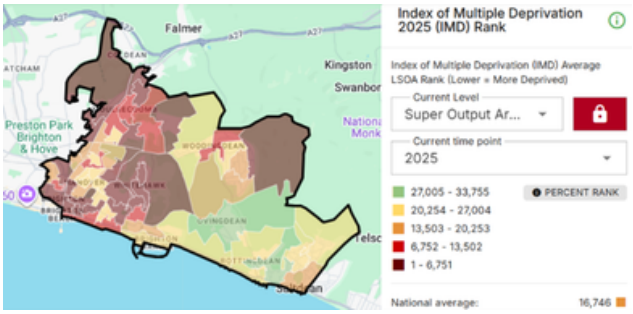
Brighton East ICT Leadership Group Delivery Plan 2026-27

Introduction

We are community-led, with decisions shaped locally through involvement and consensus. We focus on reducing health inequalities by prioritising those most in need and addressing economic deprivation. Through a prevention-focused, asset-based approach, we build on community strengths to support people to stay safe, well, and connected—especially in mental health and wellbeing. Working collaboratively, we align services to local needs to improve outcomes and build stronger, healthier communities.

Area Brighton East runs from the centre of Brighton, through Whitehawk, out to Saltdean and up to Moulsecoomb and Woodingdean. It is a registered population of 111,096. There is a strong network of community activity. It is co-terminus with : East and Central Brighton PCN and Deans and Central Brighton PCN boundaries



Our approach

Communities need to be at the heart of neighbourhood working. Our governance structure embeds community voice in all our ICT activity. We have a leadership group whose aim is to deliver health and care outcomes collaboratively, a solution focused health forum bringing together community members and services delivering in the area and a community health panel 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.

Community Insight, National and Local Priorities

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

- Mental health and well-being support
- Awareness and access to health and care 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 Leads: Dr Johannes McGavin and Dr Amy Reimoser
Management Leads: Joe Walker, Oonagh O'Brien, Laura Fernandez-Kayne
Convener/Chair: Kaye Duerdoth

- Brighton and Hove City Council: Public Health, Health and Adult Social Care, Family Hubs, Housing, Skills and Employment, Community Engagement
- Community Representatives
- 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
- University of Brighton
- VCSE: Southdown, Together Co, Trust for Developing Communities, Macmillan, British Red Cross

Maturity

We will build on our current maturity with a specific focus on governance, learning and co-ordinated care.

- Developing: shared purpose and local leadership, personalised, coordinated care, learning culture and impact
- Maturing: integrated teams and local assets, population health insights, working with people and communities

Demographics:

We are a diverse community. We have the city's youngest population, 27% of our community is from Black and Racially Minoritised communities, there are high levels of LGBQ+ and TNBI adults and we have notable proportions of unpaid carers. Deprivation is significantly higher than elsewhere, with 36% living in England's most deprived neighbourhoods.

Socioeconomic and environmental challenges are prevalent. There is high child poverty (up to 87%), low adult qualifications (31%), unemployment (7%), overcrowding, food deserts, digital exclusion, and many older adults living alone. In schools, pupils show greater exposure to racism, increased self-harm and eating difficulties, higher alcohol experimentation and lower happiness compared to city averages. Adults in the area report poorer outcomes in physical and severe mental health, higher self-harm, anxiety, smoking, gambling harm, and concerns about housing and safety.

We have a higher proportion of residents than expected with moderate to high health and care needs. Frailty affects 2% of adults aged 65+. 47% of the city's emergency department attendances are from Brighton East.

Compared to Sussex ICT averages, we see more urgent hospital visits, Urgent Treatment Centre and Minor Injury Unit attendances, mental health urgent care demand, , emergency admissions, falls in older adults and delayed discharges.

East 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. In East this includes a weekly health hub offer alongside satellite outreach.

Delivery Plan 2026/7

We will address the wider determinant of health, reduce health inequalities and drive down Emergency Department attendance by improving access to primary and community services, embedding multi professional MDT working, and delivering in neighbourhood settings.

Priority activity includes:

1. **Cancer Screening –** partnering with Act on Cancer Together to increase screening rates.
2. **Community Pharmacy –** Quality Improvement - improving awareness of Pharmacy First, contraception, and core CVD prevention services, hypertension case finding, vaccinations and locally commissioned services
3. **Diabetes –** improving CVD Prevent metrics on hypertension and lipid management and outcomes for people with Type 2 Diabetes aged 18-40
4. **East Brighton Health Hub and Satellite Community Outreach –** weekly coordinated same-day multidisciplinary support, providing open-access care in a local setting with no appointment needed. Satellite hubs will deliver outreach care in community settings. Offers will include health literacy, BP checks, digital access, cancer screening, and early intervention for groups facing the greatest inequities.
5. **Employability –** Extending our early Workwell intervention for working age adults with MSK or mental health conditions.
6. **Health and Care Research –** developing Brighton East ICT research maturity.
7. **High Intensity Users of the ED –** working with the Royal Sussex County Hospital and the British Red Cross on a targeted community health approach.
8. **Highest and Ongoing Needs programme –** delivering proactive, joined-up care through neighbourhood-based multi-disciplinary teams.
9. **Mental health –** collaborating to improve the mental health and support for residents. Aligning with Neighbourhood Mental Health Teams and developing a localised community offer through the UOK partnership.
10. **Targeted interventions –** such as a peer-led Pain Café, and a consultant-led Community Respiratory Clinic with University Hospitals Sussex.
11. **TNBI Health Offer –** developing our monthly open access care in a trusted setting for the B&H TNBI community.
12. **Vaccination uptake –** we will collaboratively boost vaccination rates through tailored strategies.
13. **Workforce and Community Engagement -** embedding community voice and leadership, working and learning together

Contact for more information:
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Brighton East 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) 75.2% is +1.9% Bowel Screening (23/24) 63.2% is -10.2% Cervical Screening 25-49yrs 58.2% is -11.4% Cervical Screening 50-64yrs 69.2% is -5.4%	Partnering with Act on Cancer Together to increase cervical, breast and bowel screening rates. Co-producing tailored comms, partnering with Primary Care to boost response to screening invitations by 30%, community outreach.	Resource to extend partnership to each GP practice in ICT area. 13 remaining practices. Impact 30% increase in uptake by nonresponders for bowel and cervical screening. Resource to provide screening awareness for non clinicians.
2. **Community Pharmacy**	ICB dashboard for quality improvement programme supports claimed data analysis for Pharmacy Contraception, Hypertension and Pharmacy First throughout the duration of the project. Data insight gaps due to visibility of data. NHSBSA data 3 months behind. Public Health data for LCS quarterly reviews.	Quality Improvement - improving awareness of Pharmacy First, Pharmacy Contraception services. Core CVD prevention service – Hypertension case finding. Vaccinations- Covid, Adult and child Flu, MenB. Locally commissioned- stop smoking, chlamydia test and treat, substance use services.	Recognised as a Core prevention and access partner improving awareness, data insight and service uptake. Contribute to reducing inequalities, supporting community priorities and preventing avoidable emergency admissions.
3. **Diabetes**	Cholesterol QRISK =20% treated with LLT 64.6% is + 1% Cholesterol CVD treated to threshold 47% is +1.1% Hypertension treated to threshold 64.2% is -4%	Improving CVD Prevent metrics on hypertension and lipid management and outcomes for people with Type 2 Diabetes aged 18-40.	Resource to continue successful hypertension project connecting general practice, community outreach and pharmacy. Resource for specific project for young people, newly diagnosed and poorly controlled diabetes. This is likely to involve clinically led community activities. Resource for active outreach to engage those with multiple complex social issues.
4. **East Brighton Health Hub & Satellite Community Outreach**	Quarterly Appointments per 1,000 Reg Pop 1,501 is -145.8 % within 2 weeks 75.7 is -2.7% %DNA 4.4% is +1.3% Total care contacts per 1,000 reg population 677.2 is +13.2 Cancelled by provider as % of care contacts 33.2 is +4.4% DNAs as % of care contacts 0.8 is -0.1%	Weekly coordinated same-day multidisciplinary support, providing open-access care in a local setting with no appointment needed. Satellite hubs deliver outreach care in community settings. Offers include health literacy, BP checks, digital access, cancer screening, and early intervention for groups facing the greatest inequities.	Exploration of need for other health hubs. Estate to host the weekly East health hub – Valley Social Centre is ideal Link to Neighbourhood Health Centre with GP offer. Resource to deliver hub and satellites including clinical offer plus community outreach and engagement. Resource to support community participation in advisory group

ICT Activity *Commissioning Intentions/ Community Priority	Data	Activities	Ambition
5. **Employability**	5% of people in the city are unemployed this is 1% higher than national average. In parts of the East ICT this rises to 20% In April 2026 5.32% of residents were claiming unemployment benefits (Compared to 4.41% in Brighton & Hove & 4.06 in England) In March 2026 22.2% of residents were claiming Universal Credit (Compared to 18.11% in Brighton & Hove & 19.7% in England)	Extending our early intervention for working age adults with MSK or mental health conditions. Support the implementation of WorkWell 2.0 (residents with low level heath need on Fitnotes).	Create a broader employability offer across our ICT by embedding employability in recognition of the positive impact of good work on physical and mental health. Resource to continue community partnership for the former WorkWell pilot and scale. Explore health and employment social prescriber and occupational health therapist.
6. **Health and Care Research**	36.3% of the population live in the 20% most deprived areas 27% of the population is Black and Racially Minoritised 5% of households have no one with English as a main language 15% of adults are unpaid carers 3% of adults have experience of living in care as a child or young person	Developing Brighton East ICT research maturity. Linking in with health and care research at Health Hub.	Resource to recruit and train community researchers to support clinical research projects. Set up health and care research working group to oversee research in area.
7. **High Intensity Users Emergency Dept**	Emergency admissions 65+ per 100,000 56.9 is +1.2% Avoidable admissions 65+ per 100,000 is 4.9 is -0.4 Falls 65+ per 100,000 is 6.3 is +0.5 Patients with Frequent admissions % 18.1 is +0.1%	Working with the Royal Sussex County Hospital and the British Red Cross on a targeted community health approach.	New pilot project with social prescriber based in the Emergency Department. We have evidence from our outreach model that proactive paramedic visits can reduce hospital visits and many people have multiple complex needs that would benefit from input from focused care practitioners
8. **Highest & Ongoing Needs Programme**	Patient Needs Groups Frailty (all ages) 0.3% of population High complexity 2% of population Dominant chronic 9% of population Moderate needs 27% of population Healthy 61% of population People discharged after the day they are medically optimised for discharge is at 13.6%, compared to 12.8%	Delivering proactive, joined-up care through neighbourhood-based multi-disciplinary teams	Resource to delivery HON Programme as currently it is being undertaken alongside existing workload rather than through dedicated resource. There are growing concerns that the current approach relies heavily on goodwill and discretionary effort. Our aim is for long-term sustainability of the HON project.

ICT Activity *Commissioning Intentions/ Community Priority	Data	Activities	Ambition
9. **Mental Health and Well-being**	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 deaths in England, and the 2nd highest for females East ICT area has significantly higher levels of anxiety and lower levels of happiness.	This is the top community priority. Collaborating to improve the mental health and support for residents. Aligning with Neighbourhood Mental Health Teams and building on the localised UOK Well-being service offer.	Named NMHT contact with capacity to develop local mental health offer with ICT Leaders. Staying Well space to provide an alternative place for people to Emergency Department when unwell. Support for community engagement and oversight. Resource for tailored offers as they emerge. Further develop the localised mental health and well-being offer.
10. **Targeted Interventions**	SMI (Severe Mental Illness) health checks are at 55.9% in East ICT, compared to 62.2%	Such as a peer-led **Pain Café**, and a consultant-led **Community Respiratory Clinic** with University Hospitals Sussex. We have successfully reduced opioids to below the 50th Centile.	Resources to support partnership and innovative targeted work Fibroscan offer We would like to build on the success of pain cafe to offer a more comprehensive pathway to help people manage pain without opioids and enable them to manage their lives better.
11. **Trans, Non-Binary & Intersex Health Offer**	6% of adults are TNBI 34% of adults are LGBQ+ 56% in "Good or Better health" compared to 69% in the city (Healthcounts 2024) LGBTQ+ community experience some of the poorest mental health in the city (Health Counts 2024)	Developing our monthly open access care in a trusted setting for the B&H TNBI community. Improve access to Health Checks and gender affirming care for people living in the city.	Specialist social prescribing support. Cross city support for project as this is work with a community of identity rather than place, and as such, doesn't fit neatly in the 'East' footprint. Dedicated mental health support needed to improve outcomes of LGBTQ+ population.
12. **Vaccination Uptake**	Covid 19 overall uptake 51% is -9.8% Covid 19 75+ uptake 58.3% is -7.4% Flu uptake 45.6% is -11.1% RSV uptake 29.9% is -34.2%	We will collaboratively boost vaccination rates through tailored strategies.	Funding for ICT vaccinator to compliment primary care offers. Large community appointment day style event with people invited for a clinical review, vaccination and also offer social prescribing , help with stopping smoking, diet, exercise, housing etc. Escalation of system concerns raised in local partner workshops.
13. **Workforce and Community Engagement**	Two organisational development sessions held in 25/26. Demand for further joint learning and development. Currently community engagement is unfunded.	Working collaboratively across the Leadership group through Tests of Change. Ensuring community voice and leadership is embedded across all our work.	Learning and evolving together to develop each other, working closer to our communities and a build a sustainable workforce for the future. Resource for Community Health Panel and East Health Forum needed.