housing, income, education, access to green spaces etc. These are the building blocks of health
- Adopting a prevention approach that focuses on the building blocks of health is cost effective.
- In the city, there is high need and inequalities, and these have been exacerbated by the impacts of Covid, the cost of living crisis and climate change. Workforce challenges make it difficult to meet current and future need
- Decision makers are not always fully aware of what works and how they can bring about desired change and there are challenges in taking a prevention approach
- Commissioning often focuses on treatment and acute care in part because many of the NHS targets are about treatments. A greater focus on prevention is needed
- The Prevention Concordat is a national evidence-based prevention-focused framework.
- Commitment to, and championing of, a population prevention approach, with tools for system leaders, commissioners, and planners to understand and implement prevention measures could lead to large improvements in mental health and reduce health inequalities.

Area 2: Communities. Co-production and co-design of mental health services with people with lived experience, community development and VCSE sector provision

No	Recommendation
2.1	Commissioners and providers to ensure co-production with experts by experience, including parents and carers, is a fundamental part of all redesigned/transformed mental health pathways working as equal partners from the beginning. Seek to engage with marginalised communities and seldom heard voices including care leavers and children in care
2.2	Ensure co-production best practice is embedded in all aspects of mental health commissioning (both NHS and Local Authority). Start by mapping co-production across the system
2.3	Ensure more peer support opportunities are built into commissioning and delivery.
2.4	Promote community development. Support communities to build on their assets and strengths so that they can improve their local mental health outcomes or the factors that affect their mental health. Consider geographical communities and communities whose voices are less often heard.
2.5	Strengthen VCSE sector provision, including support for smaller organisations. Commission and develop VCSE sector as essential providers in mental health and wellbeing pathways, as equal partners with statutory services and as trusted advocates for their communities.

Context

- Co-production with people with lived experience of services, their families and carers is a key principle of the national Five Year Forward View for Mental Health and improves outcomes
- Co-production is when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered.
- When asked for their views, children and young people and adults with lived experience said they wanted to see more involvement of peers and people with lived experience in developing and commissioning services and more peer support
- Whilst the JSNA found some examples of co-production, it was patchy and far from universal. For some services there was no routine engagement. Some communities had little or no opportunities to express their views
- Children and young who are looked after or are care leavers are at greater risk of developing mental health problems and need strong advocacy - the CIC (children in Care) council and the care leavers forum are opportunities to engage with this group.
- When there was engagement, people with lived experience were not always included from the outset of new commissioning proposals.
- The voluntary, community and social enterprise (VCSE) sector is broad and encompasses independent organisations working with a social purpose. They range from small community based groups or schemes through to larger charities and

organisations that may operate locally, regionally or nationally. The city has a strong and vibrant VCSE sector.

- The VCSE sectors plays a key role in improving health, wellbeing and care outcomes and tackling health inequalities. They do this not only by delivering services but also by shaping their design and advocating for, representing and amplifying the voice of service users, patients and carers. Their input is essential to a vibrant local health economy.

Area 3: Whole System working. Develop pathways that encompass all levels of mental health need with a focus on early intervention. Develop trauma-informed pathways that support individuals in a holistic way

No.	Recommendation
3.1	New mental health service developments, transformation work and reviews of existing services and pathways should take a trauma-informed whole systems approach. To be modelled by senior leaders and at all levels of organisational delivery. • Co-production with people with lived experience and their families and carers • Consider differing levels of need: universal support, early help, and specialist services. • Consider other needs eg substance misuse, physical health, social care, homelessness, criminal justice, healthy lifestyles. • Consider role of different sectors in providing mental health support including community groups and the voluntary, community and social enterprise (VCSE) sector • Consider role of different settings eg schools, colleges, and workplaces
3.2	Commissioners and providers to ensure that there is good communication between mental health and other services eg substance misuse, physical health, social care, homelessness, criminal justice to ensure care is provided holistically, takes account of all needs, and considers mental health in the context of what has happened to an individual (possible trauma history or adverse childhood experiences) and their whole needs.
3.3	Organisations, commissioners and providers to ensure that staff wellbeing is a priority - there are evidence based whole workplace approaches in place to promote wellbeing
3.4	Commissioners and providers to ensure universal and specialist services such as substance misuse, physical health, healthy child programme, social care, homelessness, criminal justice etc. routinely identify mental health need and where appropriate, offer brief interventions, and/or refer onwards.
3.5	Through training, increase the mental health and trauma-informed knowledge, skills and confidence of workforces both in mental health services in other sectors for example physical health services, substance misuse services, social care, housing, education etc. consider, for example, Mental Health First Aid training, suicide prevention, trauma informed approaches etc
4.6	Support the continued embedding of Trauma Informed Care, Practice and Values across the Brighton and Hove Health and Care Partnership and extend the Sussex wide Trauma Informed Care (TIC) programme to wider workforces for example blue light services, housing, education

Context

- Commitment to whole systems working is required at all levels within organisations: at a strategic level, modelled by senior managers, by team managers and team members
- An individual's mental health and wellbeing changes over time and the level and intensity of support needed varies. Early intervention can prevent problems from getting worse. Good and sustained support after a period of intense need can help a person to stay well
- Promoting population wellbeing and preventing mental illness is complex and requires a dynamic way of working in partnership with a broad range of stakeholders
- Many people with mental health conditions have experienced trauma which can impact on their ability to access and engage with services. Taking a trauma informed approach to care and practice can help improve patient engagement, treatment adherence and health outcomes, as well as provider and staff wellness.
- Many people with mental health conditions have other needs. Their needs may impact on their family and friends. For example, a parent with severe mental illness who has a housing problem and whose child is having difficulties at school may need support not only from mental health but also potentially housing, social care, the school
- Outcomes are improved if a persons' multiple needs are considered holistically and where there is a diverse and varied offer of support
- Trauma informed care can help reduce burnout among health and social care providers, potentially reducing staff turnover. Trauma Informed care seeks to:
    - **Realise** the widespread impact of trauma and understand paths for recovery
    - **Recognise** the signs and symptoms of trauma in patients, families and staff
    - **Respond** through integrating knowledge about trauma into policies, procedures and practices and
    - Actively avoid **Re-traumatisation**.

  Trauma informed services are also **Reflective** in their practice, which involves curiosity about ourselves in the work we do. With a fundamental focus on **Relationships** at the heart of our work.
- Better join up is needed across eg: Mental health and physical health; Substance misuse and mental health; People with multiple disadvantage (homelessness / domestic violence / criminal justice / mental health).

Area 4: Transform mental health services to take account of current unmet need and predicted growing future need and to improve accessibility (in context of Area 3 – Whole System Working)

No.	Recommendation
4.1	Brighton & Hove City Council and NHS Sussex commissioners to strengthen their use of intelligence (data, stakeholder views, and evidence of what works) to inform the development of services in order to make best use of resources in responding to current and emerging needs and focusing on early intervention and prevention.
4.2	Commissioners and providers to raise awareness of existing services and pathways so that those referring to and those needing services know where to go and how to access them. Promote via channels that are relevant to different communities. Promote to groups with higher need or poorer access, including: • LGBTQ+ • Ethnic Minority groups • Young people and young adults • Children in care and care leavers • Those less digitally literate eg people with learning disability, older people.
4.3	Shift the balance of investment to increase support for children and young people with mental health and wellbeing problems to bring a lifetime of benefits to young people, their families, communities and the economy.
4.4	Agree priorities for health and care commissioners and providers to work together to address areas where there is significant potential to improve performance. For example: • Long waiting lists for some services • Excess deaths in people with SMI under 75 years old. • People newly diagnosed with depression have lower rates of review by their GP 10-56 days after diagnosis. • Gaps between services for example between primary and second mental health services for adults.

Context

- The needs assessment provides evidence of very high need in the city – both in terms of the numbers of people affected, but also relative to England – and this need is growing.
- It is estimated that in Brighton and Hove, 1 in 5 adults have common mental health disorders, higher than the national average of 1 in 6
- Several crises are unfolding that increase need and increase inequalities including Covid, the cost of living crisis and climate change. Workforce challenges continue to put pressure on service capacity and quality
- The needs assessment highlighted service challenges including long waiting lists, unclear referral pathways, need for comprehensive information and support for greater advocacy

- Some services were highlighted as having very long waiting lists: assessment for neurodivergence such as ASC (autistic spectrum conditions) and ADHD (attention deficit hyperactivity disorder), eating disorder and complex trauma
- There is a lot of work underway to transform services – much of it under the umbrella of the Adult Community Transformation Programme
    - Crisis care; Complex trauma
    - All ages Sussex Eating Disorder
    - Physical health checks for those with serious mental illness
    - Trauma Informed Care (TIC).

Area 5: Children and Young people. Improve the care and support offer for young people ensuring that they and their families are at the heart of an integrated service approach

No.	Recommendation
5.1	Adult and children mental health services should have a dedicated transition function to ensure there is continuity of care for young people.
5.2	Ensure that mental health services are tailored to needs of young people particularly those aged 16 to 25.
5.3	Commissioners and providers to ensure adult and children's mental health services take a whole family approach to mental health. For example, adults' services to take account of the potential impact of poor parental mental health on children and vice versa.
5.4	Expand capacity to meet unmet need in children and young people. In particular in areas where there are rapidly growing needs or large unmet need such as substance use, eating disorder, neurodivergence assessment, self-harm, body image.

Context

- The needs assessment provides evidence of very high risk factors and need in the city – both in terms of the numbers of people affected, but also relative to England. It also provides evidence of increases in need.
- The first 1,000 days (from conception through to age 2) are crucial in laying down foundations for lifelong wellbeing. Support to families in this period is paramount
- Around half of lifetime mental health problems are established by age 14 and three quarters by age 24
- Young adulthood (age 16 to 25) is a key age: Mental health problems often arise for the first time; the service offer changes as people turn 18 (25 for people with SEND); capabilities such as planning, self-control, flexibility, awareness, continue to develop significantly up to the mid-twenties; adult and child service criteria differences mean that some people are no longer able to access services.
- The Safe & Well at School Survey shows some groups are more likely to experience negative impacts on their mental health and wellbeing. This includes girls, older pupils and pupils and students who identify as LGB+, Trans and Non-Binary; those who need additional help in school, Young Carers and those who identify as Black or Black British.
- In childhood, living in a difficult situation (parental conflict, domestic violence, parents with mental health and/or substance misuse issues etc.) can be very harmful and sometimes leads to complex trauma which can have lifelong impacts
- There are high waiting times for specialist CAMHS services, in particular for neurodivergence assessment and diagnosis and eating disorder.

Area 6: Information sharing. Improve monitoring and information sharing across the system to improve quality of care, planning and decision making

No	Recommendation
6.1	All contract monitoring should routinely monitor activity by • protected characteristics • whether people are or were in council care • whether people are neurodivergent. • whether adults are parents / carers for children and young people This should include information on referrals, access and outcomes to be able to assess if services are effectively meeting the higher needs of groups more at risk of poor mental health.
6.2	Information held by organisations on their clients and patients with mental health needs should be comprehensive, up to date and shared appropriately and in a timely manner between care providers when it needs to be.
6.3	Locally commissioned Brighton & Hove health surveys should take account of the JSNA findings to better capture the needs of groups identified as more vulnerable to poorer mental health.
6.4	Collection, collation, reporting and analysis of population level data should be improved to maximise opportunities to improve prevention. • Analysis should be conducted of the anonymised Sussex Integrated Dataset to provide a better picture of the mental health needs of the local population and how people are currently accessing services. The inclusion of data from drug and alcohol treatment services in this dataset should be explored • Annual update of mental health profile to be published.

Context

- There is a lack of routine service data to be able to clearly identify trends or to be able to compare service access and quality
- For the most part, we were not able to use routine service data to look at access and outcomes by protected characteristics beyond age and gender
- We are very fortunate to have the Safe and Well at School Survey to give us clear evidence around trends and vulnerable groups of children and young people
- Voice evidence from children and young people, and from other recent JSNAs of adults with physical and mental health conditions and adults with multiple complex needs cited the lack of information sharing across services as a key barrier to good care.
- The Sussex Integrated Dataset provides linked anonymised data to be able to look at all the contacts those with mental health conditions have with services (eg in Primary Care, hospitals and with Specialist Mental Health Services) for the first time.

Area 7: Inequalities, influence and implementation

No	Recommendation
7.1	The Brighton and Hove Health and Care Partnership to oversee the system response to the recommendations by: • developing and monitoring an action plan that identifies which team/ board/organisation/ partnership leads on each action and with goals that are SMART - Specific, Measurable, Achievable, Realistic, and Timely. • Actions specific to Children and Young People or Adults to be directed through the relevant place based oversight boards.
7.2	The findings and recommendations from this JSNA are used by commissioners, providers and decision makers to • improve outcomes and reduce inequalities. • inform relevant strategies, programmes and action plans. At the time of writing these include but are not limited to: ○ Foundations for our Future - Sussex Children and Young Peoples' Emotional Wellbeing and Mental Health Strategy 2022 – 2027 ○ Implementation of the national Mental Health Long Term Plan 2019/20 – 2023/24, including the Adult & Older Adult Community Mental Health Transformation programme ○ Sussex and Brighton and Hove Suicide and Self-harm Prevention Strategy ○ Brighton and Hove Drug Strategy ○ Relevant Brighton & Hove city council corporate and directorate strategies ○ Place Based Plans developed by the Health & Care Partnership ○ Family Hubs Transformation Programme ○ Multiple disadvantage programme
7.3	Commissioners, providers and decision makers across Brighton and Hove Health and Care partnership to ensure appropriate impact assessments are undertaken when commissioning, developing and reviewing programmes, plans, services and policies. Tools include: Equality and Health Inequalities Impact Assessments (EHIAs)/ Equality Impact assessments (EIA) and quality impact assessments (QIAs).

Context

- The Brighton and Hove Health and Care Partnership is a place-based partnership bringing together NHS Sussex (Brighton and Hove), University Hospitals Sussex NHS Trust, Brighton & Hove City Council, Sussex Community Foundation Trust, and Sussex Partnership Foundation NHS Trust, Community Works (Representing the Voluntary and Community Sector), Primary Care Networks (PCNs) - General Practice, patients and the public.
- Delivery of the recommendations will be overseen by the Brighton and Hove Health and Care Partnership with actions specific to Children and Young People or Adults directed through the relevant place based oversight boards

- Reducing inequalities needs to be at the heart of tackling and improving the mental health of the population of Brighton & Hove and this is embedded in each of the recommendation areas. There are tools that can assist in assessing impact of proposals on health inequalities.

13 Glossary

13.1 Common mental health disorders

Depression

Characterised by persistent low mood and a loss of interest and enjoyment in ordinary things Overview | Depression in adults: recognition and management | Guidance | NICE)

Generalised anxiety disorder

Characterised by excessive worry about many different things and difficulty controlling that worry Overview | Generalised anxiety disorder and panic disorder in adults: management | Guidance | NICE

Social anxiety disorder

A persistent and overwhelming fear of a social situation, such as shopping or speaking on the phone which impacts on a person's ability to function effectively in aspects of their daily life Overview | Social anxiety disorder: recognition, assessment and treatment | Guidance | NICE

Panic disorder

People with panic disorder experience repeated and unexpected attacks of intense anxiety Overview | Generalised anxiety disorder and panic disorder in adults: management | Guidance | NICE

Obsessive compulsory disorder

An anxiety condition characterised by the presence of either obsessions (repetitive, intrusive and unwanted thoughts, images or urges) or compulsions (repetitive behaviours or mental acts that a person feels driven to perform), or both Overview | Obsessive-compulsive disorder and body dysmorphic disorder: treatment | Guidance | NICE

Specific phobias

An overwhelming and debilitating fear of an object, place, situation, feeling or animal Overview - Phobias - NHS (www.nhs.uk)

Post-traumatic stress

A set of psychological and physical problems that can develop in response to threatening or distressing events, such as physical, sexual or emotional abuse, severe accidents, disasters and military action Overview | Post-traumatic stress disorder | Guidance | NICE

Health anxiety

A central feature is a persistent preoccupation with the possibility that the person has, or will have, a serious physical health problem Health anxiety - NHS (www.nhs.uk)

13.2 Severe mental illness

Bipolar affective disorder

A potentially lifelong and disabling condition characterised by episodes of mania (abnormally elevated mood or irritability and related symptoms with severe functional impairment or psychotic symptoms for 7 days or more) or hypomania (abnormally elevated mood or irritability and related symptoms with decreased or increased function for 4 days or more) and episodes of depressed mood. Introduction | Bipolar disorder: assessment and management | Guidance | NICE

Schizophrenia

Represents a major psychiatric disorder (or cluster of disorders) in which a person's perception, thoughts, mood and behaviour are significantly altered. Introduction | Psychosis and schizophrenia in adults: prevention and management | Guidance | NICE

Personality disorder

A person with a personality disorder thinks, feels, behaves or relates to others very differently from the average person Personality disorders - NHS (www.nhs.uk)

Severe depressive episodes with or without psychotic episodes

Describes the presentation and impact of severe depression and the range of social, psychological, medication and other interventions Symptoms - Clinical depression - NHS (www.nhs.uk)

Eating disorders

One of the conditions which often begin in childhood but can persist into or develop in adulthood. Eating disorders are also covered in Children and young people life course.

Self-harm

Self-harm is when individuals hurt themselves as a way of dealing with very difficult feelings, painful memories or overwhelming situations and experiences.

13.3 Perinatal mental health conditions:

Adjustment disorders

An unhealthy or excessive emotional or behavioural reaction to a stressful event or change in a person's life such as illness or relationship breakdown.

Depression

A mood disorder that can affect a woman during pregnancy (antenatal) or begins after childbirth (postnatal) and usually lasts beyond six weeks.

Postpartum psychosis

A severe episode of mental illness usually with rapid onset in the days or weeks after giving birth (see Severe Mental Illness for symptoms).

Post-traumatic stress disorder (PTSD)

Nightmares, flashbacks, anger and difficulty concentrating or sleeping; it may be pre-existing or triggered by traumatic labour.[203]

Severe mental illness (SMI)

refers to people with psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired. Can include diagnoses which involve psychosis, most commonly schizophrenia, bipolar disorder and psychotic depression.

13.4 Other definitions:

Disability adjusted life years

Mortality does not give a complete picture of the burden of disease borne by individuals in different populations. The overall burden of disease is assessed using the disability-adjusted life year (DALY), a time-based measure that combines years of life lost due to premature mortality (Years of life lost - YLLs) and years of life lost due to time lived in states of less than full health, or years of healthy life lost due to disability (YLDs). One DALY represents the loss of the equivalent of one year of full health. Using DALYs, the burden of diseases that cause premature death but little disability (such as drowning or measles) can be compared to that of diseases that do not cause death but do cause disability (such as cataract causing blindness).

LGBTQ+

The acronym for Lesbian, Gay, Bi, Trans, Queer, Questioning and Ace (asexual). In this document various acronyms are used according to the specific sexual orientation and gender identities recorded in each piece of research or data. For this reason, the acronyms may vary.

Transition:

Any change or adjustment that impacts individual's life in a significant way. There are several transition periods during the life course:

- from home to early learning and childcare
- starting school
- changing school
- leaving school – University
- Leaving University – Employment
- Leaving school – Employment
- From children's to adult's services
- Geographical transitions
- Care leavers' to adulthood.

14 Appendices

14.1 Appendix 1: Local reports reviewed for the needs assessment

This appendix lists the qualitative and quantitative sources used for this needs assessment, including other relevant reports reviewed.

14.1.1 Qualitative data sources

Year	Report title	Published by	Population
2021	Summary report Speak Your Mind report	WSCC, Brighton & Hove City Council (BHCC) ,NHS, Children First, Priority 1-54	Children and young people
2021	The impact of Covid-19 on LGBTQ people in Brighton & Hove	BHCC, NHS Brighton & Hove CCG, Switchboard	LGBTQ
2021	JSNA Adults with multiple complex needs	Awaiting publication	Adults
2020	Brighton & Hove Hospital Discharge Wellbeing Project (HOPs)	Healthwatch	Adults
2018	JSNA International Migrants	BHCC	Adults
2015	Trans Needs Assessment	BHCC	Trans - All ages
2016	Sexual orientation JSNA	BHCC	LGBTQ - All ages

14.1.2 Quantitative data sources

Data	Organisation	Summary
Fingertips	PHE	Fingertips is the central national data source of indicators across a range of health and wellbeing themes across all areas/regions in England.
Prototype Public Mental Health Dashboard	PHE	This mental health needs assessment tool that brings together and summarises existing evidence, compiled and commissioned by PHE and its partners.
NHS Digital	NHS	NHS Digital is the national body responsible for collecting processing and using data from lots of different organisations that make up the NHS. These include GP Surgeries, hospitals, clinics, care homes, local authorities. IAPT referrals, prescribing data, hospital admissions, A&E attendances, secondary (acute) admissions and inpatients, specialist services and specific activity (eg eating disorders, gender dysphoria, meeting needs of military veterans), people detained under MHA, provider performance reports.
Various datasets	Office for National Statistics	is the UK's largest independent producer of official statistics. Census, Annual Population Survey (APS) is a continuous household survey covering the UK: health, education, religion, employment, unemployment, housing, ethnicity.
Projecting Adult Needs and Service Information (PANSI)	PANSI	It gives easy access to projections of the numbers, characteristics and care needs of people aged 18-64 in England at national, regional, and council level
Projecting Older People Population Information (POPPI)	POPPI	It gives easy access to projections of the numbers, characteristics and care needs of people aged 65 and over
Adult Psychiatric Morbidity Survey	NHS Digital	
Children and Young People Mental Health Survey	NHS Digital	

14.1.3 Other reports reviewed

Year	Report	Published by	Population
2022	Services for Unaccompanied Asylum-seeking Children	NIHR Applied Research Collaboration Kent, Surrey and Sussex	Children and Young people
2022	Suicide Prevention Data	Brighton & Hove City Council	All ages
2022	The Brighton & Hove Mental Health and Housing Plan	Healthwatch	Adults
2022	The Safe and Well School Survey (SAWSS)	Brighton & Hove City Council, University of Sussex	Children and Young people
2021	CYP Digital Mental Health	Kent Surrey Sussex Academic Health Science Network, NIHR Applied Research Collaboration Kent, Surrey and Sussex, e-wellbeing YMCA downslink group	Children and Young people
2021	Covid Social study, Unequal pandemic, fairer recover		All ages
2021	Rapid CYP Mental Health needs assessment	West Sussex City council	Children and Young people
2021	Suicide Prevention Strategy	Brighton & Hove City Council	All ages
2021	Summary report Speak Your Mind report	WSCC, Brighton & Hove City Council (BHCC) ,NHS, Children First, Priority 1-54	Children and Young people
2021	The impact of Covid-19 on LGBTQ people in Brighton & Hove	BHCC, NHS Brighton & Hove CCG, Switchboard	Adults
2020	Brighton & Hove Hospital Discharge	Healthwatch	Adults

	Wellbeing Project (HOPs)		
2020	Brighton & Hove mapping report	Kent Surrey Sussex Academic Health Science Network, NIHR Applied Research Collaboration Kent, Surrey and Sussex	Children and Young people
2020	East Sussex Community Feedback COVID-19 Crisis	People in Partnership	Adults
2018	Brighton and wellbeing – Evaluation report		All ages
2018	Complex Patient Pilot: Evaluation Report	Brighton & Hove City Council	All ages
2018	JSNA International Migrants	Brighton & Hove City Council	Adults
2016	Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England		All ages
2016	Vulnerable migrants JSNA	Brighton & Hove City Council	All ages
2016	Sexual orientation JSNA	Brighton & Hove City Council	All ages
2015	JSNA Trans Needs Assessment	Brighton & Hove City Council	Adults
2013	NEET (Not in Education, Employment, or Training) JSNA	Brighton & Hove City Council	Children and Young people
	National Audit Office (NAO) suicide, Suicide by		Children and Young people

	occupation (ONS) and Suicide amongst young people in B&H		

14.2 Appendix 2: Steering Group Membership and Governance

The needs assessment steering group reported to the Mental Health Oversight Board and Children and Young Person's Health Oversight Board through the Consultant in Public Health and the Head of Mental Health Commissioning. See acknowledgements for report authors.

The voices of those with lived experience were sought through established engagement and co-production forums, review of recent consultation events, reports and JSNA**.**

Membership

Organisation	Role
Brighton & Hove City Council (BHCC) – Public Health	Consultant in Public Health
BHCC – Public Health	JSNA Specialist
BHCC – Public Health	Head of Public Health Intelligence
BHCC – Public Health	Starting Well Programme Manager
BHCC – Adult Social Care	Health and Adult Social Care Commissioning Manager – Mental Health
BHCC – Adult Social Care	General Manager Adult Social Care
BHCC – Families Children and Learning	Assistant Director - Health SEN & Disabilities - Health SEN & Disability Services
BHCC – Families Children and Learning	Assistant Director - Children's Safeguarding & Care
BHCC – Families Children and Learning	Service Manager - Directorate Policy & Business Support
BHCC – Families Children and Learning	Head of School Organisation
NHS Sussex (formerly Brighton and Hove Clinical Commissioning Group (BH CCG))	Head of Mental Health Commissioning
NHS Sussex (formerly BH CCG)	Assistant Head – Mental Health Commissioning
NHS Sussex (formerly BH CCG)	Brighton & Hove Clinical Director Mental Health and Suicide Prevention
NHS Sussex (formerly BH CCG)BH CCG (now ICB)	Brighton & Hove Clinical Director Children and Young People
NHS Sussex (formerly BH CCG)	Senior Quality Manager
NHS Sussex (formerly BH CCG)	Sussex Health and Care Partnership - Health Inequalities and Participation Lead for the Mental Health Collaborative
Sussex Partnership Foundation Trust (SPFT)	SPFT Adults- Deputy Service Director Brighton & Hove CDS
SPFT	SPFT Children - General Manager East Sussex and Brighton & Hove CYPD

SPFT	SPFT - Clinical Lead for the Brighton & Hove Wellbeing Service SPFT
UOK (formerly Community Roots)	Head of Service, Southdown
YMCA Downslink Group	Director for Children and Young People
Community works	CEO
University of Sussex	Head of School of Psychology
University of Sussex	Professor (Honorary Consultant) of Epidemiology & Public Health Medicine (Primary Care & Public Health) Brighton and Sussex Medical School

14.3 Appendix 3: National prevention frameworks

A report was commissioned to examine evidence, mainly sourced from reviews and meta-analyses, to identify public health interventions that can promote good mental health or wellbeing and prevent mental illness. The summaries appear in the boxes entitled “what works for prevention” in the life course sections. This appendix lists the documents that were used in this review.

Title	Author	Date
Public health implementation	Royal College of Psychiatrists	March 2022
The economic case for investing in the prevention of mental health conditions in the UK	LSE and Mental Health Foundations	February 2022
Prevention and mental health: Understanding the evidence so that we can address the greatest health challenge of our time	Mental Health Foundations	2019
Making Prevention Happen	Mental Health Foundations	2020
Mentally healthier council areas Manifesto ideas for the 2022 local authority elections	Centre for Mental Health	March 2022
Mental Health Promotion and prevention		
Prevention First: A Prevention and Promotion Framework for Mental Health	Hunter institute for mental health	2015
Better Mental Health For All: A public health approach to mental health improvement.	Mental Health Foundations	2016
Emotional and Wellbeing support for children and young people	Foundations for our Future	2020

Sources for the “what works for prevention” sections

Title	Author	Date
Mentally healthier council areas: Manifesto ideas for the 2022 local authority elections.’ Centre for Mental Health.	Centre for Mental Health	2022
Reducing Parental Conflict programme evaluation: Third Interim report: findings from the second and third years of delivery	Department for Work and Pensions	2022

What Works and What Doesn't Work? A Systematic Review of Digital Mental Health Interventions for Depression and Anxiety in Young People	Garrido, S., Millington, C., Cheers, D., Boydell, K., Schubert, E., Meade, T., and Nguyen, Q. V.	2019
Reducing loneliness amongst older people: a systematic search and narrative review	Hagan, R., Manktelow, R., Taylor, B.J., and Mallett, J.	2014
Prevention First: A Prevention and Promotion Framework for Mental Health	Hunter Institute	2015
Mental health promotion and mental illness prevention: The economic case London School of Economics and Political Science	The economic case London School of Economics and Political Science	2011
Prevention and mental health: Understanding the evidence so that we can address the greatest health challenge of our times	Mental Health Foundation	2019
The economic case for investing in the prevention of mental health conditions in the UK.	Care Policy and Evaluation Centre, Department of Health Policy, London School of Economics and Political Science	2022
Mental health and prevention: Taking local action for better mental health.	Mental Health Foundation	2016
Review paper on mental health risk and protective factors and interventions	Mental Health Foundation	2015
Better Mental Health For All: A public health approach to mental health improvement	Mental Health Foundation	2016
Mental Health Foundation Strategy 2020-2025 Making Prevention Happen	Mental Health Foundation	2020
All the lonely people	Mental Health Foundation	2022
Long-term conditions and mental health The cost of co-morbidities	The King’s Fund	2012
Older people: independence and mental wellbeing.	NICE	2015
Workplace resources to improve both employee wellbeing and performance: A systematic review and meta-analysis	Nielsen, K., Nielsen, M.B., Ogbonnaya, C., Känsälä, M., Saari, E., and Isaksson, K.	2017
Systematic Review and Meta-Analysis: Effectiveness of Wraparound Care Coordination for Children and Adolescents	Olsen, J. (2021)	2021
Recommendations for the provision of services for childbearing women	Perinatal mental health services	2021
Summary of evidence on public mental health interventions	Royal College of Psychiatrists	2022

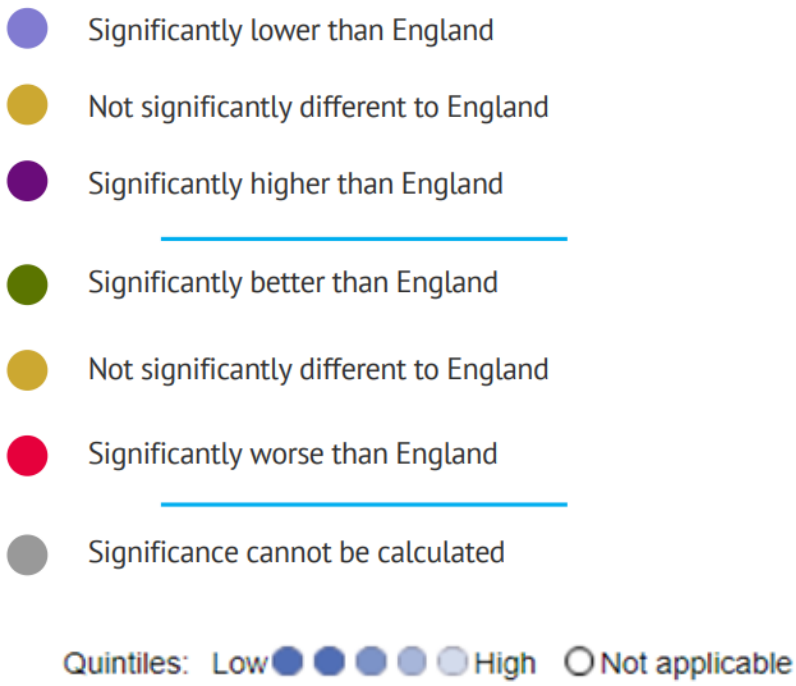
The Independent Review of Mental Health and Employers	Thriving at work	2017

14.4 Appendix 4: Comparator key

Where meaningful, throughout the JSNA we compare the city to other geographies: England; and CIPFA comparators (These are areas with similar population demographics to Brighton & Hove which allows better comparisons of outcomes and performance. The comparator local authorities for Brighton & Hove are: Bournemouth, Bristol, Coventry, Leeds, Medway, Newcastle upon Tyne, North Tyneside, Nottingham, Plymouth, Portsmouth, Sheffield, Southampton, Southend-on-Sea, Swindon, York).

Throughout the needs assessment, the colours used for comparison to England are based upon whether Brighton & Hove is statistically significantly lower / higher or better / worse than England (where this judgement can be made).

Key:



Recent trends:



14.6 Appendix 5: Summary of impacts of COVID-19 pandemic by life stage

This section provides evidence on impact from Covid19 on each life stage from a rapid review of the evidence in June-July 2022

Perinatal mental health	**Children and young people**
Women and their families faced extra pressures on their mental health, such as anxiety about giving birth during lockdown or about becoming unwell, fears about losing employment, and increasing levels of domestic violence. The impact was unequal with women from ethnic minorities and those more socioeconomically deprived disproportionately affected.[204] Changes to service provision meant that women were not able to access appropriate mental health care. Informal support from friends and family was also drastically reduced.[205] As a result of changes to mental health and other health and social care services during the pandemic, healthcare staff reported feeling less able to assess women, particularly their relationship with their baby. Reduced face-to-face contact made it harder to detect easy signs of mental health issues.[206]	Some children and young people's mental health and wellbeing has been substantially impacted due to and during the pandemic. Some children and young people coped well as life satisfaction only slightly reduced and happiness was relatively stable. It was females and those with pre-existing mental health issues who experienced more negative impacts, compared to pre-pandemic.[207] However, children and young people also appeared to have experienced a reduction in mental health symptoms as restrictions eased.[208] Children's social and emotional development, and language and physical development was negatively affected.[209] For many, school closures meant increased food insecurity, missed learning as well as the loss of important sources of emotional support. Levels of psychological distress among 18–24 year-olds had almost doubled in April 2020 compared with 2017/18. Loss of employment was significantly higher among young people. Young people from a Black background were more likely to have reduced employment than their white peers.[210] There was an increase in children with SEND experiencing worsening mental health, including anxiety, feeling unhappy and being more isolated.[211]
Working age adults	**Older people**
The COVID-19 pandemic has had a significant impact on the mental health of the population, through increased exposure to stressors. The prevalence of psychological distress in adults significantly rose from 21% in September	One pre-existing cohort study (with a convenience sample) that focuses on older adults (aged 50+) found slight increases in average self-reported depression and anxiety symptoms and that these were associated with

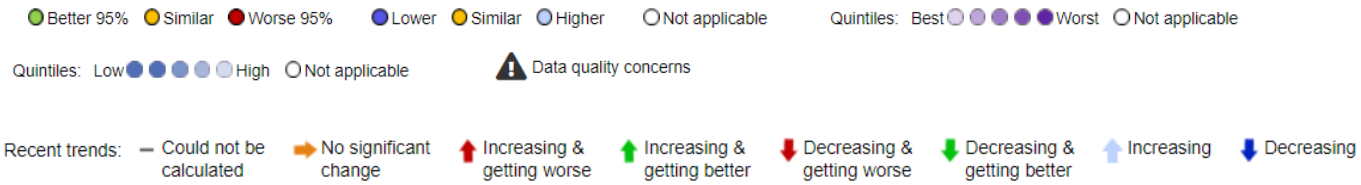
2020 to 27% in January 2021.[212] Particular issues include: • Social isolation disproportionately affected working age adults who live alone, the poor and people in rented accommodation • Jobs and financial losses have increased during the pandemic • Loss of regular coping mechanisms to relieve anxiety, like taking regular exercise, easy access to outdoor space and seeing friends and family [213] • Bereavement has affected many people. Additionally, there has been limited ability to spend time with loved ones and have the usual funeral arrangements, disrupting grieving processes[214] • Work-related stress and trauma, particularly for those working in frontline/ essential roles during the pandemic, is a risk for post-traumatic stress disorder[215] • Restrictions have increased challenges for carers[216] • Damaging or taking away their support structures of people with long-term mental health issues by.[217] Adults with a learning disability were at even greater risk of dying than those with a physical disability. Many disabled people also experienced a decline in health due to cancellations of treatment, reduced access to health care, or a worsening of conditions from a drop in physical activity and were six times more likely to report feeling depressed than the general public (in June 2020).[218]	loneliness and decreases in physical activity. However, overall levels are lower than those reported by younger adults, and these have been consistently low for the last five years.[219] The Understanding Society cohort, study however suggests that, among people aged 55 and over there was no evidence of a change in mental health and wellbeing due to Covid.[220]

14.7 Appendix 6: Risk and protective factors indicators

These tables give comparative data for Brighton & Hove, CIPFA comparators and England, as well as trend for identified risk and protective factors which can be measured and compared. They are drawn from the Office for Health Improvement and Disparities profiles (links provided in each section to relevant profiles).

14.7.1 Common risk factors

Indicators of common risk factors for mental wellbeing, Brighton & Hove, CIPFA comparators and England, various dates (see table)



Indicator	Period	Count	Trend	Rate		
				B&H	Eng.	CIPFA
Children and young people						
Children in low-income families (all dependent children aged < 20) (%)	2016	7,865	↓	16%	17%	-
Low birth weight of term babies (% of live births)	2020	55	→	2.6%	2.9%	-
Reception: % overweight (incl. obesity)	2019/20	275	→	22.6%	23.0%	
Year 6: % overweight (including obesity)	2019/20	660	→	28.3%	35.2%	36.2%
Children in need due to abuse or neglect: rate per 10,000 children aged under 18 years	2018	1,007	–	197.5	181.4	235.0
Children in care: rate per 10,000	2021	373	→	74	67	-
School pupils with social, emotional and mental health needs: %	2020	1,047	↑	3.3%	2.7%	-
Children in need due to family stress or dysfunction or absent parenting: rate per 10,000 children aged under 18 years	2017	718	–	140.0	93.8	79.2

15-year-olds with 3 or more risky behaviours: %	2014/15	-	–	23.7%	15.9%	-
First time entrants to youth justice system: rate per 100,000 10-17 yr olds	2020	32	→	143.7	169.2	-
16–17-year-olds not in education, employment or training (NEET) or whose activity is not known: %	2020	220	→	4.4%	5.5%	-
Physical health						
Percentage of adults (aged 18+) classified as overweight or obese	2019/20	-	–	49.3%	62.8%	-
Deprivation						
Fuel poverty (low income, high-cost methodology): % of households	2018	14,575	→	11.2%	10.3%	-
Employment deprivation: score	2015	-	–	0.112	0.119	-
Deprivation score	2019	-	–	20.8	21.7	
Employment and support allowance claimants	2018	11,690	↓	5.7%	5.4%	5.9%
Housing and employment						
Long term claimants of Jobseeker's allowance	2020	281	↓	1.4	2.6	3.2
Statutory homelessness (households in temporary accommodation)	2017/18	1,705	↑	13.2	3.4	2.0
Statutory homelessness (eligible homeless people not in priority need)	2017/18	110	↓	0.8	0.8	-
Housing affordability ratio	2016	-	–	11.2	7.2	-
Crime deprivation score	2015	-	–	0.13	0.01	-
First time offenders	2020	315	↓	120	160	-
Crime, safety and violence						

Domestic abuse-related incidents and crimes per 1,000 population	2020/21	-		22.1 Sussex	30.3	
Violent crime: violence offences per 1,000 population	2020/21	8,593	↑	29.5	29.5	-
Re-offending levels: percentage of offender who reoffend	2018/19	700		32.4%	27.9%	-
Alcohol, drugs and tobacco						
Admission episodes for alcohol related conditions: persons	2018/19	3,852	→	1,580	2,367	-
Admission episodes for alcohol related conditions: male	2018/19	2,451	→	2,149	3,246	-
Admission episodes for alcohol related conditions: female	2018/19	1,401	↓	1,069	1,608	
Estimated prevalence of opiate and/or crack cocaine use	2016/17	2,065		10.0	8.9	10.6
Smoking prevalence in adults (18+) - current smokers: %	2019	42,107		17.5%	13.9%	-
Smoking status at the time of delivery: %	2020/21	131	→	5.9%	9.6%	-
Smoking status in adults with anxiety or depression (18+) - current smokers: %	2016/17	-		26.9%	25.8%	-
Smoking status in adults with a long-term mental health condition (18+) - current smokers: %	2019/20	-		32.4%	25.8%	-
Drugs related deaths	2018-20	95		10.9%	5%	-
Other risk factors						
Statutory homelessness: rate per 1,000 households	2017/18	492	→	3.8	2.4	2.5
Children leaving care: rate per 10,000 children aged under 18	2017/18	176	→	34.5	25.2	30.1

Migrant GP registrations: rate per 1,000 population	2017	5,906	↓	20.5	12.6	17.8
Children subject to a child protection plan with initial category of abuse: rate per 10,000 children aged under 18	2018	186	–	36.5	21.2	28.1
Children subject to a child protection plan with initial category of neglect: rate per 10,000 children aged < 18	2018	169	–	33.1	21.8	23.5
Children who started to be looked after due to abuse or neglect: rate per 10,000 children aged < 18	2018	91	–	17.8	16.4	21.0
Looked after children aged under 5: rate per 10,000 population aged < 5	2017/18	58	–	41.0	34.9	42.0

Source: Office for Health Improvement and Disparities. Mental health and wellbeing JSNA profile. Available at: Mental Health and Wellbeing JSNA - OHID (phe.org.uk)

Indicators of common protective factors for mental wellbeing, Brighton & Hove, and England (where available), various dates (see table)

Better 95% Similar Worse 95% Lower Similar Higher Not applicable Quintiles: Best Worst Not applicable

Quintiles: Low High Not applicable Data quality concerns

Indicator	Period	Count	Trend	Rate		
				B&H	Eng.	CIPFA
Community resilience / social capital						
% of adults satisfied with Brighton & Hove as a place to live[1]	2018	-	-	88%	-	
% of adults satisfied with their local area as a place to live [1]	2018	-	-	89%	78%	
% of adults who say they have enough money to meet basic living costs [1]	2018	-	-	66%	-	

% of adults who feel they belong in their neighbourhood [1]	2018	-	-	76%	62%	
% of adults who think that people from different backgrounds get on well together in their neighbourhood[1]	2018	-	-	94%	82%	
% of adults who think that people pull together to improve their neighbourhood [1]	2018	-	-	76%	59%	
% of residents who say they have given unpaid help to groups, clubs or organisations in the past year [1]	2018	-	-	44%	38%	
Education and employment						
School readiness: % of children achieving a good level of development at the end of reception	2018/19	1,888	↑	71.5%	71.8%	69.9%
Average attainment 8 score	2020/21	111,523	–	52.4	50.9	-
Average attainment 8 score of children in care	2020	790	–	23.9	21.4	-
Percentage of people in employment	2020/21	157,600	→	76.3%	75.1%	-
Outdoor space and physical activity						
Utilisation of outdoor space for exercise/health reasons	2015/16		–	18.3%	17.9%	-
Percentage of physically active adults	2019/20		–	71.9%	66.4%	-
Social contact						
Percentage of adult social care users who have as much social contact as they would like (18+ yrs)	2019/20	1,455	–	42.8%	45.9%	44.1%
Percentage of adult carers who have as much social contact as they would like (18+ yrs)	2018/19	135	–	36.3%	32.5%	32.5%
Indicators for elsewhere:						

Satisfaction with local mental health services [1]	2018			63%	-	

Source: Office for Health Improvement and Disparities. Mental health and wellbeing JSNA profile: Protective factors. Available at: Mental Health and Wellbeing JSNA - OHID (phe.org.uk)
Unless otherwise stated

[1] Brighton & Hove City Council: City Tracker Survey 2018. Available at SURVEYS | BH Connected

14.7.2Perinatal mental health

Risk factors for maternal mental ill health issues, Brighton & Hove, England and CIPFA comparators, various dates

Better 95% Similar Worse 95% Lower Similar Higher Not applicable Quintiles: Low High Not applicable

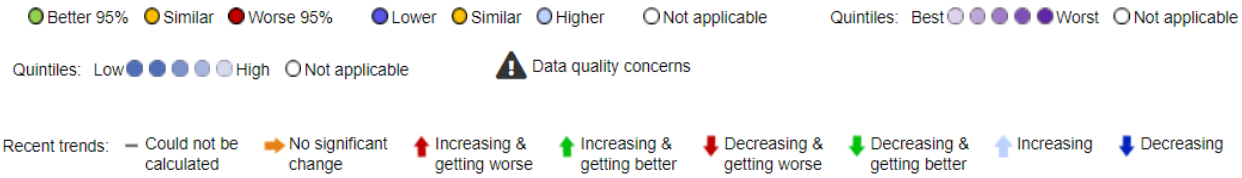
Risk factor	Indicator	Period	Count	Rate		
				B&H	Eng.	CIPFA
Poverty	Children in low-income families (all dependent children aged under 20)	2016	-	16%	17%	-
Migration status	Percentage of births to non-UK mothers	2020		28%	29% (E&W)	-
Ethnicity[221, 222,223]	Percentage of births to mothers from Black and Ethnic Minority Groups	2019/20	330	15%	20%	-
Lone parenthood [224]	Percentage of births registered to a sole parent	2017	138	5%	5%	6%
	Lone parent families (% of households)	2011	8,637	7.1%	7.1%	7.6%
Alcohol or drug abuse	Estimated number of alcohol dependent adults living with children per 1,000 population[c]	2018-19	788	3	3	3
	Estimated number of opiate dependent adults living with children per 1,000 population	2014-15	470	2	2	3
Exposure to violence[225]	Domestic abuse-related incidents and crimes per 1,000 population	2020/21	-	22.1 (Sussex)	30.3	-
Bereavement by miscarriage, stillbirth or neonatal death[226,227]	Still births per 1,000 live births	2017-2019	27	3.5	4	4
	Infant deaths per 1,000 live births	2018-2020	24	3.3	3.3	-

[c] Public Health England. Parents with problem alcohol and drug use: Data for England and Brighton & Hove, 2019 to 2020. Accessed 24/03/2022. Available at Parents with problem alcohol and drug use: Data for England and Brighton & Hove, 2019 to 2020 (ndtms.net)

Source: Office for Health Improvement and Disparities. Perinatal mental health profile. Available at: Perinatal Mental Health - OHID (phe.org.uk) unless otherwise stated

14.7.3Children and young people

Indicators of common risk factors for children and young people's mental wellbeing, Brighton & Hove, CIPFA comparators and England, various dates (see table)



Indicator	Period	Count	Trend	Rate		
				B&H	Eng.	CIPFA
Children in low-income families (all dependent children aged < 20) (%)	2016	7,865	↓	16%	17%	-
Low birth weight of term babies (% of live births)	2020	55	→	2.6%	2.9%	-
Reception: % overweight (incl. obesity)	2019/20	275	→	22.6%	23.0%	
Year 6: % overweight (including obesity)	2019/20	660	→	28.3%	35.2%	36.2%
Children in need due to abuse or neglect: rate per 10,000 children aged under 18 years	2018	1,007	–	197.5	181.4	235.0
Children in care: rate per 10,000	2021	373	→	74	67	-
School pupils with social, emotional and mental health needs: %	2020	1,047	↑	3.3%	2.7%	-
Children in need due to family stress or dysfunction or absent parenting: rate per 10,000 children aged under 18 years	2017	718	–	140.0	93.8	79.2
15-year-olds with 3 or more risky behaviours: %	2014/15	-	–	23.7%	15.9%	-
First time entrants to youth justice system: rate per 100,000 10-17 yr olds	2020	32	→	143.7	169.2	-
16–17-year-olds not in education, employment or training (NEET) or whose activity is not known: %	2020	220	→	4.4%	5.5%	-

Children leaving care: rate per 10,000 children aged under 18	2017/18	176	→	34.5	25.2	30.1
Children subject to a child protection plan with initial category of abuse: rate per 10,000 children aged under 18	2018	186	–	36.5	21.2	28.1
Children subject to a child protection plan with initial category of neglect: rate per 10,000 children aged < 18	2018	169	–	33.1	21.8	23.5
Children who started to be looked after due to abuse or neglect: rate per 10,000 children aged < 18	2018	91	–	17.8	16.4	21.0
Looked after children aged under 5: rate per 10,000 population aged < 5	2017/18	58	–	41.0	34.9	42.0

Source: Office for Health Improvement and Disparities. Mental health and wellbeing JSNA profile. Available at: Mental Health and Wellbeing JSNA - OHID (phe.org.uk)

Indicators of common protective factors for children and young people's mental wellbeing, Brighton & Hove, and England (where available), various dates (see table)

Better 95% Similar Worse 95% Lower Similar Higher Not applicable Quintiles: Best Worst Not applicable

Quintiles: Low High Not applicable Data quality concerns

Indicator	Period	Count	Trend	Rate		
				B&H	Eng.	CIPFA
School readiness: % of children achieving a good level of development at the end of reception	2018/19	1,888	↑	71.5%	71.8%	69.9%
Average attainment 8 score	2020/21	111,523	–	52.4	50.9	-
Average attainment 8 score of children in care	2020	790	–	23.9	21.4	-
Mean score of the 14 Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) statements at age 15	2014/15	-	–	47.1	74.6	-

Source: Office for Health Improvement and Disparities. Mental health and wellbeing JSNA profile: Protective factors. Available at: Mental Health and Wellbeing JSNA - OHID (phe.org.uk)

14.7.4Working age adults

Covered in common risk and protective factors

14.7.5Older people

Risk and protective factors for older people's mental health, Brighton & Hove, Various dates

Indicator	Period	Count	Trend	Rate		
		B&H	B&H	B&H	Eng.	CIPFA
Older people in poverty: Income deprivation affecting older people index (IDAOPI)	2019	9,271		18.7%	14.2%	-
Fuel poverty (low income, high-cost methodology)	2018	14,575	→	11.2%	10.3%	-
Older people living alone: % of households occupied by a single person aged 65 or over	2011	14,468		11.9%	12.4%	12.0%
Percentage of the total population aged 80 or over	2020	11,200		3.8%	5.0%	-
Percentage of population aged 65+ who are carers	2011	4,527		12.7%	13.8%	
Percentage of adult social care users who have as much social contact as they would like (65+ yrs)	2019/20	750	→	41.1%	43.4%	42.6%
Percentage of adult carers who have as much social contact as they would like (65+ yrs)	2018/19	75		41.5%	34.5%	33.5%
Healthy life expectancy at 65 (male)	2017-2019	-		11.5	10.6	-
Healthy life expectancy at 65 (female)	2017-2019	-		12.3	11.1	
Permanent admissions to residential and nursing care homes per 100,000 aged 65+	2020/21	256	→	656	498	-
Hospital admission episodes for alcohol related conditions (narrow definition) 65+ years: age standardised rate per 100,000 population (Persons)	2019/20	274		713	839	-
Males	2019/20	211		1,171	1,334	-
Females	2019/20	62		306	420	-
Emergency hospital admissions due to falls in people aged 65+: Directly age standardised rate per 100,000	2019/20	1,010	→	2,415	2,222	-
Dementia: Recorded prevalence rate aged 65+	2020	1,781		4.2%	4.0%	-

Source: Office for Health Improvement and Disparities. Productive Health Ageing Profile Productive Healthy Ageing Profile - OHID (phe.org.uk) unless otherwise stated

14.8 Appendix 7: Priority 154 engagement events

This Appendix provides a list of the various engagement events with young people between 2018 and 2022 which were synthesized for this needs assessment to provide the voice of young people.

Title	Date	Link
Takeover Day: mental health and emotional wellbeing	2018	https://1drv.ms/b/s!AvUpw5WUlW4khbFrhFshStZuSSIdQ?e=edJFIc
Building Connections: Youth Loneliness	2019	https://1drv.ms/b/s!AvUpw5WUlW4kha9MdF_tMYpEeErF-A?e=LPGQXl
Foundations for Our Futures Away Day	2022	https://1drv.ms/w/s!AvUpw5WUlW4khbFqn5q-CKKG2-zPLA?e=DzHJ7Y
Speak Your Mind: MHST project	2021	https://1drv.ms/b/s!AvUpw5WUlW4khaMnyyjReVZvGtr5vw?e=KaQNvp
Connecting Mind: MHST project	2022	https://1drv.ms/b/s!AvUpw5WUlW4khaMjNLo7gNmSc80N3w?e=VkAVqY
Supporting Early Eating Disorders	2022	https://1drv.ms/b/s!AvUpw5WUlW4khaUnywM-1Px3k482g?e=Tb6goY
Smooth Moves to Secondary School	2022	https://1drv.ms/b/s!AvUpw5WUlW4khaMp905b8Uz9B8yhHA?e=TnNRlO

14.9 Appendix 8: Summary of key outcome measures for mental health

These tables give comparative data for Brighton & Hove, CIPFA comparators and England, as well as trend for identified outcome measures which can be measured and compared. They are drawn from the Office for Health Improvement and Disparities profiles (links provided in each section to relevant profiles).

Summary of key outcome measures for mental health, Brighton & Hove, CIPFA comparators and England, various dates (see table)

Indicator	Period	Count	Trend	Rate		
		B&H	B&H	B&H	Eng.	CIPFA
Self-harm						
Emergency hospital admissions for intentional self-harm	2020/21	900	↓	265.1	181.2	-
Mental health related care						
Successful completion of drug treatment: opiate users	2020	57	↓	5.0%	4.7%	4.5%
Successful completion of drug treatment: non-opiate users	2020	162	↓	22.8%	33.0%	31.9%
Successful completion of alcohol treatment	2020	166	↓	24.9%	35.3%	34.3%
Satisfaction with social care protection: % of users	2017/18	-	–	87.3%	86.3%	-
Concurrent contact with mental health services and substance misuse services for drug misuse	2016/17	142	–	22.1%	24.3%	19.5%
Concurrent contact with mental health services and substance misuse services for alcohol misuse	2016/17	83	–	20.4%	22.7%	17.4%
Contact with mental health or learning disability services: rate per 1,000 patients on GP practice list aged 18+	2014/15	7,985	–	31.6	38.7	38.0
Admission episodes for mental and behavioural disorders due to use of alcohol (Narrow)	2018/19	209	↓	75.0	75.6	-
Severe mental illness						
Employment of people with mental illness or learning disability: %	2018 Q4	20,400	→	63.1%	48.0%	49.3%

Adults in contact with secondary mental health services who live in stable and appropriate accommodation (persons)	2020/21	-		74.0%	58.0%	-
Adults in contact with secondary mental health services who live in stable and appropriate accommodation (female)	2020/21	-		77.0%	59.0%	-
Adults in contact with secondary mental health services who live in stable and appropriate accommodation (male)	2020/21	-		71.0%	56.0%	-
Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	2019/20	-		66.7	67.2	
Premature mortality in adults with severe mental illness	2018-20	610		120.1	103.6	-
Excess under 75 mortality rate in adults with severe mental illness suicide (SMI)	2018-20	-		433.7%	389.9%	-
Suicide						
Suicide rate	2018-20	102		12.8	10.4	-

Source: Office for Health Improvement and Disparities, Mental Health and Wellbeing JSNA profile

14.10 Appendix 9: Children and young people's mental health services Brighton & Hove

This Appendix gives further detail on the services in Brighton & Hove who support children and young people's mental health.

Service	Offer	Thrive area	Age range
Allsorts	LGBTQ + support and advocacy charity	Thriving, Getting help	No age limit
Audio Active	Social initiative to support young people to reach their potential	Thriving, Getting help	
BHISS	Support for children who need extra help to learn	Getting help, getting more help	0-18
Chathealth	Text based support service	Getting help	
Mental Health Support Team Schools	Target offer aimed at reducing health inequalities: offers Low intensity Cognitive Behavioural Therapy (LI-CBT) informed interventions to young people, support and training to parents/carers and support around whole school approaches to mental health and wellbeing.	Getting help, getting more help	5 to 18
MIND/Young minds	Promotes positive mental health, information advice and guidance	Thriving, Getting help	
Mindout	LGBTQ+ support	Getting help, getting more help	18 +
Safety Net	Advice and guidance around bullying, friendships, feeling safe etc.	Getting help, getting more help	
Samaritans	Listening, signposting advice and guidance	Getting help, getting more help	No age limit
School nurses	Overall child health support and wellbeing	Getting help	0 to 18
Schools Wellbeing Service	Range of work includes 1-1 work, group work, parent/carer consultations, training for parents/carers and school staff. Focussed activities around aspects such as transition stages. Also offer specific interventions around EBSA such as	Getting help, getting more help	5 to 18

	online art therapy, mountain biking, bouldering, and Forest Schools.		
SPFT Specialist CAMHS	Urgent help Service, Home Treatment Team, Duty and Referral, FISS, LD team, Eating disorders service	Getting more help, risk support	0-18
Togetherall	Online community for mental health and wellbeing support	Thriving, Getting help	16+
Winstons Wish	National charity - support to CYP after close bereavement	Getting help, getting more help	0-18
WISE – Child Sexual Exploitation Service (YMCA)	121 long-term support, brief interventions programme, youth volunteering programme, Bespoke and multi-agency training.	Getting help, getting more help	16+
YAC	Youth advice service offers support and guidance including housing, emotional health and wellbeing needs, family mediation etc.	Getting help, getting more help	13 to 25
YAP (Youth Advocacy Project) MIND	Advocacy - care leavers, UASC, under 18's with a disability and social worker, etc		
YMCA Dialogue		Getting help, getting more help	<26
YMCA E-Wellbeing	Digital wellbeing service	Thriving, Getting help	<26
Young Carers	Support and advice for young people with regular caring responsibilities	Thriving, Getting help	8 to 24
Young Minds	Information, advice and guidance - champions mental health	Thriving, Getting help, getting more help	<26
Young Oasis	for young people affected by substance misuse - included therapeutic support, young women's services	Getting help, getting more help	5-25 (service offers vary)
Young Peoples Centre (Impact Initiatives)	Safe social space where young people can access advice, support and Counselling	Getting help, getting more help	13-25

15 References

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Although a formal committee of Brighton & Hove City Council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults and Healthwatch.

Title:	Mental Health & Housing Place Based Plan	
Date of Meeting:	8th November 2022	
Report of:	Executive Director – Health & Adult Social Care	
Contact:	Jenny Knight, Commissioning Manager	Tel: 01273 293081
Email:	jenny.knight@brighton-hove.gov.uk	
Wards Affected:	All	

FOR GENERAL RELEASE

Executive Summary

The links between mental health and housing are well established with good quality housing being a key component in enabling positive mental health and wellbeing. In Brighton & Hove there are high levels of mental health need coupled with pressures on housing with a high-cost competitive housing market and significant issues with rough sleeping and homelessness.

In July 2020 the Sussex Health & Care Partnership (SHCP) published a Strategic Plan for Integrating the Housing and Mental Health systems across Sussex[1]. This plan included the requirement to create mental health and housing plans in each place i.e Brighton & Hove, East & West Sussex. In this context the Brighton & Hove Mental Health and Housing Plan brings together the whole system – Brighton and Hove City Council (Adult Social Care & Housing Department), NHS Sussex and Mental Health Services (both statutory and voluntary) around a shared set of priorities which aim to increase access to support and accommodation provision for those with mental health needs within the city and support better integration of

[1] SHCP, Mental Health & Housing, **A strategic plan for integrating housing and mental health across Sussex, July 2020**

services to improve outcomes for service users.

Glossary of Terms

Delayed transfer of care – when a patient is ready to leave hospital but unable to do so.

Discharge to Assess – short term accommodation or community based support service for individuals being discharged from hospital to support transition and develop an onward accommodation and support plan.

Out of Area Placement – where an individual is placed in accommodation outside of the city

Supported Accommodation – Accommodation with support which can range from high support offering 24 hour staffing to low support offering 1-3 hours floating support per week.

1. Decisions, recommendations and any options

1.1 That the Board notes the content of the report

2. Relevant information

2.1 The Strategic Plan for Integrating the Housing and Mental Health systems across Sussex published in July 2020 laid out 5 strategic objectives:

- **Objective 1:** Create Mental Health and Housing Plans for each place in East Sussex, West Sussex and Brighton & Hove.
- **Objective 2:** Ensure housing expertise is embedded within the new model for community mental health services being developed across the SHCP.
- **Objective 3:** Pilot, evaluate and extend the Discharge to Assess models, building on shared learning across each pilot to optimise outcomes and improve flow and transitions from inpatient provision.
- **Objective 4:** Deliver the ambition to create new integrated models of supported housing for people with multiple and complex needs thereby reducing the need for inappropriate out of area hospital placements and residential care.

• **Objective 5:** Drive forward the integration of housing, social care and mental health clinical services, by supporting Sussex Partnerships NHS FT to establish strategic and operational partnerships with providers of housing and housing services, that improves individual outcomes, service quality and reduces unnecessary variation.

2.2 The Brighton & Hove Mental Health & Housing Plan has been developed with a view to better integrating the work of Adult Social Care, Health and Housing within the city. The plan seeks to develop better links with East and West Sussex while ensuring that it meets the needs of our local population in Brighton & Hove. The development of the Mental Health and Housing Plan has been overseen by the Mental Health Accommodation Group which has representatives from Adult Social Care, NHS Sussex, Housing and Sussex Partnership Foundation Trust and with the support of a Sussex wide place based plan development group.

2.3 The plan and the priorities within it have been developed following

- A review of previous engagement exercises, reports and needs assessments.
- A review of local mental health and housing data.
- Engagement with stakeholders via survey and meetings.
- Engagement with people with mental health needs, their families and carers undertaken by Healthwatch

Findings of the Review and Engagement:

2.4 The information gathered as part of the review and engagement detailed above has been used to develop the priorities for the plan and the actions arising from those priorities. The main findings in the report are:

Waiting Lists & Delayed Transfers of Care

A lack of appropriate accommodation is leading to waiting lists and delayed transfers of care, this includes;

- Lack of High & Medium self-contained supported accommodation leading to increased waiting times and lack of appropriate placements for those with more complex needs.
- High numbers of placements out of area for residential care and supported living.
- Lack of local supported living for those with mental health needs leading to placements in higher cost residential care.
- Lack of accommodation for those with complex support needs.

- Lack of accommodation and support for young people with mental health needs.

Housing and Homelessness

- High numbers of people in the city with multiple and compound needs including mental health with homelessness and substance misuse.
- High numbers of young people (16-25) in young peoples supported accommodation with mental health needs. 60% reporting a mental health need or with a mental health diagnosis but only 12% engaged with mental health services.
- High volume of referrals to the mental health homeless team with 30% of those supported residing in council emergency accommodation and 23% rough sleeping, in short term placements or supported accommodation for homeless people

A number of gaps in provision were identified

- Support is needed from mental health professionals to non-mental health professionals working in supported & emergency accommodation.
- Support needs to be flexible, assertive and personalised.
- There needs to be greater integration of Mental Health & Substance Misuse services especially when working with homeless individuals with complex needs.
- There is a lack of services for young people with Mental Health & Autistic Spectrum Conditions
- It is difficult to access affordable & secure social or private rented accommodation.

Feedback from professionals, users of services, families and carers

2.5 A survey was undertaken asking for the views of mental health professionals, and individuals working with people with mental illness including workers from supported accommodation, housing and charities operating in the city. This consultation found:

- 77% of professionals who responded said it was difficult for their clients to access mental health services, this included people with substance misuse and those whose needs were not deemed high enough.
- 70% of professionals felt their clients would not be able to access appropriate accommodation for their needs, some of the reasons given for this were a lack of affordable accommodation and long waiting lists for self-contained supported accommodation.
- 92% of respondents said they would know where to refer their clients to in a mental health crisis but 52% of those were not confident that their client would receive the help they needed.

- Feedback showed a lack of information and understanding between Housing, Adult Social Care and Mental Health Services of each others remits, services and pathways available.
- Housing workers and those working in supported accommodation feel they are holding high levels of need & risk with little support.

Healthwatch carried out a survey and one to one interviews with people who have mental health needs, their families and carers. They found:

- 58% of respondents found it difficult to access mental health services with reasons including waiting list times & being offered services which had previously not worked.
- Lack of specialist services specifically for Autistic Spectrum Condition.
- 70% of respondents felt listened to and treated with care and concern however 41% of people felt that the support they received did not address their needs or help them make plans to do so.

Feedback regarding supported accommodation for those with mental health needs conducted by Mind found:

- a lack of mobility accessible accommodation
- a lack of self-contained accommodation
- a lack of services which support those with complex needs
- a need for tailored support & training for staff specially those working with individuals with complex needs
- a need for therapeutic support for residents

Priorities

2.6 Five priorities have been identified as part of the Mental Health and Housing Plan. A two year action plan has been developed which has been approved by the Mental Health Oversight Board.

Priority 1: Improve Support to Young People & Transitions

Develop dedicated provision for 18–25-year-olds and improve transition from children's to adult services to support at this vulnerable life stage.

Priority 2: Reduce barriers to hospital discharge

- Improve referral pathways and communication and increase use of out of hospital provision including Discharge to Assess and step-down provision to minimise delayed transfers of care.
- Increase capacity & "appropriateness" of onward accommodation and support offers to people leaving hospital.
- Improve confidence of hospital-based clinicians to discharge into services and remove barriers to earlier, safe discharge.

Priority 3: Improve Connection Between Mental Health, Adult Social Care and Housing to Prevent Homelessness and Improve Mental Wellbeing.

- Improve knowledge and understanding of respective roles and remits.
- Trial collaborative ways of working between clinicians and providers of supported & emergency accommodation to enable mental health to be managed effectively and ensure housing expertise is embedded in mental health services.
- Develop and improve housing pathways & improve access to independent accommodation and support in the community.

Priority 4: Increase the provision of supported accommodation and support for people with mental health and co-existing conditions within Brighton and Hove.

Reduce waiting lists; out of area placements; delayed transfers of care and the risk of acute admissions and homelessness due to inappropriate accommodation placements.

Priority 5: Develop accommodation and support services to meet the needs of people with co-existing conditions & multiple and compound needs.

Particular focus on complexity including people with mental health need who also have Autistic Spectrum Condition and/or Substance Misuse needs.

Next Steps

2.7 The actions within the plan are being taken forward in a number of working groups with monthly oversight of the plan taking place at the Mental Health Accommodation Group. Regular progress reports are also going to the ICB Mental Health & Housing Working Group and the Mental Health Oversight Board.

3. Important considerations and implications

Legal:

3.1 The Council has general duties under the Care Act 2014 to promote individual wellbeing, prevent needs for care and support and promote integration of care and support with health services. The duty applies equally to specific decisions about a person and to policy and strategy. Wellbeing includes mental health and the protection from neglect. Independent living is core to the well-being principle.
s2 Care Act 2014 places a duty on the Council to reduce, prevent or delay the development of needs. With the cooperation of health services, this plan identifies the pathways for suitable accommodation for those with mental

health needs, and allows the Council through consultation to develop clear local plans to deliver the required services to this vulnerable group now and in the future.

Lawyer consulted: Farida Amin Date: 10.10.22

Finance:

3.2 The Mental Health & Housing Place Based Plan has a number of priorities which may impact on budget and resources going forward. Any changes in service delivery for the council will be subject to recommissioning processes and will need to be delivered within the available budget.

Finance Officer consulted: Sophie Warburton Date: 07/10/2022

Equalities:

3.3 An EHIA has been completed. The EHIA along with the consultation and data review has led to specific actions in the plan including the need to develop services for people with mental health needs and co-existing conditions.

Sustainability:

3.4 There are no sustainability implications arising from this report, individual actions within the plan may have implications however these will be dealt with as separate pieces of work and any implications in regard to commissioning or re-procurement will be brought to committee separately.

Supporting documents and information

Appendix1: Brighton & Hove Mental Health & Housing Plan
Appendix 2: EHIA
Appendix 3: Healthwatch Consultation Report
Appendix 4: Mind Supported Accommodation Consultation

Brighton & Hove Mental Health & Housing Plan

Draft: May 2022

Author: **Jenny Knight, Commissioning Manager, Health & Adult Social Care, Brighton & Hove City Council**

Version	Officer	Date
Draft 1	Jenny Knight, Commissioning Manager, Mental Health BHCC	18/05/22
Draft 2 & 3	Emily Ashmore, Commissioning Manager, Mental Health BHCC Josh Hall, Senior Mental Health Commissioner, CCG	19/05/22
Draft 4	Mental Health Accommodation Group	25/05/22
Draft 4	Anne Foster – Head of MH Commissioning CCG Chris Harris – Associate Director of Housing, SPFT	31/05/22
Draft 5	Sylvia Peckham – Head of Temporary & Supported Accommodation, BHCC Emma Gilbert – Tenancy Services Operations Manager Paul Cooper – Assistant Director Housing Needs & Supply	15/06/22
Draft 5	Anne Foster – Head of MH Commissioning CCG	22/06/22
Draft 6	Mental Health Accommodation Group	28/06/22
Draft 7	David Davis – Clinical Director, CCG Anna Gianfrancesco , Assistant Director, Children Families and Learning	30/06/22

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Executive Summary:

The links between mental health and housing are well established with good quality housing being a key component in enabling positive mental health and wellbeing. In Brighton & Hove there are high levels of mental health need coupled with pressures on housing with a high-cost competitive housing market and significant issues with rough sleeping and homelessness. High levels of mental health need and high levels of complexity coupled with difficulties recruiting and retaining sufficient mental health staff create significant pressures on mental health services. A lack of suitable accommodation and housing support leads to people being delayed in hospital at the end of their admission (delayed transfers of care) and waiting lists for housing and accommodation services.

In this context the Brighton & Hove Mental Health and Housing Plan brings together the whole system – Brighton and Hove City Council (Adult Social Care & Housing Department) the Clinical Commissioning Group and Mental Health Services (both statutory and voluntary) around a shared set of priorities which aim to increase access to support and accommodation provision for those with mental health needs within the city and support better integration of services, and improve outcomes for service users.

The Brighton & Hove Mental Health and Housing Plan lays out 5 key priorities for the city, which have been developed following analysis of data and engagement with stakeholders, individuals with mental health needs, their families and carers.

The development of the plan has been overseen by the Brighton & Hove Mental Health Accommodation Group ensuring that key partners have been involved throughout the process.

This document provides:

- an overview of the findings of the data gathering and engagement,
- details of the five identified priorities,
- an action plan to address the priorities including expected outcomes
- governance arrangements for implementing the plan over the next two years.

The five priorities of the Brighton & Hove Mental Health & Housing Plan are:

Priority 1: Improve Support to Young People & Transitions

Develop dedicated provision for 18–25-year-olds and improve transition from children's to adult services to support at this vulnerable life stage.

Priority 2: Reduce barriers to hospital discharge

- Improve referral pathways and communication and increase use of out of hospital provision including Discharge 2 Assess and step down provision to minimise delayed transfers of care.
- Increase capacity & "appropriateness" of onward accommodation and support offers to people leaving hospital.
- Improve confidence of hospital-based clinicians to discharge into services and remove barriers to earlier, safe discharge.

Priority 3: Improve Connection Between Mental Health, Adult Social Care and Housing to Prevent Homelessness and Improve Mental Wellbeing.

- Improve knowledge and understanding of respective roles and remits.
- Trial collaborative ways of working between clinicians and providers of supported & emergency accommodation to enable mental health to be managed effectively and ensure housing expertise is embedded in mental health services.
- Develop and improve housing pathways & improve access to independent accommodation and support in the community.

Priority 4: Increase the provision of supported accommodation and support for people with mental health and co-existing conditions within Brighton and Hove.

Reduce waiting lists; out of area placements; delayed transfers of care and the risk of acute admissions and homelessness due to inappropriate accommodation placements.

Priority 5: Develop accommodation and support services to meet the needs of people with co-existing conditions & multiple and compound needs.

Particular focus on complexity including people with mental health need who also have Autistic Spectrum Condition and/or Substance Misuse needs.

1. Introduction:

In July 2020 the Sussex Health & Care Partnership (SHCP) published a Strategic Plan for Integrating the Housing and Mental Health systems across Sussex[1]. The report highlighted the importance of the link between good quality housing and mental health and the positive impact that settled accommodation has on an individual's mental health. The plan laid out 5 strategic objectives:

Objective 1: Create Mental Health and Housing Plans for each place in East Sussex, West Sussex and Brighton & Hove.

- **Objective 2:** Ensure housing expertise is embedded within the new model for community mental health services being developed across the SHCP.
- **Objective 3:** Pilot, evaluate and extend the Discharge to Assess models, building on shared learning across each pilot to optimise outcomes and improve flow and transitions from inpatient provision.
- **Objective 4:** Deliver the ambition to create new integrated models of supported housing for people with multiple and complex needs thereby reducing the need for inappropriate out of area hospital placements and residential care.
- **Objective 5:** Drive forward the integration of housing, social care and mental health clinical services, by supporting Sussex Partnerships NHS FT to establish strategic and operational partnerships with providers of housing and housing services, that improves individual outcomes, service quality and reduces unnecessary variation.

The Brighton & Hove Mental Health & Housing Plan has been developed as a direct response to objective 1 and as an indirect response to the remaining objectives with a view to better integrating the work of Adult Social Care, Health and Housing within the city.

[1] SHCP, Mental Health & Housing, A strategic plan for integrating housing and mental health across Sussex, July 2020

The SHCP strategic plan identified the need for improved collaboration between housing, mental health and social care to enable improved system wide working. This means addressing both the issues that health and social care face with access to housing and the issues faced by housing colleagues in accessing mental health care and support for their clients. The plan's primary purpose is to meets the needs of the Brighton and Hove population, but it also seeks to develop better links with East and West Sussex and to support collaboration around shared priorities.

2. Scope

In developing the plan, the following objectives were agreed by the Brighton and Hove Mental Health Accommodation Group (see section 7) to ensure the priorities and associated action plan are evidence based and include the views of stakeholders and service users.

- Examine the level of need and demand for services in Brighton & Hove
- Examine the scale of homelessness and mental health need
- Provide an overview of current services and pathways
- Gather the views of service users, patients, families, and carers
- Gather the views of partners, providers, and the voluntary sector

The scope of the mental health and housing plan:

- Adults including young people 16+ in transition to adult services
- Those with a diagnosed mental health need, this does not include people with dementia or Autistic Spectrum Conditions or other primary neurodiverse presentations (unless there is a co-existing need alongside mental health).
- Those who are self-reporting mental health needs such as anxiety and depression
- People with mental health needs within Brighton & Hove and those placed in accommodation outside of Brighton & Hove by the council or SPFT.

The plan covers a range of accommodation including;

- **Residential care** - accommodation and 24-hour personal care and support provided on a short- or long-term basis. This includes residential nursing homes where nursing care is also provided.
- **Supported living** - personalised support to help people live within their own home as independently as possible, this support may be shared with other people living in the same service or provided in a fully independent tenancy.
- **Supported accommodation** - accommodation provided alongside support, this can include shared or self-contained accommodation and provide different levels of support from low support of 1 to 2 hours a week to services offering 24-hour on-site staffing. Services are often time limited and encourage move on to greater independence.
- **Emergency & Temporary accommodation** – Emergency accommodation is housing that can be accessed very quickly via the council, such as bed and breakfast or hotels. Accommodation is provided to those who are homeless while the local authority develops a personal housing plan and assesses their ongoing accommodation duty. This also includes commissioned 'off street' (short term) accommodation for rough sleepers.
- **Independent or general needs accommodation** – this includes privately owned, private rented accommodation or accommodation rented from the council or a housing association.

There is no support attached to this accommodation however support may be provided separately by a homecare or housing related support service.

- **Discharge to Assess (D2A) & Step Down** - short term accommodation and support provided to an individual medically ready to discharge from hospital. The service provides continued assessment and support to achieve an onward accommodation goal.
- **Crisis House** – short term accommodation placement (average stay 7 days) for those in crisis to prevent hospital admission and loss of accommodation.

3. Strategic Context in Brighton & Hove:

The Sussex Health & Care Partnership (SCHP) has been developed to join up work across the county to improve health and wellbeing and reduce health inequalities. Within the SCHP a Mental Health Collaborative has been established which provides leadership to a number of priority workstreams. One of these is a Housing & Mental Health Programme to take forward the aims of the SHCP Strategic Plan for "Integrating Housing and Mental Health across Sussex". Although the system is working jointly across the county on pan Sussex priorities there is an appreciation of the need for work to be led at a place-based level to take into account local differences.

There is currently no mental health and housing plan for Brighton & Hove in existence. However, there is collaborative work taking place on several related areas such as the joint BHCC (adult social care) and CCG redesign and procurement of mental health supported accommodation and discharge to assess services. There are also short-term funding pilots for a number of joint projects around mental health and housing, including a Homeless Prevention Officer supporting discharge from the city's mental health hospital, a pilot step down service for those with complex needs and a Mental Health and Autistic Spectrum Condition supported accommodation service.

Brighton & Hove has a series of strategies in existence which have links to the mental health and housing plan including;

Brighton & Hove Health & Wellbeing Strategy 2019-2030[2]

The Brighton & Hove Health & Wellbeing Strategy lays out the city's priorities to improve the health and wellbeing of the population and reduce health inequalities. Under the headings Starting Well, Living Well, Ageing Well and Dying Well there are a series of priorities that include;

- Risks to good emotional health and wellbeing will be addressed, including parental substance misuse and domestic abuse, and mental health services will be easier to access.
- Mental health and wellbeing will be improved and easier access to responsive mental health services will be provided
- The underlying causes of homelessness will be tackled.

Homeless & Rough Sleeper Strategy 2020 – 2025[3]

The Homeless and Rough Sleeper Strategy was developed in 2020 and has three key strategic priorities, prevention, intervention and sustainability under these priorities are actions, the ones detailed below directly relate to the Mental Health and Housing Plan.

[2] brighton-hove-health-wellbeing-strategy-2019-2030-26-july-19.pdf

[3] Homelessness and Rough Sleeping Strategy 2020 to 2025 (brighton-hove.gov.uk)

Prevention

Try to ensure that those who come through our Housing Options service do not end up rough sleeping by focusing work with those leaving institutions and by working closely with services like Somewhere Safe to Stay and Sussex Nightstop.

Intervention

Increase access to mental health support and improve advice and training for staff working with complex needs clients to create 'psychologically informed environments' within all homelessness services

Sustainability

Evaluate and develop our support for people accessing private rented accommodation to ensure they have the best possible chance of sustaining their accommodation long term

Continue to develop our relationships with private landlords to increase the accommodation available to those who have experienced homelessness

Increase our move on options for those exiting supported accommodation

Ensure that services are in place to support those transitioning between supported accommodation and independent accommodation

The following national and local plans also have priorities which link to this work.

National

- NHS Five Year Forward View[4]
- National drive for greater integration of care[5]

Local

- The Brighton & Hove City Council Plan 2020-2023[6]
- Community Mental Health Transformation Programme
- Reducing health inequalities[7]
- Brighton and Hove Suicide Prevention Strategy and associated Action Plan 2019-21[8]
- Changing Futures programme to improve the outcomes of people experiencing multiple disadvantage in East & West Sussex and Brighton & Hove[9]
- Foundations for our future – SHCP improving the mental health and wellbeing of young people[10]
- Rough Sleeper Initiative 2022-25 Priorities & Action Plan

[4] https://www.england.nhs.uk/ourwork/futurenhs/nhs-five-year-forward-view-web-version/5yfv-exec-sum/
[5] https://www.kingsfund.org.uk/projects/gp-commissioning/ten-priorities-for-Commissioner/care-coordination

[6] http://wave.brighton-hove.gov.uk/LGCSDocumentLibrary/Policy/6799%20Corporate%20Plan%202020-2023%20FINAL.pdf

[7] http://www.bhconnected.org.uk/sites/bhconnected/files/jsna-6.4.3-Rough-sleepers2.pdf
[8] https://www.brighton-hove.gov.uk/content/health/health-and-wellbeing/suicide-prevention-action-plan
[9] Changing Futures - GOV.UK (www.gov.uk)
[10] Foundations for Our Future - Sussex Health & Care Partnership (sussexhealthandcare.uk)

Sussex Partnership NHS Foundation Trust (SPFT) are the primary provider of specialist NHS mental health services across Sussex. SPFT are key stakeholders to the overarching Sussex Mental Health and Housing Strategy, and a commitment to enhancing the housing situation of people using their services is made in their 22/23 Breakthrough Objectives[11]. The objectives linked to this plan include commitment to:

- Agreeing actions, based on analysis of baseline data, to increase number of patients in settled housing and employment, with an initial focus on rehabilitation services
- Developing data capture and reporting to enable on-going monitoring of housing and employment status
- Harness care planning assurance process to drive continuous improvement in the quality of support provided to patients in areas including housing and employment

A key strategic drive for SPFT is also to end the use of out-of-area hospital placements commissioned from the independent sector when local SPFT beds in Sussex are fully occupied. There is growing national evidence about the poorer experience of care for patients using out-of-area placements, and their use is a major cost pressure for the Trust. A wider operational improvement plan is in place to reduce patient length of stay in SPFT beds, recognising that reducing delays to discharge will prevent the need for commissioning out-of-area hospital placements.

4. Process & Governance:

Project Lead: Anne Foster, Head of Mental Health Commissioning CCG

Oversight: Brighton & Hove Mental Health Accommodation Group – a Sub-Group of the Brighton and Hove Mental Health Oversight Board.

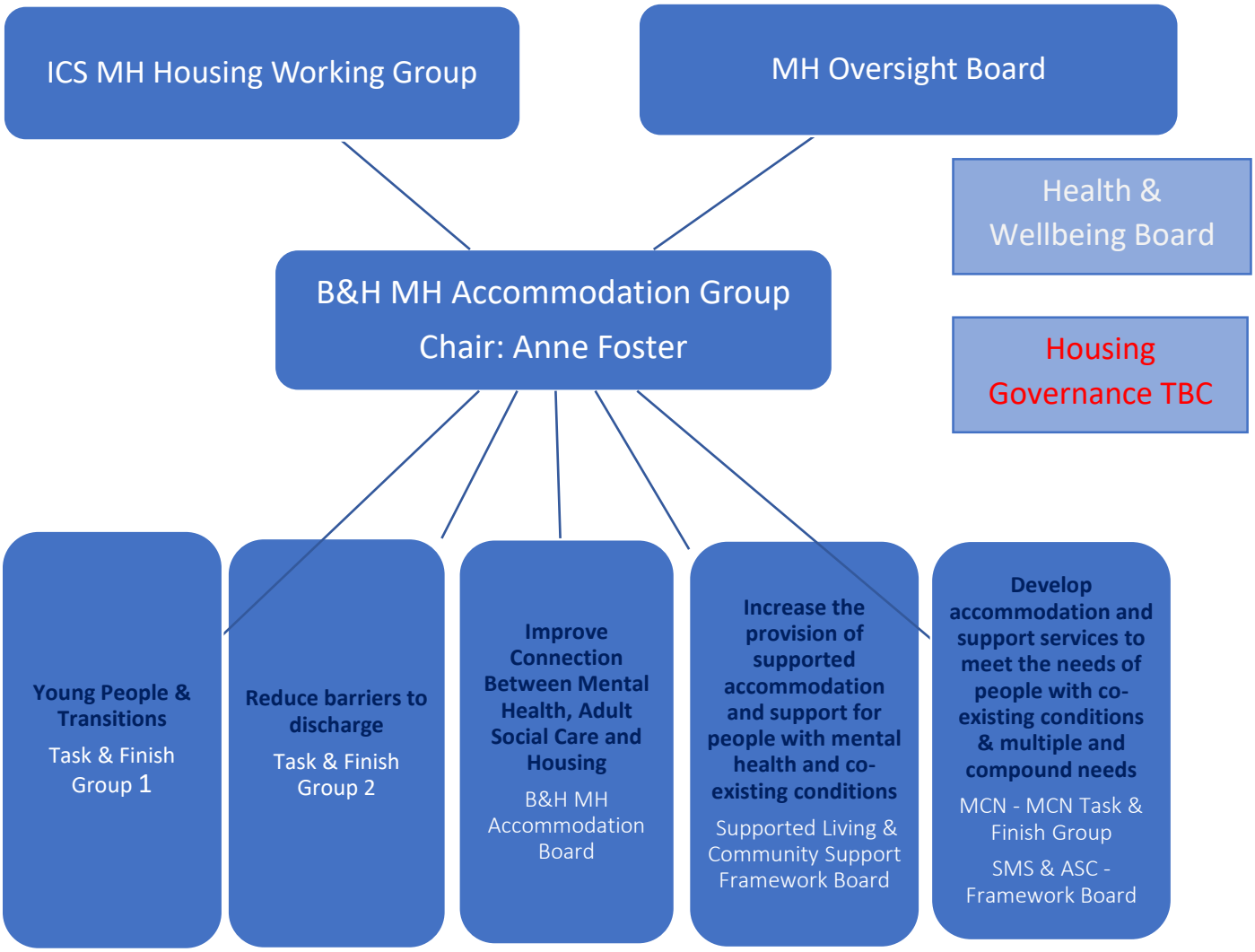
The Brighton & Hove Mental Health Accommodation Group was established to support joint working between adult social care, housing and health in the city. This group oversees the development and implementation of the Mental Health and Housing Plan. Membership of the board include the CCG, Adult Social Care, Housing & SPFT.

The five priorities within the plan will be taken forward through the forums detailed below and through specific task and finish groups with oversight of the work by the B&H Mental Health Accommodation Group which reports into both the Mental Health Collaborative's Mental Health & Housing Working Group and the Brighton and Hove Mental Health Oversight Board.

The final plan will be taken to the Brighton & Hove Health & Wellbeing Board and the TBC with updates going to those boards as and when required.

[11] SPFT breakthrough_objectives_march_2022.pptx

Governance:



5. The current position in Brighton & Hove

Brighton & Hove has a number risk factors which contribute to a higher than average level of mental health need in the local population including, higher levels of people experiencing problematic debt, a higher than average number of; people with combined physical & mental health needs; children leaving care; LGBTQ+ population and people experiencing homelessness, substance misuse and multiple disadvantage. In 2022 Brighton & Hove commenced work on a joint strategic needs assessment (JSNA) for mental health to examine the level of need in the city. Once complete the recommendations from the JSNA will be linked into the Mental Health & Housing Action Plan.

Mental Health & Housing Need:

Data analysis shows that Brighton & Hove experiences significant numbers of delayed transfers of care (i.e. people being delayed in hospital at the end of their inpatient episode of care), the main reasons for this are individuals waiting for a placement in residential care or waiting for supported accommodation. The majority of those waiting for supported accommodation are homeless.

Waiting lists for supported accommodation for those with mental health needs are extensive and demonstrate the current capacity is not sufficient to meet demand, especially for self-contained accommodation. In October 2021 there were 15 people waiting for supported accommodation with 11 of those waiting for self-contained accommodation. The analysis also showed a lack of local provision of supported living and residential care accommodation. In October 2021 there were 175 people placed in Mental Health Residential Care homes by Brighton & Hove City Council. Of these 95 (54%) were placed out of area with 70% of those placed out of area by necessity rather than by choice. 9% of those individuals placed would have been better placed in a Supported Living service if one had been available. Waiting times tended to be higher for those with more complex support needs such as substance misuse and mental health. Feedback from professionals as part of the engagement found 70% of respondents believed their clients would not be able to access accommodation, which is suitable for their mental health needs, this included lack of affordable housing within the city.

There is also a need for independent accommodation, with demand for private rented sector accommodation in the city being very competitive and high cost. The Council Interest Queue (CIQ)[12] offers a route into social housing for those who are ready for independent accommodation and have an assessed social care need, of the 67 people housed via CIQ from 2018 to 2021 50 of these (75%) were referred via mental health practitioners or were exiting mental health supported accommodation. 74% of those on the current waiting list has a mental health need. Waiting times for CIQ accommodation can be 8 to 9 months from referral to offer of accommodation impacting on flow out of supported accommodation.

In terms of mental health need within housing services there was a high need identified via stakeholder feedback and through the data that was gathered. Nationally 27.5% of households owed a housing prevention or relief duty i.e. those supported by housing services who are at risk of or are homeless were identified as having a support need related to their mental health (i.e. engaged with mental health or wellbeing services), in Brighton & Hove this was 42.6% significantly higher than the national average.

Plans have been put in place in the city throughout the covid-19 pandemic to reduce rough sleeping however there continues to be a significant rough sleeping issue. In the month of November 2021 there were 122 individuals who rough slept on the streets of Brighton & Hove with 65 of these being new to rough sleeping. In December 2021 this had decreased to 93 rough sleepers in the month with 37 new to rough sleeping.[13] The national rough sleeper count in November 2021 found that Brighton & Hove had the 5th highest number of rough sleepers in the UK [14]

As of March 2022, there were 644 households placed by the council in emergency accommodation of these 141 (22%) were placed out of city. Information on the support needs of those in emergency accommodation is not collated however anecdotal feedback from staff is that there is a high level of

[12] CIQ – The CIQ is reserved for those referred via Adult Social Care or Children's Services. Individuals referred by Adult Social Care are assessed by a panel and if approved are given priority bidding for social housing via Homemove.
[13] BHCC Housing B'think Rough Sleeper Data 2021
[14] Rough sleeping snapshot in England: autumn 2021 - GOV.UK (www.gov.uk)

mental health need within this cohort. More work is needed in this area to fully understand the situation.

Mental Health Need in Homeless Supported Accommodation

Brighton & Hove City Council Housing Commissioning Service have a range of accommodation and support services in place for the homeless and rough sleeping population which includes short term services such a No Second Night Out, shared and self-contained supported accommodation offering various levels of support, housing first provision, a young peoples' accommodation and support pathway and support to individuals in their own homes. Data and intelligence shows significant levels of mental health need within these services

In February 2021 data was collated from 6 commissioned services for young people (including care leavers) at risk of or experiencing homelessness. This included both accommodation based and community-based support services. The audit of services found 20% of users had a mental health diagnosis and 40% reporting a mental health need but with no diagnosis, 16% of young people within these services had expressed suicidal thoughts or suicide ideation. This has led to Brighton and Hove implementing a suicide contagion cluster focusing on individuals within these settings. Additionally, the Brighton and Hove CCG has identified targeted mental health support in supported accommodation as a priority for Community Transformation funding.

Through the Community Transformation funding a service has been designed with the aim of supporting young people within young people's supported accommodation services with multiple and complex needs, providing direct clinical support and supporting them to access support for mental health, substance misuse, or other support needed to stabilise their mental and physical health and accommodation. This will include Two (2) FTE Multiple & Compound Needs Navigators.

The service is currently in mobilisation, with the hopes of being operational by the Q3 2022/23

In adult homeless services the Homeless link review in 2019[15] showed 43% of people in adult homeless services reported mental health needs, with 25% of people having a dual diagnosis of mental health and drug or alcohol abuse.

Multiple & Compound Need:

Brighton & Hove has high levels of people with Multiple Compound Needs. In 2020 the Adults with Multiple Complex Needs in Brighton & Hove Report[16] found that 20 per 1,000 working age adults were estimated to receive services across at least one of the three domains examined in the report which were substance misuse, offending and homelessness. The report estimated the number of adults receiving support for at least one of these issues, who also had mental health problems. In Brighton & Hove this estimate was 1,970 adults (52% of those with Severe and Multiple Disadvantage).

Housing needs of people using SPFT services:

There is intelligence from community and acute mental health services about the impact that patient housing related needs can have on their mental health treatment outcomes. The most obvious sign of this impact is when a patient's housing needs prevents their discharge from hospital. SPFT collects information about inpatient delays to discharge. Over the last 2 financial years (Apr 20 to Mar 22),

[15] Homeless Link Brighton & Hove Single Homeless Services Review, November 2019
[16] Adults with Multiple Complex Needs in Brighton & Hove (2020)

4,628 inpatient bed days were lost due to Delayed Transfers of Care (DToC) patients with housing related discharge barriers in Sussex. This constitutes 18% of the total 25,615 DToC bed days lost over this time period. Anecdotal feedback has also identified a lack of knowledge amongst clinical staff about the support offered in accommodation services leading to a reluctance to refer and further impacting on hospital discharge.

6. Current provision:

Brighton & Hove has a range of commissioned support and accommodation services for the homeless population and those with mental health needs. For individuals with mental health needs this includes nursing and residential care services, supported accommodation for those with high, medium and low support needs and a short term discharge to assess service.

The following list is of commissioned services within Brighton & Hove and does not include placements out of the city or placements in supported living services. The Mental Health Supported accommodation pathway and D2A service have been recently tendered during 2021/22 and this will result in new services which better meet the mental health needs of the Brighton and Hove population however it will also result in reduced unit numbers as resources have been directed to support the complexity of need in the B&H population that have not always been fully met by the current configuration. New services will be in place at the end of 2022.

In addition to these other recent developments include;

- a CCG has commissioned a Crisis House, to offer short term accommodation (average 7 days) for those who are in mental health crisis to prevent hospital admission. This service is accessible to those in supported accommodation.
- A Multiple and Compound need short term accommodation service commissioned by Adult Social Care to meet the immediate accommodation needs of those with multiple support needs who are unable to be placed in general needs or mainstream supported accommodation.
- An investigation into the remodelling of an existing BHCC supported accommodation service to meet the needs of those with multiple and compound needs including mental health.

Type of Accommodation:	**Number of Units of Accommodation:**
Nursing & Residential Care	
Mental Health Long Term Nursing Care	17
Long Term Residential Care	65
Short Term Mental Health Residential Care	14
Transitional Mental Health Residential Care	19
Residential Respite	3
Total	**118**
Mental Health Supported Accommodation Pathway (May 2022 – prior to mobilisation of new services)	
Mental Health High Support	20
Mental Health Medium Support	32
Mental Health Med / Low Support	70

Total	**122**
Other	
Discharge to Assess	8 (+2 additional "winter pressure" funded beds until June 2022)
Autistic Spectrum Condition Discharge Service (short term funding)	4
Step Down / Step Up Discharge Service for greater complexity (due to go live April 2023)	5
Multiple & Compound Need Interim Accommodation Service (in mobilisation)	5
Total	**22**
Grand Total	**262**

Both the data and feedback from stakeholders and service users identified that the current level of accommodation with support provision in the city for those with mental health needs is not sufficient to meet demand with waiting lists for services, delayed transfers of care and high numbers of out of area placements.

Accommodation Commissioned by Housing Commissioning to meet the needs of those who are single homeless or rough sleepers with support needs

Accommodation Type	Number of Units
Young Peoples Supported Accommodation Age 16-25	
High Support	39
Medium Support	79
Low Support	28
Adults Supported Accommodation	
High	69
Medium	374
Low	71
No Second Night Out – Short term off the street accommodation for Rough Sleepers	
High	20
Medium	20
Low	10
Housing First	60
Total	**770**

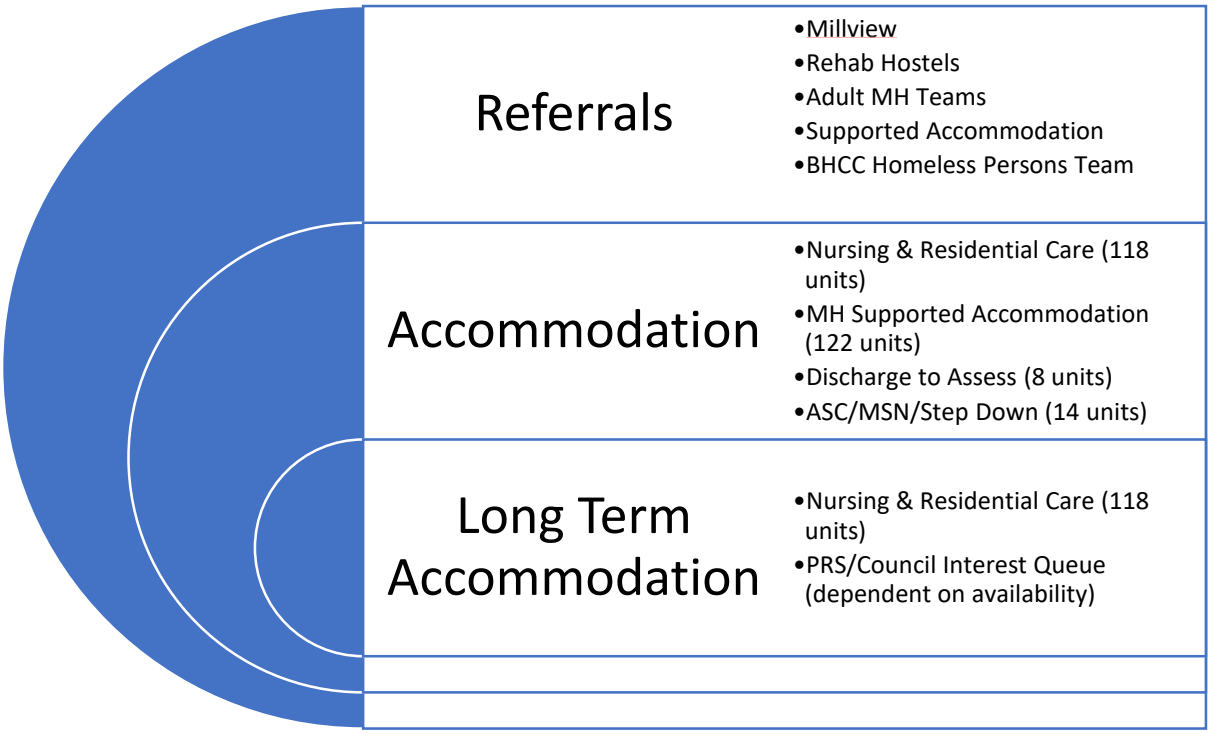
Supported Accommodation for single homeless and rough sleepers is due for recommission in 2023/24.

There are various routes available to individuals exiting supported accommodation however property availability is limited, and private rented sector accommodation is often unaffordable for those claiming welfare benefits. This leads to significant waiting times.

- Council Interest Queue (CIQ)– for those with an assessed social care need including a mental health support need the CIQ provides access to social housing. Individuals can be

referred to the CIQ if they are eligible for social housing and where their current accommodation may be detrimental to their health or they are stepping down from a supported setting and private rented accommodation is not deemed appropriate.

- Private rented sector accommodation – this can be accessed privately with support from a key worker or for individuals being supported by the Housing Options service there is a PRS access scheme via Housing.
- Council Housing – exiting supported accommodation is included in the council's allocation policy and those eligible are able to bid for social housing or seniors housing.
- A jointly commissioned Housing & Adult Social Care transition and resettlement service is available for those exiting both supported accommodation for homeless people and those with mental health needs. This service provides support to those moving into independent accommodation.



7. Overview of Service User and Stakeholder Feedback:

"The lack of accommodation in Brighton has meant that some clients are in accommodation which makes their mental health worse."
Quote from Healthwatch report

Brighton & Hove City Council and the CCG commissioned Healthwatch to undertake consultation with service users, their families and carers, and professionals from a range of sectors working with people with mental health needs. This completed report feeds into both the Mental Health and Housing Plan and the Mental Health JSNA. The full report is attached as appendix 2.

Healthwatch used both online questionnaires and one to one interviews to gather feedback.

The following key themes have been identified by Healthwatch;

- **High quality care**
  Both service users and professionals were generally complementary about mental health providers, mentioning individuals and organisations who had provided high quality of care.
- **Lack of resources**
  Service users and professionals identified the stretched, under-resourced nature of the mental health and housing service in Brighton and Hove. 57% of service users found it "difficult" to find support, and 77% of professionals found accessing the correct mental health support "difficult".
- **GPs are the first port of call, but more training is needed**
  65% of service users had approached their GP for help in accessing mental health services. However, comments from some service users showed that their GP did not understand their emotional needs.
- **People are unsure where to go**
  Some service users reported they did not know where to go for mental health support.
- **Long waiting lists and high thresholds**
  When service users were referred, many comments told of long waiting lists, or being offered services that had been tried and test before without success. 60% of service users found waiting times too long and 31% were offered a service they had used previously and had found it not to meet their needs.
- **Services are not joined up**

  Both professionals and service users commented on the need for better communication within the NHS and between NHS mental health services and third sector organisations. This was exemplified by the sometimes poor transition from children and young people's services to adult services.
- **Support is needed for longer**
  Where service users were offered support, the timescale for this was felt to be too short in duration and sometimes lacked consistency i.e. not having access to the same practitioner.
- **More tailored support**
  Both service users and professionals commented on the lack of tailored support to meet user needs and the importance of offering therapies that specifically dealt with bereavement, trauma, domestic abuse, and post-natal depression.
- **Accommodation concerns**
  70% of professionals said their clients were not able to access accommodation suitable for their mental health needs. Some providers mentioned accommodation options having negatively impacted on their client's mental health due to poor living conditions, the behaviour of other residents and being moved outside of the locality.

The report makes a number of recommendations, not all of the recommendations fall within the remit of the Mental Health and Housing Plan and those which fall outside of this plan will be taken forward as part of the JSNA and the Community Mental Health Transformation Programme. Those that fall within the remit of this plan are outlined below;

- Improve the accessibility to support, especially for those in crisis, and simplify the navigation through the system, for both service users and professionals. (Priority 2 & 3)

- Improve coordination between services, making it easier for the service user and professional to move between services and the service user's journey to be tracked with consistency.

- Address the thresholds for receiving services to allow for preventative care earlier on, rather than waiting for someone to be in extreme need. (Priority 3)

- Provide tailored support where needed, ensuring services (including accommodation offered) meet the needs of neuro-diverse service users, people identifying as LGBTQ+, non-English speaking service users, people from the travelling community and ethnic minority groups, those in temporary accommodation support or homeless, etc. (Priority 4 & 5)

- Provide support for people with co-existing conditions (substance and alcohol misuse) so they can access mental health services. (Priority 5)

- Ensure a smooth transition between children and young people's services and adult services, offering a specific care package (and accommodation) where needed. (Priority 1)

- Ensure accommodation options provide adequate living conditions, considering original locality of the resident and suitability of other residents. (Priority 3, 4 & 5)

8. Mental Health & Housing Plan Priorities

Using the data gathered and the feedback from the engagement, five priorities have been identified to address the key issues in Brighton & Hove. Under each of the five priorities there are a series of actions and outcome measures to be implemented over the next two years.

Priority 1: Young People & Transitions

Develop dedicated provision for 18–25-year-olds to improve transition from children's to adult services.

The need for specialist provision for young people (including care leavers) and those in transition to adult services was clear in the feedback gathered. The level of unmet mental health need in homeless accommodation and support services for young people was high with services struggling to meet the mental health needs of the young people they support. There is also a lack of information on young people transitioning from young peoples to adults' mental health services creating a lack of planning and appropriate services for those in transition.

Priority 2: Reduce barriers to hospital discharge

Improve referral pathways and communication, timely completion of assessments and use of out of hospital provision including D2A and step-down provision to minimise delayed transfers of care.

Increase capacity & "appropriateness" of onward accommodation and support offers to people leaving hospital

Improve confidence of hospital-based clinicians to discharge into services and remove barriers to earlier, safe discharge.

(Cross Reference priority 4)

Brighton & Hove offers a range of accommodation options for individuals with mental health needs and those who are experiencing homelessness. However, referral pathways are overly complex and knowledge of those pathways is patchy among both housing and mental health staff. Delays in completion of assessments and referrals, a reluctance among some mental health staff to refer to short term D2A services and a lack of capacity in accommodation and support services compounds delays in discharge from hospital.

Priority 3: Improve Connection Between Mental Health, Adult Social Care and Housing to Prevent Homelessness and Improve Mental Wellbeing.

Improve knowledge and understanding of roles and remits.

Trial collaborative ways of working between clinicians and providers of supported & emergency accommodation to enable mental health to be managed effectively and ensure housing expertise is embedded in mental health services

Develop and improve housing pathways & improve access to independent accommodation and support in the community.

A key element across all five priorities is communication and improving understanding between services. Engagement with stakeholders showed a lack of knowledge around services and referral pathways across the system and a need to embed housing expertise in mental health services, as well as a need for more flexible mental health services to be available to housing services and supported accommodation to enable them to better meet the needs of service users with mental health needs and prevent crisis.

Priority 4: Increase the provision of supported accommodation and support for people with mental health and co-existing conditions within Brighton and Hove to reduce waiting lists; out of area placements and delayed transfers of care and reduce the risk of acute admissions and homelessness due to inappropriate accommodation placements. (cross reference priority 2)

Ensure there is sufficient capacity within Brighton and Hove including sufficient self-contained accommodation and that the services available meet quality standards and improve individual wellbeing outcomes.

In Brighton & Hove there is a lack of capacity within available accommodation, in October 2021 there were 192 placements for people with mental health needs in residential, nursing and supported living services 53% of these were out of area placements. A further 122 units of

supported accommodation were in place with a waiting list of 15 people, the majority awaiting self - contained accommodation.

Priority 5: Develop accommodation and support services to meet the needs of people with co-existing conditions & multiple and compound needs.

Particular focus on complexity including Autistic Spectrum Condition and Mental Health and Substance Misuse and Mental Health.

Highlighted in the engagement was the difficulty in accessing accommodation and support for individuals with co-existing conditions or multiple and compound needs. People experiencing multiple and compound needs are individuals who have a number of support needs which can include mental health, homelessness, physical health needs, substance misuse and a learning disability. Commissioning to meet these needs is a key priority in the plan this includes meeting the needs of those with mental health needs coupled with autistic spectrum conditions and mental health needs and substance misuse.

9. Actions / Measures of Success:

The following table provides an overview of the key actions and outcomes of the Mental Health and Accommodation Plan. A full action plan has been produced (Appendix 1) which includes all actions, accountable Officers and will enable tracking of the work taking place over the 2 year plan.

Action:	Outcome Measure:	Date:
Priority 1		
Establish a data sharing process for transition from young peoples to adult services	**Early identification & joint planning leading to better transition and improved value for money**	**31 Oct 2022**
Redesign the support offer provided by mental health services to young people's accommodation & support providers for 18-25 year olds to better meet needs.	**Reduced evictions from supported accommodation, hospital admissions and increase in individuals reporting positive personal outcomes**	**1 April 2023**
Assess needs and commission supported living to meet needs of 18–25-year-olds	**Reduced evictions, hospital admissions and increase in individuals reporting positive personal outcomes**	**31 Oct 2023**
Priority 2		
Map, review, and remodel referral pathways to simplify the process and ensure appropriate placements in	**Reduced delays for inpatients who are medically ready to discharge, lower levels of unoccupied beds in D2A, improved flow through supported accommodation,**	**31 March 2023**

supported accommodation, supported living, residential care, D2A, Step Down and CIQ	**improved outcomes for individuals who now better accommodated in line with their needs**	
Implement engagement and training plan for clinical staff to ensure improved knowledge of referral routes, available options, and the importance of timely and complete referrals.	**Staff report increased confidence and better understanding of systems. Brokerage report increase in timely and good quality referrals enabling effective placement.**	**31 March 2023**
Priority 3		
Develop an operational memorandum of understanding between H&ASC, Housing and SPFT detailing roles, responsibilities, and lines of communication, to ensure effective implementation of the Mental Health & Accommodation Place Based Plan and to increase prevention of homelessness for people with mental ill health.	**An agreed co-created MoU is in place, understood and informing practice. Regular reviews are in place to evaluate outcomes, with an ambition that this will lead to reduced evictions, reduced hospital admissions and increase in individuals reporting positive personal outcomes.**	**1 May 2023**
Establish training packages for Housing & Mental health workers on pathways, access to services and statutory responsibilities.	**Workers report increased confidence and knowledge enabling them to access appropriate services and accommodation for their clients.**	**31 Mar 2023**
Develop an accommodation needs assessment that plots the current and future property requirements in order to meet the MH & Accommodation Place Based Plan priorities.	**Strategic commissioning and acquisition plan in place to meet the accommodation needs of the Mental Health and Housing Plan.**	**30 Sept 2023**
Priority 4		
Commission a framework contract for Supported Living and Community Support that meets the identified needs of people with mental ill health to include people with co-existing conditions	**Reduction in: hospital discharges delayed due to housing need, homelessness/street homelessness of people with mental ill health, out of area placements, residential care placements. Improved outcomes for people with mental ill health.**	**31 Oct 2023**
Mobilise the Mental Health Supported Accommodation Pathway commission (including D2A and Crisis House) to provide enhanced quality, improved outcomes, and better alignment with the self-identified needs of users of services.	**Improved outcomes for people with mental ill health, reduction in hospital admissions and reduction in waiting times for self-contained supported accommodation.**	**1 Dec 2022**

Housing and the ICS to work together to ensure the needs of people with mental ill health are included in the work streams arising from the Rough Sleeping Strategy priorities around maximising access to private rented accommodation and maximising exit routes from supported housing.	**Improved access to private rented accommodation for people with mental ill health, maximised access to social housing for people with mental ill health, and increased flow through supported accommodation.**	**31 Dec 2023**
Priority 5		
Mobilise and evaluate the pilot of the Multiple & Compound Need Interim Accommodation service	**Re-iteration, continuation, and expansion dependent on outcome of pilot**	**31 Dec 2023**
Complete feasibility study on the remodelling of a current BHCC service to better meet the needs of people with MCN including mental ill health	**Completed feasibility study to lead to funding bids as appropriate**	**30 Sept 2022**
Housing & H&ASC to mobilise Housing First pilot to meet the needs of people with Multiple & Compound Need including mental ill health.	**5 Housing First Pilot placements mobilised**	**31 Dec 2022**
Commissioners to ensure that the new Framework Commission for Supported Living and Community Support includes the needs of people with co-existing conditions including substance use, ASC, and mental health.	**Live framework, reduction in high-cost emergency accommodation placements, out of area placements and hospital admissions/delayed discharges**	**31 Oct 2023**

10. Appendices:

- Appendix 1 - Brighton & Hove Mental Health & Housing Action Plan
- Appendix 2 - Healthwatch Engagement Report
- Appendix 3 - Overview of Referral Pathways

EXTENDED

Equality and Health Inequalities Impact Assessment (EHIA)

An EHIA is a tool to explore the potential for a policy, strategy, service, project or procedure to have an impact on a particular group, groups or community. This includes the impact on one or more of these groups:

- Protected characteristic groups (as outlined in the Equality Act 2010)
- Disadvantaged or marginalised groups or communities
- Deprivation and socio-economic disadvantage within local communities
- Local health inequalities for groups and communities

Please complete this Equality and Health Inequalities Impact Assessment when the proposed change has a potential negative impact on staff, patients, public or local communities.

Please note:
To comply with our agreed Equality Policy and Procedure and meet our requirements under legislation, all new policies and new and proposed services or strategies must be impact assessed before being introduced. Within this document, you will need to provide evidence to demonstrate:

- Consideration of the impact of your initiative for each protected characteristic and other disadvantaged groups and communities
- Assessment of the impact you have identified and a clear action plan to mitigate the issues and concerns which arise from this.

For further support or advice please contact:

- **Jane Lodge – Associate Director of Public Involvement**
  jane.lodge1@nhs.net
- **Nicky Cambridge – Head of Equality, Diversity and Inclusion**
  nicky.cambridge@nhs.net

1. Introduction and overview

Title of EHIA	Mental Health Place Based Plan							**ID No.**		
Team / Department	B&H CCG Mental Health Commissioning BHCC Adult Social Care Commissioning SPFT				**Assessor Completing the EHIA**			Emily Ashmore, Mental Health and Special Projects Commissioning Manager, BHCC		
Date EHIA Started	21.10.2021				**Date EHIA Completed**					
What is the focus of this EHIA?	Workforce Policies	Organisational strategy	Clinical services x	Clinical policies	Other: x Please state: Health & Adult Social Care Services					
What is the status of this policy / function / practice or provision?	New **X**	Revised	Monitoring	End	**Who will be affected?**	Staff **X**	Carers **X**	Patients / service users X	Communities **X**	Other

Brief description of the aims of the service, policy, strategy, function that this EHIA relates to.	**This EHIA will be used to inform the planned engagement work which will be completed in January to March 2021.** **Both this engagement work and the contents of this EHIA will be used to inform the development of the Place Based Accommodation and Mental Health Plan including identifying the key priorities of the plan and shaping its strategic view.** **The aims of the Place Based Plan are;** To provide a clear articulation of the level need in Brighton & Hove. To provide an overview of current services and pathways. To reflect the voice of service users, patients, families, and the public. To work in collaboration with partner agencies, providers, and the voluntary sector. To explore how services and pathways are configured and plan to develop and improve these. To identify commissioning priorities which meet the needs identified within the plan.

Outline the links to national and local policy and strategy.	The Place Based Plan will reflect the fact that Sussex ICS now operates under a Mental Health Collaborative to deliver against the NHS Long term plan (LTP), annual operating plans, the NHS Oversight Framework and NHS Mental Health 5 year forward view. The key priorities of the Mental Health Collaborative in respect to the mental health accommodation model are: • Reduce Out of Area Placements • Reduce Delayed Transfers of Care • Increase the number of people in settled accommodation Brighton & Hove City Council has a Homeless and Rough Sleeper Strategy in place which sets out a strategic framework to inform work plans, engagement with communities and the citywide response to homelessness and rough sleeping. This Includes the provision of supported accommodation for those who are single homeless or rough sleeping and who have support needs including mental health and substance misuse. Homelessness and Rough Sleeping Strategy 2020-2025 (brighton-hove.gov.uk) In the Brighton & Hove City Council Corporate Plan 2020-2023, we will: • Increase healthy life expectancy and reduce health inequalities • Support people to live independently • Support people in ageing well • Support carers • Ensure that health and care services meet the needs of all In order to support people to live independently we will ensure that every resident who is eligible receives social care support at a level that enables them to live as independently as possible. We will work to increase understanding and reduce prejudice and discrimination relating to disability and mental health problems. We will work to prevent mental health problems and to identify and treat them as early as possible. We will ensure that all people are respected and supported to participate in decisions about their lives.

What patient and public engagement has already taken place in relation to this proposal?	A variety of information that whilst not directly gathered for the Place Based Plan is informative and provides a range of data that will help shape the plan has already been carried out this includes; • Mind Mental Health Supported Accommodation Engagement Feb 2021 • Mental Health Procurement Consultation 20th April 2021 with Stakeholders • SHCP Mental Health & Housing Strategy July 2020 • Adults with Multiple & Complex Needs JSNA 2020 • TDC BAME Mental Health & Wellbeing Engagement March 2020 • Housing Accommodation Barriers to Discharge Interim Findings – Sept 2021 • Multi Agency Discharge Event (MADE) February 2020 • Fulfilling Lives Perspectives Project Mental Health & Substance Misuse May 2021 • Common Mental Health Conditions – Rapid Needs Assessment 2018 • Rough Sleeper Strategy Consultation 2020 • Review of Homeless Supported Accommodation – Homeless Link December 2019 In addition to the previous reports we also have data from supported accommodation services: Route One and Shore House complete annual surveys with the residents living in this accommodation. Relevant feedback from the 2019 surveys have been included in this EHIA, the results of future surveys will be added to the EHIA as they are received. Questions included in the surveys include: 1. Are you getting what you need from your service? 2. How satisfied are you with the quality of the relationship between you and the main BHT staff member who supports you? 3. Does the support you receive from us motivate you to achieve your goals/plans and aspirations? 4. What do you think is the purpose of Shore Hours – can you describe what you think it's for? 5. What is the one thing we do best? Why is it important to you? 6. Do you feel confident that the staff team will treat your personal information with sensitivity? If not, please give details and suggestions. 7. How satisfied are you with the overall quality of your home or building where your service is based? 8. If you live in BHT accommodation, how satisfied are you with the way repairs and maintenance are carried out? 9. How satisfied are you with the communication from your service/BHT? (Written and verbally/in person) 10. Do you feel kept up to date about what's happening in your service?

	11. If you have made a complaint in the last 12 months, how satisfied were you with how this was handled? 12. How satisfied are you with the group activities currently running at Shore House? 13. How satisfied are you that your service seeks and acts upon your views? 14. Have you had opportunities to be involved in how your service runs? E.g. giving feedback on the service you receive, leading on activities, being part of an interview panel for new staff, being a client rep. 15. How would you like to be involved? 16. Do you think that your service treats you with dignity and respect? 17. Could we do more to meet your needs relating to the following? Disability, gender, age, marital status, sexual orientation, your cultural needs, religious needs or parental needs? 18. Do you know how to keep yourself safe? 19. Do you know how to report concerns for other people in your service? 20. How satisfied are you that staff prioritise your safety? 21. If there is one single improvement you could make to your service and/or to BHT as a whole, what would it be? E.g. longer opening hours, more on-line services, better communication etc. The Star Project completes annual surveys with residents but due to the Covid-19 pandemic the 2020 survey was not completed and instead a survey was completed around the services response to the pandemic. Relevant feedback from future surveys will be added to the EHIA as they are received.

2. Update on previous EHIA (where one exists) and outcomes of previous actions or if this is new, then record N/A.

What actions did you plan last time? (List them from the previous EIA)	**How has this action progressed?**	**What <u>further</u> actions do you need to take?** (add these to the Action plan below)
N/A	N/A	N/A

3. Health inequalities

	YES	NO	DON'T KNOW	Provide evidence to support your assessment
Will this initiative help to reduce health inequalities for any specific groups and communities? ***e.g. access to services, improved health outcomes***	X			Mental Health JSNA 2016: • Men with mental health conditions have an average life expectancy of 10 years less, and 15 years less for women, than the general population • Mental health is associated with poor self-management of long term conditions and behaviour, such as drug or alcohol abuse, which may endanger health • Social inequalities may both cause and be caused by mental ill health The aim of the new mental health and accommodation place based plan for Brighton & Hove will be to identify key priorities around the provision of accommodation to people who have a mental health condition to best meet their needs. This will include ensuring better access to housing, and to housing which meets both the individual's choice and their needs. The new plan will aim to provide a strategic framework for moving toward improved access to housing, and improved delivery of suitable housing to people with mental health needs in Brighton & Hove.

4. Impact assessment

Please consider each protected characteristic and consider whether the policy / function / practice or provision has the potential to impact on each protected characteristic group and / or community.

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions to take forward with a focus on • advance equality of opportunity, • eliminate discrimination • foster good relations

Race			X		**National population data:** Across England, BME groups are more likely to be diagnosed with a mental illness than those who are White British. People from Black ethnic groups have lower treatment rates. **Brighton & Hove population data:** 2011 census data shows that 94.3% of the population are White, this is higher than the national average for England and Wales (90.2%). 19.5% of our residents (53,351 people) are from an ethnic group other than White English / Welsh / Scottish / Northern Irish / British. 4.13% out of the 19.5% of the population are Asian or Asian British, significantly lower than the national average (7.8%). 3.8% out of the 19.5% of residents are of Mixed or multiple ethnicity, higher than the national average (2.3%). 1.5% out of the 19.5% of residents are from a Black and Black British background, significantly lower compared to England (3.5%). 0.8% out of the 19.5% of the population are Arabs, slightly higher compared to the South East (0.2%). 91.7% of people living in Brighton and Hove speak English as their first language, other languages spoken include Arabic (0.8%), Polish (0.8%), and Spanish (0.6%). **NB Brighton & Hove's current population data places people of Jewish Faith in the religion category – this is contentious as Judaism is considered to be both a religion and a racial identity. Consideration should be given to how best to locate this data.** **Race demographics of current Route One residents (MH supported accommodation):** • 59% (33) White British • 7% (4) White & Black Caribbean	**Feedback from Route One 2019 resident survey:** • Language barriers make it difficult to become more involved in activities or participation opportunities • Would like classes for example in English It would be good if an interpreter was available more often, not just every three months. Feedback from TDC BAME Mental Health & Wellbeing Engagement – March 2020 • Identified stigma around mental health as a barrier to access. • Recommended awareness raising of available services and conversations about mental health. • Community based self help groups. • Breaking the negative perception	As part of the planned engagement activities planned in January to March 2021 it will be important to ensure that BAME residents / ex-residents voices are heard. For people who speak English as a second language, the planned engagement survey may negatively impact on some who are unable to participate due to language needs. Therefore, we will ensure the survey is offered and provided in appropriate formats if required, including other languages and consider a stand alone engagement event/events to capture the views of the BAME communities in Brighton & Hove. We will use existing links with local faith communities or cultural groups in order to reach and obtain feedback from a diverse range of people, utilising already existing and trusted channels of communication from

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions to take forward with a focus on • advance equality of opportunity, • eliminate discrimination • foster good relations
					• 2% (1) White & Black African • 4% (2) Mixed other • 2% (1) Pakistani • 2% (1) Bangladeshi • 4% (2) Asian other • 4% (2) Black other • 7% (4) other ethnic group • 7% (4) speakers of another language **Race demographics of current Shore House residents (MH supported accommodation):** • 79% (15) White English/Welsh/Scottish/Northern Irish/British • 5% (1) White Irish • 5% (1) White other • 5% (1) Black African • 5% (1) Black Caribbean **Race demographics of current Sanctuary Star residents (MH supported accommodation):** • 83% (24) White English/Welsh/Scottish/Northern Irish/British • 3% (1) White other • 3% (1) Black other • 10% (3) other ethnic group	of the term mental health.	partner organisations and local stakeholder groups.

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions to take forward with a focus on • advance equality of opportunity, • eliminate discrimination • foster good relations
Sex				X	**National population data:** Women are more likely to suffer from depression and anxiety and are more likely to report more severe symptoms of common mental health conditions. Coexisting physical and mental health conditions are more common in women than men. **Brighton & Hove population data:** According to 2015 ONS data: • 50.2% of the population in Brighton & Hove are Male • 49.8% are Female. **Sex demographics of current Route One residents:** • 64% (36) Male • 36% (20) Female **Sex demographics of current Shore House residents:** • 74% (14) Male • 26% (5) Female **Sex demographics of current Sanctuary Star residents:** • 76% (22) Male • 21% (6) Female • 3% (1) Other	**Feedback from Route One 2019 resident survey:** • Women's rights to be taken seriously • More help for females being safely housed • To accommodate more care for both sexes. Feedback from the Mind consultation found • Some high support accommodation was felt unsafe for women because of the shared environment. Women would benefit from self - contained accommodation.	There are no negative impacts predicted for people in terms of sex for the engagement work planned. Housing needs based on sex will need to be explored in terms of implications for the future service model. Themes based on sex will be identified from the proposed engagement work to inform these decisions. Where face to face engagement events are planned consideration should be given to how best to ensure that the voices of women are heard. Consideration will be given to holding standalone events to capture the voice of women.

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions to take forward with a focus on • advance equality of opportunity, • eliminate discrimination • foster good relations
Gender reassignment				X	**Brighton & Hove population data:** There is no data collected on gender reassignment. However, according to the 2015 Trans Needs Assessment, it is estimated that at least 2,760 trans adults live in Brighton & Hove. The true figure is probably greater than this because a significant proportion of trans people do not disclose their gender identity in surveys. In addition, as Brighton & Hove is seen as inclusive, many trans people who live elsewhere visit Brighton & Hove to socialise, study and/or work. **Route One residents:** No existing Route One residents identified themselves as transgendered or transsexual **Gender reassignment demographics of current Shore House residents:** • 89% (17) identify with the gender assigned at birth • 11% (2) do not identify with the gender assigned at birth **Gender reassignment demographics of current Sanctuary Star residents:** • 97% (29) identify with the gender assigned at birth 3% (1) do not identify with the gender assigned at birth	No relevant engagement / feedback identified.	Ensure we are able to identify feedback provided from trans people through the planned survey, we will ensure this is included within the equalities questions / about you section. Consideration to be given to how best to capture the voices of trans people. Including engaging with identified support groups or establishing safe space events.

Age				X	**National population data:** Up to 40% of older people in care homes are affected by depression but a lower proportion of over 65s (4%) are referred to wellbeing services compared to any other age group. **Brighton & Hove population data:** According to 2018 JSNA data, in Brighton & Hove it is estimated that: • 16% (45,400 people) are aged 0 to 15 years • 71% (204,400 people) are age 16 to 64 years, • 11% (32,300 people) are aged 65 to 84 years • 2% (6,000 people) are aged 85 years or older. **Age profile of those placed by BHCC in MH Care Homes** • **18-25 2** • **26-45 37** • **45-65 97** • **65+ 39** **Age profile of those placed by BHCC in Supported Living** • **18-25 4** • **26- 45 7** • **45-65 5** • **65+ 0** **Age demographics of current Route One residents:** • 11% (6) 18-15 years old • 27% (15) 26-34 years old • 29% (16) 35-44 years old • 11% (6) 55-64 years old • 2% (1) 65-74 years old **Age demographics of current Shore House residents:**	No relevant engagement / feedback identified.	As part of the planned engagement activities it will be important to ensure that residents / ex-residents in the younger and older age groups are heard as their needs may be different and less well represented. Overall, there are no negative impacts predicted for people in terms of age.

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions to take forward with a focus on • advance equality of opportunity, • eliminate discrimination • foster good relations
					• 100% (19) aged 18-64 years old **Age demographics of current Sanctuary Star residents:** • 100% (29) aged 18-64 years old		

Religion and belief				X	**Brighton & Hove population data:** 42.9% of the population describe themselves as Christian, this is significantly lower compared to the rest of the South East (59.8%). 41% of residents have no religion (significantly higher than national average 25%), 2.2% of residents are Muslim, 1% of the population are Buddhist (this is significantly higher than the national average 0.4%), 1% of residents are Jewish,(this is significantly higher than the national average 0.5%) 0.7% of the population are Hindu (significantly lower than the national average 1.5%), 0.2% of residents are Atheist, and 0.2% are Agnostic, no residents identified as Sikh compared to the national average of 0.8%. **Religion and belief demographics of current Route One residents:** • 39% (22) none / Atheist / Agnostic • 14% (8) Christian • 5% (3) Buddhist • 2% (1) Muslim • 9% (5) other religion / philosophical belief **Religion and belief demographics of current Shore House residents:** • 63% (12) no religious belief • 16% (3) Christian • 11% (2) Buddhist • 5% (1) Muslim • 5% (1) Atheist **Religion and belief demographics of current Sanctuary Star residents:** • 20% (6) no religious belief • 3% (1) Buddhist • 23% (7) Christian	**Feedback from Route One 2019 resident survey:** • Religious needs to be considered **Note** no service reports a Jewish resident – are services accessible to people of the Jewish faith or are there other barriers to access?	There is no predicted negative impact for the engagement activity in terms of people's religion or belief. We will use existing links with local faith communities or cultural groups in order to reach and obtain feedback from a diverse range of people, utilising already existing and trusted channels of communication from partner organisations and local stakeholder groups.

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions to take forward with a focus on • advance equality of opportunity, • eliminate discrimination • foster good relations
					• 3% (1) Pagan • 20% (6) Atheist • 27% (8) prefer not to say • 3% (1) other		

Disability			X		**National population data:** One third (30%) of people with a physical long-term condition also has a mental health condition, while half (46%) of people with a mental health condition has a long-term physical illness. The contribution of mental ill-health to the morbidity burden rises with the number of long-term conditions a person has. **Brighton & Hove population data:** Sixteen per cent of Brighton & Hove residents have their day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months, lower than England (18%) and higher than the South East (15.7%). In 2013/14 there were 1,138 adults registered with local GP surgeries with a learning disability (0.5% of the total adult population). The population of Brighton & Hove residents whose day-to-day activities are limited because of a health problem or disability is older (42% aged 65 years or over) than the population whose activities are not limited (7% aged 65 years or over). An estimated 39,798 (17%) people aged 18-74 years in B&H have a common mental health disorder. The prevalence of mental illness in B&H is generally higher than England. There are 51,379 adults aged 20 years or over in Brighton & Hove recorded as having multiple long-term conditions (two or more) in March 2017, just under a quarter of the population (22%). Just over 19,000 people have both mental and physical health long-term conditions (8%). **Disability demographic data from current Route One residents:** • 9% (5) aged 55 or over with a long term need/issue • 7% (4) Autistic Spectrum Condition • 4% (2) hearing impairment	**Feedback from Route One 2019 resident survey:** • Unable to cook due to health condition as the kitchen is in the same room as bed/living room and makes them feel physically unwell • More attention to health and less about the tidying of the flat • Damp and roof leaks were identified which could have a potential impact on health conditions • Not dealing with housemate issues has impact on mental state. **Feedback from Shore House 2019 resident survey:** Roof leaks and lack of double glazing making the accommodation cold were identified which could have a potential impact on health conditions	We will ensure the planned engagement activities will be accessible for people with access needs due to living with a disability, long-term health condition or impairment. Ensure that groups and communities working with disabled people are contacted and provided with the opportunity to engage and provide their feedback and share experiences. We will use a range of formats/methods to gain feedback through the survey, such as BSL interpretation through the CCG's Video Relay Service (VRS) Sign Live, produce an Easy Read and Large Print version of the survey, ensure subtitles are used during virtual events and the communication videos we produce and ensure people can respond in a number of different ways including online, by phone, post, text message and

					• 4% (2) would benefit from level access accommodation • 9% (5) mobility • 7% (4) chronic illness / progressive disability • 11% (6) respiratory illness • 2% (1) visual impairment • 14% (8) other long term health condition • 20% (11) other physical health need • 7% (4) Dyslexia • 2% (1) Dyspraxia The existing accommodation is for those with mental health difficulties and therefore the expectation is that all residents would have a mental health need of some kind. The demographic break down of mental health needs for existing Route One residents is as follows: • 16% (9) alcohol misuse • 21% (12) drug misuse • 57% (32) high mental health need • 27% (15) medium mental health need • 20% (15) low mental health need • 27% (15) mental health need with drug or alcohol issues • 59% (33) stress / anxiety • 23% (13) risk of self-harm • 39% (22) emotional / behavioural difficulties • 4% (2) gambling difficulty • 29% (16) history of abuse / childhood trauma • 9% (5) hoarding difficulty **Disability demographic data from current Shore House residents:** • 5% (1) have a health condition that limits day to day activities a little • 83% (19) mental health condition • 4% (1) physical impairment • 4% (1) long-standing illness • 4% (1) sensory impairment • 4% (1) learning disability/difficulty		through Sign Live for BS users.

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions to take forward with a focus on • advance equality of opportunity, • eliminate discrimination • foster good relations
					Disability demographics of current Sanctuary Star residents: • 14% (4) health condition that limits day to day activities a little • 86% (25) health condition that limits day to day activities a lot • 3% (1) physical impairment 100% (29) mental health condition		

Sexual orientation				X	**National population data:** People who identify at LGBT are identified nationally as having a higher risk of developing mental health problems and/or not accessing primary care mental health services. **Brighton & Hove population data:** There is estimated to be a significantly higher LGBT population in Brighton & Hove in comparison to England, 11-15% of those over 16 are estimated to be Lesbian, gay, bisexual and trans (LGBT). There is a lack of available data on lesbian, gay and bisexual populations across England, data on civil partnerships from the Census is used as an indicator of same sex relationships. **Sexual orientation demographics of current Route One residents:** • 73% (41) heterosexual • 2% (1) Gay • 9% (5) Bisexual **Sexual orientation demographics of current Shore House residents:** • 68% (13) heterosexual • 11% (2) Bisexual **Sexual orientation demographics of current Sanctuary Star residents:** • 83% (24) heterosexual • 7% (2) Gay male • 7% (2) prefer not to say 3% (1) other	No relevant engagement / feedback identified.	Ensure that LGBTQ+ groups and communities are identified and provided with the opportunity to engage. We will continue to ensure that the needs of those with differing sexual orientations are met.
Marriage or civil partnership				X	**Brighton & Hove population data:** According to 2011 Census data, 31.8% of Brighton & Hove residents are married. 1% are registered as being in a same-sex civil partnership. 2.4% are separated (but still legally married or still legally in a same-sex civil partnership).	No relevant engagement / feedback identified.	Through the engagement process, it is expected that feedback will be provided from those with a range of partnership status. Should any specific issues

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions to take forward with a focus on • advance equality of opportunity, • eliminate discrimination • foster good relations
							emerge, they will be highlighted.
Pregnancy and maternity				X	**Brighton & Hove population data:** Population estimates from the Office for National Statistics (ONS) show that there were 67,511 women of child-bearing age (15-44 years) in Brighton & Hove in 2015: 48% of the female population. This compares with 38% in England and 37% in the South East. The general fertility rate is the number of live births per 1,000 females aged 15-44 years. In 2015, Brighton & Hove had a rate of 43.7 live births per 1,000 women aged 15-44 years. This is lower than England (62.5) and the South East.	**Feedback from Route One 2019 resident survey:** Parental needs to be considered	Through the engagement process, it is expected that feedback will be provided from a range of people. Should there be any issues specific to pregnancy and maternity, these will be highlighted.

Other Disadvantaged or inclusion groups			X		**National population data:** The following groups of individuals are identified nationally as having a higher risk of developing mental health problems and/or not accessing primary care mental health services: • Homeless individuals • Those from gypsy or traveller communities • Victims of violence • Offenders The 2012 Health Counts survey indicates that carers are at greater risk of major depression than other respondents. People misusing substances are more likely to have had ACEs and histories of trauma. (Source PHE data) - Proportions are now based on everyone in treatment in the latest rolling year which shows **61.7% of SMS clients in treatment have a mental health need.** Of this 61.7%, 12.5% are in treatment in secondary care, 33.1% in treatment via primary care and **16.1% not receiving specialist MH support**. **Brighton and Hove population data:** Brighton and Hove has a significantly higher rate of statutory homeless households than England. Recent draft guidance from NICE on Integrated Health & Care Provision for People Experiencing Homelessness notes that people who are homeless can experience greater issues accessing and maintaining links to mental health provision and that services need to be low threshold, assertive and tolerant to manage this. **Other demographic data for current Route One residents:** • 5% (3) at risk of domestic violence • 11% (6) at risk of financial exploitation • 9% (5) at risk of harm to others/offending • 4% (2) at risk of sexual exploitation • 4% (2) care leavers • 2% (1) carer for a relative or friend		As part of the engagement activities planned in January to March 2021 it will be important to ensure that any written information takes into account literacy difficulties and that complex language, jargon, acronyms etc. are removed. In the development of the future service model and specifications it will be crucial to include reference to: • Safeguarding / risk training and support for staff • Links with the carers hub, forensic services, armed forces support, and adult education programmes. • Consdier the needs of MCN/Homelessness/Inclusion Health Marginalised Groups and how they can access MH support and accommodation.

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions to take forward with a focus on • advance equality of opportunity, • eliminate discrimination • foster good relations
					• 9% (5) literacy / numeracy difficulties • 18% (10) prison experience • 34% (19) risk of self-neglect/isolation • 2% (1) served in armed forces **Other demographic data for current Shore House residents:** • 0% (0) carers • 0% (0) armed forces **Other demographics of current Sanctuary Star residents:** • 0% (0) carers • 0% (0) armed forces		

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions to take forward with a focus on • advance equality of opportunity, • eliminate discrimination • foster good relations
Deprivation and socio-economic disadvantage			X		**National population data:** Coexisting physical and mental health conditions occur most commonly in deprived areas, those from the most deprived decile (105) are more than twice as likely to have a mental health condition, the prevalence of psychiatric conditions increase significantly with the degree of deprivation. **Demographic data for current Route One residents that indicate deprivation / socio-economic disadvantage:** • 9% (5) claiming benefits • 95% (53) are long term sick from work • 84% (47) are not seeking work	No relevant engagement / feedback identified.	People who are digitally excluded, or unable to access information online, may be negatively impacted and unable to participate in an online survey. Therefore, we will ensure that alternative formats of the survey are offered, including hard copies, with a Freepost address for feedback to be returned and included in the final analysis of findings. In the development of the future service model and specifications it will be crucial to include reference to: • Links to benefits advice and employment.

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions to take forward with a focus on • advance equality of opportunity, • eliminate discrimination • foster good relations
Community Cohesion				X	**Brighton and Hove population data:** Brighton and Hove has a strong community with higher rates of belonging, pulling together, formal volunteering and feeling that people from different backgrounds get on, compared to the rest of England (City Tracker survey results, 2018).	No relevant engagement / feedback identified.	Should any issues specific to community cohesion be identified through the engagement process, these will be highlighted.

5. Cumulative Impact

What factors could increase the impact of this proposed change for some groups of people?	Which groups of people or communities are affected?	Are there any additional actions to include in this EHIA?
• Providing materials in alternative languages on request • Providing materials in alternative formats such as Easy Read, Large Print, and providing access to BSL interpretation and subtitles for any videos or virtual events • Ensure that any written information does not use complex language, jargon, or acronyms • Alternative formats of the survey are offered, including hard copies, with a Freepost return address • Consider provision of face to face engagement for underrepresented groups	• BAME groups; specifically those who speak English as a second language • Individuals with disabilities; specifically those with communication needs • Other disadvantaged or inclusion groups; specifically those with literacy difficulties • Individuals from deprived / socially-economic disadvantaged backgrounds who may not have access to digital technology	Additional service user engagement information from existing providers to be added to this EHIA as and when received. The results of the planned engagement work will be added to this EHIA to inform the development of the future model and specification for these services.

6. Equalities or health inequalities data gaps

	YES	NO	DON'T KNOW	Provide evidence to support your assessment and include this as an Action below.
As a result of undertaking this EHIA, are there any gaps in equalities or health inequalities data or information?		X		

7. Overall summary of impact. Please tick an overall equality impact grade for this initiative.



Please explain your decision:
The proposed engagement activities will – by following the identified mitigations, ensure positive engagement from all communities of interest..

8. Summary of Actions

Record all your EHIA assessment potential concerns (impact) and actions below:

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
1	BAME groups and those who speak English as a second language may not be able to engage with the materials produced	Providing materials in alternative languages on request	We will use established links with local faith communities or cultural groups in order to reach and obtain feedback from a diverse range of people, utilising already existing and trusted channels of communication from partner organisations and local stakeholder groups.	TBC	28.02.2022
2	Individuals with disabilities who have communication needs may not be able to engage with the materials produced	Providing materials in alternative formats such as Easy Read, Large Print, and providing access to BSL interpretation and subtitles for any videos or virtual events	Ensure that groups and communities working with disabled people are contacted and provided with the opportunity to engage and provide their feedback and share experiences.	TBC	28.02.2022
3	Those with literacy difficulties may not be able to engage with the materials produced	Providing written information that does not use complex language, jargon, or acronyms	Ensure that any written information are provided in easy read formats taking into account literacy difficulties and that complex language, jargon, acronyms etc. are removed.	TBC	28.02.2022

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
4	Individuals from deprived / socially-economic disadvantaged backgrounds who may not have access to digital technology may not be able to engage	Providing and offering alternative formats of the engagement survey offered, including hard copies, with a Freepost return address	Ensure that alternative formats of the survey are offered, including hard copies, with a Freepost address for feedback to be returned and included in the final analysis of findings.	TBC	28.02.2022
5	Women may feel inhibited about engaging with any face to face engagement events	Providing women only engagement events	Ensure that the commission provider of engagement has targeted engagement to capture the voice of women if they are underrepresented.	TBC	28.02.2022
6	Underrepresentation of BAME and the Jewish community in previous engagement	Commissioning stand alone work to address this deficit.	Ensure that the commission provider of engagement has targeted engagement to capture the voice of underrepresented groups.	TBC	28.02.2022

EHIA written by:	Emily Ashmore		Date:	22/10/2021
EHIA reviewed by:	Jenny Knight			23/10/2021
EHIA approved:(governance)	**YES**	NO	Date:	01/12/2021 – Kalavati Parmar (Interim Equalities Manager)
Further comments			Date:	
EHIA published on the SES website			Date	

Person to review EHIA post implementation		Date	

healthwatch Brighton and Hove

Mental Health Services – Experiences of Service Users and Professionals in Brighton & Hove

"I've been offered a service, but don't think it will help… I've been like I am for all my life, and life's been difficult. I don't think my GP believes me. I think it's too late to change the way I am, but I'd like a diagnosis to understand it, to put my finger on it, to justify it for me."



June 2022

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Introduction

"NHS services are almost universally overwhelmed with extremely long waiting lists and extremely strict inclusion criteria."

"Where people have other health conditions or issues, it often seems like a reason for mental health services to decline to support them."

"The lack of accommodation in Brighton has meant that some clients are in accommodation which makes their mental health worse."

Healthwatch Brighton and Hove (Healthwatch) were commissioned to explore service user experience of mental health services and accommodation providing mental health support, in Brighton and Hove. The purpose was to help inform the following:

- The Brighton and Hove Mental Health and Housing Plan. A joint plan by the Brighton & Hove City Council (BHCC) and Brighton & Hove Clinical Commissioning Group (CCG).
- The Mental Health section within the Joint Strategic Needs Assessment (JSNA), due end June 2022.

Two surveys were initially carried out by the BHCC and CCG in January 2022. One survey was aimed at service users and the other at professionals and clinicians (now termed "professionals" for simplicity reasons).

Although **the professional survey gained some traction (a final sample of 96),** the service user survey was less successful (initially attracting 20 responses). As a result, Healthwatch were asked to refresh the survey content and re-promote it amongst their contacts and wider networks. The second service user survey ran from 22nd March – 16th May, and was actively promoted and received the majority of responses between 22nd March – 15th April. A further 10 responses were added by Sussex Interpreting Services who had been commissioned to speak to a limited number of service users.

In addition to promoting the Healthwatch survey via mailing lists and social media (mostly Facebook), we also spoke to accommodation providers in the city, sending them promotional material to display in the accommodation and pdf versions of the survey that could be printed out if residents preferred to complete a hard copy. All providers were also asked if key staff could sit with residents and help complete the survey and most agreed to do so (as long as residents wanted this assistance).

Through the revised and re-promoted survey, **the total number of service users engaged (including the initial 20 from BHCC and the CCG) was 137**. Most service users completed the questions about mental health support services; three service users also completed questions about mental health support in their accommodation.

This report covers the findings from both service users and professionals, with combined recommendations.

Findings are presented in three sections:

- Section A: Service user experience of mental health services.
- Section B: Professionals' and clinicians' experience of mental health services.
- Section C: Three suggestions from service users that would improve mental health services in Brighton and Hove.

The report closes with recommendations to BHCC and the Brighton & Hove CCG for the purposes of informing the Mental Health and Housing Plan and the Mental Health Section of the JSNA.

Methodology

The evaluation used a combination of quantitative forced choice questions and open-ended comment boxes to assess the experiences of both service users and professionals.

There were two questionnaires:

- Service user questionnaire carried out by Healthwatch Brighton and Hove[1]
- Professionals & clinicians' questionnaire carried out by the BHCC.

Both can be viewed in the appendices. The introductory page of the survey included a link to Healthwatch's privacy statement.

The service user questionnaire contained 20 forced response and open-ended questions, followed by a further 10 equalities questions. Two final questions asked service users whether they were interested in a follow-up call to discuss their experiences further, and whether they would like to be included on the mailing list for Healthwatch Brighton and Hove. The professionals' questionnaire contained 16 forced response and open-ended questions, including one question regarding the professional's job role.

In addition, Healthwatch carried out two further pieces of related work. We spoke to service users following the completion of their survey. These are presented as case studies within the Service User Section A7 entitled Follow-up interviews.

To supplement the data, we also carried out a mailshot asking for opinions on the "top three things that could improve mental health services in Brighton and Hove".

We targeted three groups:

- Service users who had responded to the Healthwatch survey and who had given us permission to contact them again.
- Respondents to a previous survey run by Healthwatch regarding digital GP services, who had defined themselves as suffering from a mental health condition and who had given us permission to contact them again.
- We also contacted everyone on the Healthwatch mailing list asking for them to respond anonymously to the office@healthwatch email address. We phrased the question slightly differently to these people, so that it was also open to anyone who knew a service user as well as current and past service users themselves.

From the three suggestions for improvement we received responses from 29 people (providing 87 suggestions). The detailed findings from these are detailed in Section C, following the findings from the service users and professionals' questionnaires.

[1] An earlier survey run by BHCC generated 20 responses and these have been incorporated into the analysis for the service users' questionnaire. This earlier survey can be viewed in Appendix 2.

Findings

Section A: Service User experience of mental health services

A1: Sample profile

Healthwatch Brighton and Hove regularly evaluates its projects and reviews of health and care services to assess how effectively we have engaged with the general population of the city and its diverse communities. For further information on this, please see our most recent Equality Impact Assessment 2021.[2]

Appendix 1 shows all the demographic data we gathered from the sample we engaged with for the project. Below provides the typical profile of this sample.

Of the 137 service users, most (55 people) were aged between 40 and 59 years old.

Most respondents were female (64%). Male service users represented 30% of the sample. The remaining 6% defined themselves as either non-binary or A-gender (which is defined as not having a gender). Most respondents (87%) were the same sex as they were assigned at birth. People described their gender as follows: 71% of respondents were heterosexual and a further 29% were LGBTQ+ (Bisexual (7) people, Gay (5), Lesbian (4) Pansexual (4) Asexual (3) and non-binary (2)).

78% described themselves as 'White - English/Welsh/Scottish/Northern Irish/British'. 10% of the sample were from the following: Black/Asian/Minority Groups and/or Mixed Ethnic Groups. Most respondents (62%) had no religion.

71% of respondents defined themselves as having a long-term health problem or disability, which affected their everyday activities, either a little or a lot.

While most service users (71%) were not carers, 29% provided unpaid care for either a friend or family member. Most service users (98%) did not have connections with the armed forces.

Most service users were either living in their own property (42%) or in a rented property (42%).

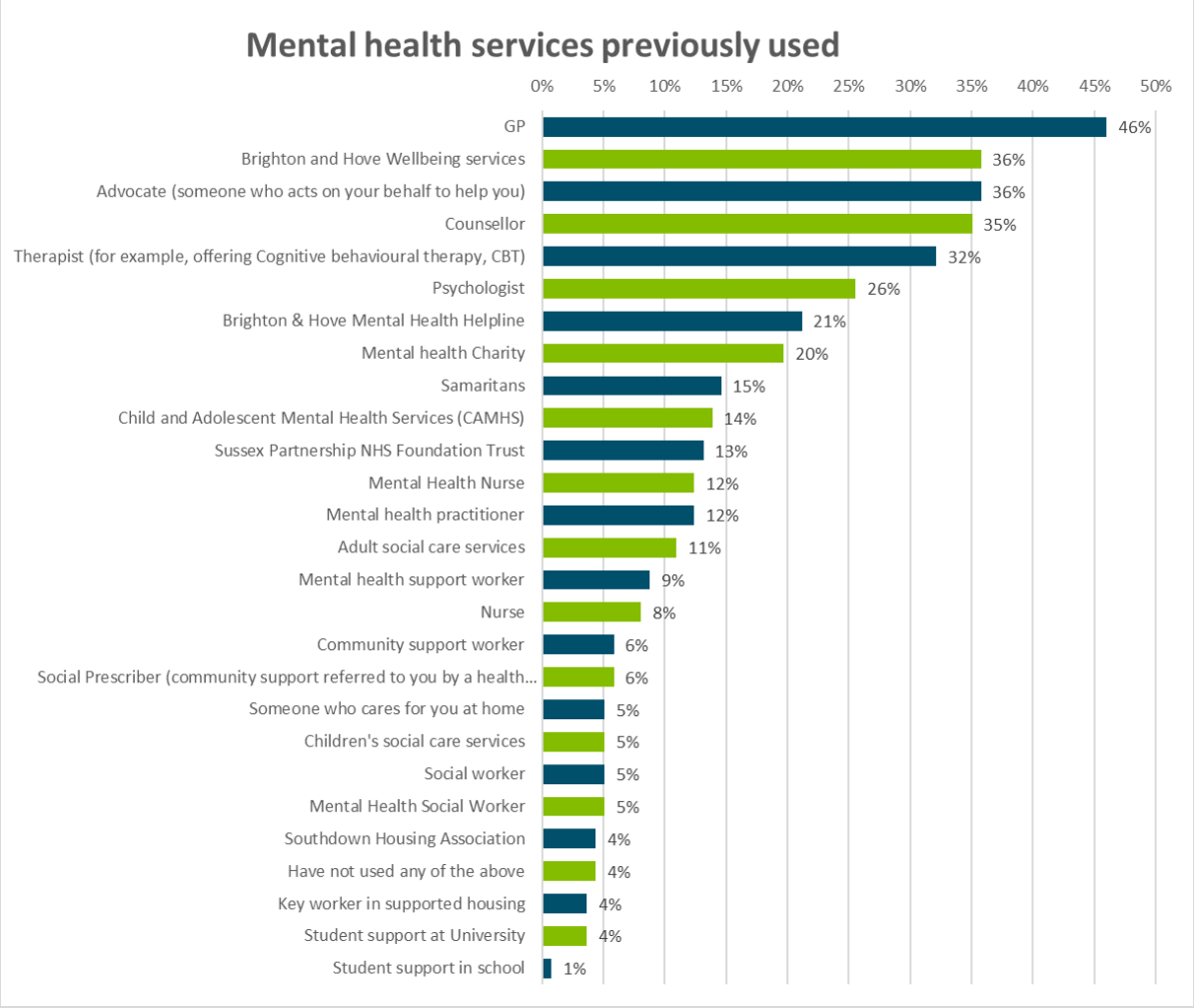
All service users were either currently or had previously received support for their mental health condition.

[2] See https://www.healthwatchbrightonandhove.co.uk/report/2021-04-26/equality-impact-assessment-2021

A2 About the service you have used or are currently using

Our first question asked about which mental health service (if any) respondents had used. The question was in two parts: one about previous use and the second part about current use.

Previous Use



Service users were asked if they had ***previously received*** support for their mental health and if so, to select as many of the services as were relevant from the options provided. There was also a separate "other" box, for services not listed. From 137 respondents, most people had previously used more than one mental health support service in the past. Therefore, percentages in the chart will not add up to 100% as respondents could choose more than one option.

We found:

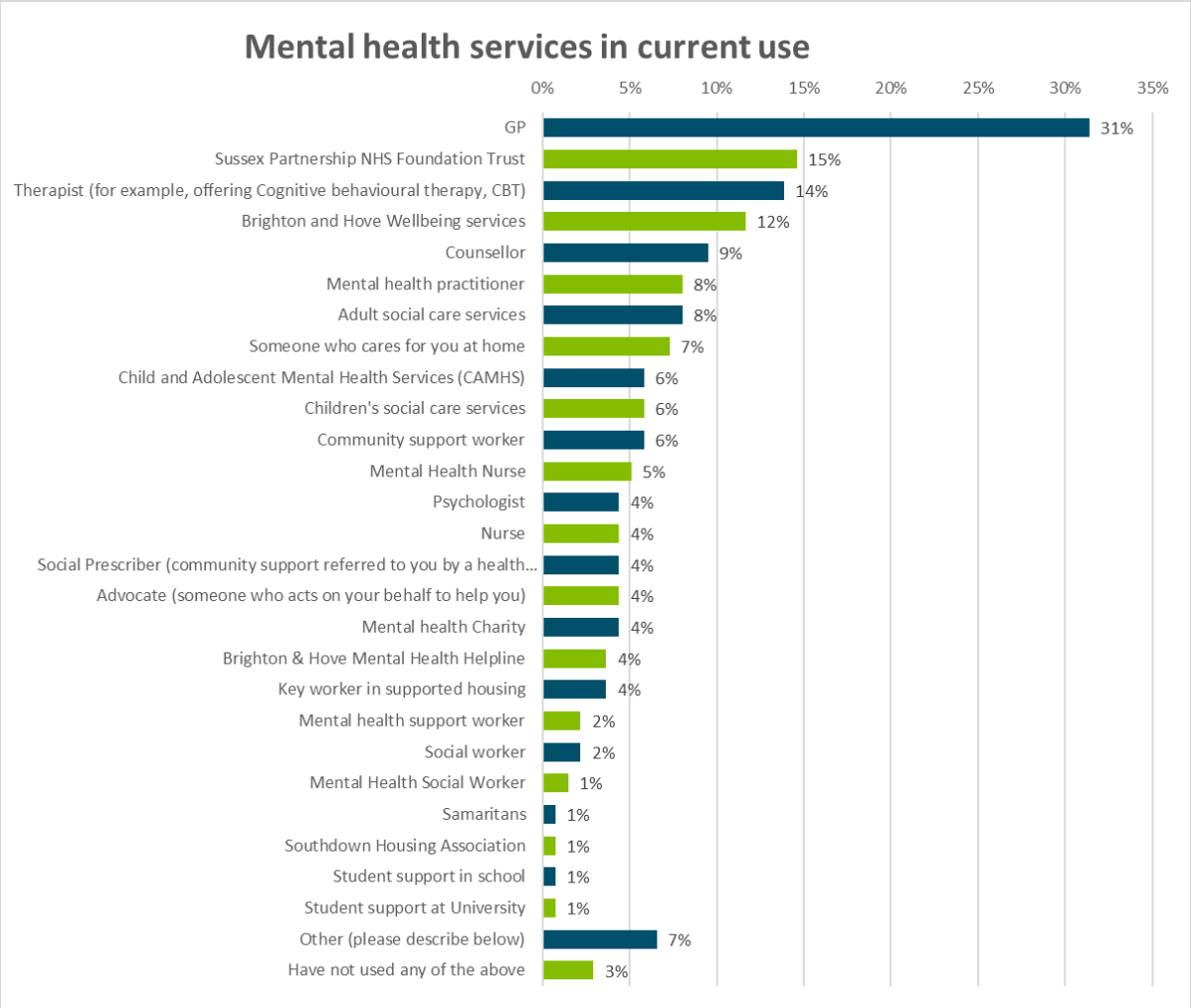
- 46% of respondents had seen their GP previously
- Approx. one third had used the following services:
    - Brighton and Hove Wellbeing services (36%)
    - Advocacy service (36%)

7

    - Counsellor (35%)
    - Therapist (32%)
- Approx. one quarter of respondents had used the following:
    - Psychologist (26%)
- Approx. one fifth had used the following:
    - Brighton & Hove Mental Health Helpline (21%)
    - Mental health Charity (20%)
- Between 11 – 15% had used the following services:
    - Samaritans (15%)
    - Child and Adolescent Mental Health Services (13%)
    - Sussex Partnership NHS Foundation Trust (12%)
    - Mental Health Nurse (12%)
    - Mental health practitioner (14%)
    - Adult social care services (11%)
- Other services listed in the response options, had been used by less than 10% of respondents, for example mental health support worker (9%) and nurse (8%), see chart above.
- Six respondents had not used any of the services previously.

There was also an opportunity for respondents to add services, not listed in the response options, that they had previously used. These included friends, complementary therapy, and Mindfulness Behavioural Cognitive Therapy.

Current Use

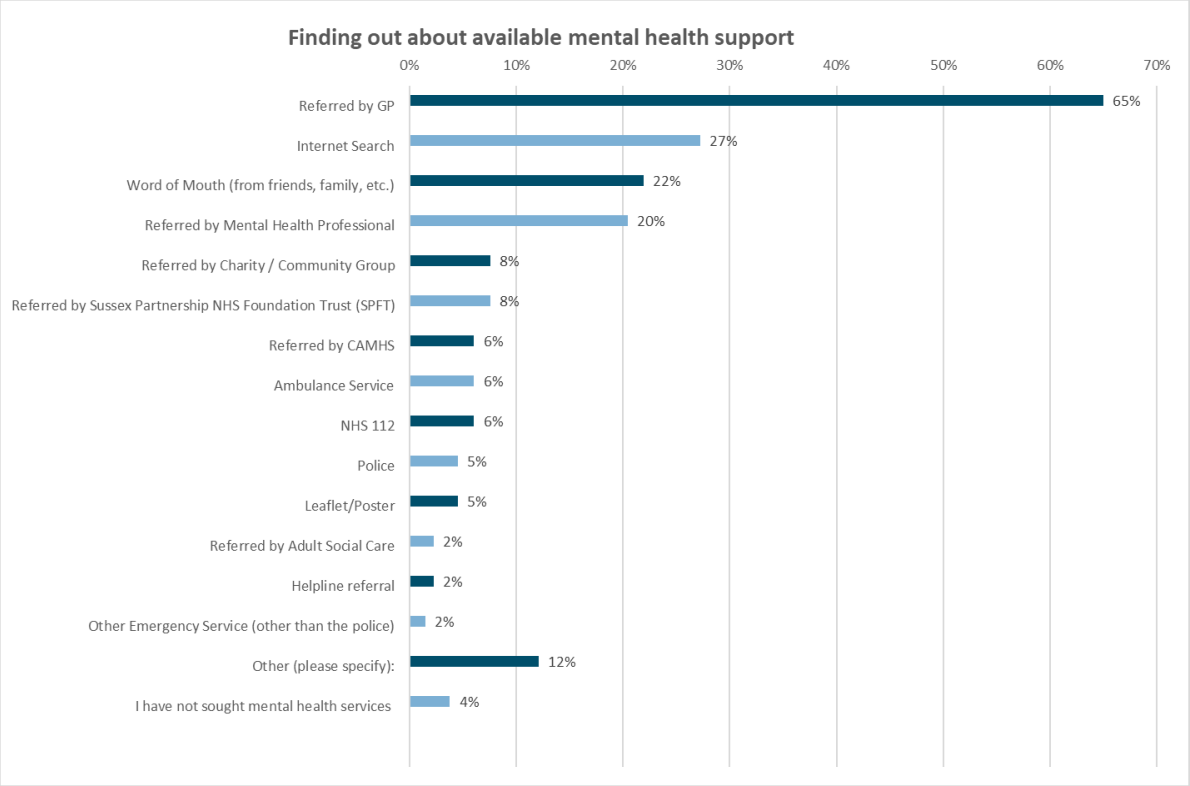


Respondents were also asked if they were ***currently using*** support for their mental health and if so, to select as many of the options listed as were relevant to their usage. There was also an "other" box, for services not already listed. From 137 respondents, most people were currently using one or more mental health support service. Again, please note that percentages in the chart will not add up to 100% as respondents could choose more than one option.

We found:

- 31% were seeing their GP.
- 15% were seeing Sussex Partnership NHS Foundation Trust.
- 14% were seeing a Therapist.
- 12% were using Brighton & Hove Wellbeing services.
- Other services listed in the response options, were being seen by less than 10% of the respondents, for example counsellor (9%) and mental health practitioner (8%), see chart above.
- Four respondents were not currently using any of these services.

A2 Finding Support



Service users were asked how they had found out about the available support. 132 service users (96%) responded to this question. Please note that percentages in the chart will not add up to 100% as respondents could choose more than one option.

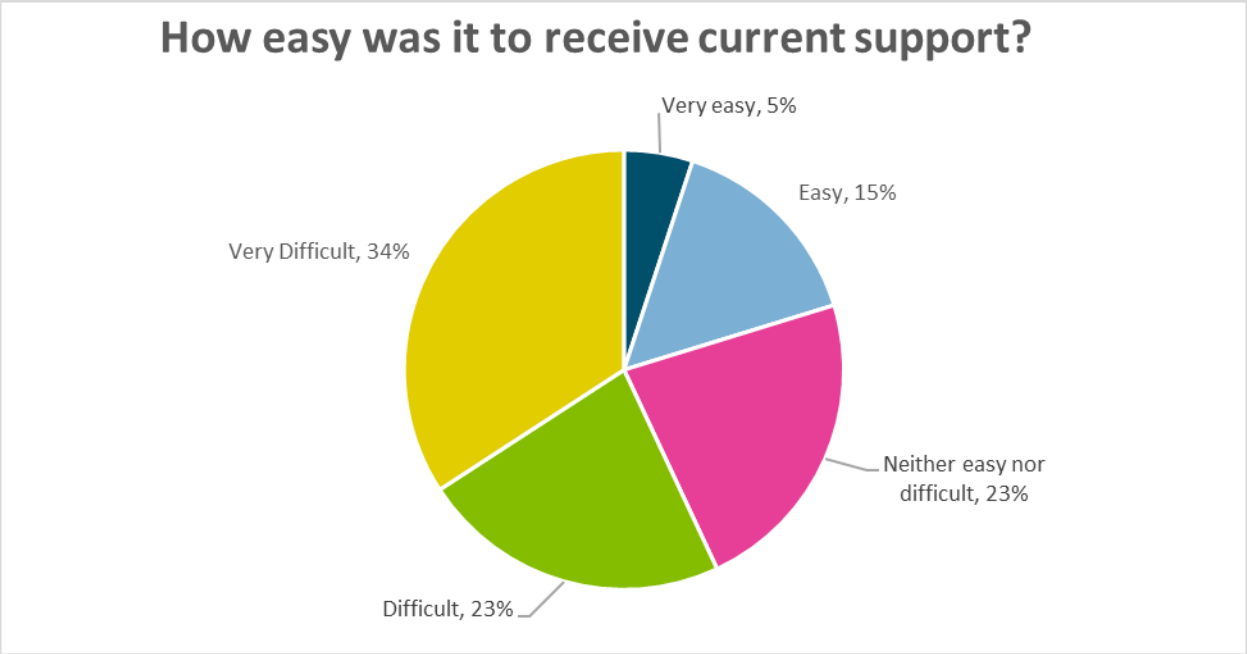
We found:

- 65% found out about mental health support through their GP.
- Between 20 – 27% of service users found out about support using these methods: Internet search (27%), word of mouth (24%) or referred by a mental health professional (20%).
- Other methods listed as possible response options, counted for less than 10% of respondents, see chart above. Examples of these are referred by charity/community group (8%) and referred by SPFT (Sussex Partnership NHS Foundation Trust), also 8%.

Service users were also given the opportunity of mentioning other ways they found out about services, which were not already listed in the response options. These included hearing about services through other people such as school staff or employers, or via other services such as in hospital, through the Lighthouse Centre[3] or via bereavement counsellors.

[3] The Lighthouse is a specialist service for people over the age of 18, living in Brighton and Hove who are experiencing Personality Disorder and Emotional Intensity. It is run by Southdown

How easy was it to find support?

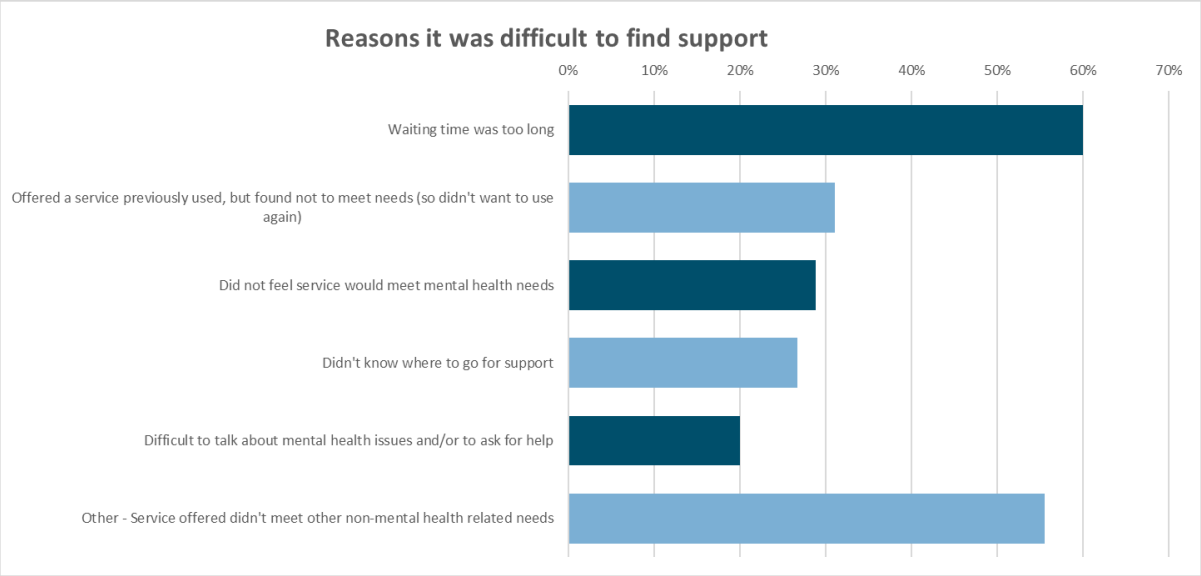


We asked those service users who had received support in the last six months (September 2021 – March 2022), as to how easy or difficult it had been to find this support. We imposed this timeframe as people would be more likely to recall the ease/difficulty compared to those receiving support more than six months ago. In addition, the findings from this current timeframe would be more beneficial to Brighton and Hove City Council and the Clinical Commissioning Group. This timeframe is also used in some of the later rating questions.

From the original 137 people who responded to the survey, 119 people provided an answer to this question. 40 people said they had not received support in the last six months. Of the 79 people who *had received support in the last six months*, we found:

- The majority (57%, 45) found it either "difficult" or "very difficult" to do so. 23% (18) of the total sample said this was "very difficult".
- 20% (16) found it "easy" or "very easy" to find support. 5% (4) of the total sample said this was "very easy", and
- 23% (18) found it "neither easy nor difficult" to do so.

Reasons for finding it difficult



We asked the 45 service users who found it "difficult" or "very difficult" in the last six months to find the support they needed, the reasons for this. They were asked to select as many of the response options listed as were relevant. Please note that percentages in the chart will not add up to 100% as respondents could choose more than one option.

- 60% (27 service users) found the waiting time was too long
- 31% (14) were only offered a service they had used previously and had found not to meet their needs (so didn't want to use it again)
- 29% (13) did not feel the service they were offered would meet their mental health needs
- 27% (12) did not know where to go to find the right support
- 20% (9) found it difficult to talk about their mental health needs
- 56% (25) found it difficult for other reasons unrelated to mental health needs:
    - 9 service users could not afford the cost.
    - 7 service users were only offered an online service, when they would have preferred face-to-face.
    - 5 service users found the service did not meet cultural/sexuality needs, for example the needs of neuro-diverse service users and non-English speaking service users.
    - 3 service users found the service offered was too far to travel.
    - 1 service user had mobility needs not met by the service offered.

Service user Comments

We gave service users the opportunity to add further comments about any difficulties they came across in finding support for their mental health issues. The following quotes provide a sample of what people told us. The majority of

responses relate to the stretched nature of the service, associated with lack of appropriate support and long waiting lists for treatment:

Service not available

“I needed open ended counselling and was told it wasn’t available on NHS or the charity I was assessed by. Had to have trial sessions with different private counsellors which was highly stressful. One trial was very traumatic, and the counsellor brought me to tears. A certain counsellor upset me when communicating with her via email about seeing her.”

“Service is limited to either CBT (Cognitive Behavioural Therapy) or talking therapy for depression. Nothing tailored or accessible for different needs. Too long to wait.”

“I was refused help by the NHS because I said I believed the route cause was childhood trauma. I only wanted someone to talk to. I didn't expect to be fixed of all my past trauma!”

“My lead practitioner used to visit me once a week in my home as I’m also physically disabled but he left in October 2021, and they say they are so short staffed that they can’t find me another lead practitioner even after all this time?”

“Several times in the past even when experiencing suicidal thoughts, I have been told that I am not a sufficiently high priority to see a psychiatrist.”

Waiting for treatment

"Still on waiting lists - since early 2021.”

“Still unable to access services with specialist medication and treatment expertise beyond 1st and 2nd line medications and/or CBT”

“The waiting times are so long that it is off-putting, and either ends up in problems escalating to crisis or finding help elsewhere. What is finally offered is so generic and limited that it doesn't address the issues individually.”

“The NHS gave me a list of charities when they refused to help me but they weren't available or the wait list was too long or too expensive. I have struggled terribly for months with my mental health but there is no help.”

“I had to wait 8 days in crisis waiting for a hospital admission without adequate support.”

“Been asking for referral to psychiatrists for decades. GP surgery always refused saying they only take on people who are a harm to others, or it’ll be over 2 years wait, there’s no point etc - gatekeeping. Finally accepted making a referral this year, now have a psychiatrist.”

“All my GP does is tell me to register with the Brighton & Hove Wellbeing Service. The last time I did this, it took over a year for me to be offered help and that was only for 6 weeks.”

"The police referred me twice to Adult Social Care, who again took so long to contact me, that I took me frustrations out on her when she did. She explained she did not feel there was anything she could do."

Services are not available to suit specific needs

"No services meet needs of autistic or ADHD (Attention-deficit/hyperactivity disorder) people."

"Only CBT offered and that doesn't suit my neurodiverse needs."

"I found that there were services that looked interesting but were not available to me because my mental health issues were deemed too complex. I feel there's a significant gap in services for those with complex mental health problems such as psychosis etc."

"Although I am a member of the Lighthouse service in Hove, I have been unable to use this service due to them not making the reasonable adjustments for my autism and additional needs."

Lack of specialist support staff

"My GP was very supportive and understanding however limited in their knowledge of how to help beyond signing me off work."

"And there was never any follow up by GPs. Just try a new tablet and off you go."

"When I'm at the point when I need help, being told to go to the wellbeing service when I know I'll just be put on a waiting list (worst past wait was 2 years) makes it pointless talking to my GP. I just feel fobbed off."

Stretched Child and adolescent mental health services (CAMHS) – other comments show criticism of CAMHS

"Only receiving the right help now as was sectioned in December. CAMHS were offering support but refusing to approve 2nd opinion for Autism, and if they had, becoming an Inservice user could have been avoided."

"CAMHS don't have email contact with parents or service users. They don't respond to telephone messages, and we don't have a lead practitioner despite our child having been detained under Section 3 Mental Health Act and continuing to be suicidal."

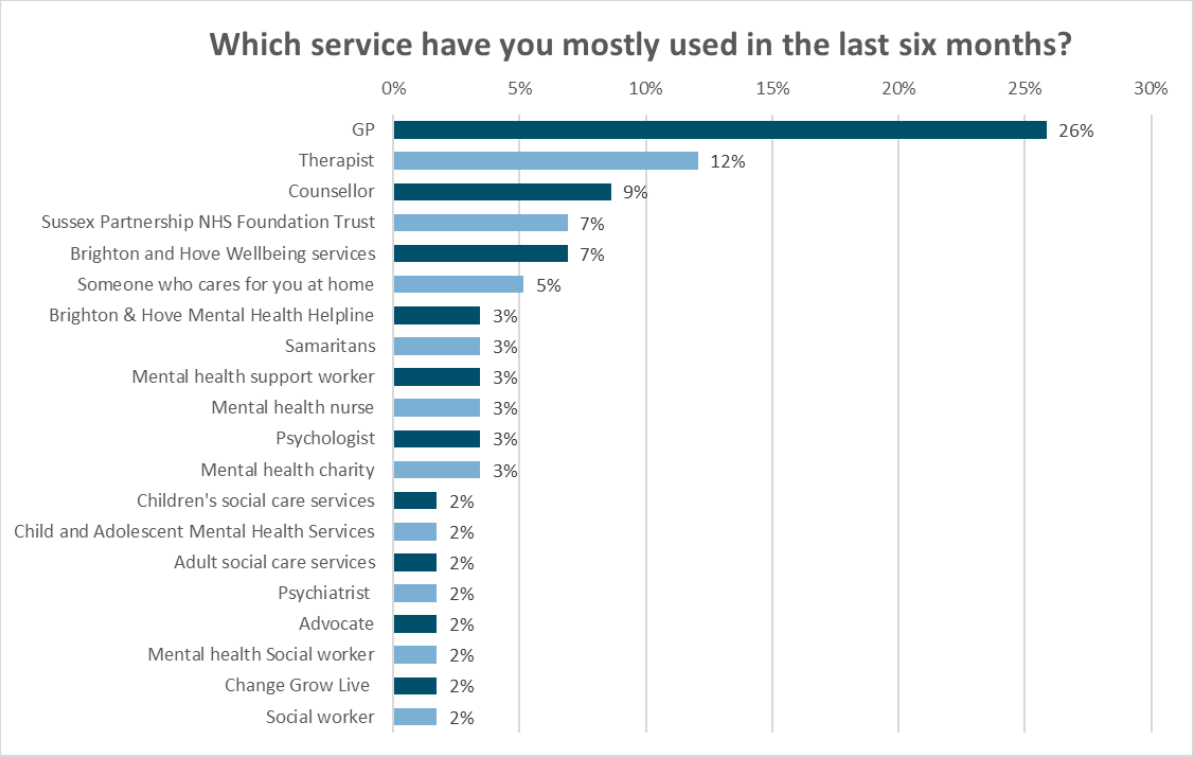
Aside to the system pressures, some people said they were frustrated about **Needing a proper diagnosis:**

"I've been offered a service, but don't think it will help. I'm on the waiting list for a space for CBT. I actually would like a diagnosis. I've been like I am for all my life, and life's been difficult. I don't think my G.P believes me. I think it's too late to change the way I am, but I'd like a diagnosis to understand it, to put my finger on it, to justify it for me."

A3 Quality of care – mental health services

The Clinical Commissioning Group (CCG) and Brighton and Hove City Council (BHCC) were interested in the quality of services used. It therefore made sense to find out which service had *mostly been used* by individual service users in the last six months (September 2021 – March 2022) to be able to link quality to a specific service.

Service mostly used in the last six months



Of the 58 service users who responded to this question, the following were chosen as the service mostly used:

- 26% (15 service users) had seen their GP more often than any other service
- 12% (7) had seen their therapist more often
- 9% (5) had mostly seen a Counsellor
- 7% (4) had respectively seen either Sussex Partnership NHS Foundation Trust or Brighton and Hove Wellbeing services
- 3 or less people had respectively seen other services (as shown in the chart above), for example someone who cares for you at home (3) and Brighton & Hove Mental Health Helpline (2).

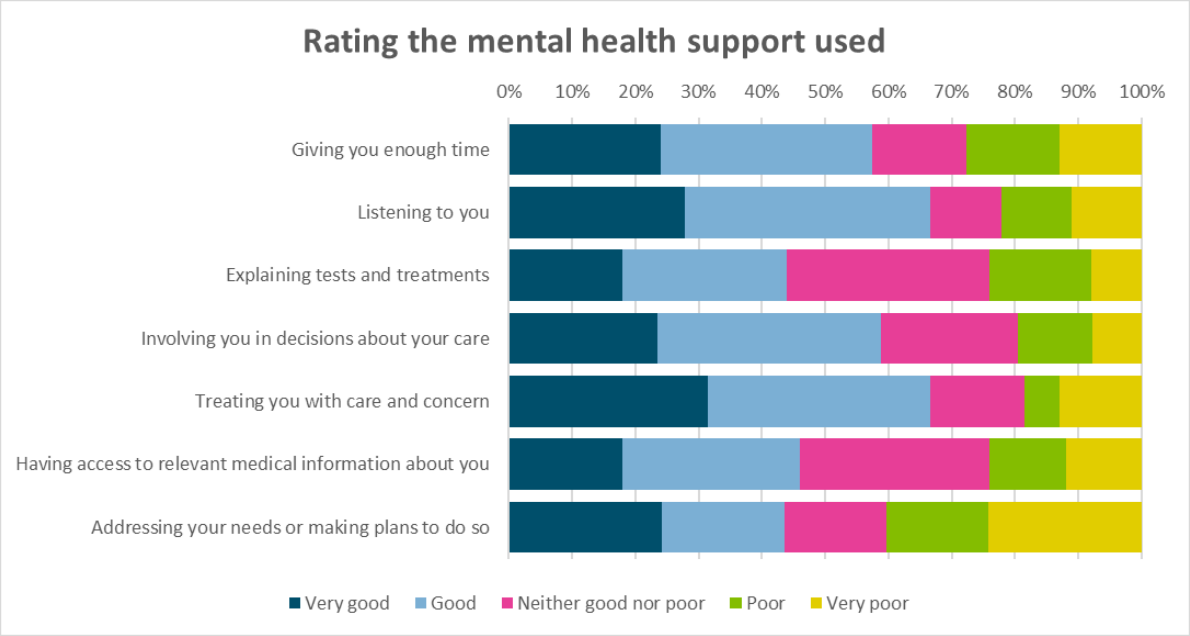
Of the categories above, we included Cognitive behavioural therapy, within the "therapists".

By way of explaining some of the categories further:

- Child and Adolescent Mental Health Services are often known as CAMHS
- An Advocate is someone who acts on your behalf to help you, and

- Change Grow Live is a charity that helps people with homelessness, drug and alcohol addiction (for more information please see: https://www.changegrowlive.org/advice-info/find-advice-info/health-and-wellbeing/mental-health-asking-for-help).

Quality of care of services in the last six months



We asked service users to rate the service they had individually mostly used in the last six months. Service users were asked to respond to this question for six different areas of service, and they were asked to rate the quality of care received under each area as either "very good", "good", "neither good nor poor", "poor" or "very poor".

We combined the overall results under each of the six areas for "good" and "very good" and "poor" and "very poor" and found:

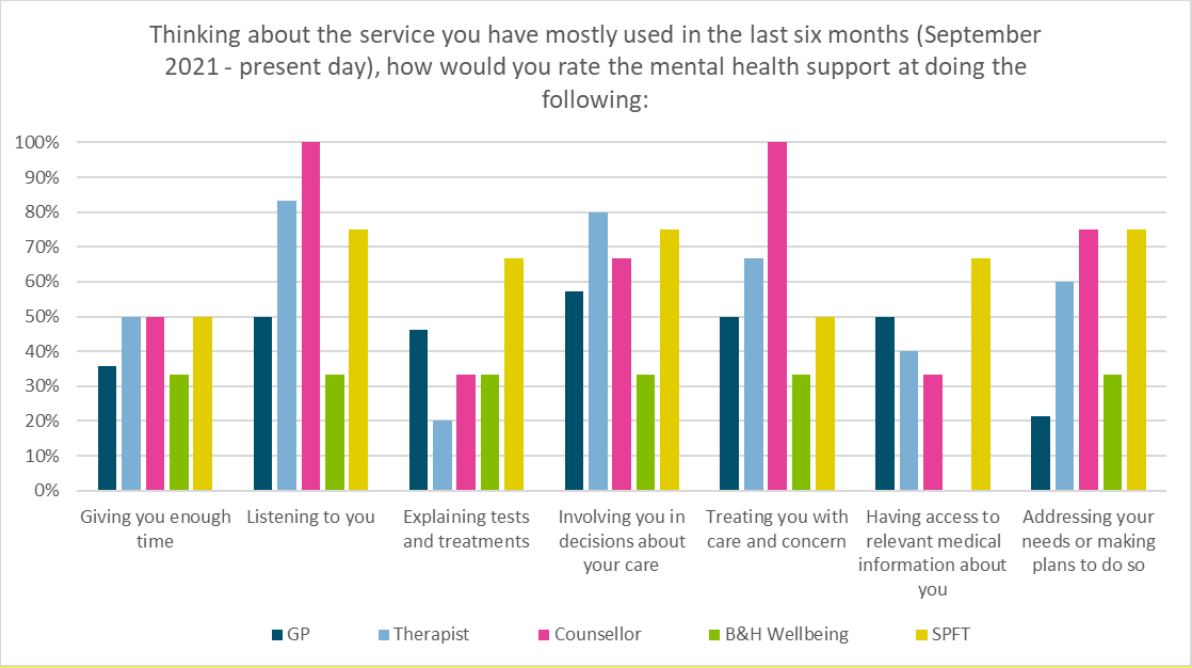
- Between 44% and 67%, felt the quality of care provided by the service was good.
- Between 19% and 28% felt the quality of care for five of the areas, provided by the service was poor; this rose to 40% for one area.

Even though more people felt the quality of care provided by the service they used was good, for each of the six different areas of service that we asked them to rate ("criteria") between one fifth (19% or 20%) and one quarter (between 22% and 28%) found the service they used to be poor. In the case of "addressing your needs or making plans to do so", the percentage of those that found it poor was much higher still, at 40%.

- **Giving you enough time** – 57% of service users found the quality of care provided by the service they used was good; 28% of service users found it was poor. 15% of service users felt it was neither good nor poor.

- **Listening to you** – 67% of service users found the quality of care provided by the service was good; 22% of service users found the service poor. 11% of service users felt it was neither good nor poor.
- **Explaining tests and treatments** – 44% found the quality of care provided by the service good; 24% found it poor. 32% found it was neither.
- **Involving you in decisions about your care** – 59% found the quality of care provided by the service was good; 20% found it poor. 22% found it neither.
- **Treating you with care and concern** – 67% found the quality of care provided by the service was good; 19% found it poor. 15% found it neither.
- **Having access to relevant medical information about you** – 46% found the quality of care provided by the service was good; 24% found the service was poor. 30% found it neither.
- **Addressing your needs or making plans to do so** – 44% found the quality of care provided by the service was good; 40% found the service poor and 16% found it neither good nor poor.

Comparing specific services with quality of care



Of the 58 service users who responded to the question about the service they had mostly used, the chart above cross-references the ratings of quality of care under the six areas we asked people to consider with some of these services, as used by the largest groups of these people. However, excepting the sample who chose GP services (15 people), even these sample groups were not in themselves large enough to draw any significant findings. We have therefore highlighted just a few of the main findings.

GP services did best at involving the service user in decisions about their care but were not so good when it came to giving the service user enough time.
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Therapists were mostly good at listening to the patient.

Counsellors were best at treating the service user with care and concern.

SPFT (Sussex Partnership NHS Foundation Trust) were best at involving the service users in decisions about their care.

Service user Comments

We gave service users the opportunity to add further comments if they had included either a poor/very poor or good/very good rating. The following quotes provide a sample of what people told us and we have grouped comments under sub-headings.

Concerns were raised about inappropriate support, not getting a proper diagnosis, long waiting times, lack of joined up support and lack of tailored support.

Comments about Poor Ratings

Inappropriate support

"I'm rating CAMHS and consider their existence has made our situation worse rather than better. There is no direct contact between us and them. We phone a helpline number if we need to contact them. They don't always come back. Sometimes it's taken them 9 days to respond. Our son is autistic and has a need to know what is going to happen. Psychiatric appointments start late or are cancelled at the last minute. It's never the same Doctor. We have to go through the history again each time. Everything discussed is never implemented. It's all a huge draining disappointment. We have no support."

"When diagnosed with PTSD relating to trauma the Psychiatrist said that I had addiction issues. But this information was ignored and inappropriate medication was clearly prescribed to be able to say that I had been treated."

"I did not feel like my views were listened to until I was properly in crisis, and even then the options I was offered were incredibly limited which didn't meet what I needed."

Asking for a proper diagnosis rather than over prescribing anti-depressants

"I've been referred for CBT, but as previously said, I really want a diagnosis to give me peace of mind, to understand the way I am… I'm asking for a diagnosis, other than that I don't want access to resources as I've been like this all my life."

Stop fobbing people off on anti depressants, start listening to people and get them the correct support they need instead of lining the pharmaceuticals pockets

"GPs need more knowledge and experience of supporting clients with mental health issues. Mine was unaware of local services and did not look at or fully consider my previous medical history. I feel time and workload is probably the main issue. I was told medication is the only thing they can do to help which isn't true."

Access and waiting times

"I feel like when I want to talk about my mental health concerns, I'm only offered medication to solve the problem. I know services exist, but I have no referral into the services and don't really know how else to access them."

"I have put neither good nor poor because it is not a substitute for more specialised NHS services that I need (beyond GP) that I have still not been able to access."

"Getting access to mental health help on the NHS takes a long time to wait. The available options for treatment are limited. The GP service is so busy it is difficult getting appointments and when you do see a doctor you have a short amount of time."

"When I'm at the point when I need help, being told to go to the wellbeing service when I know I'll just be put on a waiting list (worst past wait was 2 years) makes it pointless talking to my GP. I just feel fobbed off."

Lack of joined up support

"Charity/third sector services are not joined up with other services. While there are some benefits to the current split commissioning in Brighton and Hove it does mean that care is not joined up and you retell your story to each provider with no option for them to access past information."

Specialist support for people with unique needs

"Autistic people with mental health difficulties/illness are not adequately provided for as service users or as part of the community…Autistic people find the amount of different people very stressful to deal with. The service user is unable to engage then the team discharge you without thinking that the person is overwhelmed, and this is the reason they are not engaging. There is an assumption that the service is not required when this is often not the case."

"There is a complete lack of understanding of young people who have just transferred to adult services (18) and no appreciation as to how this transition affects these young adults."

Comments about Good Ratings

Most positive comments were around the high quality of care people received. This was mainly referring to how a specific professional or team were supportive.

High quality of care

"Saw an excellent psychiatrist who changed my meds and referred me to group support treatment."

"Cruise were communicative and caring."

"They make me feel 'normal'."

"I'm not embarrassed discussing my health with them as I don't feel like they're judging me."

"The staff I have contact with have generally been very kind."

"Actively trying to help, actually listening, making follow up appointments."

"He's good at telling me that I have mental capacity and I can do things for myself even though by him doing it, it would take some pressure off me."

"I'm currently under the care of a doctor who is very supportive. I have been diagnosed with PTSD."

"I have received incredible support from the Mental health Assessment and Treatment Service (ATS) service. I was listened to about what I wanted. My GP referred me to them as soon as I asked, I was contacted quickly & was able to receive talking therapy intervention. My assessment was four sessions to help stabilise me, before I was referred to the CAT (Cognitive Analytical Therapy). The therapist became my lead practitioner throughout the Pandemic."

Face-to-face contact

A particular aspect of the positive comments was about communication, including face-to-face engagement and direct and easy access to services.

"Seeing them in person was the best…and not having to book anything online or via an app helped a great deal."

"The home treatment team were supportive but are a crisis team so only work with families for a limited time. However, they were the opposite of CAMHS. We had their mobile and email addresses. They turned up when they said they would. They remembered who we were and what the problem was and they seemed to genuinely care."

Ease and flexibility of getting support

A further positive aspect was the ease and flexibility of getting support.

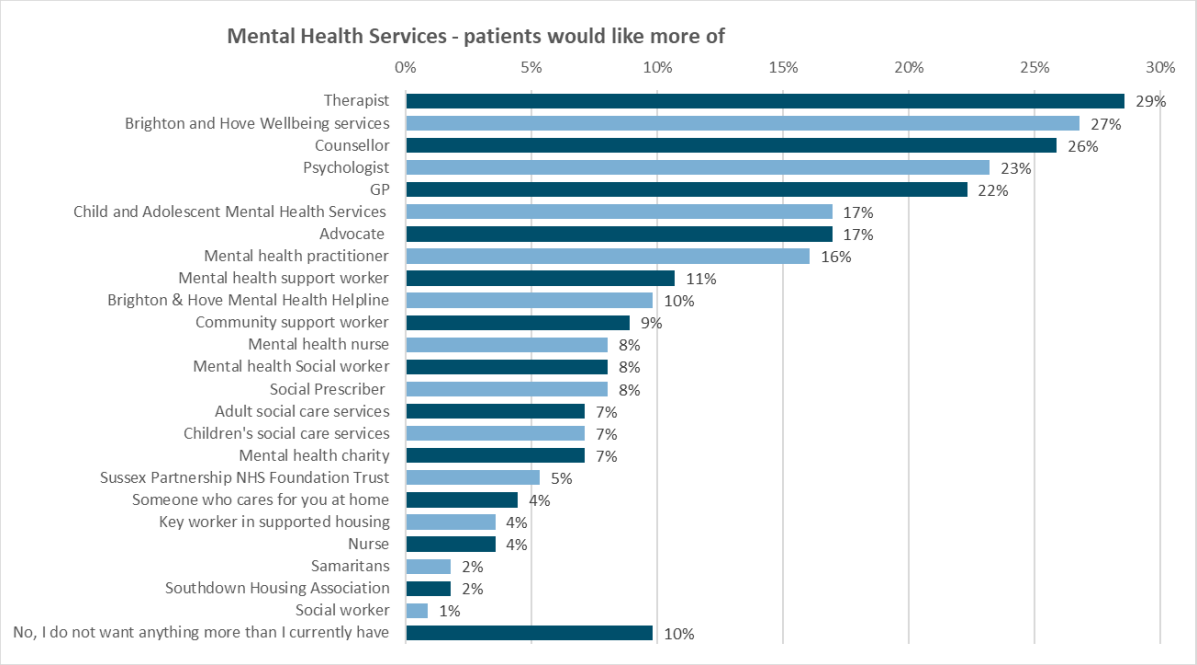
"I think aside from the long waiting lists, the process of getting support is fairly easy and quick to process."

"I am very grateful and lucky that I have been able to access highly subsidised psychotherapy and Eye Movement Desensitisation and Reprocessing (EMDR)."

"I appreciated the quickness of Sussex In Mind support being set up."

"Being able to be flexible around my needs (meeting online if I needed, offering flexible appointments, and meeting me at home if needed)."

A4 Preferred Services



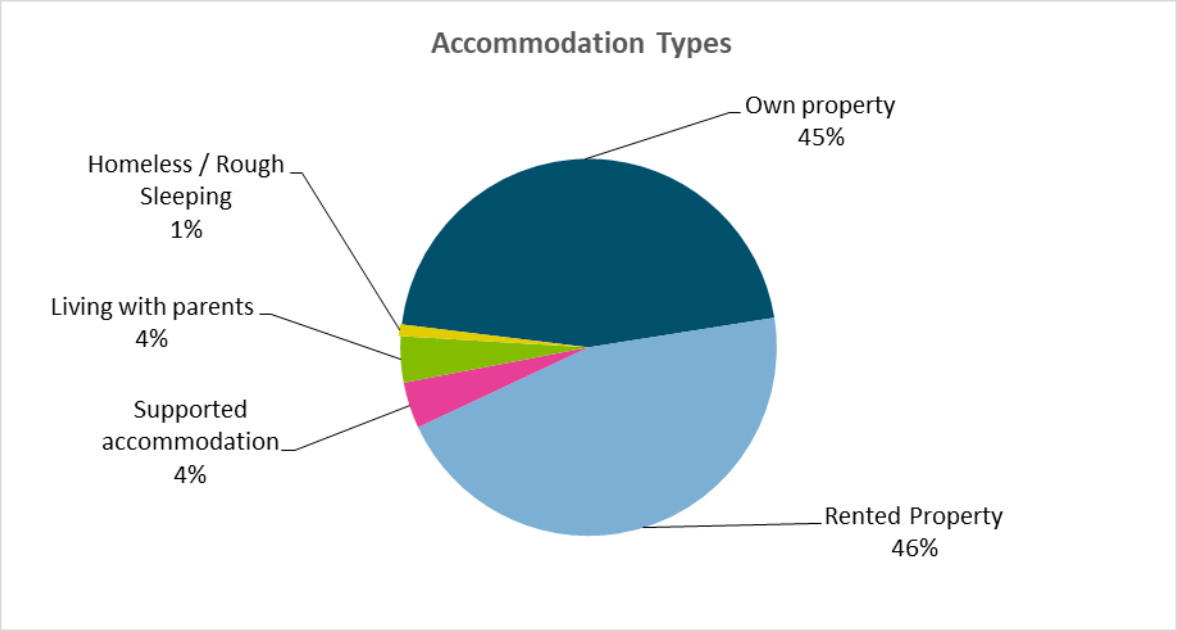
We asked service users which mental health services they would like to see more of (if any). They were able to choose as many options as they wanted. Therefore, the total percentages mentioned may exceed 100%. 112 service users responded to this question and from those who responded, we found:

- Between 20% and 30% of service users would have liked more of the following services:
    - Therapy (29%, 32 service users),
    - Brighton and Hove Wellbeing Service (27%, 30 service users),
    - Counsellor (26% 29),
    - Psychologist (23%, 26),
    - GP (22%, 25).
- Between 10% and 20% of service users would have liked more of the following:
    - Child and Adolescent Mental Health Services (17%, 19)
    - Advocate (17%, 19)
    - Mental health practitioner (16%, 18)
    - Mental health support worker (11%, 12)
    - Brighton & Hove Mental Health Helpline (10%, 11)
- Other services were requested by 10 people or less (lower than 10% of those that responded), as shown above, for example Community support worker (9%) and mental health nurse (8%).
- 11 people (10%) did not want anything more than they currently had.

A5 Accommodation

Our first question in this section was about whether people lived in Brighton & Hove or outside of the area. Four people lived outside of Brighton & Hove and were therefore removed from the data before we began analysing responses to all of the questions. 137 service users remained, which enabled us to focus only on experience of services in the local area, the purpose of this report.

Accommodation types



We asked what type of accommodation people were living in. We received 101 responses to this question, therefore percentages and numbers are the same. We found:

- The majority were either in their own property (42%) or in a rented property (42%).
- Four people were living with their parents/family.
- Four people were living in supported accommodation, one person each living in the following: Sheltered Accommodation, Southdown Community Moves, Brighton Housing Trust - Route One and Homeless Supported Accommodation.
- One person was homeless /rough sleeping.

Heated Accommodation

A defining feature of poor accommodation which has been linked to mental health issues, is the lack of central heating. [4] Therefore we asked people whether this was available in their accommodation. 83 people responded to this question and the majority did have central heating (93%, 77 people). However, six people (7%) did not.

[4] For further information on how poor housing can affect mental health, see https://www.mind.org.uk/information-support/guides-to-support-and-services/housing/housing-and-mental-health/. For further information on the UK Government's heat and building strategy, see https://www.gov.uk/government/publications/heat-and-buildings-strategy/heat-and-building-strategy-accessible-webpage

A6 Mental health support in your accommodation

Part of the objective of this survey was to find out about mental health support in accommodation. Therefore, we asked all respondents if they lived in accommodation that offered mental health support for example, advice about benefits, life skills such as cooking, advice about maintaining their tenancy, support for their general mental health needs etc.

Only three service users (living in Brighton and Hove) received this type of support. Therefore, the following case studies focus separately on each of these respondents, and their views about the accommodation questions as well as providing a context of their overall mental health support.

To preserve people's anonymity, pseudonyms have been used.

Case Study One – Financial support

"BHT tenancy sustainment worker has been very helpful"

Dave is a 58-year-old LGBTQ+ service user with long-term health issues that affect his life daily.

Dave lives in rented accommodation and is *financially supported* in this accommodation in a variety of ways, receiving advice about benefits, e.g. universal credit, budgeting advice and maintaining his tenancy, e.g. advice about paying rent and upkeeping his accommodation.

Dave thinks the support he receives is very good regarding giving time to explain any difficulties and listening to any requests and addressing concerns or making plans to do so. He thinks the support he receives is good at respecting his background, culture, and religious beliefs. He thinks the support is neither good nor poor in explaining how the accommodation works, involving him in decisions about his accommodation or having access to relevant notes about his accommodation needs and history.

Dave said he did not require any further support than he currently had.

In addition to accommodation support, he also currently receives the following mental health support:

- Adult social care services
- GP
- Mental health nurse
- Mental health practitioner
- Sussex Partnership NHS Foundation Trust
- Therapist (for example, offering Cognitive behavioural therapy, CBT)

Dave mostly uses his GP service and has found them to be good/very good at supporting. However, he found it difficult to find other mental health services in the first place, due to the length of time it took for these to be available to him.

Case Study Two – Advocacy and advice

Jill lives in Route One, a supported accommodation for adults with mental health and complex needs, managed by Brighton Housing Trust.

Jill currently receives support for maintaining her tenancy (e.g. advice about paying rent and/or the upkeep of accommodation etc.), accessing care, advice about local activities and advocacy (where someone acts on her behalf to help her access services).

Jill thinks the support she receives is good at involving her in decisions about her accommodation and supporting her in a way that respects her background, culture and religious beliefs.

However, Jill said the support was neither good nor poor at doing the following:

- Giving her time to explain any difficulties and listening to any requests/complaints
- Addressing her concerns or making plans to do so
- Explaining about how the accommodation works
- Having access to relevant notes about her accommodation needs and history.

Jill would like to receive more of the following:

- Advice on benefits (e.g. universal credit)
- Maintaining her tenancy (e.g. advice about paying rent and/or the upkeep of her accommodation etc.)
- Educational advice
- Advocacy (where someone acts on her behalf to help her)
- Support for her mental health
- Maintenance (repairs, faults etc.)

In addition to accommodation support, Jill also currently receives the following mental health support:

- Adult social care services
- Advocate (someone who acts on her behalf to help her)
- Brighton & Hove Mental Health Helpline
- Brighton and Hove Wellbeing services

Jill mostly uses the advocacy service and has found them be a mixture of good and neither good nor poor at supporting. Jill found it easy to find the services in the first place.

Case Study Three – Carer

Mark is an informal carer and is a current user of several mental health services including support through his accommodation.

Mark advised that he has been provided with life skills such as learning to cook and support with maintaining his accommodation.

Mark thinks the support he receives is very good at addressing his concerns and making plans to do so, and good at having access to relevant notes about his accommodation needs and history. However, he believes the service is poor at giving him enough time to explain difficulties and listening to requests/complaints, explaining how the accommodation works, and involving him in decisions. He also thinks the service is very poor at supporting him in a way that respects his background, culture, and religious beliefs.

Mark would like more training and more support for his mental health.

In addition to accommodation support, Mark also currently receives the following mental health support:

- Advocate (someone who acts on his behalf to help him access services)
- Brighton and Hove Wellbeing services
- Child and Adolescent Mental Health Services (CAMHS)
- Children's social care services
- Community support worker
- Counsellor
- GP
- Key worker in supported housing
- Mental health Charity
- Sussex Partnership NHS Foundation Trust
- Therapist (for example, offering Cognitive behavioural therapy, CBT)

A7 Follow-up interviews with service users

In addition to the questionnaire, Healthwatch carried out two further pieces of related work including follow-up interviews with service users. We tried to contact the 12 service users who indicated they were happy to be contacted again to arrange a short telephone interview. In many cases service users did not respond to our phone/email messages. However, four interviews took place. These are presented as case studies below.

As with previous case studies, anonymous names have been used to protect the identity of each service user.

Case Study Four – Inconsistency of care

"I had support for one hour a week, and now I have nothing…I know my mental health is going backwards…now I just want to stay in."

Shirley is a 49-year-old service user who lives with long-term health issues that affect her life daily.

Shirley has experienced multiple admissions to hospital related to her mental health including admission to Millview Hospital, where she felt there was no separation of patients with different conditions i.e. she was placed next to another patient with anger-management issues who verbally abused Shirley during her stay.

On discharge from Millview, she was assigned one lead practitioner who she felt "made my mental health worse". A second lead practitioner was assigned who Shirley got on very well with and remained with for almost a year until the Practitioner left the organisation. Shirley has been without any support for almost eight months.

Since she has been waiting, Shirley has seen a psychiatrist once, at her own request but she felt "the psychiatrist didn't know anything about me".

Shirley would like more practitioners to be available and better consistency of care, for example, seeing the same mental health professional each time.

Case Study Five – Excellent mental health support post-trauma

"My support was excellent; I can't really criticise it. But I prefer not to talk too much about my experience – It puts me back in that black hole."

Jonathan is a 75-year-old service user who lives with long-term health issues.

Jonathan was diagnosed with PTSD following an incredibly stressful period of caring for a terminally ill loved one. His loved one was misdiagnosed several times as well as receiving incorrect treatment.

Jonathan is still very much affected by this experience but doesn't like to talk too much about the past. However, he has received support from a psychologist who he described as "excellent". He was referred by his GP and found it relatively easy to find the service he needed.

Jonathan was also recommended a number of alternative services including support groups but found these less helpful. Talking to other people about their grief only added to his own.

Jonathan would like more support for informal carers, particularly those caring for family/friends with terminal illness. He would also like to see further community support groups/activities for carers after they have lost a loved one as this kind of social network can be invaluable when you are left on your own.

Case Study Six – Support is good but needs to be for longer.

"For the first time in so many years I have a mental health recovery plan."

Kevin is currently receiving support from the Community Mental Health Team, who has known him for many years. He is currently having talking therapy (in a group) which involves psychological treatment, working with a therapist, for mental and emotional problems like stress, anxiety, and depression.

Originally referred by his GP, he is also seeing a psychiatrist. Kevin feels he is being listened to and they have "prescribed me medication that makes me feel better rather than ones that make me feel worse".

Kevin would prefer more in-depth psychotherapy and access to further 121 support rather than in a group which he finds is less effective. He would also like support that is for a longer term rather than the usual six-week period offered by the Brighton and Hove Wellbeing Service.

Case Study Seven – Post-natal help good but only available to those in extreme need.

"The EMDR (Eye Movement Desensitization and Reprocessing) therapy was very good. I was dealing with incredibly high anxiety and stress. I had about 18 sessions. But preventative support would be even better."

Margaret is a 34-year-old who is not currently using mental health services but reflected on the post-natal care she received a while ago.

Margaret suffered from postnatal anxiety about six months after giving birth. She was referred by her GP to the Brighton and Hove Wellbeing Service. At first this service suggested parenting classes which Margaret felt was "patronising as I had extreme anxiety, and this was not what I needed."

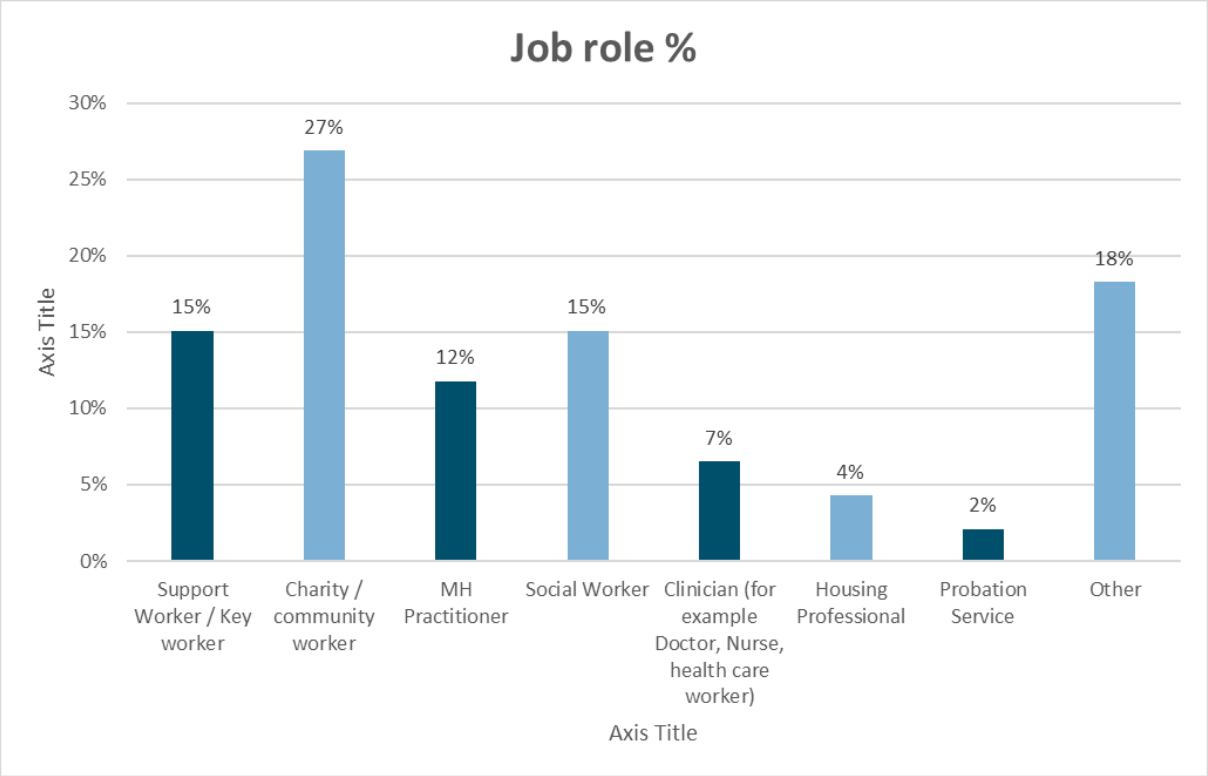
After going back to her GP, she was referred again, and this time received Cognitive Behavioural Therapy followed by Eye Movement Desensitization and Reprocessing (EMDR) therapy.

However, Margaret would like better preventative support to be available. She feels due to her "extreme need" she was given therapy. But "it would be good if they could help people before things get to that stage." Margaret also feels the services need to be better funded, with more psychotherapists available, to enable "the right support at the right time".

Section B: Professionals and Clinicians Experience of Mental Health Services

To complement the views of the service users, an important part of this engagement was to seek the views of professionals and clinicians (now termed professionals for simplicity). This section presents the main findings from the professionals' survey. Section D will look at the commonalities between their views and those of service users.

In line with the service users' survey, the professionals' questionnaire was issued in an online format and was open between January 14th to February 27th, 2022. In total 96 professionals responded, and all percentages are derived from those who gave a valid response (excluding those who did not respond). Most questions were open-ended inviting professionals to add comments.



To contextualise their responses, the professionals reported a wide range of working roles, with just over one-quarter (27%) working as a Charity / Community Worker. Additional leading professions were Support Worker / Key Worker (15%) and Social Worker (15%). The 18% who described other roles included Commissioners, Mental Health Service Leads, Access Officers, Social Prescribers, an Interpreter, and a Paramedic.

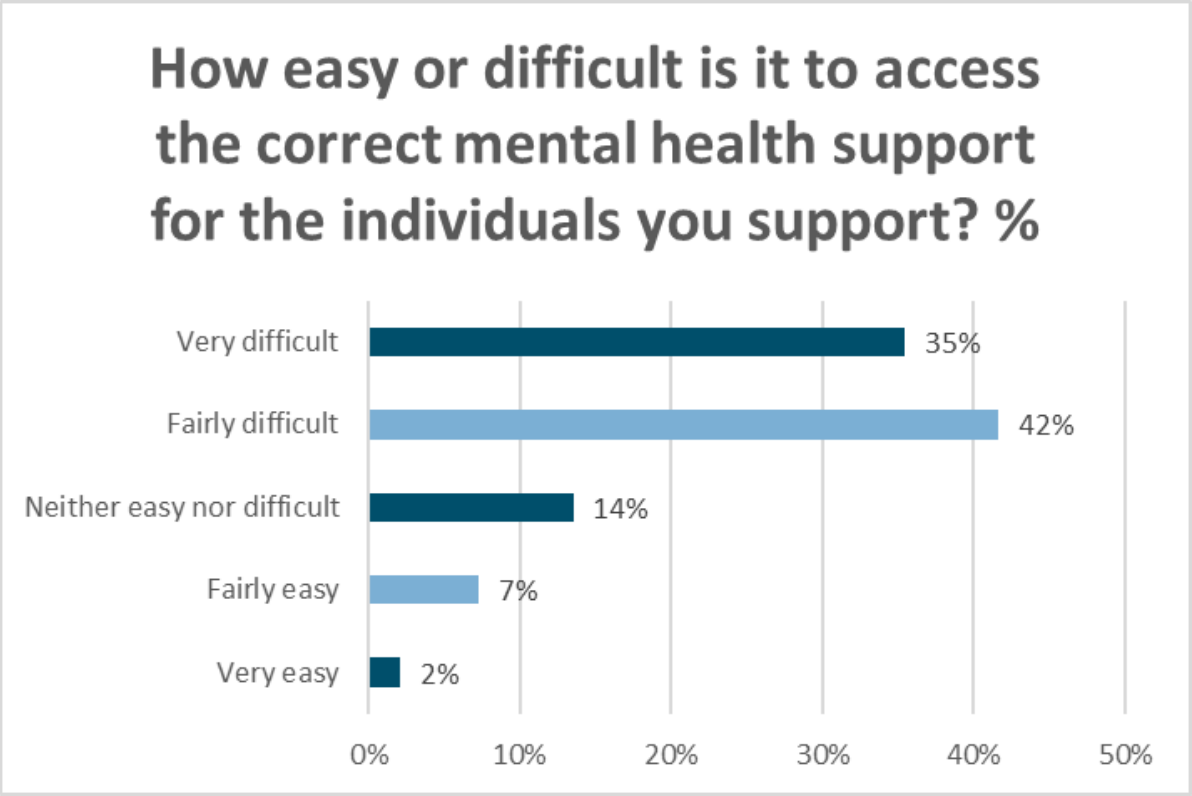
The remainder of the findings from professionals were grouped into the following:

- Accessing mental health support
- Accessing support in crisis
- Accessing accommodation support
- Mental health pathways and joined-up support

- Community-based support
- Services that respect background cultural life and religious beliefs.

B1 Accessing mental health support for clients

In terms of accessing the correct mental health support for their clients there was a strong skew to the difficulties surrounding this. As shown below, 77% of professionals found this difficult (42% 'fairly difficult' and 35% 'very difficult'). Although parallels with the service users will be made in a later section, it is worth reiterating that 57% also found it either "difficult" or "very difficult" to find support.



There were several comments around this response that highlighted the barriers towards accessing the correct mental health support for clients. The most common barrier was **providing support for people who have coexisting conditions.** This was usually where the person had substance misuse problems that acted as a barrier to their accessing services.

"If they have drug/alcohol problems then they are told they need to sort this first before receiving treatment."

"There is an unclear criterion for the service which is not widely shared and clients with co-existing substance misuse are routinely told they are 'not stable enough'."

"For clients with very complex mental health needs housing can be difficult to access. People who have a forensic history can be difficult to accommodate, and those with multiple complex needs. Risks can often be too high for providers and

complex clients are often declined. Clients who are struggling with addiction are also not easy to accommodate."

"I work with clients who have experienced domestic abuse. As they have experienced trauma, when they are referred to the local NHS mental health services, they are discharged and signposted to RISE (the charity I work for). … As well as this, my client's needs are often deemed 'too complex' or 'not complex enough' to be met by the local NHS mental health service."

Linked to the above point, there are further barriers where **people have unique needs**, with autism, LGBTQ+ support, language and literacy issues commonly mentioned.

"Where people have other health conditions or issues, often seems like a reason for mental health services to decline to support them. Particularly autism, personality disorder or substance use."

"There are no health service supports for people with autism but when they get mental health support it does not consistently meet their needs arising from autism."

"I work with LGBTQ+ people who often have multiple and complex needs which make them unsuitable for lots of types of support."

"It remains difficult for people with language support needs to access G.P services and to obtain support for their mental health needs."

"Also not reading and writing so not being able to access information and online support. Also GP surgeries doing online e-consults now and bookings being online. This is a massive barrier for illiteracy and computer illiteracy."

With regards to particular needs, there were extra comments specifically around **young people**. There were concerns around lack of provision and also people 'slipping through the net' as they transferred from children and young people services to adult services.

"Support for young people in Brighton and Hove through CAMHS is very limited. There are long waiting times between assessment and intervention and cases are often held on duty. There is a high level of need for children and young people in Brighton and Hove, from wellbeing support to crisis intervention."

"I work with young people who have a high risk of suicide. There is no provision for young people once they turn 18 and they no longer have the support of CAMHS. Adult services will not take them on, and I have referred five 18-20 year old clients recently for ATS, CAMHS assertive outreach and to their GP and none of them have been picked up any further. People take their own lives and the system still does not change."

The point about the lack of CAMHS provision above leads into many comments which detailed the **pressures within the system** and the lack of support to accommodate this. There are several barriers to accessing support within the system which are detailed below.

Lack of resource and investment

“Rather than it relating to specific services, it's simply a case of resources being stretched and wait times being long for those who are not in crisis and who are living with low to moderate mental health challenges.”

“Mental Health Services have not expanded in line with need especially in light of the global pandemic and the emerging mental health concerns as a result.”

“Child and Adolescent Mental Health Services seem to be stretched beyond their limits and even clients who have allocated workers sometimes struggle to access the service."

Lack of specific mental health services, including accommodation

“Respite for mental health carers appears to be virtually non-existent.”

"Access to structured therapy and treatment is limited, especially for individuals experiencing difficulties related to personality disorders and emotional or relational difficulties.”

“Lack of access to good quality rehabilitative and therapeutic living environments which are safe, secure and promote the highest possible wellbeing for individuals.”

Lack of clear pathways

“There seems to be very little therapy for service users who are in need. Quite often they are referred to our service it seems almost as a last resort.”

“One client was referred to the Assessment and Treatment Service (ATS). ATS reviewed referral, advised medication, and discharged them back to the GP. Service user was not contacted at all. He was unsure and upset as to why as he feels he needs some therapeutic support.”

“From our standpoint, we have to refer clients through their medical services - GP, hospital Consultant - to be able to get them mental health support. We do not have a direct link with the available mental health services in the city.”

No out-of-hours support

“Out of hours there are no adult social care or mental health services available apart from the Approved Mental Health professionals who deal with assessments only.”

“General capacity of services, and out-of-hour capability is poor.”

Lack of preventative support

“The threshold for any service is too high. Many people need support around 'mild' mental health issues but support for this is nearly non-existent. It would be great to have more free or affordable counselling before the issues become a crisis.”

“Very frequently it takes things getting to a crisis level for my clients to be listened to or heard, by which point things are a LOT worse than they were in the beginning and makes preventative work very, very difficult.”

The above points appear to be contributing to the increased **waiting times** for services, compounded by the **increase in demand** for services.

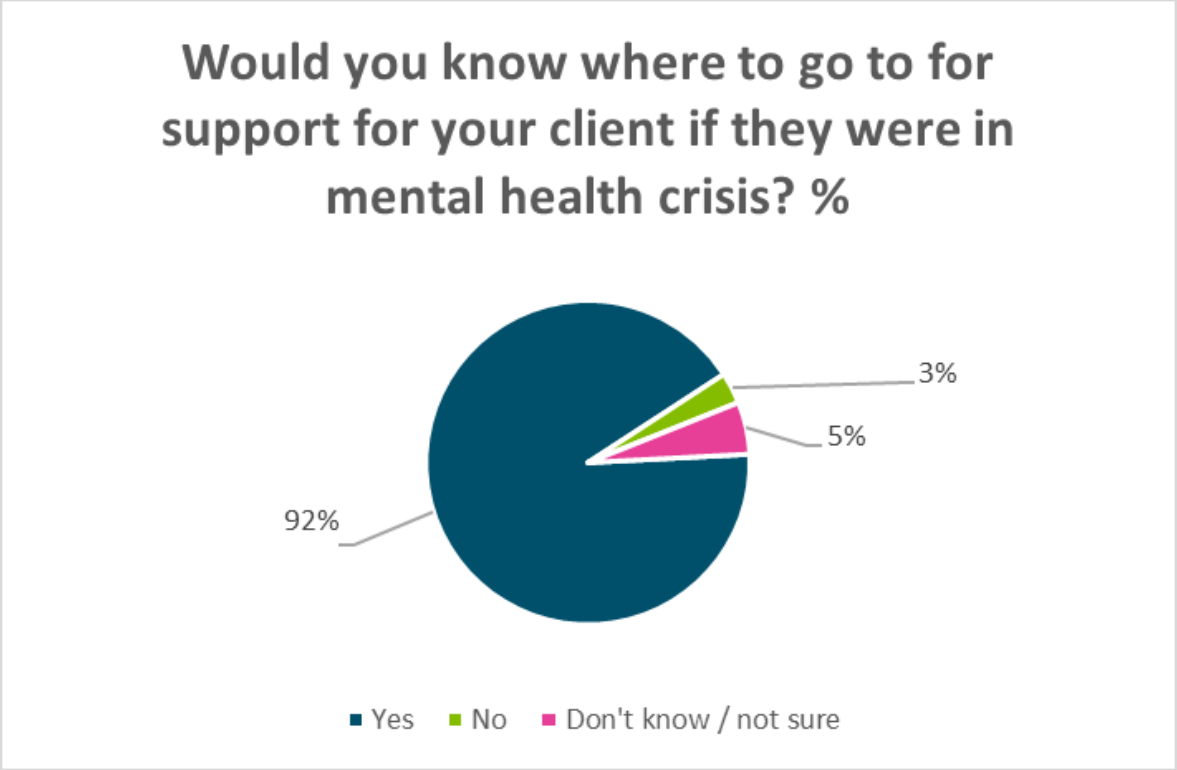
"NHS services are almost universally overwhelmed with extremely long waiting lists and extremely strict inclusion criteria...The voluntary sector in Brighton is better than most other areas of Sussex in having a huge variety of valuable support, however, this sector is also facing unprecedented cuts and pressures as well as being expected to mop up the most complex and often high-risk presentations whose needs aren't being provided for by the mental health services."

"Often the service offered, even when it is available, has a long waiting list and then a very short duration, insufficient for the complexity of challenge we see."

"Crisis, acute and inpatient support has increased 3-fold."

B2 Accessing support in crisis

Most professionals (92%) knew where to go to in order to get support for their client if they were in a mental health crisis, for example posing a risk to themselves or others.



In examining the comments, the majority response was to seek support from the Mental Health Rapid Response Service (**MHRRS**):

"Very helpful to have MHRRS team to call on for us clinicians but also service users."

This response was rarely made in isolation as others listed a range of other services including Crisis Resolution and Home Treatment Teams (CRHTs), Assessment and Treatment Service (ATS), A&E, the Police, NHS 111, and the Samaritans. This **range of additional services** explains the high levels of support options outlined in the chart above:

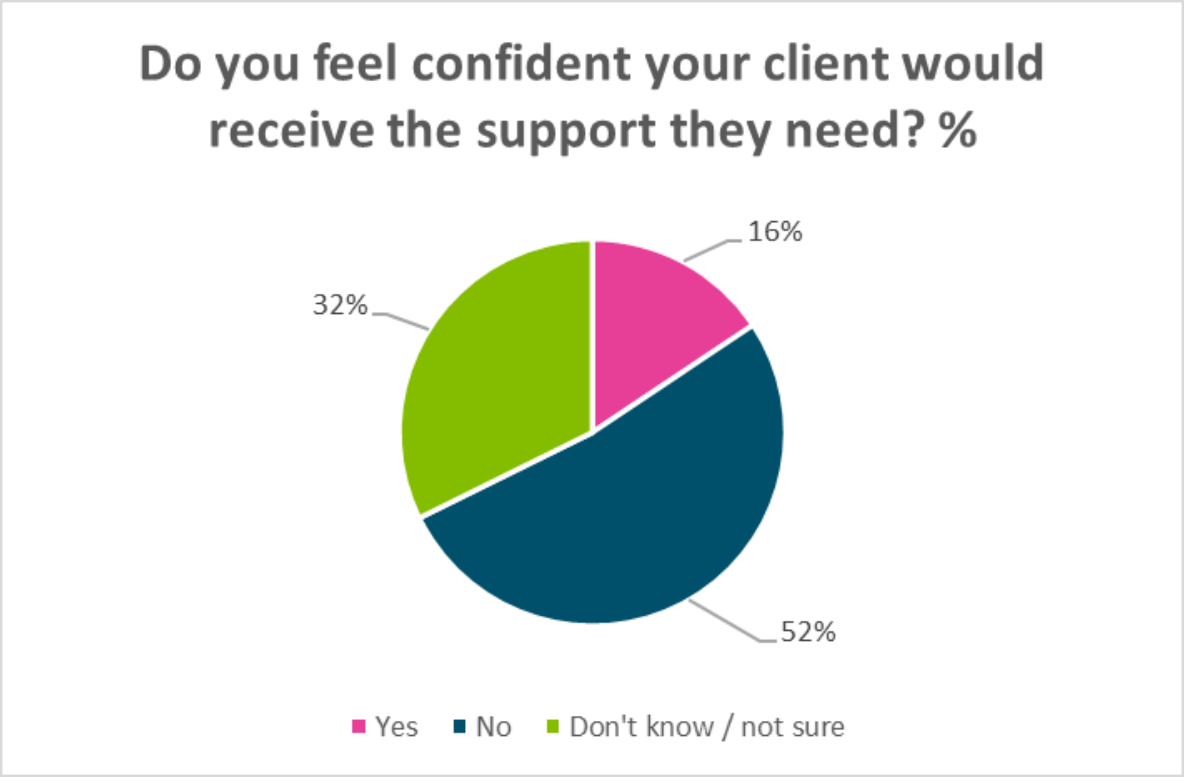
"I would contact the MHRRS if I needed advice. I would contact 111 if there was a medical incident. In case of emergency, I would contact the ambulance service or Sussex Police."

"I would contact the following: MHRRS or attend A&E; the police or emergency services; or an ATS or other secondary mental health service if the person is known to a team."

"The MHRRS, the Sussex Mental Health Line, Samaritans, the police are who I would contact."

"I would contact the MHRRS; Mental Healthline; Samaritans; A&E; The Haven or use the Stay Alive app."

Nonetheless, professionals were less certain about whether their clients would receive the support they needed, with only 16% saying they would. This is a 76 percentage point difference between awareness and confidence that service-users would receive the crisis support they needed, and is one of the most significant findings from this study.



The leading comments explaining the discrepancy in the chart responses above were about **lack of resources**, **services under pressure** and with **notable waiting lists**:

"The ATS service is very understaffed and overwhelmed currently, with a large waiting list. I am holding ATS clients on my caseload in perinatal mental health."

"I think this would depend on the need. Our community services are not working at full staffing establishment and as such are struggling to meet demand. If a placement was urgently required, this may be difficult."

"I'm worried about how stretched and under resources services are currently to cope with demand and complexity of need, disability and risk."

Nonetheless, when the need is critical there does tend to be an **immediate response**:

"If the risk was high then I know that mental health services do tend to respond in these circumstances. However, only the most extreme levels of risk tend to qualify for intervention due to pressures on services."

"Sussex Police respond immediately to suicidal clients. The ambulance service assess and respond according to that assessment."

"Unless they are about to kill themselves or others it appears that support offered is not offered."

As mentioned in the previous section, the support offered to **those with particular needs and circumstances** appear to be of greatest concern, in these examples relating to LGBTQ+, young people and language barriers:

"Absolutely not. Things are worsening in services. Budget cuts, lack of resources, poor pay and staff pressure all play a part but so does a huge lack of awareness on LGBTQ identities. LGBTQ folks, and other marginalised groups are actively fearful that they will be discriminated against, judged, and/or not believed when trying to access services."

"Young people don't always make use of MHRRS, they find the wait and the impersonal nature difficult."

"Most likely they will if they understand why they need treatment and what treatment it is. Therefore, providing language help (community interpreter) is crucial for service users whose first language is not English."

Again, as mentioned before, the likelihood of support depends on whether people present the **threshold of need**:

"I have seen too many clients turned away from mental health services as they have been deemed to be not an urgent case or in need of mental health support at the time of presenting/initial contact with the services."

"Only the most extreme levels of risk tend to qualify for intervention due to pressures on services."

"We are aware of how low numbers of mental health professionals are in the city and that the thresholds for referral or support are often too high or are reliant on self-help (apps, toolkits etc)."

"Having complex and multiple issues which make them ineligible for support from most services."

Further comments about the barriers to accessing support echoed much of the above with **lack of resources** and services in place. Additional barriers including people moving around the system and lack of **joined up working**:

"Revolving door issues. Too many people being batted around the system. People feel upset about having to tell their story over and over and may disengage. Mistrust, poor experiences."

"Many of our service users are passed along between so many services that they tend to feel unsupported when they actually need the assistance; by the time someone does get to them it can be too late."

Other barriers include **lack of awareness of services** as well as their own need, **transport issues**, and **language issues**:

"Knowing what support is out there for them to access in times of crisis."

"Sometimes themselves - lack of self-worth can prohibit self-advocacy; similarly, mental health needs might be such that there's a lack of comprehension on client's part that such support is necessary. As such, there can exist a gap between clear need but lack of severity for specific services to step in, at which point clients are at greater risk of further deterioration in terms of mental health."

"Getting someone to come out to them is often difficult. Getting to hospital without transport is difficult, especially in the middle of the night. Not having access to a phone to call for support."

"Language barriers can be a challenge. Sussex Interpreting Services provides a 24-hour emergency interpreting service and this is regularly used by an approved mental health professional across Sussex. Crisis, acute and service user interpreting support has increased 3-fold for Sussex Partnership NHS Foundation Trust compared to pre-pandemic."

B3. Accessing accommodation support

Professionals reported difficulties for their clients in accessing accommodation which is suitable for their mental health needs. 70% reported accessing suitable accommodation was not possible and only 6% thought this was possible.



There were several comments expanding on the results above, showing the problems that clients faced when trying to access accommodation. The most striking problem was the **lack of suitable accommodation.** Note that lack of suitable accommodation was mentioned in Section B1 in relation to barriers to accessing mental health support:

"There is a need for clients who need long-term supported accommodation which either doesn't exist or is extremely difficult to get into."

"Lack of affordable housing in the city, lack of adequate supported housing, that is safe and not predominately for drug and alcohol users. This has been proved unsafe especially for vulnerable women."

"Sourcing small packages of social care community outreach support for people, to enable them to live independently and maintain a tenancy, is virtually impossible."

Where housing was available, this was often found not to be suitable for those in need which can be **detrimental to their mental health**:

"Housing is a serious issue for my cases and mentally unstable people are often housed in unhealthy environments or places full of challenging people, so it is bad for their mental health."

“Due to the lack of social housing, my clients often end up in accommodation that negatively impacts their mental health, as they are often isolated or don't have access to facilities, such as cooking facilities, or there are high levels of anti-social behaviour.”

“The lack of accommodation in Brighton has meant that some clients are in accommodation which makes their mental health worse, e.g. anxiety around their safety and the other people in the accommodation.”

As a recurring theme throughout these findings, problems are compounded for **young people**, those with **language issues**, and the **LGBTQ+** community:

“Access to housing advice and guidance is very limited and some people have low literacy even in their preferred language.”

“Brighton & Hove City Council do not routinely use interpreters and cases are complex and people are bewildered.”

"Some young people with mental health problems would benefit from not being in shared accommodation or accommodation that has lots of residents. Too many people can be very triggering especially if there are lots of young people with mental health issues living in a scheme at any one time.”

“There is a need for mental health housing services for young people (aged 16-25 years old). Also, for more support for the current young people's supported housing services to be able to access wrap around mental health services easily when young people find themselves in crisis. There needs to be funding for mental health trained staff to work permanently in the staff team or to be readily available in the current young people supported housing services as many of the young people have complex mental health needs and trauma which can escalate to crisis.”

“Often people have experienced trauma and or homo/trans/biphobia in emergency accommodation.”

B4. Mental health pathways and joined-up support

The responses to mental health pathways were entirely qualitative (comment-based). Note that lack of clear pathways was mentioned in Section B1 on barriers to accessing mental health support. Professionals were asked to consider what current pathways and services were working well and what could be improved.

In terms of what was working well, professionals mentioned a number of individual services that support mental health including the perinatal service, clinical psychologists, community support, and the array of voluntary organisations:

"The perinatal service I work for has good links across adult social care, children services, physical and mental health."

"My experience of the broader clinical health psychology provision is very good - there is a wide range of services that are able to work in a flexible way that accommodates the particular needs of their client group."

"Community support e.g. Mind and Southdown are good."

"The Lighthouse is known to be an excellent, specialist service. Once the person is accepted, they are great, e.g. pregnancy/birth and mental health; eating disorders."

"Foodbanks and other services like ST Mungo's are good short-term."

"Brighton is lucky to have such an array of excellent voluntary sector organisations addressing the challenges of mental health, social isolation, HIV and others."

Some professionals **commented positively on the supported accommodation** that was available:

"The high support mental health housing also has many strengths including a strong emphasis on person centred care and promoting skills and engagement with the community, activities, and employment. There are skilled people working in these services delivering excellent examples of care and therapeutic work - often with limited support form statutory services, health services."

"Some young people's accommodation services offer access to a therapist in house."

"Route One - self-contained accommodation. Has worked really successfully for my clients and I can't praise it enough."

Nonetheless, and linking to the next set of findings, some people used this opportunity to say little was working particularly well. Once more people pointed out the issue of **coexisting conditions, inadequate services, and limited supported housing**:

"Want to find something positive to say but have not really had great experiences."

"For clients with complex needs and coexisting substance misuse, nothing works well."

"I don't feel that any of it works well at this time. I also feel that there is an urgent need for more talking therapies for people who have mental health and emotional issues and whose only recourse appears to be a few sessions with the Wellbeing Service."

"Nothing is currently working well, as services are so stretched."

"Most of our clients that have poor mental health and are facing homelessness are never given the option of supported housing. Many find the new online platform being used by Homemove and to get housing advice if they are facing homelessness really challenging and very stressful."

"Extra Care model is really community focused and lovely accommodation. However again they won't accept anyone with drinking patterns/ complex mental health. The model would be ideal for many who then end up in residential and usually out of Brighton as we've nothing in the city."

For aspects to be improved, the findings were dominated by **increasing resources and reducing waiting lists**:

"A broader range of services for specific groups as well as enough resources for the current services to be able to function (a waiting list of more than 4 to 6 months becomes actively damaging) but without compromising the duration or quality of support they offer."

"I would like to see mental health adequately funded, but it will never work well due to cuts to austerity, lack of housing and social care."

"Resources are stretched in all areas - particularly in acute or respite."

People also mentioned that the services were **insufficiently joined-up**, meaning complex pathways and people having to navigate different professionals and services:

"Crisis services and remits are not joined up - there are gaps particularly over weekends and for older people with functional mental health needs."

"Bridge the gap between discharge and housing, more placements suited for those with complex mental health needs."

"I am not clear that the relationship between mental health services and social care services is always very joined up or collaborative in approach. It can be antagonistic and defensive, and pathways are not always clear or responsive."

As noted previously, people commented on how **professionals needed to be aware of people in unique circumstances**, including the LGBTQ+ community, bereavement services, and those with language issues as examples:

"Staff should be trained on LGBTQ identities and tested to ensure that they have a true understanding and that they apply the knowledge in their practice."

"Bereavement counselling is very difficult to access with long waiting times. Again, group support is frequently offered first, and this is not always suitable or accessible."

"There is a need for additional help with completing Homemove applications for people with English as a foreign language… In addition to this, filling in these types of forms is much easier with face-to-face interpreting support so it would be helpful if there were a service that could offer appointments to fill in the forms with a face-to-face interpreter booked."

There were specific **suggestions to improve access to accommodation**, including making **applications easier and tailored provision** (in this example for young people):

"Having a much easier online housing application system, that lets you complete an application, without the need to stop and having to contact Brighton and Hove City Council (BHCC) to resolve the issue. Which currently means having to send an email to BHCC and waiting for a reply. Prolonging the process."

"Access to Housing Advocacy to help people to communicate with landlords, agencies and housing services, housing legal advice would be useful as the impact on people feeling insecurely housed or at risk of homelessness has such a major impact on someone's mental health."

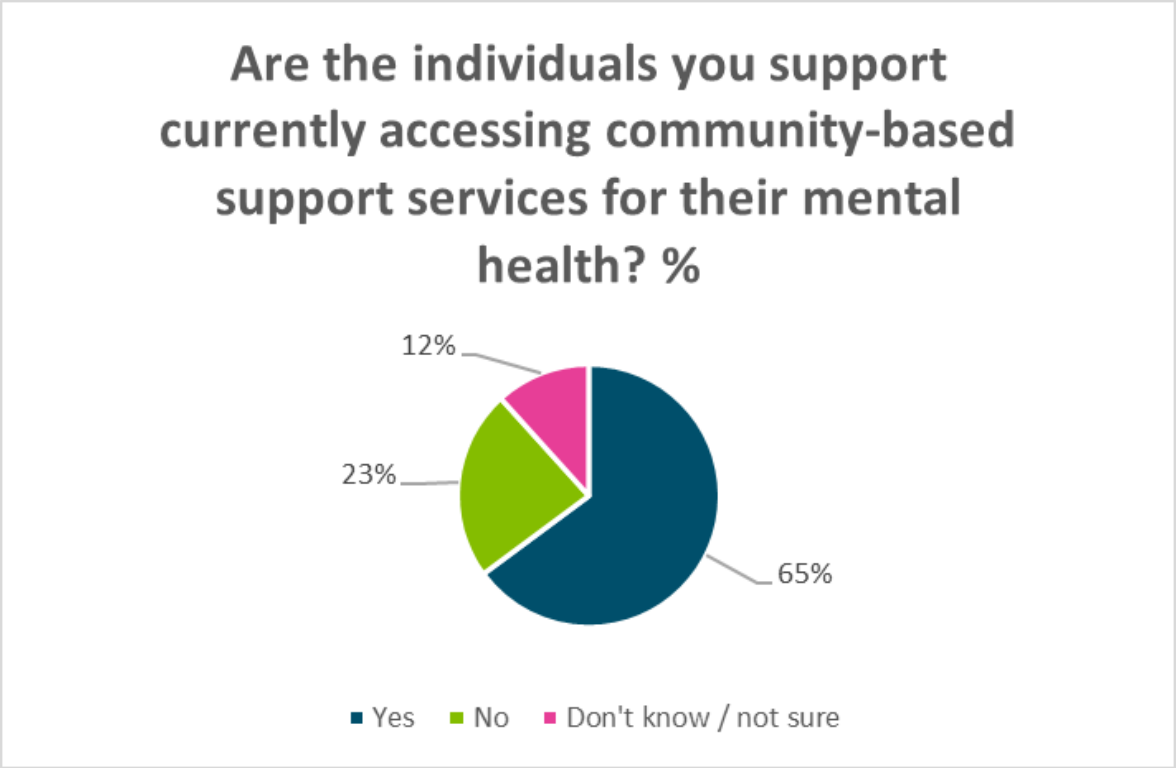
"Having a designated housing worker to support with housing needs, easier access to the housing department where the person can get through to someone they know, and the best thing would be more appropriate housing available, but I appreciate that might be hard."

"There is no support for people that need to be moved out of poorly maintained privately rented accommodation when a landlord refuses to make improvements, which Link Workers see as a frequent need."

"Specialist accommodation for young people with mental health issues - a place where young people can go when they are feeling unwell, and risks are escalating - where they can get a therapeutic help in their setting rather than moving them on because schemes can no longer manage risk. Ideally some of this could be small, shared accommodation and perhaps some self-contained too."

B5. Community-based support

Professionals were asked whether the individuals they support currently access community-based support services for their mental health (for example, a befriending service, support group, social activities). A total of 65% said they did, although a further 23% said they did not.



Professionals were asked to suggest additional models of support or social / community-based services which they felt would have a positive impact on their clients in recovery or in maintaining their wellbeing. The most commonly mentioned suggestions were **peer-led activities**:

"Mental health peer support groups."

"More peer support opportunities."

"At our project we are huge advocates of peer-led peer support models of mental health recovery."

"Maybe more peer support, more holistic support services, more community/outside activities."

The remaining suggestions were disparate in their manner, showing a range of responses including **sport and generally getting people together**:

"Access to sporting activities could be improved, and more sporting access for people with mental health issues."

"Outdoor / indoor exercise group for similar ages to get together."

"Coffee mornings!"

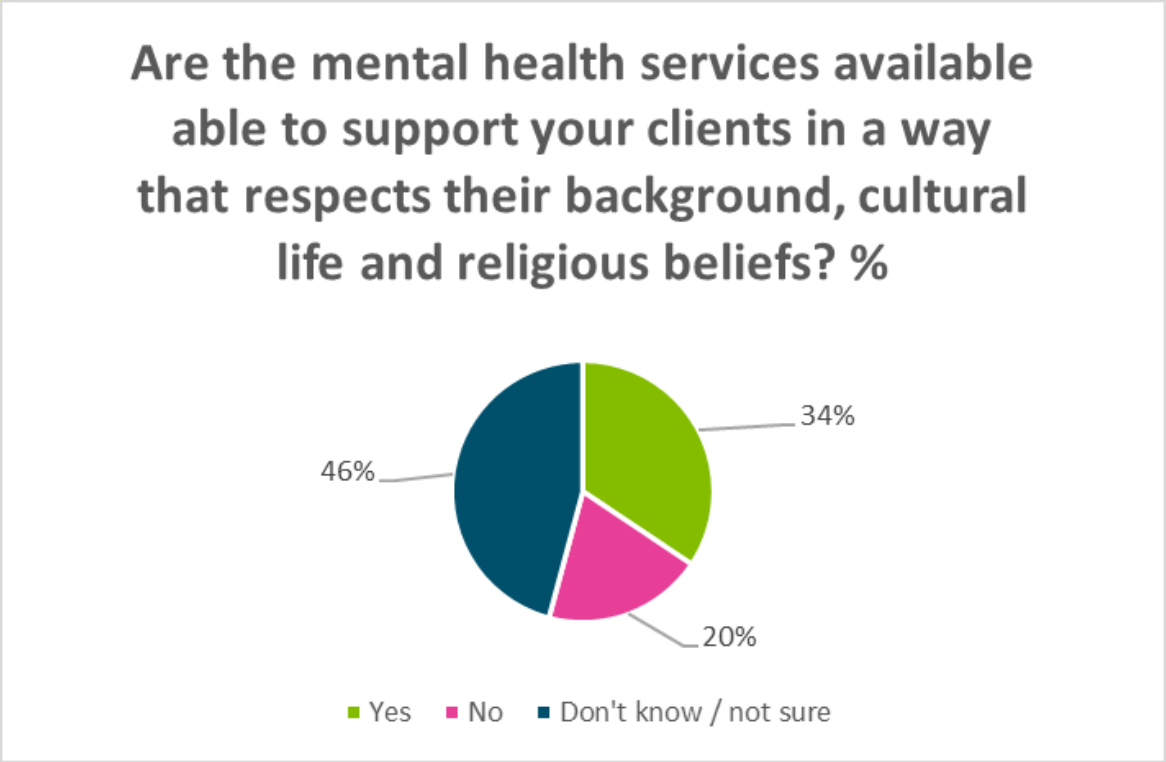
"More day services, particularly for functional older people. Isolation is huge."

"People like to do creative things, and to get out into green spaces."

"Place based support – i.e. where people come together."

B6. Mental health services that respect people's background cultural life and religious beliefs

Although just over one-third (34%) of professionals said they felt mental health services respected people's cultural life and religious beliefs; the majority (46%) did not know or were not sure whether mental health services were respectful. This particularly accounts for why only 38 people provided further detail on their answer, relative to 80 or 90 people for the other open-ended comments.



Most comments referred to the **lack of discussion over respecting the cultural and religious backgrounds**, principally because of the stretched nature of the service:

"It doesn't really appear to be discussed. It is about firefighting if I am honest."

"It seems mental health services do not have the time or contact with clients to get to know their background, cultural life and religious beliefs."

Some people mentioned local **communities with specific backgrounds or needs** that were not helped by the mental health services. These included domestic abuse victims, those from the travelling community, people not born in the UK, those for whom English is not their first language, those with marginalised gender identities and ethnic ***minority groups:***

"There are no NHS services specifically for those who have experienced trauma such as domestic abuse."

"Gypsies and Travellers way of life either ignorant of, or not respected."

"Brighton appears to maintain a hostile environment for those that do not have a local connection or are not born in the UK."

"People are facing repeated discrimination from staff members in stat services re: their marginalised identities. The deadnaming and outing of trans people is a very real problem. People are still, in 2022, assumed to be cisgender and heterosexual, often."

"The model of interpreting supports the provision of culturally appropriate information, especially where practitioners use pre and post sessions. However, a lot more work needs to be delivered within communities to de-stigmatise services and to explain what is on offer - a more preventative approach is needed."

"The experiences of young black men for example are very different living in a predominately white supremacy community, than a white young man."

Section C: Three recommendations to improve mental health services in Brighton and Hove

To supplement the data gathered from the surveys, Healthwatch carried out a mailshot asking for opinions on the "top three things that could improve mental health services in Brighton and Hove".

We targeted three groups:

- Service users who had responded to the Healthwatch survey and who had given us permission to contact them again.
- Respondents to a previous survey run by Healthwatch regarding digital GP services, who had demographically defined themselves as suffering from a mental health condition and who had given us permission to contact them again.
- We also contacted everyone on the Healthwatch mailing list asking for them to respond anonymously to the office@healthwatch email address. We phrased the question slightly differently to these people, so that it was open to anyone who knew a service user as well as current and past service users themselves.

We received responses from 29 people: in total 87 comments. We did not ask for demographic information but from the comments provided, it would indicate that responses were from a mixture of service users and professionals.

The following section provides a summary of the recommendations that were suggested. We have grouped these under headings, reflecting the three most popular recommendations made by people: Funding; Awareness and Training for GPs and the general public; and Tailored Support. We have added a fourth heading "other" collating all other suggestions that were made. Under each heading, we have used *Word clouds* to illustrate the most popular words people used when describing this recommendation and we have also included quotes from some of the respondents.

Funding



One of the most popular recommendations was regarding funding. People recommended **more staff and more services available** to enable quicker response times and **decrease the lengthy waiting times** that people had experienced when being referred or referring others for mental health services. In general, people asked for **more investment** in the NHS mental health services and other organisations that support the NHS such as Rise, survivors' network etc.

"Increase staffing levels as waiting times for initial assessment is considerable, and unacceptable for a child or adult with mental health issues, which need addressing."

"Employ more staff! This is the only way you can try to meet the ever-growing needs."

"Far more investment in CAMHS to significantly reduce waiting times."

Awareness and Training for GPs and the general public about mental health



Many of the comments referred to the lack of awareness (either by the public or by their GP) about mental health needs. Some GPs had misdiagnosed symptoms and a common complaint was too much reliance on medication, rather than emotional support. Many comments from service users suggested that GPs and other mental health professionals needed better listening skills. There was also more than one recommendation that service users should be involved in decisions about their own care.

"GPs could support people better to connect with society, activities, encourage a healthy lifestyle and being useful."

"Improve reach out to the lonely in the community, possibly though GP liaison."

"The "Health MOT" for older people should include an assessment of mental health."

Tailored support



As with other areas of the report, service users and professionals highlighted the need for mental health services to take into consideration a number of other factors regarding the patient's circumstances. These included:

- Patients who had identified as LGBTQ+.
- Patients who had been diagnosed with Autism, ADHD or other neuro-diverse conditions.
- Patients dealing with coexisting conditions such as alcohol and substance misuse.
- Domestic abuse patients.
- Homeless patients.
- One person mentioned "older men" who they felt were often ignored.

In a similar vein, other comments suggested the need for specialised therapy for patients who had dealt with specific situations or circumstances. These included:

- Other alternative therapies were suggested to accompany the usual cognitive behavioural group therapy offered, for example talking therapy, Eye Movement Desensitisation and Reprocessing (EMDR) therapy and 121 therapy.
- Bereavement therapy where appropriate.
- Specialist Trauma therapy (outside of that related to domestic and sexual assault).
- Therapeutic therapy such as painting, craft making and yoga.

“Therapy is sometimes not enough to solve the problem, but if some sort of physical works like painting and craft making or drawing, it could help to make it a better result.”

“A neuro-diversity team embedded somewhere within the mental health services would be helpful.”

“A confidential helpline and/or call centre for mental health patients.”

Other recommendations



A further 20 comments included the following recommendations. Many comments talked about consistency of care, for example seeing the same mental health practitioner and the importance of building a relationship with someone they could trust. The length of the service offered was also important to many. Once the initial service had run its course, service users and professionals recommended ongoing care or less frequent but regular check-ups. This could be similar to the Patient Initiated follow-up service offered to hospital outpatients.

Recommendations also included **better communication** between NHS services and **joined-up care** between the NHS and other supporting services. **Children's services** were mentioned in several comments, that recommended **improved links between CAMHS and schools** as well as **more services for children** in general.

"Clients are left alone with no interim support which can create more difficulties than if the services were more streamlined and connected."

"My care was good, but I could have done with six-monthly check-ups with the practitioner to keep me on track."

"We need prompt assessment and treatment for children and young people so that they can start treatment within three weeks from referral."

Section D: Summary and Conclusions

This section looks at the commonalities between the views of service users and those of the professionals. It draws from the "top three recommendations to improve mental health services in Brighton and Hove" suggested by service users and professionals. We have themed these as follows:

High quality care
Both service users and professionals were **generally complementary** about mental health providers, mentioning organisations and individuals who had provided **high quality of care**. Service users spoke positively about being "listened to and treated with concern", but less positively about providers "addressing [their] needs or making plans to do so", perhaps reflecting the short-term nature of some support.

Lack of resources
However, both service users and professionals were also acutely aware of the **stretched, under-resourced** nature of the mental health and housing service in Brighton and Hove. Note that 57% of service users found it "difficult" to find support, and 77% of professionals found accessing the correct mental health support "difficult". David, Case Study One, provides a good example of this.

GPs are the first port of call, but more training is needed
65% of service users had approached their GP for help in accessing mental health services. However, comments from some service users showed that their **GP did not understand** their emotional needs, sometimes **misdiagnosing their condition**, treating the physical need rather than seeing it as a mental health symptom, and there was a tendency to rely on medication rather than therapy.

People are unsure where to go
Some service users reported they **did not know where to go** for mental health support. Note that 27% used an internet search to find support. Comments from both professionals and service users indicate that there was not enough public awareness about these services and how to access them.

Long waiting lists and high thresholds
When service users were referred, many comments told of **long waiting lists**, or being offered services that had been **tried and test before** without success. Note that 60% of service users found waiting times too long and 31% were offered a service they had used previously and had found it not to meet their needs. There was also a lack of out of hours support offered.

The majority of professionals (92%) knew where to go for crisis support, but only 16% were confident that their clients would be able to get the help they required. Leading comments from professionals indicated that **thresholds were too high** (as in the example given by Margaret in Case Study Seven) and **waiting times were too long** and this was often linked to the knowledge that services were generally **under pressure**, **under resourced** both in funding and personnel.

Services are not joined up
These issues were compounded by **a lack of joined up services**. Both professionals and service users commented on the need for **better communication** within the NHS and between NHS mental health services and third sector organisations. This was exemplified by the sometimes **poor transition from children and young people's services to adult services**.

Support is needed for longer
Where service users were offered support, the **timescale for this was felt to be too short** and sometimes **lacked consistency** i.e. not having access to the same practitioner. In addition, service users spoke about the **lack of follow-up care,** which was particularly disappointing if progress had been made, often resulting in a return to the system, further waiting and another round of similar short-term support. Shirley in case study four spoke of the inconsistency of care and Keven, case study six, spoke about the lack of ongoing support.

More tailored support
Both service users and professionals commented on the **lack of tailored support** to meet user needs, including Mark's example in case study three. These included people who had identified as LGBTQ+, people whose first language was not English, people from the travelling community, ethnic minority groups, people diagnosed with neuro-diverse conditions, patients dealing with alcohol and substance addictions and those in temporary support or homeless.

Service users also spoke about the importance of offering **therapies that specifically dealt with bereavement, trauma, domestic abuse, and post-natal depression**. Jonathan, in case study five spoke about the importance of bereavement counselling.

Accommodation concerns
70% of professionals said their clients were not able to access accommodation suitable for their mental health needs. Some providers mentioned accommodation options having negatively impacted on their client's mental health due to poor living conditions, the behaviour of other residents and being moved outside of the locality.

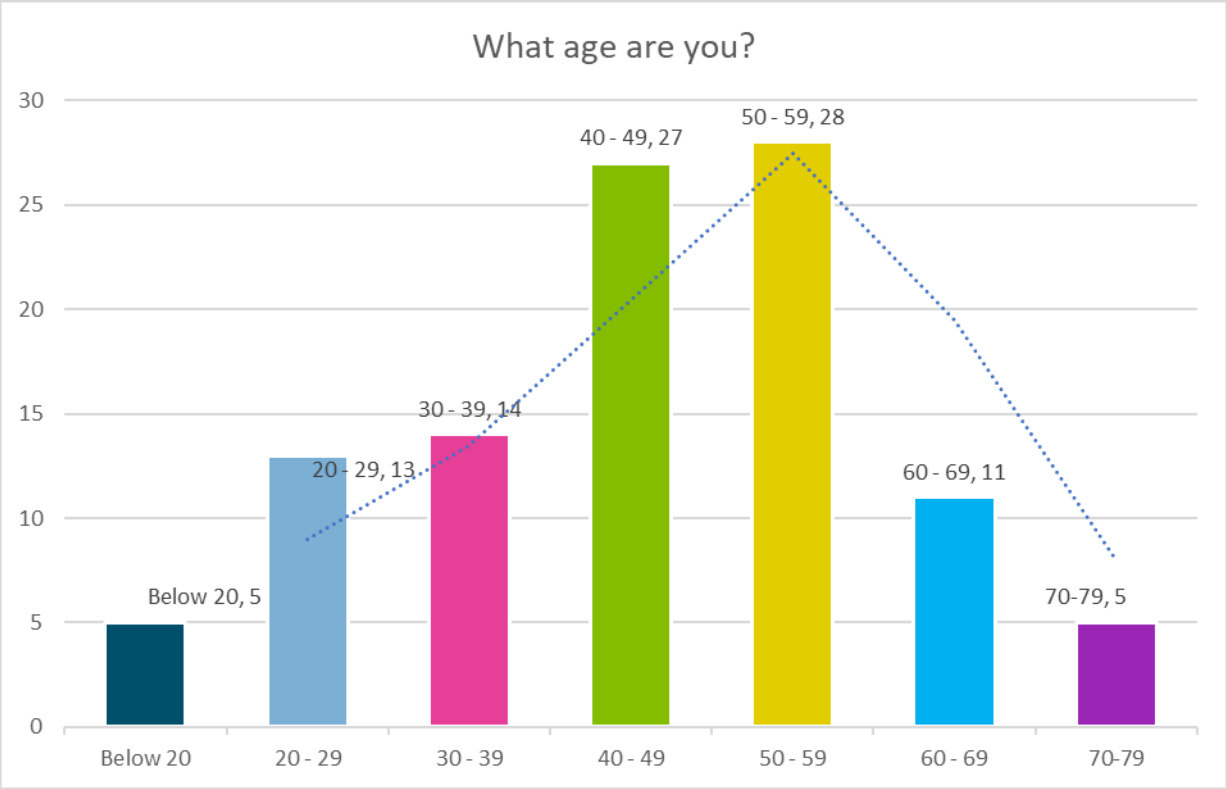
In relation to the above, service users and professionals saw the need for more services, for example Jill in Case Study Two. Between 20% and 30% of service users said they would like further support from therapy, the Brighton and Hove Wellbeing service, counselling, psychologists, or a GP.

In conclusion
Mental health services and accommodation services in Brighton and Hove need **a serious injection of funds** to ensure the service offered meets the required need. Comments from service users and professionals demonstrate that **support for mental health conditions needs to be long-term, consistent, robust, and tailored** to allow for a range of additional needs and circumstances. This is even more important when we consider the context of the COVID pandemic, in which the health and social care system has seen **a significant increase in the demand for mental health support.**

Appendix 1: Demographic Information

Every respondent was asked several questions about their demographic identity. These questions were voluntary and therefore each question was answered only by those respondents that wanted to do so. Respondents could also select the option "prefer not to say" where appropriate.

Age Groups



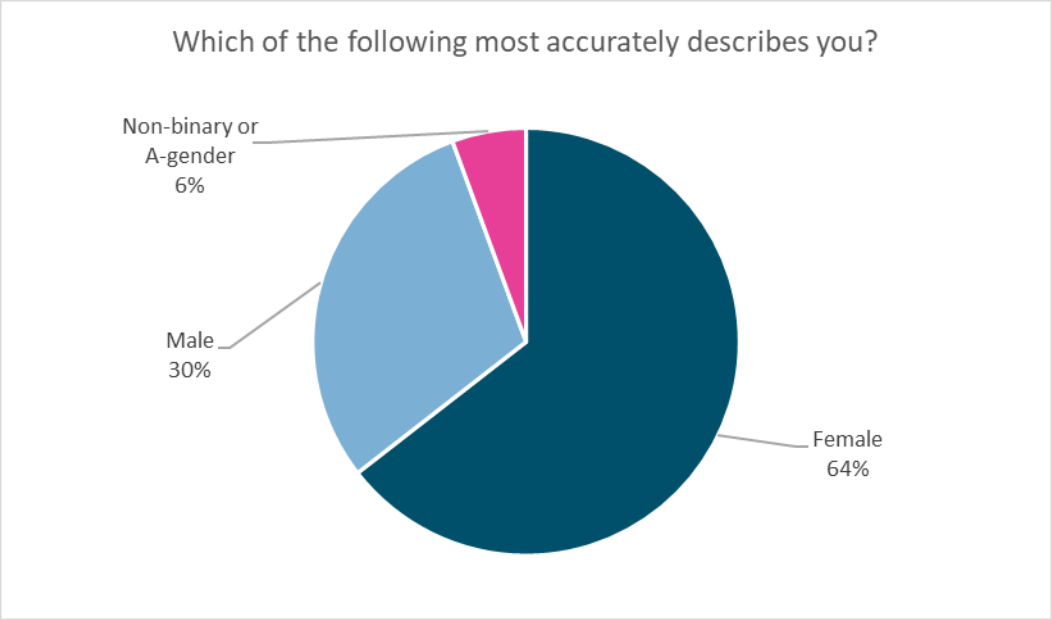
All respondents were asked what age they were with the option of leaving blank if they preferred not to say. Within the Healthwatch survey, we provided a drop-down list containing all ages from 10 – 100. Within the Council survey, the respondent completed their answer in text form. The chart above presents the combined responses that were received – 103 respondents in total. The chart also includes a trendline indicating that respondents were on average between 50 and 59 years old.

In addition to these, there was one person who responded to the Council survey who commented "older adult" and as we were unable to define them to a specific group, they have not been included in the chart above. Respondents ranged from the youngest at 10 years old to the oldest at 79 as follows:

- 5 respondents aged below 20 years old
- 13 respondents aged 20 – 29 years
- 14 aged 30 – 39 years
- 27 aged 40 – 49 years
- 28 aged 50 – 59 years

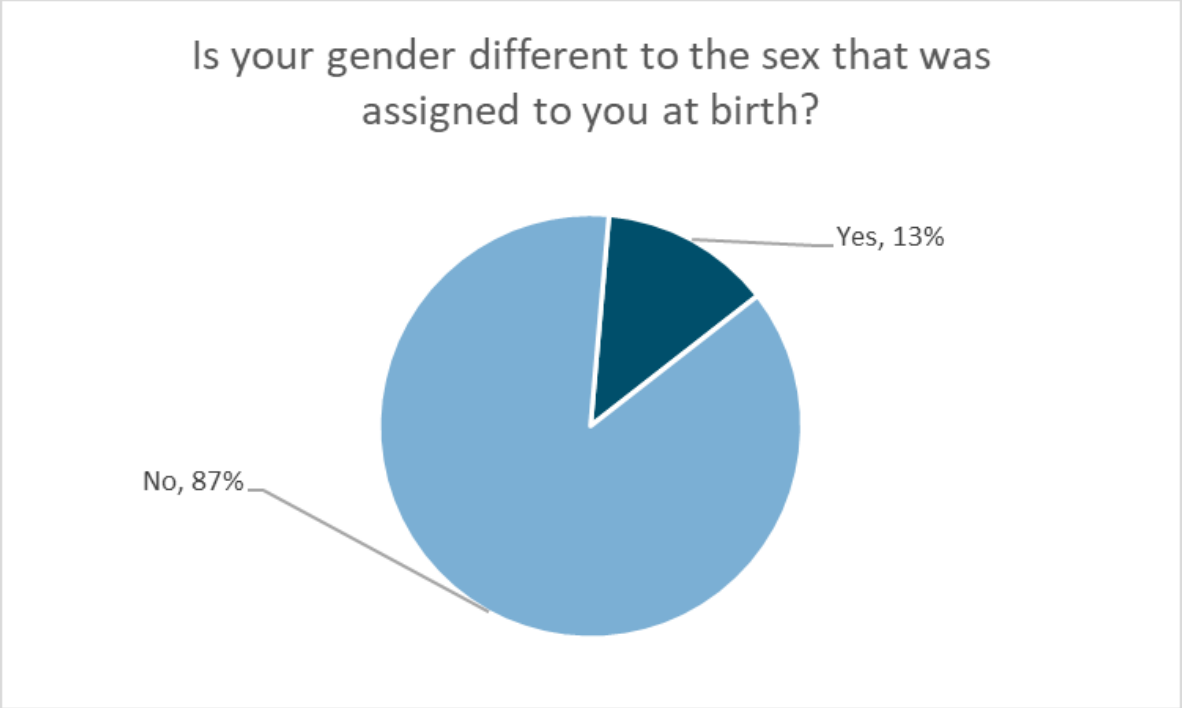
- 11 aged 60 – 69 years
- 5 aged 70 – 79 years

Gender Identity



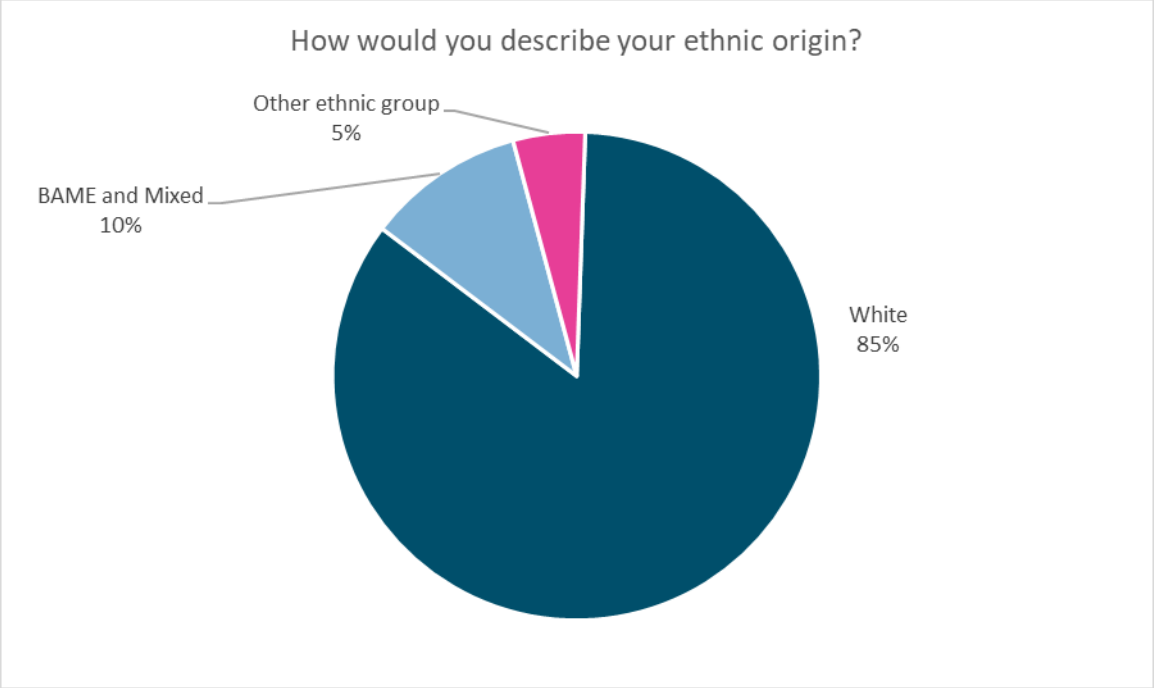
107 people responded to this question. They had the choice of “female”, “male” “non-binary”, “Transgender”, “Other” or “prefer not to say”. Of those that provided a response, 69 were female, 32 male and six people identified themselves as either non-binary or A-gender.

Gender different to sex assigned at birth



107 people responded to this question. The choices were “Yes”, “No” or “prefer not to answer”. From those that provided a response, 14 people advised that there gender was different to the sex assigned at birth (93 people advised their gender was the same as the sex assigned at birth).

Ethnic Origin



Respondents were asked to describe their ethnic origin. They were given a range of options. From the 105 respondents who provided a response, we found:

- 85% (89 respondents) were from “white” ethnic groups including the following definitions:

No of people	Definition
82	White - English/Welsh/Scottish/Northern Irish/British
2	White – Irish
1	Australian
1	White African
3	Any other White background

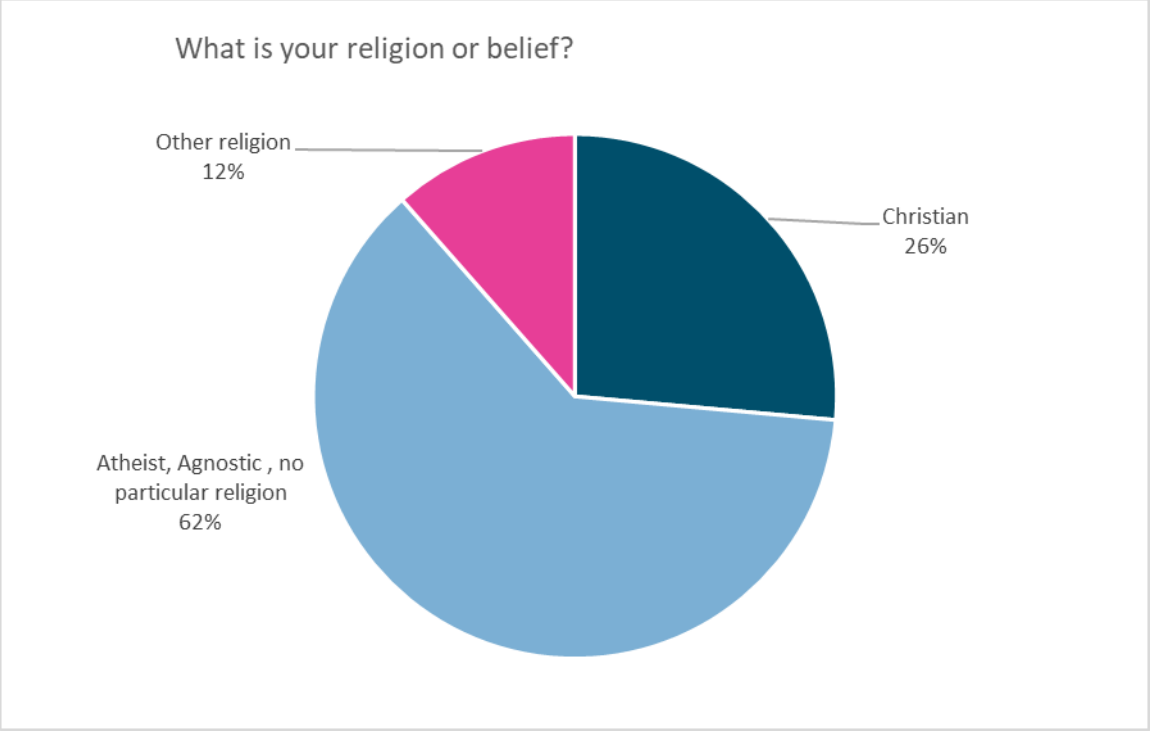
- 10% (11 respondents) were from Black/Asian/Minority Groups and/or Mixed Ethnic Groups including the following definitions:

No of people	Definition
3	Black or Black British - Caribbean
2	Mixed - Asian & White
1	Asian or Asian British – Indian
1	British, Half Thai, Half Bengali
1	Mixed - Black African & White
1	White Asian - 1/2 Bengali - 1/4 Russian (pogrom)1/4 Chinese

- 5% (5 respondents) were from Other Ethnic Backgrounds and defined themselves as below:

No of people	Definition
3	Iranian
1	Celtic
1	Kurdish from Iraq

Religion and Beliefs

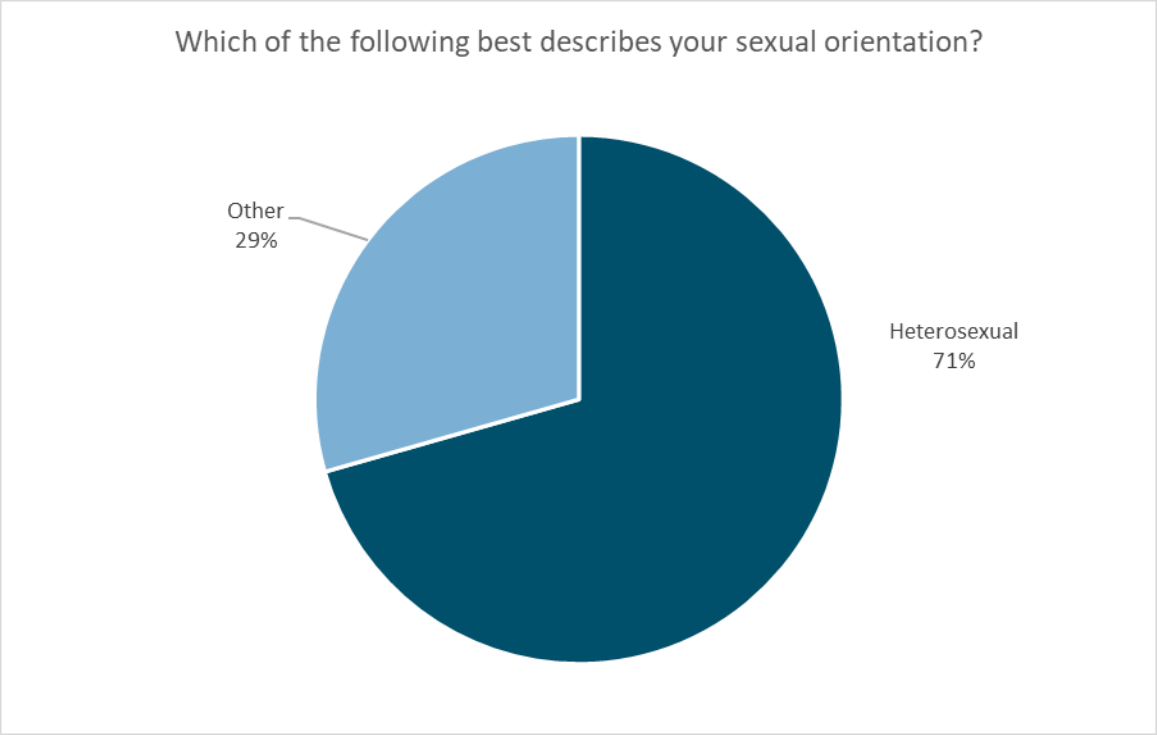


Respondents were asked what their religion or belief was. They were provided with a range of options. From the 87 people who responded to this question,

- The majority (62%, 54 in total) were atheist (7), agnostic (5) or had no religion (42).
- 26% (23 people) were Christian.
- 10 people held a different belief as follows:

- Spiritualist – 3 people
- Pagan – 2 people
- Muslim – 2 people
- Buddhist – 2 people
- Pagan Christian – 1 person

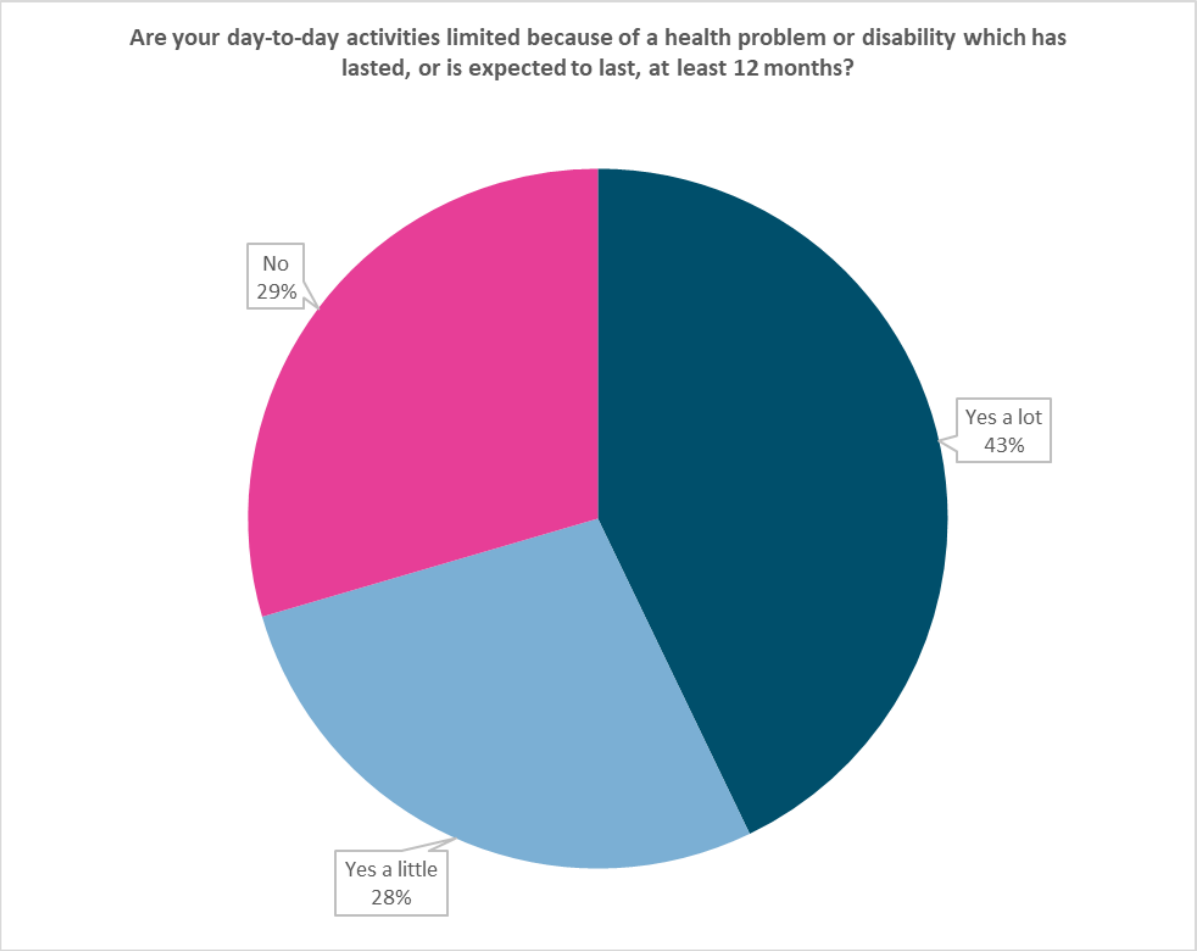
Sexual Orientation



Respondents were asked what their sexual orientation was. 85 people responded to this question, and we found:

- 71% (60 people) were heterosexual
- 29% (25 people) were non-heterosexual defining themselves as follows:
  - Asexual – 3 people
  - Bisexual – 7 people
  - Gay – 5 people
  - Lesbian – 4 people
  - Pansexual – 4 people
  - Non-binary – 2 people

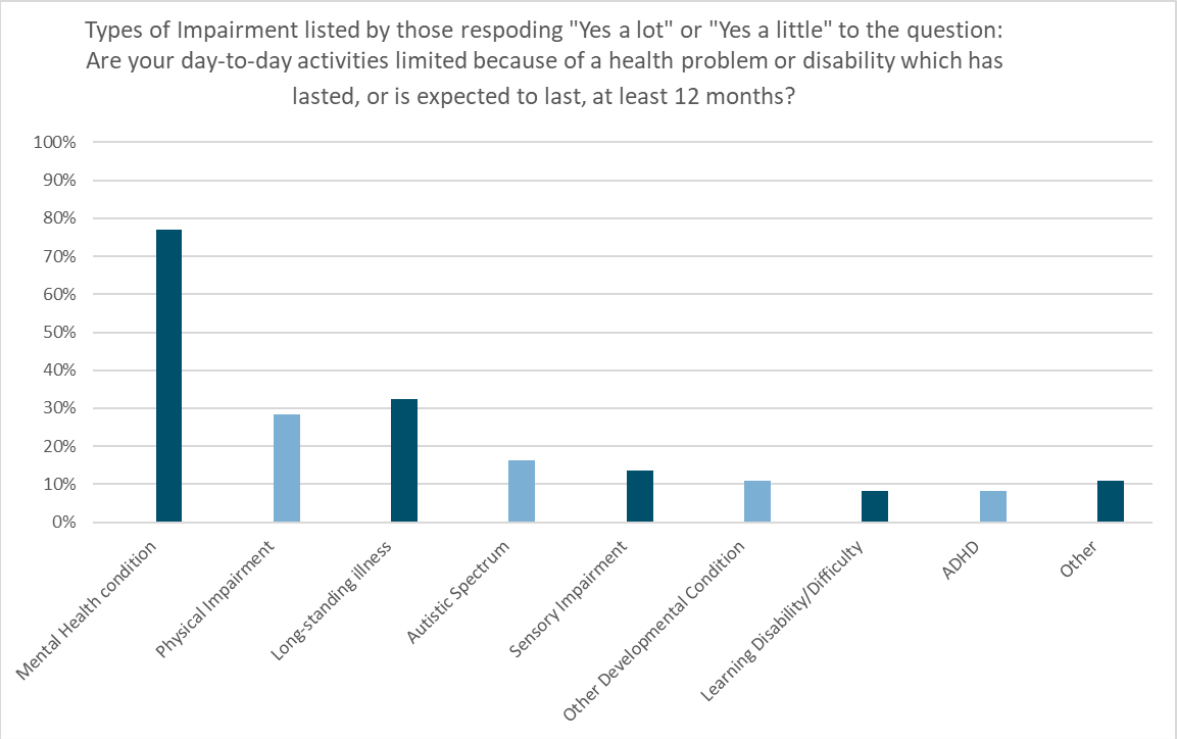
Long-term conditions



Respondents were asked if their day-to-day activities were limited because of a health problem or disability which had lasted, or was expected to last, at least 12 months? 105 people responded to this question:

- 43% (45 people) felt their activities were limited “a lot” by their health problem or disability
- 28% (29 people) felt activities were limited “a little”
- 30% (30 people) felt activities were not limited.

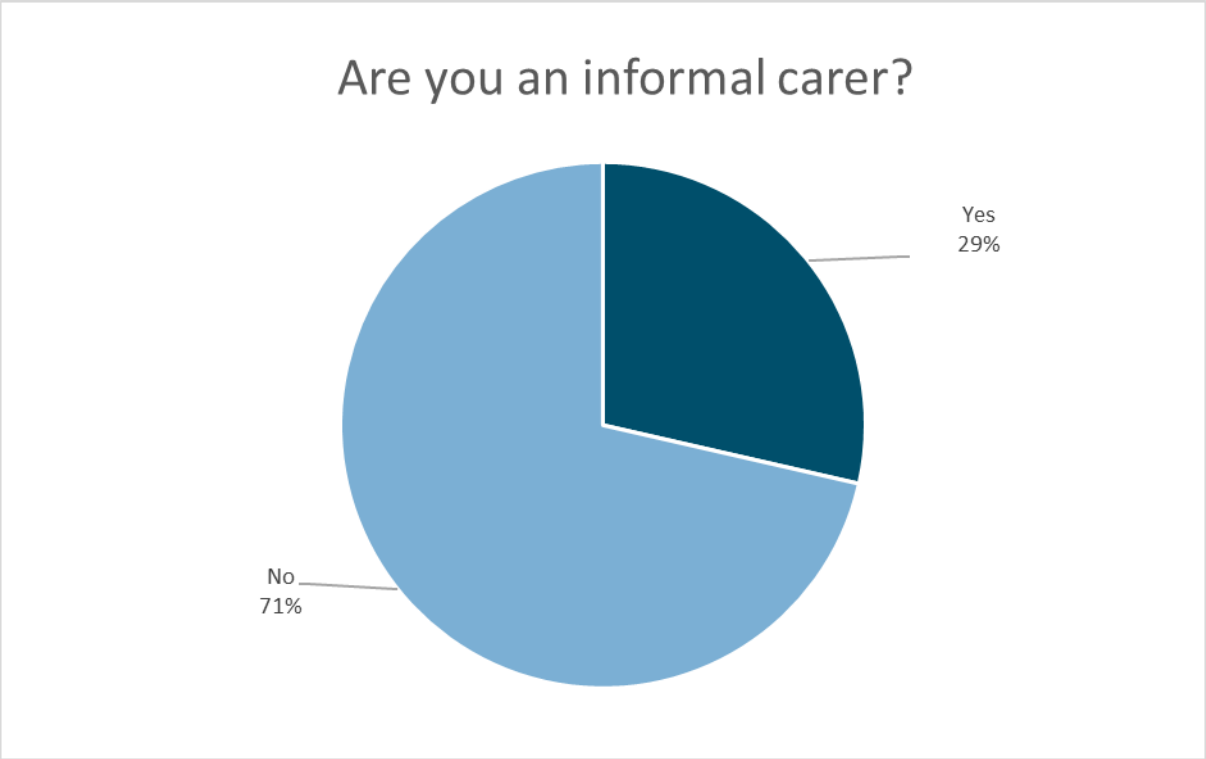
Type of impairment



Respondents who had advised that activities were limited in some way, were then asked what type of impairment they had. We had 74 responses, where people could select more than one type of impairment. Of the 74 responses, we found:

- Mental health condition affected the day-to-day activities of 57 people
- Physical conditions affected 21 people
- Long-standing illness affected 24 people
- Autistic spectrum – 12 people
- Sensory impairment – 10 people
- Other developmental condition – 8 people
- Learning disability/Difficulty – 6 people
- ADHD (attention deficit hyperactivity disorder) – 6 people
- Other impairment – 8 people as follows (in several cases, one person could have more than one of the following):
    - COPD (Chronic obstructive pulmonary disease)
    - PTSD (Post-traumatic stress disorder)
    - FASD (Fetal alcohol spectrum disorders)
    - Emotional-related impairment (e.g. Severe Emotional Dysregulation or Chronic Pain Syndrome)
    - Mobility problems
    - Dyslexia
    - Sciatica
    - Vertigo
    - Tinnitus

Informal Carers



We asked respondents if they cared for another person informally. An informal carer someone who provides unpaid support to family or friends who are ill, frail, disabled or have mental health or substance misuse problems. 91 people responded to this question and 29% (26 people) were informal carers, 71% (65 people were not).

Armed Forces

One of the sets of questions the Council raised in their survey were about the Armed forces and we included the same demographic questions.

From the 105 people who responded, no one was currently serving in the UK Armed Forces, including reservists or part-time service, such as the Territorial Army. One person had previously worked in the UK Armed Forces. Two people are members of a current or former serviceman or woman's immediate family/household.

Appendix 2: Original Questionnaires to service users and professionals

Service User Questionnaire – Healthwatch Brighton and Hove

Share your views about mental health and help to improve services

We are interested in hearing the views of people who have had or are currently experiencing mental health issues. We would like to hear about your experience of having support from health and social care services (such as GP, Social Worker, Mental Health Practitioner etc.) and your experience of receiving any support for your accommodation.

This 10-minute survey can be answered by yourself or on behalf of a friend or relative with mental health issues. If you are completing this questionnaire on behalf of someone else, the term 'you' refers to the person you are completing the questionnaire for.

Healthwatch Brighton and Hove are working with Brighton and Hove City Council and NHS Brighton & Hove Clinical Commissioning Group to find out what works well and what can be improved.

By responding to this survey, you also have the opportunity to enter a prize draw to receive one of four £25 high-street or Amazon vouchers.

If you have any questions about this survey, or need it in another format, e.g. another language, in large print, BSL or Easy Read, please contact 01273 234040 or email: info@healthwatchbrightonandhove.co.uk.

Confidentiality

Your answers will be treated as confidential and you will not be personally identified. All survey responses will be collectively analysed and shared with providers for the purpose of improving services.

Healthwatch's privacy policy can be viewed here.

About the service you have used or are currently using

1. If you have used previously or are currently receiving, support for your mental health, please select which of the following services you have used in the past or are currently using.
Please select all that apply:

	Used previously	Currently using
Adult social care services	☐	☐
Advocate (someone who acts on your behalf to help you)	☐	☐
Brighton & Hove Mental Health Helpline	☐	☐
Brighton and Hove Wellbeing services	☐	☐
Child and Adolescent Mental Health Services (CAMHS)	☐	☐
Children's social care services	☐	☐
Community support worker	☐	☐
Counsellor	☐	☐
GP	☐	☐
Key worker in supported housing	☐	☐
Mental health Charity	☐	☐
Mental Health Nurse	☐	☐
Mental Health Social Worker	☐	☐
Mental health practitioner	☐	☐

	Used previously	Currently using
Mental health support worker	☐	☐
Nurse	☐	☐
Psychologist	☐	☐
Samaritans	☐	☐
Social Prescriber (community support referred to you by a health professional to help you)	☐	☐
Social worker	☐	☐
Someone who cares for you at home	☐	☐
Southdown Housing Association	☐	☐
Student support in school	☐	☐
Student support at University	☐	☐
Sussex Partnership NHS Foundation Trust	☐	☐
Therapist (for example, offering Cognitive behavioural therapy, CBT)	☐	☐
Other (please describe below)	☐	☐
Have not used any of the above	☐	☐

If other, please describe the service

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2. How did you find out about mental health services that might be available to support you?

- [ ] Referred by GP
- [ ] Leaflet/Poster
- [ ] NHS 111
- [ ] Word of Mouth (from friends, family, etc.)
- [ ] Referred by Mental Health Professional
- [ ] Police
- [ ] Ambulance Service
- [ ] Referred by Charity / Community Group
- [ ] Internet Search
- [ ] Other Emergency Service (other than the police)

- [ ] Referred by CAMHS
- [ ] Referred by Adult Social Care
- [ ] Referred by Sussex Partnership NHS Foundation Trust (SPFT)
- [ ] Helpline referral
- [ ] Referred by an accommodation provider (please specify which one below)
- [ ] Referred by a young people's support service (please specify which one below)
- [ ] I have not sought mental health services (manage my condition myself, being supported by friends and family)
- [ ] I have not sought mental health services to date (for another reason other than managing my condition or being supported by friends and family)
- [ ] Other (please specify):

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If referred by an accommodation provider or a young people's support service, please specify which one:

Finding Support

3. If you have received support for your mental health in the last six months (September 2021 - present day), how easy or difficult was it to find? *

- [ ] Very easy
- [ ] Easy
- [ ] Neither easy nor difficult
- [ ] Difficult
- [ ] Very Difficult
- [ ] I have not received support in the last six months

Difficulties with finding support

4. If you have found it difficult in the last six months (September 2021 - present day) to find the support you needed for your mental health, what made it difficult? Please select all that apply: *

- [ ] It was difficult for me to talk about my mental health issues and/or to ask for help
- [ ] I didn't know where to go for support
- [ ] Did not feel it would meet my mental health needs
- [ ] Did not meet some of my other needs (for example, language, cultural, religious or sexuality needs)

- [ ] Too far to travel
- [ ] Waiting time was too long
- [ ] I was only offered a service I had used previously and had found not to meet my needs (so didn't want to use it again)
- [ ] Could not afford the cost (or contribution towards)
- [ ] I was only offered support online and wanted face-to-face
- [ ] Wanted to speak to someone of the same gender as me
- [ ] Only offered day-time appointments
- [ ] It was difficult for another reason - please describe what difficulty you had:

5. Please add further comments about any difficulties you came across in finding support for your mental health issues in the last six months (September 2021 - present day).

Quality of care - Mental Health Services

6. Which one of these services have you mostly used in the last six months (September 2021 - present day)? Later questions in the survey will ask you for further information on this service. *

- [ ] Adult social care services

- [ ] Advocate (someone who acts on your behalf to help you)
- [ ] Brighton & Hove Mental Health Helpline
- [ ] Brighton and Hove Wellbeing services
- [ ] Child and Adolescent Mental Health Services (CAMHS)
- [ ] Children's social care services
- [ ] Community support worker
- [ ] Counsellor
- [ ] GP
- [ ] Key worker in supported housing
- [ ] Mental health charity
- [ ] Mental health nurse
- [ ] Mental health Social worker
- [ ] Mental health practitioner
- [ ] Mental health support worker
- [ ] Nurse
- [ ] Psychologist
- [ ] Samaritans
- [ ] Social Prescriber (community support referred to you by a health professional to help you)
- [ ] Social worker
- [ ] Someone who cares for you at home
- [ ] Southdown Housing Association
- [ ] Sussex Partnership NHS Foundation Trust
- [ ] Therapist (for example, offering Cognitive behavioural therapy, CBT)

- [ ] Have not used any of the above
- [ ] If Other, please describe the service:

7. Thinking about the service you have mostly used in the last six months (September 2021 - present day), how would you rate the mental health support at doing the following:

	Very good	Good	Neither good nor poor	Poor	Very poor
Giving you enough time	☐	☐	☐	☐	☐
Listening to you	☐	☐	☐	☐	☐
Explaining tests and treatments	☐	☐	☐	☐	☐
Involving you in decisions about your care	☐	☐	☐	☐	☐
Treating you with care and concern	☐	☐	☐	☐	☐
Having access to relevant medical information about you	☐	☐	☐	☐	☐
Addressing your needs or making plans to do so	☐	☐	☐	☐	☐

8. If you have included a poor or very poor rating for any of the above, have you any suggestions as to how the service could improve?

9. If you have included a good or very good rating for any of the above, do you have anything further to say as to what works well?

Services you would like

10. Are there any of the following Mental Health Services you would like (more of)? *

- [ ] Adult social care services
- [ ] Advocate (someone who acts on your behalf to help you)
- [ ] Brighton & Hove Mental Health Helpline
- [ ] Brighton and Hove Wellbeing services
- [ ] Child and Adolescent Mental Health Services (CAMHS)
- [ ] Children's social care services
- [ ] Community support worker
- [ ] Counsellor
- [ ] GP
- [ ] Key worker in supported housing

- [ ] Mental health charity
- [ ] Mental health nurse
- [ ] Mental health Social worker
- [ ] Mental health practitioner
- [ ] Mental health support worker
- [ ] Nurse
- [ ] Psychologist
- [ ] Samaritans
- [ ] Social Prescriber (community support referred to you by a health professional to help you)
- [ ] Social worker
- [ ] Someone who cares for you at home
- [ ] Southdown Housing Association
- [ ] Sussex Partnership NHS Foundation Trust
- [ ] Therapist (for example, offering Cognitive behavioural therapy, CBT)
- [ ] No, I do not want anything more than I currently have
- [ ] If Other, please describe the service:

Where do you live?

11. Which area do you live in? *

- [ ] Brighton & Hove
- [ ] East Sussex (but not Brighton & Hove)

- [ ] West Sussex
- [ ] Other (outside Sussex)

12. What accommodation do you live in? *

- [ ] Acorn Hove (previously Loxwood House Limited)
- [ ] Arlington House, Hove
- [ ] Asher Nursing Home
- [ ] Aspen House, Hove
- [ ] Autumn Lodge, Hove
- [ ] Barford Court, Hove
- [ ] Birch Grove Nursing Home, Brighton
- [ ] Bon Accord, Hove
- [ ] Brighton Housing Trust - Archway
- [ ] Brighton Housing Trust - Route One
- [ ] Brighton Housing Trust - Sackville Gardens
- [ ] Brighton Housing Trust, Hove
- [ ] Brighton YMCA Low Support Accommodation
- [ ] Carlton House Rest Home, Hove
- [ ] Charles Lodge, Hove
- [ ] Conifer Lodge, Hove
- [ ] Davigdor Lodge Rest Home
- [ ] Dean Wood, Brighton

- [ ] Equinox Women's Service
- [ ] Fairdene Lodge, Hove
- [ ] George Williams Mews
- [ ] Glentworth House, Hove
- [ ] Glenwood Lodge
- [ ] Grosvenor Lodge, Hove
- [ ] Hazelgrove Nursing Home, Bevendean
- [ ] Highviews, Saltdean
- [ ] Hyman Fine House, Hove
- [ ] Lavender House, Hove
- [ ] Lindridge, Hove
- [ ] Lyndhurst Rest Home, Hove
- [ ] Middleton Grove, Hove
- [ ] New Steine Mews
- [ ] Parkview Care Home, Hove
- [ ] Partridge House, Brighton
- [ ] Phase One
- [ ] Sanctuary, Hove (Star Project)
- [ ] Shore House Brighton Housing Trust, Brighton
- [ ] Southdown Community Moves
- [ ] St Patricks
- [ ] Wayfield Avenue

- [ ] William Collier House
- [ ] Emergency / Temporary accommodation provided by the Council
- [ ] Homeless / Rough sleeping
- [ ] Sheltered Accommodation
- [ ] Short-term Accommodation (Discharge to Access)
- [ ] Not named above: Own property (outright or with a mortgage or loan)
- [ ] Not named above: Rented property (from council, local authority or private)
- [ ] Not named above: Shared ownership (part owned and part rented)
- [ ] Other (please describe below)

If other, please describe the accommodation

13. Does your accommodation have central heating?

- [ ] Yes
- [ ] No

14. Do you live in accommodation that offers mental health support? (for example, advice about benefits, life skills such as cooking, advice about maintaining your tenancy, Support for my general mental health needs etc.) *

- [ ] Yes
- [ ] No
- [ ] Don't know

Mental health support in your accommodation

15. What type of mental health support do you currently have in your accommodation? *

- [ ] Advice about benefits (e.g. universal credit)
- [ ] Budgeting advice
- [ ] Maintaining my tenancy (e.g. advice about paying rent and/or the upkeep of my accommodation etc.)
- [ ] Life skills such as learning to cook
- [ ] Accessing care
- [ ] Advice about local activities
- [ ] Educational advice
- [ ] Training and/or employment advice
- [ ] Advocacy (where someone acts on your behalf to help you)
- [ ] Support for my mental health (from a counsellor, therapist etc.)
- [ ] Maintenance (repairs, faults etc.)
- [ ] Other (please specify):

16. Thinking about this accommodation support, how would you rate the service at doing the following:

	Very good	Good	Neither good nor poor	Poor	Very poor
Giving you time to explain any difficulties and listening to any requests/complaints	☐	☐	☐	☐	☐
Addressing your concerns or making plans to do so	☐	☐	☐	☐	☐
Explaining about how the accommodation works	☐	☐	☐	☐	☐
Involving you in decisions about your accommodation	☐	☐	☐	☐	☐
Supporting you in a way that respects your background, culture and religious beliefs	☐	☐	☐	☐	☐
Having access to relevant notes about your accommodation needs and history	☐	☐	☐	☐	☐

17. If you have included a poor or very poor rating for any of the above, have you any suggestions as to how the service could improve? (Otherwise please leave blank)

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18. If you have included a good or very good rating for any of the above, do you have anything further to say as to what works well? (otherwise please leave blank)

Any other comments?

19. Which of the following types of mental health support would you like more of in your accommodation?

- [ ] Advice on benefits (e.g. universal credit)
- [ ] Budgeting advice
- [ ] Maintaining my tenancy (e.g. advice about paying rent and/or the upkeep of my accommodation etc.)
- [ ] Life skills such as learning to cook
- [ ] Accessing care
- [ ] Advice on local activities
- [ ] Educational advice
- [ ] Training advice
- [ ] Advocacy (where someone helps speak for me -WORDING)

- [ ] Support for my mental health
- [ ] Maintenance (repairs, faults etc.)
- [ ] I don't require any more support than I currently have
- [ ] Other (please specify):

20. Is there anything else you would like to tell us about a mental health service or accommodation support? Please add any further comments below.

About you

By telling us more information about yourself, you can help us better understand how people's experiences may differ depending on their personal characteristics. This will also help us inform those providing the services as to how to do so, in a fair way to all members of the community.

21. What age are you? (if you prefer not to say please leave blank)

22. Which of the following most accurately describes you?

- [ ] Female
- [ ] Male
- [ ] Non-Binary
- [ ] Transgender
- [ ] Prefer not to say
- [ ] Other (please state):

23. Is your gender different to the sex that was assigned to you at birth? For people who are transgender, the sex they were assigned at birth is not the same as their own sense of their gender.

- [ ] Yes
- [ ] No
- [ ] Prefer not to say

24. How would you describe your ethnic origin?

- [ ] Asian or Asian British - Bangladeshi
- [ ] Asian or Asian British - Indian
- [ ] Asian or Asian British - Pakistani
- [ ] Asian or Asian British - Chinese
- [ ] Any other Asian background (please give details in box below)
- [ ] Mixed - Asian & White
- [ ] Mixed - Black African & White
- [ ] Mixed - Black Caribbean & White
- [ ] Any other mixed background (please give details in box below)
- [ ] White - English/Welsh/Scottish/Northern Irish/British
- [ ] White - Irish
- [ ] White - Gypsy or Irish Traveller
- [ ] Any other White background (please give details in box below)
- [ ] Black or Black British - African
- [ ] Black or Black British - Caribbean
- [ ] Any other Black background (please give details in box below)
- [ ] Arab
- [ ] Any other ethnic group (please give details in box below)
- [ ] Prefer not to say

Please give details of other ethnic group:

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25. What is your religion or belief?

- [ ] I have no particular religion
- [ ] Buddhist
- [ ] Christian
- [ ] Hindu
- [ ] Jain
- [ ] Jewish
- [ ] Muslim
- [ ] Pagan
- [ ] Sikh
- [ ] Agnostic
- [ ] Atheist
- [ ] Other religion (please state in the box below)
- [ ] Other philosophical belief (please state in the box below)
- [ ] Prefer not to say
- [ ] Other (please specify):

26. Which of the following best describes your sexual orientation?

- [ ] Bisexual
- [ ] Gay
- [ ] Heterosexual / Straight
- [ ] Lesbian

- [ ] Pansexual
- [ ] Asexual
- [ ] Prefer not to say
- [ ] Other (please specify):

27. Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?

- [ ] Yes a little
- [ ] Yes a lot
- [ ] No
- [ ] Prefer not to say

28. If ‘yes’, please state the type of impairment. If you have more than one impairments, please tick all that apply.

If none of the options apply to you, please mark ‘Other’ and write a short description of your impairment in the comment box.

- [ ] Physical Impairment
- [ ] Sensory Impairment
- [ ] Learning Disability/Difficulty
- [ ] Long-standing illness
- [ ] Mental Health condition
- [ ] Autistic Spectrum
- [ ] Other Developmental Condition

☐ Other (please specify):

29. Are you a carer? A carer provides unpaid support to family or friends who are ill, frail, disabled or have mental health or substance misuse problems.

☐ Yes

☐ No

☐ Prefer not to say

30. Please can you tell us about any services in the Armed Forces.

	Yes	No	Prefer not to say
Are you currently serving in the UK Armed Forces? (this includes reservists or part-time service, such as the Territorial Army)?	☐	☐	☐
Have you ever serviced in the UK Armed Forces?	☐	☐	☐
Are you a member of a current or former serviceman or woman's immediate family/household?	☐	☐	☐

Contribute further

31. If you would like to have a brief discussion about your experience, and help contribute to the further development of the service, please select one or both of the options below:

- [ ] A one-to-one short phone conversation
- [ ] A small online group discussion between 4 and 6 people

If yes to either of the above, please add a phone number and an email address so we can arrange a suitable time:

32. Do you want to enter into our prize draw to win one of four £25 high-street/Amazon vouchers - if so, please add your phone number and an email address in the box below:

Questionnaire for Stakeholders

Brighton and Hove City Council (BHCC) in partnership with NHS Brighton & Hove Clinical Commissioning Group (BHCCG) are developing a Mental Health & Housing Plan for the city. The aim of this plan is to identify what works well and what we can improve on in the future.

We would like to hear from mental health professionals, clinicians and individuals working with those with mental health support needs.

The views of those taking part in the survey will be used to help develop a set of priorities for the Mental Health & Housing Plan. These priorities will inform how services including accommodation based support services and community support operate in the future.

If you need this survey in an alternative format or other language, or if you have any queries, please contact : ascadmin@brighton-hove.gov.uk

Q1. What capacity are you responding to this consultation?

Support Worker / Key Worker		Charity / Community Worker	
MH Practitioner		Social Worker	
Clinician (for example Doctor, Nurse, Health Care Worker)		Housing Professional	
Probation Service			
Other (please specify)			

Q2a. How easy or difficult is it to access the correct mental health support for the individuals you support?

Very Easy		Fairly difficult	
Fairly Easy		Very difficult	
Neither easy nor difficult			

Q2b. If you find it difficult or are unable to access mental health support which services are you struggling to access and what are the barriers to access for your clients?

Q3a. Would you know where to go to for support for your client if they were in mental health crisis for example posed a risk to themselves or others?

Yes	
No	
Don’t Know / Not Sure	

Please expand on your response above.

Q3b. Do you feel confident your client would receive the support they need?

Yes	
No	
Don’t Know / Not Sure	

Please expand on your response above.

Q3c. What are the barriers to your client accessing the support they need when they are in crisis?

Q4a. Are your clients able to access accommodation (supported or independent) which is suitable for their mental health needs?

Yes	
No	
Don’t Know / Not Sure	

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Q4b. Are there any problems when your clients are trying to access accommodation suitable for their mental health needs?

Q4c. Are the mental health services available able to support your clients in a way that respects their background, cultural life and religious beliefs?

Yes	
No	
Don't Know / Not Sure	

Please expand on your response above.

Q6. In terms of current mental health pathways and services (including accommodation) in Brighton & Hove what works well?

Q7. In terms of current mental health pathways and services (including accommodation) in Brighton & Hove what would you like to see improved / what are the gaps in provision?

Q8. Are the individuals you support currently accessing community-based support services for their mental health? (for example befriending service, support group, social activities)

Yes	
No	
Don't Know / Not Sure	

Q9. Are there other models of support or social / community based services which you feel would have a positive impact on your clients in recovery or in maintaining their wellbeing?

Service User Questionnaire:

Brighton and Hove City Council (BHCC) in partnership with NHS Brighton & Hove Clinical Commissioning Group (BHCCG) are developing a Mental Health & Housing Plan for the city. The aim of this plan is to identify what works well and what we can improve on in the future.

We would like to hear from people who have mental health support needs and the family and friends of those with mental health needs about their experiences of services including accommodation based support and support in the community.

The views of those taking part in the survey will be used to help develop a set of priorities for the Mental Health & Housing Plan. These priorities will inform how services, including accommodation based support services and community support operate in the future.

If you need this survey in an alternative format or other language, or if you have any queries, please contact: ContractsUnit.AdminTeam@brighton-hove.gov.uk

As part of this engagement we will be undertaking one to one conversations with people to get more in depth information about your experiences. If you would be interested in taking part and discussing your experience of mental health and housing then please email ContractsUnit.AdminTeam@brighton-hove.gov.uk

Q1. Which best describe how you are responding to this consultation?

I have mental health needs and I am receiving support	
I have mental health needs but I am not currently receiving any support (for example support from a GP, Nurse, Social Worker, Mental Health Practitioner, Community Support Worker)	

Q2a. Are you currently using any services to support your mental health.

Yes	
No	
Don't know	

Q2b. If yes please select which services are supporting you.

GP		Home Care Worker	
Nurse		Mental Health Charity	
Social Worker		Advocate	
Mental Health Practitioner		Counsellor	
Key Worker in Supported Housing		Psychologist	
Community Support Worker		Occupational Therapist	

Other (please specify)			

Q3a. How easy or difficult has it been for you to receive support for your mental health needs?

Very Easy		Fairly difficult	
Fairly Easy		Very difficult	
Neither easy nor difficult			

Q3b. If it was difficult, why was it difficult or why were you unable to access support? (Please tick all that apply).

I don't feel able to talk about or ask for help with my mental health needs	
I don't know where to go for support	
I'm on a waiting list for support	
I couldn't access support due to the distance I would need to travel for the appointment	
I couldn't access support due to the distance I would need to travel for the appointment	
My mobility / health or support needs mean I could not access the support offered	
The service I was offered does not meet my background, cultural or religious beliefs	
The service offered does not meet my language needs	
The service offered does not meet my sexuality / gender identity needs	
I did not feel the service I was offered would meet my mental health needs	
I have been referred to the service before and it did not meet my needs	
I am unable to afford the cost / my contribution to the cost of the service	

Other (please specify)

If you wish to give further information on your answer above please do so below

Q4. How do you find out about mental health services that might be available to you? (Please tick all that apply).

GP		Leaflet / Poster	
NHS 111		Mental Health Professional	
Word of Mouth		Police	
Charity / Community Group		Ambulance Service	
Internet Search		Fire Service	

Other (please specify)

Q5. Thinking about the mental health support services you have received.

What works well about the support you receive?

What could be improved?

Do you feel your needs and views are listened to?

Q6. Do you live in accommodation that offers mental health support?

Yes	
No	

If yes please answer Q7a to Q7d

Q7a. What works well about the support you receive in your accommodation?

Q7b. What could be improved?

Q7c. Is the accommodation service you live in able to support you in a way that respects your background, cultural life and religious beliefs?

Q7d. Is there anything else you would like to tell us about the accommodation service you receive?

Q8. Do you receive community based mental health support (for example a floating support worker, community support worker or carer) or mental health support from a charity?

Yes	
No	

If yes please answer Q9a to 9c

Q9a. What works well about the community support you receive?

Q9b. What could be improved?

Q9c. Is the community support you receive able to support you in a way that respects your their background, cultural life and religious beliefs?

Q9d. Is there anything else you would like to tell us about the community support you receive?

About you

The council has legal duties to make sure that we provide our services in a fair way to all members of the community. To assist us in this, we collect equality data to better understand our demographic profile of our community so we can identify and address barriers to inclusion. We do this so that we can show that we are acting in accordance with the law as well as to help us review and improve our services.

What type of accommodation are you in?

Owner Occupier		Private Rented Tenancy	
Emergency / Temporary accommodation provided by the council		Mental Health Supported Accommodation	
Homeless Supported Accommodation		Homeless / Rough Sleeping	
Care / Residential Home		Sheltered Accommodation	
Short term mental health supported accommodation for example Discharge to Assess			

How old are you?

What gender are you?

Female		Other	
Male		Prefer not to say	

If other please specify

Do you identify as the sex you were assigned at birth?

For people who are transgender, the sex they were assigned at birth is not the same as their own sense of their sex.

Yes	
No	
Prefer not to say	

How would you describe your ethnic origin?

Asian or Asian British: Bangladeshi		Mixed: Asian & White	
Asian or Asian British: Indian		Mixed: Black African & White	
Asian or Asian British: Pakistani		Mixed: Black Caribbean & White	
Asian or Asian British: Chinese		Mixed: Any other mixed background	
Asian or Asian British: Any other Asian Background		White: English / Welsh / Scottish / Northern Irish / British	
Black or Black British: African		White: Irish	
Black or Black British: Caribbean		White: Gypsy or Irish Traveller	
Black or Black British: Any other Black background		White: Any other White background	
Other ethnic group: Arab		Other ethnic group, please give details below	
Prefer not to say			

If other please specify

Which of the following best describes your sexual orientation?

Bisexual		Heterosexual / Straight	
Gay		Lesbian	
Other			

If other please specify

What is your religion or belief?

I have no particular religion		Buddhist	
Christian		Hindu	
Jain		Jewish	
Jewish		Muslim	
Pagan		Sikh	
Agnostic		Atheist	
Other religion, please give details below		Other philosophical belief, please give details below	
Prefer not to say			

If other please specify

Armed Forces Service

	Yes	No	Prefer not to say
Are you currently serving in the UK Armed Forces? (this includes reservists or part-time service, such as the Territorial Army)			
Have you ever served in the UK Armed Forces?			
Are you a member of a current or former serviceman or woman's immediate family/household?			

Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?

Yes at little		No	
Yes a lot		Prefer not to say	

Are you a carer?

A carer provides unpaid support to family or friends who are ill, frail, disabled or have mental health or substance misuse support needs.

Yes		Prefer not to say	
No			

Consultation findings about Mental Health Supported Accommodation in Brighton and Hove

By Mind in Brighton and Hove

March 2021

Date:	22 March 2021
Version:	Final
Name of originator/ author:	Jessica Bell, Employment Advisor, Mind in Brighton and Hove

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1.0 Executive Summary

Mind in Brighton and Hove (MiBH) was appointed to conduct engagement work for Brighton and Hove Clinical Commissioning Group (CCG) and Brighton and Hove City Council, to inform the re-tendering of the current mental health supported accommodation provision.

The engagement work included semi-structured interviews with former and current residents of Shore House, Sanctuary Star and Route One; a survey for former and current residents and a survey for staff, referrers and practitioners. We wanted to find out what works well and what's important to people, particular challenges or problems people had encountered, and what could be improved for the future. We had good engagement from interviewees, who shared their experiences of living in mental health supported accommodation with us, and the contributions from the resident survey and the staff and practitioner survey were equally informative with many detailed comments. The uptake was in total:

- ✓ **22 interviews** of whom 4 were former residents and 18 were current residents.
- ✓ **19 respondents to the resident survey** of whom13 were former and15 were current residents. The higher total than 19, is reflective of the fact that some of the respondents were both former and current residents.
- ✓ **32 respondents to the staff, referrer and practitioner survey** of whom 19 were a key worker, 9 were referrers or practitioners and 10 classed as other.

There was overwhelming praise for the support workers, who were described by many as committed, compassionate, caring and concerned with the residents' wellbeing. The overall experience of the support provided among residents, was largely a positive one. Residents felt well supported and they appreciated the flexible support that support workers were able to give them, guided by their needs and how much support they needed at various times. Staff, referrers and practitioners were also on the whole positive about the support being provided.

However, there were some challenges and issues highlighted by both residents and staff:

- the importance of maintenance and/or upkeep of properties and the impracticality of some of the flats/rooms
- some of the accommodation was considered unsuitable for certain groups of people, such as less mobile people, women, people with more complex support needs or for whom sharing accommodation is not ideal for their recovery
- there were reports of difficult interactions with other residents
- for some residents there were issues around isolation and difficulty breaking out of this
- noise from outside of the building or from other residents or thin internal walls was an issue
- cleanliness of shared spaces was important
- for some, the house rules were not strict enough and some people felt unsafe
- there were some concerns around staffing levels, particularly in higher and medium supported accommodation venues, and particularly at night
- the need for more staff training to enable them to support the more complex clients and the need for more therapeutic support for clients

Based on the challenges above and the improvements both staff and residents would like to see, we have been able to suggest five areas for further exploration by the CCG:

1. Explore options for how **support in supported accommodation could be better tailored to meet the needs of residents with more complex needs, including therapeutic needs.**

Tailored staff training may be an option and requested by some, or broadening the staff base to include a therapist. Therapy vouchers or offering a variety of learning methods to break out of isolation may be another consideration.

2. **Consider how prospective residents could be better prepared before moving in, including be briefed about the rules in shared houses**. Several residents mentioned feeling overwhelmed at first, particularly in shared accommodation venues. Some had also initially run in to difficult encounters with other residents, or feeling unsafe at night or unease at the use of substances on the premises.

3. Ensure that arrangements are in place to **keep on top of all maintenance issues and the general upkeep consistently** across all the different types of accommodation.

4. **Further exploration into how accommodation could be adapted to suit varied needs**, for instance access for less mobile people, creating more self-contained flats, addressing impractical or cramped rooms.

5. **Further engagement on how to encourage and help social interaction internally and externally** for people who struggle with this. Many mentioned social contacts as a key to wellbeing but often found this difficult with fellow residents. Contact with key workers and interaction with staff was positive, but insufficient to develop and maintain social interaction in the long-term.

2.0 Background

Brighton and Hove City Council (BHCC) in partnership with Brighton and Hove Clinical Commissioning Group (BHCCG) are currently evaluating the Mental Health Housing Pathway which consists of Shore House (high support), Sanctuary Star (medium support), and Route One (medium/low support). The current contracts are coming to an end and have been extended to allow adequate time for the re-procurement of services. As part of the re-procurement process BHCC and BHCCG made the decision to conduct engagement with service users and professional stakeholders to inform the future service model and specification.

The NHS has a statutory duty to engage with and involve the public in service design and redesign. The engagement process will enable commissioners to:

- understand experiences of mental health accommodation from current and ex-residents of the existing services
- explore the different priorities held by our service users when it comes to healthcare
- hear from Community Voluntary Sector (CVS) organisations and wider stakeholders who have direct contact with this cohort of service users and will have a good understanding of the needs and challenges they face
- encourage those getting involved to consider how services could be improved

3.0 Engagement Process

An Equalities Health Inequalities Impact Assessment (EHIA) was drafted by BHCC and BHCCG to identify any protected characteristic groups that should be considered as part of this engagement

work. This information was used to develop a specific engagement plan (including stakeholder mapping) for this project.

The engagement plan details a phased approach to engagement with Phase 1 seeking to gather views and experiences from current and former-residents of the existing services, as well as supporting staff, referrers and practitioners. Phase 1 of the engagement process is covered by this report and was carried out between 01 February 2021 and 01 March 2021.

Phase 1 engagement consisted of the following components:

- In depth interviews with current or ex-residents of the existing services
- Survey questionnaire for current or ex-residents of the existing services
- Survey questionnaire for staff, referrers, and practitioners that work with or in the existing services

In order to support the engagement work a Task and Finish Group was established with the following membership:

- Sussex CCG's Public Involvement and Communications team
- BHCCG Mental Health Commissioning Team
- BHCC Health & Adult Social Care Commissioning Team
- Healthwatch Brighton & Hove
- Local voluntary sector organisations which support people living with mental health conditions
- A Sussex Health and Care Partnership Community Ambassador volunteer
- Existing service providers; Brighton Housing Trust, Sanctuary Housing Association

The Task and Finish Group provided input into the engagement planning by review and comments on the following engagement documents and materials:

- EHIA
- Engagement and communications plan
- Frequently asked questions
- Survey questions for both staff and residents
- Engagement posters
- Stakeholder engagement methods and ways to reach former and current service users through local networks

Two existing service users also provided valuable input in the review and feedback on the following draft documents and materials:

- Frequently asked questions
- Current and ex-residents survey questions
- Engagement posters

In order to support the engagement work an expression of interest was released for a CVS organisation to conduct the in-depth interviews with current and former residents, as well as collate the engagement findings from both the interviews and surveys into this report. MiBH was appointed to carry out the engagement work.

A page on the EngageHQ website was dedicated to this engagement project and was used throughout the engagement process to hold information, provide links to surveys, and relevant document including the following:

- A core narrative about the engagement project
- A video describing the engagement work
- Links to online surveys
- Contact information for Brighton and Hove Mind for telephone interviews
- Frequently asked questions
- Contact details for questions and requests for materials in alternative formats

The engagement opportunity and materials were disseminated via the following communication channels:

- Existing service providers; Brighton Housing Trust, Sanctuary Housing Association
- BHCC Placement Allocation Team who disseminated to referring organisations and professionals
- The Public Involvement Team's stakeholder list of local organisations working across Brighton & Hove
- Community Roots provider organisations
- Community Works Email Forum, reaching out to the community and voluntary organisations working in Brighton & Hove
- Brighton & Hove Communications & Public Involvement Network, which includes communications and public involvement leads from across the Sussex Health and Care Partnership including the NHS, Healthwatch Brighton & Hove, BHCC, Public Health and VCS organisations

The CCG ran two weeks of Facebook advertising of the engagement opportunities for both residents and ex-residents and staff, referrers and practitioners. The following activity and reach from this advertising is a follows:

Week 1:

- Residents and ex-residents advert: 434 audience reach, 22 link clicks
- Staff, referrers and practitioners advert: 203 audience reach, 17 link clicks

Week 2:

- Residents and ex-residents advert: 445 audience reach, 9 link clicks
- Staff, referrers and practitioners advert: 354 audience reach, 4 link clicks

In addition to the Facebook advertising, the CCG also posted several organic social media posts during the same two-week period with the following activity and reach:

- Facebook posts: 1,180 audience reach
- Twitter posts: 3,026 audience reach

(N.B. Organic social media posts were also re-posted by B&H City Council but the activity and reach of these re-posts is not included in the above figures).

During the time the engagement opportunity was live there were 229 visits to the EngageHQ webpage which contained information on the engagement opportunity.

4.0 Methodology

MiBH was appointed to carry out engagement work for the CCG and BHCC to capture the views of people who live or have lived in mental health supported accommodation in Brighton and Hove to inform re-tendering of the current service offer. The aim was to find out what is/has worked well and what could be improved. The engagement work covered the current commissioned mental health supported accommodation venues:

- Shore House: High level support
- Sanctuary Star: Medium level support
- Route One: Low level support

The aim was to conduct up to 30 telephone interviews with current and former residents across the three supported accommodation venues. The interview questions were set by the CCG and consisted of five main questions in addition to a few warm up questions to find out whether interviewees were current or former residents, which of the three accommodation venues they were living/had lived at; their length of stay in that accommodation and their overall experience of mental health supported accommodation. The questions are included at Appendix A.

In addition, the engagement work also included a survey for current and former residents of the three venues and a survey for staff, referrers and practitioners. Copies of these surveys are at appendix B. The resident survey covered 13 questions and the uptake was 19 respondents, some of whom may also have taken part in the interviews. The staff, referrer and practitioner survey included 16 questions and was completed by 32 respondents.

Residents were also asked to complete a set of equality monitoring questions to inform commissioners understanding of the demographics of respondents. 29 former and current residents opted in to answer these. For a full list of the collected answers, please see the appendix C.

For the interviews, we used a grid to collate all answers under each conversational question. To show as clearly as possible what interviewees' overall experience was, what works well, what challenges they had encountered, what improvements they liked to see and what's important to keep them well, we used these as five main headings while presenting 2-3 main themes under each heading. The findings were analysed and checked for relationships and variables such as former or current resident, which accommodation venues and to some extent what type of accommodation, i.e., self-contained or shared, in order to establish relationship between experiences, where possible.

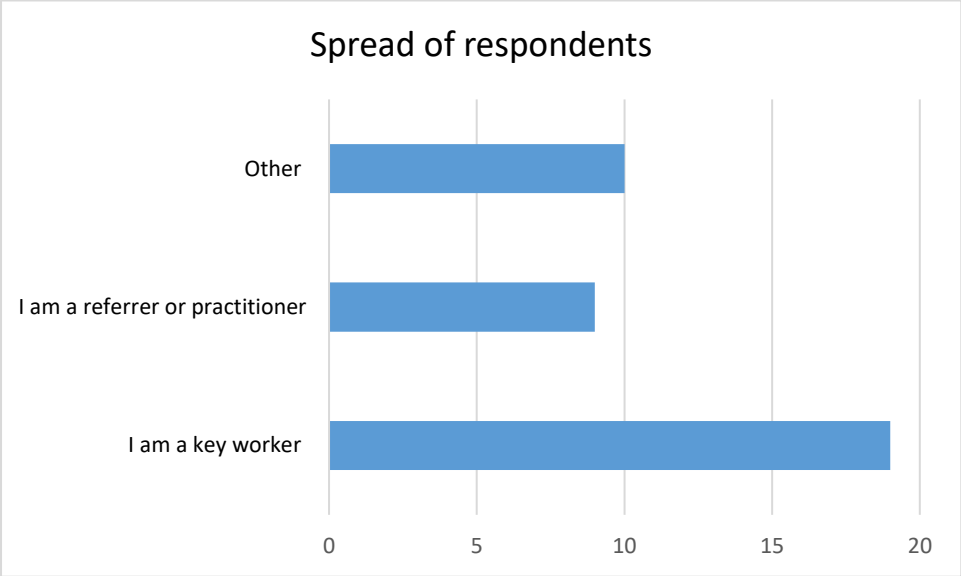
For the surveys, in agreement with the commissioner and given the timeline and scope agreed for the engagement work, we used the data where relevant and identified key themes from the free text responses. These were presented with a summary of key points, informed by quotes where appropriate.

Based on the findings of former and current residents' experiences of supported accommodation and from staff, referrers and other practitioners' experiences of working in or with supported accommodation providers, we have been able to suggest five recommendations for the commissioner to further explore.

5.0 Staff, Referrers and Practitioners Survey

5.1 Demographics

There were 32 respondents in total to the staff, referrer and practitioner survey, spread across three categories: keyworker, referrer/practitioner or other, as shown in the bar model below.



The spread across the three venues is not known from the survey, for the ten respondents who added any information 8 were support workers and 2 were managers.

5.2 Summary of Findings

To present the views from respondents in a concise way, we have collated the feedback into 4 areas: the referral process; how well services met support needs; specialised support for particularly vulnerable groups; and future service models.

1. The referral process

The survey asked respondents a number of questions about the arrangements for making a referral to each of the three supported accommodation venues.

Over half of the respondents that answered this question reported that their experience of making a referral had been excellent and only one person reported that their experience of making a referral had been poor. Generally, respondents reported that:

- they found the paperwork helpful
- there was good multi agency working when referrals were made
- the process felt client-centred
- the system was straight forward

One person fed back that they found the process repetitive and cumbersome.

When asked how the referral process could be improved the following feedback was provided:

- it would be helpful for Route One to be on the B Think system – it was felt that not being on this system slowed referrals down and made it harder to refer clients on to alternative support
- sometimes referrers did not provide enough or up to date information about prospective clients
- sometime the referral information does not marry up with the client whose needs can sometimes be more complex than those described in the referral paperwork
- it would be helpful to have more information about the individual services before making a referral
- one person thought it would be helpful if all referrals for supported accommodation could be sent to a central point

2. How well do services meet support needs?

In relation to how well respondents thought the three services met client needs, 76% thought Route One either met client needs or mostly met client needs, the figure for Shore House was 55% and for Sanctuary Star 30%. Similarly, when asked to rate the availability of staff to provide support to clients on a scale of 1-5 where, 5 is very much enough, 26% rated Sanctuary Star between 3-5, whereas the same rating for Shore House was 70% and for Route One 78%.

On the whole the services were considered to work well, with staff working well together and responding to clients' individual needs, and often working across the three venues following the mental health pathway. There were however issues reported, such as:

- unsuitable accommodation, for instance only shared houses in medium and high support accommodation
- inadequate staffing levels or staff training, in particular to meet an increase in residents with more complex needs, such as dual diagnoses, people with substance misuse and the need for night time support

"Because of the amount of chaotic clients at Shore House, many who have combined substance misuse/alcohol and mental health issues any vulnerable clients are at risk of exploitation particularly financial abuse. The staffing levels mean that they are unable to offer clients the amount of hours they are contracted to provide often leaving the less demanding clients without receiving the support that they require"

"Shore House is unsafe for women - the service is chaotic, and users of the service are often substance users. Despite several instances of women being sexually assaulted at the service the service doesn't seem to be able to keep women safe. In addition, the use of shared space is unwelcome to clients."

In terms of what respondents thought worked well, skilled and dedicated staff teams and being able to offer flexible support guided by individual clients' needs came out strongly.

"The service is able to provide a varied and flexible approach to support. Support hours can be increased or decreased according to need, support can be provided at the accommodation, in the community, at the office - whatever works best for the client. There is regular and efficient communication across the team meaning that we are quick to step in and offer responsive support on top of planned support sessions."

In terms of what could be improved, in addition to increased staff levels and further staff training, expanding the mix of skills and training among staff to incorporate more therapy and counselling was highlighted.

"Unfortunately, we often work with people with higher mental health support needs -people who would benefit from an intensive recovery focus, people who should be in therapeutic environments benefiting from nature, and various forms of therapies alongside their traditional treatments."

"Our all women house would probably work better if the women had a self-contained unit with cooking facilities as well as communal facilities. At the moment, they all just have a room and all other facilities are shared and as staff are not based their permanently, only occasionally, it is sometimes difficult to monitor and intervene immediately when conflict, ASB issues occur. This has left some clients feeling frustrated and unsafe at times."

In terms of how achievable the move-on timeframes of 18-24 months are, there was a broad consensus among respondents that they were fairly or largely achievable.

3. Specialised support for specific client groups

When asked to rate gaps in provisions for specific groups of people (e.g. women, people with learning disabilities, or people with physical health needs or other protected characteristics), on a scale of 1-5 where, 5 means No gaps, most respondents rated Shore House and Route One a 4 and Sanctuary Star a 3, suggesting the gaps were felt moderately less in the former two.

While a few respondents saw no gaps in the service provision for specific groups, most of the comments were focused on:

- restricted or limited access across the 3 sites to cater for people with impaired mobility.
- unsuitable provision for women. It was pointed out that although Route One offer women only accommodation, the women referred to this accommodation, often had high support needs and/or additional support needs, which didn't always suit a shared household. Some also commented that in the mixed accommodation, the majority were often made up of men and this sometimes left women feeling vulnerable.
- another gap that many could see was in the provision of support for people with dual diagnosis, people on the autistic spectrum, and young people.

"Route One has an all women's house but often referrals are for women with very high support needs, chaotic drug use etc and this means it is not an appropriate environment for other vulnerable women."

"None of the services are able to work well with people with dual diagnosis. Shore and Star do not offer physical environments that feel safe for women (lack of self-contained). Route One's accommodation offer is the best but cannot work with high need clients who need more support."

Most of the respondents thought that the services met the needs of people who are homeless or vulnerably housed, well or to some extent, although it was pointed out that Route One was not often the right service for this group of people initially, but usually further along the journey.

"I think the service meets the needs of most of these people. I think for those who come from homelessness it may be difficult to move straight into route one as we require participation in support as part of the tenancy and this may be too difficult for someone who has just come from being street homeless however I think that as a group of three services it seems to work well that people progress through the services from homelessness to housed. I also think that route one meets the needs of those with mental health support needs of a certain degree."

What could be an issue, was the long wait for moving-on accommodation for residents who were ready to do so, which in turn created a bottle neck for this group of people to access the supported accommodation.

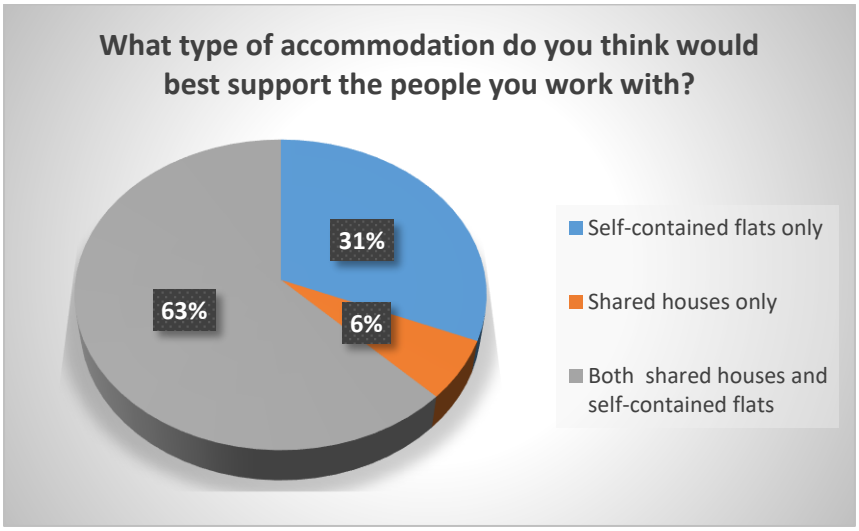
"The level of complexity for those who are homeless or vulnerably housed goes far beyond their mental health and more comprehensive, holistic support is needed at all levels. Services are divided by the area of need they meet (ie mental health) and therefore other needs are seen as being beyond the reach of the service or exceeding threshold"

Respondents were asked to what extent they considered the support provided was psychologically informed, using a PIE service model (Psychologically Informed Environment). For Shore House and Route One, most rated it 'very informed', whereas for Sanctuary Star more respondents rated it lower on the scale. Notably though, there was a disproportionately high share of respondents who answered N/A for Sanctuary Star compared to Shore House and Route One.

"At Sanctuary star the focus is the Recovery Model which is psychologically informed to a degree. Work is currently being undertaken to improve the physical space. The staff group have therapeutic/ psychological backgrounds but PIE is not explicitly referenced."

4. Future service models

The vast majority of respondents would like to see a mixture of both self-contained flats and shared houses being offered to suit residents' individual needs, and a minority would like shared houses only being offered. Some of the respondents who preferred self-contained flats, added that some communal space would also be beneficial.



61% of respondents would prefer a multiple service model that is based on needs, so that residents move to the right level of supported accommodation at the right time in their journey, compared to 39% who would prefer a multiple service model that is not based on need, instead residents are able to stay in their accommodation but receive a different level of support.

Many respondents reported that the ideal service would be:

- bright and welcoming houses
- flexible support and accommodation to meet individuals' various needs
- multi-agency working where needed
- comprehensive staffing levels to respond to more complex needs.

Below are some of respondents' comments:

"I think the key is high quality staff who are paid well, motivated, well trained and well supported. After that the accommodation needs to be spacious, well looked after and ideally have a quiet garden with space to grow flowers and vegetables."

"Increased therapeutic opportunities - groups and workshops and other positive engagement/activity."

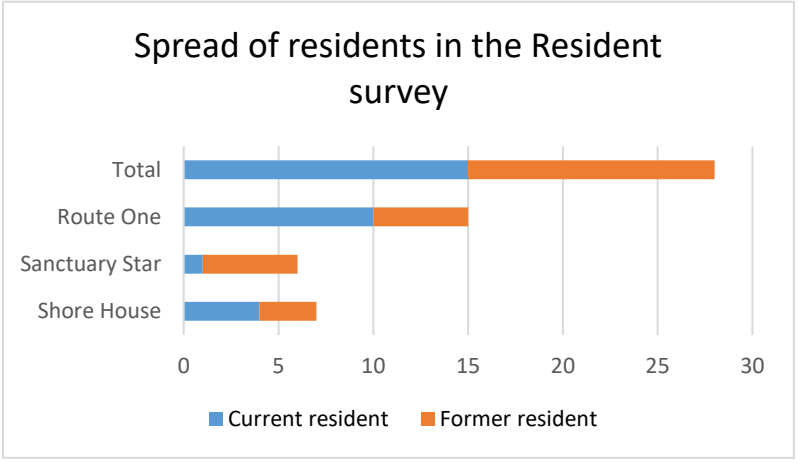
"Both staff and clients provided with psychological support from qualified counsellors/therapists/practitioners as part of the service model."

"I feel strongly that these accommodation-based support services need to be protected, with support continuing to be provided by trusted local teams who have a well-established connection to local CVS and statutory services."

6.0 Current and Previous Residents Survey

6.1 Demographics

There were 19 respondents in total to the resident survey. Some of the respondents were both former and current residents, for example a current resident of Route One and a former resident of Sanctuary Star. The spread of current and former residents across all three accommodation venues is presented below. The total is reflective of the fact that some respondents ticked that they were both a former and a current resident, bringing the total to above 19 respondents. (10 people answered the question of when they had moved in and it ranged from 2012 until 2020, five of whom were still living there at the time of the survey.)

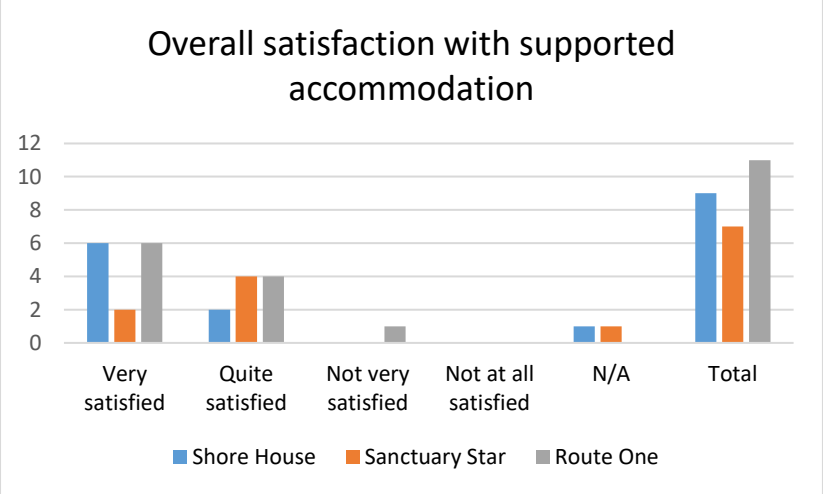


6.2 Summary of Findings

To present the views from respondents in a concise way, we gathered the answers to the 13 questions in to six headings: what people like about the current provision, problems and challenges, what's missing, type of accommodation, amount and length of support, and what a good service looks like.

1. **What people like about the current provision**

The vast majority of respondents were either very satisfied or quite satisfied with their supported accommodation. Again, some of the 19 respondents answered for more than one venue, as reflected in the bar model below.



Many of the respondents indicated having a good relationship with their key worker and feeling well supported, an overall positive experience.

"My relationship with staff and my key worker is very good. Living at Shore House has made my life so much better as I have support all day and most of all the support at night."

Some, while being happy about the support, had some reservations about the accommodation itself, to do with the upkeep and maintenance of the property, cleanliness of shared areas, or the standard of the rooms or flats.

"I have a good relationship with my key worker and feel supported by her. However, my accommodation is dire."

"The actual accommodation wasn't very nice, but the staff were amazing."

A few respondents, while similarly being happy with the support, pointed to stricter security rules in the building:

"I am quite happy about the support I get, but I think the accommodation should be more secure, e.g. use of a camera to see who is coming and going, and who is using drugs."

2. Problems, challenges, and what could be done to address these

13 respondents reported having experienced problems of some kind living in their accommodation, and 6 respondents reported having experienced none, as presented in percentages in this chart:



The most commonly reported problems had to do with:

- **The maintenance of the building, their flat/room or cleanliness of shared spaces**. Specific problems included cracks in the walls and ceiling, damp and lack of light and air or too much light, a cold flat and lack of space.

  "I could do with some more space. I am quite tall. My room is small. I have felt too confined in lockdown. This has had an impact on my mind and wellbeing."

  "The cleanliness of the top floor kitchen - it's always so dirty and not kept clean. I have to keep asking staff to clean it. Otherwise the house is kept nice and clean."

- Other issues reported by a few was **the level of noise**, in or around the accommodation, and the negative impact this had on people's mental health or sleep. This included noise from building works going on next door to the property, lack of sound-proofed internal walls which made noise from conversations or meetings coming through, or other residents being noisy.

  "I have a lot of noise problems as there is building work going on next door." "Housing for people with mental health difficulties or leaving Millview needs to consider problems of noise. I would like to see the law protect vulnerable people like me who can't tolerate noise."

- **Difficult interactions** with other residents was also reported to be an issue for some.

  "Difficult interactions with other clients when they have presented challenging behaviour. [It] can be stressful in such circumstances".

- Other problems reported by a few were **issues of safety**, as captured by this respondent:

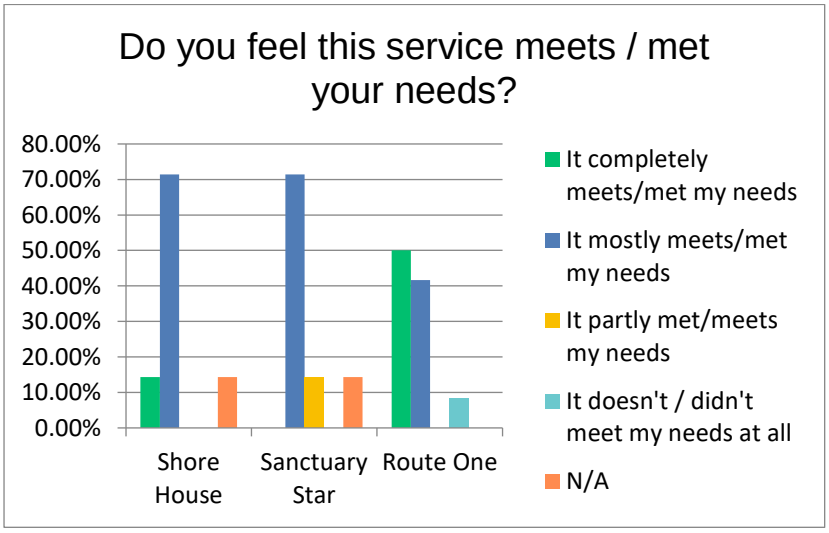
  "I don't always feel safe at night. I wish we had staff on hand at night."

- Less commonly reported issues were unclear staff rotas, deliveries to the building and spending too much money as shops are on their door step.

3. What's missing and what's important in supported accommodation?

Most respondents reported that the services mostly or completely meet/met their needs. One respondent thought it didn't meet/met their needs at all and one that it partly meet/met their needs.

Please see bar chart below for a breakdown of the three services:



Almost half of the respondents didn't think that anything is missing in their support. For the other half the most commonly reported wish was easier or more affordable access to counselling or therapy, especially to help combat isolation and getting out more:

"I found it hard to get this unless I paid for it myself. I wish I could have had a befriending and buddy support for help with going out, as I don't like going out alone and didn't know what I could access without spending a lot of money."

Related to this is the importance of assistance to break out of a cycle of isolation, more groups, a communal feel or more social interactions were also mentioned by a few:

"I would have liked more activities or group support outside of the housing. It was hard to find out what there was going on that could help with my recovery."

Having night staff on site and also feeling more protected was captured by this respondent:

"More protection at night, because there is no staff at hand and some of the other residents have psychiatric conditions. People who may try to harm us from the outside."

4. Views on the type of accommodation:

People who felt that they would have preferred a different type of accommodation to what they have or had, were exclusively from respondents in shared accommodation. They would have liked their own self-contained flat, as captured by this respondent:

"[The] quality of housing and life would be better if the accommodation was self-contained. Some people are unwell/disabled and can't/don't keep bathrooms clean."

Similarly, it was also more commonly reported by people in self-contained flats, but not exclusively, that they were happy in the type of accommodation they have or had.

"I value having a self-contained flat, as my aim is to live more independently in the future."

5. **Amount of support and the length of tenancy:**

Respondents were asked about how much support from staff they received whilst they were living in the different venues – it was acknowledged in the question that each site provided different levels of support[1] .

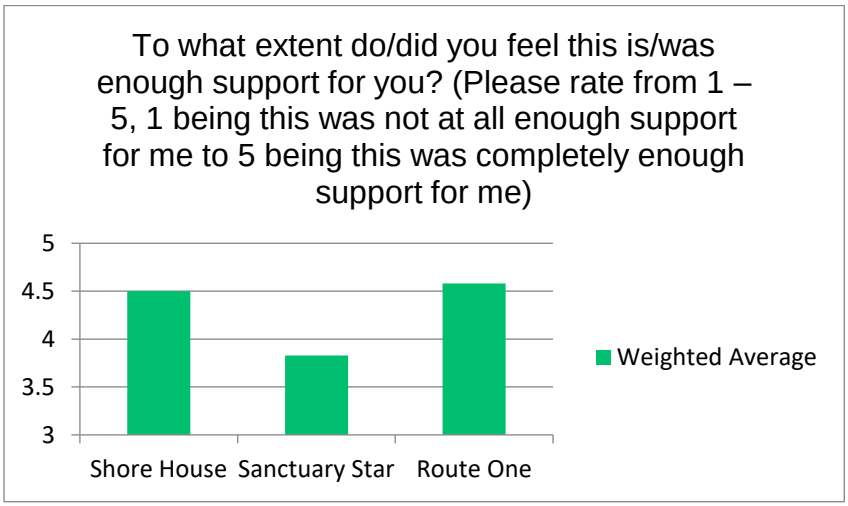
One respondent recorded 0 hours. Others answered in terms of enough or lots of support for their needs, varied hours week to week, with added support hours in times when they needed more support.

"When feeling more stable, I receive 1 hour a week. When I am struggling, I receive more."

One respondent expressed a shortage of staff:

"I believe Sanctuary Star are somewhat short staffed to provide the level of support described above", adding that *"I can only give this a 3 as my support worker isn't given the power she needs to really help me."*

The amount of support that respondents received across the three venues is captured in the bar graph below. Things mentioned that could be improved were more help with practical things like cleaning. One respondent suggested that there could be more help from support assistants, for example to help picking up medication or help cleaning when they are feeling particularly unwell.



With regards to people's views on the length of tenancy, it was either the right length or too short, with a slight variation across the three accommodation venues (More people from Route One and Shore House answered the right length for them in proportion to Sanctuary Star). Nobody answered that it was too long, a few answered that it was not applicable.

"When I first arrived, I had lots of complex issues going on so staying longer would have been helpful."

"It is really difficult to get housing, and the right type of housing, so I need more than 2 years for this."

[1] *Shore House has staff on site 24 hours a day, 7 days a week. Support will fluctuate based on individual need, however the average number of support hours is 20 hours per week per person. Sanctuary Star is staffed between 8am and 8pm 7 days a week. Support will fluctuate based on individual need, however the average number of support hours is 11 hours per week per person. Route One is staffed between 9am and 5pm Monday to Friday and 10am to 6pm on Saturday and Sunday. Support will fluctuate based on individual need, however the average number of support hours ranges between 2 and 8 hours per week per person*

6. What does a good service look like?

Many respondents thought that their supported accommodation was just right or came close to what a good mental health supported accommodation should look like, and added their thanks to the staff and support workers. Having the right people working in the service and feeling comfortable and confident to express your concerns to someone who understands and listens, were mentioned as example of what works well. A few would like to see more self-contained flats, stricter rules on who comes and goes, and substances being kept out, a mental health community garden or a place to work outside. Other suggestions are captured in these quotes:

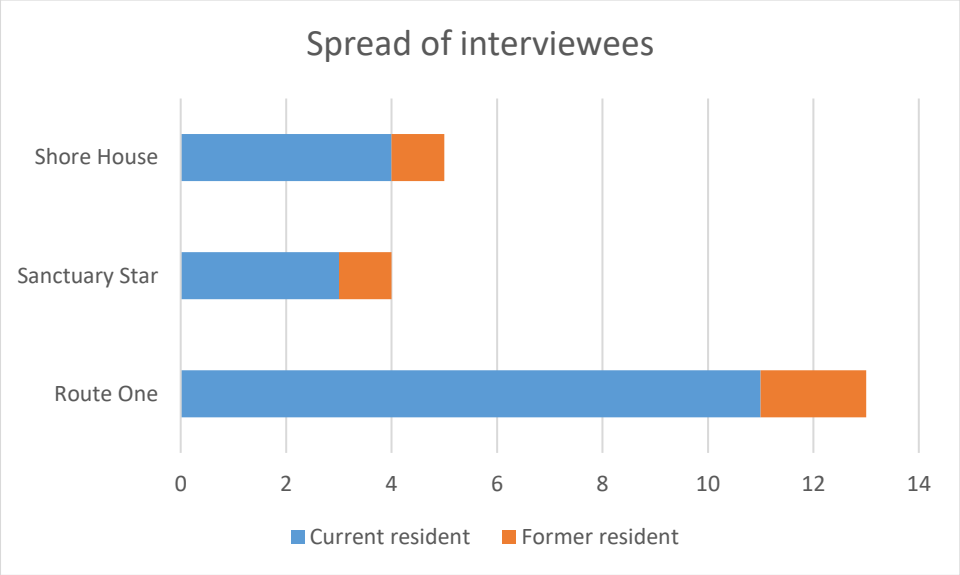
"Before someone comes into Shore House, they should be told what they can expect from other people in the house."

"It would be better if my case worker/lead practitioner stayed involved longer whilst I was at Route One. I was discharged when I didn't want to be. I would like the service to have more power to change things and help me"

7.0 Current and Previous Residents Interviews

7.1 Demographics

The aim was to conduct up to 30 telephone interviews with current and former residents across the three supported accommodation venues, Shore House, Sanctuary Star and Route One. 22 interviews were completed using nine structured and semi-structured questions to encourage conversation around what works well, what could be improved and any issues or problems encountered by residents. Of the total 22 interviews carried out, 4 were former residents and 18 current, divided as follow across the three accommodation venues.



Operational managers for all three accommodation venues were asked to gather consent forms for former and current residents who wished to take part and forward these to MiBH. Attempts were made throughout to gather further consent forms for former and current residents at Sanctuary Star and Shore House to address the imbalance across the accommodation venues, and this was to some extent achieved. However, there is a larger pool of residents to draw from for Route One compared to Sanctuary Star and Shore House. One interviewee was recruited via the

resident survey. Interviewees length of stay at their accommodation at the time of the interview ranged from 4 months to 5,5 years with most interviewees having lived at their accommodation between1-3 years.

7.2 Summary of Findings

Overall experience

The majority of interviewees told of a largely positive experience of living in supported accommodation, with committed and caring staff and with the right level of support in place. Many described it as an amazing or great experience, one interviewee commented that *"this is the happiest I've been in my life in the last two years*". Another interviewee similarly added that *"being here is the happiest I've been in many years".* For some it was a clear relief to come in to supported accommodation, and to have a place to live. People who expressed a relief at having been offered a place in supported accommodation had often come from a period of hospitalisation, having been sectioned under the Mental Health Act or from a hostel. Some were faced with potential homelessness at the point of being offered a place, and this was a major worry having been resolved.

Some spoke of an initial daunting phase of getting used to their accommodation and some difficulties this presented for them, especially in shared houses. The difficulty that interviewees had experienced had to do with other residents' mental health problems or other issues such as use of recreational drugs, and adjusting or getting used to the environment. An initially daunting or turbulent experience was particularly the case for people who had previously had their own home or had come from a self-contained flat. Most people now felt settled in their accommodation and initial issues had been dealt with or resolved and was no longer a problem or less of a problem. For some though, living in a place with other people whose mental health was precarious, remained a challenge.

For a minority of interviewees, theirs was an overall negative experience of living in their supported accommodation venues. For one former resident, living in a shared accommodation was too much for them and didn't suit their needs, with security guards checking in at the accommodation at night. *"It felt like an invasion of privacy".* The issue had, however, been resolved as they had been helped to transfer from medium to low supported housing, which worked better for them. A current resident, who had transferred from high to medium supported accommodation, had found the transition difficult and felt they generally didn't get the support they needed, especially when they just arrived, adding that there seemed to be *"no structure in place where residents and their safety comes first".*

What people like in their supported accommodation

<u>The relationship with support workers</u>

There was overwhelming praise for the support workers, who were described by many as committed, compassionate, caring and concerned with the residents' wellbeing. Notably, this was also the case for the few who expressed an overall negative experience of living in supported accommodation. Some of the interviewees spoke of support workers or staff in general and others spoke more specifically about their key worker. Many described that they felt well-supported by

their key worker, and that they could raise any issues or concerns with them. Many felt that they were listened to and understood by their key worker, who responded to the stress a particular situation or concern may cause them. *"I liked how they paid attention when you brought something up. They would listen and make sure they had understood you and why something made you feel stressed."*

The trust that they had developed for their key worker was also highlighted by many, which allowed interviewees to feel safe. One interviewee, who prior to living in supported accommodation had been homeless, described how the support workers helped them feel safe from the start: *"I was frightened of anything because of the situation I came from. They really reassured me that I didn't have to be frightened. My key worker was such a blessing."* The staff allowed time for people to settle in and get used to things, and this was important in building trust for their key worker.

The regular contact with staff was appreciated, even if it was just to say hello and exchange some words, when staff were on site, for people who lived in self-contained flats. Many commented that staff were easy to get hold of, should any issues arise in between scheduled meetings with their key worker. One interviewee had however, noticed that since lockdown, staff seemed more busy and it had become harder to get hold of staff. Another interviewee in shared accommodation commented that the staff office operated a close-door policy in response to Covid-19, which had somewhat made it feel less natural to approach staff more spontaneously. For people in accommodation venues with staff around at all times or during the day, a nice feature mentioned by some was getting to know all the staff quite well and having spontaneous chats or exchanging a few words with them. Despite lockdowns during Covid-19, the majority of interviewees hadn't experienced that staff availability had been affected.

Some interviewees had had key workers in the past whom they didn't get on with so well or didn't connect with. In those instances, they had been supported to change key workers and this had been done swiftly and without any fuss.

<u>Flexible support guided by individual needs</u>

While most interviewees had weekly meetings with their key worker, there was flexibility in this, which many liked, depending on how much support they felt they needed. Some interviewees, who felt their support need wasn't that great, had arranged to have a shorter check-in or catch-up certain weeks when they felt no real need for a meeting or visit, although it was often encouraged to keep up regular visits. Adversely, some interviewees had in periods felt a greater need for increased support when they were feeling more unwell or their mental health was deteriorating, and support workers were good at accommodating this, by adding more frequent check-ins between scheduled visits. *"They work at your pace, the level of support that you want".* It was generally felt that the support was flexible enough to meet individual needs and importantly guided by this.

This was also true of the kind of support people felt they needed. For most it involved both practical and emotional support, depending on the kind of things the interviewee struggled most with. One-to-one support included badminton sessions, going for a coffee or walk on the beach or in the park, accompany to appointments, viewings of housing etc, in addition to meeting at the accommodation to talk or help responding to paperwork, help with digitalised administration etc. Lockdown periods had affected some of the outings temporarily.

For one interviewee the tailored support to accommodate individual circumstances offered by support workers had been crucial in their recovery. Coming out of hospital and with the prospect of not having a place to live, they were offered a place in a women only shared accommodation, last minute. The interviewee accepted the offer, however, the physical location of the house was in an area associated with a trauma for the interviewee. The interviewee felt that their key worker understood the barrier to recovery that remaining in the location would pose, and helped the interviewee to successfully transfer to another of the provider's supported accommodation venues. *"I couldn't have continued to live in that location."*

Another example was brought up by an interviewee who struggled with alcohol consumption initially. Their key worker was patient and allowed the interviewee time to come to terms with the fact that they needed a period of rehab. Their key worker kept up their support during periods in rehab and had successfully coordinated their joined-up support with their alcohol worker, their clinician and other external agencies. This holistic support around the different areas of their care needs, had greatly contributed to the turning point in their recovery that they had now reached. Another aspect that was brought up by a former interviewee, who was now living in their own permanent flat provided by the council, was the support from their key worker to be patient and wait for a sustainable housing option. The interviewee had at times felt disheartened by the process of bidding and waiting for a flat via the council, but was grateful that their circumstances were taken in to consideration and they were not pushed to find another, less permanent option.

Location and setting

Many interviewees liked the location of their accommodation, as they were located in quiet and residential areas, with little through traffic and noise around. There were nice walks nearby, like the seafront or parks and other green spaces, which for some interviewees was an important part of their wellbeing. One interviewee explained that being able to easily get down to the beach or walk in a park was part of their self-therapy. "*I use a walk down to the beach or a walk in the park as distraction, which is a part of my self-therapy".* Some, in self-contained flats, also found the residence itself peaceful most of the time, with other residents being quiet and respectful, with no screaming going on or police and ambulance being called to the building, or loud music being played. Some also had spacious rooms or flats, which they liked, and the fact that it was warm and dry.

Problems/challenges encountered

A third of the interviewees couldn't think of any problems they had had, in their supported accommodation. For those who did, three main areas could be identified.

Other residents' behaviour

The most prevalent problem or challenge interviewees had experienced in their supported accommodation had to do with other residents' behaviour. This was brought up by a few people in self-contained flats, but more commonly by people who lived in shared accommodation, i.e. having their own room but shared kitchen, bathrooms and where relevant other communal spaces. In some cases, this was an issue for people when they first moved in, that had since been resolved or largely resolved. Staff had often helped to resolve the situation by talking to the other resident in question. A few of the interviewees had experienced an intrusive neighbour. For instance, one

interviewee described when they first moved in, a neighbour would knock on their door repeatedly until 6am in the morning. They barricaded the door with the sofa, as they felt frightened. They contacted the staff who subsequently spoke to the person in question. The interviewee felt reassured and safe after that. *"They never knocked again after that."*

It was felt that staff had helped to resolve any incidents or issues promptly, by talking to the resident concerned, and it had been resolved quickly. A few said that even though it had been dealt with, they were unsure what had been said to the other resident and how it had been resolved.

Other encounters had to do with smoking coming through to their room or flat, and this felt depressing as the problem was continuous. Adversely, one interviewee felt threatened by another resident because they smoke tobacco, which was allowed under house rules. But this had caused some threatening behaviour towards them. The issue had partially been resolved but they still felt uncomfortable living in the same building.

For interviewees who brought up the behaviour of other residents as a challenge, there was an understanding that the reason for challenging behaviour was usually due to a deterioration of someone's mental health. "*This is mostly due to someone becoming less well, a reflection of their mental health struggle".* For a few this negatively impacted on their own mental health, even acting as a trigger for destabilization at those times when the place felt less harmonious and with higher stress levels, due to the selection of people in the building. This fluctuated over time, and was more steady than unsteady on the whole. A few interviewees had felt unprepared, or even shocked, for what it would be like moving in to a shared accommodation, living with other people with their own difficulties and problems or substances being used on the premises. One interviewee had been asked for money by fellow residents, when they first moved in, and had given some. Later they had had the opportunity to talk about his with staff, who had explained to them that they can say no. This hadn't been clear to the interviewee, but they had since learnt to say no when people asked, and hadn't had any further problems.

<u>Facilities and maintenance of residence</u>

Some interviewees complained of impractical facilities in their studio flats and cramped spaces. For example, a few didn't have adequate cooking facilities, or enough work top space to prepare their cooking. As a consequence, one interviewee ate all of their meals out or at friends'. The lack of space also made it feel unhygienic to cook and chop up food, there would be crumbs and bits on the bed, as there was no space for a table and chairs. This felt depressing to the interviewee. Another interviewee expressed a similar situation, where they were left with no cooking facilities for a year as the hob broke down, and their only option was to cook in a microwave. Their fridge had also broken down, and was initially replaced with a mini-bar type of fridge, in which it was hard to fit in a container of milk. This made shopping difficult especially during lockdown, as it was hard to stock up to avoid frequent visits to the shop. The fridge had now been replaced, but the episode also felt depressing to them.

For others in shared accommodation, the communal spaces like kitchens and bathrooms often didn't feel clean and some described these as messy. *"It just doesn't make you feel that positive about going home"* or *"I wouldn't want to invite anyone here, it's quite embarrassing".* Other issues some interviewees brought up included a shortage of toilet paper and hand washing soap.

General maintenance and upkeep of residences was also pointed out by some interviewees, particularly where it was pointed out that the building was old *"The building is falling down soon if nothing is done to it."* One interviewee described living with a hole in the ceiling, where on occasion water would come through from the outside wall. Although attempts had been made to try to fix problems when brought to the attention of staff, it was often felt that it was probably too much of an overall structural problem that couldn't easily be fixed without a more major renovation of the whole building.

Isolation

A few felt that isolation was a problem. This had to some extent to do with lockdowns during Covid-19, as there tended to be less interaction between residents and group activities had largely been suspended, but the issue was felt to be there also before Covid-19. Feeling isolated was mentioned by a few people, both from self-contained and shared accommodation venues. It was recognised that it could be difficult to join in with activities with other residents they often didn't know, sometimes because of more problematic feelings stemming from trauma, as was the case for one interviewee. They suggested that "*staff may be missing or not fully understanding why some people don't engage in activities, the barriers that make it difficult to do so."* For another interviewee, the difficulty to take part had to do with the activities were mainly offered outside of the accommodation, typically outings like cycling, walking or visits to places of interest. For them, if the activities were organised in-house, it would probably be less of a barrier for them to take part.

Improvements/changes

Half of the interviewees wouldn't want to change anything to the support they receive from the support workers. Among the other half three main areas of suggested improvements they would like to see could be identified.

A therapeutic approach to support

Some expressed a wish to incorporate more therapy in their support. One interviewee, in low support accommodation, would like to see staff challenging themselves more. The support seemed to an extent to be lacking in direction. Even if the goal is for residents to move on to living more independently, the structure of the support seemed somewhat unclear to the interviewee, and they had the feeling it was not entirely clear to the staff either. Although the practical and emotional support was appreciated, they'd like to see staff engaging more with residents' experiences of trauma. For the interviewee that could potentially help to break out of isolation, as trauma is often what was standing in the way. Another interviewee similarly felt a need to talk more about the "deeper thoughts" as part of the support, in addition to more practical help. In-house activities were also suggested in self-contained accommodation venues, like art or writing groups, as a way of help breaking out of isolation.

Further or additional training for staff was also suggested of how to work with people with mental health difficulties in a more informed way, a "good practice" approach. They recognised that it may be difficult to come in to someone's home and knowing how to approach that person and the difficulties they are experiencing. This would also help avoiding an infantilising approach. One interviewee said *"there has to be more recognition and treatment of people as intelligent adults."*

For yet another interviewee, a way to address their need for more therapy, would be the option of choosing therapy vouchers instead of having a key worker. This was because their general support need was now less than their need to address more deep-set struggles.

Stricter house rules

A few suggested there could be clearer or stricter rules in place to help maintain a more harmonious place to live. This was expressed by people who lived in shared accommodation. Some of the suggestions had to do with having stricter cleaning rules of the shared areas among residents, but also for staff to take a more active role in making sure cleaning standards are maintained and adhered to and help instil a sense of respect and understanding of shared spaces. This also applied to more social rules. For instance, one interviewee said they would like social interaction between residents to take place in the communal areas only. They felt that residents should not be allowed to go in to each other's rooms. For them, it would be reassuring to have staff available and around when social interaction took place between residents, to avoid substances being taken or parties to erupt in private rooms that could potentially go out of control or become messy.

Another suggestion, related to creating a more harmonious shared environment, was that some kind of preparation of how to live with others struggling with their different mental health and other difficulties would be helpful, before moving in. This may help people adapting better and be more prepared for how to handle situations that may arise between residents.
Clearer policies or plans in place, at management level, for all kinds of situations was also raised by one interviewee. An example where it appeared to be lacking was in the handling of Covid-19 in the beginning of the pandemic. They had the impression that staff hadn't had clear guidelines and therefore panicked when someone was coughing.

Practical improvements to the accommodation

Some of the suggestions for improvements had to do with practical improvements to the accommodation. These included bigger or more practical flats or rooms, a general overhaul of the whole property, repairing problems, updating furniture in communal areas and addressing shortages of supplies like toilet paper or hand wash. A more specific wish mentioned by a couple of interviewees would be to have a laundry facility in the house for the self-contained flats. It was recognised that space may be an issue, but it would be an improvement to their living, if it could be done. "In this type of accommodation, it would be ideal".

Key factors to keep well

Consistent support from support worker

This was what most interviewees pointed out as the key factor to keep well. It was felt that to have someone to engage with, to talk to, help with any practical issues and who was there with you and to rely upon was an essential part to keep well. For many interviewees this was provided by their key worker in their weekly regular support. *"Someone who is alongside you with it".* For some a key thing provided by their key worker was to help establish and maintain healthy routines and habits. For instance, for one interviewee it was very important to keep healthy and maintain a healthy diet. Their key worker was an essential part in helping them to monitor diet intake, making sure fresh fruit and vegetables where part of their diet and that they are drinking enough water. The consistent support from key workers was also to help people check that they had stuck to

routines and were on top of bills for instance or they attended appointments. For others the most important role of their key worker was the chance to talk through worries and the patience shown by their key worker, feeling understood and listened to. This allowed for trust to be developed over time which made people feel confident to raise and discuss any concerns.

Social interaction

Another key factor to keep well that was important to interviewees was engaging in social interaction with others, apart from the interaction with their key worker. *"It's what keeps you sane"* and what many felt they needed to keep moving on in a healthy way. For some interviewees this was difficult to achieve with fellow residents, as many felt that people tended to keep to themselves or other residents being too unwell, both in self-contained accommodation and sometimes in shared. For a few interviewees this was provided by family members or friends, outside of their supported accommodation.

For some, while social interaction was the key factor identified to keeping well, it was also their main struggle or part of their struggle. For a few interviewees group activities helped or could help. Opinions on group activities were divided, for many interviewees this was not an important part for them, as they tended to keep to themselves. Others had taken part prior to lockdown. A few felt isolated. One interviewee reported that they would have liked group activities in the house.

8.0 Conclusion and Recommendations

We had good engagement from interviewees, who shared their experiences of living in mental health supported accommodation with us, and the contributions from the resident survey and the staff and practitioner survey were equally informative with many detailed comments. There was overwhelming praise for the support workers, who were described by many as committed, compassionate, caring and concerned with the residents' wellbeing. The overall experience of the support provided among residents, was largely a positive one. Residents felt well-supported and they appreciated the flexible support that support workers were able to give them, guided by their needs and how much support they needed at various times. Staff, referrers and practitioners were also on the whole positive to the support being provided. However, there were some challenges and issues highlighted by residents and staff:

- the importance of maintenance and/or upkeep of properties and the impracticality of some of the flats/rooms
- some of the accommodation was considered unsuitable for certain groups of people, such as less mobile people, women, people with more complex support needs or for whom sharing accommodation is not ideal for their recovery
- there were reports of difficult interactions with other residents
- for some residents there were issues around isolation and difficulty breaking out of this
- noise from outside of the building or from other residents or thin internal walls was an issue
- cleanliness of shared spaces was important
- for some, the house rules were not strict enough and some people felt unsafe
- there were some concerns around staffing levels, particularly in higher and medium supported accommodation venues, and particularly at night
- the need for more staff training to enable them to support the more complex clients and the need for more therapeutic support for clients

Based on what both residents and staff and practitioners would like to see, we have been able to identify five areas of recommendations for the commissioner to look in to further:

1. Explore options for how **support in supported accommodation could be better tailored to meet the needs of residents with more complex needs, including therapeutic needs.** Tailored staff training may be an option and requested by some, or broadening the staff base to include a therapist. Therapy vouchers or offering a variety of learning methods to break out of isolation may be another.

2. **Consider how prospective residents could be better prepared before moving in, including be briefed about the rules in shared houses**. Several residents mentioned feeling overwhelmed at first, particularly in shared accommodation venues. Some had also initially run in to difficult encounters with other residents, or feeling unsafe at night or unease at the use of substances on the premises.

3. Ensure that arrangements are in place to **keep on top of all maintenance issues and the general upkeep consistently** across all the different types of accommodation.

4.**Further exploration into how accommodation could be adapted to suit varied needs**, for instance access for less mobile people, creating more self-contained flats, addressing impractical or cramped rooms.

5.**Further engagement on how to encourage and help social interaction internally and externally** for people who struggle with this. Many mentioned social contacts as a key to wellbeing but often found this difficult with fellow residents. Contact with key workers and interaction with staff was positive, but insufficient to develop and maintain social interaction in the long-term.

9.0 Appendices

Include here a list of the following appendices and embedded documents:

- Appendix A Interview questions
- Appendix B Residents survey and Staff/Practitioner and Referrer survey
- Appendix C Equalities monitoring questions and summary of responses

10.0 Acknowledgements

MiBH would like to thank all the interviewees and respondents to both surveys for taking the time to provide us with their experiences of either living in supported accommodation or working in or with the three venues. We would also like to thank the CCG for all their support, weekly catch-up meetings and timely provision of data. Our thanks also goes to the admin team at MiBH for their administrative contribution to this project and to the managers of Shore House, Sanctuary Star and Route One for encouraging people to take part.

Appendix A Interview Questions

[Warm up questions]

1. **Are you a current or ex-resident?**
2. **Which accommodation did / do you live at?** (Shore House, Sanctuary Star, and/or Route One)
3. **How long have you / did you live there for?**
4. **Can you tell me a little bit about your experience living there?**

[Main interview questions]

5. **What do you like / did you like about your accommodation and support?**

[Prompts: What was good / that you would like to stay the same? What was good about that? How did that help? Can you explain a bit more please?]

6. **Do / did you have any problems living in your accommodation?**

[Prompts: What was not so good / that you would like to be different? What was difficult about that? How did that make you feel? Can you explain a bit more please?]

7. **Is there anything you think could be changed or improved?**

[Prompts: What would a very good mental health supported housing service look like? What makes you say that? How would that make things better? Can you explain a bit more please?]

8. **What is the most important thing to help you feel as well as possible?**

[Prompts: Why is that important to you? Can you explain a bit more please?]

9. **Is there anything else you would like to tell us?**

[Prompts: Is there anything you would like to feedback that we have not asked you / covered already?]

Appendix B Resident and Former Resident Survey and Survey for Staff/Practitioners and Referrers



Mental Health
Supported Housing

Survey for Residents and Former Residents



Mental Health
Supported Housing

Survey for Staff/Practitioners and Referrers

Appendix C Summary of collected answers to the equality monitoring questions from former and current residents of mental health supported accommodation

A. Where do you live?
21 people responded to this question:
- 10 people lived in Hove
- 11 people lived in Brighton

B. What is your age?
32 people responded to this question:
- 10 were between the ages of 26-35
- 6 were between the ages of 36-45
- 12 were between the ages of 46-55
- 4 were between the ages of 56-65

C. What gender are you?
32 people responded to this question:
- Male 20
- Female 12

D. Do you identify as the sex you were assigned at birth? For people who are transgender, the sex they were assigned at birth is not the same as their own sense of their gender.
31 people responded to this question:
- 30 Yes
- 1 No

E. How would you describe your ethnic origin?
34 people responded to this question:
- 20 White: English/Welsh/Scottish/ Northern Irish/British
- 2 Any other White background
- 1 Black or Black British: Caribbean
- 1 Mixed: Asian and White
- 1 Mixed: Black African & White
- 3 Mixed: Black Caribbean & White
- 1 Any other mixed background
- 5 Other

F. Which of the following best describes your sexual orientation?
32 people responded to this question:
- 26 Heterosexual/Straight
- 1 Gay man
- 1 Bisexual
- 2 Prefer not to say
- 2 Other

G. What is your religion or belief?
30 people responded to this question:
- 9 I have no particular religion or belief
- 3 Buddhist
- 8 Christian
- I Jewish
- 2 Atheist
- 4 Prefer not to say
- 3 Other (Taoism, Catholic, Spiritual Belief)

H. Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?
30 people responded to this question:
- 11 Yes a little
- 17 Yes a lot
- 3 No
- 1 Prefer not to say

I. Please state the type of impairment. If you have more than one please tick all that apply. If none apply, please mark ‘Other’ and write an answer:
- 11 Physical impairment
- 4 Sensory impairment
- 4 Learning disability/difficulty
- 5 Long standing illness
- 26 Mental health condition
- 4 Autistic spectrum
- 1 Other developmental condition

J. Are you a carer? A carer provides unpaid support to family or friends who are ill, frail, disabled or have mental health or substance misuse problems.
32 people responded to this question:
- 3 Yes
- 27 No
- 2 Prefer not to say

Although a formal committee of Brighton & Hove City Council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults and Healthwatch.

Title: **Fast Food & Energy Drink Advertising: Officer Response to Notice of Motion**

Date of Meeting: 8th November 2022

Report of: The Executive Director, Health & Adult Social Care

Contact:

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Martina Gregori, Healthy Food Project Officer
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Wards Affected: All wards

FOR GENERAL RELEASE

1 Decisions, recommendations and any options

That the Board recommend to the Policy and Resources Committee that a decision be taken to implement restrictions to the advertisement of high fat salt and sugar (HFSS) food and drinks on council owned and managed advertising space, this includes advertisement on the transport / bus system and other hoardings.

2 Relevant information

Why is this important?

2.1 Childhood obesity and overweight levels in Brighton and Hove have risen over the last few years. One in three 11 year olds leaves primary school already

overweight or obese. In some schools in the city this rises to one in two (see Appendix 3).

2.2 Nationally two out of three adults are overweight or obese, this brings with it a risk of diabetes, many cancers, heart disease and other health problems impacting on our residents and the health system. The recent COVID pandemic highlighted this risk as obesity increased the likelihood of serious illness and death.

2.3 Those children and adults living in more disadvantaged parts of our city have an increased chance of not being a healthy weight. Covid and its associated lockdown challenges have only widened the gap. The impact of ill health related to obesity is greatest on those living in more deprived areas of the city where the cost-of-living crisis is hitting hard.

2.4 Advertising of foods that are high in fat salt and sugar has been shown to significantly increase purchase and consumption of these items. The World Health Organisation notes this as a key contributor to the rise in obesity (WHO 2019). National evidence shows the relationship between the advertisement of unhealthy foods and more deprived areas. Restricting advertisements for these items has been recommended as one of a range of evidence-based measures to reduce consumption of these high calorie and less healthy food options, reducing the risk of obesity amongst children and adults (Thomas et al. 2018).

2.5 On 07 April 2022 full Council agreed a Notice of Motion seeking to obtain data about fast food & energy drink advertising on council properties. The Notice of Motion was subsequently referred to the 14 June 2022 meeting of the Adult Social Care & Public Health Sub-Committee where members agreed that an officer working group should be established to look at this issue, and that the group should report to the 08 November 2022 Health & Wellbeing Board meeting with proposals to improve Council policies in regard of advertising these products."

2.6 It has been reported by the advertising provider that 34% of advertising is for HFSS foods and drink. A local survey / audit underway this Autumn 2022 is reviewing the advertising content along three stretches of bus route in the city to provide detailed information on the HFSS advertising content as a percentage of food and drink adverts on the system. This will help provide a baseline to evaluate the impact of any restrictions.

What we can learn from Transport for London and other local authorities

2.7 Transport for London and a number of local authorities around the country including Bristol, Barnsley and several London boroughs have introduced restrictions on the advertising of high fat salt and sugar drinks and food on transport systems and council managed advertising spaces.

2.8 London introduced its Healthier Food Advertising policy in 2019 as part of the London Food Strategy in response to its high childhood obesity levels. An evaluation of the impact surveyed 5 million purchases in 1,970 households and showed a significant reduction in energy, fat, saturated fat and sugar purchased. The greatest reduction was in confectionary and cake purchases. (Yau et al. 2022).

2.9 Further health and economic modelling from the Transport for London research showed obesity reduction, a reduction in health problems including heart disease and diabetes and economic benefits from restricting HFSS food advertising. The modelling showed that the intervention should reduce health inequalities, result in cost savings for health and improved quality of life (Thomas et al. 2022).

2.10 Revenue was not reduced when TFL restrictions were introduced. (Thomas et all 2022) Brands are not banned but certain types of less healthy food cannot be advertised. Therefore introduction of the restrictions results in a swapping of products, rather than a loss of income from some businesses or brands choosing not to advertise. TFL found that advertising revenue increased post introduction and was sustained for the first year of the change. (Thomas et al 2022; Yau et al. 2022)

Implementation of a policy in Brighton

2.11 Council owned bus shelter based advertising space is currently managed by Clear Channel. There are 478 bus shelters of which 255 are non-advertising shelters and 223 are advertising shelters (50 panels being digital screens).There is currently a restriction on advertising fast food takeaways within 100 metres of any school or youth club, or NHS building, or public sector building/premises/facility/park/leisure centre primarily used by those under the age of 18 (or their guardian or carers). The contract is currently going through procurement and it is possible to change the terms of the tender specification to exclude HFSS products. The new contract is expected to be awarded in September 2023. The current contract is being temporarily extended and the incumbent provider is aware that the Council are reviewing HFSS advertising and are happy to work with the Council, however both sides would have to agree to a contract amendment. And sufficient notice would be required. The concession fee income paid by Clear Channel goes to towards subsidising socially necessary bus services and investment bus infrastructure in the city. The Transport team would like it noted that Transport for London have a large advertising estate beyond bus shelters e.g., London Underground and Overground, DLR and public buildings so the impact of HFSS withdrawal would have been less for them. In addition, advertising space on hoardings is leased by the council estates team at five different sites across the city.

2.12 There is no current advertising policy for the city. Introduction of a policy that restricts the advertisement of HFSS foods and drink would contribute to commitments as the first Sustainable Gold Food City in the UK, align with the

Brighton and Hove Food Strategy and action plan. The council declared a climate change emergency in 2018. The Council Plan 2020-23 includes a commitment to support the bid for Brighton & Hove to become a Gold Sustainable Food City. Working to address obesity in the city requires a Whole Systems Approach to healthy weight to create an environment in which it is easy for everyone to make healthy choices.

2.13 Advertising businesses, including Clear Channel (the current provider) are working with local authorities around the country on a variety of different contracts with restrictions and different terms in place which include HFSS in some areas. An example of a draft policy outline can be found in appendix one alongside a decision making table to support all partners. The current provider recommends a minimum three month period between decision on any new restrictions and introduction to allow for bookings already made.

3 Important considerations and implications

Legal:

3.1 Health and Wellbeing Board is a formal committee of the council and can refer matters outside of its remit to Policy and Resources Committee. Policy and Resources Committee has overall responsibility for the financial and other resources of the Council, for developing the Council's strategy and policy based on national government and local priorities.

Lawyer consulted: Sandra O'Brien Date: 11 October 2022

Finance:

3.2 There are no direct financial implications as a result of the recommendation to refer this to Policy & Resources committee. However, wider financial implications for the Council will need to be considered when presented to Policy & Resources Committee.

3.3 Public Transport budgets contain an income target for Bus Shelter Advertising revenues of £0.425m. Of the advertising revenues approximately 34% relates to HFSS advertising which if not replaced could result in lost incomes of £0.145m. If alternative advertising is identified, it is still estimated that lost income could be 8.5% in the first year, reducing to 4.25% in the second year. Lost income in the first year would be estimated between £0.036m and £0.145m, which unless mitigated with spend reductions elsewhere, would add pressure to existing budgets.

3.4 Property budgets also contain income targets for leasing of 5 advertising hoardings of c.£0.020m. Restrictions to advertising could impact the existing lease arrangements or make it difficult to find new lessees, though the impact of the proposed restriction is not known at this time.

3.5 However, it should be noted that Transport for London did not see a significant reduction in revenue as products being advertised were swapped rather than brands no longer being advertised, as outlined in the main body of the report (paragraph 2.9).

Finance Officer consulted: Sophie Warburton Date: 11/10/2022

Equalities:

3.6 The proposed policy relates to a public health issue, overweight and obesity, for which there are known differential impacts between different groups with protected characteristics. There is a strong underpinning rationale of the proposal to reduce heath inequalities between these groups. At this point in the process an Equalities Impact Assessment is not required.

Supporting documents and information

Appendix 1: Example policy outline, including guidance and exceptions

Purpose and Application:

The purpose of the policy: to be specified.

It applies to:

- Council advertising sites e.g. transport system advertising. Options to include e.g. leisure facilities and other settings, particularly sites targeting children and families as in Bristol and Barnsley.

Content of policy would include:

- How to apply the policy and what does it include
- Guidance on how to use the Nutrient Profiling Model (NPM)
- Content featuring only non HFSS products
- Content featuring only HFSS products
- Content featuring a range of food and/or drink products, some of which is HFSS
- Content featuring no food or drink directly, but the advertisement is from (or features) a food/drink brand
- Incidental advertising (e.g brand advertising HFSS unrelated content but uses HFSS graphics/images/visual representations or verbal references).
- Indirect promotion of HFSS food and/or drink
- Exceptions e.g olive oil
- Portion sizes: Advertisers should ensure that they are using portion sizes that encourage healthy eating/ go in line with national dietary recommendations
- Where should advertisers go to if they are unsure whether they are HFSS compliant or have questions

Acknowledgment: The contents and criteria of this policy have been adapted from the HFSS Guidance Policy published by Barnsley Metropolitan Borough Council, Bristol City Council and the London boroughs of Greenwich, Southwark, Haringey, and Merton.

Example decision table:
The content and criteria within this document have been adapted from the HFSS Policy Guidance Note published by Barnsley Metropolitan Borough Council

Advertising Content	**Examples**	**Outcome**	**Notes**
Only non HFSS products advertised	Fruit and vegetables, low sugar- wholegrain cereal	Approved	Subject is compliant with HFSS policy
Only HFSS products	Deep fried chicken burger with mayonnaise, large fries, high-sugar drinks and ice cream	Rejected	Subject is not compliant with HFSS policy – advertiser can promote healthier product such as grilled chicken wrap with fresh vegetables, water and fruit and include the name of the business.
A range of products some of which are HFSS	An advertisement that features a shopping basket with fruit, vegetables, ice cream and high sugar drinks	Rejected	All food and drink items must be HFSS compliant – Instead, the shopping basket could contain e.g. fresh fruit, vegetables, a loaf of bread, lentils, a yoghurt and water and include the name of the retailer.
No food or drink directly displayed but the advertisement is from (or features) a food/drink brand	A fast-food business promoting non-HFSS products such as fruit, vegetables, water, low sugar drink etc. (APPROVED) A fast food business promoting a HFSS product such as high sugar ice cream and drink (REJECTED)	Possibly approved – depends on the product featured.	

Food and/or drink is shown 'incidentally' as part of an advert	A financial services advertisement, featuring a beach with ice cream (REJECTED) A financial services advertisement, featuring a beach with fruit (APPROVED)	Possibly approved – depends on the product featured.	
Food and drink is referenced in the text, through graphical representations or other visual representation (not a real product being advertised)	A cartoon image of a banana (Approved) A cartoon image of a milk chocolate bar (REJECTED)	Possibly approved – depends on the product featured.	If the advertisement can be reasonably considered to promote HFSS products it will be rejected regardless of whether the food is an actual product.
Indirect promotion of HFSS food and/or drink	A non-HFSS soft drink with a prominent text that accompanies the image naming the specific product/retailer. (APPROVED) A non-HFSS soft drink **without** a prominent text that accompanies the image naming the specific product/retailer. (REJECTED)	Possibly approved – only if prominent text accompanies the image naming the product and retailer	A prominent product descriptor helps to differentiate it from non-compliant products. This is necessary where the product falls into a category typically associated with HFSS products (such as soft drinks).

Appendix 2: The Nutrient Profile Model (NPM) scoring

The NPM is an evidence-based tool which has been successfully used to differentiate between healthier food and drink and less healthy food and drink advertising since 2007.

It was created specifically for the purposes of advertising policies by experts in nutrition and food policy on behalf of the Food Standards Agency in 2004-5 (now held by the Department of Health and Social Care). It is already in use across television advertising, and since 2017 across non broadcast advertising (for example, online and outdoor advertising).

The model uses a scoring system which calculates the contribution made by important nutrients that are particularly vital in children's diets with components in the food that children should eat less of. The overall score indicates whether that food (or drink) can be advertised on TV during children's viewing time, or not.

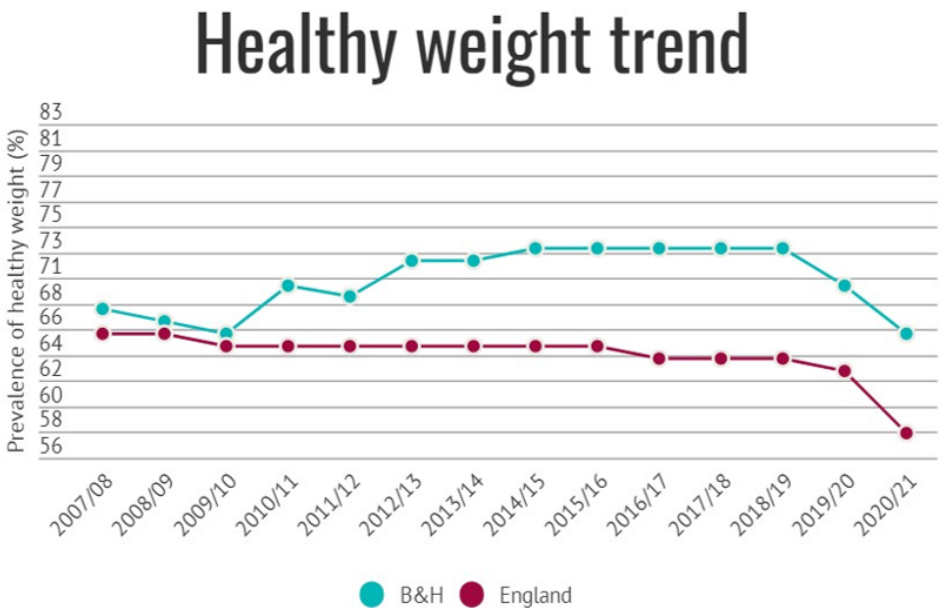
The NPM was subject to rigorous scientific scrutiny, extensive consultation and review. It is supported by the independent Scientific Advisory Committee on Nutrition (SACN) and a wide range of nutrition experts (Department of Health and Social Care, 2011).

The Technical Guidance can be found here:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216094/dh_123492.pdf

Appendix 3: National Childhood Measurement programme

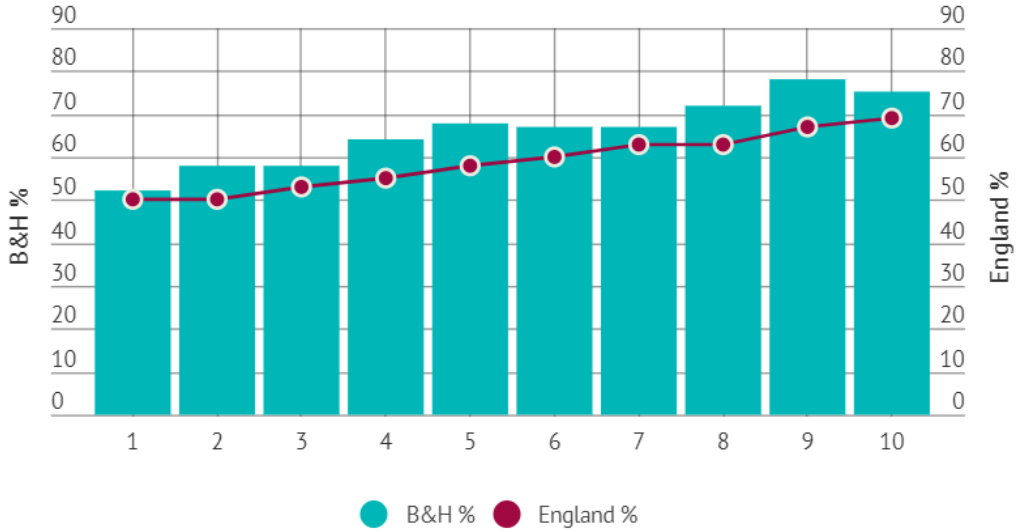
Data indicates:

- a reduction in the proportion of children of a healthy weight in the city
- a higher risk of obesity amongst children living in more deprived areas
- differences in levels of healthy weight between primary schools across the city, ranging from 51% to 85%.



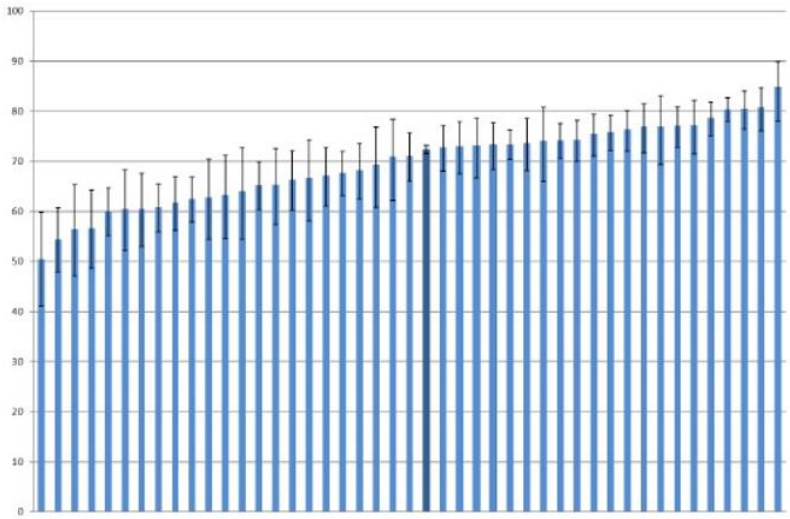
NCMP Brighton & Hove Year 6 results for 2020- 21

Healthy weight by deprivation decile



The prevalence of healthy weight in Year 6 ranges from 51% to 85% by school

Prevalence of healthy weight by school (year 6) for the last 5 years, 2016/17 to 2020/21 (dark bar is Brighton & Hove)



NCMP Brighton & Hove Year 6 results for 2020- 21

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Although a formal committee of Brighton & Hove City Council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults and Healthwatch.

Title: Better Care Fund (BCF) 2022/23 Annual Plan Submissions

Date of Meeting: 08 November 2022

Report of: Robert Persey Director of Adult Social Care, BHCC and Ashley Scarff Deputy Managing Director, NHS Sussex Brighton & Hove & East Sussex

Contact: Andy Witham, Assistant Director, Commissioning & Partnerships

Email: andy.witham@brighton-hove.gov.uk

Wards Affected: All

FOR GENERAL RELEASE

Executive Summary

This report provides an overview of the Brighton and Hove 2022/23 Better Care Fund (BCF) planning submission.

The BCF plan for Brighton & Hove is a jointly agreed plan between local health and social care commissioners and is in line with the approach agreed by the local Health and Wellbeing Board (HWB) in March 2022. The plan for the current year has now been submitted on that basis.

The plan, including a narrative plan, is drawn from the Brighton & Hove Place-Based Health and Wellbeing Strategy and existing placed-based plans. The plan

provides details of the key strategic place-based partnerships in addition to the HWB, that oversee and govern the development and delivery of the BCF; they include the relevant place statutory providers and commissioners. The planning submission for the year was complete and compliant with all national conditions and metrics and met the national 26 September 2022 submission deadline.

1. Decisions, recommendations and any options

1.1 The Board is recommended to note the requirements for 2022/23 Better Care Funds

1.2 The Board is recommended to note the place-based governance and oversight of developing plans for 2022/23

1.3 The Board is recommended to ratify the submission of the Better Care Fund planning returns for Brighton & Hove for 2022/23 to NHSE in accordance with national requirements and agreed approach submitted on 27 September 2022.

2. Relevant information

2.1 The Better Care Fund (BCF) is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and well-being and live independently in their communities for as long as possible.

2.2 The Better Care Fund (BCF) has been one of the government's national vehicles for driving health and social care integration since 2013. It required Clinical Commissioning Groups (CCGs) and now Integrated Care Boards (ICBs) and Local Government to agree a joint plan, owned by the Health and Wellbeing Board (HWB). These are joint plans for using pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act (2006).

2.3 The Better Care Fund (BCF) has provided a mechanism for joint health, housing and social care planning and commissioning, focusing on personalised, integrated approaches to health and care that support people to remain independent at home or to return to independence after an episode in hospital. It brings together ring-fenced budgets from ICB allocations, and funding paid directly to Local Government, including the Disabled Facilities Grant (DFG) and the improved Better Care Fund (iBCF).

2.4 The continuation of national conditions and requirements of the BCF in recent years has provided opportunities for health and care partners to build on their plans to embed joint working and integrated care further. This includes working collaboratively to bring together funding streams and maximise the impact on outcomes for communities whilst sustaining vital community provision.

2.5 The local HWB area has produced a narrative plan (**Appendix 1**). These draw directly from current place-based plans and read across to operating plans. The submission demonstrates how the schemes that have been invested in, meet the following three national policy areas:

- Approach to Integration
- Supporting Discharge
- Equality and Health Inequalities

2.6 The BCF plan submission is consists of:

- A narrative plan
- A completed BCF planning template, including:
  - Planned expenditure from BCF sources
  - Confirmation that national conditions of the fund are met, as well as specific conditions attached to individual funding streams
  - Ambitions and plans for performance against BCF national metrics
  - Any additional contributions to BCF section 75 agreements
- Demand and capacity template (this is a developmental return and does not form part of the NHSE assurance of place BCFs in 2022/23)

3.Governance

3.1 The Brighton & Hove Health and Wellbeing Board (HWB) retains responsibility for governance and oversight of the BCF and receives quarterly monitoring reports. Responsibility for ongoing oversight is delegated to the Health and Care Partnership (HCP) Executive Board which meets monthly. The core responsibilities of the BCF Steering Group in relation to the BCF are in the section 75 Agreement.

3.2 In addition to approval of the plan there is ongoing and regular stakeholder engagement. For example, with providers in respect of discharge planning and monitoring, system performance, and at individual scheme level with NHS providers, private sector providers, VCSE providers, and housing authorities.

4. National BCF Planning Guidance and Requirements for 2022/23

4.1 The 2022/23 BCF Policy Framework and Planning Guidance was published on 19th July with local plans to be submitted by 26th September.

4.2 The Better Care Fund plans for 2022/23 include:

- *A completed planning template which confirms the expenditure plan meets the national conditions and the ambitions to progress performance against the identified metrics.*

- *A narrative plan outlining how the Better Care Fund is used in each BCF area to support local priorities including integration, hospital discharge, support for unpaid carers, collaboration with housing and addressing health inequalities.*

- *A Capacity and demand template outlining the available capacity and predicted demand for intermediate care services for the remainder of 22/23 and the associated spend both from the BCF and from other funding streams. Whilst submission of a completed template is required, it will not be part of the BCF assurance for 2022/23.*

5 BCF National Conditions

5.1 National conditions 1-3 for the fund are broadly similar to 2021-22 and continue to require a minimum spend level on social care from the NHS minimum contribution. National condition 4 requires that local partners should have an agreed approach to implementing the two policy objectives for the BCF, set out in the Policy Framework:

1. Enable people to stay well,
2. Provide the right care in the right place at the right time.

5.2 These approaches are outlined in the narrative plan and includes:

- Approaches to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care.
- How BCF funded services support delivery of the objectives.
- Local implementation of the High Impact Change Model with identified actions.

6. BCF Metrics

The length of stay metric used in previous years is not part of requirements in 2022-23. However, it will remain a priority and the data will continue to be provided and monitored regionally and nationally. The metrics included in the new planning template that will be measured for this year are:

Metric	Detail
Avoidable admissions	Unplanned Admissions for chronic ambulatory care sensitive conditions
Residential care admissions	Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes

Effectiveness of reablement	People over 65 still at home 91 days after discharge from hospital with reablement
Discharge destination	Percentage of discharges to a person's usual place of residence

7. Financial Allocations

Funding Sources	Income
DFG	£2,312,933
Minimum NHS Contribution	£22,723,963
iBCF	£9,459,107
Additional LA Contribution	£523,046
Additional ICB Contribution	£0
Total	**£35,019,049**

7.1 The BCF requires the ICB to make minimum contributions from its base budget. The allocation is governed by national Better Care Fund Policy Framework and Better Care Fund planning requirements 2022-23. The funds are covered by a legal s75 agreement.

7.2 The planning requirements set out national conditions that must be met for a plan to be assessed as compliant and for NHSE to be able to assure each plan. The Brighton & Hove BCF plans meet the national conditions.

7.3 The NHS minimum contribution to the BCF has increased by 5.66% in 2022/23.

7.4 Improved Better Care Fund (iBCF) and Disabled Facilities Grant (DFG) conditions remain broadly the same and have been issued to local authorities the iBCF has increased by 3%. The Adult Social Care contribution and NHS commissioned Out of Hospital Services ringfences to increase in line with the overall increase i.e. 5.66%. The investment plan for Brighton & Hove is reported at **Appendix 2** and demonstrate achievement of the minimum required spend on both NHS Commissioned Out of Hospital services and Adult Social Care Services.

7.5 In Brighton & Hove new funding has been allocated to provide project to support to the transformation of community services (£72k) alongside support for High intensity users (£58k). The remaining balance is currently being held in reserves and will be allocated to support hospital discharge.

7.6 Risks related to the BCF plans are assessed as low, the majority of schemes funded by the BCF are established services and their delivery and impact was

the subject of a review in late 2021/22. Risk of plans not being compliant or not assured is assessed as low.

7 Conclusion

7.1 The Brighton and Hove BCF submission meets the national planning guidance and policy requirements. A financial analysis of the plan provide assurance that national requirements and conditions will be met. The analysis can confirm that the Brighton and Hove Plan meets the requirements to spend the BCF mandated minimum contribution and the schemes, and the model of delivery adopted is in line with the three main policy areas.

7.2 The investment being made will support the strategic and operational requirements of each system in particular supporting discharges and admission avoidance. This is particularly important this year due to the increased pressure being and expected to be experienced in coming months as we move through the fragile restoration period of the Covid pandemic.

8. Important considerations and implications

8.1 Legal: This report contains recommendations to note and therefore there are no legal implications arising from it.

Lawyer consulted: Elizabeth Culbert Date: 17/10/22

Finance:

8.2 The Better Care Fund is a section 75 pooled budget which totals £35.019m for 2022/23. The ICB contribution to the pooled budget is £22.724m and the Council contribution is £12.295m, which includes the £9.459m Improved Better Care fund. Any spend variance at outturn is subject to a risk share as per the section 75 agreement.

Finance Officer consulted: Sophie Warburton Date: 12/10/2022

Equalities:

The BCF plans set out in the narrative submission specifically how the schemes invested in will support the equalities and health inequalities of their local population. Individual EHIAs are carried out for specific new schemes as they are developed. All schemes funded by the NHS are required to apply EHIA processes to of all services commissioned. The plans and strategies have been developed jointly based upon detailed population analysis, reflecting the Place based plans that are informed by EHIAs and the local JSNAs.

There is not a formal public and engagement process supporting this annual process, but individual schemes will be informed by views of patients and public.

Health, social care, children's services and public health:
The BCF plans set out in the narrative submission specifically how the schemes invested in will support equalities and health inequalities policy and requirements of their local population. The development, agreement and delivery of the plan is the responsibility of the local Health and Wellbeing board.

Supporting documents and information

Appendix 1: Narrative Submission
Appendix 2: Financial Schedule

Appendix 2

Workstream	Description	21/22 Budget	22/23 Budget
Increasing System Capacity Workstream	Additional Care Managers working across the City localities 7 days pw	117,732	122,188
	3 Social Workers in IPCT's	103,228	107,135
	Integrated Primary Care Teams (SPFT) Additional Mental Health nurses	114,696	117,449
Total Increasing System Capacity Workstream		**335,656**	**346,772**
Integrated Discharge Planning Workstream	Integrated Primary Care Teams (SCFT)	8,474,968	8,678,367
	Incentivising care homes and homecare providers to respond 7 days pw	51,188	51,188
	Hospital Discharge	2,961,660	3,051,373
	Home First/Urgent Home Care Service	915,226	977,336
	Urgent Home Care Service	142,582	154,300
	Home Care Support	400,000	400,000
	Crisis Service - Urgent homecare support - Age UK	167,293	178,683
	Lindridge beds - Medical Cover	195,000	195,000
	District Nurse Support & Nightsitting	722,974	735,013
Total Integrated Discharge Planning Workstream		**14,030,891**	**14,421,259**
Protecting Social Care Workstream	Maintaining eligibility criteria	3,057,912	3,230,990
	Additional social workers for Access Point	70,000	72,650
	Protection for Social Care (Capital grants)	50,000	50,000
	Disabled facilities grant (Capital grants)	2,113,000	2,113,000
	Telecare and Telehealth (Capital grants)	149,933	149,933
	Additional call handling resource for CareLink out of hours	35,000	36,325
	Additional Telecare and Telehealth resource	200,000	207,570
	Protection for Social Care	7,471,359	7,730,615
Total Protecting Social Care Workstream		**13,147,204**	**13,591,082**
Supporting Recovery & Independence Workstream	Community Equipment Service	2,634,790	2,687,481
	Sussex Community Trust – Carers Back Care Advisor	36,642	37,521
	Amaze – Carers Card Development	10,000	10,000
	Crossroads – Carers Support Children and Adults	47,000	47,000
	Hospital Carers Support – IPCT Carers Support Service	54,000	56,044
	Carers Support Service - Integrated Primary Care Team (ASC Staff)	186,350	193,403
	Carers (other)	287,980	261,980
	Carers Hub	505,000	531,000
Total Supporting Recovery & Independence Workstream		**3,761,762**	**3,824,429**
Person Centred Integrated Care Workstream	Proactive Care (Primary Care)	202,930	80,000
	Link Back (Discharge Support)	77,000	91,310
	High Intensity User Service	0	57,500
	Care Navigation Service (Social Prescribing)	348,392	348,392
	Ageing Well (Impact Initiatives)	200,000	200,000
Total Person Centred Integrated Care Workstream		**828,322**	**777,202**
Dementia Planning Workstream	Dementia Plan	158,002	158,002
Total Dementia Planning Workstream		**158,002**	**158,002**
Homelessness Workstream	Homeless Model	934,471	1,005,064
Total Homelessness Workstream		**934,471**	**1,005,064**
ICP Programme Management / Support	ICP Programme Director	172,800	175,080
	Programme Manager- Community Transformation	0	72,000
Total ICP Programme Management / Support		**172,800**	**247,080**
Contingency		**149,232**	**648,157**
TOTAL		**33,518,340**	**35,019,049**

Brighton & Hove Better Care Fund Plan 2022/2023

Integration and Better Care Fund

Cover

Health and Wellbeing Board(s)

Delegated authority has been given to the Brighton and Hove BCF Steering Group to complete the 2022/23 plans and financial templates with sign off by the Executive Managing Director for Brighton and Hove, NHS Sussex.

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCSE organisations, housing organisations, district councils)

An integrated approach across the NHS, local government and wider voluntary and independent sector services plays a key role in supporting people to manage their own health and wellbeing effectively. At the local level that integration is managed through the Brighton and Hove Better Care Fund Steering Group. This brings together Brighton and Hove City Council, our new NHS Sussex Integrated Care Board.

Plans are promoted for awareness amongst other system partners including University Hospitals Trust NHS Foundation Trust, Sussex Community NHS Foundation Trust and Sussex Partnership NHS Foundation Trust, Southeast Coast Ambulance Service, primary care networks, Healthwatch, the Voluntary, and Community and Social Enterprise (VCSE) organisations.

How have you gone about involving these stakeholders?

The overall purpose of the B&H Health and Care Partnership is to support delivery of our locally agreed plans and programmes of transformation that support the local population health agenda and addresses health inequalities through commissioning an effective, sustainable and aligned health and care system.

Through a partnership approach the B&H Health and Care Partnership has the following key roles:

1. Supporting the ongoing development and implementation of a longer-term integrated local Brighton and Hove Plan which will form part of our Sussex and will form part of the 22/23 ICS Operational plan for Sussex and respond to the NHS Long Term Plan. This will cover physical and mental health services across acute, community and primary care settings, social care, housing, and prevention.

2. Supporting the delivery of initial agreed priority programmes of transformation in core areas of urgent care, planned care, community services, Mental health, and Homelessness.

3. Ensuring engagement with the delivery of the plans we agree, and collectively tackling the issues and challenges we face as a system.

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1. Executive summary

Through 2022/23, and alongside a pan-Sussex review, Brighton and Hove has undertaken its own appraisal of all schemes currently funded by the Better Care Fund (BCF) to determine their continued effectiveness in delivering national priorities. In Brighton and Hove, it has been agreed to retain all existing schemes funded. Further schemes, specifically supporting hospital discharge have been added, using additional national funding made available for 2022/23.

Integrated working across health and care provides the opportunity to deliver the best possible outcomes for local people, address health inequalities and achieve the best use of the collective resources in Brighton and Hove. By developing a joint Brighton and Hove Health and Care Place Plan and having a clear place-based focus, we continue to ensure that the priorities for service transformation and integration required to deliver a new service model for the 21st century are grounded in the needs of the local population.

The BCF is a critical element of delivering the Brighton and Hove placed based plans as it provides significant joint funding to support schemes which deliver on our local priorities.

1.1 Our priorities for 2022/23

Building on what has been delivered so far, our plans set out the collective work being undertaken at Place and the shared priorities of:

- Services that meet the needs of the population
- Fucus on reducing health inequalities
- Models of responsive, high quality, co-ordinated and personalised care, supporting prevention, early intervention, and wellbeing
- Transforming services through our integration programme.

1.2 Key changes since our previous BCF plan

Since our previous BCF plan our focus has increasingly been on the way we can further integrate our services to support people through recovery and restoration of health and social care services following the Covid-19 pandemic. The primary focus has been on increasing out of hospital support and capacity and supporting of discharge hub to ensure timely discharge and the most appropriate care being available when required.

Our 2022/23 plans include learning from the Covid-19 pandemic which have accelerated new ways of working, including greater co-ordination and joined up working to meet current challenges, across acute hospitals, social care, primary care, mental health and community-based services.

The system learnt from new models of delivery that resulted in a collaborative response and a flexible approach to deploying resources. We continue, as a system to use this learning to help reshape a stronger and sustainable future.

2. Governance

The Brighton & Hove Health and Wellbeing Board (HWB) retains responsibility for governance and oversight of the BCF and receives quarterly monitoring reports. Responsibility for ongoing oversight is delegated to the Health and Care Partnership (HCP) Executive Board which meets monthly. The core responsibilities of the BCF Steering Group in relation to the BCF are in the section 75 Agreement.

The BCF briefing paper was presented at the B&H ICP Executive Meeting on 17 August 2022, with representation from;

- Brighton and Hove City Council
- Brighton and Hove (NHS Sussex)
- Sussex Community Foundation Trust

- Sussex Partnership Foundation Trust
- University Hospitals Sussex NHS Trust
- Voluntary Sector in Brighton and Hove

The members of the meeting supported the actions outlined.

The BCF Plan will be presented at the Brighton and Hove Health and Wellbeing Board on 8 November 2022. Prior to final sign-off by the HWB Chair, the Brighton and Hove BCF Plan 2022/23 will go through the formal internal governance pathways of both Brighton & Hove City Council and NHS Brighton and Hove at Place.

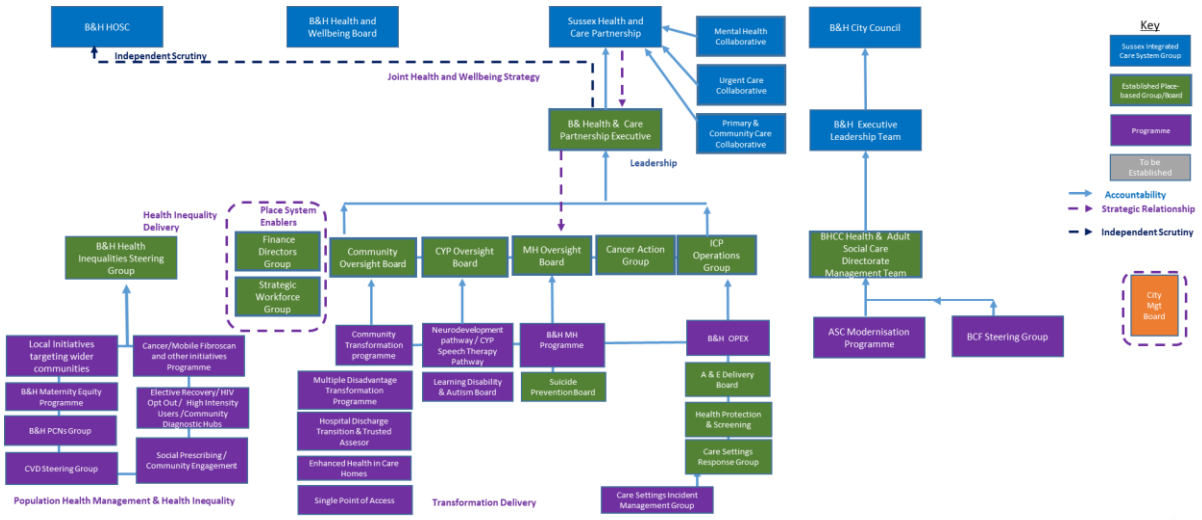
In addition to approval of the plan there is ongoing and regular stakeholder engagement. For example, with providers in respect of discharge planning and monitoring, system performance, and at individual scheme level with NHS providers, private sector providers, VCSE providers, and housing authorities.

The table lays out the approval timeline with local dates added for review by Better Care Fund Steering Group, HCP Exec Board (review by partners), ICB Commissioning Group, Chief Finance Officers and HWB *(N.B this will after submission and areas will need to inform of their HWB approval before plans can be approved).*

BCF planning requirements published	**19 July 2022**
NHS Brighton & Hove and BHCC Approval	
Better Care Fund Steering Group	30 August 2022
Brighton and Hove Operational Command Group (OCG)	9 September 2022
Brighton and Hove ICP Operational Group	12 September 2022
ICB Commissioning Group	12 September 2022
HCP Executive Board sign off (Delegated to NHS Place Executive Managing Director & Executive Director of Health & Adult Social Services)	26 September 2022
Final submission	**26 September 2022**
Brighton & Hove Health & Wellbeing Board	**11 November 2022**

The BCF plans support delivery of the Brighton and Hove transformation programmes focussed on urgent care and urgent community response. Schemes and services which fall within these areas are monitored via the relevant Oversight Boards. *See diagram 1 below for further clarification:*

Diagram 1: Brighton and Hove Place Partnership system governance structure



3. Overall BCF plan and approach to integration

As a health and care partnership, Brighton and Hove are committed to making the collective vision a reality. It is recognised this will required both cultural and behavioural shift across all system partners. But the system remains committed to working in partnership to find new and innovative ways of working with a greater emphasis on population health outcomes and reducing health inequalities.

The 2022-23 Place Based Plan sets out the ambitions for the Brighton and Hove population and provides a framework to develop plans that deliver agreed health and care priorities with the greatest positive impact. The plan sets out a concise vision, with clear outcome measures. It links together multiple health and care organisational plans and workstreams within Place and the Sussex ICB.

The Brighton and Hove HCP will also work alongside partners across Sussex as part of the Integrated Care Partnership/Sussex Assembly (ICP) and NHS Sussex Integrated Care Board (ICB). Where appropriate for supporting better health outcomes, a pan-Sussex approach will be adopted.

Significant progress has been made as a system. It is encouraging to see that through the dedication and commitment of staff the system is delivering above average levels of activity and are one of the top systems in the country in relation to recovery and restoration of services. Although, it is recognised there is more work to do, the system is in a strong position to take the next steps over the rest of 2022-23 in making the vision a reality.

3.1 Our joint priorities for 2022-23

Building on the local response to the NHS Long Term Plan and the local priorities set out in the Place Based plan, the key priorities supported by the BCF are to:

- Expand statutory and voluntary sector services directed at supporting hospital discharge. In particular, with the development of streamlined and aligned working outlined with the Brighton and Hove Hospital Transition Plan
- Build on the existing progress to enhance prevention, reduce health inequalities, the gap in life expectancy in the county. We will do this through co-ordinated action across all services that impact on the wider determinants of health such as housing, employment and leisure, as well as extending targeted approaches to empower people to make healthy choices across the whole life course to improve outcomes

- Expand support for people with mental health needs by ensuring access to a full range of services that support emotional wellbeing in primary care; enhanced support in the community to help avoid unnecessary admissions and support recovery; and working with housing teams and providers to support those people who also have housing and accommodation related support needs
- Within our community services continue to integrate health and social care services and work with our Primary Care Networks to embed proactive anticipatory care, and seamless wrap around care to people with long term care needs and conditions and those in care homes, including where people are at the end of their lives
- Continue action to improve support for people with urgent care needs including targeted support for vulnerable people; improvements in urgent care processes and systems to deliver more streamlined urgent response; support people in care homes with urgent care needs
- Further improve services that deliver planned care for local people for example continuing to support people with diabetes; and continue to support best practice with prescribing and medicines
- Build on existing progress to take forward the recommendations from the JSNA for Multiple Compound Needs (including Homelessness), which will ensure that people with lived experience will be engaged by local organisations in a broad range of roles related to service design and delivery. Services will be underpinned by a care-coordinator approach that is inclusive of all levels of needs. The services will practice a trauma informed approach, addressing the wider determinants of health in a gender informed and culturally sensitive manner

Support key and targeted intervention to our identified the “Plus” Population groups (Carers, including young carers, mental Health transition in children and young people aged 16-25 years, globally displaced communities, - those seeking asylum, refugees, vulnerable migrants and; Lesbian, Gay, Bisexual, Transgender and Questioning+ communities) Our Place based plan and priorities have been informed by what local people have told us is important to them about their health and care. Our plans are aligned across our organisations to support delivering these shared priorities and continue to test them with our stakeholders to guide how people want to be involved in shaping the way we deliver our ambitions.

3.2 Our approaches to joint/collaborative commissioning

Our local approach is supported by:

- Embedded integrated system leadership to deliver against our population health priorities, the NHS Long Term Plan and Brighton and Hove priority objectives. The alignment of organisational and strategic plans, with oversight of the Brighton and Hove Health and Wellbeing Board, supports the delivery of our place-based plans and programmes.
- A range of joint and integrated commissioning arrangements. This includes pooled budgets, along with shared arrangements for commissioning voluntary and community sector services. There is also joint work in understanding additional care capacity requirements, with an agreed approach to bedded care and lead commissioner arrangements
- Our shared Hospital Transformation Programmes aims to further align health and social care services to meet growing demand this will be done by joining up care to support people to live as independently as possible and achieve the best possible health outcomes.

3.3 Our overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centered care

As set out in the Place Based plan, the key aim shared across all organisations is to improve the health and wellbeing of local people and reduce health inequalities. This will be achieved through delivering more integrated and personalised care, and enhanced focus on prevention through early intervention and reablement after episodes of ill health. Considering the population health and care needs of the local population, the system has committed to transforming to a new model of integrated care that will:

- Support people’s independence through integrating care and offering a range of preventative services, early intervention and joined up care and treatment.

- Provide proactive support to people who are vulnerable or at risk as close as possible to where they live and enable access to good quality local and specialist hospital-based services when needed
- Increase sustainability through increased integration between community and social care services alongside closer working with Primary Care, mental health and the voluntary sector
- Promote increased aligned working between the health and social care system to maximise the impact on the broader determinants of health and reduce health inequalities, including housing, employment, welfare, transport, environment and leisure and voluntary and community sector services and support.

In addition to partnership delivery plans outlined above that are critical to improving health and wellbeing and reducing health inequalities in Brighton & Hove; our strong priority to meet our population's health and care needs is more integrated care across all age groups.

In 2022/23 the Brighton and Hove system will:

- Build on a shared approach to the leadership and management of services across acute and community health and adult social care, to support the deployment of teams and resources to work together more effectively across services for the frail elderly and others with complex and long-term care needs.
- Ensure a focus on the links and broader engagement with primary care and the VCSE to support the multi-disciplinary team (MDT) working and care coordination developments in primary care, and the implementation of anticipatory care.
- Support the above, agree and implement our approach and model for planning and delivering services in a geographically sensitive way within the city, to ensure strong links are made between core community health and social care services, primary care, mental health and other services that support people's needs holistically, for example the independent care sector, housing and voluntary and community sector services.

3.4 How BCF funded services support our approach to integration

The BCF already funds many services across health, social care and the voluntary sector that support community care and specifically hospital discharge.

Strategic plans to increase the integration of services have been agreed by Brighton and Hove partners, in the form of a transformation programme, aimed at streamlining pathways and aligning existing services towards a single operating model.

The transformation programme is significantly wider than the Better Care Fund however the BCF plans for 2022-23 seek to support the key priorities outlined above. It will also find a programme Manager, who's role it will be to deliver the system's vision

To achieve these, the range of schemes listed in the planning template cover key areas of focus including:

1. ***Enhance prevention, personalisation and reduce health inequalities***

    a. Aging Well Problem
    b. Enhanced Health in Care Homes
    c. A range of services provided by the Voluntary and community sector including support for people with sensory impairment
    d. Delivery of Personalised Care via Social Prescribing Link Workers

2. ***Support for people with mental health needs by ensuring access to a full range of services including***

    a. Improved access to psychological therapies
    b. Dementia services

c. a network of local community-based services working together to support good mental health and wellbeing in Brighton and Hove.

3. Continue to integrate health and social care services and work with our Primary Care Networks to embed proactive anticipatory care, and seamless wrap around care to people with long term care needs and conditions and those in care homes.

a. Carers Services
b. Health and Social Care Connect (Single point of Access)
c. Housing support and adaptations
d. Maintaining social care services
e. Community Equipment services

4. *Improve support for people with urgent care needs including targeted support for vulnerable people – by way of admission avoidance and supporting hospital discharge pathways:*

a. Community based Intermediate Care and Reablement, by way of both domiciliary and bed-based care and support.
b. Homelessness Primary Care Service
c. Discharge to Assess – additional bed-based capacity
d. Additional Domiciliary Care capacity
e. Hospital discharge support
f. 24/7 access to Health & Social care (Single point of Access)

These schemes support the delivery of all the national BCF metrics; many of these schemes are jointly commissioned and jointly provided by Adult Social Care and local NHS Trusts. The schemes support the development of integrated local service delivery and the move towards planning and designing services around local communities as a cornerstone of our vision for integrating care and support.

In addition, focus has been given to developing preventative services which adopt a proactive approach to supporting people at earlier stages of care pathways.

Many of the services funded partially or wholly through the BCF in 2021/22 have been continued into this year. In addition to these, further investment has been made into domiciliary home care to support the system and in particular hospital discharge pathways.

4. Implementing the BCF Policy Objectives (national condition four)

4.1 Supporting Discharge (National Condition Four)

Since March 2020 the overall focus of the health and social care system has been to support people during the Covid-19 pandemic. This has included specific support to discharge patients out of hospital, managing surge, releasing capacity, and ensuring appropriate care is provided.

The Covid-19 pandemic accelerated new ways of working to support hospital discharge in developing more integrated and joined up working across acute hospitals, social care, primary care, mental health, and community-based services. This has necessitated the development of a new delivery model, supporting greater collaboration, flexed resources, and the use of digital options to meet system pressures. It has also provided significant learning to reshape a stronger and sustainable future.

The discharge transformation programme as set out in section 4.3 seeks to build and consolidate the outcomes achieved through this integration and joint work.

We have been working in partnership across Sussex alongside patient groups for a number of years to develop strategic solutions that deliver the nationally mandated outcomes required of an Integrated Urgent Care (IUC) system and in 2022/23 we will continue to deliver this ambition. Our model for IUC covers four core components:

1) NHS111-Clinical Assessment Service (CAS) including NHS 111 First
2) Sussex Home Visiting Service
3) Urgent Treatment Centre's (UTCs) - co-located and stand-alone
4) Place-based models of Integrated Care

These four components work together alongside primary care, community pharmacy, ambulance and other community-based services, to provide locally accessible and convenient alternatives to A&E for patients who do not need to attend hospital. This also supports primary care and keeps people closer to home.

4.2 Our approach to improving outcomes for people being discharged from hospital

The system will continue to work with the Sussex Urgent Care Programme to support patient flow and reduce pressure on urgent care services. The Discharge transformation programme has commenced with the aims of supporting patient flow and reduce pressure on urgent care services through managing Medical Ready for Discharge (MRD) patients better. The system set itself an ambition to minimise the length of time a person is waiting for their supported discharge from hospital, with a focus on working collaboratively to improve system and processes to reduce delays.

Much of this work is supported by BCF funded schemes, either directly the creating community capacity, or investing in VCSE discharge to settle services, or indirectly by increasing social work assessment capacity.

4.3 D2A plans

Our plans for transforming discharge through the Discharge Transformation Programme (DTP)

Key Outcome: Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.

It is a system objective to return people to their own homes via the Home First pathway, wherever possible. Brighton and Hove system partners have agreed to further develop existing discharge models, through a Hospital Transition programme aimed at further aligning and jointly locating health and social care teams, going beyond the principles of Discharge to Assess (D2A) and work towards a 'Discharge to Recover' approach. To facilitate this change the key workstreams of this work are:

- Trusted Assessment
- Home First
- Domiciliary Care and Care Home Framework Procurement
- Combined sourcing and placement team
- Developing the functionality of Discharge Hub
- Right sizing and Reablement Streaming

The BCF will also be used to commission additional key services to support a safe transfer of patients and encourage flow. This includes investment into capacity and a dedicated programme manager to push integration between partner organisations and to facilitate a culture change required to meet achieve the desired outcomes.

In addition, the Brighton and Hove system also supports safe and effective hospital discharge by:

- Maintain a small number of providers commissioned to assess and accept patients 7 days a week
- Patients and families are engaged and fully involved in the planning long term care needs asap within the discharge process with a choice protocol in-place and implemented throughout the system and is supported by the emerging discharge transition programme that embeds personalised care across the system.
- Extensive range of VCSE services available to support discharge process – home to settle and care services in place with agreed extended roles to include medication prompts and meal prep.

Other VCSE services include:

- Post-discharge checks for high-risk patients
- Social prescribing and signposting services available
- VCSE High Intensity Users service in place

A Care Home support service is in place to work with high referring homes or homes identified as having specific risks within the Enhanced Health in Care Homes programme to include;

- Enhanced primary and community care support
- MDT support including coordinated health and social care
- Falls prevention, reablement and rehabilitation
- Joined up commissioning of health and social care
- Workforce development
- Data, IT and Technology

For housing related services, a systemic response is in place supporting early needs assessment, integrated working. There are plans in place to establish clear links between housing and discharge teams, including equipment needs.

Aligned commissioning of discharge services:

The development of the discharge model is based on an agreed set of Principles:

- Optimum utilisation of all bedded capacity (Pathway 2) to stream patients into appropriate settings
- Build Home First/Crisis Response domiciliary model alongside reduction in Interim bedded capacity
- Agreed Organisation Development across health and social care to improve consistency of approach to discharge with an emphasis on promoting independence supports implementation of future model
- Robust communications plan to be developed to support health and social care staff and patients and their families/carers
- A focus on the wider issues of workforce
- Developing in symphony with key partner programmes, such as Community and Primary Care Transformation

4.4 High Impact Change Model - action plan

The Brighton and Hove High Impact Change Review is attached here.



BH - High Impact Change Review v2 (C

4.5 How our BCF funded activity supports safe, timely and effective discharge?

A large proportion of current BCF investments are directly supporting hospital discharge or admission avoidance:

- **IPCT-SCFT** - provides community nursing capacity within each Primary Care Network to provide a proactive service to patients in their own homes
- **District Nursing Support** – Out of hours domiciliary nursing and night-sitting supporting end-of-life patients and urgent patients
- **Hospital Discharge** – Directly funding D2A bedded capacity
- **Community Equipment** – provides community equipment and minor adaptations to people in their own homes or within care to support safer independent living. In many cases, the availability of this equipment facilitates hospital discharges
- **Home First/Urgent Homecare** – provides urgent additional homecare capacity to patients following rapid community assessment after hospital discharge
- **Lindridge Medical Cover** - provides medical cover supporting 25 community step-down beds
- **Crisis Service/Link Back** – voluntary sector providers, utilising social prescribing techniques to deliver support and low-level care to discharged patients (increasingly being used as an alternative to homecare). This is increasingly being used as an alternative to homecare provision on discharge
- **Carers Hub** - highly praised by service users, providing single point of access and support to carers, helping to avoid emergency admission

A review of all current BCF funded schemes in Brighton & Hove has indicated opportunities to consolidate some component parts to improve outputs but found there were no schemes that could be stopped or scaled back without incurring an adverse impact on the local system. All the current schemes have been retained, although further reviews will be undertaken to ensure the continued robustness of each.

System pressures remain within the Brighton and Hove system. In response in 2022/23 £1m derived from a combination of the uplift to the CCG's minimum contribution and a small contingency will be used to ensure discharge supported community bedded capacity is moved to being recurrently funded via the BCF (previously HDP funded schemes). This is aimed at stabilising community capacity to support hospital discharge.

4.6 Personalised Care

Personalised Care is a key enabler to reducing health inequality, giving people the same choice and control over their mental and physical health they have come to expect in every other aspect of their life.

Social Prescribing Link workers are key in connecting people to wide range of community services that can help improve health and well-being. The delivery of Personalised care is key to the role of a Social Prescribing Link Worker to deliver the 3 population approaches in the comprehensive model of Personalised Care; Shared decision making, Personalised care and support planning, enabling choice, including legal rights to choose.

Aligned to the requirements set out in the PCN Network Contract DES for Personalised care, our Social Prescribing service will deliver a targeted programme to proactively offer and improve access to social prescribing to an identified cohort with unmet needs.

4.7 Social Prescribing

Social Prescribing improves outcomes for people by giving more choice and control over their lives and an improved sense of belonging when people get involved in community groups. It is also effective at targeting the causes of health inequalities and is an important facet of community and neighbourhood centred practice.

Together Co have been providing a **Social Prescribing** service in Brighton and Hove since 2014. This service, commissioned by NHS Sussex, is funded by the Better Care Fund. Social Prescribing is delivered in a number of different ways in order to provide targeted interventions;

- Working closely with the West Hove PCN and Brighton Deans and Central, the service provides specialist support to the **PCNs Social Prescribing Link Workers** through the provision of training, peer support and 1:1 supervision
- A **City Wide Social Prescribing service** which aims to reduce health inequality and improve outcomes for people who may not traditionally access services via their GP practice by;
- **A Social Prescribing Plus** service which aims to further tackle health inequalities in Brighton and Hove by providing complex case link workers to support LGBTQ and Black, Asian and minority ethnic (BAME) people, language and interpreting services and specialist Gypsy, Roma and Traveller link workers. This service is delivered in partnership with specialist social prescribing VCSE providers:
    - Friends, Families and Travellers – for the Gypsy, Roma and Traveller communities
    - LGBT Switchboard Trans Link – for trans and non-binary people
    - Trust for Developing Communities – for people from BAME backgrounds
    - Sussex Interpreting Services – for those with a language need

These services deliver metrics which support avoidable admissions. Local Quality Requirements to capture the impact of this service on health inequality are reporting on the impact of this service on areas of deprivation, ethnic communities, LGBTQ and people with one or more long term condition.

4.8 Population Health Management

The Brighton and Hove system is committed to delivering change through a whole-area approach with a clear focus on outcomes to improving population health and ensure partners sign up to common goals. The principles of Population Health Management (PHM) is fundamental to make this real and enables us to use data drawn from across partners to identify people with deteriorating health (including those who may be slipping through the net) to influence behaviours and lifestyles which lead to poor health.

PHM will enable PCNs to deliver true Personalised Care with their local partners. Together, the three Ps (PHM, PCNs, and Personalised Care) forms a core offer for local people which ensures care is tailored to their personal needs and delivered as close to home as possible.

The Brighton and Hove BCF schemes support the delivery of anticipatory care, providing services for those patients who are at high risk of unwarranted health outcomes, to live well and independently for longer, through structured proactive care. Schemes provide anticipatory care to the most disadvantaged in our population, informed by the population health needs, the Brighton and Hove JSNA; drug and alcohol support, Social Prescribing, services which support the elderly population, mental health (including Dementia), long term conditions, carers, homelessness and housing.

4.9 Integrated team plans

The Brighton and Hove BCF schemes provide integrated care and work across organisational boundaries including Primary Care Networks, Adult Social Care, community NHS services to maximise effectiveness and reduce duplication. Multidisciplinary teams are in place to support the needs of those with long term conditions to reduce hospital admission or to support people being able to return home quicker, with more access to practical care and non-medical support, including advice on housing, cleaning, benefits, and carers, links to other support groups/VCSE organisations.

Integration provides good patient outcomes in the provision of both immediate and longer-term care, including palliative or end of life care, following hospital discharge.

4.10 Disabled Facilities Grants (DFG) and Wider Services Objectives and Outcomes

What is your approach to bringing together health, social care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

The DFG promotes the prevention of ill health (falls), avoidable hospital admissions, improves hospital discharges, reduces residential / nursing home admissions and promotes quality of life and wellbeing through major and minor home adaptations.

For Brighton & Hove our services are aimed at achieving the following outcomes;

- Enable older & disabled people to make choices that reflect lifestyle and circumstances and being able to remain living safely at home for as long as possible
- Fund home adaptations preventing people from needing to move into a care homes
- Improve housing quality and support
- Increase effective support to vulnerable fuel poor households and those most at risk of the health impacts of cold homes
- Proactive and preventative support by helping people stay healthy and remain independent

In Brighton & Hove there are consistently <5% DFG applicants admitted to hospital during 2021/22 and we work based on an average of 168 assisted hospital discharges per annum

4.11 Supporting Unpaid Carers

How our BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

The Brighton and Hove Carers Strategy – *THINK CARER! – Building a Carer Friendly City (2016-2020)* adopted the NHS England Commissioning for Carers definition of a family and friend unpaid carer:

"A carer is a person of any age, adult or child, who provides unpaid support to a partner, child, relative or friend who couldn't manage to live independently or whose health or wellbeing would deteriorate without this help. This could be due to frailty, disability or serious health condition, mental ill health or substance misuse."

Carers Hub

Brighton and Hove Health and Adult Social Care Assessment Services, currently (date 8.8.22) have 2022 known carers within the system and have completed 784 carers assessments/reviews/joint assessment and have 910 carers receiving services.

The Carers Hub which is funded by BCF provides services which support unpaid carers, the locally commissioned single point of contact for carers within the City, have (as of 30.6.22) 3,892 carers that they have contact with, have completed 136 Carers Assessments between April-June 2022; they provide a range of services within the Hub, through a partnership of organisations, and has an excellent reputation within the City, as well as being a high performing contract.

There are 2 specific projects, within the Hub, whose referrals and activities are significantly increasing, without additional funding in place:

Changes Ahead (specialist carer support for carers of people with mental health needs) are commissioned to support 50 carers per year, and are actively supporting 73 in the first quarter –

carers of people with mental health needs are increasing significantly, and for many of these carers, the person they care for is not receiving statutory provision, and they are the sole support for some people with extremely complex needs.

Young Carers Project – this project has seen dramatic increase in referrals, and individuals they support – 2017 when the Carers Hub started the YCP supported 90 YC's; 2018 -2019 105 YC's; 2019 – 2020 120 YC's; 2020-2021 235 YC's; and in the first quarter of 2022 – 2023 82 YC's, with an estimate of over 300 YC's being supported this year.

The Brighton and Hove Carers Rapid Needs Assessment 2016 made 6 Recommendations which will form part of the work funded by the BCF in Brighton and Hove:

- Services and commissioners should consider how to target services at groups identified as being under-represented within services (e.g. males, working age carers).
- Ensure that organisations that work with young people and with young carers specifically are aware that young carers are at increased risk of a number of poor outcomes and can respond to these risks including linking them into appropriate services such as physical and mental health services.
- Ensure that impact of carers' services can be demonstrated by including the same questions in carer's reviews as the carer's assessment (for example, questions about the impact of caring on wellbeing and the risks to physical and mental health).
- Ensure that the data collected by Adult Social Care is complete and quality checked, to provide a robust source of evidence about carers and their needs.
- Ensure that Adult Social Care are collecting data on the protected characteristics for all carers accessing services, including religion and sexual orientation, as well as armed forces personnel.
- Review the list of groups of carers at higher risk/with higher needs and prioritise those that more information is needed about or more specialised work is needed on. Research could be carried out with these groups to find out why they don't access services

These recommendations fed directly into the Brighton and Hove Carers Strategy 2016-2020 – the strategy has 4 main themes regarding building on a carer friendly City – Carer Friendly Social Care; Carer Friendly Health; Carer Friendly Employment; and Carer Friendly Education.

5. **Equality and health inequalities**

Our priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services.

Our diverse City of nearly 300,000 people is the 131st most deprived local authority in England (of 317) according to the 2019 Index of Multiple Deprivation (IMD). Some areas are more affected by deprivation than others and there are significant variations in health outcomes across the city.

Brighton and Hove is a city with a very diverse community and a younger population (83% aged under 60 compared with 76% national average) that has significant diversity in all manners i.e. sexuality - Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ+) 11.5%, BAME 19.5%, 131st most deprived nationally, carers 9%. There are over 3000 known refugees/globally displaced migrants in Brighton and Hove; fifth highest homelessness, over 4000 people with known multiple disadvantages (4,180 receiving any of substance misuse, homeless or offending services (2018). Of the 4,180 people with multiple disadvantages1,670 receive two or more of these services, 460 received all three services and 2,170 were also estimated to have mental health problems. The average age of death for those with multiple disadvantages was 43 years compared to the overall average of death of 77 years.

Sussex's Vision 2025 sets out how we will achieve better health and care for all, through better health outcomes, equity of access and sustainable health and care services. Its ambitions support the

national requirements of CORE20Plus5 in relation to reducing health inequalities related to deprivation, SMI and Learning Disabilities, reducing inequalities in maternal deaths and stillbirths, improving early diagnosis of cancer, improving hypertension case finding and treatment and early mortality from Chronic respiratory disease.

The Core20PLUS5 approach is a national programme and requires each System to identify its 20% most deprived areas, its Plus /inclusion population groups experiencing worst access, experience and outcomes and plans to address 5 Clinical priorities -Hypertension treatment to target, Chronic Respiratory Disease, Serious Mental Illness Physical Health Checks, Cancer Early Diagnosis and Maternity Continuity of Carer. This national programme is firmly embedded in the Sussex Improving Population Health Strategy, Sussex HI Strategic Framework and within Tackling Neighbourhood HI DES implementation plans.

All PCNs are supported in utilising data and insight largely focused on identifying and addressing the Core20PLUS5 priorities and populations; with provision to engage target populations and to co-design interventions to address unmet needs and reduce HI. We are developing a toolkit, including a HI Dashboard for the five key clinical areas. The dashboards will provide GP practice and PCN-level data segmented by age, gender, deprivation index and ethnicity. It will be further developed to support other priorities and will enable us to segment for health inclusion and protected characteristic groups.

A number of the Brighton and Hove BCF schemes support the national requirements of CORE20PLUS5 in relation to reducing health inequalities related to deprivation, Serious Mental Illness and Learning Disabilities, reducing inequalities in maternal deaths and stillbirths, improving early diagnosis of cancer, improving hypertension case finding and treatment and early mortality from Chronic respiratory disease.

The Social Prescribing service is contributing to the delivery of CORE20PLUS5 working closely with PCNs to target social prescribing specifically to carers and to support need for translation services for our displaced communities. Our Social Prescribing service is also working with our commissioned Community Connectors in areas of deprivation to reduce health inequality.

The “Plus” Population groups for Brighton and Hove are currently being defined and but data and insights have identified population need which is supported by the schemes funded by the BCF:

I. Carers, including young carers
II. Mental Health Transition in Children and Young People aged 16-25 years
III. Globally displaced communities, - those seeking asylum, refugees, vulnerable migrants and;
IV. LGBTQ+ communities as an additional group who also experience health inequalities and that should be acknowledged through Equalities Impact Assessments (EQIAs) and system wide action

5. Conclusion and Recommendations

The Brighton and Hove scheme review has been completed for all health and social care schemes with all key lines of enquiry set out for the Sussex wide review covered in that. A consolidated summary of the review will be considered locally by Brighton & Hove BCF Steering Group with recommendations to ICP Executive and to inform the HWB report in November to sign off 2022-23 plan.

Initial findings from the review are:

1. That there are opportunities to improve contractual control, reporting and KPIs for some services that are BCF funded
2. There are opportunities to consolidate some component parts to work better together for a greater synergy and improved output
3. There are no schemes that obviously lend themselves to be stopped or scaled back without incurring an adverse impact on the local system

4. The key investments and largest investments are committed – i.e., they are funding costs that if the BCF doesn't fund will need to funded by another source so no net gain to the system resources e.g. BHCC pay costs and CCG funding towards SCFT block.
5. There are also very significant considerations (public and Cllr adverse reactions, CCG reputational risk) if we were to reduce funding commitments to BCF schemes such as carers and support to specific community groups

Although a formal committee of Brighton & Hove City Council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults and Healthwatch.

Title: Progress report for Brighton & Hove Towards Zero HIV Taskforce

Date of Meeting: 08 November 2022

Report of: The Executive Director, Health & Adult Social Care

Contact: Stephen Nicholson Tel: 01273 296554

Email: Stephen.nicholson@brighton-hove.gov.uk

Wards Affected: All

FOR GENERAL RELEASE

Executive Summary

This report provides an update on the work of the Brighton & Hove Towards Zero HIV Taskforce. The taskforce is the local delivery vehicle for the international Fast Track Cities initiative. The Taskforce supports the City to achieve the Fast Track City goals of zero HIV stigma, zero new HIV infections, and zero deaths from HIV.

1. Decisions, recommendations and any options

1.1 That the Board notes the contents of this progress report.

2. Relevant information

2.1 The Fast-Track Cities Initiative is a global partnership between the United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Human Settlements Programme (UN-Habitat) and the International Association of Providers of AIDS Care (IAPAC). Website: www.iapac.org/fast-track-cities/

2.2 In August 2017, Brighton & Hove became the first UK City to sign the Paris Declaration on ending HIV/AIDS as a public health threat in cities by 2030. There are now over 100 cities from around 65 countries around the world which are part of the Fast Track Cities initiative.

2.3 More details of the work of the taskforce are included as Appendix 1 to this report.

3. Important considerations and implications

Legal:

3.1 This report is for noting by the Board only and no specific legal implications arise.

Lawyer consulted: Sandra O'Brien Date: 11 October 2022

Finance:

3.2 There are no financial implications attached to this report and it is envisaged that any alterations to current provision will be delivered within the existing budget.

Finance Officer consulted: Sophie Warburton Date: 11/10/2022

Equalities:

3.3 The work of the Towards Zero HIV Taskforce and the reduction in HIV transmission directly addresses the inequalities for those groups disproportionately affected by HIV.

Sustainability:

3.4 No implications identified for this information report

Health, social care, children's services and public health:

3.5 These implications are explored in the main report and Appendix 1".

Supporting documents and information

Appendix1: Brighton & Hove Towards Zero HIV Taskforce Progress Report

Progress report for Brighton & Hove Towards Zero HIV Taskforce

1.1 Background

Brighton & Hove (B&H) became a Fast Track City, the first FTC in the UK, just over 5 years ago. This status has provided us with the infrastructure to accelerate the journey and better measure progress towards ZERO HIV stigma, ZERO new HIV infections and ZERO deaths from HIV within the city. Being a part of the Fast Track Cities Initiative has given us an opportunity to become more connected with other UK Fast Track Cities, share best practice and support each other through joint initiatives. As a direct consequence of being a FTC we were visited by the HIV Commission to gather evidence which informed the National HIV Action plan; have been visited by Winnie Byanyima, the Executive Director of UNAIDS; Maria Caulfield, Conservative MP for Lewes and lead minister for Sexual Health and HIV during HIV testing week (2022), all of which provided media and awareness raising opportunities to tackle stigma, improve knowledge and start conversations.

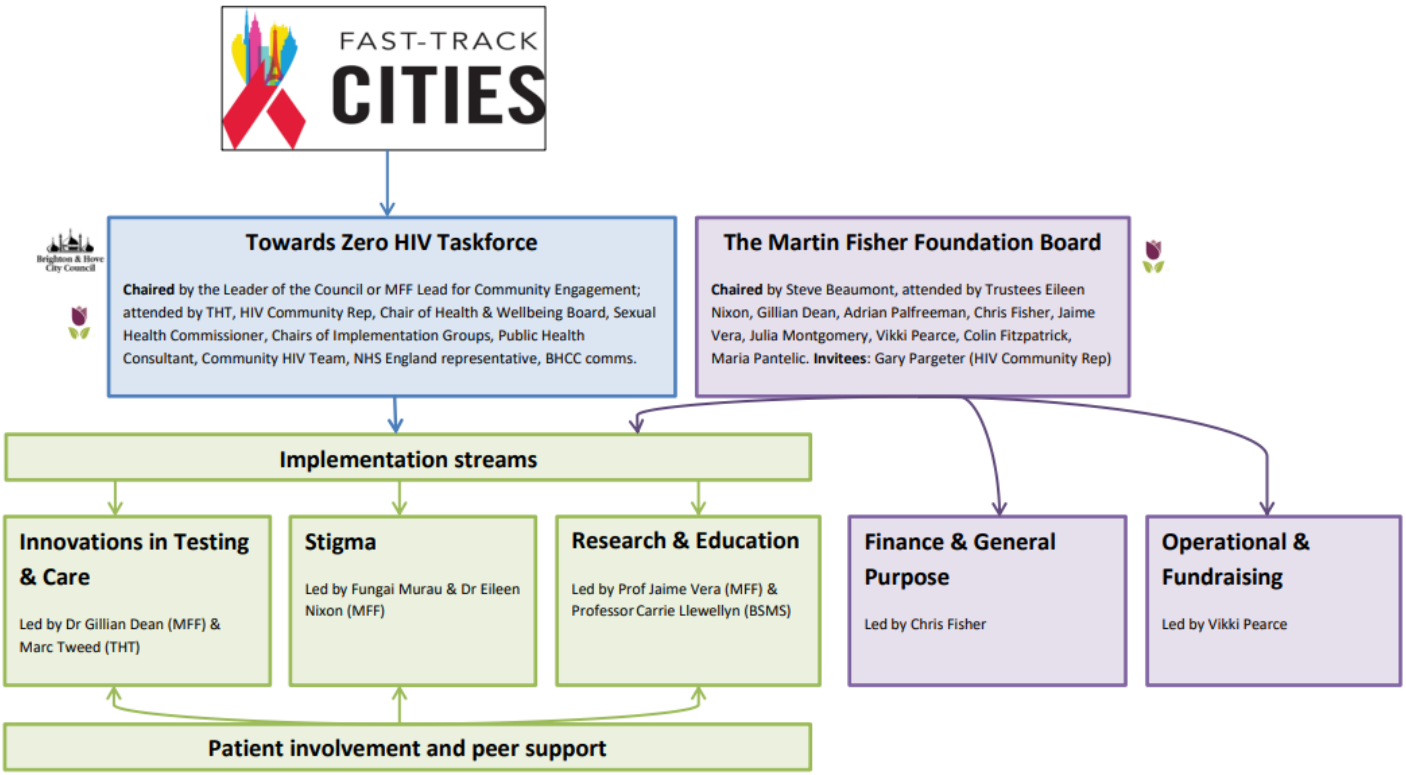
The Taskforce has provided a mechanism for us to intensify HIV prevention and treatment efforts, and ensure all key players are involved, aligned and working together towards the common goals:

- To improve patient involvement and peer support
- To deliver innovations in HIV testing and care
- To increase research and education
- To eliminate HIV-related stigma

The National HIV Action plan released in December 2021 sets out four core themes: Prevent, Test, Treat, Retain. In B&H we have been focused on these aspects of HIV prevention and care for many years now, and progress in these areas is illustrated in this short report. We are fortunate in this city to have an exceptionally well-developed community and voluntary sector working closely with B&H City Council as well as integrated clinical services (HIV/sexual health) unimpeded by tendering due to effective and sensitive commissioning for last 20 years. The clinical service has a long history of national and international research, innovation, and joined up approach across all sectors, listening to and working with the patient group and the community has always been paramount.

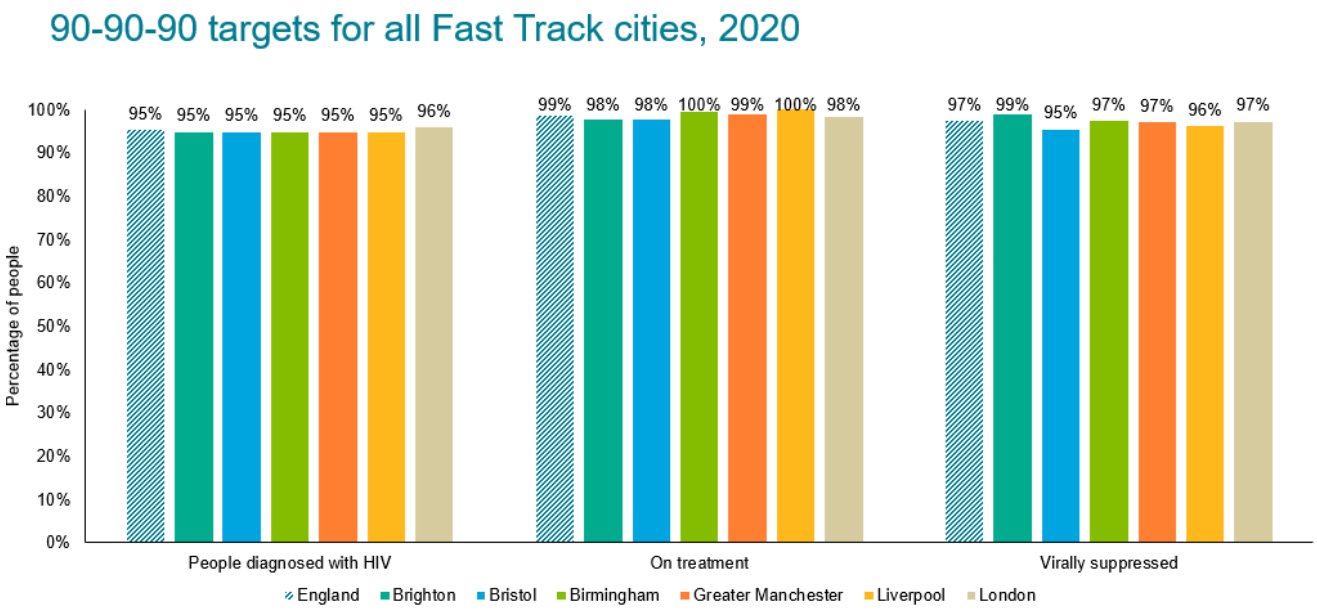
1.2 Structure

The Taskforce meets quarterly and is jointly chaired by either the Leader of the Council or the Martin Fisher Foundation lead for community engagement. Broad membership with many viewpoints and perspectives ensures issues are progressed effectively. Working collaboratively and in partnership, people with HIV are actively involved within the strategic and delivery processes; drawing upon their lived experience and connectedness to the communities we aim to reach.



1.3 Data

Nationally UKHSA provide us with annual data comparing across the six FTCs in England. It is noteworthy that since becoming a FTC the local data quality and ability to monitor progress has improved substantially. Data relating to new diagnoses are collected in real time, as well ongoing clinical and virological outcomes. For all new cases missed testing opportunities are recorded and raised supportively with the practice or department concerned. A previous late diagnosis 12-month audit in 2018/9 showed £332,803 extra costs incurred by late diagnosis for just 8 patients.



We have also developed baseline metrics to enable us to monitor progress towards zero HIV stigma and conducted a detail audit of HIV deaths as one of the key 'getting to zero' targets is to reach 'zero HIV related deaths' by 2030. From 2017 to 2020 there were 75 deaths; the cause of death was ascertained for 99%; only 5 (7%) were HIV related (2 AIDS-malignancies, 1 pneumocystis pneumonia (PCP), 1 progressive multifocal leukoencephalopathy (PML), 1 untreated HIV) which compares to 18% nationally. However there were 24 (32%) potentially preventable non AIDS deaths: 20 due to lifestyle risk factors; smoking (8) alcohol excess/substance misuse (12); suicide (2); complications of HCV infection (2), indicating there is more work to do. In 2021, there were 25 deaths, of which 8 were due to non-AIDS cancers, and none were HIV-related.

1.4 The social value of being a Fast Track City

Active involvement of the local third sector has been central to strategic planning, delivery and development of outputs, as well as reaching out to residents. Participant organisations are wide ranging, including those led and delivered by, or expressly supporting PWHIV. Over **2,000 volunteering hours** have been given during the year towards planning and delivering Fast Track City activities. New volunteering roles have been created, involving and empowering PWHIV and the wider community. New and additional voluntary activity has been undertaken by individuals, community groups and local charities, many of these small and micro-organisations, who have now incorporated greater awareness of HIV and Fast Track City strategy into their mission.

Examples of practice, impact, and learning from the delivery of activities have been shared with the wider Fast Track City network. They have also been widely disseminated within the local community and voluntary sector demonstrating examples of collaborative working, patient and public voice, innovating models of delivery and reach within communities experiencing health inequalities. This sharing has contributed to the overall robustness of the voluntary sector, and this expertise has been expressly called upon to contribute towards the development of the role and voice of the voluntary sector within integrated health structures

PWHIV voice and representation has been increased, together with a significant growth in understanding and reach of intersectionality. PWHIV voice and representation has given opportunity to influence wide-ranging local policy. With clear messaging and greater alignment of HIV and other organisations towards strategic goals, there has been sustainable expansion of HIV community engagement within the voluntary sector, increased testing to unreached groups, raised HIV awareness, reduced HIV stigma; and improved societal, social and health outcomes for PWHIV.

1.5 Co-design & co-production (to be added)

Strengthening links – sharing learning – social value

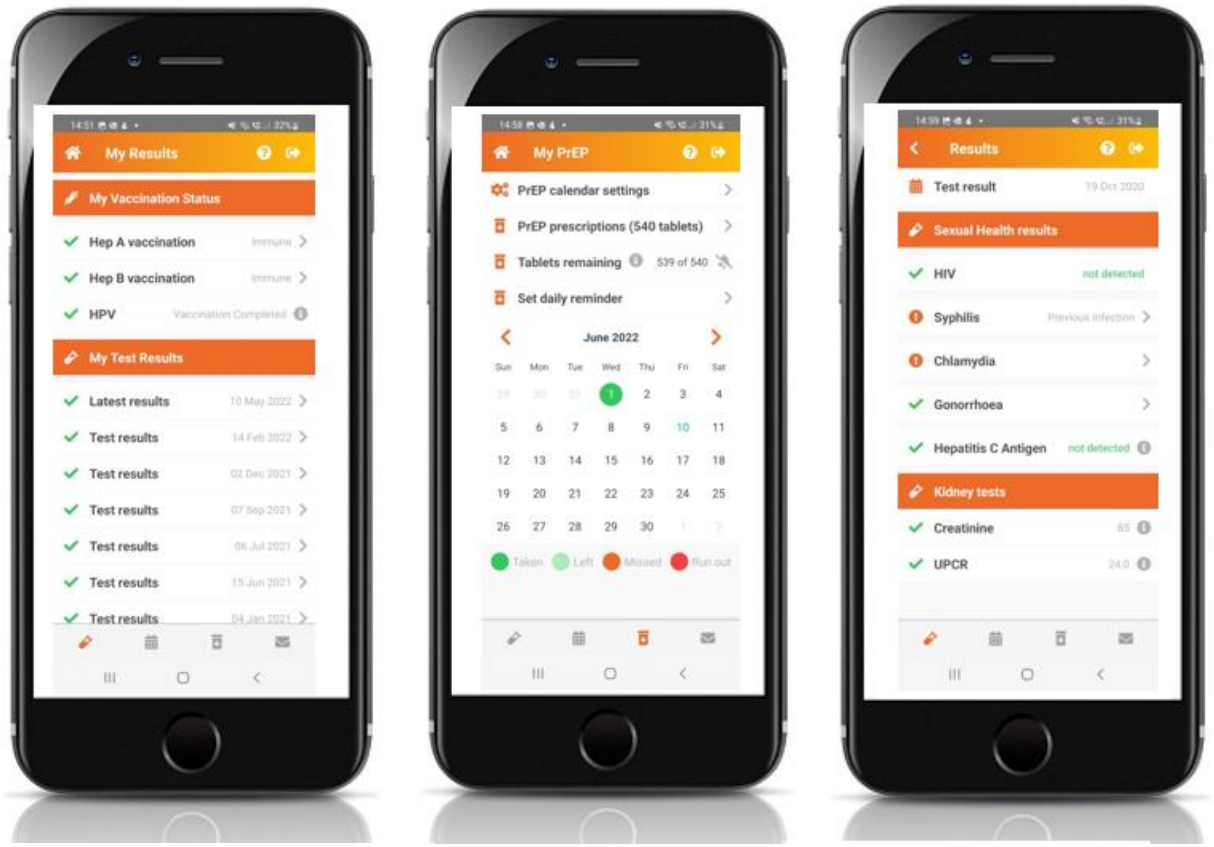
PREVENT

2.1 Pre-exposure prophylaxis (PrEP)

Over the last five years the PrEP landscape has changed significantly for the better. In 2017 potential users either had access to a very limited number of research places (IMPACT study) or had to import their own drugs, often taking medication without monitoring. In October 2020 PrEP was commissioned by NHS England and since this time the service has flourished and numbers of incident (new) infections in users become a rarity. By the end of June 2022, 1844 individuals were receiving PrEP through SHAC (60%/40% daily/event based); this means we have a PrEP uptake rate of 85% (1844/2169) in men who have sex with men (MSM) and bisexual males attending SHAC services.

2.2 Pre-exposure prophylaxis application (PrEP app)

The PrEP app has been co-designed locally and is currently being rolled out for the remote management of PrEP (stage 1). The platform provides secure access to STI/blood results, appointments and medication information (when the last script was issued, how many remaining tablets) and allows reminders for daily/event based therapy, and communication with clinical services. For 395 users without co-morbidities or vulnerabilities face-to-face follow-up has reduced to 6-12 monthly. Evaluation shows high levels of acceptibility and usability. Stage 2 (once funded) will again be co-created with users and will aim to utilise digitally enabled pathways to improve access for seldom seen groups in non-clinical settings, which again will improve capacity and provide alternative options in the menu of care.



2.3 PrEP2U

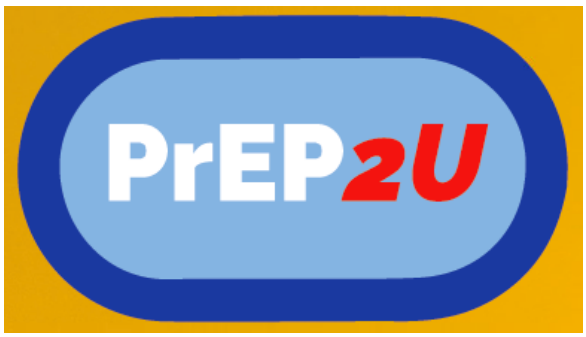
A co-designed partnership between the clinical services and THT saw the launch of a community HIV-PrEP service aimed at marginalised communities in Apr 22. THT outreach workers identify people from key populations (transgender community, hidden/silent MSM, racially minoritized communities, people experiencing homelessness) aiming to reduce barriers to healthcare and inequalities. Attendance at this weekly one-stop-shop service is facilitated; early data (n=52) shows that the majority were PrEP naïve, have not previously accessed services and seek partners online or at sex on premises venues. The service has created destigmatised experience of sexual healthcare which supports (re)engagement with mainstream services and reduces triggers linked with previous traumatic healthcare associated events.

The PrEP co-design team sought to understand the experiences of people who prefer not to access NHS sexual health services due to lack of trust and safety, as well as other recognised accessibility issues. This together with clinical and community experiences of supporting people during Covid-19 and the move to remote care caused by lockdown, made the team acutely aware of people for who experience barriers to accessing care.

Digital health service innovations can deepen health inequalities through the digital exclusions they produce. The EmERGE PrEP team recognised they needed an equal and parallel effort to reach people who have complex needs, have a distrust of mainstream services, are digitally excluded, or prefer not using digital services. Learning from the digital transformation of services that occurred during lockdown showed that strong, place-based community connections are vital for ensuring that people who are isolated and cannot (or prefer not) to use digital technologies to access care remain supported and able to access health services. Existing local networks of community groups ensured that people with complex needs and people excluded by the rapid move to digitally supported, remote care remained connected to care and support.

Based on their learning about the importance of reach and the impact of digital inequalities the PrEP EmERGE team developed the PrEP2U community care pathway and co-delivered a face-to-face service. Using their knowledge of care pathway, the co-design team have created a service via which people can access the whole PrEP pathway – from testing to prescription and medication collection – in a community setting rather than in clinic. The service has been designed and promoted to people who are least likely to use mainstream sexual health services recognising that it is these people who are likely to experience compound and complex inequalities.

Terrence Higgins Trusts experience of supporting people to access sexual health services and use PrEP shows us that groups who fall outside those normally highlighted through population-based analysis of HIV incidence, who may benefit from using PrEP, are often invisible when using quantitative, survey-based methods. Combinations of intersecting behaviours, practices and identities that change over time, together with being clinic-adverse means that identifying people who may benefit from PrEP requires alternative strategies.



TEST

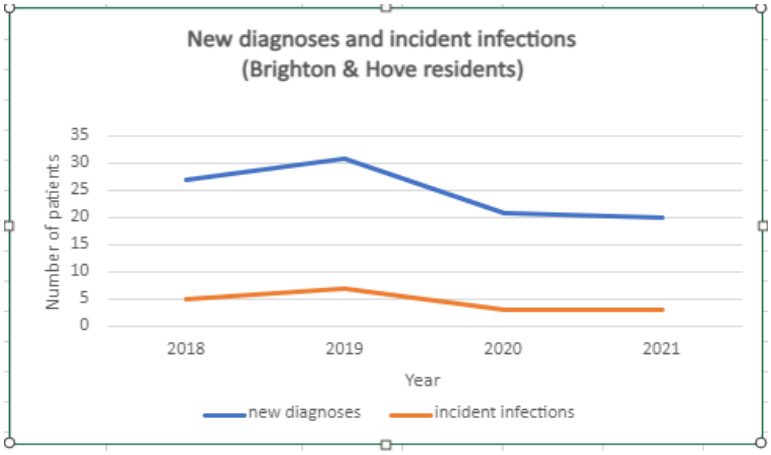
3.1 Expanding HIV testing

Our long-term goal of introducing Emergency Department opt-out testing was realised in April 2022 as a direct result of the recommendations made by the HIV Commission, followed by the National HIV Action Plan and associated funding announcement in Dec 2021. This project has raised the HIV profile within University Hospitals Sussex NHS Trust. Hepatitis B and C screening will be introduced later in 2022. In 2021/22 with funding from Gilead, we are piloting NICE guidance - that all people having blood tests in primary care should be offered an HIV test - in three Primary Care settings (Wellsbourne Health Centre, Pavilions Surgery, Brighton Health and Wellbeing Centre). This has been done with no additional workload for GPs, and simply entails the phlebotomist offering an HIV test and taking an extra vial of blood. In April 21 we also secured funding to incorporate opt-out HIV testing as part of the glandular fever screen bundle requested by GPs and secondary care. However there remains much work to be done to normalise testing in ALL settings to reach the undiagnosed.

To encourage self-testing we continue to expand the digital vending machines across the city which are now available at eight convenient locations across B&H. Further testing options in the community are clearly signposted across the city, and two decades of systematic education in primary and secondary care (bespoke HIV education course) has ensured the majority of settings feel confident in offering HIV tests.

3.2 New HIV diagnoses

The number of newly diagnosed and incident (newly *acquired*) infections continues to fall, with a concomitant increase in the proportion diagnosed with late disease (CD4<350cells/mm^3). The reduction in new infections is attributable to effective combination prevention (pre-exposure prophylaxis, treatment as prevention and increase testing coverage).



	2018	2019	2020	2021
Total no. new diagnoses	33	42	25	24
No. new diagnoses B&H residents	27	31	20	20
No. incident infections (B&H residents)	5 (19%)	7 (23%)	3 (14%)	3 (15%)
Proportion of late diagnoses (B&H)	33%	39%	43%	50%

In 2020 the rate of new HIV diagnosis per 100,000 population among people aged 15 years or above in Brighton & Hove was 12.4 (reduced from 18.3 in 2017) and compared to 5.7 in England.

3.3 Creating an 'explainer animation' to encourage testing

Since becoming a FTC we have endeavoured to ensure our residents are aware that "if everyone tests for HIV, commences prompt HIV treatment if diagnosed positive, or accesses effective prevention initiatives if negative and at ongoing risk" then we can end new HIV transmissions. The National Aids Trust's 2021 report 'HIV: Public Knowledge and attitudes' high-lighted how poor or outdated many people's understanding of HIV is. The Towards Zero HIV Taskforce identified that we needed a concise, clear 'explainer animation' to convey this message to the public.

Connections Animation Studios created the animation. The company has a strong record of working in health communications and translating complex ideas into simple messages through animation. The animation was co-produced with clinicians, HIV community workers, members of the public and people living with HIV (PLWH).

The film is being used in healthcare education and training packages. Wider dissemination through websites, on GP/dental information screens, and as part of school education packages is needed. The film will update knowledge, increase testing, and will go some way to tackling HIV related stigma and discrimination. A version with a British sign language interpreter has been produced by THT.



3.4 Testing and working during the pandemic

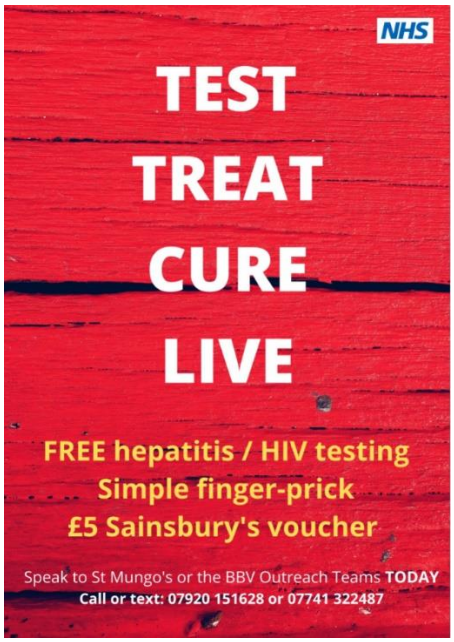
Different ways of working were adopted quickly: HIV outpatients became 100% paperless; increased repertoire of contacting patients including phone consults and Attend Anywhere; on-line HIV/STI testing expanded; website significantly improved; rapid innovation over months rather than years; many examples of resilience. HIV testing was reduced in sexual health services, now back to baseline; secondary care testing was maintained but 50% fewer new diagnoses as most tests were carried out in the Emergency Department as part of the Covid protocol where an older population were tested. The **Sussex Covid study 2020** (n=653) noted growing needs to support physical and mental health; recognised the impact was disproportionate for some e.g. if living alone, if younger but also noted enhanced resilience for many – that living with a long term virus increased coping strategies and allowed individuals to better put pandemic into context. Also reported emotional strength and good peer support networks

3.5 BBV screening in housed street homeless

During the first Covid-19 lockdown rough sleepers were accommodated in hotels in B&H. This gave us a unique opportunity to access this traditionally 'hard-to-find' group. Two experienced outreach workers collaborated with trusted keyworkers and implemented blood borne virus (BBV) screening using dried blood spots (DBS). Clients were offered a £5 food voucher. 95% were approached (256/270) with 72% uptake (192/270); median age 40 (range 18-69); 83% male; 85% white British/white other, 5% black African; 93% heterosexual, 3% GBM, 2% other; 28% previous IDU, 20% other drug use; 48% stated prison as risk factor.

Overall, 36% had not previously tested for HIV and hepatitis. 16% were hepatitis core antibody positive; 7% hep C RNA positive. All were made aware of the results; 4 started treatment; 3 deferred; 2 considering; 3 not engaged (key workers/GPs aware); 1 left area (f/u with NHS number). No cases of HIV were identified. All testers said they would recommend the project, 80% found it 'very useful'.

This project brought together professionals from different sectors to reach common goals with a large cohort sensitised to the concept of testing for HIV and HCV. New outreach testing opportunities identified. There was re-engagement of 2 known HIV patients, and other vulnerable clients were engaged with SHAC services. It was reassuring there was no undiagnosed HIV in this marginalised cohort.



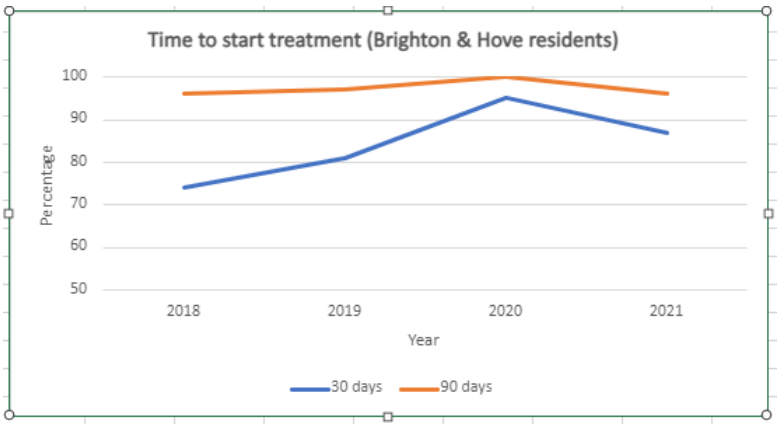
TREAT

4.1 Prevalence and time to start treatment

In 2020 the HIV diagnosed prevalence rate was 7.33 per 1,000 population aged 15-59 years (compared to 2.31/1,000 in England). This is the 8th highest unitary authority rate in England and the highest outside London, although shows a downward trend since a peak of 8.1/1,000 in previous years. In Brighton & Hove 95% of people living with HIV know their status; 99% of those are on treatment and 98% of those on treatment have undetectable virus. We estimate the undiagnosed proportion equates to ~120 individuals in the city.

Our clinic cohort size is 2,412 of whom 1,629 live in Brighton & Hove. Overall, our cohort is 82% men who have sex with men (MSM), 9% women and 9% heterosexual men

	2018	2019	2020	2021
Proportion starting treatment by 30 days (B&H)	74%	81%	95%	87%
Proportion starting treatment by 90 days (B&H)	99%	97%	100%	96%



4.2 Managing the medically stable HIV cohort

Development of the EmERGE application (EmERGE app) was a 5-year project (2015-2020), involving 5 sites in Europe led by Brighton. The project outcome was a co-designed digital health pathway of care for people living with medically stable HIV providing access to their own data (results, medication, appointments, messages) with a person-centre option in the menu of care; 2251 individuals participated in the evaluation at the five sites (3891 years of follow up). The findings were that the health app was clinically safe; that face-to-face appointments were reduced by up to 30% and 96% would recommend to a friend**.** In the B&H cohort 25% are managed through the EmERGE app and 18% through Connect (the email-based predecessor); so, 43% in total being supported in self-management and helping clinics to manage capacity.

4.3 Digi-PROMs

Patient reported outcome measures (PROMs) measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. The POSITIVE OUTCOMES PROM has been co-designed, developed and validated in UK and European settings to ensure person-centred HIV care. In Brighton & Hove, the PROM is currently in use in paper format in one HIV clinic for complex patients.

There is interest from clinics and communities nationally (and internationally) in exploring the role of such a PROM in informing and enabling person-centred care [rather than just as an outcome measure at service level]. It is anticipated that the PROM will be used to guide person-centred care across whole clinic cohorts. The PROM would be completed prior to or during the clinic visit and be used to guide person-centred pathways of care.

There is increasing use of telemedicine & digital pathways in healthcare, including HIV, which has been accelerated by the COVID pandemic. This project will enable the co-design of a digital health pathway for the PROM, ensuring that the digital delivery of the PROM is person centred and is acceptable to PLWH and their clinicians, as well as exploring digital inequalities and ensuring usability and accessibility of the digital PROM.

The creation of a digital health pathway is important as currently the PROM tool is only available for use as a hardcopy questionnaire that can only be accessed in person at the time of the clinic appointment. This creates a delay for the patient and healthcare professional and is a barrier to timely holistic care. The creation of a digital health pathway will make this process more accessible and efficient and enable the research project to be delivered to patients in a healthcare setting of their choice.

It is intended that a digital PROM will benefit PLWH in several different ways, including by:

- Creating a co-designed digital pathway for the delivery of the POSITIVE OUTCOMES PROM that will enable PLWH to report outcomes that are important to them outside the clinical setting.
- Ensuring that the digital PROM tool and pathway are accessible, usable and acceptable in a real-world situation
- Ensuring that PLWH are involved in the co-design of their person-centred services. This is particularly important to assess the service re-set post Covid of the many changes that were implemented rapidly during the pandemic.
- In the context of digital inequalities this project will ensure that “no-one is left behind” as the PROM is introduced digitally and that appropriate adjustments are available for those who may not be as digitally literate or engaged.

RETAIN

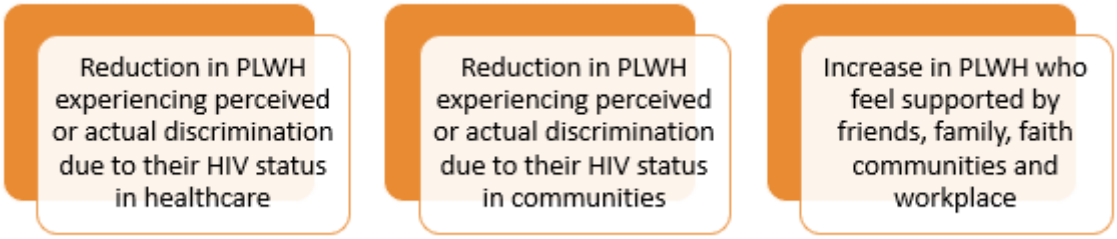
5.1 Retention in care

Once diagnosed rapid referral into treatment and retention in treatment over time is essential to achieving good health outcomes and preventing onward transmission. The proportion of our cohort lost to follow-up remains very low at 1.5% in 2020. Following intensive efforts, a proportion have since returned to care leaving the true figure at 1.1%). This compares to England figures in 2019 of ~4% (3570/90,436).

5.2 HIV Stigma

A city-wide strategic plan to reduce stigma and discrimination was developed as part of the FTC initiative by the stigma implementation stream. The aim to address HIV stigma at a multi-sectoral level in three work streams: reduce stigma among healthcare workers; empower PLWH and build resilience; develop further public awareness campaigns following on from the B&H stigma campaign in 2018.

Baseline stigma metrics have been developed using local data extrapolated from national datasets, leading to stigma reduction targets that will be utilised to evaluate forthcoming interventions and as stigma process indicators.



5.2.1 Stigma Free Hospitals & Healthcare

University Hospitals Sussex have agreed to upload the animation and a stigma flier on the induction portal for September 2022. The stigma group are scheduled for a face-to-face slot at the corporate induction in January 2023. The stigma group have secured Health Education England (HEE) funding for 4 study days in the next year for HIV education / stigma workshops to focus on stigma reduction training across our hospitals. UHS is expecting to participate in a national HIV knowledge and attitudes survey for hospitals later this year.

HIV Allies have been identified across many departments and a mandatory training module for healthcare staff is in production. A 'train the trainers' structure will be used to cascade information throughout the Trust, aiming for all workers to be aware of 'Can't Pass It On' and using a 'Train, don't Shame' approach. The "10 things" project has secured funding and will involve PLWH in the training of healthcare workers similar to successful developments in diabetes care leading to safer care and improved patient confidence.

A bespoke educational package for dental staff has been created including the animation, patient films, summary slides and pre and post questionnaires. The package is designed to take only 10 minutes to complete. Engagement and positive feedback indicate an interest amongst dental staff in B&H although qualitative work is required to identify the most effective form of intervention to significantly influence HIV-related stigma amongst this group.

5.2.2 Empowering PLWH and building resilience

The People Living with HIV Stigma Index Survey results for Southeast England (mostly from Brighton) have shown progress: in 2015, 36% of PLWH experienced gossip reducing to 19.2% experiencing gossip in 2019. Further data from the national survey is expected. To work towards B&H becoming a Stigma-free city we need to empower PLWH to speak freely about their health, and feel supported by friends, family, faith communities and workplaces. HIV needs to be viewed in the same way as any other chronic health condition so that PLWH can better access clinical, community and emotional support. Co-designing workshops with MIND are in progress, to support resilience, manage disclosure, and tackle anticipated and enacted stigma. There will be focus on intersectional vulnerabilities. All B&H HIV organisations are on the same page and collaborating well.

5.2.3 Public awareness & stakeholder engagement

2019 saw the launch of the magnificent Martin Fisher Foundation bus, a brilliant collaborative effort of the Foundation, Daniel Locke (Designer) and Brighton & Hove buses. We believe we're the first city in the world to have an HIV themed public information bus, allowing passengers to read up to date information about HIV testing, treatment and prevention.



There have been two large stakeholder events to engage the grassroots community that have helped to map ongoing public awareness plans. Suggestions have included using high profile venues to promote messages (Amex, Brighton Station, cinemas, concert venues), encouraging high visibility of PLWH reflecting diversity, and ensuring a presence at Pride, football, and other festivals. One such aim is to collaborate with the Brighton Festival presenting an HIV theme at events using art, music, drama, and poetry.

Item 28

Although a formal committee of Brighton & Hove City Council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults and Healthwatch.

Title: Brighton and Hove City Council Winter Cold Weather Plan 2022/23

Date of Meeting:08 November 2022

Report of: The Executive Director, Health & Adult Social Care

Becky Woodiwiss - Public Health Principal, Public Health, Health & ASC

Contact:
Email:
becky.woodiwiss@brighton-hove.gov.uk

Wards Affected: All

FOR GENERAL RELEASE

Executive Summary

The BHCC winter cold weather plan is updated annually. This year, planning for the winter of 2022/23 is in the context of the economic downturn, cost of living increases, political changes, ongoing challenges to the health and social care sector, continuing demands of COVID-19 and its health and socio-economic impacts, and seasonal Influenza.

The BHCC plan localises the Cold Weather Plan for England and both aim to prevent avoidable harm to health, by alerting services and people to the negative health effects of cold weather and enabling all to prepare and respond appropriately.

The CWP also aims to reduce pressure on the health and social care system

during winter through improved anticipatory actions with vulnerable people. This year these pressures will include cost of living, increasing fuel cost with associated fuel poverty, and possible seasonal surge pressures, and the impacts of Flu, Covid-19 and other seasonal viruses.

Glossary of Terms

CWP = Cold Weather Plan
EWD = Excess winter deaths
COVID-19 = coronavirus illness in humans caused by SARS-COV-2 infection.
CVD = Cardio-vascular disease
SWEP = Severe Weather Emergency Protocol
VCS = voluntary and community sector
ICB = Integrated Care Board
ICP = Integrated Care Partnership

1. Decisions, recommendations and any options

1.1 That the Board notes the content of the report and the actions to be taken by the Council services and partner organisations.

1.2 The City Council, NHS commissioners and partner organisations are assured that plans are in place and action identified to respond to Cold Weather Alerts and that service providers and stakeholders will take appropriate action according to the Cold Weather Alert level in place, their professional judgements, and remain COVID-19 safe.

2. Relevant information

2.1 The Cold Weather plan helps prevent the major avoidable effects on health during periods of cold weather. It is compiled by public health with input from all BHCC Directorates. It describes the key issues for the city, cold weather alert system, related work-streams and governance arrangements.

2.2 An estimated 28,300 excess winter deaths (excluding COVID) occurred in England and Wales in 2019/20. 19.6% higher than 2018/19. Excess winter deaths (EWDs) are the observed total number of deaths in winter (December to March) compared to the average of the number of deaths over the rest of the year. The usual peak in excess winter deaths is usually seen in January/February.

The EWD Index is as a percentage increase of the expected deaths based on non-winter deaths. Local and national excess winter mortality is highly variable year on year, so five year rolling averages are used, and shows no clear trend. For winters 2014/15 to 2018/19 the EWD Index in Brighton & Hove was 21.4% equating to 144 extra deaths each year. This is the same as England (21.4%) and similar to the South East (21.3%). For one year 2019/20 the EWD for 85+ at 19% is more similar to England (20.8%) and SE (20.7%) [1]

2.3 There is strong evidence that many of these winter deaths are related to cold temperatures, living in cold homes, respiratory illnesses, and cardiovascular conditions as well as infectious diseases such as influenza.

2.4 Those at greater risk from the ill health effects of cold weather are the over 70s, those with chronic health conditions especially respiratory and Cardiovascular disease, those clinically extremely vulnerable, pregnant people and people living in areas of higher deprivation, experiencing ongoing health and/or socio-economic inequalities and those living in cold and/or damp homes. Specifically, the cold weather affects thermoregulation and with ageing there is reduced thermoregulatory control and thermal perception, this is magnified in certain conditions e.g. dementia.

2.5 Heavy snow and ice has a small direct effect on health, predominantly as a result of falls and injuries. Additionally, it causes disruption to the delivery of health, social care and other services.

2.6 The effects of cold weather start at outdoor temps below 8°C and indoor temperatures below 18°C. Living in cold environment increases blood pressure and the risk of blood clotting (cholesterol and fibrinogen). Negative respiratory effects are seen from 18^0C increasing as temperatures lower.

2.7 People live in cold homes often due to fuel poverty [2]. The Government released a new national Fuel Poverty strategy in February 2021, which included a new definition for Fuel Poverty measurement. The Low Income Low Energy Efficiency (LILEE) measure finds a household to be fuel poor if it:

- Has a residual income below the poverty line (after accounting for required fuel costs); and,
- Lives in a home that has an energy efficiency rating below Band C.

2.8 The latest available figures released in May 2022 using this new definition, estimate that in 2020 (there is a standard two-year lag in the data), 12% of

[1] https://fingertips.phe.org.uk/search/excess deaths#page/3/gid/1000044/pat/6/par/E12000008/ati/102/are/E06000043/iid/90361/age/20/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/ovw-do-0_car-ao-1_car-do-0 [accessed 10/09/2022]
[2] Annual Fuel poverty statistics report 2018, The Department for Business, Energy and Industrial Strategy: assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/719106/FFuel_Poverty_Statistics_Report_2018.pdf

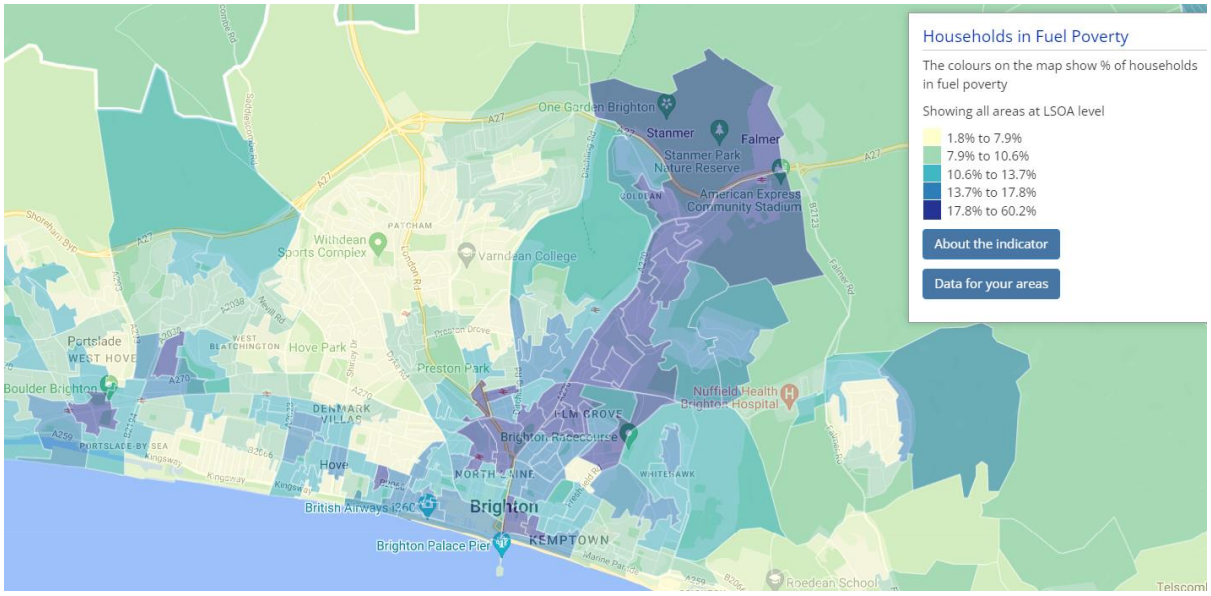
households in Brighton & Hove were in fuel poverty. This equates to 15,814 households in the city. This is fifth highest of all South East authorities, but 15th of the 16 CIPFA comparators of which 9 are midlands or northern authorities. [3]

2.9 Although the new definition of fuel poverty does not take account of energy costs directly, it can be assumed that the number of households in the city struggling to pay their energy bills has increased significantly over recent months due to the significant increases in energy tariffs and the general costs of living.

2.10 Living in a cold home as a result of fuel poverty has a disproportionate impact on the health of certain groups. Exposure to cold temperatures increases blood pressure and risk of blood clotting, heart failure/attack and stroke. It also suppresses the immune system, diminishes the lungs' capacity to fight off infection and increases constriction of the airways, increasing the risk of bronchitis and pneumonia. When a house is damp as well as cold, mould is likely to occur. This increases the risk of respiratory illness, particularly asthma.

2.11 There is an additional concern that people will be burning more fuel in fireplaces, wood burners etc in order to keep warm, impacting on internal and external air quality and respiratory conditions.

2.12 The map below shows the distribution across the city using the Low Income Low Energy Efficiency (LILEE) fuel poverty metric.[4] This map shows the concentrations of those living in fuel poverty but this may not be those who are at highest risk the ill health effects of cold homes.



[3] https://fingertips.phe.org.uk/search/fuel%20poverty#page/3/gid/1/pat/6/par/E12000008/ati/401/are/E06000043/iid/93759/age/-1/sex/-1/cat/-1/ctp/-1/yrr/1/nn/nn-12-E06000043/cid/4/tbm/1/page-options/car-do-0 [accessed 10/10/2022]

[4] https://brighton-hove.communityinsight.org/?indicator=fuel_pov_alt_11_dr_20200101# [accessed 10/10/2022]

2.13 The objectives of this plan are to:

- To define the partners engaged with the implementation of this Plan
- To ensure the requirements of the National Plan are complied with locally, by clearly stating the work-streams agreed to be relevant and those partners engaged in their delivery.
- To set out the coordination and oversight / assurance arrangements in support of the Plan.
- To understand and mitigate, as far as possible, the impact of cold weather on the community and those most vulnerable to cold weather.
- To understand this plan within the context of climate change understand the mitigations needed to continue to work towards the commitment as a city to become carbon neutral by 2030
- To safely deliver this Plan in the context of COVID19 guidance.[5]

2.14 The BHCC CWP sits alongside the NHS trusts Winter Plans that are about increases in service demands during the cold weather. It also recognises the key role of the VCS and wider partners in winter resilience. It also sits alongside the Vulnerable People's Pplan, which is about identifying vulnerable people during a major incident or crisis. This could be relevant this winter if there are power outages leaving residents reliant on medical equipment at risk.

2.15 The Plan is linked to a system of cold weather alerts – generated by the Cold weather health watch system developed by the Meteorological Office including the 'National Severe Weather Warning Service' (NSWWS). This comprises five levels of response based on cold weather thresholds. The thresholds have been developed to trigger an alert when severe cold weather is likely to significantly affect people's health and they also take account of temperature along with other winter weather threats such as ice and snow.

2.16 The national plan sets out best practice actions for each sector, services and the public at each of the five (0-4) levels based on the levels in the diagramme here. These are incorporated into the BHCC plan. Additional service specific plans are further identified as at 2.20.

[5] Living safely with respiratory infections, including COVID-19 - GOV.UK (www.gov.uk)

Level 0	**Year round planning to reduce harm from cold weather**	This emphasises that year-round planning is required to build resilience and reduce the impact of cold weather. This level of alert relates to those longer-term actions that reduce the harm to health of cold weather (e.g. housing and energy efficiency measures, and long-term sustainable approaches to influence behaviour change across health and social care professionals, communities and individuals.)
Level 1	**Winter preparedness and action**	Level 1 is in force throughout the winter from 1 November to 31 March and covers the moderate temperatures where the greatest total burden of excess winter death and disease occur. This is because the negative health effects of cold weather start to occur at relatively moderate mean temperatures (4-8°C depending on region) and there are normally many more days at these temperatures each winter.
Level 2	**Alert and readiness**	Level 2 is triggered when the Met Office forecasts a 60% chance of severe winter weather, in one or more defined geographical areas within 48 hours. Severe winter weather is defined as a mean temperature of 2°C or less and/or heavy snow and widespread ice
Level 3	**Severe weather action**	This is triggered as soon as the weather described in Level 2 actually happens. It indicates that severe winter weather is now happening, with snow and ice, and an impact on health services is expected A NSWWS warning is highly likely to have been issued as well
Level 4	**National emergency**	This is reached when cold weather is so severe and/or prolonged that its effects extend outside health and social care, and may include for example power or transport problems, or water shortages, and/or where the integrity of health and social care systems is threatened. At this level, multi-sector response at national and regional levels will be required.

2.17 The Cold Weather Watch system operates in England from 1st November to 31th March every year, in association with UK Health Security Agency (UKHSA) and Office for Health Improvement and Disparities (OHID). However, should thresholds for an alert be reached outside of this period, an extraordinary heat-health alert will be issued, and stakeholders are advised to take the usual public health actions. The alerts take account of temperature along with other winter weather threats such as widespread ice [6] and heavy snow [7].

2.18 Alerts are cascaded to Council services and all wider stakeholders and local service providers. The CWP summarises the actions to be taken by different Directorates, services and partner organisations. Each council Directorate has its own assurance processes for compliance regarding actions required. Governance oversight for the Cold Weather plan is provided by the Brighton and Hove Health Protection & Screening Forum.

2.19 Of specific relevance this winter are those actions relating to those our most vulnerable residents such as rough sleepers, those living in care settings, those in fuel poverty in cold homes.

[6] **Widespread ice** – Ice forms when rain falls on surfaces at or below zero; or already wet surfaces fall to or below zero. The ice is usually clear and difficult to distinguish from a wet surface. The term "widespread" indicates that icy surfaces will be found extensively over the area defined by the Met Office in the alert

[7] **Heavy snow** – Snow that is expected to fall for at least two hours. Geographic extent is not considered, and sometimes the event can be quite localised

2.20 The following list outlines examples of the actions required for BHCC Directorates and programmes to mitigate risks. Some of which are triggered by changes in the alert levels (as indicated), others are ongoing good practice, preparedness and response to the context of this winter.

- Level 0- All BHCC services to include winter and cold weather actions as an ongoing part of their business continuity plans.
- Level 0 - Cascading cold weather alert levels. Also cascading alerts for storms, strong winds and flooding, more likely during Winter and even more likely due to the impacts of climate change.
- Level 1 - All services to identify their service users vulnerable to cold weather, planning for, and setting in place and monitoring necessary actions.
- An increased range of initiatives to address fuel poverty through the co-ordination of the response of the (multi-agency) Fuel Poverty & Affordable Warmth Steering Group. This includes;
    - practical advice on available energy support (Help with fuel bills (brighton-hove.gov.uk) and provides a link to the Local Energy Advice Partnership.
    - An increase Warmth for Wellbeing' programme, providing money advice and small grants, and (with BHESCo) home energy checks and advice. This focusses on reaching marginalised and isolated communities, to identify and engage with those who are at elevated health risk due to living in fuel poverty and/or a cold home.
    - The council is exploring, with the local CVS sector, the practicalities of using their buildings and public spaces to provide warm spaces for people, both to help them avoid impacts on their health, and therefore avoid greater demand on health and social care services, but also to contribute to helping them to manage energy use and costs.
- The Council continues to develop the 'Brighton & Hove Warmer Homes' programme, due to be launched in Spring 2023 with additional funding to support energy efficiency improvements for eligible owner occupiers and households in the private rented sector. This is in addition to ongoing energy efficiency improvements of its council housing stock. Plus further funding via the Disabled Facilities Grant funded Warm Safe Homes Grant. to improve energy efficiency.
- The Seafront Office will issue a warning email to seafront businesses if the Met Office weather warnings identify a specific risk of overtopping or coastal flooding in Brighton & Hove.
- Active promotion of the annual flu vaccination programme and the Covid-19 Autumn vaccination boosters.
- BHCC Highways Winter Service Plan[8]:This plan sets out gritting and monitoring arrangements relating to public roads and pavements.
- BHCC maintains an information page on the council website which provides advice and updates on winter weather: http://www.brighton-

[8] https://www.brighton-hove.gov.uk/sites/default/files/migrated/article/inline/highways-winter-service-plan-2019-2020.pdf

hove.gov.uk/content/parking-and-travel/roads-and-highways/winter-weather

- Ongoing falls prevention work including Standing Tall strength & balance classes, Staying Active to prevent falls training and health promotion falls risk awareness raising.
- Ageing Well programme to reduce loneliness, social isolation, increase wellbeing and independence and prevent ill health.
- Children's Centres and Council Nurseries distribute weather related posters and leaflets, promote flu vaccine and signpost families for advice on fuel poverty.
- Family Information Service cascade information via social media (Twitter and Facebook)
- Initiatives with the VCS include support to neighbourhoods and Brighton & Hove Energy Services Co-operative working with the vulnerable in hard to heat homes.
- Proactive winter readiness information is sent out from public health through services across the city during September and October and in times of adverse weather cascade information and support to community and voluntary sector and other partners.
- Communications and campaign jointly with the NHS for the public and partners such as 'stay well this winter' to alert and inform city residents.
- Infection prevention and control support for care and homeless settings. This includes learning, development, communications and support.
- Response to health protection incidents as required in collaboration with UK Health Security Agency
- Development of a winter indoor activities and places directory, as part of a programme currently titled 'weathering winter in the city' Set up in response to cost of living and fuel poverty crisis.

- At Level 2 – preparations are started, and at Level 3 the Severe Weather Emergency Protocol' (SWEP) activates when the temperature feels like 0 degrees for 1 night, The SWEP service offers overnight shelter to rough sleepers. SWEP is manged by BHCC housing directorate. Housing have identified a provider with self-contained units to reduce transmission and risk relating to Covid19 and Flu.
- Level 3 - Emergency Planning lead and manage the BHCC Transport Hub. The Transport Hub is an agreed arrangement between partners to support BHCC in running a hub facility in periods of severe weather (Level 3) to transport patients to services or services to patients at home. This includes 4x4 vehicles and drivers in bad weather i.e. snow

2.21 There continues to be additional focus and support for the care sector with the UKHSA Winter-readiness (infection prevention) information for care homes in South East England Winter 2022/23[9]. This sets out actions relating to the increased pressure the winter may bring with the combinations of cold weather,

[9] https://www.england.nhs.uk/south-east/our-work/info-professionals/public-health/winter/care-guidance/

COVID-19 and Flu and provides information for care homes on preparing for the winter season, to help try to avoid cases and outbreaks of infectious disease. Adult Social Care and public health are supporting care settings in terms of communications, infection prevention and control and assurance relating to business continuity plans.

3. Important considerations and implications

Legal:

3.1 As described in the body of this report the BHCC Cold Weather Plan is a localised version of the Cold Weather Plan for England which is a good practice guide. This report is for noting by the Board only.

Lawyer consulted: Sandra O'Brien Date: 12/10/22

Finance:

3.2 Any additional costs resulting from the Brighton and Hove Winter Plan will need to be met from within identified resources across NHS Sussex and the Council.
Winter pressures causes significant financial strain across Health & Social Care. Current budget forecasting accounts for anticipated increased demand over this period. However, budget forecasts may be subject to variation later in the year due to the unpredictable nature of the impact on services during the winter.

Finance Officer consulted: Sophie Warburton Date: 12/10/2022

3.3

Finance Officer consulted: Date:

Equalities:

3.4 We have considered equalities in the Winter Cold Weather Plan. This includes a focus on how cold weather impacts on older people, vulnerable people, and those living in fuel poverty. This forms part of a wider assessment on 'seasonal weather impacts' to consider the different needs and provide the relevant support to the most vulnerable communities in the city.

3.5 Sustainability:
Climate change will potentially make the winter weather more variable with milder and colder spells, increases in storms, winds and floods.

3.6 Health, social care, children's services and public health:

Setting out the responsibilities and actions to support those most at vulnerable to the negative health impacts of the winter cold weather is the main focus of this Committee report and the Plan.

Supporting documents and information

Appendix1: BHCC Winter Cold Weather Plan 2022/23

Appendix 2: NHS Sussex Winter plan for Brighton & Hove (to follow for main committee meeting)

Brighton & Hove Cold Weather Plan 2022

Protecting Health and Reducing Harm During Winter

(To be read in conjunction with the Cold Weather Plan for England & supporting guidance)

This Cold Weather Plan is the overarching plan for the Brighton and Hove City Council and complements the Winter Plans produced by healthcare and partner agencies. This Plan helps prevent the major avoidable effects on health during periods of cold weather in England. The Cold Weather plan is compiled by public health with input from all BHCC Directorates. It describes the key issues for the city, cold weather alert system, related work-streams and governance arrangements.
It is over seen by the Brighton and Hove Health Protection & Screening Forum, that reports into the Integrated Care Partnership and the Health and Wellbeing Board via the Director of Public Health.

This Plan is based on the most recent Cold Weather Plan for England dated January 2022

Document Control

Version	V2.0 draft
Drafted by:	Becky Woodiwiss Public Health Principal and Barbara Hardcastle Public Health Specialist Public Health, Health & Adult Social Care Directorate, Brighton and Hove City Council and Brighton & Hove Clinical Commissioning Group
Reviewed by: **Approved by:**	Health and Adult Social Care Directorate Management Team October 2021 B&H Health Protection & Screening Forum, September 2021
Date Issued:	October 2022
Review Date:	September 2023
Target Audience:	Brighton & Hove City Council Health & Adult Social Care, other Directorates, partner agencies and Local Health Economy. Including The Health Protection & Screening Forum, NHS secondary and community providers, NHS Sussex Brighton and Hove, Primary care, Out of Hours (OOHs) Provider, & Brighton & Hove City Council, Community and Voluntary sector
Mandatory / Statutory guidance Requirements **Winter guidance and advice**	Civil Contingencies Act 2004 http://www.legislation.gov.uk/ukpga/2004/36/contents NHS EPRR Framework & associated guidance http://www.england.nhs.uk/ourwork/gov/eprr/ Public Health England Cold Weather Plan for England http://www.gov.uk/phe/cold-weather-plan BHCC Covid19 Local Outbreak Plan https://new.brighton-hove.gov.uk/local-covid-19-outbreak-plan NHS Community Health guidance https://www.england.nhs.uk/coronavirus/ Annual seasonal influenza (flu) vaccination programme https://www.gov.uk/government/publications/national-flu-immunisation-programme-plan Keep Warm Keep Well - NHS Choices (www.nhs.uk) https://www.gov.uk/government/publications/keep-warm-keep-well-leaflet-gives-advice-on-staying-healthy-in-cold-weather Met Office Weather Ready pages 'Are you ready for winter ? https://www.metoffice.gov.uk/weather/warnings-and-advice/weatherready Excess winter deaths and morbidity and the health risks associated with cold homes https://www.nice.org.uk/guidance/ng6 Preventing excess winter deaths and illness associated with cold homes Quality standard [QS117] Published date: March 2016 https://www.nice.org.uk/guidance/qs117/chapter/Quality-statement-5-Identifying-people-vulnerable-to-health-problems-associated-with-cold-homes-on-admission Cutting the cost of keeping warm https://www.gov.uk/government/publications/cutting-the-cost-of-keeping-warm

Version Control

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1. Introduction

1.1 Planning for winter 2022/2023

Planning for the Winter of 2022/23 is in the context of the economic downturn, cost of living increases, political changes, climate change and the continuing demands of COVID-19, its health and socio-economic impacts, and seasonal Influenza .

1.2 Impact of cold weather

In recent previous years there have been significant periods of severe and sustained cold weather. This has highlighted the need to have effective plans in place to mitigate the effects of cold weather on health.

The Department of Health and Social Care research [1] found that negative health effects start at relatively moderate outdoor temperatures of around 4-8°C. Although the risk of death increases as temperatures fall, the higher frequency of days at moderate temperatures means that the greatest health burden in absolute numbers of deaths, occurs at these moderate temperatures. This means that action to prevent excess winter morbidity and mortality should not be restricted to the very cold days, but should be carried out throughout the year tailoring solutions to protect the most vulnerable.

On average, there are around 25,000 excess winter deaths each year in England. Excess winter deaths (EWDs) are the observed total number of deaths in winter (December to March) compared to the average of the number of deaths over the rest of the year. Excess deaths are not just deaths of those who would have died anyway in the next few weeks or months due to illness or old age. There is strong evidence that many of these winter deaths are indeed 'extra' and are related to cold temperatures, especially for those living in cold homes. Most EWDs are due to respiratory and circulatory deaths, such as stroke and coronary heart disease, as well as infectious diseases such as influenza. Other health conditions associated with, or exacerbated by, the cold and cold housing include mental ill-health, arthritis and rheumatism.
Indirect health impacts of cold housing and fuel poverty include a negative effect on: children's educational attainment, emotional wellbeing and resilience; adult and children's dietary choices; and the risk of accidents and injuries in the home. This is predominantly in the older age groups, those with chronic illnesses and very young children.
Heavy snow and ice has a small direct effect on health, predominantly as a result of falls and injuries. Additionally, it causes disruption to the delivery of health, social care and other services.

Although there are several factors contributing to winter illness and death, in many cases simple preventative action could avoid many of the deaths, illnesses

[1] DHSC commissioned an independent evaluation of the CWP from the Policy Innovation Research Unit (PIRU) in 2012

and injuries associated with the cold. Many of these measures need to be planned by services and undertaken in advance in preparation for cold weather.

People live in cold homes often due to fuel poverty[2]. The Government released a new national Fuel Poverty strategy[3] in February 2021, which included a new definition for Fuel Poverty measurement. The Low Income Low Energy Efficiency (LILEE) measure finds a household to be fuel poor if it:

- Has a residual income below the poverty line (after accounting for required fuel costs); and,
- Lives in a home that has an energy efficiency rating below Band C.

The latest available figures released in May 2022 using this new definition, estimate that in 2020 (there is a standard two-year lag in the data), 12% of households in Brighton & Hove were in fuel poverty. This equates to 15,814 households in the city. Although the new definition of fuel poverty does not take account of energy costs directly, it can be assumed that the number of households in the city struggling to pay their energy bills has increased significantly over recent months due to the significant increases in energy tariffs and the general costs of living.

Living in a cold home as a result of fuel poverty has a disproportionate impact on the health of certain groups. Exposure to cold temperatures increases blood pressure and risk of blood clotting, heart failure/attack and stroke. It also suppresses the immune system, diminishes the lungs' capacity to fight off infection and increases constriction of the airways, increasing the risk of bronchitis and pneumonia. When a house is damp as well as cold, mould is likely to occur. This increases the risk of respiratory illness, particularly asthma.

Therefore, people living in cold homes during the winter months are at increased risk of negative health outcomes, including winter deaths. Local and national excess winter mortality is highly variable year on year, so five year rolling averages are used, and show no clear trend. For winters 2014/15 to 2018/19 the EWD Index in Brighton & Hove was 21.4% equating to 144 extra deaths each year. This is the same as England (21.4%) and similar to the South East (21.3%).[4] For just one year 2019/20, the EWD for 85+ at 19% is more similar to England (20.8%) and SE (20.7%) [5].

1.3 The cold and seasonal respiratory infections

Those at high risk of Flu and COVID19 infection, morbidity or mortality are similar population groups as those at greater risk from the ill health effects of cold weather (Fig 4). These are the over 70s, those with chronic health conditions especially

[2] The Department for Business, Energy and Industrial Strategy. Annual Fuel poverty statistics report 2022. Annual fuel poverty statistics report: 2022 - GOV.UK (www.gov.uk)
[3] Department for Business, Energy & Industrial Strategy. Sustainable Warmth: Protecting vulnerable households in England; 2021. Sustainable warmth: protecting vulnerable households in England - GOV.UK (www.gov.uk)
[4] Excess winter mortality in England and Wales - Office for National Statistics (ons.gov.uk)

[5] OHID Public Health Outcomes Framework Excess winter deaths [accessed 09/09/2022

respiratory and CVD, those clinically extremely vulnerable, pregnancy and people living in areas of higher deprivation and experiencing ongoing health and/ or socio-economic inequalities Unlike for Covid19, very young children are also at higher risk of greater ill health from Flu and childhood respiratory infections.

A combination of factors are likely to exacerbate the situation further over the colder months, the continued vulnerability of the population, and poorer weather, may mean that people spend more time in their homes, where transmission may be more likely. The impacts of the cost of living increases and socioeconomic downturn will cause greater fuel poverty and much colder homes. This may also mean people burn fossil fuels to help manage fuel bills and the associated increase in indoor and external air pollution, with greater impact for those with poorer respiratory health. If many services continue to have staff working from home, fewer people will be visiting people in their homes, so there will be less opportunities to notice a home is cold, damp or hard to heat.[6]

1.4 The Cold Weather Plan for England [7]

The Cold Weather Plan for England (CWP), published annually since 2011 aims to prevent avoidable harm to health, by alerting people to the negative health effects of cold weather and enabling services and the public to prepare and respond appropriately. It also also aims to reduce pressure on the health and social care system during winter through improved anticipatory actions with vulnerable people.

The Cold Weather Plan for England is at https://www.gov.uk/government/collections/cold-weather-plan-for-england this page contains links to the national plan, health risks of cold homes, a supporting 'making the case' document, and an easy-read summary document, action cards for all groups involved, 'Keep Warm Keep Well' leaflet and supporting guidance.

The National CWP acknowledges the roles of Local Authorities, Directors of Public Health, NHS England Regional Office, Integrated Care Partnerships , Health and Wellbeing Boards (HWB's), NHS Trusts, GP's, Emergency Planning Officers, and others.

1.5 Key messages for action

This Brighton and Hove Cold Weather Plan is a local good practice guide and the actions denoted within it are illustrative. There are five key messages recommended to all local area:

1. All local organisations should consider this document and the national Cold Weather Plan (CWP) for England and satisfy themselves that the suggested actions and Cold Weather Alerts are understood across the system, and that local plans are adapted as appropriate to the local context.

[6] https://www.nice.org.uk/guidance/NG6/chapter/1-recommendations [accessed Sept 2021]
[7] The CWP 2022 is not published at the time of writing

2. City Council and NHS commissioners should satisfy themselves that the distribution of Cold Weather Alerts and the National Severe Weather Warning Service (NSWWS) which provides information on type of weather, likelihood and potential impact levels, will reach those that need to take action.
3. City Council and NHS commissioners should satisfy themselves that providers and stakeholders will take appropriate action according to the Cold Weather Alert level in place, their professional judgements and remain COVID-19 safe.
4. Opportunities should be taken for closer partnership working with the voluntary and community sector to help reduce vulnerability and to support the planning and response to cold weather.
5. Long-term planning and commissioning to reduce cold-related harm both within and outside the home is considered core business by health and wellbeing boards and should be included in joint strategic needs assessments[8] and B&H Joint Health and Wellbeing Strategy 2019-2030.[9]

2. The Brighton and Hove Cold Weather plan aims & objectives

2.1 Aim - The aim of this plan is to set out the procedures and work-streams to be implemented within Brighton and Hove City Council, the local health economy (LHE) and with key city partners in support of the National Cold Weather Plan for England.

2.2 The objectives of this plan are to:

- To define the partners engaged with the implementation of this Plan
- To ensure the requirements of the National Plan are complied with locally, by clearly stating the work-streams agreed to be relevant and those partners engaged in their delivery.
- To set out the coordination and oversight / assurance arrangements in support of the Plan.
- To understand and mitigate, as far as possible, the impact of cold weather on the community and those most vulnerable to cold weather.
    - To understand this plan within the context of climate change understand the mitigations needed to continue to work towards the commitment as a city to become carbon neutral by 2030
-
- To safely deliver this Plan in the context of COVID19 guidance.

3. Cold Weather alerts

The Plan is linked to a system of cold weather alerts – generated by the Cold weather health watch system developed by the Meteorological Office including the 'National Severe Weather Warning Service' (NSWWS). This comprises five levels of response based on cold weather thresholds. The thresholds have been developed to trigger an

[8] http://www.bhconnected.org.uk/sites/bhconnected/files/6.4.2%20Fuel%20poverty%20FINAL.pdf
[9] https://www.brighton-hove.gov.uk/sites/default/files/health/brighton-hove-health-wellbeing-strategy-2019-2030-26-july-19.pdf

alert when severe cold weather is likely to significantly affect people's health and they also take account of temperature along with other winter weather threats such as ice and snow.

The Cold Weather Watch system operates in England from 1st November to 31th March every year, in association with UK Health Security Agency (UKHSA) and Office for Health Improvement and Disparities (OHID). However, should thresholds for an alert be reached outside of this period, an extraordinary heat-health alert will be issued and stakeholders are advised to take the usual public health actions. The alerts take account of temperature along with other winter weather threats such as widespread ice[10] and heavy snow[11].

[10] **Widespread ice** – Ice forms when rain falls on surfaces at or below zero; or already wet surfaces fall to or below zero. The ice is usually clear and difficult to distinguish from a wet surface. The term "widespread" indicates that icy surfaces will be found extensively over the area defined by the Met Office in the alert

[11] **Heavy snow** – Snow that is expected to fall for at least two hours. Geographic extent is not considered, and sometimes the event can be quite localised

3.1 Alert Levels

The levels are set out in the table below:

Level 0	**Year round planning to reduce harm from cold weather**	This emphasises that year-round planning is required to build resilience and reduce the impact of cold weather. This level of alert relates to those longer-term actions that reduce the harm to health of cold weather (e.g. housing and energy efficiency measures, and long-term sustainable approaches to influence behaviour change across health and social care professionals, communities and individuals.)
Level 1	**Winter preparedness and action**	Level 1 is in force throughout the winter from 1 November to 31 March and covers the moderate temperatures where the greatest total burden of excess winter death and disease occur. This is because the negative health effects of cold weather start to occur at relatively moderate mean temperatures (4-8°C depending on region) and there are normally many more days at these temperatures each winter.
Level 2	**Alert and readiness**	Level 2 is triggered when the Met Office forecasts a 60% chance of severe winter weather, in one or more defined geographical areas within 48 hours. Severe winter weather is defined as a mean temperature of 2°C or less and/or heavy snow and widespread ice
Level 3	**Severe weather action**	This is triggered as soon as the weather described in Level 2 actually happens. It indicates that severe winter weather is now happening, with snow and ice, and an impact on health services is expected A NSWWS warning is highly likely to have been issued as well
Level 4	**National emergency**	This is reached when cold weather is so severe and/or prolonged that its effects extend outside health and social care, and may include for example power or transport problems, or water shortages, and/or where the integrity of health and social care systems is threatened. At this level, multi-sector response at national and regional levels will be required.

Figure 1 Cold Weather Plan Alert Levels

The decision to go to a Level 4 is made at national level and will be taken in light of a cross-government assessment of the weather conditions, co-ordinated by the Civil Contingencies Secretariat (Cabinet Office)

3.2 Level 0 – year round planning

- Strong local leadership and partnership working at all levels across sectors and is vital to tackle the range of causes and reduce the health harms and number of "excess" deaths that are observed each winter.
- Long term strategic planning and commissioning to reduce cold-related harm. This is considered core business by Health and Wellbeing Boards (HWBs) and joint strategic needs assessments (JSNAs). Responses to cold weather are to be considered as part of business continuity plans.
- To alert all City stakeholders to the availability of the action cards and see Appendix 1[12] for:
  - ✓ Commissioners in the Local Authority and the NHS Sussex Brighton & Hove
  - ✓ Frontline Health & Social Care staff in community & care facilities
  - ✓ GP's & Practice Staff and Community Pharmacies
  - ✓ Community & Voluntary Sector organisations
  - ✓ Provider Organisations
  - ✓ Other relevant organisations in the city
  - ✓ Individuals.

- To ensure there is a link to the City's Vulnerable People Plan and other Emergency Planning Resilience and Response plans.
- The Public Health Outcomes Framework includes indicators to reduce excess winter deaths[13] and address fuel poverty[14]
- Working with partners to ensure that a strategic approach to the reduction of EWDs and fuel poverty . In particular:
  - ✓ To develop a shared understanding of EWD's and what partners can do to reduce them.
  - ✓ To identify those most at risk from seasonal variations.
  - ✓ To improve winter resilience of those at risk via a locally annually agreed programme.
  - ✓ To ensure a local, joined-up programme is in place to support improved housing, heating and insulation, including uptake of energy-efficient, low-carbon solutions.
  - ✓ To achieve a reduction in carbon emissions and assess the implications of climate change.

[12] Action Cards are available here https://www.gov.uk/government/publications/cold-weather-plan-action-cards-for-cold-weather-alert-service

[13] https://fingertips.phe.org.uk/search/excess%20deaths#page/0/gid/1/pat/6/par/E12000008/ati/102/are/E06000036/iid/90360/age/1/sex/4/cat/-1/ctp/-1/cid/4/tbm/1/page-options/ovw-do-0

[14] https://fingertips.phe.org.uk/search/fuel%20poverty#page/0/gid/1/pat/6/par/E12000008/ati/302/are/E06000043/cid/4/tbm/1/page-options/ovw-do-0

- ✓ Work with Communities Equalities and Third sector Team at BHCC to widen reach to vulnerable communities and population groups in the city

- To consider how cold weather and winter plans can help to reduce health inequalities, target high-risk groups and address the wider determinants of health.
- To ensure that organisations and staff are prompted to signpost vulnerable clients onwards (e.g. for energy efficiency measures, benefits or related advice).
- To work with partners and staff on risk reduction awareness, information and education including vaccinations.
- To engage with local Community and Voluntary Sector (CVS) organisations for planning and implementation of all stages of the Plan.
- Agreement that B&H communications and media messages will be jointly coordinated by BHCC and NHS Sussex communications teams.
- Annual Flu and Covid19 booster campaign to support the vaccination uptake across all eligible groups and to the wider population

4. Actions for the alert levels

The table on the next page sets out the expected minimum actions for each of the alert levels for a range of stakeholders and the public:

Summary cold weather actions for health and social care organisations and professionals, communities and individuals

	Level 0	Level 1	Level 2	Level 3	Level 4
	Year-round planning All Year	**Winter preparedness and action** 1 November to 31 March	**Severe winter weather forecast – Alert and readiness** Mean temperatures of 2°C and/or widespread ice and heavy snow predicted with 60% confidence	**Severe weather action** Mean temperatures of 2°C and/or widespread ice and heavy snow	**Major incident – Emergency response**
Commissioners of health and social care	1) Take strategic approach to reduction of EWDs and fuel poverty. 2) Ensure winter plans reduce health inequalities. 3) Work with partners and staff on risk reduction awareness (eg Flu and Covid19 vaccinations, signposting for winter warmth initiatives).	1) Communicate alerts, messages and other relevant information and materials to staff/public/media. 2) Ensure partners are aware of alert system and actions. 3) Identify which organisations are most vulnerable to cold weather and agree winter surge plans.	1) Continue level 1 actions. 2) Ensure partners can access advice and make best use of available capacity. 3) Activate business continuity arrangements as required.	1) Continue level 2 actions. 2) Ensure key partners are taking appropriate action. 3) Work with partners to ensure access to critical services.	Level 4 alert issued at national level in light of cross-government assessment of the weather conditions, coordinated by the Civil Contingencies Secretariat (CCS) based in the Cabinet Office. All level 3 responsibilities to be maintained unless advised to the contrary.
Provider organisations	1) Ensure organisation can identify and support most vulnerable. 2) Plan for joined up support with partner organisations. 3) Work with partners and staff on risk reduction awareness (eg Flu and Covid19 vaccinations, signposting for winter warmth initiatives).	1) Ensure cold weather alerts are going to right staff and actions agreed and implemented. 2) Ensure staff in all settings are considering room temperature. 3) Ensure data sharing and referral arrangements in place. 4) Communicate alerts, messages and other relevant information and materials to staff and services	1) Continue level 1 actions. 2) Ensure carers receiving support and advice. 3) Activate business continuity arrangements as required; plan for surge in demand.	1) Continue level 2. 2) Implement emergency and business continuity plans; expect surge in demand in near future. 3) Implement local plans to ensure vulnerable	

Summary cold weather actions for health and social care organisations and professionals, communities and individuals

		users		people contacted.	
Frontline staff –care facilities and community	1) Use patient contact to identify vulnerable people and advise of cold weather actions; be aware of referral mechanisms for winter warmth and data sharing procedures. 2) Ensure awareness of health effects of cold and how to spot symptoms. 3) Encourage colleagues/clients to have Flu and Covid19 vaccinations.	1) Identify vulnerable clients on caseload; ensure care plans incorporate cold risk reduction. 2) Check room temperatures and ensure referral as appropriate. 3) Signpost clients to other services using 'Keep Warm Keep Well' booklet and other relevant information and materials . 4) Communicate alerts, messages and other relevant information and materials to staff and services users	1) Continue level 1 actions. 2) Consider prioritising those most vulnerable and provide advice as appropriate. 3) Check room temperatures and ensure urgent referral as appropriate.	1) Continue level 2 actions. 2) Implement emergency and business continuity plans; expect surge in demand in near future. 3) Prioritise those most vulnerable.	
GPs and their staff	1) Be aware of emergency planning measures relevant to general practice. 2) Ensure staff aware of local services to improve warmth in the home including the identification of vulnerable individuals. 3) Signpost appropriate patients to other services when they present for other reasons.	1) Consider using a cold weather scenario as a table top exercise to test business continuity arrangements. 2) Be aware of systems to refer patients to appropriate services from other agencies. 3) When making home visits, be aware of the room temperature. 4) Share comms and campaign materials to staff and patients	1) Continue level 1 actions. 2) Take advantage of clinical contacts to reinforce public health messages about cold weather and cold homes on health. 3) When prioritising visits, consider vulnerability to cold as a factor in decision making.	1) Continue level 2 actions. 2) Expect surge in demand near future. 3) Ensure staff aware of cold weather risks and can advise appropriately.	

Summary cold weather actions for health and social care organisations and professionals, communities and individuals

	Level 0	Level 1	Level 2	Level 3	Level 4
Community and voluntary sector	1) Engage with local statutory partners to agree how VCS can contribute to local community resilience arrangements. 2) Ensure VCS organisations can identify and support their most vulnerable groups members and service users 3) Develop a community emergency plan to identify and support vulnerable neighbours. 4) Agree arrangements with other community groups to maximize service for and contact with vulnerable people. 5) Share general winter comms and campaign materials through community networks	1) Test community emergency plans to ensure that roles, responsibilities and actions are clear. 2) Set up rotas of volunteers to keep the community safe in cold weather and check on vulnerable people. 3) Actively engage with vulnerable people and support them to seek help. 4) Communicate alerts, messages and other relevant information and materials to VCS organisations and service users and to be shared onwards through community networks	1) Activate the community emergency plan. 2) Activate the business continuity plan. 3) Continue to actively engage vulnerable people known to be at risk and check on welfare regularly.	1) Continue level 2 actions. 2) Ensure volunteers are appropriately supported. 3) Contact vulnerable people to ensure they are safe and well and support them to seek help if necessary.	Level 4 alert issued at national level in light of cross-government assessment of the weather conditions, co-ordinated by the Civil Contingencies Secretariat (CCS) based in the Cabinet Office. All level 3 responsibilities to be maintained unless advised to the contrary.
National level	1) CO will lead on co-ordinating cross-government work; individual government departments will work with partners on winter preparations. 2) DHSC, UKHSA[15] and NHS England will look to improve the CWP and the monitoring and analysis of winter-related illness and deaths. 3) UKHSA/OHID[16] and NHS England will issue general advice to the public and professionals and work closely with other government departments and other national organisations that produce winter warmth advice.	1) Cold Weather Alerts will be sent by the Met Office to the agreed list of organisations and Category 1 responders. 2) UKHSA and NHS England will make advice available to the public and professionals. 3) NHS England will continue to hold health services to account for action and UKHSA will routinely monitor levels of respiratory viruses throughout the winter period, and mortality surveillance.	1) Continue level 1 actions. 2) DHSC will ensure that other government departments, particularly DLUHC are aware of the change in alert level and brief ministers as appropriate. 3) Government departments should cascade the information through their own partner networks and frontline communication systems.	1) Continue level 2 actions. 2) NHS England will muster mutual aid when requested by local services. 3) Met Office will continue to monitor and forecast temperatures in each area, including the probability of other regions exceeding the level 3 threshold.	

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Summary cold weather actions for health and social care organisations and professionals, communities and individuals

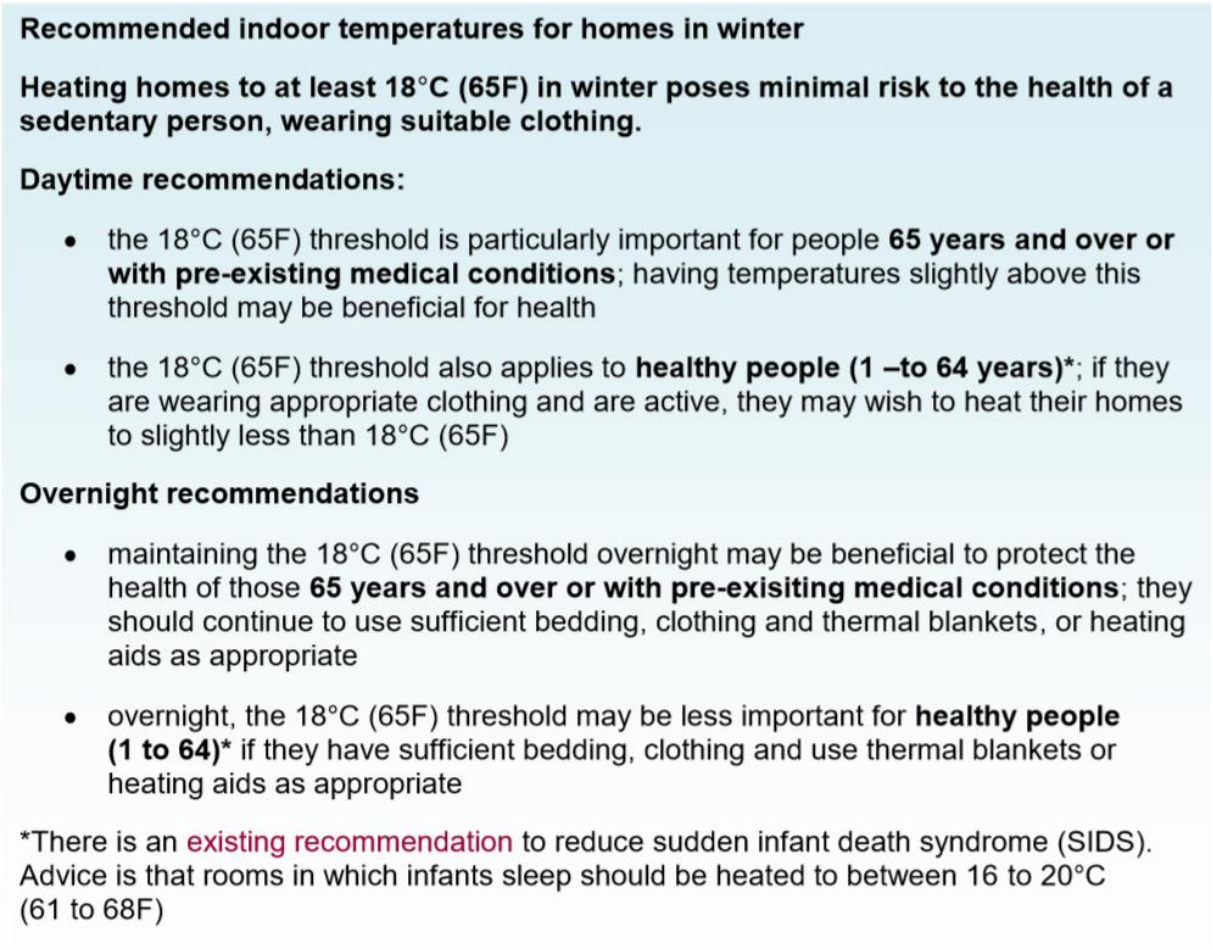
Individuals	1) Seek good advice about improving the energy efficiency of your home and staying warm in winter; have all gas, solid fuel and oil burning appliances serviced by an appropriately registered engineer. 2) Check your entitlements and benefits; seek income maximisation advice and other services. 3) Get Flu and Covid19 vaccinations.	1) If you are receiving social care or health services ask your GP, key worker or other contact about staying healthy in winter and services available to you. 2) Seek help from local community groups and networks to help you remain safe and well. 3) Check room temperatures – especially those rooms where disabled or vulnerable people spend most of their time 4) Look out for vulnerable neighbours and help them prepare for winter.	1) Continue to have regular contact with vulnerable people and neighbours you know to be at risk in cold weather. 2) Stay tuned into the weather forecast ensure you are stocked with food and medications in advance. 3) Take the weather into account when planning your activity over the following days.	1) Continue level 2 actions. 2) Dress warmly; take warm food drinks regularly; keep active. If you have to go out, take appropriate precautions. 3) Check on those you know are at risk.	Follow key public health and weather alert messages as broadcast on the media.

Figure 2 Summary cold weather actions for health and social care organisations and professionals, communities and individuals

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[15] Oct 2021 Replacement for Public Health England UKHSA = UK Health Security Agency
[16] Oct 2021 Replacement for Public Health England OHID = Office for Health Improvement and Disparities.

5. Indoor room temperatures



Recommended indoor temperatures for homes in winter

Heating homes to at least 18°C (65F) in winter poses minimal risk to the health of a sedentary person, wearing suitable clothing.

Daytime recommendations:

- the 18°C (65F) threshold is particularly important for people **65 years and over or with pre-existing medical conditions**; having temperatures slightly above this threshold may be beneficial for health
- the 18°C (65F) threshold also applies to **healthy people (1 –to 64 years)***; if they are wearing appropriate clothing and are active, they may wish to heat their homes to slightly less than 18°C (65F)

Overnight recommendations

- maintaining the 18°C (65F) threshold overnight may be beneficial to protect the health of those **65 years and over or with pre-exisiting medical conditions**; they should continue to use sufficient bedding, clothing and thermal blankets, or heating aids as appropriate
- overnight, the 18°C (65F) threshold may be less important for **healthy people (1 to 64)*** if they have sufficient bedding, clothing and use thermal blankets or heating aids as appropriate

*There is an existing recommendation to reduce sudden infant death syndrome (SIDS). Advice is that rooms in which infants sleep should be heated to between 16 to 20°C (61 to 68F)

Figure 3 Indoor room temperatures

6. Governance and Assurance

6.1 The health, social, economic and environmental risks associated with a spell of severe cold weather have been assessed by the Sussex Local Resilience Forum (SRF) (Ref H18) and included on the Sussex Community Risk Register. Information regarding the risk of severe weather can be found on the Sussex Local Resilience Forum website https://www.sussex.police.uk/SysSiteAssets/media/downloads/sussex/about-us/sussex-resilience-forum/srf-community-information-on-risks-in-sussex.pdf

6.2 It is the responsibility of the NHS England South (South-East) and for Sussex DsPH to engage with providers and multi-agency partners via the Local Health Resilience Partnership, (LHRP), a body linked to the SRF to assess risks and to ensure plans are in place to protect the communities of Sussex from health-related vulnerabilities.

6.3 Partners have been consulted to produce this updated Plan, all of whom are aware of their responsibilities and have their own organisational plans, and assurance processes and governance in place.

6.4 All council directorates have assurance processes in place and will address cold weather as part of their business continuity plans. Oversight of these arrangements will be provided by the Brighton and Hove Health Protection & Screening Forum, which reports to the Health & Wellbeing Board, in line with the National Cold Weather plan.

6.5 All partners must ensure that staff with an active part to play in the cold weather response need to be aware of the CWP and any training needed for its requirements and implementation.

7. Cascading Cold Weather Level Alerts

7.1 The Level will be publicly displayed on the Metrological office website at [Cold Weather Alerts - Met Office]

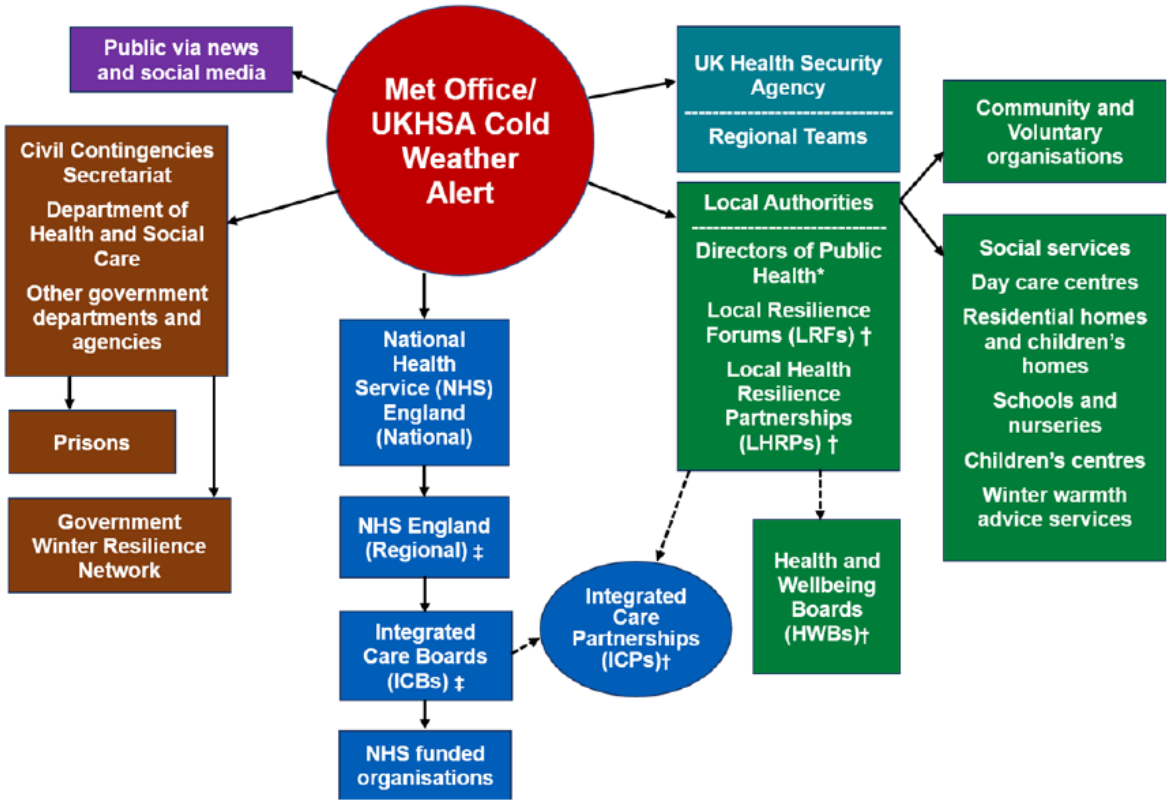


Figure 4 Met office cascade system

7.2 Local cascade arrangements within B&H

- The BHCC Emergency Planning & Resilience Team forward alerts to all internal BHCC department nominated leads;
  - Health & Adult Social Care – work with vulnerable adults
  - Families, Children & Learning – work with vulnerable children and families
  - Housing Neighbourhoods and Communities – work with vulnerable communities and neighbourhoods

    - Economy, Environment and Culture – work with local businesses and transport and the urban environment
    - Strategy, Governance and Law – for Communications team
- BHCC EPRR also send to;
    - External partners locally including the Community and Voluntary sector
    - 'Community Resilience' contacts that request the service.
- BHCC Adult Social Care (ASC) have provided assurance that they will inform ALL B&H care & residential homes and home care providers
- NHS Sussex Brighton and Hove (having delegated authority for Primary Care Commissioning), inform city GP Surgeries via a process agreed with the NHS Sussex Primary Care Team.
- The NHS Sussex Resilience lead disseminates alerts to staff (on-call managers, agreed primary care staff and Communications), and to IC24 (Out Of Hour's provider), and to Sussex Partnership Foundation Trust, (SPFT) and to the British Red Cross.
- All category 1 providers (including SCFT / University Hospital Sussex Trust / SECAmb etc) also receive alerts direct from the Met Office.

It is therefore confirmed that systems are in place to ensure that all who need to receive cold weather alerts are doing so within the city.

8. At-risk groups

Groups at greater risk of harm from cold weather (as defined by the national CWP) are detailed below.

- older people (in particular those over 75 years old, otherwise frail, and or socially isolated) NICE guidance refers to 65+.
- people with pre-existing chronic medical conditions such as heart disease, stroke or TIA, asthma, chronic obstructive pulmonary disease or diabetes
- people with mental ill-health that reduces individual's ability to self-care (including dementia)
- pregnant women (in view of potential impact of cold on foetus)
- children under the age of five
- people with learning disabilities
- people assessed as being at risk of, or having had, recurrent falls
- people who are housebound or otherwise low mobility
- people living in deprived circumstances
- people living in houses with mould
- people who are fuel poor
- homeless or people sleeping rough
- other marginalised or socially isolated individuals or groups

Figure 5 those at greater risk of harm from the cold

Brighton & Hove has an old housing stock with 66% of houses built before 1945 (compared with 43% across England) and many private sector properties labelled 'hard to treat' (for example those with solid walls) in relation to energy efficiency measures. This puts a number of people at risk of fuel poverty and therefore impact of living in a cold home.

All sectors should ask or check if people can heat their homes. People being discharged from hospital or in-patient care may be at increased risk of the cold if their home was left empty and / or unheated. All discharge, rehabilitation and reablement plans consider home circumstances and include questions about ability to heat the home. Further links and contact details should be made explicit for support with cold homes and fuel poverty given the impact on health and recuperation especially for older people and those with respiratory or CVD conditions.

9. Seasonal Vaccination Programmes

Flu is a respiratory illness and COVID-19 is primarily a respiratory illness. There are strong similarities between the two - those at higher risk of acquiring it, side effects and subsequent complications, and mortality.

9.1 Influenza vaccination programme 2022/23

This year the national Flu programme has extended uptake targets, expanded groups eligible for the vaccination and widened delivery routes..[17]

There is a joint Flu and Covid-19 NHS Sussex Programme Board with a range of workstreams focussing on key aspects such as; health & social care staff, primary care, outbreak arrangements, vaccine supply, data, communications, health promotion. Locally, the city's multi-sector Flu Planning meeting co-ordinates implementation across organisations in support of the Flu programme.

Due to the Covid prevention measures of mask wearing, social distancing and lockdowns, the amount of Flu circulating in 2021-2022 was very low. It is thought that as society has opened-up again there is a high likelihood that the 2022-23 Flu season could be up to 50% larger than typically seen and this has been the experience of the southern hemisphere. It could also coincide with Covid 19 outbreaks, placing additional pressure on the NHS. [18]

The uptake of the Flu vaccine has been consistently lower than the SE and England average for all eligible groups although big increases have been made with the over 65s (78.1%)[19]

[17] https://www.gov.uk/government/publications/national-flu-immunisation-programme-plan
[18] https://www.gov.uk/government/publications/national-flu-immunisation-programme-plan/national-flu-immunisation-programme-2022-to-2023-letter
[19] Public health profiles - OHID (phe.org.uk) Flu vaccination uptake 2021/22

This is supported by public facing marketing campaigns to encourage take up amongst eligible groups for the free Flu and Covid19 Booster vaccine, and a targeted campaign for front-line health and social care workers 'boost you immunity'. Resources will be available to from the Campaign Resource Centre.
Vaccinations are available to those not in the target groups through pharmacies at a low cost (£10-£18)

Free Flu vaccinations are available for:

- all children aged 2 to 3 on 31 August 2022
- those aged 6 months to under 50 years in clinical risk groups
- Primary school children
- Secondary school children in Years 7 to 9 (between 11 and 13 years of age on 31 August 2022) - after December 2022
- Schools years 10 and 11 – after December and subject to secondary school vaccine availability
- In pregnancy
- those aged 65 and over
- those aged 50 years to 64 – after October.
- those in long-stay residential care homes
- carers
- close contacts of immunocompromised individuals
- frontline health and social care staff including:
    - a registered residential care or nursing home
    - registered domiciliary care provider
    - a voluntary managed hospice provider
    - Direct Payment (personal budgets) and/or Personal Health Budgets, such as Personal Assistants.
    - Learning from the Covid19 vaccination programme as revealed a range of workforce who are day-to-day directly delivering health and social care to vulnerable residents and these groups will be considering as within this Flu programme. Examples include special school staff giving PEG feeds [20] to children; social care workers in supported living hostels.
- At the Brighton and Hove level additional groups are being considered as clinically vulnerable such as homeless and rough sleepers, regular services users of the Alcohol and Substance misuse services.
- BHCC have an annual scheme with pharmacies for its staff to have the Flu vaccinations for those that are not eligible for the free NHS vaccinations.

Uptake ambitions – nationally the aim is to improve uptake in all groups to above the previous year. Efforts should be made to show improvement in coverage in those groups who were more than 5% lower than the national average. General practices and school providers must demonstrate a 100% offer to all those who are eligible this season.

[20] https://patient.info/treatment-medication/peg-feeding-tubes

9.2 Covid-19 Autumn Booster and Evergreen Offer Vaccination programme

At the time of writing some of the further delivery details for the Covid-19 Autumn Booster vaccination programme are being finalised.[21] [22]

- Covid19 Autumn boosters for;
    - those working in care home
    - those living in residential care homes for older adults
    - frontline health and social care workers
    - all those aged 16 to 49 years with underlying health conditions that put them at higher risk of severe COVID-19,
    - adult carers
    - adult household contacts of immunosuppressed individuals
    - from October to all adults aged 50 years or over

- Continuing to publicise the 'Evergreen offer' of first, second and initial booster doses to those who are un/partly vaccinated. With support for those populations
- and communities with lower uptake.

10 Arrangements in local providers

These sections provide a short overview of the arrangements that are in place. The assurance processes sit within each service and the following text has been provided by the services.

10.1 BHCC Health and Adult Social Care

Public Health - Reduction of excess winter deaths and fuel poverty are Public Health (PH) priorities as highlighted in the Public Health Outcomes Framework.

Public Health and Housing co-chair a cross-sector, multi-agency Fuel Poverty and Affordable Warmth Steering Group, which meets to oversee and coordinate support, identify funding streams and collaborate on projects to support residents experiencing fuel poverty and/or cold homes.

The Steering Group membership is currently made up of representatives from the Council's Public Health, Housing, Food Policy and Revenues & Benefits Teams, as well as multiple Community & Voluntary Sector (CVS) organisations: Brighton & Hove Energy Services Cooperative (BHESCo), Citizen's Advice Brighton & Hove (CABH), Money Advice Plus (MAP), National Energy Action (NEA), East Sussex Fire & Rescue Service (ESFRS), British Red Cross (BRC) and Brighton Peace & Environment Centre (BPEC).

[21] https://www.nhs.uk/conditions/coronavirus-covid-19/coronavirus-vaccination/
[22] Covid-19 and flu vaccinations - Sussex Health and Care (ics.nhs.uk)

Public Health facilitate links between this group and the Welfare Support and Financial Assistance Group. The overarching aims of the Fuel Poverty & Affordable Warmth Steering Group are to:

- Reduce preventable excess winter death rates
- Reduce fuel poverty, cold homes and the impact on health & wellbeing
- Reduce pressure on health and social care services
- Improve the energy efficiency of homes.
- Improve the energy literacy of residents and workers in the city

The Warmth For Wellbeing programme focusses on reaching marginalised and isolated communities, to identify and engage with those who are at elevated health risk due to living in fuel poverty and/or a cold home and reduce the health and wellbeing impacts through;

- Information and advice
- Warm Home Checks providing advice, advocacy, referrals and installation of small energy saving measures
- Debt & benefits advice and casework
- Small hardship grants

In May 2022, in response to increasing demand and the Cost Of Living crisis, Public Health allocated an additional grant fund to continue provision of money advice and small grants from June 2022 to March 2023. This is a one-off investment for 2022/23, delivered by Moneyworks partners Citizen's Advice Brighton & Hove and Money Advice Plus.
Public health regularly send out information and resources through city wide networks and services about winter readiness and cold weather advice.

Adult Social Care - Both Domiciliary and bed-based services are delivered by the Directorate, which has well-rehearsed Business Continuity Plans and heightened infection prevention and control measures in response to the COVID-19 pandemic. Services and organisations across health and social care work closely together. Each service has a process in place which identifies level of need, the number of visits required and in what time scales. This assists in identifying and prioritising community visits at times of high demand / limited resources / extreme weather conditions. All services delivered are considered in light of the COVID-19 guidance.

Flu vaccination is actively encouraged in all provider and commissioned services as staff are eligible under the National Flu Programme. All HASC front line social care delivery staff are actively encouraged to visit their general practice or local pharmacies for Flu vaccinations. The COVID-19 Autumn Booster campaign is running across care homes in the city and arrangements are in place for staff to access COVID-19 vaccinations.

The ASC team has contracts with much of the independent sector providing Care and Nursing Homes, Home Care, Supported Living and Community Support in the City. Contracts require that providers have business continuity plans which include winter readiness.

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A range of resources are distributed through ASC networks for example Helping to prevent winter deaths and illnesses associated with cold homes; A quick guide for home care managers Influenza-like illness (ILI): managing outbreaks in care homes,[23] [1]

promotion of the pneumococcal and shingles vaccinations and norovirus prevention.

Cold weather information is routinely be shared widely across the city through these general contacts and via a public health bulletin to the care sector . Access.Point@brighton-hove.gov.uk and / or Contracts Unit Admin Team ContractsUnit.AdminTeam@brighton-hove.gov.uk Control.Carelink@brighton-hove.gov.uk it is in use by the call centre 24/7 for HASC related out of hours services.

The UKHSA Winter-readiness (infection prevention) information for care homes in South East England Winter 2022/23 has been widely shared to care settings. It sets out key messages for care home managers on winter preparedness, including when and how to report outbreaks to your local Health Protection Team (HPT). It has two checklists on COVID-19 & flu, and norovirus readiness plus links for posters and further information on COVID-19, flu, norovirus, and shingles.

An annual plan is agreed with the NHS to support the patients journey on discharge from hospital:

- a dedicated resource in Emergency departments to support rapid discharge from hospital
- D2A – discharge to assess beds, and additional mental health support
- Participation in HIT team in acute services in time of escalation to minimise use of care capacity and ensure correct discharge pathways are followed
- Independence at home – reablement home care to support D2A process

10.2 BHCC Families, Children and Learning Directorate

It is important to involve services for children and families in winter preparations and health protection, particularly in order to reach the city's schools. Schools closures have a clear impact on the city, and support to business continuity planning in educational settings is available. Key city gritting routes do not always cover all individual routes to schools. Following the mandatory school closures experienced in 2020 and 2021 as part of the Covid pandemic response, schools, their pupils and their families are more set up for and experienced in home and remote learning techniques. This could help with school's badly affected by poor weather and will be informed by the DfE's guidance on emergency planning and response, published in 2022.

A Families, Children and Learning (FCL) departmental representative attends the Health Protection & Screening Forum and this provides further opportunities to coordinate city winter planning. Services and information to support families in fuel

23 https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/helping-to-prevent-winter-deaths-and-illnesses-associated-with-cold-homes

poverty will be widely shared through FCL networks. Children's centres and Council nurseries distribute weather related posters and leaflets, promote the Flu vaccine and can sign-post families for advice on fuel poverty. Private, voluntary and private early years childcare settings can be sent information to pass on advice to families. The Family Information Service can also pass on information using their Twitter account and Facebook page. The Family Information Service and the Integrated Team for Families can provide advice for families to reduce fuel poverty. Information about the seasonal Flu vaccinations generally and the schools based vaccination programme will be shared through wider FCL networks. Children under 5, pregnant women are recognised at risk groups.

The NHS Flu Vaccination programme has been extended to cover all school years from Reception to year 9 and extending to older years from end December, subject to vaccine supply. There is a commitment to continue with the successful levels of vaccination uptake as seen in previous years. BHCC will be offering a reimbursed Flu vaccination to all school staff who are not eligible for the free NHS one.

10.3 BHCC Seafront Team

The City recognises that numbers of rough-sleepers across the city have risen, and this is a particular problem for the seafront area.

It has been acknowledged that advice to traders re flood defences etc can be obtained from the YouGov website at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/451622/LIT_4284.pdf

The Seafront Office will issue a warning email to seafront businesses if the Met Office weather warnings identify a specific risk of overtopping or coastal flooding in Brighton & Hove.

A number of products such as flood sacks etc can be locally obtained from B&Q and Travis Perkins etc.

Events such as the B&H 'Christmas Day Swim' are kept under review. The team put out public safety signage and press releases about the dangers of swimming in the sea at this time of year in the lead up to Christmas., The swim is not an 'event' which is recognised by the council as it has no formal organiser and has no safety cover (Brighton Swimming Club do not wish to be responsible). The Seafront Office are on duty on Christmas Day and will advise the public not to enter the water if they are considering it. However, the Seafront Officers are not there to provide lifeguard cover as this is not their role.

10.4 Cityclean

Cityclean (01273 294706/01273 292229) staff working for BHCC and trained as gritter drivers are on a rota for the winter season and operate under the direction of the BHCC 'Winter Duty Officer' who will advise on weather and road conditions, and on action required by the team. Road gritting routes cover main roads, all bus routes and access roads to emergency services such as ambulance stations. In severe snowfall, additional Cityclean staff working for BHCC may work on pavement clearance for identified priority areas such as city centre and hospital entrances. There are 7 gritters (including a pavement gritter) and they will all be serviced before the start of the Winter Gritting period.

10.5 The BHCC Highways Winter Service Plan 2022-23

This plan states the Councils gritting and monitoring arrangements specifically relating to public roads and pavements. It is available on the council's public website (see below).

The Local Authority maintains an information page on the council's public website, which provides advice on winter weather (see http://www.brighton-hove.gov.uk/content/parking-and-travel/roads-and-highways/winter-weather) and driving and 'what you can do' as well as on 'what the Council does'. The link to this page is: https://www.brighton-hove.gov.uk/content/parking-and-travel/roads-and-highways/winter-road-maintenance

The highways plan ensures that roads to NHS hospitals are gritted, as well as ambulance stations. Clearance of pavements which lead to those hospitals are also on the Priority list.

B&H Bus Company's routes are on the City's gritting routes. Salt is good at combating ice but the addition of the buses and other heavy transport is needed to make it as effective as possible, Salt will only melt a very thin layer of snow or ice so anything more than snow flurries will settle on gritted roads. Under such circumstances, the aim is to reclaim the network as soon as possible using a grit/salt mixture and snow ploughing. It is important to keep the buses running where possible to help break up snow but that is an operational decision for the bus company. Issues for Brexit; reduction in vehicle part access, fuels, etc will be covered by Business Continuity Plans

.

Pavement clearance will also be carried out during snow events. Grit bins are provided across the coldest, steepest areas of the city for the public to use.

The service operates from 1 November until the end of March, 24 hours a day, 7 days a week. The period may be extended on a day-to-day basis in cases of severe cold weather continuing into April or starting earlier in October.

10.6 BHCC Flood Management

The Council's focus is on groundwater and surface water (the Environment Agency retains responsibility for main rivers and seas) which are the main flood risks to the City. The approach is to reduce (not eliminate) risk through strategic intervention. The following strategic flood management documents are being updated. Links to our current plans and strategies are found here:

- Strategic Flood Risk Assessment
- Surface Water Management Plan
- South East River Catchment Flood Risk Management Plan
- Local Flood Risk Management Strategy

10.7 BHCC Housing

The team has responsibility for the Council's stock of social and seniors housing. The Housing Sustainability & Energy Manager works closely with the Public Health lead for fuel poverty & EWDs to plan annual winter warmth initiatives. Energy saving advice is available for vulnerable council tenants from the Housing Inclusion Team.

In an emergency the service is committed to stopping non-urgent work and to re-deploy housing staff to other services who need extra support. The Estates Services provide salt and equipment to residents to help clear communal pathways to blocks. The Council's Housing Repairs and Maintenance service and heating contractor run out of hours services. They maintain winter contingency stock including heaters etc. Out of hours the duty housing officer is contactable via the Emergencies and Resilience Team or via Carelink.

BHCC commission the 'Severe Weather Emergency Protocol' (SWEP). This activates when the temperature feels like 0 degrees for 1 night, (SWEP will also open where possible on an Amber weather warning). The SWEP service offers overnight shelter to rough sleepers. Community and third sector organisations working with rough sleepers within the city are involved in ensuring that rough sleepers are informed when the service is open and how to access. The service is open to all rough sleepers regardless of local connection.

Over the Winter of 2022-23 the SWEP service will be available in self-contained environments. Every person using the service will have their own room to try and ensure the safety and wellbeing of rough sleepers whilst COVID-19 remains a real risk.

Warm Places

BHCC and its CVS partners have attempted to identify households and people in need of support this winter.
A multi-agency group is collating and developing a directory of winter indoor activities and places, as part of a programme currently called 'weathering winter in the city' in response to cost of living and fuel poverty crisis.

10.8 BHCC Emergency Planning and Resilience team (EP&R)

Transport hub arrangements and lists of community volunteers are annually reviewed. The B&H Transport Hub results from an agreed arrangement between partners to support BHCC in running a hub facility during periods of severe weather. The Transport Hub is managed and staffed via the agreement, and by an operational document. The Hub (once setup) will:

- Ensure an overview is maintained on weather conditions.
- Liaise with the BHCC Highways department and media sources to understand the impacts of the severe weather on the cities road's.
- Understand the implications of the weather falling on roads on transport providers including buses and taxis.
- Coordinate available 4 x 4 resources (including via the NHS and SRF MOU(s) with Sussex 4x4 Response), from partner organisations and local community volunteers Match local prioritised requests for 4x4's against availability.
- Work with community and voluntary sector groups who may be able to assist with the community response to severe weather events.

The BHCC 'EP&R Team' and the Public Health lead for Health Protection and resilience both engage with external partners including the Sussex Resilience Forum (SRF), and the Sussex Local Health Resilience Partnership (LHRP), and responding agencies to ensure that B&H is fully engaged in planning, testing and exercising severe weather and winter-related plans at both the Sussex an local levels.

De-Briefing & Support Should there be a severe weather incident, a de-briefing should be held to ensure lessons are identified and learnt, and also partners should ensure that support is offered to staff in appropriate cases. This is usually led by the EP&R team.

10.9 NHS Sussex Integrated Care Board (ICB)

Local adverse weather and business continuity plans are in place across the healthcare system in Sussex and the ICB itself, to respond to severe weather and other hazards associated with winter. The ICB's assures, as part of the annual NHSE Core Standards Assurance Process, that these plans are in place, up to date and tested regularly.

Local surge management plans are in place to respond to escalations in pressure in the local health system. The level of pressure is gauged using the Operational Pressures Escalation Level Framework (OPEL) and the local response to the escalation levels identifies a set of actions to be taken by all partners within the Sussex health system to manage the increased levels of pressure. .

Key performance objectives are monitored by a system-led process known as 'SHREWD' which provides real-time monitoring of hospital flow and capacity and is able to report information nationally.

The ICB has set up the NHS Sussex Operations Centre which provides an information management facility for NHS Sussex, designed to identify, analyse, plan and mitigate health service risks and demands across Sussex over the winter period.
The ICB also leads on the Covid-19 and Flu Vaccination Programmes for Sussex.

10.10 University Hospitals Sussex NHS Foundation Trust

Plans are reviewed annually at UHSx. The Trust participates in the NHS Operational Pressures Escalation Level (OPEL) procedures, which are centred around the Hospital Trusts geographic area and seeks to ensure that 'capacity management' issues are monitored effectively and where all resources in the local health and care system (including those of BHCC) are managed on a daily basis by a teleconference and reported/monitored using appropriate management tools. It now includes risk and pressures in the system relating to COVID19 as C-OPEL. It is led by the ICB's Director of Resilience. It is recognised that the Trust is often at high levels of escalation, but the issues are actively managed with the support of other organisations.

The Trust is committed to raising staff Flu vaccination levels and vaccinate other eligible groups as identified in the annual Flu letter. Business Continuity Plans are regularly updated. UHSx operates using COVID19 infection prevention and control guidance for the safety of staff, patients and partner organisations.

10.11 Sussex Community NHS Foundation Trust

SCFT provides out-patient clinics on-site and teams of healthcare staff such as Health Visitors, who deliver frontline community health services to patients in B&H and across wider Sussex. The Immunization Team is part of this Trust and contributes to the annual Flu vaccination programme. The Trust maintains service level Business Continuity Plans and has access to 4x4 vehicles to deliver its role during severe weather. The Trust has a Cold Weather Plan, Winter Plan and Escalation Plan which are available to staff on the Trust intranet. Staff and patients are provided advice on all aspects of winter health that can be found on NHS How to Stay Well This Winter and the Keep warm- keep well leaflets.

10.12 IC24 (NHS Out of Hours Provider)

IC24 provides out of hours and roving GP services to B&H and to E Sussex, as well as a GP in A&E at Royal Sussex County Hospital, a walk-in service and other facilities. The organisation may have challenges in providing some services during periods of adverse weather but may access 4x4 support via links with Adult Social Care and the ICB.

10.13 British Red Cross

BRC has agreed to link with BHCC and other local services and is available to support them during periods of severe winter weather. BRC have other winter provision available in B&H:

- A 24 Emergency Response Call Centre (Crisis Response Contact Centre) which will mobilise staff and volunteers as required, 24/7/365 to support people

in crisis and depending on what the situation is, if BRC can help, they will respond.
• The basic “offer” to B&H is to provide practical and emotional support which will include working in rest centres etc.
•BRC can also provide blankets and hot drinks. If other support is required, such as the distribution of items to the vulnerable, please let the BRC know, and where possible, they will assist.

To access this assistance, please contact the Crisis Response Contact Centre (CRCC) which is open 24 hours a day, on 0300 023 0700.

Red Cross – Jess Macefield-North Senior Emergency Response Officer – BRC for Surrey & Sussex	0300 0230700 Jmacefieldnorth@redcross.org.uk	Please contact CRCC 0300 023 0700 If you have any queries in office hours, please feel free to ring my mobile on 07831 282581

10.14 Community and Voluntary sector

The CVS is key to building winter resilience in the city. As a trusted and first point of contact for many of the most vulnerable residents, charities and community groups play a vital role in a partnership approach to addressing the demands of cold weather.

The sector cascades Cold Weather Alerts provided by the Met Office and shares warnings, as well as other Public Health messages around cold weather harms and preventative actions. This happens through commissioned services, including infrastructure and community development groups as well as through community networks.

Advice services across the city support residents by providing support around fuel, finance, housing and advice on many other topics, food banks and community pantries offer free or low cost food. Befriending organisations help to alleviate loneliness and other community organisations work with specific groups who may be more vulnerable to cold, such as those with disabilities, older people, the homeless or vulnerably housed, those in poverty etc. Smaller groups also act at a neighbourhood level.

The local voluntary and community organisations are represented at a wide range of strategic bodies in the city, including; BHCC Flu Planning meetings and the Sussex Programme board, the Sussex Resilience Forum, the Health and Wellbeing Board, other council hosted bodies such as EquIP and welfare and financial assistance meetings, B&H Health and Care Partnership Exec Board and multiple workstream meetings. As well as enabling the sector to keep up to date with developments to share with their partners and service users, this is also an invaluable means by which their intelligence can be incorporated into the city's responses to cold weather.

11 Communication

11.1 Three areas of communication

The three areas of communication are: Awareness, Warning & informing and Advising the public.

11.2 Awareness

Pre 1st November each year. This will be done through the national and local campaigns, by informing and educating the public about the risks of cold weather, and how people in the identified vulnerable groups can prepare themselves.
BHCC has a seasonal weather opt-in cascade system for pre-emptively sharing general seasonal advice.

The UKHSA and NHS England marketing campaign, Help Us, Help You - Stay Well this Winter', will run starting in September. This phased campaign aims to help those with long-term health conditions (particularly respiratory conditions), older people, school children, pregnant people and parents of under-5s stay well and keep their loved ones well this winter. This includes messages about Flu and Covid19 vaccinations, contacting NHS 111, seeking advice at the first signs of a winter illness, accessing evening and weekend GP appointments and the advantages of consulting with community pharmacists.

Further information is available from:
https://campaignresources.phe.gov.uk/resources/campaigns/34-stay-well-this-winter/overview which also provides a link to sign up for email updates.

'Top Tips for Keeping Warm and Well', in collaboration with Age UK. The leaflet is targeted at pensioners in receipt of pension credit in England, Scotland and Wales. It will sit alongside an updated 'Keep Warm Keep Well' booklet, found at:

https://www.gov.uk/government/publications/keep-warm-keep-well-leaflet-gives-advice-on-staying-healthy-in-cold-weather

NHS Sussex runs a winter communications campaign titled Help us help you this winter Stay well this winter . The campaign encourages people to use health services appropriately and highlight the other services available. There is a strong focus on self-care and prevention, which links into the NHS England campaign as described above. Brighton and Hove city council support this communication campaign and will be also sending out and sharing key message in readiness for winter.

Appendix 3 has the general public health messages and specific for each alert level

11.3 Warning

At each change of cold weather level. The Met Office will communicate to the public any change in levels and what the changes means, taking into specific account the local weather warnings. Local supportive messages will also be sent out to services and to the public.

11.4 Local Warning and Informing

Immediately when Level 2 and above is reached. BHCC Public Health staff and Emergency Planning & Resilience Team will liaise with NHS Sussex and BHCC Communications staff to agree appropriate local messaging and specifical targeted information for those at most risk.

11.5 Staff information

All partner agencies will ensure that suitable messages are also passed to staff, detailing warnings where appropriate, actions to be taken, and measures in line with their Business Continuity Plans, which must be kept up to date. This may include the need to re-deploy staff during severe weather, arrangements for home-working where appropriate, support to access Covid-19 and Flu vaccinations, and proactive information on how to stay safe and keep well during the winter months

Appendix 1 Action Cards

Please find the full set of Action Cards here and these are updated nationally https://www.gov.uk/government/publications/cold-weather-plan-action-cards-for-cold-weather-alert-service

Appendix 2 NHS Sussex Adverse Weather Plan 2022-2023

Available on request generic email address sxicb.eprr@nhs.net

Appendix 3 Key Public Health messages

These are the core messages to be broadcast as official weather warnings alongside national and regional weather forecasts. They may be expanded or otherwise refined in discussion with broadcasters and weather presenters.

Key public health messages
Take up your Covid-19 vaccination when it is offered/available Contact your GP or pharmacist if you think you, or someone you care for, might qualify for a free Flu jab.

Free Flu vaccinations are available for those who are at risk. For a full list see the annual Flu plan, available at: www.gov.uk/government/collections/annual-flu-programme

Keep your home warm, efficiently and safely:

- heating your home to at least 18°C in winter poses minimal risk to your health when you are wearing suitable clothing
- get your heating system and cooking appliances checked and keep your home well ventilated
- use your electric blanket as instructed and get it tested every 3 years
- never use a hot water bottle with an electric blanket
- do not use a gas cooker or oven to heat your home; it is inefficient and there is a risk of carbon monoxide poisoning and this can kill
- make sure you have a supply of heating oil or LPG or sold fuel if you are not on mains gas or electricity – to make sure you do not run out in winter

Keep in the warmth by:

- fitting draught proofing to seal any gaps around windows and doors
- making sure you have loft insulation. And if you have cavity walls, make sure they are insulated too
- insulate your hot water cylinder and pipes
- draw your curtains at dusk to help keep heat generated inside your rooms
- make sure your radiators are not obstructed by furniture or curtains

Look after yourself:

- food is a vital source of energy and helps to keep your body warm so have plenty of hot food and drinks
- aim to include 5 daily portions of fruit and vegetables. Tinned and frozen vegetables count toward your 5 a day
- stock up on tinned and frozen foods so you don’t have to go out too much when it’s cold or icy
- exercise is good for you all year round and it can keep you warm in winter
- if possible, try to move around at least once an hour. But remember to speak to your GP before starting any exercise plans
- wear lots of thin layers – clothes made from cotton, wool or fleecy fibres are particularly good and maintain body heat
- wear good-fitting slippers with a good grip indoors and shoes with a good grip outside to prevent trips, slips and falls
- make sure you have spare medication in case you are unable to go out
- check if you are eligible for inclusion on the priority services register operated by your water and power supplier

Look after others:

- check on older neighbours or relatives, especially those living alone or who have serious illnesses to make sure they are safe, warm and well

Get financial support:

there are grants, benefits and sources of advice to make your home more energy efficient, improve your heating or help with bills. It's worthwhile claiming all the benefits you are entitled to before winter sets in.

Specific messages related to the Levels suggested in national Plan

Level 1: Winter preparedness and action

A spell of chilly weather might warrant a message along the lines of:

"If this does turn out to be a spell of severe cold weather, we'll try to give you as much warning as possible. But in the meantime, if you want advice about protecting your health from the cold go to the winter health pages at www.nhs.uk. If you are worried about your health or that of somebody you know, ring NHS 111."

Level 2: Alert and readiness

The Met Office, in conjunction with UKHSA, is issuing the following cold weather warning for [regions identified]:

"Severe cold weather can be dangerous, especially for the very young or very old or those with chronic disease. Advice on how to reduce the risk either for yourself or somebody you know can be obtained from the winter health pages at www.nhs.uk or from your local chemist. If you are worried about your health or that of somebody you know, ring NHS 111."

Level 3 and 4: Severe cold weather action/emergency

The Met Office, in conjunction with UKHSA is issuing the following severe cold weather advice for [regions identified]:

"Make sure that you stay warm. If going outside make sure you dress appropriately. If indoors, make sure that you keep your heating to the right temperature; heating your home to at least 18°C in winter poses minimal risk to your health when you are wearing suitable clothing. If there is anyone you know who might be at special risk, for example, an older person living on their own, make sure they know what to do to stay warm and are well stocked with food and medications. If you are worried about your health or that of somebody you know, ring NHS 111"

Item 29

Although a formal committee of Brighton & Hove City Council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults and Healthwatch.

Title:	Joint Health and Wellbeing Strategy - Outcome measures update	
Date of Meeting:	8th November 2022	
Report of:	Alistair Hill, Director of Public Health	
Contact:	Caroline Vass, Consultant in Public Health	Tel: 07717 303300
Email:	caroline.vass@brighton-hove.gov.uk	
Wards Affected:	All	

FOR GENERAL RELEASE

Executive Summary

Health and Wellbeing Boards have a duty to prepare a Joint Health and Wellbeing Strategy to describe the vision and strategic aims to address the population needs identified in the Joint Strategic Needs Assessment (JSNA).

The Brighton & Hove Health and Wellbeing Strategy 2019-30 was approved by the Board in March 2019. It sets out the vision: 'Everyone in Brighton & Hove will have the best opportunity to live a healthy, happy and fulfilling life'.

This paper provides:

- an update on the agreed outcome measures identified in the Health and Wellbeing Strategy
- advises on changes to outcome measures and proposes the inclusion of additional measures to reflect the wider impacts of Covid, and poorer performance

- proposes a recommendation with regards to monitoring outcome measures.

Glossary of Terms
JHWS - Joint Health and Wellbeing Strategy
JSNA - Joint Strategic Needs Assessment
GPs – General Practitioners
NHS Long Term Plan – the new plan for the NHS to improve the quality of patient care and health outcomes.

1. Decisions, recommendations, and any options

1.1 That the Board notes the current trend status of the Joint Health and Wellbeing Strategy outcome measures

1.2 That the Board agrees the changes to outcome measures and inclusion of additional measures

1.3 That the Board approves the proposal to monitor outcome measures by reflecting 'direction of travel'

1.4 That the Board considers and agrees how they would like to receive updates. Options include:

- Annual update
- Update at alternate meetings
- Annual update at one meeting, supplemented by summary updates based on the Wells, at the remaining two meetings (to highlight 2 of the Wells at each meeting).

2. Relevant information

2.1 Health and Wellbeing Boards have a duty to prepare a Joint Health and Wellbeing Strategy to describe the vision and strategic aims to address the population needs identified in the Joint Strategic Needs Assessment (JSNA).

2.2 The Brighton & Hove Health and Wellbeing Strategy was approved by the Health and Wellbeing Board in March 2019. It is a high-level, strategy that sets out the vision of the Board for improving health and wellbeing and reducing health inequalities in Brighton & Hove.

2.3 The vision of the Boards is that: 'Everyone in Brighton & Hove will have the best opportunity to live a healthy, happy and fulfilling life'.

2.4 The strategy states our overarching ambition that by 2030:

- People will live more years in good health (reversing the current falling trend in healthy life expectancy) and
- The gap in healthy life expectancy between people living in the most and least disadvantaged areas of the city will be reduced.

2.5 To deliver the ambition, the strategy identifies a number of outcomes for local people that are reflected under four key areas known as the 'Wells': starting well, living well, ageing well, and dying well.

2.6 The Board agreed the outcomes measures for each of the four Wells in July 2021. This paper provides

- an update on the current outcome measures, including where impacted by the Covid-19 pandemic
- an update on changes to the outcome measures included, and
- proposes a way forward for monitoring the outcome measures.

2.7 The changes to the outcome measures include:

- to remove one measure
- include an additional three measures to reflect negative trends in some outcomes not previously included as we had compared well in these outcomes

Development of the outcome measures

2.8 The initial outcome measures were based on the needs set out in the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy vision and ambition. The criteria for inclusion are:

- where they are population level outcomes (not system/process indicators)
- where Brighton & Hove performs poorly against defined comparators
- where there are significant inequalities within the city, and
- now also include where the Covid-19 pandemic response is likely to have had a significant impact eg: physical activity.

2.9 The outcome measures are predominantly taken from: the Public Health Outcomes Framework; NHS Outcomes Framework; Adult Social Care Outcomes Framework; and Office for Health Improvement and Disparities (OHID) Wider Impacts of Covid-19 dashboard.

2.10 The choice of outcome measures was informed by the engagement carried out on the Joint Health and Wellbeing Strategy in 2018/19 and by discussions across Public Health, Adult Social Care, Families Children and Learning and the NHS.

Monitoring the outcome measures

2.11 Discussions on monitoring the progress of the Strategy outcome measures have previously considered setting targets with associated trajectories. However, the Covid-19 pandemic during 2020-2022 changed the landscape in which services were delivered and affected:

- The ability of services to deliver support to meet the strategy aims
- The degree to which the population could take up support
- Population lifestyle and behaviour changes

2.12 To set defined targets based on pre-covid-19 expectations may undermine the work that services have delivered, or are currently delivering, and demoralise services that are struggling to recover and re-build their activity.

2.13 Therefore, we propose to monitor progress of our Health and wellbeing Strategy by agreed 'direction of travel' of each outcome measure, for example: '***increase*** rates of year 6 healthy weights', '***reduce*** rates of alcohol use in under 15 year olds', etc. This is reflected in the terminology in this report.

2.14 It is proposed that the Board will receive regular updates on progress report, for Board members to maintain oversight of the strategy and outcomes.

2.15 The Board is asked to consider options for update, for example, an annual update, or more regular progress reports. One option is an annual update supplemented by progress on outcome measures relating to different Wells at the other two Board meetings.

Outcomes measures update

2.16 Appendix 1 presents the key outcome measures dashboard and shows trends in the outcome measures, including the latest published data. The current status of the outcome measures is summarised below, with the corresponding required direction of travel. A static trend is one where there is no significant improvement or worsening of the trend.

2.17 **An improving trend in the following measures**:

Overarching indicators:

- Healthy life expectancy at birth (males) – aim to improve

Starting well

- MMR vaccination (two doses in 5 years olds) - aim to increase
- The percentage of pupils in years 10-11 who have ever tried alcohol is reduced – aim to reduce
- The percentage of pupils in years 10-11 who smoke – aim to reduce
- Average Attainment 8 score for children in care – aim to increase

Living well

- Smoking prevalence (all adults and those in routine and manual occupations). – aim to reduce. NB The survey was much smaller in the most recent year and may have impacted validity of this result*
- Suicide and undetermined injury deaths – aim to reduce. NB most recent data not available as at 12 Oct 2022

- Sexually Transmitted Infection (STI) diagnoses – aim to reduce, however the direction of travel is informed by local and national knowledge of testing rates and trends. During Covid-19 testing went down and so did diagnoses. In these circumstances we would want to work towards an increase in rates to reflect improved testing. When we have high rates of testing we would want to see lower rates of diagnoses

Ageing well

- Flu vaccination of at risk individuals – aim to increase
- Flu vaccination of people aged 65 years or over aim to increase

Dying well

- The proportion of people dying at home – aim to increase. It should be noted that this has been affected by deaths during the Covid19 pandemic which might not indicate a true improving trend.

2.18 A worsening trend in the following measures:

Starting well

- Child development – aim to increase the percentage of children achieving a good level of development at 2-2.5 years
- Prevalence of overweight (including obesity) – Year 6** aim to reduce
- Percentage of pupils who feel happy – aim to increase
- Percentage of pupils who feel sad – aim to reduce
- Hospital admissions as a result of self-harm (10-24 years)* – aim to reduce

Living well

- Gap in the employment rate between those in receipt of long term support for a learning disability and the overall employment rate – aim to reduce
- Percentage of adults with a low happiness score – aim to reduce
- Percentage of adults with a high anxiety score* – aim to reduce
- Percentage of physically active adults - aim to increase
- Percentage of adults classified as overweight or obese** – aim to reduce
- Deaths from drugs misuse* – aim to reduce
- Domestic abuse related incidents – aim to reduce incidents, but we want to increase reporting so this indicator will always require some narrative.

2.19 A static trend in the following measures:

Overarching indicators:

- Healthy life expectancy (females) - aim to increase

Starting well

- Having tried cannabis (Year 10-11) – aim to reduce

Living well

- Gap in the employment rate between those in receipt of long term support for a physical or mental long-term health condition and the overall employment rate** – aim to reduce
- hospital episodes for alcohol-related conditions – aim to reduce
- HIV testing and treatment coverage** - aim to increase the proportion of population tested, to ensure that people testing positive receive prompt access to antiretrovirals, and in doing so have a successful response.
- Percentage of adults walking for travel at least three days per week** - aim to increase
- Percentage of adults cycling for travel at least three days per week** - aim to increase
- Percentage of cancers diagnosed at stages 1 and 2 - aim to increase

Ageing well

- Percentage of adult carers who have as much social contact as they would like - aim to increase
- Emergency readmissions within 30 days of discharge to hospital – aim to reduce
- Emergency hospital admissions due to falls in people aged 65 years or over* – aim to reduce
- Permanent admissions to residential or nursing care homes per 100,000 aged 65 years or over* – aim to reduce
- Under 75 mortality rate from cardiovascular disease – aim to reduce
- Under 75 mortality rate from cardiovascular disease considered preventable – aim to reduce
- Under 75 mortality rate from cancer – aim to reduce
- Under 75 mortality rate from cancer considered preventable – aim to reduce

2.20 The trends include the latest published data and the appendix provides comparison to England and comparator authorities. Those marked with * are significantly worse than England outcomes and those with ** are significantly better than the England outcomes.

Changes to the proposed outcome measures

2.21 The table, appendix 1, slide 3, outlines the current outcome measures under each 'Well' and proposes changes to the measures. It should be noted that some measures cross more than one Well. In this case the measure is not duplicated in more than one Well.

2.22 Where possible, outcome measures are included for disadvantaged groups, however these data are not always available as a result of recording issues, eg: ethnicity recording is not comprehensive. We continue to focus on the improvement of data collection to improve reporting over time.

2.23 We propose to include additional outcome measures to reflect worsening trends in these areas:

- Physical activity in children and young people – aim to increase
- Adults who are overweight or obese – aim to reduce
- Physically inactive adults – aim to reduce proportion

2.24 We propose to remove the outcome measure reflecting health related quality of life for older people as the data are no longer available.

3 Important considerations and implications

Legal:

3.1 The Health and Wellbeing Board is required to publish a joint Health and Wellbeing Strategy pursuant to the Health and Social Care Act 2012 Section 193.

Lawyer consulted: Sandra O'Brien Date: 11/10/2022

Finance:

3.2 The Joint Health and Wellbeing Strategy informs priorities, budget development and the Medium-Term Financial strategy of the Council, Health and other partners. This will continue to require a joined-up process for future budget setting in relation to all local public services where applicable. There are no direct financial implications as a result of the updates provided in this paper.

Finance Officer consulted: Sophie Warburton Date: 11/10/2022

Equalities:

3.3 The strategy, and the outcomes measures set out within this paper, includes a strong focus on reducing heath inequalities. The strategy and its delivery is underpinned by the data within our Joint Strategic Needs Assessment which takes the life course approach identifying specific actions for children and young people; adults of working age and older people; and key areas for action that reflect specific equalities issues including inclusive growth and supporting disabled people and people with long-term conditions into work. An Equalities Impact Assessment is not required for the strategy itself but should be completed for specific projects, programmes and commissioning and investment decisions taking forward the strategy, as indicated within this delivery plan.

Supporting documents and information

Appendix 1: Brighton & Hove Joint Health and Wellbeing Strategy: Key outcomes measures update October 2022

Brighton & Hove Joint Health and Wellbeing Strategy

Key outcome measures dashboard

Update October 2022

Public Health Intelligence team, Brighton & Hove City Council

Overarching outcomes measures

Overarching	• People will live more years in good health (reversing the current falling trend in healthy life expectancy). • The gap in healthy life expectancy between people living in the most and least disadvantaged areas of the city will be reduced

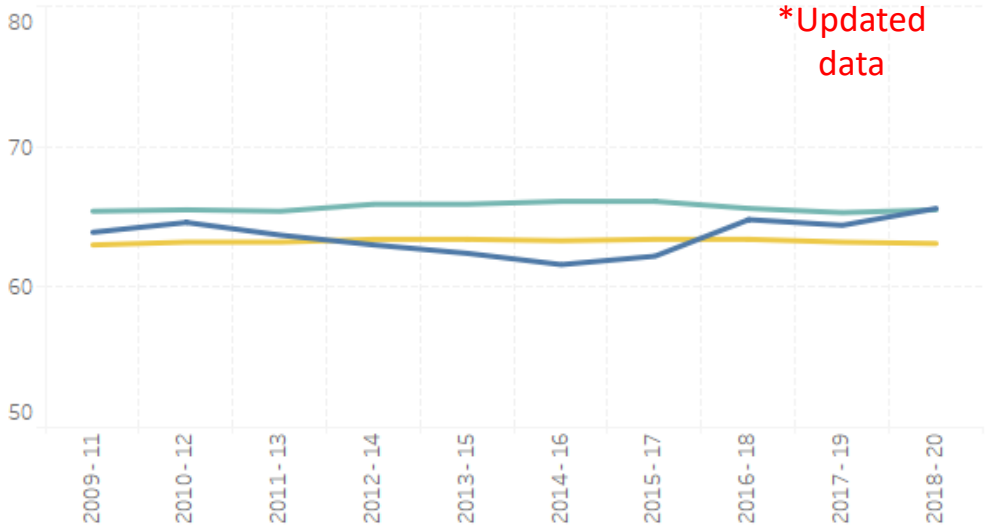
Outcomes by life course

Starting well	Living well	Ageing well	Dying well
• The gap in having a good level of development at end of reception between pupils eligible for Free School Meals (FSM) and other pupils is reduced • Immunisation rates increased (MMR two doses by five years) • Increase in good level of development at 2/2½ • Year 6 healthy weight is increased • *The rates of smoking, alcohol and drugs use in 15 year olds are reduced* – Amended to: • The percentage of pupils in years 10-11 who have ever tried alcohol is reduced (LOCAL*) • The percentage of pupils in years 10-11 who smoke is reduced (LOCAL) • The percentage of pupils in years 10-11 who have ever tried cannabis is reduced (LOCAL) • NEW Physical activity in children and young people is increased • Educational attainment at 16 is increased for all pupils and children in care (amended from disadvantaged groups) • The percentage of pupils who often/sometimes feel happy increases and often/sometimes feel sad decreases (LOCAL) (amended from worry about the future) • Hospital admissions self harm (10-24 year olds) are reduced	• The gap between the overall employment rate and the rates for those with long-term health conditions, learning disabilities and in contact with mental health services are reduced • People having enough money after bills to live (LOCAL) City Tracker not taken place since 2019 • Increase the percentage of physically active adults • Increase the percentage of adults who travel by walking and cycling at least 3 days per week • NEW Reduction in adults who are overweight or obese • NEW The percentage of physically inactive adults is reduced • The adults smoking prevalence, and the gap between routine and manual workers and other groups, are reduced • Alcohol related admissions to hospital are reduced • Drug related deaths are reduced • Sexually transmitted infections are reduced • Amended HIV – proportion of the population tested; receiving prompt antiretroviral therapy; responding well to treatment are increased • The percentage of cancers detected at an early stage (Stage 1 or 2) is increased • Domestic abuse related incidents are reduced • The percentage of adults with high levels of happiness is increased and with high levels of anxiety is reduced • Admissions for self harm (all ages) are reduced • Deaths from suicide and undetermined injury are reduced	• REMOVE Health related quality of life for older people is increased (no longer available) • Social isolation is reduced moved from living well and amended to: Percentage of adult social care users with as much social contact as they would like • Good quality of life for carers is increased • Flu vaccination rates are increased • Repeated admission to hospital is reduced • Hospital admissions due to falls are reduced • Permanent admissions to residential and nursing homes are reduced • U75 mortality from CVD and cancer are reduced	• REPLACEMENT The proportion of people dying at home is increased *Note this indicator has been affected by Covid19 pandemic LOCAL represents a local indicator which does not have comparative data

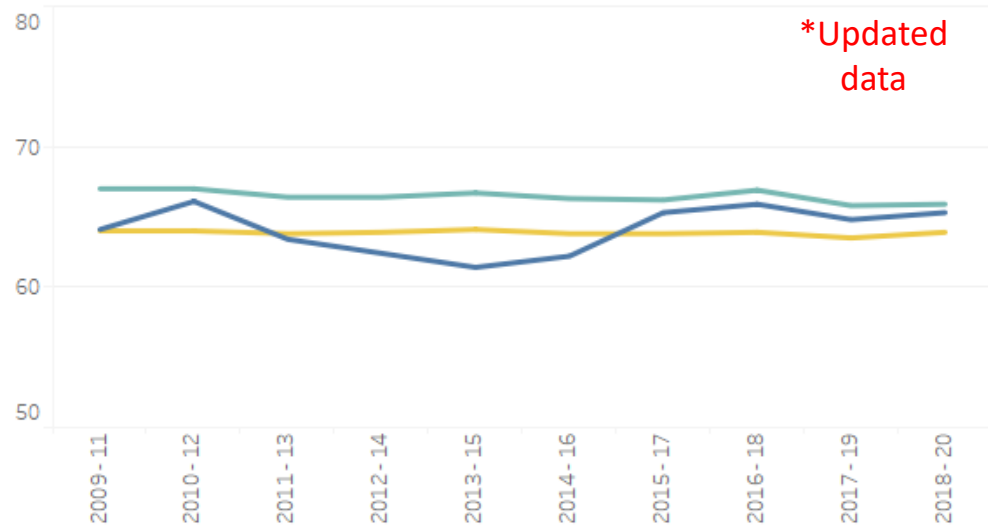
High-level strategy trends

Brighton and Hove | England | South East

Healthy life expectancy at birth (Male)



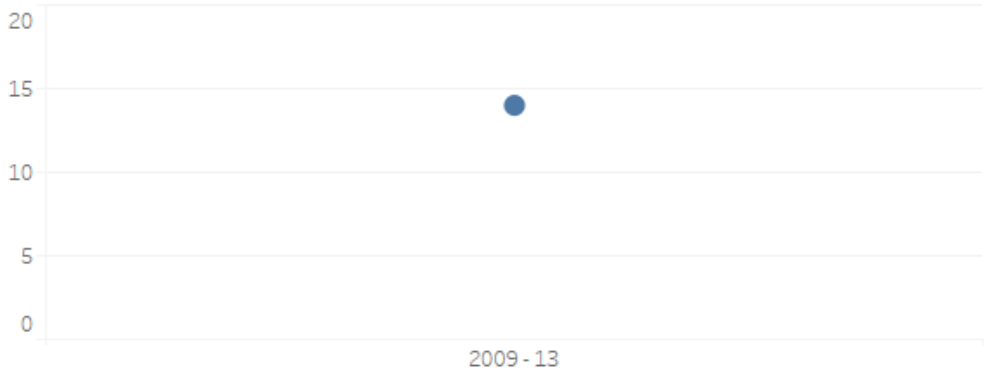
Healthy life expectancy at birth (Female)



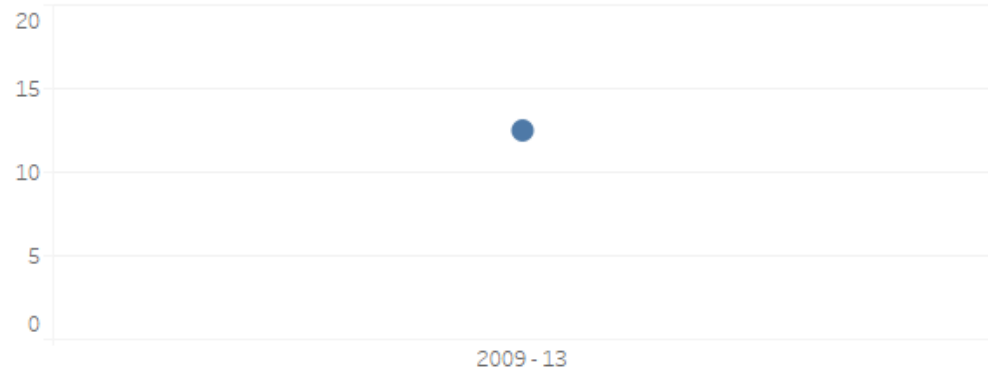
The inequality indicator measures inequalities in healthy life expectancy within local authorities. It shows how much healthy life expectancy varies with deprivation. It takes account of health inequalities across the whole range of deprivation within the local authority and summarises this in a single number. This represents the range in years of healthy life expectancy across the social gradient from most to least deprived.

For males born in the most deprived area of Brighton and Hove they have a healthy life expectancy of 14 years less than males born in the least deprived area. For females this is 12.5 years.

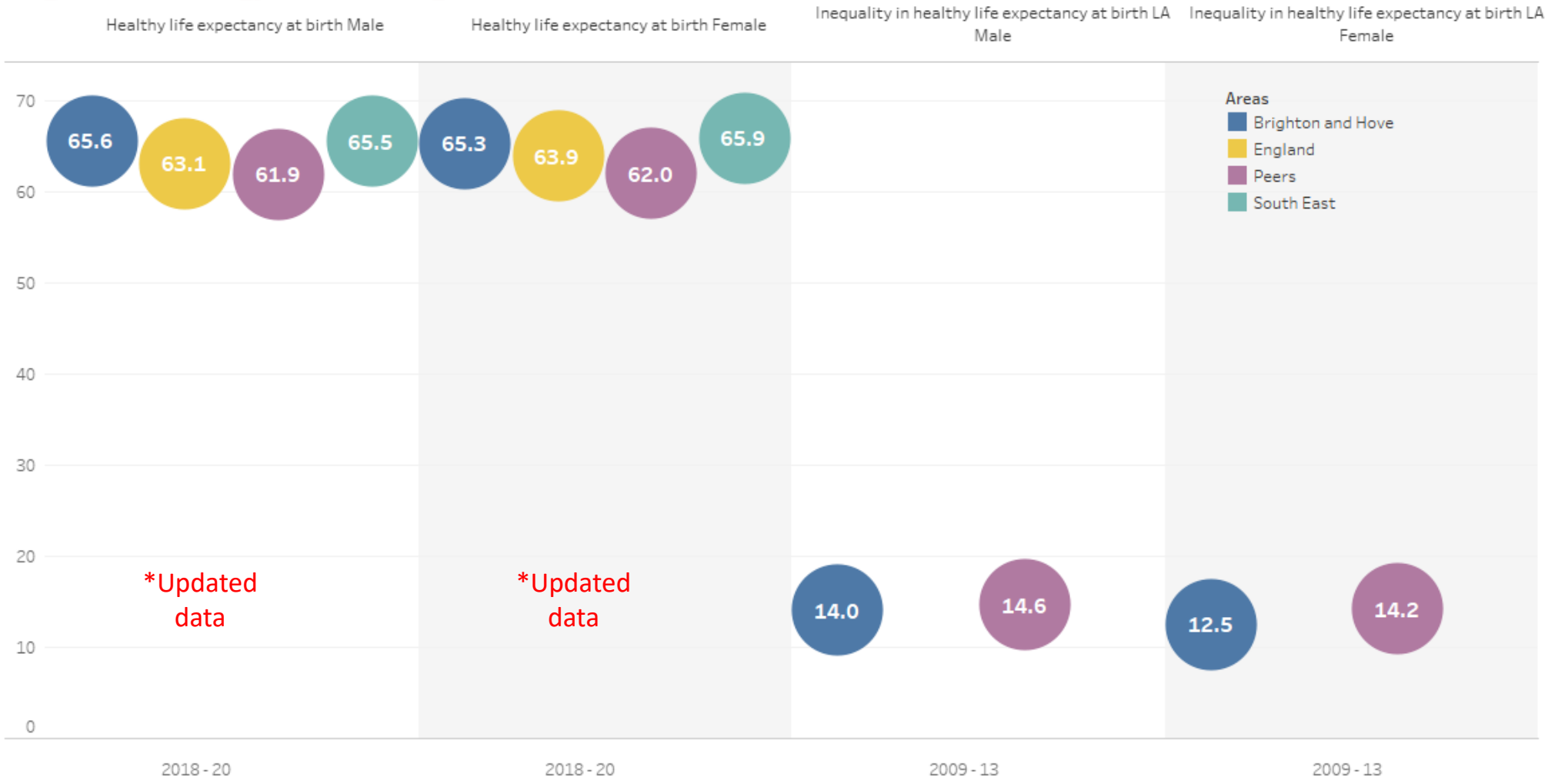
Inequality in healthy life expectancy at birth LA (Male)



Inequality in healthy life expectancy at birth LA (Female)



High-level strategy - latest comparison



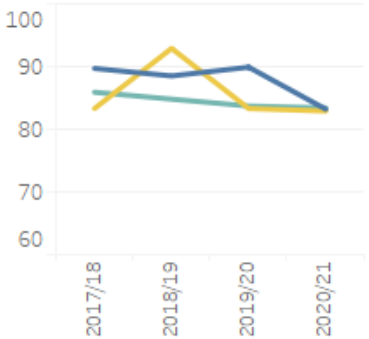
Compared to England

Healthy life expectancy at birth Male	Healthy life expectancy at birth Female	Inequality in healthy life expectancy at birth LA Male	Inequality in healthy life expectancy at birth LA Female
Similar	Similar	Not compared	Not compared

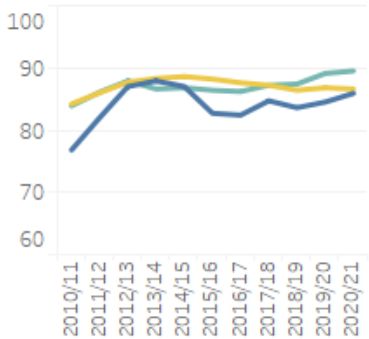
Starting Well trends

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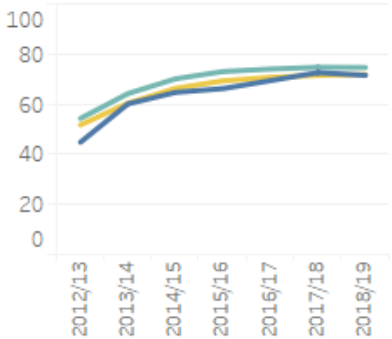
Child development: percentage of children achieving a good level of development at 2-2½ years



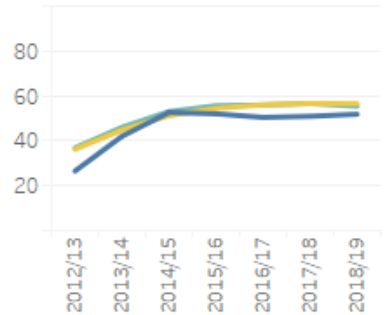
Population vaccination coverage - MMR for two doses (5 years old)



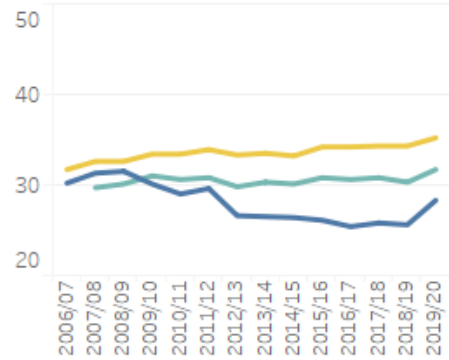
School readiness: percentage of children achieving a good level of development at the end of Reception



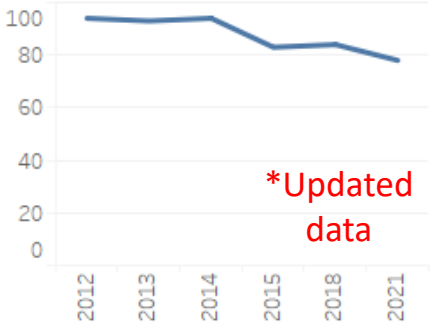
School Readiness: percentage of children with free school meal status achieving a good level of development at the end of Reception



Year 6: Prevalence of overweight (including obesity)

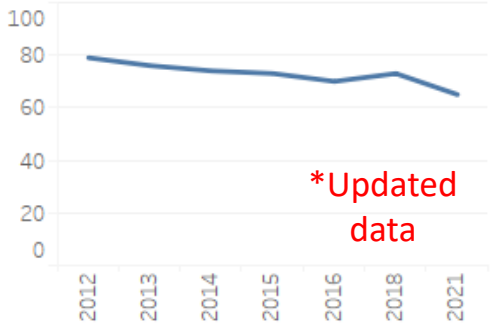


Percentage of pupils who feel happy



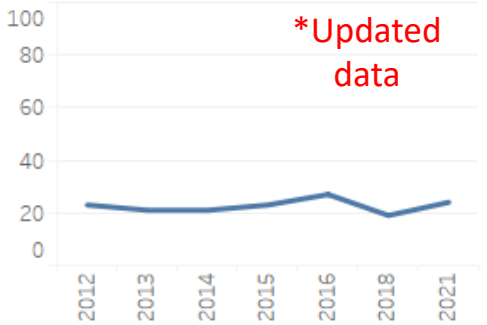
*Updated data

Alcohol prevalence Year 10 & 11



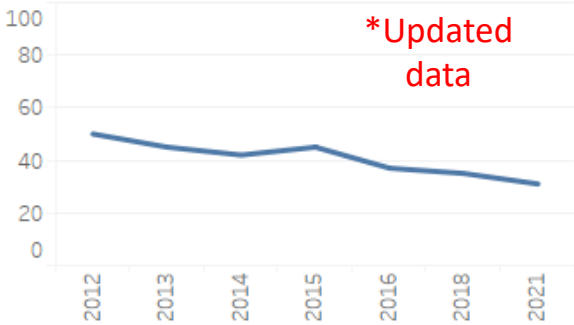
*Updated data

Cannabis prevalence Year 10 & 11



*Updated data

Smoking prevalence Year 10 & 11

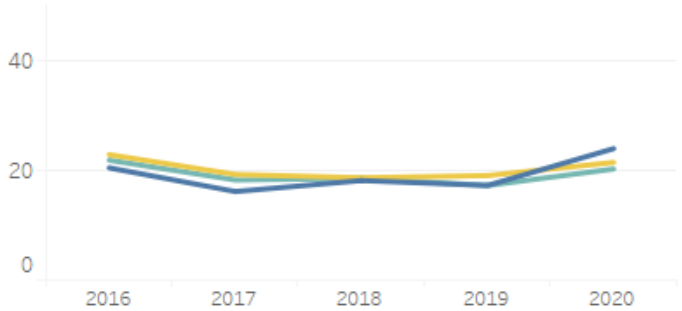


*Updated data

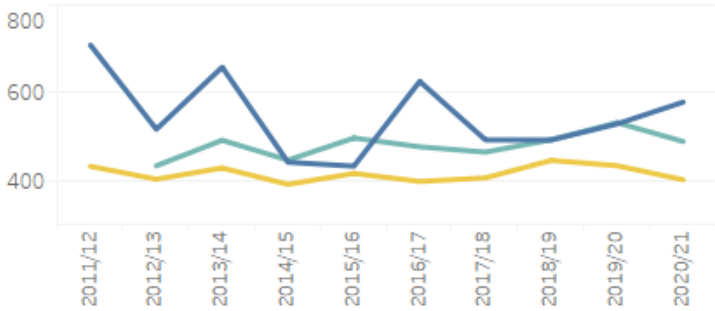
Average Attainment 8 score

Trend chart is not displayed as the way GCSE grades were awarded changed during the Covid-19 pandemic. 2019/20 and 2020/21 data should not be directly compared to attainment data from previous years for the purposes of measuring changes in student performance.

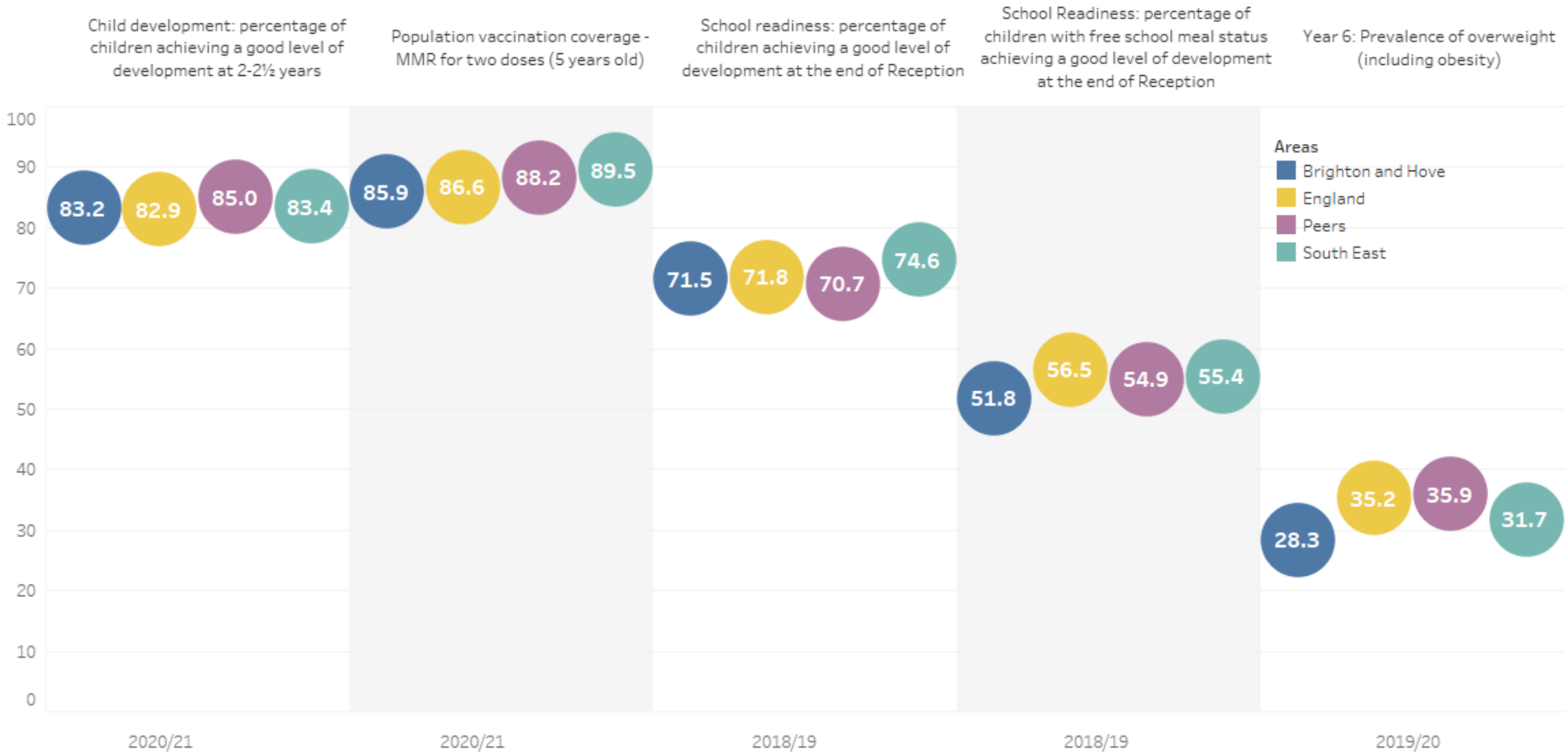
Average Attainment 8 score of children in care



Hospital admissions as a result of self-harm



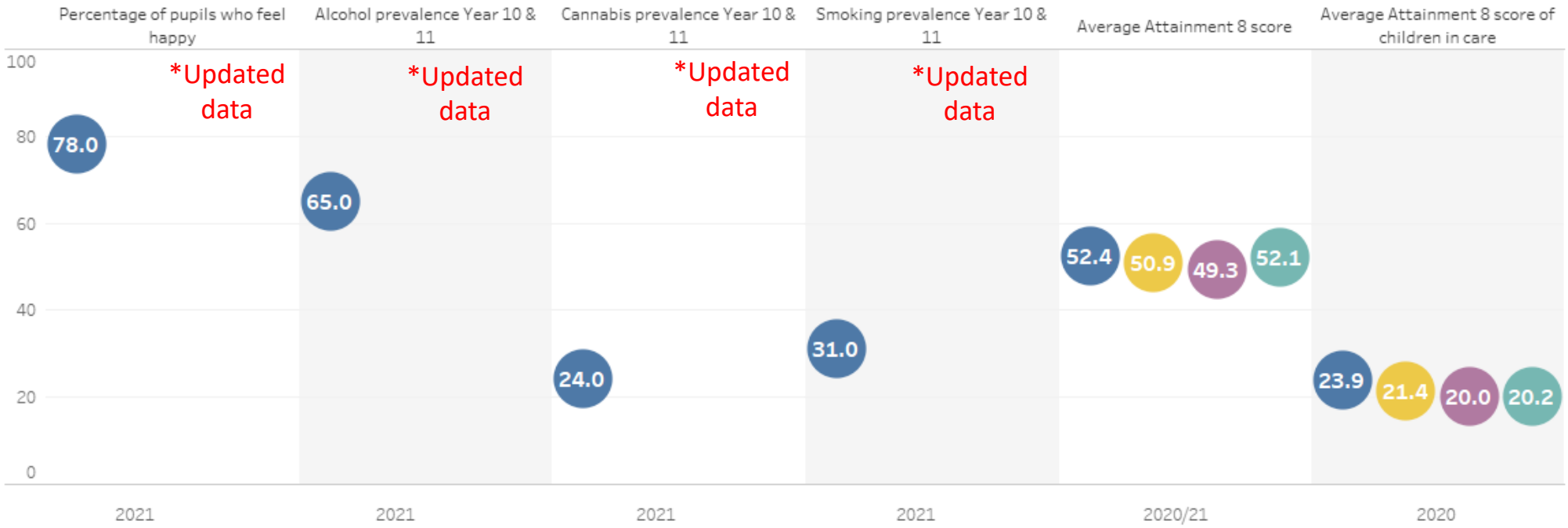
Starting Well - latest comparison



Compared to England

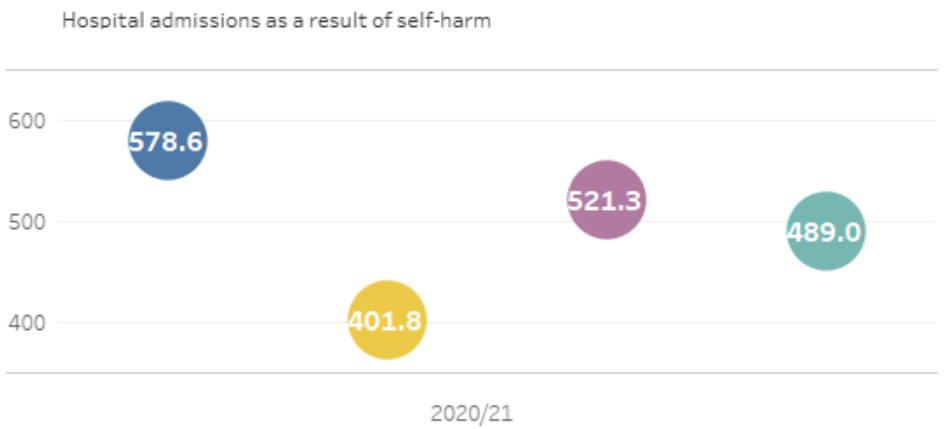
Child development: percentage of children achieving a good level of development at 2-2½ years	Population vaccination coverage - MMR for two doses (5 years old)	School readiness: percentage of children achieving a good level of development at the end of Reception	School Readiness: percentage of children with free school meal status achieving a good level of development at the end of Reception	Year 6: Prevalence of overweight (including obesity)
Similar	Similar	Similar	Similar	Better

Starting Well - latest comparison



Compared to England

Percentage of pupils who feel happy	Alcohol prevalence Year 10 & 11	Cannabis prevalence Year 10 & 11	Smoking prevalence Year 10 & 11	Average Attainment 8 score	Average Attainment 8 score of children in care
Not compared	Not compared	Not compared	Not compared	Better	Not compared



Compared to England

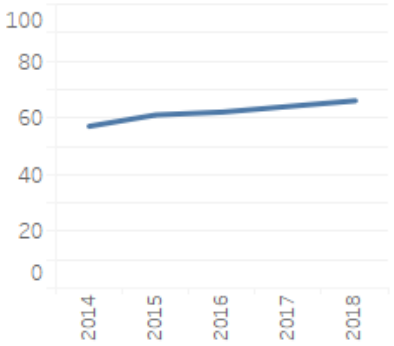
Hospital admissions as a result of self-harm
Worse



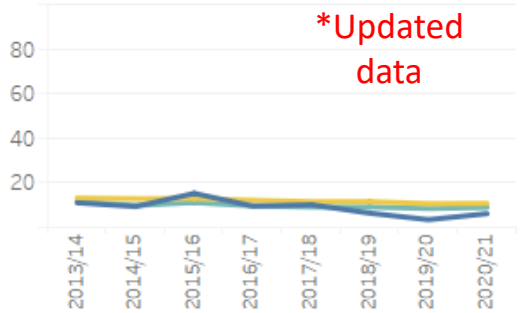
Living Well trends

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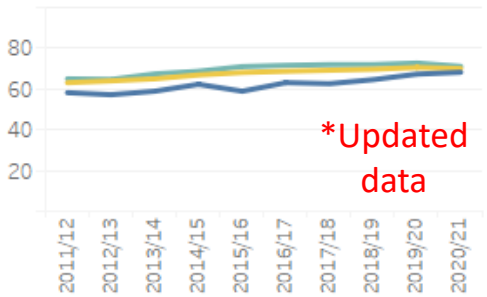
Percentage having enough money to live after bills



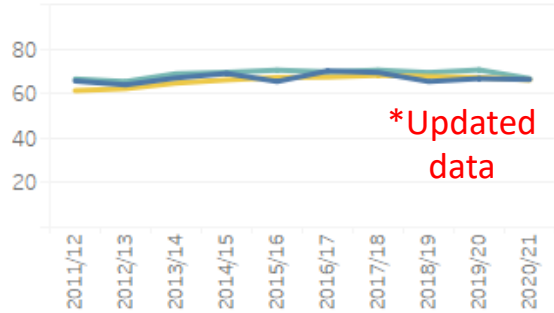
Gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate



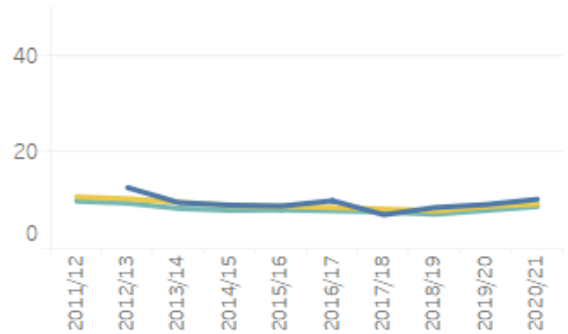
Gap in the employment rate between those who are in receipt of long term support for a learning disability (aged 18 to 64) and the overall employment rate



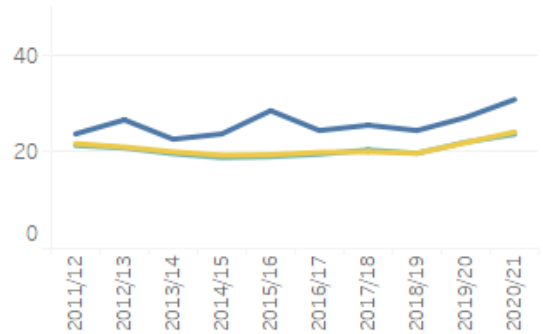
Gap in the employment rate for those who are in contact with secondary mental health services (aged 18 to 69) and on the Care Plan Approach, and the overall employment rate



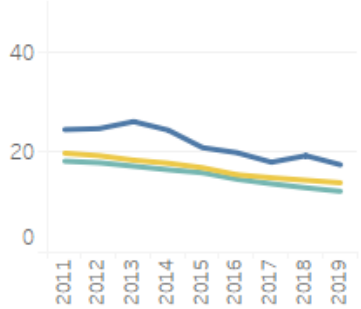
Self-reported wellbeing - people with a low happiness score



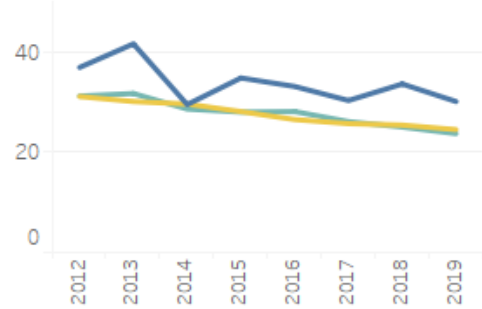
Self-reported wellbeing - people with a high anxiety score



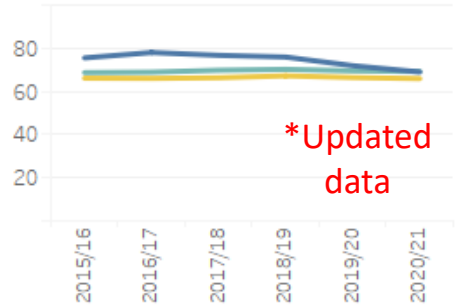
Smoking Prevalence in adults (18+) - current smokers (APS)



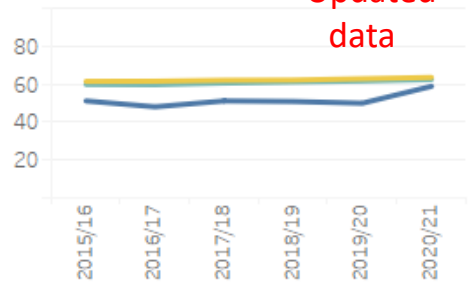
Smoking Prevalence in adults in routine and manual occupations (18-64) - current smokers (APS)



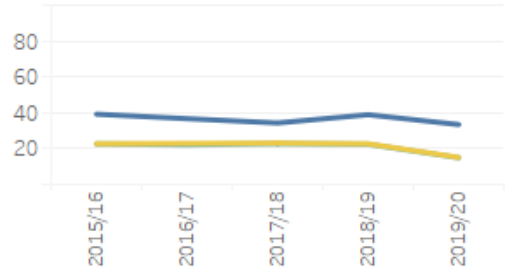
Percentage of physically active adults



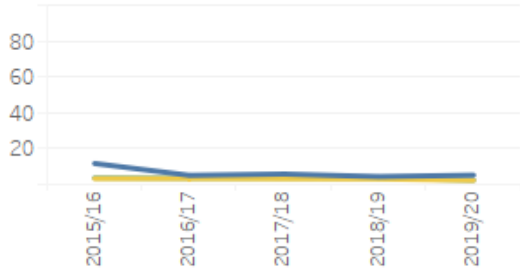
Percentage of adults (aged 18+) classified as overweight or obese



Percentage of adults walking for travel at least three days per week



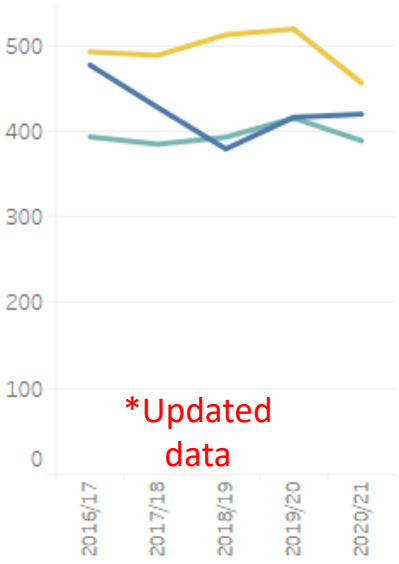
Percentage of adults cycling for travel at least three days per week



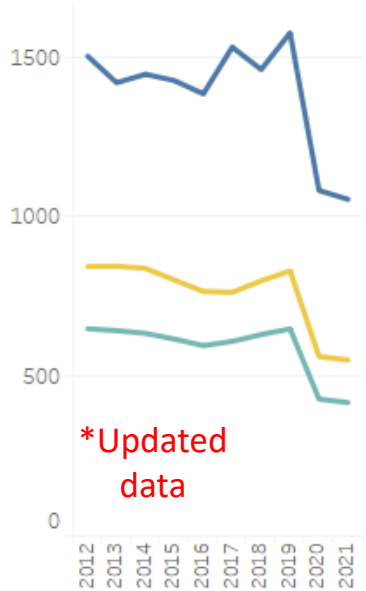
Living Well trends

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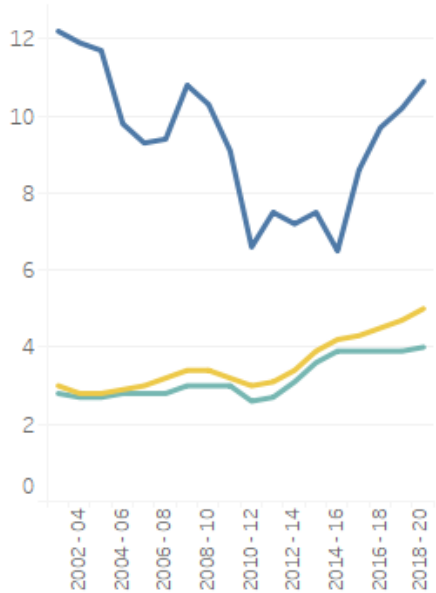
Admission episodes for alcohol-related conditions (Narrow)



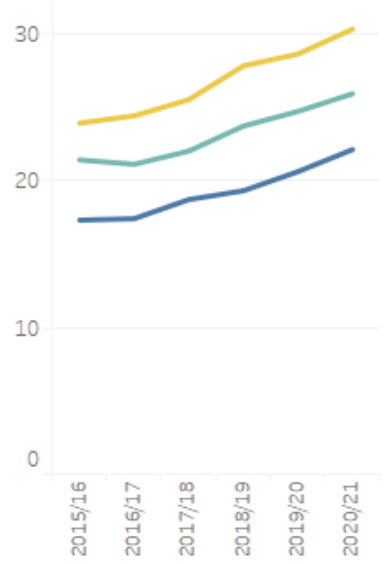
All new STI diagnosis rate / 100,000



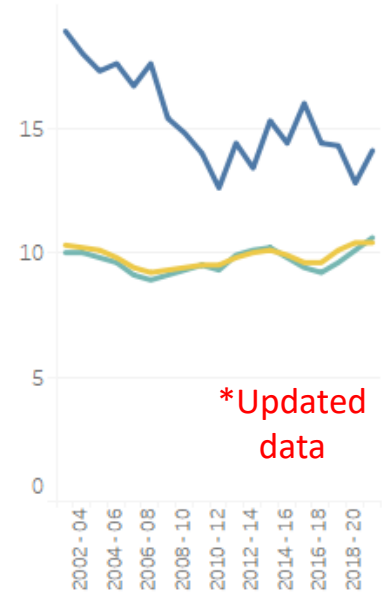
Deaths from drug misuse



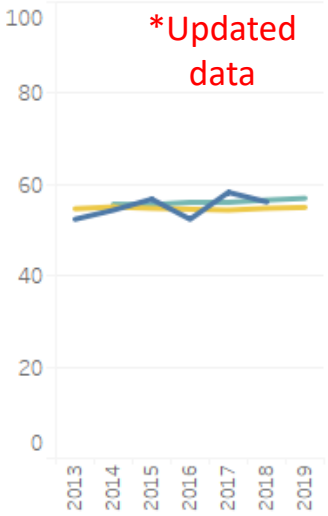
Domestic abuse-related incidents and crimes



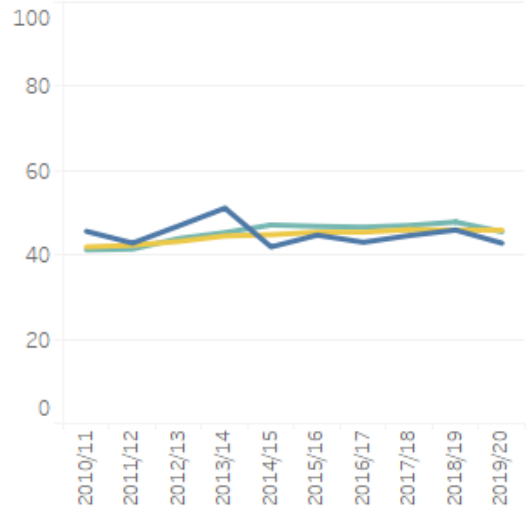
Suicide rate



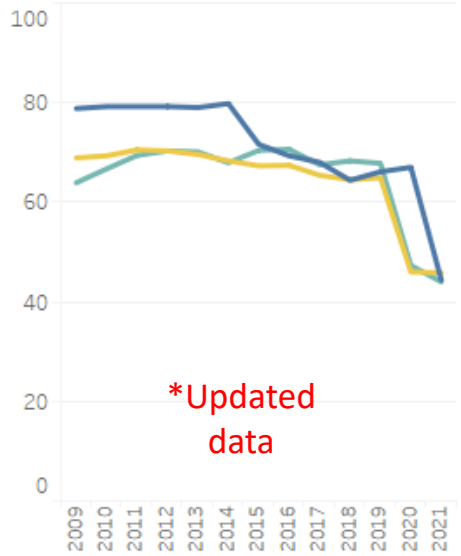
Percentage of cancers diagnosed at stages 1 and 2



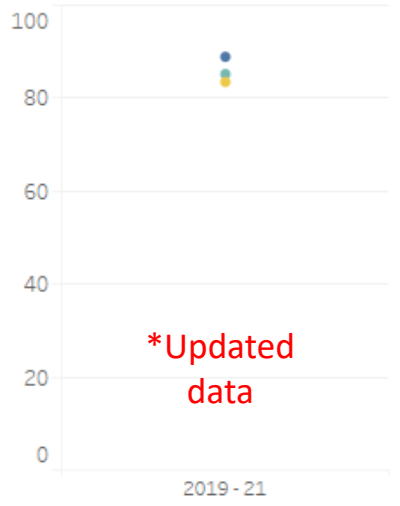
Social Isolation: percentage of adult social care users who have as much social contact as they would like



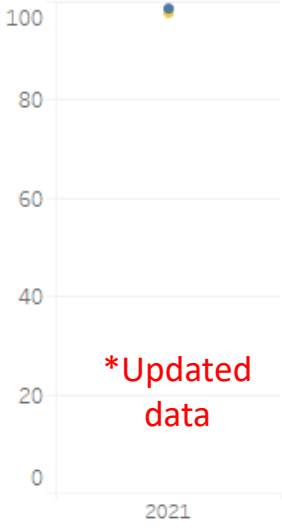
HIV testing coverage, total (%)



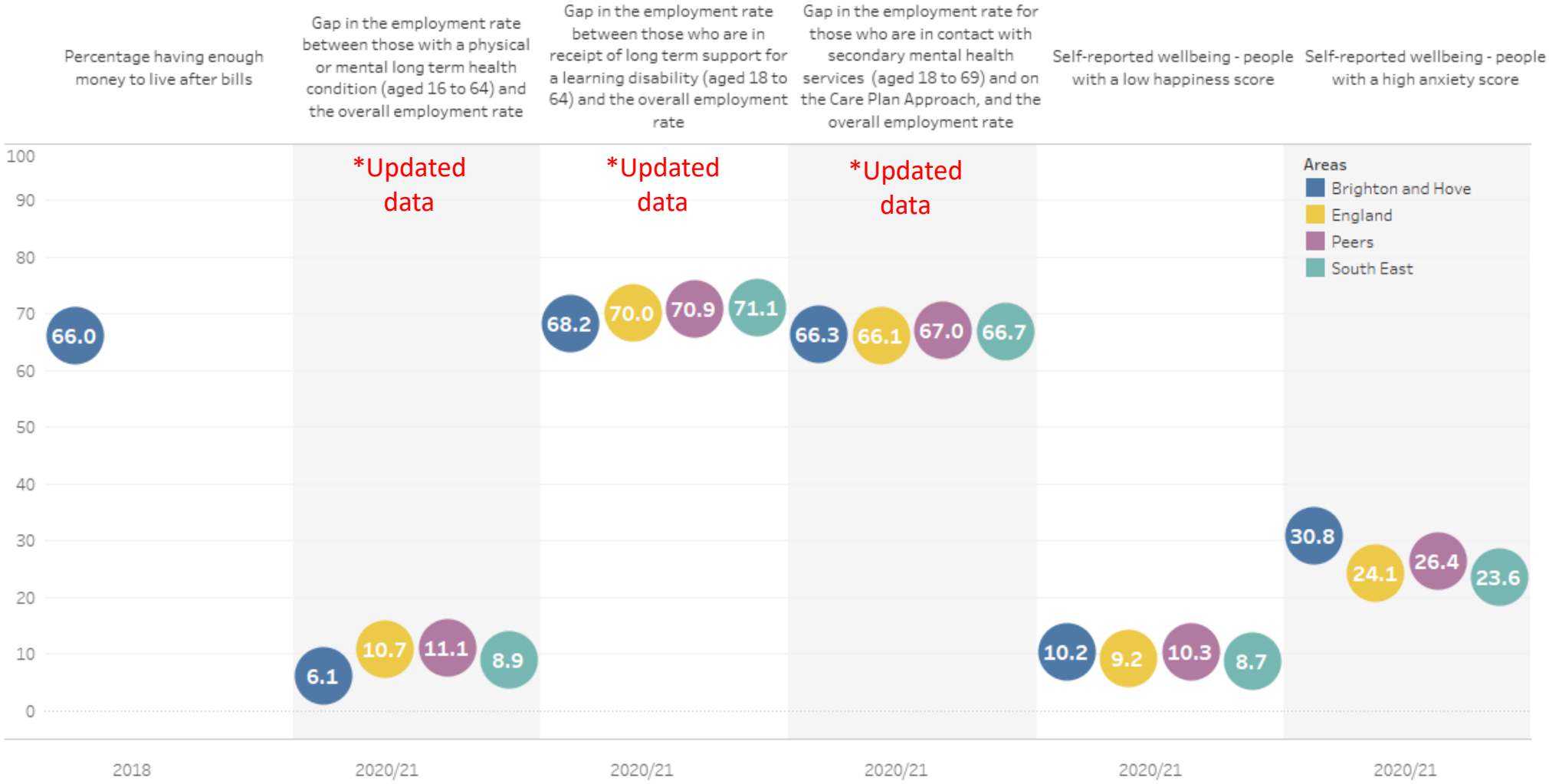
Prompt antiretroviral therapy (ART) initiation in people newly diagnosed with HIV (%)



Virological success in adults accessing HIV care (%)



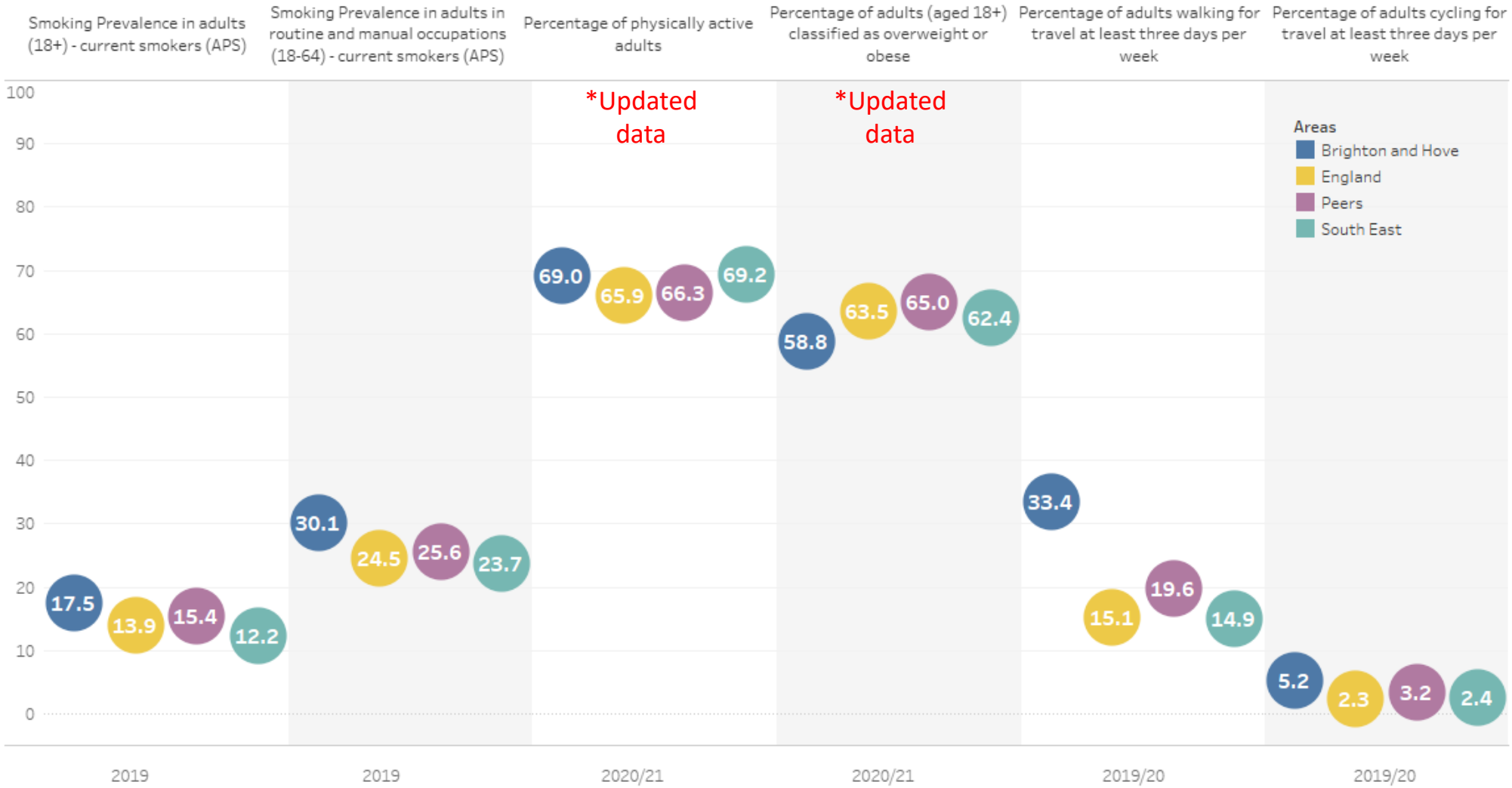
Living Well - latest comparison



Compared to England

Percentage having enough money to live after bills	Gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate	Gap in the employment rate between those who are in receipt of long term support for a learning disability (aged 18 to 64) and the overall employment rate	Gap in the employment rate for those who are in contact with secondary mental health services (aged 18 to 69) and on the Care Plan Approach, and the overall employment rate	Self-reported wellbeing - people with a low happiness score	Self-reported wellbeing - people with a high anxiety score
Not compared	Better	Similar	Similar	Similar	Worse

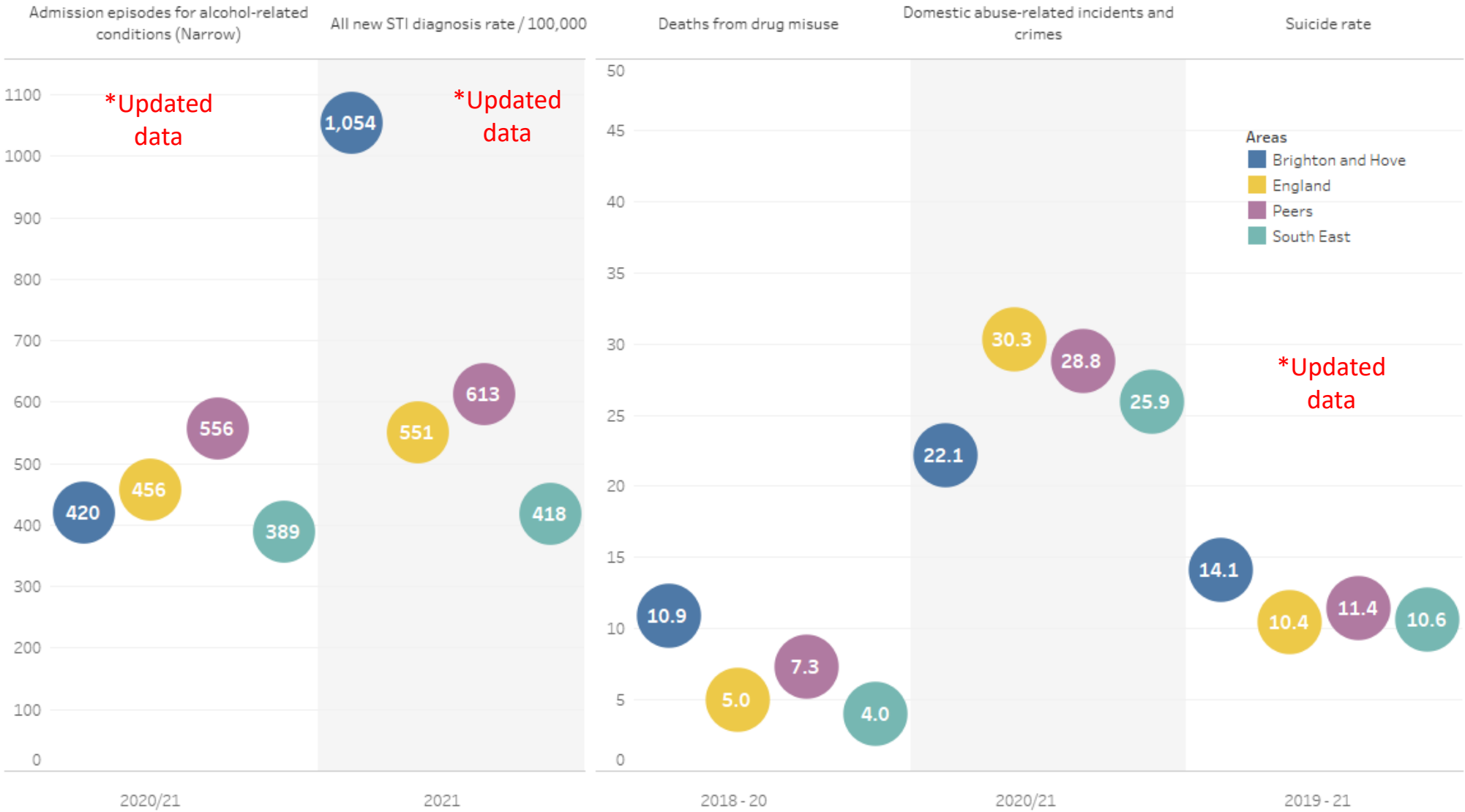
Living Well - latest comparison



Compared to England

Smoking Prevalence in adults (18+) - current smokers (APS)	Smoking Prevalence in adults in routine and manual occupations (18-64) - current smokers (APS)	Percentage of physically active adults	Percentage of adults (aged 18+) classified as overweight or obese	Percentage of adults walking for travel at least three days per week	Percentage of adults cycling for travel at least three days per week
Worse	Similar	Similar	Better	Better	Better

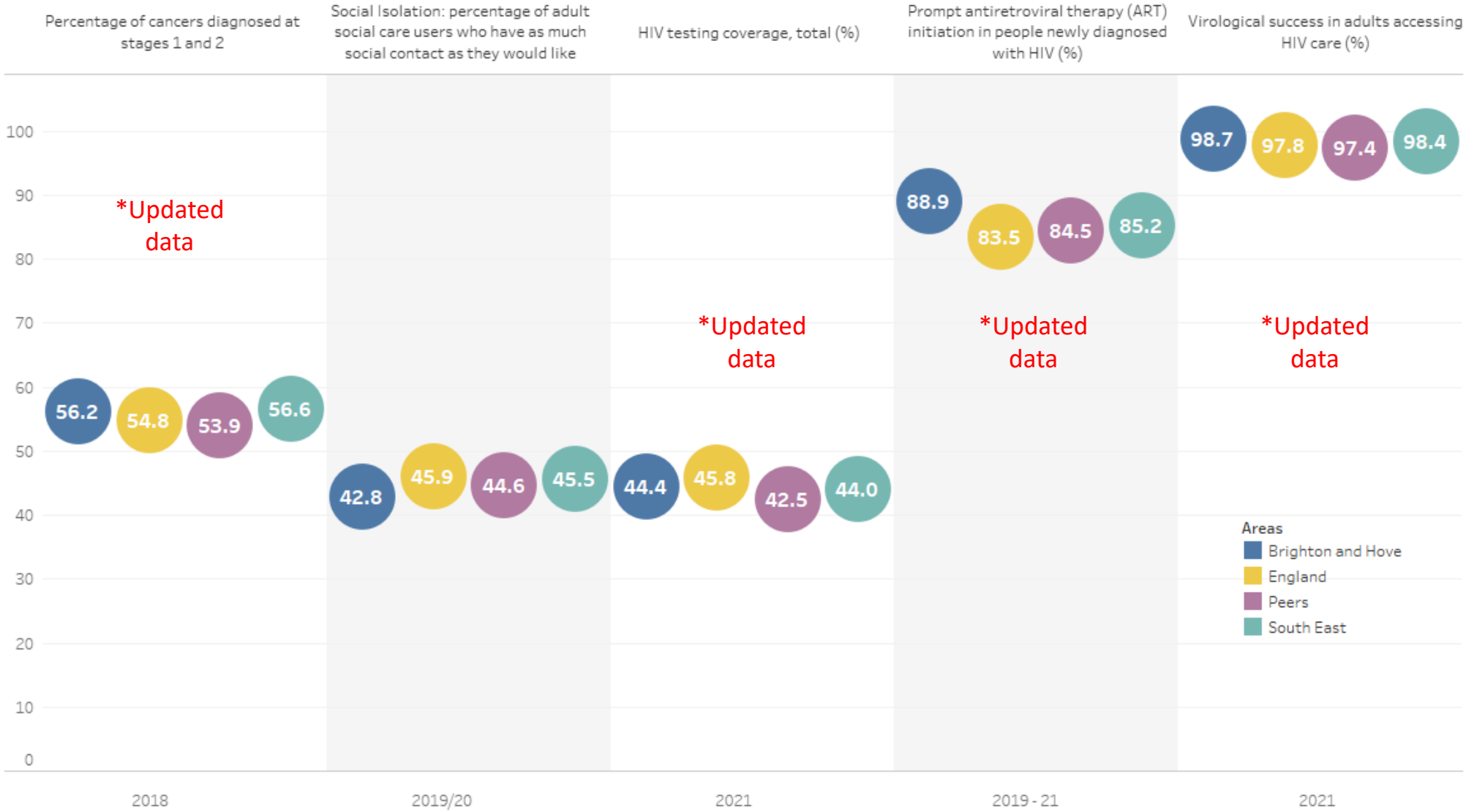
Living Well - latest comparison



Compared to England

Admission episodes for alcohol-related conditions (Narrow)	All new STI diagnosis rate / 100,000	Deaths from drug misuse	Domestic abuse-related incidents and crimes	Suicide rate
Better	Higher	Worse	Not compared	Worse

Living Well - latest comparison



Compared to England

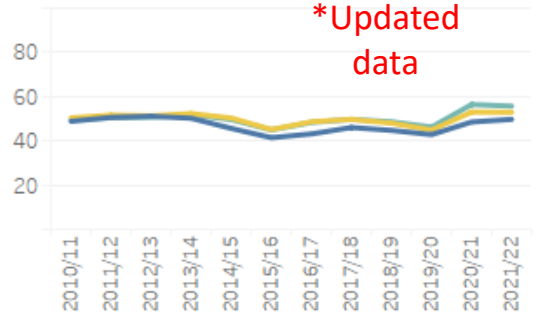
Percentage of cancers diagnosed at stages 1 and 2	Social Isolation: percentage of adult social care users who have as much social contact as they would like	HIV testing coverage, total (%)	Prompt antiretroviral therapy (ART) initiation in people newly diagnosed with HIV (%)	Virological success in adults accessing HIV care (%)
Similar	Similar	Worse	Similar	Better

Ageing Well trends

Brighton and Hove | England | South East

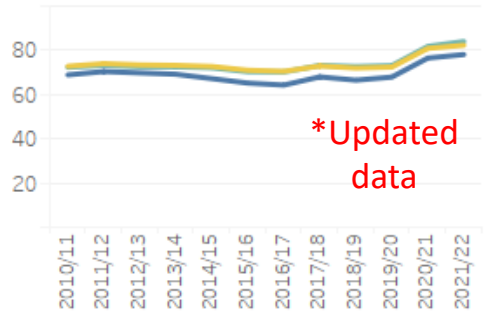
Population vaccination coverage - Flu (at risk individuals)

*Updated data

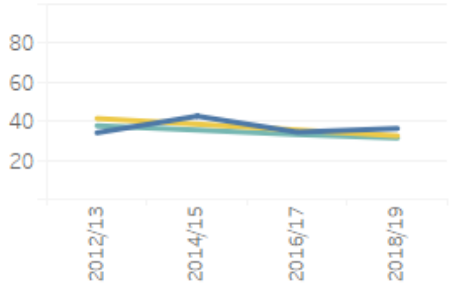


Population vaccination coverage - Flu (aged 65+)

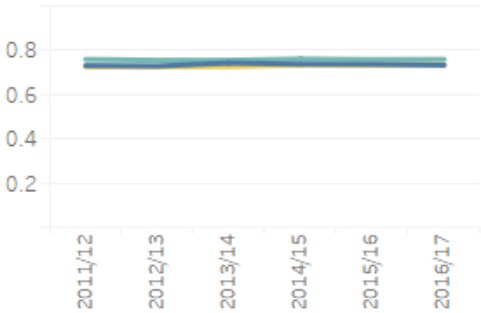
*Updated data



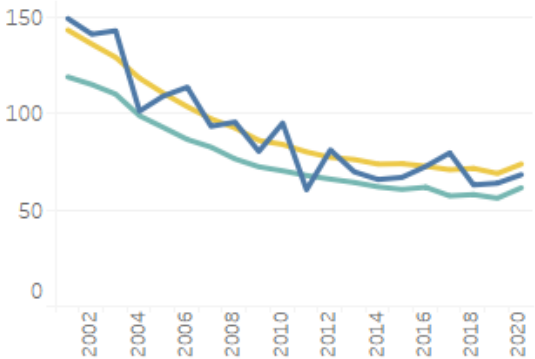
Social Isolation: percentage of adult carers who have as much social contact as they would like



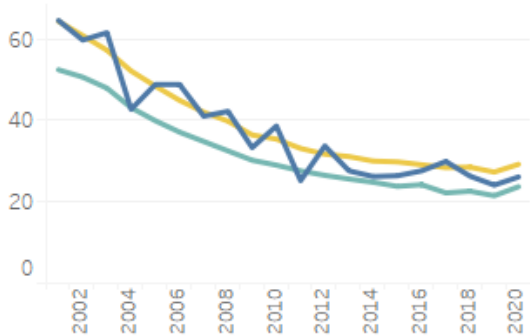
Health related quality of life for older people



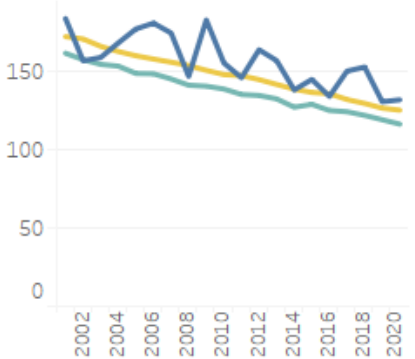
Under 75 mortality rate from all cardiovascular diseases



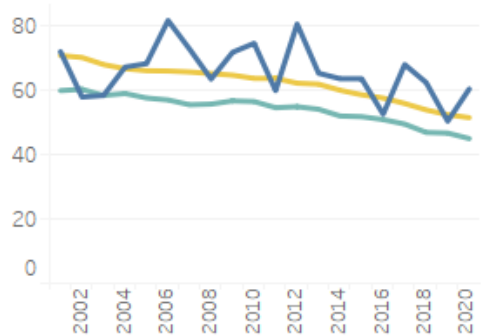
Under 75 mortality rate from cardiovascular diseases considered preventable (2019 definition)



Under 75 mortality rate from cancer

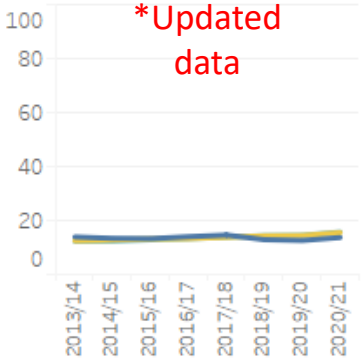


Under 75 mortality rate from cancer considered preventable (2019 definition)

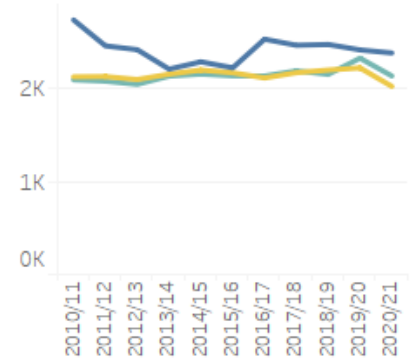


Emergency readmissions within 30 days of discharge from hospital

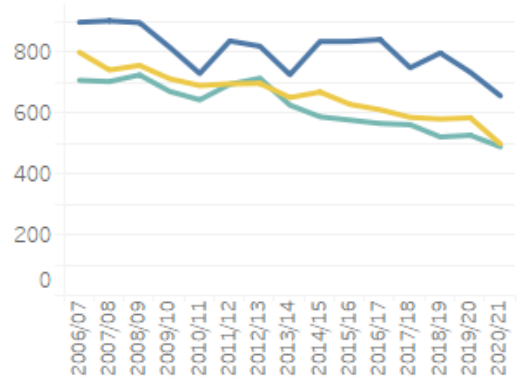
*Updated data



Emergency hospital admissions due to falls in people aged 65 and over



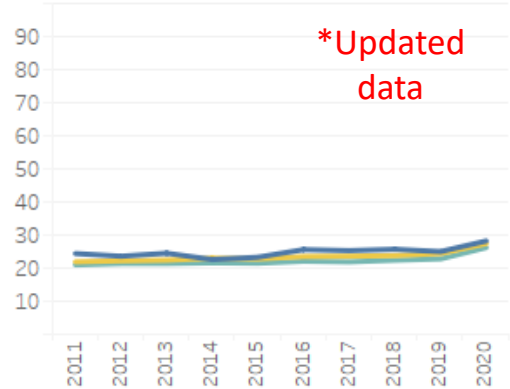
Permanent admissions to residential and nursing care homes per 100,000 aged 65+



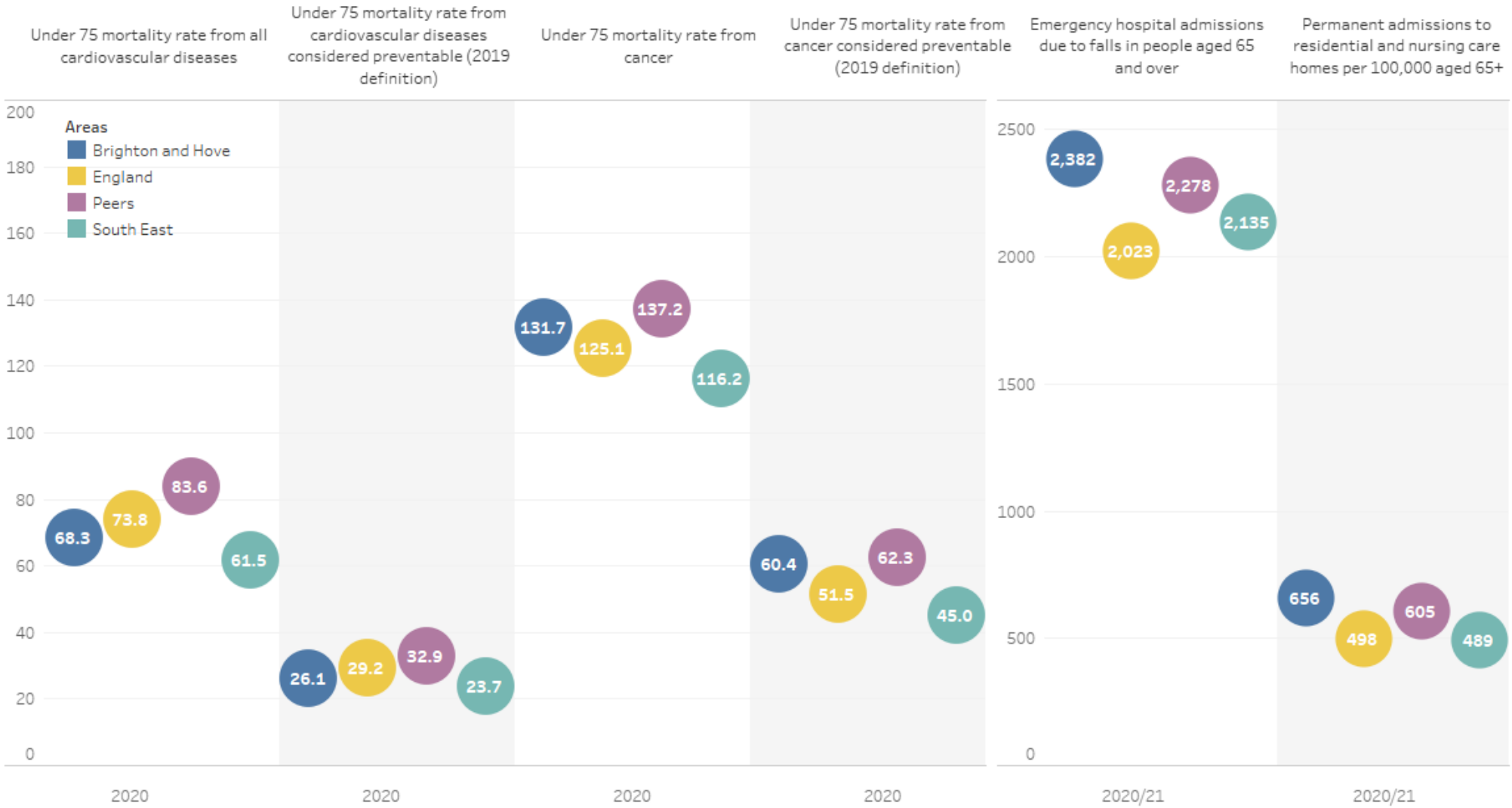
Dying Well trends

Percentage of deaths that occur at home

*Updated data



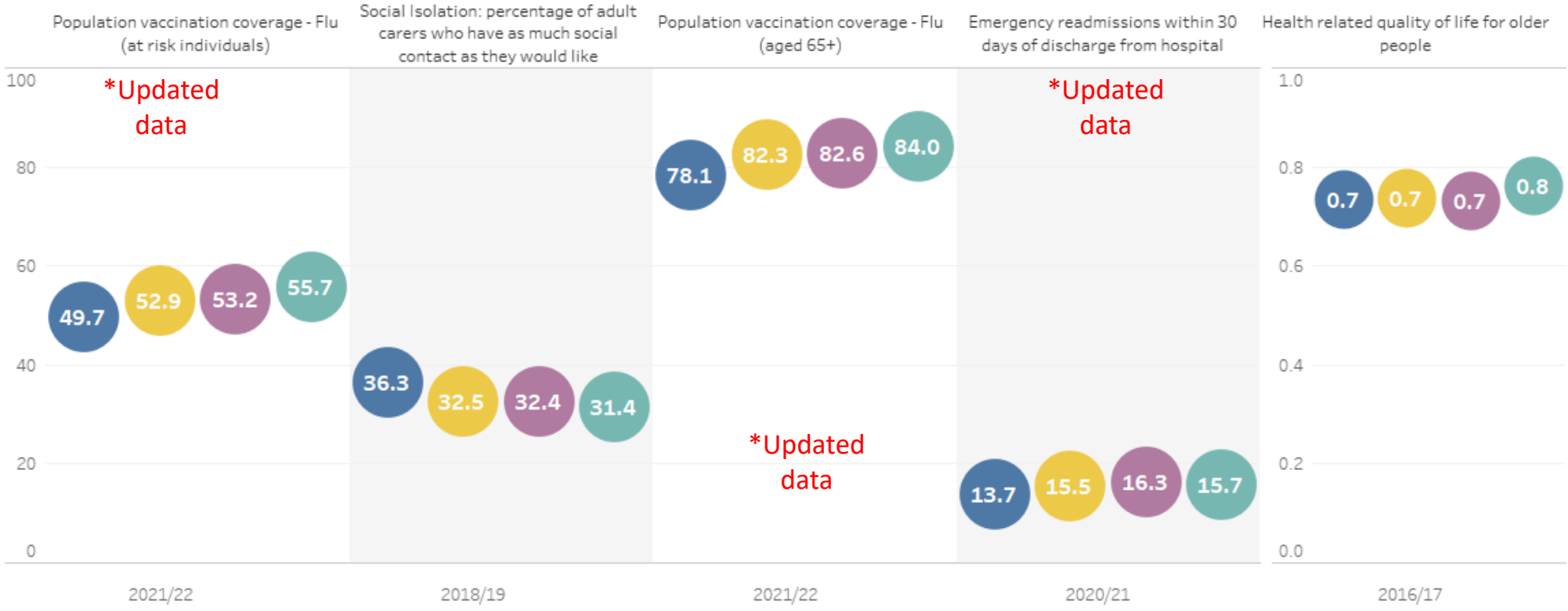
Ageing Well - latest comparison



Compared to England

Under 75 mortality rate from all cardiovascular diseases	Under 75 mortality rate from cardiovascular diseases considered preventable (2019 definition)	Under 75 mortality rate from cancer	Under 75 mortality rate from cancer considered preventable (2019 definition)	Emergency hospital admissions due to falls in people aged 65 and over	Permanent admissions to residential and nursing care homes per 100,000 aged 65+
Similar	Similar	Similar	Similar	Worse	Worse

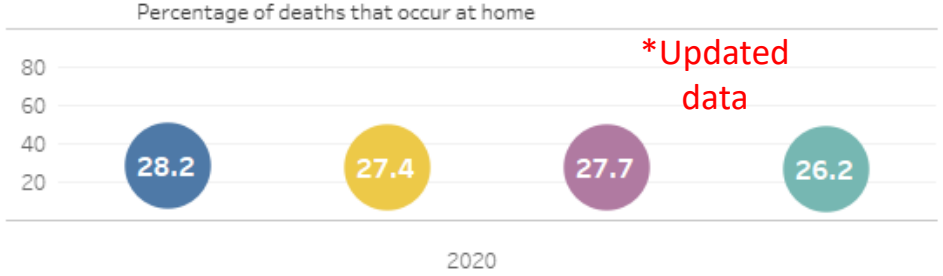
Ageing Well - latest comparison



Compared to England

Population vaccination coverage - Flu (at risk individuals)	Social Isolation: percentage of adult carers who have as much social contact as they would like	Population vaccination coverage - Flu (aged 65+)	Emergency readmissions within 30 days of discharge from hospital	Health related quality of life for older people
Worse	Similar	Worse	Better	Similar

Dying Well - latest comparison



Compared to England

Percentage of deaths that occur at home
Similar

Areas
- Brighton and Hove
- England
- Peers
- South East

Appendices

Current values for High-level strategy indicators

Indicator Name	Time period	Recent Trend	Comp to Eng	Value	
Healthy life expectancy at birth Male	2018 - 20	Cannot be calculated	Similar	65.6	Years
Healthy life expectancy at birth Female	2018 - 20	Cannot be calculated	Similar	65.3	Years
Inequality in healthy life expectancy at birth LA Male	2009 - 13	Cannot be calculated	Not compared	14	Years
Inequality in healthy life expectancy at birth LA Female	2009 - 13	Cannot be calculated	Not compared	12.5	Years

Current values for Starting Well indicators

Indicator Name	Time period	Recent Trend	Comp to Eng	Value	
Child development: percentage of children achieving a good level of development at 2-2½ years	2020/21	Cannot be calculated	Similar	83.2	%
Population vaccination coverage - MMR for two doses (5 years old)	2020/21	Increasing and getting better	Similar	85.9	%
School readiness: percentage of children achieving a good level of development at the end of Reception	2018/19	Increasing and getting better	Similar	71.5	%
School Readiness: percentage of children with free school meal status achieving a good level of development at the end of Reception	2018/19	No significant change	Similar	51.8	%
Year 6: Prevalence of overweight (including obesity)	2019/20	No significant change	Better	28.3	%
Percentage of pupils who feel happy	2021	Cannot be calculated	Not compared	78	%
Alcohol prevalence Year 10 & 11	2021	Cannot be calculated	Not compared	65	%
Cannabis prevalence Year 10 & 11	2021	Cannot be calculated	Not compared	24	%
Smoking prevalence Year 10 & 11	2021	Cannot be calculated	Not compared	31	%
Average Attainment 8 score	2020/21	Cannot be calculated	Better	52.4	Score
Average Attainment 8 score of children in care	2020	Cannot be calculated	Not compared	23.9	Score
Hospital admissions as a result of self-harm	2020/21	No significant change	Worse	578.6	per 100,000

Current values for Living Well indicators

Indicator Name	Time period	Recent Trend	Comp to Eng	Value	
Percentage having enough money to live after bills	2018	Increasing	Not compared	66	%
Gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employme..	2020/21	Cannot be calculated	Better	6.1	Percentage points
Gap in the employment rate between those who are in receipt of long term support for a learning disability (aged 18 to 64) and the overall ..	2020/21	Cannot be calculated	Similar	68.2	Percentage points
Gap in the employment rate for those who are in contact with secondary mental health services (aged 18 to 69) and on the Care PI..	2020/21	Cannot be calculated	Similar	66.3	Percentage points
Self-reported wellbeing - people with a low happiness score	2020/21	Cannot be calculated	Similar	10.2	%
Self-reported wellbeing - people with a high anxiety score	2020/21	Cannot be calculated	Worse	30.8	%
Smoking Prevalence in adults (18+) - current smokers (APS)	2019	Cannot be calculated	Worse	17.5	%
Smoking Prevalence in adults in routine and manual occupations (18-64) - current smokers (APS)	2019	Cannot be calculated	Similar	30.1	%
Admission episodes for alcohol-related conditions (Narrow)	2020/21	No significant change	Better	419.7	per 100,000
Percentage of physically active adults	2020/21	Cannot be calculated	Similar	69	%
Percentage of adults (aged 18+) classified as overweight or obese	2020/21	Cannot be calculated	Better	58.8	%
Percentage of adults walking for travel at least three days per week	2019/20	Cannot be calculated	Better	33.4	%
Percentage of adults cycling for travel at least three days per week	2019/20	Cannot be calculated	Better	5.2	%
All new STI diagnosis rate / 100,000	2021	Decreasing	Higher	1053.7	per 100,000
Deaths from drug misuse	2018 - 20	Cannot be calculated	Worse	10.9	per 100,000
Domestic abuse-related incidents and crimes	2020/21	Cannot be calculated	Not compared	22.1	per 1,000
Percentage of cancers diagnosed at stages 1 and 2	2018	NA	Similar	56.2	%
Suicide rate	2019 - 21	Cannot be calculated	Worse	14.1	per 100,000
Social Isolation: percentage of adult social care users who have as much social contact as they would like	2019/20	Cannot be calculated	Similar	42.8	%
HIV testing coverage, total (%)	2021	Decreasing and getting worse	Worse	44.4	%
Prompt antiretroviral therapy (ART) initiation in people newly diagnosed with HIV (%)	2019 - 21	Cannot be calculated	Similar	88.9	%
Virological success in adults accessing HIV care (%)	2021	Cannot be calculated	Better	98.7	%

Current values for Ageing Well indicators

Indicator Name	Time period	Recent Trend	Comp to Eng	Value	
Population vaccination coverage - Flu (at risk individuals)	2021/22	Increasing and getting better	Worse	49.7	%
Under 75 mortality rate from all cardiovascular diseases	2020	No significant change	Similar	68.3	per 100,000
Under 75 mortality rate from cardiovascular diseases considered preventable (2019 definition)	2020	No significant change	Similar	26.1	per 100,000
Under 75 mortality rate from cancer	2020	No significant change	Similar	131.7	per 100,000
Under 75 mortality rate from cancer considered preventable (2019 definition)	2020	No significant change	Similar	60.4	per 100,000
Social Isolation: percentage of adult carers who have as much social contact as they would like	2018/19	Cannot be calculated	Similar	36.3	%
Population vaccination coverage - Flu (aged 65+)	2021/22	Increasing and getting better	Worse	78.1	%
Emergency readmissions within 30 days of discharge from hospital	2020/21	Cannot be calculated	Better	13.7	%
Health related quality of life for older people	2016/17	Cannot be calculated	Similar	0.733	Score
Emergency hospital admissions due to falls in people aged 65 and over	2020/21	No significant change	Worse	2382.2	per 100,000
Permanent admissions to residential and nursing care homes per 100,000 aged 65+	2020/21	No significant change	Worse	656.1	per 100,000

Current values for Dying Well indicators

Indicator Name	Time period	Recent Trend	Comp to Eng	Value	
Percentage of deaths that occur at home	2020	No significant change	Similar	28.2	%

References

The Peers value has been calculated as an average of the values for each of the statistical nearest neighbours

Local Authority (LA) nearest neighbours

Bournemouth
Bristol
Coventry
Leeds
Medway
Newcastle upon Tyne
North Tyneside
Nottingham
Plymouth
Portsmouth
Sheffield
Southampton
Southend-on-Sea
Swindon
York

Statistical nearest neighbours are provided to give context to help interpret indicators.

The LA nearest neighhours are similar areas based on population, output area density, output area based sparsity, tax base per population, unemployment, retail premises density, housing benefit caseload, people born outside UK and Ireland, households with less than four rooms, households in social rented accommodation, persons in lower NS-SEC (social) groups, standardised mortality ratio, authorities with coast protection expenditure, non-domestic rateable value per population, properties in different tax bands and an area cost adjustment (other services block). Chartered Institute of Public Finance and Accounting. NNM 2015 - England Authorities [Internet]. Available to CIPFAstats+ subscribers from:
https://www.cipfa.org/services/cipfastats/nearest-neighbour-model