BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 22 APRIL 2026

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Wilkinson (Chair)

Also in attendance: Councillor Evans (Deputy Chair), Hill, Hogan, Lademacher, Parrott, Simon, Galvin and Winder

Other Members present: Angela Savage (OPC), Geoffrey Bowden (Healthwatch), Nora Mzaoui (CVS)

PART ONE

27 PROCEDURAL BUSINESS

27.1 Cllr Winder attended the meeting as a substitute. Angela Savage attended as a guest, replacing Mary Davies (Older People's Council) who was unable to attend.

27.2 No member declared an interest in any item.

27.3 The Press & public were not excluded from the meeting.

28 MINUTES

28.1 The minutes of the 11 February 2026 meeting were approved.

29 CHAIR'S COMMUNICATIONS

29.1 The Chair gave the following communications

We're looking at 4 issues today. As a standing item we have an update from NHS commissioners about major NHS changes, including the recent merger of the Surrey and Sussex Integrated Care Boards.

We also have an item focusing on improving urgent care. Some groups of vulnerable people, including people experiencing homelessness and people with drugs or alcohol issues, are much more likely than average to present at A&E for care, are more likely to need admitting to hospital and are much more difficult to discharge in a timely way. This is a particular problem in Brighton & Hove as we are an outlier in terms of both homelessness and substance misuse. Today's report outlines what the health and care system is doing to identify and to better

support people with these types of vulnerabilities, improving their care and hopefully reducing pressures on the urgent care system.

We also have 2 reports focusing on mental health, another issue where Brighton & Hove is an outlier. There's an update from Sussex Partnership Trust on the temporary closure of Chalkhill hospital. We'll look at what impact the closure has had and how SPFT's plans to revise the unit's clinical model, recruit staff and improve the physical environment are progressing.

Finally, we have a report on neighbourhood mental health. This is in 2 parts. SPFT will present on their reconfiguration of their community mental health teams. We also have Southdown here today to talk us through the changes they are making to the wellbeing services they run from Preston Park.

30 PUBLIC INVOLVEMENT

30.1 There was a public question from Mr Patrick Ward about changes being made to city wellbeing services provided by Southdown. Mr Ward asked:

How will Southdown ensure that its proposed changes - perceived by many as unclear, rushed and framed in a way that obscures their true impact - do not result in vulnerable people losing vital long-term support and being pushed into crisis? Specifically, can you explain how a limited drop-in and short-term interventions will safely replace consistent, relationship-based care; what concrete plans are in place to prevent a cliff-edge loss of support once the current transition phase of three months has passed; how will all service users (including those unable to attend sessions or access digital feedback) be meaningfully included; and how will you measure and be held accountable for any increase in crisis referrals or unmet need resulting from these changes?

30.2 The Chair responded that he was unable to answer Mr Ward's question at this point in the meeting, but would ensure this was asked Southdown when they presented a later item at the meeting and would ask Southdown to provide a written response after the meeting. Southdown subsequently provided the following response:

Ensuring continued ongoing support:
From July 2026, the new offer available at the Wellbeing Hub at Preston Park will provide activities each week for existing clients – we are calling these 'social spaces'. Social space will be an ongoing offer (not time limited) and will include a range of activities taken from the following:
Creative: access to art space, art and craft groups
Physical: dancing, gardening
Social: board games, music appreciation, silent book club, singing social group, walking, young person's group, anti-stress colouring, grounding techniques

We currently deliver on average 56 sessions of activity each month with a total average attendance of 288 (these figures do not include sessions run by third parties such as yoga, IT tuition, and creative writing which were included in figures in the HOSC presentation). This means that for each session the average attendance is 5 clients per session.

In the new offer which we plan to deliver from July, there will be on average 40 sessions of a range of the above activities each month. If a similar number of clients continue to access the

activities, this will mean an average attendance of 7.3 clients per session. Most sessions would have capacity for at least 10 people and therefore this indicates the clients currently accessing these groups will be able to continue to do so.

Some groups are more popular than others (singing, dancing, accessible art) and so this may mean that we need to review how we meet this need (adding in more of these groups and reducing less popular groups).
We recognise that the loss of a Saturday provision is a cause of concern to clients and the decision to remove this was an outcome of consultation with staff and the importance of having a robust staffing team available during the week to prevent service closure due to staff absence.
Due to their protective nature and following feedback from clients, we will retain two key groups and commit to their continued delivery: Hearing Voices and the Anchorpoint group for neurodivergent clients.

Transitioning to new model and including all clients:
Throughout May and June, the existing activities will reduce each month from the average of 56 sessions delivered prior to April to the intended 40 sessions in July.

Alongside this, all existing clients will be contacted and offered at least one individual support session to explain the changes, provide signposting if needed and assess risk. Safeguarding procedures will be followed and clients supported to access other immediate support if required.

These conversations will be held in the way that best suits the client, and feedback received will be used to inform how the service model is refined. It remains possible to submit feedback and ideas about services via many other methods, and clients may take the opportunity to participate in the Client Planning Group setup to ensure the timetable is designed with client's views in mind. Qualitative feedback is a key component of ongoing service development.

Crisis referrals and unmet need:
Crisis referrals are monitored via the ICB with the data gathered for the wider population, including those currently facing limited access to community-based mental health services in the Brighton and Hove neighbourhoods. The redesigned service seeks to address unmet need in the area, whilst maintaining familiar elements in the service for existing clients. The redesigned service is also intended to provide existing clients with new ways of accessing community-based support of different types.

31 MEMBER INVOLVEMENT

31.1 There were no member involvement items.

32 IMPROVING URGENT CARE PATHWAYS FOR HOMELESSNESS AND DRUGS & ALCOHOL

32.1 This item was presented by Chas Walker, joint NHS and city council Programme Director for Integration and Service Transformation; Dr Nicola Lang, Director of Public Health; Harry Williams, the council's Director of Housing, People Services; and by Tanya Brown-Griffith, NHS Surrey & Sussex, Director for Joint Commissioning and Integrated Community Teams, Brighton & Hove.

32.2 Mr Walker outlined why it was important to identify people with multiple compound needs (MCN) and to provide focused support, helping them manage health conditions and other issues in community settings and consequently reducing pressures on urgent care. Mr Walker explained how this approach aligns with the NHS Long Term Plan priorities and that it is a core focus of the local Homelessness & Rough Sleeping Strategy. There is a particular focus on supporting people with co-occurring conditions whose combination of mental health and substance misuse problems can make accessing services especially challenging. Initiatives have been developed with the active input of Common Ambition who provide lived experience. Data shows that the programme has had successes to date, with community interventions increasing and acute admissions decreasing over time for some of the most vulnerable communities.

32.3 Cllr Hill asked about the long-term plan to improve flow through the temporary and supported housing pathway. Mr Walker responded that there is a known group of people for whom housing interventions tend not to be effective. The plan is to provide better targeted mental health and drugs & alcohol support to this group, partly via in-reach into hostels. Mr Williams added that there is a long-term vision to provide better integration between support services, initially focused on temporary accommodation but eventually also across general housing.

32.4 Cllr Parrott asked how near the system was to providing a full service, given that relatively few people are covered by pilot initiatives. Mr Walker replied that the multidisciplinary team currently has capacity for around 200 highest priority clients, out of the approximately 1500 people in the city identified as having MCN. However, all people identified with MCN do receive a range of support – the enhanced support provided by the multidisciplinary team is only one type of support on offer.

32.5 Cllr Parrott asked how long people would typically be offered enhanced MCN support. Mr Walker replied that the length of support will vary. People are supported to help engage with mainstream services until they are effectively embedded in the services they need to access. This can be a lengthy process, potentially taking up to 18 months.

32.6 Cllr Evans asked how outcomes will be measured. Mr Walker replied that there will be a number of metrics including avoidable hospital admissions, the number of cases dealt with by multidisciplinary teams, the effectiveness of step-down from hostel beds and the percentage of people accessing the appropriate screening programmes.

32.7 Cllr Lademacher asked whether particular geographies are being targeted. Dr Lang replied that current service provision is patchy across the city and the ambition is to ensure that there is good access everywhere.

32.8 Cllr Parrott asked about steps being taken to prevent people developing MCN. Mr Walker noted this is a major challenge given increasing health inequalities across the city, but it is a priority. Mr Williams added that the council has a good track record of preventing homelessness, but needs to get better at reaching people at risk at an earlier point, for example by working with partners to identify people with drugs & alcohol problems before they reach the point of crisis. Ms Brown-Griffith added that the Drugs & Alcohol Partnership does important work with schools, seeking to identify young people and families in need of support at an early stage.

32.9 Cllr Hogan asked about other measures being taken to reduce avoidable hospital admissions. Dr Lang replied that there are initiatives to reduce admissions for self-harm and also for overdose, for example by ensuring that naloxone is available across a range of community settings. Ms Brown-Griffith added that Integrated Community Teams have also been rolling-out a programme of health checks which will reduce avoidable admissions by identifying people at risk at an early enough stage for them to be more effectively supported in the community.

32.10 Cllr Galvin asked about what is being done to improve communications with GPs around discharge and also to ensure that people leaving hospital have suitable accommodation. Mr Walker replied that homelessness officers are located at both the Royal Sussex and Mill View hospitals. They work closely with Arch GP practice to ensure there is effective post-discharge support and appropriate accommodation for homeless people discharged from hospital.

32.11 The Chair asked whether there is currently enough housing and community care capacity to significantly impact on avoidable hospital admissions and discharge delays. Mr Willaims replied that increasing city housing supply is a priority for the council, as is making significant improvements to the temporary accommodation model. While everyone would like to see more housing and support capacity, the current moves to integrate planning and delivery of support services will reduce pressures on urgent care. There are currently very few discharge delays from the Royal Sussex due to homelessness for Brighton & Hove residents, although the same is not always the case for people resident in other areas.

32.12 Nora Mzaoui asked about poor housing conditions such as damp impacting on health. Mr Williams responded that this is a recognised issue and work is ongoing to improve stock quality in terms of council-owned properties but also across the private rented sector. Dr Lang agreed to provide additional information in writing on how VCS or NHS partners could report damp or mould problems in their clients' homes. Information and details regarding responding to Damp & Mould related matters for both for council and private rented housing are as follows:

- Council Homes. Condensation, damp and mould in your council home.
- Private Rented Sector. Private tenants & Damp and Mould Action Plan.
- Housing association residents should follow housing association complaints procedures. Housing associations are subject to the same regulatory provisions as the council with regard to response to damp and mould, including Housing Ombudsman and Regulator of Social Housing.

32.13 Cllr Winder asked about people's sense of wellbeing and social cohesion. Mr Walker responded that these are important issues which will be addressed through the Neighbourhood Health Programme.

32.14 RESOLVED – that the report be noted.

33 NHS CHANGE APRIL 2026

33.1 This item was presented by Tanya Brown-Griffith, NHS Surrey & Sussex Director for Joint Commissioning and Integrated Community Teams-Brighton and Hove. Ms Brown-Griffith provided an update on recent NHS changes and developments, including the merger of Surrey

and Sussex Integrated Care Boards into one Surrey and Sussex ICB from 1st April and with a significantly reduced commissioning posts headcount to fit the reduced financial envelop.

33.2 Cllr Parrott asked how commissioning staff have coped with the reductions in staffing. Ms Brown-Griffith replied that as expected any consultation where there is this significant reduction would be disruptive and impacted staff negatively, leading to a spike in sickness rates. However, there is a comprehensive stall wellbeing support offer available. The filling of posts commences in May 2026.

33.3 The Chair asked about what changes would be experienced by people locally. Ms Brown-Griffith responded that the impact is on staff not services commissioned but that there will be less local commissioner capacity available. ICBs are moving to a strategic commissioning model which will be longer term and more focused on outcomes and will reduce its role in delivery forums. Providers will be required to step into some of the spaces currently occupied by commissioners.

33.4 Cllr Winder asked about impacts on patient travel time. Ms Brown-Griffith replied that there would be no impacts from the commissioning changes. However, a major service review is imminently expected, and this may include changes that increase or reduce some patient travel times.

33.5 RESOLVED – that the report be noted.

34 NEIGHBOURHOOD MENTAL HEALTH TEAMS

Neighbourhood Mental Health Services

34.1 John Child, Sussex Partnership NHS Foundation Trust (SPFT) Chief Operating Officer, presented the paper on changes to SPFT neighbourhood health services. Matt Gough, Chief Executive, Southdown, was also present. Mr Child outlined NHS Long Term Plan ambitions for mental health, including increasing focus on prevention and on community treatment. Implementing this vision locally will require better multi-agency working at a neighbourhood level, building more effective partnerships, and partners working in less siloed ways. Outcomes will include reducing the level of rejected referrals from community to acute services; increasing the percentage of people getting the right referral; better integration between mental health and public health services; and improving efficiency. Community mental health services will be aligned with the 15 Sussex Integrated Community Teams (ICT). In Brighton & Hove this has involved moving from 2 to 3 mental health community teams reflecting the 3 city ICT footprints.

34.2 Angela Savage asked about support for those people, such as older residents, who may struggle with digital services. Mr Child replied that SPFT offers a range of ways to engage with services for those who struggle with digital access. For example, many services for older people are face to face, particularly cognitive assessment services.

34.3 Cllr Parrott raised concerns about the provision of talking therapies online, noting that online provision may be sub-optimal. Mr Child acknowledged that there are issues with providing these types of therapies digitally.

34.4 Cllr Simon asked for details of how local neighbourhood services would be. Mr Child replied that there is not necessarily a single model, but referenced the existing health hubs in east Brighton and in Hangleton & Knoll and examples of what a neighbourhood might look like.

34.5 Cllr Simon asked how outcomes would be measured. Mr Child replied that key outcome measures will include patient experience, prevention outcomes and the number of people presenting at A&E with a mental health crisis.

34.6 Cllr Simon asked about accessing neighbourhood mental health services. Mr Child replied that the aim is to stop people having to go back to their GP to be referred to a different mental health service. Services will be able to refer patients directly to another service and/or there will eventually be a self-referral option.

34.7 Cllr Winder asked about outreach to seldom-heard communities. Mr Gough replied that this is a core part of a new VCSE model that engages more with VCSE partners with good links to harder to reach communities. Mr Child added that there is also lots of work involving people with lived experience.

34.8 Cllr Parrott asked about managing the risk of having gaps in provision when outsourcing to VCS organisations. Mr Child replied that contracts with the VCS are monitored and assured like any other contract. It should also be recognised that there are benefits in contracting with the VCS, particularly in terms of gaining a nuanced understanding of local populations needs which VCS partners are often best placed to deliver.

34.9 Cllr Lademacher asked about engaging with clients for whom English is not a first language. Mr Child responded that translation services are used, as are community organisations where they may be able to assist and support.

34.10 Cllr Hogan asked how the new model differs from the one it replaces. Mr Child replied that the new model is a much more integrated service rather than a group of standalone services. The ambition is also to develop a self-referral pathway which is not currently available.

34.11 Angela Savage asked about Equality Impact Assessments (EIAs). Mr Child replied that EIAs have been completed at multiple points. He would be happy to share these with the committee if requested.

34.12 Cllr Parrott asked about working with people with lived experience. Mr Child replied that there are 2 groups of people here: professionals working in services who have personal experience of mental health issues, and service users who are ‘experts by experience’. Both groups provide valuable insights.

34.13 The Chair asked whether services are fully staffed and are sufficient to meet needs. Mr Child responded that relatively few services can maintain full staffing at all times, and there is inevitably a gap between demand and capacity. However, the services are now live and will have a positive impact.

34.14 The Chair asked about services for people who do not meet the eligibility criteria. Mr Child replied that a range of support is available from the VCS, primary care and

neighbourhood hubs. Being able to refer people seamlessly between services is key to the success of the new model.

34.15 The Chair thanked Mr Child for his presentation.

Southdown Wellbeing Services

34.16 Matt Gough outlined the new service model for wellbeing services. Change is required to ensure that services deliver with the NHS Long Term Plan vision, are aligned with the reconfiguration of neighbourhood mental health services, reflect funding changes, meet additional demand, and ensure equity of provision across neighbourhoods in Brighton & Hove and East Sussex. Mr Gough acknowledged that there will be an impact on existing clients. The vision for the new service is to provide a service that is easy to access, welcoming and inclusive, and sustainable. There will be a range of support, including facilitated peer groups, walk-in welcome sessions and social spaces. As well as services provided out of the Preston Park hub there will be pop-up services in local communities.

34.17 Cllr Hill asked about crisis provision. Mr Gough replied that this is provided by the Staying Well service which operates 7 days a week. Mr Gough to provide more details following the meeting.

34.18 Cllr Hill asked about pop-up support for residents of Large Panel System (LPS) blocks facing the demolition of their homes. Mr Gough replied that he was uncertain how many residents had been engaged. This is a new way of providing services and learning from the first events is still being processed.

34.19 Geoffrey Bowden asked whether the changes were driven by the need to save money. Mr Gough responded that cost saving is not the primary focus: the challenge is to support as many people as possible within a set funding envelope.

34.20 Cllr Parrott commented that it was unclear how the new service model differs from the old one and consequently hard to conduct effective scrutiny with the information provided. Mr Gough replied that he could not explain the differences in detail at the meeting. However, in brief the current model offers a range of services via facilitated group sessions, yoga groups, and one-to-one support. The model is popular and had been successful. However, there is little or no capacity to accept new clients. The reconfiguration will reduce some services for current clients, but this is the only way to meet additional demand within the available financial envelope.

34.21 Cllr Simon asked about the evidence-base underpinning the model of 8-week peer group working. Mr Gough responded that this is designed around the ‘5 ways to wellbeing’ model.

34.22 Cllr Simon asked about community pop-ups. Mr Gough replied that the focus is currently on transitioning to the new model. Following this, a pop-up programme will be developed by the new neighbourhood lead.

34.23 Cllr Simon asked by how much social space will be reduced. Mr Gough replied that the current provision of 19.5 hours per week will be reduced to 10.5 hours. In time there may be some scope to run volunteer-led groups to replace some of this lost capacity.

34.24 Cllr Simon asked about volunteering. Mr Gough responded that there will be a new volunteer coordinator. There are also plans to roll-out a new volunteer programme in Brighton & Hove with various roles following the success of the 'community connectors' service that operated in East Sussex.

34.25 Cllr Simon asked about attendance figures. Mr Gough replied that the average client attendance is 0.6 hours per week. However, many clients will attend much more regularly than the average suggests.

34.26 The Chair asked why the new model had been adopted and whether existing clients would lose support. Mr Gough replied that the existing model did not provide enough additional capacity to take on new clients, and it was important to try to meet new as well as current client demands. The new model is a refinement of the current model that provides additional capacity. The model has been developed with reference to sectoral research and national best practice. Current service users will experience a reduced level of support. Individual risk assessments have not been conducted by default, but all current clients have been offered one-to-one sessions to assess their needs.

34.27 The Chair asked whether an EIA had been produced. Mr Gough confirmed that it had and he would share both the EIA and the Quality Impact Assessment with the committee.

34.28 Members discussed whether an additional item at committee was required and agreed that the HOSC needed more assurance that the changes would not have negative impacts and that the new model supports a preventative approach. The committee agreed to ask for an update to come to a future meeting.

34.29 RESOLVED – that the report be noted.

35 TEMPORARY CLOSURE OF CHALK HILL HOSPITAL: UPDATE APRIL 2026

35.1 This item was presented by John Child, Sussex Partnership NHS Foundation Trust (SPFT) Chief Operating Officer. Mr Child outlined progress in developing a new operating model for Chalkhill and in improving the condition of the estate.

35.2 Cllr Hill asked about admissions to acute young people mental health beds while Chalkhill has been closed. Mr Child replied that there have been 14 admissions to other adolescent units, 3 to psychiatric intensive care units, one to an under-13 inpatient unit, and 7 to specialist eating disorder beds. No patients have been admitted to adult acute mental health beds or to general paediatric wards.

35.3 Cllr Parrott asked where the general admissions had been. Mr Child replied that 10 had been within the local footprint (covering Kent and Surrey), whilst 4 had been elsewhere in the UK where particular specialist support was required.

35.4 Cllr Parrott asked whether any adverse future impacts from the temporary closure were anticipated. Mr Child responded that, to date there hasn't been any increase in waits for admission in A&E. It may be that enhancing crisis services has helped manage any additional demand.

35.5 The Chair asked when the unit will reopen. Mr Child replied that this is still scheduled for autumn 2026.

35.6 RESOLVED – that the report be noted.

The meeting concluded at 8.10pm

Signed Chair

Dated this day of