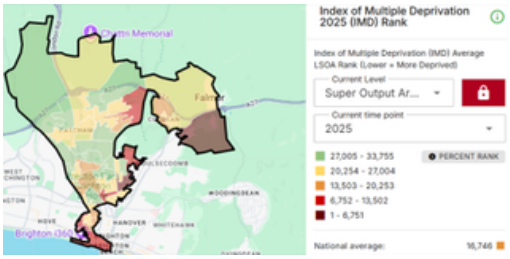
Brighton Central ICT Leadership Group Delivery Plan 2026-27

Introduction

We are committed to reducing health inequalities by prioritising those with the greatest need and addressing economic deprivation. Through a prevention-focused, asset-based approach, we empower communities to stay safe, well and connected, with a strong focus on mental health and wellbeing.

Working collaboratively across the system, we align services with local needs to improve health outcomes for all—reducing, delaying and preventing escalation of care while building stronger, healthier communities.

Brighton Central runs out from the coast in a triangle broadly between the Lewes Road and Dyke Road. It includes Hollingdean, Coldean, Patcham, Hollingbury, Preston Park, Seven Dials and Universities of Brighton and Sussex. It has a registered patient population of 89,000. There is a strong network of community activity. It is co-terminus with : Preston Park and North & Central Brighton Primary Care Network boundaries



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 of wider health and care services
- Improving access to wider 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

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.

Membership includes:

- **Clinical Lead**: Dr Neil Raymond
- **Management Leads**: Sam Lade and Emma Cartledge
- **Convener/Chair:** Kaye Duerdoth
- **Brighton and Hove City Council:** Public Health, Adult Social Care, Family Hubs, Housing, Skills and Employment, Community Engagement
- **Community Representatives** plus Hollingdean and Old Boat Community Centres
- **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, Southern Hospice Group
- **University of Brighton**
- **VCSE**: UOK -Southdown, SVLA, Together Co, Trust for Developing Communities, British Red Cross

Maturity

We will build on our current maturity with a specific focus on working collaboratively, 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:

Diverse population within our community 24% are Black and racially minoritized, 15% are unpaid carers, 27% are LGBQ+,and 5% are trans, non-binary, intersex.
Health inequalities (deprivation) Only 56% of adults in the most deprived areas reported being in good or better health, compared with 76% in the least deprived areas.
Pockets of need Whilst 73% of adults report being in good health and 43% are a healthy weight - 32% are disabled, 19% have fallen in last year, 10% say pain interferes with normal work and 16% smoke.
Mental health need 22% had a low happiness score and 38% had a high anxiety score, 9% of adults have self harmed and 26% have thought of taking their own life.

NHS health data linked to NHS commissioning intentions
Avoidable Admissions 65+ based on Q4 25/26 49.6 per 100,000 population. Average across ICTs is 55.7
Seasonal vaccination uptake based on 2024 to 2026 average uptake is 56.75% against an overall ICT average of 58.22%
Cancer screening based on 23/24 data.
Cervical 68.95% is 3.2% lower than other ICTs
Breast 75.2% is 1.8% higher than other ICTs
Bowel 73% is 0.4% lower than other ICTs
SMI Health Checks 57.4% 2.8% lower other ICTs
CVD treated to cholesterol threshold 46% 0.1% higher
Hypertension treated to threshold 66.4% 1.9% lower

Central 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 Central this includes regular themed community support hubs. In addition, the Central ICT incorporates the city's universities so will have specific focus on student health.

Delivery Plan 2026/7

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

Priority activity includes:

1. **Cancer Screening –** working with Act on Cancer Together to increase rates and develop non-responder approach.
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. **Community Support Hubs –** Themed monthly coordinated same-day multidisciplinary support hubs at Old Boat and Hollingdean. Open-access walk-in care. Offers include health literacy, CareLink, social prescribing, adult social care, BP checks, digital access, cancer screening, and early interventions.
4. **Employability –** Develop a holistic employment, housing, finance, food and health offer. Link with the Get Sussex Working Plan. Focus on young people.
5. **Health and Care Research –** developing our ICT research maturity and linking with research lead for the Federation.
6. **Highest and Ongoing Needs Programme –** delivering proactive, joined-up care through multi-disciplinary teams. Reducing falls and frailty, improving well-being.
7. **Long-term Conditions** Diabetes - improving CVD Prevent metrics on hypertension and lipid management and outcomes for people with Type 2 Diabetes aged 18-40. Respiratory to follow.
8. **Mental health and well-being –** collaborating to improve support for residents. Aligning with Neighbourhood Mental Health Teams and building on UOK offer.
9. **Prevention** - Co-produce smoking cessation offer and access to weight management support
10. **Students and Young People –** Explore the mental and physical health needs. Develop tailored Pharmacy First information and develop links around GP registration.
11. **Targeted interventions –** Continue to develop our CVD prevention project. Further identify at risk population groups (e.g. frailty, respiratory conditions) and develop innovative targeted and collaborative approaches.
12. **Vaccination uptake –** Collaboratively boost vaccination rates through tailored strategies.
13. **Workforce, shared learning, training** - Learning and evolving together, working closer to our communities and building a sustainable workforce.

Contact for more information:
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Brighton Central 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 +1.8% **Bowel Screening (23/24) 73% is -0.4%** **Cervical Screening 25-49yrs 60.3% is -9.4%** **Cervical Screening 50-64yrs 77.6% is +3%**	Partnering with Act on Cancer Together to increase screening rates. Co-producing tailored comms, partnering with Primary Care to boost response to screening invitations by 30%, community outreach	Resource to develop a neighbourhood cancer screening programme through Community Support Hubs and local partnerships to improve awareness, reduce barriers and increase participation in screening programmes
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. Improve collaboration and patient access options, better involvement in neighbourhood projects. Contribute to reducing inequalities, supporting community priorities and preventing avoidable emergency admissions.
3. **Community Support Hubs** ⦿ ⦿ ⦿ ⦿ ⦿ ⦿	5.3% of population live in 20% most deprived area 25% of the population is Black and Racially Minoritised 5% of households have no one with English as a main language 5% of adults are TNBI 27% of adults are LGBQ+ 15% of adults are unpaid carers 3% of adults have experience of living in care as a child or young person	Themed coordinated same-day multidisciplinary support at two community centres – Old Boat and Hollingdean. Providing open-access walk-in care in a local setting. Offers include health literacy, CareLink, adult social care, social prescribing, BP checks, digital access, cancer screening, and early intervention for groups facing the greatest inequities.	Develop Community Support Hubs as a neighbourhood access point for preventative support, early intervention and community-based services, helping residents access the right support at the right time and reducing avoidable demand on Primary Care and Urgent Care Services. Resource to deliver hubs plus community outreach and engagement. Resource to support community participation in advisory group. In the medium term, improve the offer and frequency available to members of the community. Develop offers for LGBTQ+ community and explore volunteering programme. This could be a primary location for the delivery of future neighbourhood projects.

ICT Activity *Commissioning Intentions/ Community Priority	Data	Activities	Ambition
4. **Employability**	5% of people in the city are unemployed this is 1% higher than national average	Develop a holistic employment, housing finance and health offer. Link with the Get Sussex Working Plan and WorkWell 2.0. Focus on young people and those not in education, employment or trainings (NEETS).	Develop a neighbourhood employability and life opportunities programme to support residents and students into employment, education, apprentiships, volunteering and training.
5. **Health and Care Research**	24% are Black and racially minoritized, 15% are unpaid carers, 27% are LGBQ+,and 5% are trans, non-binary, intersex. 56% of adults in the most deprived areas reported being in good or better health, compared with 76% in the least deprived areas. 73% of adults report being in good health and 43% are a healthy weight - 32% are disabled, 19% have fallen in last year, 10% say pain interferes with normal work and 16% smoke. 22% had a low happiness score and 38% had a high anxiety score, 9% of adults have self harmed and 26% have thought of taking their own life.	One of our PCN Directors is research lead for the Federation and works closely with the team from the National Institute of Health Research's South East Regional Research Delivery Network to facilitate recruitment and research delivery across the city. Developing Brighton Central ICT research maturity.	Recruit and train community researchers to support clinical research projects. Set up health and care research working group to oversee research in the Central ICT area. Utilise university student for research opportunities in neighbourhood working, projects, outcomes.
6. **Highest & Ongoing Needs Programme**	Patient Needs Groups Frailty (all ages) 0.4% of population High complexity 1% of population Dominant chronic 7% of population Moderate needs 26% of population Healthy 64% of population	Delivering proactive, joined-up care through neighbourhood-based multi-disciplinary teams. Reducing falls and frailty, improving well-being.	Develop a person-centred neighbourhood support model for residents with the highest levels of frailty, complexity and ongoing need, providing proactive, coordinated care to improve outcomes and reduce avoidable hospital admissions.
7. **Long-term Conditions**	**Cholesterol QRISK =20% treated with 60.5% is-3.1%** **Cholesterol CVD treated to threshold 46% is +0.1%** **Hypertension treated to threshold 66.4% is -1.9%**	Improving **CVD** Prevent metrics on hypertension and lipid management and outcomes for people with Type 2 **Diabetes** aged 18-40. CVD Prevent metrics on hypertension and lipid management and outcomes for people with Type 2 Diabetes aged 18-40.	Develop a neighbourhood hypertension and CVD prevention programme connecting community outreach, GP and Community Pharmacy to improve the early identification and management of diabetes and cardiovascular risk factors. Follow with respiratory offer.

ICT Activity *Commissioning Intentions/ Community Priority	Data	Activities	Ambition
8. **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	This is the top community priority. Collaborating to improve mental health and wellbeing support for residents. Aligning with Neighbourhood Mental Health Teams and building on the localised UOK Wellbeing Service offer.	Work with Neighbourhood Mental Health Teams, the UOK partnership and local communities to better understand local mental health and well-being needs and further develop the localised mental health offer.
9. **Prevention**	16% of adults smoke 57% of adults and 30% of 11 year olds are overweight or obese, with higher levels in individual neighbourhoods and schools	Co-producing ICT smoking cessation offer to support health and finances. Supporting active and healthy weight environments in Brighton Central ICT and access to weight management support.	Increase awareness and education around offer of smoking cessation services, devices and alternatives. Link with CVD prevention work. Develop healthy weight environments and support.
10. **Students and young people**	Highest levels of 0-19 and 20-29 years old population in the city 1 in 8 - 16-24 year olds are not in education, training or work. The economic cost of youth unemployment is a cumulative cost of £125 BILLION in the UK alone. - from The Prince's Trust and The Youth Futures Foundation.	Exploring the mental and physical health needs of the student population to develop ICT responses. Developing our tailored Pharmacy First information and links between the University and GP practices around registration.	Develop a Student Health Partnership Programme with local universities to improve access to healthcare, wellbeing support and preventative health services for students across Brighton Central. Specifically support student GP registration to reduce attendance at the Emergency Department. Develop bespoke student Pharmacy First (including contraception services and Meningitis B) communications campaign for the start of the academic year. Further engage students in community volunteering and placement opportunities. Develop a Young Futures Hub with a regular safe drop-in space with youth service and mentoring
11. **Targeted interventions**	CVD treated to cholesterol threshold 46% 0.1% higher Hypertension treated to threshold 66.4% 1.9% lower	We will develop and seek funding for group consultation approaches aligned with health inequalities and community priorities.	Develop and test innovative approaches to identifying and engaging residents at risk of cardiovascular disease, focusing on those least likely to access traditional healthcare services.

ICT Activity *Commissioning Intentions/ Community Priority	Data	Activities	Ambition
12. **Vaccination Uptake**	**Covid 19 overall uptake 56.6% is -4.2%** **Covid 19 75+ uptake 63.5% is -2.2%** **Flu uptake 51.6% is -5.1%** **RSV uptake 65.6% is +1.5%**	We will collaboratively boost vaccination rates through tailored strategies.	Funding for ICT vaccinator to compliment primary care offers. 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 Central Health Forum needed.