

Our ref: MK630/KK

23 December 2015

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Dear David

**Brighton and Sussex University Hospitals NHS Trust - Full Business Case  
Approval (3Ts Programme)**

Many thanks for your letter of 2 December. As you can imagine, we were delighted to receive this as it represents the culmination of almost eight years unstinting effort by our project team working with hundreds of our staff to devise a solution which met the needs of our patients.

I would like to express my thanks, on behalf of the Board, to your teams at the Department and to those at the Trust Development Authority (TDA), NHS England, our Clinical Commissioning Groups (CCGs) and HM Treasury who have contributed to this over the year.

We provided your team with confirmation of the Guaranteed Maximum Price (GMP) on Monday 7 December and the assurance that this was unchanged from the approval limit set out in your letter. We were provided with confirmation that this was acceptable and we signed the contract with Laing O'Rourke (LOR) that afternoon.

With regards to your specific points:

**Capital Cost**

- We will provide regular updates on how it is managing risks to its capital budget through the normal performance management mechanisms in place with NHS Improvement and also through the continuing National Programme Board as necessary
- We will explore all methods of reducing the overall capital spend where possible and where this does not require patient areas to be shelled, although there is limited opportunity for that;
- I can confirm that the final contract includes the usual ProCure 21 provisions for risk sharing and pain: gain share with LOR;
- We note the requirement to maintain the overall capital cost within that approved. Please also refer to my comment later in this letter relating to future commissioner requirements;
- We also note the condition relating to application of sale proceeds. It is worth noting that the base case in the Full Business Case (FBC) did not include the disposal of any

With our partner

assets beyond those which have already been disposed of over the last few years. The potential for land sale disposals was discussed in the context of managing downside risk to the overall affordability of the project and future financial sustainability of the Trust. The various downsides modelled implied significant reductions in patient activity (and therefore income). Part of the mitigations for these impacts was to use the space freed up by these reductions in patient activity for those functions in our remaining assets away from the main hospital site. We will continue to review the activity assumptions as we progress through the implementation phase and ensure that we put the necessary plans in place to mitigate risk, which may well include asset disposals if those are the optimal way of mitigating the risk or risks which emerge.

## Funding

- We note that the final mix of funding between Public Dividend Capital (PDC) and Capital Investment Loans (CIL) is yet to be agreed and note the indicative split generated by the TDA. We also note that indicative split reflected the modelling undertaken at a point in time earlier this year and this will need to be updated to reflect the current position. We will need to ensure that the processes which we, collectively, put in place to release capital funding as expenditure is incurred is as efficient as possible as we have contractual obligations to pay LOR within strict time limits or we incur penalties. We will progress this with the TDA and your officials.

## Subsequent Stages

- We will undertake regular and periodic reviews of the scope and functional content of Stages 2 and 3 of the development whilst Stage 1 is under construction and ensure that any issues which arise are fully explored locally with our commissioners and through the National Programme Board if necessary;
- We also undertake to share the outputs of the re-pricing of Stages 2 and 3 once it has been undertaken and to ensure that the scope reflect commissioner requirements. We will also identify clearly at that point, the changes in building price inflation where these are different to the assumptions which were made in the run-up to FBC approval.

The Trust has welcomed the role of the National Programme Board, and the role of the DH in that, of ensuring that there is continued commissioner alignment and that all organisations in the regional health community (whatever their role) understand the importance of the development and that risks must be managed appropriately with the organisations best placed to manage that risk.

In that context, I would like to underline the commitment of the Trust to continue to work collaboratively with our commissioners (CCGs and NHS England) to ensure that there is ongoing alignment between commissioning intentions and the capacity we need to deploy to meet those intentions. We will do that with our local Strategic Partnering Board (with local CCGs), the already-established performance management mechanisms in place and through the National Programme Board.

I think that it is only fair to point out that, if there are significant changes to commissioner intentions, or commissioners propose significant changes to the functional content of any stage of the development, we would need to review the impact of that. If it was so significant that there was a risk of exceeding the approval total set out in your letter, it would be our expectation that the impact of that would need to be progressed through the normal processes extant at that time.



## TDA specific approval conditions

- As noted above, we will continue to work collaboratively with commissioners to manage capacity and sustainability across the health community;
- We are currently reviewing the operational requirements of our Emergency Department and making improvements to that. We will review and assess our plans for refurbishment works in this area and ensure that these are shared with the TDA through our ongoing performance management discussions;
- I can confirm that we will ensure that we will drive benefits from the new facility - mindful of the fact that the first full year of operation of Stage 1 will be 2020/21;
- We are continuing to develop on our workforce plans and the transformation that will be required irrespective of the development. We are not unusual in needing to do this, but we acknowledge that the new facilities provide us with a powerful opportunity and lever to achieve this;
- We will absolutely continue to monitor Infection Prevention and Control issues and work with the TDA proactively on those.

## Procurement

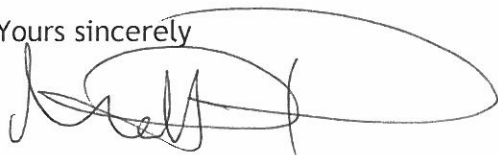
We note the requirement for reapproval if we change our relationship with LOR or revisit the procurement in future and we will ensure that this is monitored by the National Programme Board.

With regards to publication of the FBC, given that one month from the date of your letter would be 2 January, we propose to publish the FBC by the end of January given the intervening festive period.

Once again, many thanks for your letter and for your kind wishes in my new role - Amanda Fadero, my Deputy, will be Interim Chief Executive from 25 December and will be accountable officer and hence ultimately be responsible for this until a substantive CEO is in place. I am also copying this to the other colleagues to whom you copied your letter.

With best wishes.

Yours sincerely



Matthew Kershaw  
Chief Executive

Cc: Jim Mackey - Chief Executive, Monitor  
Bob Alexander - Acting Chief Executive, NHS TDA  
Anne Eden - Director of Development and Delivery (South), NHS TDA  
Paul Baumann - Chief Financial Officer, NHS England  
Amanda Fadero - Deputy Chief Executive, BSUH  
Julian Lee - Chairman, BSUH  
Spencer Prosser - Chief Financial Officer, BSUH  
Duane Passman - Director of 3Ts, BSUH