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## Table of Contents

Section 1 - The Trust’s Vision, Strategy and Priorities .....	5
Patient First .....	5
True North.....	5
Breakthrough Objectives .....	6
Strategic Initiatives.....	7
Corporate Projects .....	7
Section 2 – Our Quality Plans.....	9
Our Quality Strategy .....	9
Infection Prevention .....	10
Learning from Deaths .....	10
Seven-Day Service Commitments .....	10
BSUH Patient First Programme .....	11
CQC Rating .....	11
True North.....	12
Part A – Summary of the Quality Improvement Plan (including compliance with national quality priorities).....	12
Part B – Summary of the Quality Impact Assessment Process .....	13
QIA Review and Reporting .....	13
Section 3 – Demand, Capacity, Activity and Performance.....	15
Part A: Methodology.....	15
Part B: Commissioning (Contract) Offers.....	16
Part C: Productivity Improvements.....	17
Part D: Capacity, Beds and Performance .....	17
Access Targets.....	17
Winter Resilience .....	18
Section 4 – Workforce Planning.....	20
Workforce Position .....	20
Workforce Challenges.....	21
Workforce Planning & Triangulation .....	23
Workforce Transformation .....	24
2018/19 Priorities .....	24

Section 5 – Finance Planning .....	29
2017/18.....	30
Assumptions.....	30
Activity .....	30
Cost Improvement Plans.....	31
Workforce / Pay .....	34
Capital .....	34
Cash Flow Assumptions .....	35
Liquidity.....	35
Section 6 – Link to Sussex and East Surrey Sustainability and Transformation Plan.....	37

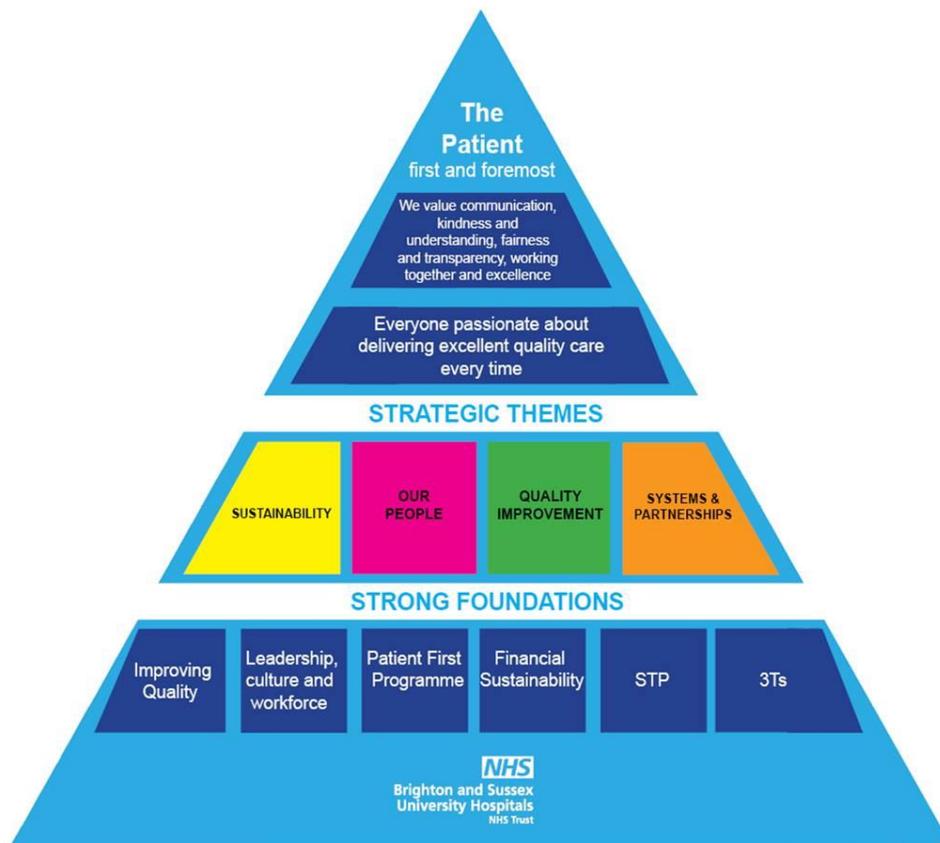
# Our Vision, Strategy and Priorities



## Section 1 - The Trust’s Vision, Strategy and Priorities

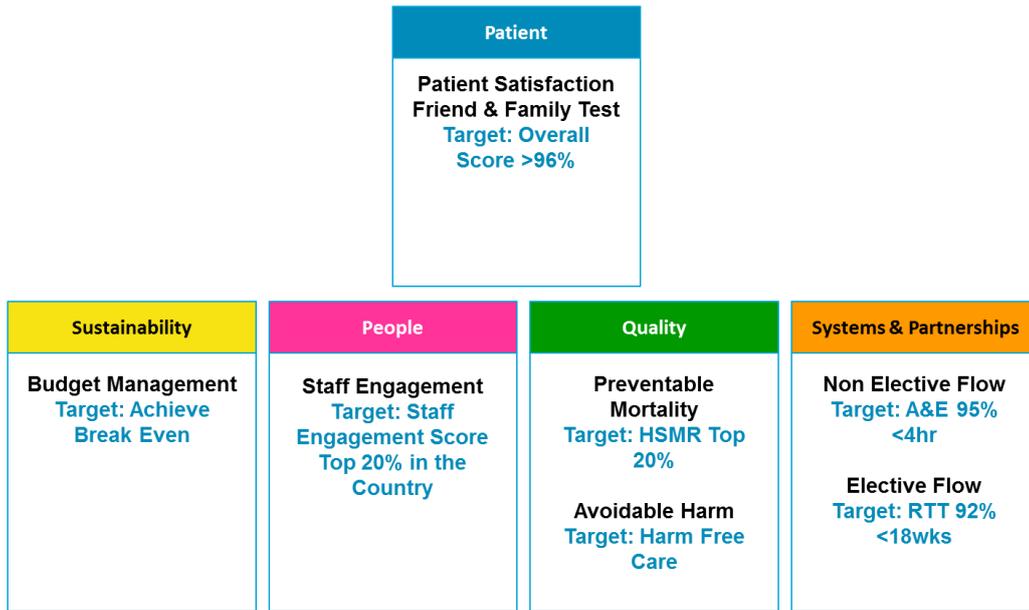
### Patient First

The Trust’s vision is one of ‘Patient First’ where improving care for the patient is our most important objective. This is supported by our key values and our Strategic themes – Sustainability, Our People, Quality Improvement and Systems and Partnerships. This approach is captured in our Patient First triangle below.



### True North

As part of this vision, the Trust has determined its ‘True North’ – its key long term aims for the organisation which will not vary from year to year and align to our Strategic Themes. These are set out in the diagram below.



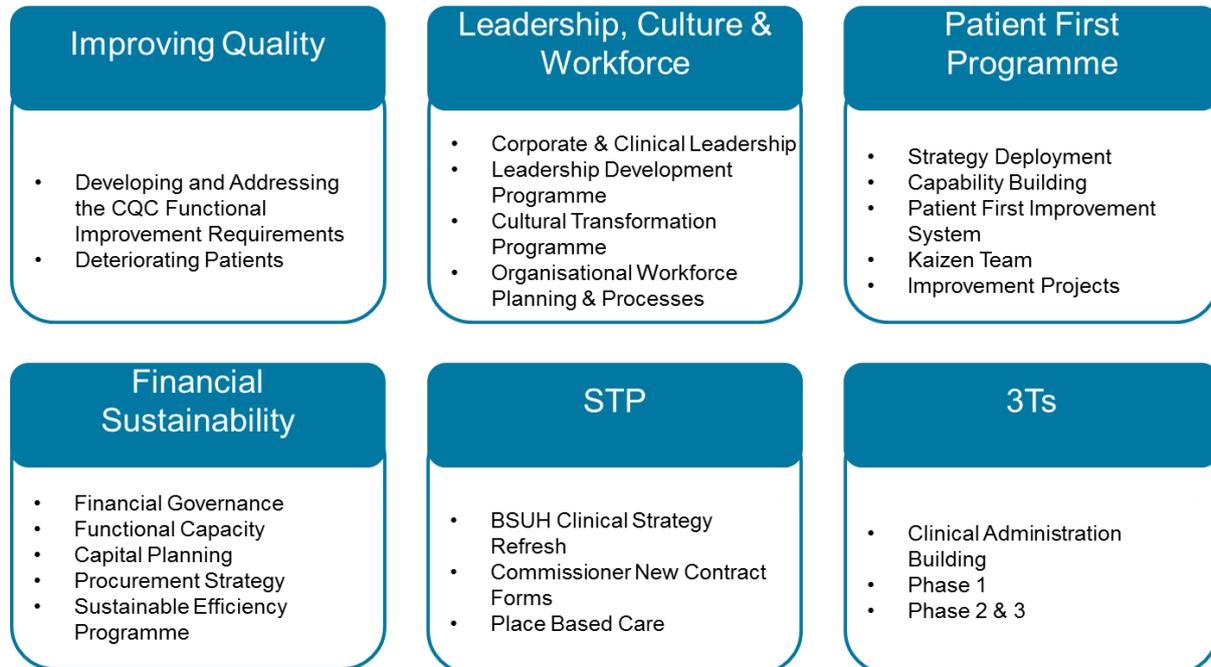
## Breakthrough Objectives

Our True North provides us with our long term aims and ensures that we continue to focus and align on the things that matter. Aligned to our True North are 'Breakthrough Objectives' which identify what we are specifically focusing on achieving in the coming year. These are given in the table below.

True North Domain	Breakthrough Objective	Metric	Outcome	Executive Lead
<b>Patient</b>	Reduction in complaints where staff attitude is cited as an issue	Number of complaints relating to staff attitude	Reduced number of complaints	Nicola Ranger (Chief Nursing Officer)
<b>Sustainability</b>	Achieve the Efficiency plan for 2018/19	4% Savings vs Planned Budget	Control Total for 2018/19 achieved	Karen Geoghegan (Chief Financial Officer)
<b>People</b>	Staff believe that Care is the top priority for the organisation	Increase in % staff agreeing "Care is the Top Priority"	Engaged staff measured through the Staff Survey results	Denise Farmer (Chief Workforce Officer)
<b>Quality</b>	Improvement in recognition and response to deteriorating patients	Met call rate per 1000 bed days	50% reduction in patient deterioration incidents	George Findlay (Chief Medical Officer)
<b>Systems &amp; Partnerships</b>	Reduction in the numbers of patients waiting >4hrs in A&E who are not admitted	75% decrease in the numbers of non-admitted breaches	Sustainably achieve >90% A&E 4hr target	Pete Landstrom (Chief Delivery Officer)
<b>Systems &amp; Partnerships</b>	Ensure no patients wait over 52 weeks for elective treatments	0 x 52 week RTT breaches	Reduction in harm and improvement in % 18wk RTT compliance	Pete Landstrom (Chief Delivery Officer)

## Strategic Initiatives

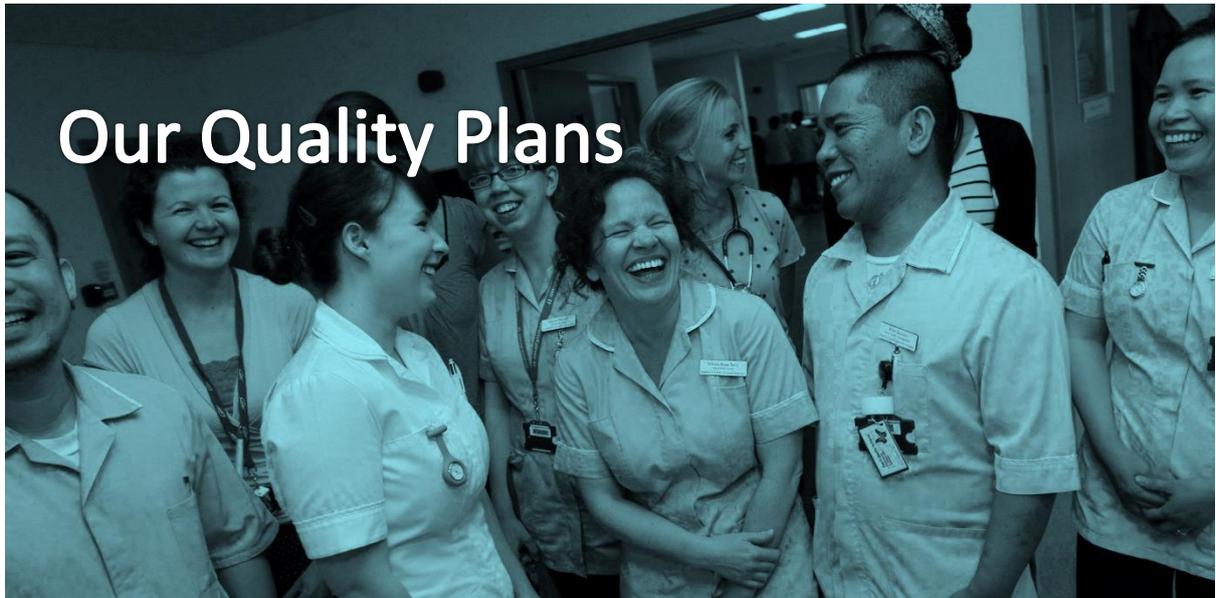
In order to ensure long term improvement, the Trust has identified six strategic initiatives, which are listed below. These are 1-3 year work programmes, aimed at strengthening the Trust’s capability, capacity and governance, to make the improvements it aspires to.



## Corporate Projects

The Trust has identified a number of specific corporate projects, which are shorter term ‘start and finish’ projects, with a 12-18 month time frame, which are of sufficiently complex nature or are cross-organisational, and therefore require specific corporate leadership and oversight. For 2018/19, these include:

- Developing the Major Trauma Centre
- Developing our Emergency Care services, through increased capacity and flow
- Pathology Joint Venture as part of our Pathology network
- Lewes Victoria Futures
- Estates and facilities – including the 6-facet survey
- IT infrastructure (including PAS and EPR)



## Section 2 – Our Quality Plans

### Our Quality Strategy

Our named Executive Lead for Quality is the Chief Medical Officer, and our Executive lead covering safe ‘harm free’ care is the Chief Nurse.

Every three years we produce a Quality Strategy, which sets out our focus to improve hospitals services for patients, visitors, staff and partners. We focus on programmes that will ensure we continuously improve the safety and reliability of care, and improve patients’ experience of this.

Key goals of our Quality Strategy include:

- Reducing mortality and improving outcomes
- Safe care
- Reliable care
- Improved patient and staff experience

Each year we engage staff, patients, the wider public and our local health economy/STP partners regarding our quality priorities, and actively act on feedback.

The Quality Strategy is monitored by the Quality and Assurance Committee and the Trust Board. The Quality and Assurance Committee is established to enable ongoing monitoring through the Quality Scorecard, to review patients’ outcomes and initiate actions to drive quality improvement.

The Quality Improvement Plan has incorporated regulatory notices following the CQC inspection in 2017 and any areas where further improvements were required following the 2016 inspection. The plan includes actions, progress and key performance indicators associated with delivering the Regulations.

A Quality Improvement and Assurance Group (QIAG) has been established, led by the Chief Nurse, to ensure the organisation maintains and sustains compliance with the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) and Care Quality Commission (Registration) Regulations 2009 (Part 4).

The Chief Nurse, Nurse Director and Associate Director of Quality meet with the Divisional leads monthly to discuss progress and review evidence for compliance. Progress against the Improvement plan and challenges are discussed at the monthly QIAG. Issues of concern in respect of performance, progress and risk are escalated to the Quality and Assurance Committee as required.

A programme of monthly peer review visits has been set up led by the Nurse Director and Nurse Director for Workforce and Education. The aim of the visits is to ensure that there is Board to ward assurance and that by a senior nurse ‘adopting’ a ward/department for four months they will be able to support the ward in identifying any improvements and escalating any challenges or concerns.

## Infection Prevention

Infection Prevention does not rest solely within the domains of the Infection Prevention Team (IPT), everyone has infection prevention responsibilities. The Trust wide programme for infection prevention (IP) incorporates the requirements for the revised Health and Social Care Act 2008 (revised 2015) – Code of practice for health and adult social care on the prevention and control of infectious and related guidance (hereafter referred to as The Health Act 2008). The IP programme therefore contains elements that reflect and address the ten criteria with a focus on BSUH activity including construction of the new hospital, a focus on water safety and ventilation as well as essential infection prevention principles activity and a comprehensive audit programme. It is our ambition that no patient has an avoidable infection.

There will be continued compliance with monitoring and national reporting of mandatory alert organisms including a focus on the Gram-negative blood stream reduction target. BSUH undertook root cause analysis of *Escherichia coli* blood stream infections for the first six months of the fiscal year 2017-18 to gather data on root cause of Trust related cases. This has been shared with our Clinical Care Group Commissioning colleagues who are leading on this Quality Premium and the aim is to continue to work collaboratively with our colleagues to identify how we can meet this reduction target. BSUH specialities including neonatology, intensive care and gastroenterology have been asked to consider how they would reduce Gram-negative blood stream infections within their specialities as well as involving our urological colleagues where the current majority of these Gram-negative blood stream infections arise.

## Learning from Deaths

In line with National Guidance on Learning from Deaths, the Trust has processes in place to review the care of patients who die in hospital. The Trust Mortality Review Group (TMRG) oversees the implementation of this process. Deaths are reviewed using the Structured Judgement Review Tool developed by the Royal College of Physicians and reported in line with the National Guidance. Deaths of patients with a Learning Disability are referred to the Leder Programme.

Learning from reviews is shared with the team who cared for the patient. The TMRG have implemented an electronic system using DATIX to capture learning from the reviews to facilitate further analysis and reporting.

The Trust has a Medical Examiner system based at the RSCH, where all deaths are independently reviewed and referred for SJR as appropriate. The TMRG are actively working to extend this system to the PRH site.

## Seven-Day Service Commitments

BSUH is expected to fulfil the Seven Day Service standards for all admitting specialities by 2020. Current performance (October 2017) is given in the table below:

	Standard 2 (Consultant Review)	Standard 5 (Access to Diagnostics)	Standard 6 (Consultant Directed Interventions)	Standard 8 (Ongoing daily consultant reviews)
BSUH	68%	100%	94%	91%
National Average	72.3%	95.9%	93.5%	85.2%

Key to meeting this priority is our project on patient flow which is ongoing and will result in increased capacity, quality and better patient care. This includes redevelopment of the acute floor, investment in staffing and other components such as reinforcing Hospital at Home. The project is well designed, including significant input from senior clinical leadership and has the commitment of the Executive Team and Chiefs.

Workforce planning will enable BSUH to meet the challenges of providing both initial and ongoing senior review. The newly formed Workforce Efficiency Working Group will be finalising our new and robust and innovative job planning processes and considering new ways of working in response to risks surrounding these projects relating to availability of appropriately skilled professionals; both non-medical and medical. The latter will be partly mitigated by changes in working patterns, development of new roles such as physician assistants and nurse practitioners and increased multidisciplinary team working particularly in areas experiencing difficulty in recruitment such as Emergency Medicine, Acute Medicine and Frailty, but also affecting some other medical specialties.

### BSUH Patient First Programme

We recognise that the strength of our hospitals lies in our staff, and have built an organisational culture that empowers teams and individuals to make lasting changes that benefit our patients and community. To do this, we have developed Patient First – the Trust's bespoke approach to sustaining a culture of continuous improvement.

Patient First is a programme based on Lean thinking, standardisation, system redesign and ongoing development of care pathways, built on a philosophy of incremental and continuous improvement by front-line staff empowered to initiate and lead positive change. We describe the structure and focus of Patient First in the form of a triangle (see section 1).

The Patient is at the apex to make explicit the commitment that everything we do should contribute to improving outcomes and experiences for the people we care for. This is the 'True North' of our organisation.

### CQC Rating

The CQC revisited the organisation in 2017 to review progress against the 2016 Quality Improvement plan. Professor Sir Mike Richards noted in the report that *'There is no doubt that improvements have been made since our last inspection and that the staff involved in the delivery of that change should be congratulated. However, there remains an extensive programme of change to be delivered in*

*order to attain an overall rating of good.* He recommended that the Trust remain in ‘special measures’ as this will ‘*provide time for the leadership to become embedded and that the outstanding patient safety, culture and equality issues are addressed*’. The overall ratings for RSCH and PRH moved to ‘Requires Improvement’ with both Stroke services and Children’s services noted as being ‘Outstanding’.

## True North

Our top priorities relate to the Trust’s ‘True North’ quality and safety improvement metrics. These establish a measure of our organisational health and provide a system-wide improvement focus – the ‘Golden Thread’ linking the organisation’s most important goals from clinical areas to the executive board.

As a Trust, we know that the people who often have the best knowledge, ability and capability to make real long-lasting improvements to the care of our patients are those who are providing that care – our staff. We also know that our staff are so busy managing the day-to-day workload of a busy acute hospital that there is no time to take a step back to identify and make the improvements that are needed.

During 2016, the Trust established the BSUH Improvement Academy offering a range of support for staff so they could use the best of what improvement science has to offer and share and celebrate the improvements that followed. Over 200 staff received training and support, encouraging them to take forward improvement opportunities.

Our longer term partnership with WSHT has enabled us to put this work onto a sustainable footing with a full commitment to roll out ‘Patient First’ providing a long-term approach to transforming hospital services for the better, empowering front-line staff to make improvements themselves by providing the training, the tools and the freedom to work out where the opportunities are, and the skills and support to make change happen and to make it sustainable.

‘Patient First’ is based on proven improvement methodologies, most notably the principles of ‘kaizen’ (or ‘continuous improvement’) and the Lean approach to management developed by the Toyota Motor Company and adapted successfully for use in healthcare by organisations such as the Virginia Mason Medical Center and Thedacare. Initiatives include:

- redesigning systems to take out waste and reduce the possibility of error, and
- standardising practices to make sure every patient gets a great service each and every time we see them.

## Part A – Summary of the Quality Improvement Plan (including compliance with national quality priorities)

The Quality Improvement Plan has programmes of work aligned to the Patient First Programme (strategic, breakthrough and operational objectives). These key priorities are:

1. **Safer Staffing** - Training, staffing numbers / skill mix, appraisals
2. **Patient Safety** - Support services across the week, patient flow
3. **Patient Environment** - Infection prevention and control, privacy and dignity, COSHH
4. **Medicines Management** - Safe storage of medicines, pharmacy services
5. **Governance** - Learning lessons from complaints and incidents, risk management and reporting, strategic planning
6. **Fire Safety** - Risk assessment and associated repairs / updates

## Part B – Summary of the Quality Impact Assessment Process

The Trust has, since 2012, followed guidance laid out by the National Quality Board to identify and risk assess potential cost improvement initiatives, predict their potential impact on quality and once implemented, monitor their actual impact.

The QIA process was updated at the commencement of the WSHT management agreement, internal policy mandates the assessment of all major projects and cost improvement initiatives under True North metrics – patient, systems & partnership, quality improvement and people. This assessment is an iterative process commencing at the outline/idea stage and progressing through quality gateways and a final review by the Chief Medical Officer and Chief Nurse prior to implementation, higher scoring QIA’s of 9 and above are also reviewed at Quality and Assurance Committee. A project can be rejected at any point throughout the quality assessment lifecycle.

The responsibility for conducting quality impact assessments and developing the key indicators to monitor project impact sits with the nominated team for each scheme/project. Written evidence of the project’s impact on the quality domains is captured in relevant documentation.

The Chief Nurse and Chief Medical Officer are responsible for the review of all QIA’s with recommendation for approval submitted to Quality and Assurance Committee.

The map below highlights the process followed for efficiency schemes and corporate projects:

### QIA Review and Reporting





## Section 3 – Demand, Capacity, Activity and Performance

The Trust is developing a comprehensive Trust wide activity plan reflecting current and expected levels of demand which is intended to be consistent with STP projections for the second year of the 2 year contract cycle. The plan is being triangulated with NHSE and CCG commissioners, with the aim of developing a single Integrated Trust Activity Plan (IAP) that incorporates the commissioning intentions of both provider and commissioner at Point of Delivery (POD), commissioner and specialty level. The plan will incorporate tariff uplift where appropriate, agreed levels of growth and a limited number of specific commissioned service developments.

The collective intent of all partners is to ensure that the plan is robust; reflects expected levels of demand, underpins delivery of the Trusts' control total and the planning assumptions associated with emergency care and RTT highlighted in the joint Planning Guidance published in February 2018.

To achieve this aim, the Trust is currently finalising the demand and capacity implications required to support these assumptions in order to identify 'by exception', areas of concern or unmitigated risk. This exercise will clarify on-going material mismatches between capacity and demand that will continue to require a collective, system-wide solution and shared 'whole system' enablers such as the following (Central Sussex Alliance Operating Plan):

Examples of Whole System Enablers - Unscheduled Care:

- Revised front door pathways and primary care streaming in Trust EDs
- Reducing mental health referrals to A&E via enhanced specialist mental health access
- A 28% increase in the proportion of NHS 111 calls dealt with by a clinician
- Redevelopment of the Emergency Department and implementation of discreet Ambulatory Care and Assessment facilities at the Royal Sussex County Hospital
- Trajectory to deliver a max of 3.5% DToC

Examples of Whole System Enablers - Scheduled Care:

- Increased scope of the Advice and Guidance service enabling GP access to Consultant expertise
- Revised clinical pathways and new models of care (which reduce avoidable delays and inefficiencies) such as: one stop services, telephone follow ups and straight to test diagnostics
- Revision of prior approval policies for specific procedures and conditions
- Robust adherence to clinical guidelines in order to reduce unwarranted variation

### Part A: Methodology

A shared planning methodology to formulate the IAP is being used by both Trust and commissioner(s) which incorporates a shared view of Forecast Outturn as the activity baseline. This has been uplifted for anticipated in-year demographic and population related growth and adjusted further for any specific growth/service development reasons where this is material such as further Major Trauma Centre (MTC) related repatriation. Currently, NHSE growth assumptions for

Specialised Services are lower than Trust expectations and this is shortly to be reviewed by both parties.

Targeted specific growth for some Specialised service with acknowledged growth models such as; Chemotherapy and Radiotherapy is expected to be applied to the baseline at POD and Specialty level prior to contract sign off. The Trust IAP will be refined further to incorporate the relatively small number of FYE impacts of agreed business cases/service developments which are 'shared goals' and therefore a component of the 18/19 planning round. In addition, a number of 17/18 commissioner attribution issues that followed the NHSE IR changes are, expected to be resolved subject to 3 way agreement.

A revised RTT trajectory is being re-evaluated against a bottom up assessment of capacity and specific areas of significant mismatch between supply and demand will be appraised with CCGs to assess the best way of managing demand going forward and may include further planned use of the independent sector.

**IAP Considerations - Summarised**

- Demographic Growth
- Targeted growth
- NG12 demand impact
- FYE of service developments/service changes e.g. Radiotherapy
- New Models of Care e.g. one stop clinics
- RTT/Cancer targets – activity required to deliver performance
- The anticipated impact of commissioner QIPP
- Tariff uplift
- Capacity Constraints

## Part B: Commissioning (Contract) Offers

At the time of writing, the Trust is working through a number of options in relation to formulating a contractual agreement around an Aligned Incentive Contract (AIC) model with CCGs. This is likely to reflect differing expectations with regard to the impact of commissioner led QIPP and other associated areas requiring an approach to the management of risk across all partners.

The Trust has been in negotiation with NHSE regarding the 2017/18 year-end financial agreement for the Specialised Services contract and is in the process of re-working its expectations following the outcome of this work for 2018/19. At the time of writing, both Trust and commissioner remain committed to resolving material differences as part of the on-going negotiation and mitigating material risks where possible.

The Trusts other key contract negotiations with for example, Public Health England and the Sussex Musculoskeletal Partnerships are nearing completion and expect to be concluded within the next few weeks.

## Part C: Productivity Improvements

Productivity improvement and operational efficiency will be a key focus for the Trust in 2018/19. The Trust is using Model Hospital comparator data, Civil Eyes, and an embedded service line management approach to target opportunities for improvement at service level and will incorporate efficiencies into the activity profile where appropriate. Through improved benchmarking, medicines optimisation, 'Right-care' and the 'Getting it Right First Time' programmes the Trust is focusing on delivering improved efficiency and productivity gains arising from new care models, improved job planning and the impact of digital technology.

## Part D: Capacity, Beds and Performance

Three years ago the LHE undertook a joint capacity planning exercise using consultants Ernst and Young. This was updated in 2016 and continues to identify a shortfall of 40-50 beds, in addition to seasonal variation of 40 beds (20 per site) during winter. Work undertaken for the East Surrey and Sussex STP by Carnall Farrar calculated the current capacity gap at 78 beds. This acknowledged capacity shortfall continues to represent the biggest single risk to the Trusts operational recovery plans during 2018/19.

In addition to the above, the Trust has extensively used the IMAS Capacity/Demand modelling tools across a range of specialties. The capacity demand shortfall remains a significant risk to the RTT recovery and sustainability plan and is reflected in final trajectories and the associated activity plan.

The Trust, in conjunction with LHE partners and commissioners will closely monitor activity levels during the year and will initiate a joint analysis and investigation if activity increases unexpectedly beyond a 5% threshold. The investigation will seek to understand the causation and recommend risk mitigations to established LHE governance groups.

## Access Targets

The Trust has submitted the following trajectories for performance against key metrics for 2018/19. These are the Trust components of the wider Local Health Economy plans to deliver on the key access targets in line with the national planning requirements.

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
<b>A&amp;E 4-hour Performance</b>	82.9%	83.9%	83.6%	84.3%	83.6%	86.7%	87.4%	86.8%	82.8%	85.7%	88.0%	92.1%
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
<b>RTT incomplete Performance</b>	84.0%	85.0%	85.7%	85.9%	85.7%	84.9%	85.0%	85.2%	83.4%	83.5%	83.0%	83.0%
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
<b>Cancer 62 Days Performance</b>	80.1%	81.1%	81.9%	85.0%	85.0%	85.3%	85.3%	85.0%	85.0%	85.0%	85.3%	85.1%
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
<b>Diagnostics over 6 weeks</b>	6.5%	4.5%	3.2%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%

A range of actions are being implemented to support the delivery of agreed access trajectories and improved performance. These include:

- The development of speciality or modality level trajectories with supporting action plans for RTT, Cancer 62 day target and diagnostics.
- Enhanced weekly/daily delivery groups.
- On-going thematic breach reviews to identify improvements in A&E.
- The Implementation of an enhanced operational governance and assurance framework for all patient access standards in line with best practice as defined by the Good Governance Institute.
- Implementation of a clear divisional Strategy Delivery Review (SDR) performance management framework.

## Winter Resilience

The following plans will support service and flow improvement in time for winter 18/19:

- Expanded emergency ambulatory centre (completed and opened in March 2018).
- ECIP supported pathway improvements.
- An expansion of the step down facilities located in Newhaven.
- Reconfiguration of existing services to deliver 30-35 additional beds in time for next winter.

In addition the Trust has longer term plans in place to deliver significant improvements to the A&E department and provide additional bed capacity at the RSCH site. The plans are complex and will deliver the following:

- A significant refurbishment and increased capacity of the Emergency Department, including increased Resus Capacity and more PATing areas; to be delivered during 2019.
- An additional short stay bedded facility with a capacity of 70 beds; to be delivered in 2019.



## Section 4 – Workforce Planning

### Workforce Position

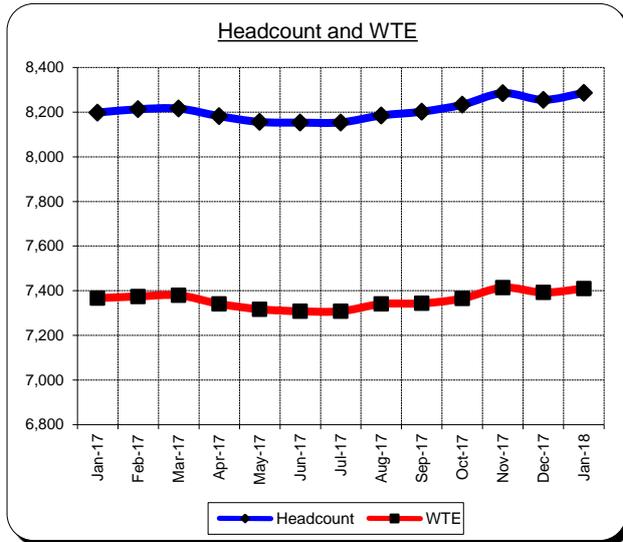
The Trust’s budgeted workforce establishment is 8,214 WTE (with 7,410 WTE in post as at 01/2018).

- Establishment WTE and headcount have remained broadly stable over the last 12 months.
- The overall vacancy rate has returned to 10.5%, although with marked differences between staff groups (from 7% vacancy in Medical to 19% in Ancillary Support).
- Staff mix (as a proportion of the total workforce) has also remained relatively static (+/- 1% point).

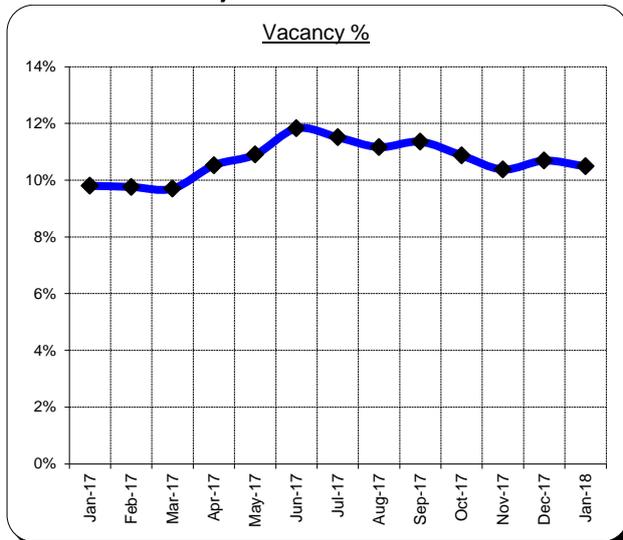
#### Staff Mix as % Total Workforce 2017-2018 (by % point variance)

Staff Mix by Type	Jan-18	Jan-17	Variance
Other Support Staff	9.0%	8.2%	0.9%
Support Staff	9.8%	9.0%	0.8%
Unregistered Nurse	11.5%	10.8%	0.7%
Qualified AHP	5.1%	4.9%	0.1%
S, T & T	15.6%	15.5%	0.1%
Qualified Healthcare Scientist	3.6%	3.5%	0.1%
Registered Midwife	2.7%	2.7%	0.0%
Consultant (Deanery)	0.0%	0.0%	0.0%
SAS Doctor	0.6%	0.6%	0.0%
A & C Management	1.8%	1.9%	0.0%
Qualified Other S,T&T	3.2%	3.3%	0.0%
Consultant	6.3%	6.3%	0.0%
Nursing	42.5%	42.6%	-0.1%
Maintenance & Works	0.7%	0.8%	-0.1%
Unregistered S,T&T	3.7%	3.8%	-0.1%
Training Grade Doctor	8.1%	8.2%	-0.1%
Medical	15.0%	15.1%	-0.2%
A & C Staffing	15.3%	15.9%	-0.6%
Admin & Clerical	17.1%	17.8%	-0.7%
Registered Nurse	28.3%	29.1%	-0.8%

### Headcount and WTE 2017-2018



### Overall % Vacancy 2017-2018



## Workforce Challenges

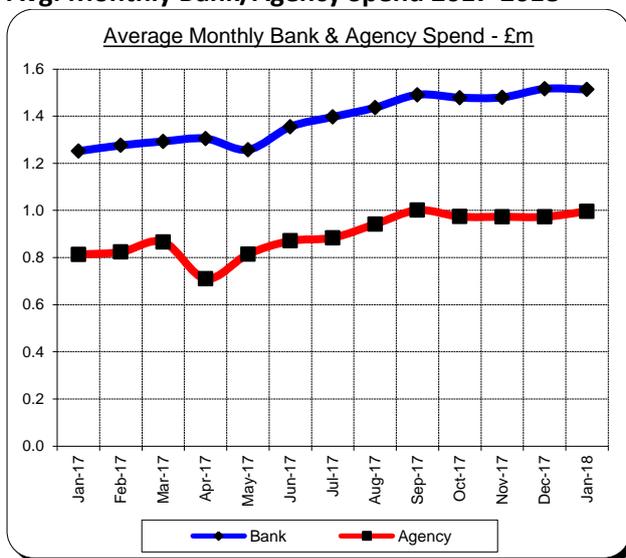
In common with other NHS organisations, the Trust faces a number of workforce challenges, including supply-side constraints (eg. EU applications, UK graduates), an ageing workforce, and securing temporary staffing to maintain safe services/patient flow within a pay cost envelope. In addition, the Trust has a number of specific local challenges, including:

- High cost of living in Brighton and mid-Sussex;
- Relatively sparse population in mid-Sussex (for the Trust's Princess Royal Hospital site, esp. for entry-level roles), and easy access to London and other NHS providers with Outer/Fringe London Weighting;
- Reduction in the number of medical training posts (eg. transfers to Primary Care and Mental Health);

- The reputational challenge of an organisation currently in financial and quality Special Measures (although with significant opportunities through the partnership/shared leadership with Western Sussex Hospitals NHS FT – rated as CQC ‘outstanding’).

In addition, the £485m capital redevelopment of the Royal Sussex County Hospital in Brighton (‘3Ts’) is underway, and Stage 1 will be complete and ready for occupation in 2020/21. This will transform the quality of patient and staff accommodation, and will also deliver a step-increase in capacity, including in some of the hardest-to-recruit specialties (eg. Critical Care). Ensuring that the benefits set out in the 3Ts Full Business Case will be realised in full will require a structured approach to workforce/service change, planning, and integration into business as usual will be refined during 2018/19.

### Avg. Monthly Bank/Agency Spend 2017-2018



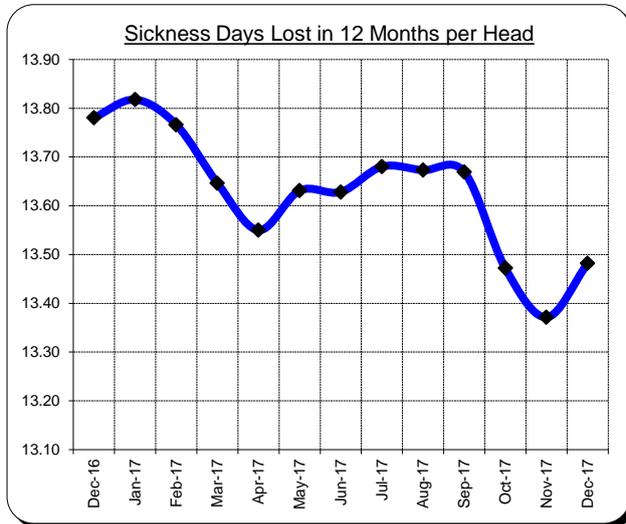
During 2017/18 an Executive Director-led Efficiency & Workforce Combined Steering Group has been overseeing a programme of work to improve sickness absence, turnover and other key HR metrics. Against the workforce backdrop described above, the Trust considers that improvements achieved have been significant, although with considerable further progress required during 2018/19 to support its True North/Breakthrough objectives (eg. staff engagement, financial sustainability).

Of note:

- Although the Trust has seen a slight increase in its overall vacancy rate (from 9.8% in January 2017 to 10.5% in January 2018), this encompasses a reduction in nursing vacancies (from 10% to 9%) but a significant increase in Medical vacancies (from 4% to 7%) over the period.
- The Trust 12 month sickness absence rate has reduced from 4.28% in December 2016 to 4.24% in December 2017.
- Overall turnover (external leavers) was 14.1% as at January 2018 and has remained broadly level across the 12 month period – although with a reduction in Nursing (by 1.7% points in January 2017 to 13.3% in January 2018) and an increase in Medical (by 2.4% points in January 2017 to 10.7% in January 2018). Benchmarking remains challenging. Association of UK University Hospitals (AUKUH) data (December 2017) indicated an average turnover of 12.1% among teaching hospitals (although the rates

ranged from 4.9% to 22.8%). University Hospitals Southampton NHS FT, which is often seen as BSUH's nearest comparator, reports a turnover of 12.9%.

### Sickness Absence (Days Lost) 2017-2018



### Staff Turnover 2017-2018



## Workforce Planning & Triangulation

During 2017/18 the Human Resources/Workforce Intelligence team has continued to work with Clinical and Corporate Directorates on a rolling five-year workforce demand forecast. This provides a wider context for planning and in particular for transition of services to 3Ts Stage 1 (from 2020/21).

These bottom-up workforce projections are being triangulated (eg. with activity/capacity, affordability, wider Trust strategy) through a series of structured processes in incremental levels of detail (aligned to the respective planning horizon):

- The refresh of the **Trust's Clinical Strategy** (due to be presented to the Board of Directors by October 2018), for which workforce supply is likely to be a significant consideration.
- The refresh of the **Trust's Medium-Term Financial Plan (MTFP)**, which has a three to five year planning horizon.
- **Workshops with key 3Ts Stage 1 clinical services** – to further test their workforce projections against the 3Ts floorplans (incl. through innovative use of the Virtual Reality environment), and establish a detailed Workforce/Service Change Plans to 2020/21.
- The **Operational Plan**, which details planned workforce changes in 2018/19 arising from Cost Improvements (CIPs), and Service Developments (as shortlisted for detailed business case consideration, and subject to final approval).

## Workforce Transformation

The Trust's Workforce Transformation Programme, which comprised c. 20 projects evaluating the Return on Investment and wider benefits of new and extended staff roles, concludes at the end of March 2018. This has benefited from investment from HEE KSS (Health Education England working across Kent, Surrey & Sussex), in particular the Health & Social Care Integration Innovation Fund, and the KSS Academic Health Sciences Network (KSS AHSN), and from wide partnership working (eg. Skills for Health, Skills for Care, Brighton & Hove City Council, neighbouring NHS Trusts/FTs). Findings have contributed to the emerging workforce strategy supporting the SES STP (Sussex & East Surrey Sustainability & Transformation Partnership).

Developments have included:

- Band 2 Clinical Technologists (to replace longstanding Healthcare Assistant vacancies).
- Band 3 Clinical Assistants (to support medical trainees in General Surgery).
- Band 4 Assistant Practitioners in Nursing and Scientific & Technical roles (and in preparation for the new Nursing Associate role).
- Physician Associate trainee placements (in partnership with Brighton & Sussex Medical School) and Band 7 substantive roles.
- Band 8a+ Advanced Clinical Practitioners (eg. to fulfil roles previously undertaken by CT1-3 medical trainees).

These have demonstrated a range of benefits, including cost reduction, enhanced recruitment, widening participation, staff engagement/job satisfaction, freeing up time to care – and time for eg. medical trainees to undertake training.

## 2018/19 Priorities

We are committed to improving staff engagement as an integral part of our Patient First programme. We have put in place a structured approach to embedding the organisations Vision and Values, improving the experience of staff through an Equalities and Inclusion programme, improving retention and investing in Leadership and management development.

The Trust is seeking to make substantial improvements during 2018/19 in the key performance indicators given below. These indicative targets will be reviewed and formalised as the supporting work programmes develop.

**Workforce Targets/Key Performance Indicators (KPIs) 2018/19**

Measure	Mar-18	Mar-19
Staff Turnover %	14.0%	11.0%
Short Term Sickness Absence %	2.0%	1.6%
Long Term Sickness Absence %	2.2%	1.9%
Total Sickness Absence %	4.2%	3.5%
Vacancy Rate %	10.5%	9.0%
AfC Appraisal Rate %	78.0%	90.0%
Medical Staff Appraisal Rate %	100.0%	100.0%
Mandatory Training Completed %	81.0%	90.0%

The Trust’s 2018/19 workforce priorities are underpinned by detailed Action Plans (incl. targets and trajectories) and are supported by the Programme Management Office (PMO). In summary, priorities are:

- Continuing focus on **workforce efficiencies**, with use of the Model Hospital for benchmarking.
- Targeted work with key staff groups and services to address specific **recruitment & retention** challenges.
- Trust-wide and targeted work to improve **Staff Engagement** (incl. addressing results of the NHS Staff Survey). This has been set as a BSUH **True North objective** – meaning that it is not only a key corporate target/priority, but also that other corporate activities (eg. 2018/19 Service Development proposals) are aligned/harnessed to also support Staff Engagement.
- **Strategic planning for future workforce**. This includes staffing for the ED/Acute Floor expansion (due to come on stream fully in 2019/20) and 3Ts (the Stage 1 building is on track to open in 2020/21).

**Workforce Efficiencies**

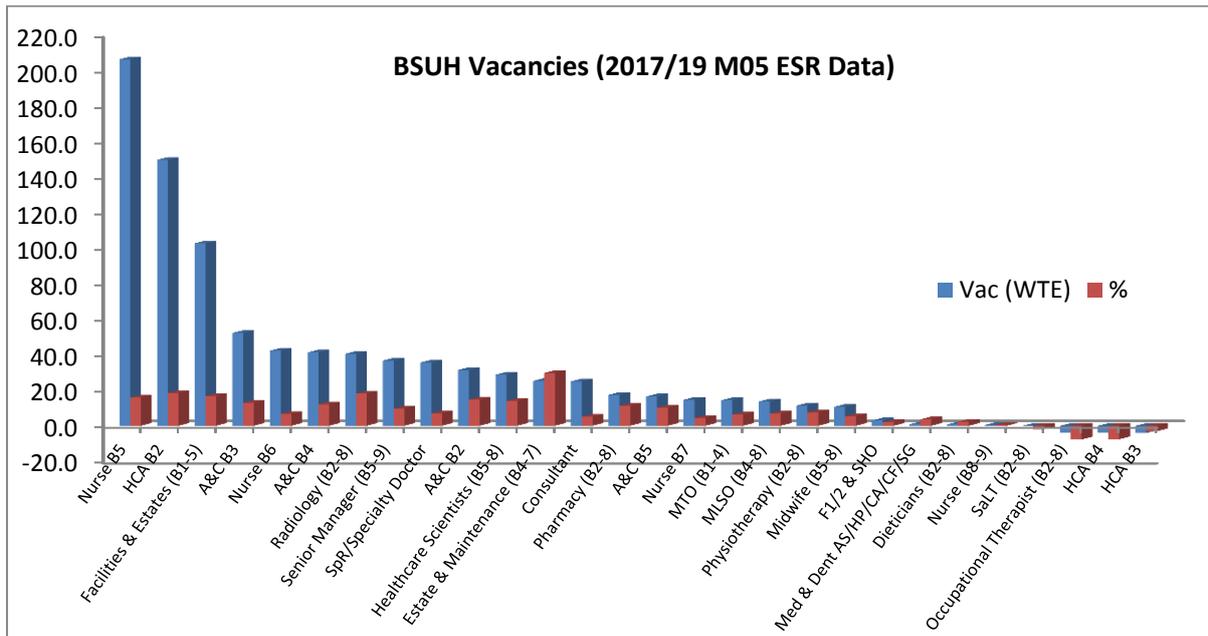
In 2018/19 the Trust will continue to focus on workforce efficiencies, with use of the Model Hospital for benchmarking. This will include:

- Rostering practice/e-rostering, strategic shift from agency to in-house staffing (incl. reduction in use of non-framework agencies, incentivising Bank rates), job planning;
- Sickness absence, turnover, workforce/workflow redesign, and the ‘engagement dividend’;
- Strategic in-sourcing or out-sourcing, back office cost reduction.

**Recruitment & Retention**

The Workforce Efficiency Working Group (WEWG) is supporting Nursing (for both Registered Nurses and Healthcare Assistants/unregistered workforce) and Facilities & Estates (in particular Soft Facilities Management, eg. Housekeepers) to address recruitment, retention and sickness absence.

In prioritising focused action to address recruitment and retention/external turnover challenges within individual services, BSUH is prioritising staff groups (i) where the absolute number of vacancies (WTE) is high, but also (ii) where vacancies (as a proportion of the staff group) are high, and will therefore have a disproportionate impact on service provision. This is shown in the graph below.



In summary, this includes:

- Proactive advertising/marketing and community outreach to promote NHS/BSUH roles (with a focus on widening participation, in line with HEE's 'Get In, Get On, Go Further' strategy).
- Pool/'one stop shop' recruitment days for priority staff groups (Registered Nurses, Healthcare Assistants, Soft FM staff) – to increase efficiency/reduce dropout, and enhance the recruitment experience for applicants.
- New HR/Employment Services administrative processes (using the Trac system) – this has reduced time taken to get appointees into post from avg. 12-16 weeks to 30 days (as at February 2018, 80% of new appointees were in post within this target period).
- Greater focus on induction, staff development and ongoing support (eg. preceptorship programme, leveraging the Apprenticeship Levy), and new staff development opportunities (eg. rotational RN posts, which have built on learning from the Recruitment & Retention project at BSUH funded by HEE KSS in 2017/18, and the HEE/Clever Together 'Let's Work Together' retention project).
- Continuing International Recruitment (where the business case continues to demonstrate a net financial benefit, and subject to national directives).
- Planned increase in the number of nursing students/placements (by 50% for the September 2018 intake, working with the three Universities), and focus on a golden 'career pathway'.

The piloting of an e-rostering system for medical staff during 2018/19 (and plan to procure/roll this out Trust-wide and to all staff group thereafter) also presents a unique opportunity to learn from the multi-award winning approach to recruitment/rostering in the BSUH Emergency Department (eg. annualised hours, self-rostering).

### Staff Engagement & NHS Staff Survey

Staff Engagement has been adopted as a BSUH True North objective/key metric, and the 2017 Staff Survey results showed some 'green shoots' of recovery, including:-

- An overall response rate of 56.3% - a significant improvement on 2016 (39.9%) and in the highest (best) 20% of Acute Trusts nationally.

- An increase of 4% points in 'Care of patients/service users is the organisation's top priority' – a BSUH True North Breakthrough Objective.
- An increase (from 3.42 to 3.49) in 'Staff recommendation of the organisation as a place to work/receive treatment' – one of the nine questions comprising the overall Staff Engagement score.

Overall, BSUH remains in the lowest 20% of Trusts nationally for staff engagement. In response, the Trust has developed a **Culture, Leadership & Workforce (CLW) Programme** (as presented to the Quality Oversight Committee in December 2017), and this will continue to be implemented in 2018/19. Each strand of work is supported by a detailed PID (Project Initiation Document), with relevant metrics/targets. Workstreams include:

- Equality, Diversity & Inclusion
- Staff Engagement
- Staff Health & Wellbeing
- Appraisal
- Managers' Conference & Leadership

BSUH also aims to be an inclusive 'employer of choice' for eg. LGBTQ+ and BME applicants, recognising its local demography and the recruitment opportunity this represents. Examples:

- The CLW programme includes engaging People Opportunities (an external specialist consultancy) to work with BSUH and its LGBTQ+ Staff Network to refresh the work programme and resourcing.
- BSUH has also agreed to re-enter the annual Stonewall Workplace Equality Index from 2018/19, with a clear ambition to be recognised as a Top 100 Employer by 2019/20.

The rollout of the **Patient First Implementation System (PFIS)**, learning from the WSHFT experience, also creates a virtuous circle of engagement and contribution to service/workplace improvements – as part of the overall **Patient First** programme.

### **Strategic Workforce Planning**

Although outside the planning horizon of the Operational Plan, in 2018/19 work will continue with Clinical and Corporate Divisions to ensure strategic planning for future workforce, and in particular adoption/diffusion of workforce innovations (new roles) aligned to Professional Workforce Strategies. Priorities include planning for:

- The changes in staffing for the ED/Acute Floor expansion (due to come on stream in 2019/20)
- 3Ts Stage 1 (on track to open in 2020/21)

to ensure that the planned workforce increases are affordable within the financial envelope and realistically recruitable, and that the investment objectives/benefits set out in the respective Full Business Cases (FBCs) will be delivered in full.



## Section 5 – Finance Planning

The Trust is in Financial Special Measures and is reporting a deficit in 2017/18 of £65.3m, excluding the £1.5m benefit of winter funding tranche 1 and £8.28m of Sustainability and Transformation Funding (STF) notified at the end of the year. The financial plan reflects actions being taken to continue stabilising the financial position whilst improving core access and quality standards for patients. The planned deficit for 2018/19 is £65.4m, in line with the agreed, revised control total deficit. The original control deficit was £7.6m, including receipt of £14.6m of STF. STF has now been replaced by the Provider Sustainability Fund, but the plan does not recognise receipt of any of this in 2018/19. The plan does not assume exit from Financial Special Measures in 2018/19 and hence the interest rate on liquidity financing is assumed to remain at 3.5%.

The financial plan is as follows:

£m	17/18 Plan	17/18 Outturn *	18/19 Plan	18/19 Plan v 17/18 Outturn
Income	557.54	553.12	576.64	23.51
Operating Expenditure				
- Pay	(365.68)	(360.47)	(375.78)	(15.31)
- Non-pay	(217.92)	(222.64)	(224.85)	(2.20)
- Sub-total	<u>(583.61)</u>	<u>(583.11)</u>	<u>(600.62)</u>	<u>(17.51)</u>
Non-operating Costs				
- Depreciation	(22.60)	(19.91)	(21.78)	(1.87)
- Impairments	(15.50)	(8.95)	(10.00)	(1.05)
- Interest	(10.86)	(9.95)	(12.12)	(2.18)
- PDC	(6.34)	(5.11)	(5.41)	(0.31)
- Other gains/(losses)	0.00	0.03	0.00	(0.03)
- Sub-total	<u>(55.30)</u>	<u>(43.88)</u>	<u>(49.31)</u>	<u>(5.44)</u>
Total	<u>(81.37)</u>	<u>(73.86)</u>	<u>(73.30)</u>	0.56
Technical adjustments	16.02	8.52	7.90	(0.62)
Net deficit	<u>(65.34)</u>	<u>(65.34)</u>	<u>(65.40)</u>	<u>(0.06)</u>
<b>EBITDA</b>				
Income	557.54	553.12	576.64	23.51
Adjust for donations	(0.30)	(1.04)	(2.60)	(1.56)
Adjusted income	557.24	552.09	574.04	21.96
Operating expenditure	<u>(583.61)</u>	<u>(583.11)</u>	<u>(600.62)</u>	<u>(17.51)</u>
EBITDA	<u>(26.37)</u>	<u>(31.02)</u>	<u>(26.58)</u>	4.44
EBITDA %	-4.7%	-5.6%	-4.6%	1.0%

\* Excludes £1.5m of winter funding tranche 1 and £8.28m of STF

The financial plan is risk rated as 4 because of the deficit plan and the impact that this has on financial efficiency.

The plan EBITDA percentage of -4.6 is an improvement on both the 2017/18 plan and outturn.

Non-operating costs increase from 2017/18 outturn by £5.4m up to £49.3m. Interest increases as a consequence of interest payments on capital and liquidity financing (at a rate of 3.5%), and depreciation also increases as buildings associated with the 3Ts and other developments come into

use. The level of impairments is uncertain at this time as it is dependent on the annual revaluation exercise, but the plan anticipates £10.0m, £1.1m more than in 2017/18 outturn.

The plan assumes that deficits will be backed by funding to maintain liquidity and this funding is subject to approval.

The key risks to the delivery of this plan are controlling pay costs, achieving the efficiency requirement, whilst meeting performance targets, and reaching income agreements with commissioners to secure the level of income included. There are governance processes in place to manage these risks.

## 2017/18

The deficit for 2017/18 is £65.3m, excluding winter funding tranche 1 funding and STF, which meets the revised 17/18 control total deficit of £65.4m. The reported deficit including winter funding tranche 1 and STF is £55.6m. While the control total has been met overall, there are issues of underachievement of contract income and non-pay pressures; these are being offset by pay and non-operating cost underspends.

## Assumptions

The 2018/19 planning assumptions reflect national guidelines and local pressures:

- Generic tariff inflation of 0.1% with the Market Forces Factor remaining at 7.4%.
- Cost inflation increases as follows: pay 2.1%, non-pay (excluding CNST premium) 2.1%
- Increase in CNST premium: 11.6%
- No financial penalties imposed by commissioners, including 100% payment of CQUIN.

These assumptions are modelled in the accompanying financial plan template.

## Activity

Activity plans reflect current and expected levels of demand consistent with the STP projections. They also include additional activity in order to meet the national requirement for RTT waiting list sizes not to increase between March 2018 and March 2019. The financial plan includes the anticipated cost consequences of delivering the planned level of activity.

The risks to delivering activity relate to the ability to effectively utilise available capacity.

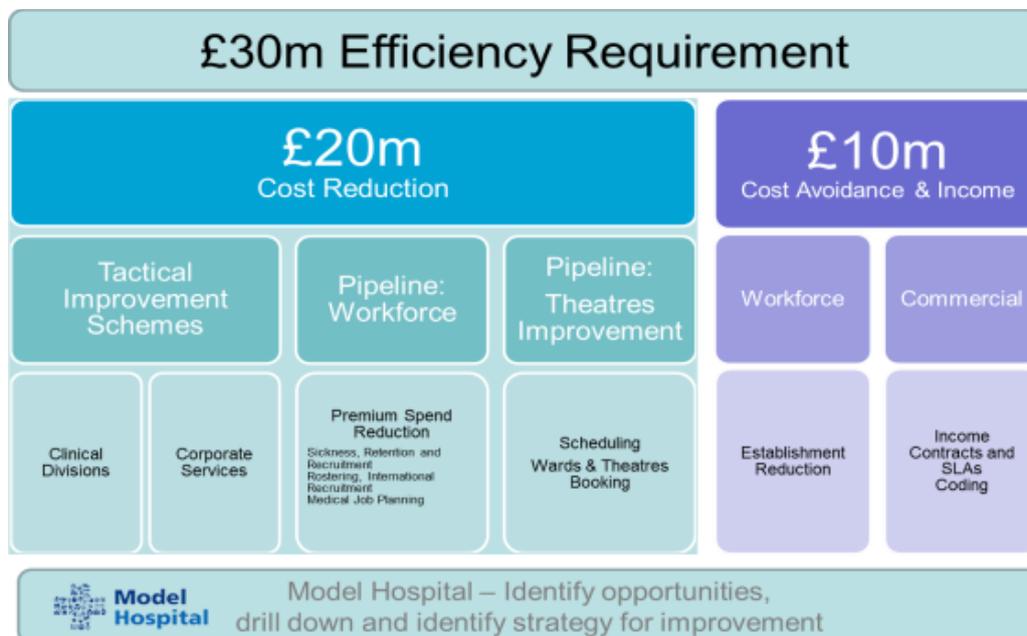
## Cost Improvement Plans

Cost improvements of £30m are needed in 2018/19 (£20m cost reduction with a further £10m to be identified via cost avoidance). This level of saving is required to meet the control total for both 2017/18 and 2018/19 and delivers the savings required through changes to tariff.

We are focused on the development and delivery of robust efficiency savings programmes, primarily in relation to cost reduction across both pay and non-pay rather than through increases in income. BSUH has adopted the WSHT approach to efficiency development as illustrated below, to ensure all opportunities are identified, developed and delivered via a consistent and agreed approach.



The diagram below illustrates the construction of the BSUH efficiency programme:



The cost avoidance and income is currently subdivided as follows:

Type of Efficiency	Description	Plan
Non-operating expenditure reduction	Linked to capital plan and associated capital charges (Low Risk/Non Pay)	2,933
Inflation avoidance	Pay and non-pay cost avoidance linked to tariff inflation assumptions (Low Risk/Procurement)	2,000
Long term vacancy	Removal of long term vacancies that have not	2,169

removal	been backfilled historically to mitigate future pay growth and address CIP shortfall in 17/18.(Medium Risk/workforce other)	
Income opportunities	Limited to identified opportunities in relation to PbR exclusions order, capture and reporting. Limited contribution from growth in specific areas that match commissioning intentions. (Medium Risk/Income)	500

The cost reduction programme will be delivered via a blend of low complexity tactical schemes which will enable delivery in the first part of 2018/19 with a smaller number of more complex improvement projects including Theatres Improvement and Job Planning which are intended to improve productivity later in 2018/19 and beyond. Workforce efficiency schemes will focus on premium cost reduction and will be supported by cross cutting enablers to be delivered via Workforce Efficiency Steering Group including e-Rostering roll out for all staff groups, productive job planning, implementation of premium workforce trackers and continual review and response to workforce dashboards.

It is intended to focus on these few high potential areas of saving rather than dissipate effort across a plethora of small schemes.

The Model Hospital (and previous Carter work) has identified a number of areas (including the above) which provides useful triangulation for the identification of high cost areas. Benchmarking data is being used in conjunction with internal datasets to gain a greater understanding of where the Trust can bear down on areas of apparent high costs and variation.

There are multiple risks to delivering plans which will be managed by following an established development, review and implementation process supported by the Trusts PMO with assurance reporting on a monthly basis via an Executive led Efficiency and Workforce steering group into a Trust Board subcommittee.

The current values categorised by risk of delivery are as follows:

Risk of Delivery	£000's
High	13,274
Medium	7,551
Low	9,175
<b>Grand Total</b>	<b>30,000</b>

NB High risk schemes are formed of:  
 - £5.719m confirmed schemes with complex delivery  
 - £7.556m which will fully mature in April/May, do not expect the full value to remain at high complexity. Timing of profiles reflects this.

The Trust acknowledges the level of risk involved in delivering the plans, these are realistically categorised to ensure the appropriate level of visibility and scrutiny to manage delivery. To manage risk the Trust continues to utilise the following tools to ensure that high risk schemes are fully articulated and delivered as required:

Deployment plans and roadmaps: Each scheme has a standard PID which includes deployment plans which are closely linked to scheme by scheme roadmaps which are routinely reporting from

fortnightly assurance meetings up to board committees. The roadmaps are simple but focused actions/decisions which are performance managed by visual trackers.

Performance Trackers: A formal summary of performance by scheme is reported on a monthly basis via two specific trackers.

- A Performance/Highlight report managed by the PMO shows schemes performance using standardise RAG ratings, delivery against leading and lagging non-financial KPIs and performance against roadmaps (see above). The PMO supports responsible areas to populate this report to ensure that mitigation (if required) is clearly articulated along with improvement actions.
- A Finance Tracker – a tracker which will contain phased profiles at cost centre level is managed by the finance department to ensure that delivery is tracked and reported in a standardised manner, this is aligned to the latest NHSI categorisation of efficiency schemes.

The full year effect (or carry forward from 17/18) is £2.6m which consists of low risk schemes that have delivered in the previous financial year accompanied by over programming and development of pipeline schemes including job planning and theatres improvement will provide mitigation to risk and new schemes for future years.

The construction of the cost reduction and cost avoidance plan by NHSI savings categories is as follows:

<b>NHSI Category</b>	<b>£000's</b>
Estates and Facilities	1,068
Income	1,262
Income NHS	515
Income Other	589
Medicines Management	1,009
Non pay	6,096
Procurement	6,373
Workforce - A&C	627
Workforce - AHP	149
Workforce - Ancilliary	284
Workforce - Medical	2,756
Workforce - Multiple	3,409
Workforce - Nursing	2,158
Workforce - Other	2,304
Imaging	32
Corporate and Admin	1,369
<b>Grand Total</b>	<b>30,000</b>

## Workforce / Pay

Pay cost assumptions are being developed through the workforce plan that will aim to support capacity modelling and the activity plan. The overall pay cost pressure will be offset by cost improvements.

The agency expenditure ceiling is £11.8m in 2018/19, £1m lower than in 2017/18; remaining in the ceiling will require a £1.0m reduction from the 2017/18 outturn of £12.8m. Monthly phasing of the agency ceiling has been amended in the updated plan so that the planned level of agency expenditure is within the ceiling each month, not just in total. Delivery will be supported by recruitment to substantive posts, including through international nurse recruitment, and the continued development of the e-rostering system.

## Capital

BSUH has a well-established Executive led Capital Investment Group. The purpose of this group is to coordinate the capital plan, ensuring effective control, prioritisation and use of capital expenditure. In an environment of scarce resources, the Capital Investment Group ensures investments are aligned with the Trust's True North objectives, and there is a systematic, consistent and 'risk based' approach to asset management and prioritisation of investments.

The Trust's capital plan is refreshed annually with robust process used to agree funding priorities, whilst balancing the need for significant investments in clinical service developments against investment in estates backlog maintenance, IM&T infrastructure and replacement medical devices. A programme of identified priorities is brought forward by clinical divisions, our estates and facilities division and corporate departments. Strategic business cases (SOC, OBC, and FBC) are prepared in line with best practise national guidance and scrutinised by the Trusts Business Case Scrutiny Panel and Capital Investment Group and Trust Executive Committee. In line with national guidance, business cases set out the strategic case for change, option appraisals, benefits of the investment, the economic case, workforce implications, affordability, feasibility, deliverability and an assessment of value for money.

An estates workstream prepares prioritised plans for investment in infrastructure, developed from a 6-facet survey and a review of risk and weaknesses in business continuity plans. These investments cover high and significant risks associated with, but not limited to, backlog maintenance and statutory compliance. National efficiency targets, such as the Carter report, are prioritised with asset management being one of the key workstreams in the Trust's Efficiency Transformation Programme. The estates workstream considers the best achievable performance from current and future investments in physical assets over their available life and ensures that assets are used efficiently, coherently and strategically to support identified clinical strategies and new models of care.

The Trusts clinically led Medical Devices and Equipment Management Group (MDEMG) produce a risk assessed and prioritised list of replacement medical devices based upon, but not limited to, divisional risk registers; clinical/patient safety risks; business continuity plans; service impact; maintainability and reliability.

The Trusts IMT strategy supports clinical delivery and sits alongside the national eHealth agenda. The IMT workstream is also responsible for undertaking a robust risk based assessment of priorities linked to the condition of the IT infrastructure, age profile of desktop computers and a strategic system development plan.

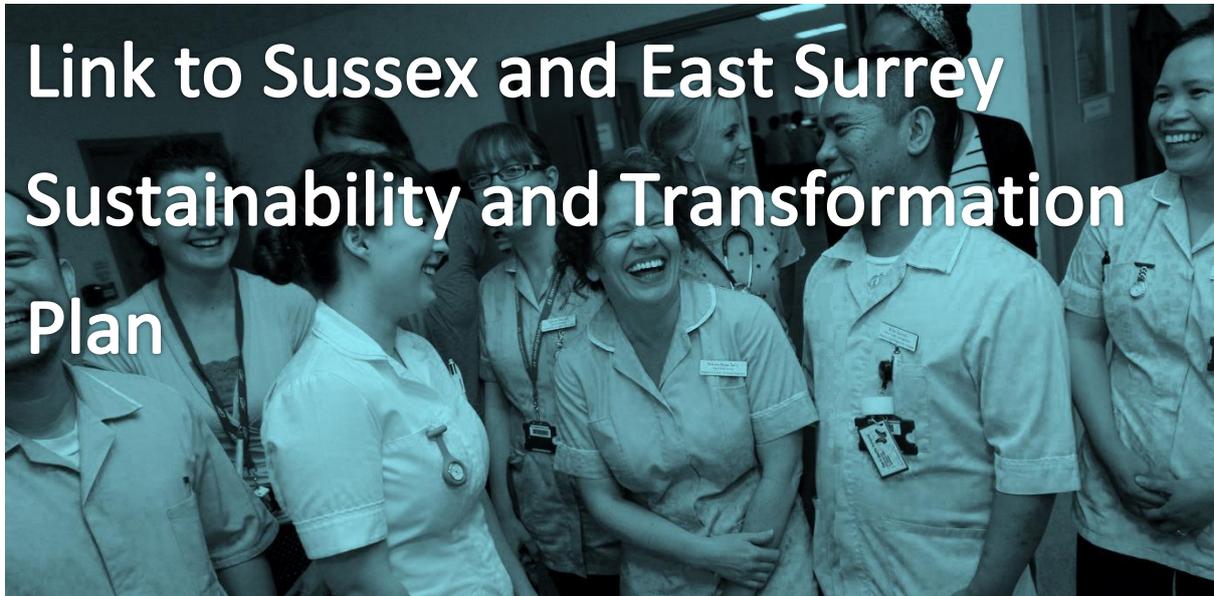
### Cash Flow Assumptions

The phasing of emergency funding and the funding for the ED department are below:

Cash Flow	2017/18	2018/19	2019/20
Emergency Department	£4.5m	£12.0m	£13.4m
Estates Backlog	£0.0m	£10.0m	£9.4m

### Liquidity

The deficit plan and the level of capital expenditure mean that the management of liquidity and funding is a continued priority in 2018/19. The planned funding streams are Public Dividend Capital (PDC) for the 3Ts development, revenue loans for the planned deficit and capital loans for the Emergency Department development, emergency backlog maintenance and pathology schemes.



# Link to Sussex and East Surrey Sustainability and Transformation Plan

## **Section 6 – Link to Sussex and East Surrey Sustainability and Transformation Plan**

In partnership with its partners, the Trust is progressing a number of strategic initiatives during 2017-2019 which are captured as part of our Strategic Initiatives and Corporate Projects. Of particular note is the need to:

- Ensure that BSUH continues to develop as a sustainable Major Trauma Centre (MTC)
- Progress the 3Ts Build
- Develop the Frontier Pathology Joint Venture
- Strengthen our clinical networks across Sussex
- Strengthen our Cancer services as part of a Surrey and Sussex Alliance