Report to	HOSC
Meeting date	February 2026
Report Title	**Brighton & Hove Services Reducing Health Inequalities**
Key question	How is Brighton and Hove Partnership and Integration approach reducing health inequalities.
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Recommendation (outcome/ action requested):

The Board/ Committee/ Group is asked to:

- Endorse continued investment in ICTs, MCN programme and CHIP to sustain impact.
- Recognise the statutory role of local Health & Wellbeing Boards to support population health and address local health inequalities. The Brighton & Hove Health & Wellbeing Board members have agreed the need to refresh the current Joint Health & Wellbeing Strategy to recognise the results of the recent Health Counts survey and the need to refocus on our partnership work to address local health inequalities
- Support data sharing and PHM capability to enhance targeted interventions.
- Strengthen joint commissioning between NHS and BHCC for inclusion health.
- Prioritise screening, hypertension, and smoking cessation recovery to narrow clinical inequality gaps.
- Advocate for housing and complex needs support, essential for improving health outcomes.

Executive summary:

Brighton & Hove faces some of the starkest health inequalities in the Southeast, driven by deprivation, homelessness, complex needs, mental illness, long-term conditions, and poor access to preventive care. In response, the NHS, Brighton & Hove City Council, and the VCSE sector have built one of the most comprehensive local approaches to tackling inequalities .System wide initiatives include Integrated Community Teams facilitating neighbourhood based interventions, Primary Care Networks focusing on clinical inequality improvement, the Multiple Compound Needs programme targeting individuals with the most complex needs and multiple disadvantages, and the Community Health Improvement Programme alongside community development activities to promote prevention and engagement. Additional measures such as the Ageing Well programme support older residents at risk of poverty, frailty and isolation, while dedicated homelessness healthcare initiatives address inclusion health. Public health interventions further tackle wider determinants of health. Collectively, these programmes constitute a robust, multi-layered approach aimed at addressing

inequalities, removing barriers to access, tackling social determinants, reducing structural disadvantage, and meeting the needs of specific population groups. The below programs form a whole system, multi-agency effort that directly reduces unfair, avoidable and systematic differences in health across the city.

- Integrated community level services (ICTs, community health hubs, Ageing Well, community development)
- Targeted clinical improvement (Core20PLUS5, PCN DES delivery, screening & hypertension improvement, SMI health checks)
- Inclusion Health and multiple disadvantage services (MCN programme, homelessness healthcare, rough sleeper outreach, dual-diagnosis support)
- Population health management and preventive activities (JSNA insights, PHM MDTs, health checks, smoking cessation improvements)

Brighton & Hove has implemented robust cross system governance structures, including ICT Leadership Groups, joint oversight by the Health & Wellbeing Board, and dedicated steering groups for Population Health Management and Inclusion Health. These bodies, supported by shared citywide data and dashboards, facilitate unified priorities, collaborative data sharing, and coordinated delivery of targeted health interventions.

1. Population Inequalities and Drivers

Brighton & Hove experiences pronounced and persistent health inequalities, with significant deprivation in areas such as Whitehawk, Moulsecoomb, Hollingbury, and Woodingdean. The city faces high unemployment rates closely tied to mental health challenges, acute housing insecurity, and a substantial number of residents experiencing homelessness. Additional pressures include elevated levels of mental illness, substance misuse, and complex needs, alongside marked disparities in life expectancy, cancer screening uptake, and mortality from serious mental illness. Given Brighton & Hove's younger, diverse population, including large LGBTQ+, neurodivergent, and migrant communities, these issues demand integrated, system-wide action in line with the Core20PLUS5 framework to drive meaningful and sustained improvements in health equity.

2. Current Systemwide Programmes Reducing Health Inequalities

2.1 Integrated Community Teams (ICTs) represent the core architecture for reducing health inequalities at neighbourhood level

- ICTs in East, West, Central and Multiple Compound Needs (MCN) areas provide multidisciplinary, neighbourhood level care aimed at those with the greatest health and social complexity.

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- Local health hubs delivering accessible walk-in support (e.g. East Health Hub)
- Proactive MDTs addressing frailty, long-term conditions, mental health and social complexity
- Shared population health data and dashboards targeting CORE20 areas
- VCSE partnership embedded in all ICTs
- Improved access to BP checks, LTC reviews, mental health support, wellbeing activities
- Reduced avoidable admissions through proactive care (e.g., West Frailty MDT pilot)

2.2 Homelessness and Multiple Compound Needs (H&MCN)

H&MCN is one of the city's Health & Care Partnership population health priorities. The programme was established through the City's Health & Wellbeing Board to help address one of the biggest Health Inequalities in our city. People who are homeless with Multiple Compound Needs have 34 years less life expectancy than the average person. The programme was established in 2022 as our Health & Wellbeing Board community frontrunner programme for the implementation of Integrated Community Teams. In 2024 our partnership agreed to establish Homeless & MCNs as one of our 4 Integrated Community Teams. This model is supported by an investment of over £1.5 million from the Better Care Fund supporting specialist inclusion health. This funding is combined with local authority commitments to housing, social care, and lived experience, forming the H&MCN ICT.

The Brighton & Hove MCN Programme addresses health inequalities by uniting partners across medical, health inclusion, mental health, public health, housing, social care, and VCSE sectors. It focuses on individuals experiencing the greatest disadvantage by delivering integrated, multidisciplinary care encompassing health, housing, mental health, and social needs. The programme aims to reduce crisis service dependency and improve outcomes, as evidenced by external evaluation. Inclusion Health is embedded in ICT neighbourhood models to ensure long-term system alignment, with data, lived experience, and co-production informing targeted interventions for those least served by traditional healthcare.

The Brighton & Hove MCN Programme reduces health inequalities by bringing together partners across ARCH medical, health inclusion teams, mental health services, Local authority Public Health, housing, social care and VCSE partners like Change Grow Live, Common Ambition to:

- Focusing on people experiencing the deepest disadvantage, who face the starkest gaps in life expectancy and access.

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- Providing integrated multidisciplinary care that addresses health, housing, mental health, and social factors together.
- Reducing crisis service reliance and improving individual outcomes, as shown through external evaluation.
- Embedding Inclusion Health into ICT neighbourhood models, ensuring long term system alignment.
- Using data, lived experience, and co production to shape targeted interventions that reach those most excluded from traditional healthcare.

The ICT operates under a Compact Partnership Agreement, has mapped the local H&MCN population, and delivers intensive, proactive care coordination through a multidisciplinary team—including an in-reach presence at the County Hospital. It also informs the future design and commissioning of an integrated health and care system for people experiencing homelessness and multiple complex needs.

2.3 Primary Care Networks (PCN DES & Core20PLUS5 Delivery)

This PCN DES is a key driver in Brighton & Hove's approach to reducing health inequalities, providing the operational framework through which primary care delivers targeted, data driven and community integrated services. Through the DES, all Brighton & Hove PCNs use population health management, neighbourhood level intelligence and Core20PLUS5 priorities to identify residents experiencing the poorest access, experience and outcomes, ensuring resources and interventions are focused where they are most needed.

PCNs are central partners within the city's Integrated Community Teams (ICTs), enabling coordinated, place-based delivery of prevention, early intervention and personalised care. The DES mandates close working with community, social care, pharmacy and VCSE organisations, allowing PCNs to co design and deliver targeted support for groups such as young people in mental health transition, carers, globally displaced communities and LGBTQ+ residents local "PLUS groups" identified through Brighton & Hove's inequality profiling. This joined up DES enabled approach ensures that primary care is consistently and systematically closing the inequality gap across the city.

Delivery through the DES ensures systematic action on the five national CORE20PLUS5 clinical priorities, this is reflected locally in PCN led projects. PCNs contribute through clinical improvement, personalised care and prevention. PCNs are a core delivery arm for clinical inequality priorities.

- Hypertension case-finding and treatment
- Chronic respiratory disease support & vaccination drives
- SMI annual physical health checks
- Cancer early diagnosis via screening outreach

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- Social prescribing targeted to carers, migrants, vulnerable adults
- Data-driven work using PHM tools to identify high-risk cohorts
- Workforce expansion: pharmacists, mental health practitioners, physios, care coordinators

2.4 Ageing Well Partnership (50+)

The Ageing Well Partnership, led by Impact Initiatives, is a citywide programme supporting adults aged 50 and over to maintain independence, wellbeing, and social connection. It provides a single point of access to coordinated community-based activities, advice, and tailored interventions, reducing barriers for older people particularly those at risk of isolation, poverty, poor health, or digital exclusion. The partnership conducts targeted outreach to socially isolated individuals, BAME and LGBTQ+ communities, people aged 85+, and those on low incomes, offering culturally relevant support and dedicated groups to foster inclusion and belonging. Delivered by ten local organisations and jointly commissioned by Brighton & Hove City Council and NHS Sussex, the service reduces health inequalities through befriending services, wellbeing groups, specialist mobility and activity support, and the Age Without Limits anti-ageism campaign. A strong emphasis on equity ensures that those most affected by inequality are proactively supported and included across Brighton & Hove. This service systematically reduces poor ageing outcomes and improves independence and wellbeing providing:

- Single point of access for older adults
- Targeted outreach to socially isolated, BAME, LGBTQ+ and very elderly (85+) residents
- Befriending, wellbeing groups, financial/benefits advice
- Specialist support for mobility, activity and reducing loneliness
- Age Without Limits campaign tackling ageism

2.5 Social Prescribing

Brighton and Hove Social Prescribing service, in partnership with local organisations, is committed to reducing health inequalities by providing targeted support to underserved communities, ensuring equitable access to healthcare resources and promoting early intervention and personalised care. The Service delivered by Together Co works within CORE20 areas across the city and is integrated within the city's neighbourhood teams.

The service uses trusted and well-established community and neighbourhood links to reach people who face the greatest barriers to accessing support and who are experiencing some of the worst predicted health outcomes locally and nationally, supporting people from communities: LGBTQIA+, black and racially minoritised people, refugees, migrants and asylum seekers, people with language translation need, Gypsies, Roma and Traveler's and people with learning disabilities VCSE partners work together to deliver a combination of

specialist social prescribing link worker support, community-based triage, outreach and engagement.

Engagement with those who face health inequality is undertaken via the delivery of neighbourhood drop-ins, groups, outreach and supportive conversations before linking people with appropriate support services, or where needed, referred into the provider's specialist social prescribing service. In quarter 1 and 2 (2025/26) 44% of people supported were from CORE20 areas, 32% were people within ethnic communities, 20% were LGBTQ+. Interventions have included increasing social interactions, supporting people with literacy or language barriers to complete forms e.g. benefits and advocating for people with multiple long-term conditions with their health, wellbeing and housing needs. Using a personalised care approach, other inventions are offered e.g. vaccination.

2.6 Carers Hub

Carers Hub services in Brighton & Hove play a crucial role in reducing health inequalities by improving early identification of unpaid carers, many of whom do not recognise their caring role and ensuring they receive timely, proportionate support that protects their own health and wellbeing.

Through a single point of contact offering information, advice, assessment and tailored support, alongside specialist projects for young carers, carers of people with mental health needs, dementia carers and end-of-life carers, the Hub reaches groups at heightened risk of poor outcomes.

Hospital links with our carer's hub help support carers at A&E, on wards and through discharge pathways, reducing crisis escalation and improving continuity of care. Carer identification across primary and secondary care and aligning with local Core20PLUS5 priorities particularly young carers and mental-health-related needs the Carers Hub makes a significant local contribution to addressing health inequalities and improving outcomes for both carers and the people they support.

2.7 Act on Cancer Together (ACT)

ACT is a local partnership between The Trust for Developing Communities and The Hangleton and Knoll Project. It's supported by Macmillan Cancer Support, Brighton and Hove City Council Public Health and NHS Sussex. The service aims to make sure everyone can access the information and support they need because we want cancer to be found early and treated quickly. Partnership working within the VCSE enables specialist and targeted outreach to reduce health inequalities and support healthier communities. Across the West hove PCN patients who had not responded to bowel and cervical screening invitations were called to offer them support to complete screening. We have delivered cancer awareness sessions to people through workshops, events and outreach to community groups. We have actively promoted public health campaigns around breast, bowel, cervical screening and prostate cancer across our communities.

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2.8 Domestic Abuse Specialist Service

As part of the Violence Against Women and Girls (VAWG) Strategy this service continues to make a measurable contribution to reducing health inequalities, in line with the Core20PLUS5 framework. In Q2(25/26) the service supported 558 victims, with significant reach into the most disadvantaged groups, including those experiencing poverty, unstable housing, severe mental illness, and multi-disadvantage, as well as PLUS groups such as people with no recourse to public funds, BME communities, younger adults, and LGBTQ+ survivors. Through trauma-informed early intervention, increased helpline access, and strong multi-agency working with Adult Social Care, SPFT, MARAC and housing services.

DASS ensures that individuals at highest risk of harm particularly those who often fall between service thresholds receive timely safeguarding, advocacy and support. This activity provides strong assurance that the service is actively addressing inequalities in safety, health outcomes and access to care across Brighton and Hove.

2.9 High Intensity User Program

The service delivered by British Red Cross provides targeted support to individuals who disproportionately rely on Emergency Department services due to complex physical, mental, and social needs, many of whom fall within the most disadvantaged Core20PLUS5 population groups. By delivering intensive psychosocial support, personalised care planning, and active coordination with GP practices and community services, the program addresses the underlying drivers of repeated crisis presentations including social isolation, severe mental illness, homelessness and long-term conditions, thereby improving health outcomes for the city's most vulnerable residents. Evidence shows the HIU service consistently reduces unplanned ED attendances and hospital admissions while enhancing quality of life, making it a key local intervention for tackling health inequalities and supporting system priorities around Multiple Compound Needs

2.10 WorkWell

WorkWell is a nationally funded, locally delivered programme designed to reduce economic inactivity and unemployment among working-age adults with disabilities and health conditions (specifically MSK and mental health conditions).

Sussex faces higher-than-average economic inactivity, health inequalities, and deprivation, particularly in coastal and urban areas. Brighton and Hove deliver WorkWell through Integrated Neighbourhood Teams and Primary Care, embedding multidisciplinary teams to provide early, holistic, and personalised support. The approach aligns with the Department of health and social care WorkWell Prospectus 2025 and leverages local insights to ensure the programme is clinically connected, community-based, and scalable across all ICTs.

The East Brighton WorkWell Pilot is designed to reduce health inequalities by supporting residents who are out of work or at risk of unemployment due to mental health, MSK

conditions, or wider social and digital barriers. Through a local partnership delivery, the pilot provides accessible coaching, peer support, and digital inclusion for people who face the greatest challenges in accessing employment and health related support.

Using a peer champion model and co-produced resources, the pilot empowers participants, builds confidence, strengthens local referral pathways, addressing key drivers of inequality such as digital exclusion and social isolation. Intensive occupational therapy led support for 10–12 individuals, alongside foundational employment guidance for a further 8–10 residents, helps people progress toward improved wellbeing, job readiness, volunteering, and employment.

By integrating health, employment, and community services, the pilot strengthens local system working and builds sustainable community capacity. Its legacy of a trained WorkWell Champion and a co-produced resource pack supports ongoing community resilience and contributes to reducing economic inactivity in East Brighton.

Integrated Community Teams and Community development

As set out in the introduction Integrated Community Teams (ICTs) are a Sussex System programme that supports the aims of our Sussex Improving Lives Together Strategy and the new direction of the national NHS long-term plan and the reform ambition around the new Neighbourhood Health Model.

We have four established ICTs, 3 neighbourhood-based teams East, West and Central. One city wide community of Interest ICT supporting people who are homeless with multiple compound Needs. Brighton & Hove Health & Care Partnership took the decision to ask our established Community Development Partners to (HKP and TDC) to convene and chair our 3 neighbourhood ICTs. This ensures our ICTs have strong community engagement foundations especially in communities with higher levels of deprivation and associated health inequalities.

Based on the learning from the Health Inequalities Programme, each of our ICTs have established new models of integrated community health delivery which have targeted local communities with higher levels of health inequalities. In the West of the city the local Health Forum has been delivering community health days in the Hangleton, Mile Oak and Knoll areas of the city. The East ICT has established the East community health hub in the heart of the Whitehawk Estate with satellite models working into the Bevendean and Moulescomb. The Central ICT have been supporting existing community hubs in the Hollingdean, Hollingbury and Tanner areas of the city. The key aims of these integrated community health models is to make health care more accessible and tailored to the needs of these local communities and ensuring these solutions are co-designed with these communities.

Our ICTs are now leading on responding to the key health inequalities identified through the recent Health Counts Survey. The Health Counts data has been presented at an ICT level,

and each ICT is developing a local plan, which will include how they will help address the local health inequalities in their local communities

3. Children and Young People

Brighton & Hove delivers a comprehensive, system wide offer to reduce health inequalities for children and young people through an integrated partnership across BHCC, NHS Sussex and the VCSE sector. Guided by the Children & Young People's Board and a population health approach, the city prioritises early intervention, improved access and targeted support for groups with poorer outcomes, including young carers, young people with mental health needs, neurodivergent children and those transitioning into adulthood. A jointly funded expansion of school based mental health counselling ensures that every secondary aged pupil can access emotional wellbeing support, while wider community-based programmes such as the Community Health Inequalities Programme (CHIP), neighbourhood health forums and targeted outreach to migrant, refugee and inclusion health groups strengthen prevention and access to services.

The emerging Family Hubs model, currently being aligned with Integrated Community Teams, will further integrate early years, parenting, health visiting, SEND, mental health and community support to provide a single, accessible local offer for families, with a strong focus on addressing inequalities from the earliest stages of life. Family Hubs form part of the national Family Help framework and deliver a broad offer of targeted services, including navigation support, evidence-based interventions, whole family keywork, Team Around the Family (TAF) coordination, youth participation, and access to health services, information and advice.

In Brighton & Hove, the model operates through four Family Hub network areas, each with a main Hub and multiple spoke delivery points located in areas of highest deprivation, ensuring support is accessible where need is greatest. The Hubs provide routes into free early years entitlement, crisis support, SEND and learning support, on site nurseries, and community-based activities. They are being aligned with Integrated Community Teams, strengthening neighbourhood level integration and enabling families to access health, wellbeing, and community provision in a single, coordinated system.

3.1 Asthma

Medicines Optimisation Incentive Scheme for Primary Care for 25/26 with a focus on Asthma launched on 01 April 2025 in collaboration between ICB Meds Op and Community team. 146 out of 156 practices in Sussex have signed up to the scheme.

Existing smoking and vaping cessation offer across Sussex have been mapped out and two information pages have been created: one for clinicians hosted on the intranet, and one public-facing one on the website. These pages include the CYP offer. Youth Consultants will review public-facing information to ensure it is young-person friendly. There has been 8

assurance provided by smoking cessation services being designed for young people and clear guidelines BH to confirm position (response pending). Discussions have been held with Specialist Respiratory Nurse in Kings College London who is happy to support with hosting webinar for clinicians to discuss vaping solutions.

A breadth of resources is being developed for patients/parents/carers, healthcare professionals and schools. These materials are currently being reviewed by families, young people and wider stakeholders and will be made available on the ICB public website. Current work underway to understand how Beat Asthma resources can be adopted and promoted locally.

Ongoing progression of the Asthma Friendly Schools programme to increase the number of accredited schools in Sussex. A new sustainable model launched from September 2025, seeing the AFS programme being integrated within existing School Health Teams. December 2025, a new Brighton and Hove lead in place supporting progression of this work. A new live webinar training model for schools is also being trialled, utilising accredited materials from the Royal College of Paediatrics and Child Health.

Embedding education offer within all paediatric settings in primary care and acute trusts. Tier 1 training rates for Sussex are up 54% compared to the same time last year, and Sussex is the best performing ICB in the region for Tier 1 training completion. Sussex ICB is also the best performing ICB for Tier 2 training in the SE region.

3.2 Epilepsy

Sussex has been selected as one of five systems across the country to pilot a new Epilepsy app for CYP and their families. The pilot will run at Royal Alexandra Children's Hospital in Brighton. Regular monthly meetings take place between ICB, Tiny Medical Apps (TMA) and UHSx to ensure progress. Contractual arrangements are being finalised between UHSx and TMA. Communications materials are being developed by TMA and ICB and UHSx comms teams will help to promote the app. Local materials are being collated which will link into the app once launched.

4. Conclusion

Brighton & Hove has developed a strong, coordinated approach to reducing health inequalities, bringing together the NHS, council services and community partners to support residents with the greatest needs. By strengthening neighbourhood-based teams, improving access to preventative care, and focusing on groups most affected by poor health outcomes, the city will continue its focused work to reducing gaps in health inequalities. Continued investment in integrated working, data-driven planning and community-led services will be essential to sustaining this progress and ensuring that every resident has fair and equal access to services provided.