Working together to end long-term rough sleeping

Brighton & Hove
Long-Term Rough Sleeping Partnership Plan 2026 – 2029

Our plan on a page

Our ambition	Nobody in Brighton & Hove is left experiencing long-term rough sleeping. When rough sleeping does occur, it is rare, brief and not repeated.
Our goal	This plan contributes to the Government's ambition to halve long-term rough sleeping by the end of this Parliament. In Brighton & Hove we will go further, reducing long-term rough sleeping from 24 people per month to 8. We will also reduce the annual rough sleeping count by more than 50%, from 57 to 20 people.
Who we focus on	People who have spent the longest periods experiencing rough sleeping, those who repeatedly return to experiencing rough sleeping, and those facing the greatest risk of harm and exclusion. Together, they form our Target Priority Group. Rough sleeping is the most acute and extreme form of homelessness. It is characterised by someone about to, or actually, bedding down in the open air (such as, on the street, in tents, doorways, parks, bus shelters or encampments) or places not designed for habitation (including cardboard boxes, stairwells, cars and other makeshift and not fit for purpose places). Someone experiencing long-term rough sleeping is defined by the UK Government as a person who has been seen experiencing rough sleeping in the current reporting month and in at least three separate months within the previous 12 months. This measure is used by the Ministry of Housing, Communities and Local Government (MHCLG) to monitor local authority performance, inform national reporting, and allocate funding. Key criteria: • Assessed over a rolling 12-month period. • Rough sleeping must be recorded in three or more separate calendar months; continuous rough sleeping is not required. • The individual must also have been seen rough sleeping within the current reporting month to be counted in local statistics. Why this matters: This definition provides a consistent national measure of persistent rough sleeping, helping local

	authorities identify people facing the greatest barriers to leaving the streets and target support and resources accordingly.
Our shared system	A seven-stage pathway from being at risk of experiencing long-term rough sleeping through to settling in and sustaining a home: at risk, finding support, understanding needs, coordinating support around multiple compound needs, temporary or supported accommodation, finding longer term housing, and sustaining a home.
How we work	One shared understanding of need. This approach will include: • One coordinated plan around the person; • Trusted relationships over time; • Continuity of support; • Housing, health, the criminal justice system, social care and community services working together; • Trauma informed practice; • Lived experience/living experience at the centre; and • Shared responsibility for outcomes.
How we are organised	**Cabinet** members have approved the Homelessness and Rough Sleeping Strategy 2025-2030. The Action Plan which includes this Long-term Rough Sleeping Partnership Plan and a Suitability of Temporary Accommodation Policy are approved by Cabinet. Performance will be reported annually to Cabinet members. The **Homelessness and Rough Sleeping Partnership Board** provides strategic leadership across the pathway, supported by health and care, safeguarding, and criminal justice partnerships. Cabinet members also form part of the Partnership Board alongside two Partnership Board members with lived experience/living experience. Partnership Board members ensure good governance, that progress remains on track against targets and unlock challenges that sit at a system level where collective and collaborative leadership is required. Performance will be reported quarterly to the Partnership Board.

	The **Working Group** is responsible for delivering the actions required to achieve the targets. It reports updates into the Partnership Board quarterly and updates other groups and partners across the city regularly via the Chair of the Working Group. It combines teams from across the Council with partners from across the city to ensure that the targets are on track and that learning is applied in an agile and iterative way. Work undertaken by the Working Group includes collaboration and co-creation with lived experience/living experience. The Working Group meets every four weeks reporting performance against targets and sharing learnings to ensure collaborative working in partnership.
What success looks like	We will have succeeded when long-term rough sleeping in Brighton & Hove has reduced by more than 50% and continues to fall; when fewer people are prevented from experiencing rough sleeping in the first place; when people move more quickly from rough sleeping into accommodation and support; and when fewer people return to experiencing rough sleeping after receiving an offer of accommodation and support. We will know our partnership is making a difference when people leaving prison, hospital, care or asylum accommodation are less likely to experience rough sleeping, when people with the most complex needs receive coordinated support, and when more people are able to sustain a settled home. Beyond the numbers, success is a system where support arrives before crisis, services work together around the person, and nobody has to experience rough sleeping to get help.

1. Our city and our partnership

Brighton & Hove is a vibrant, creative and coastal city that attracts people from across the region and beyond. Its diverse communities, strong voluntary, community and faith sector, universities, visitor economy, and well-established health and support services make it a place of opportunity for many. However, some of the qualities that make the city attractive can also create significant challenges. Demand for housing continues to outstrip supply, affordability remains a major issue, and the city's geography, bounded by the sea and the South Downs, limits opportunities for expansion.

Within this context, people experiencing rough sleeping remains one of the most visible and complex forms of homelessness in the city. People experiencing long-term rough sleeping are often navigating multiple challenges at the same time, including poor physical and mental health, trauma, substance use, social isolation, poverty and contact with the criminal justice system. There is a common perception that rough sleeping only takes place on the street. In reality, experiencing rough sleeping can take many forms and is not always visible, despite being the most acute and extreme forms of homelessness.

People experiencing rough sleeping is characterised by someone about to, or actually, bedding down in the open air, such as on the street, in tents, doorways, parks, bus shelters or encampments, or in places not designed for habitation, including cardboard boxes, stairwells, vehicles and other makeshift locations. The challenges people face rarely exists in isolation and can make it difficult to access, engage with, and sustain support over time.

Addressing long-term rough sleeping therefore requires more than individual interventions. People often need support from housing, outreach, health, mental health services, drug and alcohol treatment, adult social care, criminal justice services, accommodation providers and community organisations at different points in their journey. While many people are in contact with multiple services, support is not always coordinated around the person.

Our partnership brings together organisations from across Brighton & Hove to respond collectively. This includes Brighton & Hove City Council, NHS Sussex, Sussex Partnership NHS Foundation Trust, probation and prison services, Sussex Police, accommodation providers, registered providers, voluntary, community and faith organisations, and people with lived experience/living experience. Together, partners work through a network of arrangements that support prevention, early intervention, coordinated support and long-term system change. This includes the Homelessness and Rough Sleeping Partnership Board, the Homelessness and Rough Sleeping Working Group, the Homelessness and Rough Sleeping Network, the Homelessness Operational Forum, Brighton & Hove Frontline Network, Common Ambition, the Multiple Compound Needs Transformation Programme, the Integrated Care Team, the Mental Health Accommodation Group, the Health and Wellbeing Board, Safeguarding Adults Board, Young Homeless Working Group, Temporary Accommodation Action Group and Refugee and Migrant Forum.

Together, these partnerships provide leadership, challenge, accountability and learning across the system. They enable us to identify risks earlier, intervene more effectively, improve coordination around the people who need us most, and continually learn from data, frontline practice and lived experience.

This plan sets out how we will strengthen collaboration, improve our shared understanding of need and align support around common outcomes. It describes how partners will work together to prevent people becoming trapped in long-term rough sleeping, reduce the time people spend on the streets, and create sustainable routes into housing and recovery.

1.1 What this plan is

This is our Partnership Plan for long-term rough sleeping. It sets out how partners will work together across the system, including our shared approach, governance arrangements, delivery model and collective priorities.

The plan sits alongside the Homelessness and Rough Sleeping Strategy within the Action Plan. The Strategy sets out what we want to achieve. This Partnership Plan describes how we will work together to achieve it for people experiencing long-term rough sleeping. The Action Plan provides the framework for delivery, monitoring and accountability and includes the Local Outcomes Framework Targets, the Suitability of Temporary Accommodation Policy and this Long-Term Rough Sleeping Partnership Plan.

The Strategy's three priorities are preventing homelessness and rough sleeping; improving temporary accommodation pathways and experiences; and improving joined up support for people who most need help. Alongside these sits a dedicated chapter focused on tackling homelessness among children, families and young people. Together, they shape the approach set out in this plan.
Through these priorities and chapter, we will work as one system around the people who need us most, ensuring support is coordinated, person-centred and focused on helping people move away from long-term rough sleeping for good.

2. Our shared ambition

Meets MHCLG section (a): Partnerships, shared vision and outcomes.

Together, we want to end rough sleeping in Brighton & Hove. When someone does experience rough sleeping, it should be rare, brief and never repeated, and nobody should be left on our streets long-term.

For a person in our city, that means someone notices early; there is at least one person they can trust; they tell their story once; they feel safe, heard and valued; there is a safe place to go that leads somewhere; and when they move into a home, support stays with them until they are settled and connected to their community. People with lived experience told us that lasting change comes not just from housing, but from trusted relationships, continuity of support, hope and a sense of belonging.

2.1 Our shared goal

We will reduce long-term rough sleeping in our city by two-thirds, from 24 people a month to 8, in line with - and moving beyond - the national ambition to halve long-term rough sleeping. We will also reduce the number of people experiencing rough sleeping on a single night in autumn from 57 to 20.

Ending Long-term rough sleeping.	Baseline (2025)	2026	2027	2028
Long-term rough sleeping (monthly)	24	23	18	8
Single-night count (autumn)	57	46	32	20
Prevention and relief success for people facing multiple disadvantage	25.16%	38.5%	41%	44%

We expect the biggest change to come later, as new settled homes with intensive support open. In the preceding timeframe, our focus is on building the foundations that make that change last: a shared priority list, one plan around each person, intensive support from winter 2026, and stopping as many new people as possible from experiencing long-term rough sleeping.

2.2 Success criteria

This plan is about the people with the most complex needs, who have slept rough longest. It is judged against three success criteria, each a Local Outcomes Framework (LOF) measure with a local target for every year of the plan.

Code	Success criterion	LOF outcome	Already used locally in	Baseline (2025)	2026	2027	2028	Reported by
M1	Number of people sleeping rough over the month who are long term (headline measure)	3 and 4	Homelessness and Rough Sleeping Strategy 2025–2030, Priority 3 indicator	24	23	18	8	Partnership Board
M2	Number of people sleeping rough on a single night (autumn snapshot)	3	Strategy, Priority 1 indicator	57	46	32	20	Partnership Board
M3	Prevention and relief success for people facing multiple disadvantage	3 and 4	Strategy, Priority 3 indicator	25.16%	38.5%	41%	44%	Homeless and Multiple Compound Needs Partnership

2.3 What the targets mean

- **M1:** halving long-term rough sleeping would mean 12 by the end of this Parliament. A target of 8 by 2028 is a two-thirds reduction, reached sooner.
- **M2:** a single-night count of 20 would be around 7 people per 100,000 residents. That is below the England rate in 2025 (8.2), down from around 20 per 100,000 now, which is roughly two and a half times the England rate.
- **M3:** in 2025, homelessness was prevented or relieved for around one in four households facing multiple disadvantage (25.16%). The target is more than four in ten (44%) by 2028. For comparison, 66% of all prevention duties ended with accommodation secured in 2024, so households facing multiple disadvantages currently do much worse than others.

2.4 Progress measures for the long-term cohort

M1 changes only when more people leave long-term rough sleeping for good than join it. Four progress measures show whether that is happening, so the Working Group can see each month whether the plan is on track before the annual figures move. T1, T2 and T4 come from MHCLG's Rough Sleeping Data Framework, which also produces M1. T3 comes from the shared case-level tracker.

Code	Progress measure	What it shows	Source	Reviewed
T1	People sleeping rough over the month who have recently left an institution, such as prison, hospital or care	Whether prevention at transition points is working (rare)	Rough Sleeping Data Framework, Rough Sleeping Programme	Monthly, Working Group, Rough Sleeping Programme
T2	People who become long term each month (new entrants to the long-term cohort)	Whether fewer people are becoming entrenched (brief)	Rough Sleeping Data Framework / CHAIN, Rough Sleeping Programme	Monthly, Working Group, Rough Sleeping Programme
T3	Target Priority Group members accommodated, and still accommodated at 6 and 12 months	Whether people are leaving the street and staying off it	Case-level tracker, Rough Sleeping Programme	Monthly, Working Group; quarterly, Partnership Board, Rough Sleeping Programme
T4	People returning to rough sleeping	Whether housing and support are holding (non-recurrent)	Rough Sleeping Data Framework, Rough Sleeping Programme	Monthly, Working Group, Rough Sleeping Programme

2.5 Understanding the figures

Two rough sleeping rates are used in this plan, and they measure different things. The single-night count (57 in autumn 2025) equals around 20 people per 100,000 residents, roughly two and a half times the England rate of 8.2. The monthly figure counts everyone seen sleeping rough over a month: 30 per 100,000 in March 2025, against 13.4 in England and 11.5 in the South East, the joint 19th highest rate in England. The Review of Homelessness 2025 cautions that the single-night count is not a reliable guide to trends, so M2 is always reported alongside the monthly rate.

2.6 What the baselines tell us

In March 2025, 29% of people sleeping rough were new and almost a quarter were returning. Need is high: in the Multiple Needs Audit (Q4 2024/25), 704 people experiencing homelessness had two or more other needs, 88% had mental health needs, 77% had substance use needs and 53% had criminal justice involvement. The city had the 7th highest rate of drug misuse deaths in England (12.7 per 100,000, more than double the England rate of 5.2, 2020–22), and one in five people who died from drugs in 2024 had been homeless in the previous year.

2.7 How the target will be met

Long-term rough sleeping falls only when the number of people leaving the cohort into accommodation they keep is greater than the number becoming long term. To move from 24 to 8, sustained exits must exceed new entrants by 1 in 2026, by 5 in 2027 and by 10 in 2028.

Year	Reduction needed	What makes it possible
2026	24 to 23	Target Priority Group, fortnightly case review and transition protocols slow the number becoming long term (T1, T2)
2027	23 to 18	Prison navigator and no first night out reduce new entrants; the lettings quota and private rented package create the first sustained exits; lead worker continuity and step-down support reduce returns (T2, T3, T4)
2028	18 to 8	Housing First expansion and settled housing provide enough homes for around 10 more sustained exits than new entrants (T3)

2.8 What could get in the way

We are realistic about the challenges ahead. Brighton & Hove continues to face a shortage of affordable and settled housing, increasing complexity of need, workforce pressures, recruitment and retention challenges, and funding uncertainty. Partners also recognise that effective information sharing, service integration and system change take time to develop.

Progress will be reviewed regularly through the Homelessness and Rough Sleeping Working Group and Partnership Board, using Local Outcomes Framework measures, pathway data, Target Priority Group reviews and lived experience insight. Where barriers are identified, we will adapt our approach, update our Action Plan and work together to remove them.

2.9 What success will look like

We will have succeeded when long-term rough sleeping in Brighton & Hove has reduced by more than 50% and continues to fall; when fewer people are prevented from experiencing rough sleeping in the first place; when people move more quickly from rough sleeping into accommodation and support; and when fewer people return to experiencing rough sleeping after receiving an offer of accommodation and support.

We will know our partnership is making a difference when people leaving prison, hospital, care or asylum accommodation are less likely to experience rough sleeping, when people with the most complex needs receive coordinated support, and when more people are able to sustain a settled home.

Beyond the numbers, success is a system where support arrives before crisis, services work together around the person, and nobody has to experience rough sleeping to get help.

3. Our Target Priority Group

Meets MHCLG section (b): Agreeing local needs.

Reducing people experiencing long-term rough sleeping requires partners to focus collectively on the people who face the greatest barriers to moving away from rough sleeping. Central to this plan is our Target Priority Group (TPG).

The Target Priority Group (TPG) is a partnership approach that brings together housing, outreach, health, social care, criminal justice, accommodation and voluntary, community and faith sector partners to identify people who have spent the longest periods experiencing rough sleeping, repeatedly return to experiencing rough sleeping, or face the greatest risk of becoming trapped in experiencing rough sleeping. It creates a shared understanding of who requires the highest level of partnership attention and coordinated action.

The purpose of the Target Priority Group (TPG) is not simply to identify people. It is to help partners work differently with people facing the most entrenched forms of rough sleeping. Through the Target Priority Group, partners share intelligence, coordinate support, address barriers and focus collective effort on helping people move forward.

The Target Priority Group helps partners to:

- identify people experiencing the greatest barriers to moving away from experiencing rough sleeping;
- bring together intelligence, evidence and professional insight from across services;
- coordinate support around shared goals and outcomes;
- identify barriers that are preventing progress and agree how partners will respond;
- focus partnership attention, resources and problem-solving where they can have the greatest impact;
- support escalation where system barriers, service thresholds or gaps in provision are preventing progress.

Being identified through the Target Priority Group should lead to meaningful partnership action. While individual organisations will continue to operate within their own duties, policies and eligibility criteria, partners will work together to consider how services, accommodation, support and opportunities can be aligned around people within the group. The expectation is that the system responds collectively to barriers rather than expecting individuals to navigate those barriers alone. Each person within the Target Priority Group will have a regularly reviewed multi-agency case plan, with agreed actions, ownership and oversight through the partnership.

The Target Priority Group is informed through outreach services, enhanced support teams and intelligence from across the partnership. It is reviewed regularly throughout the year to reflect changing circumstances, emerging risks, progress away from rough sleeping and changing support needs. This enables partners to maintain a shared focus on those facing the greatest barriers while responding flexibly as circumstances change.

4. Brighton & Hove: Long-term rough sleeping system

Meets MHCLG section c. Working together - delivering sustainable impacts

People with lived experience/living experience in our city, worked alongside support workers through Brighton & Hove's Common Ambition. Together, they mapped the housing pathway experienced by single adults facing homelessness in Brighton & Hove. That work provided a shared understanding of how people move through local services, where they encounter barriers, and where they are most likely to become stuck. It remains a recognised pathway across the city and an important foundation for this plan.

Through wider engagement with partners, local evidence and people with lived experience/living experience, we built on that housing pathway to develop a broader long-term rough sleeping system. We recognised that people experiencing long-term rough sleeping are often interacting with multiple services and systems at the same time, and that outcomes depend not only on housing, but on how housing, health, social care, substance use, criminal justice, welfare and community services work together.

The result is a shared seven-stage pathway, from being at risk of experiencing long-term rough sleeping through to settling in and sustaining a home. Every partner can identify their role within it, and every stage presents an opportunity to prevent someone from reaching, remaining in or returning to experiencing long-term rough sleeping.

People with lived experience/living experience told us that experiencing long-term rough sleeping is rarely caused by one issue alone. Many described experiences of trauma, poor mental health, substance use, poverty, exclusion, unsafe relationships and repeated transitions between services. Partners highlighted that people do not experience support in the same way, with different groups facing different barriers at different points in the pathway. This reinforces the need for a flexible system that responds to people's needs, rather than expecting people to fit existing services.

Around every stage sits a wider system of housing, outreach, physical and mental health, drug and alcohol treatment, adult social care, justice, employment and welfare support, alongside specialist services for women, young people, care leavers and people experiencing hidden homelessness. This plan focuses not only on the pathway people experience, but on how the whole system aligns around shared priorities, shared accountability and shared outcomes.

5. What we will do together at each stage

The pathway describes the journey people take from being at risk of experiencing long-term rough sleeping through to sustaining a home. At every stage, there are opportunities to prevent rough sleeping, reduce harm, improve coordination between services, and support people to move towards stable housing and recovery.

People do not experience this journey in a linear way. Many people move between different stages over time, interact with multiple services simultaneously, or experience repeated homelessness before finding lasting stability. Partners told us that people often become stuck where support is fragmented; transitions are poorly coordinated, or systems are unable to respond flexibly to changing needs. People with lived and living experience consistently highlighted the importance of trust, continuity and services working together around the person rather than expecting the person to navigate the system alone.

Prevention is not confined to the earliest stages of the pathway. Every point of contact with housing, health, care, criminal justice and support services represents an opportunity to prevent someone experiencing rough sleeping, prevent escalation of harm, and prevent a return to experiencing homelessness.

The Target Priority Group provides an additional focus for partnership action across every stage of the pathway. It helps partners to identify people facing the greatest risk of long-term rough sleeping, coordinate support across organisations, and focus on resources where they can have the greatest impact. However, the responsibilities set out below apply across the wider system and are intended to improve outcomes for everyone at risk of, or experiencing, rough sleeping.

This section sets out 20 priority commitments: the changes that will make the most difference to people experiencing long-term rough sleeping. Wider actions sit in the Homelessness Action Plan. For each stage of the pathway, we describe what is happening in Brighton & Hove today, who plays a part, and what people with lived and living experience told us. A table then sets out, for each commitment:

- **Challenge:** what people experience, or where they get stuck;
- **Barrier:** the specific reason the system creates that problem;
- **What we will do together:** the change partners will make and based on lived/living experience;
- **Who is involved:** the partners who deliver the commitment together. Lead partners, outputs and dates sit in the Action Plan;
- **Intended outcome:** what will be different for people;
- **Measure of success:** the three success criteria (M1 to M3), the supporting Local Outcomes Framework measures (M4 and M5) and the progress measures for the long-term cohort (T1 to T4) the commitment contributes to. Commitments that make measurement possible are marked as enablers;
- **Year and what will be delivered:** the output that shows the commitment is done, and when (Year 1: 2026; Year 2: 2027; Year 3: 2028).
- Each stage links to the strategic priorities of the Homelessness and Rough Sleeping Strategy 2025–2030, supports delivery of the Rough Sleeping Programme, and every commitment is carried into the Action Plan.

5.1. At risk of experiencing long-term rough sleeping

Strategy Priorities 1 and 4 · Rare · Meets MHCLG section (b): agreeing local needs through early identification and prioritisation; and section (f): collaboration with prisons and probation through prevention, resettlement and transition planning.

Many people who experience long-term rough sleeping are known to a range of services before they began to experience rough sleeping. This can include people living in temporary or supported accommodation, leaving prison, hospital, care or asylum accommodation, as well as people experiencing hidden homelessness, sofa surfing or repeated housing instability. The earlier we identify people at risk of experiencing a cycle of long-term rough sleeping, the greater the opportunity to prevent harm and provide coordinated support.

Who plays a part here: Housing Options and homelessness prevention, probation and prison resettlement teams, hospital discharge teams, Children's Services and leaving care, residential treatment providers, asylum accommodation providers and the Refugee and Migrant Forum, supported and temporary accommodation providers, and the Young Homeless Working Group.

Lived experience/living experience: People told us they often felt support only when they had reached a crisis point. Many described experiences of leaving prison, hospital, temporary accommodation or other services without a clear plan, feeling they had to become more visible or more unwell before support was available.

Challenge	Barrier	What we will do together	Who is involved	Intended outcome	Measure of success	Year and what will be delivered
Resources are not focused on the people at greatest risk	No shared, agreed list of people at highest risk of harm and long-term rough sleeping	We commit to creating the Target Priority Group together, based on need, harm and repeat rough sleeping rather than housing status, and review it monthly on a shared case-level tracker	Housing People Services, outreach, Multiple Compound Needs Integrated Community Team, probation, adult social care, Working Group partners	Partners focus on the same people, with one plan each	**M1**; **T3 (section 2)**	Year 1: Target Priority Group agreed and on the tracker by March 2027
People leave prison, hospital, care, residential treatment or asylum accommodation	Duty to Refer referrals arrive late (in some instances), and in those cases there might be	We commit to creating transition protocols with each discharging service, with referral at least 56 days before a known release, discharge or move-on date. Any release or discharge to no	Housing Options, probation and prisons, hospital discharge teams, leaving care, residential treatment providers, asylum	People leave services with somewhere to go	**M2**; **M3**; **T1 (section 2)**	Year 1: protocols agreed. Year 2: in operation, with every

with nowhere to go	no agreed transition protocols or triggers	accommodation is escalated to the Working Group	accommodation providers, Refugee and Migrant Forum			discharge without a plan escalated
People leaving prison lose their home or have nowhere to go	Pre-release planning starts too late, and nobody manages rent or housing benefit during short sentences	Put a prison navigator in place for people in the Target Priority Group, starting planning 12 weeks before release, and agree a tenancy retention protocol for sentences or remand of up to 13 weeks	Probation, prisons, Housing Options, housing providers, Combatting Drugs Partnership	People leaving prison keep or move straight into accommodation and treatment	**M4**; **T1 (section 2)**	Year 1: tenancy retention protocol agreed. Year 2: navigator in post (subject to funding)
People known to services still spend a first night on the street	Same-day accommodation is not guaranteed for people already known to services	Deliver an early intervention prevention offer: using learnings from the Rough Sleeping Programme (strategy action 1.3)	Housing Options, outreach, emergency accommodation providers	Nobody known to services sleeps out for a first night	**M2**; **T2 (section 2)**	Year 1, 2 and 3 – linked to the Rough Sleeping Programme

5.2. Initial support

Strategy Priorities 1 and 3 · Rare and brief · Meets MHCLG section (c): working together to deliver coordinated, person-centred and multi-agency support.

For many people, finding support is the first step away from rough sleeping. In Brighton & Hove, this support is provided through a network of outreach, health, housing and community services that work to engage people wherever they are and help them access the support they need. The Street Outreach Service (SOS) is often the gateway into the wider system, creating opportunities to build trust, understand individual circumstances and connect people with accommodation, healthcare and longer-term support.

Who plays a part here: This is often the widest point of the system. Alongside outreach services and day centres, people may come into contact with peer advocates, health services, specialist support organisations, accommodation providers, community and faith groups, libraries, food projects, police and community safety services, and members of the public reporting concerns through StreetLink. Each provides an opportunity to identify need, offer support and help someone move away from rough sleeping.

Lived experience/living experience: People repeatedly told us they want one trusted person who stays alongside them. They described having to navigate multiple services, repeat their story, and start again when workers changed. Trust and continuity were identified as some of the most important factors in helping people engage with support.

Challenge	Barrier	What we will do together	Who is involved	Intended outcome	Measure of success	Year and what will be delivered
Outreach cannot always offer something people can accept	Offers depend on what is available that night, and few options accept couples or pets	Review every declined (align this with Rough Sleeping Programme delivery approach) to find what would work, and add flexible rooms that accept couples and pets and offer single occupancy	Street Outreach Service, Housing Options, emergency accommodation providers, housing commissioning	People are offered something they can accept, quickly, and fewer become long term	**M2**; **T2 (section 2)**	Year 1: review of declined offers. Year 2: flexible rooms available
People navigate the system alone and start again when workers change	No single trusted worker, and limited advocacy	Give every person in the Target Priority Group one named lead worker from first contact, with access to advocacy or peer support. (This is aligned to the Rough Sleeping Programme and the wrap around support offer)	Outreach, Multiple Compound Needs Integrated Community Team, peer advocacy and voluntary sector partners, Common Ambition	People have one trusted person who stays with them	**M1**; **T3 (section 2)**	Year 1: lead worker for every Target Priority Group member. Year 2: advocacy offered to all

5.3 Understanding of needs

Strategy Priorities 1 and 2 · Brief · Meets MHCLG section (b): agreeing local needs through shared assessment, intelligence, risk identification and multi-agency case planning.

At this stage, people work with services to understand their housing situation, identify support needs and agree the next steps. Housing Options and partners work alongside outreach, hospitals, probation, adult social care, mental health, substance use and other relevant services to build a shared understanding of a person's circumstances, support and risk and safety needs. For people who have experienced long-term rough sleeping, partners will coordinate support by developing a shared plan, so that services work together around the individual rather than through separate referral pathways.

Who plays a part here: Housing teams and outreach, health, mental health and drug and alcohol services, adult social care, probation, advocacy and peer support, interpreters and immigration advice, and the person themselves, whose account of what they need comes first.

Lived experience/living experience: People described assessment processes that felt overwhelming, difficult to navigate and centred on proving eligibility rather than understanding need. People highlighted digital exclusion, literacy barriers and repeatedly retelling trauma as significant obstacles to engagement. People also highlighted the value of advocates and trusted supporters who helped them navigate systems, understand decisions and ensure their voice was heard.

Challenge	Barrier	What we will do together	Who is involved	Intended outcome	Measure of success	Year and what will be delivered
People repeat their story to every service	No agreement to share information, and partners hold separate records	Undertake a review of all touch points that someone would encounter and work together with lived/living experience, to improve that experience	All Partnership Board members, NHS partners, adult social care, probation, voluntary sector providers	People tell their story once, and partners work from the same picture	Enabler: makes M1 and T1 to T4 measurable **(section 2)**	Year 1: end-to-end journey with all relevant services & partners engaged
Support is planned service by service, and people at greatest risk are not always identified	No single plan, and risk is judged by individual services against their own eligibility	Retain an up-to-date live data set, which includes risk indicators a multi-agency case plan within for each person in the Target Priority Group	Housing teams, outreach, mental health and drug and alcohol services, adult social care, probation, advocacy	One plan around each person, focused on those at greatest risk	**M1**; **M3**; **T3 (section 2)**	Year 1: working with partners to create live data set, and define realistic route

5.4 Receiving support to address multiple compound needs

Strategy Priority 3 · Joined-up support · Meets MHCLG section (c): coordinated support and multi-agency case management; section (e): collaboration between housing, health and social care partners; and section (f): coordination with criminal justice partners where required.

People experiencing long-term rough sleeping often face multiple and interconnected challenges. Local evidence shows many people are interacting with housing, health, substance use, adult social care, criminal justice and voluntary sector services at the same time. For people with multiple compound needs, outcomes are often determined not by a single service, but by how well services work together around the individual.

Who plays a part here: The Integrated Homeless and Multiple Compound Needs Team, health and mental health services, drug and alcohol treatment, adult social care, housing, probation and police, accommodation providers, voluntary sector support workers and peer mentors.

Lived experience/living experience: People consistently told us that they experience their challenges together, even when services respond to them separately. They described having to navigate multiple systems, repeat their story and coordinate support themselves. People wanted services to communicate, share responsibility and work around their goals rather than organisational boundaries.

Challenge	Barrier	What we will do together	Who is involved	Intended outcome	Measure of success	Year and what will be delivered
People are passed between services when needs overlap	Each service holds its own plan, with no shared review	Review live data set for those identified in the Target Priority Group.	Multiple Compound Needs Integrated Community Team, Adult safeguarding Board, housing, primary care, mental health, drug and alcohol treatment, adult social care, probation, police, City Leadership Board	Services share responsibility for one plan	**M1**; **M5**; **T3 (section 2)**	Year 1: review running for the whole Target Priority Group

Challenge	Barrier	What we will do together	Who is involved	Intended outcome	Measure of success	Year and what will be delivered
People with co-occurring mental health and substance use needs cannot get support for both	Services can require one need to be treated first, and people are discharged after missed appointments	We commit to Improving access to integrated support through multi-disciplinary team (MDT) approaches between primary care, mental health services, drug and alcohol treatment and social care, including via outreach and in-reached models. We will do this through Implementing the NICE Guideline on Integrated Health and Social Care for People Experiencing Homelessness, ensuring services are designed around the needs of people experiencing homelessness	Sussex Partnership NHS Foundation Trust, drug and alcohol treatment provider, Combatting Drugs Partnership, working group	People get support for both needs together and keep their services	**M5 (section 2)**	Year 2: Implementing the NICE guidelines
Health leaders are not fully sighted on this TPG	Housing, health and care are not always fully aligned	We will consider opportunities for integrated delivery, including joint commissioning, pooled budgets, multidisciplinary teams and other collaborative approaches that improve outcomes and support delivery of local priorities	Health and Wellbeing Board, Sussex Integrated Care Board, Public Health, adult social care, housing, working group, partnership board, Rough Sleeping Programme	Senior health leaders act on barriers, and people get a more joined-up response	**M1**; **T3 (section 2)**	Year 1: first report to the Health and Wellbeing Board by June 2027

5.5 Accessing temporary or supported accommodation

Strategy Priority 2 · Brief · Meets MHCLG section (c): coordinated delivery of accommodation, support and move-on pathways that help people move away from rough sleeping and sustain recovery.

For many people, moving into temporary or supported accommodation is the first opportunity to step away from the instability of rough sleeping and begin focusing on recovery. Brighton & Hove offers a range of accommodation options, including emergency accommodation, supported housing, Housing First, women-only provision and specialist accommodation. Alongside this, the city's Off the Street Offer and Severe Weather Emergency Protocol provide important routes away from immediate street homelessness. The pathway shows that entering accommodation is a significant milestone, but that people can still become stuck if support does not adapt to their individual needs.

Who plays a part here: Supported accommodation providers and their staff teams, housing teams, drug and alcohol and mental health services, registered providers and landlords, the providers forum, advocacy and peer support, and the people living in the accommodation, whose experience tells us whether it works.

Lived experience/living experience: People told us that there is no single pathway out of rough sleeping and that support needs to look different for different people. Participants emphasised the importance of feeling safe, respected and understood, with accommodation that reflects individual circumstances, strengths and support needs. Some described placements that increased vulnerability, lacked privacy or disconnected them from trusted support networks. People consistently highlighted the importance of continuity of support, access to mental health and wider support services, and approaches that work alongside them to address the reasons that led to rough sleeping in the first place, and allow them to maintain connection with the people, pets and places that support them in feeling a sense of trust, stability and mutual care.

Challenge	Barrier	What we will do together	Who is involved	Intended outcome	Measure of success	Year and what will be delivered
People are evicted or abandon placements and return to the street	Providers, housing, health and treatment services do not act together before a placement breaks down	Council works directly with temporary accommodation providers to ensure that people are not evicted from placement	Supported and temporary accommodation providers, providers forum, housing, drug and alcohol and mental health services	Placements hold, and as few people as possible return to experience rough sleeping	**M2**; **T4 (section 2)**	Year 1: revised way of working with temporary accommodation providers

Challenge	Barrier	What we will do together	Who is involved	Intended outcome	Measure of success	Year and what will be delivered
Placements do not meet the needs of people with the most complex needs	Placement is by vacancy, with limited options for women, couples, pets and people needing self-contained accommodation	Understanding where there is a shortfall of temporary accommodation and increasing provision of those types, to best meet the needs of people who otherwise would not feel able to enter temporary accommodation Applying same standard for suitable move on accommodation. (Aligns to Rough Sleeping Programme)	Housing commissioning, accommodation providers, Temporary Accommodation Action Group, Common Ambition	People are placed somewhere safe that suits them, and fewer offers are refused	**M1**; **T3 (section 2)**	Year 1: Continuous review of live data set, Year 2-3: Increasing relevant Temporary Accommodation and settled accommodation provision
Some people's needs are too high for supported housing but do not meet residential care thresholds	No provision for this group	Wrap around support that sit alongside accommodation offers, recognising those needs may change over time. (Aligns to Rough Sleeping Programme)	Adult social care, housing commissioning, Mental Health Accommodation Group, NHS partners, Rough Sleeping Programme, working group	People with the highest needs have somewhere suitable to live	**M1**; **T3 (section 2)**	Year 1: Rough Sleeping Programme assessing live data sets and alignment with wrap around support. Year 2-3: work continues

5.6 Obtaining longer-term housing

Strategy Priorities 2 and 3 · Lasting · Meets MHCLG section (c): delivering sustainable impacts through settled housing, coordinated move-on planning and long-term support.

Moving on from temporary or supported accommodation is an important stage in the pathway. It creates opportunities for greater independence, stability and recovery, but it can also be one of the most challenging transitions. People may be preparing to move into social housing, private rented accommodation, Housing First or other longer-term housing options, often while continuing to manage health needs, recovery, finances and wider support needs. Partners and people with lived experience highlighted that moving indoors after extended periods of rough sleeping can be a significant transition. Adjusting to a home, rebuilding routines and managing isolation may require ongoing practical and emotional support.

Who plays a part here: Housing teams, registered providers and private landlords, Housing First and floating support services, health, treatment and social care, benefits and money advice, furniture and practical help projects, and neighbours and communities who make somewhere feel like home.

Lived experience/living experience: People told us that moving on is not simply a set of keys. Participants highlighted the importance of continuity of support, trusted relationships and practical help during transitions. Many described needing time to adjust, support that recognises trauma and multiple compound needs, and services that understand the reasons they began to experience a cycle of rough sleeping in the first place. People emphasised that successful move-on depends on feeling safe, seen and valued, having hope for the future, and knowing that support will remain in place while they build a life beyond rough sleeping.

Challenge	Barrier	What we will do together	Who is involved	Intended outcome	Measure of success	Year and what will be delivered
There are not enough accommodation for people who have slept rough longest	Limited affordable housing, an expensive private rented sector, and no agreed share of lettings for this group	Working in close alignment with the Rough Sleeping Programme and dedicated funding for accommodation beyond initial offer	Council housing and allocations, registered providers, private landlords, Housing First providers, Rough Sleeping Programme and Working Group	People who have slept rough longest move into accommodation	**M1**; **T3 (section 2)**	Year 1: identification of TPG and their requirements more settled accommodation. Year 2-3: standing up provision and ensuring people have wrap around support to sustain those offers

Challenge	Barrier	What we will do together	Who is involved	Intended outcome	Measure of success	Year and what will be delivered
People wait too long to move on	Move-on delays are not reviewed across partners, and there is no consistent practical help	We will understand the barriers from people moving on from Temporary accommodation and continue to increase suitable supply, whilst continue to work with partners and residents in temporary accommodation to ensure people are best set up to sustain accommodation	Working Group, housing, registered providers, VCSE partners, mental health support	People move on when ready, into a home they can live in and afford	**M1**; **T3 (section 2)**	Year 1: understanding barriers from people moving on from TA Year 2-3: increasing suitable supply and working alongside partners and residents in TA to ensure people best set up to sustain accommodation

5.7 Sustaining a home

Strategy Priority 3 · Lasting · Meets MHCLG section (c): supporting people to sustain their housing, maintain wellbeing and prevent returns to rough sleeping.

Moving into a home is a significant step but sustaining it can bring new challenges. For people who have experienced long-term rough sleeping, settling in often involves rebuilding routines, managing finances, maintaining physical and mental health, continuing recovery, and developing connections within the community. The pathway highlights that housing alone does not guarantee stability; people are often still navigating many of the same challenges that contributed to homelessness in the first place.

Who plays a part here: Health and social care, drug and alcohol recovery services, peer and community organisations, faith groups, employment, training and volunteering, landlords and providers, and the person's own networks and community.

Lived experience/living experience: People told us that receiving the keys to a home is only one part of the journey away from rough sleeping. Participants highlighted the importance of ongoing support, trusted relationships and having somewhere to turn when challenges arise. Many described the need for consistency, community connections and support that adapts as circumstances change. Sustaining a home was seen as more than maintaining a tenancy; it was about building confidence, stability, wellbeing, purpose and a life beyond experiencing rough sleeping.

Challenge	Barrier	What we will do together	Who is involved	Intended outcome	Measure of success	Year and what will be delivered
Support reduces before people feel settled	Resettlement support is time-limited rather than based on need	Partners take a collaborative approach to ensure that people have the right support at the right time (including after they have accommodation)	tenancy sustainment services, Housing First providers, Multiple Compound Needs Integrated Community Team	People sustain accommodation and feel part of community	**T4**; **M1 (section 2)**	Year 2: Residents feel a greater sense of connection and support from partners and community
Help arrives only once eviction proceedings start	Early warning signs, including cuckooing, are not shared between landlords and support services	Provider, partners and council work closely to ensure person centred trauma informed approach occurs at every point. Agree a temporary accommodation charter	Council housing, registered providers, private landlords in the access package, Sussex Police and community safety	Risks are dealt with before tenancies break down	**T4 (section 2)**	Year 1: TA charter agreed. Year 2-3: Implement the charter

6. Children, families and young people

Strategy Priority 4: tackle homelessness in children, families and young people · Rare · Meets MHCLG section (b): early identification and prioritisation.

The seven stages above describe a common pathway through homelessness and rough sleeping. However, children, families and young people often experience homelessness differently. For many, homelessness is triggered by a sudden change in circumstances rather than years of escalating need. This matters to our Long-Term Rough Sleeping Partnership Plan because the factors associated with long-term rough sleeping often emerge much earlier in life. Experiences such as family relationship breakdown, care experience, exclusion, trauma, unstable housing and poor transitions into adulthood can increase vulnerability to homelessness and rough sleeping later on. Preventing homelessness among children and young people is therefore one of the most important opportunities to reduce future rough sleeping.

Who plays a part: Preventing future rough sleeping among children, families and young people requires coordinated action across Housing, Children's Services, education, health, youth justice and the voluntary and community sector. The city already has strong foundations through joint Housing and Children's Services arrangements, family mediation and prevention services, young people's supported accommodation, the 18 to 25 pathway, care leaver support and the Young Homeless Working Group. Voluntary and

community organisations play an important role in identifying risks early, building trusted relationships and helping young people navigate support.

Shared by the voluntary and community sector: Services report increasing complexity in the needs of children and young people seeking support. Housing insecurity is often experienced alongside poor mental health, trauma, neurodiversity, family challenges and financial insecurity. Practitioners highlight that young people can find services difficult to navigate, reinforcing the importance of coordinated support before housing issues become more entrenched.

Challenge	Barrier	What we will do together	Who is involved	Intended outcome	Measure of success	Year and what will be delivered
Young people fall through gaps at 16, 17, 18 and on leaving custody	Transitions between children's and adult services, and from custody, are not joined up	Agree data review for every homeless 16- and 17-year-old, alongside clear accommodation planning for care leavers from 6 months before they reach 18 and align release planning with youth justice	Children's Services and leaving care, Housing, youth justice, Young Homeless Working Group, YMCA DownsLink Group, VCSE	Young people move into adulthood with somewhere safe to live	**M2**; **T1 (section 2)**	Year 1: joint arrangements in place Year 2-3: implement accommodation planning for 18-25 years
Young people lose support when they move into their own accommodation	Support ends at the point of move-on	Continue support through the 18 to 25 pathways into supported and settled accommodation	Young people's supported accommodation providers, leaving care, Housing, voluntary and community sector	Young people sustain independence, and homelessness and rough sleeping is not a risk	**T4**; **M2 (section 2)**	Year 2: support continues into settled accommodation including connection with suitable partners across city and feeling part of a community

7. Working together across the system

Meets MHCLG sections (c), (d), (e) and (f): partnership working, governance, health collaboration and criminal justice collaboration

The pathway describes the experience of people at risk of, or experiencing, long-term rough sleeping. Alongside it sits our partnership model, which describes how organisations work together at each stage. Different challenges emerge at different points in the pathway, and different parts of the system need to come together to respond. Partners have reflected that positive outcomes often depend on informal relationships and individual knowledge of the system.

Our approach is based on three principles:

- **Shared responsibility**. Long-term rough sleeping is not the responsibility of a single service. Housing, health, social care, criminal justice, substance use, welfare and community services each have a role in preventing people from reaching, remaining in or returning to rough sleeping.
- **Coordinated decision making**. Where people experience multiple compound needs, partners come together around shared plans, shared intelligence and shared outcomes, rather than working through separate service pathways.
- **Escalation and accountability**. When barriers cannot be resolved through day-to-day partnership working, there are clear routes for escalation through our governance arrangements, including the Homelessness and Rough Sleeping Partnership Board, Health and Wellbeing Board, Safeguarding Adults Board and Community Safety Partnership.

The Homelessness and Rough Sleeping Partnership Board provides strategic leadership across the whole pathway. Alongside this sit our health and care, safeguarding, and criminal justice partnerships, ensuring that decisions affecting people experiencing long-term rough sleeping are addressed within the wider systems that shape their lives.

7.1 The pathway: what a person experiences

Demonstrates how MHCLG sections (a) to (f) are applied in practice, linking the Strategy, Target Priority Group, shared pathway, partnership arrangements and governance framework.

The diagram below is our pathway out of long-term rough sleeping. Reading it from the top:

- **Our strategy sits above everything:** The four priorities of the Homelessness and Rough Sleeping Strategy 2025–30 run across the top, so partners can see that this plan delivers commitments we have already made.
- **Prevention, Rare, brief and lasting:** Each part of the pathway contributes to one of these: stopping people reaching the streets, getting them off quickly, and making sure a home is sustained.
- **The Target Priority Group runs through every stage:** The people experiencing the most entrenched forms of rough sleeping, or at greatest risk of becoming trapped in rough sleeping, are identified through shared intelligence, need, risk and vulnerability, rather than solely where they are sleeping.
- **Seven areas:** From being at risk, through finding support, understanding needs, coordinated support around multiple compound needs, temporary or supported accommodation, finding long-term housing, and settling in and recovery.
- **The whole system underneath:** Eleven parts, from housing and outreach to physical and mental health, drugs and alcohol, adult social care, justice, money and work, women and domestic abuse, young people and care leavers, and asylum, migration and hidden homelessness. It is never only about housing.
- **Running through it all:** people with lived experience, voluntary, community and faith sector, embedding trauma-informed practice, sharing data, and learning together.

The pathway reflects our current understanding of how people experience and move away from long-term rough sleeping. It will continue to evolve as we develop our evidence base, including learning from the Supported Accommodation Needs Assessment and the implementation of the Supported Accommodation Strategy

Our pathway out of long-term rough sleeping, and the system around it

What our Homelessness and Rough Sleeping Strategy 2025–30 commits us to

Priority 1
Prevent homelessness and rough sleeping

Priority 2
Improve temporary accommodation pathways and experiences

Priority 3
Joined-up support for people who need help most

Chapter
Tackle homelessness for children, families and young people

Rare: stop people reaching the streets

Brief: off the street quickly, with the right support

Lasting: a home that holds, and a life beyond it

1. At risk of long-term rough sleeping
Strategy 1 and 4 · Rare
People known to services before the streets: in temporary or supported housing, leaving prison, hospital, care or asylum accommodation, sofa surfing or facing eviction.
Housing Options, supported housing providers, probation and prisons, hospital discharge teams, mental health services, leaving care, asylum support, drug and alcohol services

2. Finding support
Strategy 1 and 3 · Rare and brief
First contact, on the street or through a door someone chooses to walk through, with a real offer and a trusted person.
Street Outreach Service, YMCA Youth Advice centre, StreetLink, First Base, Antifreeze, Clock Tower Sanctuary, Sussex Nightstop, faith and community groups, peer advocates

3. Understanding needs
Strategy 1 and 2 · Brief
Assessment that is trusting rather than doubting; agreeing together who is in our Target Priority Group and what each person needs.
Housing Options, outreach, Arch Healthcare, mental health and drug and alcohol services, adult social care, probation, risk assessment tools

4. Receiving support around multiple compound needs
Strategy 3 · Brief and lasting
One plan and one lead worker around the person, with services flexing to them: the heart of this partnership.
Integrated Homeless and Multiple Compound Needs Team, Changing Futures Sussex, multi-agency case meetings, Homeless and MCN Partnership, health, care, treatment and justice partners

5. Accessing Temporary or supported accommodation
Strategy 2 · Brief
Somewhere safe that supports recovery and leads onwards, with move-on planned from day one.
Severe Weather Emergency Protocol, Off Street Offer, supported accommodation pathways, women-only and specialist provision, providers forum, supported housing licensing

6. Obtaining long-term housing
Strategy 2 and 3 · Lasting
A settled home of their own, with the support that makes it possible to keep it.
Housing First, council and registered provider homes, private rented access, Rough Sleeping Programme settled homes, tenancy sustainment, move-in support

7. Settling in, recovery and a life beyond homelessness
Strategy 3 · Lasting
Staying well, staying housed, and building connection, purpose and income.
Health and social care, drug and alcohol recovery, mental health support, peer support, employment and meaningful activity, community and faith groups

Our Target Priority Group runs through every stage: the people at highest risk of harm, furthest from services and least likely to ask for help, identified by need rather than where they are sleeping

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Housing and accommodation
Housing Options and homelessness duties, Severe Weather Emergency Protocol, Off Street Offer, supported accommodation pathways, Housing First, council and registered provider homes, private rented access, move-on and tenancy sustainment

Outreach and day services
Street Outreach Service, StreetLink, First Base, YMCA Youth Advice Centre drop-in', Antifreeze, Clock Tower Sanctuary for 16 to 25-year-olds, Sussex Nightstop, food and drop-in projects, night shelters and faith provision

Physical health
Arch Healthcare specialist GP practice, Pathway hospital in-reach, Homeless Health Inclusion Team, integrated homeless healthcare hub, hospital discharge, dentistry and screening

Mental health
Community, crisis and inpatient care, dual diagnosis support, Mental Health and Housing Plan, Mental Health Accommodation Group, psychologically informed practice

Drugs and alcohol
Change Grow Live treatment and recovery, rough sleeping treatment funding, harm reduction, Combatting Drugs Partnership, learning from drug-related deaths

Adult social care and safeguarding
Integrated Homeless and Multiple Compound Needs Team, Care Act assessments, Mental Capacity Act, self-neglect and safeguarding, Safeguarding Adults Board, learning from deaths

Prisons and Probation
Prisons, probation and the Duty to Refer, police and Community Safety Partnership, courts and remand, women leaving custody, navigator and resettlement support

Money, welfare and work
Welfare benefits and Universal Credit, identification documents, budgeting and debt, discretionary help, employment, training and meaningful activity

Women, domestic abuse and specialist support
Violence against women and girls services, women-only accommodation, domestic abuse support, women's rough sleeping census, LGBTQ+ and culturally specific support

Children, Families and Young People
Children's services and leaving care, *young people's supported accommodation, YMCA Youth Advice Centre,* Clock Tower Sanctuary, Sussex Nightstop, targeted youth prevention, education and training

Asylum and migration
Move-on from asylum accommodation, support for newly granted refugees, no recourse to public funds advice, immigration and rights advice,

Hidden homelessness
People who are sofa surfing, living in insecure accommodation, staying temporarily with friends or family, or otherwise experiencing homelessness that is not visible to services.

Running through every stage and every service
People with lived experience and Brighton & Hove Common Ambition · our voluntary, community and faith sector · trauma-informed and trusting practice · shared data and information sharing · learning together from what works and from every adverse circumstance including those who have died whilst experiencing homelessness and long-term rough sleeping

7.2 The partnership: when we come together

Meets all MHCLG sections

The second diagram below uses the same seven stages along the top. Beneath them:

- **The Homelessness and Rough Sleeping Partnership Board spans the whole pathway:** This is our strategic board for this plan: it owns the shared goal, agrees what goes into the Action Plan, holds partners to their contributions, unblocks what other boards cannot, and reports to Cabinet and our MHCLG adviser.
- **Three statutory strands sit beneath it, each with its own family of groups:** Health and care through the Health and Wellbeing Board, with the Multiple Compound Needs Board, Combatting Drugs Partnership, Mental Health Accommodation Group and Integrated Community Teams. Safeguarding and learning through the Safeguarding Adults Board, covering reviews, audits, the Multi-Agency Risk Management framework and safeguarding for 18 to 25-year-olds. Justice and community safety through the Community Safety Partnership, with Integrated Offender Management, MAPPA, anti-social behaviour powers and prison and probation resettlement arrangements.
- **Seven coordination moments:** The middle row is the practical part: what triggers partners to come together at each stage, and which meeting does it. This is where the plan stops being a diagram and becomes a way of working.
- **An accountability loop at the bottom:** What comes back up, where it is considered, what changes, and how we know it is working.

Which part of our system meets at which point on the pathway

The pathway	1. At risk of long-term rough sleeping	2. Finding support	3. Understanding needs	4. Receiving support to address multiple compound needs	5. Accessing Temporary or supported accommodation	6. Obtaining long-term housing	7. Sustaining a home
Owns the plan	**Homelessness and Rough Sleeping Partnership Board — our strategic board across the whole pathway** Sets the shared goal, agrees with the Action Plan, holds partners to their contributions, unblocks what other boards cannot, and reports to Cabinet and MHCLG						
Health and care Health and Wellbeing Board	**Health and Wellbeing Board: system leadership for health, care and public health** Underneath it: Multiple Compound Needs Board and Homeless and MCN Partnership · Combatting Drugs Partnership · Mental Health Accommodation Group · Integrated Community Teams and inclusion health · Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and Shared Delivery Plan						
Safeguarding and learning Safeguarding Adults Board	**Safeguarding Adults Board: statutory oversight of adults at risk** Through it: Multi-Agency Risk Management framework for complex and self-neglect cases · Safeguarding Adult Reviews, audits and learning · Learning and Development and Pan-Sussex policy · Practitioners Alliance · transitional safeguarding for young people moving from children to adult services at 18 to 25, with the Safeguarding Children Partnership						
Justice and community safety Community Safety Partnership	**Community Safety Partnership, with prisons and probation** Through it: Integrated Offender Management delivery group · MAPPA · anti-social behaviour and the powers replacing the Vagrancy Act · youth offending · with HMPPS prison and probation resettlement arrangements, including the Community Accommodation Service for prison leavers at risk of homelessness, and the Sussex Criminal Justice Board						

When does coordination need to happen, and who meets?

The moment	Someone is about to lose their housing, leave prison, hospital or care	Someone is found sleeping rough	We need to understand what someone needs	Support is not working, or services disagree	Someone needs somewhere to stay	Someone is ready for a home of their own	Someone is settling in, or at risk of losing their home
What triggers partners to come together at this point	Pre-release and resettlement planning with prisons, probation and the Community Accommodation Service · hospital and mental health discharge planning · transitions planning for 18 to 25-year-olds leaving care · alerts from supported housing about evictions · asylum move-on notifications	Daily outreach coordination and referrals · review of who is in our Target Priority Group · severe weather protocol · decisions about enforcement only alongside a real offer	Multi-agency assessment and one agreed support plan with a named lead worker · Multi-Agency Risk Management for the highest-risk cases · Care Act and Mental Capacity Act decisions	Multidisciplinary team and case meetings · health, treatment and social care in-reach · blockages escalated to the MCN Board or the relevant partnership, then to the Partnership Board	Placement and exclusion decisions · providers forum on quality, move-on and evictions · supported housing licensing · risk management where there are justice concerns	Housing First and allocations panels · Rough Sleeping Programme settled homes · move-on planning with providers and registered providers.	Tenancy sustainment and step-down reviews · continuing health, treatment and peer support · learning where a tenancy or a life is lost, through the Safeguarding Adults Board and death reviews.

The wider system	**Our voluntary, community and social enterprise sector works alongside every stage** Homelessness and Rough Sleeping Network (sector leaders) · Supported Accommodation Providers Forum · Frontline Network and Homelessness Research Forum · outreach, day services, health, advice and faith organisations · registered providers and landlords
Lived experience	**People with lived experience shape, test and check every stage and every board** Our lived experience group and Brighton & Hove Common Ambition · peer roles in services · a direct route to the Partnership Board

How the structure keeps us on track to halve long-term rough sleeping

What comes back up
Learning from Safeguarding Adult Reviews, death reviews and audits · repeated blockages seen in case meetings · what frontline workers and people with lived experience tell us

→

Where it is considered
The relevant board first: health and care, safeguarding, or justice · then the Partnership Board for anything needing partners to change how they work

→

What changes
The Action Plan is updated with who will do what, by when · partners change practice, policy or commissioning · what changed is shared back with frontline teams

→

How we know
Monthly review of the Target Priority Group · quarterly Local Outcomes Framework and case-level data ·

Strategy → this partnership plan → Action Plan → each partner's own plans
The strategy sets what we want to achieve · this plan sets how we work together across the pathway · the Action Plan provides the framework

8. A journey through the system

Demonstrates how MHCLG sections (a) to (f) operate in practice. The example shows how partners identify people most at risk of long-term rough sleeping, coordinate support around the individual, use governance and escalation arrangements to address barriers, and work together across housing, health, social care, criminal justice and community services to achieve lasting outcomes.

The table below follows one person across the seven stages of our pathway, in four rows.

- **What we want to be true for the person**
  The experience we are working towards, in their words: someone notices before I lose my home; someone finds me and has something real to offer; I tell my story once and I am believed; one person sticks with me; I have somewhere safe that suits me; I get a home of my own and support moves with me; I stay well, stay housed and build a life I choose.

- **What usually gets in the way**
  The barriers we hear about most often, from support arriving only once someone is experiencing rough sleeping, through repeated assessments and fragmented services, to support ending before people feel settled in their home.

- **What we do differently**
  The partnership's response: identifying people most at risk through the Target Priority Group, coordinating outreach around a real offer, developing one shared plan and lead worker, preventing accommodation breakdown, planning move-on earlier, and ensuring support steps down rather than stops.

- **Who clears the way when it gets stuck**
  The governance, operational groups and partnerships that work together to remove barriers. No challenge should have to be solved by a single worker alone. When barriers cannot be resolved around the individual, they are escalated through partnership arrangements so that services, commissioners and leaders can act together.

8.2 The Journey:

	1. At Risk of Long-Term Rough Sleeping	2. Initial Support	3. Understanding Needs	4. Coordinated Support for Multiple Compound Needs	5. Temporary or Supported Accommodation	6. Longer-Term Housing	7. Sustaining a Home
What we want to be true for the person	Someone notices I am at risk and helps before I lose my home	Someone knows my name and has something real to offer	I tell my story once and my situation is understood	One person stays alongside me and services work together around me	I have somewhere safe that suits me and supports my recovery	I get a home of my own and support moves with me	I stay well, stay housed and build a life I choose
What usually gets in the way	Support arrives after crisis, and people leave services without a housing plan	People struggle to find support they can accept and have to start again when workers change	Assessments are repeated and people have to prove their need repeatedly	Services operate separately and people are passed between systems	Placements do not always meet people's needs and can break down	There are not enough settled homes and move-on takes too long	Support reduces too soon and problems are identified only when tenancies are at risk
What we do differently	We identify a Target Priority Group, plan transitions early and prevent a first night on the street	Everyone has a lead worker, flexible support and access to advocacy	One shared assessment, shared information and one plan around the person	Multi-agency teams share responsibility for outcomes and review progress together	We match people to the right accommodation and prevent evictions to the street	We create routes into settled housing and plan move-on from day one	Support steps down rather than stops, with early intervention when risks emerge
Who clears the way when it gets stuck	Prevention and transition planning arrangements identify risks early and escalate unresolved barriers	Outreach and operational partners review people not engaging and adapt the response	Multi-agency case planning resolves disputes and agrees the shared plan	The Multiple Compound Needs Integrated Community Team coordinates action across agencies	Providers, commissioners and housing partners act when placements are breaking down or suitable options do not exist	Housing providers and partners unblock move-on and increase access to settled homes	Tenancy sustainment, housing, health and community safety partners intervene before tenancies fail

8.3 Why this matters for our governance

Every working group, operational forum and board exists to remove barriers that prevent people moving through the pathway. Most barriers should be resolved around the individual through coordinated case planning and multi-agency support. Where the same barriers continue to affect multiple people, governance provides a route for escalation.

Operational groups identify the issue, partnership forums review why it continues to occur, and the Partnership Board agrees the changes needed to prevent it happening again. This creates a clear link between lived experience, service delivery and strategic leadership.

In practice, this means that:

- individual barriers are addressed through multi-agency support and case coordination;
- recurring barriers are escalated to the appropriate forum or board;
- system-wide issues become priorities for service improvement, commissioning or policy change;
- learning is fed back into the pathway so that fewer people encounter the same barrier in future.
- This approach ensures that no person is left trying to navigate system barriers alone. The responsibility for removing obstacles sits with the partnership, creating a system that is increasingly able to prevent, identify and end long-term rough sleeping.

9. Working together from here

This plan sets out how we will work together to reduce and ultimately end long-term rough sleeping in Brighton & Hove. It translates the ambitions of our Homelessness and Rough Sleeping Strategy 2025-2030 into a shared approach that brings together housing, health, social care, criminal justice, voluntary, community and faith sector organisations, accommodation providers, and people with lived experience/living experience.

Throughout this plan, we have identified where people become trapped in long-term rough sleeping, where the system works well, and where stronger partnership action is needed. We have set out a shared pathway, established a collective focus through our Target Priority Group, and described how organisations will work together to prevent rough sleeping, respond earlier, coordinate support and help people move towards stable housing and life beyond the streets.

The plan is supported by an Action Plan which sets out the specific actions, responsibilities and timescales required to deliver change. Together, these documents provide the framework for achieving our shared ambition and improving outcomes for people experiencing long-term rough sleeping.

Ending long-term rough sleeping will require sustained commitment across the whole system. No single organisation can achieve this alone. Success depends on partners sharing responsibility, aligning resources, listening to people with lived experience/living experience, and working together around shared priorities and outcomes.

By working together, we can intervene earlier, reduce the number of people experiencing a rough sleeping cycle, strengthen routes away from the streets, and provide the housing, support and opportunities people need to build lasting stability. Our ambition is simple: fewer people experience long-term rough sleeping, fewer people return to it, and more people are able to move into and sustain a home of their own.

10. Keeping this plan under review

Meets MHCLG section (d): ownership, governance and continuous learning through regular review, systems maturity assessment, partnership oversight and plan refresh.

This Partnership Plan is a live document. It reflects our current understanding of long-term rough sleeping in Brighton & Hove, the needs of people experiencing it, and the collective action required to reduce it.

We recognise that needs, evidence, services and partnerships will continue to evolve. New opportunities will emerge, barriers will be identified, and learning from delivery, lived experience/living experience, data, reviews and system maturity assessments will help us improve our approach over time.

The plan will therefore be reviewed regularly through the Homelessness and Rough Sleeping Working Group and Partnership Board. Progress, performance, learning and emerging priorities will be considered alongside Local Outcomes Framework measures, Target Priority Group reviews and feedback from partners and people with lived experience/living experience.

Where changes are required, the plan will be updated to reflect new evidence, changes in local need, national policy developments, partnership learning and agreed improvements to the way we work together. Any changes will be reflected through the Action Plan and reported through the governance arrangements set out in this document.

By treating this plan as a living partnership commitment, we will ensure that our response to long-term rough sleeping remains ambitious, responsive and focused on achieving lasting change.