West BH ICT Leadership Group Delivery Plan 2026-27

Introduction

We believe communities need to be at the heart of ICT working and are committed to building trust across organisational boundaries to achieve our goals
WestBH Team Purpose: 'To work together to create joint solutions for Health and social care and address the wider determinants, in order to reduce the gap in healthy life expectancy in WestBH and give everyone the opportunity to live healthy, happy and fulfilling lives"

West Brighton and Hove ICT footprint runs from the boundary with West Sussex and takes in the communities of Portslade, Hangleton, Knoll, and Hove. It has a total population of 122,797 with 21,350 0-19 years old

Our approach

We will deliver both commissioning intentions and local priorities collaboratively as our core purpose. We hold a health forum bringing together community members and services to focus on areas of Health Inequality and a dedicated whole West community health panel with diverse membership which gathers and shares crucial community insight to inform our work.

Our neighbourhood health model is designed to deliver a coordinated, system wide collaboration across partners so that outcomes are owned by all and there is joint working across providers to enable this. Our governance structure embeds community voice in all delivery and co production as a principle of community partnership.

Community Insight, National and Local Priorities

Community research and insight from community groups and health panel have identified these priorities:

- Mental health support
- Access to services
- Screening and health checks

BHCC Health Counts commitment to tackling health inequalities associated with deprivation.
The Integrated Care Board have identified these outcome priorities in their commissioning intentions.

- Reduction in emergency admissions (65+ and ambulatory care sensitive conditions)
- Increased immunisation, screening, and falls prevention
- Improved experience and outcomes for high-need cohorts
- Increased same-day urgent care access

The 10-year Health Plan for England and the Neighbourhood Health Framework outlines three significant shifts for transforming healthcare. Theses are

- From treatment to prevention
- From hospitals to community
- From analogue to digital

Membership includes:

- **Clinical Lead: Dr Rowan Brown**
- **Management Leads:** Tory Lawrence, Gemma Clayton Chair: Joanna Martindale
- **Brighton and Hove City Council:** Public Health, Adult Social Care, Family Hubs, Housing, Employment,
- **Community Health Panel Chair:** Sharon Lyons
- **Primary Care:** General Practice, Community Pharmacy, B&H GP Federation
- **Trusts:** Sussex Partnership Foundation Trust, Sussex Community Foundation Trust, Royal Sussex County Hospital, NHS Sussex, Hospice
- **VCSE: T**he Hangleton and Knoll Project (HKP), Southdown, Together Co, AgeUk

Photo of leadership team

Maturity

We will continue to develop our current maturity with a specific focus on developing work strands and growing local leadership.

Demographics

We have 2% of 65+ considered frail across the West and 8% living with chronic conditions

We have the oldest population in Brighton and Hove with 41% over 60

26% of residents are from black and racially minoritised communities with over 4% of both Bengali and Arab speakers. We have areas in WestBH which are in highest 20% nationally for non English speakers

Data shows we need to work on increasing breast, cervical and bowel screening, vaccine uptake of all ages (flu/rsv and childhood imms especially) and falls prevention as specific areas of focus and that we need to focus on West Hove PCN patients to address health inequalities especially around hypertension.

We have a degree of variation in demographics in the West for example 67% of children live in income deprivation in North Hangleton and Knoll estates, areas of Hangleton are in top 20% in England for greatest food desert character and Knoll has 42% of residents living in the top 10% most deprived in England (compared to 7% for whole West), Knoll also have 24% of residents living with a long term physical or mental health condition and areas in Hangleton, Knoll and Aldrington are in the top 20% at risk of digital exclusion

Other parts of the West have indices much more in common for the average of Brighton and Hove and we have wealthy areas around Hove Park with better health

West ICT leadership Group spotlight

The city's Health & Care Partnership has asked ICTs to support our response to health inequalities, and the recent results of the city's health counts survey. Each ICT is actively delivering localised health engagement models through the city's Healthy Communities Programme. WestBH has been selected by BHCC Early Help Partnership to 'frontrun' Children and Young Peoples (CYP) integrated working in Brighton & Hove; acknowledging population need, maturity of ICT working and possibilities created by the new Weller Youth Centre.

Delivery Plan 2026/7

WestBH will drive down Hospital admissions and ED attendance by improving access to primary and community services, embedding multi professional MDT working, delivering in neighbourhood settings and improving our joint planning and delivery processes. In 26/27 we will also focus on proactive prevention and tackling health Inequalities

We will focus on **ESTATES** as we recognise them as a limiting factor to our ambitions. We are keen to develop a Neighbourhood Health Hub and develop local surgeries

Workstream priorities include

1. **Childrens/Young peoples work –** with a focus on Mental health and wellbeing, asthma, oral health and vaccinations by creating a core universal community based offer
2. **Cancer Screening –** partnering Act on Cancer Together delivered in West between general practice and HKP
3. **Employment and Health –** improving health through employment support for first steps to work
4. **Metabolic diseases and their causes –** Hypertension, CVD, Diabetes prevention and support
5. **Health and Care Research –** developing WestBH ICT research maturity through community research programme (NIHR) in partnership with Public Health
6. **Highest and Ongoing Needs programme –** delivering proactive, joined-up care through PCN-based multi-disciplinary working. Integrating a locally designed frailty intervention for core20
7. **Remote Monitoring –** maximising implementation
8. **Mental health –** collaborating to improve the mental health and support for residents. Aligning with Neighbourhood Mental Health Teams and developing a localised community hub through the UOK partnership. Inequalities include ESOL/Digital access to services
9. **Targeted interventions and proactive prevention –** programme of events and community collaborations supporting HON, MSK, Falls prevention and all other West Priorities in partnership with HKP and other CVSE orgs
10. **Vaccination uptake –** we will collaboratively boost ALL AGE vaccination rates through tailored strategies
11. **Pharmacy –** increasing uptake of all pharmacy services

Contact for more information:
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West Brighton and Hove ICT Leadership Group Delivery Plan 2026-27

Commissioning Intentions and Priorities

⦿ **Reducing emergency admissions to hospital** ⦿ **Targeting health inequalities in our communities** ⦿ **Innovating with our communities to improve services** ⦿ **Supporting communities to access vaccinations and screening** ⦿ **Community priority** ⦿ **Health and Wellbeing Board** (Multiple Compound Needs, Cancer, Long-term Conditions, Children & Young People, Mental Health)

ICT Activity *Commissioning Intentions/ Community Priority	Data	Activities	Ambition
1. **Cancer Screening** ⦿ ⦿ ⦿ ⦿	Breast Screening (23/24) 65.3% is -8.0% Bowel Screening (23/24) 66.7% is -6.7% Cervical Screening 25-49yrs 65.9% is -3.7% Cervical Screening 50-64yrs 73.5% is -1.2% West is 2nd lowest for Bowel screening and 3rd lowest for youngest age cervical of all 15 ICT areas West ICT has lowest rates of breast screening of all 15 ICTs – community insight is issue is access to Park centre – location and access	Partnering with Act on Cancer Together – Primary Care partnership to boost response to screening invitations working in Trinity and WellBN Macmillan funded project (TDC lead) for peer support for those who test positive Proactive cancer screening outreach as part of events programme	Consider expanding ACT to all surgeries adding capacity and embedding method Further develop ACT training Inequalities – specific ESOL outreach trans (wellBN) and LD outreach (all) Breast screening available in West - local or mobile centre
2. **Employability** ⦿ ⦿ ⦿	5% of people in the city are unemployed this is 1% higher than national average. In parts of the West ICT this rises to 20% Hangleton, Knoll, Aldrington are in top 20% nationally for digital exclusion. Low rates of connectivity and skills, 29% w no qualifications in estate areas West in top 20% areas nationally where residents are ESOL Knoll has 7% and Hangleton 13% Youth Unemployment (4%BH) Community insight that ·wait lists for MSK are an issue for residents in West and causing people to stop work ·Confidence and MH a major barrier in West	Connect to work coaches employed by BHCC Link to MSK early prevention Rethinking our Health and persistent pain intervention Pathways to UOK employment support	Persistent pain support – successful pilot expanded – HERE and HKP BHCC to lead workstream on employment – pathway to Work coaches – cost neutral and pathways created to community learning outreach run by HKP (cost neutral) Employment support located in communities linked to events/outreach – link to SP and MH coordinator work

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3. **Metabolic Disease – all ages**	Cholesterol QRISK> =20% treated with LLT 62.9% is -0.7% Cholesterol CVD treated to threshold 48.1% is +2.2% Hyper tension treated to appropriate threshold 64.8% is -3.4%	Improving metrics for CVD – hypertension and lipid management Target for Covid/flu vaccinations WHPCN Health checks programme Building on learning from T2day event and diabetes group consultations and peer support	Increase pharmacy interventions and use of Pharmacy first/specialist offer including core CVD prevention and hypertension case finding Capacity to deliver community BPs, sugars and lipid tests at all events/in community
4. **Health Events/Hubs and proactive targeted interventions**	The portion of residents in the 20% most deprived areas as a % of west ICT population 7.3% masking high levels of deprivation in Hangleton, Knoll, Aldrington and parts of Portslade where deprivation is in highest 10/20 % in England (knoll has 42% of residents living in 10% most deprived nationally) 4% of population is Bengali speaking and 4% Arabic speaking - - top 20% of ESOL speakers nationally There are large gaps in self-reported good health: around 76% in least deprived areas vs 56% in most deprived areas Higher numbers of children living in Poverty (up to 67%) and older people living alone	Proactive for cancer screening/BP management/falls preventions Working and networking wide range of partners involved in local community events and actvities Changing culture away from dependency and towards self care	Regular Health Events programme funded providing proactive work on smoking cessation, weight, exercise, CVD, BP via multi year Public Health Healthy Communities commission with all health and social care stakeholders Adult Social Care wait list targeted with community assessments (see HON) Target digital inequality – digital outreach across West to surgeries and community venues – increasing uptake of NHS app – better access Tackle ESOL Inequality to services and broaden range of community activity Secure Citywide/Self refer SP funding
5. **Highest Ongoing Needs and proactive frailty work**	Patient Needs Groups Frailty (all ages) 0.3% of population 2% of adults over 65 live w frailty High complexity 1% of population Dominant chronic 8% of population Moderate needs 27% of population Healthy 63% of population Emergency admissions 65+ per 100,000 53.9 is -1.8 Avoidable admissions 65+ per 100,000 is 4.9 is -0.4 Falls 65+ per 100,000 is 6.4 is +0.6 Patients with Frequent admissions % 15.5 is – 2.5%	Joined up work on falls prevention from proactive prevention in events, to holistic meds review and targeted SP and MDT for highest needs Frailty project developed MDT work commenced	Expand frailty pilot - 1 full time SP role (ageUK) and pharmacy time in WHPCN – Core 20 area to tackle inequalities and prevent hospital admission – evaluated by Hospital and scaled up to get impact Community falls prevention expanded SCFT led community appointment days including ASC OT/assessments MDT operating to include Adult Social Care wait list/priorities Expansion of front line operational delivery to do work of MDTs

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6. **Mental Health - Adults**	% with SMI health checks 52.5% is -7.7% Across the city it is estimated that 1 in 5 adults has a common mental health problem and 1 in 10 adults have self-harmed in last year Brighton & Hove has the 10th highest rate of suicide and undetermined injury 20% of over 66 live alone	Good range of community offer especially for older people NMHT started Gap within support for people with ND but pilot work promising on workshop offer	Gap in targeted community offer for higher SMI need of all ages. Peer support/expert patient opportunities to socialise locally and cheaply Better pathways SP/MH coordinator and local Community offer Further develop NMHT via GP services, CVS and local offers Deliver community learning to enable and encourage peer support for ASC/ADHD linked to primary care pathways and all MH conditions
7. **Mental health – Children and Young people**	Brighton & Hove self harm admissions to hospital, 456 per100,000 population (age 10–24). Highest of the 3 ICTs in Brighton – that's 80 CYP in 24/25 Safe & Well @ school survey 77% often felt happy (83%) 14% self harm sometimes/often (12%) 24% have eating difficulties often (20%) 28-67% CYP live in poverty in West	Weller Youth Centre as asset for collab – open access youthwork offer funded BHCC HKP Youth advisory Board for West giving youth voice New role – Children's wellbeing Pracs being trialed at WYC CYP workstream commenced as frontrunner School MH offer funded BHCC Partnership w Allsorts for LGBTQ+ specialism and with YAC at YMCA for homeless prevention via Young Futures partnerships Partnership w Police on ASB early support (often YM w underlying MH issues)	Link youthworker – Family Hub and CAMHS to community offer Redesign of CAMHS including wider stakeholders YIACS available in Weller Alternative education provision located in West Better links School/Community/Primary Care

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8. **Vax and Imms – all ages**	Covid 19 overall uptake 53.5% is -7.2% Covid 19 75+ uptake 60.5% is -5.2% Flu uptake 49.7% is -7.0% RSV uptake 59.2% is -4.9% DTaP vaccine 90.2% is -1.4% MMR vaccine 88.5% is -2.1% DTaP/IVO &MMR is 84.2% is -3.0% (5th and 4th lowest vax rates of all ICTs)	Build on workshop model Work w Public Health to escalate system barriers Work as local partners collaboratively Work with Schools New pharmacy contract to enable mop up vax when missed within School	ICT vaccinator to enhance capacity for outreach Better commissioning and procurement for GP and Pharmacy Increased awareness of all vaccination options via community outreach and education
9. **Asthma Children and Young people**	Brighton & Hove self harm admissions to hospital, 456 per100,000 population (age 10–24). Highest of the 3 ICTs in Brighton – that's 80 CYP in 24/25 Safe & Well @ school survey 77% often felt happy (83%) 14% self harm sometimes/often (12%) 24% have eating difficulties often (20%) 28-67% CYP live in poverty in West	40 children and young people aged 0-19 years living in West ICT Area admitted to hospital for asthma 24/25 Rate of 199 per 100,000 – lower than Brighton ICT East (239) but higher than ICT Central (185)	Create asthma CYP plan for West agreed w all partners Including pharmacy role in inhaler technique/better diagnostics/better links GP and specialist improved awareness mould and damp/better community/FH and School training SCFT asthma nurse post extended
10. **Smoking cessation**	The West ICT area has the lowest rates of smokers across the three ICTs at 15% of the population YP insight is that young people are vaping at high levels and that some are switching to smoking following advice against vaping	Continue to deliver as part of Healthy Communities Programme in West – vape and follow up offer in core20 areas	Explore work with PH on CYP offer on smoking/vaping
11. **MSK and pain**	13% of adults say that pain interferes with their day to day lives. In Portslade and Hangleton & Knoll areas this is a higher % than the city average Link to employability and falls prevention Community insight that wait lists are causing significant problems	Build upon what works from Rethinking Our Health partnership with HERE Persistent pain peer support group currently developing	Monthly MSK hub for early intervention

ICT Activity *Commissioning Intentions/ Community Priority	Data	Activities	Ambition
12. **Community Engagement & Research**	Currently NO engagement funded	NIHR community research partnership UNFUNDED panel and forum Youth advisory Board	Funded adult Community Health Panel and West Area Health Forums via Neigh Alliance as per commissioning intentions SVLA work on COI engagement w specialist partners eg Cancer work Speakout LD/Switchboard/Clare trans Ongoing consistent West and BH research Outreach to BRM and ESOL communities and to target estates (CHWW) employed in CVS