Sussex Health&Care

# HOSC: Health inequalities in Brighton & Hove

47

February 2026

*Improving Lives Together*

# Understanding our population and their health and wellbeing needs

- ❑ What are health inequalities
- ❑ Our population
- ❑ The building blocks of health
- ❑ Population Outcomes Framework priority areas
- ❑ Inequalities and Health Counts
- ❑ System Event (December 2025)
- ❑ B&H Partnership Approach to Reducing Health Inequalities
- ❑ Next Steps

# Health inequalities are not inevitable, and the gaps are not fixed. Evidence shows that a comprehensive, multifaceted approach to tackling them can make a difference.

**Definition of Health Inequality;**

- Unfair or unjust differences in health determinants or outcomes within or between defined populations

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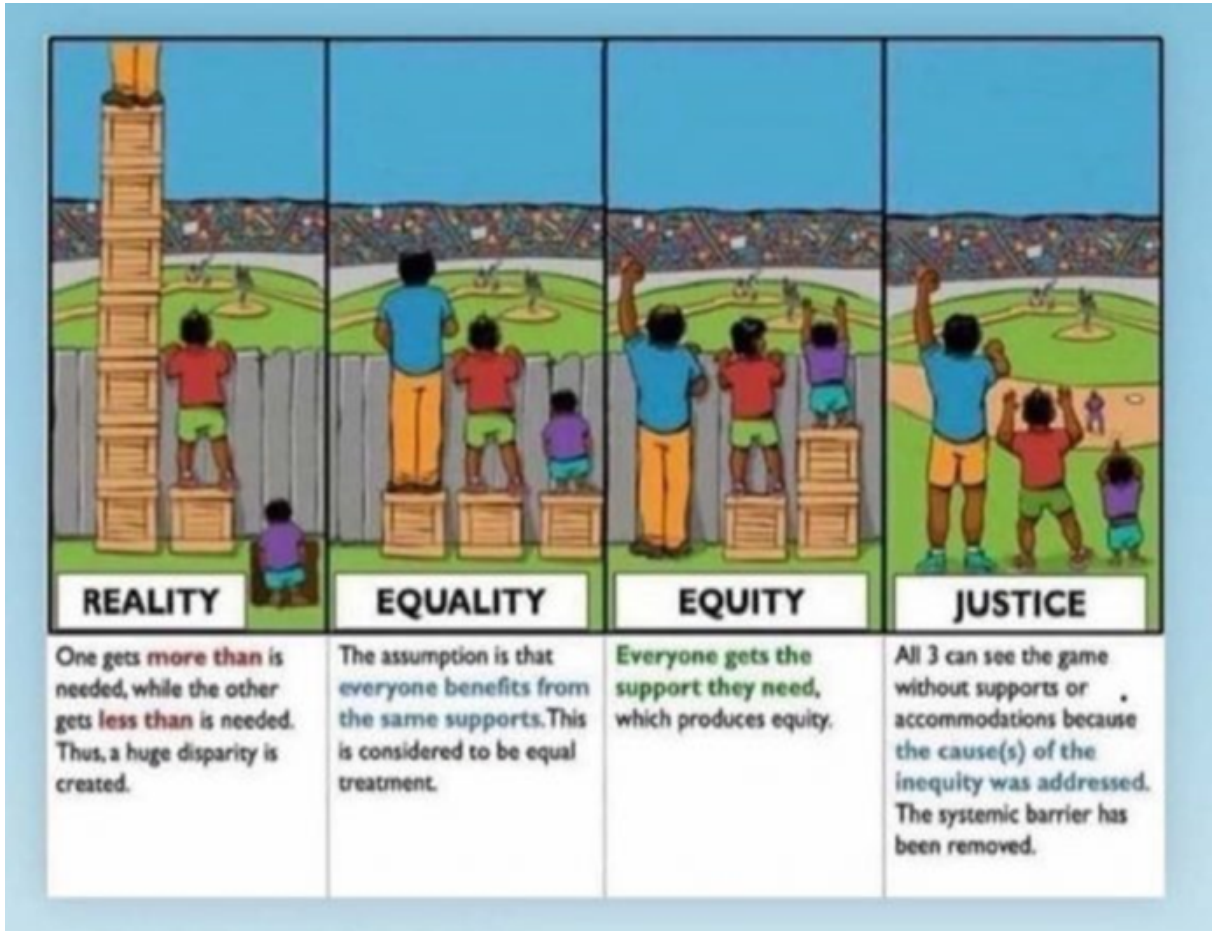
**Definition of Health Equity;**

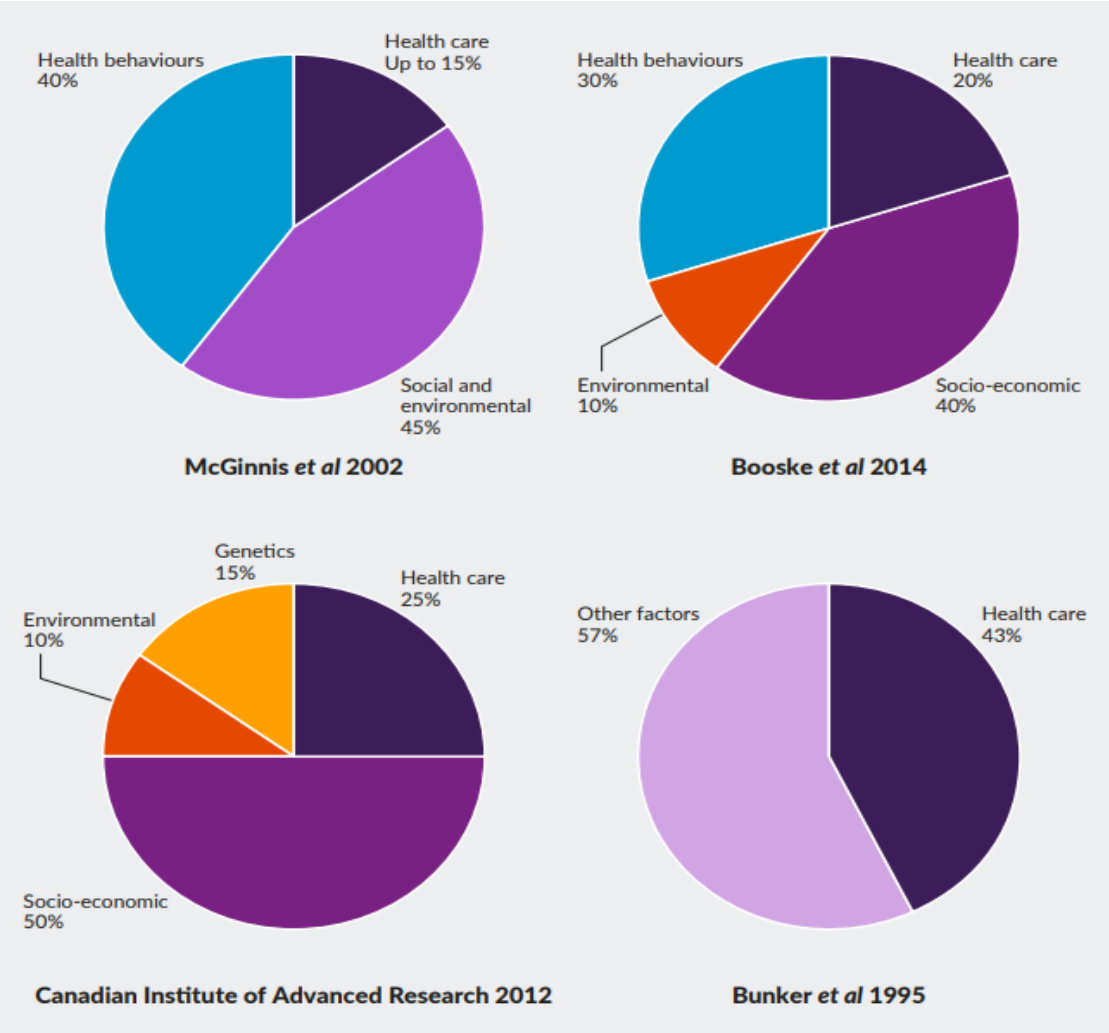
- "Fair" distribution of health/health care resources or opportunities according to population need
- Allocating relatively more resources where there is relatively more need
- Equal quality of care for all
- 'Proportionate universalism'



# Health care has a large impact on our health, but the greatest impact is from the wider determinants of health

- Our health is determined by our genetics, lifestyle, the health care we receive and our wider economic, physical and social environment

- Although estimates vary, the wider environment and socio-economic circumstances has the largest impact




The King's Fund A vision for population health: towards a healthier future

# Joint Health and Wellbeing Strategy

Brighton & Hove's Joint Health & Wellbeing Strategy (2019–2030) commits to embedding equity across all policies and tackling root causes (housing, education, income, transport).

## Improving Lives Together (ILT): NHS Sussex's overarching strategy sets four goals

- ❑ Improve health outcomes for disadvantaged communities.
- ❑ Reduce health inequalities across Sussex.
- ❑ Maximise resources for best value.
- ❑ Support social and economic development.

## Core20PLUS5 Framework

Focus on the 20% most deprived, inclusion health groups, and five clinical priorities (hypertension, maternity/perinatal, severe mental illness, respiratory disease, cancer).

## Population Outcomes Framework (POF)

Tracks 80 indicators for Life Expectancy (LE) and Healthy Life Expectancy (HLE). Brighton & Hove flagged for:

- ❑ Hazardous drinking: 40.7% of adults.
- ❑ Low NHS Health Check uptake: 23.5% vs 29.6% nationally.
- ❑ High SMI mortality: 442% vs 384% nationally.
- ❑ Cancer screening gaps and falls admissions in older adults.

# Our population and building blocks of health

# 2024 population and change since 2014

## Total population

**283,870**
**people**

up from 275,999 people in 2014

## Median age

**38 years**

An increase from 35 years in 2021

## Net international migration

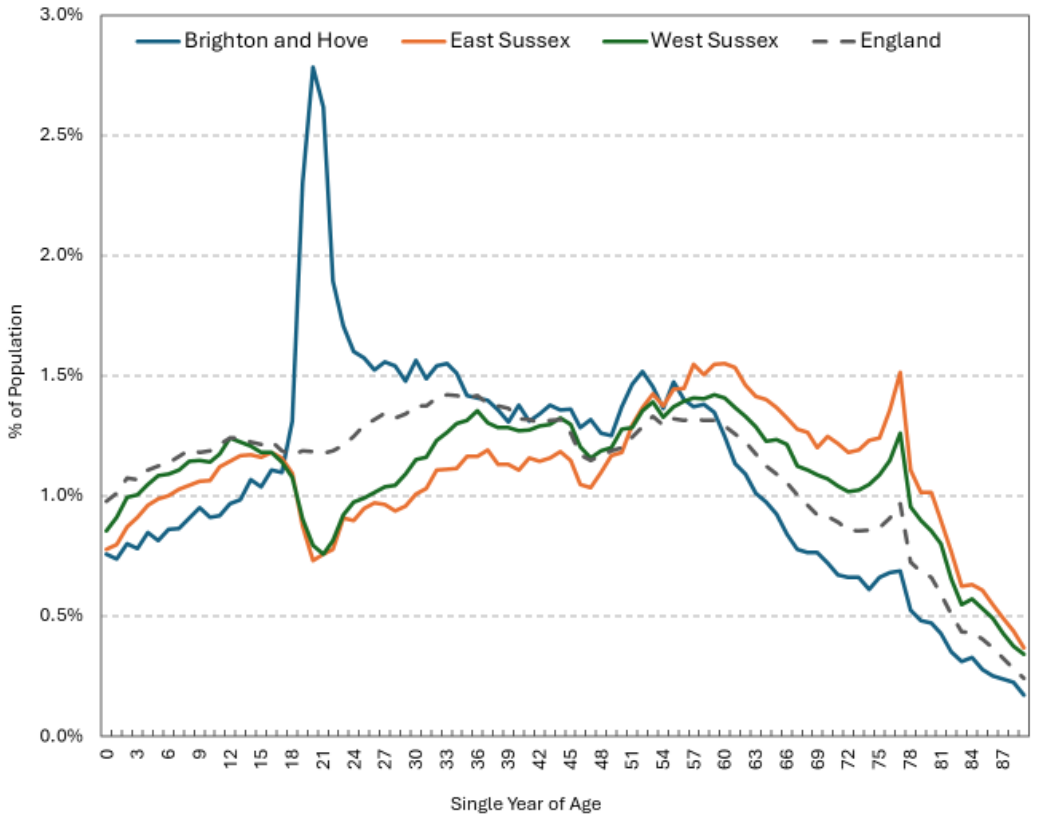
**+22,868**
**people**

Has been the largest factor in the population increase between 2014 and 2024

## Net internal migration

**-11,537**
**people**

More people leaving Brighton & Hove to elsewhere in England than moving to the city



# Wider determinants – reframing the discussion to talk about the building blocks of health

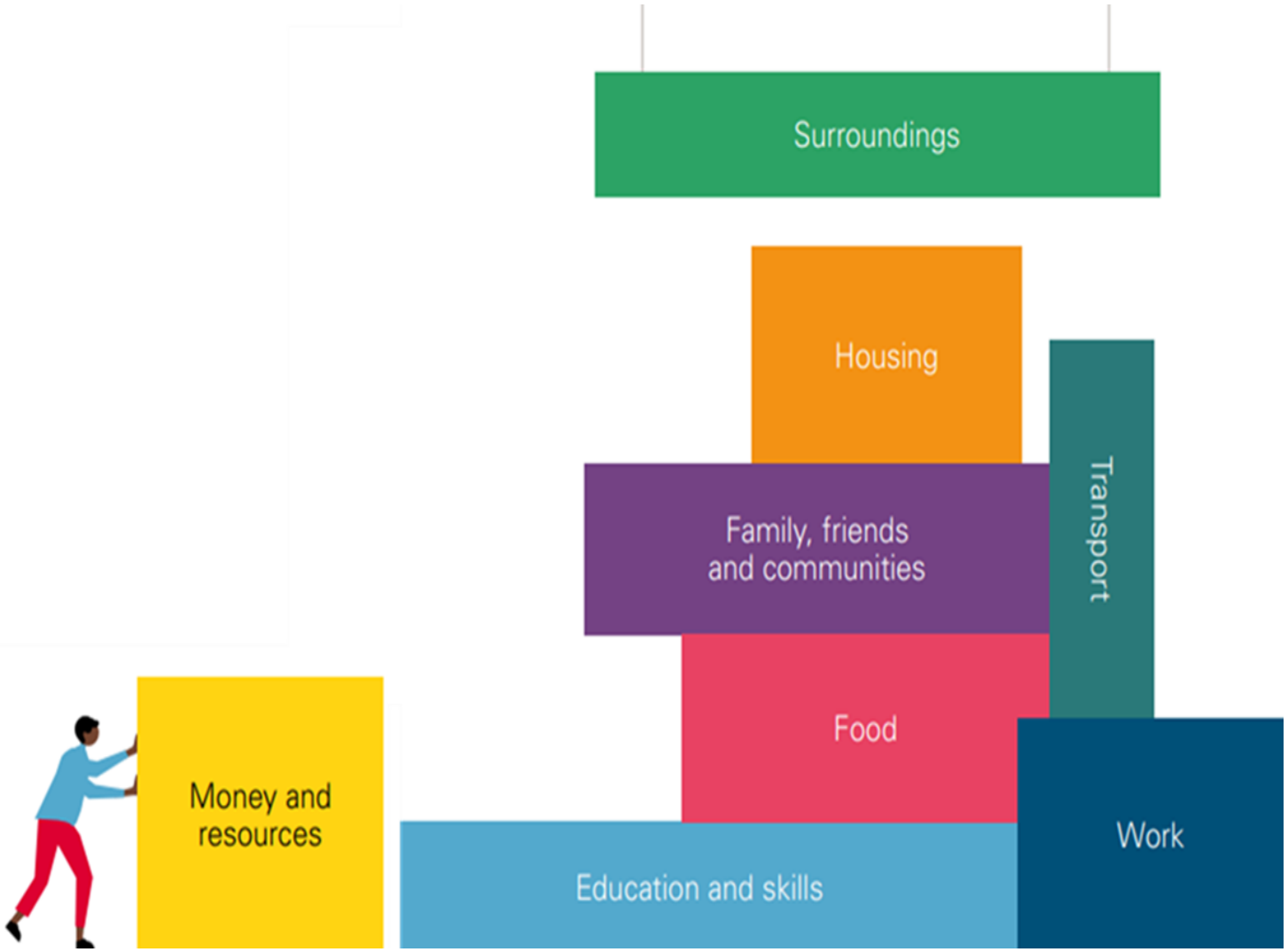
- When we don't have the things we need, like warm homes, healthy food, and are constantly worrying about making ends meet, it puts a strain on our physical and mental health

- Almost every aspect of our lives impacts our health and ultimately how long we will live – our jobs and homes, access to education and public transport and whether we experience poverty or discrimination

- This results in poorer physical and mental health, earlier onset of conditions and earlier death

- These are the building blocks of health

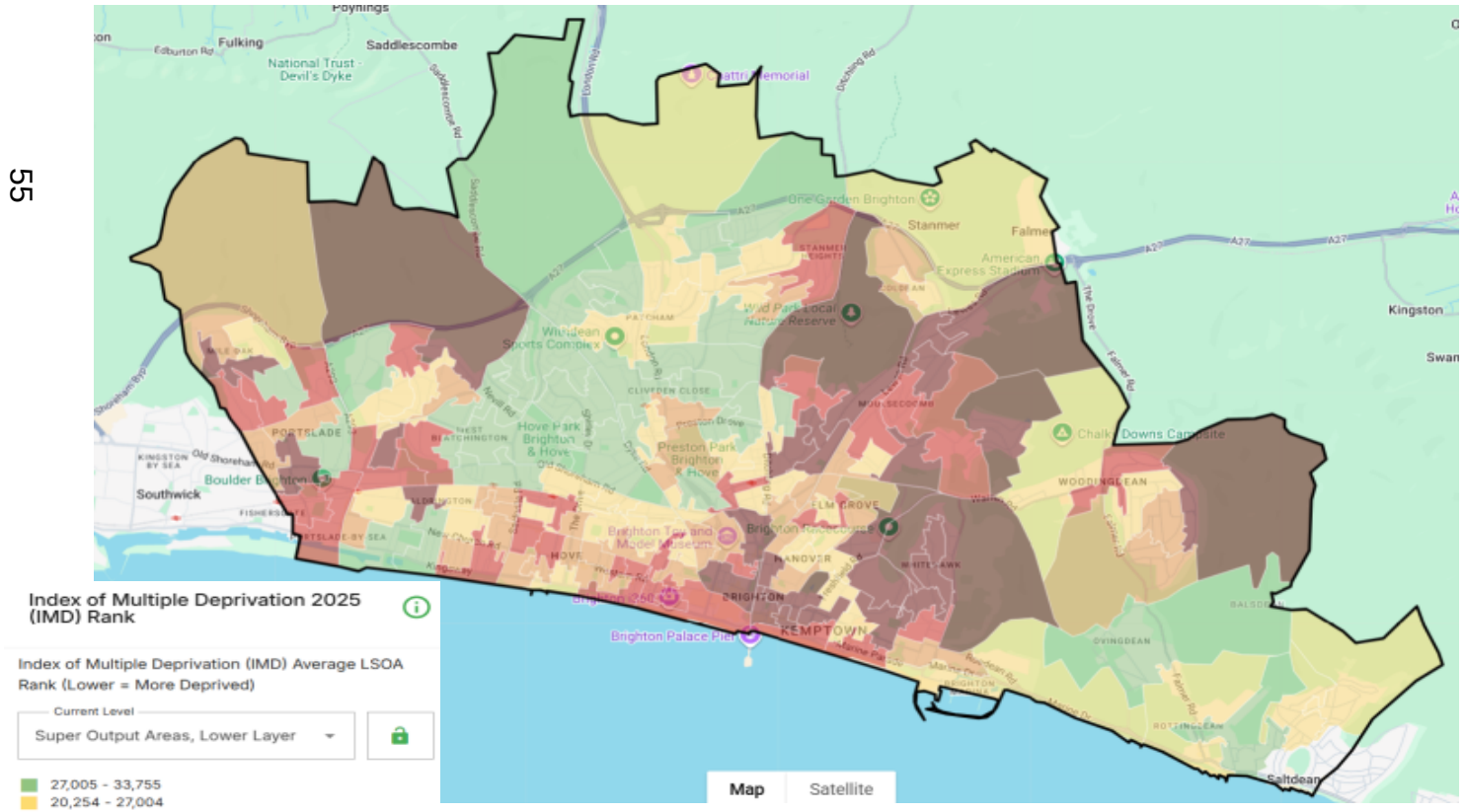
- To create a city where everybody can thrive, we need all the right building blocks in place:




Source: How to talk about the building blocks of health - The Health Foundation

# Index of multiple deprivation (IMD) 2025

- Brighton & Hove is the 92nd most deprived upper tier local authority in England (of 153)
- At lower tier LA level, 133 most deprived (of 296)
- In 2019 it was 131st out of 317 lower tier LAs and in 2015 102nd out of 326 LAs




- 31% of children and young people in the city are living in income deprivation according to the Income Deprivation affecting Children Index (IDACI) of the IMD – this is up to 87% of children in some parts of the city
- 21% of older people in the city are living in income deprivation according to the Income Deprivation affecting Older People Index (IDAOPI) of the IMD – this is up to 87% of children in some parts of the city

# Housing and Health

We all need somewhere to call home – not just walls and a roof but a secure, stable, safe place to grow up and live in. Our homes influence our health in many ways, both physically and mentally.

- Housing in Brighton & Hove is less affordable than England and is continuing to become more expensive – those on the lowest 25% of earnings need 12 times their earnings to afford the lowest 25% of house prices (Southeast 10.4, England 7.3) – increased from 8.5 times over the last decade
- More than 1 in 3 households live in privately rented accommodation (the highest outside of London) – an increase of 10% over the last decade
- Half of households live in a flat (more than double the Southeast and England at 22%)

**Good housing should be:**


In Health Counts 2024 survey, our residents who live in temporary or emergency (72%), social rented (53%) or privately rented (47%) accommodation where much more likely to have high anxiety levels than those who own their own home (25%)

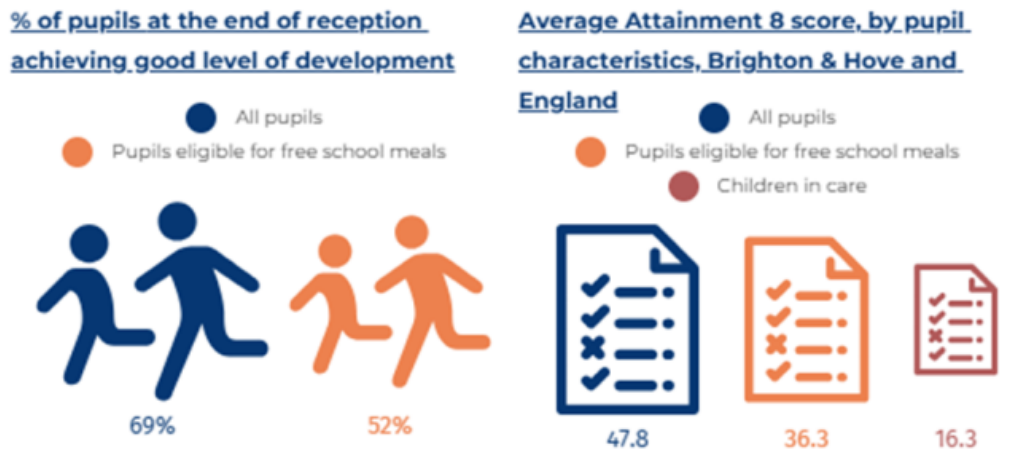
# Education

Education has direct consequences on people's long term health outcomes: whether through increasing someone's likelihood of being able to get a good job, afford a good quality life, or through better managing or being less exposed to life's challenges.

By the age of 30 those with the highest level of education expected to live 4 years longer

Than those with the lowest levels of education

There are significant inequalities in development and education across all ages in the city:




- For adults across England, 18% had no qualifications (2021 Census) - in Brighton & Hove, lower at 12%
- There are significant inequalities in the city - ranges from 4% to 31%. Areas in Hangleton, Mile Oak, Moulsecoomb, Whitehawk, Kemptown and Woodingdean are in the 20% of areas in England with the highest rates of people with no qualifications

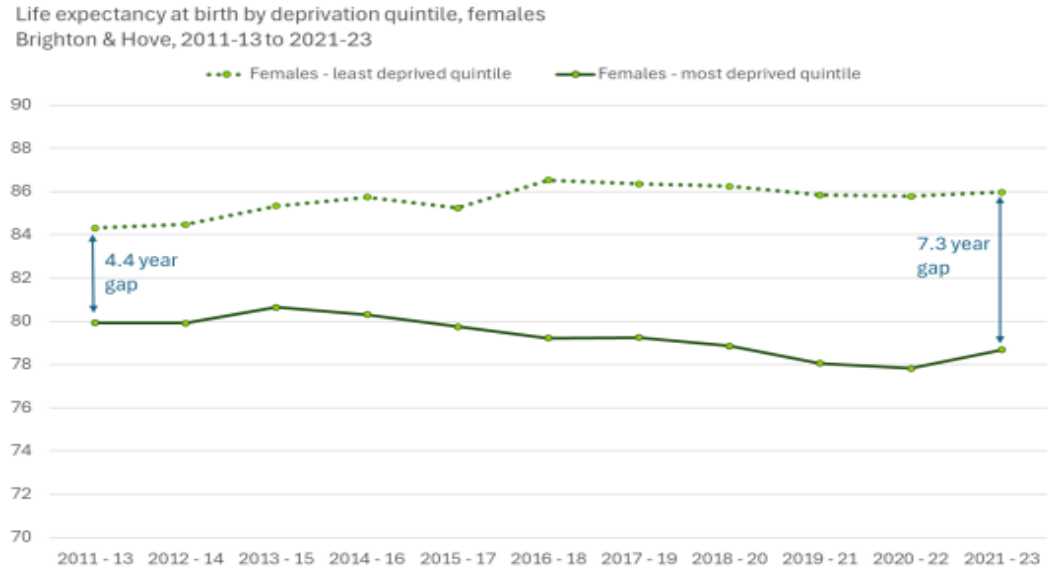
# Inequalities and Health Counts

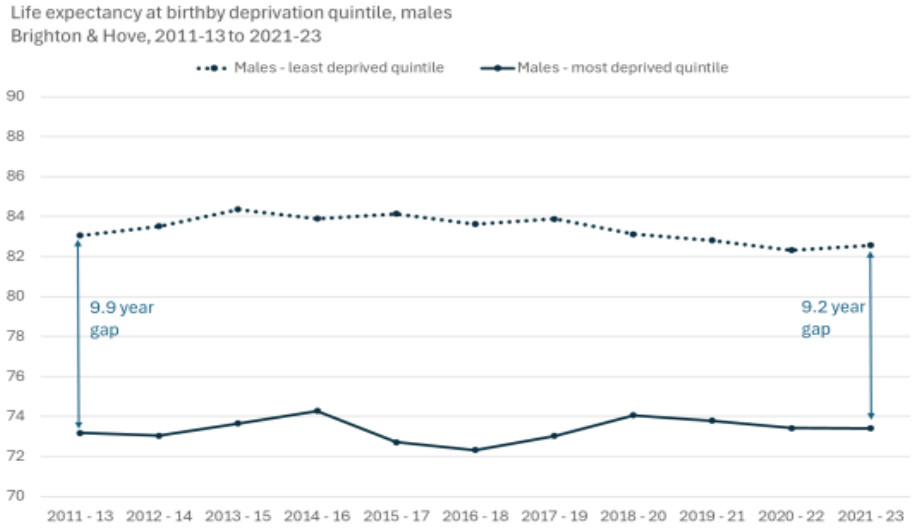


*Improving Lives Together*

# Inequalities in life expectancy – Brighton & Hove

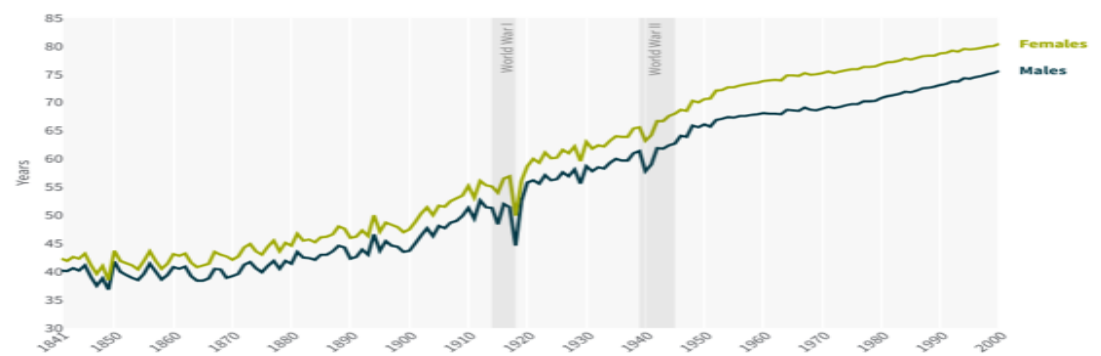
- The gap in life expectancy for females has **widened** from 4.4 years in 2011-13 to 7.3 years in 2021-23
- The gap has **reduced** slightly for males, but remains at 9.2 years
- There are many **societal inequalities** which lead to these health inequalities




- Life expectancy saw continual increases throughout the 20th century, except for world wars

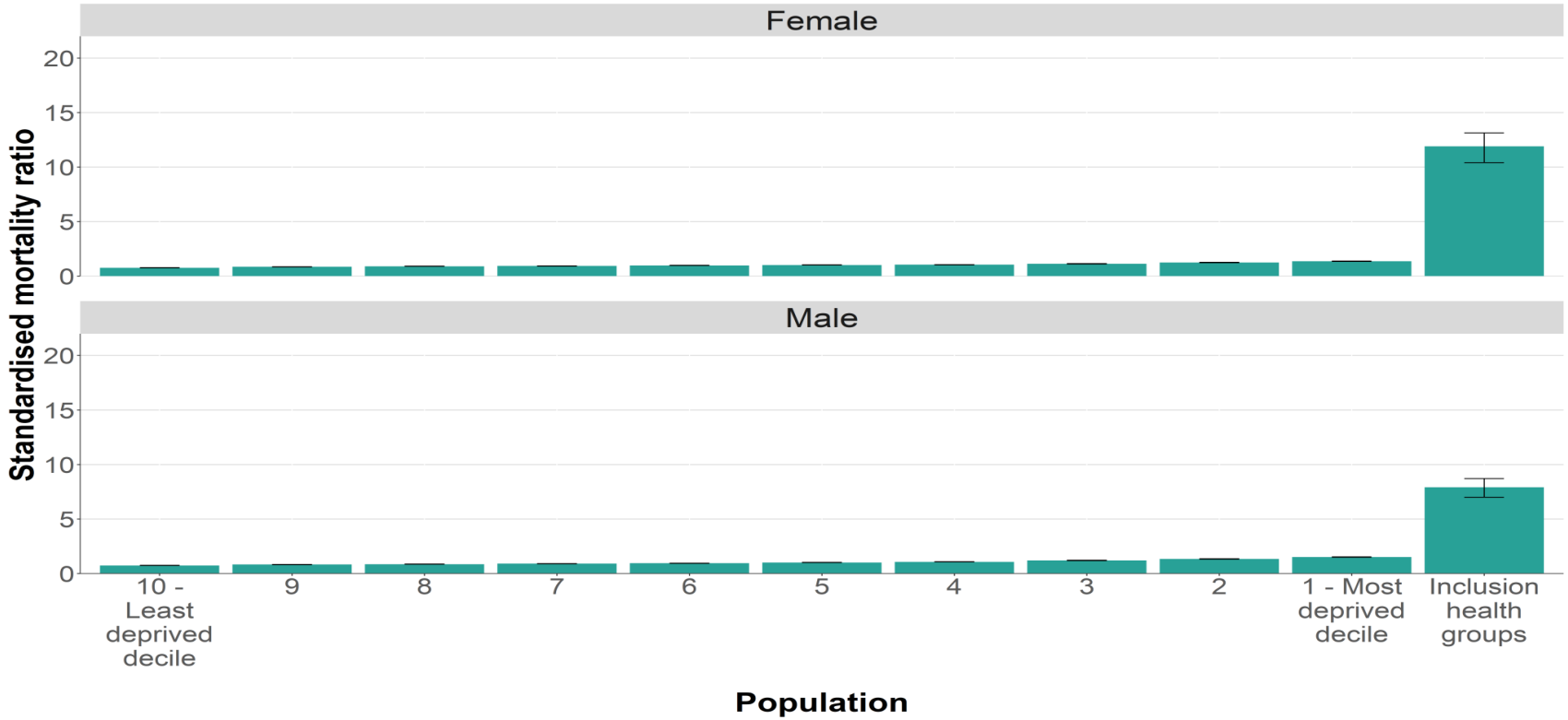
**Figure 1 Life expectancy at birth**
England and Wales, 1841–2000




Source: Office for National Statistics (2020)
World War I 1914–18. World War II 1939–45.

The King's Fund

# Standardised all-cause mortality ratio for inclusion health groups, compared to the general population by deprivation decile




Office for Health Improvement and Disparities (2022) Spotlight indicator SP260
Source data: Office for National Statistics Deaths by underlying cause, deprivation decile areas, 5 year age groups and sex, England and Wales, 1981 to 2015
Office for National Statistics Populations by deprivation decile areas, 5 year age groups and sex, England and Wales, 2001 to 2015
Aldridge et al. 2017

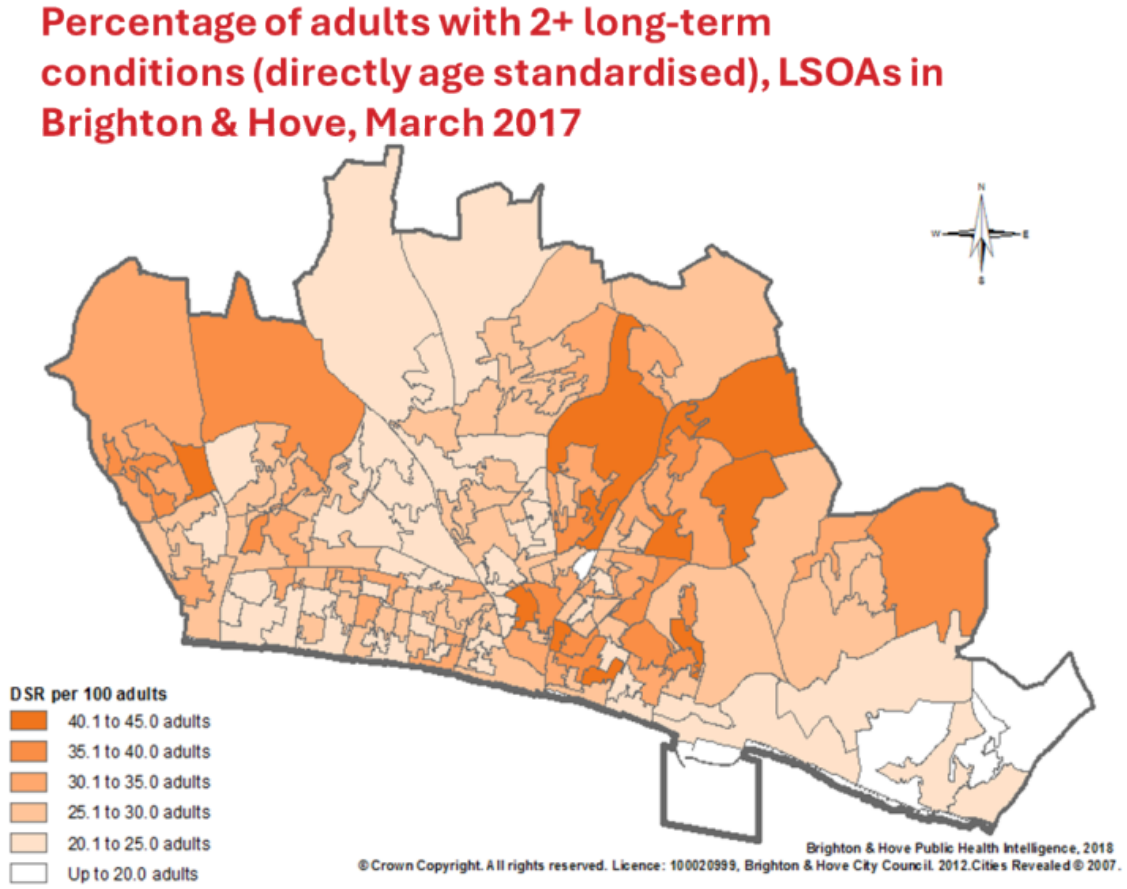


Source: analytics.phe.gov.uk/apps/spotlight/

# Prevalence of multiple long-term conditions is higher in the most deprived areas

- 51,000+ adults = 2+ physical or mental health conditions in Brighton & Hove (22%)
- 8,000 = 5+ conditions (3%)

People have 5+ conditions around 15 years earlier in the most deprived areas of the city

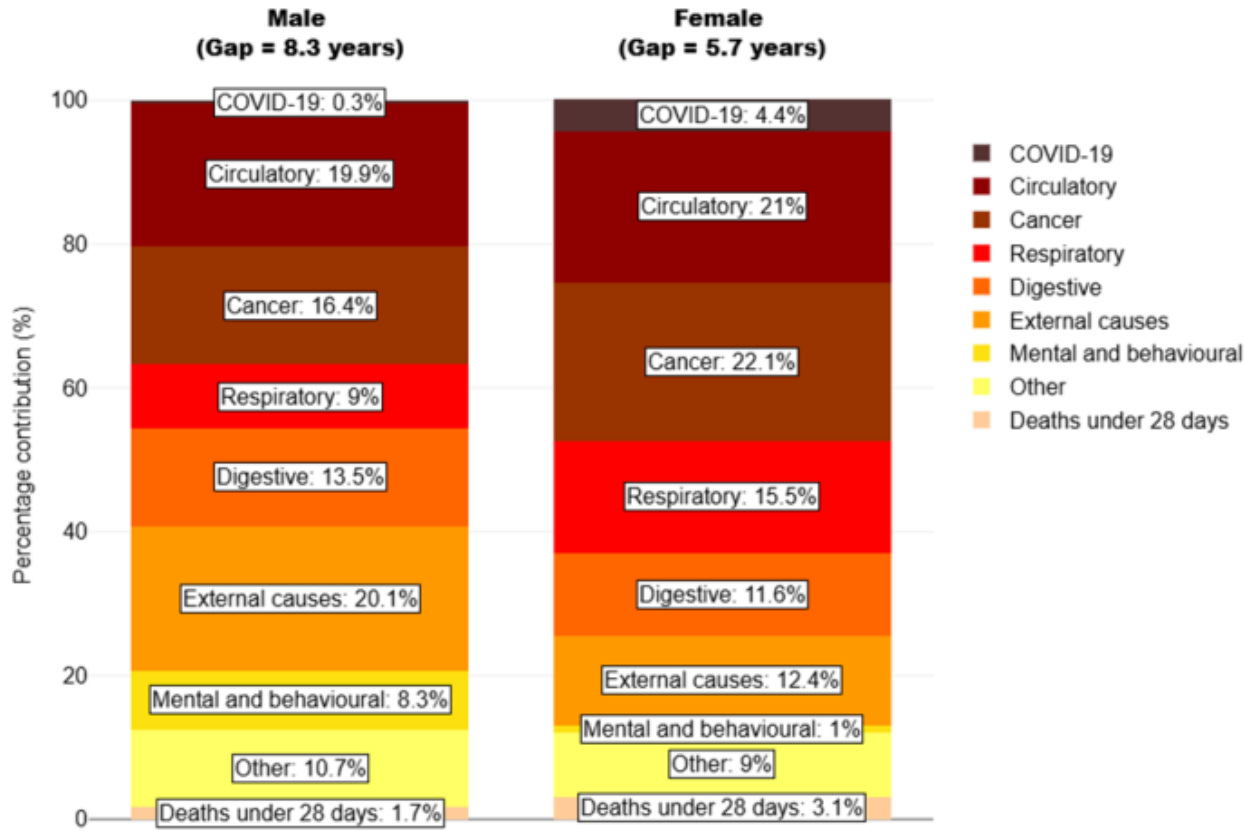



Source: Joint Strategic Needs Assessment (JSNA) (brighton-hove.gov.uk)

# Causes contributing to the gap in life expectancy in Brighton & Hove

The causes of death which contribute the most to inequalities in life expectancy in Brighton & Hove are:

- For males - external causes (injury, poisoning and suicide), circulatory, and cancer and digestive diseases
- For females - cancer, circulatory and respiratory diseases and external causes

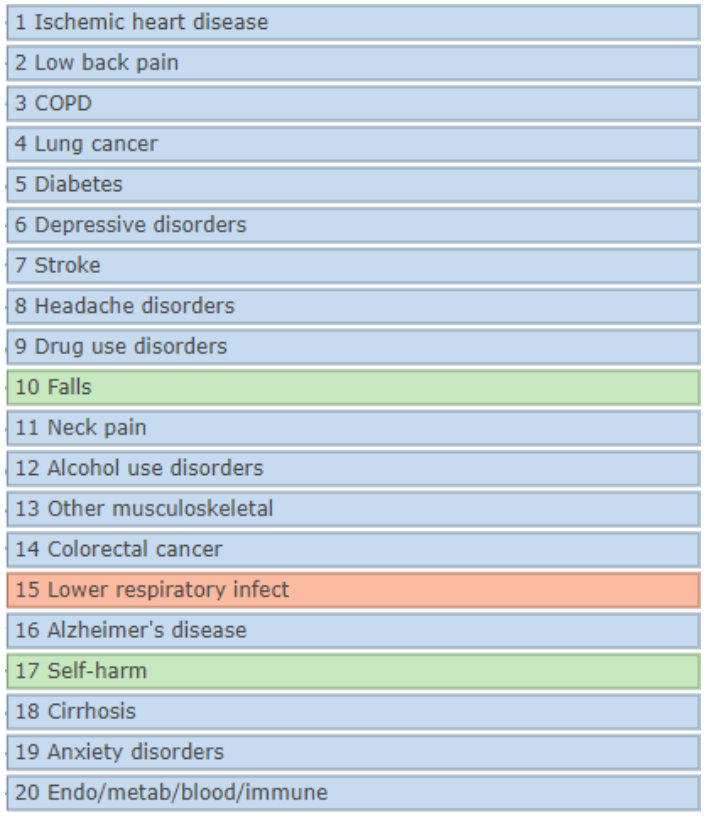



Source: Segment Tool (phe.gov.uk)

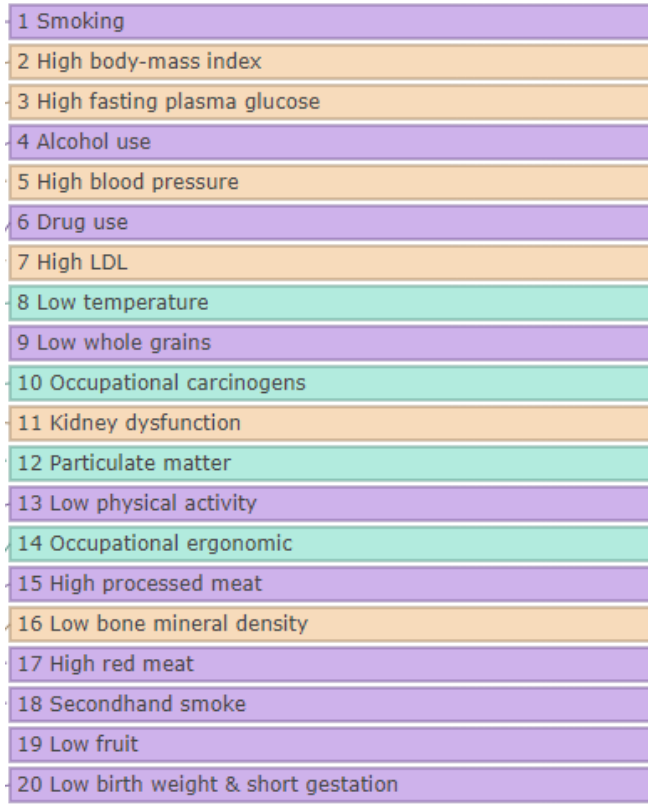
# Key risk factors and greatest burden of disease – Brighton & Hove

If we want to improve population health, we need to understand what the risk factors are for Brighton & Hove's population and whether, and how, we can modify them. These figures are only available for the whole of Brighton & Hove.

**Top 20 causes of the greatest burden of ill health**




**Top 20 risk factors**




Source: Brighton & Hove JSNA from Global Burden of Disease Visualisations: Compare (thelancet.com)

**To improve life expectancy, healthy life expectancy, inequalities in both life expectancy and healthy life expectancy:**

- Tackle major behavioural risks – tobacco, diet, exercise, alcohol and drugs
- Diabetes is a rising concern
- CVD reduction – including controlling blood pressure key and has considerable population impact
- Cancer major cause of ill health, importance of behaviours and screening
- Mental health
- Immunisation
- Air quality and cold homes

**In addition, for healthy life expectancy and inequalities in healthy life expectancy tackle:**

- MSK and pain management
- Sensory impairment

# Health Counts

- As well as health and wellbeing trends, the 2024 Health Counts survey of over 16,700 adults in the city gives us important evidence on population groups in the city
- Providing information on communities we haven't had evidence for before - with such a large sample, there is the ability to look at inequalities and intersectionality

**5% TNBI**

(Trans, non-binary or intersex)

Higher than the 2021 Census at 1% of adults.

**28% LGBQ+**

(Lesbian, gay, bisexual, asexual, queer or prefer another term to describe their sexual orientation but are not heterosexual)

Higher than the 2021 Census at 11% of adults.

**13% Neurodivergent adults**

No comparative data available.

**24% Black and Racially Minoritised**

(Non-White British) Similar to the 2021 Census at 26%.

**0.4% are a refugee and 0.2% are an asylum seeker**

No comparative data available.

**4% have ever lived in care as a child or young person**

This is the first time that this question has been asked. No comparative figure available.

**0.9% live in temporary or emergency accommodation**

This is the first time these results are able to be presented in Health Counts.

## Trends

We have seen **worsening trend** for:

- General health
- Happiness and anxiety
- Pain
- Drugs use
- Community cohesion – belonging, social contact and support
- Community safety

We have seen **improving trend** for:

- Smoking

# Health Counts - Inequalities

- The survey evidences **stark inequalities** in the city by deprivation, and for particular communities
- We see large, and in some cases **widening inequalities**
- The full report provides **interactive maps** at ward and small area level
- And tables with questions broken down by **population groups**
- There are also ward, PCN and ICT area profiles available

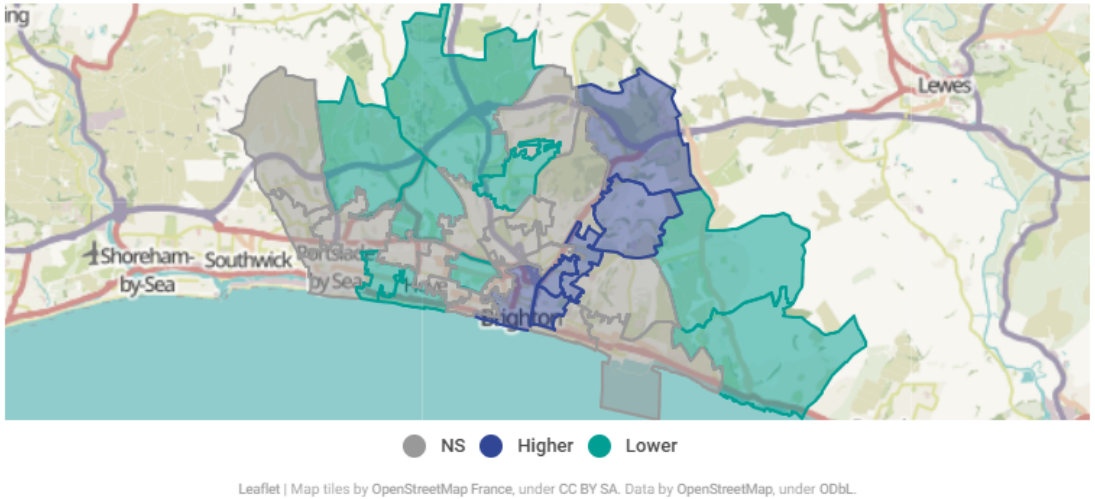
| | Most deprived 20% | Least deprived 20% |
|---|---|---|
| In good or better health | 56% | 76% |
| Low happiness score | 35% | 17% |
| High anxiety score | 46% | 29% |
| Self harmed in last year | 12% | 6% |
| Experienced suicidal thoughts in last year | 30% | 18% |
| Smoke | 25% | 9% |
| Vape | 18% | 8% |
| Binge drink daily or almost daily | 3% | 2% |
| Experience gambling related harms | 25% | 14% |
| <30 mins sport / fitness activity in last week | 65% | 48% |
| 5 a day (fruit and veg consumption) | 42% | 56% |
| Spend time in nature at least monthly | 82% | 92% |
| Never visit the dentist | 16% | 6% |
| Taking action due to cost of living | 88% | 81% |
| Fairly or very worried about housing conditions | 27% | 10% |
| Very/fairly strong sense of belonging | 45% | 64% |
| Could ask someone for help if they were ill in bed and needed help | 62% | 79% |
| Feel very or a bit unsafe walking along at night | 48% | 25% |
| Very /fairly worried about physical violence against you | 31% | 15% |

# Inequalities – self harm

People in the following groups/areas of the city are more likely, compared to Brighton & Hove as a whole, to have self-harmed in the last 12 months (Brighton & Hove 9%):

- Aged 18-24 and 25-34 years (28% and 13% respectively)
- Adults from Mixed/multiple ethnic groups (16%), Gypsy, Roma, and/or Traveller adults (29%)
- Trans, non-binary or intersex adults (TNBI) (31%)
- LGBQ+ adults (20%)
- Adults living in temporary or emergency accommodation (20%), social renting (17%) or private renting (14%)
- Adults with experience of the care system as a child/young person (19%)
- Disabled adults (19%)

**% of adults who have deliberated harmed themselves in the last 12 months, but not with the intention of killing themselves by MSOA**




- Autistic adults (35%), neurodivergent adults (excl. Autistic adults without a learning difference) (29%), adults with a developmental condition (20%), learning disability (30%), mental health difference / condition (28%), physical difference (13%), speech and language condition (23%), visible difference with a disabling and/or discriminatory impact (21%)
- Adults living in more deprived areas: 12% of those in the most deprived 20% of areas, compared to 6% of those in the least deprived 20% of areas
- Areas of Moulsecoomb and Bevendean, Coldean and Stanmer, Kemptown, and Central Brighton

# Safe and Well at School Survey - Inequalities

- The safe and well at school survey evidences **stark inequalities** in children and young people in the city by deprivation, and for particular groups of pupils
- The full report provides more information on these inequalities
- As well as by deprivation, SEND children and young people (CYP), Neurodivergent CYP, CYP with a learning disability, Children in Care, Black and Racially Minoritised CYP, young carers, LGBQ+ and TNBI children and young people face significant inequalities and discrimination

| | High deprivation (Family Affluence Scale (FAS) 0-5) | Low deprivation (FAS 9-10) |
|---|---|---|
| Been bullied this term | 24% | 17% |
| Met physical activity recommendation | 16% | 27% |
| 5 a day (fruit and veg consumption) | 48% | 65% |
| Often felt happy in last few weeks | 76% | 84% |
| Tried alcohol | 38% | 49% |
| Brush teeth twice a day | 81% | 91% |
| Accessed nature recently | 74% | 87% |

# Population outcomes Framework priority areas

# Population Health Outcomes Framework

**Sussex Population Outcomes Framework Revised June 2025**

**Overarching Outcomes** - Life Expectancy, Healthy Life Expectancy, Reducing the inequalities gap in life expectancy

## Starting Well

### 1 Good Infant & Maternal Health

**1.1) Neonatal & still birth, infant mortality**

**Maternal Focus**

- 1.2) Booked maternity - 70 days
- 1.5) Specialist perinatal MH measure
- 1.6) Maternal smoking (at booking and at delivery)

**Baby focus**

- 1.08d) Low Birth Weight babies
- 1.09) Admissions of babies aged 0-14 days
- 1.12) Babies breastfed (full/partial 6-8 weeks and first milk) (%)

### 2 Strong Foundations for Health

**2.1) Children Assessed as being Ready for School** (% - all and by FSM)

- 2.2) Children in low income hlds
- 2.3) Uptake - childhood imms/ vaccs (%)
- 2.4) Children achieving expected level in comm skills 2/2½ yrs (%)
- 2.5) Children with a healthy weight (Year 6) (%)
- 2.6) Attainment 8 (and for children FSM and CLA) (Average score)
- 2.7) 16/17 yr olds NEET (%)
- 2.8) Care-leavers (17-21 yrs) EET (%)
- 2.9) Oral health - tooth extractions for under 10s (tbc) CORE20 HIState

### 3 Tackling Childhood Long Term Conditions

**3.1) Hospital admissions for asthma** (under 19 years) (Rate)
**Unplanned admissions with primary diagnosis of epilepsy**

- 3.3) Patients with Asthma (6-19 yrs): where second-hand smoking status recorded in the last 12 months (%)
- 3.7) Emergency admissions for under 18s HIState

### 4 Mental Health Support

**4.1) Children and young people's mental health access** CORE20HIState

- 4.3) CYP with Eating Disorders Waiting Times (Routine and Urgent) - (% seen within standards)
- 4.4) Hospital admissions for self-harm (10-24 years) (Rate)

## Working Age - Wider Determinants, Increasing Challenges

### 5 Core Determinants

**Main measure has been discontinued by the ONS**

- 5.2) People in employment (16-64 yrs and 50-64 yrs) (%)
- 5.3) Households owed a duty under the Homelessness Reduction Act (Rate per 1,000 households)
- 5.4) Fuel poor households (% of households)
- 5.5) Air pollution: fine particulate matter (concentrations of PM2.5)
- 5.6) Adults walking for travel - three days per wk (%)

### 6 Tackling increasing burdens - Diabetes

**6.1) Obesity rates (Adults) (%)**
**6.2) Management of diabetes** (% achieved 8 CPP / 3TT) (Type 1 and 2) HIState

- 6.4) People (%) completing education < 1st yr of diagnosis
- 6.7) Amputation - major & minor lower limb amputation

To be added

- 6.6) DKA admissions (risk rate)
- 6.9) Admissions for Renal Replacement therapy

### 7 Tackling Alcohol

**7.1) Admission episodes for alcohol-specific** conditions (rate)

- 7.2) Adults drinking over 14 units of alcohol a week (%)
- 7.4) People waiting >3 weeks for treatment (%)
- 7.5) Successful completion of treatment (% completed treatment who do not represent to treatment within 6 months)

## Working Age - Tackling major burdens of ill health and premature mortality

### 8 Tackling major burdens of ill health and premature mortality

- 8a.1) Under 75 mortality - **cardiovascular diseases**
  - 8a.2) Uptake - NHS Health Checks
  - 8a.3) Case finding, diagnosis & management of hypertension / NICE guidance CORE20 HIState
  - 8a.4) Recording of BP amongst higher risks groups including people with diabetes & following a stroke.
  - 8a.9) % adults with no GP recorded CVD and a GP recorded QRISK score of 20% + on lipid lowering therapy HIState
  - 8a.10) % adults with GP recorded atrial fibrillation and record of a CHAD2DS2-VASc score of 2+ - currently treated with anticoagulation drug therapy HIState
- 8b.1) Under 75 mortality - **respiratory disease**
  - 8b.2) Smoking cessation support and treatment offered to patients
  - 8b.3) Take up of COVID, flu and pneumococcal vaccinations CORE20
  - 8b.4) % of patients with COPD or asthma who had a review in last 12 months
  - 8b.6) Emergency admissions (rate) for COPD, asthma or pneumonia
- 8c.1) Under 75 mortality - **cancer**
  - 8c.2) Smoking prev (%)
  - 8c.3) HPV Coverage (%)
  - 8c.4) Cancer screening coverage (%).
  - 8c.8) Emergency present.
  - 8c.9) Proportion of people diag (stage 1 or 2), case mix adjusted for cancer site, age at diagnosis, sex CORE20 HIState
  - 8c.10) % adult acute and mental health inpatient settings offering smoking cessation

### 9 Improving Adult Mental Health & Wellbeing

**9.1) Self-reported wellbeing** (ONS)
**9.2) Excess under 75 mortality rate** in adults with severe mental illness

- 9.4) Uptake of SMI and LD Health checks (%) CORE20 HIState
- 9.5) Record of BP check in last 12 mths, smoking cessation offered (%)
- 9.6) Referrals "suspected autism" > 13 weeks for appt (%)
- 9.9) Drug related deaths
- 9.10) Suicide rate
- 9.11) NHS Talking Therapies recovery rate HIState
- 9.12) Rates of total Mental Health Act detentions HIState

## Active Ageing and Later Life

### 10 Maintaining health & mobility

**10.1) Adult Physical Activity & Inactivity Rates**

- 10.2) Economic inactivity (due to long term sickness)
- 10.4) Emergency hospital admissions due to falls in people aged 65+ (rate)
- 10.7) Readmission following hip replacement

### 11 Care & Support

**11.1)** % of people **feeling confident & supported to manage their LTC**
**11.2) Quality of life** - adults 65+ in receipt of social care - with as much social contact as they would like.

- 11.3) Referrals to Social Prescribing
- 11.4) Reablement - Older people still at home 91 days after discharge from hospital into reablement/rehabilitation services (reablement coverage)
- 11.6) Adult carers (65+) who have as much social contact as they would like (%).
- 11.7) Diagnosis rate of Dementia

### 12 Inclusive Elective

- 12.1 Reduction in people waiting over 52 wks
- 12.2) Reduction in Do Not Attend rates
- 12.4) LoS in outlying specialities
- 12.6) Improved access to diagnostics
- 12.7) Size and shape of the waiting list; those waiting longer than 18 weeks, 52 weeks and 65 weeks HIState
- 12.8) Age standardised activity rates for elective and emergency admissions and outpatient, virtual outpatient and emergency attendances HIState
- 12.9) Elective activity vs pre-pandemic levels for under 18s and over 18s HIState

**Health inequalities**

Where possible measures should be comparable across place & for subgroups.

CORE20Plus5 measures

HIState - Measures in the 2024 NHS Health Inequalities Statement

# Indicators highlighted for Brighton & Hove in the Sussex Population Outcomes Framework as outliers of concern

**Tackling major burdens**

- NHS Health Checks - offered, Persons, 40-74 yrs, 2020/21-24/25
- Take up of flu jab (65+), Persons, 65+ yrs, 2023/24
- Take up of flu jab (at risk), Persons, 6 months-64 yrs, 2023/24
- Take up of flu jab (primary school aged children), Persons, 4-11 yrs, 2023
- Hypertension: Treated to appropriate threshold, Persons, All, Q32024/25
- Hypertension: BP monitoring, Persons, All, Q32024/25
- Cholesterol: QRISK >= 20% treated with LLT, Persons, All, Q32024/25
- AF: Treated with anticoagulants, Persons, All, Q32024/25
- Smoking cessation support and treatment offered to patients, Persons, All ages, 2023/24

# Indicators highlighted for Brighton & Hove in the Sussex Population Outcomes Framework as outliers of concern

**Maintaining health and mobility**

- Emergency admissions due to falls (65+), Female, Male, Persons, 65+ yrs, 2023/24
- Uptake PPV, Persons, 65+ yrs, 2022/23

**Care and support**

- Older people who received reablement/rehabilitation services after discharge from hospital, Persons, 65+, 2023/24

**Inclusive elective**

- Monthly Referral to Treatment (RTT) 52+ Week Waits, Persons, All, M122024/25

**Improving adult mental health and wellbeing**

- Self reported wellbeing, Persons, 16+ yrs, 2022/23
- Excess U75 mortality rate in adults with SMI, Persons, 18-74 yrs, 2021-23
- Drug related deaths, Female, All ages, 2021-23
- Serious Mental Illness (SMI) Physical Health Checks, Persons, All, 2024/25
- Learning Disabilities (LD) Annual Health Checks, Persons, All, M122024/25
- Serious Mental Illness (SMI) - Blood Pressure Checks, Persons, All, 2024/25

# Indicators highlighted for Brighton & Hove in the Sussex Population Outcomes Framework as outliers of concern

**Strong foundations and for health indicators**

- Children assessed as being ready for school (FSM), Female, 5 yrs, 2023/24
- Uptake MMR for one dose (5-year-olds), Persons, 5 yrs, 2023/24
- Uptake DTaP and IPV Booster (5-year-olds), Persons, 5 yrs, 2023/24

**Mental health support indicators**

- Hospital Admissions for Self-Harm (10-24), Female, 10-24 yrs, 2023/24
- Hospital Admissions for Self-Harm (10-24), Persons, 10-24 yrs, 2023/24

**Increasing burdens**

- Amputation - minor limb, Persons, 17+ yrs, 2018/19-20/21
- Amputation - major limb, Persons, 17+ yrs, 2018/19-20/21

**Tackling alcohol**

- Adults drinking over 14 units of alcohol a week, Persons, 18+ yrs, 2015-18
- Successful completion of alcohol treatment, Persons, 18+ yrs, 2023

# Outputs from the Shaping Sussex's Future on Health Inequalities- System Event

3rd December 2025

# Shaping Sussex's Future on Health Inequalities- System Event Overview

- Co-hosted by Sussex Voluntary Leaders Alliance (SVLA) and NHS Sussex
- Brought together 85 people from VCSE, communities, NHS and wider partners together
- Focused on collective action and shared responsibility for reducing inequalities
- Coproduction morning and co-design afternoon

Open Space co-production mechanism:

**"What do we need to change now and, in the future, so that everyone in Sussex has a fair chance of living well and healthily, and how do we make that happen?"**

12 themes picked from over 30 suggestions

Solution focused discussions - 40 minutes each

# Themes and solutions

| Theme | What we heard | Possible solutions |
|---|---|---|
| **1. Data Gaps: Who Gets Missed?** | Those without stable housing, people who don't use digital services, migrants, sex workers, and people who move around a lot. Because they're missing from the data, their needs are often overlooked. Smaller voluntary and community groups also feel left out of NHS planning. | Create a single directory of services for Sussex.<br>Provide more support for social prescribers and phone-based help.<br>Agree a shared understanding of what 'prevention' means across sectors.<br>Improve data sharing and infrastructure.<br>Clarify funding and partnership models. |
| **2. Digital Access: Not Everyone's Online** | Digital barriers affect both patients and staff. Some people are forced to use digital services, which excludes those with language barriers, low digital skills, or who simply prefer face-to-face support. Costs and lack of access to devices or Wi-Fi are also real issues and can affect main communities across Sussex. | Funding specifically for digital inclusion, including training and support.<br>Test digital platforms robustly for accessibility.<br>Keep non-digital options available so the digital does not become the exclusive offer for access. |
| **3. Include Smaller and Grassroots Organizations** | Smaller VCSE organisations are trusted by the communities they serve but often find it hard to be included in NHS referral pathways. Processes are complex, and there's a lack of visibility and support. | Enhance VCSEs involvement in both clinical and non-clinical pathways where able.<br>Create a single point of access for services for VCSEs in order to maximise reach and communication.<br>Develop a validated directory of all VCSEs, including grassroots groups.<br>Invest sustainably in VCSE leadership and workforce. |
| **4. Listening to Lesser-Heard Voices in Maternity and Neonatal Care** | Women and families from marginalised communities can face barriers to accessing and shaping maternity and neonatal services. Language, culture, and trust feel a big issue, and many feel the system isn't designed for them. | Go to where women already gather, like schools or community hubs.<br>Work with faith and community leaders.<br>Tailor engagement to individual preferences.<br>Build trust and show how feedback leads to real change. |
| **5. Housing and Health** | High housing costs and unstable accommodation make it hard for people to register with a GP and access other services. Poor housing conditions also affect health, and people without a fixed address often miss out on care. | Train or provide tools to enable GP practices to better understand how to register people without a fixed address.<br>Develop community hubs in unused spaces.<br>Bring health services to people where they are.<br>Support social spaces to reduce isolation. |
| **6. Supporting Children and Young People** | It was felt we're not doing enough, early enough, to support children and young people, especially around mental health and development. Long waits for help are common, and families often struggle to get the support they need. | Provide early intervention and support for families.<br>Develop co-located hubs where multiple services are available.<br>Share good practice and learn from what works elsewhere.<br>Recognise youth workers as key partners when working with children and young people. |

# Themes and solutions

| Theme | What we heard | Possible solutions |
|---|---|---|
| **7. Involving People with Lived Experience** | People want to be genuinely involved in designing services, not just consulted as a tick-box exercise. There's frustration when feedback doesn't lead to change when can lead to engagement feeling tokenistic. Involving people with lived experience throughout the design and implementation of service will lead to more effective person-centered care | Involve people from the start, not just at the end.<br>Communicate clearly about how feedback will be used.<br>Share resources and build long-term relationships. |
| **8. Working Across Systems** | Health inequalities are multifaceted with many factors contributing to why a person or community may experience disparity in health outcomes. These include housing, income, transport, education, and social connection. The system feel like it is still too focused on clinical care and works in silos. To really improve health inequalities the system needs to work a truly integrated way | Create multi-professional hubs and improve data sharing.<br>Listen to communities and use their insights.<br>Strengthen governance and joined-up planning. |
| **9. Making Services Easier to Navigate** | It's hard for people to know where to go for help. Information is often out of date or hard to find, digital tools don't work for everyone and don't always point people to the right support. | Develop a single, live directory of services.<br>Keep phone support and social prescribers.<br>Agree a shared understanding of prevention.<br>Improve data and open access to information. |
| **10. Community-Led Solutions** | Communities want to be involved in designing solutions that work for them. This means listening, building trust, and recognising diversity within and between communities. Evidence is clear that when communities are included in the development of solutions outcomes are improved and health inequality disparities improve. | Co-design services with communities.<br>Use both data and local insight.<br>Fund and support grassroots initiatives. |
| **11. Integrated Care Teams (ICTs) and Accountability** | ICTs are seen as a mechanism to tackle inequalities, they will provide a mechanism to bring many of the solutions described in the document together, supporting not only the management of health at a local level but also a way that Mult professionals can work other to build support around individuals. However, there's confusion about how they work and who's involved. Local voices need to be heard, and roles and responsibilities should be clear. | Communicate roles and responsibilities clearly.<br>Use local data and insight.<br>Adopt inclusive, person-centred approaches. |
| **12. Supporting People Waiting for Acute Services** | Long waits for care cause anxiety and can make health problems worse, especially for those with fewer resources or support. People need better information and support while they wait. This support can be developed early working with partners and communities to describe what information is needed and how it should look to maxmise effective early support. | Provide better support and information for people waiting.<br>Engage locally and communicate realistically.<br>Map local support organisations. |

# Health Inequality Funding 2025/2026

25/26 Health Inequality funding: we will co-design the £75K NHS grant process considering the Principles, Process, Priorities

**In response to conversations from the event :**

- We have rewritten the Expression of Interest (EOI) to focus on **two opportunities** – insight capture and taking forward community led solutions from previous NHS reports.
- We are going to offer **more funding** to organisations working with grassroots or smaller organisations.
- We have listed the communities of focus for insight capture based on high need. We have extended community led solutions to **all communities** that experience health inequalities.
- The submission process will be easier. We will allow **video submissions** and face-to-face submission by exception for those who require reasonable adjustments.
- We have developed a way to **track and monitor actions** and progress with commissioners and partners. Completed actions will be shared back, while ongoing actions are monitored iteratively to support continuous improvements.
- We will prioritise **quality over quantity**. We are looking for deep, new insights into the “why” behind the findings and clear, actionable recommendations that can be implemented to improve outcomes.

# Insight to Action

Maternity services were identified as a key area of concern at a Brighton and Hove "Improving lives for Minority Ethnic Communities" event. The Maternity Commissioners worked with the **Brighton and Hove Community Voices Group** and **Maternity and Neonatal Voices Partnership** to implement actions:

| You said | We did |
|---|---|
| Maternity information should be accessible, culturally appropriate and shaped by communities. | NHS Sussex completed a year-long review of antenatal resources with Black, Asian, mixed-ethnicity, asylum-seeking and refugee communities. New easy-read and video resources were co-produced and are available in the 10 most spoken languages in Sussex. These are being shared via the LMNS website, VCSE organisations, GP practices and libraries. |
| Maternity services should be visible and accessible in communities. | Services are delivered in community settings such as Family Hubs, with targeted outreach including midwifery support for Traveller communities. Trusts may also support local events where staffing allows. |
| The NHS needs better insight into experiences of racialised minorities and stronger data. | Perinatal Equity Steering Groups are developing targeted engagement with minoritised communities, and Sussex maternity services now exceed national standards for ethnicity data collection, supporting more focused action on inequalities |

# Brighton and Hove Partnership and Integration Approach to tackling Health Inequalities

*Improving Lives Together*

# Jointly Commissioned Services addressing Health Inequalities

The NHS, Brighton & Hove City Council, and the VCSE sector have built a suite of 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 with public health interventions further tackling wider determinants of health. Collectively, these programmes constitute a robust, multi-layered approach aimed at addressing clinical inequalities, removing barriers to access, tackling social determinants, reducing structural disadvantage, and meeting the needs of specific population groups.

The below programs collectively 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, Children and Young People Core20PLUS5, PCN DES delivery, screening & hypertension improvement, SMI health checks)**
- **Inclusion Health and multiple disadvantage services (MCN programme, homelessness healthcare, rough sleeper outreach)**
- **Population health management and preventive activities (JSNA insights, PHM MDTs, health checks, smoking cessation improvements)**

Brighton & Hove continue to build 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.

Attached is a detailed paper of all the services and initiatives that directly support reducing health inequalities across the city.

# Services addressing Health Inequalities

## Integrated Community Teams (ICTs):

- ICTs in Brighton & Hove are delivering a neighbourhood-based, multi-agency model that brings health, social care and voluntary sector partners together to tackle entrenched health inequalities across the city. Their focus is on improving access, strengthening prevention, and coordinating personalised support for communities experiencing the greatest disadvantage, in line with the CORE20PLUS5 framework.
- Across East, West and Central areas, ICTs are embedding community-based health hubs, outreach, and multidisciplinary team (MDT) approaches that target populations with higher prevalence of long-term conditions, frailty, mental health needs, and social vulnerability. Evidence from recent neighbourhood hubs shows strong uptake among ethnic minority residents and high satisfaction with accessible, walk-in support. Community health events, diabetes and menopause support groups, wellbeing workshops, and vaccination/immunisation outreach strengthen early intervention and population health management.
- ICTs are also reducing inequalities for those with the most complex needs. The West MDT Frailty Pilot, for example, has delivered proactive, multidisciplinary care planning that reduces pressure on acute services and improves stability for older adults. In addition, the Homeless & Multiple Compound Needs program aligns specialist partners to improve outcomes for people facing homelessness, severe mental illness, substance use, or exposure to domestic abuse, groups recognised as key local PLUS populations.
- Underpinning this is a growing infrastructure of shared digital tools, collocated working, neighbourhood profiles, and consistent MDT models, which enhance coordination and support proportionate resource allocation. This reflects the wider ambitions set out in the city's Health & Wellbeing Strategy and NHS Sussex's Improving Lives Together plan.
- Overall, ICTs are enabling more equitable access, more preventative and personalised care, and more integrated system working, resulting in tangible improvements for residents who historically face barriers to health and care.

# Services addressing Health Inequalities

## Homeless and Multiple Compound Needs (H&MCN):

H&MCNs is one of the city's Health & Care Partnership population health priorities. It was chosen in 2022 as the Place Community Frontrunner Programme and in 2024 the city's health & care partnership agreed to create a new and distinct Homeless & Multiple Compound Needs Integrated Community Team (H&MCNs ICT). This model is supported through funding from the partnerships Better Care Fund

The core partners in the ICT are- Arch Healthcare (Chair & clinical lead), BHCC Changing Futures Team (ASC & Housing). CGL Rough Sleeper and Drug & Alcohol Recovery Team, SCFT Health Inclusion Team, SPFT Homeless Mental Health Team, Common Ambition lived experience service and VCSE Homeless & Rough Sleeping Network

- Focusing on people experiencing the deepest disadvantage, who face the starkest gaps in life expectancy and access.
- Providing integrated multidisciplinary care that addresses health, housing, mental & physical 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.



Key outcomes delivered by the H&MCNs ICT:

- 180 people with 3 or MCNs supported by the Changing Futures multidisciplinary team (MDT) over the three years
- Assessed the impact of the service through the New Directions Team Assessment model. This demonstrated the positive impact the MDT has had in reducing the risk individuals face because of MCNs
- Completed an external evaluation of the MDT and are delivering on its recommendations B&H MDT evaluation report
- Mapped the levels, types of need and engagement in services of MCNs amongst the city's homeless population B&H Multiple Needs Audit
- Mapped the impact of pro-active multidisciplinary working and the benefit for individuals and cost saving benefit for the wider system
- Set outcome targets for 26/27 that include- 1) reducing avoidable presentations in A&E 2) doubling the capacity & throughput of the MDT 3) developing a H&MCNs hostel model in partnership with BHCC 4) support delivery of BHCC Homeless & Rough Sleeping Strategy priority area 3 improving outcomes for the most vulnerable 5) further developing our lived experience approach 6) supporting training offer in the city's high needs homeless hostels

# Next Steps: Addressing Health Inequalities

- Our Health & Care Partnership will use the latest data available through the Health Counts Survey and the Sussex Integrated Data set to support us in our work to understand our local communities, where health inequalities exist and how best to address local health inequalities
- Our Health & Wellbeing Board will refresh our Joint Health & Wellbeing Strategy to respond to the health inequalities identified in results of the Health Counts Survey
- Our three Neighbourhood based Integrated Community Teams will develop local plans to help address local health inequalities in their partnership areas building on the learning from their community health pilots. These plans will feed into our overarching refresh of our Joint Health & Wellbeing Strategy
- Our Health & Care partnership will continue its work to improve outcomes for people who are homeless with multiple compound needs through the new Homeless and Multiple Compound Needs Integrated Community Team (H&MCNs ICT)
- Our Health & Care Partnership will consider the learning from our H&MCNs ICT and whether this approach can support other key communities of interest where our health counts data is showing significant health inequalities i.e. our LGBTQ+ and TBI communities.