Brighton & Hove City Council

# Health Overview & Scrutiny Committee

Date: **8 July 2026**

Time: **4.00pm**

Venue: **Council Chamber, Hove Town Hall**

Members: **Councillors:** Wilkinson (Chair), Evans (Deputy Chair), Oliveira, Hill, Hogan, Galvin, Mackey, Parrott and Simon. **Co-optees:** Geoffrey Bowden (Healthwatch Brighton & Hove), Nora Mzaoui (Community & Voluntary Sector), Mary Davies (Older People's Council), Clemmie Anstead (Youth Council)

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Chief Executive
Hove Town Hall
Norton Road
Hove BN3 3BQ

Date of Publication - Tuesday, 30 June 2026

# AGENDA

**Part One** **Page**

## 1 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.*

## 2 MINUTES **7 - 16**

To consider the minutes of the previous Health Overview & Scrutiny Committee meeting held on 22 April 2026 (copy attached).

## 3 CHAIR'S COMMUNICATIONS

## 4 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 4th July 2026.
(c) **Deputations:** To receive any deputations submitted by the due date of 12 noon on the 4th July 2026.

## 5 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.

## 6 ROYAL SUSSEX COUNTY HOSPITAL: ACUTE FLOOR RECONFIGURATION 17 - 50

Report of the Chair, Health Overview & Scrutiny Committee (copy attached)

## 7 CANCER DIAGNOSIS AND TREATMENT JULY 2026 UPDATE 51 - 64

Report of the Chair, Health Overview & Scrutiny Committee (copy attached)

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

## 8 NHS CHANGE: JULY 2026 65 - 72

Report of the Chair, Health Overview & Scrutiny Committee (copy attached)

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

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**Further information**
For further details and general enquiries about this meeting contact Giles Rossington, Scrutiny Manager, email giles.rossington@brighton-hove.gov.uk) or email democratic.services@brighton-hove.gov.uk

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**BRIGHTON & HOVE CITY COUNCIL**

**HEALTH OVERVIEW & SCRUTINY COMMITTEE**

**4.00pm 22 APRIL 2026**

**COUNCIL CHAMBER, HOVE TOWN HALL**

**MINUTES**

**Present**: Councillor Wilkinson (Chair)

**Also in attendance**: Councillor Evans (Deputy Chair), Hill, Hogan, Lademacher, Parrott, Simon, Galvin and Winder

**Other Members present**: Angela Savage (OPC), Geoffrey Bowden (Healthwatch), Nora Mzaoui (CVS)

## PART ONE

### 27 PROCEDURAL BUSINESS

27.1 Cllr Winder attended the meeting as a substitute. Angela Savage attended as a guest, replacing Mary Davies (Older People's Council) who was unable to attend.

27.2 No member declared an interest in any item.

27.3 The Press & public were not excluded from the meeting.

### 28 MINUTES

28.1 The minutes of the 11 February 2026 meeting were approved.

### 29 CHAIR'S COMMUNICATIONS

29.1 The Chair gave the following communications

We're looking at 4 issues today. As a standing item we have an update from NHS commissioners about major NHS changes, including the recent merger of the Surrey and Sussex Integrated Care Boards.

We also have an item focusing on improving urgent care. Some groups of vulnerable people, including people experiencing homelessness and people with drugs or alcohol issues, are much more likely than average to present at A&E for care, are more likely to need admitting to hospital and are much more difficult to discharge in a timely way. This is a particular problem in Brighton & Hove as we are an outlier in terms of both homelessness and substance misuse. Today's report outlines what the health and care system is doing to identify and to better

support people with these types of vulnerabilities, improving their care and hopefully reducing pressures on the urgent care system.

We also have 2 reports focusing on mental health, another issue where Brighton & Hove is an outlier. There's an update from Sussex Partnership Trust on the temporary closure of Chalkhill hospital. We'll look at what impact the closure has had and how SPFT's plans to revise the unit's clinical model, recruit staff and improve the physical environment are progressing.

Finally, we have a report on neighbourhood mental health. This is in 2 parts. SPFT will present on their reconfiguration of their community mental health teams. We also have Southdown here today to talk us through the changes they are making to the wellbeing services they run from Preston Park.

## 30 PUBLIC INVOLVEMENT

30.1 There was a public question from Mr Patrick Ward about changes being made to city wellbeing services provided by Southdown. Mr Ward asked:

How will Southdown ensure that its proposed changes - perceived by many as unclear, rushed and framed in a way that obscures their true impact - do not result in vulnerable people losing vital long-term support and being pushed into crisis? Specifically, can you explain how a limited drop-in and short-term interventions will safely replace consistent, relationship-based care; what concrete plans are in place to prevent a cliff-edge loss of support once the current transition phase of three months has passed; how will all service users (including those unable to attend sessions or access digital feedback) be meaningfully included; and how will you measure and be held accountable for any increase in crisis referrals or unmet need resulting from these changes?

30.2 The Chair responded that he was unable to answer Mr Ward's question at this point in the meeting, but would ensure this was asked Southdown when they presented a later item at the meeting and would ask Southdown to provide a written response after the meeting. Southdown subsequently provided the following response:

**Ensuring continued ongoing support:**
From July 2026, the new offer available at the Wellbeing Hub at Preston Park will provide activities each week for existing clients – we are calling these 'social spaces'. Social space will be an ongoing offer (not time limited) and will include a range of activities taken from the following:
Creative: access to art space, art and craft groups
Physical: dancing, gardening
Social: board games, music appreciation, silent book club, singing social group, walking, young person's group, anti-stress colouring, grounding techniques

We currently deliver on average 56 sessions of activity each month with a total average attendance of 288 (these figures do not include sessions run by third parties such as yoga, IT tuition, and creative writing which were included in figures in the HOSC presentation). This means that for each session the average attendance is 5 clients per session.

In the new offer which we plan to deliver from July, there will be on average 40 sessions of a range of the above activities each month. If a similar number of clients continue to access the

activities, this will mean an average attendance of 7.3 clients per session. Most sessions would have capacity for at least 10 people and therefore this indicates the clients currently accessing these groups will be able to continue to do so.

Some groups are more popular than others (singing, dancing, accessible art) and so this may mean that we need to review how we meet this need (adding in more of these groups and reducing less popular groups).
We recognise that the loss of a Saturday provision is a cause of concern to clients and the decision to remove this was an outcome of consultation with staff and the importance of having a robust staffing team available during the week to prevent service closure due to staff absence.
Due to their protective nature and following feedback from clients, we will retain two key groups and commit to their continued delivery: Hearing Voices and the Anchorpoint group for neurodivergent clients.

**Transitioning to new model and including all clients:**
Throughout May and June, the existing activities will reduce each month from the average of 56 sessions delivered prior to April to the intended 40 sessions in July.

Alongside this, all existing clients will be contacted and offered at least one individual support session to explain the changes, provide signposting if needed and assess risk. Safeguarding procedures will be followed and clients supported to access other immediate support if required.

These conversations will be held in the way that best suits the client, and feedback received will be used to inform how the service model is refined. It remains possible to submit feedback and ideas about services via many other methods, and clients may take the opportunity to participate in the Client Planning Group setup to ensure the timetable is designed with client's views in mind. Qualitative feedback is a key component of ongoing service development.

**Crisis referrals and unmet need:**
Crisis referrals are monitored via the ICB with the data gathered for the wider population, including those currently facing limited access to community-based mental health services in the Brighton and Hove neighbourhoods. The redesigned service seeks to address unmet need in the area, whilst maintaining familiar elements in the service for existing clients. The redesigned service is also intended to provide existing clients with new ways of accessing community-based support of different types.

## 31 MEMBER INVOLVEMENT

31.1 There were no member involvement items.

## 32 IMPROVING URGENT CARE PATHWAYS FOR HOMELESSNESS AND DRUGS & ALCOHOL

32.1 This item was presented by Chas Walker, joint NHS and city council Programme Director for Integration and Service Transformation; Dr Nicola Lang, Director of Public Health; Harry Williams, the council's Director of Housing, People Services; and by Tanya Brown-Griffith, NHS Surrey & Sussex, Director for Joint Commissioning and Integrated Community Teams, Brighton & Hove.

32.2 Mr Walker outlined why it was important to identify people with multiple compound needs (MCN) and to provide focused support, helping them manage health conditions and other issues in community settings and consequently reducing pressures on urgent care. Mr Walker explained how this approach aligns with the NHS Long Term Plan priorities and that it is a core focus of the local Homelessness & Rough Sleeping Strategy. There is a particular focus on supporting people with co-occurring conditions whose combination of mental health and substance misuse problems can make accessing services especially challenging. Initiatives have been developed with the active input of Common Ambition who provide lived experience. Data shows that the programme has had successes to date, with community interventions increasing and acute admissions decreasing over time for some of the most vulnerable communities.

32.3 Cllr Hill asked about the long-term plan to improve flow through the temporary and supported housing pathway. Mr Walker responded that there is a known group of people for whom housing interventions tend not to be effective. The plan is to provide better targeted mental health and drugs & alcohol support to this group, partly via in-reach into hostels. Mr Williams added that there is a long-term vision to provide better integration between support services, initially focused on temporary accommodation but eventually also across general housing.

32.4 Cllr Parrott asked how near the system was to providing a full service, given that relatively few people are covered by pilot initiatives. Mr Walker replied that the multidisciplinary team currently has capacity for around 200 highest priority clients, out of the approximately 1500 people in the city identified as having MCN. However, all people identified with MCN do receive a range of support – the enhanced support provided by the multidisciplinary team is only one type of support on offer.

32.5 Cllr Parrott asked how long people would typically be offered enhanced MCN support. Mr Walker replied that the length of support will vary. People are supported to help engage with mainstream services until they are effectively embedded in the services they need to access. This can be a lengthy process, potentially taking up to 18 months.

32.6 Cllr Evans asked how outcomes will be measured. Mr Walker replied that there will be a number of metrics including avoidable hospital admissions, the number of cases dealt with by multidisciplinary teams, the effectiveness of step-down from hostel beds and the percentage of people accessing the appropriate screening programmes.

32.7 Cllr Lademacher asked whether particular geographies are being targeted. Dr Lang replied that current service provision is patchy across the city and the ambition is to ensure that there is good access everywhere.

32.8 Cllr Parrott asked about steps being taken to prevent people developing MCN. Mr Walker noted this is a major challenge given increasing health inequalities across the city, but it is a priority. Mr Williams added that the council has a good track record of preventing homelessness, but needs to get better at reaching people at risk at an earlier point, for example by working with partners to identify people with drugs & alcohol problems before they reach the point of crisis. Ms Brown-Griffith added that the Drugs & Alcohol Partnership does important work with schools, seeking to identify young people and families in need of support at an early stage.

32.9 Cllr Hogan asked about other measures being taken to reduce avoidable hospital admissions. Dr Lang replied that there are initiatives to reduce admissions for self-harm and also for overdose, for example by ensuring that naloxone is available across a range of community settings. Ms Brown-Griffith added that Integrated Community Teams have also been rolling-out a programme of health checks which will reduce avoidable admissions by identifying people at risk at an early enough stage for them to be more effectively supported in the community.

32.10 Cllr Galvin asked about what is being done to improve communications with GPs around discharge and also to ensure that people leaving hospital have suitable accommodation. Mr Walker replied that homelessness officers are located at both the Royal Sussex and Mill View hospitals. They work closely with Arch GP practice to ensure there is effective post-discharge support and appropriate accommodation for homeless people discharged from hospital.

32.11 The Chair asked whether there is currently enough housing and community care capacity to significantly impact on avoidable hospital admissions and discharge delays. Mr Willaims replied that increasing city housing supply is a priority for the council, as is making significant improvements to the temporary accommodation model. While everyone would like to see more housing and support capacity, the current moves to integrate planning and delivery of support services will reduce pressures on urgent care. There are currently very few discharge delays from the Royal Sussex due to homelessness for Brighton & Hove residents, although the same is not always the case for people resident in other areas.

32.12 Nora Mzaoui asked about poor housing conditions such as damp impacting on health. Mr Williams responded that this is a recognised issue and work is ongoing to improve stock quality in terms of council-owned properties but also across the private rented sector. Dr Lang agreed to provide additional information in writing on how VCS or NHS partners could report damp or mould problems in their clients' homes. Information and details regarding responding to Damp & Mould related matters for both for council and private rented housing are as follows:

- Council Homes. Condensation, damp and mould in your council home.
- Private Rented Sector. Private tenants & Damp and Mould Action Plan.
- Housing association residents should follow housing association complaints procedures. Housing associations are subject to the same regulatory provisions as the council with regard to response to damp and mould, including Housing Ombudsman and Regulator of Social Housing.

32.13 Cllr Winder asked about people's sense of wellbeing and social cohesion. Mr Walker responded that these are important issues which will be addressed through the Neighbourhood Health Programme.

**32.14 RESOLVED –** that the report be noted.

## 33 NHS CHANGE APRIL 2026

33.1 This item was presented by Tanya Brown-Griffith, NHS Surrey & Sussex Director for Joint Commissioning and Integrated Community Teams-Brighton and Hove. Ms Brown-Griffith provided an update on recent NHS changes and developments, including the merger of Surrey

and Sussex Integrated Care Boards into one Surrey and Sussex ICB from 1st April and with a significantly reduced commissioning posts headcount to fit the reduced financial envelop.

33.2 Cllr Parrott asked how commissioning staff have coped with the reductions in staffing. Ms Brown-Griffith replied that as expected any consultation where there is this significant reduction would be disruptive and impacted staff negatively, leading to a spike in sickness rates. However, there is a comprehensive stall wellbeing support offer available. The filling of posts commences in May 2026.

33.3 The Chair asked about what changes would be experienced by people locally. Ms Brown-Griffith responded that the impact is on staff not services commissioned but that there will be less local commissioner capacity available. ICBs are moving to a strategic commissioning model which will be longer term and more focused on outcomes and will reduce its role in delivery forums. Providers will be required to step into some of the spaces currently occupied by commissioners.

33.4 Cllr Winder asked about impacts on patient travel time. Ms Brown-Griffith replied that there would be no impacts from the commissioning changes. However, a major service review is imminently expected, and this may include changes that increase or reduce some patient travel times.

**33.5 RESOLVED –** that the report be noted.

## 34 NEIGHBOURHOOD MENTAL HEALTH TEAMS

### Neighbourhood Mental Health Services

34.1 John Child, Sussex Partnership NHS Foundation Trust (SPFT) Chief Operating Officer, presented the paper on changes to SPFT neighbourhood health services. Matt Gough, Chief Executive, Southdown, was also present. Mr Child outlined NHS Long Term Plan ambitions for mental health, including increasing focus on prevention and on community treatment. Implementing this vision locally will require better multi-agency working at a neighbourhood level, building more effective partnerships, and partners working in less siloed ways. Outcomes will include reducing the level of rejected referrals from community to acute services; increasing the percentage of people getting the right referral; better integration between mental health and public health services; and improving efficiency. Community mental health services will be aligned with the 15 Sussex Integrated Community Teams (ICT). In Brighton & Hove this has involved moving from 2 to 3 mental health community teams reflecting the 3 city ICT footprints.

34.2 Angela Savage asked about support for those people, such as older residents, who may struggle with digital services. Mr Child replied that SPFT offers a range of ways to engage with services for those who struggle with digital access. For example, many services for older people are face to face, particularly cognitive assessment services.

34.3 Cllr Parrott raised concerns about the provision of talking therapies online, noting that online provision may be sub-optimal. Mr Child acknowledged that there are issues with providing these types of therapies digitally.

34.4 Cllr Simon asked for details of how local neighbourhood services would be. Mr Child replied that there is not necessarily a single model, but referenced the existing health hubs in east Brighton and in Hangleton & Knoll and examples of what a neighbourhood might look like.

34.5 Cllr Simon asked how outcomes would be measured. Mr Child replied that key outcome measures will include patient experience, prevention outcomes and the number of people presenting at A&E with a mental health crisis.

34.6 Cllr Simon asked about accessing neighbourhood mental health services. Mr Child replied that the aim is to stop people having to go back to their GP to be referred to a different mental health service. Services will be able to refer patients directly to another service and/or there will eventually be a self-referral option.

34.7 Cllr Winder asked about outreach to seldom-heard communities. Mr Gough replied that this is a core part of a new VCSE model that engages more with VCSE partners with good links to harder to reach communities. Mr Child added that there is also lots of work involving people with lived experience.

34.8 Cllr Parrott asked about managing the risk of having gaps in provision when outsourcing to VCS organisations. Mr Child replied that contracts with the VCS are monitored and assured like any other contract. It should also be recognised that there are benefits in contracting with the VCS, particularly in terms of gaining a nuanced understanding of local populations needs which VCS partners are often best placed to deliver.

34.9 Cllr Lademacher asked about engaging with clients for whom English is not a first language. Mr Child responded that translation services are used, as are community organisations where they may be able to assist and support.

34.10 Cllr Hogan asked how the new model differs from the one it replaces. Mr Child replied that the new model is a much more integrated service rather than a group of standalone services. The ambition is also to develop a self-referral pathway which is not currently available.

34.11 Angela Savage asked about Equality Impact Assessments (EIAs). Mr Child replied that EIAs have been completed at multiple points. He would be happy to share these with the committee if requested.

34.12 Cllr Parrott asked about working with people with lived experience. Mr Child replied that there are 2 groups of people here: professionals working in services who have personal experience of mental health issues, and service users who are ‘experts by experience’. Both groups provide valuable insights.

34.13 The Chair asked whether services are fully staffed and are sufficient to meet needs. Mr Child responded that relatively few services can maintain full staffing at all times, and there is inevitably a gap between demand and capacity. However, the services are now live and will have a positive impact.

34.14 The Chair asked about services for people who do not meet the eligibility criteria. Mr Child replied that a range of support is available from the VCS, primary care and

neighbourhood hubs. Being able to refer people seamlessly between services is key to the success of the new model.

34.15 The Chair thanked Mr Child for his presentation.

**Southdown Wellbeing Services**

34.16 Matt Gough outlined the new service model for wellbeing services. Change is required to ensure that services deliver with the NHS Long Term Plan vision, are aligned with the reconfiguration of neighbourhood mental health services, reflect funding changes, meet additional demand, and ensure equity of provision across neighbourhoods in Brighton & Hove and East Sussex. Mr Gough acknowledged that there will be an impact on existing clients. The vision for the new service is to provide a service that is easy to access, welcoming and inclusive, and sustainable. There will be a range of support, including facilitated peer groups, walk-in welcome sessions and social spaces. As well as services provided out of the Preston Park hub there will be pop-up services in local communities.

34.17 Cllr Hill asked about crisis provision. Mr Gough replied that this is provided by the Staying Well service which operates 7 days a week. Mr Gough to provide more details following the meeting.

34.18 Cllr Hill asked about pop-up support for residents of Large Panel System (LPS) blocks facing the demolition of their homes. Mr Gough replied that he was uncertain how many residents had been engaged. This is a new way of providing services and learning from the first events is still being processed.

34.19 Geoffrey Bowden asked whether the changes were driven by the need to save money. Mr Gough responded that cost saving is not the primary focus: the challenge is to support as many people as possible within a set funding envelope.

34.20 Cllr Parrott commented that it was unclear how the new service model differs from the old one and consequently hard to conduct effective scrutiny with the information provided. Mr Gough replied that he could not explain the differences in detail at the meeting. However, in brief the current model offers a range of services via facilitated group sessions, yoga groups, and one-to-one support. The model is popular and had been successful. However, there is little or no capacity to accept new clients. The reconfiguration will reduce some services for current clients, but this is the only way to meet additional demand within the available financial envelope.

34.21 Cllr Simon asked about the evidence-base underpinning the model of 8-week peer group working. Mr Gough responded that this is designed around the ‘5 ways to wellbeing’ model.

34.22 Cllr Simon asked about community pop-ups. Mr Gough replied that the focus is currently on transitioning to the new model. Following this, a pop-up programme will be developed by the new neighbourhood lead.

34.23 Cllr Simon asked by how much social space will be reduced. Mr Gough replied that the current provision of 19.5 hours per week will be reduced to 10.5 hours. In time there may be some scope to run volunteer-led groups to replace some of this lost capacity.

34.24 Cllr Simon asked about volunteering. Mr Gough responded that there will be a new volunteer coordinator. There are also plans to roll-out a new volunteer programme in Brighton & Hove with various roles following the success of the 'community connectors' service that operated in East Sussex.

34.25 Cllr Simon asked about attendance figures. Mr Gough replied that the average client attendance is 0.6 hours per week. However, many clients will attend much more regularly than the average suggests.

34.26 The Chair asked why the new model had been adopted and whether existing clients would lose support. Mr Gough replied that the existing model did not provide enough additional capacity to take on new clients, and it was important to try to meet new as well as current client demands. The new model is a refinement of the current model that provides additional capacity. The model has been developed with reference to sectoral research and national best practice. Current service users will experience a reduced level of support. Individual risk assessments have not been conducted by default, but all current clients have been offered one-to-one sessions to assess their needs.

34.27 The Chair asked whether an EIA had been produced. Mr Gough confirmed that it had and he would share both the EIA and the Quality Impact Assessment with the committee.

34.28 Members discussed whether an additional item at committee was required and agreed that the HOSC needed more assurance that the changes would not have negative impacts and that the new model supports a preventative approach. The committee agreed to ask for an update to come to a future meeting.

**34.29 RESOLVED –** that the report be noted.

## 35 TEMPORARY CLOSURE OF CHALK HILL HOSPITAL: UPDATE APRIL 2026

35.1 This item was presented by John Child, Sussex Partnership NHS Foundation Trust (SPFT) Chief Operating Officer. Mr Child outlined progress in developing a new operating model for Chalkhill and in improving the condition of the estate.

35.2 Cllr Hill asked about admissions to acute young people mental health beds while Chalkhill has been closed. Mr Child replied that there have been 14 admissions to other adolescent units, 3 to psychiatric intensive care units, one to an under-13 inpatient unit, and 7 to specialist eating disorder beds. No patients have been admitted to adult acute mental health beds or to general paediatric wards.

35.3 Cllr Parrott asked where the general admissions had been. Mr Child replied that 10 had been within the local footprint (covering Kent and Surrey), whilst 4 had been elsewhere in the UK where particular specialist support was required.

35.4 Cllr Parrott asked whether any adverse future impacts from the temporary closure were anticipated. Mr Child responded that, to date there hasn't been any increase in waits for admission in A&E. It may be that enhancing crisis services has helped manage any additional demand.

35.5 The Chair asked when the unit will reopen. Mr Child replied that this is still scheduled for autumn 2026.

35.6 RESOLVED – that the report be noted.

The meeting concluded at 8.10pm

Signed Chair

Dated this day of

# Brighton & Hove City Council

## Health Overview & Scrutiny Committee

## Agenda Item 6

**Subject:** **Royal Sussex County Hospital: Acute Floor Reconfiguration**

**Date of meeting:** **08 July 2026**

**Report of:** **The Chair, Health Overview & Scrutiny Committee**

**Contact Officer:** **Name: Giles Rossington, Scrutiny Manager**

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

**Ward(s) affected: (All Wards);**

**Key Decision: No**

**For general release**

| glossary | |
|---|---|
| RSCH | Royal Sussex County Hospital |
| UHSx | University Hospital Sussex NHS Foundation Trust – acute NHS trust that manages RSCH and other hospitals |
| ED | Emergency Department (including A&E) |
| SAU - Surgical Assessment Unit | dedicated unit for diagnosis and support of patients with acute surgical conditions |
| MAU - Medical Assessment Unit | dedicated unit for triage and diagnosis of acutely ill patients, either referred by GPs or by A&E |
| 3Ts | Major programme to redevelop RSCH site as a regional centre for Trauma, Tertiary and Teaching |
| Resus | 'resuscitation' – area within A&E providing critical care, advanced life support |
| Majors | Subdivision of A&E for seriously ill patients |
| PAT - Patient assessment & triage unit | space within A&E where patient needs are assessed and prioritised |
| UTC – urgent treatment centre | Provides medical help for urgent but not life-threatening injuries and illnesses such as sprains, minor burns and infections. |
| Emergency Care | For life-threatening or critical conditions such as chest pain, loss of consciousness or severe trauma (most people refer to this as A&E) |
| Acute Floor | The area of the hospital where UTC and Emergency Care (A&E) are co-located |
| No criteria to reside (NCTR) | Term used to describe patients occupying hospital beds whose medical care has finished but who cannot be discharged e.g. because they are waiting for a care placement |

## 1. Purpose of the report and policy context

1.1 This report presents members with an update from University Hospitals Sussex NHS Foundation Trust (UHSx) on progress in reconfiguration of the acute floor at the Royal Sussex County Hospital (RSCH). Information provided by UHSx is included as Appendix 1.

## 2. Recommendations

2.1 Health Overview & Scrutiny Committee notes the information provided in this report.

## 3. Context and background information

3.1 The RSCH emergency department, and the wider acute floor, have long been seen as outdated and in need of improvement. The major improvements that have taken place at RSCH in recent years (the '3Ts programme'), including the construction of the Louisa Martindale Building and the Sussex Cancer Centre, have improved many aspects of the hospital, but have not directly addressed issues relating to the acute floor.

3.2 Capacity is a major issue. When it was opened in 1070, RSCH A&E was intended to manage around 20,000 patients per year. It currently manages more than 100,000. In addition to demand having outstripped capacity, there are significant issues with flow through the RSCH, particularly in terms of patients who have 'no criteria to reside' occupying beds they have no medical need for. Addressing RSCH emergency capacity problems requires a two-pronged approach: modernising urgent and emergency care facilities and working with system partners including NHS mental health and council social care to improve flow and discharge. This report focuses on the work being undertaken to modernise urgent and emergency care facilities; the HOSC has previously considered reports on how the local health and care system is working in partnership to better manage discharge pressures.

3.3 In order to modernise facilities, UHSx and NHS Sussex Integrated Care Board (ICB) agreed an Acute Floor Reconfiguration Programme (AFR), supported by more than £60 million of capital funding.

3.4 AFR is in 3 phases. The first phase, constructing a new Surgical Assessment Unit (SAU) and a new Medical Assessment Unit (MAU), was completed in December 2025. The SAU and MAU provide dedicated spaces for the assessment and treatment of patients, ensuring the patients are seen more quickly and relieving pressure on the rest of the acute floor.

3.5 Phase 2 of the programme is the modernisation of majors and resus. (Majors is the subdivision of urgent & emergency care for the most seriously ill patients; Resus is the area where staff provide critical care including advanced life support.) Phase 3 is the modernisation of PAT and UTC.

(PAT, or patient assessment & triage, is the space within urgent & emergency care where patient needs are assessed and prioritised. The UTC, or urgent treatment centre, is where patients with urgent but not life-threatening conditions are treated.)

3.6 Once completed, the phase 2 and 3 works will increase capacity and provide a much better environment for both patients and staff (see Appendix 1 for more detailed information). However, phases 2 and 3 pose significant logistic and other challenges as they require UHSx to build new facilities while continuing to deliver extremely complex services on the same site. Appendix 1 includes details of how the build will be managed, the major risks identified and how these risks will be mitigated. Phase 2 and 3 works and will take several years to complete; the target completion date for phase 2 is December 2028 and phase 3 is May 2030.

3.7 UHSx has previously briefed the HOSC (23 May 2025) on the acute floor reconfiguration programme. Minutes of this discussion are available here For enquiries on this agenda please contact. UHSx has also invited stakeholders, including the HOSC Chair, to visit RSCH to see the progression of works. The HOSC has also previously received reports on health and care system plans to better manage flow at RSCH, for example in July 2024: PowerPoint Presentation.

## 4. Analysis and consideration of alternative options

4.1 Not relevant to this information report.

## 5. Community engagement and consultation

5.1 None directly for this information report.

## 6. Financial implications

6.1 None identified for this report to note.

Name of finance officer consulted: Ishemupenya Chagonda Date consulted: 29/06/26

## 7. Legal implications

7.1 There are no implications for this report to note.

Name of lawyer consulted: Elizabeth Culbert Date consulted: 29/06/26

## 8. Risk implications

8.1 None directly from this decision as this is an information report. The RSCH acute floor reconfiguration programme is intended to reduce the risks associated with the city's main acute hospital having an emergency department that is sub-optimally configured and has inadequate capacity. However, as the programme moves into Phases 2 and 3, there are short

term risks associated with managing a live acute floor alongside a building site. Specifically, members may wish to seek assurance that robust plans are in place to manage services with reduced capacity/floorspace while works take place.

## 9. Equalities implications

9.1 None directly for this information report. Members may wish to seek assurance that the acute floor reconfiguration plans and risk mitigation of Phases 2 and 3 of the programme take into account the specific needs of people with protected characteristics. This might include: how the reconfigured services will ultimately provide a better environment for patients who struggle with current waiting arrangements, particularly people with autism or with learning disabilities, and what mitigations are being considered to support the these vulnerable patients while works take place.

## 10. Sustainability implications

10.1 None directly for this information report.

## 11. Health and Wellbeing Implications:

11.1 These are addressed in the body of the report.

## Other Implications

## 12. Procurement implications

12.1 None identified.

## 13. Crime & disorder implications:

13.1 None identified.

## 14. Conclusion

14.1 Members are asked to note the update on the RSCH acute floor reconfiguration programme.

## Supporting Documentation

## 1. Appendices

1. Information provided by UHSx on the acute floor reconfiguration programme

University Hospitals Sussex
NHS Foundation Trust

# Modernising Urgent and Emergency Care at RSCH



Chief Delivery Officer - Nigel Kee
Head of Nursing, Acute Floor - Craig Marsh
Transformation Programme Manager – Nikki Mead

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# Introduction

Nigel Kee

***"The urgent and emergency care system is a complex web of services...***

***The term 'system' is used because these services are highly interdependent: a change in one will almost certainly affect others.***

***This complexity is compounded by the fact that the terminology used to describe these services has shifted over time***

***…and different terms are often used to describe the same thing."***

The King's Fund *Urgent and Emergency Care: A guide to the system in England*, 2021

# What is UEC or “urgent and emergency” care?

**UEC is an umbrella term for services treating illness or injury requiring immediate attention.**

- **Urgent Care:** For illnesses or injuries that are not life-threatening but still require swift attention such as sprains, minor burns, or infections. These are managed by Urgent Treatment Centres (UTCs).
- **Emergency Care:** For life-threatening or critical conditions, such as chest pain, loss of consciousness, or severe trauma. This is the primary role of the Emergency Department (ED).

The **Acute Floor at RSCH** is where these two services meet, alongside diagnostic services and rapid assessment units, to ensure patients are "streamed" to the right specialist swiftly.

Our **Acute Floor Reconfiguration programme** (AFR) includes what most people refer to as A&E - which is what we call ED - as well as a variety of other UEC services.

# Modernising UEC care in Brighton

**1970** - the current A&E opened on the ground floor of the newly built Thomas Kemp Tower – purpose-designed for a *new era of medicine* and to replace "Casualty" services at the front of the old Barry Building.

**20,000 patients** - the new A&E was intended to manage around 20,000 patients per year – but it now sees more than 100,000 patients per year.

**Acute Floor Reconfiguration** - in 2014, the CQC rated the service inadequate, and said the 1970s footprint was *no longer fit for purpose*. But options to change were limited as it was too late to change the 3Ts redevelopment plans that did *not* include UEC services.


Casualty at the front of the Barry Building


Thomas Kemp Tower being built in 1968

# Key moments

| | | |
|---|---|---|
| 2009 | **3Ts redevelopment mooted** | Former CEO Duncan Selbie announces the "Trauma, Teaching, and Tertiary" care redevelopment and emergency helipad. |
| 2012 | **Major Trauma Centre status** | RSCH becomes regional lead for life-threatening injuries across Sussex and plans for the new helideck take off. |
| 2014 | **3Ts stages 1-3 approved** | HM Treasury gives "green light" for major transformation. |
| 2017 | **New leadership team begins** | Various plans to improve UEC by expanding current area or adding to Stage 2 of 3Ts rejected by HM Treasury. |
| 2022 | **Urgent Treatment Centre opens** | A new "front door" for walk-in patients with non-life-threatening issues. |
| 2023 | **Louisa Martindale Building opens** | Services move into LMB, freeing up space around A&E for the first time to support expansion. |
| 2023 | **Acute Floor Reconfiguration** | NHS Sussex commissioners provide £48m for a multi-year modernisation programme of UEC services at RSCH. |
| 2024 | **Surgical Assessment Unit opens** | SAU opens on Level 6 of Millennium Wing to complete Phase 1a of Acute Floor Reconfiguration programme. |
| 2025 | **Acute Medical Unit opens** | AAU and EACU move into new home on Level 5 of Millenium Wing and become AMU and Medical SDEC. |

# Acute Floor Reconfiguration programme

Craig Marsh

Nikki Mead

# Current challenges

**RSCH operates under sustained pressure - patient flow is often challenged because our "back door" is “blocked” by patients unable to leave**

- Their medical care has finished - but what they need next isn’t ready for them
- Often vulnerable and elderly patients - they have "no criteria to reside" (NCTR)
- When NCTR patients cannot leave, unwell patients in ED cannot be admitted
- This leads to “exit block” and “corridor care” in ED
- Poor flow compromises patient safety and dignity, and distresses staff

**Discharge delays are mainly driven by complex challenges affecting our partners in mental health, community care, social care and the private sector**

- 100 -140 beds every day at are occupied by NCTR patients
- UEC services never close - so bottlenecks lead to corridor care
- At peak times, 80% of RSCH medical beds are occupied by NCTR patients

A picture sent to The Argus by a concerned family in 2024

# Two main challenges require dual solutions

## 1. Demand has massively outstripped the size of our constrained 1970s A&E footprint

## 2. Patient flow is fundamentally challenged due to system issues and challenges our partners face

So, we need a dual approach to solving our challenges.

*Bricks and mortar alone cannot address patient flow*.

We need to modernise UEC facilities and work in new ways with partners to improve flow and discharges.

Today we are focusing on improving our UEC facilities at RSCH.

# AFR is a multi-million-pound modernisation programme

## Our vision is clear…

***Our UEC services at RSCH will provide excellent care for our patients in modern, safe and dignified environments -*** *whether they walk in for urgent treatment, arrive by ambulance for expert assessment, or land in a helicopter for major trauma care.*


## …but so are the challenges we face

- Facilities no longer meet national standards
- Configuration doesn't optimise patient flow
- Our environment is not fit for purpose
- Funding is limited and works expensive
- The Emergency Department can never close

# Complex and complicated multi-year programme

## Our Acute Floor Reconfiguration programme is a complete modernisation of our UEC services (2023-30)

*"It's like performing open-heart surgery on the hospital while we continue to provide life-saving urgent and emergency care, 24 hours a day, seven days a week, for 100,000 patients a year."*

Dr Andy Heeps, Chief Executive

## Significant constraints:

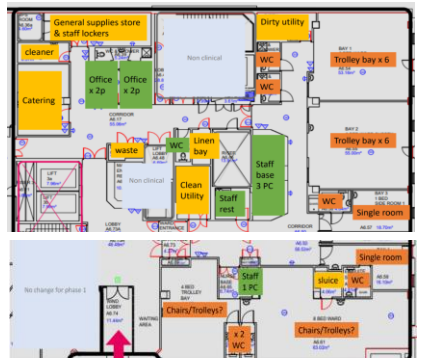
- Continuous service delivery: The Emergency Department must remain 100% operational throughout the construction period.
- Shared environment: Building works are happening directly next to critical clinical areas that care for hundreds of patients a day.
- Adapt and overcome: The programme has faced various design and budget challenges as clinical guidelines, standards and costs have changed.

# Phase 1 completed in December 2025

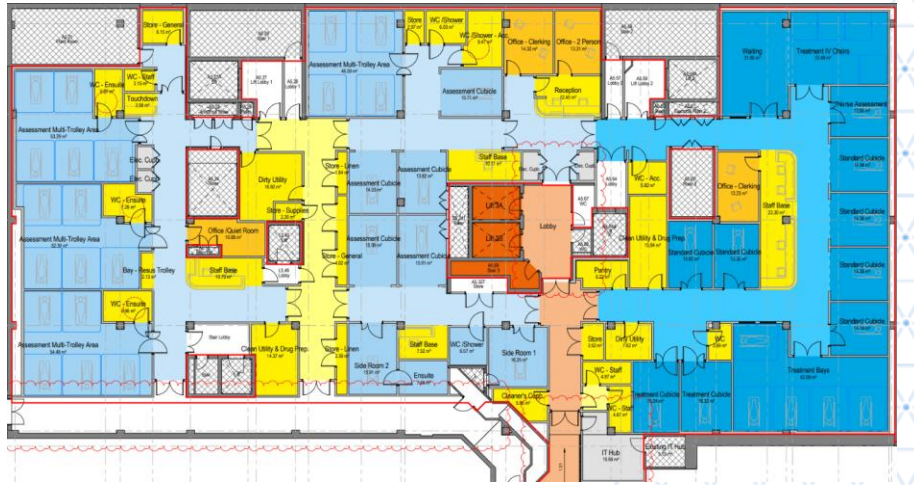
**In Phase 1 we delivered two Acute Floor assessment units to stream patients to the right specialist swiftly.**

- **Surgical Assessment Unit (SAU):** A dedicated space for rapid surgical review, reducing the time patients spend in the main ED. Located on Level 6 above AMU.
- **Acute Medical Unit (AMU):** A high-turnover assessment unit which aims to treat, discharge or transfer patients to a specialist within 12 hours. AMU also contains a new Medical Same Day Emergency Care unit (MSDEC), which is now available for patients *24 hours a day*.

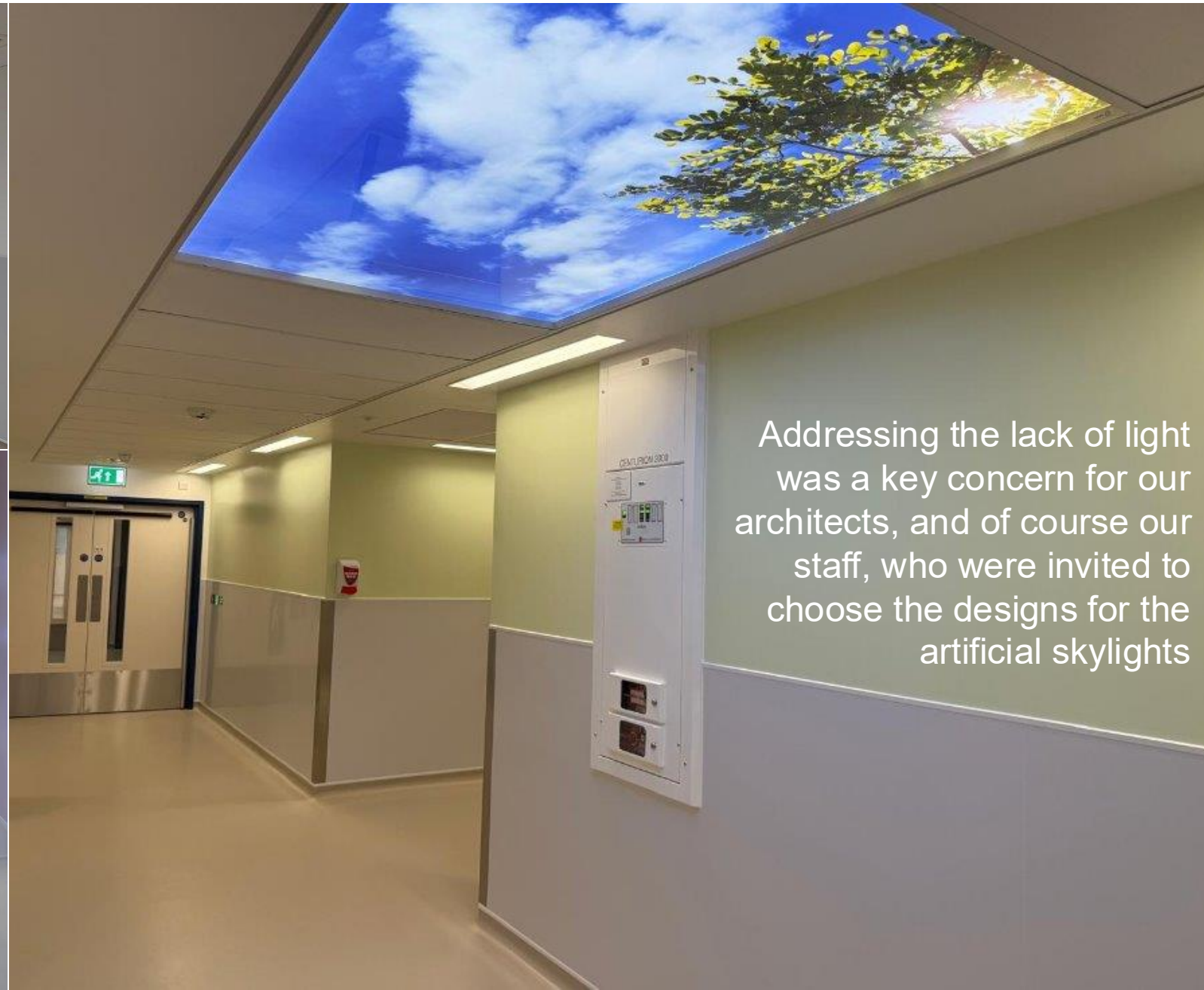
These units ensure patients are seen sooner and they act as relief valves for ED in the modern Acute Floor model.




Colleagues from AMU above, and floorplans for SAU L6 and AMU L5 left and below



# **AMU – a modern, spacious and bright clinical environment** - despite being located underground



Addressing the lack of light was a key concern for our architects, and of course our staff, who were invited to choose the designs for the artificial skylights

# Looking ahead – the future of the Acute Floor

**Phases 2 and 3 will double the footprint dedicated to our most critically unwell patients and expand the Urgent Treatment Centre**

ADP designed Guy's & St Thomas' new Emergency Department, pictured below

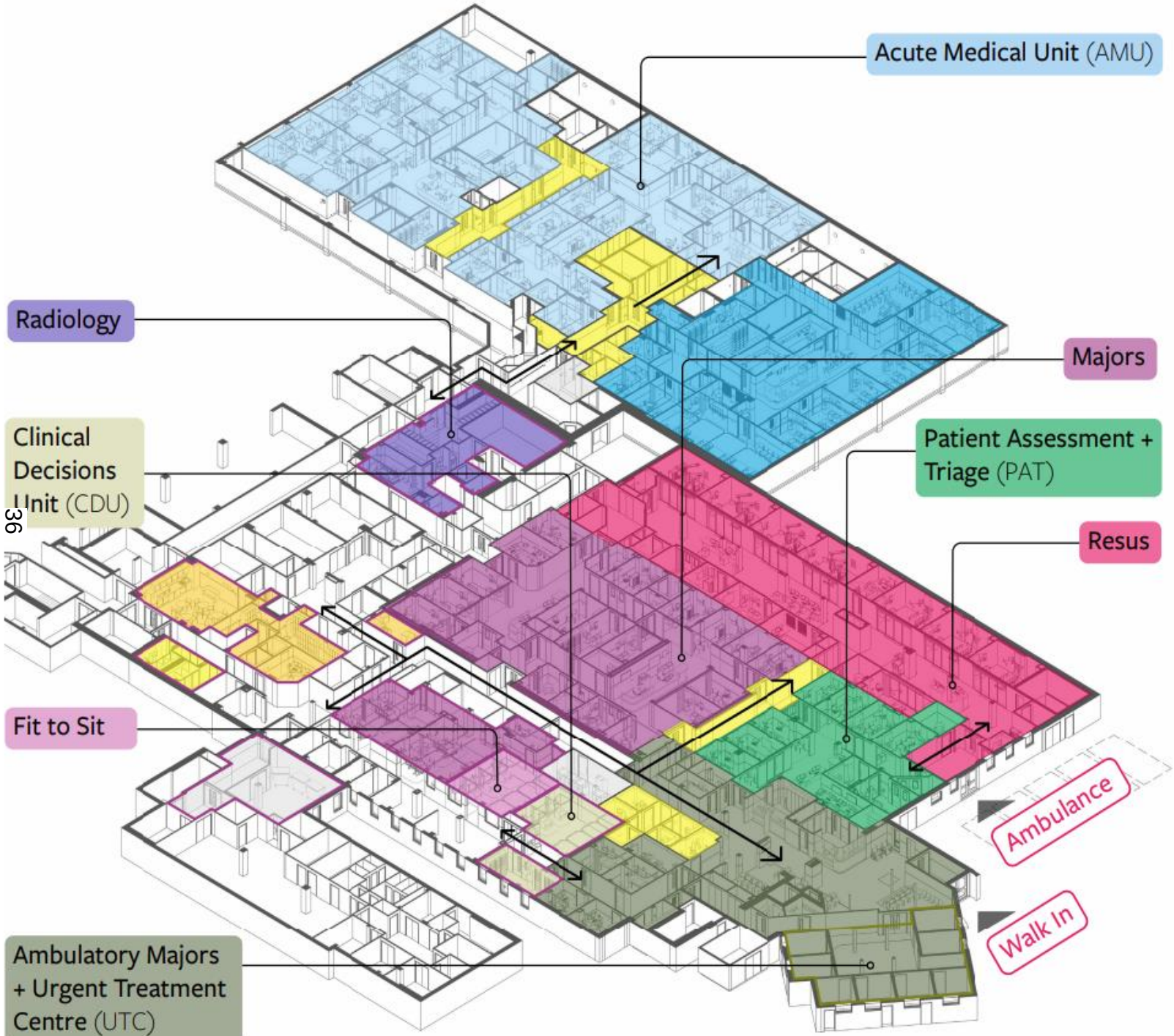

## Phase 2: Majors & Resus (target completion: December 2028)

- Upgraded "Resuscitation" area - fit for Major Trauma Centre standard with addition of two more treatment cubicles.
- Modern "Majors" area – with improved clinical cubicles and purpose-designed mental health assessment facilities.

## Phase 3: PAT and UTC (target completion: Mid-2030)

- "Patient Assessment and Triage" - larger with new isolation suite and point of care testing lab.
- "Urgent Treatment Centre" - larger with improved waiting area and four additional consultation rooms to reduce waiting times.

# Our partners ADP also designed the Breast Care Centre and Emergency Floor at Worthing Hospital


# Acute Floor Redevelopment

*Royal Sussex County Hospital, Brighton*

## Proposed Final Design

Increased Capacity:

- Majors: **13** patient spaces
- Ambulatory Majors + UTC: **35** patient spaces

TROUP BYWATERS + ANDERS

P&M

acp

NHS
University Hospitals Sussex
NHS Foundation Trust

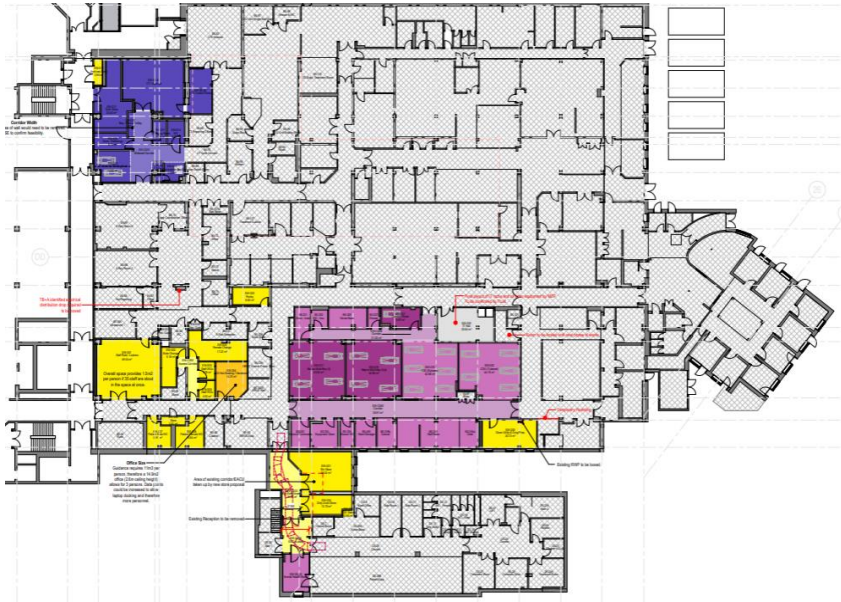
# Challenging ED modernisation programme ahead

**The next phases of the Acute Floor Reconfiguration programme are the most challenging.**

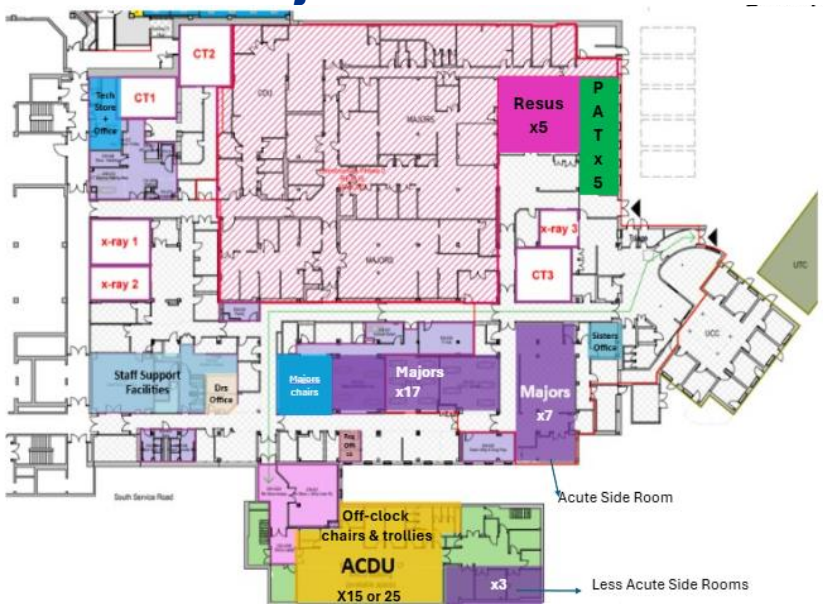
- We will be moving high-acuity team such as “Resus” and “Majors” into new temporary areas.
- First, enabling works must ensure these new areas meet rigorous clinical standards
- Temporary areas must accommodate thousands of patients, 24 hours a day, for up to three years.
- During this period, different teams will work from different temporary homes while their permanent facilities are rebuilt. The works are due to complete by 2030.



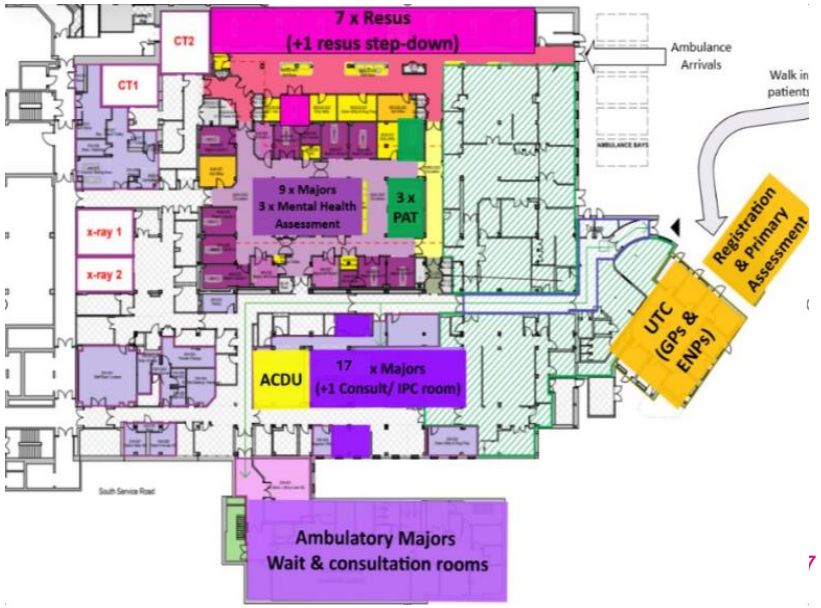
## Enabling works



## Phase 2 – Majors & Resus



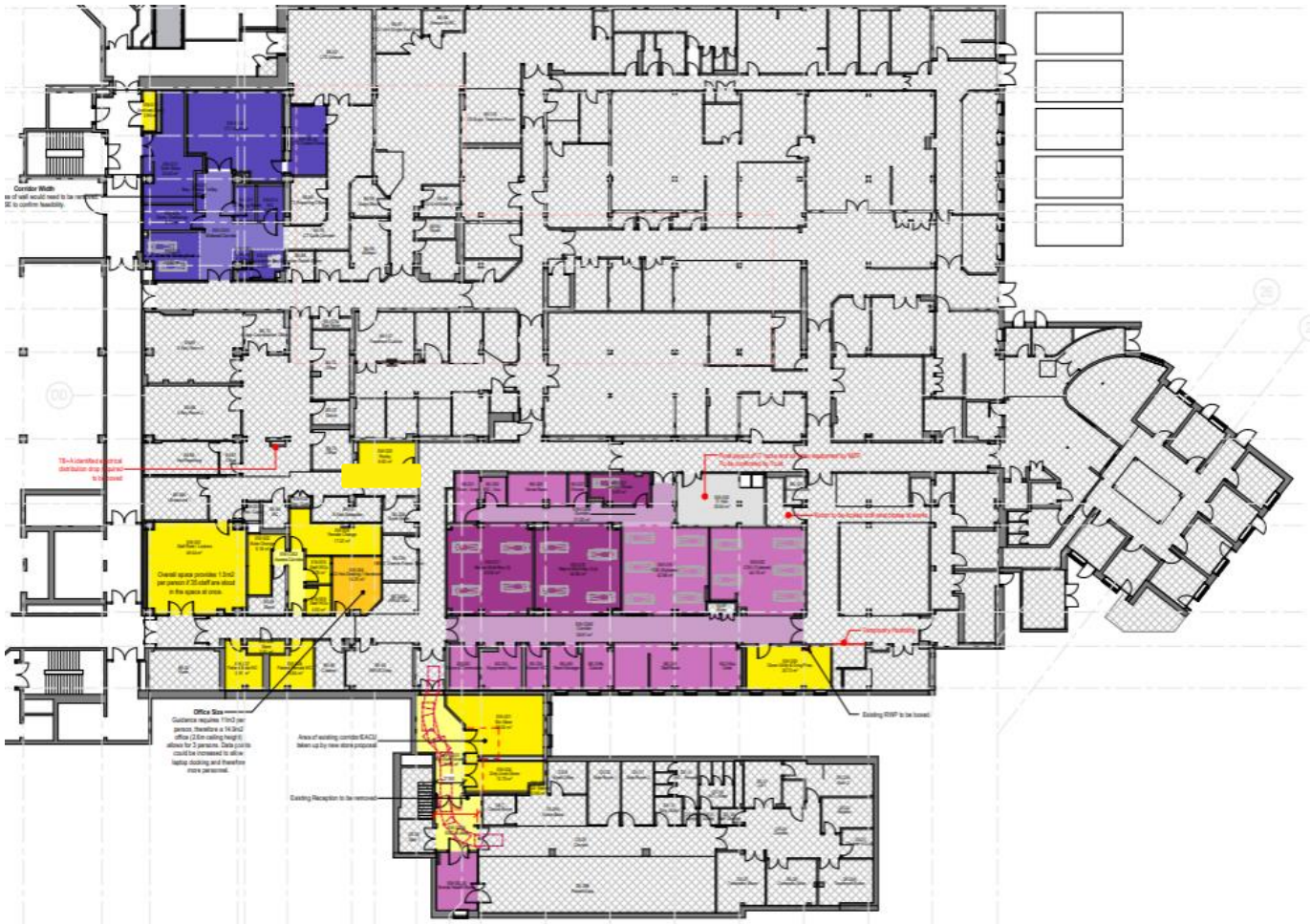

## Phase 3 – PAT & UTC



# Enabling Works Overview

**Start: Oct 26** | **End: Apr 27**

**Key**
Coloured areas: Enabling Works areas



## What we're delivering

- Critical infrastructure: IT hub, waste store, catering space and Air Handling Units
- Refurbishment of future Majors South clinical area
- Improved staff support hub (staff rest, change and WCs)

## How we'll deliver it

- No change to the front door for either walk in or ambulance arrivals or current clinical areas
- Impact to public areas will be co-ordinated between the contractor, the Hospital Director and affected clinical teams

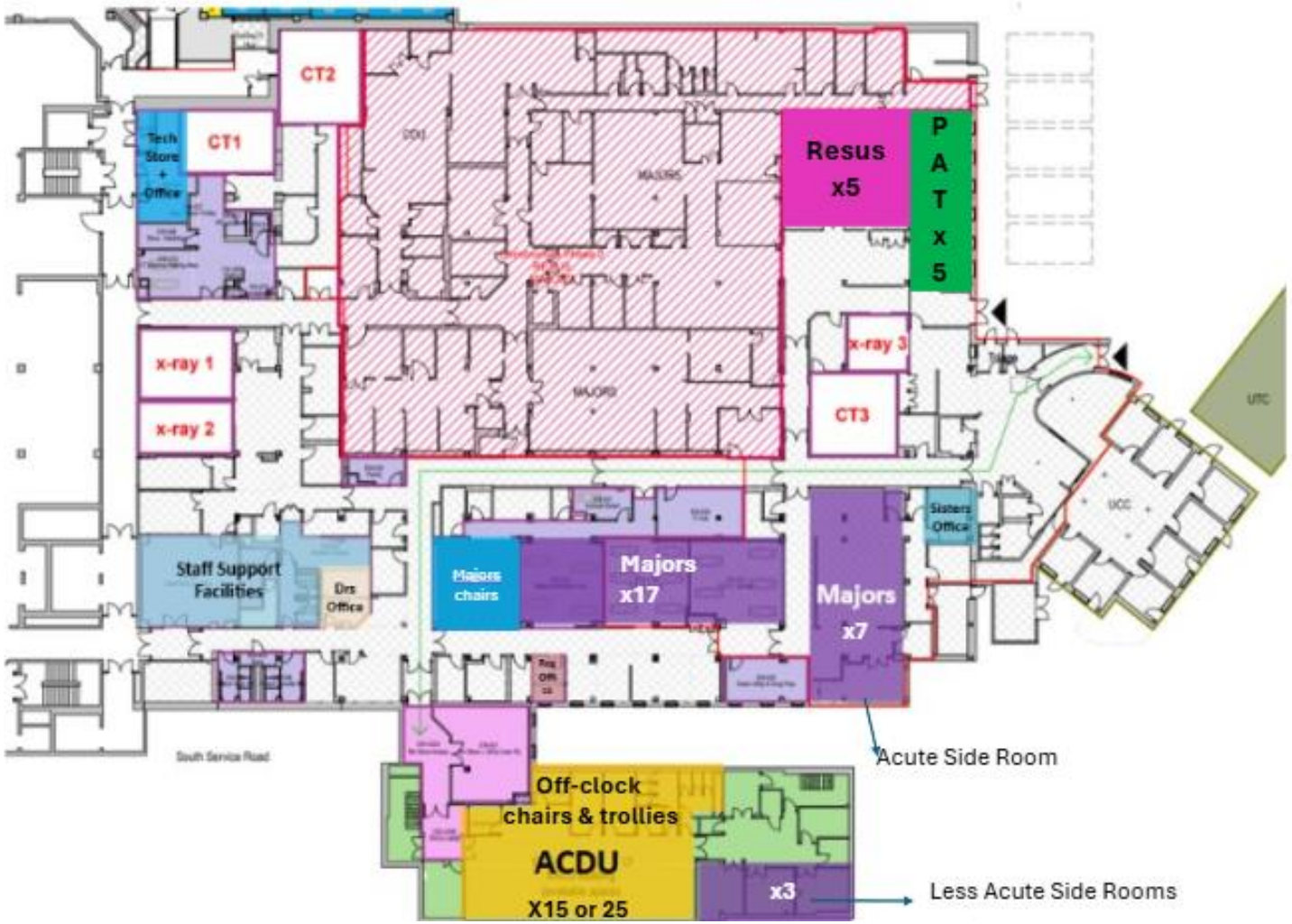
# Enabling Works Risks

| | Key Risks | Mitigations |
|---|---|---|
| **1.** | **Logistics -** Maintaining safe separation of construction activities from public and clinical areas | - Joint detailed planning and risk assessment between UHSx teams and contractors to identify and mitigate risks |

# Phase 2 Overview

**Start: May 27** | **End: Dec 28**

**Key**
Red hatch: Construction zone




## What we're delivering

- Resus department (90% in this phase), compliant with modern standards for a Major Trauma Centre
- Majors North, with 100% individual cubicles, improving patient privacy and dignity as well as infection prevention

## How we'll deliver it

- No change to the front door for either walk in or ambulance arrivals
- No change to resus
- Majors will decant to Majors South and the decant space; +2 majors cubicle spaces
- Introduction of dedicated bay for Majors Chairs
- Opportunity to improve non-admitted flow through increased Ambulatory Clinical Decision Unit (ACDU) capacity

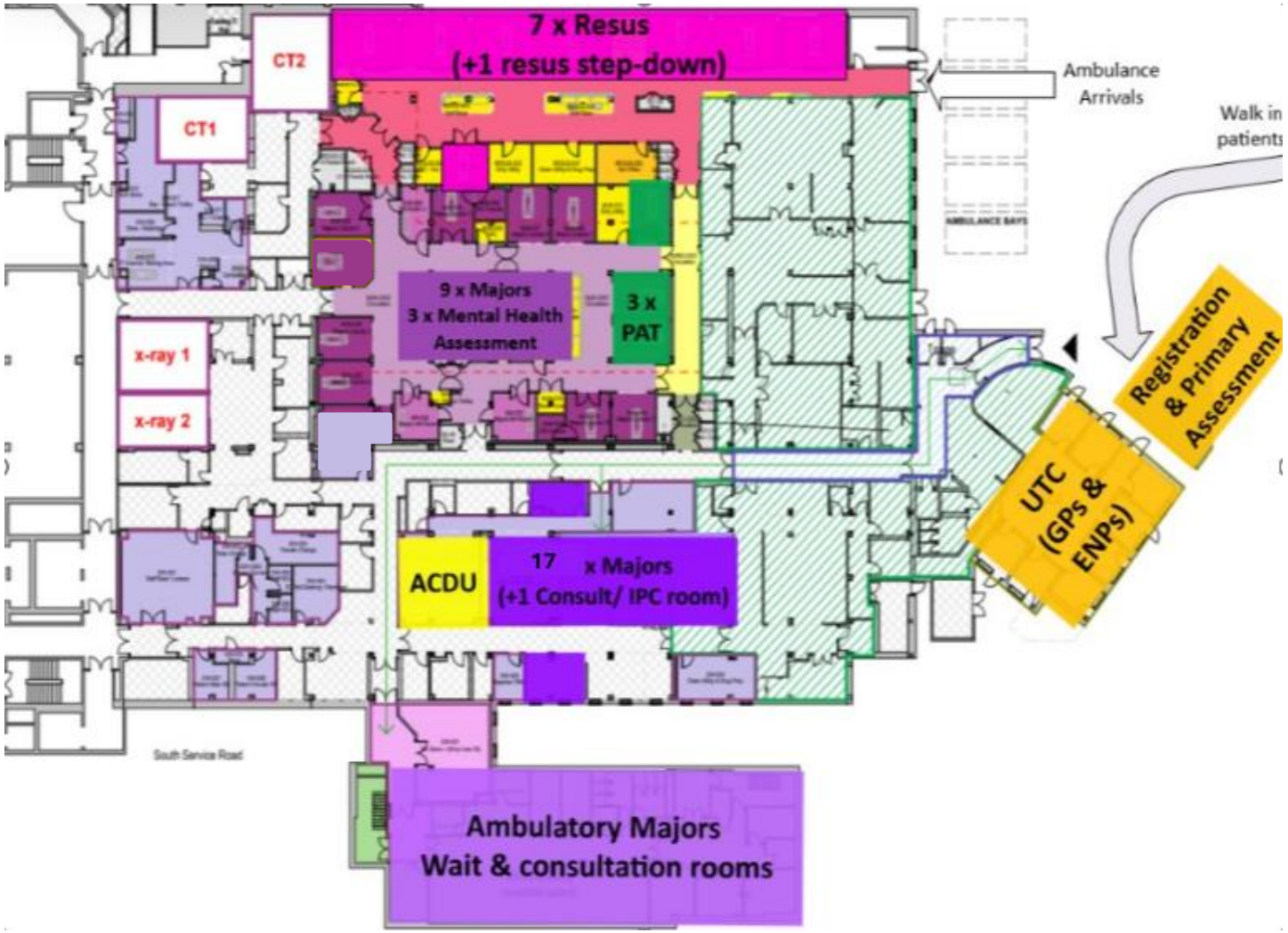
# Phase 2 Risks

| | Key Risks | Mitigations |
|---|---|---|
| 1. | **Mental Health (MH) patients** – current cohorting area for medically ready patients waiting MH inpatient beds closes at the start of Phase 2 with no re-provision | - Collaborative UHSx and SPFT Task & Finish Group has improved joint working, developed common understanding and objectives<br>- This risk cannot be resolved through operational actions alone. It requires system-level working |
| 2. | **Patient flow challenges** – current delays to patients awaiting an acute inpatient bed creates overcrowding in the emergency department. There will be an overall reduction space in Phase 2 | - Divisional Hospital Alternative Liaison Programme (HALO) focusing on attendance and admission avoidance<br>- Trust-wide flow improvement programme<br>- Wider system working e.g. Neighbourhood Alliance development |
| 3. | **Larger footprint and distances between clinical areas** - impact on clinical coverage e.g. ability to observe patients and increased travel time between clinical areas | - Detailed planning with Acute Floor team and key stakeholders to understand impact on patient journeys and staff<br>- Planning of staff deployment across the department in this phase to understand workforce impact |
| 4. | **Logistics** - Maintaining safe separation of construction activities from public and clinical areas | - Close collaboration between the Trust and contractors to identify and mitigate risks ahead of time<br>- Involvement of key stakeholders |
| 5. | **Wayfinding** – risk of confusion for patients and staff | - Targeted communications before during and after each phase<br>- Wayfinding signage to be update as service moves happen<br>- Increased volunteer presence in the Emergency Department to support patients |

# Phase 3 Overview

| Start: Jan 29 | End: May 30 |
|---|---|

**Key**
Red hatch: Construction zone




**What we're delivering**

- New front door for both walk-in patients and ambulance arrivals
- Increased Ambulatory ED waiting room and consultation room capacity
- Improved waiting area facilities (vending, public toilets)

**How we'll deliver it**

- All walk-in patients will arrive to the modular building before steaming to the most appropriate clinical area
- New resus and majors north areas open
- Ambulatory ED, incl. majors chairs, to move to the decant space
- Opportunity to increase Ambulatory Clinical Decision Unit (ACDU) capacity to improve non-admitted flow

# Phase 3 Risks

| | Key Risks | Mitigations |
|---|---|---|
| 1. | **Walk-in patients** – Walk in entrance will be in the physically separate from main Ambulatory ED. Need to maintain throughput of patient registration and primary assessment to avoid patient queuing and overcrowding | - Split of primary and secondary assessment functions, in line with national best practice<br>- Review of staffing deployment at this phase to ensure timely assessment and streaming at the front door |
| 2. | **Reduction of dedicated Patient Assessment & Triage (PAT) cubicles** – risk of delay to ambulance handover | - Increase in resus capacity will release PAT cubicle capacity<br>- Clinical team agreement to implement mobile PAT model meaning that patients could be placed in any cubicle and triage team come to them |
| 3. | **Ambulance entrance goes through resus –** risk to privacy and dignity of resus patients and impact on patient experience for other patients | - New resus cubicles are walled with doors, providing improved separation from circulation areas<br>- Joint work with SECAMb to plan ambulance route |
| 4. | **Logistics -** Maintaining safe separation of construction activities from public and clinical areas | - Joint detailed planning and risk assessment between UHSx teams and contractors to identify and mitigate risks |
| 5. | **Wayfinding** for patients and staff | - Targeted communications before during and after each phase<br>- Wayfinding signage to be update as service moves happen<br>- Increased volunteer presence in the Emergency Department to support patients |

# Benefits for patients

**Our aim is for all patients to receive excellent care from the right specialist in a modern environment that respects their privacy and safety.**

- Faster clinical decisions: Dedicated SAU and AMU assessment areas provide rapid specialist review, reducing time spent in ED.
- Enhanced privacy and dignity: Modern, private cubicles and zoned waiting areas replace the current "cramped“ 1970s infrastructure.
- Specialised mental health support: Three purpose-designed cubicles in “Majors” to provide a safe environment for assessing patients in crisis.
- Improved infection control: New isolation cubicle in PAT and increased individual cubicles and new ventilation will improve infection control.
- Better trauma care: Locating “Resus”, ambulance bays, and CT scanners near each other saves life-critical seconds for major trauma.

# Benefits for staff

**Modernising our Acute Floor gives staff the tools and workspace they need to provide high-quality emergency care to the people we serve.**

- Integrated clinical model: Bringing the ED, SAU, and AMU into an Acute Floor model enables better teamwork and resilience for UEC services.
- Essential support facilities: Staff rest areas, changing rooms, and toilets that were potentially jeopardised by previous design challenges.
- Dedicated workspace: Additional desk positions and new "hot offices" within clinical zones help to keep clinicians closer to their patients.
- Modernised tools and workflow: A total IT infrastructure overhaul ensures reliable digital services, and new drug prep and storage improve safety.
- Sustainable environment: New layouts and ventilation built to national standards provide a professional workplace "conducive to safe care“.

# Summary and questions

Nigel Kee



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We are compassionate. We are inclusive. We are respectful.

# The future is bright, but requires patience and understanding

**Conducting "open heart surgery" on the hospital to deliver a total overhaul of our UEC services while keeping our front door open 24 hours a day will prove challenging.**

- Despite the urgency of our challenges, the constraints and complexity of the AFR programme mean *it will take time to complete* and disruption is sadly unavoidable.
- We look for your understanding and support as we deliver a long-term solution to address these long-entrenched issues that we know affect care and experience for our patients.
- AFR will deliver a new, modern ED fit for the 21st Century, but it is equally important people understand that *quicker wins and bigger improvements will be delivered in other ways...*

*...as the NHS 10 Year Plan says:*

**“To fix the front door of the NHS, we must first fix the back door. We cannot improve emergency care in isolation; it requires a fundamental shift of care from hospital to community, and a partnership between health and social care that is seamless for the patient.”**

*Fit for the Future: 10-Year Health Plan - Policy Framework and Consultation*.

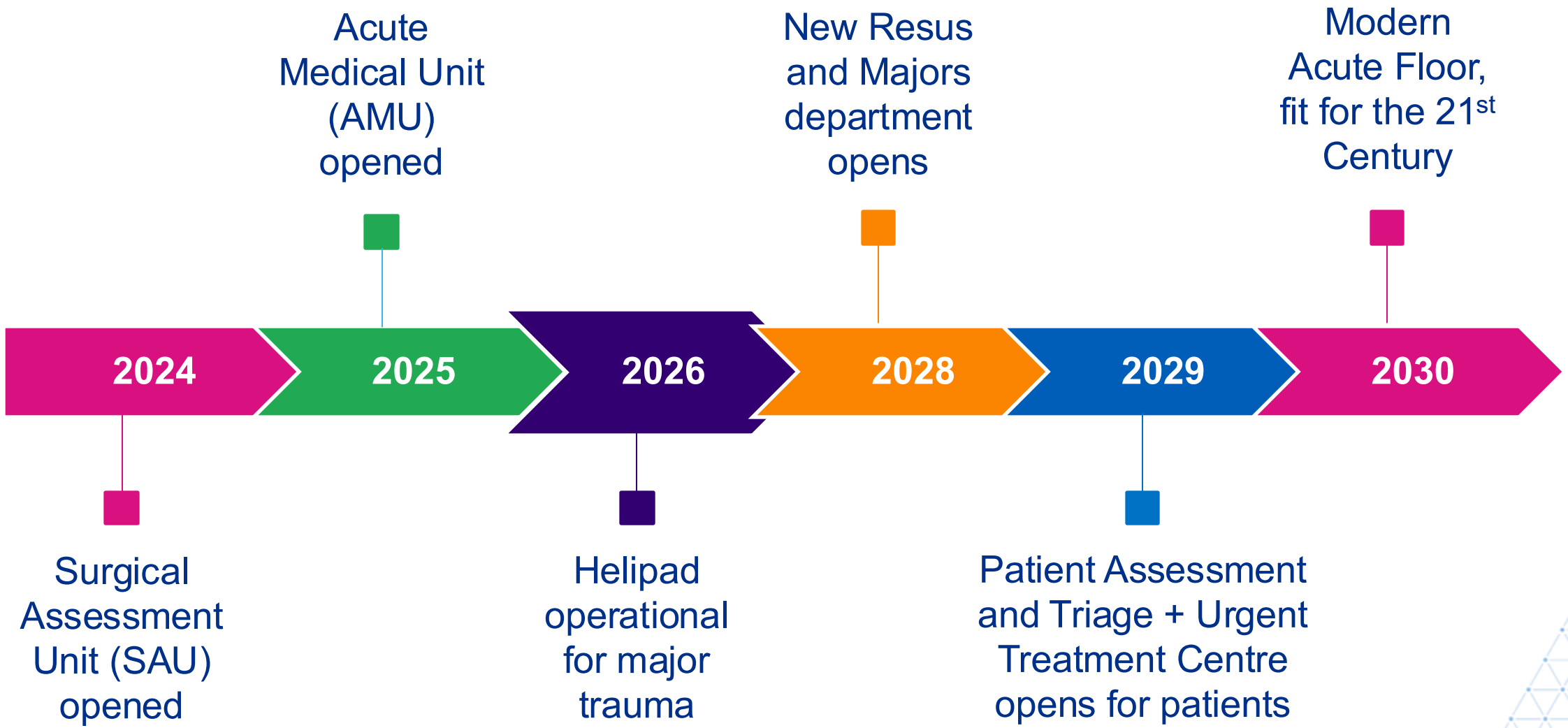
# Making the shift from hospital care to the community



## The Neighbourhood Alliance: Integrated Community Teams programme

- **Reducing admissions:** The primary goal for 2026/27 is a 10% reduction in avoidable emergency admissions. This targets over-65s, care home residents, and patients at risk of falls, flu, pneumonia, or heart failure.
- **Tackling inequalities:** Alongside the core offer, teams will use local data to target other high-risk groups, such as those with mental health needs or specific long-term conditions.
- **Vaccinations and screening:** There is a phased plan to increase uptake in deprived communities by 15%. Plans on cardiovascular disease (CVD) prevention are also being developed.

# Reminder: Acute Floor Reconfiguration key dates



# Brighton & Hove City Council

**Scrutiny Report Template**

## Health Overview & Scrutiny Committee

## Agenda Item 7

**Subject:** **Cancer Diagnosis and Treatment July 2026 Update**

**Date of meeting:** **08 July 2026**

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

**Contact Officer:** **Name: Giles Rossington, Scrutiny Manager**

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

**Ward(s) affected: (All Wards);**

**Key Decision: No**

**For general release**

| Glossary | |
|---|---|
| 28 day NHS Faster Diagnosis Standard | Target for patients urgently referred with suspected cancer by GP or screening to be diagnosed or definitively cleared within 28 days |
| 31 day cancer standard | Target: patients should wait a maximum 31 days following diagnosis and patient agreeing a treatment plan for treatment to commence |
| 62 day cancer standard | Target: patients should wait a maximum of 62 days between initial referral and treatment commencing |

### 1. Purpose of the report and policy context

1.1 In November 2025, University Hospitals Sussex NHS Foundation Trust (UHSx) and NHS Sussex Integrated Care Board (ICB) presented to the HOSC on local performance and planning with regard to cancer diagnosis and treatment. Members requested an update report be brought to committee at a future meeting. This report provides the requested update.

1.2 Information provided by UHSx is included as Appendix 1 to this report.

## 2. Recommendations

2.1 Health Overview & Scrutiny Committee notes the report.

## 3. Context and background information

3.1 Improving the detection and treatment of cancer is both a national and a local priority. Lord Darzi's 2024 Independent Investigation of the National Health Service notes that the UK continues to have appreciably higher cancer mortality rates than other countries. The Darzi report identifies an urgent need to improve national cancer diagnosis and to reduce waiting times for treatment. There are national cancer targets, including the 62-day referral to treatment standard, the 28-day faster diagnosis standard and the 31-day treatment standard.

3.2 Locally The Sussex Integrated Care Strategy, Improving Lives Together, lists improving cancer services as one of the five strategic priorities for Brighton & Hove: "we will complete the recovery of cancer services affected by the pandemic, improve performance against cancer waiting times standards and deliver the ambitions of the Long Term Plan to diagnose more people with cancer at an earlier stage, with a particular focus on disadvantaged areas and underserved communities where rates of early diagnosis and screening uptake are lower" (p37).

3.3 Appendix 1 to this report contains information provided by University Hospitals Sussex NHS Foundation Trust (UHSx). This paper includes data on Sussex and Brighton & Hove performance against the national cancer targets as well as details of local plans to improve performance in some areas.

3.4 Members should refer to the appendix for more detailed performance information. In brief, local performance shows continuing, consistent improvement against the 28 day and 62-day targets. There are challenges in terms of the 31-day target. Local performance is currently around 80%, which is some way short of the 96% national standard. The Cancer Patient Tracking List (PTL) shows the number of patients who are over 62 days into their cancer pathway, broken down by specialty. This shows general improvements, but with skin cancers as a significant local (and national) outlier. Appendix 1 outlines a number of initiatives to further improve performance.

3.5 The HOSC previously considered a report on cancer diagnosis and treatment in November 2025. The minutes of this meeting can be viewed here: For enquiries on this agenda please contact Members should note that screening is also an important element of improving cancer performance. The HOSC has previously received reports on local cancer screening

performance and improvement planning, for example a paper on cervical cancer and Human Papillomavirus (HPV) immunisation in November 2024.

## 4. Analysis and consideration of alternative options

4.1 Not relevant for this information report.

## 5. Community engagement and consultation

5.1 None for this information report.

## 6. Financial implications

6.1 No direct financial implication arising from this information only report.

Name of finance officer consulted: Ishemupenyu Chagonda Date consulted: 29/06/2026

## 7. Legal implications

7.1 There are no direct legal implications arising from this report which is to note.

Name of lawyer consulted: Elizabeth Culbert Date consulted 290626

## 8. Risk implications

8.1 None for this information report.

## 9. Equalities implications

9.1 None directly for this information report. Members may wish to note that the most deprived communities typically experience greater prevalence of some cancers and tend to have lower rates of screening and of early diagnosis than wealthier communities. These differences may contribute significantly to health inequalities, including life expectancy and healthy life expectancy.

## 10. Sustainability implications

10.1 None identified.

## 10. Health and Wellbeing Implications:

10.1 None directly for this information report.

## Other Implications

## 11. Procurement implications

11.1 None identified.

## 12. Crime & disorder implications:

12.1 None identified.

## 13. Conclusion

13.1 Members are asked to note the update on cancer diagnosis and treatment performance.

## Supporting Documentation

### 1. Appendices

1. Information provided by UHSx.

We are compassionate
We are inclusive
We are respectful

University Hospitals Sussex
NHS Foundation Trust

# Cancer Annual Review



HOSC Meeting

June 2026

Excellent Care Everywhere

# Cancer Constitutional Standards

University Hospitals Sussex NHS Foundation Trust

Progress being made but not at the pace required for our patients:

- Faster Diagnosis (28 days to diagnosis)
  - 2023/24 12-month average = 65.3%
  - 2024/25 12-month average = 70.5% (**+5.2 pp**)
  - 2025/26 12-month average = 76.0% (**+5.5 pp**)

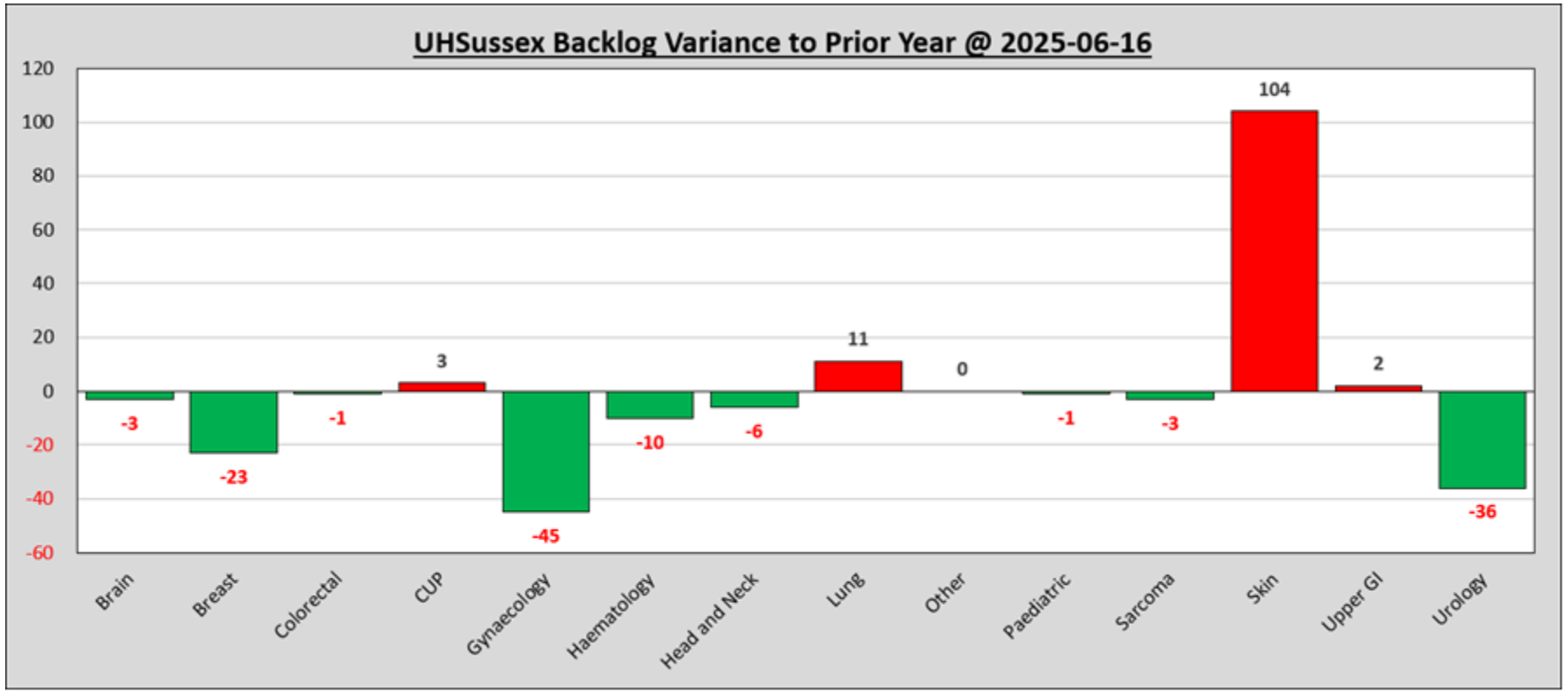
- 62 Days to Treatment
  - 2023/24 12-month average = 55.1%
  - 2024/25 12-month average = 60.1% (**+5.0 pp**)
  - 2025/26 12-month average = 63.8% (**+3.7 pp**)
    - Reaching a Trust high of 72.4% in March 2026

- 31 Days DTT to Treatment
  - Around 80% of patients treated within 31-days of a Decision-To-Treat
  - National standard is 96%, with national improvement target of 94% by March 2027
  - Biggest challenges with surgery first treatment and radiotherapy (RT) subsequent treatments

# Cancer PTL Backlog

University Hospitals Sussex
NHS Foundation Trust

Definition: The number of patients on the Cancer Patient Tracking List (PTL) who are over 62 days into their pathway is used by NHS England as a gauge for good patient pathway management.



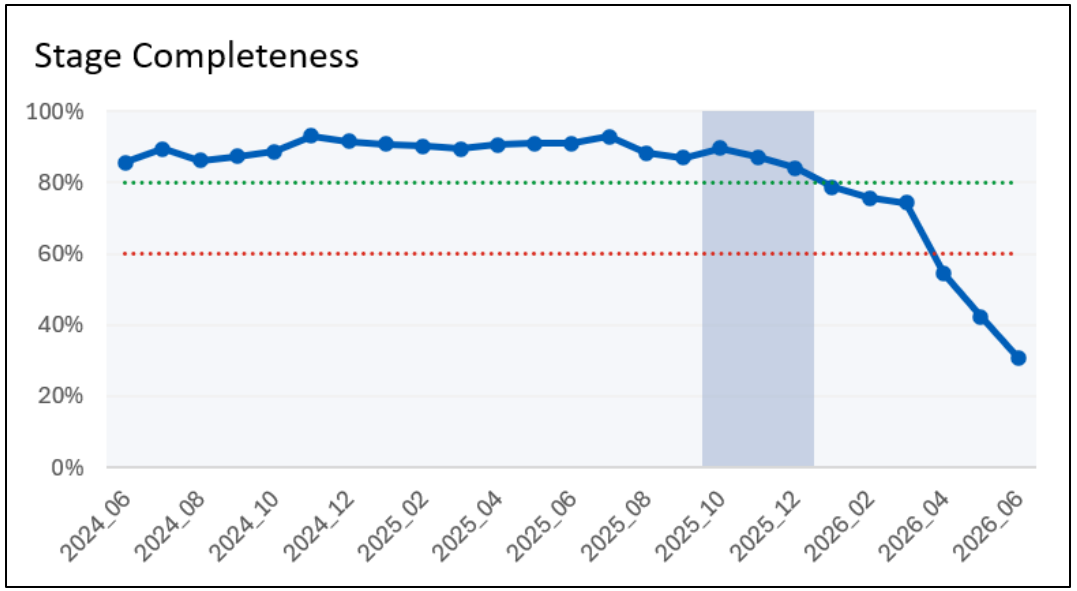

Improvements in volume of patients waiting over 62 days has improved across all tumour sites except Skin which has over 100 pts waiting over 62D more than 12 months ago – this is linked to seasonality which affects Skin cancer performance across the country

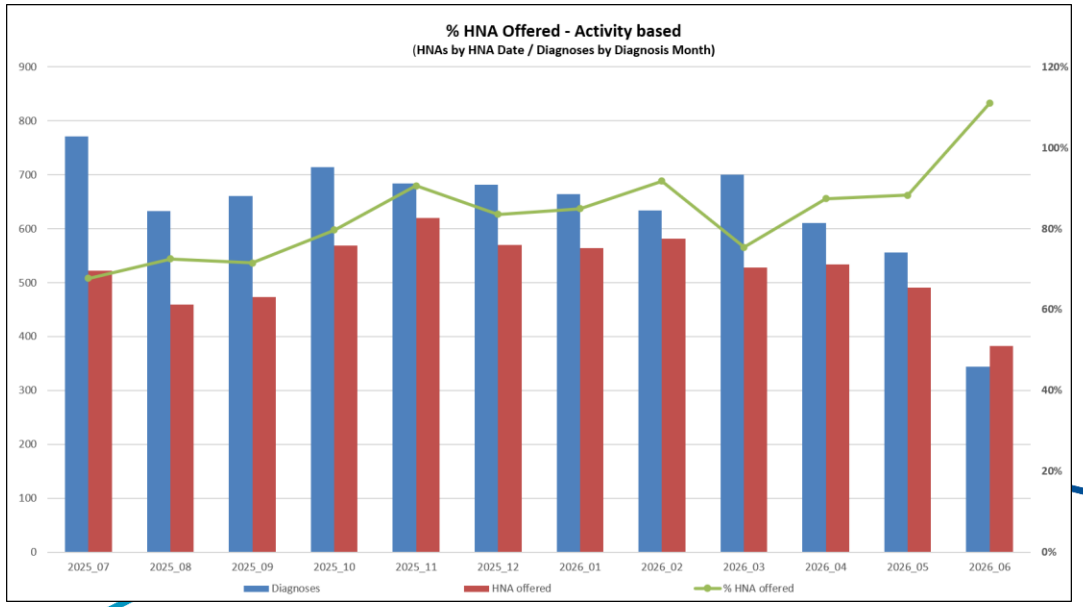
# Cancer Outcomes and Services Dataset (COSD)

University Hospitals Sussex
NHS Foundation Trust

- Staging Completeness
  - Significant work has been undertaken to redesign the data capture and monitoring processes, and to retrospectively go back and recapture missing data which has impacted positively on timely data capture and therefore data quality.
    - Jan-Mar 2023 = 63.8%
    - Jan-Mar 2024 = 74.7% (**+10.9%**)
    - Oct-Dec 2025 = 82.4% (**+7.7%**)

    (most recent "quarter of interest" shaded blue in the graph on the right)




- Holistic Needs Assessments
  - Patient welfare reviews, to signpost patients to the right support, information and help
    - Covers psycho-social wellbeing, financial, nutritional and physical wellness
  - Rebuild of Trust "Cancer Information" patient website currently underway for better accessibility, formatting and timely information

# MDT Transformation

University Hospitals Sussex NHS Foundation Trust

- Agenda
  - Continued roll-out of automated circulation of MDT Meeting Agendas
    - Standardised layout
    - More effective use or workforce
    - Work underway to digitally support MDT preparation

- Standards of Care (SOC)
  - Development and implementation of SOC to optimise MDT Meetings
  - Continued work on this is required to embed current practices

- MDT Meeting Outcomes
  - Working to ensure all MDT Meeting outcomes are visible to Trust-wide clinicians
  - Digital solution to make this more efficient and consistent

# Service Transformation & Improvement

University Hospitals Sussex
NHS Foundation Trust

- Improved turnaround times (TAT) for Endoscopy access for suspected cancer patients
  - From an average of 44.5% TAT within 10 days of request in 2024/25 to 63.3% in 2025/26 (to note YTD in 2026/27 10-day TAT performance is 76.1%)

- Patient Stratified Follow-Up (PSFU)
  - Implemented PSFU protocolised follow-up pathway for Colorectal and Prostate Trust-wide
  - Just finalising last bits for full go-live in Breast
  - Already well underway in developing the SOP's and procedure guides for Endometrial, High-Grade Lymphoma and Uveal Melanoma

- RT Operational Transformation
  - Review of demand & capacity (seeking outsourcing and mutual aid) and recovery trajectories
  - Review of internal use of data, to better understand the specific issues
    - Looking to develop a real-time pathway capacity report (i.e. no. of pts waiting CT, waiting volumning, waiting start date, waiting to start, waiting follow-up dose)

# Service Transformation & Improvement

University Hospitals Sussex
NHS Foundation Trust

- Relocation of LGI Surgery from Brighton to Worthing
  - Significant transformation project to move all LGI cancer surgery to Worthing involving complete remapping of pathways and appointment of 4 new surgeons
  - Benefits relate to improved access to theatres and zero cancellations on the day which was often a theme in RSCH due to acute pressures on the site
  - 62D performance has improved but still work to do in the middle part of the pathway (diagnosis to decision to treat)

- Skin Demand & Capacity
  - Detailed assessment of demand based on machine learning of past 5 years of referral patterns
  - Capacity review including:
    - Base funded capacity
    - Internal options for extra capacity
    - Externally sourced capacity (insourcing and outsourcing)

# Future Plans

University Hospitals Sussex
NHS Foundation Trust

- NHS Cancer Plan – in partnership with SSCA and ICB – roadmap to meet key ambitions (community/digital/prevention)
- Full recovery of radiotherapy delays by Christmas 26 – new (additional) linear accelerator due for installation July 26
- Best use of our workforce
  - Optimising pathways
    - right test first time
    - linked to the frailty work, test requirements
  - Utilising digital solutions
    - EPR
    - Using our systems more holistically for patients
- Building inequalities into our daily work
  - Plain English letters to patients
  - Looking at areas of higher late-stage presentation for patterns and unmet needs
  - Considering frailty earlier in the pathways to better manage these patients
  - Continuing to support Lung Cancer Screening to identify patients at an earlier stage

# New Sussex Cancer Centre at RSCH


## The new Sussex Cancer Centre is a unique catalyst for improvement and transformation

- Transforming treatment – *best-practice care*
- Transforming experience - *a healing place*
- Transforming research - *improving outcomes*

Foundation Stone Ceremony - 22 May 2026
Opening for patients - Spring 2029

# Brighton & Hove City Council

**Scrutiny Report Template**

## Health Overview & Scrutiny Committee

## Agenda Item 8

**Subject:** **NHS Change: July 2026**

**Date of meeting:** **08 July 2026**

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

**Contact Officer:** **Name: Giles Rossington, Scrutiny 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 There is standing item on 'NHS Change' at HOSC meetings where NHS Surrey & Sussex Integrated Care Board provides a verbal or written update on recent and planned local and national NHS developments. Information provided by NHS Sussex is in Appendix 1 to this report.

### 2. Recommendations

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

### 3. Context and background information

3.1 The NHS is undergoing a significant programme of change. This includes the reorganisation of NHS commissioning, with Integrated Care Boards merging and re-focusing on strategic commissioning. It also includes priorities to improve neighbourhood services, shifting activity from acute to community settings and developing a more preventative approach to health care.

### 4. Analysis and consideration of alternative options

4.1 Not relevant to this report for information.

## 5. Community engagement and consultation

5.1 None for this information report.

## 6. Financial implications

6.1 None for this information item

## 7. Legal implications

7.1 None for this information item

## 8. Risk implications

8.1 None for this information item

## 9. Equalities implications

9.1 None for this information item

## 10. Sustainability implications

10.1 None for this information item

## 10. Health and Wellbeing Implications:

10.1 None for this information item

## Other Implications

## 11. Procurement implications

11.1 None for this information item

## 12. Crime & disorder implications:

12.1 None for this information item

## 13. Conclusion

13.1 Members are asked to note the NHS Surrey & Sussex Integrated Care Board update on NHS change.

## Supporting Documentation

## 1. Appendices

1. Information provided by NHS Surrey & Sussex Integrated Care Board – NHS Change July 2026

NHS
Surrey and Sussex

# Brighton and Hove Health Overview and Scrutiny Committee

## June 2026 v1

**Introduction**

NHS Surrey and Sussex Integrated Care Board (ICB) was formally established on 1 April 2026, bringing together the former NHS Surrey Heartlands and NHS Sussex organisations into a single ICB responsible for planning and commissioning health and care services across the two areas.

As a strategic commissioner, the ICB's core purpose is to improve population health outcomes, reduce inequalities, and ensure the effective use of NHS resources for a population of over three million people. It works in partnership with providers, local authorities and community organisations to plan services that better meet local needs, shifting the focus from reactive treatment to prevention and proactive care.

The creation of a single ICB reflects wider NHS reforms to strengthen system leadership, reduce duplication and enable more coordinated, place-based care, supporting improved outcomes, better experience and greater long-term sustainability for communities across Surrey and Sussex.

**Key updates**

1. **ICB update – transition and new operating model**

Further to the successful launch of the new NHS Surrey and Sussex Integrated Care Board (ICB) on 1 April 2026, our transition programme continues, focusing on a number of non-statutory areas of work that we continue to work on and bring together. This includes areas such as culture development, ICB estates (office locations), the creation of a new digital, data and insight directorate across Surrey, Sussex and Kent, and transition of services previously provided by the Commissioning Support Units (CSUs).

We are also continuing the implementation of our new operating model and organisational structure following staff consultation earlier in the year. The new ICB will become a much leaner organisation, about half the size of our two combined organisations at the outset of this change in March 2025 and we are now part-way through the filling of posts process. To date, most senior appointments have now been made and we expect most new teams to be in place by the end of June 2026.

Supporting colleagues through this process continues to be a priority for the organisation. We have a full programme of support available – from practical support to personal support – and this continues to be well accessed. We will continue to work with those colleagues who have not yet secured a role to find suitable alternative employment wherever possible, including working closely with system partners.

2. **Five Year Strategic Commissioning Plan**

A focus for our new organisation has been the finalisation of our Surrey and Sussex Five Year Strategic Commissioning Plan Our five-year commissioning plan | ICB - Surrey and Sussex. Together with an Integrated Needs Assessment (INA), the two key documents set out the health and wellbeing needs of our population, and what we need to do to address these over the next five years.

Following a submission to NHS England in February, the plan and the INA will be presented to the NHS Surrey and Sussex Integrated Care Board on 24 June 2026. After this, the next stage will be to design year-by-year phasing and outcome measures through a series of internal and external engagement workshops, linked to a clear evaluation framework to map and track both delivery and associated health outcomes for our population.

Last month we held a first internal workshop where we considered five key priorities for year one - the continued development of Integrated Neighbourhood Teams, outpatient transformation, urgent and emergency care, planned care and prevention. A further session is taking place this month, and this will be followed by system workshops to ensure provider and partner alignment.

We expect to engage before the next HWWBs in September and consider together how this shape future planning and assurance of the work across Surrey and Sussex.

## 3. Neighbourhood Health

A key foundation of our Five Year Strategic Commissioning Plan is neighbourhood health. Much work is underway across our communities to further develop our approach and implement this shift of care closer to home for our population.

Work across all of our Integrated Community Teams (ICTs) in Sussex and our neighbourhoods in Surrey is progressing well this year in line with our Commissioning Intentions. The two schemes in the National Neighbourhood Health Implementation Programme – East Surrey and Hastings and Rother – continue to progress; Crawley remains a key part of the regional scheme, and work in East Brighton has been recognised in the national NHS Excellence Awards (more below).

As part of this development, the Government has a clear ambition to develop 250 neighbourhood health centres by 2035.

This will comprise a mix of upgrades to existing buildings (via public capital routes and existing capital allocations) and new build centres (based on local need, value for money and deliverability), delivered both through public capital and public/private partnerships.

Last month, ICBs were asked to develop a neighbourhood health centre pipeline, with expressions of interest for national funding (from a £50m pot) submitted to the national team.

Our teams prepared an initial baseline of proposed locations (across Surrey and Sussex), intended as a starting point for engagement and discussion – and submitted this list with 70 schemes included. These schemes reflect local insight and need and take account of the most suitable estate approaches in different areas. Following feedback from the national teams, we were asked to streamline this further in terms of prioritisation, and we await further communication on any potential national funding. In the meantime, schemes continue to be developed with wider sources of funding and partner support to enable our ambition of neighbourhood health for Surrey and Sussex.

## 4. System overview

Both the Surrey and Sussex healthcare systems continue to experience high demand and we continue to work closely with providers to bring colleagues together and support wider system coordination.

Attendances remain high with acute and community providers continuing to experience pressures in flow and discharge. Ambulance handover times have continued to improve as the systems support flow and alternative patient pathways are maximised where possible to get people seen in a timely fashion and in the most appropriate place.

Both systems responded with well-prepared plans to the resident doctor industrial action which took place after the Easter bank holiday weekend (7 – 13 April 2026), ensuring patient safety was prioritised. Following discussions at national level, the four-day industrial action by resident doctors due to take place from 15-19 June 2026 was suspended on 13 June 2026, with the British Medical Association (BMA) agreeing to ballot their members on a new offer. Colleagues across Surrey and

Sussex worked hard to stand-down preparations that had been put in place to minimise patient disruption.

**Delivering for our population**

Since the last update there has been several key achievements and successes across the health and care system:

- *East Brighton Team wins regional NHS Excellence Award for Neighbourhood Health*

The East Brighton Integrated Community Team (ICT) has been recognised in the NHS Excellence Awards for its innovative work to improve people's access to the care they need and reduce health inequalities - winning the South East award for Neighbourhood Health and shortlisted for the national ceremony.

The team is one of three driving forward a neighbourhood health approach in the city, focusing on the needs of the local community and identifying new ways to support people closer to home.

Local data shows higher than average Accident and Emergency (A&E) attendance and hospital admissions that could have been prevented, alongside lower uptake of cancer screening and services that support people to stay well.

At the heart of the team's approach is the Whitehawk Health Hub, which launched in November 2024. The Hub operates a weekly open-access drop-in service, bringing together healthcare professionals and VCSE organisations at Robert Lodge - a trusted community space on a local housing estate.

Residents can access support from a wide range of professionals in a single visit, including GPs, pharmacists, physiotherapists, mental health practitioners, benefits advisors and housing support services, providing early intervention and practical support for both medical and non-medical needs.

Alongside the hub, the team has also delivered outreach sessions in trusted local venues such as food projects and women's groups - helping to reach people who may face barriers to accessing traditional healthcare services. These sessions focus on prevention and early intervention, including blood pressure checks, health literacy support, cancer screening awareness, digital inclusion and NHS App support.

Over the past 15 months, the model has delivered measurable benefits for local residents, communities and staff. The weekly drop-in service alone has supported 1,269 residents, with more than half of attendees reporting they would otherwise have sought help from their GP or acute care.

- *Lung Cancer Screening Programme reaches key milestone*

The NHS Lung Cancer Screening Programme, currently being rolled out across Surrey and Sussex, has diagnosed more than 300 local people with lung cancer since it was first launched in the region in June 2022. More than three-quarters of those patients were diagnosed at Stage 1 and 2 which widens the treatment options and improves survival rates.

Lung cancer screening is being offered to residents aged between 55 and 74 with those who smoke or have smoked in the past invited for a lung health check. To date, more than 100,000 people across the region have been invited for lung screening.

Lung screening is a national initiative being rolled out in phases across the country with the aim of reaching all eligible populations by 2030. Since its launch locally four years ago, lung screening has reached 30% of the eligible population - starting in Sussex and recently launched into Surrey.

- *Sussex NHS pilot offers Attention Deficit Hyperactivity Disorder (ADHD) assessment and support closer to home*

Adults in parts of Sussex are benefiting from a new NHS pilot designed to improve access to ADHD assessment and support closer to home. The ADHD Primary Care Connect service operates across Brighton and Hove, Crawley and Hastings, offering neighbourhood-based care through local GP practice teams. The pilot was developed by Sussex Primary Care Provider Collaborative, Sussex Partnership NHS Foundation Trust and NHS Sussex in response to growing demand for neurodevelopmental services.

More than 300 people have already received assessments through the service, which also provides up to 12 months of personalised support, including care coordination, wellbeing advice and links to community resources. Early feedback has been highly positive, with patients praising the speed, communication and supportive approach.

- *Transforming NHS hospital care in Sussex*

Two landmark milestones in transforming hospital care for people living across Sussex and beyond were marked last month. The Brighton helipad was formally opened by the first patient flown directly onto the new platform, in March 2026. At ground level, the foundation stone was laid for the Sussex Cancer Centre, the state-of-the-art facility due to open for patients across the county by 2029.

These are the latest developments in the "3Ts" project, funded by the government's New Hospital Programme. Phase 1 was the £500m Louisa Martindale Building, Phase 2 is building a modern cancer centre on the site of the old, iconic Barry Building, and Phase 3 will be the installation of a new service yard on the site of the current cancer centre.

Elsewhere, work is also underway to develop a new and improved £50m emergency floor in Brighton, while the Trust has delivered a new centre of excellence in colorectal cancer surgery (in Worthing), and is working to open a new stroke centre (at St Richard's, Chichester).

**Across the ICB**

- *Elective progress at SASH*

In the latest data released in June 2026, Surrey and Sussex Healthcare NHS Trust is amongst the top 10 trusts for elective improvement, its best performance since the pandemic

It has increased the number of patients being treated within 18 weeks from 55% to 67% in 2025-26, the highest level achieved in recent years.

In the same year it has also reduced its overall waiting list by 14% - more than 7,000 patients.

- *Sussex Surgical Centre celebrates Royal Opening*

The Sussex Surgical Centre at Eastbourne District General Hospital was formally opened in June by Her Royal Highness The Duchess of Gloucester, marking a significant milestone for planned surgical care across East Sussex and the wider region.

The Duchess toured the state-of-the-art facility, meeting clinical, operational and project colleagues whose work has shaped the Centre since its opening last year. The visit followed the same route a patient takes through the Centre, from reception and pre-operative assessment to the operating theatre and second-stage recovery – offering Her Royal Highness a close look at the patient experience and the teams delivering it.