CHAPTER THREE – STRATEGIC CONTEXT

3.1 Introduction

3.1.1 This section deals with the national, regional and local policy drivers that are key to the development of the Trust's 3Ts Programme. It also provides further details of the context within which the Trust operates with a description of the local health community and the other providers that operate within it.

3.2 National Strategy and Government Policy

Equity and Excellence: Liberating the NHS 2010

3.2 The White Paper sets out a new organisational structure for the NHS and passes commissioning responsibilities to Clinical Commissioning Groups (CCGs). It heralds the abolition of Strategic Health Authorities by 2012 and Primary Care Trusts (PCTs) by 2013. CCGs will hold the commissioning budget to support the ambition that the patient and their clinician will be at the centre of decision making; '*no decision about me without me'*. Commissioning will be overseen by the National Commissioning Board, which will keep responsibility for commissioning dentistry, community pharmacy and primary ophthalmic services along with the commissioning of regional specialised services.

NHS Operating Framework 2011/12

3.2.1 The *Operating Framework for the NHS* sets out the objectives for the NHS in England. For 2011/12 these are focussed on improving quality of outcomes, safety, effectiveness and experience for patients. The key elements of the *Operating Framework* as they impact on the 3Ts development are outlined below and include major trauma services, stroke services, research and education & training.

High Quality Care for All: The NHS Next Stage Review Final Report (June 2008)

3.2.2 Published in June 2008, this Review was the concluding report on the future of health and healthcare in England undertaken by the then Parliamentary Under Secretary of State at the Department of Health, Professor the Lord Darzi of Denham. Developed by over 2,000 frontline staff and following consultation with eight clinical pathway groups in each region of England, it encapsulated a shared diagnosis of the current status of the NHS, a unified vision of where it needs to be and shaped the next stage of reform.

Fit for Purpose Accommodation

3.2.3 The Review states that the NHS will continue to seek improvements in safety and reductions in healthcare-associated infections in order to support the vision for safe and effective clinical services associated with high quality care. There was also a strong emphasis on the importance of patient safety. The aim is to make hospitals and health centres clean and as free of infection as possible. The Care Quality Commission has new enforcement powers. There will be national campaigns to make care even safer.

3.2.4 The Review also said that practical steps would be taken to improve the quality of workplaces.

Supporting the Development of Specialist Centres

3.2.5 The acute care groups provided compelling arguments for saving lives by creating specialised centres for major trauma, heart attack and stroke care, supported by skilled ambulance services. The Review said the most effective treatments should be available for all NHS patients. For people with stroke – the third largest cause of death and single largest cause of disability in the UK - the clinical evidence clearly demonstrates that the quality of care is greatly improved if people with strokes are treated in specialist centres. Each region is therefore pushing forward with the development of specialised centres for their populations with access to 24/7 brain imaging and thrombolysis delivered by expert teams. For example, NHS South East Coast committed in *Healthier People, Excellent Care* (2008) that all people with strokes, heart attacks and major trauma will be treated in such specialist centres. Once implemented, these plans will save lives.

3.2.6 All the visions emphasised the importance of rapid access to diagnostics in convenient locations. On the one hand, this means tests such as X-rays and blood tests carried out in primary care or even at patients' homes, avoiding needless travel to and from hospital and with results made available more quickly. On the other, it means provision of interventional radiology and specialist pathology in centres of excellence.

3.2.7 The research underpinning the Review confirmed that patients want the most effective treatments, and staff also want to be able to provide them. As the NHS becomes more personal, patients and the public want to be assured that the most clinically and cost effective treatments are available, everywhere. Patients and the public were clear that they had zero tolerance for variations in access to the most effective treatments.

3.2.8 At the same time the Review sees the NHS of the future providing convenient care closer to home. The local visions will make care closer to home a reality for many patients.

Our Health, Our Care, Our Say, DH (January 2006)

3.2.9 This white paper was published in January 2006 and sets out how healthcare services would be re-orientated to focus on prevention and health promotion. The paper recommends a shift in the location where healthcare services are delivered so that most care is undertaken outside hospitals and in patients' homes. Hospitals will then have the freedom to excel at providing the services only they are able to provide, and more services and support will be brought closer to where people need it most.

3.2.10 The main impact of the paper was on outpatients and shifting these into GP practices and other community settings. Reprovision of the Trust's Outpatient facilities as part of the 3Ts programme was considered initially but rejected on the basis that the national direction of travel is into the community. It was therefore felt that further development of general Outpatient facilities should only be undertaken once the Trust and its primary and community care partners feel that as much activity as realistically possible has been transferred from the acute hospital setting.

Major Trauma

3.2.11 All regions are required to move major trauma service provision into network configurations from 2012. Tariff changes introduced in April 2011 are designed to more accurately reimburse providers for the complexity of multiple-injury patients. Designated Major Trauma Centres (MTC) should be planning the continuous provision of consultant-led trauma teams, immediate CT scan options, and access to interventional radiology services for haemorrhage.

3.2.12 The RSCH has been identified as the MTC for the Sussex Trauma Network, subject to formal assessment against the agreed criteria, and is aiming to be operational from April 2012. It will be supported by emergency neurosurgery and integrated spinal surgery services. The whole Neurosciences Centre will be relocated to the RSCH campus once the 3Ts Stage 1 building is complete. This development will also replace planned temporary major trauma facilities with bespoke accommodation.

Regional Networks for Major Trauma, NHS Clinical Advisory Groups (2010)

3.2.13 This reports draws on research evidence and best practice nationally and internationally in recommending the standards that Trauma Networks/Systems, Major Trauma Centres and Trauma Units should meet in order to achieve optimal benefit from the regionalisation of care.

Stroke

3.2.14 The *National Stroke Strategy* (December 2007) is a ten year programme for implementing high quality stroke care across the care pathway from prevention to long term care and support. The *NHS Operating Framework* sets out the future scope for improvement by identifying two key areas for action:

- *Prevention*: improving diagnosis and treatment of people with atrial fibrillation and ensuring that people who are at high risk of stroke who present with a transient ischaemic attack (TIA) are assessed and treated as emergencies. The best practice tariff introduced for outpatient TIA services in April 2011 aims to support high quality care for this group of patients;
- *Acute care*: ensuring all stroke patients are admitted directly to a stroke unit, access timely scanning, are assessed for thrombolysis and receive it where clinically indicated

3.2.15 3Ts includes the relocation of the Regional Centre for Neurosciences to the RSCH site, which will mean faster access to services and clinical expertise for patients with stroke.

Safe Neurosurgery 2000, Society of British Neurological Surgeons (2000)

3.2.16 This report sets out recommendations to bring standards of safety and quality to acceptable levels for the twenty-first century, and to enable planning to be conducted that ensures the long term development of the specialty. Some of the key recommendations are:

- Neurosurgical units should be situated within a multi-disciplinary Neurosciences centre and on a General Hospital site. Each unit must provide a full core neurosurgical service before any sub-specialities are developed.

- For maintenance of neurosurgical expertise and satisfactory training there must be an adequate volume and diversity of work and sufficient population to generate this. Whilst this must be reconciled with equity of access, a one million catchment population should be the minimum.

- Where amalgamation of units is proposed, the criteria against which any decision is made should include equity of access and maintenance of local infrastructures.

- All neurosurgical units must provide a full twenty-four hour consultant led service and be staffed accordingly, i.e. a minimum of 6 WTE consultant surgeons increasing with populations of more than 1.5 million.

- 30 neurosurgical beds and four dedicated neurosurgical intensive therapy beds per million population are needed to deliver safe practice.

- Every neurosurgical unit should have at least two fully resourced operating theatres; those serving a population of more than 2 million need three.

- Neurosurgical units and the Society of British Neurosurgeons should encourage the development of local and national workforce plans to ensure targets on service, staffing and training are co-ordinated and systematically reached.

- Continuing professional training and development (CME/CPD) should be explicitly encouraged and reflected in local budgets.

3.2.17 The coordination of academic neurosurgery, service neurosurgery and research and development in respect of planning and financing needs to be improved. Additionally, increased impetus should be given to implementing the priority recommendations of the Report of the Independent Task Force – *Clinical Academic Careers.*

Improving Outcomes: A Strategy for Cancer, January 2011

3.2.18 This strategy builds on the principles set out in *Equity & Excellence: Liberating the NHS* (described below) by putting the patient at the centre of choices about their care. It focuses on the following:

- tackling the preventable causes of cancer by providing better information to people about risk factors and how individuals and communities might work to minimise them as well as improving the experience of cancer patients and support the increasing number of cancer survivors;

- setting out the ways in which choice for patients in their cancer care will be extended and implemented throughout the health and social care systems; and

- identifying the gaps in information on health outcomes which are crucial to ensuring patients are empowered – in consultation and with the support of their clinicians – to exercise real choice over the care they receive.

3.2.19 The 3Ts development will provide a new modern cancer centre with 5 Linear Accelerators for radiotherapy treatment (and six bunkers) in order to contribute to the Trust's achievement of this objective.

Privacy and Dignity

3.2.20 In January 2009 the Health Secretary announced that from April 2010 hospitals that treat patients in mixed sex accommodation would not be paid for their care. These new penalties are part of a package of measures being introduced in a drive to eliminate mixed sex accommodation – a longstanding commitment by the Department of Health.

3.2.21 The Department of Health guidance[1] to Trusts is that "*men and women should not have to share sleeping accommodation or toilet facilities*." From 2010/11 hospitals that have failed to deliver, unless there is an overriding clinical justification, have incurred financial penalties.

Commitment to Research

3.2.22 *High Quality Care for All* reinforced the ongoing commitment continuing to transform health research in the NHS by implementing, consolidating and building on the Government's strategy for research in the NHS, for the benefit of patients and the public. Innovation is viewed as a broader concept than just research, encompassing clinical practice and service design. The Review supports service innovation by people at the frontline finding better ways of caring for patients – improving outcomes, experiences and safety.

3.2.23 The promotion and conduct of research is a core NHS function. Continued research and the use of research evidence in design and delivery of services is key to achieving improvements in outcomes. The 3Ts redevelopment will provide research facilities (to be funded by Brighton & Sussex Medical School) to contribute to meeting this objective.

Education and Training

3.2.24 The White Paper, *Equity and Excellence: Liberating the NHS* (July 2010), signalled a new approach to workforce planning, education and training to give employers greater autonomy and accountability for planning and developing the workforce, alongside greater professional ownership of the quality of education and training. It will be important for providers such as BSUH to work with regional structures, patients, staff, commissioners, universities and other education providers on the design and implementation of the new framework. Advice on workforce planning, education and training will set out how the new system will develop. Providers will need to work in partnership to ensure that suitable local arrangements are in place by April 2013. 3Ts is providing new education and training facilities to support the achievement of this objective.

European Working Time Directive (EWTD)

3.2.25 *The European Working Time Directive (EWTD)* sought to protect the health and safety of workers by limiting the number of hours that they are allowed to work over

[1] Dear Colleague letter on Eliminating Mixed Sex Accommodation (PL/CNO/2009/2) May 2009

an average week. It was enacted into UK law in 1998 as the Working Time Regulations.

3.2.26 The *EWTD* rest and break requirements listed below became legally enforceable in 2004, and from August 2009 the 48-hour maximum working week will be enforced.

3.2.27 Although the *EWTD* is not a direct driver of the development of the 3Ts programme (as it has been a requirement since August 2009), it is an important policy driver for the Trust and shapes the operation of clinical services.

3.3 Regional Strategies

3.3.1 South East Coast covers the PCTs in the area as shown in Figure 3.1 below.[2]

Figure 3.1 NHS South East Coast Area, by PCT

3.3.2 Regional strategies pertinent to this case are as follows:

NHS South East Coast: *Healthier People, Excellent Care*

3.3.3 *Healthier People, Excellent Care* consolidated the recommendations of leading clinicians in consultation with patients, the public and staff across the region. It set out NHS South East Coast's vision to 2018 and focused on changes that would make real improvements in patient health and healthcare. Thedocument included the pledges that:

- *There will be no avoidable hospital acquired infections - by 2011, there will be no avoidable cases of hospital acquired MRSA - and less than 2,000 cases of C. difficile;*
- *By 2010 all appropriate patients with heart attack, stroke and major trauma will receive specialist care from 24/7 services meeting national guidelines. All such patients will be taken to the most appropriate specialist units under an*

[2] This configuration is not changed by the 2011Sussex Commissioning Clusters (NHS Sussex) which are coterminous.

agreement with South East Coast Ambulance Trust and local hospitals commissioned by Primary Care Trusts;

- *Patients will be able to have medical tests to help diagnose and manage their illness at their local high street or at home;*
- *The tide will be turned on the rising numbers of obese people;*
- *Special programmes to help patients cope better with long-term conditions such as diabetes will be widely available;*
- *Most dying people will be able to die where they prefer - at home, in a hospital or hospice;*
- *They will reduce the differences in life expectancy seen in the South East Coast area so that all men can expect to live at least 78.6 years and women 82.5 years;*
- *All patients will hold their own medical records."*

3.3.4 The strategy also sets out that the South East Coast area did not at the time have a regionally based designated Major Trauma Centre that meets the criteria set out in the NCEPOD report. It confirmed that the Royal Sussex County Hospital would be the Major Trauma Centre for Sussex.

***Developing a County-wide Tertiary Services Commissioning Strategy for Sussex*, July 2008**

3.3.5 This strategy was undertaken on behalf of the Sussex PCTs. The objectives were to:

- develop a medium term commissioning plan for tertiary services for the five year period from 2008/09 onwards for each PCT;
- develop a joint commissioning plan for the four PCTs for tertiary services at the Brighton & Sussex University Hospitals NHS Trust that is explicitly linked to the provision of services in other local secondary providers; and
- identify opportunities for the development of and repatriation of tertiary services to local tertiary and linked secondary providers.

3.3.6 The strategy considered the provision of tertiary services in eight specialties:

- Cancer
- Cardiac
- Neurosciences
- Major Trauma
- Neonatology
- Paediatrics
- Plastics
- Renal

3.3.7 The tertiary services particularly pertinent to the 3Ts programme are cancer, neurosciences and major trauma. The recommendations to the PCTs for these three services are shown below and the key extracts are set out in this section:

Cancer

- Sussex Cancer Network to investigate further as a matter of urgency the apparent shortfall in the rate of cancer mortality improvement relative to the national average and relative to neighbouring counties/cancer networks, e.g. Surrey/SWSH cancer network. Some of this is thought to be caused by pressures on diagnostic capacity.

- Continuing to pursue a more distributed radiotherapy strategy designed to serve all Sussex patients – specifically giving Sussex patients access to 13-14 Linacs by 2016[3] by locating Linac satellite units at:

  - Eastbourne in East Sussex;

  - Worthing;

  - at least one location serving patients in the mid/ northern part of Sussex.

  - add two more bunkers, giving a total of seven.

- In planning the overall configuration, consideration also needs to be given to the need to accommodate Linac replacements and the need for a service machine to cope with Linac breakdowns and servicing.

- Work with BSUH / BSMS to create a workforce development plan for radiotherapy, consistent with the growth in and proposed reconfiguration of radiotherapy activity which is being planned.

- Initiate discussions via the Sussex Cancer Network and where required neighbouring Cancer Networks to evaluate potential changes in the cancer services operating model within Sussex in relation to adopting a more distributed model for the location of oncologists.

- Changing the boundaries of the Sussex Cancer network to be more closely aligned with those of the commissioning PCTs, particularly as regards RWS, Chichester.[4] This means that Hastings/Eastbourne may link more closely with BSUH as Western Sussex Hospitals already do.

- Commissioners should either directly or indirectly, via the Cancer networks, own the capacity planning for chemotherapy provision and may be assisted in this by using the capacity planning tool, CPORT[5].

- Consideration is being given, in the case of oesophageal cancer, to relocating the service to BSUH once appropriate clinical quality has been demonstrated.

[3] Estimated future requirement of 13-14 Linacs by 2016 should be kept under review as treatment patterns evolve and fresh guidance is issued
[4] Note that any decision to change the boundaries of Sussex Cancer Network would have resourcing implications for the specialist commissioning group, which would have to be explored as part of any such decision
[5] Sussex Cancer Network was involved in the development of this tool

- Patients who require upper gastro-intestinal surgery can now receive follow-up treatment at BSUH.

Neurosciences

- For clinical and patient access reasons, there is a strong rationale for relocating the Neurosciences Centre to Royal Sussex County Hospital and to increase the range of neurosurgery treatments offered;

- The clinical case for having Neurosurgery at Royal Sussex County Hospital will be materially affected (either positively or negatively) by the IOG designation decision on CNS / brain tumours. [Note: The National Cancer Action Team confirmed in February 2009 that "*the configuration of neuroscience MDTs outlined in the Sussex Cancer Network part of the South East Coast SCG IOG implementation plan is acceptable*."]

- Although much of the neurology service is a secondary service delivered at DGHs, neurology in Sussex would benefit very strongly from an integrated Neurosciences centre in Sussex.

- Note that because of the clinical unsustainability of Hurstwood Park in its current form, a long delay on the neurosurgery decision would not be appropriate.

3.4 Local Strategies

Fit for the Future

3.4.1 The *Fit for the Future* consultation undertaken by West Sussex PCT and Brighton & Hove PCT aimed to achieve the following objectives:

- Clinical sustainability:
  - ensuring that services meet current or evolving clinical guidance and advice and deliver best outcomes for patients;
  - ensuring local services provision take account of changes to medical workforce and
  - ensuring that services are able to make the best use of latest advances in the delivery of clinical care, for example, the latest techniques and equipment.

- Improving access:
  - reducing inequalities of access to care;
  - ensuring achievement of waiting time targets and
  - improving journey times for the population served.

- Financial sustainability:
  - ensuring providers achieve a recurring financial balance and move to surplus in line with Foundation Trust targets and
  - ensuring the PCTs achieve recurring balance or a surplus in line with recent guidance.

3.4.2 In all areas PCTs developed plans to ensure that care is delivered from the best location. This included finding ways to deliver some forms of care that are currently

provided from district general hospitals in more convenient locations such as local GPs surgeries.

3.4.3 As a result of the extensive *Fit for the Future* programme, the West Sussex PCT Board concluded that three major services should be centralised: inpatient paediatrics, consultant-led inpatient maternity services and emergency surgery. The Board also made several commitments to mitigate any risks associated with centralisation and to address a number of access issues.

3.4.4 The local Joint Health Overview and Scrutiny Committee (JHOSC) referred the PCT Board's decision to the Secretary of State, requesting an Independent Reconfiguration Panel (IRP).

3.4.5 West Sussex PCT Board formally placed on hold its *Fit for the Future* process in October 2008 in the light of the decision by Worthing and Southlands Hospitals NHS Trust and the Royal West Sussex Trust to agree in principle to merge. The Secretary of State's letter (October 2008) to the IRP asked it not to undertake a formal three month review until such time as a merged Trust was in place and a new and incoming Board had had the opportunity, in conjunction with the JHOSC, to review the original and future reconfiguration proposals.

3.4.6 At their November 2008 meeting, the Board agreed the PCT's letter of support to the Trusts' Outline Business Case (OBC) for their statutory merger and delegated authority to the Chair and Chief Executive to review the Full Business Case (FBC) with an offer of further support, if this were appropriate.

3.4.7 This was the consultation that endorsed the move of Hurstwood Park neurosciences services to the Royal Sussex County Hospital campus as part of the Critical Care Hospital (now Major Trauma Centre) development.

***Best Care Best Place* - 2004 Consultation**

3.4.8 In 2004 Mid Sussex Primary Care Trust and Brighton and Sussex University NHS Trust undertook a consultation programme, *Best Care Best Place*, about the best way of providing local health care services. This included consultation on the transfer of the Regional Centre for Neurosciences to the Royal Sussex County Hospital.

External Review of Neurosurgical Services at Brighton & Sussex Hospitals Trust (December 2010)

3.4.9 In late 2010, BSUH asked the Society of British Neurological Surgeons to undertake an external review of neurological services with a remit to:

1. Provide guidance on the configuration, structure and management of the neurosurgical service to support the development of the Royal Sussex County Hospital as the Major Trauma Centre for Sussex and the wider region in the interim period before the move of neurosciences to Brighton in 3Ts Stage 1.
2. Address the repertoire of neurosurgical services provided across the network and within the Trust, including the management of serious head injuries and acute spinal injury (traumatic and non-traumatic).

3. Advise on options in the interim period for ensuring the safe and high quality delivery of non-traumatic neurosurgical activity (acute and elective) as well as neurotrauma, whilst the service continues to work across two sites.

- The review concluded that the transfer of neurological services to the RSCH site is a:

  golden opportunity to expand and secure the neurosciences in modern facilities alongside other specialist services and the Major Trauma Centre and that the 'provision of adequate neurosurgical services within the current outdated facilities at Hurstwood Park is a challenge

- The provision of trauma services in the interim period at a site remote from the Neurosurgical Centre presents an additional challenge.

- An additional four consultant neurosurgeons (with specialist trauma and/or spinal training) should be appointed immediately. At least one of these posts should include a significant number of Research PAs to establish collaborations with the rich Academic Neuroscience and Imaging resources of the University of Sussex.

- A two tier 1 in 5 rota should be established to provide emergency consultant cover for both sites supported at the RSCH site by the resident trauma team and neuro-intensivists, and by the current team at Hurstwood Park.

3.5 The Local Health Community

NHS Brighton & Hove

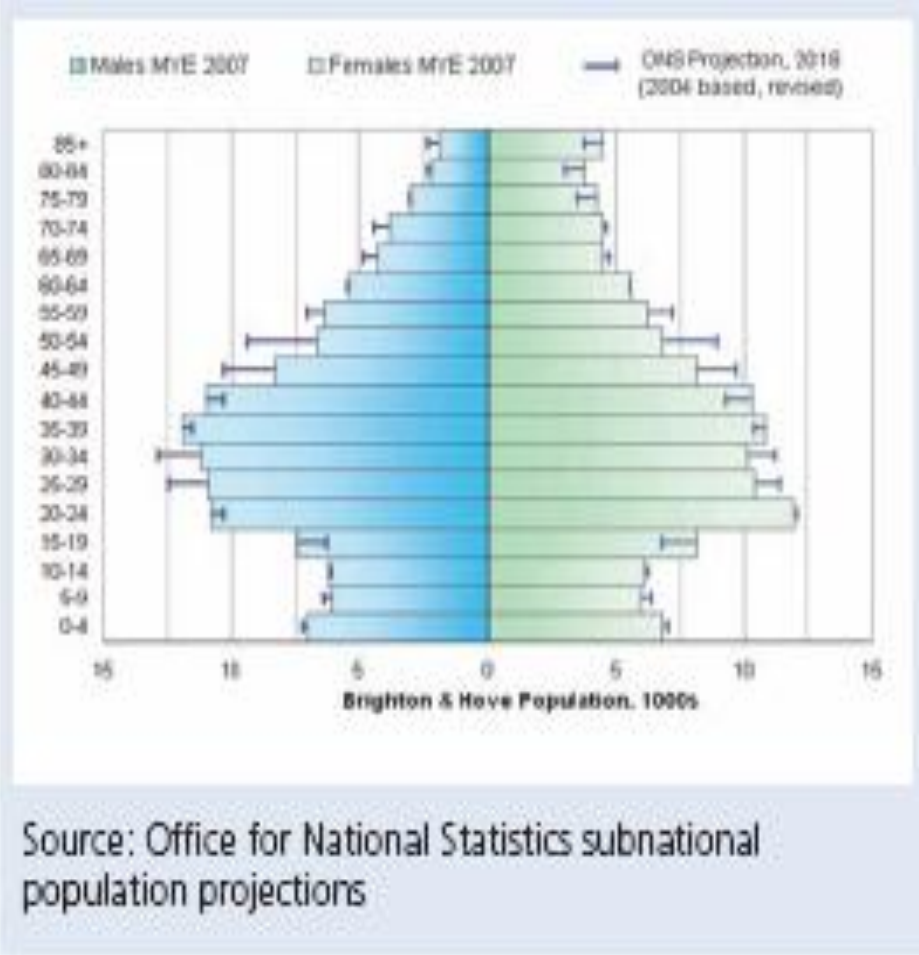
3.5.1 The PCT (now encompassed within NHS Sussex) is the Trust's main commissioner, representing 48% of its NHS commissioned income.

3.5.2 The city's population is predicted to rise from 256,600 in 2008 to 259,500 by 2013 and 265,700 by 2018, with the greatest increase in the 45 to 54 year age group. The population of younger adults and younger children will continue to increase, but the number of people aged 75 years and above is expected to fall.

3.5.3 The city's two universities host some 32,000 students, many of whom stay in the City after graduation.

3.5.4 Brighton & Hove also has an unusually and increasingly diverse population compared with other areas on the South East Coast. 15% of the population was born outside England.

Figure 3.2 Population profile & projections 2018



Source: Office for National Statistics subnational population projections

3.5.5 MOSAIC population profiling shows that:

- 34% of households are educated, young single people living predominately in areas of central Brighton and Hove with a high transient population (MOSAIC group E);
- 15% are independent older people with relatively active lifestyles, mainly clustered in Rottingdean Coastal, Central, Hangleton, Knoll and Westbourne wards (MOSAIC group J);
- 13% are older families living in suburban areas of Portslade, Patcham, Woodingdean, Preston Park, Hangleton, Knoll and Wish wards (MOSAIC group C)and
- 10% are people with uncertain employment who live in social housing in deprived areas, mostly in central Brighton and Hove (MOSAIC group F);

3.5.6 The ethnic mix of the city is changing. The 2001 Census classed 94% of the local population as White. Estimates for 2007 suggest decreases in the White British and White Irish population but increases in all other ethnic groups. This is significant as different ethnic groups experience different disease patterns (for example, people of Asian, Black African or Caribbean origin have a higher risk of cardiovascular disease and diabetes).

3.5.7 Between 2001-2004 black and minority ethnic groups grew at a rate of 35% compared to only 13% nationally.

3.5.8 The city has a large lesbian, gay, bisexual and transgender (LGBT) community, estimated at about 1 in 6 people. Sections of this community have an increased risk of mental illness and sexually transmitted infections (including HIV) and are more likely to be smokers and to drink above recommended safe levels of alcohol.

3.5.9 The 2001 census identified 59% of the city as Christian with 5% being from another religious group. National figures are 72% and 6% respectively. This census also found that there were 21,800 carers in Brighton & Hove with 510 young carers under 18 – these figures are likely to be under stated due to under-reporting.

3.5.10 It is estimated that 1,060 people aged over 18 in the city have a moderate or severe learning disability and 15,480 have a moderate or severe physical disability. Projections also show 6,020 people ages 65+ with mobility problems.

3.5.11 Brighton & Hove city faces substantial socio-economic issues. The Index of Multiple Deprivation 2007 identifies Brighton & Hove City as the 79th most deprived authority in England (out of 354), with 9% of all Super Output Areas (SOAs) in the City falling within the 10% most deprived SOAs in England and eight SOAs falling in the 5% most deprived.

3.5.12 Life expectancy in Brighton and Hove is 76.6 years for men (more than a year less than the England average) and 82.5 for women (six months longer than the national average). These figures compare well with the city's ONS cluster.

3.5.13 The gap in life expectancy between the most deprived and least deprived areas is 10.4 years for men (almost two years greater than the national average) and 5.8 years for women.

3.5.14 Mortality rates are falling for all groups but are falling at a faster rate in the least deprived quintile of the population. Inequalities will therefore continue to widen unless there is focused intervention in the more deprived groups.

3.5.15 The biggest contributor to the life expectancy gap for men in the most deprived quintile is coronary heart disease, followed closely by lung cancer, chronic cirrhosis of the liver, suicide and undetermined injury, and other accidents.

3.5.16 For women the biggest contributors are coronary heart disease and other cardiovascular diseases, lung and other cancers, and suicide and undetermined injury.

3.5.17 NHS Brighton & Hove has set the following strategic objectives:[6]

- Be the leading advocate for health and health care in the city:
  - . promote healthy living and a healthy city;
  - . provide strong leadership to the local NHS and
  - . develop effective relationships with social care and other organisations

[6] Reference: *Improving Health and Developing World Class Healthcare in Brighton & Hove: Strategic Commissioning Plan 2008-13*, NHS Brighton & Hove (March 2009).

across the city.

- Improve health and reduce health inequalities:
  - deliver measurable improvements in the health of local people;
  - reduce the 'health gap' between different local communities.

- Increase service quality and choice:
  - . commission high quality, evidence-based services;
  - . use people's experiences to improve the quality of services;
  - . offer people a choice of providers where this is realistic and
  - . achieve and maintain an 'excellent' rating in the annual health check.

- Increase people's confidence in, and engagement with, the NHS:
  - extend public confidence in local health service;
  - give people a stronger voice in the NHS and
  - be an excellent employer.

- Manage resources effectively:
  - deliver a sustainable financial position for NHS Brighton & Hove;
  - help the rest of the local health economy do the same and
  - demonstrate value for money and effective stewardship of public funds.

3.5.18 Health issues are reflective of this population profile with HIV and sexually transmitted diseases, mental illness, specifically substance misuse, alcohol and drugs, and teenage pregnancy being significant issues.

3.5.19 Life expectancy at birth for people in Brighton & Hove City is close to the national average (one year less for men than the national figure, and two months more for women). Major causes of death are circulatory diseases, cancer and respiratory disease. In the last ten years, the proportion of deaths from circulatory diseases has been falling, but it is rising for cancer – lung and breast cancer are both significant in this.

3.5.20 NHS Brighton & Hove received a 'fair' rating for the quality of services rating under the Health Care Commission 2008 health-check and a rating of 'good' for use of resources. This was an improvement in both categories since the previous Annual Health Check.

3.5.21 The PCT is unusual in that it was established as a commissioner-only organisation in 2002.

3.5.22 The main providers to the PCT are:

- Sussex Community NHS Trust – a stand-alone community provider Trust;

- a Children and Young People's Trust – providing children's community services;

- Brighton & Sussex University Hospitals NHS Trust – the main provider of local acute and specialised tertiary services for the PCT;

- Care UK, which operates the Sussex Orthopaedic Treatment Centre (an independent sector treatment centre on the Princess Royal Hospital campus in Haywards Heath);
- a small number of local private hospitals; and
- Sussex Partnership NHS Foundation Trust – a large mental health Foundation Trust, which covers Sussex wide, services with local provision of inpatient and outpatient services.

3.5.23 The financial allocation to the PCT in 2010/11 was £492.8 million, allocated as shown in the table below:

Figure 3.3: NHS Brighton & Hove Financial Allocation 2010/11

Area of Expenditure	£'m
Primary Care	50.7
Prescribing	47.5
Public Health	2.6
Community Health Services	73
Acute & Specialist Healthcare	231.8
Mental Health & Learning Disabilities	62.9
Corporate Costs	19.7
Surplus	4.6
Total Net Funding	492.8

3.5.24 The PCT declared a surplus of around £4.6m in 2010/11. Of the £231.8m spent on acute and specialist care, the expenditure with the Trust was around £172m.

NHS West Sussex

3.5.25 The PCT (also now encompassed within NHS Sussex) is the Trust's second largest, representing 30% of its NHS commissioned income.

3.5.26 There are 781,500 people living in West Sussex (ONS Mid Year Estimate 2008) and this is projected to increase to over 790,000 by 2011:

- 20% of the population are aged 65 years or over. (England – 16%);
- 23% are aged 19 years or less (England – 24%);
- 52% are women (England – 51%);
- the largest minority ethnic group is Indian, representing less than 1% of the total population. (England – largest ethnic minority group is Indian, 2.09% of total population; (ONS Census 2001)
- 16.8% of people have a long-term illness (England 17.9%); (ONS Census 2001)
- 3.4% of 16 to 74 year olds are permanently sick or disabled (England & Wales 5.3%) - *ONS Census 2001;*
- just under 10% of people are providing unpaid health care (England 10.06%) (Clinical & Health Outcomes Knowledge Base) ;
- the percentage of people claiming job seekers allowance has increased more rapidly in West Sussex than nationally over the past 2 years.

- people who are long term unemployed or unemployed represent 2.4% of the population of 16 – 74 year olds (England rate 4.4%);
- over a third of deaths (36.9%) are due to circulatory diseases (England rate 35.8%);
- a quarter of deaths (25.25%) are from cancer (England rate 26.5%); and
- diseases of the respiratory system account for 10.5% of deaths (England rate-10.9%).

3.5.27 Life expectancy at ward level in West Sussex ranges from 70.8 years to 83.0 years and electoral wards with lower life expectancy tend to have poorer health status than wards with longer life expectancy. (The England & Wales range for wards 65.4 to 93.4 years, 5th to 95th centile (excludes outliers) range 74.6 to 83.0 years).

3.5.28 The prevalence of most diseases is better than the national and regional average. This correlates with greater overall affluence and a relatively high standard of basic health services. However there is considerable variation within the county: Crawley, in the north of the county, is relatively younger, poorer and with a wider ethnic mix. The coastal strip also has significant pockets of deprivation and is relatively old, with many people retiring to the coast. Within the middle of the county population density is low, and although health status is relatively good, accessing services can be a major problem.

3.5.29 In particular, cancer mortality rates vary significantly across the county and there are currently no radiotherapy services within the PCT's boundary. As a consequence, patients have to travel to receive this treatment. Research undertaken in 2007 in the North of England found that:

> *'the likelihood of receiving radiotherapy was reduced for all sites studied with increasing travel time to the nearest radiotherapy hospital. Lung cancer patients living further from a thoracic surgery hospital were less likely to receive surgery, and both lung cancer and rectal cancer patients were less likely to receive chemotherapy if they lived distant from these services. Services provided in only a few specialised centres, involving longer than average patient journeys, all showed an inverse association between travel time and treatment take-up.*[7]

3.5.30 NHS West Sussex' population straddles two cancer networks: the Sussex Cancer Network and Central South Coast Cancer Network. The PCT has identified through the Sussex *Tertiary Services Commissioning Strategy* the number of Linear Accelerators required for its whole population as well as for the proportion of the population covered by the Sussex Cancer Network.

3.5.31 The financial allocation to the PCT in 2010/11 was £1,293 million, allocated as shown in the table below:

Figure 3.4: NHS West Sussex Financial Allocation 2010/11

Area of Expenditure	£'m
Primary Care	154.8
Prescribing	154.3

[7] 'Travel time to hospital and treatment for breast, colon, rectum, lung, ovary and prostate cancer', Jones, Haynes, Sauerzap, Crawford, Zhaoa and Forman, *European Journal of Cancer*; 44 (2008) 992-999

Public Health	8.7
Community Health Services	178.2
Acute & Specialist Healthcare	642.4
Mental Health & Learning Disabilities	129.9
Corporate Costs	24.1
Surplus	0.7
Total Net Funding	1293.1

3.5.32 The PCT has reported a marginal surplus. Of the £642.4m spent on acute and specialist care, the expenditure with the Trust was around £100m.

3.5.33 The main provider of local acute services to the West Sussex PCT catchment is the Western Sussex Hospitals NHS Trust, which is the new Trust formed by the merger of the Royal West Sussex NHS Trust (St Richard's Hospital in Chichester) and Worthing & Southlands Hospitals NHS Trust (Worthing Hospital in Worthing and Southlands Hospital in Shoreham-by-Sea) on 1 April 2009.

3.5.34 The other major acute provider is Surrey and Sussex Hospitals NHS Trust (SaSH), which received around £76.0m in 2010/11 from the PCT. West Sussex PCT took on the role of lead commissioner role for SaSH from Surrey PCT in 2009.

3.5.35 The PCT was assessed as compliant for quality of service and use of resources in the August 2009 Care Quality Commission assessment.

NHS East Sussex Downs & Weald

3.5.36 The PCT is the Trust's third largest provider and provides 20% of the Trust's NHS commissioned income.

3.5.37 NHS East Sussex Downs & Weald serves a population of approximately 330,000, which is both urban and rural and has a number of deprived wards. This population is due to expand over the coming years.

3.5.38 The population in the East Sussex geographical area as a whole is generally healthy (compared to England), but in a number of wards (9 within the PCT area) life expectancy is much lower.

3.5.39 The Average Life Expectancy (AvLE) across East Sussex is 81.1 years (excluding the wards with reduced life expectancy), but within 9 of the wards in the PCT's catchment, the AvLE ranges from 77.0 (in Devonshire) to 78.7 (in Hellingly). Key population statistics for the East Sussex county area are:

- The county has the highest number of over 75, 85 and 90 year olds anywhere in England;
- The problems of multiple deprivation appear to have increased since 2004;
- Nearly 1 in 5 children (19%) live in low income households;
- Nearly 14% of older people live in low income households (this rose from 11% in 2004);

- Nearly 67,000 of the county's residents are 'income deprived' while just under 25,000 experience 'employment deprivation'.

3.5.40 The financial allocation to the PCT in 2010/11 was £573.2 million, allocated as shown in the table below:

Figure 3.5: NHS East Sussex Downs & Weald Financial Allocation 2010/11

Area of Expenditure	£'m
Primary Care	63.4
Prescribing	69.5
Public Health	n/a
Community Health Services	81.7
Acute & Specialist Healthcare	285.9
Mental Health & Learning Disabilities	52
Corporate Costs	18.1
Surplus	2.6
Total Net Funding	573.2

3.5.41 The PCT declared a small surplus. ESDW spent £285.9m on acute and specialist care, of which around £67m related to BSUH.

3.5.42 The PCT's main acute provider is East Sussex Healthcare NHS Trust, which includes Eastbourne District General Hospital and the Conquest Hospital in Hastings.

3.5.43 The PCT's provider arm successfully registered with the Care Quality Commission in January 2010 and has maintained full compliance with its essential standards of quality and safety for the year ended 1 April 2011. The community services and prison healthcare services under the PCT's provider arm transferred on 1 April 2011 to other NHS trusts which are registered for those services with the Care Quality Commission.

NHS Hastings & Rother

3.5.44 NHS East Sussex Downs & Weald has a shared management team with neighbouring NHS Hastings & Rother. The Trust income from NHS Hastings & Rother is circa £11m.

Other Local Providers

3.5.45 There are several other local providers of acute services within the area served by the Trust.

3.5.46 As can be seen from the description of the Trust's commissioners above, the Trust is the main provider of local services for the people of Brighton & Hove (from the Royal Sussex County Hospital) and a major provider of services for the people of Mid Sussex (which is covered by West Sussex PCT and East Sussex Downs & Weald) from the Princess Royal Hospital.

3.5.47 The other local providers within the health community are:

- Western Sussex Hospitals NHS Trust;
- East Sussex Healthcare NHS Trust;
- Queen Victoria Hospital NHS Foundation Trust;
- Surrey and Sussex Healthcare NHS Trust;
- Sussex Community NHS Trust;
- Sussex Partnership NHS Foundation Trust;
- South East Coast Ambulance NHS Foundation Trust.

Western Sussex Hospitals NHS Trust

3.5.48 The former Royal West Sussex and Worthing & Southlands Hospitals Trusts provide a comparable range of general and acute hospital services, including medicine, surgery, orthopaedics and trauma, paediatrics, maternity and Accident and Emergency (A&E). Both hospitals operate from relatively modern hospital buildings.

3.5.49 The new Trust comprises:

- The 430-bed St Richard's Hospital in Chichester. The hospital serves a population of around 210,000, living in and around Chichester, Littlehampton, Bognor, Selsey, Chichester Harbour, Midhurst, Billingshurst, Pulborough, Arundel and Petworth. There is also a significant flow of patients from east Hampshire.

- Worthing and Southlands hospitals with a total stock of 730 inpatient and daycase beds. The hospitals serve a population of around 250,000, living in Worthing, Shoreham-by-Sea and surrounding areas of West Sussex, with some more specialist services serving a larger population.

3.5.50 The new Trust employs around 6,000 staff (whole-time equivalent).

3.5.51 In 2010/11 income for the merged Trust was £361.5m The Trust is of significant size, with forecast activity of around 67,000 inpatients, around 35,000 day cases and around 376,000 outpatient visits or treatments per annum.

3.5.52 Western Sussex Hospitals Trust is one of the main acute and general health care providers for much of West Sussex, excluding the north east area, which is mainly served by Brighton and Sussex University Hospitals NHS Trust (BSUH) and Surrey and Sussex Hospitals NHS Trust (SaSH).

3.5.53 The Royal Surrey County Hospital NHS Trust (Guildford) serves the rural areas along the northern border of West Sussex while Portsmouth Hospitals NHS Trust is a significant provider of services to the west.

East Sussex Healthcare NHS Trust

3.5.54 The Trust provides a comprehensive range of general acute hospital services, and community services, from two main district general hospitals: the Conquest Hospital in Hastings and the Eastbourne District General Hospital and from community locations across East Sussex. Both acute hospitals provide acute medical, surgical, paediatric and maternity care, plus a comprehensive range of diagnostic and therapy back up:

- Emergency Department services at both the Conquest Hospital (469 inpatient and day case beds) and Eastbourne District General Hospital (535 inpatient and day case beds);
- outpatient services and day surgery from Bexhill Hospital (which also hosts a satellite renal dialysis centre managed by BSUH);
- midwife-led services at Crowborough Birthing Centre;
- outpatient services and some surgery at Uckfield Community Hospital and
- outpatient services at Lewes Victoria Hospital and Rye Memorial Care Centre.

3.5.55 Over 7,500 full and part-time staff are employed by the Trust, which had an income of circa £270 million in 2010/11.

Queen Victoria Hospital NHS Foundation Trust

3.5.56 Queen Victoria Hospital, East Grinstead (QVH) was built as a community hospital in the 1930s and developed as a specialist unit during World War II. It became world famous for pioneering treatment of RAF and allied aircrew who were badly burned or crushed and required reconstructive plastic surgery.

3.5.57 Today QVH remains at the forefront of reconstructive surgery - the use of specialist techniques such as tissue transplant and microvascular surgery in the restoration of people who have suffered disfigurement or destructive damage from disease, trauma, burns, major surgery, or congenitally.

3.5.58 Specialties include head and neck (maxillofacial surgery, orthognathic, orthodontics), plastic surgery - particularly hands and breasts, corneo plastic surgery (eyes), sleep disorders and paediatrics.

3.5.59 In addition to being southern England's regional centre of excellence in reconstructive surgery, the Trust continues to develop clinically excellent community healthcare services for the people of East Grinstead and its surrounding villages. The Jubilee Centre houses two elderly care wards and there is a well established rehabilitation unit. There is also a Minor Injuries Unit open daily from 8am-10pm.

3.5.60 In addition to the main hospital site in East Grinstead, the Trust also provides many of its specialist services throughout Kent, Sussex and Surrey, at hospitals run by other Trusts. In 2008, QVH and BSUH agreed to co-operate on the provision of burns and plastics services, delivered on an outreach basis, on the Royal Sussex

County Hospital campus. This allows BSUH to have access to all the key services which are integral to the provision of a major trauma service.

3.5.61 In 2010/11, the Trust had an income of £56m and generated a surplus of £2m. The Trust has a varied and broad income base, with the major commissioner being West Sussex PCT, which provided £10m of the Trust's income. The Trust is planning a phased redevelopment of key areas of the hospital campus.

3.5.62 In the 2010 Trust maintained registration without compliance conditions with the Quality Care Commission.

Surrey and Sussex Healthcare NHS Trust

3.5.63 Surrey and Sussex Healthcare NHS Trust was formed on 1st April 1998 following the merger of Crawley, Horsham and East Surrey NHS Trusts. In 2009/10, the Trust's total income was £195m and it generated a surplus of £7.8m. It received £196 million in 2010/11. It provides over 400,000 treatments each year across eastern Surrey and north-west Sussex. The lead commissioner role for the Trust is NHS West Sussex (now NHS Sussex).

3.5.64 Just over 2,500 people work for the Trust. The major site is East Surrey Hospital in Redhill. The Trust also provides a range of services at Crawley, Dorking, Caterham Dene and Horsham hospitals in partnership with the Primary Care Trusts that own and manage those sites.

3.5.65 The Trust and BSUH are currently investigating areas for collaboration in key service areas. The two Trusts have appointed a joint Medical Director.

3.5.66 In the 2008/09 Healthcare Commission Health Check, the Trust was rated as being 'Fair' for Quality of services and 'Fair' for use of resources.

3.5.67 The Trust has not yet published its 2010/11 report at this time.

Sussex Community Trust (SCT)

3.5.68 SCT was formed in September 2010 as a result of the merger of South Downs Heath and West Sussex Community services.

3.5.69 The Trust provides a wide range of mainstream and specialist community and rehabilitation services for children and adults across West Sussex and Brighton & Hove. Treating 9,000 people daily, helping them to lead healthier lives. The Trust's budget for 2010/11 was just over £189m and it posted a small surplus.

3.5.70 The Trust's main campus is Brighton General Hospital, which is just over 1 mile away from the Royal Sussex County Hospital campus. From April 2011 BSUH assumed responsibility from SCT for management of the inpatient Sussex Rehabilitation Centre at the Princess Royal Hospital.

Sussex Partnership NHS Foundation Trust

3.5.71 The Trust provides specialist mental health, learning disability and substance misuse services for Brighton & Hove, East Sussex and West Sussex.

3.5.72 The Trust:

- employs 4,800 people;
- provides services to 1.5m people from 126 sites across Sussex;
- earned £224m from its activities in 2010/11 and generated an operating surplus of £10.7m.

3.5.73 The Trust works in partnership with BUSH to provide specialist mental health and substance misuse services on the RSCH and PRH campuses.

3.5.74 In the 2008 Healthcare Commission Health Check, the Trust was rated as being 'Excellent' for Quality of services and 'Good' for use of resources.

3.5.75 Later annual reports are not currently available.

South East Coast Ambulance NHS Foundation Trust

3.5.76 South East Coast Ambulance Trust (SECAmb) was formed in 2006 from the merger of the former Kent, Surrey and Sussex Ambulance Trusts. The Trust responds to 999 calls from the public, urgent calls from health professionals and in Kent and Sussex, provides non-emergency patient transport services (pre-booked patient journeys to and from healthcare facilities). The Trust became an NHS Foundation Trust in February 2011.

3.5.77 South East Coast Ambulance Service:

- covers a geographical area of 3,600 square miles (Brighton & Hove, East Sussex, Kent, Surrey, North East Hampshire, West Sussex);
- serves a resident population of 4,500,000;
- operates from 63 ambulance station and three Emergency Dispatch Centres, as well as numerous administrative, fleet, equipment and training bases;
- responded to 460,000 emergency calls during 2005/06 (as the three former Trusts);
- responds currently to a 999 call every 1.14 minutes and
- employs approximately 3,000 staff.

3.5.78 The South East Coast Specialised Commissioning Group (SECSCG) is responsible, on behalf of the PCTs, for commissioning pre-hospital care from SECAmb, including tasking of the Air Ambulance provided principally by the Kent, Surrey & Sussex Air Ambulance Trust (an independent charitable organisation).

3.5.79 In 2009/10, the Trust received income of £152.3m and posted a surplus.

3.5.80 In the 2008 Healthcare Commission Health Check, the Trust was rated as being 'Good' for Quality of services and 'Good' for use of resources.

3.5.81 The 2010/11 annual report is not currently published.

Strategic Context – Conclusions
• The 3Ts development responds directly to the future direction of the NHS in providing services and facilities which will support high quality care for all. • The 3Ts development responds to the local need for providing modern, fit for purpose inpatient and diagnostic facilities for the people of Brighton & Hove. • The 3Ts development responds directly to the future plans of our commissioners across Sussex in providing capacity for local people to receive cancer, neurosciences and major trauma care locally. • The 3Ts development responds to the regional strategy for developing specialist centres and a Major Trauma Centre.