BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 8 JULY 2026

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Wilkinson (Chair)

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

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

PART ONE

1 PROCEDURAL BUSINESS

1(a) substitutes

1.1 There were no substitutes. Cllrs Baghoth and Hogan sent apologies.

1(b) Declarations of Interest

1.2 Cllr De Oliveira declared an interest in Item 8, NHS Change, noting that his partner is employed at NHS Surrey & Sussex.

1(c) Exclusion of Press & Public

1.3 The press & public were not excluded from the meeting.

2 MINUTES

2.1 The minutes of the meeting of 22 April 2026 were agreed as an accurate record.

3 CHAIR'S COMMUNICATIONS

3.1 The Chair gave the following communications:

We're looking at 3 issues today. First, I've asked the hospital trust to come and present on their plans to reconfigure the acute floor at the Royal Sussex County Hospital. This is a major capital project that has already seen the creation of new surgical and medical assessment units. We are now entering the phase where the hospital's emergency department is being

revamped. We all know that improvements to A&E are urgently needed and I'm sure we all welcome the reconfiguration. Members will be keen to know what improvements are being made and how this will improve patient experience and the conditions that emergency department staff have to deal with every day.

However, rebuilding an emergency department while still running services from the same building is a challenging prospect and I wanted to give members the opportunity to seek assurances that everything possible is being done to minimise the impact on patients of what will be a long and complex build. While this is the hospital trust's project, health and care system partners have an important role to play in working together to reducing unnecessary admissions and discharge delays during the build, and members may have questions for NHS commissioners and for adult social care as well as for University Hospitals Sussex.

Second, we have an item on cancer diagnosis and treatment. This is an update requested by committee members following a presentation at last November's committee. This item will also be led by University Hospitals Sussex.

Finally, we have our regular update from NHS Surrey & Sussex Integrated care Board on changes to the local NHS commissioning landscape.

4 PUBLIC INVOLVEMENT

4(a) public question from Jo

4.1 Cllr Evans read out the public question at Jo's request: How does Southdown redesign of services demonstrate empowering mental health service user voices when their feedback and complaint portal is designed too small to hold complaints and AI is used to change the meaning of complaints into inaccurate versions of those complaints?

4.2 The Chair told members that he had forwarded the question to Southdown who manage the services in question and had received the following response:

Southdown's complaints process uses a Microsoft Customer Voice form, which includes a 4,000-character field for describing a complaint. This is normally sufficient for people to explain their concerns. Where additional information is required, it can be submitted by email and is retained in full as part of the complaint record. In some cases, people choose to submit their complaint by email rather than using the form. Where this happens, the service manager enters the complaint into the Microsoft Customer Voice form on the complainant's behalf. If the original email exceeds the 4,000-character limit of the relevant form field, the full email is retained within the complaint record and considered as part of the investigation.

In all cases, complaints are explored using all the information we receive. Information recorded within the complaints system is used to support acknowledgement and response correspondence. Where the length of a complaint exceeds the capacity of a relevant field within the system, a summary is used instead, while the full complaint remains available to inform the investigation. This approach is explained to the complainant and is not intended to alter the meaning of the complaint, only to summarise its content. Supporting software may be used to produce this summary and, if the complainant feels it is inaccurate, the summary can be updated.

4(b) public question from Mr Gary Vallier

4.3 Mr Vallier asked: The independent NHS investigation into WellBN has now identified actual and potential harm arising from prescribing practices affecting children and young people in Brighton. For many months HOSC declined to pursue questions about local safeguarding arrangements on the basis that an investigation was underway.

Now that the report has been published, what specific scrutiny activity will HOSC undertake to examine the wider system issues identified, including relationships between schools, youth services, primary care and specialist gender services?

4.4 The Chair responded:

Thank you for your question. I note the publication of the NHS England review. The review has identified serious issues regarding the clinical approach to care by some GPs at the WellBN practice and I welcome the actions taken by NHS England and NHS Surrey & Sussex as set out in the report.

Following today's meeting, I will discuss with committee members whether this is an issue they wish to scrutinise in depth. I will consider whether it is appropriate to scrutinise NHS Surrey & Sussex Integrated Care Board's role in commissioning and overseeing local primary care services. This may include inviting the ICB to attend a future meeting.

5 MEMBER INVOLVEMENT

5.1 A member letter was received from Cllr Mitchie Alexander, Cabinet Member for Communities, Equalities, Public Health and Adult Social Care. Cllr Alexander attended to present her letter which reads

I have been having various conversations recently with advocate groups for people with learning disabilities and autism and also direct conversations with people with learning disabilities and/or autism.

They tell me that they find the waiting area in A&E very, very difficult due to their autism and in fact one man told me that he avoided going to A&E because he couldn't face the busy waiting room and in the end his medical condition got suddenly worse, due to the fact that his issue couldn't be dealt with when it first arose.
Can the chair and the committee members ask UHSx to please include within the designs of the new A&E, at least one 'quiet, autism friendly' room. Where someone with certain needs, such as a learning disability or autism can wait to be assessed.

The impact of being very unwell and/or in a lot of pain is extremely heightened for a person with learning disabilities and/or autism and this could be better managed by having a quiet space available to them, whilst they wait for an assessment.

The redesign of the A&E department is the perfect opportunity to consider persons in our city with complex needs and how the area can include provision in the future for those with more

complex needs, so that their wait for assessment can be more manageable for them and their carers and indeed for the other people waiting in the communal area for medical assessments.

5.2 The Chair responded, thanking Cllr Alexander for her letter and agreeing to raise this important subject with representatives of University Hospitals Sussex NHS Foundation Trust when the plans to reconfigure the acute floor of the Royal Sussex County Hospital were discussed later in the meeting.

6 ROYAL SUSSEX COUNTY HOSPITAL: ACUTE FLOOR RECONFIGURATION

6.1 This item was presented by Nigel Kee, University Hospitals Sussex NHS Foundation Trust (UHSx) Chief Delivery Officer; Nikki Mead, Transformation Programme Manager; Craig Marsh, Head of Nursing, Acute Floor; and Stephen Mardlin, Royal Sussex County Hospital (RSCH) Hospital Director.

6.2 Mr Kee told members that the acute floor at RSCH needed to be reconfigured to improve capacity and bring services up to modern standards. Ms Mead added that the reconfiguration would provide an improved environment for all patients, including people with dementia, people with learning disabilities and neurodiverse people. There will be more quiet areas and a 76% increase in individual cubicles, which will reduce noise and provide for adjustable lighting to help patients feel comfortable. The capacity and the footprint of waiting areas will be increased and they will be spilt into different sections so not everyone has to wait in the same space for treatment. Earlier clinical triage will help identify those who need additional support to wait. Colour will be used to split the area into zones, helping patients orientate through the department. There has also been a focus on the materials used, recognising that some vulnerable patients struggle with glare from walls or similar issues.

6.3 Mr Marsh told the committee that staff and patient feedback has informed the reconfiguration plans. For example, the creation of separate waiting areas will allow patients to progress in their waits, moving from general to more specific areas once their needs have been identified. This is something that many patients value. Close attention has been paid to ensuring that the new environment works for staff, with additional staff facilities and equipment storage.

6.4 Mr Kee added that there are other significant, but less visible, elements of the reconfiguration, including an upgrade of digital services and improvements to ventilation systems. The new acute floor will provide more privacy and dignity for patients, more capacity, better infection control and better trauma care. Ms Mead outlined the timeline for completion of the Phase 2 enabling works and of Phases 2 and 3 of the build. The work is expected to complete in 2030.

6.5 Cllr De Oliveira stated that system pressures such as discharge delays and a lack of mental health acute beds meant that improvements to the acute floor would not necessarily address the local crisis. Mr Kee responded that it was important that, in addition to the reconfiguration, there are better pathways for patients, recognising that some people do not need to be treated in the emergency department. The trust is working closely with partners to tackle the system pressures identified by Cllr De Oliveira. Ms Mead added that she agreed that additional capacity is not a panacea; people presenting at A&E who require a mental health bed, and discharge flow are identified as major project risks.

6.6 Mary Davies (Older People's Council) praised the Phase 1 facilities that have already been opened. She asked whether an Equality Impact Assessment (EIA) could be shared with the committee. Ms Mead replied that an EIA for Phases 2 and 3 was being developed as part of the project business case. Once complete, this can be shared with the committee. ACTION

6.7 Cllr Parrott questioned the degree to which patients had been involved in the reconfiguration plans. Mr Kee responded that he welcomed the challenge around patient voice. The trust recognises the importance of involving patients at all stages of the reconfiguration. Mr Marsh noted that it is particularly difficult to capture patient views of emergency services. He works closely with nursing staff and via an Emergency Department Patient Forum to get information. Mr Mardlin added that he had recently attended the West Integrated Community Team (ICT), to discuss how to use ICT and GP practice-level data on admissions to better understand patterns of admission and where best to intervene to reduce unnecessary admissions. This is a key element of improving the experience of those people who do need to use emergency services.

6.8 Geoffrey Bowden (Healthwatch) queried whether there was sufficient capital funding to deliver the programme of changes. Ms Mead replied that the programme is in a strong position. There is contingency funding and some aspects of the programme have already been delivered within budget.

6.9 Cllr Evans told members that she had recently attended A&E on a weekday afternoon and had found it chaotic, with far too many people waiting in an unsuitable environment. She contrasted this with the reception at the Louisa Martindale Building, where a very large space is underused. Cllr Evans questioned whether it was possible for the trust to maintain clinical capacity and sufficient waiting space for the duration of the works and queried the 2030 end date. She also asked about engagement with staff and unions, making the point that staff in some hospitals report that permanent staff are treated differently to staff working temporarily or on rotation. Mr Kee replied that relations with staff are good. The trust does not discriminate between permanent and temporary staff. UHSx is confident it can meet the 20230 target for completion of works. However, there is always the possibility that this may be impacted by geopolitical factors beyond the trust's control. Mr Marsh added that recent weeks had been very challenging, with the trust going into business continuity at one point. Patient pathways need to be improved, and this work should not wait for the reconfiguration to be completed. If people are waiting in A&E for many hours to be seen, then they probably should not be in A&E and would be better served being directed elsewhere for treatment. Mr Marsh explained some of the measures taken to engage staff. Mr Mardlin explained that the recent heat wave had impacted hospital services, both because some equipment did not function properly in the high heat and humidity and because South East Coast Ambulance Service was overwhelmed with demand. This meant that it took them longer to reach and convey patients, leading to patients arriving in hospital with their conditions more acute than they should have been. Whilst the weather had subsequently cooled somewhat, the heatwave had a knock-on effect which was still being felt in the following week.

6.10 Nora Mzaoui (CVS representative) asked about access and wayfinding to A&E and about the use of sub-waiting areas. Mr Kee replied by acknowledging that more needs to be done in terms of improving wayfinding. In terms of sub-waiting areas, some patients do dislike this, but there are real advantages in being able to progress patients to less crowded waiting areas that are appropriate for their medical needs. Ms Mead added that sub-waiting areas should only be used for different stages of a patient's treatment journey – patients should not

simply be moved from waiting area to another. Wayfinding is a challenge. However, the staff at the Louisa Martindale reception are excellent and can help direct and sometimes accompany patients to A&E.

6.11 Cllr Winder asked about the role of GPs in improving A&E. Mr Kee responded that the business of A&E inevitably makes it harder to deliver good clinical outcomes and positive patient experience. GPs have a key role to play in avoiding unnecessary A&E attendance and admissions and the trust is committed to working with local GP practices via city ICTs to reduce unnecessary attendances.

6.12 Cllr Hill asked questions about RSCH performance in terms of corridor care and ambulance handover times. Mr Kee replied that the trust is working hard to reduce incidents of corridor care and is receiving national support for this. Mr Marsh responded that, unlike many other trusts, UHSx has a policy of not delaying ambulance handovers by making patients wait in ambulances when there are no beds available for them. However, this can mean that more people have to be accommodated in corridors.

6.13 Cllr Hill asked a question about out of hours capacity at the early pregnancy unit. Mr Kee agreed to take away this question. Mr Kee subsequently confirmed that the Early Pregnancy Unit is open 24/7 and can be accessed by patients self-presenting as well as via the Emergency Department.

6.14 Cllr Simon asked about the lack of natural light in the ED. Ms Mead replied that the use of lightbox skylights has been successfully trialled in the AMU and will be rolled out across ED.

6.15 Cllr Simon asked about people waiting in the ED for a mental health bed after presenting at A&E. Mr Kee replied that Sussex Partnership NHS Foundation Trust (SPFT) has an improvement plan to reduce these presentations, and UHSx is working in partnership with SPFT on this. Ms Mead added that the current area used for people waiting for a mental health bed is not replicated in the reconfiguration plans. This is an issue that needs to be addressed by the entire local health and care system.

6.16 Cllr Simon asked about work with the most deprived communities around admission prevention. In response, Tanya Brown-Griffith (NHS Surrey & Sussex) outlined neighbourhood health improvement plans, including the development of neighbourhood hubs. Mr Mardlin added that the trust is committed to working closely with ICTs across the city to understand and address local community needs.

6.17 Cllr De Oliveira asked how confident the trust could be in its modelling. Mr Kee responded that UHSx uses national tools to model capacity and demand. Ms Mead added that the modelling for the reconfiguration project was based on a 10 year forecast for demand which uses current activity as a baseline and allows for significant demographic growth.

6.18 Mr Bowden raised the issue of police bringing people in mental health crisis into A&E as a Section 136 place of safety. Mr Kee replied that there will be SPFT presence at the reconfigured site, but not a dedicated space to house people waiting for admission into acute mental health beds as is currently the case. UHSx will continue to work with Sussex police to manage the issue raised by Mr Bowden.

6.19 Cllr Parrott noted that providers across the local health and care system face significant challenges, including performance problems at UHSx, SPFT and council adult social care. This is important context when thinking about reconfiguration project risk and risk mitigations.

6.20 Cllr Wilkinson asked about reconfiguration project risks in a scenario where discharge delays worsened and further put pressure on ED. Mr Kee replied that there is no loss of ED bed space during reconfiguration, so this is not necessarily a greater risk during Phase 2 and 3 than it is currently. However, UHSx operates a number of acute sites and spare capacity in other hospitals can potentially be used to relieve pressure on RSCH.

6.21 Cllr Wilkinson asked about plans to engage with particularly vulnerable groups, including people with learning disabilities, people with autism and people with dementia, in advance of Phases 2 and 3 of the reconfiguration. Mr Kee responded that engagement plans are in place. Ms Mead added that the main disruption will be from mid-2027 onwards so there is still some time to focus on community engagement.

6.22 RESOLVED – that the report be noted.

7 CANCER DIAGNOSIS AND TREATMENT JULY 2026 UPDATE

7.1 This item was presented by Nigel Kee, Chief Delivery Officer, and by Dr Sarah Westwell, Lead Cancer Clinician, UHSx. Mr Kee and Dr Westwell outlined recent performance across a number of cancer metrics, including the national waiting times targets. Issues highlighted included:

- A focus on better data collection which supports earlier diagnosis and holistic support
- A multi-disciplinary team approach is key to effective cancer care in many instances, but needs to be used appropriately as it can slow the delivery of care for people with relatively straightforward treatment pathways
- Recent improvement in access for endoscopy
- A focus on patient follow-ups, with personalised follow-up offers that fit around individual patients' lives
- Better use of Patient Recorded Outcome Measures to drive service improvement
- The development of the Sussex Cancer Centre is on track and will deliver many benefits, including a consolidation of radiotherapy machines, with the 6 units currently situated across Sussex being based at the centre plus an additional unit that has recently been purchased
- The consolidation of LGI surgery at Worthing has been very successful
- The introduction of analytical AI for diagnosis of non-malignant skin cancers has been successful, increasing capacity. There is further potential for this technology to be accessed through primary care.

7.2 Cllr Evans asked about people from the most deprived communities tending to present for treatment at a later point. Dr Westwell replied that this is a complex issue, with multiple factors impacting screening rates. Services need a detailed understanding of individual communities in order to understand what specific improvements need to be made.

7.3 Cllr Parrott noted that skin cancer rates are particularly high in over-75s, which is also the group with the highest levels of digital exclusion. Making access to these services digitally is consequently risky. It can also be very difficult for people to manage complex treatment

regimes; having a named nurse can really help. Dr Westwell replied that cancer pathways have traditionally been designed around the needs of doctors and nurses and need instead to be designed around the needs and abilities of patients.

7.4 Cllr Simon asked for more information about improvements to patient follow-ups. Dr Westwell responded that the standard approach is often based around annual appointments with consultants irrespective of whether this makes sense in each individual case. A more stratified approach to follow-up will adopt approaches that are appropriate to each individual's needs.

7.5 Cllr Simon asked why skin cancer performance is an outlier and queried why AI was being used to drive improvement. Dr Westwell replied that there are increasing numbers of skin cancer due to climate change and poor understanding of the risk of developing melanoma. Improving services is particularly challenging because there is a marked variation in presentation across the seasons, with many more people discovering and presenting with potential melanomas in the summer months which can lead to services being overwhelmed. Using AI in this context is appropriate: AI is significantly better and much quicker than humans for some purposes, for example in the identification of unambiguously non-malignant growths. Around 93% of patients seeking diagnosis do not have malignant growths.

7.6 Cllr Winder asked about public confidence in screening. Dr Westwell acknowledged that this is an issue. There is scope to do more, for example by looking to bundle screening for different cancers and by doing focused engagement with low take-up communities.

7.7 Mr Bowden asked why there is no screening programme for prostate cancer. Dr Westwell replied that there is no reliable test for prostate cancer. In addition, prostate cancer is not a single disease; some cancers are very aggressive, but others are not. Identifying and treating non-aggressive cancers may not always be the best option.

7.8 Cllr Hill asked whether the messaging on screening and on prevention was always effective, noting that different approaches may need to be taken for the TNBI population or for young people. Sr Westwell agreed. Services have much to learn from the success of the HPV vaccination programme.

7.9 RESOLVED – that the report be noted.

8 NHS CHANGE: JULY 2026

8.1 This item was presented by Tanya Brown-Griffith, NHS Surrey & Sussex. Ms Brown-Griffith informed the committee of recent NHS developments including the development of an Integrated Needs Assessment for Surrey and Sussex; the development of a 5-year Strategic Commissioning Plan; work on neighbourhood health; and the NHS Excellence award recently given to the East Brighton Integrated Community Team.

8.2 Cllr Parrott commented that recently introduced ADHD assessment pilot seems to be working well and has received good feedback. Cllr Hill asked about the future of the pilot and enquired whether people can transfer onto it. Ms Brown-Griffith agreed to provide a response outside of the meeting.

8.3 Cllr Simon asked how the focus of each neighbourhood health area is agreed. Ms Brown-Griffith replied that each ICT will develop a delivery plan. These will be informed by Joint Strategic Needs Assessment data, Commissioning and Health data jointly agreed by ICT partners and the Sussex Neighbourhood Alliance before being signed off by the Health & Wellbeing Board.

8.4 Cllr Galvin raised concerns about the potential closure of the Sussex Eye Hospitals. Nigel Kee (UHSx Chief Delivery Officer) replied that UHSx was conducting a strategic review of ophthalmology. The trust had written to the HOSC about this in April. No decisions have yet been reached on the long term future of services. However, significant maintenance needs to be undertaken at the Sussex Eye Hospital which will require the temporary relocation of some services to Southlands Hospital.

8.5 RESOLVED – that the report be noted.

The meeting concluded at 8.20pm

Signed Chair

Dated this day of