Brighton and Sussex University Hospitals NHS Trust

INTEGRATED BUSINESS PLAN

Version 8 – June 2014

Setting the standard for great care

Contents

1. Executive Summary

1.1 Brighton and Sussex University Hospitals NHS Trust (BSUH) is a provider of acute and specialist healthcare, based in Brighton and mid-Sussex. The Trust operates two principal sites with general acute beds, in Brighton and Haywards Heath, both of which admit emergency patients via A&E departments. The Trust operates an eye hospital and children's hospital, both based in Brighton, and a number of services from other sites throughout Sussex. The Trust is the major trauma centre for Sussex and provides specialist renal, neurological, neurosurgical, neonatal, paediatric, vascular, cardiac, HIV, infectious diseases and cancer care across Sussex. The Trust is also the main general acute hospital provider for the 500,000 people living in Brighton and mid-Sussex.

1.2 BSUH is a historically high-performing organisation with two consecutive years of delivering financial surplus on plan. However, it faces specific challenges around the delivery of timely and responsive unscheduled care, having not met the key A&E 4-hour standard consistently since Q2 2012/13. The Trust has a strong focus on patient safety and experience with established clinically-led safety and quality governance.

1.3 The Trust also operates on some of the oldest clinical estate in the NHS at its Royal Sussex County Hospital site in Brighton. It has recently received OBC approval for its 3Ts re-development of the site which will replace these older buildings with state of the art facilities, leading to a transformation in both estate and models of care. The first stage of 3Ts will open after the end of this IBP period, however, and thus a strategy and plan is required that develops sustainable services for the next five years.

1.4 This IBP sets out the Trusts' vision for the next five years and how this will be realised. The Trusts' vision is to set the standard for great care, by working together; adapting, improving and innovating; and acting with fairness, kindness and compassion.

1.5 The Trust has undertaken a clinical strategy exercise led by clinicians across the Trust and supported by the management team and external expertise. It has identified that to meet its vision it needs to:

- Deliver acute unscheduled care in a way which is fully integrated with the wider health and social care system, leading to a lower level of utilisation of its bed base by patients who are frail and elderly
- Work with partners to improve planned care pathways in a collaborative way that recognises their contribution to overall sustainability of the Trust
- Modernise the pathways for more acutely unwell patients starting with strokes and fractured hips, moving to 7-day working for inpatient care
- Design and operate networked models of care, with partner providers, for more specialised care, whilst developing our teaching and research bases.

- Consolidate and grow its tertiary interests for patients across our wider catchment, using the bed base released by changes in local unscheduled care provision

1.6 The Trust is confident that its market environment facilitates this clinical strategy. There is competition for general acute elective services, where the Trust must become more responsive to commissioner aspirations for lower levels of care utilisation. However BSUH occupies a dominant provision for most of Sussex for the specialist services it operates. Growth in these services is predicated on increasing the breadth and catchment of those services so that BSUH-led networks of care operate for all of Sussex and have the opportunity to expand into Kent and Surrey where feasible to do so, and increasing the scope of provision so that patients can be repatriated from London.

1.7 The Trust believes that its clinical strategy will deliver the right services for our patients and has mutually supportive goals and aspirations with its principal commissioners, most notably in terms of their ongoing support for the 3Ts re-development and the inherent principle that the RSCH site remains, and further develops as, the acute specialist hub for Sussex and a notable fixed point in the health economy.

1.8 This strategy mitigates some of the severe financial pressure faced by NHS providers over the coming period, but further change will be required. This IBP projects that prices for the work the Trust does will fall by 0.6 – 1.5% per annum for the next five years. The Trust's main cost driver is its staff and the like-for-like costs of employing staff will increase by 1.5 – 3.5% per annum in the same period. In five years' time the Trust will need to be providing more units of clinical activity in all settings of care, with fewer substantively employed staff, compared with today. This will require significant transformation to the way the Trust operates its clinical services. However, the Trust has already identified its 2014/15 CIP plan and a significant part of its 2015/16 plan, and has an extremely strong track record in successfully delivering challenging cost improvement plans in a way that is safe and maintains the quality of care provided.

1.9 This IBP sets out potential sensitivities to the financial assumptions which have been made and in particular a potential downside scenario. The Trust has identified a number of potential mitigations which would recover its cash and I&E positions to sustainable levels should the downside occur. The deployment of mitigations would be dependent on whether the challenge that emerged was cost/price or volume driven. A mitigation strategy was discussed by the Board ahead of the 2013 3Ts OBC submission and the Trusts' clinical leadership have discussed CIP mitigations looking at all aspects of costs.

1.10 In support of this strategy, the Trust has made significant progress in moving its governance structures and processes to Foundation Trust readiness. The Trust is undertaking further work on its internal values and behaviours, management structure and safety and quality governance which will complete this calendar year. The Trust has consulted on a proposal for Foundation Trust governance, which has been revised in the light of comments and feedback from other FTs and commissioners.

2. Trust Profile

Purpose, location and catchment

2.1 Brighton and Sussex University Hospitals (BSUH) is an acute teaching Trust working across two principal sites: the Royal Sussex County Hospital in Brighton and the Princess Royal Hospital in Haywards Heath. The Brighton campus includes the Royal Alexandra Children's Hospital and the Sussex Eye Hospital, and the Haywards Heath campus includes the Hurstwood Park Regional Centre for Neurosciences.

2.2 The Trusts' core market is the area for which BSUH is the nearest acute hospital provider. By local authority area this is Brighton and Hove City Council (co-terminous with B&H Clinical Commissioning Group), Mid-Sussex District Council (part of Horsham & mid-Sussex CCG), and most of Lewes District Council (part of High Weald, Lewes and Havens CCG)

2.3 The outlying market includes the Horsham and High Weald areas, who are served by DGHs in Surrey and Kent; and the populations served by the other four Sussex CCGs.

Services, staff and infrastructure

2.4 Local acute provision of A&E, inpatient medicine and outpatient planned care is provided across both sites. In addition, the Princess Royal Hospital is our centre for elective surgery and the Royal Sussex County Hospital is our centre for complex emergency and tertiary care. Our specialised and tertiary services include neurosciences, neonatal, paediatrics, cardiac, cancer, renal, infectious diseases and HIV medicine. We are also the major trauma centre for Sussex.

2.5 Bed capacity by site is as follows:

Site	13/14 Beds
Royal Sussex County Hospital	595
Royal Alexandra Children's Hospital	41
Princess Royal Hospital	314
Sussex Orthopaedic Treatment Centre	36
Total	986

Our full portfolio of services by site is included in Appendix A.

2.6 Total planned clinical income in 2014/15 is £434m. As of 1st April 2014, the Trust had 6,928 staff in post constituting 6,179 WTE.

2.7 Excluding pathology tests, the Trust had 790,000 patient contacts in 2013/14. This has grown by an average 1.2% per year over the previous five years as indicated below:

	2009/10	2010/11	2011/12	2012/13	2013/14
Daycase	32,412	37,424	37,078	41,834	41,180
Elective	14,568	14,585	13,462	15,302	15,117
Non Elective	56,142	57,254	52,876	52,267	52,260
Outpatients	495,657	457,665	432,933	529,112	530,504
A&E	144,828	148,441	154,392	154,894	151,700
Direct Access diagnostics (inc. pathology)	2,288,238	2,567,647	2,729,951	2,945,559	3,272,186

2.8 In May 2014 the Trust received Outline Business Case approval for plans to redevelop the Royal Sussex County Hospital site, known as "3Ts" (teaching, trauma and tertiary care). The 3Ts programme proposes a £420m redevelopment of the RSCH site to improve facilities for secondary and tertiary care. This development has the support of the NHS across Sussex. Whilst the majority of the development is focused on the improvement of District General Hospital services, the development will also support the relocation and expansion of neurosciences work, enhancement of the work of the Major Trauma Centre, the relocation and expansion of the Sussex Cancer Centre and the provision of facilities for teaching and research.

Performance

2.9 The table below shows the Trusts' performance against key Monitor Risk Assessment Framework outcome and access measures for the year 2013/14. The Trust has a longstanding challenge in relation to performance against the A&E 4-hour standard which has not been achieved in any quarter since Q1 2012/13. The challenge within A&E performance is generally localised to the RSCH main adult A&E, with PRH A&E, the paediatric A&E at the RACH, and the eye A&E at the Sussex Eye Hospital, being generally compliant with the 4-hour standard. The RSCH has a comparatively high number of conveyances per adult acute bed and whilst there are ongoing challenges in the effective management of presenting patients, inpatient bed capacity is recognised as a key challenge, there being no growth capacity within the existing RSCH campus.

2.10 Performance against other nationally recognised access measures has been historically strong with the two cancer measures showing as non-compliant for the year 2013/14 expected to recover early in 2014/15. Whilst the Trust breached the clostridium difficile measure for 2013/14, the Trust has never exceeded the 2014/15 target which has been rebased to accurately reflect the level of inpatient bed days within the Trust.

Indicator		Standard / Threshold	2013-14
Access			
18w RTT - Percentage of Admitted RTT Pathways completed within 18 weeks		90%	92.7%
18w RTT - Percentage of Non-Admitted RTT Pathways completed within 18 weeks		95%	96.3%
18w RTT - Percentage of Incomplete Pathways waiting less than 18 weeks		92%	93.6%
Diagnostic Tests waiting longer than 6 weeks - Percentage of all waiters		99%	99.8%
A&E - Percentage of patients who spent 4 hours or less in A&E		95%	93.09%
Cancer: 2 week wait referral to date first seen		93%	92.6%
Cancer: 2 week wait referral to date first seen - Breast Symptomatic		93%	97.7%
Cancer: 31 day wait from diagnosis to first treatment		96%	97.7%
Cancer: 62 day wait for first treatment from urgent GP referral		85%	85.9%
Cancer: 31 day wait for second or subsequent treatment - surgery		94%	96.7%
Cancer: 31 day wait for second or subsequent treatment - Chemotherapy		98%	99.7%
Cancer: 31 day wait for second or subsequent treatment - Radiotherapy		94%	97.7%
Cancer: 62 day wait for first treatment from referral from an NHS cancer screening service		90%	88.1%
Cancer: 62 day wait for first treatment from referral following a Consultants Decision to Upgrade		90%	99.3%
Outcomes			
Nos of C. Difficile infections		34	48

Patient experience and quality

2.11 Patient experience, as measured by the NHS Friends and Family Test, is close to the national average for inpatient areas but significantly below the average for A&E. This reflects the challenges noted above. Evidence from Board to Ward and other engagement mechanisms highlights the empathy and professionalism of staff as key drivers of a positive patient experience.

2.12 Measurements of quality and safety highlight the strong clinical care received by the majority of patients. For the year 2013/14, the Hospital Standardised Mortality Rate (HSMR) was 95.5. Rates of harm free care are higher than typically expected. The Trust is in Band 3 of CQC's intelligent monitoring system, with no flagged outliers for mortality at speciality or procedure level.

2.13 The Trust has a strong track record for improving quality, with noted innovations in dementia care, investigating and learning from clinical errors and incidents, and reducing rates of harm from falls. The Trust has had a Chief of Safety post for five years, expanded in 2013 to a Chief of Safety and Quality, providing clinical leadership to the longstanding safety and quality function. S&Q governance is founded on a strong culture of incident reporting and investigation.

2.14 The Trusts' principal challenge in relation to safety and quality relates to the flow of patients through A&E where patient experience has been affected by long waits in the main A&E at the Royal Sussex County Hospital, driven in turn by limited bed availability. The Trust has a dedicated action plan to resolve these issues and this IBP recognises the interdependency of the Trusts' strategy on resolution of concerns regarding A&E.

Academic links

2.15 As the regional teaching hospital, BSUH provides education and training and works in collaboration with the University of Sussex and the University of Brighton to train healthcare professionals. BSMS is one of four new medical schools created as part of the Government's strategy of increasing the number of qualified doctors from the UK working in the NHS. It is a joint school of the University of Sussex and the University of Brighton. The first intake of students began their five-year medical degree programmes in September 2003 and, on graduation, took their foundation training posts in 2008. The medical school supports the Trust in making joint academic/clinical appointments which support a number of its key specialist areas.

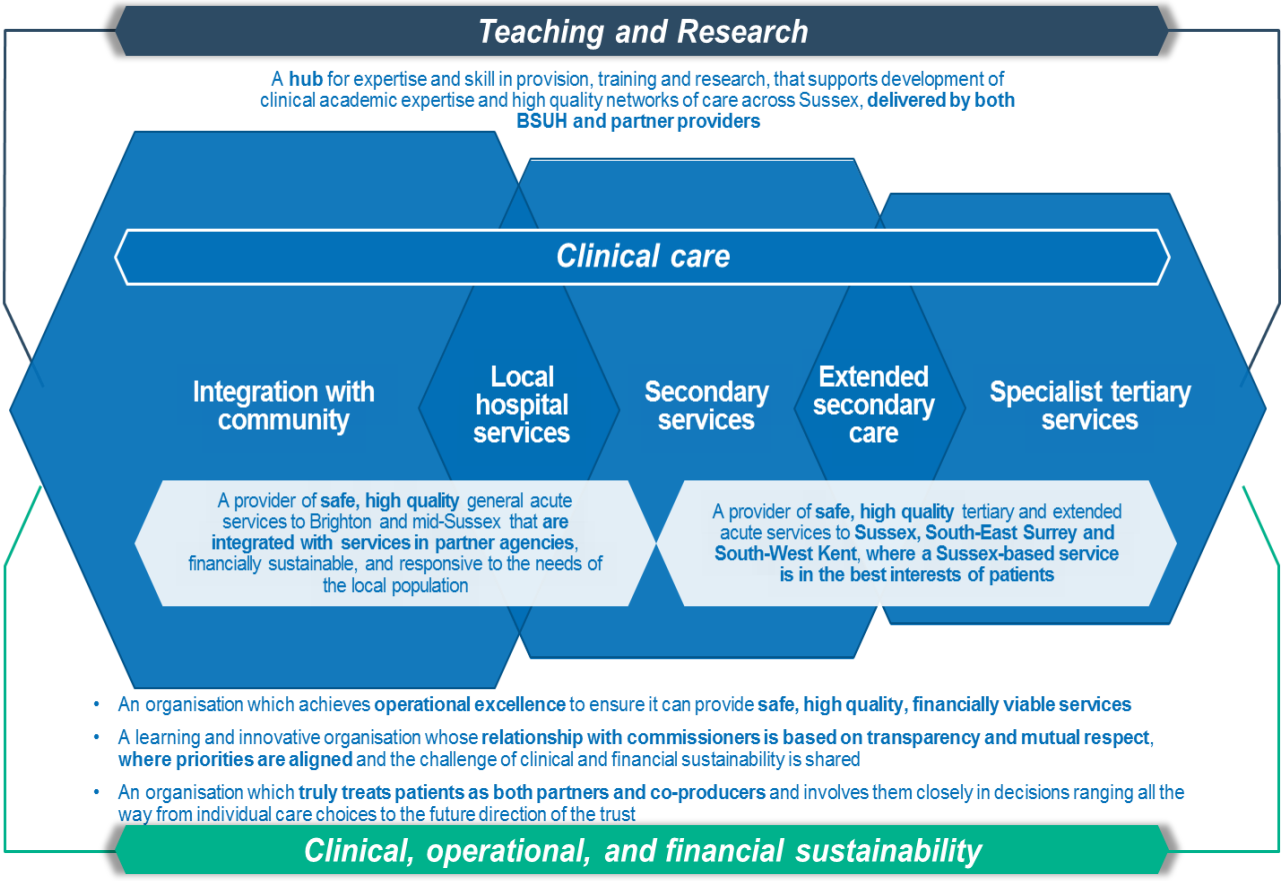
2.16 Our partnership with BSMS facilitates interests in clinical research. The Trust and medical school have five jointly established research groups and operates two clinical research units within the Trust. Research income has grown from £220,000 in 2003 to £6.5m in 2013/14. The Trust has a dedicated clinical investigations unit at the Royal Sussex County Hospital which is in the process of applying for clinical trials unit status.

3. Strategy

3.1 Over the last year, our clinicians, our managers, our patients, local partners and other stakeholders have together helped to develop our strategy. From this we have set out our strategic vision for BSUH: to set the standard for great care, by

- Working together
- Adapting, improving and innovating
- Acting with fairness, kindness and compassion

Vision for the BSUH clinical strategy



3.2 Our vision is underpinned by aspirations for our clinical services. These are described below.

Unscheduled care

3.3 To deliver BSUH's vision of providing high quality general acute services to Brighton and mid-Sussex, as well as regional emergency care, we will:

- Deliver on our commitment to offer a high quality Major Trauma service
- Continue to run two emergency departments - one at RSCH and one at PRH, delivering seven day services, working actively with commissioners and local GPs to manage the demand for urgent hospital care, focusing on ensuring appropriate rapid access to care and integrated support with the community
- Establish PRH as a centre for supporting frail patients, starting with consolidating all fractured neck of femur (hip) work at PRH and increasing senior medical input. Working with commissioners and local authorities, we will ensure frail patients with complex care needs have these needs identified before they become acutely ill
- Building on the Major Trauma Centre designation and specialised emergency provision developed, establish a single-site combined hyper-acute/acute stroke service that means patients with stroke get access to senior clinicians and the latest treatment, as quickly as possible
- This means the RSCH will seek designation under new national standards as a Major Emergency Centre, and PRH will seek designation as an Emergency Centre with 7-day acute medical cover

Elective care

3.4 Our vision for elective services is to improve patient experience, and quality and responsiveness of service provision. We will do this by:

- Working in partnership with our commissioners and patients as well as primary and community care providers to transform and remodel services so that patients have a modern and seamless service inside and outside the hospital

- Challenging whether the current location of services is best for patients. We will provide services as locally as possible. For example, we will establish clinics outside BSUH for outpatient services in high volume specialties

- Challenging the current medical focus of service delivery and building on the use of clinical nurse specialists, therapists and others

Sussex-wide services and Neurosciences

3.5 Our vision is to provide high quality tertiary and extended acute services to Sussex, south-East Surrey and south-West Kent. The local NHS needs to develop a sustainable model for Sussex-based tertiary provision. Responding to the strategic intention of NHS England to move to a smaller number of contracts for most specialist services, we intend to remain a specialist contract holder for our main tertiary services. We will need to work closely with partner providers of secondary care services in Sussex, specifically Western Sussex Hospitals NHS FT, Surrey and Sussex Healthcare NHS Trust and East Sussex Healthcare NHS Trust; and with partner tertiary centres in London, to establish appropriate pathways. We will work closely with our commissioners to ensure our proposals align with their aspirations for high quality services for local residents.

3.6 Specifically, we will

- Continue to develop the RSCH site as the main centre for specialist work

- For renal, neurological and cardiac care, we will continue to support the provision of a wider range of specialist inpatient and outpatient provision at other hospitals by acting as a hub for scarce expertise and skills, offering this expertise to other providers. We will continue to focus on delivering the benefits of the previously agreed network approach for vascular services.

- We will develop an integrated service with Sussex Community NHS Trust for genito-urinary medicine provision in Brighton and Hove, which has critical links with our well established and highly respected HIV service

3.7 We may also take decisions not to provide some specialised services, based on working with commissioners to assess Sussex-wide needs and best layout of provision.

Cancer

3.8 Our vision for cancer services is to further develop the Sussex Cancer Center and RSCH as the hub for cancer care in Sussex working with partner hospitals, ensuring that our services:

- Implement the pre-existing radiotherapy strategy, upgrading and widening radiotherapy provision in Brighton and introducing satellite radiotherapy centres in East and West Sussex
- Serve cancer patients across Sussex by spreading provision across the area whilst maintaining the quality associated with a centralised cancer service. A key initiative will be the development of satellite haematology-oncology at PRH
- Continually improve outcomes for patients, meeting new and existing service standards
- Are highly regarded by patients and partner agencies
- Meet or exceed quality standards
- Serve as a hub for innovation, research and teaching

3.9 This will be achieved through improving the networking between oncology services and changing the way the oncology workforce is managed, in line with our aspirations for our other specialised services.

Obstetrics, neonatology and paediatrics

3.10 Our vision is to deliver high quality general acute maternity and paediatric services to the population of Brighton and mid-Sussex and a wide range of extended acute / tertiary maternity and paediatric services to the population of Sussex we will:

- Enhance the services at RSCH by the further development of the full range of obstetric services including a midwife-led unit and neonatal transitional care
- Develop the Royal Alexandra Children's Hospital as a tertiary centre for Kent, Surrey and Sussex and work with community children's services to improve patient experience and manage pressure on the paediatric emergency department and general paediatric medicine

- Maintain level 3 tertiary neonatal provision via the Trevor Mann Baby Unit
- Develop ambulatory obstetrics and gynaecology at both PRH and RSCH, reducing antenatal attendance pressure on both labour wards

Support services

3.11 We will:

- Give support services such as therapies, diagnostics and pathology a greater voice within strategy and service development work
- Develop strong 7-day based services where clinically appropriate, maximizing the benefits for patient flow and site capacity as well as an improvement in quality outcomes.
- Find opportunities to improve the scope and efficiency of clinical support services by working closely with services in other agencies

A quality-driven strategy

3.12 Quality has been at the forefront of the development of this strategy which will support BSUH in:

- Achieving core service standards for Major Trauma Centre with co-location of Neurosurgery, achievement of oncology peer review standards
- Extending maternity choices to include midwife-led care in a hospital setting
- Reducing the pressure on an unscheduled care pathway that operates at very high levels of bed occupancy with resultant ED underperformance and quality concerns
- Securing 7-day, intensive input approaches to core acute emergency pathways
- Improving key outcomes which have been historic challenges, particularly in stroke care
- Protecting critical co-dependent services i.e. planned ophthalmology which supports the eye A&E and tertiary provision

- Maintaining and provide to others, Sussex-based specialist expertise and act as a hub for teaching, training and research

- Improving standards in specialist provision across Sussex

What this means for our main hospital sites and the people they serve

3.13 BSUH is continuing to pursue approval for its 3Ts capital development scheme, which will provide modern, fit for purpose and expanded estate at the Royal Sussex County Hospital site. This clinical strategy emphasises the importance of 3Ts, both to provide high quality general acute care for Brighton and Hove and the infrastructure for the Trust to operate as a hub for specialised services. The Outline Business Case for 3Ts was approved in May 2014 and the Trust is working towards Full Business Case approval.

3.14 RSCH will continue to operate a mixture of local acute services for the Brighton and Hove population, and specialist services for a Sussex-wide population including the operation of a Major Trauma Centre, with the major addition being co-located neurosurgery to support the provision of brain surgery expertise to patients with major traumatic injuries. The RSCH will meet the new national definition for a 'Major Emergency Centre'.

3.15 PRH will continue to develop its dual focus on care of the elderly and elective work, while retaining the majority of its current service provision. PRH will retain medically-led A&E services that meet the new definition of an 'Emergency Centre', and an acute medical inpatient bed base. The consolidation of routine elective care to PRH will continue with moves of Head and Neck surgery and Urology.

3.16 BSUH will continue to run outpatient and ambulatory care services from a number of other sites including Hove Polyclinic, Brighton General Hospital and Lewes Victoria Hospital. RSCH-based services not requiring advanced diagnostic and inpatient facilities will increasingly look to use other estates.

Building on our academic and research strength

3.17 BSUH prospers from its links with Brighton and Sussex Medical School, the University of Sussex, the University of Brighton and Health Education England. With our academic partners the trust will prioritise the research agenda in key services such as cardiology, oncology, paediatrics, renal, HIV and neurology, developing with the Medical School, a joint strategy for more rapid growth in research activity. Teaching

will remain a priority with the Trust working closely with HEE KSS to support its programmes and with BSMS to achieve its aim of remaining a top tier medical school for undergraduate teaching. We will continue to be a major partner within the KSS Academic Health Science Network.

Enablers of our clinical strategy

3.18 There are four important enablers of our clinical strategy:

- Foundations for Success: the Trust has committed to an internal development programme, Foundations for Success, described in more detail in chapter 8
- IT: the strategy will require improved information technology to be effective. BSUH is implementing an Electronic Patient Record system to support this
- Information: the Trust will need to make improved use of information and data. We are currently refreshing our informatics strategy to allow us to do this
- Supportive commissioning initiatives, specifically the plans of our two main commissioning CCGs for delivering unscheduled care activity reductions in line with the Better Care Fund.

Implementation and further developing the strategy

3.19 The majority of initiatives described in our strategy will be implemented by the end of 2016 although some will work through over a longer timescale.

3.20 In parallel BSUH will need to continue maintain its financial performance and maintain and improve clinical quality. To achieve this, BSUH will:

- Develop a Transformation Board that supports significant change in the way we deliver care and links closely with our clinical commissioners including NHS England. Internal transformation is key to our clinical and financial sustainability going forward but must be taken forward alongside wider system challenges
- Continue our clinical and operational strategy development. We will continue to assess what additional strategic and operational changes are need to deliver our vision. We will consider

further options for changes to methods of delivering care, including opportunities for further Sussex-wide partnerships, opportunities not to provide some services which could be provided by neighbouring organisations and further opportunities for service moves within BSUH.

PESTL analysis

3.21 The Trust conducted a PEST analysis on the constraints that affected the development of its clinical strategy. Specific parameters were identified which were:

a. **Political –** BSUH exists in a politicised NHS and a politically contested local context. Any strategy needs to be politically realisable. This does not mean avoiding any service moves but it does mean that there has to be a reasonable prospect of the population in both catchments being content to accept that any service move is in their best interests as patients.

b. **Economic -** the Trust must both continue to seek its own efficiencies, and also co-operate in system-wide efficiency improvements. The capacity constraints in the acute bed base make this a particularly pressing challenge for BSUH; whilst financially a strategy of continual growth across all services might mitigate some of these pressures, this is operationally unviable and the future success of the Trust is dependent on lower demand for acute unscheduled care. This means that:

   i. Strategic initiatives that require a growth in demand for beds would have to identify reductions elsewhere, or would only be actionable in a demand scenario where the bed requirement reduced significantly
   ii. Large-scale capital investment would require changes to the 3Ts plan as the Trusts' overriding strategic capital priority
   iii. The overall strategy should make a net contribution to meeting the recurrent 4% per year efficiency challenge

c. Social – changes in societal expectations lead to greater demand for accessibility in service provision. Therefore it was not anticipated that any strategic initiative would lead to a reduction in the accessibility of planned elective services.

d. Technological – changes were discussed during the strategy development process in a number of specific areas including the increase in rates of survival in many serious diseases including renal disease and oncology, leading to increased long-term reliance on service provision such as

dialysis. However, for a 5-year timescale the most pressing strategic constraints were perceived to be:

i. Any strategic initiative must be consistent with current known commissioning standards and NICE guidance
ii. Specifically known clinical co-dependencies must be respected i.e. the requirement for certain specialties, types of intervention and diagnostic tests to be on the same site. The biggest constraint is the requirement to co-locate services that support a Major Trauma Centre which include major, bed-intensive specialties of Neurosurgery and Cardiac surgery.
iii. The Trusts' commitment to its existing Electronic Patient Record implementation programme

e. Legal – a key test for the strategy is its compliance NHS legislation and the wider law. In particular any merger, acquisition or other organisational change would require regulatory clearance.

Support from key commissioners

3.22 During the clinical strategy process, BSUH worked with key representatives of its principal commissioners to ensure alignment of its strategic vision to commissioner strategies.

3.23 This alignment is particularly critical for BSUH in the context of the requirement to secure approval for the 3Ts Full Business Case (see chapter 5). Detailed work will be underway between commissioners and providers throughout summer 2014 to secure full support for the detailed activity and income projections within the 3Ts business case.

3.24 BSUH has discussed with CCGs and NHS England, the 5-year plan submission being made on behalf of all Sussex commissioners. The Trust will continue to work with commissioners, and partner providers, as 5-year plans develop. However, on the basis of discussions to date, the Trust is confident that

- The plans of BSUH and its commissioners contain mutually supportive aspirations and objectives
- Commissioners support the commitment of BSUH's Board to remain a standalone organisation, with progression to Foundation Trust status when appropriate

- The role that BSUH wishes to pursue within the local health economy, of a comprehensive, multi-specialist teaching hospital providing a range of services, from general acute to selected tertiary provision, is supported by all commissioners

- That there is a shared commitment between BSUH and CCGs to reducing both the financial spend related to, and performance and capacity impacts of, general acute unscheduled care admissions related to long-term and age-related conditions

- That, subject to agreement on detailed activity projections, NHS England supports the planned profile of tertiary provision envisaged as part of the 3Ts plan, i.e. BSUH offering comprehensive tertiary provision for the population of Sussex in:

    - Major Trauma
    - Neurosurgery
    - Neurology
    - Cardiac surgery
    - Vascular surgery
    - Interventional radiology
    - Radiotherapy and related oncology provision

Initial consultation - 2011

3.25 We undertook a sixteen week consultation on our plans to become an NHS foundation trust between January and May 2011. As part of this, four public meetings were held. Two drop-in events were held for BSUH staff. 15 members of staff attended.

3.26 The consultation document was sent to over 50 key stakeholders including MPs, partner providers and other key local stakeholders.

3.27 A mailing was sent out to 10% of patients. Around 3,000 recipients received a cover letter and a consultation document and the remainder received a membership form and a covering letter detailing how to get involved in the consultation (e.g. online, through the helpline, by email, by post, etc.)

3.28 A dedicated micro-site complete with an online version of the consultation document was made available along with an online questionnaire. A significant number of respondents made use of this.

3.29 A dedicated helpline was set up and 243 calls were taken during the consultation period.

3.30 A dedicated enquiries email address was set up. 162 emails were taken during the consultation period.

3.31 377 responses to the consultation were received and have since been independently reviewed. There was overwhelming support for the Trusts' then vision and strategic goals, and, in the main, for our proposed governance arrangements. In light of the observations made on the size and composition of our Council of Governors, some minor amendments were made to the then governance proposals.

Consultation refresh

3.32 Following discussion with the Board, a revised, smaller Council of Governors was proposed in 2013. As this represented a significant change to the Trusts' governance proposals, the Trust undertook a consultation refresh exercise in November and December 2013.

3.33 Two public meetings were held and a consultation refresh document, detailing the changes, was issued to 1900 enlisted public members and all respondent organisations to the original consultation.

3.34 Broad support for the changes, as well as the continuing intention to achieve Foundation Trust status, was received. One remaining issue for resolution is the exact configuration of public constituencies in respect of local authority and Clinical Commissioning Group boundaries, with CCGs having a preference for public constituencies that are co-terminous with their boundaries. The BSUH Board will formally consider this issue in advance of submitting its application for Foundation Trust status.

Rationale for NHS foundation trust status

3.35 We believe foundation trust status will help us to harness the commitment, passion and hard work of all our staff, volunteers and partners.

3.36 It will also provide our patients and the wider public with greater opportunities to be more involved in their local and regional healthcare provider and for us to better plan and deliver services that reflect their needs.

We will encourage and act on feedback from our public, staff and stakeholders through the establishment of a Council of Governors and membership that represents the people we serve.

3.37 The increased financial flexibility associated with foundation trust status will allow us to invest more in research, innovation and facilities that further our aim of providing the best and safest care. This will provide a strong incentive to our doctors and nurses – whose decisions have the biggest impact on the safety and quality of services and use of resources – to continue to increase efficiency and productivity in all that we do.

3.38 Becoming a foundation trust will enable us to achieve our vision, realise a range of ambitions for our services and support us to strengthen our local and regional services. Becoming a foundation trust is part of a journey of improvement that will help us to drive rigour and embed a culture of good governance and strong leadership throughout the organisation, and not an end in itself.

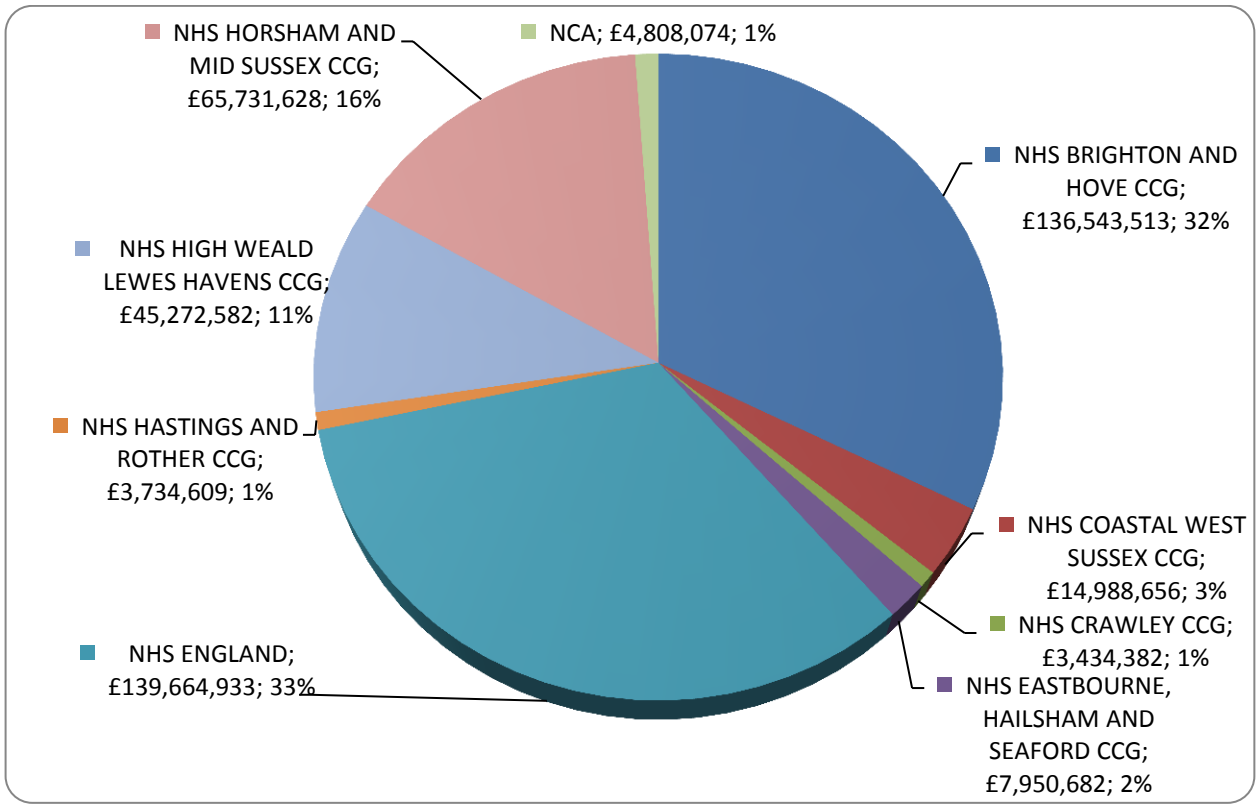
4. Market assessment

Commissioning landscape

4.1 Sussex contains seven Clinical Commissioning Groups. BSUH provides general acute services for populations within the areas served by Brighton and Hove CCG, Horsham and mid-Sussex CCG and High Weald Lewes Havens CCG. BSUH provides more specialised and extended acute provision for Coastal West Sussex CCG, Crawley CCG, Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG

4.2 67% of BSUH's income is derived from CCGs. 33% of services are commissioned by NHS England, via the Surrey and Sussex Area Team. Of the Trusts' principal specialties, renal care, HIV, Neurosurgery, Cardiac Surgery, Neonatal care, Cancer and genito-urinary medicine receive in excess of 75% of their funding from specialised commissioning.

Projected clinical income by commissioner, 2014/15



Demographics and patterns of disease

4.3 Throughout this analysis, a convention will be used that describes a 'local acute' and 'extended' market within Sussex. We characterise the 'local acute' market as being that for which BSUH is the nearest acute

hospital provider. i.e. the population served by the three largest contributing CCGs. We characterise the 'extended' market as being the larger Sussex market which includes the southern borders of Surrey and Kent for trauma care.

4.4 Two areas within Sussex – the Brighton area itself, and the Crawley-Gatwick area, have been designated by local government as focal points for future population and infrastructure growth. Generally the demographic projections below reflect changes anticipated in the birth rate and age profile of the population. Net internal migration of working age people to the area is likely to have been underestimated, particularly in the Crawley-Gatwick area.

Local acute market demographics

4.5 Within the local acute market, demographics vary considerably between the urban area of Brighton and Hove and the mid-Sussex/Lewes areas to the north and east. Brighton and Hove has a larger working age population, with 64% of residents being between 17 and 60 years old, as opposed to 53% in mid-Sussex and 50% in Lewes. Mid-Sussex and Lewes combined contain 47% of all residents, but 58% of residents aged 60 or over.

Demographic profile, ACORN 2012, district council/unitary authority areas in local acute market

	Brighton and Hove		**Mid-Sussex**		**Lewes**	
	Base	**% of Area**	**Base**	**% of Area**	**Base**	**% of Area**
Age	**261,668**	**100.00**	**133,832**	**100.00**	**98,724**	**100.00**
0-16	45,620	17.43	28,484	21.28	17,962	18.19
17-21	20,716	7.92	7,089	5.30	5,121	5.19
22-29	39,944	15.27	9,251	6.91	6,986	7.08
30-39	39,186	14.98	15,181	11.34	8,929	9.04
40-49	40,911	15.63	21,131	15.79	14,402	14.59
50-59	27,515	10.52	18,344	13.71	13,818	14.00
60-74	28,448	10.87	22,097	16.51	19,039	19.29
75+	19,328	7.39	12,255	9.16	12,467	12.63

Brighton and Hove

4.6 The headline assessment of health needs in Brighton and Hove is that disease prevalence is below the national average in every recorded area except depression and mental health disorders. This reflects the fact that B&H has a relatively young, educated, healthy population with good access to infrastructure and services.

4.7 However, Brighton's population faces typical urban population challenges. Factors identified from the local Joint Strategic Needs Assessment and public health indicators which are particularly relevant to the market for healthcare services include that:

- The proportions of people living in inappropriate housing conditions, and outright homelessness, are double the national average. Hazardous drinking levels are 26% higher than the average for South-East England and higher than statistically similar areas of the UK. These trends reflect Brighton's significant homeless/itinerant communities and large areas of urban deprivation
- Prevalence of drug use is typical for this type of population, and not significantly different to similar areas of the UK. However, alcohol-related hospital stays are 50% above the UK average.
- Brighton residents are less obese, participate in more sport and consume greater amounts of fruit and vegetables than the UK average.
- Deaths attributable to smoking are 18% higher than across the wider South-East (but comparable with similar areas of the UK)
- The younger population carries distinct challenges with acute sexually transmitted diseases and hospital stays for self-harm both in the top decile nationally.
- Rates of dementia diagnosis are well below the assumed prevalence, suggesting under-diagnosis and treatment

4.8 Cancer mortality is above the national average across all tumours and in each of the three most prevalent tumour sites. Deaths from circulatory, coronary and respiratory disease are 7 – 11% lower than both the UK average and statistically similar parts of the UK.

4.9 Brighton's population has a similar ethnic mix to the UK average; 89% of the population is white versus an 87% national average. 4% of the population are of Asian ethnicity versus a UK average of 7%, 1.5% are black versus a national average of 3%, but double the UK average are of mixed race, at 4%.

4.10 Brighton has a student term-time population of 34,000, one of the largest in the UK. Additionally, because of the resurgent tourist industry, non-residents present in the city during peak times of summer weekends can be as high as 10 – 15,000 staying overnight, with significantly higher numbers coming to the town for the day. The volume of visitors to the city can have a significant influence on A&E activity, stimulating high levels of demand for minor/primary unscheduled care.

Horsham and Mid-Sussex

4.11 The CCG covers the area directly to the north of Brighton and Hove, up to the boundaries with Crawley, Kent and Surrey. The area is characterised by smaller market towns and villages, the largest of which is Haywards Heath, containing the Princess Royal Hospital.

4.12 The prevalence of Asthma, atrial fibrillation, cardiovascular disease and stroke are all slightly above the national average. The prevalence of cancer and hypothyroidism are in the top quartile nationally. Mortality from cancer is relatively low, except for breast cancer which is in the top quartile. Unsurprisingly given the nature of local infrastructure, road injuries and deaths are in the top quartile.

4.13 Whilst there is no separate JSNA analysis for mid-Sussex, its population is generally characterised as affluent, with high levels of physical activity and low levels of obesity. Smoking rates, however, are in the top quartile nationally. The dominant factor affecting the healthcare market is the high proportion of older residents; mid-Sussex has a high population in nursing homes, with one particular major sheltered residential development. A third of all residents are registered as having a long-term condition.

4.14 The population is 95% white, well above the national average. The mixed race population is close to the average percentage, with much smaller than average asian and black populations.

Lewes

4.15 The Lewes District Council area is to the north-east of Brighton and Hove, covering the towns of Lewes and Newhaven, and the rural area up to the border with Uckfield. BSUH operates daycase and outpatient services from Lewes Victoria Hospital, owned by East Sussex Healthcare NHS Trust.

4.16 The large elderly population drive needs associated with long-term conditions and general frailty, and can be isolated with poor access to infrastructure and services. Rates of alcohol misuse are high, as again are deaths and injuries from road accidents. High Weald Lewes Havens CCG has prevalence in the top quartile nationally, and above comparator CCGs, for atrial fibrillation, cancer and cardiovascular disease and stroke. However, cancer and cardiovascular disease mortality is better than expected based on national and comparator levels.

4.17 The population of Lewes is 96.6% white, well above the national average. All minority ethnic groups are relatively smaller than the national average.

Local acute market – demographic growth

4.18 Applying ONS population projections to the current populations, across all ages, population growth is relatively modest. The overall catchment population is forecast to grow by 4.0% to 2018, with annual growth rates as below. Analysis of the causes of population growth by ONS suggests that migration is not a significant factor for any part of the local acute market, with both internal and international migration expected to be roughly balanced. However there is a trend observed in local housing developments, and not reflected in these projections, of growth in development in the mid-Sussex area which is becoming increasingly popular with London commuters. Brighton continues to have a significant commuting population.

	2014 growth	**2015 growth**	**2016 growth**	**2017 growth**	**2018 growth**
Brighton and Hove	0.68%	0.63%	0.59%	0.55%	0.53%
Lewes	1.22%	1.21%	1.17%	1.15%	1.13%
Mid Sussex	0.73%	0.77%	0.77%	0.77%	0.78%

4.19 However, broken down by age, there are marked variances in the rate of growth. The annual rate of growth in the 70+ population across the three areas is over 2.5%, with the 90+ population growing at 3 -4% per annum dependent on geography. The population aged 20 – 50 is projected to shrink. This presents a significant challenge for the NHS in BSUH's local acute market, as, with all acute healthcare, the utilisation of services is concentrated with older people. Patients aged 80+ account for 15% of spells from the three local acute CCGs, but 38% of bed days. This highlights the challenge across the health economy to reduce not only the rate of admission amongst this cohort, but particularly the amount of time spent in an acute bed prior to discharge.

4.20 These trends continue over a 10 – 15 year time horizon. Whilst not a matter for this IBP, the growth in the elderly population in the Trusts' catchment, and increasing inclusion in the London commuter belt, strongly reinforce the demographic growth case for the 3Ts development which will be set out in more detail in the 3Ts FBC.

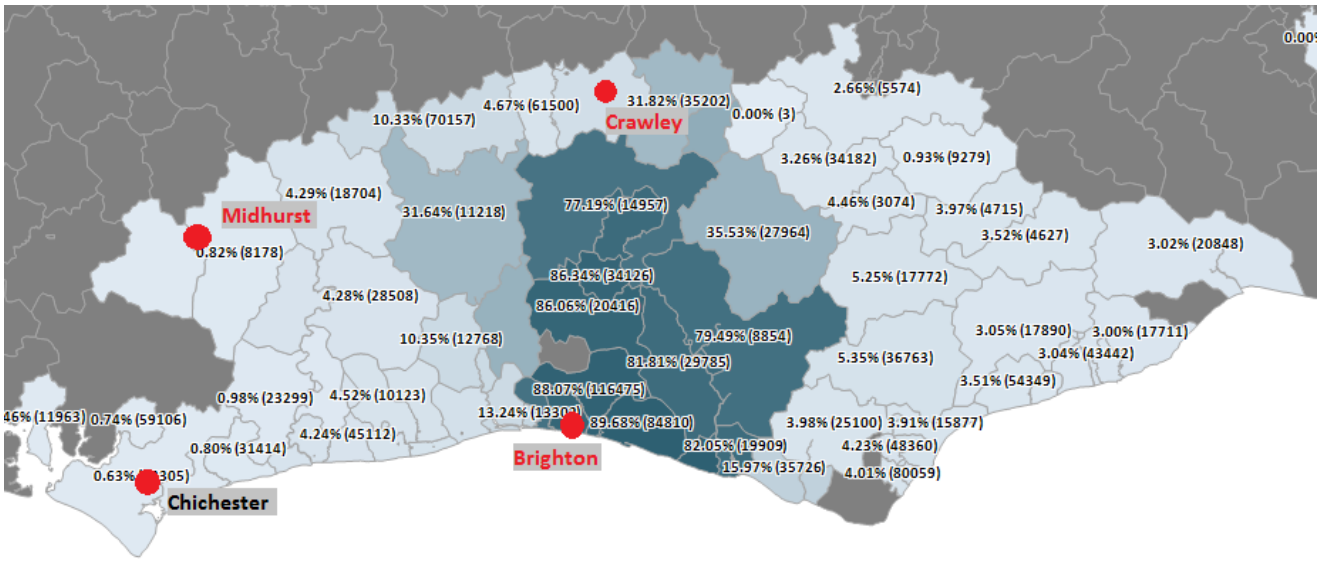
4.21 There is also 1 – 1.5% p.a. growth in the 0 – 9 years category for the catchment. Given the pressures of providing a full range of paediatric and obstetric services in a district hospital setting, as evidenced by recent changes in provision in East Sussex, the Trust must plan on the basis of consistent growth in both maternity and paediatric activity throughout the period.

Sussex-wide demographics

4.22 In terms of catchment, it is of note that Sussex contains very few major roads (East Sussex is the worst served, with only 20 miles of dual carriageway) and the railway infrastructure consists principally of the ends of radial lines that run into London, with limited coastal lines running in and out of Brighton. Because of the requirements to co-locate services, much of the specialised/tertiary provision offered by the Trust has to be located at the RSCH site, which depending on local circumstances can be 15 – 25 minutes from either of the nearest trunk roads, and is 10 – 15 minutes by car from the railway station. This means that for many service lines, journey times from the north and west of Sussex may be comparable or shorter to BSUH's competitors:

Town	Time to RSCH	Comparable provider	Time to comparator
Chichester	57 minutes	Southampton University Hospitals NHS FT	44 minutes
Midhurst	69 minutes	Southampton University Hospitals NHS FT	53 minutes
Crawley	42 minutes	St George's Healthcare NHS Trust	50 minutes
East Grinstead	51 minutes	St George's Healthcare NHS Trust	54 minutes

4.23 Whilst Sussex has a population of around 1.6m people, the population for whom RSCH is the nearest specialist centre is 1m – 1.6m dependent on the specific service in question.



Map: BSUH market share for inpatient spells, Sussex by Lower Super Output Area

4.24 The mitigation to the impact of this on BSUH's strategy is the long-standing commissioning policy under successive organisations to allow as wide a range of services as possible to be provided from a Sussex base. This reflects the fact that without this provision, journey times to providers out of the area would be unacceptable for many patients in outlying parts of East Sussex leading to poor outcomes and, as had been seen with radiotherapy treatment for cancer, low rates of uptake of modern treatment techniques for serious conditions. Where certain volumes are required to make services financially viable or clinically safe, this has led to the institution of network structures where all patients from certain geographies are referred in to these tertiary centres. As an example, BSUH acts as the hub for a Sussex vascular network which

includes St. Richard's Hospital in Chichester, supporting a model of provision which offers advanced vascular provision to all of Sussex, despite the fact that tertiary vascular care is available closer at Portsmouth Hospitals NHS Trust. Therefore this analysis considers the Sussex population as a whole, but this should not be interpreted as meaning that BSUH faces no competitive threat for services where it is the only provider in Sussex.

The population of Sussex as a whole breaks down by age as follows. This indicates that the wider Sussex population has a markedly older population than the rest of the UK:

	Base	**% of Area**	**UK %**
0-29	535,077	33.53	37.50
30-39	179,664	11.26	13.1
40-49	235,349	14.75	14.6
50-59	205,262	12.86	12.2
60-74	269,656	16.90	14.7
75+	170,686	10.70	7.9

4.25 The projections by age bracket for the Sussex-wide population indicate that the most marked trend is growth in the 70+ age category but with significant movement from the 40 – 49 category into the 50 – 59 category. Life expectancy across Sussex is higher than the national average for both men and women.

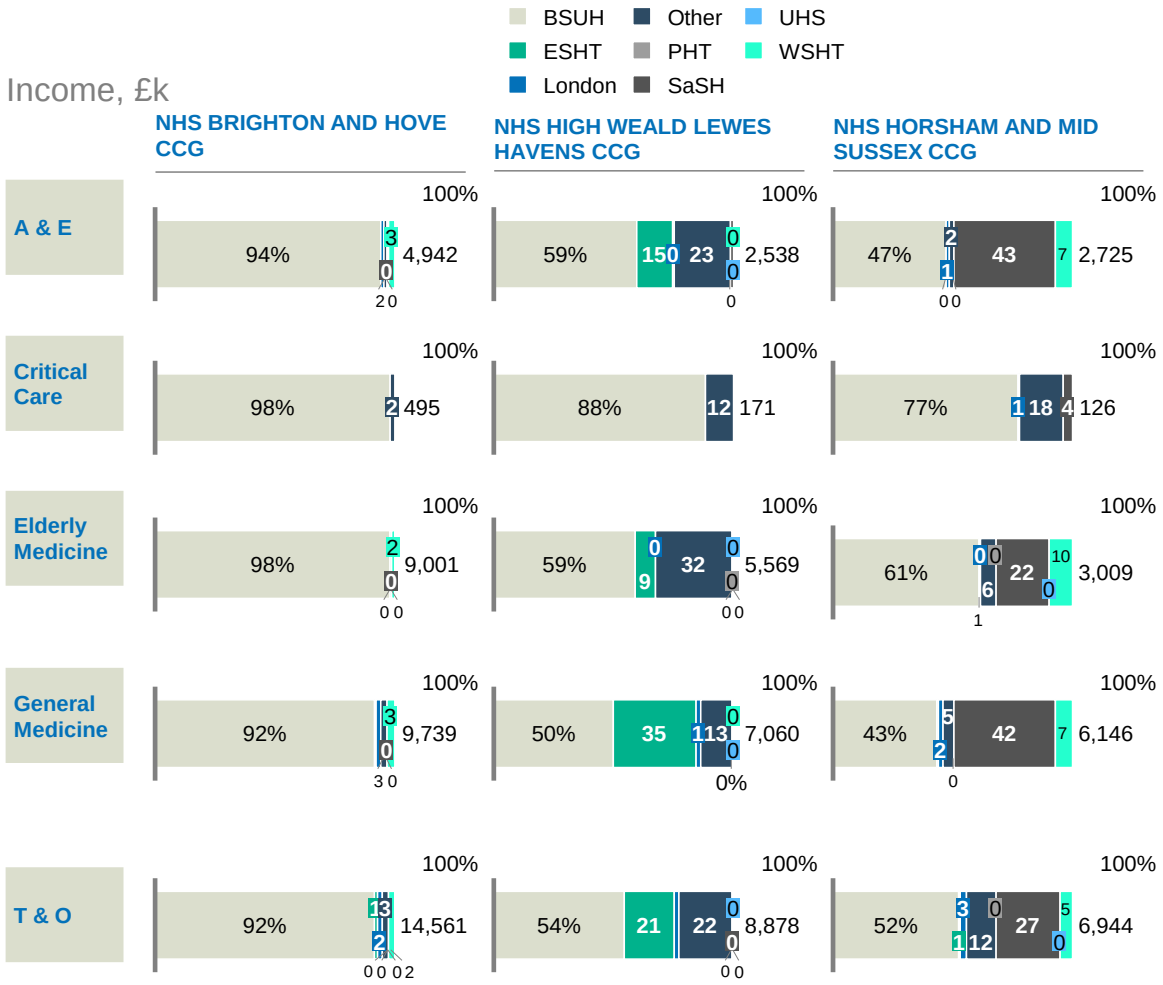
Age	2014 growth	2015 growth	2016 growth	2017 growth	2018 growth
0 to 9	2.06%	1.42%	1.11%	0.69%	0.77%
10 to 19	-0.40%	0.04%	0.13%	0.62%	0.71%
20 to 29	0.25%	0.33%	0.25%	-0.27%	-0.40%
30 to 39	0.84%	1.08%	1.28%	1.55%	0.85%
40 to 49	-1.79%	-1.91%	-2.11%	-1.67%	-1.05%
50 to 59	3.02%	2.56%	2.40%	1.69%	1.45%
60 to 69	0.32%	0.30%	-2.23%	-0.49%	0.71%
70 to 79	2.87%	3.20%	6.63%	4.32%	3.05%
80 to 89	1.40%	1.49%	1.68%	2.17%	1.85%
90+	3.38%	3.52%	3.73%	3.39%	4.20%

Market share – local acute catchment

4.26 The key characteristics of BSUH's market share across the local acute catchment are:

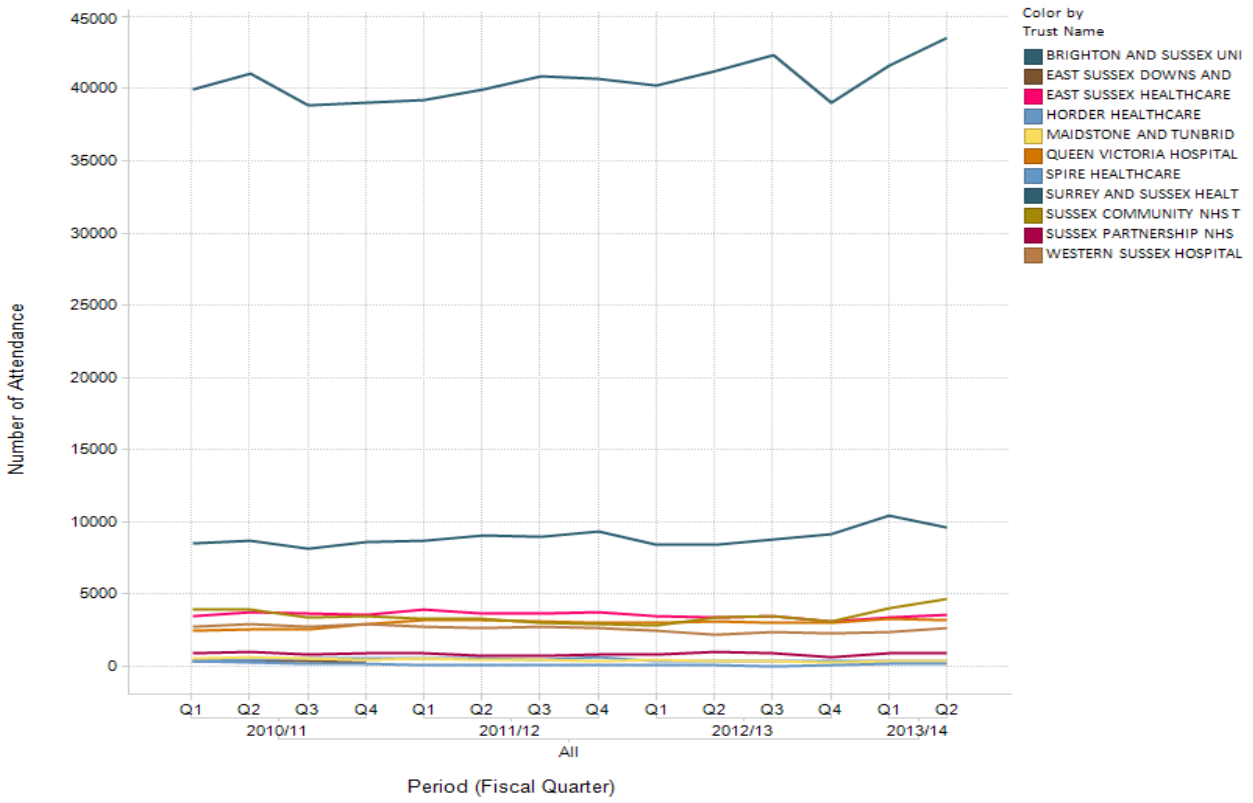
- **90%+ market share for local acute general acute services from Brighton and Hove CCG**
- **40 - 60% of the market share from Horsham and mid-Sussex CCG** where the mid-Sussex area around Haywards Heath is dominated by BSUH, and the Horsham area is within the SaSH catchment.
- **40 – 60% of the market share from High Weald Lewes Havens CCG** where the Lewes/Havens catchment is dominated by BSUH and the High Weald area is within the MTW catchment.

This is demonstrated by the graphs below which reflect 2012/13, SUS-coded income for key unscheduled care specialties.

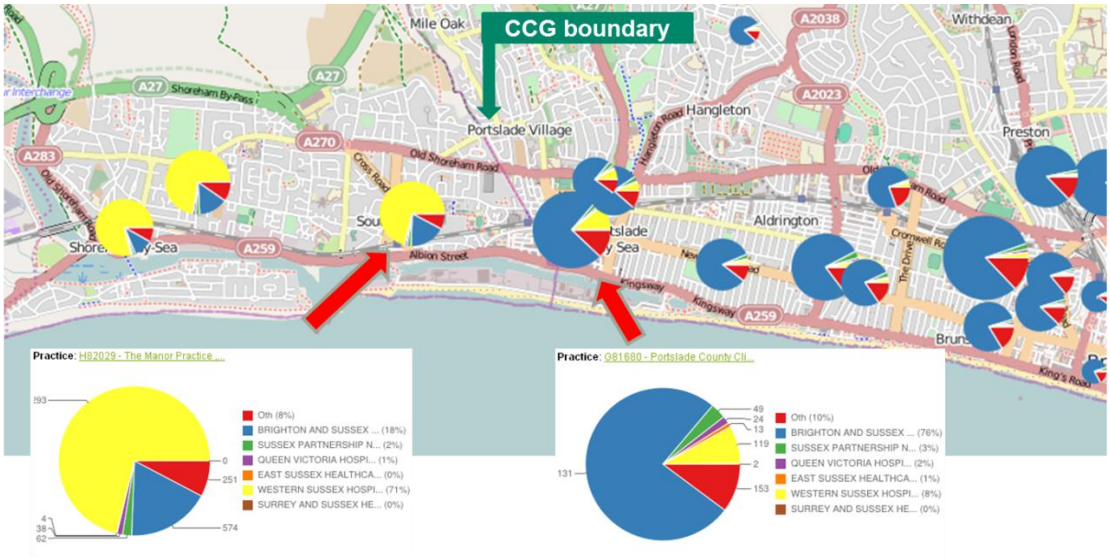


4.27 Trend analysis of first outpatient appointments for the local acute catchment shows no significant movement in the patterns of elective activity since 2010/11, with all providers seeing modest growth.

Recent tendering activities led by Brighton and Hove CCG (and involving others) for musculoskeletal and dermatology care will lead to the Trusts' market share dropping significantly in 2014/15:



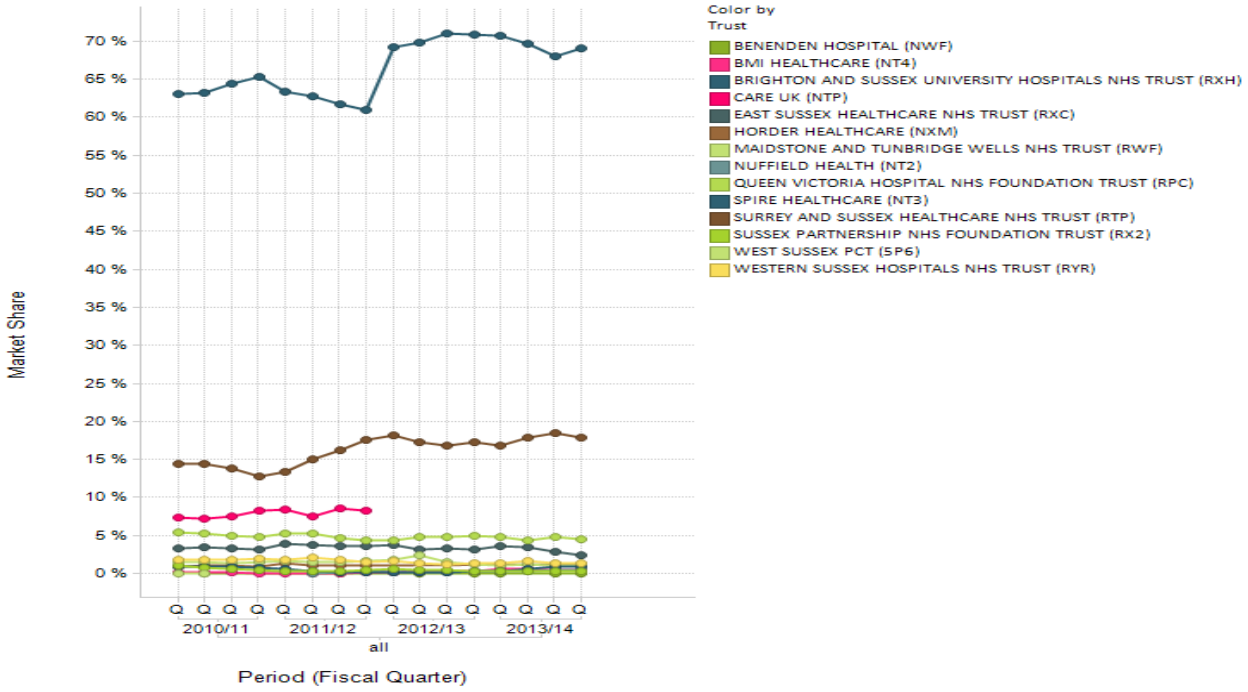
4.28 To the west, Brighton constitutes a continuous settlement with towns up to and including Worthing, containing a main site of Western Sussex Hospitals NHS Trust. The strength of the catchment boundary, co-terminous with CCG and local authority boundaries, is particularly notable. At neighbouring practices each side of the boundary, with drive times to both acute sites almost identical, 75% of referrals are received by BSUH to the east and WSHT to the west respectively.



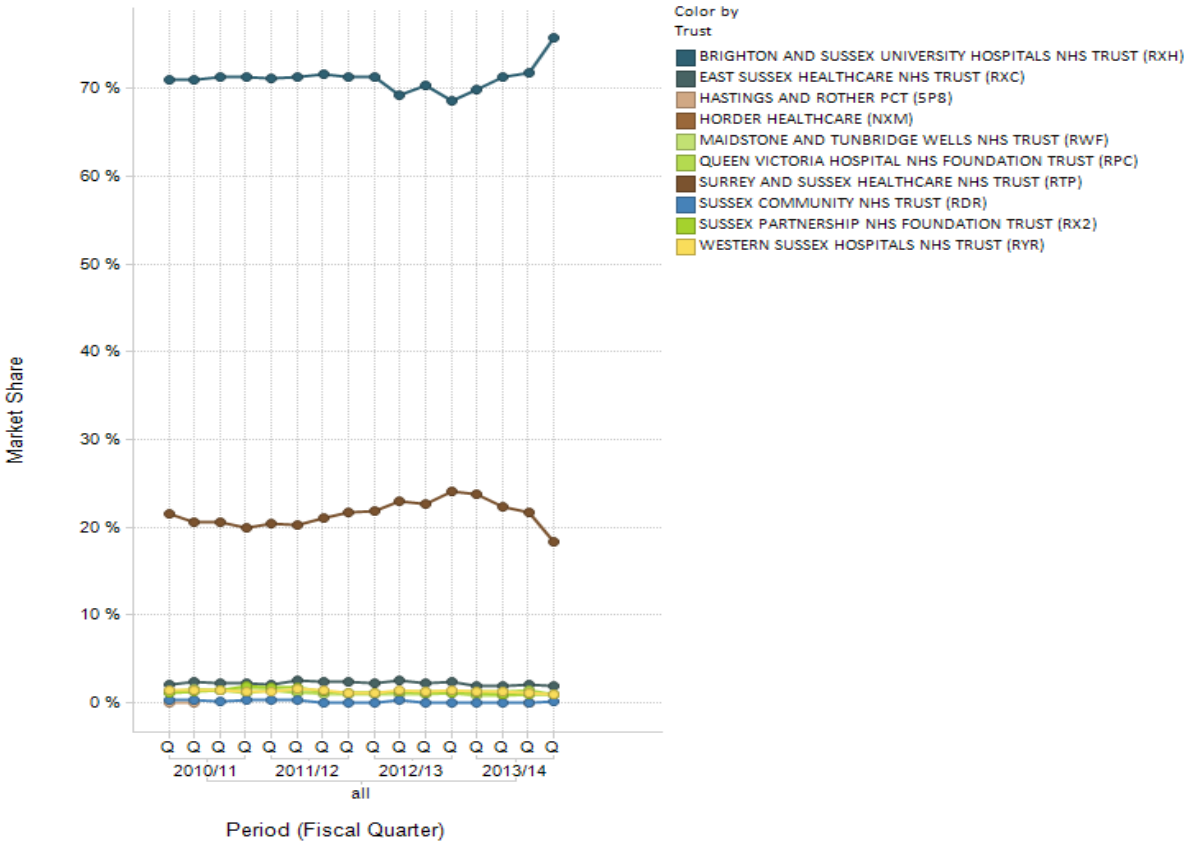
Manor practice
- RSCH: 19 minutes
- Worthing GH: 16 minutes

Portslade clinic
- RSCH: 17 minutes
- Worthing GH: 18 minutes

4.29 Elective inpatient market share grew significantly in 2012/13 as a result of the absorption of the Sussex Orthopaedic Treatment Centre, previously provided by Care UK. Market share has fallen slightly from 71 to 69% since. Movements in the elective market share are mirrored by corresponding movements in the market share at SaSH, with the most volatile areas of activity being gastroenterology and orthopaedics.

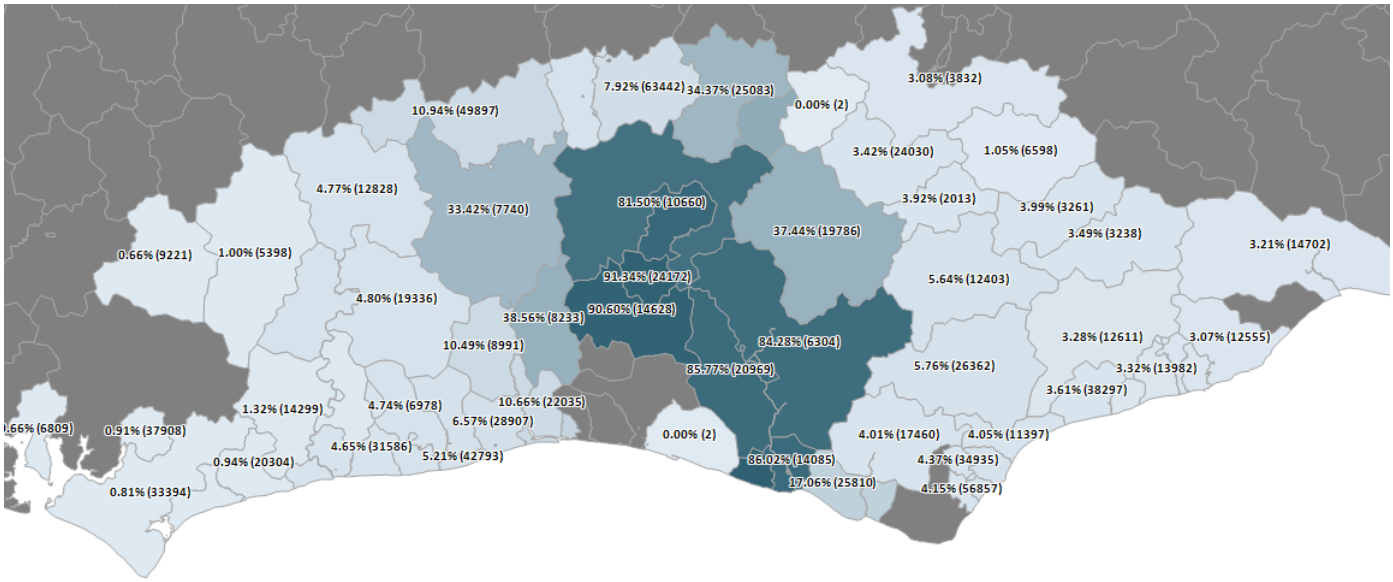


4.30 Unscheduled care market share has increased significantly over the period from 71 to 76% principally at the expense of Surrey and Sussex Healthcare NHS Trust. This reflects the continual aggregation of more acute unscheduled care into the RSCH site, principally in vascular and trauma care which has been seen with further changes in this financial year as a result of reconfiguration of acute services in East Sussex.

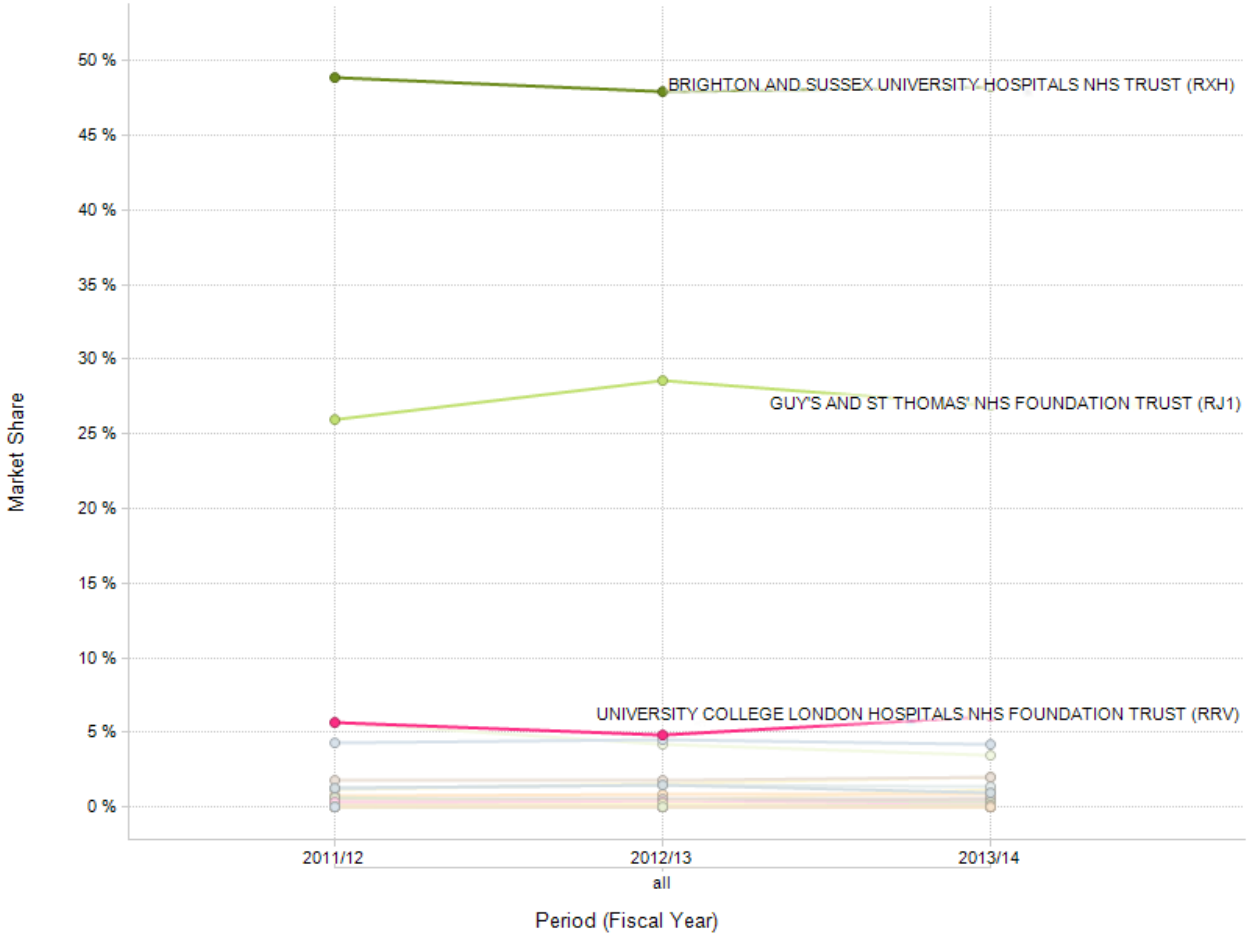


Market share – extended catchment

4.31 Analysis of the Trusts' market share for inpatient spells by geographical area shows the clear delineation between the local acute market and the wider Sussex catchment. By percentage of spells, market share in the wider catchment is consistently 3 – 10%.



4.32 Looking at the market share for specialised services in these outlying regions, BSUH is the largest provider of inpatient spells, with a stable market share at 49, 48 and 48% of the market in the last three financial years. Guys' and St' Thomas NHS Foundation Trust and University college London Hospitals NHS Foundation Trust are the main competitors for the Sussex market. GSTT undertakes significant cardiothoracic, paediatric tertiary and renal activity on Sussex patients, whereas UCLH undertakes significant sub-speciality Neurology work. This work is typically undertaken for all Sussex patients.



4.33 Whilst GSTT and UCLH offer the greatest competition for tertiary work for Sussex patients, it is of note that of the London providers, it is St George's that provides the most practical barrier to overall growth of tertiary activity, as it has major cardiac and neurosciences departments and is the most accessible provider both electively and non-electively, for all patients north of Crawley. This limits the BSUH catchment along the populous A23/M23 corridor, to the Sussex border. BSUH continues to pursue joint working with St George's where tactically appropriate, principally in Neurosurgery.

Care utilisation and commissioning strategy – Brighton and Hove

4.34 In comparison to statistically similar CCGs, NHS Brighton and Hove has a relatively high level of elective activity but low levels of non-elective activity. In circulatory disease in particular, there is a correspondingly high level of elective activity and low level of non-elective activity in circulatory disease. Rates of acute intervention in cancer are significantly below comparators[1].

[1] NHS England/Public Health England 'Commissioning for Value' tool http://ccgtools.england.nhs.uk/cfv/flash/atlas.html

4.35 Management of chronic disease in primary care is poor. Brighton and Hove GPs are in the worst quartile nationally for the management of hypertension in patients registered as having endocrine, circulatory and diabetes-related illness, and cholesterol levels in endocrine and circulatory disease.

4.36 Brighton and Hove CCG's 2012 – 2017 commissioning strategy identifies elective care costs as a significant area to address[2]. NHS England analysis has identified Musculoskeletal-related elective care as the greatest area of potential cost reduction. This is reflected in the CCGs' leadership of a recent joint procurement exercise for a prime provider in musculoskeletal care, which will lead to the development of improved triage and redirection away from acute care. A similar procurement exercise has taken place in Dermatology services and other areas are likely to follow, notwithstanding improved engagement from BSUH as part of the implementation of its clinical strategy.

4.37 Brighton and Hove CCG have reflected their relatively low rates of unscheduled care utilisation, in their plans for the Better Care Fund. The CCG has projected a reduction of £4.2m in acute care costs, which equates to ~11% of relevant admissions, significantly below the national projection of 15%. The basis of the CCGs' plans to achieve this target is the institution of general practice-based teams to manage frail service users at high risk of acute admission. The CCG is also proposing to strengthen its community rapid responsive services and to institute comprehensive walk-in primary care, co-located with the A&E at the Royal Sussex County Hospital, which will be co-developed with BSUH.

Care utilisation and commissioning strategy - Horsham and mid-Sussex

4.38 Overall rates of care utilisation from Horsham and mid-Sussex CCG are below the national average for every major indicator and in the lowest quartile nationally for every indicator except day-case and elective care. Spend on non-elective admissions is better than comparator for ten similar CCGs. The only areas of relative overspending at disease level are for musculoskeletal care, which is reflected in the CCGs' participation in the recent tender for a musculoskeletal prime provider, and neurological care.

4.39 Hypertension and cholesterol levels in patients with chronic disease are relatively poorly managed, similar to the pattern in Brighton and Hove.

4.40 Horsham and mid-Sussex CCG, with West Sussex County Council and the other West Sussex CCGs, have a well-developed sub-acute care strategy which forms the basis of their plans in relation to the Better Care

[2]http://www.brightonandhoveccg.nhs.uk/sites/default/files/resources/2295_-_nhs_sussex_-_strategic_commissioning_plan_v6.pdf

Fund[3]. This strategy calls for the development of risk stratification to identify service users most likely to be admitted to care, strengthened multi-disciplinary teams to manage these patients, the use of early supported discharge pathways, and continuing development of the existing One Call admission avoidance service which will co-ordinate all community bed utilisation in West Sussex in the future. The CCG and Trust have recently worked closely to implement a Rapid Access Medical Unit (RAMU) at Princess Royal Hospital, a model proposed for further development.

4.41 In order to deliver the Better Care Fund requirements, Horsham and mid-Sussex CCG must reduce non-elective admissions with BSUH by £3m. This has been assessed to represent 15 – 16% of relevant admissions. In the context of the relatively low levels of acute care utilisation seen in the H&MS region, this is a stretching aspiration.

Care utilisation and commissioning strategy – High Weald Lewes Havens

4.42 In comparison to similar CCGs, High Weald Lewes Havens CCG has relatively high levels of elective acute care utilisation with spend on first outpatient attendances following referral being a particular outlier. Spend on non-elective care is in the lowest quartile nationally and better than comparator CCGs. In major disease groups, the pattern of demand follows the overall trend, with high rates of planned care utilisation being particularly apparent in musculoskeletal services. Trauma and Injury spend is also relatively high.

4.43 Indicators for the management of circulatory disease in primary care show control of hypertension and cholesterol levels in the worst quarter nationally. In other chronic diseases, primary care effectiveness is close to national and comparator areas.

4.44 The CCG has also recently launched a procurement for the management of the musculoskeletal pathway, and has expressed interest in exploring with BSUH, opportunities to transform planned care pathways, reflecting the relatively high levels of utilisation in this area.

4.45 HWLH CCG operates in an unusual strategic context, with acute flows splitting evenly between BSUH and Maidstone and Tunbridge Wells NHS Trust (MTW), but community services including step-down and community nursing provision from East Sussex Healthcare NHS Trust (ESHT). Reflecting concerns with community provision by ESHT, the CCG has recently served notice on its community services contract for April 2015. The CCG has an explicit strategy of strengthening both planned and unscheduled care provision in its three main community sites, in Uckfield, Lewes and Crowborough. In terms of patient flow, Uckfield's population is jointly served by MTW and BSUH from the PRH site. Lewes is served almost solely by BSUH,

[3]http://www.horshamandmidsussexccg.nhs.uk/search/?q=strategy

from both sites. Any eventual redesign and re-procurement of community services in the HWLH catchment will therefore have a significant impact on BSUH provision.

4.46 HWLH's Better Care Fund plans will be part of a wider East Sussex plan. Relatively little detail is known at this time, but it is expected that the plans will contain similar intentions as those seen in B&H and West Sussex.

Care utilisation and commissioning strategy - NHS England

4.47 NHS England have been responsible for the commissioning of specialist services since April 2013.

4.48 There is little empirical data concerning the rate of utilisation of specialist-commissioned services in Sussex and NHS England's specialist commissioning strategy is currently under development. However, NHS England has an £800m forecast overspend on specialised commissioning in 2014/15 and the Surrey and Sussex Area Team of NHS England have the largest overspend of any area team at 11.1% of contract value, which is subject to ongoing negotiation.

4.49 As of May 2014, the status is unclear of a previous public commitment to reduce specialist commissioned contracts from around 200 to 15 – 30 nationally. Had this commitment been followed through, BSUH's current maximum catchment for specialised services of 1.6m (see above) would represent approximately 1/30th of the population of England. Whilst the future of this strategic intent is unclear, this illustrates that BSUH can work towards a viable catchment for most specialised services.

4.50 Around 200 service specifications and national policies became effective in October 2013 which the Trust is now contractually obliged to meet. Where specifications could not be met, a process of derogation was required whereby a plan was agreed to secure the required standard by an agreed timescale. The Trust has undertaken this process in conjunction with our local area team for a number of specialties, most notably for Major Trauma Centre services and has agreed plans for meeting all derogated services by the end of 2014/15. Of 65 relevant service specifications, the Trust required derogation against nine.

4.51 In light what is understood of specialist commissioning strategy, key issues to be resolved for BSUH in specialised commissioning strategy are:

- The commissioning levers to be used to deliver financial balance in the context of current overspends. QIPP schemes are expected which providers have yet to receive comprehensive details of

- The mechanism and process for market entry and exit in specialised services, and the mechanism for allowing repatriation of activity to a centre closer to a patient following a change in patient flows

- The process for agreeing clinical co-dependencies between specialised services in terms of services being both within a specific provider's portfolio and physically co-located

- Contractual mechanisms for consolidating provision around a smaller number of providers, including federated provision where one provider leads on specialist elements of general acute care provided by a number of other organisations

Supply side analysis

4.52 The analysis below describes key local providers and their status as competitors or potential partners to BSUH.

4.53 Key independent and third sector providers are as follows:

Provider	Competitive advantages	BSUH strategic mitigations
Nuffield Health - has hospital sites within 5 miles of both BSUH acute hospitals. There are no known developments to expand either capacity, or the range of services offered from the Nuffield sites. BSUH outsources excess elective surgical demand to Nuffield on a spot purchase basis, and the Nuffield hospitals rely in turn on BSUH critical care infrastructure for their surgical patients.	> Private care infrastructure - parking, improved facilities etc. - for patients receiving choice services	> Elective strategy aligned to commissioning plans i.e. agreeing preferred pathways > Consultant loyalty > Reputation with patients
Care UK - runs a Primary Care walk-in centre in the middle of Brighton and provides GP out of hours care to the PRH catchment via its acquisition of Harmoni in 2012, and part of the NHS 111 contract that serves the Kent, Surrey and Sussex catchment. Former provider of elective orthopaedic services from the PRH site, and has undertaken collaborative work with local community providers. Care UK has also been involved in partnerships that have competed for musculoskeletal prime provider contracts.	> Experience of service redesign across UK including planned and unscheduled care pathways	> Elective strategy aligned to commissioning plans i.e. agreeing preferred pathways
Spire Healthcare - Spire have developed a private facility in central Hove. Opened in November 2012, The Montefiore Hospital now offers a broad range of interventions, from MRI scans and detailed diagnostic investigations to minor procedures and hip replacements. Spire is accepting NHS referrals and from zero in Q2 2012/13 has now captured 0.22% of the first OP market.	> Private care infrastructure - parking, improved facilities etc. - for patients receiving choice services	> Elective strategy aligned to commissioning plans i.e. agreeing preferred pathways > Consultant loyalty > Reputation with patients
Virgin Healthcare – provider of a musculoskeletal pathway management service in Hastings and Rother and involved in collaboratives competing for similar contracts as outlined above in other parts of Sussex. Has previously competed for sexual health services contracts.	> Experience of service redesign across UK including planned and unscheduled care pathways	> Elective strategy aligned to commissioning plans i.e. agreeing preferred pathways
Horder Healthcare – not for profit provider of elective orthopaedic services in the Sussex Weald, largely led by the consultant body of MTW. Current market share in parts of the ESHT/MTW catchments for elective orthopaedics is 8 – 10%. However, part of a strong collaborative competing for a number of musculoskeletal prime provider contracts and actively marketing choice services in the East of the BSUH catchment.	> Private care infrastructure - parking, improved facilities etc. - for patients receiving choice services	> Elective strategy aligned to commissioning plans and extending access points into Lewes/Weald catchment
Brighton and Hove Integrated Care Service – partnership company based in local general practice. BICS designs and delivers pathway management services. With a prominent role in responding to recent procurement exercises, BICS has moved to an increasingly competitive approach in its relationship with BSUH. Its approach is closely aligned with Brighton and Hove CCG's commissioning strategy for planned care services and it has so far targeted service lines within the acute portfolio that cross-subsidise unscheduled care and critical infrastructure, and has been successful. Where BICS has won contracts, BSUH is engaged in working with them to deliver effective transitions and is likely to deliver parts of BICS-led contracts in the future	> Being perceived by commissioners as better able to engage in a meaningful way with primary care in order to improve referral patterns and reduce associated healthcare spend	> Elective strategy aligned to commissioning plans and extending access points into Lewes/Weald catchment > Partnership with BICS where successful in response to tenders and commercially viable for BSUH

4.54 Key neighbouring NHS Trusts are as follows:

Provider	Competitive advantages	BSUH strategic mitigations
East Sussex Healthcare NHS Trust - Eastbourne (23 miles), Hastings (40 miles). ESHT provide general acute care to the East Sussex catchment, east of the end of the BSUH catchment at Lewes. In the last 12 months, the BSUH catchment has been extended to the edge of Eastbourne itself, for maternity, paediatrics, general surgery and T&O, as a result of consolidation of services by ESHT as part of its clinical strategy. East Sussex is now a challenged health economy and thus further consolidation of services may affect BSUH in the future. BSUH and ESHT work together in vascular, oncology and neurological care. The Trust also provides community services for all of the East Sussex area, co-terminous with the local authority and including the Lewes/Havens catchment served for acute care by BSUH. Whilst consolidating general services at Hastings and thus offering opportunities for catchment growth to BSUH, these are in low margin services and ESHT is competing with BSUH for higher margin elective surgical care.	None identified	N/A
Western Sussex Hospitals NHS Foundation Trust - Worthing (12 miles), Southlands (6 miles), St Richard's, Chichester (28 miles). WSHFT provide general acute services to the coastal West Sussex population, with a catchment largely co-terminous with Coastal West Sussex CCG. Generally the BSUH/WSHFT relationship is collaborative with joint provision in vascular, oncology and neurological care. However, WSHFT have made a recent decision to locate their elective ophthalmology provision at Southlands, which threatens the western part of the B&H catchment for this key margin-generating service. It will be critical for operationalizing BSUH's oncology strategy to maintain the Sussex Cancer Centre's links with WSHFT as Surrey-based cancer networks represent an emergent challenge	> Access to better estate for Ophthalmology at Eastbourne > Opportunity to choose alignment on cancer provision between multiple networks	> Ophthalmology plan for implementation of clinical strategy to include satellite provision at Southlands (subject to detailed agreement with WSHT) > Oncology strategy to offer clear plan for development of improved provision and critical mass across Sussex
Surrey and Sussex Healthcare NHS Trust (SaSH) 28 miles – general acute provider based at Redhill, Surrey, operating outpatient- based services at Crawley. Typically SaSH operates as part of Surrey-based networks for extended care, with little active competition on the catchment boundary. However SaSH is increasingly looking to shore up its planned care catchment and will also be ahead of BSUH in opening extended radiotherapy capacity, as part of a renewed FT bid that reflects historic challenges around catchment size and financial sustainability.	> Has secured access to radiotherapy facilities ahead of delivery of BSUH satellites	> Oncology strategy to offer clear plan for development of improved provision and critical mass across Sussex
Queen Victoria Hospital NHS Foundation Trust (QVH) 33 miles – provider of specialist burns, plastics and ophthalmology care. Facing a significant threat from NHS England strategy and new service standards, QVH will increasingly seek multi-specialist providers to work as partners to provide key infrastructure for its services.	None identified - looking for integration partners	> Key potential strategic partner for delivering Sussex-wide services strategy
Sussex Community NHS Trust (SCT) – provides community services Brighton and Hove and West Sussex. In the last three years SCT has exited a number of small planned care services, focussing on its core business areas of community nursing and therapies and sub-acute bed provision and key unscheduled care service developments such as One Call in West Sussex. Therefore SCT is a key integration partner for BSUH in implementing its strategy.	> Improving reputation and smaller scale meaning more nimble in responding to commissioner aspirations	> Key strategic partner > Mitigation to strategic threat is closer working relationship on key initiatives: - Unscheduled care and frailty - 7-dy working - HIV/GUM

Policy challenges

4.55 April 2013 saw the commencement of the main clauses of the Health and Social Care Act 2012. Much of the political commentary regarding the Act during its development had concerned the potential consequence of the NHS being opened up to competition.

4.56 There is a threat from the extension of Any Qualified Provider-type procurements into a wider range of services, and it is also clear that CCGs are using new contract levers to address areas of perceived over-utilisation in current services or too focussed on acute care. However, the case that recent reforms significantly change BSUH's market environment is not compelling for the following reasons:

- In most of the Trusts' non-elective services, there are critical interdependencies between aspects of provision that will have a significant and (under new competition regulations, legitimate) impact on commissioners' consideration of whether to put existing services out to competition. Most of these interdependencies involve critical and capital-intensive infrastructure. Longstanding support for the overall levels of provision by the Trust in many of these services is a factor in the business case process for the 3Ts development.

- Under the previous SHA, the South East Coast region was a national leader in introducing a free choice market, under AQP rules, for routine elective services. In 2010, the SEC area was responsible for less than 10% of NHS spending, but over a quarter of NHS spending on private providers for routine surgery. Therefore the Trust has already seen market entry occur with relatively little impact.

5. Service development

5.1 Building on the organisational strategy and market assessment, this section sets out the proposed service developments the Trust intends to pursue over the next five years, based on an analysis of strengths, weaknesses, opportunities and threats.

5.2 The SWOT analysis undertaken in support of the clinical strategy identified:

Strengths -

Assets

- Much modern fit for purpose estate – PRH, TKT, Millenium, RACH
- 3Ts case well progressed with OBC signoff and FBC to follow
- Staff culture is very patient-oriented, pro care,

Capabilities

- Designate MTC status
- Teaching hospital status and sub-specialties mean desirable to trainees in medicine & other disciplines
- Compliance across most statutory targets notably RTT
- Lower than expected mortality at Trust-wide level
- Research facility
- Notable areas of good practice:
  - Fractured hip
  - Paediatrics
  - Breast care
  - GUM/HIV
  - Renal
  - Major Trauma
  - Dementia

Relationships

- Good clinical reputation in most services
- Good HOSC relationships
- Consensus that RSCH is 'fixed point' for emergency and many specialised services
- Strong commissioner relationships in BH CCG, Surrey and Sussex AT
- Developing a Trust-wide strategy a relatively new exercise so garnering enthusiasm

Patient experience

- Anecdotal/NHS Choices patient perception is high
- Many services delivered in high quality estate
- Support for delivering specialist services locally

Weaknesses –

Assets

- Fabric of parts of RSCH estate (Barry, Jubilee, Latilla) and HWP
- Physical space at RSCH ahead of 3Ts opening
- Capital constraint under 3Ts plans i.e. full commitment of available strategic capital

Capabilities

- Lack of quality and safety data at service level – challenge in demonstrating we are best placed to deliver
- Lack of internal expertise to deliver a strategy, i.e. business development
- Challenges in delivering against NHS England service specifications – 9 services requiring designation including major trauma and radiotherapy
- Quality concerns highlighted in some services
  - Cardiac surgery
  - Digestive Diseases
  - Unscheduled care pathway
- Track record in delivering internal transformation – challenges with recent booking hub project

Relationships

- Challenging commissioner relationship with Horsham & mid-Sussex CCG
- Relationships with other Sussex DGHs often challenging; Brighton perceived as acquisitive and not collaborative
- Recent track record on some statutory targets (e.g. 4 hour A&E standard) does not create confidence with commissioners and system leaders

Patient experience

- Low Friends and Family Test score
- Poor privacy and dignity in older parts of RSCH estate
- Patients cite built environment and food as biggest concerns

Opportunities -

Assets

- Making full use of the PRH estate including potentially surplus and under-utilised areas
- 3Ts development: new estate with opportunities for flexibility in utilisation
- Potential options to access estate in East Sussex
- Fixed point in the Sussex system for key services

Capabilities

- BSMS and growing reputation of medical school
- Growing R&D base
- Supporting services in other DGHs which are not compliant with NHS England service specifications
- Growing sub-specialism within paediatrics, with opportunities to develop links to London centres
- Proactive role in shaping prime provider arrangements across the patch i.e. by creating robust partnerships with other organisations
- Proactive role in leading local unscheduled care system, directing support required to meet organisational commitments

Relationships

- HWLH CCG relationship could flourish
- BSMS relationship
- Opportunities to extend networked provision with other providers
- Clinical strategy provides opportunity to share and communicate clearer vision across all services, to staff and partners

Patient Experience

- Opportunity to offer more local provision of key specialist services where proximity is a key factor i.e. sub-speciality paediatrics

Threats –

Assets

- All strategic capital being 'tied up' around 3Ts – inability to respond nimbly to opportunities/threats
- Challenge in meeting new quality standards, especially on PRH site

Capabilities

- Immediate pressures on operational delivery and finances could challenge aspirational elements of strategy
- Where complex pathways require integrated working, the ability to design and execute a shared vision with commissioners and other providers – track record is mixed
- Challenge in sustaining appropriate staffing levels in part of estate including medicine at PRH, specialist nursing at RSCH
- Prime provider models reducing caseload in work that provides positive impact to overall Trust position i.e. MSk, GUM, Dermatology

Relationships

- Further unanticipated performance or quality challenges
- Other providers able to make more compelling offering to commissioners in terms of managing budget risk, quality or prompt access to services
- Partner providers look for other strategic alliances on e.g. cancer, burns, because of BSUH capacity challenges

Patient experience

- Patient perceptions could deteriorate during 3Ts development due to construction
- Barry/Jubilee/Latilla experience worsens before 3Ts decant complete

5.3 The service developments proposed represent a pragmatic vision of development that responds to this analysis, reflecting wider financial constraints within the Sussex local health economy. They reflect the need to maintain the current full range of acute, extended and tertiary provision during the 3Ts build, which will only be possible with significantly lower utilisation of inpatient beds in acute unscheduled care.

5.4 The table below shows the current evaluation of the contribution that will be made by each of the principal areas of service development, to the Trusts' baseline I&E position. This anticipates that changes in unscheduled care provision will lead to relatively lower income on a similar cost base to the current time, and the costs of increasing support service provision to reflect new service standards, principally in seven-day working, will also create a cost pressure. This is funded by planned efficiency savings, a targeted growth and income improvement strategy in identified tertiary priorities, principally paediatrics, nephrology, neurology and oncology. Modest income growth is projected in elective care, reflecting the challenging market conditions in this area.

Development area	2014/15	2015/16	2016/17	2017/18	2018/19
3Ts	£ 1.93	£ 25.95	£ 20.83	£ 20.83	£ 20.83
Sussex-wide	£ 1462.56	£ 2,149.56	£ 2,547.56	£ 2,550.56	£ 2,550.56
Elective	£ 790.87	£ 1,081.87	£ 1,333.77	£1,333.77	£ 1,333.77
Obs &paeds	£ 294.00	£ 853.17	£ 799.04	£ 1,913.07	£ 3,299.28
Cancer	-£ 500.00	£ 600.00	£ 925.00	£ 925.00	£ 925.00
Support Services	£ -	-£ 337.50	-£ 554.00	-£ 554.00	-£ 554.00
Unscheduled care	£ -	-£ 1,176.28	-£ 1,509.28	-£ 1,843.28	-£ 1,843.28

5.5 Major service developments of note within this overall portfolio are highlighted below.

Site reconfiguration programme (Sussex-wide services, unscheduled and elective care)

5.6 **Vision and rationale -** On 1 April 2012 RSCH was designated as the regional Major Trauma Centre for Sussex subject to establishing a neuro-trauma service on the RSCH site. Following publication of the new national service specification for major trauma by NHS England in February 2013 it was determined that Neurosurgery would require co-location with trauma services ahead of the opening of 3Ts Stage 1 as initially planned. Furthermore, a number of developments were required within the Trusts' neurosurgical service. A business case describing the series of service moves needed to relocate Neurosurgery was developed throughout 2013 and approved by the Trust Board in December 2013. Under this plan Urology, planned trauma and fractured hip services move to PRH, both to create space but also to facilitate their own development and patient experience. The Trust plans to relocate the Neurosurgery service onto the RSCH site by October 2014.

5.7 **Benefits –** as well as securing ongoing Major Trauma Centre status and securing the future of Neurosurgical provision, the move will facilitate improved efficiency and patient experience in orthopaedic services and provide urology with a secure base from which to bid to be the provider of all urological cancer services across Sussex.

Frailty pathways (unscheduled care)

5.8 **Vision and rationale –** A key enabler of the Trusts' overall strategy is the reduction in demand on the bed base, from elderly patients admitted into general specialties as emergencies. RSCH in particular sees

50% more ambulance conveyances per general acute bed than any other acute site in Sussex, and the resultant pressure on a finite bed base has traditionally inhibited its tertiary aspirations. At the same time, the current levels of utilisation for this group of patients, is unaffordable to the wider health economy. From a Trust perspective, the costs and quality impacts of using high levels of temporary staffing, opening temporary bed areas and the pressure on the emergency department are much greater than the benefit of the additional income received, particularly where this work is covered by the 30% marginal rate for excess non-elective admissions.

5.9 For the clinical strategy to be effective, the Trust must therefore actively support initiatives that reduce admissions and delayed discharges for this cohort of patients. The Trust has previously supported the deployment of a Rapid Access Medical Unit (RAMU) at the PRH site and runs a similar Rapid Access Clinic for Older People (RACOP) at the RSCH site.

5.10 The Trust is further committed to:

- Actively supporting the key principle of its main commissioners Better Care Fund plans, the common element in which is the strengthening of general-practice based teams managing patients at high risk of admission. Specifically, the Trust will deploy senior clinical staff into practice-based teams to facilitate early access to RAMU/RACOP, ward attendances for treatment and planned short stay admissions, in support of the goal of reduced emergency admissions

- Comprehensive senior assessment of frail patients in front-door services (ED, Acute Medical Unit etc) to be aligned to existing care plans, with the option to discharge directly to community services without admission where appropriate supporting services exist in community settings

- Single assessment processes for care needs on discharge that facilitate clear identification of acute, community, mental health and social services requirements

5.11 **Benefits** – the Trusts' principal CCGs are forecasting 11 – 16% reductions in acute emergency admissions during 2015/16. The Trusts' strategy is predicated on these levels of demand changes occurring, as well as significant reductions in length of stay in target specialties. Achieving this initiative will reduce excess costs related to provision of care in escalation areas, improve substantive staffing levels across the bed base and facilitate the development of specialised provision in other areas of the strategy.

3Ts programme

5.12 Whilst the impact for services on 3Ts is outside the timescale of this IBP, clearly the provision of such a major change to available estate and infrastructure influences the pattern of other service developments, and also impacts on the Trusts' financial projections in the period to 2019. 3Ts is shown in the LTFM in two elements:

- Decanting of part of the Royal Sussex County Hospital site to enable the main development to commence
- The main development itself.

5.13 **Vision and rationale -** The 3Ts programme will provide a modern, fit for purpose environment for patients from Brighton & Hove and across Sussex and the South East. It will mean that many patients who currently have to travel to other centres outside the region can be treated closer to where they live and cut travel times and distance for them, their relatives and carers.

5.14 **Benefits -** The programme has five main objectives:

- Replace the wards and other clinical accommodation currently in the Barry and Jubilee buildings on the Royal Sussex County Hospital (RSCH) campus with accommodation that is 'fit for purpose' and meets standards of privacy and dignity, in line with existing and emerging national priorities.
- Transfer the Regional Centre for Neurosciences from Hurstwood Park (on the Princess Royal Hospital site) and expand its capacity, in line with NHS England commissioning standards for Neurosurgery and Major Trauma
- Develop and expand non-surgical cancer services to provide a comprehensive, Sussex-based cancer centre.
- Develop the Royal Sussex County Hospital as the Level 1 Major Trauma Centre for Sussex and the South East
- Develop teaching, training and research activities within the Trust, in partnership with the Brighton & Sussex Medical School; Kent, Surrey & Sussex Deanery; and the Universities of Brighton and Sussex.

5.15 **Decant -** The decant element of the programme is comprised of a series of interconnected projects which provide temporary and, in some cases, permanent accommodation for those departments and functions on the RSCH site which lie between the Sussex Cancer Centre to the east and the Barry Building to the west. This facilitates the provision of like-for-like estate during the Stage 1 build process.

5.16 **Main Development -**The first stage of the development, which will replace the secondary care facilities in the Barry Building, relocate Neurosciences and expand the facilities for the Major Trauma Centre as well as provide a helipad on the existing Thomas Kemp Tower will commence in late mid-2014 and be complete in early 2020 (subject to approval of the main Outline Business Case during the financial year 2014/15). The second stage of development, to provide an expanded Sussex Cancer Centre and facilities for teaching and research will be complete in 2022.The third stage, which will provide a logistics centre for the campus will be complete in 2023.

5.17 The effect of the implementation of 3Ts will have a transformational effect on the RSCH campus, providing modern fit for purpose accommodation, transforming services and the way the organisation operates them, and providing patient and staff links across the campus at various levels. It will also almost double the amount of clinical space on the site.

Pathology Hub (support services)

5.18 **Vision and rationale** - Large, successful pathology networks have now been established In the South East, South West and London and across England. Single-trust pathology services that stand alone risk becoming unviable. In line with this, Brighton & Sussex University Hospitals NHS Trust (BSUH) and Surrey & Sussex Healthcare NHS Trust (SASH) have identified significant opportunities to be realised in partnership. These opportunities have been further tested since an original business case was presented in December 2012.

5.19 Pathology is core hospital business offering a key service, essential for accurate and timely clinical diagnosis. It also serves two other key markets, primary care and a growing market for non-NHS external specialist work, the first essential to ensuring seamless services for patients, the second with potential growth opportunities.

5.20 **Benefits -** securing the service now for the medium to longer term will enable us to compete successfully for staff, for business and provide an aspirational service to the population in Sussex. This case therefore proposes that BSUH form a contractual Joint venture with SASH for provision of pathology services, Brighton, Surrey and Sussex Pathology services – BSS Pathology. This will both improve cost effectiveness (by spreading fixed costs) and provide strategic advantages based on size, expanding order communications coverage, greater range of complex tests and improved staffing that will secure the service in the medium to longer term.

5.21 The programme will:

- Deliver a modern, lean, clinically-effective pathology service
- Build a sustainable model for resilience and growth of the service
- Deliver best value for money and affordability
- Capitalise on tertiary and academic credentials to enhance service reputation and improve research and development (R&D) capability
- Maximise income-generating potential

Radiotherapy (Cancer)

5.22 **Vision and rationale -** demand for radiotherapy provision is projected to increase significantly over the next decade, with this trend being particularly strong in Sussex as a consequence of population demographics. Key to the Trust's strategy is to develop hub-and-spoke models for services where patients benefit from both local provision, but a co-ordinated pathway and concentration of expertise. BSUH are developing linked radiotherapy centres based at Eastbourne and Chichester acute sites and decant plans to allow for replacement of the machines based at the Royal Sussex County Hospital.

5.23 **Benefits -** these developments will ensure timely provision of enhanced radiotherapy access to populations served by the BSUH Sussex Cancer Centre, but living a significant distance from the RSCH site. The developments maintain and enhance the Trust's role as the regional cancer centre, cementing partnership working with neighbouring providers along the cancer pathway, supporting the maintenance of a high level of service performance. This is the first development in the Trusts' broader plans to develop its cancer strategy.

Hyper-acute stroke provision (unscheduled care)

5.24 **Vision and rationale** – BSUH currently delivers a stroke service at both acute sites. At the RSCH this service is generally delivered by specialist stroke physicians with telemedicine input at the weekends; at the PRH the service is delivered by general physicians. Modern standards of stroke care call for a consultant-led, 7-day service with very rapid access to diagnostics, drugs and rehabilitative therapy. In

order to deliver this the Trust will centralise stroke care onto a single site, maximising skills and resource and ensuring the best possible access to services that are linked to stroke care such as vascular science.

5.25 **Benefits –** the development will deliver a 7-day, single site stroke service that is capable of meeting on a sustainable basis, modern standards for stroke care including 90% of time being spent on a specialist stroke unit and admission to a stroke unit within four hours. The single site service will require less beds in aggregate than the current split-site model, due to quicker access to intensive therapy support.

Neurology strategy (Sussex-wide services)

5.26 **Vision and rationale –** Currently, BSUH provides inpatient Neurology from Princess Royal Hospital, supported by a good range of outpatient general and sub-speciality provision. The Trust has identified an opportunity for closer joint working across all Sussex-based Neurologists, with the aim of:

- Delivering the full range of sub-speciality care to Sussex patients, in Sussex
- Providing consistent specialist neurological support to admitted patients in other Sussex hospitals
- Providing comprehensive specialist inpatient care at BSUH

5.27 This will require closer joint working between all of the consultant Neurologists working in Sussex, and their supporting teams including nurses and allied health professionals.

5.28 **Benefits –** the development will deliver services closer to patients, improved market share and improved use of the BSUH Neurology service. It is also anticipated that the development will significantly increase BSUH's ability to deliver research activity in Neurology, utilising the specialist Neurological input to other sites to identify and enrol prospective patients for clinical trials and to lead multi-centre research activity. The development is also anticipated to facilitate maintaining the support of NHS England for Sussex-based Neurology in the context of increasing service standards.

7-day working (support services)

5.29 **Vision and rationale –** in order to reduce length of stay and improve patient care, the Trust needs to introduce 7-day provision in key aspects of inpatient care such as senior review, diagnostics and therapies. These interventions will be introduced in line with the NHS England standards for 7-day working published in December 2013.

5.30 No specific central funding is available for the achievement of 7-day working standards. The Trust has forecast investment required in future years to meet this requirement, however it will prioritise interventions based on the Evergreen exercise underway in June 2014, to ensure maximum benefit for its investment

5.31 **Benefits –** lower length of stay (contributing to the overall Trust goal of reducing length of stay over the life of the strategy), improved patient experience and improved overall efficiency.

Birth centre (obstetrics)

5.32 **Vision and rationale** – the Trust runs a busy obstetric service, delivering approximately 6000 births per year from its two sites. BSUH is well known for one of the highest rates of home birth in the country, supported by well-established community midwifery. This means that many settings of birth are available to expectant families. One option that is not currently available is midwife-led delivery in a birth centre. For the BSUH catchment, this model will work best if the birth centre is co-located with the labour ward, combining choice of place of birth with rapid access to medical obstetric, neonatal and anaesthetic input.

5.33 **Benefits –** having a birth centre will firstly deliver the capacity at the RSCH site necessary to absorb growing demand for services, both from the existing catchment and as a consequence of changes to provision in East Sussex. More importantly, the birth centre will help the Trust achieve clinically appropriate rates of caesarean section and other obstetric interventions and will markedly improve the service user experience.

6. Financial evaluation

6.1 This section contains the financial projections over the planning period. It contains analysis of the financial position and historic financial performance, and summarises the assumptions that have been made to underpin the forecast figures.

6.2 Although the Trust has had some well documented historic financial difficulties, overall the analysis shows that the Trust is in good financial health, with a strong history of CIP delivery, consistent delivery of plan and four years of operational surpluses (before impairments and other technical accounting adjustments).

6.3 Highlights of the plan, summarised below, include:

- Surpluses in every year, gradually increasing in value over the planning period
- CoSRR rating of at least three in each year
- Delivery on minimum efficiency targets
- Delivery of adequate cash balances
- Significant investment in the 3Ts capital scheme

Summary Financial Evaluation	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
	Actual	Actual	Actual	Forecast	Plan	Plan	Plan	Plan	Plan
Continuity of Service Risk Rating (CoSRR)				3	3	3	3	3	3
Cash (at year end) £m	10.0	14.9	35.7	22.2	18.3	17.0	20.0	20.5	24.2
Implied Efficiencies					4.0%	4.6%	4.1%	4.1%	4.1%
Revenue £m	554.1	574.2	605.4	558.1	505.6	509.0	525.6	532.9	540.2
EBITDA £m	28.6	28.6	31.8	34.5	35.2	40.4	41.0	43.4	46.3
EBITDA %	5.2%	5.0%	5.2%	6.2%	7.0%	7.9%	7.8%	8.1%	8.6%
NHS Reported Net Surplus	3.0	0.0	3.3	5.1	2.1	2.3	2.5	3.4	5.6
Net Surplus (after impairments) £m	-13.0	-16.2	-0.2	-9.6	-9.7	-2.6	-0.8	0.1	2.3
Net Surplus %	-2.3%	-2.8%	0.0%	-1.7%	-1.9%	-0.5%	-0.2%	0.0%	0.4%
Cost Improvement Plan £m				29.5	30.4	25.0	21.4	23.1	23.7
Cost Improvement Plan % of Cost				6.1%	6.2%	5.1%	4.3%	4.6%	4.6%
Asset Base £m	353.8	351.3	356.8	370.0	402.6	420.7	478.2	531.1	578.6
Capital spend	0.0	45.0	31.8	24.8	70.1	51.6	77.7	79.5	71.1
Loans and leases Received £m	0.0	15.0	14.4	1.1	43.5	0.0	0.0	0.0	0.0
Public Dividend Capital Received	0.0	12.3	0.2	1.0	0.0	26.4	59.8	57.6	50.1
Asset Sales (proceeds) £m	0.0	0.0	2.0	2.2	4.0	0.0	0.0	0.0	0.0

Historical Financial Analysis

Income and Expenditure - Historical	Actual 2010/11 £m	Actual 2011/12 £m	Actual 2012/13 £m
Operating Income	554.1	574.2	606.1
Operating Costs	(525.5)	(545.6)	(573.6)
EBITDA	**28.6**	**28.6**	**32.5**
EBITDA %	*5.2%*	*5.0%*	*5.4%*
Gain (Loss) on Asset Disposal	0.0	(0.1)	0.4
Interest Receivable / (Payable)	(2.8)	(2.6)	(2.6)
Depreciation and Amortisation	(15.1)	(18.0)	(19.7)
PDC Dividend	(7.7)	(7.8)	(7.3)
Impairment Losses	(16.0)	(16.0)	(3.2)
Net Surplus / Deficit	**(13.0)**	**(16.0)**	**0.1**
Net Surplus %	*(2%)*	*(3%)*	*0%*
Performance before impairments	3.0	0.0	3.3
Net Surplus % before impairments	**0.5%**	**0.0%**	**0.5%**

6.4 Included in the above is delivery of CIPs totalling £89m. The above figures also include pass through receipts and payments relating to hosting of the KSS deanery, these are separated out in the table below. The normalised deficit in 2012/13 is driven by the receipt of enablement and stranded cost funding.

Income and Expenditure - Historical	Actual 2010/11 £m	Actual 2011/12 £m	Actual 2012/13 £m
Performance before impairments	3.0	0.0	3.3
Less non recurrent income			
KSS receipts	(114.9)	(119.7)	(118.0)
Other non recurrent income	(3.1)	(3.6)	(3.9)
Add back non recurrent costs			
KSS payments	114.9	(119.7)	(118.0)
Other non recurrent expenses	3.1	243.1	239.8
Restated surplus	**3.0**	**0.0**	**3.3**

6.5 The historic Statement of Financial Position shows a stable organisation with increasing cash reserves, and reducing receivable and payable balances. The reduction in retained earnings in 2011/12 is driven by a £16 million impairment charge.

Historic Statement of Financial Position	Actual 2010/11 £m	Actual 2011/12 £m	Actual 2012/13 £m
Fixed assets	264.1	252.9	251.5
Fixed assets (PFI)	33.0	33.1	32.5
Other non current assets	2.8	3.3	3.3
Total non current assets	**299.9**	**289.4**	**287.3**
Inventories (stock)	7.1	7.3	8.1
Receivables (debtors)	32.2	19.4	6.7
Other current assets	4.6	20.3	18.9
Cash	10.0	14.9	35.7
Current assets	**53.9**	**61.9**	**69.5**
Loans and leases (current)	0.0	0.0	(3.8)
Payables (creditors) & accruals	(58.7)	(51.0)	(48.5)
Other current liabilities	(4.8)	(5.8)	(7.4)
Current liabilities	**(63.5)**	**(56.8)**	**(59.7)**
Loans and leases (non current)	0.0	(13.5)	(20.9)
PFI Liability	(38.5)	(37.1)	(35.6)
Other non current liabilities	(2.7)	(4.2)	(3.8)
Total non current liabilities	(41.2)	(54.8)	(60.3)
Total assets employed	**249.1**	**239.6**	**236.8**
Public dividend capital	230.4	234.7	234.9
Retained earnings	(8.8)	(23.8)	(22.3)
Other reserves	27.5	28.7	24.2
Total taxpayers equity	**249.1**	**239.6**	**236.8**

6.6 The Trust's historic cash flow is shown in the table below.

Historic Cash flow	Actual 2011/12 £m	Actual 2012/13 £m
Opening cash balance	**10.0**	**14.9**
EBITDA	28.3	32.4
Non cash items	(1.4)	2.9
Operating cash flows before movements in working capital	27.0	35.3
Working capital movements	17.2	15.6
Capex spend	(45.0)	(31.8)
Capex receipts	0.0	2.0
PDC received	4.3	0.2
Dividends paid	(7.8)	(7.6)
Interest paid	(2.6)	(2.6)
Loans and leases drawndown	15.0	14.4
Repayment of loans and leases	(3.2)	(4.7)
Total inflow/(outflow)	**4.9**	**20.8**
Closing cash balance	**14.9**	**35.7**

6.7 Drawdown of loans relates to the third cardiac theatre development and 3Ts decant.

Current financial performance

6.8 The table below summarises the current financial performance for month 11, year ending 31 March 2013/14.

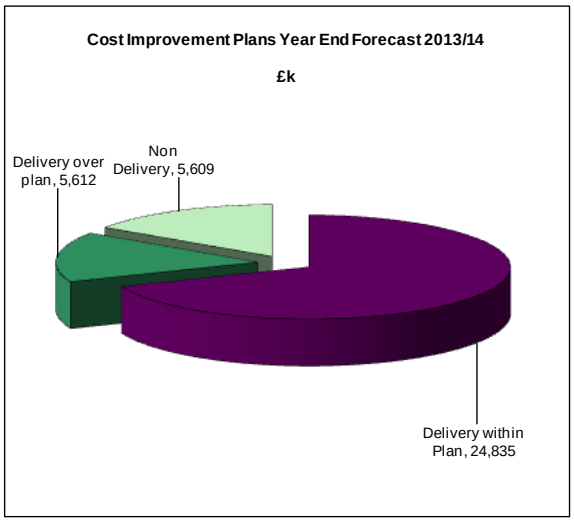
YTD Performance	M12 Act 2013/14 £m	M12 Bud 2013/14 £m	M12 Var 2013/14 £m
Protected revenue	424.4	411.5	12.9
Non Protected/Non Mandatory Clinical income	7.6	9.6	(2.0)
Other revenue	126.5	126.2	0.3
Total income	**558.6**	**547.3**	**11.2**
Employee Benefit Expenses	(286.5)	(283.0)	(3.5)
Drug expenses	(54.4)	(45.5)	(8.9)
Clinical supplies and services expenses	(52.6)	(52.4)	(0.2)
Other expenses	(130.1)	(127.7)	(2.4)
Total expenses	**(523.6)**	**(508.6)**	**(15.0)**
Adjustment for donated asset income	(0.5)	(3.4)	2.9
EBITDA	34.5	35.3	(0.8)
Net Surplus	(9.6)	0.8	(10.3)
NHS Reported Position*	**5.1**	**5.2**	**(0.1)**

* excluding impairments and donated asset income and expenditure.

6.9 The 2013/14 outturn position is distorted by a number of factors not related to the operational performance of the Trust. The NHS reported position (not shown in the above table) was £5.1 million surplus against a planned surplus of £5.2 million.

6.10 The Trust was hoping to secure a £2.5 million donation for the purchase of a stereotactic therapy device, unfortunately this did not come to fruition and this is the main driver of the variance on donated assets. Additionally the Trust planned for impairments of its fixed assets of £7.0 million, however following the DVs annual valuation the impairment was actually £14.3 million.

6.11 The chart below demonstrates full delivery of the Trust's efficiency challenge for 2013/14. Where scheme have slipped or under-delivered replacement schemes have been found to mitigate the shortfall.



Income and Expenditure projections

6.12 The below table illustrates the financial projections for the Trust. This shows recurrent surpluses after adjusting for impairments.

Forecast Income and Expenditure	2014/15 Plan £m	2015/16 Plan £m	2016/17 Plan £m	2017/18 Plan £m	2018/19 Plan £m	2019/20 Plan £m	2020/21 Plan £m	2021/22 Plan £m	2022/23 Plan £m
Operating Revenue	506.1	509.5	526.1	533.4	540.7	558.3	562.5	571.1	586.3
Operating Costs	(470.4)	(468.6)	(484.5)	(489.5)	(493.9)	(510.0)	(509.7)	(516.0)	(528.5)
EBITDA	**35.7**	**41.0**	**41.6**	**44.0**	**46.9**	**48.3**	**52.8**	**55.1**	**57.8**
EBITDA %	7.1%	8.0%	7.9%	8.2%	8.7%	8.7%	9.4%	9.6%	9.9%
Net Surplus	**-9.7**	**-2.6**	**-0.8**	**0.1**	**2.3**	**-69.5**	**-0.4**	**0.0**	**-39.8**
Net Surplus %	-1.9%	-0.5%	-0.2%	0.0%	0.4%	-12.4%	-0.1%	0.0%	-6.8%
Impairments	(11.5)	(4.6)	(3.0)	(3.0)	(3.0)	(72.7)	(3.0)	(3.0)	(43.5)
Net Surplus before Impairments	**1.8**	**2.0**	**2.2**	**3.1**	**5.3**	**3.3**	**2.6**	**3.0**	**3.7**
Net Surplus %	0.3%	0.4%	0.4%	0.6%	1.0%	0.6%	0.5%	0.5%	0.6%

6.13 The above forecast includes 3Ts projections, which are predominately based on the recently approved OBC. The Trust is in the process of reviewing and updating these figures and they will be presented within the 3Ts FBC produced later in the year. The one significant change is that the PDC assumed to be drawn down in 2014/15 has been replaced by loan funding as advised by the NHS Trust Development Authority.

6.14 There are a number of assumptions which underpin the above projections.

Inflation	2014/15 Plan %	2015/16 Plan %	2016/17 Plan %	2017/18 Plan %	2018/19 Plan %	2019/20 Plan %	2020/21 Plan %	2021/22 Plan %	2022/23 Plan %
NHS income	-1.5%	-1.6%	0.4%	-0.6%	-0.7%	-0.7%	-0.7%	-0.7%	-0.7%
Other income	0.0%	-1.6%	0.4%	-0.6%	-0.6%	-0.6%	-0.6%	-0.6%	-0.6%
Employee Benefit Expenses	1.6%	1.5%	3.5%	2.5%	2.4%	2.4%	2.4%	2.4%	2.4%
Drug expenses	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
Clinical supplies and services expenses	1.5%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Other expenses	2.1%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%
Unitary Charge indexation	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Capex inflation	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

6.15 Tariff deflation has been modelled as per Monitor guidance up to and including 2018/19, the deflator is due to the continuing squeeze on public sector spending. After 2018/19 Monitor does not issue any guidance and a constant deflator has been assumed. Inflation on employee expenses has been assumed to move in proportion to the tariff. The increase in employee benefits in 2016/17 relates to an increase in employer pension contributions.

Activity projections

6.16 There are a number of factors driving the changes in activity, these include:

- demographic growth
- disease prevalence
- demand management, specifically the reduction in volumes required to fund the Better Care Fund in 2015/16. This produces the significant planned drop in non-elective activity. BCF schemes affect only a subset of non-elective activity from a subset of commissioners and are offset by underlying demographic growth
- Service developments (including clinical strategy initiatives)

6.17 These lead to aggregate growth rates summarised below.

CCG Activity	Total Elective FFCEs	Non-elective FFCEs	All First Outpatient Attendances	All Subsequent Outpatient Attendances
2014/15 Total	**57960**	**57060**	**195000**	**426660**
Forecast growth in 2014/15	**2.4%**	**4.8%**	**1.5%**	**1.6%**
2015/16 Total	**59184**	**55272**	**205080**	**448832**
Forecast growth in 2015/16	**2.1%**	**-3.1%**	**5.2%**	**5.2%**
2016/17 Total	**60127**	**56147**	**208920**	**457410**
Forecast growth in 2016/17	**1.6%**	**1.6%**	**1.9%**	**1.9%**
2017/18 Total	**60871**	**57034**	**212502**	**465395**
Forecast growth in 2017/18	**1.2%**	**1.6%**	**1.7%**	**1.7%**
2018/19 Total	**61628**	**57914**	**216156**	**473554**
Forecast growth in 2018/19	**1.2%**	**1.5%**	**1.7%**	**1.8%**

6.18 Base case activity driven income changes are highlighted below.

Activty driven income changes	2014/15 Plan £m	2015/16 Plan £m	2016/17 Plan £m	2017/18 Plan £m	2018/19 Plan £m	2019/20 Plan £m	2020/21 Plan £m	2021/22 Plan £m	2022/23 Plan £m
Demographic growth	4.1	4.2	4.2	4.3	4.3	4.4	4.5	4.5	4.6
Disease prevalence increases	2.2	2.3	2.4	2.5	2.6	2.8	2.9	3.1	3.2
Demand management	0.0	(8.0)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)
Total	**6.3**	**(1.5)**	**6.5**	**6.7**	**6.9**	**7.1**	**7.3**	**7.5**	**7.7**

6.19 Demographic growth has been modelled using age weighted population projections by CCG, based on forecasts produced by the Office of National Statistics (ONS). Broadly these changes represent an overall increase of 1% per annum, however due to the general aging of the populations higher rates are applicable in those specialties that have a larger proportion of elderly patients, there are corresponding lower rates in other specialties.

6.20 Disease prevalence increases have been assumed in four specialties (breast care, cancer, HIV and renal), this is where the overall incidence of a disease is increasing at a faster rate than the general population.

6.21 A number of the Trusts' CCGs have plans in 2014/15 which assume recovery of their non-recurrent spend to a level in line with NHS England guidance. This impact aside, the impact of the Better Care Fund is the only demand management scheme which the Trust believes will have a material impact on the activity flows to BSUH. This assumption is based on demand growth not exceeding modelled factors outlined above. The Better Care Fund has been modelled as a reduction in A&E attendances and non-elective admissions across a range of medical specialties. As outlined in chapter 3, the Trust is in discussion with its commissioners regarding the exact financial profile and risk pooling arrangements relating to the Better Care Fund.

Detailed income forecast

Income detail	2014/15 Plan £m	2015/16 Plan £m	2016/17 Plan £m	2017/18 Plan £m	2018/19 Plan £m	2019/20 Plan £m	2020/21 Plan £m	2021/22 Plan £m	2022/23 Plan £m
NHS clincial income	434.5	439.4	455.4	463.1	470.7	481.8	492.4	501.3	512.3
Private patient revenue	7.7	8.0	8.6	8.5	8.5	9.0	9.5	9.4	10.7
Education and Training	32.6	32.1	32.2	32.0	31.8	31.6	31.5	31.3	31.1
Research & Development	5.8	5.7	5.7	5.7	5.6	5.6	5.6	5.5	5.5
Other Revenue	25.6	24.3	24.2	24.1	24.1	30.2	23.6	23.6	26.8
Total income	**506.1**	**509.5**	**526.1**	**533.4**	**540.7**	**558.3**	**562.5**	**571.1**	**586.3**

6.22 The above tables includes all of the elements described earlier and therefore is stated in nominal terms (including inflation or deflation).

6.23 It is of note that NHS clinical income grows slightly quicker than activity. This is due to two principal factors:

- Service developments with impacts not reflected in activity projections, specifically radiotherapy which uses a separate activity currency.
- Growth in non-activity driven revenue. The most significant area of growth is tariff-excluded drugs expenditure which historically has grown 2 – 4% faster than activity. Tariff-excluded drugs are those which due to their exceptional costs, are reimbursed separately to activity-based payment mechanisms.

Detailed expenditure forecast

Forecast operating expenditure	2014/15 Plan £m	2015/16 Plan £m	2016/17 Plan £m	2017/18 Plan £m	2018/19 Plan £m	2019/20 Plan £m	2020/21 Plan £m	2021/22 Plan £m	2022/23 Plan £m
Employee Benefit Expenses	(289.2)	(285.0)	(293.2)	(293.2)	(292.3)	(290.5)	(286.5)	(286.4)	(288.2)
Drug expenses	(55.6)	(58.5)	(62.4)	(66.5)	(71.0)	(75.9)	(81.2)	(86.7)	(92.9)
Clinical supplies and services	(51.2)	(49.8)	(49.9)	(49.6)	(49.4)	(48.9)	(48.0)	(47.9)	(48.1)
Other expenses	(74.4)	(75.3)	(79.1)	(80.1)	(81.2)	(94.8)	(94.0)	(95.0)	(99.3)
Total operating expenses	**(470.4)**	**(468.6)**	**(484.5)**	**(489.5)**	**(493.9)**	**-510.0**	**(509.7)**	**(516.0)**	**(528.5)**

6.24 The above table shows the pay bill remaining broadly flat after inflationary pressures and against a backdrop of increasing demand. An analysis of forecast WTE movements is shown in Section 8.

Cost improvement plans

6.25 The Trust has developed a robust Financial Efficiency Programme. The purpose of the Programme is to:

- Ensure the Trust remains financially viable and delivers high quality services to its patients in a safe, effective and efficient manner.
- Supports and underpins a programme of transformation and service improvement, be clearly linked with the Trust's Strategy, vision, aims and objectives, enabling us to "connect" with staff, partners and the public as fully as possible.
- Develop and implement some major clinical redesign initiatives across the Trust, and the wider health economy, to improve the flow, utilisation, management and effectiveness of the services we provide to our patients.
- Work closely with our CCG partners, to ensure alignment with the Quality Improvement Productivity and Prevention (QIPP) agenda through modernizing our services, developing a regional Pathology network, improving the productivity of our workforce and support functions.
- Support the implementation of our 3T's strategy to become the major Regional Centre for Teaching, Trauma and Tertiary care.
- Support the Trust's application to become a foundation Trust.

6.26 Service and cost improvement is a long established practice at BSUH. The pursuit of improvements in productivity, economy and efficiency coupled with a focus on high quality patient care, innovation, research and development are embedded within the organisation. Over the years this has been evidenced by

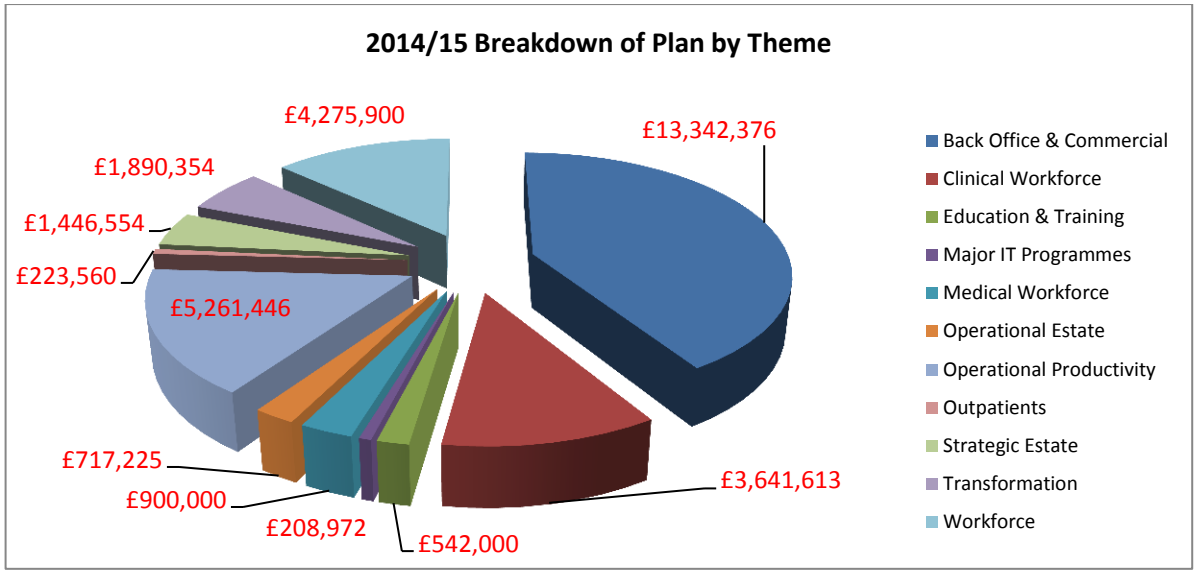
improving patient outcomes, patient and staff feedback, the development of leading edge services and a long track record of strong financial performance. This has been achieved during a period of growing demand for the Trust's services, increasing patient acuity and substantial funding pressures.

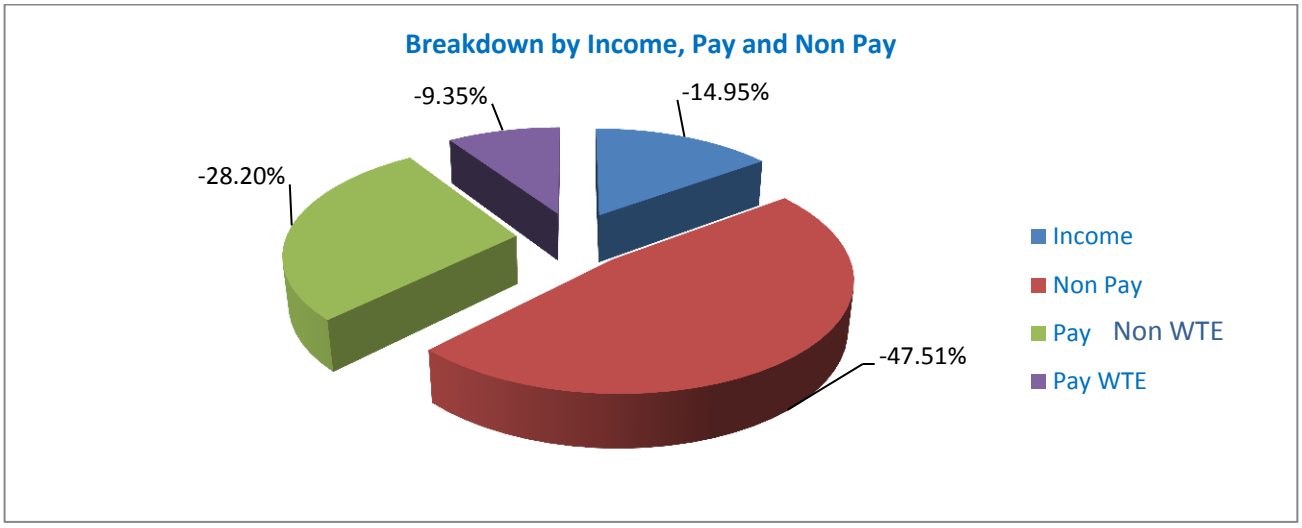
6.27 Service and financial pressures have increased in the recently and are predicted to continue for the foreseeable future. The Trust continues to respond to these challenges and has a well-developed formal CIP process and governance framework.

6.28 The Efficiency Programme consists of twelve programmes. The programmes are Executive or Director led with accountabilities relating to the projects they oversee.

Back Office Schemes focusing on support services for example to ensure best value for money on items for which we buy or how we capture our Trust activity.	**Clinical Workforce** Ensuring nursing, therapies and health care professionals are in recruited, trained and supported; that we maximize staff productivity by improvements in e-rostering, and establishing a flexible workforce pool.
Operational Productivity Schemes focusing on the frontline care, pathway redesign to ensure that we are working with clinical teams to provide optimum flow and best patient experiences.	**Workforce** Ensure that our workforce meet the changing and developing needs of 21st Century hospital services and care provision.
Operational Estate A major focus is to ensure our Support services are efficient, safe and are maximized supporting frontline care.	**Major IT** Using new or existing technology to leverage efficiencies.
Outpatients Improving outpatient services by following the productivity methodology which will give more choice and availability to our patients and clinicians.	**Transformation Change/Pathology/Radiology** Align diagnostic and therapeutic services to be more responsive, and where opportunities exist provision of BSUH services to other providers. Looking at all transformation services.
Strategic Estate Includes ensuring our estate is aligned to our future plans and that we minimize our impact on the environment.	**Education and Training** This workstream will review all Educational opportunities across the organisation. It will modernise how we provide learning to staff.
Medical Workforce Aligning the medical workforce to optimize changes in capacity and demand.	**QIPP** Alignment with commissioning intentions with a cost-reduction element to ensure a complementary approach

6.29 Shown below are graphical presentations of the Efficiency Programme, showing the 14/15 plan broken down by programme and savings category.





6.30 Due to the composition of the 2014/15 scheme, the required impact on the Trusts' paybill is relatively small in comparison to the overall scheme. The impact on substantive WTE establishments is further mitigated by national pay settlement restraint and significant opportunities to reduce the use of temporary staffing. The move from high utilisation of temporary staff to full recruitment against clinically appropriate establishments in nursing continues to be central to the Trusts' cost improvement strategy in this area where a contribution to cost reduction is required alongside pressures to increase ward-based staffing levels and clinical supervision.

Forecast statement of financial position

6.31 The table below summarises the Trusts' forecast financial position for the LTFM period. The overall size of the balance sheet is driven to increase significantly by the 3Ts development.

Forecast Statement of Financial Position	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Fixed assets	299.5	319.7	374.7	427.2	470.0	450.7	485.5	517.6	489.0
Fixed assets (PFI)	37.9	36.9	36.0	35.0	34.0	32.9	31.9	30.8	29.8
Other non current assets	4.1	4.8	5.1	5.7	7.6	8.6	9.0	9.5	10.3
Total non current assets	**341.4**	**361.4**	**415.8**	**468.0**	**511.6**	**492.2**	**526.3**	**558.0**	**529.1**
Inventories (stock)	6.8	6.7	6.9	6.9	7.0	7.2	7.2	7.2	7.4
Receivables (debtors)	21.7	21.6	21.5	21.6	21.9	23.1	22.6	22.9	23.9
Other current assets	14.5	14.1	14.1	14.1	14.1	14.1	14.1	14.1	14.1
Cash	18.3	17.0	20.0	20.5	24.2	27.1	26.7	27.4	26.1
Current assets	**61.2**	**59.3**	**62.4**	**63.1**	**67.1**	**71.4**	**70.5**	**71.6**	**71.5**
Loans and leases (current)	(5.3)	(3.8)	(2.3)	(2.3)	(2.3)	(2.3)	(2.3)	(2.3)	(2.3)
Payables (creditors) & accruals	(61.1)	(58.3)	(62.1)	(61.1)	(59.1)	(61.1)	(58.7)	(57.9)	(55.3)
Other current liabilities	(5.1)	(8.1)	(8.0)	(7.1)	(7.9)	(8.4)	(8.4)	(8.3)	(8.9)
Current liabilities	**(71.5)**	**(70.1)**	**(72.4)**	**(70.4)**	**(69.2)**	**(71.8)**	**(69.3)**	**(68.4)**	**(66.4)**
Loans and leases (non current)	(56.0)	(52.2)	(49.9)	(47.7)	(45.4)	(43.2)	(40.9)	(38.6)	(36.4)
PFI Liability	(32.9)	(31.4)	(29.9)	(29.3)	(28.0)	(26.1)	(24.3)	(22.5)	(20.1)
Other non current liabilities	(3.3)	(4.2)	(4.2)	(4.2)	(4.2)	(4.2)	(4.2)	(4.2)	(4.2)
Total non current liabilities	(92.2)	(87.8)	(84.0)	(81.2)	(77.6)	(73.5)	(69.4)	(65.3)	(60.7)
Total assets employed	**238.9**	**262.8**	**321.8**	**379.4**	**431.8**	**418.4**	**458.2**	**495.8**	**473.5**
Public dividend capital	236.0	262.4	322.3	379.8	429.9	485.9	526.1	563.8	581.3
Retained earnings	(41.6)	(44.2)	(45.0)	(44.9)	(42.6)	(112.1)	(112.5)	(112.5)	(152.3)
Other reserves	44.5	44.5	44.5	44.5	44.5	44.5	44.5	44.5	44.5
Total taxpayers equity	**238.9**	**262.8**	**321.8**	**379.4**	**431.8**	**418.4**	**458.2**	**495.8**	**473.5**

6.32 The above balance sheet assumes that 3Ts is PDC funded from 2015/16 as per the OBC preferred option, only those elements of decant specifically agreed are assumed to be loan funded.

Cash flow

Forecast Cash flow	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Opening cash balance	**22.2**	**18.3**	**17.0**	**20.0**	**20.5**	**24.2**	**27.1**	**26.7**	**27.4**
EBITDA	35.7	41.0	41.6	44.0	46.9	48.3	52.8	55.1	57.8
Non cash items	(0.5)	(0.5)	(0.5)	(0.5)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)
Operating cash flows before movements in working capital	**35.2**	**40.4**	**41.0**	**43.4**	**46.3**	**47.7**	**52.2**	**54.5**	**57.2**
Working capital movements	0.3	3.2	(0.4)	(0.9)	(0.9)	(0.6)	(0.4)	(1.0)	(1.3)
Capex spend	(70.1)	(51.6)	(77.7)	(79.5)	(71.1)	(76.7)	(66.6)	(63.4)	(46.8)
Capex receipts	4.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PDC received	0.0	26.4	59.8	57.6	50.1	56.1	40.2	37.7	17.5
Dividends paid	(8.1)	(8.6)	(10.1)	(12.1)	(14.0)	(15.9)	(17.6)	(18.9)	(19.9)
Interest paid	(3.0)	(4.7)	(4.3)	(4.2)	(3.9)	(4.1)	(4.2)	(4.1)	(4.0)
Loans and leases drawndown	43.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Repayment of loans and leases	(5.6)	(6.5)	(5.3)	(3.8)	(2.8)	(3.6)	(4.1)	(4.1)	(4.0)
Total inflow/(outflow)	**(3.9)**	**(1.3)**	**3.0**	**0.5**	**3.7**	**3.0**	**(0.4)**	**0.7**	**(1.3)**
Closing cash balance	**18.3**	**17.0**	**20.0**	**20.5**	**24.2**	**27.1**	**26.7**	**27.4**	**26.1**

6.33 The Trust maintains an adequate cash balance throughout the planning period after reflecting more challenging cash collection environment and greater creditor pressure leading to reduced balance in trade payables.

Monitor risk ratings

Continuity of Service Risk Rating (CSRR)	2014/15 Plan 'Score'	2015/16 Plan 'Score'	2016/17 Plan 'Score'	2017/18 Plan 'Score'	2018/19 Plan 'Score'	2019/20 Plan 'Score'	2020/21 Plan 'Score'	2021/22 Plan 'Score'	2022/23 Plan 'Score'
Liquidity ratio score	3	2	2	2	2	3	3	3	3
Capital servicing capacity score	3	3	3	3	3	3	3	3	3
OVERALL Risk Rating (CSRR)	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**

6.34 The Trust secures a minimum overall CoSRR score of three throughout the planning period. The final agreed funding route for 3Ts will materially impact the scores.

Capital expenditure

Capital expenditure	2014/15 Plan £m	2015/16 Plan £m	2016/17 Plan £m	2017/18 Plan £m	2018/19 Plan £m	2019/20 Plan £m	2020/21 Plan £m	2021/22 Plan £m	2022/23 Plan £m
3Ts Decant	23.6	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0
3Ts Main	11.4	27.0	56.4	53.2	45.3	49.8	35.0	32.1	14.6
Radiotherapy decant	6.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PFI	0.3	0.7	0.4	0.6	1.9	0.9	0.4	0.5	0.8
Backlog maintenance	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9
Operational capex	27.7	17.3	17.5	16.5	13.2	15.7	18.4	18.3	18.9
Donated	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Inflation	1.4	1.9	4.7	6.0	6.4	8.7	8.4	9.3	7.2
Total	**74.0**	**50.6**	**82.4**	**79.7**	**70.3**	**78.5**	**65.6**	**63.7**	**44.9**

6.35 3Ts is obviously the largest consumer of capital expenditure over the planning period. Operational capex is predominately made up of replacement medical equipment, IT investments and estate improvements roughly in equal proportions.

External funding

External funding	2014/15 Plan £m	2015/16 Plan £m	2016/17 Plan £m	2017/18 Plan £m	2018/19 Plan £m	2019/20 Plan £m	2020/21 Plan £m	2021/22 Plan £m	2022/23 Plan £m
PDC received	0.0	26.4	59.8	57.6	50.1	56.1	40.2	37.7	17.5
Loans and Leases	43.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Cash receipt from asset sales	4.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	**47.4**	**26.4**	**59.8**	**57.6**	**50.1**	**56.1**	**40.2**	**37.7**	**17.5**

6.36 With the exception of 2014/15, where there is an element of loan funding, PDC received exactly off-sets 3Ts capital expenditure after adjusting for inflation. The £43.5 million loan drawdown in 2014/15 comprises of £16.4m of previously agreed loans yet to be drawn down, £20.8m loan to fund 3Ts decant and FBC; and £6.3 million in respect of the radiotherapy decant scheme.

7. Risk

7.1 The Trusts' risk management framework is described in detail in section 9 of this document. Key elements of the risks management framework are:

- A Board Assurance Framework, containing the highest level organisational risks to the achievement of the Trusts' objectives and strategy
- Oversight of the Board Assurance Framework by the Board of Directors, Board Assurance Committees and Hospital Management Board , and oversight of the Hospital Risk Register by HMB, supported by a Risk Review Committee
- Clear committee responsibilities for management of specific areas of risk
- Delegated executive responsibility for risk to the Director of Corporate Affairs.

Risks to the LTFM base case

7.2 Principal risks to the LTFM base case are as follows:

- That the costs of service delivery exceed the projections made for cost pressures in the LTFM base case. This could be as a result of new service standards, decisions on pay levels made under national collective agreements, higher than projected costs of employer superannuation contribution to NHS pensions, or wider economic factors such as higher fuel, drug or supplies costs. Failure to plan major service developments sufficiently robustly, leading to higher operating costs than projected, could also be a factor. Given the macroeconomic and political constraints on NHS spending in the IBP period, volatility of industrial relations and inflationary tendencies of economic recovery from recession, this is assessed as a **high risk**
- That the income associated with service delivery falls because of factors not related to the amount of clinical activity performed. Principally this would relate to the structure and levels of payment by results tariff income set by NHS England and Monitor respectively. However, local price structures and levels could also change, either as a consequence of, or separately from, national tariff. Given the forward clarity provided by Monitor on future tariff levels, which takes account of macroeconomic factors, this is assessed as a **medium risk**

- That the income associated with service delivery falls because of a reduction in volume of clinical activity performed. This would be as a consequence of patient choice to attend other providers, decisions by commissioners to award contracts for service to other providers, or changes to commissioned pathways leading to lower levels of demand in Trust services. In light of recent procurement exercises by commissioners, but the relatively static nature of the Trusts' market share, this is assessed as **medium risk**

- That income other from NHS service delivery falls, for example training income from Health Education England, income from clinical research or from private patient activity. This is assessed as **low risk.**

Mitigations to LTFM base case

7.3 At a strategic level, available types of mitigations for the Trust are:

- Consolidation of the Trusts' estate to a smaller footprint, reducing capital charges, estate maintenance and facilities management costs. As well as these recurrent revenue cost reductions, these mitigations would release cash on disposal of surplus estate. Alternatively, estate can be retained but rented out to other parties to retain flexibility and increase non-clinical income

- Vacating non-Trust owned estate used on a lease basis, for example at Hove Polyclinic, Lewes Victoria Hospital and Brighton General Hospital. These would reduce revenue costs on a recurrent basis.

- Omitting high cost elements of future service developments. Whilst potentially releasing cash, such mitigations have potential implications in terms of the governance of capital projects and approved uses of capital funding. Whilst there would be revenue cost reductions, the potential clinical impact implications would require careful consideration.

- Withdrawing from unprofitable services. This would be done on the basis of SLM analysis where full withdrawal would improve the Trusts' I&E position. Whilst having a potentially significant I&E impact, the Trust would need to consider the interdependency of the service in question with other areas of provision, and the risks of making other services unsustainable in the process. It is also of note that a service needs to be in very significant deficit for this to be a valid mitigation, as services with a small P&L deficit continue to provide an income base that supports the Trusts'

overhead costs. It may also be that the prospect of withdrawal from a service would lead to further discussions with commissioners.

- Making global changes to the Trusts' cost base. In practice, the largest element of Trust expenditure, and the area with the most discretionary ability, is pay. Therefore mitigations would involve changing the overall levels of staff benefits which impact the costs of employing staff.

- Reducing operational capital expenditure. NHS Trust operational capital expenditure budgets are generated from the charging of depreciation as a non-cash item to the Trusts' Income and Expenditure account, creating a cash surplus when compared to the I&E balance. High levels of depreciation on a Trusts' estate may generate a larger nominal operational capital budget than is required, or the Trust may choose to delay planned capital developments or estate maintenance. It is a particular feature of BSUH's financial projections that because of the 3Ts development, depreciation increases, at the same time that the most maintenance-intensive part of the Trusts' estate, the older Barry, Jubilee and Latilla buildings at the RSCH site, are demolished. On a smaller scale, operational capital expenditure could be held back in advance of 3Ts.

- Extending creditor payment terms and improved debt collection, improving short-term liquidity but with no ultimate impact on I&E.

7.4 The availability of types of mitigations is driven by which downside risks occur. The matrix below illustrates, at a high level, the linkage of specific downsides to specific mitigation types.

Downside➔ Mitigation ➘	i. Higher costs	ii. Lower NH income (not activity-driven)	iii. Lower NHS income (activity-driven)	iv. Lower non-NHS income
a. Consolidate estate	No*	No*	Yes – recurrent I&E and cash	Dependent on factor influencing lower income
b. Vacating leased estate	No*	No*	Yes – recurrent I&E and cash	Dependent on factor influencing lower income
c. Omitting service development costs	Yes – recurrent I&E, possible cash	Yes – recurrent I&E, possible cash	Yes – recurrent I&E, possible cash	Yes – recurrent I&E, possible cash
d. Withdrawing from services	Only if cost pressure is service specific	Only if income pressure is service specific	Yes – recurrent I&E and cash	No
e. Reducing cost base	Yes - recurrent	Yes - recurrent	Yes - recurrent	Yes – recurrent
f. Reducing capex	Yes – cash only but accruable benefit	Yes – cash only but accruable benefit	Yes – cash only but accruable benefit	Yes – cash only but accruable benefit
g. Changing payment terms	Yes – cash only and single year	Yes – cash only and single year	Yes – cash only and single year	Yes – cash only and single year

**There being no opportunity in these scenarios from consolidating estate, is based on the assumption that through the estate element of the CIP programme and estate strategy, estate use is maximised i.e. no further consolidation is possible without a lower requirement for estate from the Trusts' clinical services*.

Sensitivity analysis

7.5 The Trust has identified sensitivities on each of the income and cost drivers in the long-term financial model. The consensus upside and downside ranges identified are as follows:

	Volumes	Capacity	Productivity	Prices	Costs/Inflation
Upside	+1% on base	N/A – fixed	+25% of forecast CIP	+1% on base	-1% on base
Downside	Flat - no demographic growth. Service developments still apply	N/A - fixed	-25% of forecast CIP	-1% on base	+1% on base

Probable downside scenario

7.6 As a realistic scenario, the Trust has modelled a downside scenario which is based on a £1.5m impact from the downside scenario for volumes, and 70% of the downside scenario for prices, with a net 1% per annum I&E impact which progressively erodes cash reserves. Under this scenario the Trust goes into I&E deficit in 2015/16 and would require cash support to continue to operate from 2017/18 onwards. No downside impact is assumed in 2014/15 on the basis that to materialise in year, risks would be visible at the time of writing and as yet are not.

£000	2014/15	2015/16	2016/17	2017/18	2018/19
Base case					
I&E (NHS reported position)	2,182	2,743	2,907	3,714	5,894
Cash	18,637	18,738	20,404	20,796	24,307
Downside					
I&E (NHS reported position)	2,182	(1,232)	(5,183)	(8,489)	(10,455)
Cash	18,637	14,861	8,630	(3,010)	(15,660)
Impact of downside					
I&E (NHS reported position)	-	3,976	8,090	12,203	16,349
Cash	-	3,877	11,774	23,806	39,967

Mitigations

7.7 A schedule of mitigations has been developed in response to this scenario. This scenario is based on discussions held by the Trust Board in seminars.

7.8 Furthermore there have been specific discussions with the Hospital Management Board regarding the implementation of changes in the Terms and Conditions of staff. The Trust has identified significant opportunities to deliver paybill-related efficiencies. Hospital Management Board has taken the view that significant opportunities exist to improve the efficiency of the Trusts' clinical services and this should be the focus of future CIP schemes. There is however a shared understanding in the Trusts' leadership that should these transformation opportunities not be delivered, or should the downside scenario articulated above occur, this direction would be reviewed.

7.9 The summary recurrent I&E impact of proposed mitigations to the above downside scenario is as follows. Schemes are listed in order of preference to implement.

Scheme	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000
Vacate BGH	-	103	205	205	205
Vacate and sell Hurstwood Park	-	-	316	632	632
Paybill spend reductions	-	-	2,500	2,500	2,500
Contingency and Local cost pressures	-	2,500	2,500	2,500	2,500
Bring forward future CIP scheme	-	-	1,000	-	-
Vacate and sell Outpatients Building	-	-	-	-	200*
Vacate day surgery at Lewes Victoria Hospital	-	900	900	900	900
Omit Helipad	-	210	424	424	424
Vacate Hove Polyclinic	-	-	-	-	150
Shell and Core a Floor of Stage 1	-	-	-	-	600
Further paybill spend reductions	-	-	-	6,000	8,000

*A further £100k non-recurrent benefit also applies

7.10 The non-cumulative cash impact of these mitigations is set out below:

Scheme	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000
Vacate BGH	-	103	205	205	205
Vacate and sell Hurstwood Park	-	-	2,158	316	316
Paybill spend reductions	-	-	2,500	2,500	2,500
Contingency and Local cost pressures	-	2,500	2,500	2,500	2,500
Bring forward future CIP scheme	-	-	1,000	-	-
Vacate and sell Outpatients Building	-	-	-	-	2,900
Vacate day surgery at Lewes Victoria Hospital	-	900	900	900	900
Vacate and Sell Sussex Eye Hospital	-	-	-	-	-
Omit Helipad	-	116	233	233	233
Vacate Hove Polyclinic	-	-	-	-	150
Shell and Core a Floor of Stage 1	-	-	-	-	513
Further paybill spend reductions	-	-	-	6,000	8,000

7.11 Brief summaries of each of these schemes are:

- **Vacate BGH:** Dermatology and physiotherapy outpatients are currently located in A Block of Brighton General Hospital. The space is occupied under a Service Level Agreement (SLA) with Sussex Community Trust (SCT). An opportunity exists to vacate this space by increased utilisation of existing operational estate at RSCH or PRH, saving the costs of the SLA.

- **Vacate and sell Hurstwood Park:** Neurosurgery will vacate Hurstwood Park in October 2014. At this point, other uses including the new Haem-Onc satellite unit are planned for the space. In a circumstance where less clinical accommodation was required in general, other space at PRH and within the SOTC could be used for this purpose, releasing cash on disposal, PDC and estate maintenance costs.

- **Pay-bill spend reductions:** Potential changes have been categorised by deliverability. The initial £2.5m could be delivered through relatively low impact schemes. The further £8m of schemes are assessed as carrying higher organisational risk.

- **Contingency and local cost pressures:** Contingency has been factored into each year of the LTFM which could be released if required. The Trust has a £2.5m non recurrent contingency in 2015/16. The plan would be to realise all bar £500k of this provision and to supplement with a £500k reduction in local cost pressures.

- **Bringing forward future CIP schemes:** would require delivering earlier than planned on 2016/17 CIPs

- **Vacate and sell outpatients building:** The Outpatients Building at the RSCH provides that site's main general outpatient facilities. This mitigation envisages that the OP activity could be absorbed into the OP facilities which are to be provided in Stage 1 of 3Ts through increased utilisation of the facilities proposed there through greater use of generic outpatient space where appropriate.

- **Vacate Lewes Victoria Hospital:** This mitigation proposes that the Trust withdraws from the day surgery facility at Lewes Victoria Hospital, leaving only outpatient facilities there. This would require additional capacity to be provided in the shell space in the new Day Surgery Unit to allow relocation of the activity. The new unit at PRH was completed in July 2013. It is assumed that the cost of this development will be met from the Trust's operational capital programme. Therefore the additional capital charges already from part of the Trust's baseline position. It is also assumed that the transfer is cost neutral in FM terms.

- **Omit Helipad:** Omission of the helipad on the Thomas Kemp Tower (TKT) would mean that 55-70 Trauma patients per annum would not be able to be treated at the RSCH and would still require transfer to London. The alternative is to continue to use East Brighton Park and effect a secondary transfer by road ambulance. This is not ideal for patient care and contrary to the direction of travel by other Major Trauma Centres. The total capital out-turn cost, plus the trauma lift tower which will be built adjacent to the Thomas Kemp Tower is £9.5m.

- **Vacate Hove Polyclinic:** Increased utilisation of the RSCH/PRH and 3Ts (Stage 1) facilities provides the opportunity to withdraw activity from Hove Polyclinic and absorb within the future operational estate. The space at Hove Polyclinic is currently covered by an SLA between Sussex Community Trust and BSUH. This mitigation would be less desirable than vacating BGH or LVH because of the strategic importance of Hove to maintaining the Trusts' market share in high margin service lines and because of the ease of access to services that Hove Polyclinic facilitates.

- **Shell and core a floor of 3Ts Stage 1:** If there is significant downward pressure on activity then, potentially, this would see 80 further beds being surplus to capacity. This would equate to one ward floor in Stage 1 of 3Ts. Rather than change the shape of the building and breach the Planning Consent, the mitigation would be to omit the fit-out of one entire floor of the building - saving the marginal cost of capital of the fit-out and the operational FM costs of that space.

Mitigated downside

7.12 The mitigations set out above deliver I&E and cash positions as identified below. These mitigations are sufficient to deliver:

- An overall CoS risk rating of 3 throughout
- 10 days operating expenditure available in cash
- A positive I&E position
- Maintenance of core services i.e. those assessed as likely to be covered by designated services provisions on authorisation as a Foundation Trust

7.13 In order to generate an acceptable I&E position, an excess £4m of cash is generated. Whilst this projection is subject to a number of dependencies, if this were delivered the cash could be used to pay down PDC, improving the I&E position further through a reduction in capital charges.

£000	2014/15	2015/16	2016/17	2017/18	2018/19
Mitigations					
I&E (NHS reported position)	-	3,713	7,845	13,161	16,211
Cash	-	3,618	13,114	25,768	43,986
Mitigated position					
I&E (NHS reported position)	2,182	2,480	2,662	4,672	5,756
Cash	18,637	18,479	21,744	22,759	28,325
Variance to base (+'ive = favourable)					
I&E (NHS reported position)	-	(263)	(245)	958	(138)
Cash	-	(259)	1,340	1,962	4,019

Further mitigations

7.14 The analysis above contains mitigations identified as valid at the current time. The Trust has identified a further pipeline of mitigations including further asset disposals and changes to the configuration and occupancy of 3Ts. This work has also identified a number of mitigations that affect the cash position only, which could be deployed in the case of a liquidity issue.

8. Leadership and workforce

Board of Directors

8.1 The Board of Directors provides proactive leadership of the Hospital towards achievement of corporate objectives and oversight of the framework of sound internal controls, risk management and governance in place to support achievement of those objectives. It is responsible for:

- setting the Trust's strategy
- setting the Trust's values and standards
- the safety and quality of services
- holding the organisation to account for the delivery of the strategy
- seeking assurance that systems of internal control are robust and reliable
- ensuring that the necessary financial, human and physical resources are in place to enable the Trust to meet its priorities and objectives
- periodically reviewing management performance
- ensuring that the Trust complies with its Rules of Procedure, Standing Orders, Standing Financial Instructions, Scheme of Delegation and statutory obligations at all times.

8.2 The Hospital is led by an experienced Board of Directors whose experience is summarised on the following pages.

Chair and Chief Executive

Julian Lee, Chairman of the Board of Directors

Julian Lee was joined BSUH as Chairman in August 2009.

Julian has lived in Sussex for 26 years. He is a Chartered Accountant and was a Partner in an international accounting firm before moving into industry where he was Chief Executive or Executive Chairman of various listed and privately held UK and US companies over 20 years. From 2006 until 2009, he was Chairman of NHS Brighton and Hove, the Primary Care Trust for the City of Brighton and Hove.

Julian is Chairman of the Nomination and Remuneration Committee.

Matthew Kershaw, Chief Executive

Matthew Kershaw joined Brighton and Sussex University Hospitals as Chief Executive in April 2013.

Matthew has over 20 years' experience in healthcare including most recently as the first Trust Special Administrator (TSA) in the country. He worked with South London Healthcare NHS Trust as Accountable Officer to maintain safe, effective and high quality services for patients in an extremely challenging environment whilst simultaneously developing recommendations for the Secretary of State that identified how the services provided by the Trust could be clinically and financially sustained in the long term.

Immediately prior to this Matthew held the position of National Director for Provider Delivery at the Department of Health, focusing on the Foundation Trust pipeline and the establishment of the NHS Trust Development Authority. His previous roles within the NHS in Kent, Berkshire, Surrey and Sussex include Chief Executive of Salisbury NHS Foundation Trust and Chief Operating Officer of East Kent University Hospitals.

Non-Executive Directors

Michael Farthing

Michael Farthing was appointed on 1 April 2010.

Michael is Vice-Chancellor of the University of Sussex. He was formerly Principal and Professor of Medicine at St. George's, University of London, Executive Dean of the Faculty of Medicine at the University of Glasgow and, before that, Dean of the Faculty of Clinical Medicine at Bart's and the London.

He graduated from University College Hospital Medical School and undertook training posts in Cambridge, London and Boston. He has served on the General Medical Council's Education Committee and chaired the group that recently revised 'Tomorrow's Doctors', the GMC's guidance on undergraduate medical education.

He is chair of the Health and Social Care Policy Committee of Universities UK, the representative body of executive heads of UK universities.

Michael is Chair of the Quality and Risk Committee.

Craig Jones

Craig Jones was appointed on 1 July 2011. Craig is a workplace diversity expert and advisor to industry and the Government on diversity. He has been acclaimed for his work to make financial services companies better places for women to work and received, on behalf of Barclays, the Opportunity Now Award for Advancing Women in the Workplace in 2011.

Craig's move into financial services followed a 20-year career in the Royal Navy. As a serving Lieutenant Commander, he led ground-breaking work to help integrate gay men and women in the Armed Forces and was appointed a Member of the Order of the British Empire in 2006 for service to equality and human rights. In his lengthy frontline military career he served in operations in Northern Ireland and the Northern Arabian Gulf.

Craig is an owner Director of Brighton and Sussex Care which provides support services to men and women with learning disabilities and mental health issues in Kemp Town.

Craig is a member of the Nomination and Remuneration Committee and the Finance and Workforce Committee.

Lewis Doyle

Lewis Doyle was appointed as Non-Executive Director designate on 1 July 2011 and subsequently as a Non-Executive Director on 1 April 2012.

Lewis has extensive public and FTSE sector experience and has worked in the public sector, financial services, support services and defence and aerospace. During his career Lewis has held a number of Directorships, Executive Committee, operational and audit appointments and led a number of diverse teams including IT, estates, marketing and digital exploitation, customer services and Health & Safety.

Lewis is a Chartered Public Accountant and has a number of diverse business interests and, in addition, is a member of two audit committees, a volunteer with The Sussex Air Ambulance Trust and sits on the disciplinary panel of the Chartered Institute of Public Finance and Accountancy (CIPFA).
Lewis is a member of the Nomination and Remuneration Committee and Chair of the Audit Committee.

Julie Nerney

Julie was appointed on 1 February 2007.

Julie spent the first twelve years of her career as an entrepreneur, starting, running and selling a number of businesses in the UK and overseas across a range of industry sectors.

She now has a portfolio career which includes Non-Executive roles in the public, private and third sectors, voluntary work with The Prince's Trust and ambassadorial roles for the Government in respect of diversity in public life and as a Chartered Director for the Institute of Directors. This is complemented by Board-level interim assignments centred on business transformation, organisational turnaround and delivery of complex projects. She played a key role as part of the leadership team in delivering the London 2012 Olympic and Paralympic Games.

Julie is a member of the Nomination and Remuneration Committee and Chair of the Finance and Workforce Committee.

Stephen Woodford

Stephen joined the Board in August 2013.

Stephen has recently moved to Sussex. He has spent his career to date working in advertising and marketing. His last role was Chairman of adam&eve DDB, a large London-based advertising agency, and prior to this has had management roles in 3 other agencies. He was President of the Institute of Practitioners in Advertising, the advertising industry's trade organisation and was also President of the National Advertising Benevolent Society. He recently founded a new business called Ffrees Family Finance, which aims to give people more control and better returns on their everyday spending. He is a Board Director of Creative Skillset, the sector skills council for the creative industries and this role reflects his strong interest in people development and training. He is a trustee and former Chairman of Changing Faces, the facial disfigurement charity and is also a trustee of the History of Advertising Trust.

Stephen is a member of the Quality and Risk and Audit Committees.

Antony Kildare

Antony joined the Board in August 2013.

He is currently Chief Executive of Aquaterra, an innovative Not for Profit organisation which delivers leisure, fitness, sports and wellbeing services that benefit communities. An experienced Chief Executive, he has a strong commercial background in UK-wide regeneration, business investment, complex programme, project and service development and delivery. His previous appointments include CEO of a large economic development company, Industry Director for Government, Public Sector and Not for Profit business at Ernst & Young LLP, a period at the DTI where he led on a UK-wide Governmental review, Chief Executive of Renaissance Yorkshire and Executive Director of East Midlands Regional Development Agency. Antony has held a number of trustee and non-executive roles during his career.

Antony is a member of the Finance and Workforce Committee.

Christine Farnish

Christine joined the Board in August 2013.

She is currently Chair of the UK's only statutory consumer body, Consumer Futures, which works with policy makers and regulators to promote the consumer interest in complex regulated markets. During her varied career she has worked at senior level as a regulator and, on the other side of the fence, in highly regulated firms and sectors. She has a deep understanding of UK competition and consumer policy.

She served on the Board of Papworth NHS Trust from 1998 to 2002 and on the OFT Board from 2002 to 2006. She currently serves as a Civil Service Commissioner and is Chair of the Peer to Peer Finance Association.

Christine is a member of the Quality and Risk and Audit Committees.

Executive Directors

Steve Holmberg, Medical Director

Steve was appointed as Medical Director on 1 March 2012.

Steve has been a Consultant Cardiologist in Brighton for over 20 years and has previously been Divisional Director for Specialised Services and Chair of the BSUH Medical Advisory Committee.

Steve is Chair of the Cardiology Expert Working Group at the NHS Information Centre and is a Vice-President of the British Cardiovascular Society. Until recently, he was Training Programme Director for Cardiology at the London/KSS Deaneries and a member of the Sussex Heart Network Board.

Steve is a member of the Quality and Risk Committee.

Spencer Prosser, Chief Financial Officer

Spencer was appointed into the post of Chief Financial Officer in January 2014.

He has worked in a number of local Trusts, most recently as Director of Finance/Deputy Chief Executive at Western Sussex Hospitals NHS Foundation Trust where he played a key role in the Trust's attainment of FT status in 2013. Prior to that, he held Board-level posts at Sussex Partnership NHS FT, Western Sussex Health and Social Care NHST, East Sussex County Healthcare NHST and Queen Victoria NHS FT.

Spencer is a qualified accountant (IPFA) with a BA (Hons) in Economics.

Sherree Fagge, Chief Nurse

Sherree was appointed as Chief Nurse in January 2010.

Sherree has worked in the National Health Service for 33 years. She started as a Cadet Nurse at St Francis Hospital and was appointed as a Junior Ward Sister on the Male surgical ward at Cuckfield Hospital after only being qualified for 10 months.

She has held several posts including Ward Manager for Gynaecology, Service Manager for Medicine at PRH, General Manager for Orthopaedics and Inpatient Access, Directorate Nurse Manager for Critical Care, Director of PRH and Operational Director of Nursing. She is very keen for BSUH to be known for its quality of nursing care.

Sherree is a member of the Quality and Risk Committee.

Nikki Luffingham, Chief Operating Officer

Nikki was appointed as our Chief Operating Officer in November 2011.

Nikki was previously Chief Operating Officer at Maidstone and Tunbridge Wells NHS Trust and Deputy Chief Executive at Mayday Hospital NHS Trust.

Nikki is a member of the Finance and Workforce Committee.

Hospital Management Board

8.3 The Hospital Management Board supports the Chief Executive and its members (including the other Executive Directors) to deliver the Hospital's corporate objectives through the implementation of agreed strategy, operational plans, policies, procedures and budgets; monitoring of quality, safety, operational and financial performance; the assessment and control of risk; and the prioritization and allocation of resources.

8.4 The members of the Hospital Management Board are:

1. Chief Executive (Chairman) – executive director 2. Medical Director – executive director 3. Chief Nurse – executive director 4. Chief Financial Officer – executive director 5. Chief of Medicine 6. Chief of Specialised Services 7. Chief of Surgery 8. Clinical Chief of 3Ts and Director of Digestive Diseases 9. Chief of Women and Children 10. Clinical Chief of Finance 11. Chief of Safety and Quality	12. Director of Medical Education 13. Chief Operating Officer 14. Director of Human Resources 15. Director of 3Ts 16. Director of Corporate Affairs 17. Director of Health Informatics 18. Director of Communications 19. Director of HR 20. Director of Service Transformation 21. Director of Education and Knowledge 22. Chief Pharmacist 23. FT Programme Director

Current workforce

8.5 A brief summary of our workforce profile for the past 5 years up to 2013/14 is shown below.

Staff in post	2009/10	2010/11	2011/12	2012/13	2013/14
Total Trust Headcount	6,254	6,617	6,903	7,122	6,928
Total Trust WTE	5,489	5,830	6,004	6,254	6,178

Staff group mix (WTE %)	2009/10	2010/11	2011/12	2012/13	2013/14
Consultants	5.7%	5.8%	6.4%	6.8%	6.6%
Other Medical Staff	9.8%	9.6%	9.4%	9.2%	9.3%
Registered Nurses & Midwives	34.1%	34.5%	33.9%	34.1%	35.2%
Non-registered Nurses & Midwives	9.6%	9.8%	10.0%	10.7%	10.3%
Scientific, Therapeutic & Tech. Staff	15.9%	15.9%	15.9%	16.1%	17.5%
Administration & Estates Staff	19.1%	19.2%	20.0%	20.1%	18.2%
Support & Ancillary Workers	5.7%	5.2%	4.3%	3.1%	2.8%

Staff profile (WTE%)	2009/10	2010/11	2011/12	2012/13	2013/14
Full time	75.5%	75.7%	74.8%	76.1%	75.9%
Permanent	87.8%	88.1%	87.3%	87.3%	86.8%
Female	71.1%	71.6%	71.1%	71.5%	72.1%
Staff of White Ethnicity	80.8%	80.6%	80.6%	80.2%	80.8%
Staff of Asian Ethnicity	6.9%	6.6%	6.9%	7.4%	7.4%
Staff of Black Ethnicity	2.9%	2.6%	3.0%	2.9%	2.7%
Staff of Mixed Ethnicity	2.0%	2.2%	2.3%	2.3%	2.3%
Staff of Other Ethnicity	3.5%	3.6%	3.4%	3.8%	3.6%
BME at Management Level	5.4%	6.5%	7.1%	6.9%	5.6%

Workforce planning

8.6 Summary changes to the Trusts' substantive staffing for 2014/15 are shown below. As noted in Chapter 6, impacts on establishment WTEs from the CIP plan are relatively modest. However, in order to deliver the cost reduction required in this manner, a significant reduction in the use of temporary staffing is required.

Establishment Changes 2014/2015	Medical & Dental	Nursing & Midwifery (Registerd)	ST&T Staff (Registerd/ Qualified)	Support to Clinical Staff (inc HCAs)	NHS Infra-Structure Support	Totals
Baseline Mar-14	1,020.38	2,332.48	842.48	1,799.69	636.33	6,631.36
In Year Changes - Growth	14.00	101.43	19.34	43.99	4.60	183.36
In Year Changes - CIPS	-1.31	-69.55	-3.02	-29.08	-3.42	-106.38
Predicted Mar-15	1,033.07	2,364.36	858.80	1,814.60	637.51	6,708.34

8.7 The Trust workforce plan recognises:

- The need to reduce the use of flexible labour
- Current recruitment efforts to appoint to substantive positions
- Delivery of efficiencies
- Changes in patient activity flows and service developments

8.8 The Trust workforce plan has an overall reduction over the 5 year period of 248 whole time equivalents (WTEs) staff in post.

8.9 Flexible labour accounted for 8% of the Trusts pay expenditure in 2013/14. The workforce plan is to reduce this to 5% by 2015/16 and 3% by 2018/19.

8.10 Summary tables for the workforce plan are set out below.

	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019
Establishments (Budget WTES)	*Excluding Bank & Agency*				
Opening Balance	6,631.36	6,708.34	6,601.99	6,616.05	6,521.33
Closing Balance	6,708.34	6,601.99	6,616.05	6,521.33	6,417.64
Change in Establishment (Bud WTES)	76.98	-106.35	14.06	-94.72	-103.69
Establishments (Budget WTES)	*Excluding Bank & Agency*				
Activity Growth:	183.36	-28.10	58.58	60.02	61.52
Cost Pressures & Serv Devs:		296.87	220.41	123.43	112.97
Efficiencies:	-106.38	-375.12	-264.94	-278.18	-278.18
Change in Establishment (Bud WTES)	76.98	-106.35	14.06	-94.72	-103.69
Staff in Post (Actual WTES)	*Substantive staff only*				
Opening Balance	6,178.49	6,204.49	6,104.17	6,117.47	6,028.03
Closing Balance	6,204.49	6,104.17	6,117.47	6,028.03	5,930.13
Change in Staff in Post (Act WTES)	26.00	-100.32	13.30	-89.43	-97.91
Staff in Post (Actual WTES)	*Substantive staff only*				
Activity Growth:	20.39	-26.52	55.29	56.65	58.06
Cost Pressures & Serv Devs:	102.95	280.00	208.09	116.50	106.62
Efficiencies:	-97.34	-354.07	-250.07	-262.58	-262.58
Change in Staff in Post (Act WTES)	26.00	-100.59	13.30	-89.43	-97.91
Average Cost Per WTE	£47,193	£47,056	£47,761	£48,737	£49,430
Temporary Staffing					
Bank WTES:	319.11	310.61	234.76	229.19	223.27
Agency WTES:	96.07	93.51	77.55	75.71	73.76
Change in Temporary Staffing WTES	-141.32	-11.06	-91.81	-7.41	-7.87
Total SiP (Act WTES) inc B&A WTES	6,619.67	6,508.29	6,429.78	6,332.93	6,227.16
Change in Total SiP inc B&A WTES	-115.32	-111.38	-78.51	-96.84	-105.78

8.11 The table below shows a breakdown of the Trusts paybill over the 5 year period, adjusted to exclude inflation.

Pay (£'m) by category	*2013/14*	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019
Substantive	*267.8*	272.9	265.7	267.8	261.5	254.7
Bank	*13.5*	11.5	11.2	8.5	8.3	8.0
Agency	*11.6*	7.0	6.8	5.6	5.5	5.4
	£ 293.0	**£ 291.4**	**£ 283.7**	**£ 281.9**	**£ 275.2**	**£ 268.1**

8.12 The Trusts plan assumes that 80% of Pay efficiencies delivered from 2015/16 onwards have an impact on WTEs. The remainder of the pay efficiencies will be delivered from changes in skill mix and reduced premium paid for the use of flexible labour.

8.13 The projected movements for staff in post, split by principal staff group, are as below.

Substantive Staff by Staff Group	2014/15	2015/16	2016/17	2017/18	2018/19	Totals
Consultants	6.91	2.08	5.43	-3.45	-4.55	6.41
Other Medical Staff	-31.06	-10.14	2.02	-6.89	-7.54	-53.61
Registered Nurses & Midwives	26.53	-25.15	10.86	-22.53	-25.46	-35.75
Registered/Qualified ST&T Staff	-5.54	-2.31	10.43	-9.48	-10.91	-17.80
Support to Clinical Staff (inc HCAs)	28.30	-25.49	0.78	-26.47	-29.20	-52.09
NHS Infrastructure Support	0.86	-39.31	-16.23	-20.61	-20.23	-95.52
Totals:	26.00	-100.32	13.30	-89.43	-97.91	-248.36

Workforce performance indicators

8.14 The Trusts' finance and workforce committee tracks key performance indicators relating to stability of the workforce, sickness rates and how fully established the Trust is. Key metrics are shown below:

	2009/10	2010/11	2011/12	2012/13	2013/14
Vacancy	9.3%	7.8%	7.6%	4.9%	7.7%
Turnover	10.4%	11.0%	10.8%	13.2%	14.5%
Sickness	4.1%	4.0%	3.8%	3.9%	3.5%

HR Strategy

8.15 In line with the Trust's clinical strategy, the HR Strategy is designed to make the Trust and its services the best that they can be for patients. The HR strategy supports the Trust's clinical strategy by developing and implementing leading edge HR policies, progressive people development and effective performance management as part of our workforce development plans that incorporate employees, partners and volunteers.

8.16 In each of these areas there are a number of work streams addressing culture, behaviour and values. The strategy:

- Supports staff and managers through on-going change – change, development and innovation that will transform the way we work and how our people are managed, as well as reduce our cost base to meet the challenges of the NHS in the future (People)

- Ensure patient care and patient safety remain the focal point of all outcomes from staff engagement (Patient Care)

- Set in train a rolling programme of innovative HR development, which will create energy among line managers to manage people within a modernised and responsive set of management tools (Performance)

8.17 The programme is built on six principles that act as the underpinning on which the foundation of the strategy is built. These are:

- Joint solutions – partnership working

- Culture, values and behaviours

- Seeking inefficiencies and implementing technology

- One HR

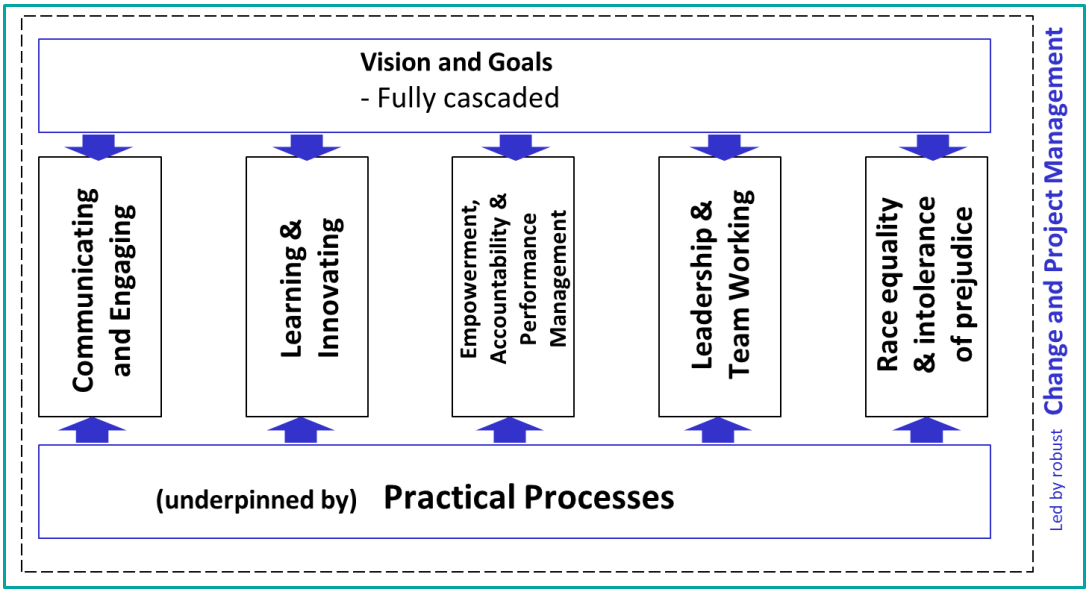
- Health and wellbeing

- Equality and diversity

Foundations for Success

8.18 The Trust introduced its Foundations for Success (F4S) programme in July 2013. F4S is a programme of organisational development, leading to the development of the clinical strategy, revisions to the management structure, a new framework for empowerment, accountability and performance and a major review and engagement exercise focussing on the organisation's values and behaviours.

8.19 The outputs of the clinical strategy and clinical structure pieces are set out in other parts of this document. The Values and Behaviours workstream has now concluded its diagnostic phase, has published a new behavioural blueprint, and is moving into implementation of a number of workstreams shown below with empowerment and accountability moved into values and behaviours as a workstream:



Temporary Staffing

8.20 The Trust positively promotes managed use of temporary staffing to provide cover for its core operations as well as predictable variations in demand. Historically, staff in post have been significantly below establishment levels, particularly in nursing roles, and analysis of internal bank rates in 2013 demonstrated that rates of bank pay were significantly above both nearby Trusts and substantive rates, potentially contributing to the inability to recruit substantively. As a result, a decision was made to simultaneously lower bank rates significantly, and streamline recruitment to substantive positions for staff covering a regular pattern of bank shifts. This has created some operational challenges in filling requested temporary staff shifts.

8.21 Controls have also been strengthened in the deployment of medical locums by devolving the authority and accountability for this to the Divisional Chief, supported by his management team and Medical HR. This has reduced the use of medical locums. Robust challenge for replacement of posts vacant through absence, more effective deployment of existing staff through challenging rota patterns and working practices has been implemented by ward managers and for administrative staff.

Appraisal

8.22 Staff survey and CQC inspection findings indicated that the Trust needed to improve the quality and frequency of appraisals. As a result, the Trust has designed and launched a simplified appraisal system, introducing organisational values and behavioural competencies; a line of sight to ensure Trust objectives

are cascaded down to individual objectives; and senior reviewer sign off to ensure objectivity. The appraisal system makes provision for clear job expectations and comprehensive and structured feedback. Managers have been supported in implementing this new appraisal system via performance management briefings delivered by the HR Development Team. As a consequence, appraisal systems have risen from 35% to c 70% since the start of 2012/13 with more work planned to increase this again in 2014/15.

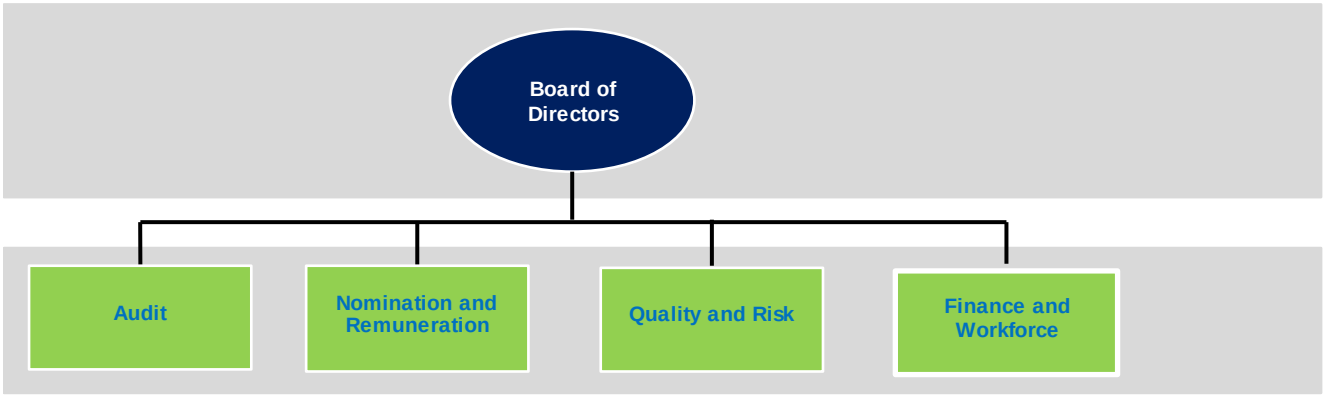
9. Governance

The Trust Governance framework

9.1 The Trust Governance Framework is defined in the Rules of Procedure, which set out the corporate governance arrangements for the Trust and which is reviewed and updated by the Board annually.

9.2 The Trust's corporate governance structure is designed to ensure appropriate oversight and scrutiny and to ensure good corporate governance practice is followed. There are four Committees of the Board of Directors.

9.3 Following review and observation of the Board of Directors and Board Committees by external assessors and the NHS Trust Development Authority, significant recent changes have been made to the Trusts' governance mechanism. These changes have been made in particular to strengthen the Boards' visibility and oversight of safety and quality issues and integrate the management of clinical and non-clinical risk. Account has been taken of the Board Governance Assurance Framework and Quality Governance Framework, in determining the most appropriate models to take forward.



Board of Directors

9.4 The Board of Directors sets the Trusts' strategic direction, agrees annual objectives and plans, monitors delivery of objectives and ensures corrective action is taken. The Board is responsible for the management of resources, representing the Board to external stakeholders and standards of governance.

Audit Committee

9.5 In line with the requirements of The NHS Audit Committee Handbook and the NHS Codes of Conduct and NHS Code of Accountability, which are consistent with Monitor's NHS Foundation Trust Code of Governance, the Audit Committee provides the Board of Directors with an independent and objective review of its financial systems, financial information, system of internal control and compliance with laws, guidance and regulations governing the NHS.

9.6 The Audit Committee's membership is drawn exclusively from independent non-executive directors and has been supported by the work programmes of internal and external audit. This ensures independence from executive and operational management

9.7 The Audit Committee meets quarterly and provides independent monitoring and scrutiny of the processes implemented in relation to governance, risk and internal control. The Committee reports its proceedings to the Board of Directors following each of its meetings together with an annual report.

Quality and Risk Committee

9.8 The Quality and Risk Committee, has delegated authority to assure the ongoing development and delivery of the Trust's Safety and Quality strategy.

9.9 It is supported by the work of the Executive Safety and Quality Committees and reports from the Trust Safety and Quality team. The Chair of the Quality and Risk Committee, a Non-Executive Director, has reported on key issues to the Board of Directors after each meeting, and, raises any issues relating to internal control systems with the Audit Committee.

Finance and Workforce Committee

9.10 The Finance and Workforce Committee provides assurance to the Board of Directors in the following areas: strategic financial and workforce matters; implementation of the HR strategy; delivery of in-year financial plans and cost improvement plans; the Trust's financial and investment policies; long-term financial sustainability, capital investment, delivery of significant projects and financial sustainability; and health and safety in relation to the Trust's estate, and implementation of effective internal controls around the health and safety of staff.

9.11 The Chair of the Finance and Workforce Committee, a Non-Executive Director, reports on key issues to the Board of Directors after each meeting together with an annual report.

Nomination and Remuneration Committee

9.12 The Nomination and Remuneration Committee's role is to appoint, and, if necessary, dismiss the executive directors; establish and monitor the level and structure and reward of the Chief Executive and executive directors, ensuring transparency and fairness and consistency; develop and implement succession planning for key senior management posts; ensure that contractual terms on termination and any payments in respect of executive directors are lawful and represent value for money; and ensure all provisions regarding disclosure of remuneration, including pensions, are fulfilled.

9.13 The terms of reference of the Nomination and Remuneration Committee were revised in 2013/14 to ensure transparency in respect of any compromise agreements made by the Trust, as part of the Trust response to the Francis Inquiry.

Charitable Funds

9.14 The Trust is also the corporate trustee of the Brighton and Sussex University Hospitals NHS Trust Charitable Fund (Registered Charity 1050864), which is overseen by the Charitable Funds Committee, which is a Committee of the Board

Board health review

9.15 A Board health review was undertaken by Foresight LLP between September and November 2013. The output of the review was considered by the full Board at a Board development day in January 2014 and a Board development plan was approved by the Board of Directors in March 2014. The Board development plan focus on the further development of the Board in the following areas:

- Formulating strategy and building strategic capability
- Building on Engagement foundations
- Ensuring accountability and board disciplines – embedding systems and processes
- Board as a team: board capability, capacity and corporate working
- People strategy and shaping culture

Organisational management structure

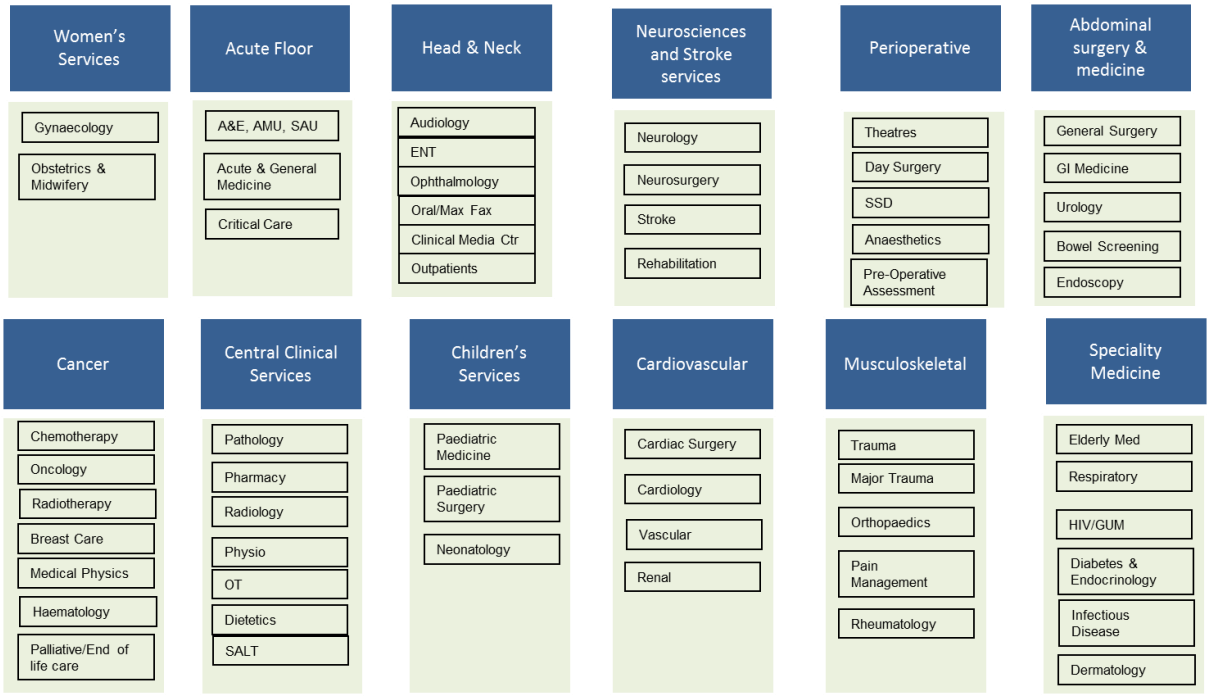
9.16 At the present time, the organisation is organised into five clinical divisions: Medicine, Surgery, Women and Children, Specialised and Neurosciences. At the head of each division is a three-way relationship between the Clinical Chief, Associate Director of Operations and Associate Chief Nurse. The Chief and ADO of each division report to the Chief Operating Officer, and the ACN to the Chief Nurse. A second tier of operational management below the divisions, consists of service managers, working with matrons and principal lead consultants at speciality level. At the current time the division of Women and Children has a combined ADO/ACN postholder.

9.17 Each division operates a division-wide management meeting, with clinical and managerial representation from its clinical specialties and other departments.

9.18 In May 2014 BSUH launched a pre-consultation exercise with the management body over a proposed move to a single-tier management structure. The rationale for changing the management structure is to:

- Empower the front line
- Streamline administrative processes around service developments
- Manage services around disease-based structures and bring services together with similar challenges and agendas
- Give staff opportunities for development

9.19 The proposed directorate model, outlined below, will be implemented in September 2014, subject to changes following formal staff consultation.



Risk management

9.20 The Board of Directors provides proactive leadership of the Trust towards achievement of corporate objectives and oversight of the framework of sound internal controls, risk management and governance in place to support their achievement.

9.21 The implementation of a sound system of internal control that supports the effective achievement of the Trust's corporate objectives is the personal responsibility of the Chief Executive as the Accounting Officer. The system of internal control in place in the Trust is designed to manage risk to the lowest reasonable level.

9.22 The Trust has implemented a risk management accountability structure which overlays the risk management strategy and ensures its effective delivery. The risk management strategy aims to implement a risk management framework which:

9.23 It provides a framework for delivering:

- the control and management of risk to achieve the Trust's objectives
- the Board Assurance Framework, the prime vehicle for informing the Trust's Annual Governance Statement
- the integration of risk management within the Trust's strategic aims and objectives

9.24 All staff are responsible for delivering the risk management strategy, in particular, for their own safety and for ensuring risks to the organisation, colleagues, patients and visitors are minimised.

9.25 The Board of Directors is responsible for identifying, evaluating and managing strategic risk. In order to ensure that these are managed appropriately within the Trust, the Board of Directors is provided with evidence-based assurance on the adequacy of the Trust's processes for managing risk so that objectives can be achieved.

9.26 On behalf of the Board of Directors, the Audit Committee has primary responsibility for reviewing the establishment and maintenance of an effective system of corporate governance and internal control across the whole of the Trust's activities that supports the achievement of the Trust's corporate objectives.

9.27 The Quality and Risk Committee has primary responsibility within the Trust for safety and quality assurance of the clinical services provided. It is supported by the work programmes of the Safety and Quality Committee, and Divisional and Speciality Safety and Quality Committees.

9.28 On behalf of the Board of Directors, the Finance and Workforce Committee has primary responsibility for financial and workforce-related risks and assuring the Board of Directors that appropriate arrangements are in place to deliver in-year financial plans, Human Resources Strategy and the efficiency plan.

9.29 The Hospital Management Board is responsible for the primary review and monitoring the Hospital Risk Register on a quarterly basis at an operational level. HMB will review the Hospital risk register on a quarterly basis. They also have the management of operational risks and assuring the Quality and Risk committee appropriate arrangement are in place to manage operational risk.

9.30 The Chief Executive has overall individual responsibility for risk management. The Chief Executive has delegated this responsibility to an Executive Lead for Risk.

9.31 The Director of Corporate Affairs is the director lead for risk and responsible for ensuring that the Risk Management Strategy is implemented and evaluated effectively. The Head of Risk Management supports the Executive Lead for Risk. They are also the director responsible for suitable and sufficient arrangements relating to Health and Safety.

9.32 Directors are accountable and responsible for ensuring that the Corporate and Clinical Directorates are implementing the Risk Management Strategy and related policies. They also have specific responsibility for managing the Trust's principal risks which relate to their Directorates, for example:

- the Chief Financial Officer is responsible for managing the Trust's principal risks relating to ensuring delivery of financial plans agreed by the Board,
- the Medical Director is responsible for managing the principal risks relating to infection control as Director of Infection Prevention and Control.
- the Director of Human Resources is responsible for managing the Trust's principal risks relating to Workforce planning.
- the Medical Director is responsible for ensuring risk is managed associated with maternity services. Further specific duties are defined in the Maternity Risk Strategy;
- the Medical Director is responsible for managing risks associated with Medical Workforce planning; and
- the Director of Health Informatics is responsible for managing risks associated with Information Governance.
- the Chief Operating Officer who has delegated responsibility for managing the Trust's risks relating to operational performance, fire safety and resilience.
- the Medical Director and Chief Nurse are jointly responsible for managing the principal risks relating to patient care.

9.33 These designated Directors sit on the appropriate Assurance Committees which cover their area of risk.

9.34 The Trust has recently instituted a risk review committee. The role of the risk review committee is to support HMB in reviewing all risks on the Trust Risk Register, escalating risks to the HMB or BAF as appropriate, and ensuring the risk register is fully up to date and well managed.

Governance of quality and safety

9.35 The Trust operates a system of safety and quality management, which is overseen by the Quality and Risk Committee.

9.36 The principal Trust-wide mechanism for safety and quality management is the Executive Safety and Quality committee, which reviews a Trust-wide S&Q scorecard with all key quality metrics, and receives exception reports on S&Q risks from each division.

9.37 The divisional reports to Executive S&Q Committee are prepared by an appointed Deputy Chief of Safety, a senior doctor with time set aside from clinical responsibilities to oversee the management of safety and quality in their division. The Deputy Chief chairs a Divisional committee, which considers by exception issues in clinical services and specialties. Each clinical speciality has a nominated S&Q lead and, as part of an S&Q

or broader clinical governance meeting, reviews defined quality metric reports prepared by the corporate safety and quality team.

9.38 Defined agendas and metric reports for S&Q governance meetings at each level of the organisation were implemented during 2013. This was part of an overall programme of improving S&Q processes and structures, instituted in response to an internal audit review of S&Q structures and processes. Other actions included changes to the Board committee responsible for S&Q management, the appointment of a Chief of Safety and Quality, and the provision of improved safety and quality information at Board level.

9.39 This led to an external assessment against the Quality Governance Framework in February 2014 with a score of 5.5. Whilst a non-compliant score for FT authorisation, this assessment provided clarity on further improvements required to improve S&Q capability and secure a compliant score, particularly concerning the management and governance of clinical audit, and the management of safety and quality risk in the context of the Trusts' wider risk management framework.

Performance management framework

9.40 The Trust Board integrated performance report reflects both the Trusts' corporate priorities and objectives, and also key performance measures on which the Trust is held to account by regulators and system managers. For 2014/15, this is principally the TDA Accountability Framework, which is in turn closely aligned to the Monitor Risk Assurance Framework. The Board performance report was extended in 2013, to become an integrated performance report reflecting quality and staff metrics as well as the access to care and effectiveness measures for which the Chief Operating Officer is held accountable. Performance is benchmarked against historic levels and trends, and accepted external benchmarks and thresholds.

9.41 The integrated performance report does not attempt to provide comprehensive assurance for all aspects of Trust business. The Board therefore continues to receive detailed finance and safety and quality reports, in support of the integrated performance report.

9.42 The Board has regularly reviewed the performance report, with metrics being changed to reflect objectives and priorities.

9.43 Divisional performance review meetings take place on a quarterly or monthly basis, dependent on the assessed degree of risk within a divisions' access, quality, workforce and financial performance.

9.44 The Trust is proposing to review its performance management framework as a consequence of the new clinical structure and the Values and Behaviours workstream of Foundations for Success.

Internal and external audit

9.45 The Trusts' external auditor is Ernst & Young, appointed for the 2012/13 financial year following the withdrawal of the Audit Commission from NHS Trust external audit responsibilities. The Trust has received an unqualified audit opinion on its accounts for 2012/13 and 2013/14.

9.46 Internal audit is sub-contracted to TIAA Ltd. For 2013/14, the Head of Internal Audit opinion stated that 'significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk'. Significant issues related to performance, in respect of the 4 hour A&E standard and infection prevention and control, and control issues in relation to quality governance.

9.47 Audit Committee has agreed monitoring schedules and actions to rectify these weaknesses in the systems of internal control.

Financial controls and reporting

9.48 The BSUH Standing Orders, Schemes of Reservation and Delegation and Standing Financial Instructions detail our financial control and reporting arrangements. Budgetary responsibility is delegated in accordance with the Standing Financial Instructions to Clinical and Corporate Directorates, each of whom is who are supported on day-to-day issues by a dedicated management accountant. All budget managers have access to the SFIs, SOs and Scheme of Delegation. Financial performance is monitored on at least a monthly basis and reported to the Management Board and Board of Directors by the Chief Financial Officer by way of a monthly finance report. This is considered in the open session of the Board of Directors meetings.

Cost Improvement Programme

9.49 The Cost Improvement Programme is overseen by an Efficiency Plan Steering Group, reporting to the Hospital Management Board. The EPSG reviews the progress of all in-year CIP plans, and the arrangements for the identification and agreement of future years' CIPs.

9.50 In-year delivery and preparatory actions for future years are managed by the Delivery Unit. The DU acts as a programme management office, co-ordinating CIP plans between workstreams and assuring delivery of plans and their projected financial and non-financial benefits.

9.51 All CIPs are assessed for quality impact via a star chamber process, compliant with established best practice and co-chaired by the Chief Nurse and Medical Director. All approved CIPs have a signed quality impact assessment.

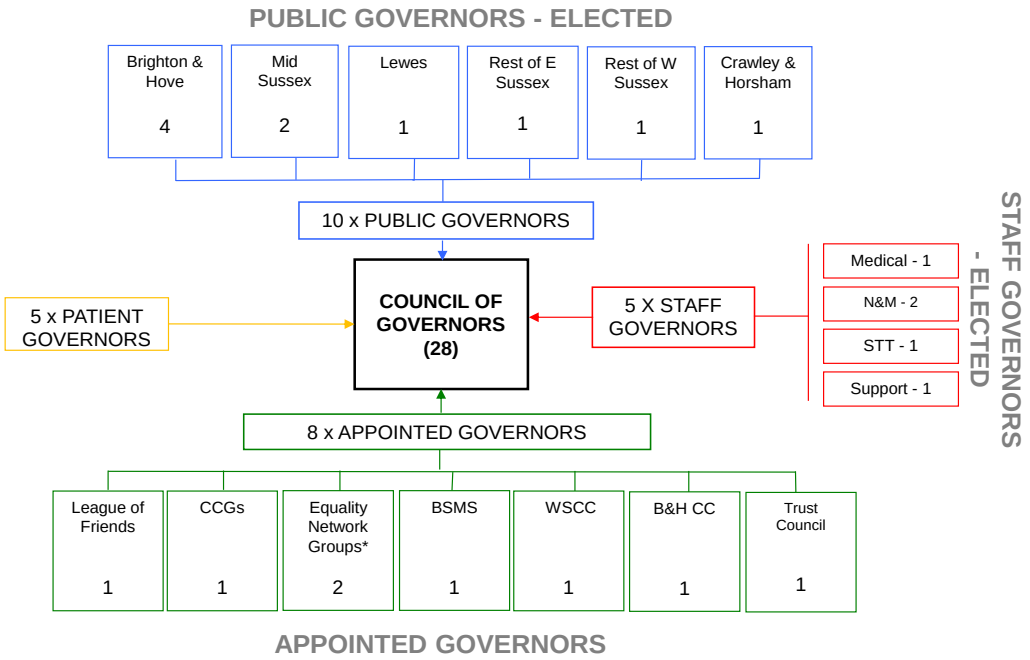
IT Systems

9.52 BSUH undertook a fundamental review of its health informatics requirements in the summer of 2010. As a result of this review and as detailed above, the Trust is making a significant investment in the development of an Electronic Patient Record system including Pathology Order Comms and e-prescribing that will significantly develop its core informatics capability.

9.53 The Trust is in the process of reviewing its informatics strategy to maximise the benefits of EPR and implement a comprehensive data warehouse for the improved reporting and management of financial and non-financial metrics.

Council of Governors

9.54 The Trust has revised its Council of Governors proposals in light of feedback from existing Foundation Trusts and its original consultation in 2011. The Trust now proposed a Council of Governors of 28 which is summarised below:



* Initially BSUH BME Network and LGBT Forum

Appendix – portfolio of services by site

Speciality	PRH OP	PRH IP/DC*	RSCH OP	RSCH IP/DC
Critical Care		X		X
Dermatology	X	X	X	X
Diabetes & Endocrinology	X	X	X	X
Dietetics			X	X
Elderly Medicine	X	X	X	X
Acute & General Medicine	X	X	X	X
Rehabilitation		X		
Respiratory Medicine	X	X	X	X
Rheumatology	X	X	X	X
Stroke	X	X	X	X
Occupational Therapy	X	X	X	X
A&E	X		X	
Audiology	X		X	
Digestive Diseases	X	Endo	X	X
Ear Nose & Throat	X	X	X	X
Ophthalmology	X	X	X	X
Oral Surgery	X		X	X
Pain Medicine	X		X	
Physiotherapy			X	
Retinopathy Screening	X		X	
Thyroid			X	X
Trauma & Orthopaedics	X	X	X	X
Urology	X	X	X	X
Vascular	X	X	X	X
Cardiac Services	X	X	X	X
Breast	X	X	X	
Oncology			X	X
Radiotherapy			X	
Haematology	X		X	X
GUM/HIV			X	X
Renal	X		X	X
Path	LAB		LAB	
Radiology	X	X	X	X
Neonatology**		X (L1)		X (L3)
Paed Medicine			X	X
Paed Surgery			X	X
Obstetrics	X	X	X	X
Gynaecology	X	X	X	X
Neurology	X	X	X	
Neurosurgery	X	X		

*Med specs via general take
**Level 1 Special Care Baby Unit; Level 3 Neonatal Intensive Care Unit