Brighton & Hove City Council

Health Overview & Scrutiny Committee

Date:	**20 November 2024**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
Members:	**Councillors:** Fowler (Chair), Baghoth (Deputy Chair), Evans, Hill, Wilkinson, Hogan, Galvin, Mackey, O'Quinn and Cattell **Invitees:** Mo Marsh (Older People's Council), Nora Mzaoui (CVS) and Geoffrey Bowden (Healthwatch), Youth Council
Contact:	**Giles Rossington** Policy, Partnerships & Scrutiny Team Manager 01273 295514 giles.rossington@brighton-hove.gov.uk

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AGENDA

PART ONE **Page**

14 PROCEDURAL BUSINESS

(a) **Declaration of Substitutes:** Where Councillors are unable to attend a meeting, a substitute Member from the same Political Group may attend, speak and vote in their place for that meeting.

(b) **Declarations of Interest:**

(a) Disclosable pecuniary interests;
(b) Any other interests required to be registered under the local code;
(c) Any other general interest as a result of which a decision on the matter might reasonably be regarded as affecting you or a partner more than a majority of other people or businesses in the ward/s affected by the decision.

In each case, you need to declare:
(i) the item on the agenda the interest relates to;
(ii) the nature of the interest; and
(iii) whether it is a disclosable pecuniary interest or some other interest.

If unsure, Members should seek advice from the committee lawyer or administrator preferably before the meeting.

(c) **Exclusion of Press and Public:** To consider whether, in view of the nature of the business to be transacted, or the nature of the proceedings, the press and public should be excluded from the meeting when any of the following items are under consideration.

NOTE: *Any item appearing in Part Two of the Agenda states in its heading the category under which the information disclosed in the report is exempt from disclosure and therefore not available to the public.*

A list and description of the exempt categories is available for public inspection at Brighton and Hove Town Halls and on-line in the Constitution at part 7.1.

15 MINUTES 7 - 22

To consider the minutes of the previous Health Overview & Scrutiny Committee meeting held on 10 July 2024, and of the special meeting held on 16 September 2024 (copy attached).

16 CHAIR'S COMMUNICATIONS

17 PUBLIC INVOLVEMENT

To consider the following items raised by members of the public:

(a) **Petitions:** To receive any petitions presented by members of the public to the full Council or to the meeting itself;
(b) **Written Questions:** To receive any questions submitted by the due date of 12noon on the 14th November 2024
(c) **Deputations:** To receive any deputations submitted by the due date of 12 noon on the 8th November 2024

18 MEMBER INVOLVEMENT

To consider the following matters raised by Members:

(a) **Petitions:** To receive any petitions submitted to the full Council or to the meeting itself.
(b) **Written Questions:** A list of written questions submitted by Members has been included in the agenda papers (copy attached).
(c) **Letters:** To consider any letters submitted by Members.
(d) **Notices of Motion:** To consider any Notices of Motion.

19 CERVICAL SCREENING & HPV VACCINATION: UPDATE 23 - 42

Report of NHS England, NHS Sussex and the Director of Public Health (copy attached).

Contact Officer: *Katy Harker*
Ward Affected: *All Wards*

20 ACCESS TO DIABETES TECHNOLOGY 43 - 72

Report of NHS Sussex (copy attached).

Contact Officer: *Giles Rossington* *Tel: 01273 295514*
Ward Affected: *All Wards*

21 PRESENTATION ON MATERNITY SERVICES AT THE ROYAL SUSSEX COUNTY HOSPITAL 73 - 82

Presentation from University Hospitals Sussex NHS Foundation Trust (UHSx) on maternity services at the Royal Sussex County Hospital (verbal- presentation slides attached)

22 SUSSEX WINTER PLAN 2024-25 83 - 94

Contact Officer: *Giles Rossington* *Tel: 01273 295514*
Ward Affected: *All Wards*

23 COLOREACTAL CANCER POTENTIAL SERVICE CHANGE 95 - 122

Report of the Corporate Director, Corporate Services (copy attached).

Contact Officer: *Giles Rossington* *Tel: 01273 295514*

Ward Affected: *All Wards*

24 FOR INFORMATION: LETTER FROM UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST ON LIVER DISEASE **123 - 124**

For Information: letter from UHSx to Ms Jo Harvey-Barringer on liver disease services. This letter provides information on improvement measures being taken by UHSx following Ms Harvey-Barringer's recent presentation to the HOSC (copy attached).

Date of Publication - Tuesday, 12 November 2024

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FURTHER INFORMATION
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BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 10 JULY 2024

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Fowler (Chair)

Also in attendance: Councillor Baghoth, Evans, Hill, Galvin, Mackey, O'Quinn and Theobald

Other Members present: Geoffrey Bowden (Healthwatch Brighton & Hove), Mo Marsh (Older People's Council), Nora Mzaoui (CVS representative)

PART ONE

1 PROCEDURAL BUSINESS

36(a) **Substitutes and apologies**

36.1 Cllr Theobald attended as substitute for Cllr Hogan.

36.2 Apologies were received from the Youth Council.

36(b) **Declarations of interest**

36.3 There were none.

36(c) **Exclusion of the press and public**

36.4 RESOLVED – that the press and public be not excluded from the meeting.

2 MINUTES

2.1 The Chair informed members that, following the April HOSC meeting she had contacted the Chief Executive of University Hospitals Sussex NHS Foundation Trust (UHSx) seeking a clarification of some remarks he had made at the meeting. Dr Findlay responded, apologising for inadvertently misleading the committee when he had stated that the Royal College of Surgeons was always invited to participate in the recruitment of surgical consultants. Dr Findlay believed this to be the case, but had subsequently learnt that the Royal College had been invited to participate in some, but not all recruitments. Whilst NHS Foundation Trusts are not required to involve the Royal

Colleges in recruitment, they will be invited to participate in all future recruitment. There is a note in the minutes explaining this correction.

2.2 **RESOLVED -** the minutes of the 10th April 2024 committee meeting be approved as an accurate record.

3 CHAIR'S COMMUNICATIONS

3.1 The Chair gave the following communications:

I'd like to welcome everyone to the Health Overview & Scrutiny Committee. We have some new members and some members who have been with us for a while, or who are returning after some time away from the committee.

The council has recently adopted a new governance system, including 2 new Overview & Scrutiny committees, people and place, which will focus on council services, including adult social care and council-run Public Health. The HOSC will continue to hold local NHS services to account for the planning and delivery of service to local residents. However, where there's a significant cross-over between NHS services and council care or public health, as in today's item on A&E pressures, the HOSC will continue to work with council departments as well as NHS partners.

As we're not a new committee, we are not starting from scratch, and we have a number of legacy issues which we are committed to scrutinising, including the performance of local NHS providers and the provision of trans healthcare. However, there will be an opportunity for members to help shape the HOSC work plan going forward, and I will be asking officers to arrange an informal work planning meeting to which all members, including our co-optees will be invited to contribute.

4 PUBLIC INVOLVEMENT

4.1 There were no public involvement items.

5 MEMBER INVOLVEMENT

5.1 There were no member involvement items.

6 LIVER DISEASE AND PALLIATIVE CARE

6.1 This item was presented by Jo Harvey-Barringer. Dr George Findlay (University Hospitals Sussex NHS Foundation Trust [UHSx] Chief Executive); Professor Catherine Urch (UHSx Chief Medical Officer); Dr Andrew Heeps (UHSx Chief Operating Officer and Deputy Chief Executive) and Peter Lane (RSCH Hospital Director) joined the meeting remotely. Ms Harvey-Barringer had asked to address the committee on her experiences of the care provided to her wife, Joanne, after she was diagnosed with liver disease; and on problems she had encountered accessing palliative care for her partner in the last months of her life.

6.2 Ms Harvey-Barringer outlined the progress of her wife's care, from initial diagnosis to her eventual death. Ms Harvey-Barringer described a number of instances where aspects of care, communication, or the attitude of staff were of an unacceptable standard. In particular, many aspects of hospital care did not allow Joanne the dignity and respect she was due; and although community palliative support was excellent, there was insufficient hospital-based support.

6.3 The Chair thanked Ms Harvey-Barringer for addressing the committee, noting that it must take a lot of courage to speak in public about such distressing experiences.

6.4 Professor Catherine Urch (UHSx Chief Medical Officer) told the committee that Ms Harvey-Barringer has raised a number of important points and thanked her for sharing her testimony. Professor Urch offered to meet with Ms Harvey-Barringer to discuss what the Trust can do to change. Dr George Findlay (UHSx Chief Executive) reiterated that the Trust was happy to follow up on all of the issues that Ms Harvey-Barringer had raised.

6.5 Cllr Wilkinson noted that patients with liver disease often require extensive palliative care. He asked that the committee focus on local provision of palliative and end of life care at a future meeting.

6.6 Geoffrey Bowden (Healthwatch Brighton & Hove) told members that he used to help run the GB Association for the Study of the Liver, and was acutely aware of the important role palliative care plays in liver disease. Mr Bowden also noted that Healthwatch Brighton & Hove deals with numerous issues relating to dignity and respect. He offered to meet with Ms Harvey-Barringer to discuss how Healthwatch might assist her.

6.7 Mo Marsh (Older People's Council) supported calls for palliative/end of life care to be scrutinised by the committee.

6.8 Cllr Galvin asked whether early primary care diagnosis may have helped Joanne. Ms Harvey-Barringer responded that as far as she was aware, the GP had done everything they should: prior to her diagnosis Joanne had been receiving regular liver function tests due to some thyroid issues.

6.9 Cllr Evans told members that no one should face discrimination because of perceptions that their illness may have been partly caused by their own behaviour. She echoed calls for the committee to scrutinise palliative/end of life care.

6.10 Cllr Baghoth noted that it was sometimes the case that patients make a choice not to receive much information about their condition. Ms Harvey-Barringer responded that this was not the case with Joanne; although Joanne was sometimes forgetful because of her illness, she did want information, and Ms Harvey-Barringer helped her by leaving lists of questions with her. However, this did not lead to improved communication with hospital staff.

6.11 The Chair thanked Ms Harvey-Barringer for her attendance at the meeting and noted that the support officer would make introductions to Professor Urch and Mr Bowden so they could follow-up with Ms Harvey-Barringer outside the meeting. The Chair also read out a statement from the Sussex Integrated Care Board:

ICB statement on Palliative Care
The NHS Sussex Palliative and End of Life Care (PEoLC) commissioning team would like to thank Jo Harvey Barringer for raising concerns regarding the care her late wife Joanne received following a diagnosis of cirrhosis of the liver. We are sorry that your experience of care did not live up to the high quality we would wish for people across Sussex.

The palliative and end of life care services that NHS Sussex commission are intended for all people to access irrespective of diagnosis and are not commissioned solely for those with a cancer diagnosis. We are therefore saddened to hear that Joanne's non-cancer diagnosis appears to have been a barrier to her receiving that high quality of end of life care we strive for.

We continually work to improve the care that the population of Sussex receive at the end of their life, and consciously work in a way that is inclusive of those with non-cancer as well as cancer diagnoses. For example, by working together we have now been able to launch a Pan Sussex Standard Operating Procedure (signed up to by all providers) with a full suite of supporting documentation to deliver safer and more consistent PEoLC (palliative & end of life care) medication for adults with any condition being cared for in the community.

Looking forward we are working to implement a Sussex-wide all hours PEoLC (palliative & end of life care) co-ordination hub. The introduction of this hub should enable the experience of those being cared for in the community to be of a significantly higher standard than Jo has described regarding her late wife's care. It will be a part of the work being developed within in the formation of Integrated Community Teams (ICT) in Sussex. The initial focus of ICT Development will on be about improving care and support for those with complex needs. Many of those with PEoLC (palliative & end of life care) needs will be included in that first cohort so NHS Sussex is confident that this will improve the care for that sector of our population.

To provide further detail of the way in which we have been working to improve the provision of PEoLC (palliative & end of life care) **care.**
The NHS Sussex PEoLC (palliative & end of life care) team co-ordinates a Pan Sussex PEoLC (palliative & end of life care) Programme Oversight Group, which convenes every 2 months, with stakeholders across the whole Integrated Care System represented. This group looks at PEoLC (palliative & end of life care) provision for people of all ages with the aim of identifying ways to improve service provision.

The group developed a Sussex PEoLC (palliative & end of life care) strategic action plan to reflect a number of workstreams being undertaken which in addition to those already highlighted include:

- The introduction of the ReSPECT process (**Re**commended **S**ummary **P**lan for **E**mergency **C**are and **T**reatment) to facilitate the creation ReSPECT plans to reflect patient's wishes for the care they receive when they have health crises and cannot express their views in those crisis situations. This supports patients to receive the level of care they wish for in their preferred place of care.

- Input into service specification for the Frailty and End of Life Care Locally Commissioned Service to improve identification of those who are likely to be in the last year of life in the Primary Care setting, allowing for anticipatory care planning conversations to take place in a timely fashion to support the delivery of the right care in the right place.
- Co-ordination of an education programme, funded by NHS Sussex, and delivered by Hospice colleagues to support the whole Sussex workforce involved in the care of those with PEoLC (palliative & end of life care) needs, including for staff working in the social care sector.

These agreed workstreams are our starting ambition to achieve our collective aim in Sussex 'to continue to make the last stage of a person's life as good as possible, through working together confidently, honestly, and consistently to help each individual and the people important to them'. We acknowledge there is still work to be done and all feedback on experiences, negative as well as positive, is considered as we reflect and work together to improve care for people at the end of their life.

6.12 Members agreed that palliative/end of life care should be added to the committee work programme, and that scrutiny of this issue would be informed by the work that Healthwatch Brighton & Hove has already undertaken.

7 ROYAL SUSSEX COUNTY HOSPITAL A&E PRESSURES

7.1 The Chair told members that this item arose from a letter to the last HOSC by Cllrs De Oliveira and Burden, expressing concerns about conditions at the Royal Sussex A&E. The committee did explore some of these issues with Dr Findlay, CE of University Hospitals Sussex, at the last meeting, but members were keen to have a dedicated item at the following meeting. Members also agreed that a future item should have a whole health & care system focus, recognising that A&E is not just about the hospital trust.

7.2 The item was presented by Claudia Griffith, NHS Sussex Chief Delivery Officer. Ms Griffith was joined by Dr George Findlay, UHSx Chief Executive; Dr Andy Heeps, UHSx Chief Operating Officer and Deputy CEO; Professor Katy Urch, UHSx Chief Medical Officer; Peter Lane, UHSx Hospital Director for the Royal Sussex County Hospital; John Child, Chief Operating Officer, Sussex Partnership NHS Foundation Trust; Steve Hook, BHCC Interim Corporate Director (Health & Adult Social Care), Housing, Care & Wellbeing; and by Chloe Rogers, Sussex Community NHS Foundation Trust, Area Director (Brighton & Hove).

7.3 Ms Griffith told the committee that the Royal Sussex County Hospital (RSCH) A&E department faces significant pressures and that the local health and care system works together to meet these challenges. RSCH A&E is a busy department, with 270-300 patients per day. The site is also very constrained, which makes managing these patient numbers complex. There are high levels of attendance from people living locally, from

people in deprived communities, and from students and younger people. There are particular challenges in meeting the statutory 4 and 12 hour waiting time targets and in terms of patient experience.

7.4 In the long term, there is a plan to re-build the RSCH emergency department., and NHS capital funding is reserved for this. In the short term, system partners are taking a number of measures to mitigate pressures. These include:

- The Urgent Treatment Centre situated next to A&E
- The use of virtual wards
- Funding for additional GP appointments
- Better use of community pharmacy capacity
- The Brighton walk-in centre
- Better liaison with and support for care homes
- Outreach work with the local nighttime economy
- Additional support for the most vulnerable groups (e.g. homeless and rough sleepers via Arch GP practice)
- A focus on high intensity (repeat) users, with services supporting those who attend A&E most frequently
- Additional primary care appointments can be offered to people presenting at A&E
- A homeless team operates in A&E providing support to homeless and rough sleeping patients.

7.5 Chloe Rogers informed members of services that Sussex Community NHS Foundation Trust (SCFT) is involved in. These include:

- An Emergency Community Response Team (around 200 referrals per month). The team is meeting national 2 hour targets and is able to handle increasingly complex cases
- SCFT works closely with ambulance services, attending in response to calls in situations where they can offer a better treatment option than an ambulance call-out
- Virtual wards – these offer an alternative to hospital admission for some patients
- Admission prevention – there is a team at A&E meeting patients from ambulances and providing care instead of admission where appropriate.

7.6 Dr George Findlay informed the committee that UHSx is focused on the 4 hour wait target; there has been improvement, but there is still some way to go. Similarly, waits associated with ambulance handovers have improved, but more work is needed. Although the number of people presenting at A&E has remained fairly stable, we are seeing a higher proportion of people who require hospital admission.

7.7 Peter Lane told members that other measures being taken to mitigate A&E pressures include:

- The use of a continuous flow model to make flow through the RSCH as efficient as possible
- The introduction of a surgical assessment unit
- Development of a pharmacy first programme
- Regular staff huddles to better manage flow
- A focus on reducing the time it takes for patients in critical care to be transferred to a ward environment.

7.8 Ms Griffith outlines some measures being used to streamline discharge processes. These include:

- Working in partnership with VCS organisations which offer a 'settle' service to help patients immediately following discharge
- A transfer of care hub – a multi-disciplinary team which focuses on discharge arrangements for more complex patients
- Maximising the use of community bed capacity
- A team which supports patients once they have returned home.

7.9 John Child told members that:

- Patients whose discharge from acute mental health beds is delayed due to waiting for supported accommodation, nursing placements and packages of care (patients clinically ready for discharge) is the root cause of people waiting at A&E for admittance to an acute mental health bed.
- Sussex Partnership NHS Foundation Trust (SPFT) is working with system partners to address this issue: e.g. via the Sussex Mental Health and Housing Programme.
- There are many more initiatives ongoing, including improving the urgent and emergency mental health care pathway, focusing on admission avoidance through enhanced community services, the Sussex Mental Health Helpline, and remodelling the SPFT crisis and home treatment teams
- There is no single initiative that will resolve the long standing challenges rather a series of planned improvements across urgent, acute and community mental health services with each having an incremental impact.
- Whilst the pressures remain there have been improvements- the number of patients assessed as needing hospital admission each month has reduced over the last 18 months, the number of patients waiting and the length of time waiting have also improved since highs in autumn 2023

7.10 Steve Hook told the committee that A&E is part of a much larger system, with flow through and out of the hospital a critical factor in managing A&E capacity.

- There are two hospital social work teams, one focusing on acute beds and the other on step-down beds
- Around 200 people are supported at any one time
- The Sussex system is challenged, but there is a major focus on discharge and this is having an impact – currently there are around 20 patients in RSCH who are medically fit for discharge but awaiting a care package; this is down from an average of around 30 at Easter
- There is a focus on improving pathways into step-down beds and into the Discharge to Assess initiative (where patients receive care assessments once they have returned home)
- There has been an increase in in-house reablement beds at Craven Vale
- Adult social care works closely with SCFT to prevent admissions, with around 1500 patients seen in the last year. The team helps divert lots of activity from the RSCH emergency department.

7.11 Cllr Evans noted that the Secretary of State for Health had recently described the NHS as 'broken'. Cllr Evans stated that we know that the problems with A&E locally are being repeated across the country, and, although it is good to hear about effective initiatives,

we should not pretend that the system is functioning well. Dr Findlay replied that he challenged the notion that the NHS was broken: there are significant problems across the country and patient experience is often not great, but staff are working very hard and the great majority of patients continue to receive good care. Patient feedback from the RSCH emergency department is over 80% positive.

7.12 In response to a question from Cllr Wilkinson on rates of people presenting at RSCH A&E with mental health problems compared to other parts of the country, John Child agreed to provide a written response.

7.13 In response to a question from Cllr Wilkinson on the success to date of the Mental Health Urgent & Emergency Care Improvement Plan, Mr Child told members that the situation at RSCH has improved, but significant challenges remain. There are smaller numbers of patients waiting for a mental health bed, but some people are waiting far longer than they should.

7.14 Mo Marsh told the committee that care in RSCH A&E is excellent, but that communication between hospital departments and primary care is often poor; that patient experience is often not good, particularly in terms of waiting times; much more work is needed on patient records; and a more holistic approach to care is required. Ms Griffith responded, acknowledging that there can be a disconnect between services. However, this is being addressed via the Integrated Care Team (ITC) programme. Digital patient records are being improved also, although there is still a long way to go.

7.15 The Chair noted that she had heard about a number of GP appointments being cancelled. Ms Griffith responded that she was happy to follow up on this outside the meeting.

7.16 In response to a question about disruption to the hospital when the Emergency Department is reconfigured, Dr Findlay responded that the Trust is well-used to managing complex building projects on the RSCH site.

7.17 In response to a question from Cllr Baghoth on why there are such long waits at RSCH A&E when the numbers of people attending are not unusually high, Dr Findlay responded that there are not more people attending, but their care needs are increasing and they do take longer to treat. However, the main issue is flow through the site rather than demand. The system needs to work together to tackle delays in discharge and to reduce average length of stay.

7.18 Geoffrey Bowden noted that the NHS treats around 1.7 million people a day, with an increasingly older population and greater deprivation and with a third less beds than 25 years ago. The NHS is not broken, but staff are doing an amazing job to continue to deliver services despite these challenges.

7.19 In response to a query raised by Cllr Evans about hospital staff not always volunteering their names, Dr Findlay responded that all staff should be wearing ID (this is regularly checked), and that staff are encouraged to use their names when talking to patients.

7.20 In response to a question from Cllr Hill on the Red Cross homeless support service, Ms Griffith told the committee that the system works with the Red Cross to evaluate people

with a homeless/rough sleeping background to ensure they are offered wrap-around care so as to mitigate the risk of an escalation of their health problems.

7.21 In answer to a question from Cllr Hill on the processes to recruit surgical consultants, Dr Findlay confirmed that processes have been refreshed and the Royal Colleges are being invited to all panels, although they are not always able to attend, and there is no requirement for them to be involved in recruitment.

7.22 The Chair thanked everyone attending for their contributions.

8 WINTER PERFORMANCE 2023-24

8.1 This item was presented by Claudia Griffith, NHS Sussex Chief Delivery Officer. Ms Griffith told the committee that a report on local health and care system planning for winter 2023-24 had been presented to the Brighton & Hove Health & Wellbeing Board in November 2023, and that the report before members today was to follow up on this. The health and care system plans every year for additional pressures over the winter period, particularly in terms of the demand for hospital services. The aim is to mitigate risk, especially in terms of risk to the most vulnerable people and communities. Steps taken over the past winter included a mix of demand management, admission avoidance and flow improvement measures:

- Additional capacity for the 111 phone service (there were still some capacity problems and more work with the provider, South East Coast Ambulance NHS Foundation Trust, is needed to address these going forward)
- 27,000 more GP appointments (67% of these face to face)
- 98% of community pharmacies signed up to the pharmacy first initiative which empowered pharmacies to treat and prescribe for certain conditions
- There was generally good vaccination take-up
- A single point of access for hospital admissions avoidance services helped coordination, especially with support to care homes
- There was expanded virtual ward capacity, with 192 virtual beds made available. However, benchmarking shows this is a relatively under-used service with room to expand
- There was reduced attendance at hospital A&E by people seeking help for mental health issues
- Length of stay in community beds was reduced
- There was successful falls prevention work led by the city council
- There was effective workforce support, with lower levels of sickness than in the previous year
- Industrial action had a significant impact, but there was also excellent partnership working to support the acute sector and minimise the negative impact on patients.
- Learning for future years includes the need to focus more on supporting the most vulnerable people; and on further simplifying urgent care pathways in order to divert patients from A&E.

8.2 Cllr Wilkinson asked for details of winter plan actions that had not been fully met due to resource constraints. Ms Griffith agreed to provide a written response.

8.3 Cllr Hill asked for details of any regional evaluation of the effectiveness of virtual wards. Ms Griffith agreed to pick this up with regional colleagues.

8.4 RESOLVED – that the report be noted.

The meeting concluded at 7:15pm

Signed Chair

Dated this day of

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 16 SEPTEMBER 2024

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Fowler (Chair)

Also in attendance: Councillor Baghoth, Evans, Hill, Wilkinson (Deputy Chair), Hogan, Galvin, Mackey and Cattell

Other Members present: Geoffrey Bowden (Healthwatch), Nora Mzaoui (CVS representative), Mary Davies (Older People's Council)

PART ONE

9 PROCEDURAL BUSINESS

9(a) Substitutes and Apologies

9.1 Cllr Cattell attended as substitute for Cllr O'Quinn; Mary Davies attended as substitute for Mo Marsh (Older People's Council; apologies were received from the Youth Council.

9(b) Declarations of Interest

9.2 Cllr Hogan declared a personal interest in Item 13 Brighton & Hove Specialist Inpatient Dementia Services. Cllr Hogan works as a consultant psychiatrist, including undertaking work for Sussex Partnership NHS Foundation Trust.

9(c) Exclusion of Press & Public

9.3 RESOLVED – that the Press & Public be not excluded from the meeting.

10 CHAIR'S COMMUNICATIONS

10.1 The Chair told members that she had been approached by Sussex Partnership NHS Foundation Trust and by NHS Sussex about plans to make changes to city specialist inpatient dementia provision. The Chair believed that this was an important issue that members should have the opportunity to scrutinise. However, the timetable for delivering the changes did not fit with scheduled Health Overview & Scrutiny Committee (HOSC) meetings, so it proved necessary to call a special meeting.

11 PUBLIC INVOLVEMENT

11.1 There were no public questions.

12 MEMBER INVOLVEMENT

13 BRIGHTON & HOVE SPECIALIST INPATIENT DEMENTIA SERVICES

13.1 The item was introduced by John Child, Chief Operating Officer, Sussex Partnership NHS Foundation Trust (SPFT); Laura Brummer, SPFT Clinical Director (East Sussex); Padma Dalby, SPFT Director - Specialist Older Adults Mental Health Services; and Jessica Britton, Sussex Integrated Care Board (ICB) Deputy Chief Delivery & Strategy Officer. Steve Hook, BHCC Interim Corporate Director, Health, Care & Wellbeing (Health & Care); and Tanya Brown-Griffith, ICB Director for Joint Commissioning & Integrated Care, were also in attendance.

13.1.1 Mr Child introduced the paper, explaining that each area of Sussex has a unique population, with Brighton & Hove having a high proportion of working age adults, and East and West Sussex both having a high proportion of older people. Due in part to these demographic factors, Brighton & Hove has a relatively high instance of mental health issues and East and West Sussex of dementia.

13.1.2 Ms Brummer added that this translates to high demand for mental health beds within Brighton & Hove. This results in long waits for beds (a particular issue where people have presented for treatment at the Royal Sussex County Hospital, and need to be kept safe at the hospital until an acute mental health bed can be found). It also results in frequent out of area placements.

13.1.3 Ms Dalby told members that there are 50 specialist inpatient dementia beds across Sussex: 30 in Worthing, 10 in Brighton & Hove and 10 in Uckfield. The whole of this bed base is used for admissions, so people will be admitted to a bed outside their immediate area if nothing is available more locally. Acute admissions should be used as a last resort; treating people in community settings is preferred wherever possible. With better community care, more than 40% of people in acute beds could be treated at home.

13.1.4 Brunswick ward is a 10 bed mixed gender dementia ward within Mill View hospital. Over the past 2 years there have been 79 admissions to the ward, with the majority being people from East or West Sussex. Admissions for city residents are low, averaging less than one person per month. In the past 12 months there were slightly more city residents admitted to beds in Worthing or Uckfield (5) than to beds in Brunswick ward (4).

13.1.5 The proposal is to convert Brunswick ward into a 15 bed acute mental health inpatient ward. This will mean that 60-70 additional adult mental health patients per year will receive a local admission and will decrease the wait for acute beds, reducing pressure on the Royal Sussex County hospital.

13.1.6 All current community services for people with dementia will remain, with some additional funding for intensive support at home/respite. City residents who do require admission to specialist dementia beds will be accommodated at Worthing or Uckfield. There will also be additional funding for East Sussex community dementia services,

improving care and reducing acute admissions. Where city patients are admitted to out of city beds, services will make families and carers aware of schemes to support travel to hospital as well as other aspects of carer support.

13.1.7 The refurbishment of Brunswick ward is scheduled to begin in November 2024, finishing in March 2025. There will be engagement with stakeholders and with individuals and families impacted by the move.

13.2 Cllr Evans noted that beds at Mill View had been reduced only a few years ago and questioned why additional beds were required now. Mr Child responded that the beds taken out of Mill View were detoxification beds rather than acute mental health beds. However, the demand for acute mental health beds has become more urgent in recent years.

13.3 In response to a question from Cllr Evans on why changes were being made now, Mr Child told members that the changes are not opportunistic; an expansion of East Sussex community services has been in planning for several years. Ms Dalby added that the focus is to improve the dementia pathway, supporting people in the community wherever possible, as acute admission can be very settling for patients who are already confused. Once people are admitted to hospital it can also be challenging to get them back home, so admission avoidance is key.

13.4 Cllr Evans asked what engagement has taken place to date. Mr Child responded that some informal engagement has taken place with staff. There is a commitment to engage fully going forwards.

13.5 Mary Davies told members that Brighton & Hove claims to be an Age Friendly City, but in recent years a number of services for older people have been lost to the city or re-purposed, including Ireland Lodge, Knoll House, and rehab services moving to Newhaven. The proposal to move specialist inpatient dementia beds out of the city will be disorientating for people with dementia who will be cut off from family and carers, and is discriminatory on the basis of age and disability. Carers of people with dementia are themselves likely to be older residents with their own health and care issues, for whom travelling to Uckfield or Worthing may well be difficult. If there was some local bed provision going forward, then people placed out of area could be moved back when appropriate to do so. Ms Davies considered the changes to constitute a ‘substantial variation in services’ such that the HOSC should be formally consulted on change plans. Ms Davies also queried what the findings of any Equality Impact Assessment (EIA) of the changes had been. Mr Child responded that an EIA had been conducted, but had identified an impact only on the small number of patients who are currently treated in city beds. Services are committed to working with families to ensure the best admission choices are made. Jessica Britton commented that best practice in dementia services is increasingly focused on providing high quality community support. Ms Dalby added that patients placed out of area would not typically be moved to an acute bed closer to home as moving can itself be very unsettling for patients. Giles Rossington (scrutiny support) told the committee that his advice, and that of the committee’s legal adviser, was that these plans do not constitute a ‘substantial variation in services’ as any impact was on a small number of people. Steve Hook told members that changes to Ireland Lodge have not led to a reduction in city residential care dementia beds, as any beds lost have been re-provided by the independent sector.

13.6 Cllr Galvin expressed concerns about the loss of dementia services in the city, including day centres and respite care. Mr Child responded that the change plans are focused on acute beds; care provision is the responsibility of the city council. Mr Hook added that traditional models of respite such as the use of day centres can increase disorientation for people with dementia, and the current focus is on carer relief in people's homes. He would be happy to discuss these issues with Cllr Galvin outside the meeting.

13.7 Cllr Cattell asked whether there was any scope to provide dementia care at the Royal Sussex County Hospital (RSCH), particularly in terms of the new Louisa Martindale building. Mr Child replied that, although many patients admitted to the RSCH for physical care will also have dementia, the RSCH is not used as a setting to deliver acute mental health services. These are provided at dedicated mental health acute units. Ms Dalby added that acute dementia inpatients are likely to be in a distressed state and to evince challenging behaviours and it is therefore appropriate to care for them in a dedicated mental health setting unless they have physical health issues that require general hospital admission.

13.8 Cllr Baghoth asked what the main barriers are to treating more patients in the community rather than acute beds. NHS colleagues responded that barriers include different funding arrangements across Sussex, a lack of specialist nursing home placements, and delayed discharge from acute dementia beds.

13.9 Cllr Baghoth asked what support is available to families and carers of people admitted to acute dementia beds. Ms Dalby responded that the NHS Healthcare Travel scheme is available to support people on a low income. Ms Brummer added that there is also a community sector run scheme in place locally. Mr Child agreed to provide the committee with additional information on specific services available to support family and carer travel.

13.10 In response to a request from Cllr Hill, Mr Child agreed to share presentation slides and a copy of the Equality Impact Assessment with the committee.

13.11 Cllr Hill asked what the impact of these changes was likely to be on BHCC adult social care services. Mr Child replied that a number of patients are already admitted outside the city, so social care are well used to this issue. Opening additional adult mental health beds in the city will mean a net increase in local residents being treated in city beds. Mr Child added that there was good integration between NHS mental health and council social care services.

13.12 In response to a question from Cllr Hill about the high prevalence of mental health issues in Brighton & Hove, Mr Child told members that factors include local demographics and challenges to the flow of patients through the acute care pathway. There is a detailed system improvement plan which could be shared with the committee.

13.13 Geoffrey Bowden asked whether there was a guarantee that the changes would improve patient care. Ms Brummer responded that it was impossible to provide a guarantee. However, the changes will definitely deliver improvements to adult acute mental health services, and in terms of better experience for people with dementia being supported by community services rather than admitted to acute beds. Mr Child added

that the evidence suggests that the changes will improve both patient outcomes and patient experience. The system will work hard to minimise any negative impacts.

13.14 In response to a question from Mr Bowden about negative financial impacts on social care, Mr Hook responded that the local market for residential dementia care is relatively buoyant. The market for dementia nursing care is more challenged, but adult social care has good relations with the nursing care market. The changes are expected to have minimal impact on social care.

13.15 Cllr Grimshaw asked why people from outside the city are currently using Brighton & Hove dementia beds. Ms Dalby responded that Sussex beds are used as a single resource; people will be placed as close to home as possible, but if there are no local spaces they will be admitted to another Sussex unit rather than delay admittance.

13.16 In response to a question from Cllr Grimshaw about the impact of suddenly closing 10 dementia beds, Ms Brummer responded that the closure of 10 beds had already been trialled in Uckfield over the winter with no increase in waits. Given this, the loss of 10 beds in Brighton & Hove is not anticipated to cause major issues.

13.17 Cllr Grimshaw asked that some more thought be given to the support that could be offered to families and carers of people being placed out of the city. Ms Dalby agreed that partners would focus on this issue.

13.18 Cllr Wilkinson noted that the committee had been told on previous occasions that increasing the number of beds available does not necessarily deal effectively with demand issues in the longer term. How confident are the NHS that adding more acute mental health beds will work as intended? Ms Britton responded that a good deal of work has been undertaken to understand mental health needs and bed requirements across Sussex, and partners are confident that increasing beds in Brighton & Hove will lead to improvements in flow through the acute mental health pathway. More work will be required to understand and mitigate any negative impacts of the changes.

13.19 Cllr Wilkinson suggested that it would be sensible to revisit this issue after the changes have been implemented. The Chair agreed with this.

13.20 Cllr Evans asked what would happen if there were delays admitting city residents to acute dementia beds in East or West Sussex once the changes have been made. Ms Dalby responded that additional waits were not anticipated, but if people do have to wait longer appropriate community support will be provided.

13.21 In response to a question from Cllr Evans about current staff at Brunswick ward, Mr Child responded that staff will be offered opportunities to work in community services.

13.22 Ms Davies asked whether services are confident that city demand will not significantly increase due to demographic change. Ms Britton responded that there is confidence in the data. However, demographic projection is complex and needs to be continually monitored.

13.23 In response to a question from Ms Davies on public consultation, Ms Britton responded that there will be specific engagement with service users, their carers and their families.

13.24 In response to a query from Cllr Evans as to why beds were being taken from Brighton & Hove, Ms Dalby told members that Worthing is by far the largest unit in Sussex, but it is also a state of the art dedicated dementia unit with a dementia friendly lay-out. It would consequently make little sense to reduce beds at Worthing.

13.25 Nora Mzaoui asked whether there would be additional support provided to community services (e.g. transport support) if the changes meant that there was greater demand for them. Mr Child agreed to respond to this point.

13.26 The Chair asked about consultation with staff. Mr Child responded that the case for change was developed with staff representatives from various disciplines.

13.27 The Chair asked that there be a follow-up item in spring 2025. This should cover what staff think about the changes, carer opinions and any impacts on the residential care sector or social care.

13.28 RESOLVED – that the report be noted.

The meeting concluded at Time Not Specified

Signed Chair

Dated this day of

Agenda Item 19

Brighton & Hove City Council

Health Overview & Scrutiny Committee

Subject	**Update on Cervical Screening and HPV Vaccination in Brighton and Hove**
Date of meeting:	**20 November 2024**
Report of:	**NHS England, NHS Sussex and Director of Public Health**
Contact Officer:	**Morag Armer** Consultant in Public Health, Screening and Immunisation Lead (Surrey and Sussex), NHS England morag.armer1@nhs.net **Katy Harker** Consultant in Public Health, Brighton and Hove City Council Katy.Harker@Brighton-Hove.gov.uk
Wards affected:	**All**

1. Purpose of the report and policy context

1.1 The purpose of this paper is to report on coverage and access for NHS Cervical Screening Programme and NHS Human Papillomavirus (HPV) Vaccination Programmes in Brighton and Hove. Data is presented which allows comparison with other areas, informs barriers to uptake and outlines the improvement work that is underway together with plans for the future.

2. Recommendations

2.1 That Committee notes the information provided on the NHS Cervical Screening Programme and NHS Human Papillomavirus (HPV) Vaccination Programmes.

3. Context and background information: Cervical Cancer Screening

3.1 Cervical screening identifies presence of HPV, changes in the cervix, and precancerous changes. Appropriate timely treatment can prevent cancers developing.

3.2 The city supports the World Health Organization aim[1] to eradicate cervical cancer by 2030 via the three key pillars of HPV vaccination, screening, and timely treatment.[2] This report covers the first two pillars.

3.3 Screening refers to the testing of an asymptomatic population to detect disease at a stage when treatment is more effective. Cervical screening is for people with a cervix aged 25 to 64 and saves approximately 4500 lives a year nationally[3]. It is important that GP records reflect eligibility (existence of a cervix) so that all are invited for screening correctly, regardless of gender identity.

3.4 The NHS Cervical Screening Programme coverage standard is for ≥ 80% of the eligible population to have an adequate screen in their last recall period. GPs are the main point of access for cervical screening sample taking with opportunistic cervical screening also commissioned from sexual health clinics in Brighton and Hove to increase accessibility to the programme. Some Primary Care Networks (PCNs) are undertaking delivery across their PCN and the Brighton GP Federation also offers some cervical screening capacity accessible to all practices.

3.5 People with a cervix are invited every three years from 25-49 years and every five years 50-64. After 65, they can request a screen but the data for the over 65s is not included.

3.6 If people have changed their NHS or GP record gender marker to male and are eligible, they will need to contact their practice directly to book a screen or have the screen via Clinic T. Data is currently only collected for 'females'.

3.7 The most recent cervical cancer data is from 2020 and the age standardised incidence rate of cervical cancer in Brighton and Hove was 13.2 per 100,000 (n=18), higher than East Sussex (9.8), West Sussex (9.0) and England (8.5) [4]

3.8 It is estimated that screening currently prevents 69.7% of cervical cancer deaths nationally. In England 2018-2020 the age standardised mortality rate was 2.5 (n=2,048), in Brighton and Hove, for the same period, the rate is 3.2 higher, n= 12 deaths due to cervical cancer [5]. However, if everyone attended screening regularly 82.9% of deaths could be prevented (i.e. half of deaths currently occurring could be prevented). [6]

3.9 NHS Sussex has a focus on Cancer Health Inequalities and, in collaboration with the local NHS England Public Health Commissioning Team, Surrey & Sussex Cancer Alliance, Berkshire & Surrey Pathology Services (Cervical Screening Laboratory) and Local Authority colleagues, strives to support all Sussex sample taking organisations to achieve the 80% target.

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[1] https://www.who.int/publications/i/item/9789240014107
[2] Cervical Cancer Elimination Initiative
[3] OHID fingertips data definitions Public health profiles - OHID (phe.org.uk)
[4] https://www.cancerdata.nhs.uk/incidence_and_mortality
[5] https://www.cancerdata.nhs.uk/incidence_and_mortality
[6] Impact of cervical screening on cervical cancer mortality: estimation using stage-specific results from a nested case–control study. British Journal of Cancer volume 115, pages1140–1146 (2016)

3.10 There has been a downward trend in eligible people aged 25-49 years attending cervical screening since 2010 across the country, region and locally.

Period	Brighton & Hove	East Sussex	West Sussex	South East	England
2010	72.4%	76.3%	76.4%	75.8%	74.1%
2011	72.3%	76.7%	76.3%	75.6%	73.7%
2012	72.6%	76.7%	75.8%	75.3%	73.4%
2013	69.7%	74.4%	74.2%	73.3%	71.5%
2014	69.4%	74.8%	74.2%	73.2%	71.8%
2015	68.2%	74.1%	73.4%	72.7%	71.2%
2016	67.3%	73.4%	72.6%	71.8%	70.2%
2017	66.3%	72.8%	72.7%	71.1%	69.6%
2018	65.6%	72.3%	72.6%	70.6%	69.1%
2019	65.4%	73.4%	73.5%	71.4%	69.8%
2020	64.9%	74.3%	74.0%	71.6%	70.2%
2021	62.4%	72.1%	72.2%	69.5%	68.0%
2022	61.2%	71.8%	72.1%	69.1%	67.6%
2023	59.2%	69.7%	70.5%	67.3%	65.8%

Table 1: CSP Coverage 25-49 Year Olds[7]

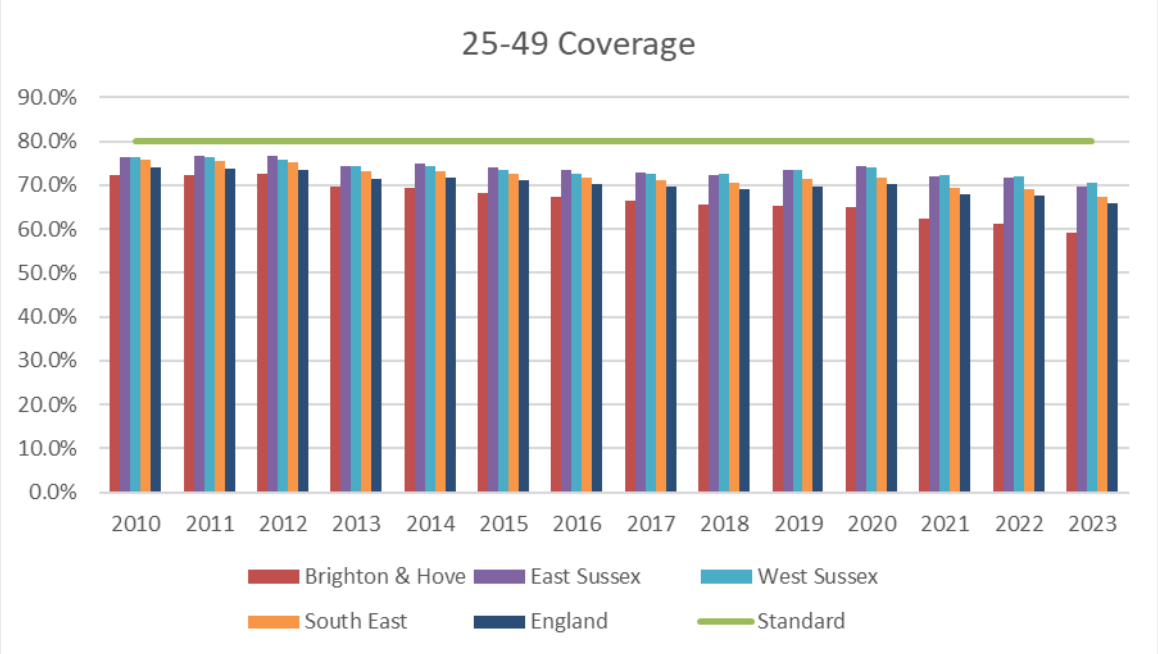

Figure 1: CSP Coverage 25-49 Year Olds[7]

[7] Fingertips Fingertips | Department of Health and Social Care (phe.org.uk)

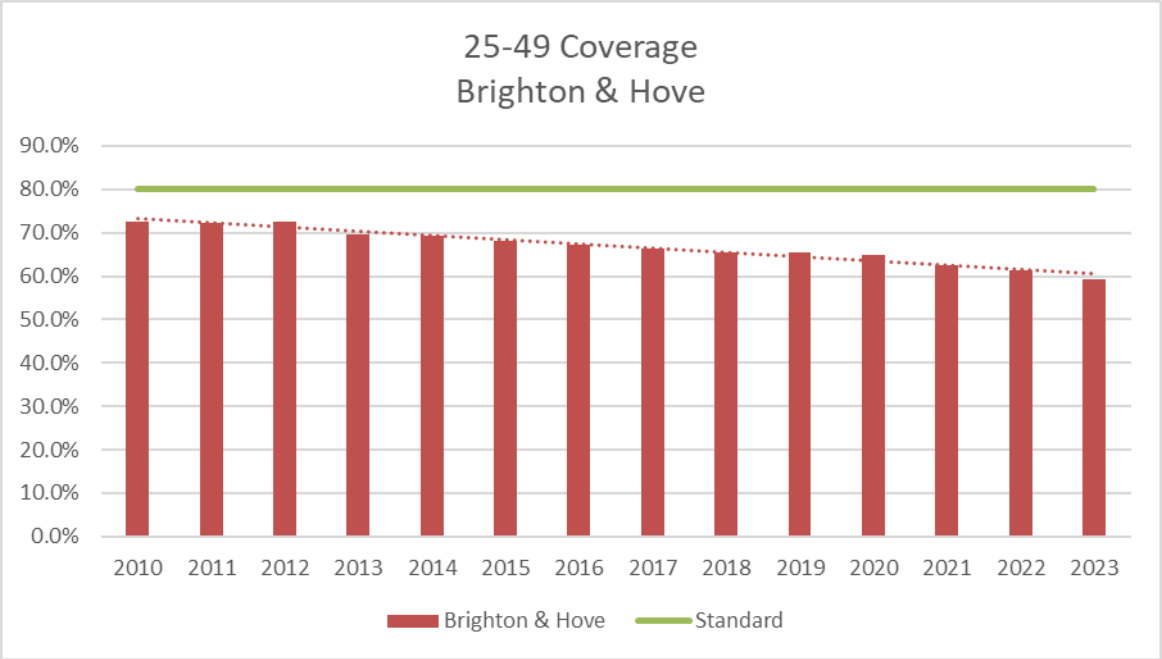

Figure 2: Brighton & Hove CSP Coverage 25-49 Year Olds

Period	Brighton & Hove	East Sussex	West Sussex	South East	England
2010	76.7%	79.1%	80.3%	80.2%	78.7%
2011	76.8%	79.7%	80.2%	80.7%	80.1%
2012	77.0%	79.6%	79.8%	80.5%	79.9%
2013	77.0%	79.3%	79.5%	80.1%	79.5%
2014	77.0%	79.3%	78.6%	79.7%	79.4%
2015	76.0%	78.1%	77.9%	78.8%	78.4%
2016	75.6%	77.7%	77.8%	78.3%	78.0%
2017	74.7%	76.6%	76.9%	77.4%	77.2%
2018	74.3%	75.7%	75.9%	76.4%	76.2%
2019	74.5%	75.4%	75.9%	76.4%	76.2%
2020	74.4%	75.2%	76.1%	76.2%	76.1%
2021	72.6%	73.9%	74.8%	74.8%	74.7%
2022	72.6%	73.9%	75.1%	74.7%	74.6%
2023	72.8%	74.0%	75.1%	74.6%	74.4%

Table 2: CSP Coverage 50-64 Year Olds

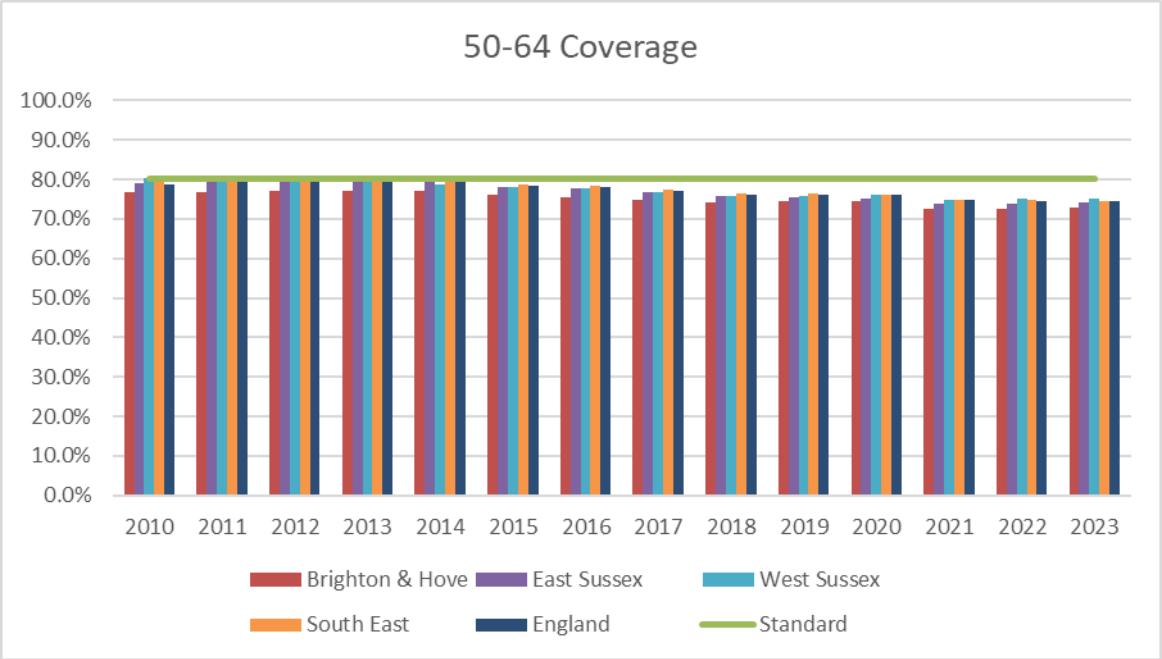

Figure 3: CSP Coverage 50-64 Year Olds[8]

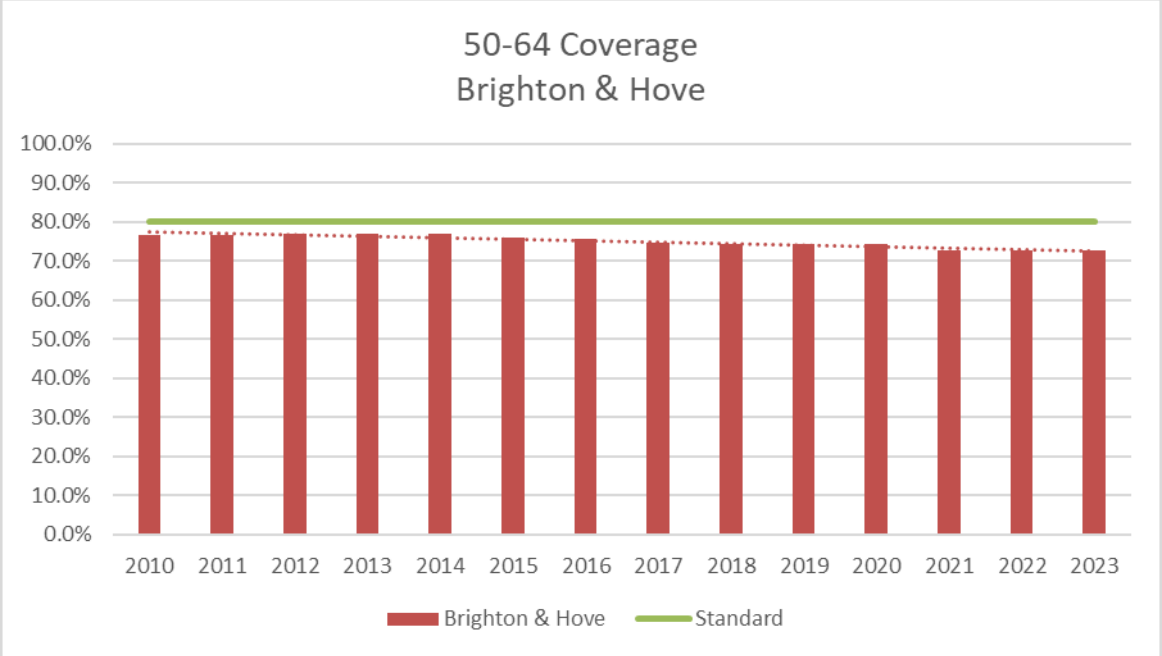

Figure 4: Brighton & Hove CSP Coverage 50-64 Year Olds

3.11 There is a correlation between deprivation and cancer screening coverage; people from more deprived areas are less likely to access screening, the data at GP practice level corroborates this. There are national and local strategies that aim to address these inequalities.[9]

3.12 In October 2019, NHS England published their independent review of the National Adult Screening programmes in England. Recommendations included developing new IT systems for screening programmes, implementing evidence-

[8] Fingertips Fingertips | Department of Health and Social Care (phe.org.uk)
[9] NHSEI PHE Screening inequalities strategy. Available at: PHE Screening inequalities strategy - GOV.UK (www.gov.uk) and https://www.gov.uk/government/collections/nhs-population-screening-access-for-all

based initiatives to improve screening uptake, and investing in screening equipment and facilities.[10]

3.13 The COVID-19 pandemic impacted on the delivery of cervical screening and, whilst the system made great progress to recover, there remains much to do to address health inequalities in coverage and uptake of services, (including targeted support for people with protected characteristics)[11],[12],[13]This is important as the pandemic exacerbated preexisting inequalities.

3.14 The Core20Plus5 [14] objectives for early cancer diagnosis are that 75% of cases diagnosed at stage 1 or 2 by 2028. The 2023 Major Conditions Strategy [15] includes emphasis on early diagnosis of cancers and evaluating self-sample cervical screening tests for women who have not attended previous screening appointments.[16]

3.15 As an Essential Service within the Standard General Medical Services Contract[17], cervical screening is a well-established General Practice (GP) service and included in CQC inspections.[18] Practices are able to use the Sussex Integrated Data Set cervical screening dashboards to view segmented data to review gaps in coverage and address within their action plans, demonstrating the importance of continuing with the system wide collaborative work to support the population effectively, as described in this paper.

3.16 As detailed in the Primary Care Network Directed Enhanced Service (PCN DES)[19], PCNs must work with partners to improve screening to support earlier cancer diagnosis and improve health outcomes. There are PCNs in Brighton & Hove where improvement is needed in cervical screening coverage performance:

[10] Report of THE INDEPENDENT REVIEW OF ADULT SCREENING PROGRAMMES in England
[11] bma-mitigating-the-impact-of-covid-19-on-health-inequalities-report-march-2021.pdf
[12] Population screening: review of interventions to improve participation among underserved groups - GOV.UK (www.gov.uk)
[13] https://phescreening.blog.gov.uk/2021/03/22/new-website-home-page-for-guidance-on-reducing-screening-inequalities/#:~:text=The%20COVID%2D19%20pandemic%20has%20replicated%20existing%20health%20inequalities%20and%2C%20in%20some%20cases%2C%20increased%20the.
[14] NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities
[15] Major conditions strategy: case for change and our strategic framework - GOV.UK (www.gov.uk)
[16] Self-sampling HPV kits could screen an extra million people for cervical cancer | King's College London (kcl.ac.uk)
[17] Standard General Medical Services Contract (england.nhs.uk) 8.1.2
[18] CQC guidance available here: https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-104-cervical-screening#:~:text=the%20appropriate%20time.-,When%20we%20inspect,-When%20we%20inspect
[19] PRN01583_i_network-contract-DES-contract-spec-24-25-PCN-requirements-entitlements_260924.pdf (england.nhs.uk) 8.1.6

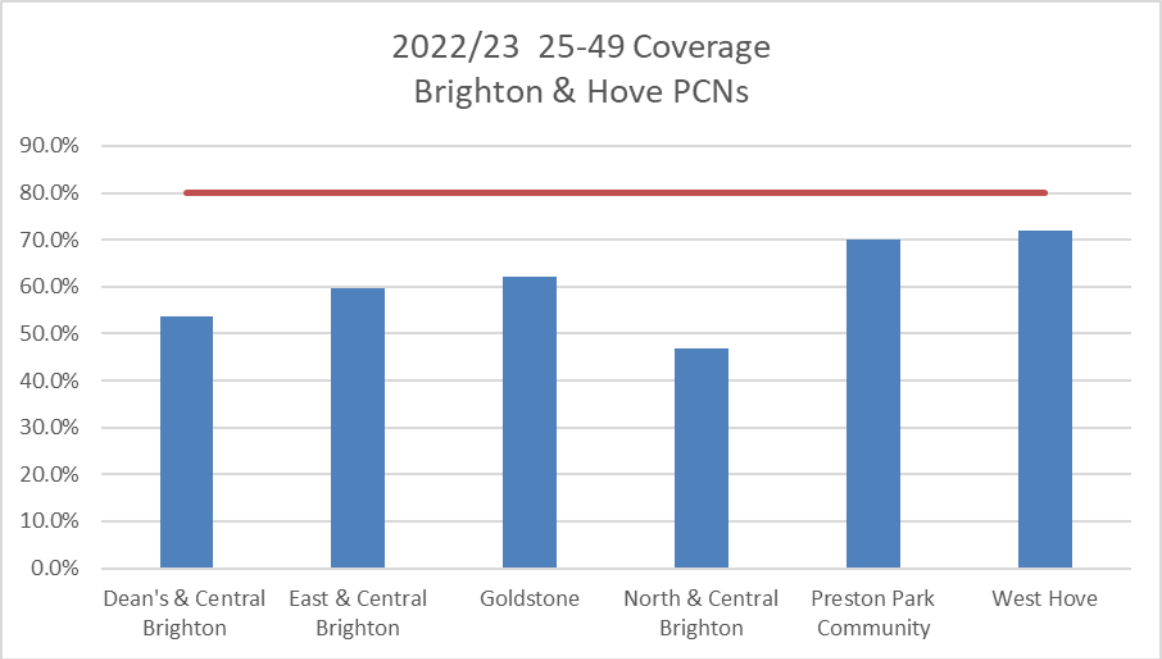

Figure 5: Brighton & Hove CSP Coverage 25-49 Year Olds by Primary Care Network[7]

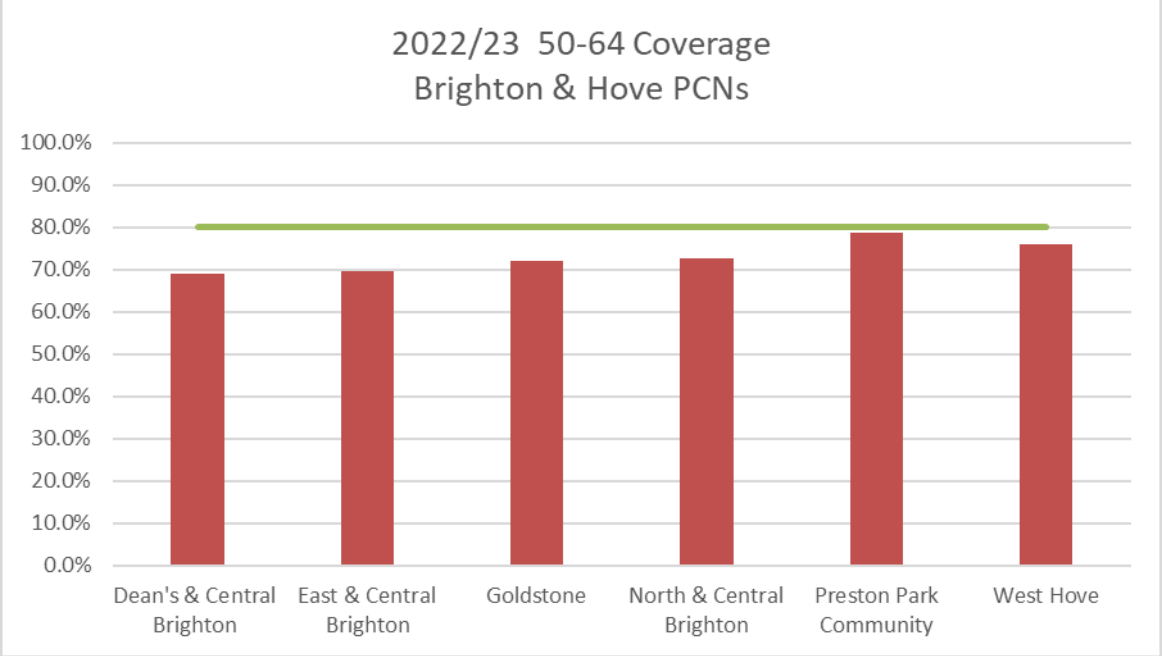

Figure 4: Brighton & Hove CSP Coverage 50-64 Year Olds by Primary Care Network[720]

4 Support for increasing coverage of cancer screening, cancer awareness and early diagnosis service (Act on Cancer Together)

[20] Coverage - percentage of people eligible for screening at a given point in time who were screened adequately within a specified period (within 3.5 years for people aged 25 to 49, and within 5.5 years for people aged 50 to 64). https://www.gov.uk/government/publications/nhs-cervical-screening-programme-good-practice-guidance-for-sample-takers/nhs-cervical-screening-programme-good-practice-guidance-for-sample-takers

4.1 In 2022, The Public Health Team at Brighton and Hove City Council and NHS Sussex ICB (Brighton and Hove), jointly commissioned Act on Cancer Together (ACT)[21], a programme to raise awareness of the early signs and symptoms of cancer, support community members to learn about and attend screening appointments and access the support available to them if they receive a diagnosis of cancer.

4.2 ACT is delivered by a partnership between the Trust for Developing Communities (TDC), the Hangleton and Knoll Project (HKP), and the Macmillan Horizon Centre.
During 2022/2023, ACT targeted engagement in neighbourhoods of deprivation and ethnically diverse communities. The focus for 2023/2024 has expanded to include people with learning disabilities and autism, LGBTQIA+, and Gypsy, Roma, and Traveller communities. Communications are tailored to specific audiences to address health inequalities. The ACT publicly available Padlet holds a wide range of differing resources for people to access.

4.3 A campaigns calendar[22] and action plan links to national campaigns and uses these as a hook onto which the team focuses on priority groups and communities using data and information from local insights. In June 2023 in line with cervical screening awareness week, the local campaign was aimed at people eligible for smear tests aged 25 – 64. In June 2024 ACT ran a month-long campaign to raise awareness about cervical cancer and screening. This involved presence at community events, cervical cancer awareness sessions for some community groups, a social media campaign, and with digital and paper posters in Brighton & Hove buses and Metro buses.

4.5 Messaging was targeted and delivered via the partnership's community development networks, reaching people in deprived communities, and via the ethnically diverse staff members and volunteers, reaching people from ethnically diverse communities with the aid of its communications cascade. Campaign materials were developed/amended to make them accessible, for example, translating into appropriate languages and ensuring paper resources were available to avoid digital exclusion. Several community events and locations served as venues to disseminate tailored information about cervical cancer and screening.

a. In the first quarter of 2023, ACT commenced the Primary Care Partnership pilot at Portslade Health Centre. This involved a team member (HKP ACT coordinator) seconded to the practice to contact people (by telephone) who had not taken up their offer of cervical cancer screening with the aim of increasing patient engagement with, and uptake of, the cervical screening programme. The objective was to discuss any barriers to screening and offer support to attend screening, where necessary. The support provided included assistance with booking a screening appointment, bespoke arrangements for clients during the screening appointment (for

[21] https://www.trustdevcom.org.uk/what-we-do/equalities/health-projects/act/
[22] Cancer workforce events and awareness dates (surreyandsussexcanceralliance.nhs.uk)

example, provision of chaperone and double appointments), pick-up and drop-off of clients at appointments, and translation support.

Following a successful delivery at Portslade Health Centre, the pilot has been rolled out to the Benfield Valley Branch of Well BN practice, (part of Goldstone PCN), and also with Wellsbourne Healthcare CIC (East and Central PCN). [23]

Barriers to screening identified include:

- Fear of the procedure – either perceived or due to a previous negative experience. such as sexual violence.
- Worries about physical discomfort (pain).
- Feeling overwhelmed due to other physical health issues or personal circumstances.
- Inertia and forgetfulness to book a screening appointment.
- Physical mobility issues.
- Uncertainty about the need for a smear test, especially if not currently sexually active or or previously received HPV vaccine.
- Lack of availability of appointments out of working hours.
- Caring responsibilities, including childcare makes it difficult to find the time to book and attend a screening appointment.
- Mental health issues.
- Some clients had complex needs which required access to advice from medical staff to assess the appropriateness of screening, and at times access to a clinician was limited. e.g. people who had experienced sexual violence and female genital mutilation
- Language barriers – some individuals did not receive accessible or translated information about cervical screening to enable them to make an informed decision about attending screening.
- Lack of knowledge and understanding of screening programme.
- Uncertainty about the need for screening if they have had a full or partial hysterectomy.

b. Summary of findings from Portslade Health Centre were as follows:

- Out of 545 clients on the non-responders list, 195 were reached via phone call, and 30% of these resulted in completed test.
- Following this, text reminders were sent to 241 clients following no response when called, and 8% of these texts resulted in completed test
- Letters/email reminders were sent to 74 clients who did not respond to phone calls or text messages. Letters or emails produced no responses.
- Results showed that speaking directly with the client was the most effective method of engaging with clients and improving screening uptake, while texts had some, albeit limited, positive impact on engagement.

c. Next steps for ACT

- Continue learning and refining this delivery model at Well BN practice and Wellsbourne Healthcare CIC practices in Brighton & Hove.

[23] Final report due December 2024

- Continued development of the support to be offered to clients facing barriers to screening, for example transport, translated materials, chaperone, 1:1 pre-appointment to discuss fears and questions.
- Develop initiatives to reduce fear/embarrassment among young women
- Collaborative work with specialist services, carers, support staff, and family members when dealing with individuals in groups experiencing high levels of health inequalities.eg inclusion health groups.

4.6 Recommendations for primary care and wider system:

- Work with Brighton & Hove Federation to explore extending access to cervical screening appointments, for example out of working hours and weekend clinics. Including consideration of other venues for screening – other than the GP practice.
- Translation of screening invitation letters and texts in most common languages.
- More information about the screening procedure and why it is important and still needed.
- Practices to send regular reminders to book a screening after the initial letter. ACT research indicates that an email or text rather than printed materials is more effective and needs to include self-bookable links for clients due cervical screening.
- Review and implement strategies to address DNA issues.
- Work with ACT team to facilitate wider uptake of this work.

5 Key actions to increase uptake of cancer screening for all partners

5.1 All partners – ACT, NHS Sussex ICB, the NHS England Surrey and Sussex Screening and Immunisation Team, Cancer Alliance, Cancer Research UK, Local Authorities through the place-based Cancer Action Group and community networks to take direct action to improve access, uptake and coverage especially in seldom heard groups and those living in areas of deprivation.

5.2 Examples of actions taken at local level include:

- A task and finish group set up with commissioning colleagues for Learning Disability and Autism to enable a focus on improving all cancer screening uptake to these groups *(incl. Brighton & Hove place)*.
- Presented to the learning disability and supported living forums to engage staff and raise awareness of the Learning Disabilities Mortality Review (LeDeR) programme and their complementary role in improving screening awareness.
- Co-production of screening videos for use by individuals with Learning Disabilities (LD), carers and health care workers to better understand the processes, what will happen and what is required. These have been widely distributed, can be shared via text messaging from General Practice, are available via the ICS Website. They have also been used to facilitate education for residential and day care staff groups. Support for people with a learning disability - Sussex Health & Care (ics.nhs.uk)
- Co-production of a Mental Capacity Act (MCA) video which is directly aimed at clinical teams and now used within MCA training across Sussex especially where people with LD are to be opted out of cancer screening.

- Building greater understanding of Transgender, Non-Binary and Intersex (TNBI) issues. There are two main aspect to this; working with general practice to improve coding and developing TNBI welcoming clinics. Additionally working with the community to raise awareness about eligibility and how to access screening. Initiatives already completed;
- Transgender webinar held with primary care colleagues and FAQs document produced to 'debunk' common assumptions and address key areas of need. *(incl. Brighton & Hove place)*
- Production of a whole-life screening graphic for TNBI in 2024 to increase health literacy and awareness of routes to access cancer screening when current call and recall systems rely solely on current recorded gender for call and recall. NHS population screening: Information for trans and non-binary people - Sussex Health & Care (ics.nhs.uk)
- Deep dive by Community Researchers - Community Participation in Action Research in 2021-2022 by the Hangleton and Knoll Project focusing on cervical screening uptake, undertaking critical path analysis and identifying case studies. Shared widely to inform practice. *(specifically Brighton & Hove place)*
- Participation in the Gypsy, Roma and Traveller Health Promotion event Stoneywish 2023 and the subsequent co-production of screening videos de-mystifying and debunking myths for this community group.
- Co-Produce Cancer awareness leaflets and videos for cancer and cancer screening.

- Healthy Lifestyles: How to reduce the risk of cancer for Gypsies and Travellers
- Men's Health: FFT Gypsy and Traveller Health Leaflet
- Cervical screening: FFT Screening resources for Gypsies and Travellers
- Breast screening: FFT: Breast Cancer Information for Gypsies and Travellers

https://www.youtube.com/@FriendsFamiliesandTravellers

- Cross county working to disseminate learning and implement learning from others such as the Eastbourne cultural diversity and cancer screening work which was used in Brighton and Hove to link with the Chinese communities about Bowel and Cervical screening.

5.3 Further work underway with communities and populations

- Develop further the work with relevant VCSE groups to tailor appropriate awareness raising with the Black and Racially Minoritised communities of the importance of cervical screening.
- Develop further work with the Violence Against Women and Girls (VAWG) commissioner and related services to gain understanding of the most appropriate way to promote cervical screening and how best to offer/deliver the screening.
- Investigate the proposed development of an NHS-branded Trauma Card, based on a Healthwatch Essex initiative for affected women to bring to appointments.

- Scoping a pilot scheme for a DIY HPV Sample kit as is currently under trial by Kings College, London and NHSE[24]. This helps address concerns about time the screening takes and potential embarrassment.
- As part of all cervical screening campaigns, promote awareness that an abnormal result does not necessarily mean cancer.

- The Public Health funded Healthy Communities programme uses community development approaches to co design very local neighbourhood health initiatives, an example includes work with GP practices and a PCN to support people to their cervical screens.
- Cancer awareness training for staff of other VCS organisations domiciled in Community Base.
- Cancer screening awareness training to be promoted and made available to other key workers eg Housing teams.
- Outlook Foundation Cancer Awareness training session delivered by ACT project coordinator and volunteer for a group of people with learning disabilities and their carers at residential setting.
- The Cancer Communications Network meeting is now led by ACT with a focus on galvanising city-wide action to increase awareness of cancer and uptake of screening.
- Work with the Healthy Lifestyles team colleagues to engage their presence at ACT community health events , as appropriate, discuss screening with their clients.

5.4 Ongoing initiatives with practices

- All relevant partners to continue to work collaboratively to support PCNs to deliver improvements in cervical screening, which are remunerated to practices via the Quality Outcomes Framework and PCN Directed Enhanced Services (DES) elements for improving cancer screening uptake.
- A population health management approach is being taken to the 'segmentation' of data to produce a cancer screening dashboard that is able to effectively target activities to local super output area (LSOA) and recorded ethnicity through the Sussex Integrated Data set (SID) this linked to the preparation of a Cancer Screening deep dive by the ICS in 2023 which has in turn led to more actions to support the Brighton and Hove GP Federation to establish a cervical screening hub.
- Developing a cancer screening educational offer to all practice staff comprising of the Cancer Alliance community of practice, NHS Sussex education hub and co-development and learning for practices on cancer screening led by the Bowel Hub but covering all three programmes.
- Working with NHS England Screening and Immunisations Team to address errors in cervical screening and investigating/addressing areas of commonality – supported by the production of a Standard Operating Procedure to support practices to avoid common errors, resulting in significant improvement in the sample rejection rate and the need for a repeat sample *(incl. Brighton & Hove place*.
- Proactive feedback and learning from the analysis of the reasons for rejected cervical samples to practices and where practical implementing

[24] Self-sampling HPV kits could screen an extra million people for cervical cancer | King's College London (kcl.ac.uk)

system wide changes or support offers, such as the purchase and distribution of label printers to reduce vial labelling errors.
- Promoting the recently updated good practice guide for practice staff, especially the sample takers.

6 Human Papillomavirus (HPV) Vaccination

Background

6.1 For the purposes of this paper, the focus is on HPV vaccination and its role in preventing cervical cancer.

6.2 There are 100+ types of human papillomavirus (HPV) which sits on and in the skin; the vast majority are harmless and most HPV infections do not cause any symptoms and clear up on their own. Some do not clear up and can lead to oral-genital cancers, whilst others cause genital warts.[25]

6.3 This is important to note as oral cancer in particular is showing worse outcomes with oral cancer incidence for B&H (20.2 per 100,000), higher than England (15.4 per 100,000) and mortality rate (7.1 per 100,000) compared to England (4.7 per 100,000).[26]

6.4 The HPV vaccination programme is offered as a universal programme for adolescents and as a programme for gay, bisexual and other men who have sex with men (GBMSM) up to and including 45 years of age.

6.5 The adolescent programme is delivered in schools (including state, independent and special schools) and community clinics by the Sussex school-age immunisation service (SAIS). GPs are contracted to offer catch-up to 14-to-24 year olds that missed their vaccination through the schools programme.

6.6 The GBMSM programme is delivered through sexual health and HIV clinics. Non-GBMSM individuals with a similar risk profile and attending these clinics are also eligible.

6.7 From 1 September 2023, the HPV vaccination schedule changed from 2 doses to 1 dose for the routine adolescent programme and GBMSM aged under 25 years. GBMSM aged 25 to 45 years remain on a 2-dose schedule. Eligible individuals who are known to be immunosuppressed at the time of vaccination and those who are living with HIV should continue to be offered 3 doses.

6.8 In the adolescent programme, the single HPV dose is given in year 8 (children aged 12 to 13). The evidence indicates that to give the best protection, the vaccine should be given before people become sexually active. If children miss their vaccine there are opportunities to catch up in school and community clinics, or via their GP.

[25] https://www.nhs.uk/conditions/human-papilloma-virus-hpv/
[26] Prepared by National Cancer Registrations and Analysis Service. NHS digital. OHID: Population Health Analysis Team ONS. Annual deaths registrations extracts.

6.9 Children that were eligible for the HPV vaccination programme before 1 September 2023 and have already received one dose of the vaccine are considered fully vaccinated. All other cohorts who require catch-up via their SAIS provider or GP moved to a 1 dose schedule from 1 September 2023, and remain eligible until their 25th birthday.

6.10 The adolescent HPV vaccination programme was introduced for girls in 2008 and there has since been a big decline in HPV infections and in the number of young people with genital warts. The programme for boys was introduced in 2019.

6.11 The only HPV vaccine now used in the national programme is Gardasil®9, a 9-valent vaccine which was introduced to replace the previously used Gardasil® (quadrivalent) vaccine and prevents against 5 additional cancer-causing HPV types. The vaccine will prevent up to 90% of cervical cancer cases, but women and people with a cervix should still attend for cervical screening when invited to do so.

6.12 National research has determined that women who are vaccinated against HPV have a much lower risk of developing cervical cancer than those who are not vaccinated, and that the effect is even greater for women at a young age. In 2021 research was published in the Lancet indicating that the HPV vaccination programme has successfully almost eliminated cervical cancer in vaccinated women born since Sept 1, 1995[27].

6.13 In November 2023, the NHS set out its ambition to eliminate cervical cancer by 2040 by ensuring as many people as possible are being vaccinated against HPV, while also coming forward for cervical screening.

7 HPV vaccine coverage data – adolescent programme

7.1 The COVID-19 pandemic and resulting closure of schools led to some disruption of school-based HPV vaccination programme delivery and the impact varied by region and local authority. HPV vaccine coverage has improved significantly in the last 3 years from the low levels reported for the 2019 to 2020 academic year but is still not back up to pre-pandemic levels.

HPV vaccine coverage data for the adolescent programme is published annually for the previous academic year by local authority.

The published[28] coverage data for school year 2022/23 for Brighton and Hove is as follows:

	Denominator	Vaccinated with at least 1 dose	% coverage	Vaccinated with 2 doses	% coverage
Year 8 Female	1569	1089	69.4	Figure suppressed	Figure suppresse

[27] The effects of the national HPV vaccination programme in England, UK, on cervical cancer and grade 3 cervical intraepithelial neoplasia incidence: a register-based observational study - The Lancet

[28] Human papillomavirus (HPV) vaccine coverage estimates in England: 2022 to 2023 - GOV.UK (www.gov.uk)

				due to small numbers	d due to small numbers
Year 8 Male	1522	907	59.6	Figure suppressed due to small numbers	Figure suppressed due to small numbers
Year 9 Female	1545	1155	74.8	990	64.1
Year 9 Male	1396	954	68.3	778	55.7

HPV vaccine coverage across England in the 2022/23 academic year is shown below:

	Coverage – 1 dose	Coverage – 2 doses
Year 8 Female	71.3%	-
Year 8 Male	65.2%	-
Year 9 Female	75.7%	62.9%
Year 9 Male	69.7%	56.1%

Compared to national figures in 2022/23, Brighton and Hove coverage was lower for 1 dose in females and males in year 8 and year 9 and for 2 doses in males in year 9 but higher for females with 2 doses in year 9[29]. Compared to the South East Region, Brighton and Hove had lower coverage across all these groups in 2022/23.

This comparison shows no change from the 2020/21 data presented in the previous iteration of this report.

Coverage data for the 2023/24 academic year will be published in January 2025.

Please note that there is no equivalent coverage report for the GBMSM programme – activity data is submitted monthly by providers to the NHS England commissioning team for management purposes.

8. HPV and Colposcopy

8.1. Collaborative work between NHS Sussex and Brighton and Hove City Council has enabled links to be made between the HPV vaccination programme with communications and education work on prevention of cervical cancer (recognising the impact of the pandemic on vaccination rates in schools).

[29] Public health profiles - OHID (phe.org.uk)

8.2. HPV primary screening has increased referrals into Colposcopy services for a more thorough examination of the cervix, potential biopsy and treatment to prevent cervical cancer.

8.3. This increase in referrals coincided with COVID recovery and the financial arrangements attached. This meant that there was not sufficient substantial colposcopy capacity to manage the increase demand and 'low grade squamous intraepithelial lesion' referrals could not be seen within the waiting time standard of 6 weeks.

8.4. NHS England and University Hospitals Sussex NHS Foundation Trust continue to work very closely to address capacity pressures and ensure the service has access to required resources, workforce and estates to meet the demands of the service within the NHS Cervical Screening Programme colposcopy standards[30] on a substantive basis.

9. HPV vaccination delivery and actions for improvements

9.1. NHS England, the Surrey and Sussex Cancer Alliance (SSCA) and system stakeholders, including the school-age immunisation teams, have agreed a plan for improving HPV vaccination delivery in 2024/25, with emphasis on raising awareness and improving communication, improving data sharing to identify and act on areas of low uptake, and identifying and acting on barriers to vaccination. Progress on agreed actions will be monitored via the Surrey and Sussex Cancer Alliance Primary Care Advisory Group.

9.2. The Sussex school-age Immunisation Service (SAIS) delivered by Sussex Community Foundation Trust is commissioned to offer HPV vaccination to the eligible cohort, predominantly delivered within schools.

9.3. Locally, this is offered in Year 8 through all schools including SEN and Prep schools. Home educated and those that are not in school are contacted and offered the vaccine via a clinic or in some instances a home visiting service. Catch up for missed vaccinations is available from SAIS for those young people that are under 20 years of age.

9.4. For all school sessions the SAIS offer:

- School Pack with session information sent by email to schools
- Material to promote the upcoming vaccinations on school websites and school electronic info boards
- Information leaflet and online consent information, including FAQs, sent via schools to parents
- Parent consent reminders sent via school two weeks prior to vaccination date
- For those parents that need a paper consent, this is provided once schools provide the info to SAIS

[30] Cervical screening supporting information - GOV.UK (www.gov.uk)

- Verbal consent obtained in advance by phoning parents (as required) for those with no consents received
- Gillick[31] consent of young person taken on the day, if appropriate
- Low uptake schools an extra member of staff (staffing levels permitting) to spend the session phoning for verbal consent, using details provided by school
- Outstanding positive consents in years 10 upward are offered to catch up at each school visit
- SAIS staff member to assist parents with completing consent forms where indicated by schools
- Additional visits to Alternative Provision and SEN schools, as appropriate. Clinics in these settings are adapted to address the needs of the students.

9.5. For those not in School or hard to reach SAIS offer:

- Home Educated: links are sent by BHCC, including consent information, for each programme to all eligible young people that are on home education roll
- Traveller site visits by link nurses several times per term
- For Looked After Children - link nurses in each team promote uptake and immunisation status is noted at Initial Health Assessment and catch up will form part of the health care plan
- Dedicated clinics with longer appointments for anxious children
- Community mop-up clinics available and promoted for those that cannot access school service
- Home visits offered when required

9.6. Post School Session SIS offer includes the following:

- Mop up session for those with a high DNA (Did not attend) numbers
- Email sent to all who DNA with clinic link and SIS contact information
- Email sent via schools to whole year group with consent link informing them they can still consent with the clinic booking link
- Community clinics in Brighton & Hove are held at Brighton General Hospital, Whitehawk Roundabout Children's Centre, Withdean Stadium and Hove Polyclinic. 89 Community Clinics in Brighton & Hove were held between 01/09/2023 – 31/08/2024. There is the option to book on to any available clinic in Sussex.

9.7. Annually, each July, the SAIS provide the following:

- Clinic booking information email sent to all who remain unvaccinated but consented
- Those who have School Pack with session information sent by email to schools
- Material to promote the upcoming vaccinations on school websites and school electronic info boards
- Information leaflet and online consent information, including FAQs, sent via schools to parents
- Parent consent reminders sent via school two weeks prior to vaccination date

[31] Gillick competency is used to assess whether a child is mature enough to make their own decisions regarding vaccinations and to understand the implications of those decisions

- For those parents that need a paper consent, this is provided once schools provide the info to SAIS
- Verbal consent obtained in advance by phoning parents (as required) for those with no consents received
- Gillick consent of young person taken on the day, if appropriate
- Low uptake schools an extra member of staff (staffing levels permitting) to spend the session phoning for verbal consent, using details provided by school
- Outstanding positive consents in years 10 upward are offered to catch up at each school visit
- SAIS staff member to assist parents with completing consent forms where indicated by schools
- Additional visits to Alternative Provision and SEN schools, as appropriate. Clinics in these settings are adapted to address the needs of the students

9.8. The Sussex school-age Immunisation Service has undertaken a variety of measures to improve uptake.

- Measures to improve consent completion: a small team of assistants calling parents who have not submitted consent forms (year 8 and above) and offering information and support in completing a consent, extra staff being sent to sessions to complete verbal consents, letters with information for parents being sent out via schools and QR codes to help access the e-consent platform, where we have email information that has been supplied by schools with their roll lists we email reminders to complete consents to pre and post school sessions.
- Measures to assist schools: monthly Q and A drop-in, on Teams, for schools with upcoming sessions for support and feedback, sharing U-tube and other links to NHS HPV information to share with the children in advance of sessions, exploring links in schools to work collaboratively to coordinate the delivery of HPV PHSE lessons before the vaccination session. SEN schools are offered an on-site delivery of this, which also provides the opportunity to assist parents with the consent process.
- Measures to improve opportunities to access vaccination: increased the variety of venues across the area, using the help of local authority teams, booked additional larger venues for holiday catch up, reintroducing trial drop-in clinics in some areas offering greater flexibility for families (these were stopped during the pandemic due to restrictions).
- The SAIS team is sending a hard copy of the NHS HPV leaflet to every year 8 student via schools later this term with the econsent QR code on the front for easy access to our consent system. This process will also be discussed with the LA Home Educated link to send out to parents directly (or via LA).
- These measures apply to the current year 8 cohort and all the catch-up cohorts.

9.9. Local actions to improve uptake include:

- Public Health team have worked with the PHSE lead in a school to develop a lesson plan on HPV and this was shared with all schools.
- Distributed HPV materials to all schools

- Shared information on HPV with the Sussex Interpreting Service for them to upload onto their Language specific pages
- Publicised catch up and anxiety clinics in schools.
- Created the Vaccine Uptake Inequality Forum, which will focus on school age immunisations as part of a rota. Members include BHCC, NHSE, VCSE, Primary care.

9.10. Potential next steps and future actions include:

- To send reminder clinic emails immediately following DNA, now that the system is in place to do this.
- To send invites to non-attenders in areas of the city with lower uptake for catch up clinics
- To share communications in local area magazines to promote Missing Vaccines poster
- Use banners at venues to improve visibility of the immunisation team at sites
- HPV vaccination leaflets to be shared in different languages with communities
- SAIS to promote in a parent letter and via schools the functionality of viewing the e-consent in the language their phone is set to.
- SAIS to promote access to leaflets in other languages for HPV.
- Link with other areas on best practice ideas to increase uptake including the provision of vaccinations through Primary Care for specific Cohorts such as LD 19-25 year old people and other identifiable target groups.
- Work with the Cancer Alliance to identify target groups and implement catch up clinics for those aged 19-25.
- Consider how to link the TNBI coding at GP Practice level to the vaccination of gay, bisexual, and other men who have sex with men (GBMSM) who are eligible up to the age of 45.
- Preparing for the Integrated Community Teams (ICT) development by supporting the development of Data Packs highlighting cancer screening.
- Continue to support the annual student Freshers week materials (national) encouraging catchup HPV vaccinations.

10. Analysis and consideration of alternative options

10.1. Not applicable for this report to note.

11. Community engagement and consultation

11.1. Not applicable for this report to note.

12. Conclusion

12.1. Members are asked to note information presented.

13. Financial implications

13.1. The cancer awareness and early diagnosis programme is joint funded by Health and the ring-fenced Public Health grant (Health & Adult Social Care directorate). The budget for financial year 2022/23 is £0.077m funded by the Public Health grant and £0.023m from NHS Sussex.

No financial implications have been identified for this report.

Sophie Warburton, Principal Accountant, BHCC *28.10.2022*

14. Legal implications

14.1. No legal implications have been identified for this report, which is for noting only.

Sandra O'Brien, Senior Lawyer, BHCC *27.10.2022*

15. Equalities implications

15.1. Equalities implications are addressed throughout the report.

16. Sustainability implications

16.1. Plans for improving action on sustainability and climate change are included in NHS Sussex, NHSE and BHCC commissioning plans.

Supporting Documentation

None

Brighton & Hove City Council

Scrutiny Report Template

Health Overview & Scrutiny Committee

Agenda Item 20

Subject: **Access to Diabetes Technology in Brighton & Hove**

Date of meeting: **20 November 2024**

Report of: **Chair of the Health Overview & Scrutiny Committee**

Contact Officer: **Name: Giles Rossington, Policy, Partnerships & Scrutiny Team Manager**

Email: giles.rossington@brighton-hove.gov.uk

Ward(s) affected: (All Wards);

Key Decision: No

For general release

1. Purpose of the report and policy context

1.1 Diabetes UK is a national charity which campaigns for improvement in the care and treatment of people with diabetes. Diabetes UK has recently contacted Sussex Health Overview & Scrutiny Committees (HOSCs), to ask them to consider the topic of access to diabetes technology across Sussex.

1.2 In response, the HOSC Chair has requested a paper on access to diabetes technology in Brighton & Hove from NHS commissioners (Sussex Integrated Care Board: ICB). Diabetes UK have also been invited to the HOSC to present on their concerns.

1.3 Appendix 1 contains information provided by the ICB. Appendix 2 contains slides provided by Diabetes UK.

2. Recommendations

2.1 Health Overview & Scrutiny Committee notes the information provided by Diabetes UK and by the Sussex Integrated Care Board; and

2.2 Determines whether the committee requires further information on this issue.

3. Context and background information

3.1 Diabetes is a long-term condition occurring when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces. The most common types of diabetes are:

Type 1 diabetes. Type 1 diabetes is characterised by deficient insulin production and requires daily administration of insulin. It is an autoimmune condition though neither its cause nor the means to prevent it are fully understood. Type 1 diabetes is usually diagnosed in children and young adults, although it can appear at any age. Management of type 1 diabetes is delivered by specialist diabetes services.
Type 2 diabetes. Type 2 diabetes affects how your body uses sugar (glucose) for energy. It stops the body from using insulin properly, which can lead to high levels of blood sugar if not treated. Type 2 diabetes can be preventable. Factors that contribute to developing type 2 diabetes include genetics, being overweight, not getting enough exercise, and older age. This is the most common form of diabetes. People with type 2 diabetes are predominately cared for by primary care, with specialist services managing the most complex patients.

3.2 Diabetes effects many people, significantly impacting their health and quality of life. Diabetes care is also very expensive, costing the NHS around £10 billion per year (around 6% of the entire NHS budget), with more than half of this sum spent on treating preventable complications. Supporting people to effectively manage their diabetes, specifically in terms of maintaining a healthy blood sugar level, is key to improving people's lives and managing cost.

3.3 In recent years new technologies have emerged which have the potential to make it much easier to support people with diabetes to maintain their blood sugar levels within a safe range. Diabetes UK have raised concerns about whether access to these technologies for people with diabetes in Sussex is in alignment with NICE (National Institute for Health and Care Excellence) guidance. Both Diabetes UK and Sussex NHS commissioners have been invited to submit information to the HOSC on access to diabetes technology for Brighton & Hove residents, and to present to the committee. Information provided by the Sussex Integrated Care Board is attached as Appendix 1 to this report, and information provided by Dementia UK is attached as Appendix 2.

4. Analysis and consideration of alternative options

4.1 Not applicable to this report for information.

5. Community engagement and consultation

5.1 None for this information report.

6. Financial implications

6.1 This report indicates no financial implications to BHCC

Name of finance officer consulted: Jamiu Ibraheem Date consulted (13/11/24)

7. Legal implications

7.1 The Council's Health Overview & Scrutiny Committee has delegated to it the statutory responsibility of reviewing and scrutinizing matters relating to the planning, provision and operation of health services in Brighton & Hove. As a result, it may properly consider the information made available to it in this topic, as suggested by the recommendations to this Report.

Name of lawyer consulted: Victoria Simpson Date consulted 11/11/2024

8. Equalities implications

8.1 Diabetes is more prevalent in some communities than others, including in non-white populations, people experiencing deprivation, people with severe mental illness and people with learning disabilities. This is explored in more depth in Appendix 1: ICB submission.

9. Sustainability implications

9.1 None identified.

10. Health and Wellbeing Implications:

10.1 This is covered in Appendix 1: ICB submission.

13. Conclusion

13.1 Members are asked to note the information provided by both the Sussex Integrated Care Board and Diabetes UK.

Supporting Documentation

1. Appendices

1. Information on access to diabetes technology in Brighton & Hove provided by ICB
2. Information provided by Diabetes UK

NHS Sussex

Access to Diabetes Technology in Brighton and Hove

A Report for the Health Overview and Scrutiny Committee

November 2024

Access to Diabetes Technology in Brighton and Hove.

Introduction.

1. Diabetes is a long-term condition that occurs when either the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces. The most common types of diabetes are:

    - **Type 1 diabetes.** Type 1 diabetes is characterised by deficient insulin production and requires daily administration of insulin. It is an autoimmune condition though neither its cause nor the means to prevent it are fully understood. Type 1 diabetes is usually diagnosed in children and young adults, although it can appear at any age. Management of type 1 diabetes is delivered by specialist diabetes services.

    - **Type 2 diabetes.** Type 2 diabetes affects how your body uses sugar (glucose) for energy. It stops the body from using insulin properly, which can lead to high levels of blood sugar if not treated. Type 2 diabetes can be preventable. Factors that contribute to developing type 2 diabetes include genetics, being overweight, not getting enough exercise, and older age. This is the most common form of diabetes. People with type 2 diabetes are predominately cared for by primary care, with specialist services managing the most complex patients.

2. The NHS spends over £10 billion each year on diabetes, equating to 6% of its budget, with over half of this money (60%) spent on treating preventable complications[1]. As such supporting people living with diabetes to manage their condition, specifically through improved glycaemic control has the potential to reduce the costs to the NHS in managing the condition, but more importantly supports a healthier population.

3. The evolution of diabetes technology is a key component in transforming diabetes care and empowering people living with diabetes to better manage their condition, ultimately leading to improved clinical outcomes. Efficacy alongside safety and cost effectiveness is driving adoption of diabetes technology[2], which, when used appropriately, improves the lives and health of people with diabetes, and reduces the NHS costs related to management of diabetes and its complications. The focus until recently has been on providing this technology for people with type 1 diabetes, but this has now shifted to include a small cohort of people with type 2.

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[1] Estimation of the direct health and indirect societal costs of diabetes in the UK using a cost of illness model (wiley.com)
[2] Evolution of Diabetes Technology - ScienceDirect

4. In managing type 2 diabetes a whole pathway approach needs to be considered, focusing on early identification (pre-diabetes), prevention and improved diabetes management through embedding sustainable behavioural and lifestyle changes to prevent people requiring technology to manage their diabetes. This contrasts with type 1 where there is no ability to reverse or enable remission although lifestyle factors can impact the condition.

5. This paper will set the context of the current diabetes landscape, alongside providing an up-to-date position on access to diabetes technology in Brighton and Hove.

Background.

6. Diabetes technology can help people live better lives, and guidance from the National Institute of Clinical Excellence (NICE) advocates the use of technology to support some people living with diabetes through both NICE guidance (NG) and Technology Appraisals (TA).

7. NICE guidance is developed with health care professionals and people who use services to help with decision making on prescribing and recommended treatment[3]. Apart from Technology Appraisals, the use of NICE guidelines is not mandatory. Technology Appraisals are based on a review of clinical evidence and cost effectiveness, with a statutory responsibility for the NHS to make funding available for a recommended drug or treatment with a TA, normally within three months (unless otherwise specified)[4].

8. There is a range of diabetes technology available, with multiple guidelines available over the years, which are summarised below.

9. Continuous Glucose Monitoring (CGM) systems monitor glucose. These devices are worn continuously on the body and provide a glucose reading to a smart phone or reader. Certain CGM devices are prescribable, however there are some devices with increased functionality which are non- prescribable.

10. A Continuous Subcutaneous Insulin Infusion (CSII) pump provides a steady stream of insulin to the body, with the person needing to test blood sugar levels, adjusting administration rate of the pump, and delivering boluses as needed. All CSII pumps are non-prescribable technology, and as such within the scope of this work. Pumps are used by patients to manage their diabetes by working alongside CGM monitors. CSII is almost exclusively used for people with Type 1 diabetes.

[3] NICE guidelines | NICE guidance | Our programmes | What we do | About | NICE
[4] Technology appraisal guidance | NICE guidance | Our programmes | What we do | About | NICE

11. More recently, Hybrid Closed Loop Systems (HCL) have become available; these comprise of a CGM device, and an insulin pump linked to a computer algorithm that can adjust the amount of insulin needed based on glucose readings. This feedback loop responds quickly to changes in glucose levels and "semi-automates" many of the processes people living with diabetes currently use to control their blood glucose levels.

12. The NHS Long Term Plan (2019) signalled NHS England's intent to rapidly improve access to diabetes technology. Subsequent NICE guidance (May 2022) for adults with type 1 diabetes (NG17), broadened the offer to state that all people living with type 1 diabetes should be offered CGM, with the device with the lowest cost offered if multiple devices meet the patients' needs and preferences.

13. In 2008, NICE recommended CSII pumps to support management of type 1 diabetes in TA151. This recommendation was built on in the 2022 guidance for adults with type 1 diabetes recommending CSII pumps for the cohort of patients living with type 1 diabetes who are the most clinically vulnerable and therefore at the greatest risk of accessing unplanned care or developing diabetes related complications.

14. In December 2023, NICE published a Technology Appraisal (TA943), which outlined a phased rollout of HCL to people living with type 1 diabetes. The NHS England, HCL implementation strategy describes a three-year plan for Children and Young People (CYP), and a five-year plan for the adult population. It is estimated over 150,000 people will be eligible for HCL in England and Wales by 2030, with 100% of CYP and c70% of adults estimated to be using HCL. This is a significant shift from the current landscape.

15. NICE Guidance 28, Type 2 diabetes in adults (NG28), recognises management of blood glucose is a core component of diabetes care, and that if type 2 diabetes is not well controlled, patients are at an increased risk of long-term complications. When NG28 was updated in June 2022 it recommended CGM is offered to adults living with type 2 diabetes who fulfil a specific set of clinical criteria. Contrasting the position for people with type 1, this recommendation equates to a smaller percentage of the people living with type 2, equating to only around 3.55% of people with type 2 diabetes.

16. Through dietary changes and weight loss, type 2 diabetes can be improved, or in some cases reversed, enabling someone to reach and hold normal blood sugar levels, living 'diabetes free' without medication. This puts a person's type 2 diabetes into remission (rather than cured) making it possible to go years without needing to control blood glucose and the health concerns that come with living with type 2 diabetes.

Strategic Context

17. There are more than five million people living with diabetes in the UK with national prevalence increasing year-on-year from 5.4% in 2009/10, to 7.5% in 2022/23[5], and it is predicted to increase to 9% by 2030[6] . Due to the differing aetiology between the types of diabetes this increase is driven by an increasing number of people diagnosed with type 2 diabetes, the causes of which are complex, with age, family history, ethnicity and socio-economic background all contributing to a person's risk. Obesity also increases this risk, which is also heightened at a younger age.

18. In Sussex, just over 105,000 of the adult population are living with Diabetes; 12,820 of which reside within Brighton and Hove (where the total population is 276,300). 92% (96,650) of all adults with diabetes in Sussex have type 2, as opposed to 8% (8,505) of adults living with type 1. This split differs in Brighton and Hove, likely attributed to a younger demographic, with 11,360 people (89%) with type 2 diabetes and 11% (1,460) of people living with a diagnosis of type 1.

19. Diabetes does not affect everyone equally, with factors driving inequalities complex and interrelated.

20. The links between ethnicity and type 2 diabetes are well documented with a disproportionate number of people diagnosed with diabetes from ethnically diverse groups (excluding white minorities). People from ethnic minority backgrounds are more likely to be living in areas of deprivation than those of white ethnicity, creating multifactorial risk[7]. The proportion of the Brighton and Hove population who fall within the high level 'white' category in 2021 was 85.4%, down from 89.1% in 2011[8]. This is lower than both the Southeast and English national averages of 86.3% and 82%, respectively. In Brighton and Hove 74% of type 2 diabetes is recorded within the white population with 16% recorded in ethnic minority groups. The remaining 10% currently have no ethnicity recorded.

21. In Sussex over 96% of people living with type 1 diabetes are from white population groups, or have no recorded ethnicity, with less than 5% known as being from an ethnic minority population group. Brighton and Hove differ from the wider Sussex position with 90% of type 1 diabetes in white population groups, or having no recorded ethnicity, with 10% in ethnic minority groups.

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[5] Cardiovascular Disease | Fingertips | Department of Health and Social Care (phe.org.uk)
[6] NHS England » NHS scheme reduces chances of Type 2 diabetes for at risk adults
[7] What Are Health Inequalities? | The King's Fund (kingsfund.org.uk)
[8] How life has changed in Brighton and Hove: Census 2021 (ons.gov.uk)

22. Socio-economic factors also influence outcomes for people with type 2 diabetes, with deprivation associated with unhealthy behaviours including access to nutritious food due to economic hardship, and a sedentary lifestyle, which increases the risk of obesity, and type 2 diabetes. People from the most deprived areas in England are 2.5 times more likely to be living with type 2 diabetes than people from less deprived areas.

23. Nationally, prevalence of type 1 diabetes by deprivation is equally split across all Indices of Multiple Deprivation (IMD) quintiles. Figure one sets out type 1 diabetes registrations by IMD quintile, and it can be noted at a Sussex level there is a lower prevalence than the national distribution in the most deprived areas (10.2% in Sussex contrasted with 19.9% nationally), and a slightly higher prevalence in the least deprived areas (23.0% in Sussex versus 19.4% nationally), with the highest distribution falling within the middle quintile. When looking at Brighton and Hove distribution, 17.1% of type 1 are living within the most deprived quintile, and 12.3% in the least deprived quintile. This breakdown is reflective of the significant variation in levels of deprivation across the city, with Brighton and Hove ranked 131 most deprived authority in England (out of 317) placing them in the third quintile (41%), with 15 out of 165 (9%) of neighbourhoods in the 10% most deprived in England[9].

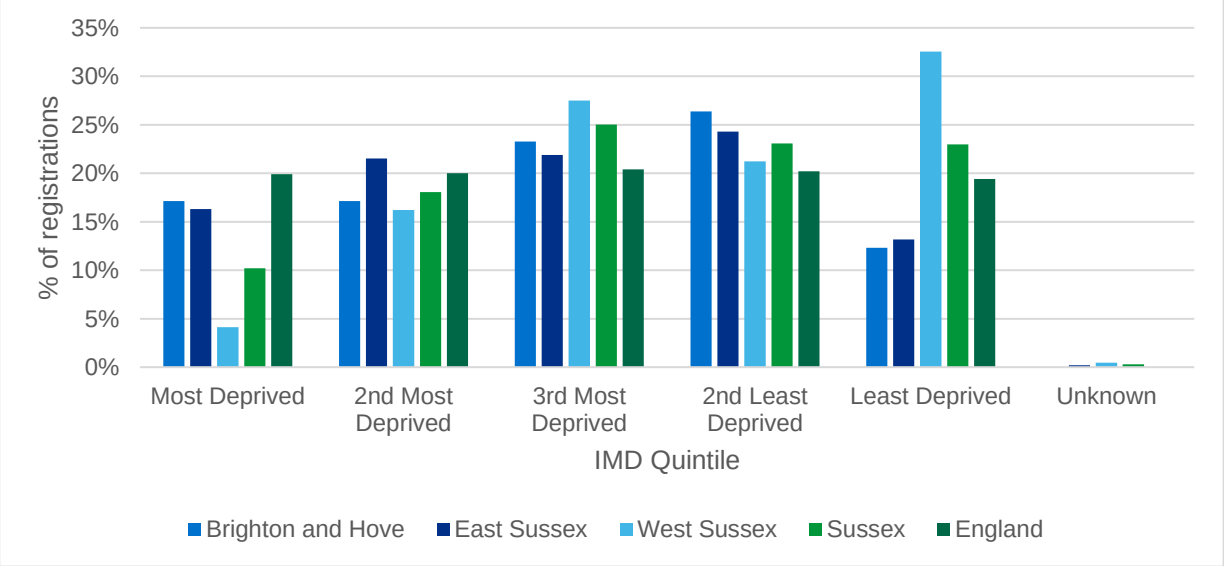

Figure one: Type 1 diabetes registrations by IMD Quintile and place. Source: NDA 2022/23

24. Nationally there is a higher prevalence of type 2 diabetes in the most deprived areas when compared to the least deprived. This is reflective of socioeconomic factors increasing the risk of type 2 diabetes. Figure two sets out type 2 diabetes registrations by IMD quintile, and it can be noted at a Sussex level there is a lower prevalence than the national distribution in the most deprived areas (11.2% in Sussex contrasted with

[9] Index of Multiple Deprivation 2004 (brighton-hove.gov.uk)

23.6% nationally), and a slightly higher prevalence in the least deprived areas (19.4% in Sussex versus 15.0% nationally), with the highest distribution falling within the middle quintile. Looking at Brighton and Hove distribution, 8.9% of people live in the least deprived quintiles, below both national and Sussex averages. When looking at the number of people living with type 2 diabetes in the most deprived quintile, at 26% this is higher than the Sussex average, and of all the Sussex places individually, most likely reflective of the population distribution described in paragraph 23.

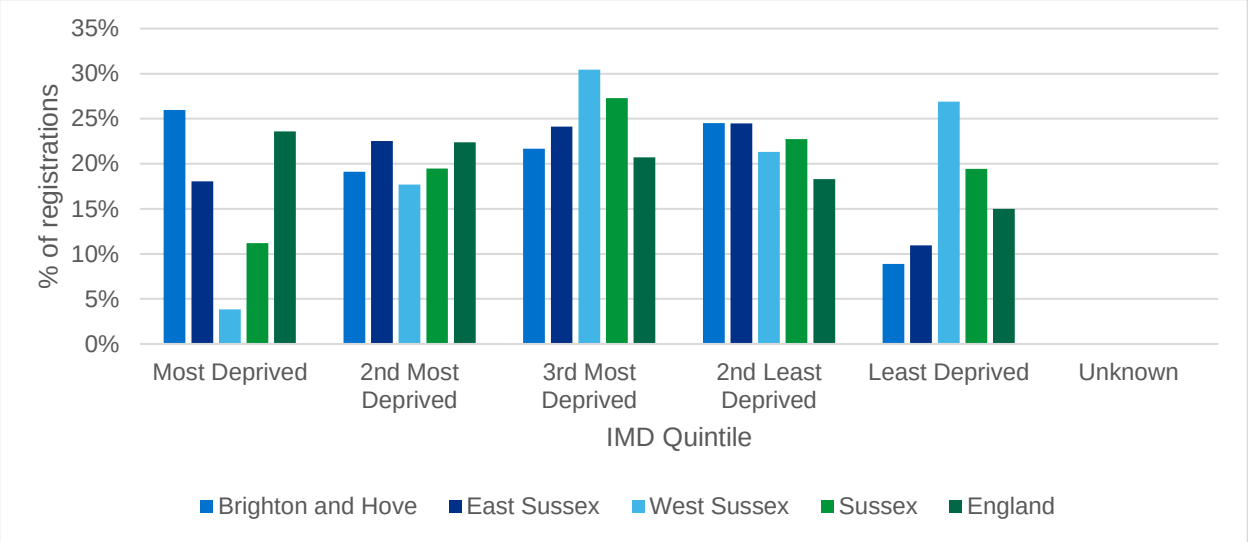

Figure two: Type 2 diabetes registrations by IMD Quintile and place. Source: NDA 2022/23

25. Type 2 diabetes is also two to three times more prevalent in people living with a severe mental illness (SMI). Various risk factors have been implicated, including side effects of antipsychotic medication and unhealthy lifestyles, which often occur in the context of socioeconomic disadvantage and health care inequality.

26. Prevalence of both type 1 and type 2 diabetes in people living with a learning disability (LD) is higher than in the general population[10]. According to data, 0.8% of people with LD in England have a diagnosis of type 1 diabetes, compared with 0.4% of the general population, with estimates for type 2 stating prevalence at 10%, almost double than in the general population[11]. There are an estimated 970 people living with a LD and type 2 diabetes in Sussex equating to 9.2% of the local population.

[10] rightcare-pathway-diabetes-reasonable-adjustments-learning-disability-2.pdf (england.nhs.uk)
[11] Diabetes deep dive Canva Version (kcl.ac.uk)

Accessing Diabetes Care in Brighton and Hove

27. Type 1 diabetes is predominantly managed by specialist services in line with national recommendations[12] . For the population of Brighton and Hove this is provided by both University Hositals Sussex NHS Foundation Trust (UHSx) and the Diabetes care for You (DCFY) service sitting within Sussex Community NHS Foundation Trust (SCFT). Care within specialist services includes the provision of diabetes technology, foot protection teams, and multi-disciplinary foot team services, transition services (paediatric to adult), antenatal care, inpatient care, combined renal clinics, psychology, LD, HIV, and patient structured education programmes.

28. Management of type 2 diabetes is predominantly within primary care. In July 2024, the new 'improving diabetes care' locally commissioned service (LCS) went live across Sussex, resourcing practices to deliver enhanced care over and above the General Medical Servies (GMS) contract and the Quality and Outcomes Framework (QOF). For practices delivering the LCS there is an expected tier one service which includes the maintenance of registers, an enhanced service for newly diagnosed type 2 diabetes, enhanced care planning, pre-pregnancy counselling, optimising care prior to surgery, referral to the NHS National Diabetes Prevention Programmes (NHS DPP) and Type 2 Diabetes Path to remission Programme (T2DR) and ongoing management of insulin in general practice. There is in addition a discretionary tier two within the LCS, supporting risk reviews for patients at high risk of diabetes, and initiation of injectables (basal insulin and GLP-1 analogues). Due to the LCS only being active from 1st July 2024 data is not currently available, however we do know there is 100% practice sign up from Brighton and Hove to the tier one service, which is very positive.

29. The new LCS is clear that all people living with type 1 diabetes should be offered specialist care in line with national guidance, however the new LCS does allow for people who decline specialist services to be supported in primary care. There has been extensive work to harmonise the seven legacy LCS's and with a new Sussex wide offer now in place there is a real opportunity to continue to improve outcomes for people across the entire diabetes pathway.

30. GPs have access to specialist advice provided by UHSx and SCFT for people with type 1 diabetes. There are also pathways for managing type 2 diabetes in specialist services for the most complex and clinically vulnerable patients. Additionally, UHSx offers an electronic 'advice and guidance' service to primary care clinicians. This model supports the training and upskilling of the primary care workforce in diabetes management.

31. An important service offer within the end-to-end type 2 diabetes pathway are the prevention services. Localised offers within Brighton and Hove compliment the NHS offers which include the NHS Diabetes Prevention Programme (NHS DPP), the NHS

[12] Overview | Type 1 diabetes in adults: diagnosis and management | Guidance | NICE

Type 2 Diabetes Path to Remission Programme (T2DR), and the NHS Digital Weight Management Programme (DWMP).

32. In Brighton and Hove the Diabetes Clinical Network have worked in collaboration with Voluntary, Community, and Social Enterprise (VCSE) partners and primary care to pilot three projects looking at innovative models of diabetes care.

- The Hangleton and Knoll Project helps people manage diabetes through courses, workshops, and peer support groups. It focuses on self-care and prevention, especially in underserved communities. The project encourages healthy living, early intervention, and provides a supportive space for sharing advice, leading to better health outcomes and less pressure on local healthcare services.
- 'Justlife', is a homelessness charity in Brighton that employs a diabetes health engagement worker to support clients who are insecurely housed and either at risk of developing or living with type 2 diabetes. The worker assists clients by taking them to medical appointments and offering advice on managing their condition.
- Wellsbourne and Bridging Change. This is a collaboration between primary care and a VCSE organisation in Brighton. They are trialling the use of a point-of-care testing machine to combine two appointments into one. This initiative is complemented by focus group workshops with patients, aiming to improve appointment attendance and enhance self-care knowledge.

Each project took a different approach to supporting people who were at risk of or living with type 2 diabetes. Outcomes of the projects were predominately aligned with all seeing increased empowerment and understanding within the type 2 population on how to manage their condition, increased engagement with services to support diabetes management, and for those living at risk of diabetes an increased number of referrals to diabetes prevention services. All projects noted the 'power of peers' when sharing experiences relating to healthcare and prevention services.

Diabetes Technology in Brighton and Hove Sussex

Access to technology for people living with type 1 diabetes.

33. In Sussex there are pathways for all people living with type 1 diabetes to access prescribable technology with NHS Sussex spending over £6.5 million on this in 2023/24. These prescribable CGM devices are initiated by specialist diabetes nurses or doctors but prescribed within primary care. The prescribable CGM technologies 'Freestyle Libre 2' and 'Dexcom One' currently support just over 70% (National Diabetes Audit 2022/23) of the adult type 1 population in Sussex. These devices are not suitable for all patients. Some adults and children who are unable to stabilise their diabetes with these devices need access to more complex technology provided through specialist diabetes services and is non-prescribable. Legacy commissioning arrangements from CCGs have led to different commissioned pathways for non-prescribable technology creating variable access to these devices, with Brighton and Hove, and West Sussex having previously far better access than those living in East Sussex.

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34. For the population of Brighton and Hove, non-prescribable technology pathways are in place to access devices at UHSx, with SCFT able to refer patients to UHSx to access this pathway. NHS Sussex will be implementing this year the use of a single system for monitoring these devices (Blueteq) to enable higher visibility of device usage.

35. The new HCL technology will change the current landscape, with a shift away from all current technology towards devices that have the functionality to work as a HCL system, and it is predicted that all CYP and circa 70% of adults will be using HCL within the next five years.

36. Sussex has been working with providers to develop an implementation plan fully informed by information from NHS England, and aligned with the national plan for prioritisation groups, with local clinicians collaborating to further refine the prioritisation framework to ensure implementation of devices in the early phase (year one) is supporting those who are the most clinically vulnerable including those who are at greatest risk of hospital admission and deterioration of their disease.

37. We know through baselining that at the start of the five-year implementation (1st April 2024) there were at least 300 HCL devices being used by adults in Sussex to manage their diabetes and over 350 devices in the CYP population. As this is a new technology there is no baseline data to compare the Sussex position against, however, we do know anecdotally that there are other Integrated Care Boards (ICB's) who had no or very minimal HCL provision at the start of the five-year implementation, meaning that there was a higher baseline in Sussex than in other ICB's.

38. Since 1st April 2024 pathways have been put in place for all acute specialist services in Sussex to access HCL for patients who are clinically vulnerable and assessed as being in a priority group.

39. On 19th July 2024 NHS England wrote to all ICBs detailing an indicative allocation for year one of the implementation directly linked to a 75% reimbursement scheme. This indicative cap establishes access in year one will be for maternity and the CYP population as well as switching the most clinically vulnerable who currently use CSII pumps. As further detail for years two to four become available modelling will be updated, reflecting priority groups in each year acknowledging both clinical needs, and addressing the inequalities in access. Sussex is fully aligned to the national delivery plan. Sussex has noted efficiencies can be realised through procuring non-prescribable devices through the national HCL procurement framework and is working with specialist providers to ensure this is in place.

Access to technology for people living with type 2 diabetes.

40. In type 2 diabetes, CGM is commissioned for people who are living with a learning disability (recorded on their GP Learning Disability Register) and have their diabetes managed through the administration of insulin. It is also available to people who are on haemodialysis and on insulin treatment requiring intensive monitoring >8 times daily.

41. NICE guidance proposes that CGM is offered to a wider group of people living with type 2 diabetes. It is estimated that this would mean about 3.55% of the type 2 population,

which would equate to 403 people within Brighton and Hove, or 3,431 people Sussex wide.

42. It is known from prescribing data that many people in this cohort already are using this technology, but NHS Sussex is developing a policy to ensure an increased focus on providing equal access. The current priorities are the most clinically complex and vulnerable patients.

43. The most clinically complex patients with Type 2 diabetes are already under specialist services and will be supported to receive CGM as per the NICE criteria. Once training has been carried out, primary care services will also be able to provide this technology to ensure we reach all the 400 people who are eligible. The diabetes clinical reference group have led on developing proposals for increasing access to technology, alongside ensuring that our wider clinical model of care is fit for the future.

What are the Clinical Outcomes for People Living with Diabetes in Brighton and Hove?

44. To understand the impact of the current diabetes services and pathways in Sussex, we regularly review clinical outcomes with provider colleagues for the local population. The position for Brighton and Hove is set out below showing how it is performing in relation to the other Sussex places but also nationally.

Diabetes Care Processes and Treatment Targets

45. There are a range of measures used to inform and benchmark the quality of delivery and outcomes for diabetes services. In line with National Institute of Clinical Excellence (NICE) recommendations, the National Diabetes Audit (NDA) measures eight care processes (8CP) annually delivered by diabetes care providers, with a ninth the responsibility of NHS Diabetes Eye Screening (NHS England), alongside three treatment targets (TTT), outlined in table one, which should be conducted annually for all patients with diabetes.

Nine Care Processes	Three Treatment Targets
• **Blood glucose** level measurement (HbA1c) for glucose control. • **Blood pressure** measurement for Cardiovascular risk. • **Serum Cholesterol**, a blood test for Cardiovascular risk. • **Serum Creatinine,** a blood test for Kidney function. • **Urine Albumin / Creatinine Ratio**, a urine test for risk of kidney disease. • **Weight check.** • **Smoking status.** • **Foot surveillance**, an examination for foot ulcer risk. • **Digital Retinal Eye Screening** for early detection of eye disease – delivered by screening services**.**	• **HbA1c target** (≤58 mmol/mol) reduces the risk of all diabetic complications. • **Blood Pressure target** (≤140/80) reduces the risk of cardiovascular complications and reduces the progression of eye and kidney disease. • **Cholesterol target** (<5mmol/L) reduces the risk of cardiovascular complications. Or patients aged 40-80 prescribed a statin

Table One: Diabetes Care Processes and Three Treatment Targets.

46. Completion of the 8CPs in type 1 diabetes in Sussex is presented in table two and demonstrates a year-on-year improvement in Sussex since 2020/21 when completion was at 34.1%, following the impact of COVID. The latest validated NDA data showed 47.86% completion in 2022/23. The unvalidated 2023/24 data indicates an 48.43% completion, 0.5% lower than the 2019/20 pre-pandemic baseline. The trend for year-on-year improvement in Brighton and Hove has been variable. From 2019/20 to 2022/23, it was the top area, outperforming both Sussex and England averages. Preliminary 2023/24 data suggests it may align with the Sussex average while still exceeding the England average. However, the final results are expected to improve once validated. Brighton and Hove have not yet reached its pre-pandemic baseline. This is likely due to a higher completion of care processes prior to the pandemic. Further exploration of the detail demonstrates that for those who don't achieve completion of all care process, this is driven by only one process being missed, rather than a non-completion off all the required processes.

	2019/20	2020/21	2021/22	2022/23	2023/24
Brighton & Hove	60.73%	42.29%	51.56%	50.34%	*48.97%
East Sussex	48.90%	34.50%	38.55%	43.78%	*42.73%
West Sussex	44.94%	31.03%	39.98%	49.54%	*51.82%
Sussex	48.95%	34.10%	41.54%	47.86%	*48.43%
England	42.34%	27.39%	35.16%	42.76%	*44.27%

*Table two: Completion of Care Processes in Type 1 diabetes 2019/20 – 2023/24. Source: NDA. * 2023/24 data unvalidated.*

47. Table three displays 8CP completion for people with type 2 diabetes in Sussex, showing this rose to from 53.73% in 2021/22 to 62.81% in 2022/23, outperforming the national average of 57.89%. Brighton and Hove sit below the Sussex average completing 54.18% of all care processes in 2022/23, an increase of 7% on the previous year where 47.13% were completed. Looking back to 2019/20, Brighton and Hove have seen a year-on-year improvement from the pandemic baseline, with completion broadly in line with national averages except for 2022/23.

	2019/20	2020/21	2021/22	2022/23	2023/24
Brighton & Hove	59.87%	36.03%	47.13%	54.18%	*56.28%
East Sussex	64.61%	38.74%	52.87%	61.43%	*64.33%
West Sussex	66.60%	43.17%	55.65%	65.51%	*66.46%
Sussex	65.16%	40.88%	53.73%	62.81%	*64.53%
England	58.46%	36.88%	47.91%	57.89%	*62.28%

*Table three: Completion of Care Processes in Type 2 diabetes 2019/20 – 2023/24. Source: NDA. * 2023/24 data unvalidated.*

48. Attainment of the TTT in type 1 diabetes is presented in table four and demonstrates performance in Sussex better than the national average across all years, with a year-on-year improvement seen in England and Sussex since 2019/20, with no impact of the pandemic seen in TTT attainment in 2020/21. In Brighton and Hove, 2019/20 attainment at 22.62% was higher than both the Sussex and national averages, with a year-on year improvement seen through to 2023/24 where the current unvalidated performance is comparable to the previous year.

	2019/20	2020/21	2021/22	2022/23	2023/24
Brighton & Hove	22.62%	25.43%	23.04%	25.46%	*25.69%
East Sussex	21.48%	23.03%	25.49%	25.44%	*25.72%
West Sussex	19.45%	22.24%	23.99%	26.26%	*26.99%
Sussex	20.68%	23.06%	24.29%	25.87%	*26.37%
England	19.98%	21.50%	22.44%	23.92%	*24.71%

Table four: Attainment of the Three Treatment Targets in Type 1 diabetes 2019/20 – 2023/24. Source: NDA.
** 2023/24 data unvalidated.*

49. For the attainment of the TTT in type 2 diabetes, set out in table five, Sussex has seen some improvement to 37.35% in 2022/23 compared to 33.68% in 2021/22, though falling slightly behind the national average of 37.90%. Focusing on Brighton and Hove, this achievement sits below the national and Sussex average across all years achieving a 34.75% completion in 2022/23, a 3.5% increase from 31.29% in the preceding year. A decline has been seen both nationally and within Sussex, across all three places in the unvalidated 2023/24 data. Following validation, further interrogation of this data is required to understand the reasons for this decline.

	2019/20	2020/21	2021/22	2022/23	2023/24
Brighton & Hove	36.84%	31.82%	31.29%	34.75%	*31.54%
East Sussex	37.66%	32.59%	31.63%	35.78%	*34.39%
West Sussex	38.57%	33.69%	35.42%	38.86%	*37.38%
Sussex	38.07%	33.12%	33.68%	37.35%	*35.69%
England	40.09%	35.75%	35.73%	37.90%	*36.37%

Table five: Attainment of the Three Treatment Targets in Type 2 diabetes 2019/20 – 2023/24. Source: NDA.
** 2023/24 data unvalidated.*

50. Overall, in type 1 diabetes, Brighton and Hove performs better than both Sussex and England in completion of care processes with attainment of treatment targets varying but predominately aligned with the Sussex average. In type 2 diabetes performance in relation to both care processes and treatment targets is lower than Sussex and England averages, but year-on-year improvement is recorded through validated data since 2020/21.

Impact of Diabetes Related Complications in Brighton and Hove

51. Poorly managed diabetes can lead to serious foot problems and amputations, many of which are preventable with the right care. Sussex has seen an increase in all amputations from 1.30 (per 100,000 population) in 2021/22 to 1.56 in 2023/24. An increase is also

seen when breaking down to minor (0.90 in 2021/22 up to 1.04 in 2023/24) and major (0.40 in 2021/22 up to 0.51 in 2023/24) amputations. Concentrating on Brighton and Hove, minor amputation rates, as presented in figure three, saw a decrease from 0.78 in 2021/22 to 0.63 in 2022/23. An increase up to 1.08 has been seen in the 2023/24 year, with rates in Brighton and Hove in line with the Sussex average. Prior to 2023/24 amputation rates in Brighton and Hove were lower than the Sussex average. Across the same years, major amputations as shown in figure four, have remained consistently below the Sussex average, with a notable dip in the 2022/23 year.

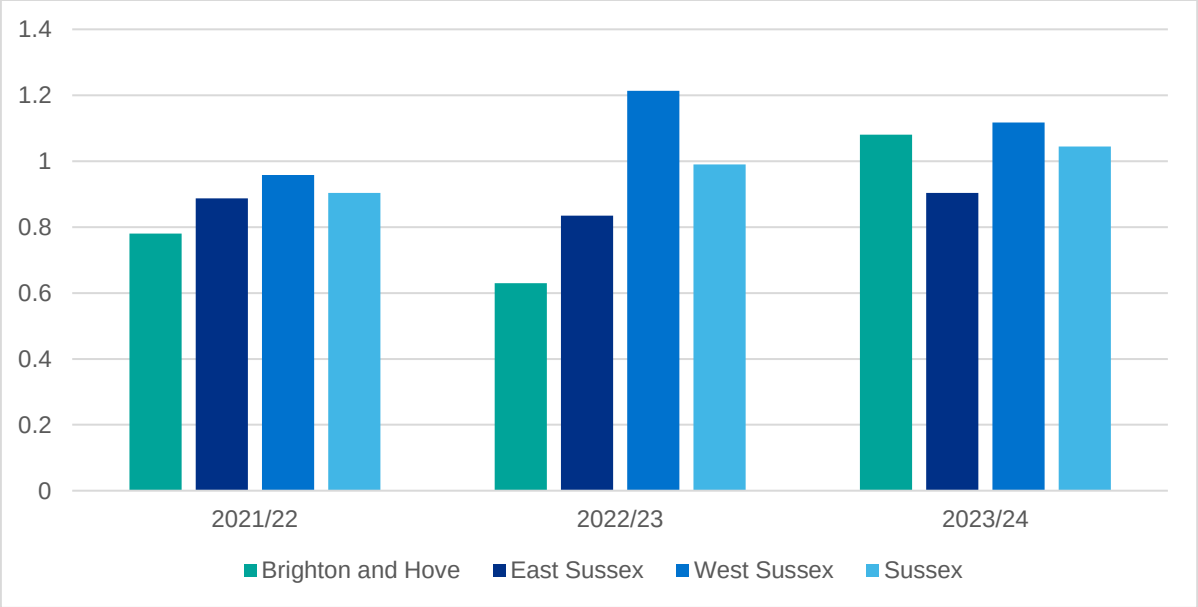


Figure three: Minor amputations in people living with diabetes by place per 100,000 population. 2021/22 – 2023/24. Source: SUS data

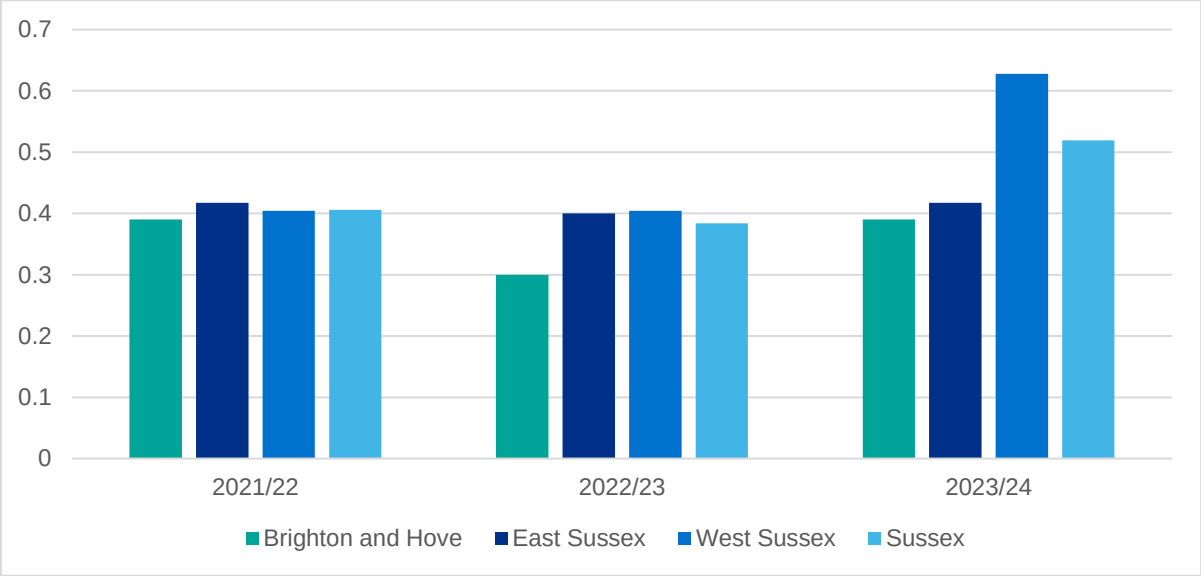


Figure four: Major amputations in people living with diabetes by place per 100,000 population. 2021/22 – 2023/24. Source: SUS data.

52. The Model Healthcare System can inform benchmarking for amputations. For non-

elective major amputations in diabetes, Sussex ICB is in the third (second worst performing) quartile with a denominator of 119 benchmarked against a system median of 104.

53. Diabetic ketoacidosis (DKA) is a life-threatening complication of diabetes and is more often seen in people living with type 1 diabetes, though can occur in people with type 2 diabetes.

54. When looking at admissions per 100,000 population by place Brighton and Hove saw a drop in admissions in 2021/22 to 23.8 per 100,000 in comparison to 29.1 the previous year (2020/21), however in 2022/23 admissions have increased back to 29.4. Across all years Brighton and Hove have a consistently lower number of admissions per 100,000 than the other Sussex places.

	2020/21	2021/22	2022/23
Brighton & Hove	29.1	23.8	29.4
East Sussex	38.3	38.9	38.4
West Sussex	38.5	31.3	32.6

Table Six: DKA admissions by place per 100,000 population. 2020/21 – 2022/23. Source: SUS data

55. DKA admissions can be benchmarked through the Model Healthcare System data platform. This is only available at a provider level, rather than place and therefore the picture is distorted through UHSx providing in-patient services for people living outside Brighton and Hove. Quarter 4 data from 2023/24 shows a national provider median of 206, with UHSx in the fourth (worst performing) quartile, and a value of 348. As a system, Sussex sits within quartile 2, the second-best performing quartile, with a value of 540, in line with a national system median of 541.

56. Primary coded diabetes admissions (Non DKA) data per 100,000 of the population presented in table seven shows admissions for all types of diabetes by place. This cannot be broken down by diabetes type. Across all years Brighton and Hove have a lower number of admissions than the other Sussex places, sitting at 45.2 per 100,000 in 2020/21, dropping to 36.5 per 100,000 in 2021/22, then increasing back up to 43.8 in 2022/23.

	2020/21	2021/22	2022/23
Brighton & Hove	45.2	36.5	43.8
East Sussex	77.3	73.7	74.8
West Sussex	139.5	118.3	85.4

Table Seven: Primary coded diabetes admissions (non-DKA) by place per 100,000 population. 2020/21 – 2022/23. Source SUS data.

57. Benchmarking for non-DKA diabetes admissions on the model healthcare system is available through a monthly metric detailing the number of non-elective admissions with hypoglycaemia. As with DKA benchmarking this is only available at a provider level, rather than place and therefore the picture is distorted through UHSx providing in-patient services for people living outside Brighton and Hove. April 2024 data shows a national provider median of 41, with UHSx showing a value of 84, placing them in the highest (worst performing) quartile. As a system, Sussex sits with a value of 152, against a national system median of 140.

58. Overall Brighton and Hove performs favourably in comparison to the rest of Sussex, and nationally, in data pertaining complications because of poorly managed diabetes. The rate of both major and minor amputations; admissions due to DKA; and admissions due to hypoglycaemia is lower in Brighton and Hove than the rest of Sussex.

Next Steps

59. Moving through this year and beyond, work in Sussex will continue to enable access to non-prescribable technology for management of type 1 diabetes. This work will be informed by, and align with the national HCL plan, with implementation ensuring there is a strategy to address any known or emerging inequities of access as roll out of HCL progresses.

60. For CGM to support around 400 people living with type 2 diabetes in Brighton and Hove, the diabetes clinical reference group alongside an NHS Sussex team are working to develop an approach that will improve access for all and especially those most disadvantaged. This is taking a phased approach, technology to the most clinically vulnerable who have their care managed by specialist services in UHSX and SCFT and then spreading this out to practices in Brighton and Hove.

61. Work to address variation in service provision will continue. As the new LCS matures, data will be reviewed to enable targeted support at practice level to further improve outcomes for the population. As Integrated Care Teams (ICTs) develop, diabetes services will form part of their core offer to their population. Diabetes prevention will also be an integral part of this offer, working in collaboration with public health and wider community services to support people living at risk of developing type 2 diabetes.

Implications

Financial Implications

62. NHS England have written to all ICB's detailing an indicative allocation for year one of HCL implementation directly linked to a 75% reimbursement scheme. Further detail is expected in September 2024, which will support financial modelling. Sussex has noted efficiencies in diabetes technology can be realised through procuring non-prescribable devices through the national HCL procurement framework and is collaborating with specialist providers to shift procurement across to this to support HCL implementation.

Legal Implications

63. Although NICE clinical guidelines are regarded as best practice in England and should be considered to facilitate shared decision-making between patients and healthcare providers, there is no legal requirement for funding. This applies to both NG17 (Type 1 diabetes in adults: diagnosis and management) and NG28 (Type 2 diabetes in adults: management).

64. The NHS is legally obliged to fund and resource medicines and treatments recommended by NICE's technology appraisals. This applies to TA943, Hybrid closed loop systems for managing blood glucose levels in type 1 diabetes.

Risks

65. Without tackling the current challenges in accessing diabetes technology there is a risk that the current position will continue and further exacerbate the known inequalities. This risk has been mitigated through:

- Aligning Sussex HCL implementation with the national plan to ensure we are aligned with peers.
- Implementing Blueteq to enable data collection of technology provision enabling targeted approach to ensure all people living with diabetes have access to the technology they are eligible for to empower them to self-manage their condition.
- Ensuring implementation of all technology in Sussex is clinically led to guarantee the most vulnerable and complex people are prioritised.
- Collaborating with all specialist providers to develop HCL implementation plans in Sussex.

Quality and Safety Implications

66. A Quality Impact Assessment (QIA) has been undertaken looking at access to all non-prescribable diabetes technology in Sussex. The QIA recognises diabetes technology as having a positive impact on patient safety acknowledging the positive impact on diabetes outcomes and a potential reduction of preventable risk and harm. The QIA recognises the need to develop agreed governance processes to support delivery of diabetes technology, and the importance of ensuring training and competencies to guarantee development of a skilled workforce to deliver diabetes technologies. The assessment was carried out in 2022 and is due an update in Q3 of 2024/25.

67. From a clinical effectiveness, patient safety, and patient experience perspective the outcomes of implementing CGM in management of type 2 diabetes include improved glycaemic control, reduced mental burden, and positive clinical results. Patients experience better blood glucose management, and an enhanced quality of life.

Equality, diversity, and health inequalities

68. A national Equality Health Impact Assessment (EHIA) is expected as part of the HCL work programme, but in the interim a Sussex EHIA has been undertaken. Refinements to the Sussex Diabetes EHIA will also be made when data emerges from NDA submissions to ensure the current inequalities are reflected within the assessment.

69. For CGM to support people living with type 2 diabetes the current EHIA has also been updated.

Patient and public engagement:

70. Engagement networks are in place for the Diabetes Clinical Network to approach to understand the patient and public lens on this work. Diabetes UK are on the membership of the diabetes programme board and the clinical reference group and can advocate for the diabetes population at these forums. Working in collaboration with VCSE who engage with both the service user and public supports the programme with outputs used to refine the approach.

Conclusion

71. As an outcome of the scrutiny committee investigation, DUK has requested policies in place to enable access to technology for all people living with diabetes living in Brighton and Hove.

72. Brighton and Hove are fully compliant with NICE guidance for type 1 diabetes, with a high baseline position for the implementation of HCL technology.

73. There remains further work in relation to expanding technology access for the 400 people with type 2 diabetes in Brighton and Hove and this is part of a wider review for transforming our care for people with diabetes, the recent implementation of the new single LCS in primary care being the first step.

74. We recognise there is further opportunity for continuous improvement of outcomes for people living with diabetes in Brighton and Hove. There is commitment to continue to transform diabetes care for our population through collaboration with key stakeholders and ensuring that high quality diabetes care, including a focus on prevention, becomes a key offer within our emergent Integrated Community Teams.

Glossary

CGM	**Continuous Glucose Monitoring** Systems that monitor blood glucose. These devices are worn continuously on the body and provide a glucose reading to a smart phone or reader.
CP	**Care Processes** Care processes recommended bu NICE and recorded in the NDA that should be completed for all people living with diabetes annually.
CSII	**Continuous Subcutaneous Insulin Infusion (pumps)** A pump that provides a steady stream of insulin to the body, with the person needing to test blood sugar levels, adjusting administration rate of the pump, and delivering boluses as needed.
DKA	**Diabetic ketoacidosis** A life-threatening complication of diabetes, usually seen in people living with type 1 diabetes
HCL	**Hybrid Closed Loop (Systems)** A system that comprises of a CGM device, and a CSII pump linked to a computer algorithm that can adjust the amount of insulin needed based on glucose readings.
NDA	**National Diabetes Audit.** A major national clinical audit, which measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards.
NG	**Nice Guidance** NICE guidance is developed with health care professionals and people who use services to help with decision making on prescribing and recommended treatment.
TA	**Technology Appraisal** Technology Appraisals are based on a review of clinical evidence and cost effectiveness, with a statutory responsibility for the NHS to make funding available for a recommended drug or treatment with a TA, normally within three months (unless otherwise specified)
TTT	**Three Treatment Targets** Targets for the three main risk factors for diabetes complications, attainment of which is recorded annually for all people living with diabetes.

Diabetes technology in sussex

DIABETES UK
KNOW DIABETES. FIGHT DIABETES.

Vicki White, Healthcare Engagement and Systems Change Manager

Proposed outcome

It is important that all people living with type 2 diabetes who meet NICE guidelines for CGM receive this important technology in a timely manner. Progress on CGM implementation is very slow in Sussex and we want to see a clear timeline for implementation for all eligible patients. We are also particularly interested in understanding how Sussex ICB are defining the most vulnerable patients.

DIABETES UK
KNOW DIABETES. FIGHT DIABETES.

Implications for People Living With Diabetes

1. Diabetes technologies have significant impacts on people's lives: improving their well-being, preventing devastating complications and enabling them to work and socialise.
2. CGM has been shown to be cost effective:
   - Better self-management to reduce risk of complications which take up bulk of diabetes spending in NHS
   - Has been shown to reduce hospitalisations for hypos (cost of hospitalisation for a severe hypo is estimated at £2,600 each time)
   - Reduces costs for test strips/lancets (estimated saving on this equipment of £650 per person per year)
3. Current inequality of care: people with type 2 diabetes who are on insulin and have similar needs to people with type 1 diabetes, don't currently have access and are being treated differently. This will create a two-tier system for people living with diabetes
4. Sussex ICB has a remit to tackle inequalities, and failure to act will result in an increase in inequalities

DIABETES UK
KNOW DIABETES. FIGHT DIABETES.

Mick's story

"Having this tech would allow me and encourage me to check my sugars more often….. I just need that little help."

"I feel that I'm being punished for trying my best to control this condition for many years. No matter how hard I try I still have hypos which can leave me feeling unwell and affect my ability to work."

DiABETES UK
KNOW DIABETES. FIGHT DIABETES.

Closing remarks

- There is strong evidence to demonstrate that CGM is both clinically and cost-effective in helping people live well with diabetes
- We are pleased to hear that Sussex ICB have approved CGM for those eligible people living with type 2 diabetes, starting with the most clinically vulnerable
- We would like a clear timeline, as soon as possible, of when the guidance is to be implemented and how the most vulnerable people are being defined

- **We are happy to support every step of the way.**

DiABETES UK
KNOW DIABETES. FIGHT DIABETES.

Thank you

DIABETES UK
KNOW DIABETES. FIGHT DIABETES.

University Hospitals Sussex
NHS Foundation Trust

Health Overview Scrutiny Committee
Maternity update

November 2024

Background

- In September 2021, our maternity services were inspected by the CQC:
  - St Richard's, Princess Royal and Worthing – **Requires Improvement**
  - Royal Sussex County – **Inadequate**

- Maternity Safety Support Programme (MSSP) support commenced in February 2022
- Informal CQC visit April 2022 showed improvements being made
- No further formal inspection of maternity since September 2021

- All CQC actions completed:
  - Training compliance
  - Governance improvements and equipment checking
  - Datix improvements
  - Workforce funding improvements
  - Estate work to improve triage facilities at PRH – funded and planned for September

Maternity Safety Support Programme (MSSP)

- Entered programme February 2022.
- Maternity Improvement Plan monitored under bi-monthly executive led Maternity. Improvement Group attended by Trust, system and regulatory stakeholders.
- Review and Reset meeting by MSSP and regional and national stakeholders on 30th May - **"demonstrable improvements from ward to board noted by all stakeholders".**
- Trajectory to move to Sustainability phase by November 2024 with a view to programme exit early next year.

Exit Criteria and CNST

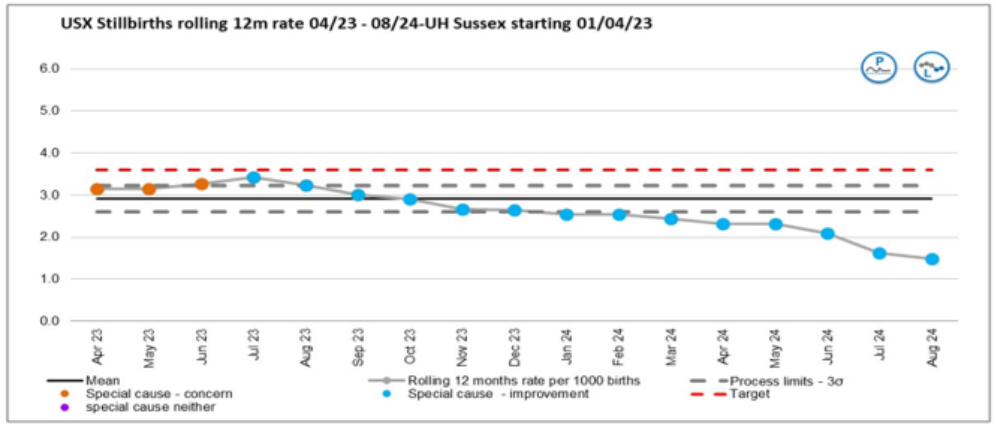
Criteria	Actions required	Estimated completion
Permanent midwifery leadership structure	Clinical Operating Model (COM) finalisation then recruitment	Q4 2024/25
Developed Perinatal leadership structure	Clinical Operating Model (COM) finalisation then recruitment	Q3-4 2024/25
Consultant job planning re leadership and governance	Clinical Operating Model (COM) finalisation then recruitment	Q3 2024/25
Maternity Governance Framework	Finalisation and ratification	Q3 2024/25
Access to separate theatre for elective caesareans on Brighton site with a view to relocation on other sites.	Successful pilot completed – negotiations with surgery underway	Q4 2024/25
Developed maternity strategy	Discussion with Chief Strategy Officer	Q4 2024/25
Cross site maternity audit plan and guideline group	Central guideline group in place, audit plan in development	Q3 2024/25

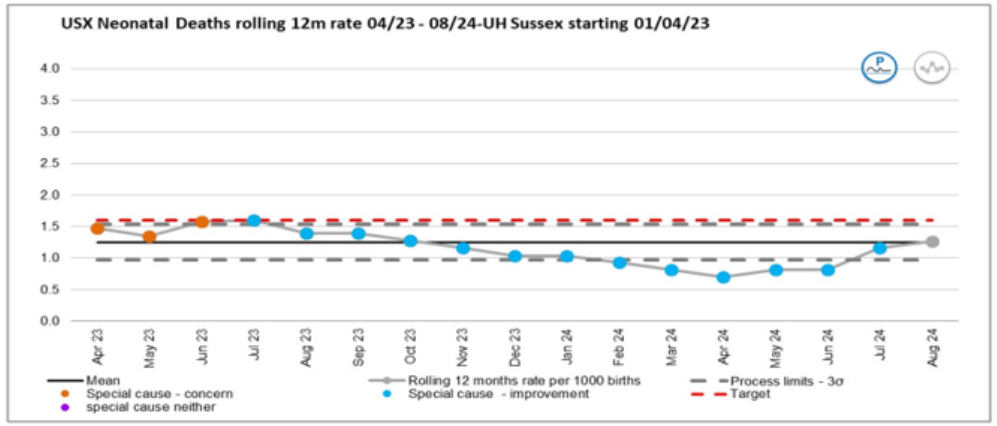
NHS Resolution

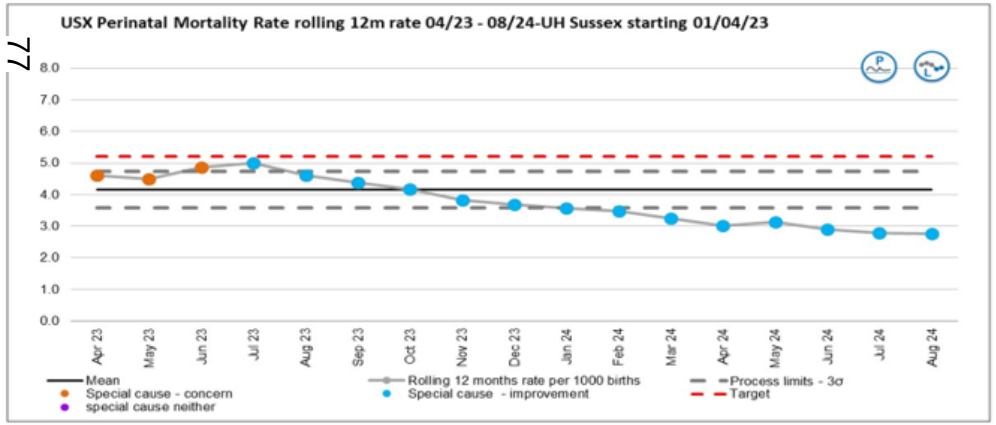
University Hospitals Sussex maternity service met the full requirements of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme year 5 (2023/24) and is on track to be fully compliant with the year 6 requirements (submission due Feb 2025).

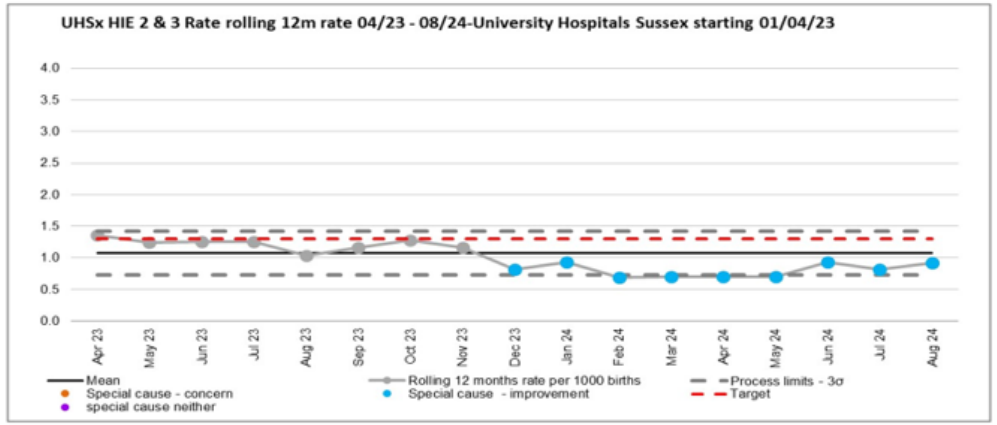
What our data is showing us - outcomes

University Hospitals Sussex NHS Foundation Trust









Any loss during pregnancy is a tragedy for the family.
Sadly, pregnancy loss will never be completely preventable, however, we are determined to continue to reduce cases involving avoidable harm.
The Trust is proposing a programme of Restorative Justice work with bereaved families.

- These charts demonstrate a statistically significant reduction in both perinatal mortality rates (stillbirths and neonatal deaths combined) and Hypoxic Ischemic Encephalopathy (brain injury) rates.
- Both measures are well below national benchmark rates for equivalent service configurations.
- Quality improvements within the Saving Babies Lives care bundle v3 have contributed to this. The service achieved 100% implementation of the bundle requirements in June 2024.
- Maternal death rates are also below national rates (national - 0.28/ 1000 – UHSx 0.12/1000).

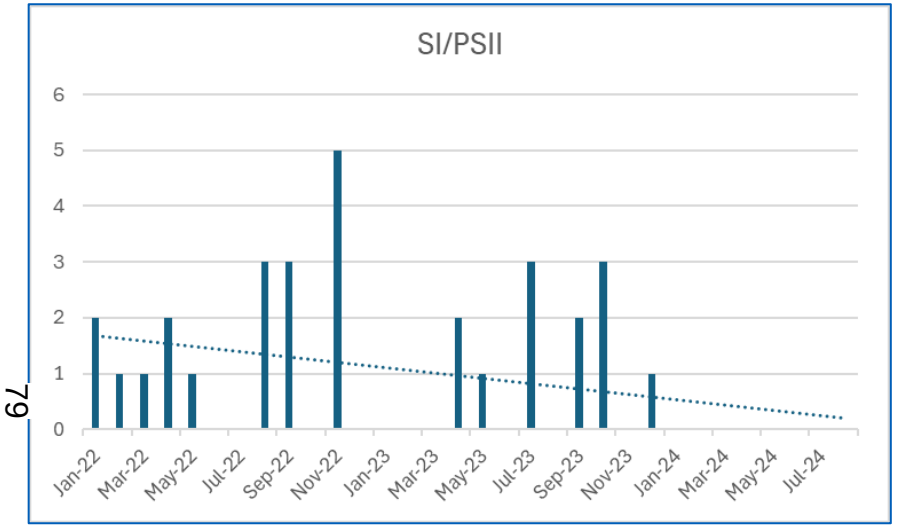
Outcomes - Brighton

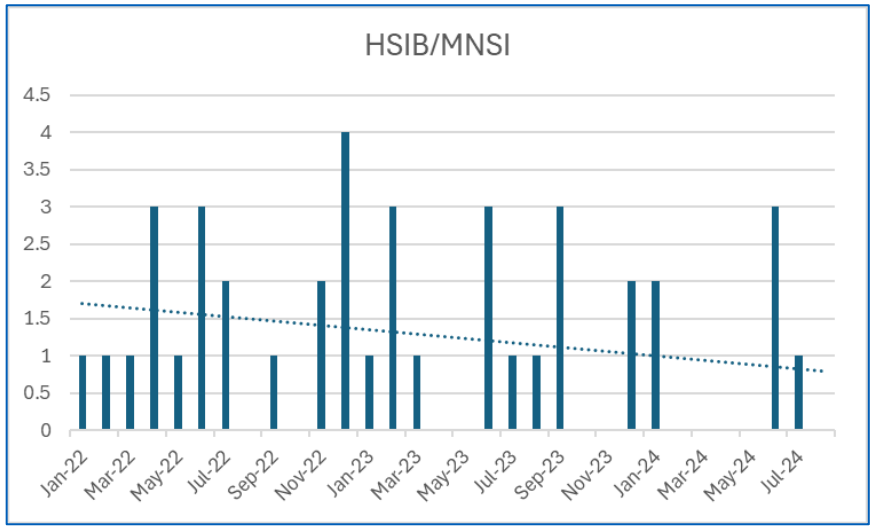
These charts demonstrate statistically significant special cause improvement in all measures. Orange markers demonstrate special cause concern in stillbirth rates earlier this year, triggering a review of cases where no themes were identified.

What our data is showing us - incidents

University Hospitals Sussex NHS Foundation Trust

Trust Wide





- Numbers of serious incidents (SI) now known as Patient Safety Incident Investigations (PSII) have reduced.
- The governance process for the assessment of grading of incidents and therefore, the type of investigation required is more robust supported by the central Patient Safety team.
- Referrals to the Maternity and Neonatal Safety Investigations (MNSI) team (previously HSIB), have also reduced.
- MNSI referrals have very specific triggers.
- Robust process of learning from incidents and complaints in place.
- Collaborative system sharing and learning processes in place.

Brighton only

There have been no PSII's in Brighton this calendar year to date.
There has been one case which has met criteria for referral to the MNSI team.

The Trust is exploring the provision of a restorative programme led by expert facilitators with lived experience of baby loss. This will be offered to families locally.

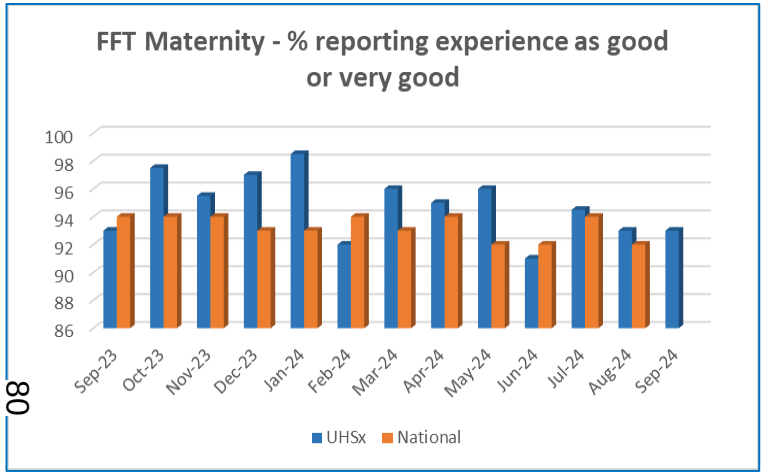
What our service users say

Service user feedback themes are triangulated quarterly, and quality improvements actioned

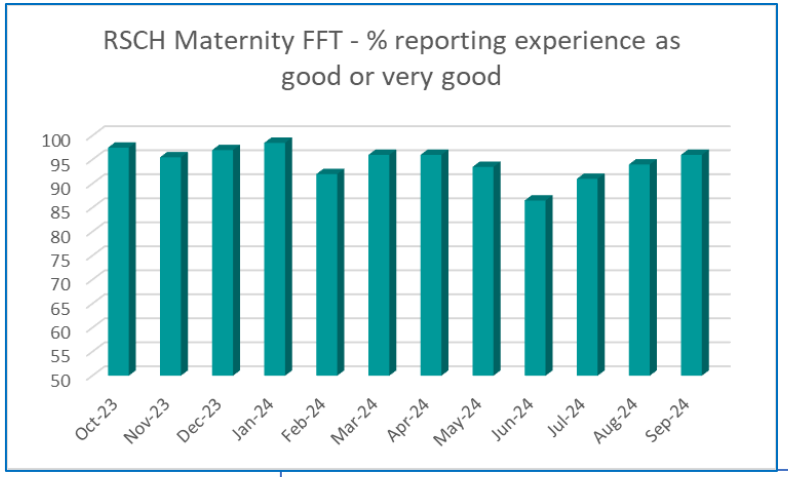
University Hospitals Sussex NHS Foundation Trust

Friends and Family Test

Trust wide vs national



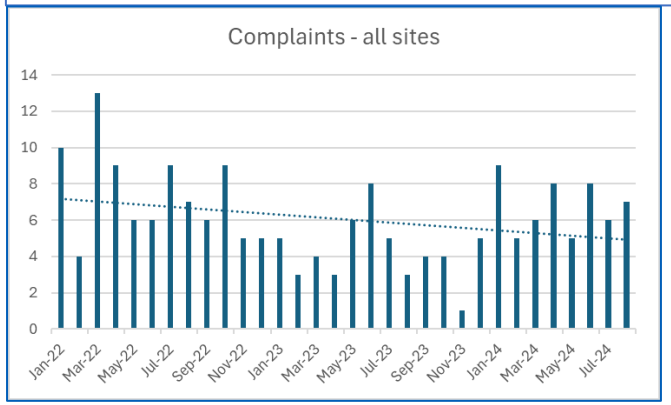
Brighton only

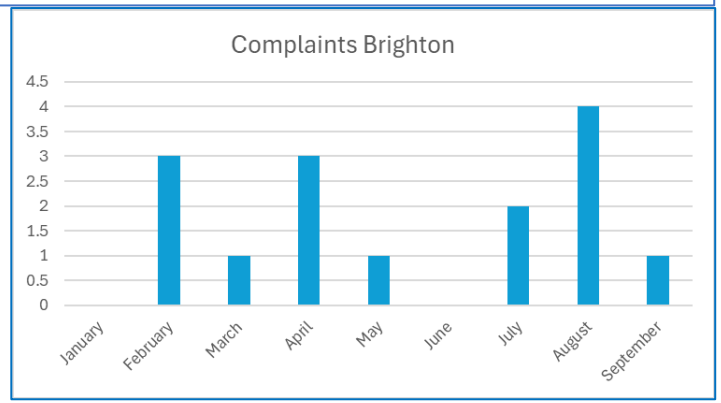


FFT summary – the Trust maternity service 'good' or 'very good' ratings exceed national rates the majority of the time. Workforce issues over the summer have been mentioned in narrative feedback via FFT.

We have an excellent working relationship with the Maternity and Neonatal Voices Partnership service user group.
Significant amounts of 'above and beyond' feedback for named staff members is received from service users via their survey and other contacts.
We have a robust process or communication with service leads to address any concerns raised directly to the MNVP.

Our formal complaint numbers have reduced since 2022, although we are reviewing and monitoring a recent increase, possibly impacted by workforce issues and media attention. We have a process of immediate contact by a senior midwife when a complaint is received to ensure support of the family and discussion of concerns.

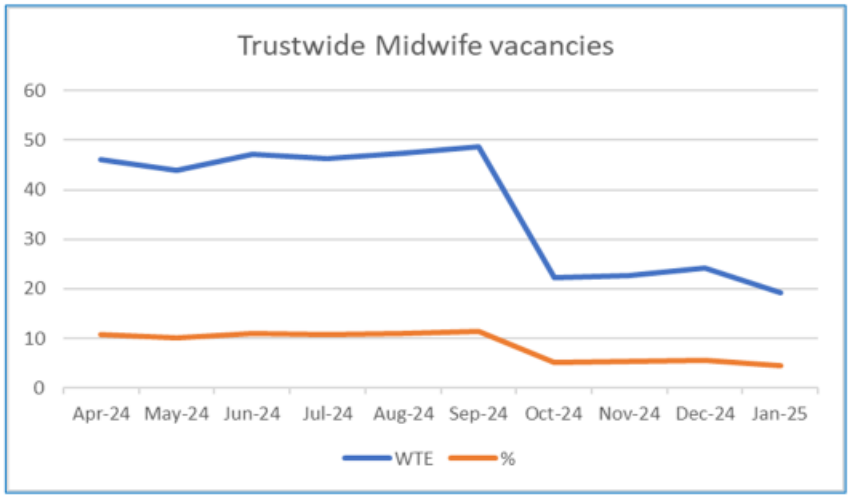




Supporting our teams

- Monthly maternity safety forum chaired by Board Maternity safety Champion
- Monthly listening events by director of midwifery
- Monthly site-specific listening events with heads of midwifery
- Bespoke listening events as needed
- Monthly update video messages
- Divisional and maternity newsletters and improved communications
- Dedicated Microsoft Teams communication channel
- Staff social media communication groups
- Perinatal Culture Event held in June (85 attendees from MDT) – feedback positive, further improvement actions planned
- ImproveWell app implemented in June – 15% uptake so far (aim 35% at 6 months) with 41 improvement ideas submitted

Vacancy in some of our teams continues to be one of our greatest issues and has been a priority to find a permanent and sustainable solution. Various issues impact our vacancy, such as national shortages and cost of living locally, however, the vacancy has reduced from 22% in March 2022 to <5% by January 2025.



Brighton & Hove City Council

Scrutiny Report Template

Health Overview & Scrutiny Committee

Agenda Item 22

Subject: **Sussex Winter Plan 2024-25**

Date of meeting: **20 November 2024**

Report of: **Chair of the Health Overview & Scrutiny Committee**

Contact Officer: **Name: Giles Rossington, Policy, Partnerships & Scrutiny Team Manager**
Email: giles.rossington@brighton-hove.gov.uk

Ward(s) affected: (All Wards);

Key Decision: No

For general release

1. Purpose of the report and policy context

1.1 Integrated Care Systems (e.g. the Sussex Integrated Care Partnership) are required to produce annual winter plans. Winter plans aim to ensure that the local health and care system effectively manages additional demand across the winter months.

1.2 The Sussex winter plan is currently being developed. The strategic approach underpinning the plan is being presented to the Health Overview & Scrutiny Committee (HOSC) for information and comment (see Appendix 1). A follow-up report will come to the HOSC in spring/summer 2025 to update the committee on actual system performance over the winter period and on lessons learnt.

2. Recommendations

2.1 Health Overview & Scrutiny Committee notes and comments on the contents of this report.

3. Context and background information

3.1 The overall purpose of the Sussex-wide winter plan is to ensure that the system is able to effectively manage the capacity and demand pressures

anticipated during the winter period to meet the needs of the local population. The winter planning period covers the period November 2024 to April 2025. The plan should ensure that the local systems remain resilient and are able to manage demand surge effectively, maintain patient safety, and support delivery of the relevant business plan objectives and locally agreed system improvements during this period.

3.2 Health and care systems typically experience increased demand pressures during the winter months due to a number of factors including:

- Seasonal illnesses (e.g. flu, norovirus)
- Covid 19
- Extreme weather (e.g. falls in icy conditions)
- Exacerbation of respiratory illnesses and a range of long-term conditions due to cooler weather
- Ongoing impact from the cost-of-living crisis affecting the most vulnerable in the local population to keep well

3.3 Health and care systems have been planning systemically for winter surge pressures for a number of years, and typically a key part of this process is assessing how well the previous year's plans met demand, and using learning from this to inform the subsequent year's planning.

3.4 The definitive Sussex winter plan has not yet been agreed, and is in any case a detailed document which addresses a wide range of operational matters rather than a strategic plan. Appendix 1 outlines a high-level approach to winter planning agreed by system partners.

4. Analysis and consideration of alternative options

4.1 Not applicable to this report for information.

5. Community engagement and consultation

5.1 None undertaken for this information report.

6. Financial implications

6.1 Any additional costs resulting from the Sussex-Wide Winter Plan will need to be met from within identified resources across NHS Sussex and the Council.

6.2 Winter pressures cause significant financial strain across Health & Social Care. Current budget forecasting accounts for anticipated increased demand over this period. However, budget forecasts may be subject to variation later in the year due to the unpredictable nature of the impact on services during the winter.

Finance Officer consulted: Jamiu Ibraheem Date: 13/11/2024

7. Legal implications

7.1 The Council's Health Overview & Scrutiny Committee has delegated to it the statutory responsibility of reviewing and scrutinising matters relating to the planning, provision and operation of health services in Brighton & Hove.

7.2 While the Winter Plan appended to this Report is a high level strategic plan as opposed to a proposal to make specific changes to existing healthcare provision, it nonetheless has potential to impact on the lives of the people of Brighton & Hove. As a result, this Committee is invited to consider the appendix and if it wishes to make comment on the matters reported on.

Name of lawyer consulted: Victoria Simpson Date consulted 11/11/24

8. Equalities implications

8.1 The aims of effective collaborative winter plan arrangements are to ensure that local health and care systems are able to continue to deliver the services that have been developed to meet the needs of the local population. Cold weather disproportionately affects our most vulnerable residents and the Sussex Wide Winter Plan seeks to ensure that resources are targeted to support those at greatest risk. Specific services will be further developed to support delivery of the Plan during the winter period and equality impact assessments will be undertaken to support the development of those specific services.

9. Sustainability implications

9.1 The Sussex-Wide winter plan considers how best to use NHS and local authority resources across Sussex in order to cope with seasonal demand surges for health and care services. Any negative carbon impacts of these plans (e.g. through people potentially having to travel further from home to access services where local capacity is stretched) need to be considered. However this needs to be balanced against the risks to individuals of not being able to access appropriate health or care.

10. Health and Wellbeing Implications:

10.1 Health and wellbeing implications are addressed in Appendix 1.

11. Conclusion

11.1 Members are asked to note information provided by the Sussex Integrated Care Board on Sussex health and care system planning for winter 2024/25.

Supporting Documentation

1. Appendices

1. Information provided by Sussex Integrated Care Board on system winter planning 2024-25.

Brighton & Hove County Council Health Overview and Scrutiny Committee (HOSC)

Sussex System Winter Plan 2024/25
November 2024

1. Introduction

1.1 This report provides a summary of the approach to the Sussex System Winter Plan that spans the period from November 2024 to March 2025. The report highlights the Sussex wide and Brighton and Hove specific approaches and aims to provide information to the Brighton & Hove City Council HOSC that the health and social care needs of the local population will be met over the winter period. The final Winter Plan will be considered by the NHS Sussex Integrated Care Board on 27 November 2024 and once agreed, further detail can be provided to the HOSC.

1.2 The Sussex System Winter Plan is a whole system health and social care plan, recognising the interdependencies of the system to meet the needs of the local population. It is an annual national planning requirement and provides assurance that the system and partners have the necessary measures in place to deliver health and care for the local population.

1.3 We know there has been continued increased demand across primary, secondary, community and mental health services. Over the winter months this can become increasingly challenging as there are seasonally driven increases in illness such as acute respiratory illness, flu, Covid, and norovirus, together with the impact of cold weather and the ongoing impact from the cost-of-living crisis which constrains the ability of the most vulnerable in our population to keep themselves well.

1.4 The key focus of the plan is action to support people to stay well and to maintain patient safety and experience. We will focus on five key areas as part of this:

1. Prevention and case finding to support people to stay well and to target additional support to our most vulnerable populations to prevent hospital admission where possible
2. Same day urgent care to help maximise access to urgent help for local people, reducing the need for people to attend Emergency Departments
3. Improvements in discharge to support patient flow to help people to get home from hospital in a timely way and to ensure good access to inpatient beds when people need them

4. Sound operational management to ensure we have robust mechanisms in place with clear coordination across the system and rapid routes for escalation where required
5. Oversight, governance and escalation to ensure we have the right oversight in place.

1.5 Our plans are underpinned by a series of principles designed to ensure that a focus on quality and safety in maintained. These are:

- Maintaining the quality and safety of services is the primary objective of all system partners
- System partners will work together to ensure timely access to services for the entire population, supported by a clinical risk-based focus at times of surge in demand
- We will prioritise the most vulnerable and at risk
- System resources will be targeted in the areas where we will get greatest impact or in the areas of greatest need
- We will protect the wellbeing of our workforce
- System partners will work together to balance clinical risk
- Our clinical leaders will be at the heart of decision making throughout the winter period.

2. Sussex system approach to developing our Winter Plan

2.1 The Sussex system approach to developing our Winter Plan was driven by two key influences.

National requirements

2.2 Every year NHS England issue guidance to local systems setting out key priorities. This includes a planning and financial framework and focuses on:

- Providing safe care over winter, including a focus on access to urgent and emergency care with the further development of same day emergency care; the development of access hubs, and the further development of virtual wards.
- Supporting people to stay well, including the national flu immunisation programme; the COVID-19 autumn/winter vaccination programme for eligible groups; and the Respiratory Syncytial Virus (RSV) Vaccine
- Maintaining patient safety and experience.

2.3 In addition to this, NHS England has indicated specific requirements for all trusts and provider organisations. These relate to:

- reviewing general and acute core and escalation bed capacity plans
- reviewing and testing full capacity plans.

- ensuring the fundamental standards of care are in place in all settings at all times:
- ensuring appropriate senior clinical decision-makers are able to make decisions in live time to manage flow.
- ensuring plans are in place to maximise patient flow throughout the hospital, 7 days per week.

Sussex requirements

2.4 In addition to the national requirements, the Sussex system considers what specific priorities or areas of focus are required to best meet the needs of the local population, based on locally observed demand and capacity, and the governance arrangements required to ensure all parts of the system work together to best mitigate the risks for the entire population.

2.5 We bring together actions and intelligence at neighbourhood, place and system level, and prioritise the areas of focus so we can respond effectively together. We also undertake a learning exercise after winter every year to ensure that the system follows a cycle of continuous improvement. We therefore build on learning from previous years to improve our framework for system oversight with a focus on the key actions all system partners are taking to deliver continued access to safe services.

2.6 Together with our key priority areas of focus, we have the following four areas of work that underpin these:

- Demand and Capacity modelling
- Principles designed to ensure that we maintain a focus on quality and safety
- Clinical risk monitoring and escalation processes
- Clinical Leadership.

3. Key Areas of Focus

Prevention and Case finding

3.1 The key aim is to support our population to stay well and ensure we have proactive care in place for those most at risk.

3.2 Our vaccination programme is central to this in protecting the Sussex population and we are working with partners to optimise the take up of this within eligible populations.

3.3 For the Covid vaccination we are working with across Sussex with network of providers which include 24 local Primary Care Networks (PCN), 107 Community Pharmacies and 3 General Practice Federations to develop and deliver our programme. In Sussex there are 609,706 people eligible for the Covid Booster, as of 7th November 2024, 279,340 doses have been administered. In Brighton and Hove 78,752 people are eligible for a Covid Booster, as of 7 November 2024, 31,127 doses have been administered.

3.4 As with previous campaigns we will be working alongside our local public health colleagues, engagement teams and local providers to deliver our targeted access and inequalities programme.

3.4 Flu Vaccination: Sussex has a total eligible cohort of 1,009,239 people. Between 1 September 2024 and 7 November 2024, 457,049 vaccinations have been administered. In Brighton and Hove there are 144,836 eligible people and as of 7 November 2024, 37,102 vaccines have been administered. Flu vaccinations are delivered across a range of providers organisations and settings, including general practice.

3.6 Respiratory Syncytial Virus (RSV) Vaccinations: In August it was announced that the NHS would be rolling out a new vaccination for RSV for all adults turning 75 after 1st September 2024, women who are 28 weeks pregnant or more, and a catch-up programme for adults between 75-79 years. Sussex has a total eligible population of 75-79 years old of 93,612 and in Brighton and Hove the eligible population is 9,498. To date, 27.4% of older adults (25,615 have been vaccinated) in Sussex, including 2,573 in Brighton and Hove. Communication promotions are underway, with news stories being shared, films with clinicians, targeted social media and work through community and voluntary groups to share the message.

3.7 ***Case finding*** is the Sussex system proactive approach to identifying those patients most at risk of needing non-elective care or urgent and emergency care over the winter months. We want to better support these people and will focus on:

- Identifying at risk individuals and ensuring a proactive care approach is taken to minimise the risk of a deterioration in their health
- Optimising VCSE support, and reprofiling existing resource to focus on at risk patients
- Ensuring that there are clear alternatives to acute admission and should their health deteriorate.
- Ensuring that we have a clear 7-day support offer for care home in order to reduce the risk of admission for vulnerable residents.

3.7 This is supported by General Practice who are best placed to identify those in most need who can be supported by a multi-disciplinary teams' approach linked to wider voluntary and community sector support offers.

3.8 In Brighton and Hove there are services designed to support this proactive approach including a multi-disciplinary team frail elderly pilot in the West and East Health Hub that covers the East and Central parts of the city.

Same Day Urgent Care

3.9 The approach to improving same day urgent care for the winter period focuses on four key areas to: improving access to same day non-urgent care services; improve flow in the Emergency Departments; improve access to community physical and mental health services; and ensure people are supported by our services out of hospital where possible and appropriate.

3.10 To respond to this we are focusing on:

- Optimising our existing services such as Urgent Treatment Centres to make sure people are seen in a timely way that responds to need
- Increasing capacity in the system by increasing how we use virtual wards to support people and increasing the use of pharmacy services
- Navigating people to the right service and implementing our unscheduled care hubs which will support the utilisation of alternatives to hospital and reduce conveyances to hospital by the ambulance service.

Improving discharge from hospital

3.11 Our aim is to reduce the number of patients in acute, community and mental health beds who are ready to be discharged home or to their onward setting of care. This improves patient outcomes and experience as well as supporting system flow. We have a system wide discharge improvement programme to focus on rapidly reducing the numbers of people waiting for discharge and freeing up bed capacity to support patient flow over the winter months.

3.12 The four workstreams that will support this are:

- Implementation of the SAFER patient flow bundle
- Support to patients to stay active whilst in hospital to minimise any deterioration in their health and well-being

- Optimisation of the Transfer of Care Hubs which are multi-disciplinary hubs focused on getting the right support in place to enable timely discharge
- Development of a needs-based demand and capacity model to help us get the right type of support in place to respond to people's needs.

3.13 In Brighton and Hove specific work includes an increase in bariatric short-term reablement beds; and increase in workforce capacity for the same day discharge team; increased pathway 2 beds to support people in community settings; increased Homecare packages of care hours; increased Social Worker capacity; and increased discharge workforce at University Hospitals Sussex NHS Foundation Trust and Sussex Community Foundation NHS Trust.

4. Workforce and Wellbeing

4.1 As in previous years, maintaining the capacity and resilience of our workforce will be key to the delivery of safe and high-quality services and is an important part of our plan.

4.2 A range of targeted action is in place to help us: manage our temporary workforce; improve our staff wellbeing; increase uptake of vaccinations amongst staff; manage our staff absences; maximise opportunities to share staff; work with our voluntary and community sector; and minimise the risk of the cost of living on staff. This will be regularly monitored throughout the period.

5. Clinical Leadership

5.1 We will ensure effective clinical leadership throughout winter, and we will focus on key metrics that help us understand how the system is performing and any action we may need to take to continue to ensure safe and effective access to care.

6. Public Communication

6.1 A coordinated system wide communications and engagement plan has been developed with system partners to ensure clear communications are in place to support operational delivery over the winter period. This includes global approaches to key messages for the public, partners, and staff, as well as targeted and focused approaches based on data and insight.

6.2 The plan will bring together activity over the Winter period, covering Flu and Covid19 vaccinations, preventative advice and support to key audience groups

such as respiratory advice for children and young people and urgent and emergency care pathway information.

6.3 Our communications plans will focus on addressing health inequalities, and insight will shape communications activity and ensure that work considers the whole population.

7. Sound Operational Management and Governance and Oversight

7.1 Our objective is to ensure that the Sussex system has robust operational management in place with clear coordination across the system and rapid routes for escalation where required.

7.2 The following systems and processes are in place to support this objective:

System Co-ordination Centre (SCC)
a dedicated operational team who provides support interventions across the ICS on key systemic issues that influence patient flow.
Winter Standard Operating Model
seven days a week capability to monitor and respond to operational pressures in the system.
ICB Rapid improvement approach
a multi-disciplinary team that can respond in an agile way to emerging pressures.
Protect the delivery of elective care, cancer and diagnostic services
system capacity will be prioritised for the effective operational management of elective care throughout winter.

7.3 We have clear governance for overseeing delivery of the winter plan, with clear routes to escalation where needed. This includes clear roles and responsibilities; clear reporting; implementation of national escalation frameworks; and clear underpinning policies in place.

8. Individual organisational plans

8.1 Underpinning the overarching Sussex system winter plan, each of our provider Trusts have developed their own winter plans and have contributed to the system wide demand and capacity modelling.

8.2 These ensure a specific focus on ensuring the right capacity is in place, the right processes are in place to support timey care and good patient flow, the use of all

extra capacity and schemes in place are maximised and robust infection prevention and control measures are maintained.

8.3 Local authorities play a role in many of the initiatives that are developed to support winter and as in previous years, our approach to planning has been in collaboration across all organisations Sussex wide, and with a focus on each place, including Brighton and Hove. In addition to work focusing directly on supporting the plan, work is underway to consider any further action that could be taken to support people living in or at risk of deprivation.

9. Conclusion

9.1 The approach to the Winter Plan will enable us to focus on the action we need to take to maximise support for people this winter focusing on particular initiatives that will help keep people well; avoid unnecessary hospital admission; and ensure access to safe services for local people. The plan will be submitted to the NHS Sussex Integrated Care Board on 27 November 2024 and will be closely monitored over the winter as part of a whole system approach.

Brighton & Hove City Council

Scrutiny Report Template

Health Overview & Scrutiny Committee

Agenda Item 23

Subject: **Colorectal Cancer Surgery Potential Service Change**

Date of meeting: **20 November 2024**

Report of: **Chair of the Health Overview & Scrutiny Committee**

Contact Officer: **Name: Giles Rossington, Policy, Partnerships & Scrutiny Team Manager**

Email: giles.rossington@brighton-hove.gov.uk

Ward(s) affected: (All Wards);

Key Decision: No

For general release

1. Purpose of the report and policy context

1.1 This report provides information about plans by University Hospitals Sussex NHS Foundation Trust (UHSx) to make changes to the provision of elective colorectal cancer surgery across their Sussex hospital sites. More details of the planned changes are included as Appendix 1 to this report.

1.2 When planning to make significant changes to services, NHS organisations are required to inform local Health Overview & Scrutiny Committees (HOSCs). Should a HOSC consider that the plans constitute a Substantial Variation in Service (SViS) with the potential to have a negative impact on health services for local residents, it may wish to explore the change plans in greater detail.

2. Recommendations

2.1 Health Overview & Scrutiny Committee notes the information provided by University Hospitals Sussex NHS Foundation Trust on plans to create a centre for excellence for colorectal cancer surgery in Worthing. (Appendix 1); and if

2.2 Health Overview & Scrutiny determines whether it considers the change to be a Substantial Variation in Services (SViS) requiring further scrutiny.

3. Context and background information

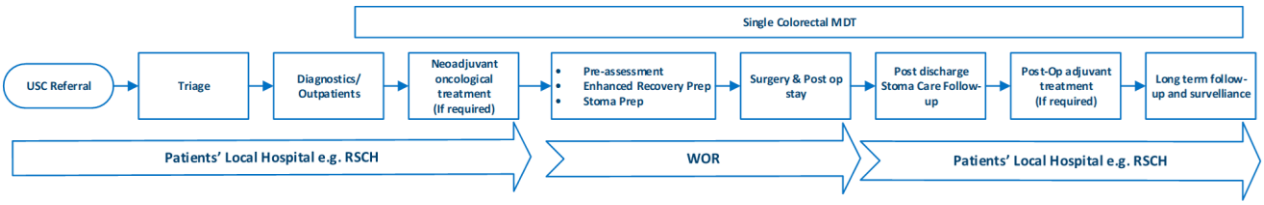
3.1 Colorectal (bowel, colon or rectum) cancer is a relatively common form of cancer. Treatment is varied, but in some circumstances may include surgery.

3.2 University Hospitals Sussex NHS Foundation Trust (UHSx) manages seven hospitals: Royal Sussex County (RSCH), Royal Alexandra Children's (RACH) and Sussex Eye Hospitals (SEH) in Brighton, Princess Royal Hospital in Hayward's Heath, Worthing General Hospital, St Richard's Hospital in Chichester and Southlands Hospital in Shoreham.

3.3 Currently, elective colorectal cancer surgery is delivered at the RSCH in Brighton, as well as Worthing and Chichester. However, UHSx plans to concentrate all elective colorectal cancer surgery at centres of excellence at Worthing and St Richard's. Patients from Brighton and Hove would be offered surgery at Worthing.

3.4 All emergency general surgery will continue to be delivered on the RSCH site, as well as elective benign (non-cancer) colorectal and lower GI surgery.

3.5 For RSCH patients, everything except the surgery would continue to be provided at their local hospital in Brighton. Referral triage, diagnostic services, outpatient services and oncology treatments for people with suspected and confirmed colorectal cancers will continue to be delivered locally, as well as long term ongoing surveillance and follow-up.



3.6 The aim is to improve patient care, experience and outcomes by providing more timely access to elective colorectal cancer surgery, reducing length of stay in hospital for these patients after surgery, reducing time to receive stoma reversal surgery (where appropriate) and to improve their overall experience.

Due to the number of available operating theatres at RSCH and rising demand for this type of surgery, the current service provided at RSCH is less than optimal.

- Although the quality of surgical care is good, RSCH is a very busy hospital dealing with lots of emergency surgery. This can negatively affect the number of operating theatres, ward beds and surgical teams available for elective (non-emergency) surgery, leading to a relatively high rate of on-the-day and late notice cancellations.

6.1.1. Moving elective colorectal surgical activity to Worthing, a hospital which is quieter in terms of emergency demands for surgical capacity,

would lead to fewer cancellations, better patient experiences and timelier access to surgery.

3.7 The transfer of elective colorectal cancer surgical activity would impact a relatively small number of patients, but to this cohort it would offer significant improvements (as above). On average, this would affect seven patients a week; five new colorectal cancer patients and two returning for temporary stoma-bag reversal procedures.

- To meet this increased elective colorectal cancer surgical volume on the Worthing site, additional theatre capacity will be funded and opened.
- A new ward will provide the necessary beds on the Worthing site.
- This increased capacity will help reduce late notice cancellations due to capacity issues, improving patient experience.

3.8 Under this model, surgeons would conduct higher numbers of this type of surgery. There is typically a positive correlation between the volume of procedures undertaken by surgical teams and better clinical outcomes. Therefore, it is anticipated that concentrating surgical expertise into a single specialised team at Worthing and St Richard's would improve quality of provision.

- National guidance for colorectal cancer encourages a minimum of 10 – 20 procedures per surgeon per year.
- Moving to this model, with colorectal cancer specialist surgeons focusing on this type of surgery, would mean each surgeon will be delivering between 30 – 35 procedures per year.
- There are also recruitment benefits for specialist centres with high levels of activity

3.9 However, the planned changes would mean that elective colorectal cancer surgery for Brighton & Hove residents would no longer be delivered within the city. Although there are good private and public transport links to Worthing, there would be some additional travel for some patients, and their families and carers, and there will be some people who will struggle with this, either because of their frailty or for cost reasons. Colorectal cancers are most commonly diagnosed in older people, with the highest rates of new diagnoses in people aged 85-89. Older patients are likely to have older family and carers and are the group most likely to be reliant on public transport.

3.10 This potential area of concern was discussed at the last Patient Focus Group held in September, where it was highlighted that the Trust has a robust Transport Policy which offers patient transport support. The accessibility of this policy will be reviewed as part of implementation, as well as ensuring patients are clearly and consistently signposted to the policy throughout their pathway.

3.11 The Carers Association also noted the Healthcare Travel Costs Scheme may benefit some patients.

3.12 By relocating this surgical activity to Worthing, it is anticipated that length of stay in hospital will be halved, due to investment in the existing service's Enhanced Recovery Model and more timely access to surgery. And so, in turn, halving the time relatives / carers would need to travel.

3.13 Or, if the patient themselves are the carer, reduced length of stay and speedier recovery, will reduce the burden of needing to be away from those they care for by halving the time they are in hospital.

4. Analysis and consideration of alternative options

4.1 Members are asked to consider whether they consider this change plan to be a Substantial Variation in Service (SViS) requiring further consultation with the HOSC. If members do have outstanding concerns about the plans, they can request further meetings with UHSx or can make recommendations to the Trust.

5. Community engagement and consultation

5.1 None directly to this report. Members may be interested in UHSx's plans in regard to stakeholder or public engagement on this service change.

5.2 To inform the decision-making process, UHSussex has developed a staged patient engagement plan to provide an opportunity for feedback from patients, carers and patient representatives.

Stage 1 – in August 2024 all patients that underwent colorectal cancer surgery at RSCH in the last year were contacted via text and given the opportunity to respond to a survey on the potential surgery move.

- Both quantitative and qualitative responses were sought and 47 of 122 patients responded to the survey giving comprehensive feedback.
- Overall patient feedback was positive to the move if it brought the anticipated benefits.
- 90% felt reducing length of stay was very important
- 95% felt reducing time to surgery was important.

Stage 2 – in September an engagement workshop was set up with invitees from Healthwatch, Carers Association, ICB, Trust Governors, EDI team, patients and Charities to provide feedback on the proposal and to discuss options to mitigate concerns. Trust participants included the Director of Patient Experience and Engagement, Chief of Surgery and Trust Programme Director.

Stage 3 – A further Patient Focus Group is currently being organised in January 2025 to provide an update on the plans and involve stakeholders in a workshop to revise patient information leaflets and the accessibility process for the Trust's Patient Transport Policy.

6. Financial implications

6.1

Name of finance officer consulted: Date consulted (dd/mm/yy):

7. Legal implications

7.1

Name of lawyer consulted: Date consulted (dd/mm/yy):

8. Equalities implications

8.1 Bowel cancer rates are higher in older people, with more than 90% of new cases diagnosed in people over 50, and more than 40% of new cases diagnosed in people over 75. Rates are highest in white ethnic groups and lower in black or Asian groups and in people of multiple or mixed ethnicity. There is evidence of a link to deprivation in the incidence of bowel cancer in men, but no clear evidence for women.

8.2 See Appendix 2 at the end of this document for the Trust's full EIA (Equality Impact Assessment)

8.3 Relocating colorectal cancer from the RSCH site to the Worthing site will affect the travel footprint for some patient journeys if they live to the East of Brighton. To understand the potential impact, analysis of the residential addresses for patients diagnosed with these types of cancers over thew past 12 months took place to understand the geographical range of this snapshot of patients.

- The findings from the analysis demonstrates that up to 63% could have been impacted to varying distances by the proposal to relocate colorectal cancer surgery from RSCH to Worthing.
- However, it should be noted that not all diagnosed patients are treated by surgery, and so only a percentage of this group would be impacted.
- It is also noted that on sharing this review with the NHS Sussex Integrated Care Board (ICB), the ICB consider only 45.5% of patients will have to travel further as they consider those living north of Brighton are minimally or not impacted.

Short postcode addresses	Number of patients living in postcode	Percentage of in postcode (%)
BN10	18	5.98
BN2	48	15.95
BN25	4	1.33
BN6	12	3.99
BN7	14	4.65
BN8	14	4.65
BN9	11	3.65
CR3	1	0.33
HS1	1	0.33
NG11	1	0.33
RH15	21	6.98
RH16	15	4.98
RH17	11	3.65
RH18	1	0.33
RH19	2	0.66
TN22	13	4.32
TN33	1	0.33
TN38	1	0.33
TN40	1	0.33

Total	**190**	**63.12**

There are three typical road routes from Brighton to Worthing. The distances are:

- A27 – 16.1 miles
- A23 & A27 – 14.8 miles
- A259 – 11.6 miles

The connection between Brighton and Worthing is very well served by both bus and train services. Parking at Worthing Hospital is more plentiful and easier to navigate than that in Brighton, with similar terms and conditions for users.

To counter any potentially negative impact for some patients, the preferred option delivers significant benefits to the wellbeing of patients. Patients would benefit from:

- Significant reduction in short notice surgery cancellations
- Reduction in length of stay in hospital for colorectal cancer surgery from an average of 13 days in Brighton to an average of 6.7 days in Worthing due to enhanced recovery model employed in Worthing
- Reduction in length of stay for stoma reversals by an average of two days from 7.6 days to 5.6 days.
- More timely stoma reversals – average 6 months for Worthing patients compared to 12-18 months at RSCH

9. Sustainability implications

9.1 The plan to concentrate colorectal cancer surgery across the two sites, with patients who would have previously received their surgery on the Brighton site, now receiving it in Worthing, is likely to result in longer journeys for Brighton & Hove patients and their families and carers. However, there are relatively low numbers of journeys involved and the impact is not significant.

10. Health and Wellbeing implications:

10.1 The planned changes aim to improve outcomes for colorectal cancer surgery in Sussex, particularly in terms of reducing the relatively high level of cancelled operations currently experienced by services based at RSCH, providing timelier access to surgery and reducing length of stay. In addition to this timelier access to stoma reversals would be offered. All patients would benefit from the enhanced recovery model in place at ST Richard's Worthing which directly impacts the length of stay, recovery and rehabilitation time.

11. Conclusion

11.1 The committee is asked to note plans to develop a UHSx centre of excellence for elective colorectal cancer surgery which would concentrate the expertise across two sites, and improve care, experience and outcomes for this small patient group as described above. The Trust's Chief Medical Officer, Professor Katie Urch, and Chief Executive Officer Dr Goerge Findlay are both available to the committee to answer any questions you may have.

Supporting Documentation

Appendices

1. **Appendix 1** Supporting slide deck with information on the plans to create the centre of excellence for elective colorectal cancer surgery provided by University Hospitals Sussex NHS Foundation Trust

2. **Appendix 2** Equalities Impact Statement

University Hospitals Sussex
NHS Foundation Trust

Proposed change to Colorectal Cancer Surgery pathway

Appendix 1 - HOSC Supporting Information Slide Deck

Professor Katie Urch | Chief Medical Officer

November 2024

Introduction

University Hospitals Sussex NHS Foundation Trust

- University Hospitals Sussex is one of the largest NHS Trusts and we have a large waiting list for patients
- Colorectal & Lower GI is a specialty with growing demand and a long waiting list to receive treatment
- Current demand for colorectal cancer surgery at RSCH significantly outstrips the available capacity
- RSCH is also a busy hospital dealing with large numbers of emergency surgeries
  - Elective Colorectal Cancer demand increases by approximately 5% a year – a national trend
  - Elective Colorectal non-Cancer surgery waiting list grew by 11%, comparing June 2024 with June 2023
- Conflicting emergency surgery demands, growing elective surgery demand and constrained capacity, means Colorectal & Lower GI is not able to meet its cancer or non-cancer elective activity demands.

Need for Change

University Hospitals Sussex NHS Foundation Trust

Currently, patients at RSCH can experience a sub-optimal service due to lack of capacity.

For example, we have:

- Far higher number of short notice cancellations than desirable
- Increased waiting times for treatment
- Growing patient waiting lists for colorectal cancer surgery

Between July 2023 – July 2024, there were 87 Colorectal & Lower GI surgery cancellations.
93% of these cancellations were made due to capacity issues

- This is stressful for patients, delays treatment and provides a poorer patient experience

Waiting longer for surgery may:

- Increase poorliness (acuity)
- Require increasingly complex procedures
- Extend recovery times
- Increase length of stay in hospital
- Increased risk of harm

Colorectal / Lower GI service at RSCH

University Hospitals Sussex NHS Foundation Trust

- Colorectal surgery describes a number of surgeries that fix problems in the lower gut. This can include organs such as the bowel, colon, rectum, and anus.
- Colorectal or Lower Gastro-Intestinal (GI) cancer is also called colon or bowel cancer
- Around 5,500 patients are referred to RSCH on the Urgent Suspected Cancer pathway for colorectal/lower GI each year – and around 200 patients will need surgery for colorectal/lower GI cancer
- Around 100 patients would return to have a temporary stoma bag reversal procedure
- **This means our proposed change in the pathway for elective colorectal cancer surgery would affect an average of seven patients a week**; five new colorectal cancer patients and two stoma reversals

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Our Proposal

University Hospitals Sussex NHS Foundation Trust

- We are proposing to relocate all Elective Colorectal & Lower GI Cancer Surgery and Stoma Reversal Surgery from RSCH to the Worthing site, creating a centre of excellence for Colorectal Cancer Surgery delivered across at Worthing and St Richard's hospitals

- Our proposal includes investment in new theatre and bed capacity and associated surgeon, anaesthetic, nursing, therapies and other workforce requirements to meet the additional demand in Worthing.

- We would increase the number of consultant surgeons, and they would also perform on-call emergency cover in Brighton which would also help address other known challenges.

- The proposal would deliver a specialised team of colorectal elective cancer surgeons consistently performing more than 30 surgeries per year, exceeding the minimum threshold recommended by national guidance and leading to anticipated clinical outcomes.

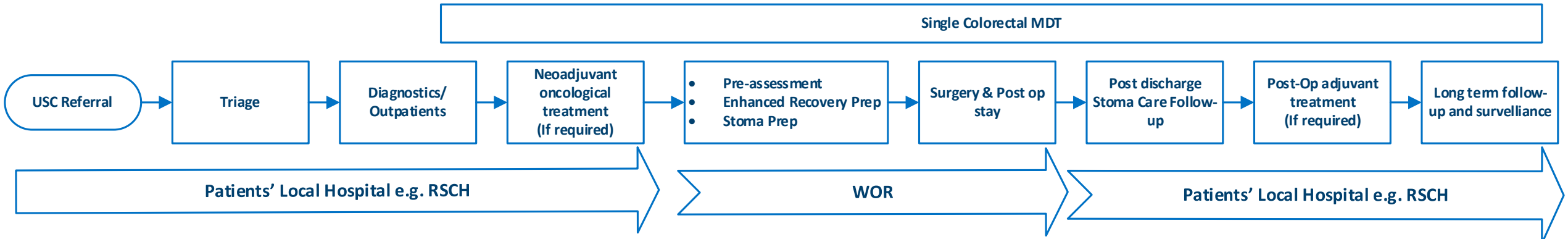
Proposed pathway

Patients will continue to receive the majority of their care at RSCH, or their local hospital. This includes:

- Diagnostic element of their pathway
- All pre or post-operative Oncology treatment
- Ongoing long-term surveillance and follow-up

<u>Patients would only go to Worthing for their surgery treatment</u>

- The new standardised pathway would encompass the best elements of current pathways, such as the enhanced recovery model used in Worthing, as well as other national best practice opportunities.
- The standardised pathway would strive to minimise the impact on patients caused by moving surgery away from a patient's “local” site.



Benefits

Benefit	Current State	Future State
Release of capacity on RSCH site	Lack of capacity leading to late cancellations of surgery	4 theatre sessions per week 4.4 beds per day
Reduction in length of stay for RSCH patients due to timelier access to surgery and Enhanced Recovery Model at Worthing	Current length of stay at RSCH above average	Length of stay reduced to meet national standards
Reduction in length of stay for the RSCH stoma reversal patients	Current length of stay at RSCH above average	Length of stay reduced to meet national standards
More timely reversal of temporary stomas (where medically appropriate)	Current RSCH wait average – 12-18 months	Significantly reduced wait time – improving outcomes for patients
Improved patient experience from reduced cancellations, reduced length of stay and timelier access to Stoma reversals	Cancellations are highly stressful and can increase risk of harm	Better experience with a new service designed to meet demand with capacity
Increased Level 1 bed capacity on Clapham Ward, to reduce impact on Critical Care	Colorectal cancer uses RSCH Intensive Therapies Unit (ITU) capacity	Proposal would minimise use of critical care in Worthing due to timelier access to surgery and enhanced recovery model

Patient and Carers Engagement

A full case for change highlighting patient benefits has been provided to NHS Sussex Integrated Care Board (ICB).

The Equality impact Assessment / Due Regard document is Appendix 2 in the Cover Report in committee papers.

To inform the decision-making process, we have developed a staged patient engagement plan to provide an opportunity for feedback from patients, carers and their representatives.

Stage 1 – In August 2024, all patients that underwent colorectal cancer surgery at RSCH in the last year were contacted via text and given the opportunity to respond to a survey on the potential surgery move. Both quantitative and qualitative responses were sought.

Stage 2 – In September, a Patient Focus Group was set up with invitees from Healthwatch, Carers Association, ICB, Trust Governors, EDI, patients and charities to provide feedback on the proposal and to discuss options to mitigate concerns. Trust participants included the Director of Patient Experience and Engagement, Chief of Surgery and Trust Programme Director.

Stage 3 – A further patient engagement workshop is currently being organised to update stakeholders on the proposal and hold a workshop on how best to improving patient information leaflets and accessibility of the Trust Patient Transport Policy.

Almost 40% of patients (47 patients out of 122) that had colorectal cancer surgery in Brighton last year responded to the survey.

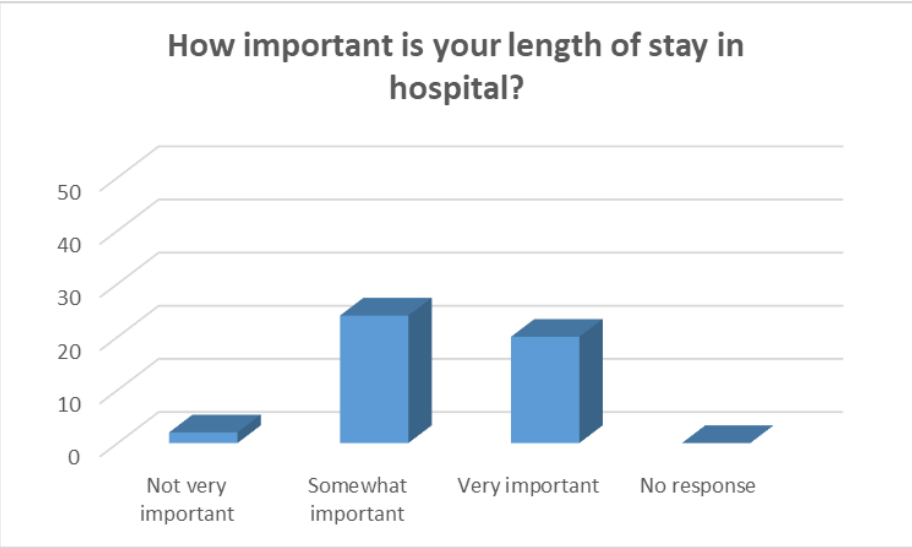
Overall, feedback was positive to the move if it brought the anticipated benefits.

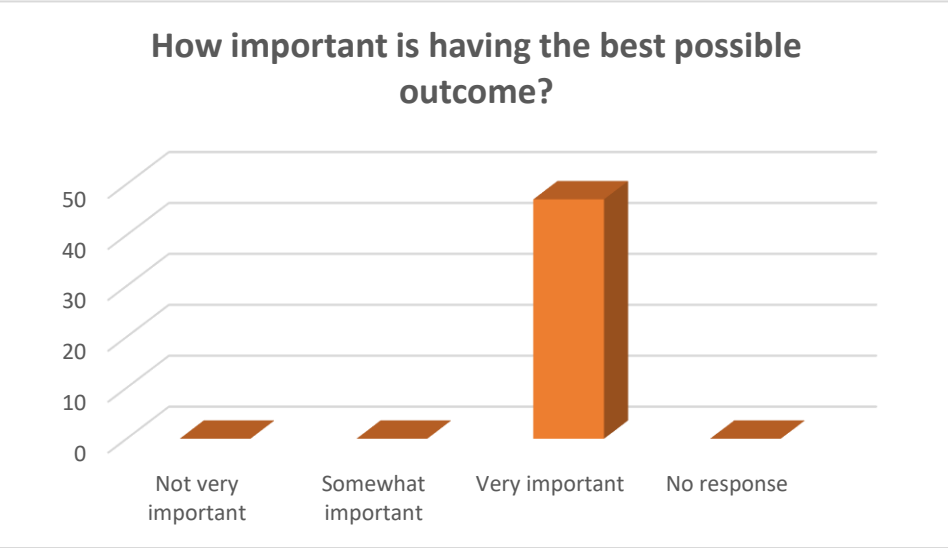
The most important criteria for patients were:

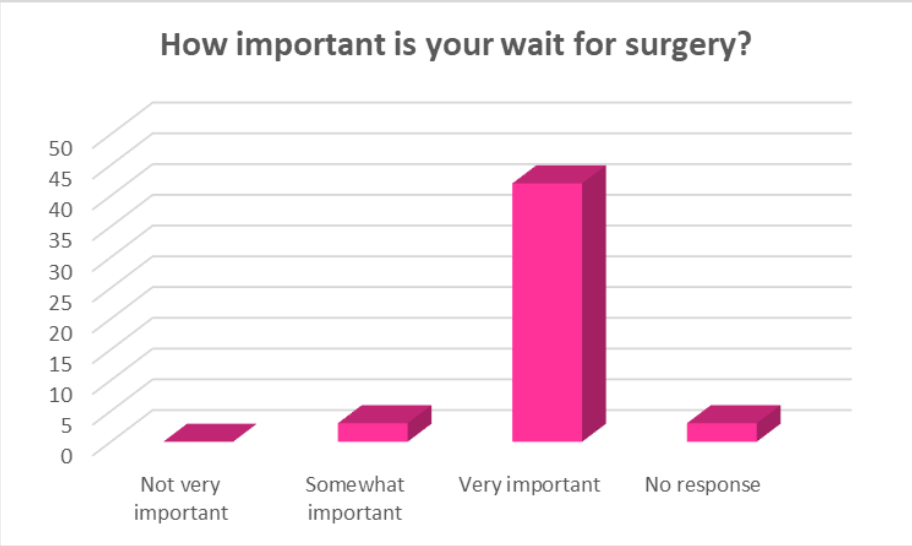
- Length of time to surgery
- Outcomes from surgery

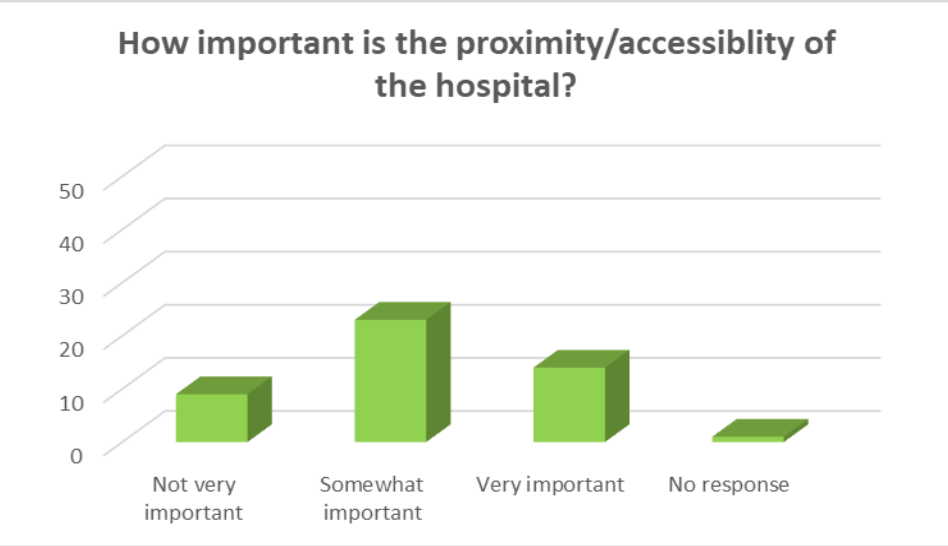
'I think the worst thing would be going into your day of surgery and it being cancelled, so if there's more a chance the surgery will go ahead at a different location then this is really important' **Patient feedback**

Patient views









Patient feedback

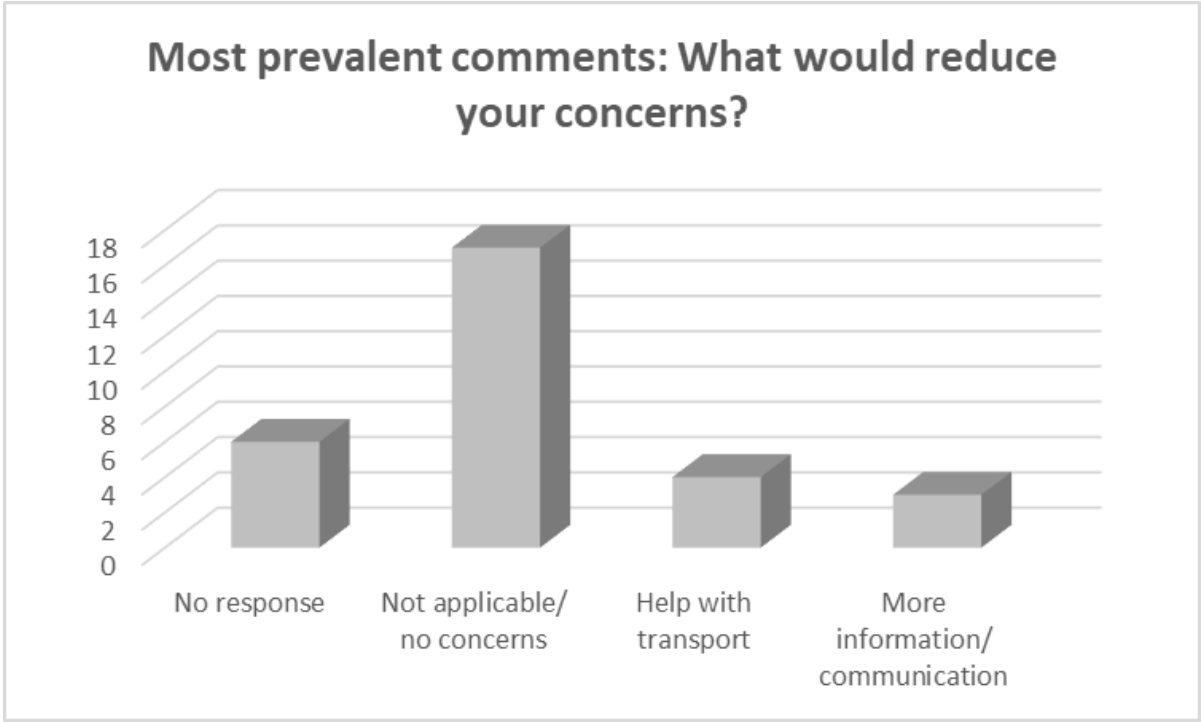
I myself had my Colorectal surgery cancelled on the day at Brighton due to capacity issues. It was extremely stressful as I was very concerned about delays to my treatment.

Lives are at stake when cancer surgery is cancelled or delayed. Anything that can reduce this risk should be considered

A new unit in the existing hospital would be much more accessible

I would be happy to attend a hospital out of area if this meant my reversal surgery could happen quicker.

I agree with the strategy that provides centres of excellence as a priority over geographical distances.



How have we responded to feedback?

Communication

- A new patient information leaflet will be developed to help with communication.
- This will be reviewed by a lay panel and available printed and online.

Understanding impact on different patient groups

- A full equality impact assessment was undertaken.
- Patients at higher risk of colorectal cancer, or stoma management, would be better supported by the enhanced recovery model

Transport

- Reviewed the research base to understand who might be disadvantaged, including protected characteristics
- Identified that reduced length of stay would benefit patients who are carers, and those who care for them
- Reviewed Transport Policy and information – identified access issues, including for patients with language or neurodiversity barriers – so will develop a brochure for patients to receive at their appointment. This would also be available online, with language conversion tools.
- Patient transport is available for patients whose medical and other needs mean that this is necessary.

In Summary …

University Hospitals Sussex NHS Foundation Trust

- Our proposal is to relocate all Elective Colorectal & Lower GI cancer surgery and Stoma Reversal Surgery from RSCH to Worthing Hospital, creating a high-volume centre of excellence for Colorectal Cancer Surgery

- This proposal would impact a small number of patients (approximately seven patients a week), but these patient the benefits would be significant and include:
  - Timelier access to surgery
  - Fewer late cancellations of surgery
  - Surgery at specialist centre
  - Reduced length of stay in hospital
  - Enhanced Recovery Model
  - Improved patient experience and outcomes
  - Care at local hospital, except for surgery

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Appendix 2

EIA/ Due Regard Assessment Tool

To be completed and attached to any policy when submitted to the appropriate committee for consideration and approval.

Proposed Colorectal Cancer Surgery Relocation from Royal Sussex County Hospital to Worthing General Hospital

		Yes/No	Comments
1.	**Does the document/guidance affect one group less or more favourably than another on the basis of:**		
	• Age	Yes	94% of new bowel cancer cases are identified in patients over 50 years of age. Older patients are therefore disproportionally affected. However the proposed change will improve treatment by reducing cancellations, reducing LoS and providing earlier stoma reversals. These will positively impact over 50s as reduced stays will reduce deconditioning and earlier stoma reversals will assist rehabilitation
	• Disability	Yes	All patients impacted by the move will have cancer and therefore will be considered as disabled. Moving the location of surgery will improve the access to treatment which will serve all patients better. Access to patient transport assistance policy will serve to mitigate challenges rising from the relocation. Reduction in surgery cancellations will reduce impact on carers as well as patients as they won't need to change their plans at short notice. In addition to being less stressful on patients, reduced cancellations will improve the situation for family.
	• Gender (Sex)	No	1 in 17 men and 1 in 20 women are diagnosed and therefore there is little difference in impact between sexes
	• Gender Identity	Yes	In the USA, data shows that Colon cancer screening (CRC) rates are lower in transgender (TGD) people compared to cis-gender people. Studies have identified several barriers to screening. TGD people experience discrimination such as unemployment, lack of education, access to health care, housing insecurity. This impacts patients at the diagnosis stage as they are less likely to come forward for screening.

			It is reasonable to assume that this disparity may also exist in the UK and that patients may present later with more complex cancer. The colorectal cancer service relocation is focused on the patients post diagnosis. Once diagnosed we would expect the impact of gender identity to be reduced as they would have come forward for treatment. The Trust's trans gender guidelines will be followed as for all patients. The Trust has two policies that address transgender patients that are applied consistently across all hospitals: *Privacy, dignity and respect policy*, and *Policy for the provision of same sex accommodation*.
	• Marriage and civil partnership	No	
	• Pregnancy and maternity	Incredibly rare but possibly	A case every 5 years might occur therefore this is so rare that this should not impact the service move consideration
	• Race (ethnicity, nationality, colour)	Probably	There is documented evidence in the US that race and socioeconomic status has a negative impact on colorectal cancer outcomes. Patients present later with more complex cancer. The data is US focused, complex and is impacted by patients having inadequate healthcare insurance that is different to the UK. That said cancer research UK highlights that rates of bowel cancer are lower in Asian and black ethnic groups. The colorectal cancer service relocation is focused on the patients post diagnosis. Once diagnosed we would expect the impact of race to be reduced. However, the impact of travelling slightly further may impact more frequently those in a lower socioeconomic cohort. This can be lessened through access to the Patient transport provisions, as these patients would most likely be eligible for assistance.
	• Religion or Belief	yes	There is research that suggests prevalence of colorectal cancer in some religions is lower than the wider population. However, religious and cultural differences may affect how a patient feels about having a stoma. For some people, these beliefs can make it harder to adjust to life with a stoma. This can be mitigated through post-surgery individual care from stoma nurses and therefore concerns can be mitigated.
	• Sexual orientation, including lesbian, gay and bisexual people	Yes	Colorectal cancer disproportionately affects the LGBTQ+ community for a number of reasons, including fear of discrimination and other lifestyle factors. The colorectal cancer service relocation is focused on the patients post diagnosis. Once diagnosed we

			would expect the disparity of impact for the LGBTQ+ community to be reduced.
2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**	Yes	Overcoming Racial and Ethnic Disparities in Rectal Cancer Treatment | Colorectal Cancer | JAMA Network Open | JAMA Network Racial and Ethnic Disparities in Colorectal Cancer Incidence and Mortality - PMC (nih.gov) Services | The Rose Thompson Foundation (rosetf.org.uk) Bowel cancer statistics | Cancer Research UK Let's talk about...LGBTQ+ in cancer research - Cancer Research UK Manchester Centre Cancer Risks for Gay and Bisexual Men - Health Encyclopedia - University of Rochester Medical Center Having a stoma | Bowel cancer | Cancer Research UK Religious beliefs, practices, and health in colorectal cancer patients in Saudi Arabia - Shaheen Al Ahwal - 2016 - Psycho-Oncology - Wiley Online Library
3.	**If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?**	Yes	The objective of the relocation of colorectal cancer surgery is to improve outcomes for patients. The clinical benefits would be significant -Cancellations, especially multiple cancellations would be reduced, minimising the likelihood of harm being caused. -Length of stay would be nearly halved through the enhanced recovery model delivered at Worthing -Length of Stay for stoma reversals reduced by 37% -Access to stoma reversals would be in line with national guidelines at 6 months (where appropriate). Currently they are delivered in a 12-18 month timeline. The enhanced recovery model that is offered to patients at Worthing drives the earlier discharges. This is a model that results in earlier planning for discharge and interventions during the hospital stay.

			This will be especially beneficial to patients with protected characteristics. Pre-surgery consultations and post-surgery follow up is planned to be offered at the home hospital, so primary impact would be on patient during the period of receiving surgery
4.	**Is the impact of the document likely to be negative?**	No	Some patients will experience a longer journey to and from the hospital that will perform surgery. This should be a single extended journey distance. Visting families and friends could also experience this longer travel distance, but it would be for a shorter time as length of stay will be reduced. If the patient is also a carer, then the significantly reduced length of stay has the opportunity to reduce the impact if the surgery.
5.	**If so, can the impact be avoided?**	Mitigated	All patients will have access to the Trusts' patient transport offering. Not all patients are aware of the offering and therefore at the point that patients are offered surgery the patient transport offering could be proactively communicated. It is the recommendation of the Trust's EDI team that clear details of the patient transport policy be made available in the documentation issued to these patients about their surgery.
6.	**What alternative is there to achieving the intent of the document without the impact?**	None	There is very little opportunity for an alternative approach. There is a current demand for 141 sessions in general theatres compared to a maximum capacity of 120 sessions. This does not factor in any growth. Due to these theatre capacity constraints at the county site and emergency surgery taking priority over elective there is little opportunity to reduce cancellations for this cohort of patients without the service move. Building additional theatres is not a short-term possibility and would be extremely challenging on the Brighton campus, therefore moving surgery for some specialties off the RSCH site is the most effective way to address this constraint.
7.	**Can we reduce the impact by taking different action and, if not, what, if any, are the reasons why the policy should continue in its current form?**	Yes	See above
8.	**Has the document been assessed to ensure service users, staff and other stakeholders are treated in line with Human Rights FREDA**	Yes	This document has been reviewed and discussed with the Trust's EDI team. Recommendations from the team have been incorporated into the EHIA.

	principles (fairness, respect, equality, dignity and autonomy)?		

If you have identified a potential discriminatory impact of this policy, please refer it to the Trust's EDI lead, together with any suggestions as to the action required to avoid/reduce this impact. For advice in respect of answering the above questions, please contact **uhsussex.equality@nhs.net (01273 664685).**

NHS
University Hospitals Sussex
NHS Foundation Trust

Sent via email to:
[redacted]

Worthing Hospital
Lyndhurst Road
Worthing
West Sussex
BN11 2DH
www.uhsussex.nhs.uk
[redacted]
Direct Dial: 01273 664668 (Senior Executive Assistant)

6 November 2024

Dear Jo,

I wanted to formally extend my gratitude to you for attending the hepatology and palliative care meeting on the 4th October 2024. We greatly appreciate you taking time to share the experience of your partner, Jo. It is a privilege and essential for the service to have these reflections and work with the experience of patients.

Further to the meeting there was an agreement we have an unmet need around palliative care and end of life care in hepatology at Royal Sussex County hospital and at Worthing and St Richards Hospital. Moving forward the agreed key points from the meeting included an audit being undertaken, a business case for expansion and a charity grant application. I wanted to provide assurance of the next steps we have taken and expand upon these further.

We heard about excellent work at Worthing hospital with hepatology and palliative care which provided a model that maps to national guidance. Professor Verma is leading and working with the national team on the audit on the faculty of ascites and being present on basal and AA LSD.

We are proactively working on a business case to support the expansion of palliative care team in order to start delivering routine palliative care team training. Stephen Bass will lead on this with cross site hepatology leads with the support of the general managers to map the demand and capacity.

Within our current staffing model we will be working towards a collaborative approach, we are in the process of establishing funding for consultant time to attend hepatology MDT at all sites and have a weekly MDT to review inpatients and advanced liver disease patients. We agreed to move to clinical nurse specialist time with specialist interest in hepatology.

With regards to the charity grant, Stephen Bass is in the process of submitting the grant. This will support with the expanding of communication skills training.

In addition to the above we will be holding a further joint cross site hepatology team and palliative care in 8 weeks.

Thank you once again for your time.

Yours sincerely

Professor Katie (C) Urch
Chief Medical Officer
University Hospitals Sussex (UHSx)

Cc.

Councillor Theresa Fowler, Chair of Brighton & Hove Health Overview and Scrutiny Committee (HOSC)
Dr Ollie Minton, Consulant in Pallitative Medicine, UHSx
Stephen Bass, Lead Nurse Palliative & End of Life Care, UHSx
Dr Suzanne Ford-Dunn, Consultant in Pailliative Medicine
Prof Sumita Verma, Hon Consultant in Hepatology, UHSx
Dr Stephen Kriese, Chief of Service, Division of Medicine, UHSx