

3Ts Hospital Redevelopment Programme

Full Business Case

Strategic Case: Strategic Context



February 2016, v3

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| | Education Learning Strategy |
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Introduction

1. As set out in national guidance¹, the purpose of the Strategic Case is to demonstrate that the investment proposal provides business synergy and strategic fit (against national, regional and local priorities) and is predicated on a robust and evidence-based case for change. This includes the rationale for why intervention is required as well as a clear definition of outcomes (benefits) and the potential scope of what is to be achieved.
2. The Strategic Case and case for change were set out and accepted in the Outline Business Case (OBC). At Full Business Case (FBC) stage, the purpose is to demonstrate continuing strategic alignment, identify any material changes and provide further detail on implementation.
3. The FBC has been developed to align with the NHS Trust Development Authority (TDA) and NHS England (NHSE) Business Case checklists^{2,3} and supporting documents.

Opening Remarks

4. *‘The health and social care system is facing pressures from an ageing population and from increasing numbers of people with multiple, complex conditions... Investment in our health and care infrastructure is therefore crucial in order to modernise services and ensure that they are fit for the challenges of the 21st Century.’*

HM Treasury, 2013⁴
5. *‘The Royal Sussex is a great hospital, and testament to you and your staff, but as I clearly saw from my visit, the buildings and facilities need to be improved. That’s why I have given the green light to the £420m redevelopment plan for the hospital to bring the buildings and facilities up to modern standards and enhance and improve patients’ care and experience... It’s an ambitious project, but one which I am sure will be successful.’*

Chancellor of the Exchequer, May 2014⁵
6. *‘This redevelopment is good news for patients, not only in Brighton & Hove but across Sussex and the South East. It will represent a far better environment for patients and staff and make it easier to deliver the best and safest care.’*

Secretary of State for Health, July 2014⁶
7. *‘The older buildings and some aspects of the layout of the Brighton campus presented a significant challenge in delivering care, eg. patients could not be moved between buildings during bad weather... Staff were excited about the recent announcement of the £420m redevelopment of the Royal Sussex County Hospital site, which was described as a “huge boost”.’*

Care Quality Commission Quality Report, August 2014⁷
8. *‘I was delighted to visit the Royal Sussex County Hospital today, where I used to work... [This] will receive Government investment of £420m and be rebuilt to create the modern 21st Century hospital Brighton and the surrounding area deserves.’*

Health Minister, September 2014⁸

¹ HM Treasury (2013) *Public Sector Business Cases Using the Five Case Model: Green Book Supplementary Guidance on Delivering Public Value from Spending Proposals*

² NHS Trust Development Authority (June 2014) *Capital Regime and Investment Business Case Approvals: Guidance for NHS Trusts*

³ NHS England Project Appraisal Unit (November 2013) *Five Case Model Consolidated Business Case Checklist*

⁴ HM Treasury (June 2013) *Investing in Britain’s Future*

⁵ Rt Hon. George Osborne MP, letter to Trust CEO (10th May 2014)

⁶ Rt Hon. Jeremy Hunt MP, on a visit to the Royal Sussex County Hospital on 3rd July, 2014

⁷ Care Quality Commission (August 2014) *Brighton & Sussex University Hospitals NHS Trust: Quality Report*

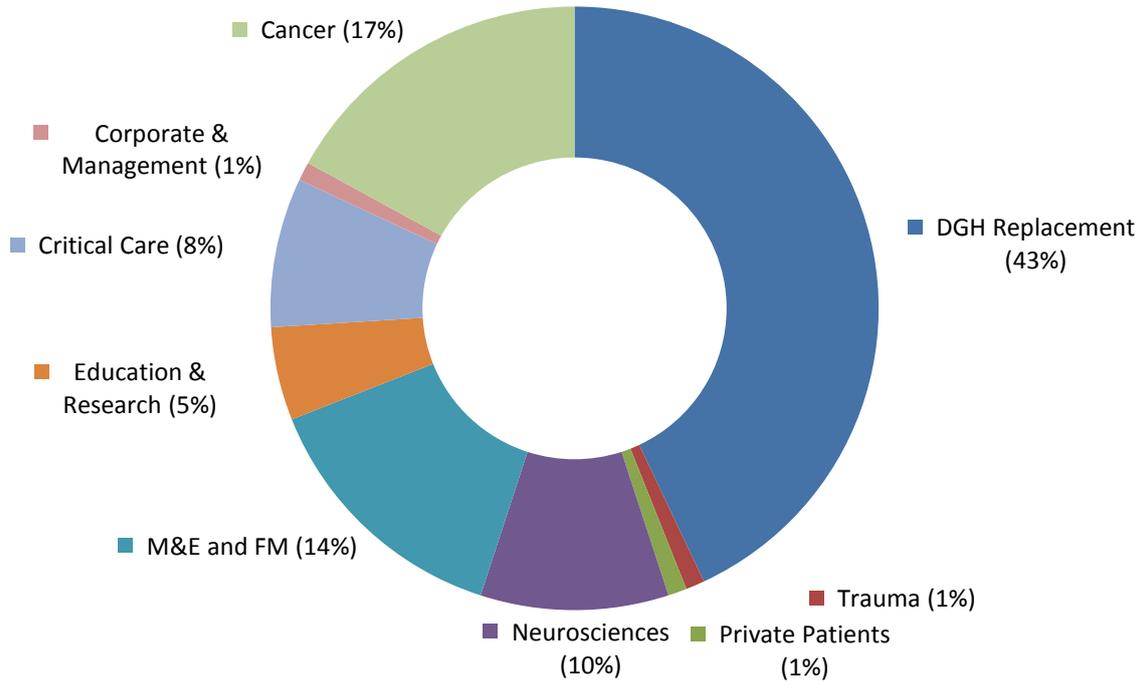
⁸ Dr Daniel Poulter MP, Parliamentary Under Secretary of State for Health. Quoted in Newsletter from Simon Kirby MP (18th September 2014)

Investment Objectives

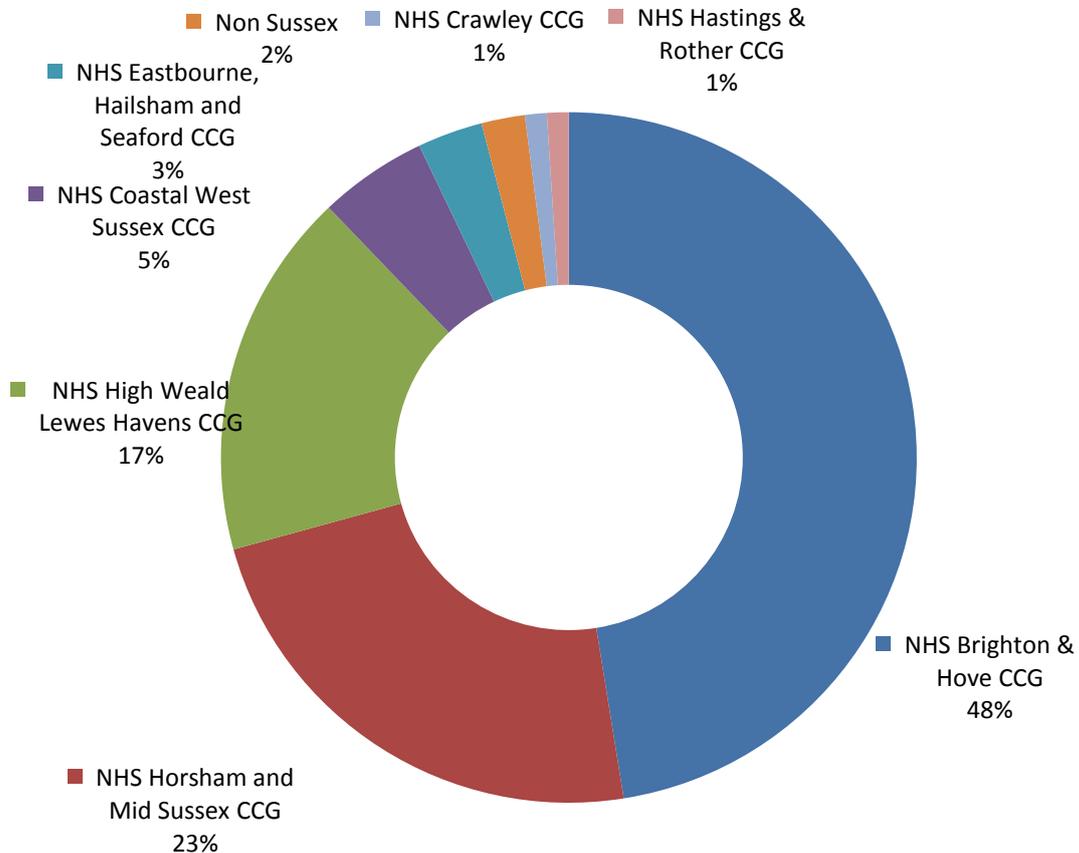
9. The '3Ts' (Teaching, Trauma & Tertiary Care) redevelopment will provide 92,350m² of new/replacement clinical and support accommodation on the Royal Sussex County Hospital (RSCH) site in Brighton & Hove. As set out in the Outline Business Case (OBC), this investment has five overarching objectives:-
- i) Replace the Barry and Jubilee buildings, which include 182 elderly/medical and other inpatient beds, with modern, fit for purpose accommodation. The original building opened in 1828 (20 years before Florence Nightingale started nursing) and in 2015 will be the oldest building in the NHS still providing acute/inpatient care.
 - ii) Transfer the Regional Centre for Neurosciences from the Trust's Haywards Heath campus to new, expanded accommodation at the RSCH. The current Hurstwood Park facility was built in 1938 as the acute psychiatric admissions unit for the Sussex Asylum. It is now too small and functionally outdated. It is also on the wrong site: the Trust's specialist/tertiary site and Major Trauma Centre is in Brighton, requiring co-location with Neurosciences to meet specialist commissioning requirements.
 - iii) Replace the Sussex Cancer Centre and fragmented cancer service provision with a larger, integrated facility to meet continuing growth in population/demand and future projections. Planning is aligned with separate business cases for the development of linked radiotherapy units in East and West Sussex as part of the networked model of care.
 - iv) Replace temporary clinical facilities supporting the Major Trauma Centre with bespoke accommodation that fully meets NHS England (NHSE) specialist commissioning standards. The redevelopment also includes a helideck for use by the Kent, Surrey & Sussex Air Ambulance and HM Coastguard Search & Rescue vehicles.
 - v) To support the Trust's role as the university Teaching Hospital for the region, provide additional and expanded facilities for teaching, training and Research & Development (R&D). This element is being developed with the Trust's academic partners: Brighton & Sussex Medical School (BSMS), the Universities of Brighton and Sussex, and Health Education Kent, Surrey & Sussex (HEKSS).
10. The table below identifies the floor area/proportion of the redevelopment represented by each of the five investment objectives. Of particular note:
- District General Hospital (DGH) services account for 43% of the floor area (excl. plant and car parking). As Brighton & Hove Clinical Commissioning Group (CCG) notes, *'[e]ven though the name of the programme is '3Ts' (Teaching, Trauma & Tertiary Care), this does not necessarily do justice to the significant element of the redevelopment which relates to District General Hospital services.'*⁹
 - 48% of the floor area will be used by Brighton & Hove residents (for both secondary and specialist/tertiary care services); and
 - although 5% of the floor area is allocated specifically for teaching and research facilities (eg. the Simulation Centre), 100% of the floor area will support teaching and research activities. Teaching and research are not 'niche' roles within the regional Teaching Hospital but permeate all aspects of the Trust's work.

⁹ Brighton & Hove Clinical Commissioning Group (May 2014) *Five Year Plan 2014-2019*

Space Allocation in 3Ts (by floor area)



Notional Split of Floor Area by CCG of Residence



Business Case History

11. Work on the Strategic Outline Case (SOC) for the redevelopment began in 2008, although the aspiration to replace the Trust's most outdated accommodation long predates this. Although the planning process has therefore straddled the introduction of new commissioning, supervisory, regulatory and other arrangements through the Health & Social Care Act 2012, the redevelopment has enjoyed consistent support from key stakeholders/partner organisations, including:

- local GPs;
- Primary Care Trusts/Clusters;
- Clinical Commissioning Groups;
- Strategic Health Authority/Cluster;
- NHS England (Area Team);
- Brighton & Hove City Council;
- Patient & Public Involvement Forums, Local Involvement Networks and Healthwatch organisations.

12. Key business case approvals to date are as follows (supporting evidence is appended):

| Date | Body | Status | Evidence |
|--------------------------------|---|------------------------------------|----------|
| Strategic Outline Case | | | |
| 3 rd June 2008 | BSUH Board of Directors | Approval | Minutes |
| 8 th July 2008 | South East Coast Strategic Health Authority | Approval | Letter |
| Outline Business Case | | | |
| 1 st June 2009 | Central Sussex Independent Patients' Forum | Support | Letter |
| 30 th June 2009 | BSUH Board of Directors | Approval | Minutes |
| 10 th July 2009 | Brighton & Hove City Council | Support – Planning Consent Process | Letter |
| 17 th November 2009 | South East Coast Strategic Health Authority | Approval | Minutes |
| 13 th January 2011 | Kent, Surrey & Sussex Deanery | Support | Letter |
| 17 th January 2011 | South East Coast Ambulance Service | Support | Letter |
| 19 th January 2011 | Brighton & Sussex Medical School | Support | Letter |
| 4 th March 2011 | Sussex PCT Cluster (NHS Sussex) | Support | Letter |
| 13 th June 2011 | South East Coast Specialised Commissioning Group | Support | Letter |
| 28 th June 2011 | Sussex Managed Clinical Networks | Support | Letter |
| 25 th July 2011 | NHS Sussex | Approval | Letter |
| 2 nd August 2011 | Mid Sussex CCG | Approval | Letter |
| 30 th October 2011 | Central Sussex Independent Patients' Forum | Support | E-mail |
| 8 th February 2012 | Brighton & Hove Local Involvement Network (LINK) | Support | E-mail |
| 27 th February 2012 | BSUH Board of Directors | Approval | Minutes |
| 27 th March 2012 | East Sussex Local LINK | Support | E-mail |
| 27 th March 2012 | NHS Sussex | Approval | Letter |
| 29 th March 2012 | NHS South of England (Strategic Health Authority Cluster) | Approval | Letter |
| 1 st May 2014 | HM Treasury | Approval | Letter |
| 9 th June 2014 | Department of Health | Approval | Letter |
| Decant Schemes | | | |
| 22 nd November 2012 | St Mary's Full Business Case: NHS South East Coast | Approval | Letter |

| Date | Body | Status | Evidence |
|--------------------------------|--|---------------|-----------------|
| 3 rd January 2013 | Front Car Park, Courtyard and Paediatric Audiology Full Business Case : NHS South of England | Approval | Letter |
| Full Business Case | | | |
| 9 th September 2014 | Brighton & Hove Health and Wellbeing Board | Support | Minutes |
| 17 th October 2014 | BSUH 3Ts Programme Board | Approval | Minutes |
| 20 th October 2014 | BSUH Board of Directors | Approval | Minutes |
| 21 st October 2014 | Healthwatch (Brighton & Hove, East Sussex, West Sussex, Surrey, Kent) | Support | Letter |
| 9 th September 2014 | Brighton & Sussex Medical School | Support | Letter (OBC) |
| 9 th September 2014 | Health Education Kent, Surrey and Sussex | Support | Letter (OBC) |
| 9 th September 2014 | East Sussex Health & Wellbeing Board | Support | Minutes |

Trust Description

Trust History

13. Brighton & Sussex University Hospitals NHS Trust (BSUH, or the Trust) is an acute teaching Trust working across two principal campuses: the Royal Sussex County Hospital in Brighton & Hove and the Princess Royal Hospital (PRH) in Haywards Heath.
14. The Trust was formed in April 2002 from the merger of Brighton Health Care NHS Trust and Mid Sussex NHS Trust. Brighton & Sussex Medical School (a partnership between the University of Brighton, the University of Sussex and local NHS providers) gained its licence at the same time: this development aimed to increase access to medical education and provide additional teaching centres outside London. BSMS admits c. 140 undergraduate students per annum and continues to enjoy one of the highest application rates of any UK medical school.
15. The Trust employs c. 6,600 Whole-Time Equivalent (WTE) staff and is supported by c. 500 volunteers. In close collaboration with its academic partners, it provides placements for c. 395 student nurses and midwives, Allied Health Professionals, Pharmacists and Healthcare Scientists, plus c. 400 medical students and c. 650 doctors in training (incl. c. 60 working in GP practices).

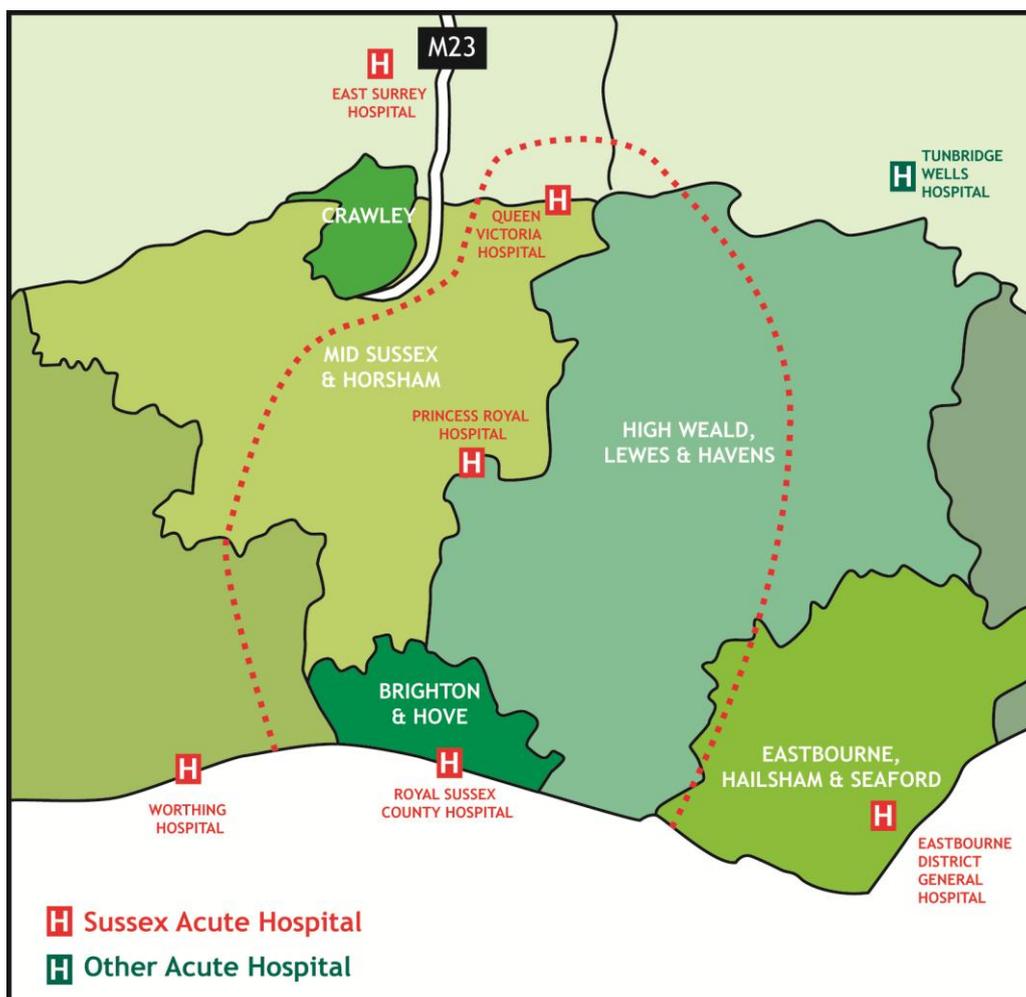
Trust Vision

16. The Trust's vision is to be:
 - i) a provider of safe, high quality secondary/local acute services to the populations of Brighton & Hove and Mid-Sussex – responsive to the needs of the local population, financially sustainable and integrated with services in partner organisations;
 - ii) a provider of safe, high quality and financially sustainable tertiary services to the populations of Sussex, South East Surrey and South West Kent (where a Sussex-based service is in the best interests of patients). These services are currently neurosciences, neonatology, paediatrics, cardiac, cancer, renal medicine, infectious diseases and HIV medicine. The Royal Sussex County Hospital is also the Major Trauma Centre;
 - iii) a hub for expertise and skill in specialist provision, innovation, training and research that supports the development of clinical academic expertise and high quality networks of care across Sussex – delivered by both the Trust and partner providers; and
 - iv) an organisation that achieves operational excellence, continually innovates and works closely and transparently with commissioners and patients to ensure it provide high quality, financially sustainable services.

Trust Sites & Estate

17. The Trust provides services from two principal acute sites:
 - the Royal Sussex County Hospital in Brighton & Hove, which includes the Sussex Eye Hospital and Royal Alexandra Children's Hospital; and
 - the Princess Royal Hospital in Haywards Heath, which includes the Trust's Hurstwood Park Regional Neurosciences Centre and Sussex Orthopaedic Treatment Centre.
18. The Royal Sussex County and Princess Royal Hospital campuses provide c. 159,000m² (Gross Internal Area) of accommodation. Of this, 68% (by floor area) is used for direct patient care, 26% for support services and education, 3% for residences and 3% is currently unoccupied.
19. Core services (Emergency Department, inpatient medicine and outpatient planned care) are provided from both sites. In addition, following the *Best Care, Best Place* public consultation in 2004/5, the Princess Royal Hospital operates as the Trust's centre for elective surgery, and the Royal Sussex County Hospital as the centre for emergency and tertiary care.

Principal Trust Sites and Neighbouring Hospitals



20. The Trust also provides ambulatory/outpatient and diagnostic services from a number of community locations, including:

- Lewes Victoria Hospital and Bexhill Hospital (owned by East Sussex Healthcare NHS Trust);
- Brighton General Hospital (owned by Sussex Community NHS Trust);
- Hove Polyclinic (owned by Sussex Partnership NHS Foundation Trust); and
- The Park Centre in Brighton & Hove (private landlord).

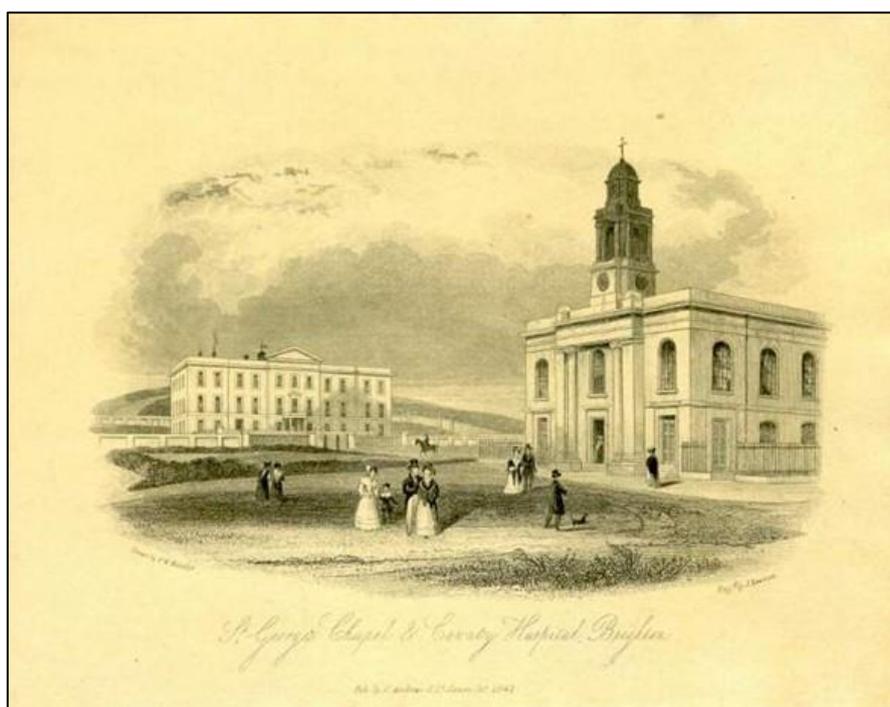
21. The Trust is registered to provide the following regulated activities, per Schedule 1 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010:

Trust Registration with Care Quality Commission (Regulated Activities by Site)

| Activity | RSCH | PRH | Bexhill | HPC | LVH | Park Centre | BGH | Dixon Ward (Renal) |
|---|------|-----|---------|-----|-----|-------------|-----|--------------------|
| Accommodation for persons who require nursing or personal care | ✓ | ✓ | | | | | | |
| Treatment of disease, disorder or injury | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ |
| Assessment of medical treatment for persons detained under the Mental Health Act 1983 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| Surgical procedures | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| Diagnostic and screening procedures | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ |
| Maternity and midwifery services | ✓ | ✓ | | | | | | |
| Termination of pregnancies | ✓ | ✓ | | | | | | |

Royal Sussex County Hospital

22. The Royal Sussex County Hospital campus occupies a 5.19 hectare site c. 1km to the east of Brighton & Hove city centre. The original hospital was built here in 1828 on what was then a greenfield site, as part of a specialist group of ‘sea bathing infirmaries’. On opening, it accommodated 80 inpatients¹⁰. Its original construction was a three storey building designed by Sir Charles Barry, an English architect best known for his role in remodelling Trafalgar Square, the Palace of Westminster and the Cabinet Office (the Old Treasury) in the 1840s.



The County Hospital (left) and St George's Chapel, 1841

23. The Barry Building has been substantially altered and extended, including the Adelaide Wing in 1839 and Victoria Wing in 1841. The Jubilee and Latilla Buildings, which sit alongside, were constructed in a manner sympathetic to the Barry Building in the latter half of the 19th century.

¹⁰ Carder T. (1990) *The Encyclopaedia of Brighton*

24. Numerous temporary structures have been erected and subsequently retained on site as the need for service developments and increased capacity has outpaced the development of permanent, specialised buildings in which to accommodate them. This has resulted in an inefficient archipelago of outdated, disconnected and functionally poor buildings along the South (Eastern Road) side of the site.
25. The Royal Alexandra Children’s Hospital is the most recent addition to the site (2007). The history of the hospital is covered definitively in *Brighton’s County Hospital, 1828-2007*¹¹. The Planning Statement and Historic Buildings Appraisal (provided as part of the Trust’s application for Full Planning Consent for the redevelopment) are appended.
26. In 2010 the campus was extended through the purchase of the former St Mary’s Hall Senior School (1.74 hectare) site to the East of the main hospital. Refurbishment of this site and service moves are now complete, and this has supported rationalisation of the wider Trust estate as well as providing a significant proportion of the non-clinical accommodation required for 3Ts ‘decant’ (ie. clearing the site in preparation for demolition and construction).

Aerial Photograph of the RSCH Campus



27. Although a series of refurbishments has been undertaken to the Barry Building/Jubilee Wing, the photographs (below) illustrate how little the basic design has changed over time, other than to subdivide the Nightingale¹² (open plan) wards into smaller, multi-bed bays. (The recent photographs are part of an arts commission to document the history of the estate¹³).

¹¹ Gaston, H. (2008) *Brighton’s County Hospital, 1828-2007*

¹² A ‘Nightingale ward’ is configured as one large room without subdivisions. A number of wards in the Barry Building include large, open-plan bays. Since the Barry Building opened in 1828 and predated Florence Nightingale’s nursing career, these might more accurately be described as *pre-Nightingale*.

¹³ Bronwen Rowlands (University of Brighton).

Overton Ward (c. 1915, 2014)



Bristol Ward (c. 1915, 2014)



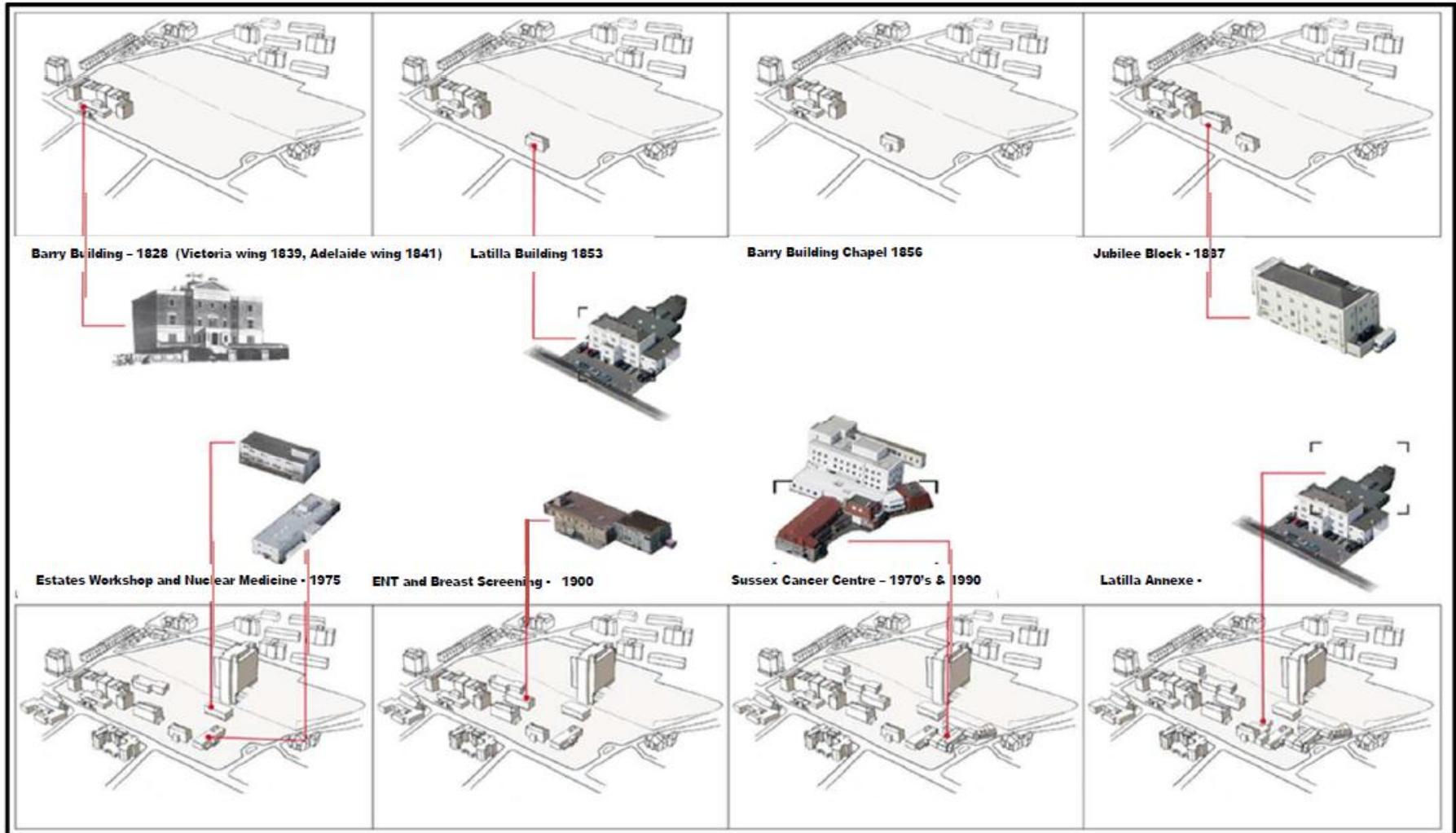
Egremont Ward (c. 1915, 2014)



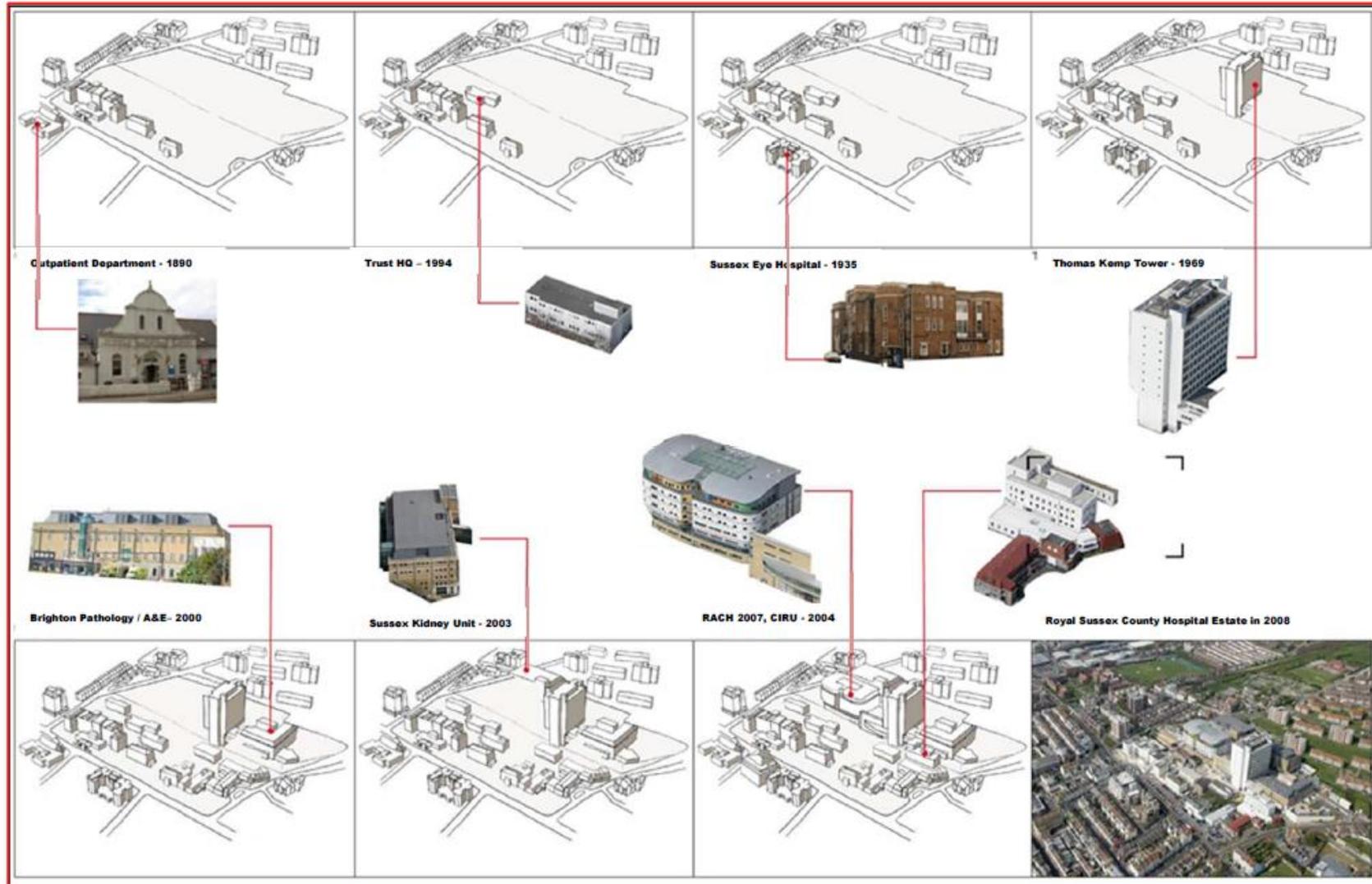
Latilla Ward (c. 1915, 2014)



History of the RSCH Campus



History of the RSCH Campus



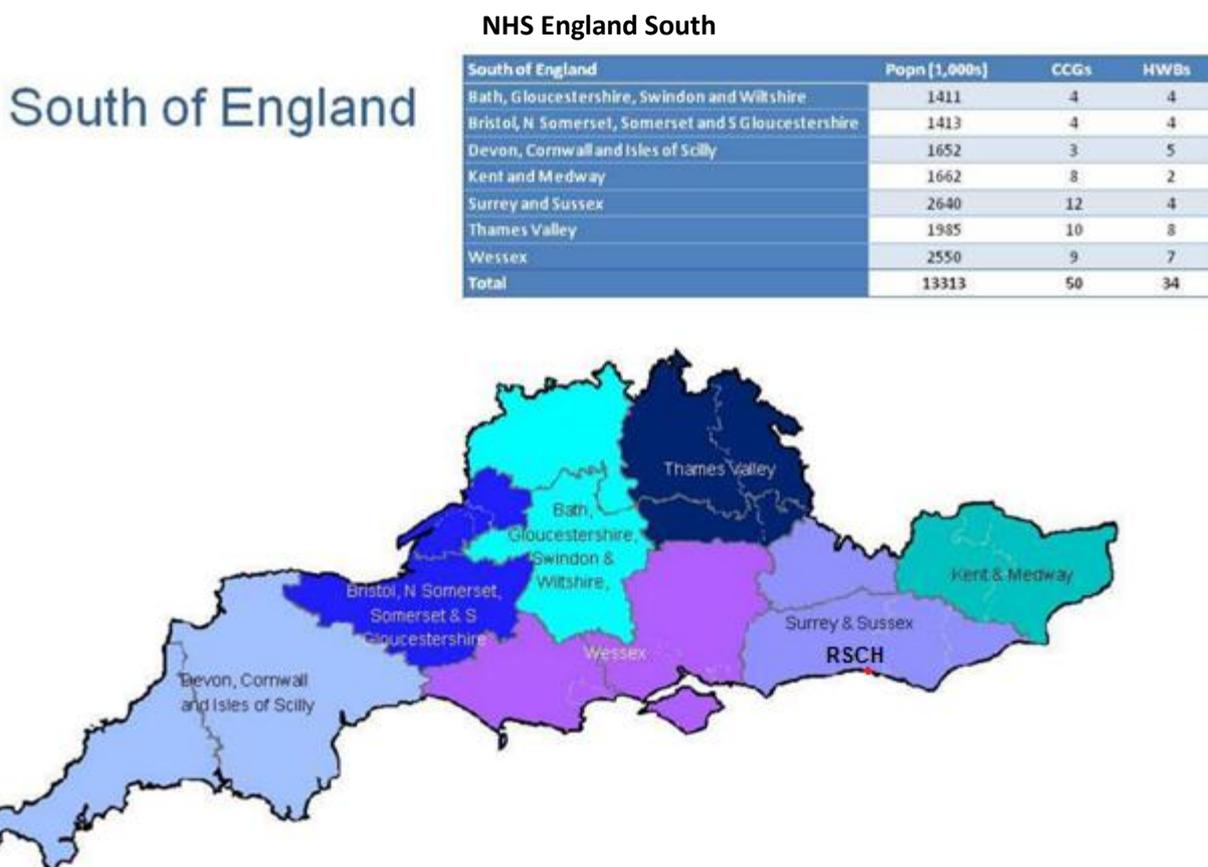
Key Stakeholders

City Context

28. Brighton & Hove is a Unitary Authority with a population of c. 275,000 residents (Office of National Statistics, 2012). Approximately 64% of the activity in the 3Ts development (ie. both District General Hospital and specialist/tertiary services) will be for Brighton & Hove residents.

Commissioners

29. The Trust is located in NHS England South (Surrey & Sussex Area Team).

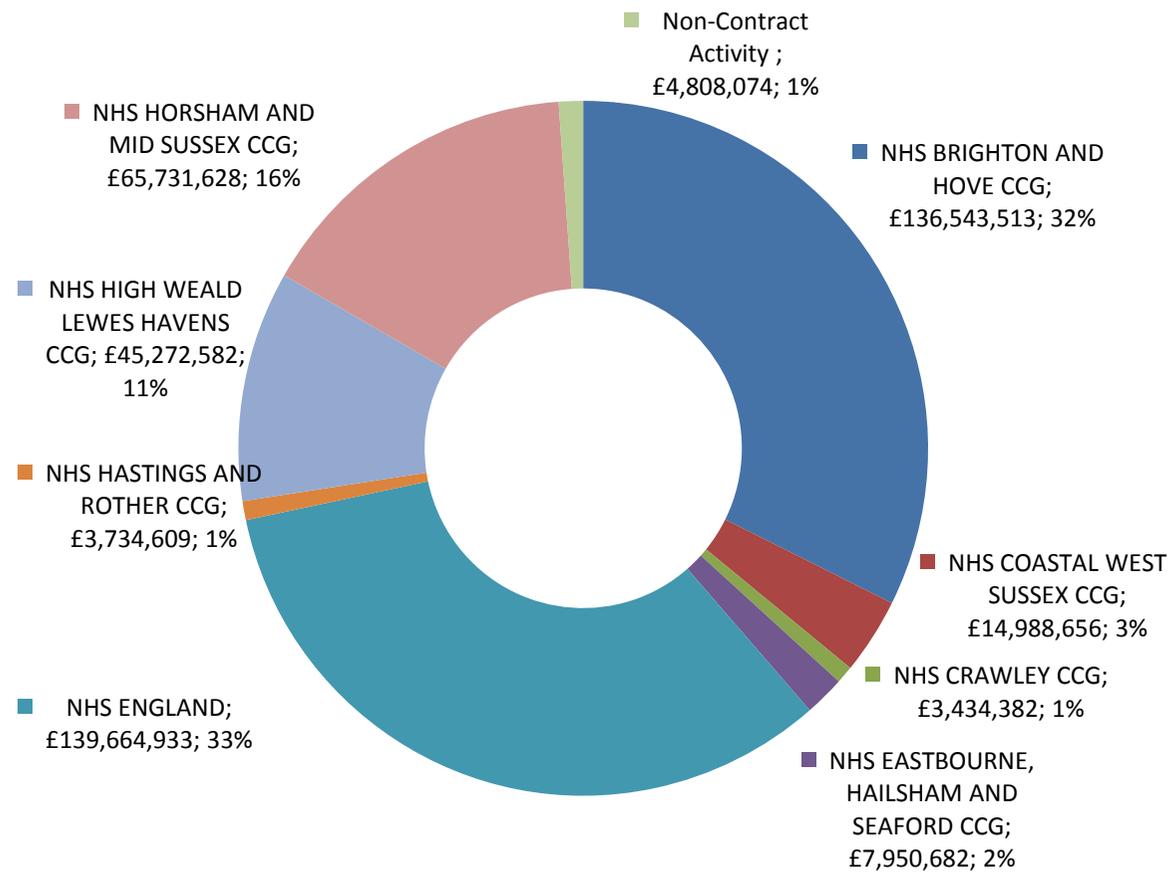


30. Sussex comprises seven Clinical Commissioning Groups (CCGs). The Trust provides general acute services for populations within the areas served by Brighton & Hove CCG, Horsham and Mid-Sussex CCG and High Weald Lewes Havens CCG. It provides more specialised and extended acute services for Coastal West Sussex CCG; Crawley CCG; Eastbourne, Hailsham and Seaford CCG; and Hastings and Rother CCG.
31. 67% of the Trust’s NHS income (excluding R&D and private patient income) is derived from CCGs, and 33% from NHS England via the Surrey & Sussex Area Team. Further analysis (at specialty level) is appended.
32. The Trust’s catchment/market share for both local and specialised services is set out in more detail in the Trust’s draft Integrated Business Plan (appended).

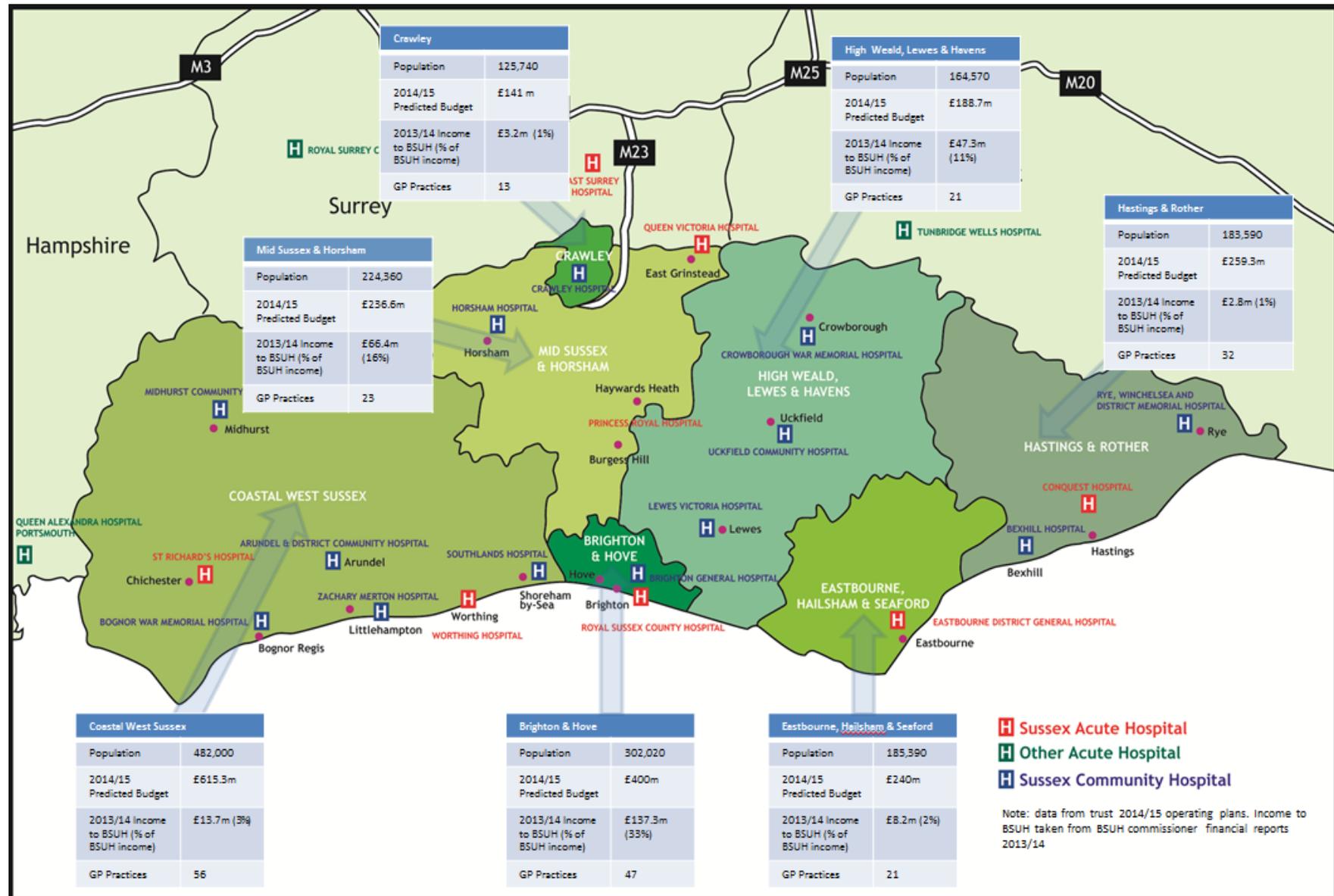
Local Authority / Public Health

33. In April 2013 responsibility for public health transferred from the NHS to Local Authorities. Brighton & Hove City Council is therefore the responsible commissioner for the Trust’s sexual health services.

BSUH Projected Clinical Income by Commissioner, 2014/15

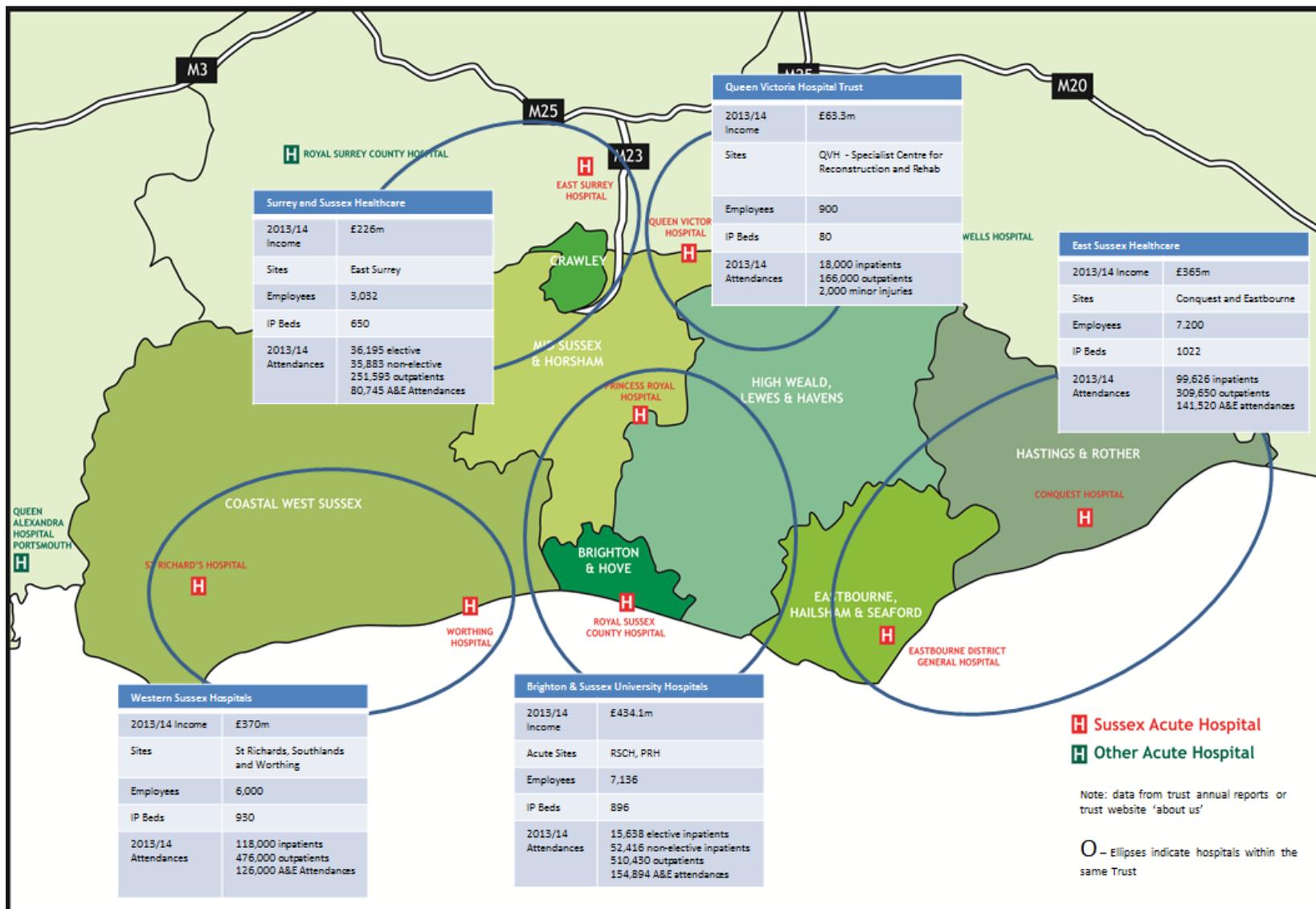


Local CCGs: Key Statistics



Neighbouring NHS Providers

34. The map below shows the principal neighbouring NHS acute and community providers.

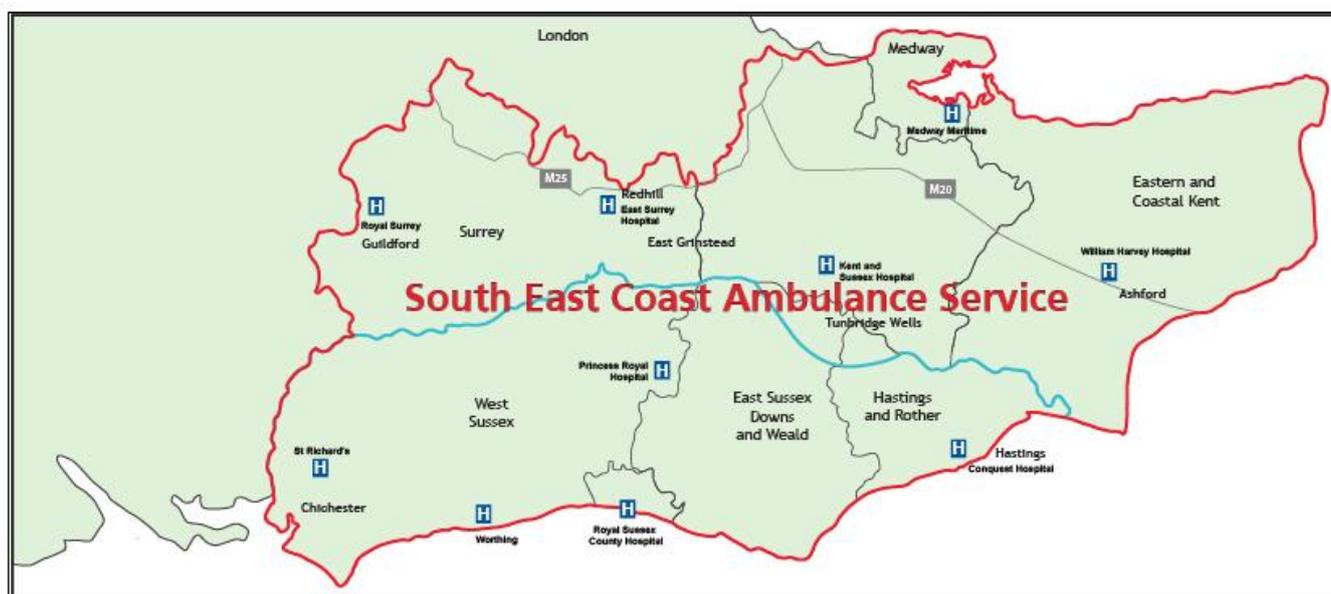


35. The three principal pan-Sussex NHS providers are:

South East Coast Ambulance Service NHS Foundation Trust (SECamb)

- Covers a geographical area of 3,600 square miles (Brighton & Hove, East Sussex, West Sussex, Kent and Surrey).
- Serves a population of 4.4m.
- Employs over 3,200 staff working across 70 sites.
- During 2013, received 862,466 emergency calls from members of the public or other healthcare professionals: 5,863 of the calls were categorised as immediately life-threatening ('Category A'). Reached 76.8% of these patients within eight minutes.
- In 2013 the Patient Transport Service undertook 501,590 patient journeys.

Map Showing SECamb Service Area



Sussex Partnership NHS Foundation Trust

- Provides NHS mental health, learning disability, substance misuse and prison healthcare services across Sussex, and a developing range of specialist services across the South East of England and beyond.
- Sees 100,000 people a year and growing.
- Employs 5,000 staff.
- Income 2012/13: £240 million

Sussex Community NHS Trust

- The main provider of community NHS healthcare across Brighton & Hove and West Sussex.
- Expert teams provide essential medical, nursing and therapeutic care to over 8,000 adults, children and families a day.
- In 2012/13 total budget was £188m.

Clinical Networks

36. *The Way Forward: Strategic Clinical Networks*¹⁴ set out the range and role of clinical networks in the new health system. This described a range of networks performing different functions, including:
- a small number of Strategic Clinical Networks (SCNs), established and supported by NHS England to advise commissioners, support strategic change projects and improve outcomes; and
 - Operational Delivery Networks (ODNs), which are focused on coordinating patient pathways between providers over a wide area to ensure access to specialist resources and expertise (this was further developed in *Developing Operational Delivery Networks*¹⁵).
37. Further detail was provided in the 2012 *Single Operating Framework*¹⁶, which confirmed the purpose of networks in *'bring[ing] together those who use, provide and commission the service to make improvements in outcomes for complex patient pathways using an integrated, whole system approach.'* Networks also work on cross-cutting themes aligned to the domains of the NHS Outcomes framework: prevention, rehabilitation, parity of esteem, transition, urgent and emergency care, end of life care, integration.
38. SCNs support key areas of major health and wellbeing challenge, currently:
- Cardiovascular (including cardiac, stroke, renal and diabetes);
 - Maternity, Children and Young People;
 - Mental Health, Dementia and Neurological Conditions; and
 - Cancer.
39. ODNs work with other organisations, including Clinical Senates, Academic Health Science Networks and local professional networks, to cover clinical services such as:
- neonatal intensive care;
 - adult critical care;
 - burns; and
 - major trauma.
40. The Trust recognises the requirement for increasing co-operation between providers in order to preserve and develop Sussex-based specialist services in the context of financial pressures and rising service quality standards. While delivery on existing commitments in Vascular and Major Trauma is key, the Trust is working with partner providers in Sussex on the establishment of collaborative approaches for service delivery in other areas, including neurology and renal medicine. The Sussex ODNs are described in more detail in the table below.

Stroke Services

41. The CCGs' quarterly strategy meeting on stroke in January 2014 highlighted the variability of stroke service and clinical outcomes across Sussex, evidenced through the Sentinel Stroke National Audit Programme (SSNAP) data, and agreed that this requires a Sussex-wide approach. A baseline review is currently underway to identify gaps against national best practice, and a case for change will follow. This will also consider the impact of various scenarios on patient travel times and associated activity at each provider.

¹⁴ NHS Commissioning Board (2012) *The Way Forward: Strategic Clinical Networks*

¹⁵ NHS Commissioning Board (2012) *Developing Operational Delivery Networks: the Way Forward*

¹⁶ NHS Commissioning Board (2012) *Strategic Clinical Networks: Single Operating Framework*

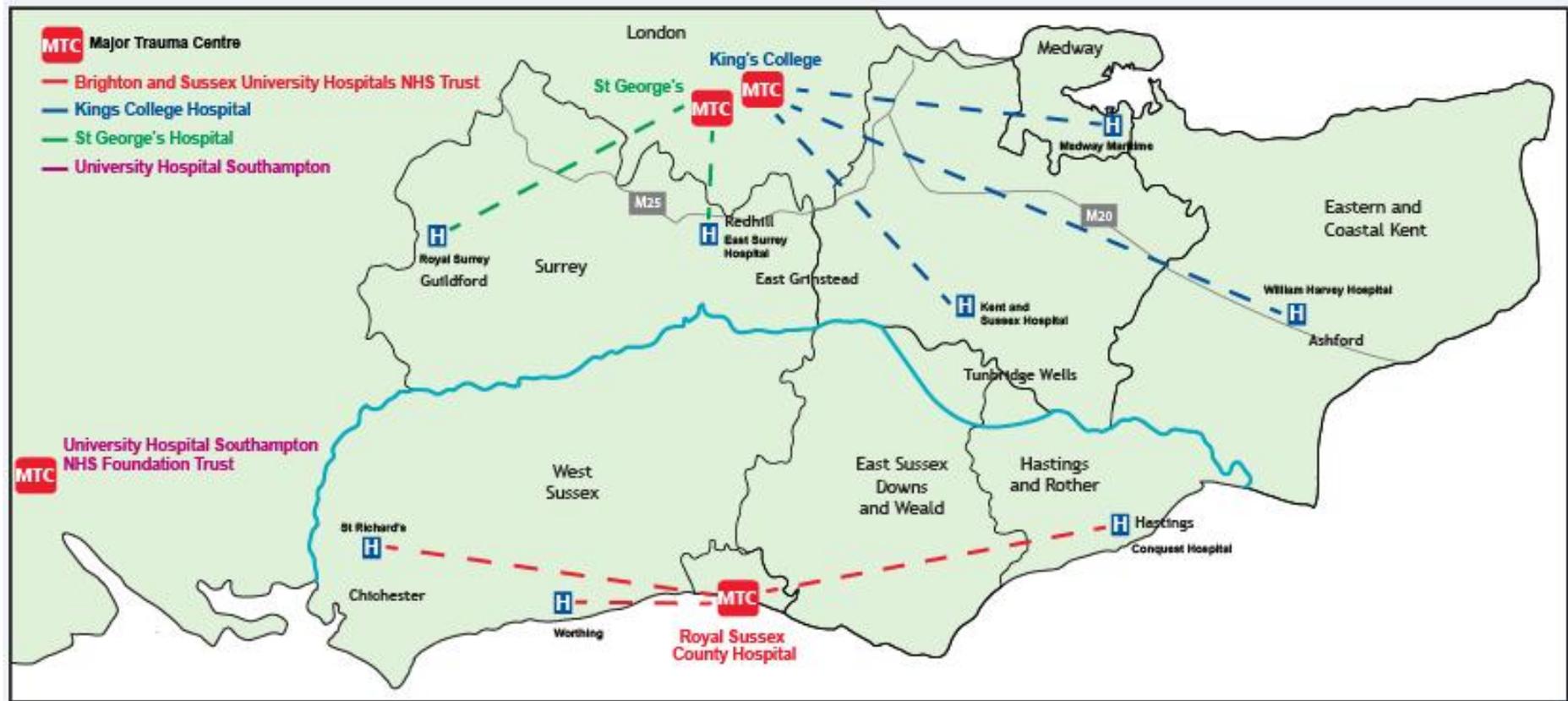
Operational Delivery Networks

| Network | Host | Geography/population | Configuration | Description |
|--------------|------|---|---|---|
| Major Trauma | BSUH | <ul style="list-style-type: none"> Sussex 1.6 million | <ul style="list-style-type: none"> Royal Sussex County Hospital is the Major Trauma Centre Conquest Hospital (Hastings), Worthing Hospital, St Richard's Hospital (Chichester) are Trauma Units Eastbourne District General Hospital is a Local Emergency Hospital | <ul style="list-style-type: none"> Network Clinical Lead and Manager are employed by BSUH as the host provider. The Network Board is co-chaired by the Area Team Medical Directors for Kent & Medway and Surrey & Sussex. The Board includes representatives from provider Trusts; South East Coast Ambulance Service NHS Foundation Trust (SECAMB); Kent, Surrey & Sussex Air Ambulance; NHS England and Clinical Commissioning Groups; patients. The Network works closely with neighbouring Trauma Networks to ensure that effective pathways for residents living in boundary areas. This is coordinated through the overarching South East Coast Trauma Board. A Network Clinical Advisory Group is being established to provide clinical advice, principally to commissioners. Working Groups have been established to progress eg. clinical governance, data, rehabilitation and education and training activities. The Network and Major Trauma Centre were peer-reviewed in March 2014. Trauma Unit and Local Emergency Hospital peer review visits have been scheduled for Quarter 1 of 2015/16. |
| Vascular | BSUH | <ul style="list-style-type: none"> Sussex 1.6 million | <ul style="list-style-type: none"> Royal Sussex County Hospital is the hub. Conquest Hospital (Hastings), St Richard's Hospital (Chichester) and East Surrey Hospital (Redhill) are 'spokes' that manage inpatients. Eastbourne District General Hospital and Worthing Hospital are 'spokes' that provide outpatient services. | <ul style="list-style-type: none"> Phased implementation agreed, with full implementation of the network model by February 2015. Network Clinical Lead and Manager are employed by BSUH as the host provider. The Network Board includes representatives from provider Trusts; NHS England and Clinical Commissioning Groups; and patients. A Network Oversight Group is co-chaired by the Area Team Medical Directors for Kent & Medway and Surrey & Sussex. The national Abdominal Aortic Aneurysm Screening Programme is a key partner. This has recently been peer-reviewed recently, with the resulting action plan was co-developed by the programme and network. |

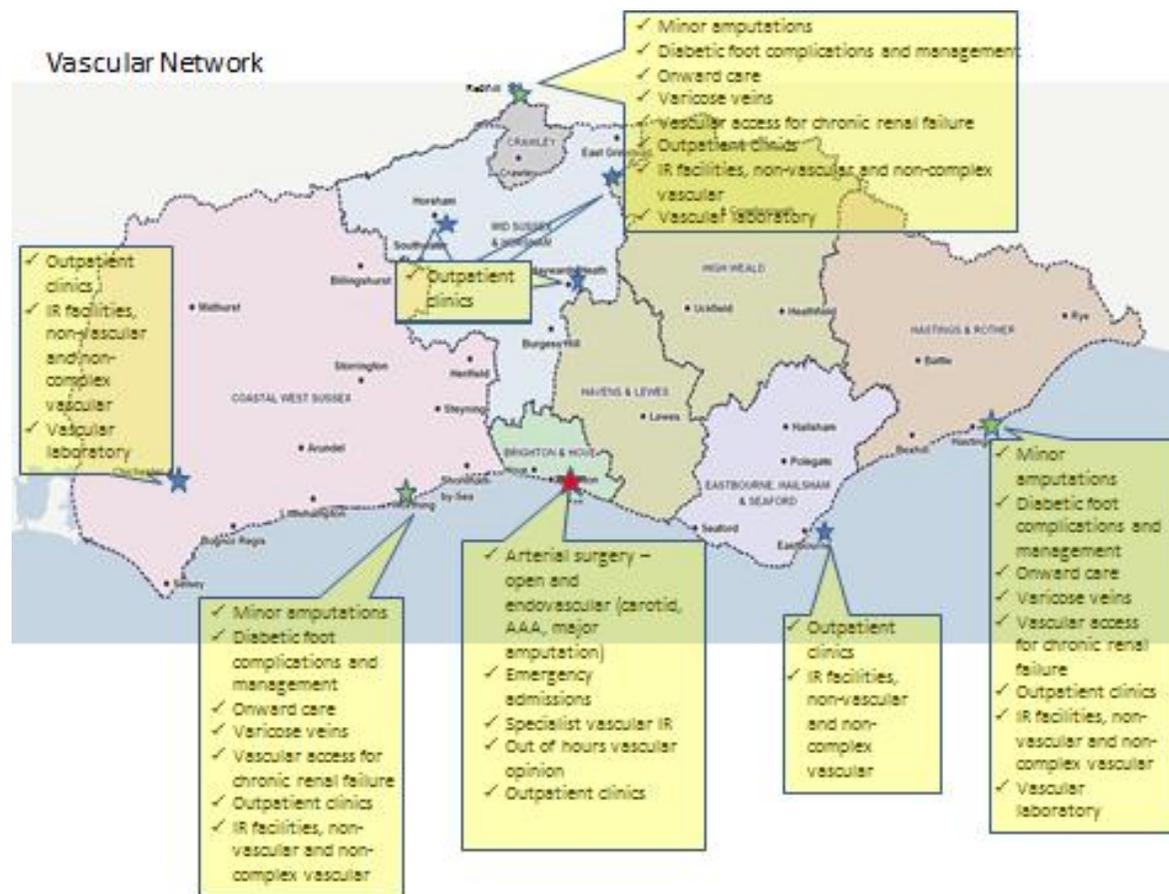
| Network | Host | Geography/population | Configuration | Description |
|---------------------|-----------------------------|--|--|---|
| Adult Critical Care | Medway NHS Foundation Trust | <ul style="list-style-type: none"> • Kent, Surrey & Sussex • 4.4 million | <p>Within Sussex the following hospitals have Critical Care Units:</p> <ul style="list-style-type: none"> • Royal Sussex County Hospital • Eastbourne District General Hospital • Conquest Hospital, Hastings • Worthing Hospital • St Richard’s Hospital, Chichester | <ul style="list-style-type: none"> • Network Manager and Clinical Lead are employed by Medway NHS Foundation Trust. • The National Clinical Reference Group includes representation from South East Coast. • A work programme is agreed annually, which includes submission of data to the Intensive Care National Audit & Research (ICNARC) database. |
| Neonatal | Medway NHS Foundation Trust | <ul style="list-style-type: none"> • Kent, Surrey & Sussex • 4.4 million | <p>Neonatal Intensive Care Units:</p> <ul style="list-style-type: none"> • Medway Maritime Hospital • Royal Sussex County Hospital • St Peter’s Hospital • William Harvey Hospital. <p>Local Neonatal Units:</p> <ul style="list-style-type: none"> • East Surrey Hospital • Tunbridge Wells Hospital <p>Special Care Units:</p> <ul style="list-style-type: none"> • Conquest Hospital, Hastings • Darent Valley Hospital • Eastbourne District General Hospital • Frimley Park Hospital • Princess Royal Hospital • Queen Elizabeth the Queen Mother (QEQM) Hospital; • Royal Surrey Hospital • Worthing Hospital | <ul style="list-style-type: none"> • Network Manager and Clinical Lead are employed by Medway NHS Foundation Trust. • The National Clinical Reference Group includes representation from South East Coast. • A work programme is agreed annually, which includes submission of network data. |
| Burns | Chelsea & Westminster | <ul style="list-style-type: none"> • London & South East • 20 million | Within Sussex the only Burns Unit is at Queen Victoria Hospital, East | <ul style="list-style-type: none"> • There are four networks in the country. • The London & South East Network is well established. |

| Network | Host | Geography/population | Configuration | Description |
|---------|-------------------------------|----------------------|---------------|---|
| | Hospital NHS Foundation Trust | | Grinstead. | <ul style="list-style-type: none"> • There is a major review of burns services underway to determine the long term configuration. • There is five day/week presence from Queen Victoria Hospital at the Royal Sussex County Hospital to support the provision of major trauma services within Sussex. |

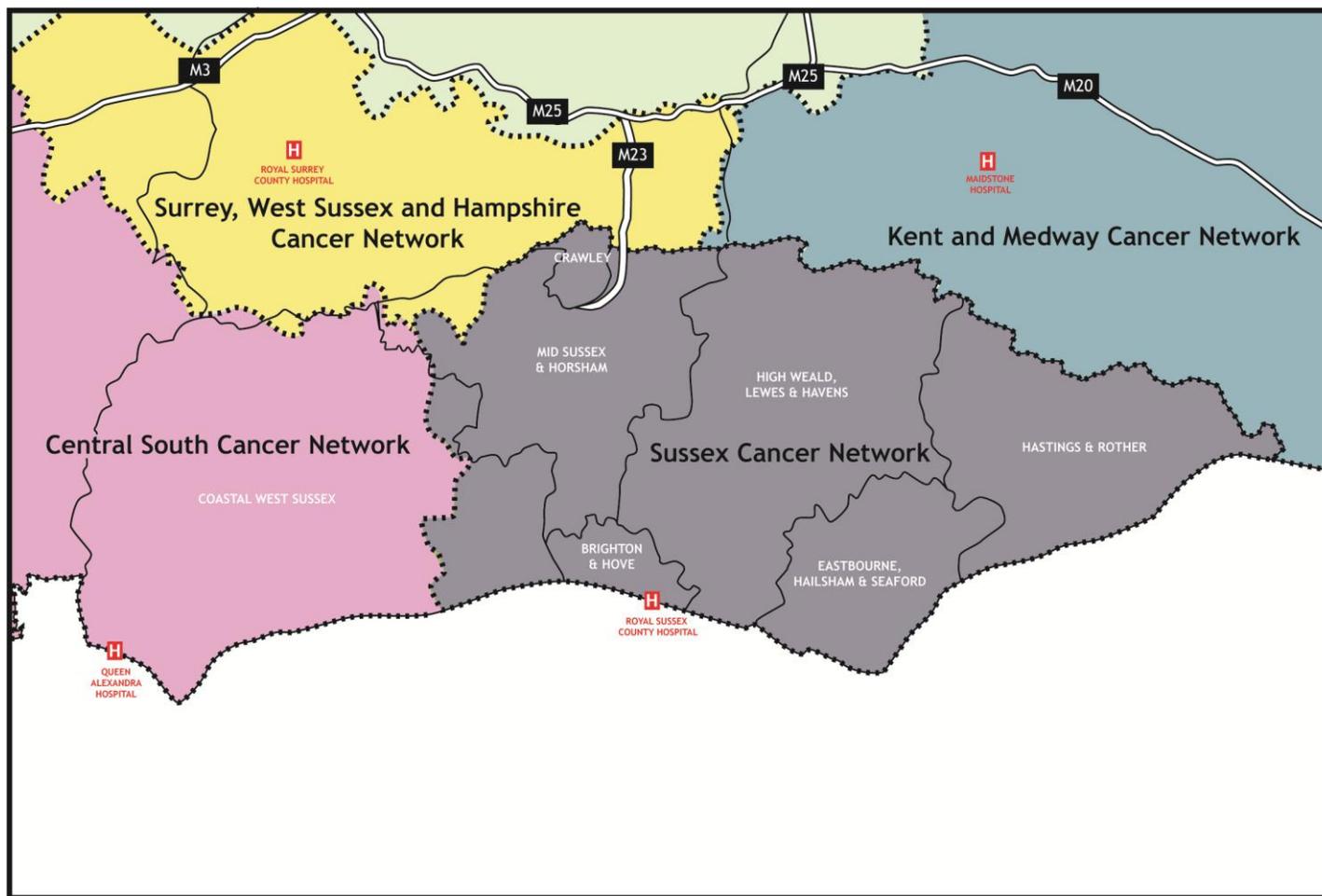
Major Trauma Networks (Adult)



Vascular Network



Sussex and Surrounding Cancer Networks



Health Education

Health Education Kent, Surrey & Sussex

42. Health Education Kent, Surrey & Sussex (HEKSS) is the Local Education & Training Board, authorised as a subcommittee of Health Education England. Its role is to ensure the effective planning, education and training of the 100,000-strong NHS workforce within the region, which services a population of over 4m people.
43. The HEKSS *Skills Development Strategy*¹⁷ sets out the five year strategic workforce and education interventions required to support providers of NHS services in delivering excellent, patient-centred care. The five strategic priorities are:
 - dementia;
 - primary care;
 - emergency care;
 - children and young people; and
 - compassion and patient safety.

Brighton & Sussex Medical School

44. Brighton & Sussex Medical School (BSMS) opened in 2003 as a partnership between the Universities and Brighton and Sussex and NHS organisations across the region. The School is fully committed to the principles of *Tomorrow's Doctors*¹⁸ and endorses the value of education in a multiprofessional context. Its undergraduate degree programme has an annual intake of c. 140 students. In the most recent national survey of final year students, BSMS achieved 96% overall satisfaction – one percentage point higher than the previous year's results and 10 points higher than the sector average.
45. BSMS has recently appointed as its new Dean Professor Malcolm Reed, a leading academic surgical oncologist, and this will support the development of new areas of research activity. The Trust's long-established partnership with BSMS demonstrates its own track record in innovative student education, its ability to continue to strengthen postgraduate education and its commitment to research.

Research & Development

46. BSMS' research income has more than doubled over the last five years. Research priorities include cancer, cell & development biology, elderly care & stroke, imaging, infection & immunity, medical education, medical ethics & humanities, medical informatics, neurosciences, paediatrics and rheumatology – many of which clinical services are included within the scope of the 3Ts redevelopment.
47. The 2008 Research Assessment Exercise (RAE) identified that more University of Brighton academics are working at international standards of excellence than in any other post-1992 university. At the University of Sussex, over 90% of research activity was rated as world-leading, internationally excellent or internationally recognised, which places the University among the top 30 research universities in the UK (on a simple average across all RAE scores). The Research Excellence Framework (REF) will replace the RAE in 2014 (results are due to be available in December 2014).

Academic Networks

48. *Innovation, Health & Wealth*¹⁹ (2011) recommended the establishment of Academic Health Science Networks to 'offer a more systematic delivery mechanism so that innovation spreads quickly and successfully through the NHS, making the best possible use of precious NHS resources and ensuring the most advanced treatments, technologies and medicines are available to patients.'

¹⁷ Health Education Kent, Surrey & Sussex (2013) *Skills Development Strategy for Kent, Surrey & Sussex 2013-2018*

¹⁸ General Medical Council (2009) *Tomorrow's Doctors: Outcomes and Standards for Undergraduate Medical Education*

¹⁹ Department of Health (2011) *Innovation, Health & Wealth: Accelerating Adoption & Diffusion in the NHS*

49. The Kent, Surrey & Sussex (KSS) AHSN was authorised in 2013. Its priorities are:
- supporting people to live healthy lives;
 - improving outcomes (preventing people from dying prematurely, including reducing variation in access to Stroke and Major Trauma specialist care; enhancing quality of life for people with long-term conditions, including dementia; and helping people recover from episodes of ill-health or following injury, including care for stroke patients and people experiencing major trauma); and
 - reducing variation in care.
50. The KSS AHSN currently fulfils a more facilitative role than some other AHSNs: for example, it does not lead reconfiguration programmes across the region.

Research Networks

51. The National Institute for Health Research (the clinical research delivery arm of the NHS in England) operates 15 Local Clinical Research Networks (LCRNs), based on the geographical footprint of the Academic Health Science Networks (AHSNs). The Trust provides clinical leadership to the Kent, Surrey & Sussex Network and is committed to ensuring that it achieves its objectives and that patients have a wide range of opportunities to participate in clinical research.
52. The UK Clinical Research Facilities Network (UKCRFN) was established in 2007 to identify, develop and share systems for the delivery and management of operational activities across the UK clinical research and experimental medicine infrastructure. The Network is responsible for delivering early phase clinical trials, in partnership with industry.
53. The National Institute for Health Research (NIHR) funds the Brighton Clinical Research Facility at the Royal Sussex County Hospital (also known as the Clinical Investigations & Research Unit). This provides a focal point for the development of strategic partnerships, as well as ‘hub and spoke’ delivery models in which patients are referred from other locations to participate in highly specialised research studies.
54. The Experimental Cancer Medicine Centre (ECMC) Network was established in 2006 with funding from Cancer Research UK and the UK health departments. There are now 18 individual ECMCs across the country, with the goal of driving the development of new therapies to bring benefits to patients faster.
55. The Barts & Brighton ECMC was established in 2012 as a partnership between the Barts Cancer Institute and Brighton & Sussex Cancer Research Centre. It is also linked with the Medical Research Council Genome Damage & Stability Centre at the University of Sussex. Its clinical focus areas are haemato-oncology, thoracic malignancies, women’s cancers, hepatobiliary cancers, urological cancers and cancer imaging. Its scientific focus areas are cancer and inflammation, angiogenesis, DNA damage signalling, cancer cell signalling and metabolism, complex biological therapies and cancer imaging.
56. The 3Ts investment will support the continued development of these research networks through the provision of bespoke facilities, repatriation of specialist clinical activity from London to Brighton & Sussex University Hospitals as the local provider, and development of innovative models of care that will support additional research activity. This is set out in more detail in the case for change.

Continuing Strategic Alignment

National Policy & Strategy

57. The following key national policies have particular implications for the 3Ts redevelopment and are summarised below. The outcomes/benefits from the investment are set out in detail in the case for change (Strategic Case) and Benefits Realisation Plan (Management Case).

| Principal Driver | National Policy Agenda |
|------------------|---|
| Quality | <ul style="list-style-type: none"> • NHS Constitution • NHS Mandate and Outcomes Frameworks • Quality & Safety / Fundamental Standards of Care • Dignity in Care for Older People • Single-Sex Accommodation • Patient Choice |
| Innovation | <ul style="list-style-type: none"> • Innovation, Health & Wealth • Better Care Fund • Transforming Urgent & Emergency Care Centres |
| Productivity | <ul style="list-style-type: none"> • Financial challenge |
| Prevention | <ul style="list-style-type: none"> • Public Services (Social Value) Act 2012 • Public Health • Emergency Preparedness, Resilience & Response |

NHS Constitution

58. The NHS Constitution *‘establishes the principles and values of the NHS in England. It sets out the rights to which patients, public and staff are entitled, the pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure that the NHS is operated fairly and effectively.’*²⁰
59. The 2013 edition of the NHS Constitution includes a new pledge that patients admitted to hospital *‘will not have to share sleeping accommodation with patients of the opposite sex, except where [clinically] appropriate.’* This reflects long-standing Government policy to eliminate mixed-sex accommodation.
60. Much of the accommodation to be replaced by 3Ts is old and no longer fit for purpose. Specifically, and in spite of a number of refurbishments over the years, this accommodation does not meet the NHS Constitution’s commitments to:
- *‘convenient, easy access to services...’* and *‘a comprehensive service, available to all irrespective of... disability...’*;
 - *‘...the highest standards of excellence... in the provision of high-quality care that is... focused on patient experience...’*; and
 - *‘[treat patients] with dignity and respect... [and with] privacy and confidentiality...’*

NHS Mandate & Outcomes Frameworks

61. The Government has refreshed the NHS’ priorities, in particular through *The Mandate to NHS England*²¹, the *NHS Outcomes Framework 2014/15*²² and *Public Health Outcomes Framework 2013-2016*²³, and the *Mandate to Health Education England 2013-2015*²⁴.

²⁰ Department of Health (2013) *The NHS Constitution: the NHS Belongs to Us All*

²¹ Department of Health (2013) *A Mandate from the Government to NHS England: April 2014 to March 2015*

²² Department of Health (2013) *NHS Outcomes Framework 2014/15*

²³ Department of Health (2012) *Improving Outcomes and Supporting Transparency: A Public Health Outcomes Framework for England 2013-2016*

²⁴ Department of Health (2014) *Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values: a mandate from the Government to Health Education England – April 2013 to March 2015*

62. NHS England has provided an overall context through *Everyone Counts: Planning for Patients 2014/15 to 2018/19*²⁵ (2013), its *Call to Action*²⁶ (2013) and *Putting Patients First: NHS England's Business Plan 2014/15-2016/17*²⁷ (2014).
63. The Secretary of State has also set out (2012) the four key areas of improvement²⁸ expected by 2015:
- improvement in standards of care throughout the system;
 - a technological revolution, including patient information and service integration;
 - treatment and care of people with dementia; and
 - improving mortality rates for the 'big killer diseases'.
64. The investment objectives for the 3Ts redevelopment have been mapped against the NHS Outcomes Frameworks. This, and other read-across between national priorities and the outcomes/benefits to be realised, are detailed in the Management Case. A summary is provided in the table below.

Quality, Innovation, Productivity & Prevention

65. The Quality, Innovation, Productivity & Prevention (QIPP) programme is a large-scale programme launched in 2011 by the Department of Health to drive forward quality improvements in NHS care, at the same time as making up to £20 billion of efficiency savings by 2014/15.
66. QIPP represents a broad policy agenda rather than a single definable policy. There are a number of national workstreams within QIPP designed to support the NHS to improve care and lower costs. These range from improving commissioning of care for patients with long-term conditions to improving how organisations are run, staffed and supplied. The specific changes required to meet this agenda have been left to local providers and commissioners to identify and implement.
67. The underlying assumption of the QIPP approach, which originates from the US Institute for Healthcare Improvement (IHI), is that improved efficiency will lead to improved quality of care. Recently, the IHI has developed the Impacting Cost + Quality Programme. In 2010, a six-month pilot with a group of 40 US healthcare organisations led to plans to remove a collective US\$30 million in 'excess' costs.
68. The cross-cutting themes of quality, innovation, productivity and prevention underpin the entire 3Ts business case. The alignment between the 3Ts investment objectives and QIPP framework is shown in the table below, and discussed in more detail in the Management Case.

²⁵ NHS England (2013) *Everyone Counts: Planning for Patients 2014/15 to 2018/19*

²⁶ NHS England (2013) *The NHS Belongs to the People: a Call to Action*

²⁷ NHS England (2014) *Putting Patients First: the NHS England Business Plan for 2013/14-2015/16*

²⁸ <http://conservativehome.blogs.com/platform/2012/11/i-have-now-been-health-secretary-for-just-over-two-months-i-said-when-i-was-appointed-that-it-was-the-biggest-privilege-of.html> (November 2012)

Current 3Ts Benefits: Strategic Alignment

| 3Ts Benefit Group | QIPP Element | NHS Mandate | CCG Assurance Framework | 3Ts Investment Objective | | | | |
|---|---|--|--|--------------------------|--------|--------|--------|-----|
| | | | | Barry | Neuro. | Cancer | Trauma | T&R |
| 1. Clinical (Improved outcomes and reduced mortality) | <ul style="list-style-type: none"> Prevention | <ol style="list-style-type: none"> Preventing people from dying prematurely Enhancing quality of life for people with long-term conditions | Domain 1 <ul style="list-style-type: none"> Are patients receiving clinically commissioned, high quality services? The CCG consistently demonstrates a strong clinical and multi-professional focus which brings real added value, with quality at the heart of governance, decision-making and planning arrangements to commission safe, high quality and compassionate care for patients. | ✓ | ✓ | ✓ | ✓ | ✓ |
| 2. Quality & Safety (incl. patient experience) | <ul style="list-style-type: none"> Quality Productivity Prevention | <ol style="list-style-type: none"> Helping people to recover from episodes of ill health or following injury Ensuring that people have a positive experience of care Treating and caring for people in a safe environment and protecting them from avoidable harm | Domain 3 <ul style="list-style-type: none"> Are CCG plans delivering better outcomes for patients? The CCG is delivering improved outcomes within financial resources, supported by clear and credible plans which are in line with national requirements (including excellent outcomes), and local Joint Health & Wellbeing Strategies. | ✓ | ✓ | ✓ | ✓ | ✓ |
| 3. Societal | <ul style="list-style-type: none"> Quality Prevention | <ol style="list-style-type: none"> The broader role of the NHS in society | Domain 2 <ul style="list-style-type: none"> Are patients and the public actively engaged and involved? The CCG demonstrates active and meaningful engagement with patients, carers and their communities which is embedded in the way that the CCG works. | ✓ | ✓ | ✓ | ✓ | ✓ |
| 4. Teaching & Research | <ul style="list-style-type: none"> Innovation | <ol style="list-style-type: none"> Freeing the NHS to innovate | Domain 5 <ul style="list-style-type: none"> Are CCGs working in partnership with others? | ✓ | ✓ | ✓ | ✓ | ✓ |

| 3Ts Benefit Group | QIPP Element | NHS Mandate | CCG Assurance Framework | 3Ts Investment Objective | | | | |
|-------------------------|---|---|--|--------------------------|--------|--------|--------|-----|
| | | | | Barry | Neuro. | Cancer | Trauma | T&R |
| | | | <ul style="list-style-type: none"> The CCG has strong collaborative arrangements in place for commissioning with other CCGs, local authorities and NHS England, as well as appropriate external commissioning support services and wider stakeholders including regulators. | | | | | |
| 5. Building design | <ul style="list-style-type: none"> Quality Innovation | 5. Treating and caring for people in a safe environment and protecting them from avoidable harm | Domain 1 <ul style="list-style-type: none"> Are patients receiving clinically commissioned, high quality services? The CCG consistently demonstrates a strong clinical and multi-professional focus which brings real added value, with quality at the heart of governance, decision-making and planning arrangements to commission safe, high quality and compassionate care for patients. | ✓ | ✓ | ✓ | ✓ | ✓ |
| 6. Facilities & Estates | <ul style="list-style-type: none"> Productivity | 5. Treating and caring for people in a safe environment and protecting them from avoidable harm | Domain 1 <ul style="list-style-type: none"> Are patients receiving clinically commissioned, high quality services? The CCG consistently demonstrates a strong clinical and multi-professional focus which brings real added value, with quality at the heart of governance, decision-making and planning arrangements to commission safe, high quality and compassionate care for patients. | ✓ | ✓ | ✓ | ✓ | ✓ |
| 7. Income | <ul style="list-style-type: none"> Productivity | 8. Finance | Domain 3 <ul style="list-style-type: none"> Are CCG plans delivering better outcomes for patients? The CCG is delivering improved outcomes within financial resources, supported by clear and credible plans which are in line with national requirements (including excellent outcomes), and local Joint Health and Wellbeing Strategies. | ✓ | ✓ | ✓ | ✓ | ✓ |

Quality & Safety / Fundamental Standards of Care

69. Since 2010 there have been at least eight major national reports and policy/strategy documents (including Keogh²⁹, Berwick³⁰, Willis³¹, Cavendish³², Clwyd-Hart³³ and *Compassion in Practice*³⁴) addressing Quality & Safety issues in the NHS and recommitting the service to fundamental standards of care.
70. In particular, the first independent inquiry into the care provided by Mid Staffordshire NHS Foundation Trust (Francis) was published in 2010; the second, which focused on the broader monitoring system, in 2013. These inquiries identified six core themes: culture, compassionate care, leadership, standards, information and openness, transparency and candour. The Government published its initial response, *Patients First and Foremost*³⁵, in 2013 and its full response, *Hard Truths*³⁶, in 2014.
71. The Trust has given careful consideration to the issues arising from the Francis Inquiry, including the formal recommendations and the Government's responses, and subsequent reports. It believes that the redevelopment of the Royal Sussex County Hospital estate is entirely aligned. Specifically:
- in the *scope* of the redevelopment, which includes replacement of the Barry Building's pre-Nightingale elderly care/medical wards with modern accommodation;
 - in the *process* of engaging patients, patient groups and wider stakeholders in the design; and
 - in supporting the '6Cs' of Compassion in Practice³⁷ (Care, Compassion, Competence, Communication, Courage, Commitment) through both the *process and design* of the redevelopment.
72. The ways in which Quality & Safety have been embedded in the planning and the redesign of 3Ts is detailed in the Commercial Case.

Dignity in Care for Older People

73. Frail older people, who often have complex care needs, constitute the largest group of patients in English hospitals (King's Fund, 2012). However the Health Service Ombudsman concluded in 2011 that *'the reasonable expectation that an older person or their family may have of dignified, pain-free end of life care, in clean surroundings in hospital, is not being fulfilled. Instead... NHS provision... is failing to respond to the needs of older people with care and compassion and to provide even the most basic standards of care.'*³⁸
74. In 2012 the Commission on Dignity in Care for Older People³⁹ reported that the *'unthinking disregard for older people's preferences and aspirations in the design and delivery of public and private services, and the*

²⁹ Prof. Sir Bruce Keogh (2013) *Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England: Overview Report*

³⁰ National Advisory Group on the Safety of Patients in England (2013) *A Promise to Learn – a Commitment to Act. Improving the Safety of Patients in England*

³¹ Willis Commission on Nursing Education (2012) *Quality with Compassion: the Future of Nursing Education*

³² Camilla Cavendish (2013) *An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings*

³³ Rt Hon. Ann Clwyd MP and Prof. Tricia Hart (2013) *A Review of the NHS Hospitals Complaints Systems: Putting Patients Back in the Picture*

³⁴ Department of Health (2012) *Compassion in Practice: Nursing, Midwifery and Care Staff – Our Vision & Strategy*

³⁵ Department of Health (2013) *Patients First and Foremost: the Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry*

³⁶ Department of Health (2014) *Hard Truths: the Journey to Putting Patients First – the Government Response to the Mid Staffordshire NHS Foundation Trust Public Enquiry*

³⁷ NHS England (2012) *Compassion in Practice: Nursing, Midwifery & Care Staff – Our Vision and Strategy*

³⁸ Parliamentary & Health Service Ombudsman (2011) *Care and Compassion? Report of the Health Service Ombudsman on Ten Investigations into NHS Care of Older People*

³⁹ Commission on Dignity in Care for Older People (2012) *Delivering Dignity: Securing Dignity in Care for Older People in Hospitals and Care Homes*

lack of consideration towards them, means that those who need support most often do not receive the right help of treatment.'

75. The 3Ts redevelopment aligns with the government's proposal to enshrine fundamental standards of care in legislation (from April 2015, subject to parliamentary approval). These regulations⁴⁰ address:
- dignity and respect;
 - consent;
 - safe care and treatment;
 - safeguarding service users from abuse and improper treatment;
 - meeting nutritional and hydration needs;
 - premises and equipment;
 - receiving and acting on complaints;
 - good governance;
 - staffing;
 - fit and proper persons employed; and
 - duty of candour.
76. In particular, the Commercial Case describes the focus on healthcare planning and design to provide bespoke clinical accommodation that:
- is clean, secure, suitable, properly used and properly maintained; and
 - supports patient privacy, dignity and respect.

Single-Sex Accommodation

77. Eliminating mixed-sex accommodation (except where it is in the overall best interest of the patient) is a long-standing NHS policy commitment. The Department of Health issued a series of guidance documents⁴¹ in 2009 and this was reinforced through subsequent NHS Operating Frameworks. The 2013 edition of the NHS Constitution also includes a new pledge that patients will not have to share hospital sleeping accommodation with patients of the opposite sex, except where clinically appropriate.
78. Only 12% of inpatient beds in the Barry/Jubilee Building are in single rooms; the remainder are in multi-bed bays of between two and ten beds each. Contrary to the recommendations of the Future Hospital Commission⁴², this therefore requires frequent patient moves to try to allocate single rooms to patients with the greatest need and avoid mixed-sex accommodation. This also impacts operational performance/efficiency: although data are not currently recorded by the Trust, research undertaken by the King's Fund found that *'every ward move puts at least one day on a length of stay and has a detrimental impact on patient experience.'*⁴³
79. Inpatient wards in 3Ts have been designed to address these issues. The proportion of single rooms varies between clinical specialties to reflect the needs of the particular patient group, ranging from 100% on the Clinical Infection Unit to 43% on the Neurosurgery ward. On average, 65% of inpatient beds will be in single rooms, with the remainder in four-bed multi-bed bays. This exceeds the government minimum of 50% single room accommodation in newbuilds. All single rooms and multi-bed bays will have single-sex en suite bathrooms and toilets.

⁴⁰ (Draft) Health & Social Care Act 2008 (Regulated Activities) Regulations 2014

⁴¹ Department of Health (2009) *NHS Single Sex Standards*

⁴² Royal College of Physicians (2013) *Future hospital: Caring for medical patients. A report from the Future Hospital Commission to the Royal College of Physicians*

⁴³ Royal College of Physicians (2012) *Hospitals on the Edge? The Time for Action*

Patient Choice

80. The NHS Constitution and Handbook set out patients' right to *'make choices about the services commissioned by NHS bodies and to information to support these choices.'* Specifically, *'the right to choose the organisation that provides your NHS care when you are referred for your first outpatient appointment with a service led by a consultant.'*
81. The NHS Future Forum⁴⁴ and NHS England⁴⁵ have described the role of choice and competition in improving the quality and efficiency of services. The obligations on commissioners to enable and extend patient choice are set out in the Health & Social Care Act 2012 and associated NHS (Procurement, Patient Choice and Competition) Regulations 2013 as well as in the *NHS Mandate 2014/15*.
82. Although there is relatively little elective patient activity within the scope of 3Ts (accounting for only 13% of the inpatient beds), the expansion in capacity for the Regional Centre for Neurosciences and Sussex Cancer Centre will ensure that patients and their GPs are able to choose their local provider, which many are not currently able to do. For example:
- the lack of neurosciences inpatient, critical care and theatre capacity means that 30% of GP referrals for Sussex residents (as measured by new neurosurgery Outpatient attendances) have to be made to London or other providers – in effect, these patients do not have the choice of their local provider or receiving services closer to home;
 - without the increase in capacity planned in 3Ts, the Sussex Cancer Centre will not be able to support its local population. Lack of inpatient capacity already means that Sussex patients who have undergone Bone Marrow Transplantation are not able to choose to return to the Royal Sussex County Hospital (their local provider) as quickly as they could, and a proportion of Sussex patients requiring inpatient radiotherapy have to 'board' at neighbouring NHS acute Trusts and then make the daily journey by ambulance for specialist treatment at the Sussex Cancer Centre.

Innovation, Health & Wealth

83. The 2011 national *Plan for Growth*⁴⁶ challenged the NHS, industry, academia and other interested parties to identify how the adoption and diffusion of innovation could be accelerated across the NHS. *Innovation, Health & Wealth*⁴⁷ (IHW) was published in December 2011 as part of the wider *Strategy for Life Sciences*⁴⁸. *Creating Change: IHI One Year On*⁴⁹ was published in 2012.
84. IHW defines innovation as *'an idea, service or product, new to the NHS or applied in a way that is new to the NHS, which significantly improves the quality of health and care wherever it is applied.'* It identified four key drivers for this:
- improving the health of the population (healthy population is more productive and economically active);
 - improving NHS productivity (managing increasing demand/expectations from within real-terms funding);
 - supporting growth in life sciences industries (which in turn enables the R&D the NHS requires for its development); and
 - international business opportunities (exporting innovation, ideas, expertise).

⁴⁴ NHS Future Forum (2011) *Choice and Competition: Delivering Real Choice*

⁴⁵ NHS England (2014) *Putting Patients First: NHS England's Business Plan 2014/15 – 2016/17*

⁴⁶ HM Treasury and Department for Business, Innovation & Skills (2011) *The Plan for Growth*

⁴⁷ Department of Health (2011) *Innovation, Health & Wealth: Accelerating Adoption and Diffusion in the NHS*

⁴⁸ Department for Business, Innovation & Skills (2011) *Strategy for UK Life Sciences*

⁴⁹ Department of Health (2012) *Creating Change: 'Innovation, Health & Wealth' One Year On*

85. As described in more detail in the Case for Change, the 3Ts investment contributes to the innovation agenda by:
- strengthening the Trust's R&D infrastructure;
 - strengthening the infrastructure for pre- and post-registration Learning & Development;
 - ensuring that the design itself reflects research evidence and best practice; and
 - ensuring that the investment objectives are formally evaluated through the Benefits Realisation framework and Post-Project Evaluation, which can therefore be shared more widely (diffusion).

Better Care Fund

86. The £3.8bn Better Care Fund (formerly the Integration Transformation Fund) was announced in 2013 to facilitate a transformation in the integration of health and social care. The fund is a single pooled budget to support health and social care services in achieving better outcomes for individuals, eg. delayed transfers of care, emergency admissions, re-ablement, admissions to residential and nursing care.
87. The aim of the Better Care Fund programme for Brighton & Hove is to provide person-centred, integrated care to the frail population (and those at risk of becoming frail), thereby improving health outcomes and delivering a more sustainable health and social care system. Initiatives in Mid Sussex and Lewes & the Weald have similar aims.
88. The Better Care Fund is predicated on the assumption that providing more integrated and proactive services in the community will reduce the need for hospital-based emergency and planned care. At a national level it is anticipated that hospital emergency activity will reduce by c. 15%. It should be noted, however, that Brighton & Hove already has comparatively low rates of emergency hospital admissions per capita, as do other Sussex CCGs. Brighton & Hove CCG has achieved a downward trend over recent years against the national trend of increasing rates and is in the lowest quintile nationally for non-elective admissions and for non-elective admissions for primary Ambulatory Care Sensitive conditions.
89. Given this relative performance and the investment already made in out-of-hospital services, the scope for achieving further savings from the acute sector in the short term (2015-2017) is considered more limited. However the Better Care Fund programme involves substantial redesign of the whole system and this transformational approach is expected to address inefficiencies created as a result of multiple barriers between services.
90. The associated reduction in acute sector activity (inpatient admissions, inpatient length of stay) has been factored into the Trust-wide activity/capacity model, and therefore into planning for the 3Ts redevelopment. However longer-term projections show increases in activity as at 2027 (five years after the completion of the 3Ts development). The demand/capacity section sets out scenarios/sensitivities and associated mitigations in planning over this timescale.

Transforming Urgent & Emergency Care

91. *Transforming Urgent & Emergency Care Services in England*⁵⁰ sets out the vision to provide highly responsive, effective and personalised services outside hospital for people with urgent but non-life threatening conditions, and hospital centres with the best expertise and facilities for people with more serious or life-threatening emergency needs. The latter will comprise 'Emergency Centres' and 'Major Emergency Centres' as part of emergency care networks, building on the success of Major Trauma Networks.
92. The recent Care Quality Commission inspection of the Royal Sussex County Hospital identified that the Emergency Department (ED) *'does not have enough physical space to deal with the number of patients*

⁵⁰ NHS England (2013) *High quality care for all, now and for future generations: Transforming urgent and emergency care services in England*

*that attend.*⁵¹ The ED is outside the scope of the 3Ts redevelopment. However by transferring sub-optimal facilities, including the temporary major trauma and neurosurgery theatres, into bespoke accommodation in the 3Ts Stage 1 building, space adjacent to the ED is freed up for future expansion. This therefore supports the Trust's ambition to be designated as a Major Emergency Centre and is a radiated benefit of the 3Ts investment.

The Financial Challenge

93. As recently reported by the Health Foundation⁵², it is calculated that there will be a shortfall in NHS funding of around £28-34bn by 2021. Cost pressures are projected to continue to grow at 4% a year. A growing and ageing population, rising incidence of chronic conditions and increasing input costs (principally pay) are all increasing pressure on the NHS. However funding is projected to grow by an average of only one-tenth of this: 0.4% in real terms (ie, adjusted for inflation) in 2014/15 and 2015/16.
94. NHS England has signalled a funding shortfall of a further £30bn between 2013/14 and 2020/21⁵³ – the '*most sustained budget crunch in the 66-year history [of the NHS].*'⁵⁴ The demographic, activity, financial and productivity assumptions underpinning the 3Ts redevelopment have been assessed in this context, and these are set out in detail in this Full Business Case.

Social Value

95. The Public Services (Social Value) Act 2012 '*requires public authorities to have regard to economic, social and environmental wellbeing in connection with public services contracts and for connected purposes*'. Social Enterprise UK describes social value as '*a way of thinking about how scarce resources are allocated and used [that] involves looking beyond the price of each individual contract and... at what the collective benefit to a community is when a public body chooses to award a contract.*'⁵⁵
96. Innovative work has already been undertaken with the Department of Health to articulate the societal benefits of the redevelopment (eg. local employment) and monetise non-financial benefits (through use of Quality Adjusted Life Years) as part of the benefits realisation plan. This has provided a more accurate and comprehensive assessment of the return on the planned investment. For example:
- a report for the UK Contractors Group⁵⁶ assessed that every £1 spent on construction output generates a total of £2.84 in total economic activity (ie. GDP increase); and
 - the Joseph Rowntree Foundation recently summarised the evidence that '*[f]or every incremental increase in [individual/family] income, there is an associated higher level of good health.*'⁵⁷
97. The charity Stonewall notes that '*[t]he financial leverage businesses exercise with suppliers... can also be used to advance equality.*'⁵⁸ The Race Equality Foundation has also recently highlighted the '*many potential synergies between the Equality & Diversity and Health Inequalities agendas: both are fundamentally concerned with reducing inequity in access to health-promoting resources.*'⁵⁹ Equality and involvement in 3Ts are discussed in more detail in the Consultation & Engagement section.

Public Health

98. The Government's strategy for public health⁶⁰ identifies that people living in the poorest areas will, on average, die seven years earlier than people living in richer areas and spend 17 more years living with

⁵¹ Care Quality Commission (August 2014) *Brighton & Sussex University Hospitals NHS Trust – Quality Report*

⁵² The Health Foundation (2014) *More than Money: Closing the NHS Financial Gap*

⁵³ NHS England (2013) *The NHS Belongs to the People: a Call to Action*

⁵⁴ NHS Chief Executive (April 2014) <http://www.england.nhs.uk/2014/04/01/simon-stevens/>

⁵⁵ Social Enterprise UK (2012) *Public Services (Social Value) Act 2012: A Brief Guide*

⁵⁶ L.E.K. Consulting (2009) *Construction in the UK Economy: the Benefits of Investment*

⁵⁷ Joseph Rowntree Foundation (2014) *How Does Money Influence Health?*

⁵⁸ Stonewall (2011) *Procurement: Embedding Lesbian, Gay & Bisexual Equality in the Supply Chain*

⁵⁹ Race Equality Foundation (2014) *Race Equality & Health Inequalities: Towards More Integrated Policy & Practice*

⁶⁰ HM Government (2011) *Healthy Lives, Healthy People: Update and Way Forward*

poor health. Against this backdrop, the *Public Health Outcomes Framework for England*⁶¹ sets two overarching outcomes for the public health system and beyond:

- increased healthy life expectancy; and
- reduced differences in life expectancy and healthy life expectancy between communities.

99. Planning for 3Ts has sought to promote public health across the range of its activities:

- a number of service developments within the scheme address key public health outcomes, eg. the role of the Major Trauma Centre in preventing premature mortality, reflecting the relative prominence of traumatic injury/mortality in the local area;
- a Health Impact Assessment has been undertaken on the scheme to ensure that potential benefits are maximised and disbenefits minimised, eg. ensuring that the design and Interior Design recognise the role that natural light and views of landscape/greenery play in patient recovery. (The associated recommendations and response/action plan are included in the Commercial Case);
- National Institute for Health & Care Excellence (NICE) public health guidance (including promoting physical activity and mental wellbeing, and management of obesity) has been incorporated into the brief for the Interior Design Strategy (eg. behavioural ‘nudges’ to increase use of stairs rather than lifts where appropriate) and the Trust’s Green Travel plan (which seeks to achieve a 5% modal shift among staff and patient/visitors from private cars to public transport, including cycling and walking); and
- the redevelopment also provides opportunities to improve the economic, social and environmental wellbeing of the local area (Social Value) through, for example, the Planning Conditions that at least 20% of the construction workforce be local and that 450 new jobs be created at the hospital (see Legal & Commercial Issues within the Commercial Case). The 1998 Acheson Report⁶² into health inequalities described the positive correlations between employment and household income and between income and health: providing additional training and employment to local people therefore also serves to contribute to the health of the local population.

Emergency Preparedness, Resilience & Response

100. Emergency Preparedness, Resilience & Response (EPRR) is governed by the Civil Contingencies Act 2004. The NHS’ approach to EPRR is set out in a number of policy documents: principally NHS England’s *Emergency Preparedness Framework 2013*⁶³, *Core Standards for EPRR*⁶⁴, *Business Continuity Management Framework*⁶⁵, NHS Standard Contract⁶⁶ and *Everyone Counts: Planning for Patients*⁶⁷. Resilience of the physical estate is also addressed in Health Building Note 00-07 (appended to the Commercial Case).

101. The 3Ts redevelopment supports the Trust’s planning for EPRR. Specifically:

- the Critical Care Unit has been designed so that it will be possible *in extremis* to double the number of ventilated patients, for example in the event of a ‘flu pandemic (currently the top risk on the UK Civilian Risk Register⁶⁸);

⁶¹ Department of Health (2013) *Improving Outcomes and Supporting Transparency Part 1A: a Public Health Outcomes Framework for England, 2013-2016*

⁶² Department of Health (1998) *Independent Inquiry into Inequalities in Health Report*

⁶³ NHS England (2013) *NHS England Emergency Preparedness Framework 2013*

⁶⁴ NHS England (2013) *Core Standards for Emergency Preparedness, Resilience & Response (EPRR)*

⁶⁵ NHS England (2013) *Business Continuity Management Framework (Service Resilience)*

⁶⁶ NHS England (2014) *NHS Standard Contract 2014/15: Particulars*

⁶⁷ NHS England (2013) *Everyone Counts: Planning for Patients 2014/15 to 2018/19*

⁶⁸ Cabinet Office (2013) *National Risk Register of Civil Emergencies – 2013 Edition*

- the Clinical Infection Service (CIS) facility will have 24 single inpatient rooms, each with en suite bathroom and toilet facilities, and no multi-bed bays. Eight of the inpatient rooms will be pressure-controlled, with separate gowning lobbies so potentially infectious patients can be isolated. These rooms are co-located so this zone can be 'locked down' (isolated and managed separately) in the event that this is required;
 - there will also be a pressure-controlled assessment/treatment area within the CIS facility, which has a separate entrance, waiting area and gowning lobby, and a separate staff changing facility (in other areas this is shared between wards).
102. Requirements for maintaining business continuity have also been factored into planning for the 3Ts decant programme, main scheme build and commissioning programme.

Summary of Strategic Alignment

| 3Ts Investment Objective | NHS Outcomes Frameworks | Putting Patients First 2014-2017 | The Mandate 2014/15 | NHS Constitution | Other National Policy | Contract/Registration Requirement | Monitor's Strategy 2014-17 |
|---|-------------------------|----------------------------------|---------------------|------------------|-----------------------|-----------------------------------|----------------------------|
| Barry Building Replacement | | | | | | | |
| • Elderly Care | ✓ | ✓ | ✓ | ✓ | ✓ | | |
| • Acute Brain Injury | ✓ | ✓ | | | ✓ | | |
| • Clinical Infection * | ✓ | ✓ | | | ✓ | | |
| Neurosciences | ✓ | ✓ | | | | ✓ | |
| Cancer | ✓ | ✓ | | | ✓ | ✓ | |
| Major Trauma & Critical Care | ✓ | ✓ | | | ✓ | ✓ | ✓ |
| Teaching & Research | | | | | | | |
| Teaching & Research | | | | ✓ | | | |
| Wider Benefits | ✓ | | | | ✓ | | |

* Also specialist/tertiary service.

Alignment with National, Regional and Local Strategy/Commissioning

| 3Ts Investment Objective | National Outcomes Frameworks | NHSE Commissioning/Standards | National | Regional (incl. Senate, HEKSS) Local (CCG, HWB) |
|-----------------------------------|---|--|--|---|
| Barry Building Replacement | | | | |
| Elderly Care | <ul style="list-style-type: none"> • Ensuring that People have a Positive Experience of Care: patient experience of hospital care (NHSOF 4b/c, 4.1) • Treating and caring for people in a Safe Environment and Protecting them from Avoidable Harm: patient safety (5a/b), HCAs (5.2) • Health Improvement: injuries due to falls in people aged 65+ (PHOF 2.24) • Safeguarding Adults whose Circumstances Make Them Vulnerable & Protecting from Avoidable Harm: proportion of people who feel services have made them feel safe and secure (4B) | <p>‘High quality care for all, now: [Priorities include] patient experience, patient safety, Compassion in Practice, Older People and End of Life Care...’ <i>Putting Patients First 2014/15-2016/17</i></p> <p>‘[P]riority areas where the Government is expecting particular progress to be made [include] improving standards of care and not just treatment, especially for older people and at the end of people’s lives [and] the diagnosis, treatment and care of people with dementia.’ <i>The Mandate 2014/15</i></p> | <p>‘The NHS also commits [pledges] to ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice.’ <i>NHS Constitution (2013)</i></p> <p>‘The NHS aspires to the highest standards of excellence and professionalism – in the provision of high quality care that is safe, effective and focused on patient experience... Respect, dignity, compassion and care should be at the core of how patients and staff are treated...’ <i>NHS Constitution (2013)</i></p> | <p>‘The current wards in the Barry Building were built 20 years before Florence Nightingale became a nurse... There are currently only 5% of single bedrooms in the Barry and Jubilee buildings. The number of bathrooms and toilets is also inadequate...</p> <p>Even though the name of the programme is ‘3Ts’ (Teaching, Trauma & Tertiary Care), this does not necessarily do justice to the significant element of the redevelopment which relates to District General Hospital services.’ <i>Brighton & Hove CCG Five-Year Plan 2014-19</i></p> |
| Acute Brain | <ul style="list-style-type: none"> • Preventing People | ‘In addition, we will seek to promote the | ‘Effective treatment [of stroke] | ‘By 2010 all appropriate heart |

| 3Ts Investment Objective | National Outcomes Frameworks | NHSE Commissioning/Standards | National | Regional (incl. Senate, HEKSS) Local (CCG, HWB) |
|--|--|--|--|---|
| <p>Injury Centre (incl. Stroke)</p> | <p>from Dying Prematurely: cardiovascular disease (NHSOF 1.1)</p> <ul style="list-style-type: none"> • Helping People Recover from Episodes of Ill-Health or Following Injury: improving recovery from stroke (NHSOF 3.4) • Healthcare Public Health & Preventing Premature mortality: under 75 mortality rate from all cardiovascular diseases (PHOF 4.4) • Delaying & Reducing the Need for Care & Support: the effectiveness of reablement services (ASCOF 2E) | <p>reconfiguration of stroke services across the country, building on the evidence-based model developed in London.’ <i>Putting Patients First 2014/15-2016/17</i></p> <p>‘Specialised services: concentrated in centres of excellence. The strategy will be built on the planning guidance statement: <i>For those who need them, specialised services for less common disorders need to be concentrated in centres of excellence where we know that the highest quality can be delivered.</i>’ <i>Putting Patients First 2014/15-2016/17</i></p> | <p>requires rapid transfer to a highly specialised unit... Stroke services in London have been reorganised to offer this... but this required [reducing] 32 admitting hospitals to only 8. The end result is that London has the best stroke services of any capital city in the world...’ <i>Transforming Urgent & Emergency Care Services in England: End of Phase 1 Report (2013)</i></p> <p>‘CCGs will wish to ensure that all stroke patients have access to timely specialist care... Strategic Clinical Networks can help to support this process.’ <i>Cardiovascular Disease Outcomes Strategy (2013)</i></p> <p>‘[T]he clinical evidence clearly demonstrates that the quality of care is greatly improved if stroke is treated in specialist centres. Each region is therefore pushing forward with the development of specialised centres for their populations with access to 24/7 brain imaging and thrombolysis delivered by expert teams. For example, by 2010, NHS South East Coast intends that all strokes, heart attacks and major injuries will be treated in such</p> | <p>attack, stroke and major trauma patients will receive their care from 24/7 specialist units.’ <i>Healthier People, Excellent Care (2008)</i></p> <p>‘Hyperacute services provide expert specialist clinical assessment, rapid imaging and therapeutic intervention, including delivery 24/7 of intravenous thrombolysis. Prompt access to high quality stroke care should involve a rapid stroke specialist assessment from a stroke physician and specialist nurse as well as a multidisciplinary assessment, including a swallow screen.’ <i>South East Coast Strategic Clinical Network Stroke Minimum Standards (August 2014).</i></p> |

| 3Ts Investment Objective | National Outcomes Frameworks | NHSE Commissioning/Standards | National | Regional (incl. Senate, HEKSS) Local (CCG, HWB) |
|---|---|--|---|---|
| | | | <p>specialist centres.’ <i>High Quality Care for All</i> (2008)</p> <p>‘People with suspected stroke should be immediately transferred to a hospital providing hyperacute services throughout the day and night...’ <i>National Stroke Strategy</i> (2007)</p> | |
| <p>Clinical Infection (HIV, ID)*</p> | <ul style="list-style-type: none"> • Ensuring that People have a Positive Experience of Care: patient experience of hospital care (NHSOF 4b/c) • Health Protection: people presenting with HIV at a late stage of infection (PHOF 3.4) • Healthcare Public Health & Preventing Premature mortality: mortality rate from communicable diseases (PHOF 4.8) | <p>‘Specialised services: concentrated in centres of excellence. The strategy will be built on the planning guidance statement: <i>For those who need them, specialised services for less common disorders need to be concentrated in centres of excellence where we know that the highest quality can be delivered.</i>’ <i>Putting Patients First 2014/15-2016/17</i></p> <p>‘HIV inpatient care will take place in acute providers who are able to demonstrate that they meet the specified criteria... [including] provision of 24-hour access for acute care...’ <i>2013/14 NHS Standard Contract for Specialised HIV Services (Adults)</i></p> <p>‘Key components of a specialised infectious diseases service [include]... dedicated inpatient beds staffed by specialist nurses and Professionals Allied to Medicine...’ <i>2013/14 NHS Standard Contract for Specialised Services for Infectious Diseases (Adult)</i></p> | <p>‘People with proven or suspected complications of HIV infection or its treatment who require admission to hospital should receive equitable and rapid access to care by appropriately trained staff either within a Consultant-led HIV specialist multidisciplinary team or within an acute medical team supported by immediate and continued engagement with specialist HIV expertise and advice.’ <i>Standards for HIV Clinical Care</i> (2013)</p> <p>‘We support the establishment of Infection Centres as they would provide an excellent opportunity to (a) develop expertise in clinical services and research; (b) improve collaboration between hospital, community and university settings; (c) provide training of infection specialists and others.’ <i>House of</i></p> | <p>HIV/Aids is identified as a specific health issue: ‘In 2011 Brighton & Hove had the ninth highest HIV prevalence in England... compared with England as a whole. This was the highest prevalence anywhere outside of London. Brighton & Hove also has the highest rates of common Sexually Transmitted Infections outside London.’ <i>Brighton & Hove Joint Health & Wellbeing Strategy</i> (2013)</p> |

| 3Ts Investment Objective | National Outcomes Frameworks | NHSE Commissioning/Standards | National | Regional (incl. Senate, HEKSS) Local (CCG, HWB) |
|--|---|---|--|---|
| | | | <i>Lords Science & Technology 4th Report (2003)</i> | |
| Regional Centre for Neurosciences | | | | |
| Neurosciences | <ul style="list-style-type: none"> Ensuring that People have a Positive Experience of Care: patient experience of hospital care (NHSOF 4b/c) | <p><i>‘Specialised services: concentrated in centres of excellence. The strategy will be built on the planning guidance statement: For those who need them, specialised services for less common disorders need to be concentrated in centres of excellence where we know that the highest quality can be delivered.’ Putting Patients First 2014/15-2016/17</i></p> <p><i>‘Access to elective care: Ensure that the full range of elective care services is commissioned in a way to deliver the NHS Constitution standards and quality for these services. This includes services for routine elective care, diagnostic, cancer services and a range of other quality markers.’ Putting Patients First 2014/15-2016/17</i></p> <p><i>‘Neurosurgical Units will provide a full range of elective and emergency services to meet the immediate needs of their catchment populations... These neurosurgical units are an integral part of regional clinical neuroscience centres and the majority form an essential component of their local Major Trauma Centre.’ NHS Standard Contract for Neurosurgery – Adult (2013)</i></p> | | |

| 3Ts Investment Objective | National Outcomes Frameworks | NHSE Commissioning/Standards | National | Regional (incl. Senate, HEKSS) Local (CCG, HWB) |
|-----------------------------|---|--|--|--|
| Sussex Cancer Centre | | | | |
| <p>Cancer</p> | <ul style="list-style-type: none"> • Preventing People from Dying Prematurely: cancer (NHSOF 1.4) • Healthcare Public Health & Preventing Premature mortality: under 75 mortality rate from cancer (PHOF 4.5) | <p>Cancer Services ‘Access to elective care: Ensure that the full range of elective care services is commissioned in a way to deliver the NHS Constitution standards and quality for these services. This includes services for routine elective care, diagnostic, cancer services and a range of other quality markers.’ <i>Putting Patients First 2014/15-2016/17</i></p> <p>Radiotherapy Standards include: ‘The radiotherapy capacity is adequate to meet the current demand, to improve cure rates, prevent and relieve symptoms, and improve patients’ experience, whilst minimising any long-term side effects of treatment.’ <i>2013/14 NHS Standard Contract for Radiotherapy (All Ages)</i></p> <p>Chemotherapy ‘There should be timely treatment with delivery of waiting time targets... The treatment environment is required to be fit for purpose and provide adequate privacy for patients...’ <i>2013/14 NHS Standard Contract for Chemotherapy (Adult)</i></p> | <p>Cancer Services ‘The quality of treatment has already improved significantly, with more widespread and rapid access to the latest forms of surgery, radiotherapy and drugs as well as the establishment of local and specialist MDTs across the country. However, there is more to do. Improving the quality of cancer treatment necessarily requires action from providers but it is for commissioners to ensure that the necessary action is taken so that the patients they serve are receiving a high quality of service and that the steps outlined in this chapter are acted upon.’ <i>Improving Outcomes: A Strategy for Cancer (2011)</i></p> <p>Radiotherapy ‘Commissioners should ensure that their radiotherapy providers have robust plans to provide adequate capacity to meet local demand... Cancer is predominantly a disease of later life and, with an ageing population, the demand for radiotherapy is expected to continue to increase. Due to inevitable fluctuations in referrals for treatment, services need to plan</p> | <p>Cancer is one of five strategic priorities: ‘Mortality from all cancers in people under 75 years of age is significantly higher in Brighton & Hove than England and the South East... In Brighton & Hove, screening uptake rates are generally lower than both regional and national figures.’ <i>Brighton & Hove Joint Health & Wellbeing Strategy (2013)</i></p> <p>‘Cancer is a high priority in East Sussex with particular areas in the county showing significantly higher rates than England for specific cancers.’ <i>East Sussex Health & Wellbeing Strategy 2013-16</i></p> <p>‘Cancer services are a key local priority.’ <i>Horsham & Mid Sussex CCG Five-Year Plan 2014-19</i></p> |

| 3Ts Investment Objective | National Outcomes Frameworks | NHSE Commissioning/Standards | National | Regional (incl. Senate, HEKSS) Local (CCG, HWB) |
|--------------------------|------------------------------|------------------------------|--|---|
| | | | <p>for a 13% greater capacity than average demand to ensure that they are able to treat patients in a timely way and comply with waiting times standards.’ <i>Radiotherapy Services in England</i> (2012)</p> <p>‘Access to radiotherapy is critical to improving outcomes and, to improve outcomes from radiotherapy, there must be equitable access to high quality, safe, timely, protocol-driven quality-controlled services focused around patients’ needs.’ <i>Improving Outcomes: A Strategy for Cancer</i> (2011)</p> <p>‘[T]he need for radiotherapy services was significantly underestimated by experts 15-20 years ago. As a result... there is a significant gap in radiotherapy capacity... and the position is set to worsen as cancer incidence increases over the next 10 years.’ <i>Radiotherapy: Developing a World Class Service for England</i> (2007)</p> <p>Chemotherapy ‘Commissioners should ensure that all providers use C-PORT or a similar capacity and demand modelling</p> | |

| 3Ts Investment Objective | National Outcomes Frameworks | NHSE Commissioning/Standards | National | Regional (incl. Senate, HEKSS) Local (CCG, HWB) |
|---|---|--|---|--|
| | | | <p>tool, in view of the year on year changes in activity and the recognition in this NCAG report that service infrastructure has not adequately responded in increases in demand... The quality of the environment for giving chemotherapy should also be assessed.' <i>Chemotherapy Services in England</i> (2009)</p> <p>'[C]oncerns and issues raised by both the local clinicians and the NCEPOD advisors [included] insufficient capacity on chemotherapy units, lead[ing] to unacceptable waiting times for treatment; shortage of beds in the Cancer Centre, lead[ing] to delays in admission for chemotherapy; insufficient beds in Cancer Centres to admit all patients who are neutropenic post chemotherapy; lack of HDU or ITU beds.' <i>For Better, for Worse</i> (2008)</p> | |
| Major Trauma Centre | | | | |
| Major Trauma & Critical Care | <ul style="list-style-type: none"> Helping People Recover from Episodes of Ill-Health or Following Injury: improving recovery from injuries and trauma (NHSOF 3.3) | <p>'Specialised services: concentrated in centres of excellence. The strategy will be built on the planning guidance statement: <i>For those who need them, specialised services for less common disorders need to be concentrated in centres of excellence where we know that the highest quality can be delivered.</i>' <i>Putting</i></p> | <p>'We must ensure that those people with the more serious or life-threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise changes of good survival and recovery [Major</p> | <p>'By 2010 all appropriate heart attack, stroke and major trauma patients will receive their care from 24/7 specialist units.' <i>Healthier People, Excellent Care</i> (2008)</p> |

| 3Ts Investment Objective | National Outcomes Frameworks | NHSE Commissioning/Standards | National | Regional (incl. Senate, HEKSS) Local (CCG, HWB) |
|--------------------------------|--|---|--|---|
| | <ul style="list-style-type: none"> • Enhancing Quality of Life for People with Long-Term Conditions: improving functional ability (NHSOF2.2) • Improving the Wider Determinants of Health: killed and seriously injured casualties on England's roads (PHOF 1.10) • Healthcare Public Health & Preventing Premature mortality: mortality rate from causes considered preventable (PHOF 4.1) • Delaying & Reducing the Need for Care & Support: the effectiveness of reablement services (ASCOF 2E) | <p><i>Patients First 2014/15-2016/17</i></p> <p>Current derogation (co-location of neuro-trauma) will be addressed through temporary move of neurosurgery, pending full move of Neurosciences into 3Ts.</p> <p>Extension of Interventional Radiology provision?</p> | <p>Emergency Centres].’ <i>Transforming Urgent & Emergency Care Services in England: End of Phase 1 Report (2013)</i></p> <p>‘All regions should be moving trauma service provision into regional trauma network configurations in 2010/11.’ <i>NHS Operating Framework for England 2011/12</i></p> <p>‘As major trauma is a relatively small part of the work of an Emergency Department, optimal care cannot be delivered cost-effectively by all hospitals.’ <i>Major Trauma Care in England (2010)</i></p> | <p>‘Hastings has significantly worse hospital admission rates for a range of different injuries including the rate of children and young people aged under-18 years admitted to hospital due to injuries... Road injuries and deaths are significantly worse than England in all districts and boroughs except Eastbourne. All districts and boroughs except Lewes have significantly worse admission rates than England for burn injuries.’ <i>East Sussex Health & Wellbeing Strategy 2013-16</i></p> |
| Teaching & Research | | | | |
| Teaching & Research | | | ‘The NHS aspires to the highest standards of excellence and professionalism... in the people it employs, and in the support, | |

| 3Ts Investment Objective | National Outcomes Frameworks | NHSE Commissioning/Standards | National | Regional (incl. Senate, HEKSS) Local (CCG, HWB) |
|--------------------------|---|------------------------------|--|--|
| | | | <p>education, training and development they receive...' <i>NHS Constitution</i> (2013)</p> <p>'Research and research evidence is part of the day to day operation of the NHS and is fundamental to creating an evidence based decision making culture within NHS England commissioning and the broader commissioning community.' <i>NHS England R&D Strategy</i> (draft) 2013-2018</p> | |
| Wider Benefits | | | | |
| General Benefits | <ul style="list-style-type: none"> Improving the Wider Determinants of Health: 16-18 year olds NEET (PHOF 1.5), sickness absence rate (PHOF 1.9), utilisation of outdoor space for exercise/health reasons (PHOF 1.16) | | | <p>Workplace health is identified as one of three priorities for 2013/14. <i>West Sussex Joint Health & Wellbeing Strategy 2013-15</i></p> |

Commissioning Strategies & Local Health Profiles

Societal Changes

103. The King's Fund⁶⁹ describes a number of significant societal changes that provide the background to this business case:

- demographic change: people are living longer and the population is ageing;
- social change: more people are living in single-person households and further from their extended family;
- the shifting burden of disease: premature death rates from cardiovascular diseases and cancer have declined but chronic conditions such as diabetes, asthma, chronic obstructive pulmonary disease, heart failure, arthritis and dementia have become more prevalent;
- public expectations: increased levels of per capita income and educational attainment have contributed to rising public expectations of the NHS. The NHS of the future will need to deliver more personalised, patient-centred services that give people genuine choice and control; and
- medical advances: new forms of diagnosis and treatment have contributed to long-term improvements in population health, and developments in genomics, stem cell research and other fields hold out promise for the future but have significant implications for future spending on health care.

NHS England

104. NHS England (NHSE) has been responsible for the commissioning of specialist services since April 2013. There is currently little empirical data on the rate of utilisation of specialist-commissioned services in Sussex, and NHS England's specialist commissioning strategy is currently under review. However NHSE has an £800m forecast overspend on specialised commissioning in 2014/15 and the Surrey & Sussex Area Team has the largest overspend (11.1% of contract value), although this is subject to ongoing negotiation.
105. The status is unclear of a previous public commitment to reduce specialist commissioned contracts from c. 200 to 15-30 nationally. Had this commitment been followed through, the Trust's current maximum catchment for specialised services of c. 1.6m would represent approximately 1/30th of the population of England. Although the future of this strategic intent is unclear, this illustrates that the Trust can achieve a viable catchment for most specialised services.
106. 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 has agreed the plan and timescales to achieve compliance. The Trust has undertaken this process in conjunction with the Area Team for a number of specialties, most notably for Major Trauma Centre services, and has agreed plans for addressing all service derogations by the end of 2014/15. Of 65 relevant service specifications, the Trust required derogation against nine, the majority of which were in non-3Ts services.
107. In light what is understood of specialist commissioning strategy, key issues to be resolved are:
- the commissioning levers to be used to deliver financial balance in the context of current overspends;
 - 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 pathways;
 - the process for agreeing clinical co-dependencies between specialised services where services are within a specific provider's portfolio and physically co-located; and
 - contractual mechanisms for consolidating provision around a smaller number of providers, including federated provision (ie. where one provider leads on specialist elements of general acute care provided by a number of other organisations).

⁶⁹ The King's Fund (2011) *Where Next for the NHS Reforms? The Case for Integrated Care*

108. The 3Ts investment objectives continue to align with these strategic priorities, and in particular replacement of poor and functionally unsuitable clinical estate with bespoke facilities that enable the Trust to address current specialised commissioning derogations, and expansion in capacity (required even after allowing for Trust efficiencies, Local Health Economy Demand Management plans and Better Care Fund assumptions, as set out in the Long-Term Financial Model).

Clinical Commissioning Groups

109. This summary is drawn from the NHS England Public Health Profiles⁷⁰ (2013) for the Trust's three principal CCGs, which collectively account for 59% of the Trust's NHS income. (Other CCGs each account for no more than 8% of the Trust's NHS income).

Brighton & Hove

110. The headline assessment of health needs in Brighton & Hove is that disease prevalence is below the national average in every recorded area except for depression and mental health disorders. This reflects the fact that the city has a relatively young, educated, healthy population with good access to infrastructure and services.
111. However, Brighton faces the challenges of a typical urban population. Key factors identified from the local Joint Strategic Needs Assessment and Public Health Indicators:-
- 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 large areas of urban deprivation.
 - Prevalence of drug use is typical for this type of population and is 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. However deaths attributable to smoking are 18% higher than across the wider South East (but are comparable to other similar areas in the UK).
 - The younger population carries distinct challenges: sexually transmitted infections and hospital stays for self-harm are both in the top decile nationally.
 - Rates of dementia diagnosis are well below the assumed prevalence, suggesting under-diagnosis and treatment.
 - Deaths from circulatory, coronary and respiratory disease are 7-11% lower than both the UK average and statistically similar parts of the UK. Cancer mortality is above the national average across all tumours and in each of the three most prevalent tumour sites.
 - Brighton has a term-time population of 34,000 students, one of the largest in the UK. Because of the resurgent tourist industry, non-residents staying overnight in the city during summer weekends can be as high as 10-15,000, with significantly higher numbers visiting for the day. The volume of visitors to the city has a significant influence on Emergency Department activity, stimulating high levels of demand for minor/primary unscheduled care.
112. In comparison to statistically similar CCGs, Brighton & Hove has a relatively high level of elective activity but low levels of non-elective activity per capita. Based on NHS England/Public Health England 'Commissioning for Value' analysis, rates of acute intervention in cancer are significantly below comparators.
113. Brighton & Hove CCG's 2012-2017 commissioning strategy identifies elective care costs as a significant area to address. NHS England analysis has identified musculoskeletal-related elective care as the most significant area of potential cost reduction; this is reflected in the CCG's leadership of a recent joint procurement exercise for a prime provider in musculoskeletal care, which aims to achieve improved triage

⁷⁰ Public Health England (2013) *Health Profiles 2013*

and redirection away from acute care. A similar procurement exercise has taken place in dermatology services and other areas are likely to follow.

114. Brighton & Hove CCG has reflected its relatively low rates of unscheduled care utilisation in planning for the Better Care Fund. The CCG is projecting a reduction of £3.3m in acute care costs, which equates to c. 9% of relevant admissions and is below the national projection of 15%. Plans to achieve this target assume the development 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 institute comprehensive walk-in primary care, co-located with the Emergency Department at the Royal Sussex County Hospital.

Horsham & Mid-Sussex

115. Horsham & Mid Sussex CCG covers the area directly to the north of Brighton & Hove, up to the boundaries with Crawley, Kent and Surrey. This area is characterised by smaller market towns and villages; the largest of these is Haywards Heath, where the Trust's Princess Royal Hospital is located.
116. 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.
117. Although there is no separate Joint Strategic Needs Assessment (JSNA) analysis for mid-Sussex, the 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 healthcare is the high proportion of older residents: mid-Sussex has a high population of people in nursing homes, with one particular major sheltered residential development. A third of all residents are registered as having a long-term condition.
118. Horsham and Mid-Sussex CCG released a *Strategic Service Development Plan* (SSDP) in July 2014. The SSDP highlighted the medium to long-term need for more integration of acute ambulatory and community/primary care services. It recognised the role of the Princess Royal Hospital as both a local hospital for the mid-Sussex community and also an elective surgical hub across the Trust's catchment. The SSDP also indicated opportunities for greater utilisation of the PRH estate in the future, redeploying space released by commissioning initiatives planned to reduce emergency demand.
119. Overall rates of care utilisation for Horsham & Mid-Sussex CCG are below the national average for every major indicator and are in the lowest quartile for every indicator except day-case and elective care. Spend on non-elective admissions per capita is lower than for ten comparator CCGs. The only areas of relative overspending at disease level are musculoskeletal care and neurological care; the former is reflected in the CCG's participation in the recent tender for a musculoskeletal prime provider. Hypertension and cholesterol levels in patients with chronic disease are assessed as relatively poorly managed, similar to the pattern in Brighton & Hove.
120. Horsham & Mid-Sussex CCG, with West Sussex County Council and the other West Sussex CCGs, has a well-developed sub-acute care strategy, which forms the basis of planning for the Better Care Fund. 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 the Princess Royal Hospital.
121. The CCG has recently shared with the Trust a draft *Strategic Service Development Plan*, which confirms the Princess Royal Hospital's status in the CCG's plans as a hub for both acute and community-facing

healthcare, and the requirement for ongoing development of services that serve the mid-Sussex population in the face of significant population growth.

122. In order to deliver the Better Care Fund requirements, Horsham & Mid-Sussex CCG will need to reduce non-elective admissions by 19%, which equates to £3m in income. In the context of the relatively low levels of acute care utilisation seen in the Horsham & Mid-Sussex area, this is considered a stretching aspiration.

High Weald Lewes Havens

123. Lewes District Council area is to the North East of Brighton & Hove, covering the towns of Lewes and Newhaven and the rural area up to the border with Uckfield. The Trust operates daycase and outpatient services from Lewes Victoria Hospital, which is owned by East Sussex Healthcare NHS Trust.
124. The large elderly population has 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. Cancer and cardiovascular disease mortality is lower than expected based on national comparators. However High Weald Lewes Havens CCG has prevalence in the top quartile nationally and is above comparator CCGs for atrial fibrillation, cancer and cardiovascular disease and stroke.
125. In comparison to similar CCGs, High Weald Lewes Havens CCG has relatively high levels of elective acute care utilisation: spend on first outpatient attendances following referral is a particular outlier. Spend on non-elective care is in the lowest quartile nationally and lower than comparator CCGs. In major disease groups, the pattern of demand follows the overall trend, with high rates of planned care utilisation in musculoskeletal services in particular. Trauma and Injury spend is also relatively high.
126. For almost all chronic diseases, primary care effectiveness is assessed to be similar to national and comparator areas. The CCG has also recently launched a procurement for the management of the musculoskeletal pathway, and has expressed interest in exploring with the Trust opportunities to transform planned care pathways, reflecting the relatively high levels of utilisation in this area.
127. The CCG operates in an unusual strategic context, with acute flows split between the Trust, Maidstone & Tunbridge Wells NHS Trust and East Sussex Healthcare NHS Trust, but community services (including step-down and community nursing provision) provided by East Sussex Healthcare NHS Trust. Reflecting concerns with current provision, the CCG has recently served notice on its community services contract from April 2015. The CCG has an explicit strategy of strengthening both planned and unscheduled care provision in its three main community sites: Uckfield, Lewes and Crowborough.
128. In terms of general patient flow, Uckfield's population is served by both Maidstone & Tunbridge Wells NHS Trust and by BSUH from the PRH site. Lewes is served almost exclusively by the Trust, from both sites. Any eventual redesign and re-procurement of community services in the CCG's catchment will therefore have a significant impact on Trust provision.
129. The CCG's Better Care Fund plans will be part of a wider East Sussex plan; relatively little detail is known at this time but in order to deliver the Better Care Fund requirements, High Weald Lewes Havens CCG will need to reduce non-elective admissions by 19%, which equates to £3m in income.

Neighbouring Acute Providers' Strategies

| Provider | Competitive Advantages | BSUH Strategic Mitigations |
|---|--|--|
| <p>East Sussex Healthcare NHS Trust Eastbourne District General Hospital (23 miles); The Conquest Hospital, Hastings(40 miles)</p> <ul style="list-style-type: none"> • ESHT provides 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 Trauma & Orthopaedics, 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. • ESHT also provides community services for all of the East Sussex area, coterminous with the Local Authority area and including the Lewes/Havens catchment (served by BSUH for acute care). • While consolidating general services at Hastings and thus offering opportunities for catchment growth to BSUH, these are in low-margin services; ESHT is competing with BSUH for higher-margin elective surgical care. | <ul style="list-style-type: none"> • None identified | <p>N/A</p> |
| <p>Western Sussex Hospitals NHS Foundation Trust Worthing General Hospital (12 miles); Southlands Hospital (6 miles); St Richard's Hospital, Chichester (28miles).</p> <ul style="list-style-type: none"> • WSHFT provides general acute services to the coastal West Sussex population, with a catchment largely coterminous with Coastal West Sussex CCG. • Generally the BSUH/WSHFT relationship is collaborative, with joint provision in vascular, oncology and neurological care. However WSHFT has made a recent decision to locate its elective ophthalmology provision to Southlands Hospital, which threatens the western part of the Brighton & Hove catchment for this key margin-generating service. • It will be critical for operationalising BSUH's oncology strategy to maintain the Sussex Cancer Centre's links with WSHFT since the Surrey-based Cancer Networks represent an emergent challenge. | <ul style="list-style-type: none"> • Access to better estate for Ophthalmology at Eastbourne. • Opportunity to choose alignment on cancer provision between multiple networks. | <ul style="list-style-type: none"> • 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. |

| Provider | Competitive Advantages | BSUH Strategic Mitigations |
|--|---|---|
| <p>Surrey & Sussex Healthcare NHS Trust SaSH is a general acute provider based at Redhill, Surrey. It operates outpatient-based services at Crawley and Horsham Hospitals.</p> <ul style="list-style-type: none"> Typically SaSH operates as part of Surrey-based networks for extended care, with little active competition on the catchment boundary. However it 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 Foundation Trust application that reflects historic challenges around catchment size and financial sustainability. | <ul style="list-style-type: none"> Has secured access to radiotherapy facilities ahead of delivery of BSUH satellites. | <ul style="list-style-type: none"> Oncology strategy to offer clear plan for development of improved provision and critical mass across Sussex. |
| <p>Queen Victoria Hospital NHS Foundation Trust Queen Victoria Hospital (33 miles) –provider of specialist burns, plastics and ophthalmology care.</p> <ul style="list-style-type: none"> 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. | <ul style="list-style-type: none"> None identified - looking for integration partners. National/international reputation as centre for excellence in Burn Care & Plastic Surgery. | <ul style="list-style-type: none"> Key potential strategic partner for delivering Sussex-wide services strategy. |
| <p>Sussex Community NHS Trust SCT provides community services across Brighton & Hove and West Sussex.</p> <ul style="list-style-type: none"> In the last three years SCT has exited a number of small planned care services, focussing on its core business areas of community nursing, therapies and sub-acute bed provision, and on key unscheduled care service developments such as OneCall in West Sussex. SCT is a key integration partner for BSUH in implementing its strategy. | <ul style="list-style-type: none"> Improving reputation and smaller scale meaning more nimble in responding to commissioner aspirations. | <ul style="list-style-type: none"> Key strategic partner. Mitigation to strategic threat is closer working relationship on key initiatives: unscheduled care and frailty, 7-day working, HIV/GUM. |

Brighton & Hove City

130. Brighton & Hove Strategic Partnership's *Sustainable Community Strategy* (2010)⁷¹ sets out a vision for the city for the next two decades. This includes eight key priorities, which the Council's 2011 *Corporate Plan*⁷² translates into specific actions:

- promoting enterprise and learning;
- reducing crime and improving safety;
- improving health and wellbeing;
- strengthening communities and involving people;
- improving housing and affordability;
- living within environmental limits and enhancing the environment;
- promoting sustainable transport; and
- providing quality advice and information services.

131. In April 2013 Brighton & Hove's Sustainability Action Plan received accreditation from sustainable development charity BioRegional, establishing it as the world's first 'One Planet City'. The One Planet Living⁷³ initiative has ten core principles:

- making buildings more energy efficient and delivering all energy with renewable technologies;
- reducing waste, reusing where possible, and ultimately sending zero waste to landfill;
- encouraging low carbon modes of transport to reduce emissions and reducing the need to travel;
- using sustainable healthy products, with low embodied energy, sourced locally, made from renewable or waste resources;
- choosing low impact, local, seasonal and organic diets and reducing food waste;
- using water more efficiently in buildings and in the products we buy; tackling local flooding and water course pollution;
- protecting and restoring biodiversity and natural habitats through appropriate land use and integration into the built environment;
- reviving local identity and wisdom; supporting and participating in the arts;
- creating bioregional economies that support fair employment, inclusive communities and international fair trade; and
- encouraging active, sociable, meaningful lives to promote good health and wellbeing.

132. These principles/priorities have significantly informed planning for the 3Ts redevelopment, for example the Sustainability Statement (appended – Commercial Case) shows the alignment with Brighton & Hove Local Planning Policy SU2 (efficiency of development in the use of energy, water and materials) and SU16 (production of renewable energy). The approach to sustainability is set out in more detail in the Commercial Case.

⁷¹ Brighton & Hove Strategic Partnership (2010) *Creating the City of Opportunities: a Sustainable Community Strategy for the City of Brighton & Hove (3rd Edition)*

⁷² Brighton & Hove City Council (2011) *Corporate Plan 2011-2015*

⁷³ <http://www.oneplanetliving.net/what-is-one-planet-living/the-ten-principles/>

Trust Business Strategies

133. The Trust has a number of business strategies that are of particular relevance in considering this business case. These are set out below.

Foundation Trust / Integrated Business Plan

134. Foundation Trust status is a key aspiration and the Trust expects to be authorised during 2016. It remains committed to achieving this on its current 'footprint', ie. without merging with another specialist centre or community services provider.

135. The Integrated Business Plan (appended) sets out the Trust's vision and plan for the next five years. The Trust is historically a high-performing organisation, with two consecutive years of delivering financial surplus on plan. It also has a strong focus on patient safety and experience, with established clinically-led safety and quality governance. However it faces specific challenges in the delivery of timely and responsive unscheduled care and has not consistently met the key Emergency Department 4-hour standard since Q2 2012/13.

136. As set out in its Clinical Strategy 2014-2017 (appended), the Trust has a number of immediate priorities to progress its strategic vision:

- deliver acute unscheduled care that is fully integrated with the wider health and social care system, leading to a lower level of utilisation of its inpatient bed base by patients who are frail and elderly;
- work with partners to improve planned care pathways, recognising the contribution this makes to the overall sustainability of the Trust;
- modernise clinical pathways for more acutely unwell patients (initially those with stroke and fractured hips, and then addressing seven-day working for inpatient care);
- work with partners to design and operate networked models of care for more specialised services, and in parallel progress teaching and research opportunities; and
- consolidate and grow tertiary services for patients across the wider regional catchment, reusing inpatient capacity released by changes in local unscheduled care provision.

137. The Trust is confident that the market environment facilitates this 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 it occupies a dominant position across most of Sussex for the specialist services it operates. Growth in these services is predicated on expanding catchment and increasing clinical repertoire/sub-specialisation so that Trust-led networks operate across the whole of Sussex and have the opportunity to expand into Kent and Surrey where feasible to do so, and on increasing the scope of provision so that patients can be repatriated from London.

138. This vision is fully aligned with the goals of the Trust's principal commissioners, evidenced in particular through their ongoing support for the 3Ts redevelopment and the underlying principle that the Royal Sussex County Hospital continue to develop as the acute specialist hub for Sussex and a notable 'fixed point' in the Local Health Economy.

139. This strategy mitigates some of the severe financial pressure faced by NHS providers over the coming years but recognises that further change will be required. The Integrated Business Plan (IBP) projects that prices for the work the Trust undertakes will fall by 0.6-1.5% per annum for the next five years, whereas pay costs, which are the Trust's principal cost driver, are expected to increase by 1.5-3.5% per annum over the same period. In five years' time the Trust will therefore need to be providing more units of clinical activity in all settings of care, with fewer substantively employed staff compared with today.

140. This will require significant transformation in the way the Trust operates its clinical services. However the Trust has a strong track record in delivering challenging Cost Improvement Plans (CIPs) while maintaining the safety and quality of care. Work to refine the three-year rolling CIPs programme, which was supported by PricewaterhouseCoopers (PwC) in 2013 and KMPG in 2014, is currently nearing completion.

141. The IBP includes sensitivities for the financial assumptions and sets out a number of potential mitigations, approved by the Board of Directors and clinical leadership, that would recover the Trust's cash and Income & Expenditure positions to sustainable levels should the downside scenario occur, whether the challenge relates to cost/price or activity volume.
142. In support of this strategy, the Trust has made significant progress in preparing its governance structures and processes for Foundation Trust status. It is currently undertaking further work on Values & Behaviours, management structure and Safety & Quality governance, which is due for completion by the end of 2014. The Trust has consulted on a proposal for Foundation Trust governance, which has been revised in the light of comments and feedback from other Foundation Trusts and commissioners.
143. Planning for the 3Ts redevelopment is fully integrated and aligned with work to prepare for Foundation Trust application/status and many of the requirements are the same, eg. development of the Long-Term Financial Model and related assumptions, scenario planning and commissioner support.

Clinical Strategy

144. In March 2014 the Board of Directors approved a five-year Clinical Strategy for the Trust (appended). The strategy sets out:
 - key service developments for 2014-17;
 - activity/capacity assumptions to 2019 (ie. the year before 3Ts Stage 1 is expected to open), which has enabled the development of a seamless capacity model from 2014 to 2028 (five years after 3Ts Stage 3 is expected to complete), including the impact of demand management and the Better Care Fund; and
 - a strategic direction for each of the Trust's principal sites for the five year planning period and beyond.
145. The development of the Clinical Strategy has enabled the Trust and key partners/stakeholders to test and reconfirm that the 3Ts plans continue to align with the overall strategic direction of the organisation and in particular the Royal Sussex County Hospital site.

Values & Behaviours

146. In 2013 the Trust launched its *Foundations for Success* programme, which included the development of a framework for staff Values & Behaviours (appended). Following an extensive programme of engagement, the Trust Values & Behaviours 'blueprint' was launched in May 2014 and covers five core domains:
 - Communication;
 - Kindness & Understanding;
 - Fairness & Transparency;
 - Working Together; and
 - Excellence.
147. Detailed planning for the implementation phase is currently underway. Work previously undertaken to 'embody' patient-centred values in the design of the 3Ts buildings is fully aligned with this, eg. the adoption of a 'therapeutic landscape' philosophy and innovations that embed Quality & Safety (such as Infection Prevention & Control) within the physical design. This is described in more detail in the Commercial Case.

HR & Workforce Strategies

148. The Trust ten-year HR strategy (appended) was approved by the Board of Directors in 2012 and sets out a modernisation plan to support the Trust's strategic ambition. This focuses on three elements: leading-edge HR policies, progressive people development and effective performance management.

149. In line with this plan, the HR function's focus since 2012 has been on identified areas of weakness, including resourcing, recruitment, long-term sickness absence management, performance management and staff engagement.
150. Workforce planning for 3Ts is set out in more detail in the Management Case. This has been aligned with the development of various iterations of the Trust-wide Ten-Year Workforce Plan, as submitted to the Trust Development Authority in January (2013/14 Forecast Outturn and Full Year 2014/15), March and April (updated 2013/14 Forecast Outturn and Two Year Operating Plan 2014/15 to 2015/16) and June 2014 (Five Year Strategic Plan 2014/15 to 2018/19), and to Health Education Kent, Surrey & Sussex in June 2014 (Five Year Forecast Demand Plan 2014/15 to 2018/19, as amended).

Recruitment & Retention

151. The Trust's strategy for Recruitment & Retention includes recruitment from local, UK and overseas areas and a renewed focus on retention and on 'grow your own' development programmes. This aims to ensure regular availability of both professionally-registered and non-professionally registered staff, in particular in high turnover and hard-to-fill posts.
152. To support the selection and appointment of competent and compassionate clinical staff, the Trust will continue to roll out competency- and value-based recruitment training for staff responsible for selection, as well as developing a more flexible workforce through new and extended roles that support more innovative models of care.

Education & Learning

153. *'Every person working in NHS-funded care has a duty to identify and help to reduce risks to the safety of patients, and to acquire the skills necessary to do so in relation to their own job, team and adjacent teams. Leaders of health care provider organisations, managers, clinical leaders and Health Education England have a duty to provide the environment, resources and time to enable staff to acquire these skills.'* (Berwick review⁷⁴)
154. In 2014 the Board of Directors approved the Trust Education & Learning Strategy (appended). This drew on a number of national reports, including *Innovation, Health & Wealth*⁷⁵, Francis⁷⁶, Keogh⁷⁷, Berwick, Willis⁷⁸, Cavendish⁷⁹, Clwyd-Hart⁸⁰ and *Compassion in Practice*⁸¹. The strategy identifies five immediate education and learning priorities for the Trust:
- Multidisciplinary (and multi-organisational) learning;
 - Technology-Enhanced Learning (TEL), incl. simulation;
 - Human Factors⁸²;
 - Ethics & Compassion; and
 - 'Fitness for Purpose' (including quality, efficiency and cost-effectiveness).

⁷⁴ National Advisory Group on the Safety of Patients in England (2013) *A Promise to Learn – a Commitment to Act. Improving the Safety of Patients in England*

⁷⁵ Department of Health (2011) *Innovation, Health & Wealth: Accelerating Adoption and Diffusion in the NHS*

⁷⁶ Robert Francis QC (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*

⁷⁷ Prof. Sir Bruce Keogh (2013) *Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England: Overview Report*

⁷⁸ Willis Commission on Nursing Education (2012) *Quality with Compassion: the Future of Nursing Education*

⁷⁹ Camilla Cavendish (2013) *An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings*

⁸⁰ Rt Hon. Ann Clwyd MP and Prof. Tricia Hart (2013) *A Review of the NHS Hospitals Complaints Systems: Putting Patients Back in the Picture*

⁸¹ Department of Health (2012) *Compassion in Practice: Nursing, Midwifery and Care Staff – Our Vision & Strategy*

⁸² Defined as 'environmental, organisational and job factors, and human and individual characteristics, that influence behaviour at work...' Health & Safety Executive

155. The 3Ts contribution to the Trust's Education & Learning Strategy is set out in more detail in the Case for Change.

Estate Strategy

156. The Board of Directors approved the Trust ten-year Estate Strategy in 2012. This assesses the current Condition Backlog Maintenance requirement as £15.8m at 2011 prices (works cost, ie. excluding VAT, professional fees and contingency). This is split almost equally between the Brighton and Haywards Heath campuses. The likely deterioration of the estate between 2011/12 and 2021/22 adds a further £26.0m (works cost) over the period.
157. Within the context of the 3Ts redevelopment, the age and condition of the estate at the Royal Sussex County Hospital varies considerably. The condition of buildings within the 3Ts redevelopment area have been assessed as poor ('Condition C') including the majority of buildings within the Stage 1 site area and within Stage 2 the Barry Building (1828). The Sussex Cancer Centre which forms the Stage 3 site area has been assessed as satisfactory ('Condition B').
158. The Trust has continued to invest in the operational estate and this is reflected in the relatively low assessed works cost of high-risk backlog maintenance (£272k). However backlog maintenance will need to be addressed to ensure that the estate is maintained to an appropriate level of quality and safety, and careful attention paid to other categories of backlog maintenance to ensure that they do not become high risk. Statutory compliance can never be considered acceptable until the Trust is fully compliant; the principal risk currently relates to fire compliance.
159. The recent Care Quality Commission inspection identified the challenges of providing the appropriate levels of patient privacy and dignity in such outdated estate. This is described in more detail in the Case for Change.

Carbon Management Plan

160. The Climate Change Act 2008 requires reductions in carbon emissions of 26% by 2020 and 80% by 2050 (against the 1990 baseline). The 2009 *NHS Carbon Reduction Strategy*⁸³, 2010 update⁸⁴ and *Sustainable Development Strategy*⁸⁵ identify the challenges and opportunities for the NHS in progressing the sustainability and carbon reduction agenda. The NHS is responsible for c. 25% of the total public sector carbon emissions and 5% of all road traffic in England. Carbon dioxide emissions attributable to the NHS in England alone are greater than the total emissions from all aircraft departing from London Heathrow airport⁸⁶.
161. In 2011 the Trust approved its Carbon Management Strategy, *Saving Carbon, Improving Health*. Investment in 3Ts will contribute to this, for example by:
- including a Combined Heat & Power (CHP) plant within the scope of the redevelopment;
 - utilising modern design, insulation and building materials, which will minimise energy wastage (described in more detail in the Commercial Case); and
 - supporting the extension of the Green Travel Plan, which includes a 5% modal shift from private cars to public transport (including bicycles and walking) among staff, patients and visitors.

Electronic Patient Record

162. In 2012 the Trust signed a strategic partnership with Alert Life Sciences to implement an Electronic Patient Record (EPR) system. The value of the investment is £25.3m, against which the business case now

⁸³ NHS Sustainable Development Unit (2009) *The NHS Carbon Reduction Strategy for England*

⁸⁴ NHS Sustainable Development Unit (2010) *Saving Carbon, Improving Health*

⁸⁵ NHS England & Public Health England (2014) *Sustainable, Resilient, Healthy People & Places: a Sustainable Development Strategy for the NHS, Public Health and Social Care System*

⁸⁶ The King's Fund / Naylor, C. et al (2012) *Sustainable Health and Social Care: Connecting Environmental and Financial Performance*

projects £25m (net) cash-releasing benefits over the planning period, plus significant additional non-cash releasing efficiencies and other patient Quality & Safety benefits. (This is described in more detail in the IM&T section).

Research & Development Strategy

163. The Trust's Research & Development Strategy (appended) was approved in 2014. The Trust's aim is to make the necessary step-change in research capacity/capability to produce outputs comparable to other, long-established Teaching Hospitals. The ambition for the next ten years is to become a centre of research excellence, operating at an international level.
164. The Strategy envisages maintaining a mixed portfolio of research, combining commercial, National Institute for Health Research, charity, Research Council and other funding sources. It aims to build on existing areas of clinical expertise (eg. Cancer, Cardiology, Infection, Major Trauma, Neurology, HIV, Paediatrics, Rheumatology) and explore new opportunities, including:
- through cross-specialty working (eg. Medical Informatics and Integrated Health Care);
 - network studies, in line with the Kent, Surrey & Sussex Local Clinical Research Network recommendations; and
 - engaging with the local Academic Health Science Network on key research themes such as dementia.
165. This will involve broadening the scope of work, securing more complex interventional work (including overnight stays) and establishing a relationship with an industrial partner to develop business and research opportunities. The Trust and local academic partners intend to establish a Clinical Trials Unit (CTU), with a view to seeking provisional NIHR accreditation at the next opportunity in Spring 2015.
166. The Trust is also planning to develop (initially within Local Clinical Research Network Division 5) the 'patient identification centre' model, in partnership with other acute Trusts and primary and community care providers. The Trust will be developing shared care agreements within the Sussex Cancer Network to widen opportunities for patient participation in clinical trials. In addition to increasing the number of patients who have the opportunity to enrol in trials, this also aims to mitigate the potential disadvantages for research activity in the Any Qualified Provider⁸⁷ commissioning model, and to broaden research beyond solely hospital-based activity.
167. The investment in 3Ts will make a significant contribution to the Trust Research & Development Strategy – this is detailed in the case for change.

Linked Radiotherapy Unit

168. Separate business cases are being developed to establish radiotherapy units at Eastbourne District General Hospital (East Sussex Healthcare NHS Trust) and St Richard's Hospital in Chichester (Western Sussex Hospitals NHS Foundation Trust), linked to the Sussex Cancer Centre. These developments form part of the overall capacity planning for radiotherapy for East Sussex, West Sussex and Brighton & Hove. This includes the planned redevelopment of the Sussex Cancer Centre in 3Ts, and activity/capacity planning for radiotherapy provision in 3Ts is therefore aligned.

Site Reconfiguration

Background

169. The Royal Sussex County Hospital went live as the regional Major Trauma Centre in April 2012 although the Regional Centre for Neurosciences is not due to transfer onto the site until 3Ts Stage 1 (assumed

⁸⁷ The Any Qualified Provider (AQP) policy means that when patients are referred, usually by their GP, for a particular service, they should be able to choose from a list of qualified providers that meet NHS service quality requirements, prices and normal contractual obligations.

2019/20). As a result c. 80 major trauma cases/year with suspected head injury are being conveyed to other Major Trauma Centres, principally the Royal London Hospital. This inevitably involves further travel for visitors/carers and constitutes a formal derogation⁸⁸ against the 2013 NHS England specialised commissioning/service standards for major trauma.

170. The Major Trauma Centre go-live was therefore conditional on the establishment of an interim, co-located neuro-trauma service. The interim model of care was recommended in 2013 in an independent review undertaken by Mr James Palmer (Clinical Director for Specialised Services, NHS England), at the request of the Trust and Trust Development Authority and with the support of the NHS England Area Team.
171. In July 2014 the Trust Board of Directors approved the investment in clinical infrastructure (incl. bi-planar angiography facilities) and workforce required to transfer the neuro-trauma service from Hurstwood Park (Princess Royal Hospital) to the Royal Sussex County Hospital. This transfer ahead of the 3Ts redevelopment necessitates splitting the Regional Centre between campuses, which creates some significant operational challenges. It has also necessitated a number of clinical service moves between and within the Royal Sussex County and Princess Royal Hospital sites to create sufficient capacity:-
- The inpatient urology service will transfer from the RSCH to create a single-site inpatient service at the PRH for both elective and non-elective activity. (The majority of Brighton & Hove patients already receive their elective inpatient urology treatment at the PRH). Additional critical care capacity (four Level 2 beds) is being created at the PRH to support this move. Outpatient sessions will continue to be provided from both sites.
 - Patients with suspected fractured neck of femur are currently admitted for surgery through the Emergency Department at the RSCH. Some patients then transfer to the PRH for their rehabilitation phase, although Brighton & Hove residents currently remain at the RSCH. The new, integrated patient pathway will involve initial in-ambulance diagnosis (in partnership with the South East Coast NHS Foundation Trust), fast-tracking through the Emergency Department, and both treatment and rehabilitation at the PRH ('enhanced recovery project').
 - Outpatient neurosurgery clinics will continue to be provided from both the RSCH and PRH sites. Neuro-rehabilitation will continue to be provided from the Sussex Rehabilitation Centre on the PRH site. The change in patient pathway will therefore only affect neurosurgery inpatients, and the number of patients affected is relatively small.
172. The neuro-trauma service is due to start at the RSCH by the end of 2014/15, once capital works for the temporary facilities are complete. The fractured neck of femur and urology patient pathway changes will be implemented at the same time.

Stakeholder Engagement & Consultation

173. As set out in the case for change, extensive public and stakeholder engagement and consultation has been undertaken on the transfer of the Regional Centre for Neurosciences to Brighton since the first recommendations from the then Sussex Health Authorities in 1996.
174. A review commissioned by the Trust in 2010 from Society of British Neurological Surgeons into neurosurgery reconfiguration described it as '*a golden opportunity to expand and secure the neurosciences in modern facilities alongside other specialist services and the Major Trauma Centre.*'
175. An assessment has been undertaken and legal advice provided into whether the transfers of the urology and trauma & orthopaedics patient pathways constitute 'substantial and significant change':

⁸⁸ 'Derogation' is a time limited agreement that one or more contractual standards or requirements of the national service specification will not be in place during the contractual period.

- 361 patients from the Brighton & Hove catchment will be affected by the urology move. The total number of elective and day case urology patients in 2012/13 was 3,678 (so affected patients represent c. 10%); and
 - 228 patients from the Brighton & Hove catchment will be affected by the proposed fractured neck of femur pathway change (these patients currently receive their rehabilitation at the RSCH site). The total number of fractured neck of femur patients treated in 2012/13 was c. 570 (so affected patients represent c. 40%).
176. The service changes have also been presented to, and are supported by, Brighton & Hove Health & Wellbeing Overview & Scrutiny Committee, West Sussex Health & Adult Social Care Select Committee (formed in 2012 from the merger of the former Adults' Services Select Committee and the West Sussex Health Overview & Scrutiny Committee) and Brighton & Hove Clinical Commissioning Group.
177. A public sector equality duty ('due regard') analysis has also formally been undertaken on the urology pathway transfer, and will be undertaken for the fractured neck of femur pathway. In order to mitigate potential concerns, in particular about travel time/costs:
- the 40X bus, which runs between the Royal Sussex County and Princess Royal Hospitals, is available free of charge for patients, and the Trust will increase publicity for this service; and
 - additional travel planning support will be available for visitors/carers (the Trust already has a Travel Plan Coordinator as part of its Green Travel Plan).

Summary

| Summary Points | |
|----------------|---|
| 1. | The five Investment Objectives remain unchanged from Outline Business Case stage, however the urgency of the need has increased. |
| 2. | Although the redevelopment is titled '3Ts' (Teaching, Trauma and Tertiary Care), c. 43% of the floor area is allocated to District General Hospital/secondary care services (ie. for the local population) and c. 64% of the activity (both secondary care and tertiary/specialist services) can be attributed to Brighton & Hove residents. |
| 3. | The redevelopment remains a critical element of the Trust's strategic vision and is aligned with: <ul style="list-style-type: none">• the Trust Clinical Strategy and Integrated Business Plan;• NHS, Public Health and Health Education England Outcomes Frameworks; and• national, regional and local policy and strategy priorities, including the Joint Strategic Needs Assessments/Health & Wellbeing Strategies, QIPP (Quality, Innovation, Productivity & Prevention), single-sex accommodation, patient choice, Fundamental Standards of Care and Emergency Preparedness, Resilience & Response (EPRR). |
| 4. | The Full Business Case has been approved by the Trust Board of Directors and principal Clinical Commissioning Groups. It has been endorsed by the Brighton & Hove Health & Wellbeing Board and a range of other stakeholders, including patient groups, Brighton & Sussex Medical School and partner NHS organisations. |