Brighton and Sussex University Hospitals NHS Trust

ANNUAL REPORT AND FULL ACCOUNTS 2014-15

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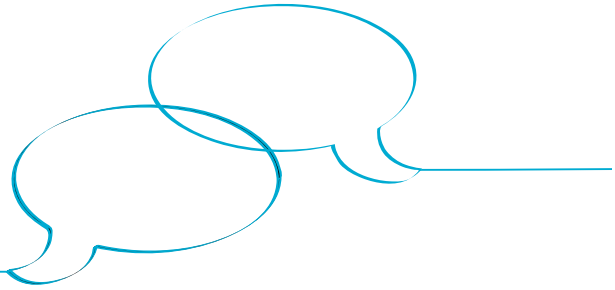
CHAIR & CHIEF EXECUTIVE'S JOINT MESSAGE



Welcome to our 2014/15 annual report. The report covers our finances and other main performance headlines and is designed to give you an overview of the financial year ending 31 March 2015.

In May 2014 the Care Quality Commission (CQC) inspected Brighton and Sussex University Hospitals (BSUH) and in August they published their full report of that inspection. In total the report contained 90 ratings – 64 good, 25 requires improvement and 1 inadequate. We were rated good for the effectiveness of our services and the quality of care we provide and our overall rating was requires improvement. The CQC commended our exceptionally open approach to their inspection and said they did not find any issues that we hadn't already made them aware of. They also mentioned our hard-working, compassionate and dedicated staff and said they observed many examples of good and excellent practice.

Our inadequate rating was for the responsiveness of the Emergency Department (ED) at the Royal Sussex County Hospital in Brighton. However the CQC were very clear that this was not just about what happens within the ED itself nor does it mean that the ED is unsafe or failing. What it does reflect are the ongoing challenges we have in relation to unscheduled care and the flow of patients through the hospital which includes the number and type of patients who come to the ED; how quickly we admit or treat and discharge them; and the onward care of patients who no longer need to be in an acute hospital inpatient bed. Since then we have been implementing a multi-agency action plan to tackle the system-wide issues which impact on the way we manage unscheduled care.

TAKING CARE OF AND CELEBRATING OUR STAFF

In 2014/15 we did more to improve how it feels to work at BSUH and to recognise the exceptional contribution of our staff. Our values and behaviours programme, which was designed to address some longstanding and complex cultural issues, has made significant progress. During the consultation phase the views of over 700 members of staff were collected and these were combined into themes from which five overarching values, and for each a set of behavioural do's and don'ts, were created and published in April 2014. Since then we have been working hard on the implementation phase of the programme which is about ensuring our new values and behaviours are highly visible and embedded in the way that we operate.

In May 2014 we ran our second half-day leadership conference which was attended by around 130 clinical and non-clinical leaders from across the Trust. Over the summer we invited staff to nominate colleagues who they thought should appear on the BSUH "Happy List" and the number of nominations exceeded 200. In November we held our annual Hospital Star Awards which were, once again, a really powerful and uplifting celebration of the dedication and professionalism of our staff.

MODERNISING OUR HOSPITAL

2014/15 was also the year that we received Government approval of the Outline Business Case for the redevelopment of the Royal Sussex County Hospital. This was an historic moment for the Trust. The first phase of construction, which will be ready in the summer of 2019, will house replacement wards for the Barry and Jubilee Buildings, expanded facilities for neurosciences and the Major Trauma Centre and improved facilities for stroke patients and those suffering from dementia. The second stage will be built between 2019 and 2022 and will include an expanded Cancer Centre and new facilities for Brighton and Sussex Medical School. This project involves an investment of £480 million of public money and the magnitude of opportunity this presents us with is unparalleled.

> **"Thank you to the BSUH team, which includes over 7000 members of staff, 600 Sodexo staff and 450 volunteers, for the dedication, hard work and commitment to improving patient care they bring to their roles. We have a great deal to be very proud of.**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LOOKING AHEAD TO 2015/16

The year ahead is set to be another extremely challenging one for BSUH and for the NHS as whole. We have a financial efficiency requirement of £29 million and we are looking closely at how we can increase our efficiency and reduce our costs in order to achieve this. In addition we will be continuing in our efforts to improve flow through our hospitals for patients who are admitted in an emergency and also for those who come to us for elective or planned treatment and care, for whom the 18 week referral to treatment standard applies.

We will also continue to work closely with a number of partner organisations to progress improvements projects including the introduction of satellite radiotherapy services in Eastbourne and Chichester; the provision of more capacity in the community and care for patients closer to or in their own homes; and the co-ordination of a networked approach to services such as trauma and vascular through working in collaboration with our neighbouring acute providers.

Everything we have achieved in 2014/15 including the quality of care and outcomes we have continued to deliver for our patients, in spite of the challenges described in this report, is a credit to the people who work for BSUH. Thank you to the BSUH team, which includes over 7000 members of staff, 600 Sodexo staff and 450 volunteers, for the dedication, hard work and commitment to improving patient care they bring to their roles. We have a great deal to be very proud of.

Matthew Kershaw
Chief Executive

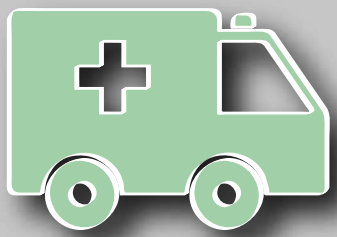
Julian Lee
Chair

Statement:
All BSUH Executive Directors can confirm they have taken all appropriate steps to ensure there is no relevant audit information of which the NHS body's auditors are unaware.

They have also taken all the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the auditor is aware of that information.

OUR YEAR IN NUMBERS 2014-15

Winners and runners up in the Surrey and Sussex *Proud to Care Awards*

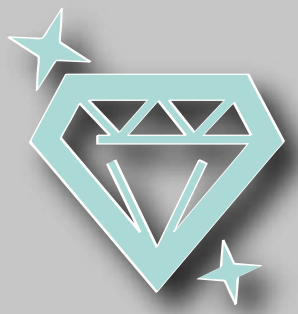


156,414
emergency attendances

500
compliments and plaudits received

"avoidable" MRSA bloodstream infections

The year the Barry Building admitted its first patient



Our longest serving volunteer has been volunteering for

42 years

52,439 non-elective admissions

14,603 elective admissions

42,179 day case admissions

395,051 outpatient attendances

56,421 outpatient procedures

5935 babies born

2,500,000 hits on the BSUH website

members of staff took part in our Values and Behaviours consultation

02

OPERATING AND FINANCIAL REVIEW

ABOUT BSUH

Brighton and Sussex University Hospitals (BSUH) is an acute teaching hospital working across two main sites: the Royal Sussex County Hospital in Brighton and the Princess Royal Hospital in Haywards Heath.

The Brighton campus includes the Royal Alexandra Children's Hospital and the Sussex Eye Hospital, and the Haywards Heath campus includes the Hurstwood Park Regional Centre for Neurosciences. We also provide services from Brighton General Hospital, Hove Polyclinic, Lewes Victoria Hospital and the Park Centre for Breast Care.

We provide District General Hospital services to our local populations in and around Brighton and Hove, Mid Sussex and the western part of East Sussex and more specialised and tertiary services for patients from across Sussex and the South East of England.

The Princess Royal is our centre for elective surgery and the Royal Sussex County Hospital is our centre for emergency and tertiary care. Our specialised and tertiary services include neurosciences, arterial vascular surgery, neonatal, paediatrics, cardiac, cancer, renal, infectious diseases and HIV medicine. We are also the Major Trauma Centre for the South East of England.

Central to our ambition is our role as an academic centre, provider of high quality teaching, and a host hospital for cutting edge research and innovation. On this we work in partnership with Brighton and Sussex Medical School, the Health Education England Kent, Surrey and Sussex Postgraduate Deanery and the Universities of Brighton and Sussex.

VALUES AND BEHAVIOURS (V&B)

From September 2013 to early 2014 we ran a consultation during which over 700 staff contributed their thoughts and ideas to what our new, Trust-wide Values and Behaviours should include. From this we developed our 'behavioural blueprint':

Each of these five values is underpinned by a set of behavioural do's and don'ts and in 2014/15 work has been ongoing to embed these across the organisation through a number of staff engagement activities including the recruitment of around 150 V&B Champions; a leadership training programme for our executive and clinical directors and management teams; the development of a 'bringing the behaviours to life' toolkit and a 'back to the floor' programme for senior management. This work is overseen and managed by the V&B Programme Board.

Our Values and Behaviours

Below is our behavioural blueprint which sets out our values.

We value.....	Because.....
Communication that's respectful, personal, honest and helpful 	it is the bedrock of effective teamwork and high quality patient care
Kindness and Understanding so that we feel supported and enabled to do our jobs 	it is what our patients need from us and what we need from each other
Fairness and Transparency in our decisions and actions 	it builds trust and confidence in each other and for our patients
Working Together to get the best outcome for patients 	patients expect seamless care and more effective team working improves clinical outcomes
Excellence always striving to be the best we can be 	as professionals we should always try to do the best job we possibly can

VISION, APPROACH PRIORITIES AND OBJECTIVES

Our vision is to set the standard for great care by working together; adapting, improving and innovating; and acting with fairness, kindness and compassion.

Our approach is to be positive and proud of what we do well; be open and honest about the things we need to do better; and be clear about what we are doing about them.

Our strategic priorities are:

Quality and Safety – providing the best and safest care for our patients and demonstrating we are doing this through regulatory compliance, effectiveness of case outcomes, patients experience feedback and clinical opinion.

Performance – delivering national and local standards, and establishing targets for best and safest care that meet the expectations of our public and staff.

Finance – every pound counts. We spend £550 million of public money each year and we have a legal and professional responsibility to get the best value for that money and not spend more than we earn. Along with the rest of the NHS we also had to make efficiency savings in 2014/15 in the region of £29 million.

It is the responsibility of all our staff to contribute to the delivery of these strategic priorities.

For 2014/15 the Trust agreed the following five corporate objectives:

1. Excellent Patient Outcomes
2. Excellent Patient Experience
3. Empowered, Skilled Staff
4. Top Productivity
5. Clinical Strategy

This is how we did.

OBJECTIVE 1: EXCELLENT OUTCOMES	HOW DID WE DO?
Reduction in falls with harm	1.4% reduction in falls rates
Reduction in pressure damage	14.4% increase in pressure damage rates
Reduction in incidence of hospital-acquired infections	0 avoidable MRSA infections and 45 C. Difficile infections (target no more than 50)
Mortality	SHMI score of 94.2 = 5.8% fewer than "expected" deaths

OBJECTIVE 2: EXCELLENT EXPERIENCE	HOW DID WE DO?
Unscheduled Care performance (including 4-hour access standard)	Delivered for 84.4% of patients (standard = at least 95% of patients)
Scheduled Care performance (including 18-week RTT standard)	Delivered for 82.2% of admitted patients (standard = at least 90%) and 89.8% of non-admitted patients (standard = 95%)
Improve uptake and results from Friends and Family Test	Response rate improved from 21% (04/14) to 33% (03/15)
Deliver CQUIN improvement targets	Achieved

OBJECTIVE 3: EMPOWERED, SKILLED STAFF	HOW DID WE DO?
Implementation and forward plan for Values and Behaviours	2015/16 plan signed off by V&B Programme Board and project ongoing
Develop staff appraisal framework linked to V&B Blueprint	New non-clinical appraisal forms linked to Blueprint now live
Recruitment Strategy for 'hard to recruit' staff groups	Achieved
Roll out of Education and Knowledge Strategy	Achieved

OBJECTIVE 4: TOP PRODUCTIVITY	HOW DID WE DO?
Deliver financial plan for 2014/15	The Trust reported a deficite of £0.45 million compared to a retained surplus of £5.1 million in 2013/14.
Deliver our 2014/15 Cost Improvement Programme	The Trust achieved efficiencies of £29.8 million.
Deliver our 2014/15 Capital Programme	The Trust delivered an in year capital programme of £33.9 million.
Deliver on objectives and timelines for Site Reconfiguration	Achieved relocation of neurosurgery to the RSCH and fractured neck of femur and urology services to PRH in June 2015.
Secure sign off of the 3Ts Full Business Case	Government endorsement and commitment to project achieved. Ongoing work with TDA, DH and HMT to secure FBC sign off.

OBJECTIVE 5: CLINICAL STRATEGY	HOW DID WE DO?
Deliver new fractured neck of femur service at PRH	Achieved in June 2015
Implement new inpatient frailty pathway	Ongoing – partially achieved
Discharge to Assess on all Care of the Elderly wards	Piloted on three wards – to be rolled out in 2015/2016
Improvements against 7-day working standards	Ongoing

REVIEW OF THE YEAR

APRIL 2014:
INNOVATIVE HYBRID CARDIAC THEATRE OPENS AT BSUH

One of the UK's first 'hybrid' cardiac operating theatres opened at BSUH that allows patients with multiple, complex or previously untreated heart conditions to be treated in one place. The new £4 million theatre has state-of-the-art equipment and high spec imaging facilities to cater for all types of heart procedures, improving the efficiency of the service and the safety for patients.

"It is of huge benefit to patients and the clinicians. It allows us to deal with everything a patient may need in one area, rather than having to transfer them to another lab or theatre. This reduces the risk to patients because if there is a problem during a procedure we are fully equipped to deal with it there and then.

Mr Uday Trivedi, Consultant Cardiac Surgeon

MAY 2014:
HOSPITAL REDEVELOPMENT FUNDING GIVEN THE GREEN LIGHT

The Chancellor of the Exchequer George Osborne visited the Royal Sussex County Hospital to announce Treasury approval of the Outline Business Case for the £480 million redevelopment of the oldest parts of the hospital. The project will greatly improve the care and treatment of patients in a number of services, including elderly care, cancer services, major trauma services and neuroscience. Temporary buildings are being constructed on the hospital site to house clinical services for the redevelopment, which is expected to be completed by 2022.

"This is great news for Brighton and the whole local community. Bringing the buildings and facilities of this venerated hospital up to modern standards will enhance and improve patients' care and experience.

Chancellor of the Exchequer George Osborne

JUNE 2014:
NEW SIMULATION CENTRE TO IMPROVE CARE FOR YOUNG PATIENTS

A new state-of-the-art simulation facility opened at the Royal Alexandra Children's Hospital to help improve the medical education of professionals involved in the care of children and young adults. The centre enhances the development of technical and human factor skills training at all levels across Kent, Surrey and Sussex, which helps to provide better care for young patients in the region.

"Through the use of simulation techniques, this state-of-the-art facility will enable us to provide doctors, nurses and paramedics from across Kent, Surrey and Sussex with high quality training and enable us to continue enhancing the treatments and interventions we provide to our youngest patients.

Matthew Kershaw, Chief Executive


JUNE 2014


NOVEMBER 2014

NOVEMBER 2014

OCTOBER 2014: MAJOR IMPROVEMENTS FOR MATERNITY SERVICES GIVEN THE GO AHEAD

Major plans to improve maternity services at the Royal Sussex County Hospital were given approval. The project involves creating a new Women's Centre for outpatient gynaecology and antenatal clinics and a new Birthing Centre which will include five birthing rooms with pools and en suite facilities.

NOVEMBER 2014: WORK BEGINS ON RECONFIGURATION OF SERVICES

New operating theatres for neurosurgery were created at the Royal Sussex County Hospital as part of a large-scale site reconfiguration programme to move and improve key services across the Trust. The project will see a new state-of-the-art centre for neurosciences created at the County Hospital to enhance the existing Major Trauma Centre, and the centralisation of urology and fractured neck of femur services at the Princess Royal Hospital.

> **"These plans have been developed with extensive engagement from clinicians across the Trust and our partners in the wider health system, they are aligned with our clinical strategy and they include significant investment in both workforce and infrastructure.**
>
> Matthew Kershaw, Chief Executive

NOVEMBER 2014: NEW CLINIC INSTALLED TO IMPROVE EMERGENCY CARE FOR OLDER PATIENTS

A new building was installed outside the A&E department at the Royal Sussex County Hospital to improve emergency care of older patients during winter. The modular building houses the Rapid Access Clinic for Older People (RACOP) which was previously located in the Barry Building. Moving the clinic to the front of the Emergency Department improves access for older people to emergency care and reduces the number of these patients being admitted to hospital.

> **"These developments, alongside continuing to refine the way we manage patient flow, help reduce the pressure on our Emergency Departments, create some much-needed additional capacity and improve the experience of so many of our patients.**
>
> Matthew Kershaw, Chief Executive

03

OUR WORKFORCE

Brighton and Sussex University Hospitals employs **7,178** people, including:

3,315 nursing and midwifery staff

1,109 medical staff

1,217 scientific, therapeutic and technical staff

1,537 administrative, clerical and estates staff

23.0% **of staff are aged 30 or less.**

24.3% **of staff are aged over 50.**

Sickness absence rate = **3.8%**

A total of **72.2%** **of staff are female**

A total of **5.8%** of staff define themselves as Disabled

A total of **5.8%** of staff define themselves as Gay, Lesbian or Bisexual

A total of **16.1%** of staff define themselves as BME.

17.3% **of staff have worked at BSUH for less than a year.**

45.5% **of staff have worked at BSUH for over five years.**

36.2% of non-medical staff are Bands 1 to 4.

6.1% of non-medical staff are Band 8a or higher.

87.6% of staff are Permanent (with the rest being Fixed Term).

76.3% **of staff are full time.**

Staff Recruitment

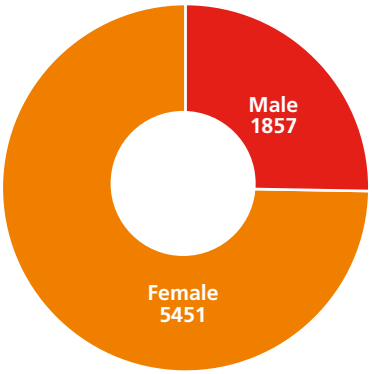
The HR Services team successfully recruited 1427 employees to BSUH in 2014 – a 16% increase in recruitment on 2013. A number of changes were introduced in 2014/15, the main ones being:

- April 2014 Development and implementation of "values-based" recruitment training for recruiting managers. This includes training on all elements of the recruitment process, alongside considerations for unconscious bias at shortlisting, interview and appointment. This training continues to be delivered and well-received.
- May 2014 Introduction of a recruitment pool for nursing staff, which allows the Trust to recruit ahead of vacancies, shortening the timeline for getting new staff into post. From January 2014 to date this has allowed us to recruit 1044 nursing staff into post (nurses and HCAs of various grades) for all areas of the Trust.
- June 2014 Implementation of social media sites such as Facebook and Twitter specifically for recruitment, to increase awareness of the Trust and its vacancies to potential applicants.
- August 2014 Development and introduction of a candidate survey, to improve the recruitment and joining experience of new starters. A local all staff survey was also introduced during this month with a view to improving employee experience and engagement.
- September 2014 Development of an Applicant Tracking System (ATS) to improve the recruitment experience for both recruiting managers and applicants. This service also allows the team to build a talent database for new roles and offer updates in real-time to recruiting managers at each stage of the recruitment journey.
- November 2014 Work undertaken to improve the external profile of the Trust with an increased attendance at targeted recruitment events.
- December 2014 BSUH welcomed the first cohort of international nurse recruits. This campaign resulted in the recruitment of over 180 new nursing staff during 2014/2015.
- February 2015 Introduction of an in-house "headhunting" service.
- March 2015- Implementation of several bespoke scanning units to expedite the verification of ID documentation and legal right to work checks.

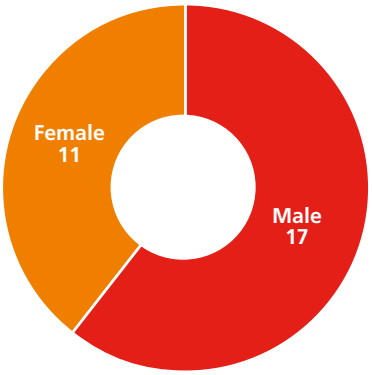
Occupational Health

BSUH has an in-house Occupational Health Service that offers a full range of Occupational Health services to all Trust staff. Services include sickness absence and reasonable adjustments advice, vaccination and testing services, health surveillance, needle stick and splash injury management, manual handling training, specialist ergonomic workplace assessments and physiotherapy. The BSUH OH Service holds fully accredited SEQOHS status (Safe, Effective, Quality, Occupational Health Service).

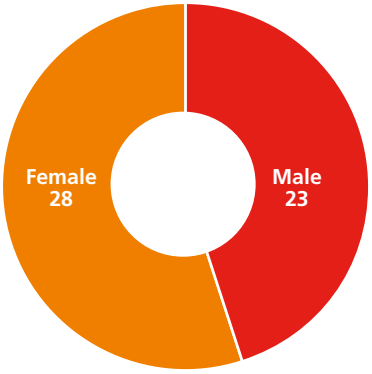
Gender distribution of staff



All staff



Directors



Senior Managers

Health, Employee Learning and Psychotherapy (HELP) Service:

The HELP service provides staff with confidential support, counselling and psychotherapy for a range of issues. Sometimes work related, from stress management to relational issues, employment difficulties or following critical/ traumatic events; to personal issues that may be affecting the individual. These may include: personal ill-health or ill-health of partner/friend/relative/colleague, relationship difficulties in or out of work, financial problems, bereavement, traumatic incident, coping with stress and caring responsibilities.

The HELP Service was launched in 2009 and has grown in use and capacity to provide a highly professional, confidential service to BSUH staff across two sites and satellite premises.

HELP has two full time UKCP registered psychotherapists who offer an integrated approach to therapy. They provide:

- Tailored psychotherapy sessions for individual staff members
- Specialist EMDR (Eye Movement Desensitisation and Reprocessing) Trauma Therapy in accordance with NICE Guidelines to staff who have experienced traumatic incidents on wards/units or in their personal lives
- Advice to managers
- A placement for student psychotherapists from Sussex, Brighton and London Universities. The service has built a reputation which has been described as 'second to none' by students on placement
- An administrator who has streamlined the service resulting in a two week waiting list for one-to-one therapy
- Stress awareness and support workshops in wards and departments, including preceptorship course

A Senior Nurse's experience of the HELP Service:

> **I was initially referred to the HELP services following a traumatic coroner's case. My experience of the HELP Team is:**
> ***The care I received was kind, compassionate and insightful into assisting me to reach a stable point of view regarding not only work-related issues but also within my personal life. I find that just knowing that the HELP team are available is invaluable and this in itself supports me within my daily working life.***

Doctors' experiences of the HELP Service:

> **I attended the HELP service as I was struggling to come to terms with the death of a patient and the impact it had on me. Attending the sessions not only helped me realise why I had reacted in the way I had to the event, but also has now given me insight and strategies to deal with situations that I may find difficult or emotive. I feel the EMDR trauma sessions that I attended were key to this process and gradually with each session I felt as though a cloud was clearing in my head and I could begin to think clearly again.**

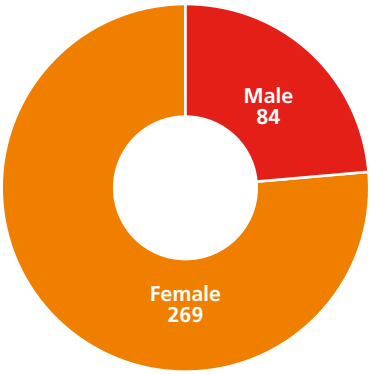
> **The HELP service provided me with a safe place to re-evaluate my work, my health and my goals in life. Things were very dark for me, but I am now happier, back at work and more fulfilled. I am very grateful.**

Trust Work Performance

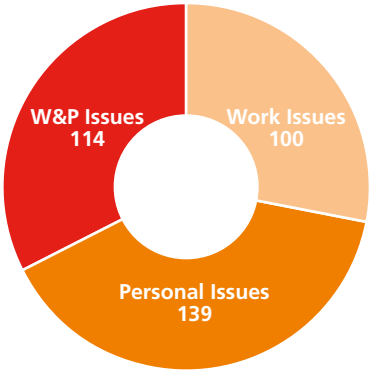
Key performance indicators, according to HR Dashboard, sickness and absence, stress/depression/psychiatric categories are showing the highest indicators for sickness absence 2013-2014, with a slight drop in 2014 (16.1 in 2013 and 15.4 in 2014). This reflects a national pressure on the NHS highlighting the importance of staff support and the benefits of the provision of support by the HELP Service.

Service Evaluation

Feedback from individuals and workshops is fed back to appropriate parties, adhering to confidentiality, so that there is a continual loop of feedback which not only informs future practise within the HELP Service but highlights emerging themes which can be used in the development of other Trust-wide programmes of work including Values and Behaviours.



Referrals made for male or female staff members

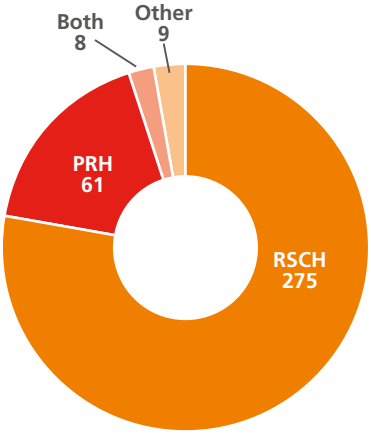


Referral is considered by the referrer to relate to: Work Issues, Personal Issues, or Work and Personal Issues.

Work Issues include: relational difficulties, investigations, significant events/serious incidents, complaints, work related stress, HR issues, BME individuals' issues, bereavement/health of colleagues

Personal Issues include: relational difficulties, significant events (e.g. RTC of self or other and consequences, such as caring), BME individual issues, bereavement/health of self and/or colleagues

Work & Personal related issues include: life events affecting home and work (study/bereavement/health), work related stress affecting work and home, any of above noted in Work or Personal Issues.



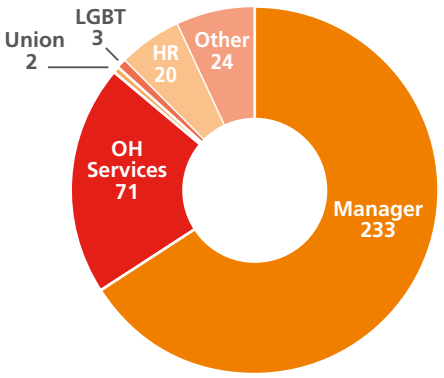
Hospital/Venue where staff member is working:

RSCH – Royal Sussex County Hospital includes Royal Alexander Children's Hospital, St Mary's, Sussex Eye Hospital, Pharmacy

PRH – Princess Royal Hospital including Hurstwood Park Neurological Centre, Sussex Orthopaedic Treatment Centre

BOTH – member of staff is working across sites at RSCH and PRH

OTHER – includes Satellite Sites, such as Hove Polyclinic, Brighton General Hospital, Breast Care Centre



Referral Received From:

Referral to HELP Service received from staff member's Manager, Occupational Health Service, Union (Staff Side) LGBT, Human Resources, OTHER (including, occasional self-referral, BME, Trust advisors, and referrer not fitting another category)

04

HOSPITAL STAR AWARDS

Staff from across Brighton and Sussex University Hospitals NHS Trust enjoyed a glittering awards night to recognise and celebrate the efforts of our hospital stars. Clinical, non-clinical, frontline and behind-the-scenes staff in departments and clinics across BSUH had their hard work recognised with awards and prizes at the fifth annual Hospital Star Awards, held at the Corn Exchange in Brighton.

Over 550 nominations for 11 different categories were received from colleagues, patients and their families, with the winners and runners-up chosen by a panel of independent judges, and Chief Executive Matthew Kershaw also presented his own special award.

> **"This event is a real celebration of everything that is good about our hospitals and the people who work in them. The fact that 550 of our staff, patients and their relatives took the time to submit a nomination in itself demonstrates how much of what we do matters to people and hearing just a selection of what was said about our winners and runners-up is genuinely uplifting and humbling.**
>
> Matthew Kershaw, Chief Executive

Hospital Star Awards 2014
Support Services
Star of the Year

05

EQUALITY AND DIVERSITY

BSUH is committed to delivering fair and equitable services for our patients and service users, and to providing a workplace that is free from discrimination for our staff and where everyone is given equal opportunity to develop and progress. This commitment is underpinned by the principles set out in the Equality Act 2010, the NHS Constitution and the Care Quality Commission's regulatory standards.

Some notable achievements we have delivered in 2014/15 include:

- Improved quality and efficiencies of services from our renegotiated Communications Support Contract – this covers all activities relating to British Sign Language and overseas language interpretation and translation.
- Achieving the 'gold' standard in the Inclusive Communications standards – the scheme looks at ways organisation make their information and services accessible to people with Learning Disabilities.
- Through the Health and Social Care Faith Forum we have had ongoing engagement with local religious and faith groups about issues within the hospital that impact them.

During 2014/15 a number of areas for improvement and challenges have been identified which will form part of our work plan next year linking in with our Equality Objectives which include:

- Stonewall Work Equality Index rating.
- Implementation of the Equality Delivery System 2 – this provides a way of demonstrating the Trust's compliance with equality duties.
- Ongoing work to roll out and improve uptake of new communication support services e.g. telephone interpreting (overseas) and online British Sign Language interpreting.

In 2014/15 we also developed and launched a new Race Equality Staff and Engagement Strategy.

06

OUR COMMITMENT TO SUSTAINABILITY

Cutting carbon emissions as part of the fight against climate change and the significant impacts on human health is a key priority for the Trust. In February 2011 the Trust Board approved its first 'Carbon Management Plan' (2011-2015) with the vision:

> **"To become a leading low carbon organisation within Sussex, meeting the needs of our patients by providing high quality care with excellent outcomes, whilst ensuring a sustainable future for all.**

Much has been achieved since then but we still have a long way to go. The Carbon Management Steering Group, which meets under the leadership of the Director of 3Ts, recently committed to developing the Carbon Management Plan into a new comprehensive five-year 'Sustainable Development Management Plan' (2015-2020).

This will build on work that has already been initiated with regard to building energy use, travel and waste; but will widen the scope to include further work on procurement, our community responsibilities, and engagement with our staff in conjunction with the Values & Behaviours programme.

It will also incorporate a refresh of the Trust's carbon reduction targets.

The Trust's Carbon Footprint is just over 26 thousand tonnes of CO2 and has remained roughly around the figure for the past five years. The vast majority of our emissions (94%) come from the energy used in our buildings; the rest being made up from transport, water and waste.

In 2004/2005 the Trust's annual energy bill was £1.6m. Since then costs have tripled to £4.8m. A lot of work has been carried out to try and reduce this, but we are always fighting against a background of increasing patient activity, so the fact it has remained fairly steady is an achievement.

The Trust is seeking approval to invest £12.7m in an Energy Performance Contract (EPC) with British Gas, who will deliver a programme of work to significantly save energy and carbon, and improve the patient environment through the upgrade of our energy infrastructure with more efficient systems. The energy savings will be financially underwritten by British Gas and are guaranteed to be greater than the project costs.

Once approved, the project will take two years to complete and the contract will guarantee 20% energy savings and 15% carbon saving for 17 years.

The latest energy cost savings are estimated at £808,490 (23.7%) per annum; which will produce carbon savings of 3,546 tonnes (20.2%) per annum.

One major project included within this work stream is the replacement of the existing PRH boilers with a Combined Heat and Power (CHP) plant. This alone could account for saving over 800 tonnes of CO2 a year.

07

EMERGENCY PLANNING

BSUH continues to be committed to developing and maintaining prepared and resilient services by taking a proactive approach to Emergency Preparedness, Resilience and Response (EPRR).

2014/2015 has seen the introduction of a new Trust-wide Resilience Group which meets monthly to discuss all resilience issues. The new EPRR Policy outlines how the Trust will develop and maintain prepared and resilient services that meet the statutory and mandatory duties as set out in the Civil Contingencies Act 2004 and the NHS England Emergency Preparedness Framework 2013.

During 2014/2015 the Head of Resilience attended a number of external meetings including safety advisory groups for events, the Sussex Health Responders Group and Sussex Resilience Forum planning meetings. The Trust has an appointed Executive Lead for Emergency Preparedness and nominated Accountable Emergency Officer (AEO) who attends the Local Health Resilience Partnership meetings and provides strategic leadership for resilience to the Trust.

Training was provided throughout the year including for major incident loggists, on call directors and managers, drop in training sessions at the Royal Alexandra Children's Hospital and Decontamination training in the Emergency Department. The new training awareness workbook was also completed by 97 members of staff and we had some positive feedback following the resilience presentation at Trust induction.

As well as taking part in a number of exercises and simulations the Emergency Planning Team has also supported the Trust's response to a number of actual significant and major incidents including power failures, a system-wide IT failure, the evacuation of areas of the Princess Royal Hospital following reports of a fire on site and infectious disease outbreaks. Staff activated plans and responded very well under significant pressure and learning from these incidents has driven reviews and amendments to current plans and procedures.

08

RESEARCH AND INNOVATION

Alongside many other organisations across the South East Coast we are working together to transform healthcare quality, delivery and outcomes through research in partnership with higher education and industry. Working jointly with our medical school, we have been able to deliver an integrated research strategy that crosses most medical disciplines.

BSUH received £6.3 million of research income from National Institute of Health Research (NIHR), various charity and research council funding streams, and collaborations with the Life Sciences Industry.

We continue to perform well in respect of recruitment to the NIHR portfolio of clinical trials maintaining our position in the top performing 10% of NHS Trusts. We recruited over 3000 patients and had 240 studies running during 2014/15. We are implementing strategic and structural changes to expand our portfolio into new areas over the coming years, to offer more research opportunities to our patients across the full range of tertiary services we provide. Examples of progress to date include the development of a local orthopaedic research portfolio.

The Brighton National Institute for Health (NIHR) Clinical Research Facility saw more 700 patients during the past 12 months. The facility specialises in running early phase life sciences studies in a range diseases including cancer, rheumatic disease, HIV, cardiothoracic disease and neurological conditions such as MS, Alzheimer's and Motor Neurone Disease.

BSUH has become one of the most efficient Trusts in setting up complex clinical trials. The Trust's average set-up time is ten days (against a national benchmark of 45 days). This in turn leads to more patients being offered the opportunity to access innovative healthcare in Sussex. We have improved our total recruitment rates to randomised controlled trials, now achieving recruitment to total target in over 50% of projects. We are working to improve our systems to ensure this performance continues on an upwards trend.

Nine new NIHR and other research grants were awarded to our researchers (total value £1.2 million). To support the delivery of these we established the first Clinical Trial Unit in in the South East. This has strengthened the partnership between BSUH and Sussex University the co-hosts of the CTU. In 2015 we aim to seek registered status with the UK Clinical Research Collaborative; this will help to deliver further benefits to the population we serve, particularly in areas with less research infrastructure, such as community care.

BSUH has developed an excellent training programme to support and grow clinical researchers. In recognition to this our training leads have been contributing to the role out of national training programmes.

09

OUR PARTNERSHIPS

We work closely with our Clinical Commissioning Groups, local GPs, neighbouring hospitals, community and NHS services, local authorities, social services, local voluntary sector and South East Coast Ambulance Service to provide co-ordinated treatment and care for patients from across the region. As the regional teaching hospital we also work with our partner medical school and the Universities of Brighton and Sussex to teach and train the doctors, nurse and health professionals of the future.

TEACHING AND TRAINING

The first intake of students to Brighton and Sussex Medical School (BSMS) began their five-year medical degree programmes in September 2003 and since then BSMS has become one of the most popular medical schools in the country. In partnership with BSUH, it is developing a strong reputation, nationally and internationally, for leading edge medical research which aims to improve medical treatment, answer fundamental biomedical questions and deliver more personalised healthcare to patients.

FUNDRAISING

BSUH has numerous fundraising charities and groups that work tirelessly to raise money to help us enhance our services, improve our buildings and facilities and make coming into hospital a more comfortable and less anxious experience.

The Sussex Cancer Fund has been giving invaluable assistance to the Sussex Cancer Centre at the Royal Sussex County Hospital for many years, providing additional equipment and building improvements for the treatment of cancer patients. This year work started to build Sussex's first cancer information and support centre at BSUH. The £5.96 million Sussex Macmillan Cancer Support Centre has been designed with input from people affected by cancer and will provide a friendly, nonmedical environment to give specialist information, advice and support. It is being built opposite the Sussex Cancer Centre at the Royal Sussex County Hospital and is expected to open to the public in Spring 2015. The centre is a partnership between Macmillan Cancer Support, the Sussex Cancer Fund and BSUH.

Rockinghorse is the official fundraising organisation of the Royal Alexandra Children's Hospital and the Trevor Mann Baby Unit. They raise money for equipment and to help ensure children are treated in an environment in which they feel safe and comfortable and which best meets their needs.

We also receive support from the Leagues of Friends for Brighton and Hove Hospitals, the Princess Royal Hospital and Hurstwood Park Hospital. As a way of saying thank you to these organisations for everything they do and the time and energy they put in to fundraising for our hospitals, Chief Executive Matthew Kershaw chose the Brighton and Hove League of Friends his charity when he ran the 2014 Brighton Marathon.

VOLUNTEERING

We have around 450 local people who volunteer their time to help BSUH maintain quality of care for patients. Collectively devoting many hundreds of hours a week, the volunteers work in a variety of roles on wards, in outpatient clinics, and across all the sites and locations from which we provide services. They range in age from 16 to over 90 and our longest serving volunteer, who helps the clerical team in the Sussex Cancer Centre, has been volunteering with us of over 42 years. Individually and collectively the contribution made by our small army of volunteers is vital to the smooth and safe running of the hospital and the positive experience of our patients.

Volunteering is also something that our own staff also do for other organisations and causes. For example, in 2014/15 Emily Clement, Tom Harman, Thomas Somassa, Adrian Atterbury, Fearghal Tucker and Jackie Longbone from our microbiology staff volunteered to go to Sierra Leone to work in the Public Health England laboratories which are carrying out diagnostic services for the local treatment centres and the community. In addition PRH staff nurse Jim Wood volunteered in the Kerry Town Ebola Treatment Centre. Speaking about the experience Jim said:

“Providing rudimentary healthcare was a goal we all aspired to, and indeed all that we could hope to provide in the temporary buildings clad in plastic sheeting and corrugated iron that formed our wards. Striving to keep our patients fed, hydrated, pain free and clean was a world away from the type of care that our patients at home deserve and demand. However, when you leave behind the bureaucracy, technology and politics of western medicine, basic healthcare is all that really matters.

“We left Kerrytown a better hospital, with national staff more able to provide the healthcare their patients so desperately needed. I feel privileged to have been part of the international response, and remain eternally grateful to BSUH management for releasing me at such short notice, and to my colleagues for the support they gave me throughout the deployment and since – I would have struggled without it.

It goes without saying what an immense personal sacrifice these individuals are making and how exceptionally proud we all should be of these members of the BSUH team.

In addition, our Advanced Neonatal Nurse Practitioner Kathy Mellor was awarded an MBE in the 2015 New Year’s Honours List for “services to neonatal nursing and charitable work to improve the survival of newborn babies in developing countries.” Kathy is the co-founder and Director of the charity BirthLink which supports maternal and neonatal healthcare in developing countries including Armenia, Rwanda and Mongolia. They focus on providing sustainable, low tech developments which are proven to improve the outcomes of these babies as well as buying the high quality neonatal equipment needed. Several neonatal nurses from TMBU and the SCBU at PRH have worked alongside Kathy on BirthLink projects.

10

OUR PATIENTS

This year over 800,000 patients came through our doors, including:

- **14,603 elective admissions**
- **42,179 day case admissions**
- **52,439 non-elective (emergency) admissions**
- **395,051 outpatient attendances**
- **56,421 outpatient procedures**
- **We also delivered 5935 babies**

We are constantly striving to give our patients the best possible treatment and a positive experience whilst they are in our care. We actively encourage patient feedback and use this to make improvements to our services whenever possible. We seek patients' feedback proactively through our ongoing patient satisfaction survey Patient's Voice, which is offered to all patients admitted to our hospitals and outpatient clinics. Feedback from the survey is reported to the Board monthly and to individual ward leaders allowing them to respond quickly to any areas of concern or issues requiring immediate attention.

In addition the Friends and Family Test is an initiative to provide a national benchmark for all NHS hospitals. All adult inpatients who have stayed at least one night in hospital or attended A&E are asked the question: "How likely are you to recommend your ward/A&E Department to friends or family if they needed similar care or treatment." They can respond with one of six options ranging from 'extremely likely' to 'extremely unlikely' and the results of this are also reported to the Trust Board each month. For 2014/17 our Friends and Family Test results were:

INPATIENTS	TOTAL RESPONSES	TOTAL ELIGIBLE	RESPONSE RATE	FRIENDS AND FAMILY TEST SCORE
Apr-14	569	2,706	21.0%	0.4
May-14	542	2,910	18.6%	0.6
Jun-14	588	2,860	20.6%	1.6
Jul-14	717	2,845	25.2%	1.0
Aug-14	719	2,796	25.7%	1.4
Sep-14	731	2,702	27.1%	1.8
Oct-14	879	2,833	31.0%	2.1
Nov-14	882	2,654	33.2%	2.3
Dec-14	778	2,704	28.8%	1.3
Jan-15	695	2,567	27.1%	2.9
Feb-15	745	2,466	30.2%	2.3
Mar-15	911	2,783	32.7%	2.4
Total	**8,756**	**32,826**	**26.7%**	**1.8**

We also receive feedback reactively through our Patient Advocacy Liaison Service (PALS), formal complaints and national patient surveys.

COMPLIMENTS

2012/13	2013/14	2014/15
510	512	500

COMPLAINTS

	2012/2013	2013/2014	2014/2015
Total number of complaints	1561	1535	1278
Number of contacts to the Ombudsman	33	20	12
Ombudsman referrals upheld against the Trust	0	0	0
Ombudsman referrals partially upheld against the Trust	0	3	2

“I cannot thank you enough for the faultless care you have given my mother over the last few days. You have all been wonderful to her and to me and you should be proud of your excellent standards of care and compassion.

11

PERFORMANCE

FINANCE

Overall

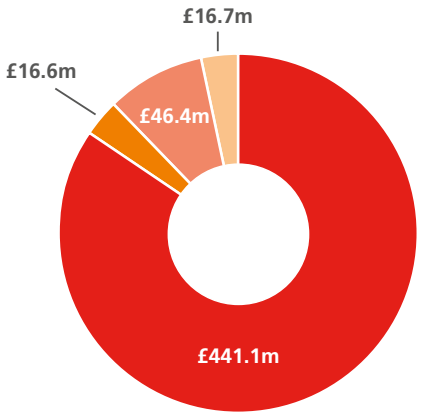
The Trust is reporting a deficit of £0.45m in 2015/16. This reflects the operational pressures faced during the year. The pressures are reflected in the change in performance from 2014/15 when the adjusted retained surplus was £5.1m.

Income and Expenditure

The chart below shows the sources of the Trust's income. The trust earned £520.8m in income in 2014/15 from the £558.6m earned in 2014/15.

The majority of the Trust's income is for patient care services and this income grew from £451.0m to £457.7m. Non-patient care income reduced from £107.6m to £63.1m mainly caused by the reduction in Education, training and research income from £98.2m to £46.4m

Income by category 2015/16

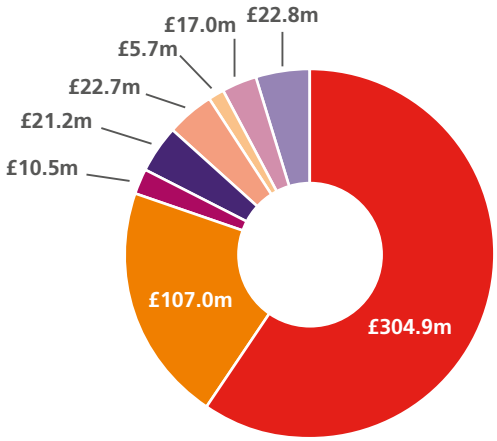


- CCGs and NHS England – £441.1m
- Patient Care Services to other bodies – £16.6m
- Education training and research – £46.4m
- Other – £16.7m

The chart below shows the Trust's expenditure by category.

Total operating expenses were £511.8m in 2014/15, a reduction from £558.3m in 2013/14 mainly due to a reduction in Education and training costs of £50.5m that reflects the reduction in Education and Training income.

Expenditure by category 2014/15



- Gross employee benefits – £304.9m
- Clinical supplies and services – £107.0m
- Clinical negligence – £10.5m
- Premises, transport and establishment – £21.2m
- Depreciation and amortisation – £22.7m
- Education and training – £5.7m
- General supplies and services – £17.0m
- All other operating costs – £22.8m

Efficiency

The Trust achieved efficiencies of £29.9m in 2014/15.

The themes of the efficiency programmes in 2014/15 were

EFFICIENCY PROGRAMME	£M
Bank Office and Commercial	£14.1m
Clinical Workforce	£2.0m
Education and Training	£2.6m
Major IT Programme	£0.1m
Medical Workforce	£0.4m
Operational Estate	£0.5m
Operational Productivity	£4.0m
Outpatients	£0.1m
Transformation	£1.2m
Strategic Estate	£1.2m
Workforce	£3.7m
	£29.9m

Property Valuation

The revaluation of property led to an increase in the value of land and buildings to £20.5m. There is also a charge of £0.5m for impairment to assets cause by changes in market price of the assets concerned.

Capital Expenditure

Additions to assets in 2014/15 were £33.9m.

Liquidity, cash and working capital

The Trust remained within its external financing limit (EFL) and increased its year end cash balance from £22.2m to £25.4m. The cash associated with the slippage in the capital programme is carried forward by the Trust to fund future capital investment.

Better Payments Practice Code (BPPC)

The Better Payment Practice Code requires that the Trust pays all invoices within 30 days of receipt of a valid invoice. The performance target is 95% compliance.

Measure of Compliance

	2014/15	2014/15	2013/14	2013/14
	NUMBER	£K	NUMBER	£K
NON-NHS PAYABLES				
Total Non-NHS Trade Invoices Paid in the Year	126,673	274,031	116,486	234,617
Total Non-NHS Trade Invoices Paid Within Target	103,308	190,281	93,519	158,234
Percentage of Non-NHS Trade Invoices Paid Within Target	81.55%	69.44%	80.28%	67.44%
NHS PAYABLES				
Total NHS Trade Invoices Paid in the Year	2,717	42,896	3,228	90,354
Total NHS Trade Invoices Paid Within Target	1,837	23,326	2,366	74,389
Percentage of NHS Trade Invoices Paid Within Target	67.61%	54.38%	73.30%	82.33%

FINANCIAL OUTLOOK

The plan for 2015/16 is a deficit of £19.2m and this reflects the continuing challenges around delivering activity, maintaining staffing levels and limiting other costs. The financial risks to achieving the planned level of performance and the recovery actions being taken are noted below.

Underlying financial position

The deficit plan for 2015/16 reflects the operational pressures that grew during 2014/15 and that are expected to continue during the first half of the financial year and beyond.

Commissioning arrangements

The Trust secures the majority of its income from NHS England and local Clinical Commissioning Groups. The Trust works collaboratively with these organisations to ensure that its services meet the needs of the population and are affordable.

Financial efficiency programme

TAs the Trust is faced with a fall in tariff prices and increases in pay and non-pay costs the need for a financial efficiency programme remains. The financial efficiency programme for 2015/16 is £26.4m across a number of work streams covering both pay and non-pay spend.

Capital plans and cash position

The capital plan for 2015/16 is £82.4m including £27.4m for the 3Ts project, £21.1m for Radiotherapy and £33.9m for a range of estates, IT and medical equipment projects. The cash position that backs these projects is supported by loan funding. The planned deficit is being supported by a revolving credit facility that ensures that the Trust has adequate working capital.

Financial risks

The main risks to the delivery of the financial plan are

- Matching capacity to demand and delivering activity efficiently.
- Risks of fines on contract performance.
- Achievement of the efficiency programme.
- Availability and cost of staff.

Recovery actions

To ensure delivery of the plan the financial risks are being managed and the actions include

- Working in partnership with commissioners to ensure that patient care pathways operate efficiently across the health economy.
- Further development of performance management systems within the Trust.
- Continued focus on transformational change so that efficiency programmes are embedded and deliver improvement in the patient care pathway.
- Enhanced focus on recruitment and retention to meet staffing needs.

Summary

2014/15 was a challenging year and these challenges will continue into 2015/16.


clinell

NATIONAL STANDARDS AND WAITING TIMES

INDICATOR	STANDARD/ THRESHOLD	2014-15	2013-14
18w RTT - Percentage of admitted RTT pathways completed within 18 weeks	90%	82.2%	92.7%
18w RTT - Percentage of non-admitted RTT pathways completed within 18 weeks	95%	89.8%	96.3%
18w RTT - Percentage of incomplete pathways waiting less than 18 weeks	92%	88.7%	93.6%
18w RTT - Numbers of over 52 week waiters at month end	0	0	0
Diagnostic Tests waiting longer than six weeks - percentage of all waiters	1%	0.9%	0.2%
Operations cancelled on the day not re-booked within 28 days	0	24.7%	5.08%
Number of urgent operations being cancelled for the second time	0	7	3
A&E - Percentage of patients who spent four hours or less in A&E	95%	84.4%	93.03%
A&E - Numbers of patients who have waited >12 hours in A&E from decision to admit	0	19	0
Cancer: Two week wait referral to date first seen	93%	93.7%	92.6%
Cancer: Two week wait referral to date first seen - breast symptomatic	93%	97.6%	97.7%
Cancer: 31 day wait from diagnosis to first treatment	96%	97.6%	97.7%
Cancer: 62 day wait for first treatment from urgent GP referral	85%	81.4%	85.9%
Cancer: 31 day wait for second or subsequent treatment - surgery	94%	97.2%	96.7%
Cancer: 31 day wait for second or subsequent treatment - chemotherapy	98%	99.8%	99.7%
Cancer: 31 day wait for second or subsequent treatment - radiotherapy	94%	96.1%	97.7%
Cancer: 62 day wait for first treatment from referral from NHS cancer screening service	90%	89.6%	88.1%
Cancer: 62 day wait for first treatment from referral following a consultant decision to upgrade	90%	94.4%	99.3%
Emergency re-admissions within 30 days of discharge (%)	10.50%	13.4%	13.4%
Stroke: % of patients who spend > 90% of time on stroke unit	80%	86.4%	85.9%
Stroke: % admitted directly to stroke unit	90%	72.5%	78.1%
Stroke: % scanned in less than one hours of hospital arrival	50%	68.4%	69.0%
Stroke: % of patients scanned within 24 hours	100%	96.7%	98.8%
Stroke: % of high risk TIA cases treated in 24 hours	60%	88.64%	68.4%
Stroke: % of low risk TIA patients seen in seven days	100%	96.4%	94.0%

INDICATOR	STANDARD/ THRESHOLD	2014-15	2013-14
Delayed Transfers of Care (DToC)	3.50%	4.2%	3.30%
Number of falls resulting in severe injury or death	-	21	25
Number of cases of MRSA bloodstream infections	0	0	6
Number of C. Difficile infections	50	45	48
"Never Events" reported in month	0	5	1
Summary Hospital Mortality Indicator (SHMI)	100	93.1	90.79
Hospital Standardised Mortality Ratio (HSMR) - all week	100	95.46	95.5
Hospital Standardised Mortality Ratio (HSMR) - weekdays	100	85.47	94.0
Maternal deaths	0	2	0
Percentage of completed VTE risk assessments	95%	97.1%	96.3%
Number of single sex accommodation breachers	0	0	0

QUALITY AND SAFETY

Providing safe, high quality and patient centred care and treatment for all of our patients by creating a learning culture is the primary aim of the Trust's strategic approach to Safety and Quality.

In order to understand the needs and experiences of our patients better, every inpatient discharged from our adult wards is offered the opportunity to complete the Patient Voice survey. We anticipate that 25% (9000) of the patients discharged will have completed a survey this year. Results for every ward are displayed on a poster outside the ward. The poster also includes information on changes implemented by staff as a result of the feedback given.

Set up in 2011, Staff Stories is a monthly multidisciplinary forum that aims to promote compassionate care through reflection on a complex and/or interesting case and the personal and professional dilemmas involved. This year, the Trust joined the Schwartz community run by the Point of Care Foundation - an independent charity working to improve patients' experience of care and increase support for the staff who work with them.

To widely share the learning from incidents resulting in harm, the Safety and Quality Team produce a monthly publication called Patients 1st. This details the story of an incident affecting a patient and the actions the Trust has taken to reduce the likelihood of a recurrence. In addition, anonymised investigation reports of the Trust's Serious Incidents are shared with all staff via a Serious Incident Directory on the Trust's intranet. As another medium to share learning, 2-4 minute podcasts have been made of these incidents which are publicised on the front page of the intranet. The audio file contains a brief summary of the incident, the key lessons learnt and actions taken. Staff are encouraged to share and discuss these at team meetings and educational sessions.

In order to develop the approach to incident investigation and gain greater insight into complex safety issues, the Trust has been fortunate enough to work with a Human Factors scientist from Sussex University. This has resulted in the redesign of one of our patient referral pathways alongside the development of human factors training for theatre staff.

The new statutory Duty of Candour came into force on 27 November 2014. The Safety and Quality Team have dedicated resource to support this important recommendation arising from the Francis Inquiry.

The falls rate in BSUH has continued to come down and is now 48% lower than five years ago. In recognition of this success, the project was a finalist at the Kent, Surrey and Sussex Service Improvement and Innovation Awards.

In addition to our focus on falls, project teams have also been working on a variety of the Trust wide initiatives. For example, increasing the safety and quality of patient transfers and improving the care pathway for our frailest patients. These two projects form part of the "Towards a Safer Hospital" programme which is summarised in a short film outlining the philosophy behind this approach.

The importance of grassroots input into the Trust's Safety and Quality programme is emphasised throughout the film. This concept is translated into practice by the Innovation Forum. Now in its second year, the forum aims to provide a platform and support for any member of staff who has an idea that might improve the patients care and experience.

Finally, 2015 began with the first ever joint Safety Conference between Brighton and Sussex Medical School and BSUH. The conference was open to all members of BSUH and BSMS staff as well as partner organisations. Over 250 delegates attended to hear how BSUH staff and others are working together to improve patient safety. The conference was themed on how good medical care not only depends on individual expertise but a whole raft of other factors, such as effective teamwork, leadership, an appropriate set of behaviours and values, functioning systems and an ability to accept that we are fallible.

patients 1st

Vera's story

March 2015

- Amikacin is an aminoglycoside antibiotic and is in the same class as gentamicin and tobramycin. Severe side effects include kidney damage, hearing loss, vertigo and tinnitus.
- When given intravenously, these antibiotics need to be carefully monitored by measuring the levels in the blood to ensure these drugs do not accumulate increasing the risk of severe side effects. Long courses or prolonged high levels put patients at increased risk of kidney toxicity and hearing loss.

Vera is 70 years old and lives with her daughter Wendy. She has suffered for years with chronic lung disease which has resulted in her being susceptible to chest infections requiring hospital admission. On this occasion, Vera had again been admitted to hospital to treat a chest infection but seemed more unwell than usual and Wendy feared her mother wouldn't pull through this time. Prescribing treatment for Vera was made more complicated by the fact that she had multiple allergies to antibiotics and had received multiple previous courses of different antibiotics.

Following discussion, and as there were no other appropriate alternatives, the Medical Team decided to treat Vera with intravenous amikacin. It was not an antibiotic that was regularly used by the team – or within the hospital generally – and information about the drug was not on the Trust's antibiotic guidelines. Vera's kidney function was normal and she was prescribed the standard initial dose of the antibiotic. Vera was going to need a course of the drug lasting several weeks and so her drug levels would need to be monitored.

After 11 days of the antibiotic, Vera reported hearing loss – it was something her daughter had commented on several days earlier. Vera was referred to the ENT team and they found her hearing was significantly impaired and a hearing aid was ordered. Reviewing Vera's recent history, her treatment with amikacin was thought to be the cause of her rapid hearing loss. Sadly, despite the drug being immediately discontinued, Vera's hearing did not return. Debriefing what had happened, it was noted that patients on courses of amikacin lasting more than one week are highly likely to be at risk of hearing loss even when levels are appropriately monitored and acted on. Vera had not been informed of this at the time the treatment was prescribed and the team were in agreement that she should have been. It also became clear during the review that although some staff were aware of the risk of hearing loss, because the drug is usually prescribed as a short course, the risks of accumulation (and, therefore, hearing loss) are low. Vera's kidney function was normal and so the drug would be eliminated appropriately for a short course. However, because Vera's course of treatment was longer, amikacin had accumulated even though appropriate blood monitoring had taken place.

The medical team were candid with Vera about the presumed cause of her hearing loss and the steps taken to reduce the risk of the same thing happening again.

What we are doing at Brighton and Sussex University Hospitals NHS

- The guidelines for amikacin are now more widely available through the antibiotic prescribing App (Microguide™) which all prescribers use (via the intranet or smart phone)
- The Anti-Microbial Stewardship Group are deciding on a level of consent for any course of aminoglycosides that is prescribed for longer than one week
- The Lead antimicrobial pharmacist is working with ENT regarding hearing tests that could be used to closely monitor any hearing side-effects during treatment with these antibiotics
- The pharmacy department are producing a patient information leaflet for patients on long courses of IV aminoglycosides which includes details about the risks of this medication
- For further information regarding antibiotic treatment please contact Samantha.Lippett@bsuh.nhs.uk

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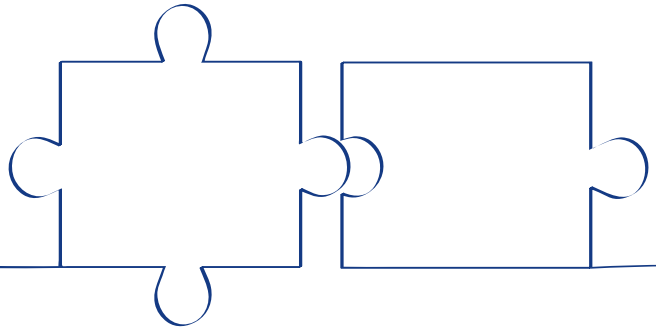
GOVERNANCE



We want to make sure that our patients receive the highest quality care possible and we are always working to ensure this, looking at our internal systems and learning from national assessments, which examine the services we provide and how we handle our resources. Following our *Board Health Review and Board Governance Assurance Framework* review, we continue to implement our Board development plan. Our key priorities next year are the implementation of our People and Well-being Strategy, the development and implementation of the Communications and Engagement Strategy and the embedding of the Values and Behaviours programme.

ACCOUNTABILITY

The NHS Trust Development Authority is responsible for appointing Trust Chairs and other Non-Executive Directors. All these appointments are subject to annual review and appraisal. The remuneration of Non-Executive Directors is determined nationally. All substantive Executive Directors and advisors to the Board are appointed through national advertisement, on permanent contracts. Any changes in remuneration for Executive Directors are agreed by the Nomination and Remuneration Committee.

THE BOARD AND ITS COMMITTEES

The Trust Board discharges its responsibilities through monthly Board meetings, an annual public meeting and a number of Board committees.

BOARD MEETINGS

The Board meets each month and these meetings are open to the public, subject to the proviso that the Board may go into confidential session as appropriate. Information about Board meetings, including agendas and papers, is posted on the Trust's website, www.bsuh.nhs.uk.

It is also available from:

Dominic Ford, Director of Corporate Affairs,
Brighton and Sussex University Hospitals,
St Mary's Hall, Eastern Road, Brighton BN2 5JJ

ANNUAL GENERAL MEETING

The Trust had its Annual General Meeting on 18th September, which was well attended by Trust staff and our partners. The theme of the AGM was our Values and Behaviours and the clinical teams which model those values every day. James Yassin, Clinical Director, Acute Floor, and the Critical Care Team, talked about the approach to excellence and team-working in Critical Care identified as outstanding practice by the CQC in their recent inspection. Karen Lee, Ward Manager of Jowers Ward, talked movingly of hers and the team's approach to compassionate care, which was recognised in the Sussex Proud to Care awards.

HEALTH AND SAFETY PERFORMANCE

Health and Safety in the Trust is managed through the Head of Risk Management and the Health and Safety Committee which is chaired by the Director of Corporate Affairs. The Committee reports to the Executive Team and provides regular assurance to the Board Finance and People Committee against our Health and Safety Key Performance Indicators. The Finance and People Committee also receives an Annual Report measuring progress against the objectives we set ourselves for 2014/15.

ATTENDANCE AT THE BOARD OF DIRECTORS AND BOARD COMMITTEES

Attendance of Board members at the Board of Directors in 2014/15 is detailed below

Board of Directors record of attendance 2014/15

NAME	APR	JUN (16TH)	JUN (30TH)	JUL	SEP	OCT (20TH)	OCT (27TH)	NOV	JAN	FEB	MAR	POSSIBLE	ACTUAL
CHAIR													
Julian Lee	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11	11
NON-EXECUTIVE DIRECTORS													
Lewis Doyle	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11	11
Michael Farthing	✓	✓	✓	✓	✗	✗	✗	✓	✓			9	6
Craig Jones	✗	✓	✗	✓	✓	✓	✗	✓	✓	✗	✓	11	7
Julie Nerney	✓	✓	✓	✗	✓							5	4
Christine Farnish	✓	✓	✓	✓	✓	✓	✗	✗	✓	✓	✓	11	9
Stephen Woodford	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11	11
Antony Kildare	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	11	10
Malcolm Reed										✗	✓	2	1
EXECUTIVE DIRECTORS													
Matthew Kershaw	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11	11
Spencer Prosser	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11	11
Sherree Fagge	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11	11
Steve Holmberg	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11	11
Nikki Luffingham	✓	✓	✓	✓								4	4
Amanda Fadero					✓	✓	✓	✓	✓	✓	✓	7	7

Attendance of Board members at Board Committees in 2014/15 is detailed below

NAME	MAY	JUL	SEP	NOV	JAN	MAR	POSSIBLE	ACTUAL
QUALITY AND RISK COMMITTEE								
MEMBERS								
Michael Farthing	✓	✓	✓	✗	✓		5	4
Stephen Woodford	✓	✓	✓	✓	✓	✗	6	5
Christine Farnish	✗	✗	✗	✓	✓	✓	6	3
Malcolm Reed						✓	1	1
Steve Holmberg	✓	✓	✓	✓	✓	✓	6	6
Sheree Fagge	✓	✓	✗	✓	✗	✗	6	3

NAME	APR	MAY	JUL	SEP	NOV	JAN	MAR	POSSIBLE	ACTUAL
FINANCE AND WORKFORCE COMMITTEE									
MEMBERS									
Julie Nerney	✓	✓	✓	✓				4	4
Craig Jones	✗	✓	✓	✓	✓	✓	✓	7	6
Antony Kildare	✓	✓	✓	✗	✓	✓	✓	7	6
Spencer Prosser	✓	✓	✓	✓	✓	✓	✓	7	7
Nikki Luffingham	✗	✓	✓					3	2
Amanda Fadero				✗	✗	✓	✓	4	2

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the Trust;
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Matthew Kershaw
Chief Executive

April 2015

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

Matthew Kershaw
Chief Executive

Spenser Prosser
Chief Financial Officer

April 2015

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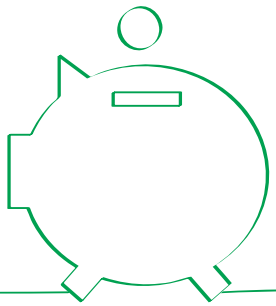
REMUNERATION REPORT



NOMINATION AND REMUNERATION COMMITTEE

The Nomination and Remuneration Committee is a committee of the Trust Board and comprises the Chair of the Trust, the Non-Executive Directors and the Chief Executive. The committee is supported by the Operational Director of Human Resources. The Director of Corporate Affairs attends meetings in an advisory capacity.

The committee is chaired by the Chair of the Trust. No member is involved in any decision as to their own remuneration. The committee is responsible for:

- The appointment and remuneration of the Chief Executive and Executive Directors
- The level and structure of remuneration for senior management
- Ensuring that contractual terms on termination and any payments made are lawful, consistent with the requirements of the Public Interest Disclosure Act (PIDA), contain no inappropriate restrictions and are otherwise within the powers of the Trust
- Approving severance payments as defined within the committee terms of reference, consistent with TDA guidance
- Ensuring that all provisions regarding disclosure of remuneration, including pensions, are fulfilled

Pay multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid director of Brighton and Sussex University Hospitals in the financial year 2014-15 was £245-£250k (2013-14 was £240-£245k). This was 8.9 times (2013-14 was 8.6 times) the median remuneration of the workforce, which was £27.9k (2013-14 was £27.9k).

In 2014-15 zero (2013-14 was zero) employees received remuneration in excess of the highest paid director. Remuneration ranged from £10k to £248k (2013-14 was £14.2k to £241k).

Total remuneration includes salary, nonconsolidated performance related pay, benefits in kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Remuneration policy

The Nomination and Remuneration Committee carries out an annual pay review for all senior staff and staff on ad hoc salaries (staff not on Agenda for Change terms and conditions). It was agreed that those staff would forego any pay increase in 2014/15.

Performance related pay

An element of the remuneration of the Medical Director was a bonus payment relating to a clinical excellence award; and an element of the remuneration of the Chief Financial Officer was performance related.

NAME AND TITLE	REAL INCREASE IN PENSION AT AGE 60	REAL INCREASE IN PENSION LUMP SUM AT AGE 60	TOTAL ACCRUED PENSION AT AGE 60 AT 31 MARCH 2015	LUMP SUM AT AGE 60 RELATED TO ACCRUED PENSION AT 31 MARCH 2015	CASH EQUIVA-LENT TRANSFER VALUE AT 31 MARCH 2015	CASH EQUIVA-LENT TRANSFER VALUE AT 31 MARCH 2014	REAL INCREASE/ (DECREASE) IN CASH EQUIVA-LENT TRANSFER VALUE	EMPLOYERS CONTRI-BUTION TO STAKE-HOLDER PENSION
	(bands of £2500)	(bands of £2500)	(bands of £5000)	(bands of £5000)				
	£000	£000	£000	£000	£000	£000	£000	To nearest £100
Matthew Kershaw	0-2.5	5-7.5	40-45	125-130	654	578	60	
Spencer Prosser	2.5-5	7.5-10	45-50	145-150	828	741	67	
Nikki Luffingham to 31/8/14	0-2.5	0-2.5	45-50	145-150	1,030	965	16	
Sheree Fagge	0-(2.5)	0-(2.5)	50-55	155-160	1,108	1,051	29	

SALARY AND PENSION ENTITLEMENTS OF SENIOR MANAGERS

Remuneration

		2014-15					
NAME & TITLE		SALARY	EXPENSE PAYMENTS (TAXABLE)	PERFOR-MANCE PAY AND BONUSES	LONG TERM PERFOR-MANCE PAY AND BONUSES	ALL PENSION RELATED BENEFITS	TOTAL
		(bands of £5000)	total to nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2500)	(bands of £5000)
		£000		£000	£000		£000
NON-EXECUTIVE							
Julian Lee	Chair	20-25					20-25
Julie Nerney	Non-Executive - until 30th September 2014	0-5					0-5
Michael Farthing	Non-Executive - until 20th January 2015	5-10					5-10
Malcolm Reed	Non-Executive - from 23rd February 2015	0-5					0-5
Lewis Doyle **	Non-Executive	5-10					5-10
Stephen Woodford **	Non-Executive	5-10					5-10
Antony Kildare	Non-Executive	5-10					5-10
Christine Farnish **	Non-Executive	5-10					5-10
Craig Jones	Non-Executive	5-10					5-10
EXECUTIVE							
Mathew Kershaw	Chief Executive	195-200				50-55	245-250
Spencer Prosser	Chief Financial Officer	155-160		5-10		45-50	210-215
Nikki Luffingham	Chief Operating Officer - until 31st August 2014	55-60				5-10	65-70
Sheree Fagge	Director of Nursing	120-125					120-125
Dr Steve Holmberg	Medical Director	190-195	100	55-60			245-250
Amanda Fadero	Director of Strategy and Change - from 15th September 2014	85-90					85-90

2013-14					
SALARY	EXPENSE PAYMENTS (TAXABLE)	PERFOR-MANCE PAY AND BONUSES	LONG TERM PERFOR-MANCE PAY AND BONUSES	ALL PENSION RELATED BENEFITS	TOTAL
(bands of £5000)	total to nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2500)	(bands of £5000)
£000		£000	£000		£000
20-25					20-25
5-10					5-10
5-10					5-10
5-10					5-10
0-5					0-5
0-5					0-5
0-5					0-5
5-10					5-10
195-200				70-75	265-270
35-40				55-60	90-95
135-140				15-20	150-155
120-125				5-10	125-130
180-185	100	55-60		(15-20)	220-225

** Audit Committee member

14 APPENDICES

APPENDIX 1 – FULL ANNUAL ACCOUNTS
APPENDIX 2 – ANNUAL GOVERNANCE STATEMENT 2014/15
APPENDIX 3 – GLOSSARY OF TERMS

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CONSOLIDATED FINANCIAL STATEMENTS

REPORT FROM THE CHIEF FINANCIAL OFFICER

During 2014/15 the Trust delivered a deficit of £0.45m after technical adjustments. These technical adjustments relate to the revaluation of hospital estate in advance of a number of significant capital projects. The deficit position reflected the challenging financial environment faced by the NHS as whole. The Trust met the External Financing Limit and Capital Resource Limit statutory duties.

We received total income of £520.8m of which £457.7m came from patient care and £63.1m came from research, education, commercial and non-clinical services to other organisations. Although there was a reduction in the national tariff total patient care income increased by 1.0%.

Operating expenditure (excluding impairments and donated assets adjustments) was £511.8m with our productivity and efficiency programme delivering £29.9m savings through a number of initiatives that were driven through the Trust's clinical and corporate divisions. During the year we invested significant amounts of capital expenditure totalling £33.9m including the following areas: 3Ts redevelopment £19m, Estates infrastructure £4.3m, Neurology reconfiguration £2.9m, and Vascular Centre £2.0m.

BSUH acts as a Trustee for charitable funds of £10m. Income from donations, legacies and grants totalled £1.8m in 2014/15. During the year £2.4m was spent on clinical research, patient and staff welfare. The annual accounts for charitable funds have been consolidated with the accounts of the Trust in accordance with national reporting requirements relating to common control. We continue to be extremely grateful for the continuing support we receive from our volunteers, supporters, Friends and other providers of charitable funds and for the additional facilities they enable us to provide.

The Trust is operating in a challenging financial environment. Pressures exist around investing in clinical staffing ratios, providing services seven days a week and responding to service demand.

Overall, 2014/15 was a challenging year financially with the pressures continuing into 2015/16.

Spenser Prosser
Chief Financial Officer

STATEMENT OF COMPREHENSIVE INCOME FOR YEAR ENDED 31 MARCH 2015

	NOTE	**TRUST 2014-15 £000s**	TRUST 2013-14 £000s	**CONSOLIDATED 2014-15 £000s**	CONSOLIDATED 2013-14 £000s
Gross employee benefits	10.1	**(304,930)**	(293,018)	**(305,246)**	(293,122)
Other operating costs	8	**(206,910)**	(265,327)	**(208,464)**	(266,457)
Revenue from patient care activities	5	**457,703**	450,962	**457,763**	450,964
Other operating revenue	6	**63,062**	107,593	**62,890**	110,261
Operating surplus		**8,925**	210	**6,943**	1,646
Investment revenue	12	**75**	86	**381**	373
Other gains	13	**1,136**	707	**2,198**	1,118
Finance costs	14	**(3,566)**	(3,094)	**(3,566)**	(3,094)
Surplus (deficit) for the financial year		**6570**	2091	**5956**	43
Public dividend capital dividends payable		**(7,879)**	(7,481)	**(7,879)**	(7,481)
Tax				**(38)**	0
Retained deficit for the year		**(1,309)**	(9,572)	**(1,961)**	(7,438)
OTHER COMPREHENSIVE INCOME					
Impairments and reversals taken to the revaluation reserve		**0**	(1,771)	**0**	(1,771)
Net gain on revaluation of property, plant & equipment		**20,249**	10,295	**20,249**	10,295
Net gain on revaluation of available for sale financial assets		**522**	0	**522**	0
Total comprehensive income for the year*		**19,462**	(1,048)	**18,810**	1,086

* This sums the rows above and the deficit for the year.

The prior year comparatives have been restate to include the 2 months of trading of Pharm@Sea Limited.

	NOTE	**TRUST 2014-15 £000s**	TRUST 2013-14 £000s
FINANCIAL PERFORMANCE FOR THE YEAR			
Retained surplus/(deficit) for the year		**(1,309)**	(9,572)
IFRIC 12 adjustment (including IFRIC 12 impairments)		**0**	0
Impairments (excluding IFRIC 12 impairments)		**190**	14,272
Adjustments in respect of donated gov't grant asset reserve elimination		**669**	414
Adjusted retained (deficit)/surplus		**(450)**	5,114

A trust's reported financial performance position is derived from it's retained surplus/(deficit), but adjusted for the following:

a) An impairment charge is not considered part of the organisation's operating position.

b) The incremental revenue expenditure resulting from the application of IFRS to PFI, which has no cash impact and is not

c) The Treasury FReM for 2011-12 changed the accounting treatment for the funding element of charitable donations so that NHS Prior year performance is not re-assessed following accounting restatements.

The notes on pages 2 to 5 form part of this account.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2015

	NOTE	**TRUST 2014-15 £000s**	TRUST 2013-14 £000s	**CONSOLIDATED 2014-15 £000s**	CONSOLIDATED 2013-14 £000s
NON-CURRENT ASSETS:					
Property, plant and equipment	15	**329,717**	**297,951**	**330,059**	298,350
Intangible assets	**16**	**461**	408	**461**	408
Other investments - Charitable				**10,627**	9,573
Other financial assets		**1,101**	1,101	**0**	0
Trade and other receivables	22.1	**1,409**	3,349	**1,409**	3,349
Total non-current assets		**332,688**	302,809	**342,556**	311,680
CURRENT ASSETS:					
Inventories	21	**7,178**	6,507	**7,933**	6,760
Trade and other receivables	22.1	**40,827**	36,428	**39,799**	37,197
Other financial assets	24	**0**	0	**0**	0
Other current assets	25	**0**	0	**0**	0
Cash and cash equivalents	26	**25,395**	22,176	**26,203**	23,433
Sub-total current assets		**73,400**	65,111	**73,935**	67,390
Non-current assets held for sale	27	**653**	2,765	**653**	2,765
Total current assets		**74,053**	67,876	**74,588**	70,155
Total assets		**406,741**	370,685	**417,144**	381,835
CURRENT LIABILITIES					
Trade and other payables	28	**(59,905)**	(60,030)	**(59,865)**	(60,085)
Other liabilities	29	**0**	0	**0**	0
Provisions	35	**(388)**	(693)	**(388)**	(693)
Borrowings	30	**(1,220)**	(1,461)	**(1,220)**	(1,461)
Other financial liabilities	31	**0**	0	**0**	0
DH revenue support loan	30	**(3,000)**	(3,000)	**(3,000)**	(3,000)
DH capital loan	30	**(1,609)**	(803)	**(1,609)**	(803)
Total current liabilities		**(66,122)**	(65,987)	**(66,082)**	(66,042)
Net current assets		**7,931**	1,889	**8,506**	4,113
Total assets less current liabilities		**340,619**	304,698	**351,062**	315,793

	NOTE	TRUST 2014-15 £000s	TRUST 2013-14 £000s	CONSOLIDATED 2014-15 £000s	CONSOLIDATED 2013-14 £000s
NON-CURRENT LIABILITIES					
Trade and other payables	28	**(579)**	(867)	**(579)**	(867)
Other liabilities	31	**0**	0	**0**	0
Provisions	35	**(1,927)**	(2,929)	**(1,927)**	(2,929)
Borrowings	30	**(32,907)**	(34,127)	**(32,907)**	(34,127)
Other financial liabilities	31	**0**	0	**0**	0
DH revenue support loan	30	**(1,500)**	(4,500)	**(1,500)**	(4,500)
DH capital loan	30	**(35,436)**	(13,617)	**(35,436)**	(13,617)
Total non-current liabilities		**(72,349)**	(56,040)	**(72,349)**	(56,040)
Total assets employed:		**268,270**	248,658	**278,713**	259,753
FINANCED BY:					
Public Dividend Capital		**236,123**	235,973	**236,123**	235,973
Retained earnings		**(17,866)**	(18,928)	**(19,734)**	(20,577)
Revaluation reserve		**50,013**	31,613	**50,013**	31,613
Charitable funds reserve				**12,157**	12,835
Pharm@Sea Limted Reserve		**0**	0	**154**	(91)
Total Taxpayers' Equity:		**268,270**	248,658	**278,713**	259,753

The notes on pages 6 to 43 form part of this account.

The prior year comparatives have been restate to include the 2 months of trading of Pharm@Sea Limited.

The financial statements on pages 2 to 5 were approved by the Audit Committee (with delegated authority by the Board) on 11 June 2015 and signed on its behalf by:

Matthew Kershaw
Chief Executive

June 2015

STATEMENT OF CHANGES IN TAXPAYERS EQUITY FOR THE YEAR ENDING 31 MARCH 2015

TRUST				
	PUBLIC DIVIDEND CAPITAL £000S	RETAINED EARNINGS £000S	REVALUATION RESERVE £000S	TOTAL RESERVES £000S
Balance at 1 April 2014	**235,973**	**(18,928)**	**31,613**	**248,658**
Changes in taxpayers' equity for 2014-15				
Retained deficit for the year		(1,309)		**(1,309)**
Net gain on revaluation of property, plant, equipment			20,249	**20,249**
Net gain on revaluation of available for sale financial assets			522	**522**
Impairments and reversals			0	**0**
Transfers between reserves		2,371	(2,371)	**0**
Reclassification Adjustments				
On disposal of available for sale financial assets			0	**0**
New temporary and permanent PDC received - cash	150			**150**
Net recognised revenue for the year	150	1,062	18,400	**19,612**
Consolidation Adjustment				
Balance at 31 March 2015	**236,123**	**(17,866)**	**50,013**	**268,270**
Balance at 1 April 2013	**234,942**	**(22,291)**	**24,193**	**236,844**
Changes in taxpayers' equity for the year ended 31 March 2014				
Retained deficit for the year		(9,572)		(9,572)
Net gain on revaluation of property, plant, equipment			10,295	10,295
Impairments and reversals			(1,771)	(1,771)
Transfers between reserves		1,104	(1,104)	0
Transfers under Modified Absorption Accounting - PCTs & SHAs		11,831		11,831
Reclassification Adjustments				
New temporary and permanent PDC received - cash	1,031			1,031
Net recognised revenue for the year	**1,031**	**3,363**	**7,420**	**11,814**
Consolidation Adjustment				
Balance at 31 March 2014	**235,973**	**(18,928)**	**31,613**	**248,658**

CONSOLIDATED					
PUBLIC DIVIDEND CAPITAL £000S	RETAINED EARNINGS £000S	REVALUATION RESERVE £000S	CHARITABLE FUNDS RESERVE £000S	PHARM@SEA RESERVE £000S	TOTAL RESERVES £000S
235,973	**(20,577)**	**31,613**	**12,835**	**(91)**	**259,753**
	(1,309)		(897)	245	**(1,961)**
		20,249			**20,249**
		522			**522**
		0			**0**
	2,371	(2,371)			**0**
		0			**0**
150					**150**
150	1,062	18,400	(897)	245	**18,960**
	(219)		219	0	**0**
236,123	**(19,734)**	**50,013**	**12,157**	**154**	**278,713**
234,942	**(23,455)**	**24,193**	**10,125**	**0**	**245,805**
	(9,572)		2,225	(91)	**(7,438)**
		10,295			**10,295**
		(1,771)			**-1,771**
	1,104	(1,104)			**0**
	11,831				**11,831**
1,031					**1,031**
1,031	3,363	7,420	2,225	(91)	13,948
	-485		485	0	**0**
235,973	**(20,577)**	**31,613**	**12,835**	**(91)**	**259,753**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2015

	NOTE	**TRUST 2014-15 £000s**	TRUST 2013-14 £000s	**CONSOLIDATED 2014-15 £000s**	CONSOLIDATED 2013-14 £000s
CASH FLOWS FROM OPERATING ACTIVITIES					
Operating surplus		**8,925**	210	**6,943**	1,646
Depreciation and amortisation		**22,736**	20,662	**22,793**	20,671
Impairments and reversals		**190**	14,272	**190**	14,272
Other losses on foreign exchange		**(71)**	(24)	**(71)**	(24)
Interest paid		**(3,300)**	(2,957)	**(3,300)**	(2,957)
Dividend paid		**(7,707)**	(6,866)	**(7,707)**	(6,866)
(Increase)/Decrease in Inventories		**(671)**	1,629	**(1,173)**	1,376
Increase in Trade and Other Receivables		**(3,585)**	(15,128)	**(1,787)**	(15,144)
Increase in Trade and Other Payables		**2,839**	3,602	**2,704**	3,047
Provisions utilised		**(1,702)**	(1,169)	**(1,702)**	(1,169)
Decrease in movement in non cash provisions		**1,254**	(1,448)	**1,254**	(1,448)
Net Cash Inflow from Operating Activities		**18,908**	12,783	**18,144**	13,404
CASH FLOWS FROM INVESTING ACTIVITIES					
Interest Received		**75**	86	**75**	373
Payments for Property, Plant and Equipment		**(37,305)**	(24,152)	**(37,305)**	(24,560)
Payments for Intangible Assets		**(207)**	0	**(207)**	0
Payments for Other Financial Assets		**0**	(1,101)	**0**	0
Net cash flows relating to investing activities		**0**	0	**315**	(1,408)
Proceeds of disposal of assets held for sale (PPE)		**3,433**	2,171	**3,433**	2,171
Net Cash Outflow from Investing Activities		**(34,004)**	(22,996)	**(33,689)**	(23,424)
Net Cash Outflow before Financing		**(15,096)**	(10,213)	**(15,545)**	(10,020)

	NOTE	**TRUST 2014-15 £000s**	TRUST 2013-14 £000s	**CONSOLIDATED 2014-15 £000s**	CONSOLIDATED 2013-14 £000s
CASH FLOWS FROM FINANCING ACTIVITIES					
Gross Temporary and Permanent PDC Received		**150**	1,031	**150**	1,031
Loans received from DH - New Capital Investment Loans		**23,730**	1,018	**23,730**	1,018
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**(1,104)**	(782)	**(1,104)**	(782)
Loans repaid to DH - Working Capital Loans		**(3,000)**	(3,000)	**(3,000)**	(3,000)
Capital Element of Payments in Respect of On-SoFP PFI		**(1,461)**	(1,547)	**(1,461)**	(1,547)
Net Cash Inflow/(Outflow) from Financing Activities		**18,315**	(3,280)	**18,315**	(3,280)
Net Increase/(Decrease) in Cash and Cash Equivalents		**3,219**	(13,493)	**2,770**	(13,300)
Cash and Cash Equivalents at Beginning of the Period		**22,176**	35,669	**23,433**	36,733
Effect of exchange rate changes in the balance of cash held in foreign currencies		**0**	0	**0**	0
Cash and Cash Equivalents at year end		**25,395**	22,176	**26,203**	23,433

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2014-15 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Consolidation

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust or where the subsidiary's accounting date is not co-terminus.

From 2013-14, the results of Brighton and Sussex University Hospitals NHS Charitable Funds, over which the Trust considers it has the power to exercise control in accordance with IFRS10 requirements, have been consolidated.

The Trust established a wholly owned subsidiary, Pharm@Sea Limited, on 13 January 2014, to deliver outpatient pharmacy dispensing services. The subsidiary commenced trading on 10 February 2014. The results of the subsidiary are fully consolidated in 2014-15.

Intercompany transactions, balances and unrealised gains on transactions between group companies are eliminated in full on consolidation.

Separate notes have not been prepared for the Trust.

1.4 Movement of assets within the DH Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCNE/SOCNI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS20 and similarly give rise to income and expenditure entries. For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, Treasury agreed that a modified absorption approach should be applied. For these transactions and only in the prior-period, gains and losses are recognised in reserves rather than the SOCNE/SOCNI.

1.5 Pooled Budgets

The Group has not entered into any pooled arrangements during the financial year 2014-15.

1.6 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Group's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying

assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.6.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Group's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Holiday Pay Accrual

The cost of holidays earned but not taken is based on an extrapolation of the average cost of those returns from staff identifying holiday owing but not yet taken.

Assets Under Construction

The costs of the 3T's project (the redevelopment of the Royal Sussex County Hospital), which represent costs capitalised on assets not currently complete, are included in Asset Under Construction. At 31 March 2015 these amounted to £36.2m (2013-14 - £17.3m). The project is at Full Business Case stage and "in principle" agreement has been given by the Secretary of State for Health for the total costs of £486m of the project. If the project were to be aborted before completion the accumulated costs held in Assets Under Construction would be impaired in full in the year the project was aborted and any costs incurred in that year would be charged to revenue.

1.6.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Fully Depreciated Plant and Equipment

The Group is reviewing fully depreciated items of plant and equipment held on the capital asset register. Pending the completion of this exercise £24m has been eliminated from the gross cost and accumulated depreciation as representing the best estimate of those assets that are no longer held by the Group.

1.7 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end is measured at the price per day for each patient spell apportioned across the financial years.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Group receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Group recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.8 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the

liability for the additional costs is charged to expenditure at the time the Group commits itself to the retirement, regardless of the method of payment.

1.9 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.10 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the Group;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Group's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Group; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.12 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Group expects to obtain economic benefits or service potential from the asset. This is specific to the Group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives

The estimated useful lives are:

	YEARS
Buildings	1-90
Medical equipment and engineering plant and equipment	5-15
Furniture	5-15
Soft furnishings	5-15
Office and information technology equipment	5-10
Vehicles	7

At each reporting period end, the Group checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from

a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set. AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.13 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.14 Government grants

The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.15 Other Investments - Charitable

Investment are stated at market value as at the balance sheet date. The statement of comprehensive income includes the net gains and losses arising on revaluation and disposals throughout the year. The Common Investment Fund Units are included in the Statement of Financial Position at the closing dealing price at 31 March 2015. An official pooling scheme is operated for the funds of the Charity.

1.16 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.17 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Group as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Group's deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The Group as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Group's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.18 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Group therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;

b) Payment for the PFI asset, including finance costs; and

c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Group to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Group's Statement of Financial Position.

Other assets contributed by the Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the Group to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Group, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.19 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.20 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Group's cash management.

1.21 Provisions

Provisions are recognised when the Group has a present legal or constructive obligation as a result of a past event, it is probable that the Group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates of -1.5% to +2.2% in real terms (1.3% for employee early departure obligations).

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.22 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Group. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Group is disclosed at note 35.

1.23 Non-clinical risk pooling

The Group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Group pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.24 Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the Group makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.25 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.26 Financial assets

Financial assets are recognised when the Group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the Trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset. Fair value is determined by reference to quoted market prices where possible, otherwise they are held at amortised cost using the effective interest method, less impairment. Interest is recognised using the effective interest method.

Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition. Fair value is determined by reference to quoted market prices where possible, otherwise they are held at amortised cost using the effective interest method, less impairment. Interest is recognised using the effective interest method.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise they are held at amortised cost using the effective interest method, less impairment. Interest is recognised using the effective interest method.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Group assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the

difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.27 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the NHS trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial guarantee contract liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

The premium received (or imputed) for entering into the guarantee less cumulative amortisation.

The amount of the obligation under the contract, as determined in accordance with IAS 37 *Provisions, Contingent Liabilities and Contingent Assets.*

Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.28 Value Added Tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.29 Foreign currencies

The Group's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Group's surplus/deficit in the period in which they arise.

1.30 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Group has no beneficial interest in them. Details of third party assets are given in Note 44 to the accounts.

1.31 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the Group. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Group, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except

for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.32 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS bodies not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.33 Subsidiaries

Material entities over which the Trust has the power to exercise control are classified as subsidiaries and are consolidated. The Trust has control when it is exposed to or has rights to variable returns through its power over another entity. The income and expenses; gains and losses; assets, liabilities and reserves; and cash flows of the subsidiary are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

From 2013-14, the Trust has consolidated the results of Brighton and Sussex University Hospitals NHS Charitable Funds over which it considers it has the power to exercise control in accordance with IFRS10 requirements.

1.34 Associates

Material entities over which the Groupt has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the Group's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the Group share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the Group from the entity.

Associates that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

1.35 Joint arrangements

Material entities over which the NHS trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the Group is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

1.36 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCNE/SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.37 Charitable Funds Structure

Charitable Funds are classified into three categories, Restricted, Unrestricted and Endowment Funds.

Restricted funds are those which are to be sued in accordance with specific restrictions imposed by the donor and/or Trustee at the inception of the fund. Unrestricted funds are those which the Trustee is free to use for any purpose in furtherance of the charitable objectives. Unrestricted funds include designated funds which are not legally restricted but which the Trustee has chosen to earmark for set purposes. Endowment funds are funds where the capital is held in perpetuity to generate income for charitable purposes and cannot itself be spent.

1.38 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2014-15. The application of the Standards as revised would not have a material impact on the accounts for 2014-15, were they applied in that year.

IFRS 9 Financial Instruments - subject to consultation

IFRS 13 Fair Value Measurement - subject to consultation

IFRS 15 Revenue from Contracts with Customers

2. Pooled budget

The Group has not entered into any pooled budget arrangement during the financial year 2014-15.

3. Operating segments

The Group has only one operating segment.

Income from transactions with a single external customer which amount to 10% or more of total income is as follows:

	2014-15 £M's	2013-14 £M's
CCG *	**295**	283
NHS England	**153**	150
	448	433

This income all relates to patient activity.

* As commissioners are under common control they are classed as a single customer for this purpose.

4. Income generation activities

The Group undertakes income generation activities with an aim of achieving profit, which is then used in patient care but has not undertaken any income generation activities whose full cost exceeded £1m.

5. Revenue from patient care activities

	2014-15 £000s	2013-14 £000s
NHS Trusts	**2,154**	1,898
NHS England	**146,799**	148,128
Clinical Commissioning Groups	**294,277**	285,735
Foundation Trusts	**2,204**	2,888
Department of Health	**414**	361
NHS Other (including Public Health England and Prop Co)	**489**	120
Additional income for delivery of healthcare services	**0**	
Non-NHS:		
Local Authorities	**3,369**	3,485
Private patients	**4,284**	4,078
Overseas patients (non-reciprocal)	**164**	285
Injury costs recovery	**1,282**	1,351
Other	**2,267**	2,633
Total Revenue from patient care activities	**457,703**	450,962

6. Other operating revenue

	2014-15 £000s	2013-14 £000s
Recoveries in respect of employee benefits	**3,290**	2,642
Education, training and research*	**46,429**	98,150
Receipt of donations for capital acquisitions – Charity	**189**	453
Non-patient care services to other bodies	**2,677**	0
Income generation	**5,894**	5,803
Rental revenue from operating leases	**425**	282
Other revenue	**4,158**	263
Total Other Operating Revenue	**63,062**	107,593
Total operating revenue	**520,765**	558,555

* the significant change in income for education, training and research relates to the de-hosting of the Deanery in 2013-14.

7. Overseas Visitors Disclosure

	2014-15 £000	2013-14 £000
Income recognised in year (invoiced amounts and accruals)	**164**	285
Cash payments received in-year (re receivables at year end)	**50**	61
Cash payments received in-year (re invoices issued in year)	**83**	81
Amounts added to provision for impairment of receivables (re receivables at year end)	**0**	0
Amounts added to provision for impairment of receivables (re invoices issued in year)	**145**	257
Amounts written off in-year (irrespective of year of recognition)	**265**	103

8. Operating expenses

	2014-15 £000s	2013-14 £000s
Services from other NHS Trusts	**3,787**	4,921
Services from CCGs/NHS England	**0**	70
Services from other NHS bodies	**0**	0
Services from NHS Foundation Trusts	**2,034**	2,248
Total Services from NHS bodies*	**5,821**	7,239
Purchase of healthcare from non-NHS bodies	**6,506**	5,314
Trust Chair and Non-executive Directors	**66**	66
Supplies and services - clinical	**107,031**	101,720
Supplies and services - general	**16,956**	17,507
Consultancy services	**713**	1,180
Establishment	**4,490**	4,282
Transport	**1,005**	977
Service charges - ON-SOFP PFIs and other service concession arrangements	**1,449**	
Business rates paid to local authorities	**2,253**	
Premises	**15,709**	20,861
Hospitality	**10**	127
Insurance	**480**	629
Legal Fees	**1,143**	1341
Impairments and Reversals of Receivables	**1,320**	(969)
Inventories write down	**88**	65
Depreciation	**22,582**	20,549
Amortisation	**154**	113
Impairments and reversals of property, plant and equipment	**(218)**	14,272
Impairments and reversals of non current assets held for sale	**408**	0
Audit fees	**155**	150
Other auditor's remuneration -Internal audit fees	**177**	164
Clinical negligence	**10,490**	10,608
Research and development (excluding staff costs)	**2,249**	2,015
Education and Training	**5,715**	56,174
Change in Discount Rate	**129**	144
Other	**29**	799
Total Operating expenses (excluding employee benefits)	**206,910**	265,327

* the significant change in expenditure on education and training relates to the de-hosting of the Deanery in 2013-14.

Employee Benefits

Employee benefits excluding Board members	**304,022**	292,142
Board members	**908**	876
Total Employee Benefits	**304,930**	293,018
Total Operating Expenses	**511,840**	558,345

*Services from NHS bodies does not include expenditure which falls into a category below

9 Operating Leases

The Group leases four properties which are for periods of between ten and twenty years. The leases cannot be cancelled unless through agreed break clauses. There are no contingent rents and the Trust may not assign any of the leases without the landlord's permission.

Details of the leases are set out below:

	TERM YEARS	START DATE	END DATE	BREAK CLAUSE	BREAK CLAUSE NOTICE
Sussex House, Brighton	18	29.03.07	28.03.25	N/A	N/A
Freshfield, Brighton	19	24.06.03	23.06.22	23.06.2017	12 months
Preston Road, Brighton	20	21.05.13	10.02.33	11.02.2022	6 months
Bloomsbury, Brighton	10	29.05.09	28.05.19	N/A	N/A

The Group has entered into service level agreements with other local NHS organisations for use of facilities on their sites. The service level agreements are renegotiated annually and include cancellation clauses of between 0 and 1 year.

9.1 Group as lessee

	LAND £000s	BUILDINGS £000s	OTHER £000s	TOTAL £000s	2013-14 £000s
Payments recognised as an expense					
Minimum lease payments				1,388	1,710
Total				1,388	1,710
Payable:					
No later than one year	0	1,358	6	1,364	1,341
Between one and five years	0	3,677	0	3,677	3,591
After five years		0	4,701	0	4,701
Total	0	9,736	6	9,742	10,318
Total future sublease payments expected to be received:	0	0			

9.2 Group as lessor

The Group leases space to third parties to provide food, beverages and newspapers, the swimming pool on the St Mary's Hall site in Brighton, office space and use of sites for the location of aerials.

	2014-15 £000s	2013-14 £000s
RECOGNISED AS REVENUE		
Rental revenue	**425**	282
Contingent rents	**0**	0
Total	**425**	282
RECEIVABLE:		
No later than one year	**323**	303
Between one and five years	**878**	1,053
After five years	**33**	70
Total	**1,234**	1,426

10 Employee benefits and staff numbers

10.1 Employee benefits

	TOTAL £000s	PERMANENTLY EMPLOYED £000s	OTHER £000s
EMPLOYEE BENEFITS - GROSS EXPENDITURE 2014-15			
Salaries and wages	**257,911**	228,414	29,497
Social security costs	**19,478**	19,478	0
Employer Contributions to NHS BSA - Pensions Division	**28,362**	28,362	0
Other pension costs	**4**	4	0
Termination benefits	**30**	30	0
Total employee benefits	**305,785**	**276,288**	**29,497**
Employee costs capitalised	**855**	855	0
Gross Employee Benefits excluding capitalised costs	**304,930**	**275,433**	**29,497**

	TOTAL £000s	PERMANENTLY EMPLOYED £000s	OTHER £000s
EMPLOYEE BENEFITS - GROSS EXPENDITURE 2013-14			
Salaries and wages	246,262	221,276	24,986
Social security costs	19,140	19,140	0
Employer Contributions to NHS BSA - Pensions Division	28,344	28,344	0
Other pension costs	0	0	0
Termination benefits	122	122	0
TOTAL - including capitalised costs	293,868	268,882	24,986
Employee costs capitalised	850	850	0
Gross Employee Benefits excluding capitalised costs	293,018	268,032	24,986

10.2 Staff Numbers

	2014-15 TOTAL NUMBER	2014-15 PERMANENTLY EMPLOYED NUMBER	2014-15 OTHER NUMBER	2013-14 TOTAL NUMBER
AVERAGE STAFF NUMBERS				
Medical and dental	**1,085**	1,025	60	1,065
Administration and estates	**1,502**	1,237	265	1,361
Healthcare assistants and other support staff	**125**	125	0	832
Nursing, midwifery and health visiting staff	**3,504**	2,950	554	3,361
Nursing, midwifery and health visiting learners	**33**	33	0	29
Scientific, therapeutic and technical staff	**1,116**	1,093	23	730
Other	**2**	2	0	387
TOTAL	**7,367**	**6,465**	**902**	7,765
Of the above - staff engaged on capital projects	**12**	12	0	17

10.3 Staff Sickness absence and ill health retirements

	2014-15 NUMBER	2013-14 NUMBER
Total Days Lost	52,582	49,319
Total Staff Years	6,280	6,242
Average working Days Lost	**8.37**	7.90
	2014-15 NUMBER	2013-14 NUMBER
Number of persons retired early on ill health grounds	**4**	7
	£000s	£000s
Total additional pensions liabilities accrued in the year	**291**	500

10.4 Exit Packages agreed in 2014-15

Exit package cost band (including any special payment element)	2014-15			2013-14		
	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
	NUMBER	**NUMBER**	**NUMBER**	NUMBER	NUMBER	NUMBER
Less than £10,000	0	0	0	0	6	6
£10,000-£25,000	0	0	0	0	3	3
£25,001-£50,000	1	0	1	0	0	0
£50,001-£100,000	1	0	1	0	0	0
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	2	0	2	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost)	**4**	**0**	**4**	0	9	9
Total resource cost (£'000s)	**449**	**0**	**449**	0	66	66

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

10.5 Exit packages - Other Departures analysis

	2014-15		2013-14	
	AGREEMENTS NUMBER	TOTAL VALUE OF AGREEMENTS £000s	AGREEMENTS NUMBER	TOTAL VALUE OF AGREEMENTS £000s
Voluntary redundancies including early retirement contractual costs	0	0	3	25
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	7	41
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval*	0	0	0	0
Total	0	0	10	66
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

As a single exit packages can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 10.4 which will be the number of individuals.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

10.6 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

On advice from the scheme actuary, scheme contributions maybe varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties

effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the statement of comprehensive income at the time the Trust commits itself to the retirement, regardless of the method of payment.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

NEST

The Pensions Act 2008 and 2001 Automatic Enrolment Regulations required all employers to enrol workers meeting certain criteria into a pension scheme and pay contributions toward their retirement. Employees who are unable to join the NHS Pensions Scheme are covered by the National Employers Savings Trust ("NEST"). Nest is a defined contribution pension scheme.

The auto enrolment "staging" date for the Group compliance was 1 April 2013. For those staff not entitled to join the NHS Pension Scheme, the Group utilised an alternative pension scheme called NEST to fulfil its automatic enrolment obligations.

NEST stands for National Employment Savings Trust and is a defined contribution pension scheme established by law to support the introduction of auto enrolment.

Contributions are taken from qualifying earnings, which are currently from £5,668 up to £41,450, but will be reviewed every year by the government. The initial contribution is 1% of qualifying earnings, with an employer contribution of 1%. This will increase in stages to meet levels set by government.

Annual contribution to a NEST retirement fund is limited to £4,700 for the 2014/15 tax year. This will be reviewed each year and is likely to increase. Pension members can make additional contributions to their pension fund at any time up to the annual limit.

Pension members can choose to let NEST manage their retirement fund or can take control themselves and alter contribution levels and switch between different funds. If pension members leave the Group they can continue to pay into NEST.

NEST pension members can take their money out of NEST at any time from age 55. If suffering from ill health or incapable of working due to illness members can request to take their money out of NEST early. They can take the entire retirement fund as cash, use it to buy a retirement income or a combination. Additionally members can transfer their NEST retirement fund to another scheme.

NEST is run but NEST Corporation, a trustee body which is a non-department public body operating at arm's length from government and is accountable to Parliament through the Department for Work and Pensions.

DATE	EMPLOYEE CONTRIBUTION	EMPLOYER CONTRIBUTION	TOTAL CONTRIBUTION
1st March 2013	1%	1%	2%
1st October 2017	3%	2%	5%
1st October 2018	5%	3%	8%

11 Better Payment Practice Code

11.1 Measure of compliance

	2014-15 NUMBER	2014-15 £000s	2013-14 NUMBER	2013-14 £000S
NON-NHS PAYABLES				
Total Non-NHS Trade Invoices Paid in the Year	**126,673**	**274,031**	116,486	234,617
Total Non-NHS Trade Invoices Paid Within Target	**103,308**	**190,281**	93,519	158,234
Percentage of NHS Trade Invoices Paid Within Target	**81.55%**	**69.44%**	80.28%	67.44%
NHS PAYABLES				
Total NHS Trade Invoices Paid in the Year	**2,717**	**42,896**	3,228	90,354
Total NHS Trade Invoices Paid Within Target	**1,837**	**23,326**	2,366	74,389
Percentage of NHS Trade Invoices Paid Within Target	**67.61%**	**54.38%**	73.30%	82.33%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

11.2 The Late Payment of Commercial Debts (Interest) Act 1998

There were no costs associated with the late payment of commercial debts (2013-14: nil).

12 Investment Revenue

	2014-15 £000s	2013-14 £000s
INTEREST REVENUE		
Bank interest	**75**	86
Total investment revenue	**75**	86

13 Other Gains and Losses

	2014-15 £000s	2013-14 £000s
Gain on disposal of assets held for sale	**1,207**	731
Loss on foreign exchange	**(71)**	(24)
Total	**1,136**	707

14 Finance Costs

	2014-15 £000s	2013-14 £000s
INTEREST		
Interest on loans and overdrafts	**743**	388
Interest on obligations under PFI contracts:		
main finance cost	**1,921**	2,001
contingent finance cost	**635**	567
Total interest expense	**3,299**	2,956
Other finance costs	**1**	1
Provisions - unwinding of discount	**266**	137
Total	**3,566**	3,094

15.1 Property, plant and equipment

	LAND £000's	BUILDINGS EXCLUDING DWELLINGS £000's	DWELLINGS £000's	ASSETS UNDER CONSTRUCTION & PAYMENTS ON ACCOUNT £000's
2014-15				
COST OR VALUATION: AT 1 APRIL 2014	**28,481**	**188,505**	**325**	**28,013**
Additions of Assets Under Construction				**30,260**
Additions Purchased	0	0	0	
Additions - Purchases from Cash Donations	0	0	0	189
Reclassifications	0	8,552	0	(8,552)
Reclassifications as Held for Sale and reversals	0	0	0	0
Disposals other than for sale	0	0	0	0
Upward revaluation/positive indexation	2,517	17,700	32	0
Impairments/negative indexation	0	0	0	0
Reversal of Impairments	0	0	0	0
At 31 March 2015	**30,998**	**214,757**	**357**	**49,910**
DEPRECIATION AT 1 APRIL 2014	0	0	0	0
Reclassifications	0	0	0	0
Reclassifications as Held for Sale and reversals	0	0	0	0
Disposals other than for sale	0	0	0	0
Upward revaluation/positive indexation	0	0	0	0
Impairments	0	4,492	0	0
Reversal of Impairments	0	(4,697)	0	0
Charged During the Year	0	8,017	12	
At 31 March	**0**	**7,812**	**12**	**0**
Net Book Value at 31 March 2015	**30,998**	**206,945**	**345**	**49,910**
ASSET FINANCING:				
Owned - Purchased	30,898	166,447	345	49,804
Owned - Donated	100	2,290	0	106
On-SOFP PFI contracts	0	38,208	0	0
Total at 31 March 2015	**30,998**	**206,945**	**345**	**49,910**

PLANT & MACHINERY £000's	TRANSPORT EQUIPMENT £000's	INFORMATION TECHNOLOGY £000's	FURNITURE & FITTINGS £000's	**TOTAL £000's**
87,458	**236**	**34,294**	**4,317**	**371,629**
				30,260
2,254	0	1,178	0	**3,432**
0	0	0	0	**189**
0	0	0	0	**0**
0	0	0	0	**0**
0	0	0	0	**0**
0	0	0	0	**20,249**
0	0	0	0	**0**
0	0	0	0	**0**
89,712	**236**	**35,472**	**4,317**	**425,759**
50,551	229	19,442	3,456	**73,678**
0	0	0	0	**0**
0	0	0	0	**0**
0	0	0	0	**0**
0	0	0	0	**0**
0	0	7	0	**4,499**
(20)	0	0	0	**(4,717)**
9,583	3	4,613	354	**22,582**
60,114	**232**	**24,062**	**3,810**	**96,042**
29,598	**4**	**11,410**	**507**	**329,717**
27,922	4	11,319	444	**287,183**
1,676	0	91	63	**4,326**
0	0	0	0	**38,208**
29,598	**4**	**11,410**	**507**	**329,717**

Revaluation Reserve Balance for Property, Plant & Equipment

	LAND £000's	BUILDINGS EXCLUDING DWELLINGS £000's	DWELLINGS £000's	ASSETS UNDER CONSTRUCTION & PAYMENTS ON ACCOUNT £000's
At 1 April 2014	5,241	24,746	32	0
Movements - in year revaluation	2,516	16,524	32	**0**
At 31 March 2015	7,757	41,270	64	0
Additions to Assets Under Construction in 2014-15				
Land				0
Buildings excl Dwellings				26,534
Dwellings				0
Plant & Machinery				3,726
Balance as at YTD				30,260

PLANT & MACHINERY £000's	TRANSPORT EQUIPMENT £000's	INFORMATION TECHNOLOGY £000's	FURNITURE & FITTINGS £000's	**TOTAL £000's**
660	0	0	0	**30,679**
0	0	0	0	**19,072**
2,254	0	1,178	0	**49,751**

15.2 Property, plant and equipment prior-year

	LAND £000's	BUILDINGS EXCLUDING DWELLINGS £000's	DWELLINGS £000's	ASSETS UNDER CONSTRUCTION & PAYMENTS ON ACCOUNT £000's
2013-14				
COST OR VALUATION: AT 1 APRIL 2013	**25,779**	**167,378**	**0**	**35,670**
Transfers under Modified Absorption Accounting – PCTs & SHAs	0	11,831	0	**0**
Additions of Assets Under Construction				**15,193**
Additions Purchased	0	0	0	
Additions - Purchases from Cash Donations & Government Grants	0	0	0	453
Reclassifications	0	23,303	0	(23,303)
Reclassifications as Held for Sale and Reversals	860	(94)	325	0
Disposals other than for sale	0	0	0	0
Revaluation	1,586	8,709	0	0
Impairments/negative indexation charged to reserves	(65)	(1,184)	0	0
Reversal of Impairments charged to reserves	0	0	0	0
At 31 March 2014	**28,160**	**209,943**	**325**	**28,013**
DEPRECIATION AT 1 APRIL 2013	0	0	0	0
Reclassifications	0	0	0	
Reclassifications as Held for Sale and Reversals	0	0	0	
Disposals other than for sale	0	0	0	
Revaluation	0	0	0	
Impairments/negative indexation charged to operating expenses	70	19,028	0	0
Reversal of Impairments charged to operating expenses	(391)	(4,435)	0	0
Charged During the Year	0	6,845	0	
At 31 March 2014	**(321)**	**21,438**	**0**	**0**
Net Book Value at 31 March 2014	**28,481**	**188,505**	**325**	**28,013**
ASSET FINANCING:				
Owned - Purchased	28,381	152,158	325	27,808
Owned - Donated	100	2,156	0	205
On-SOFP PFI contracts	0	34,191	0	0
Total at 31 March 2014	**28,481**	**188,505**	**325**	**28,013**

PLANT & MACHINERY £000's	TRANSPORT EQUIPMENT £000's	INFORMATION TECHNOLOGY £000's	FURNITURE & FITTINGS £000's	**TOTAL £000's**
81,534	**236**	**28,956**	**4,317**	**343,870**
0	0	0	0	**11,831**
				15,193
5,942	0	5,338	0	**11,280**
0	0	0	0	**453**
0	0	0	0	**0**
(18)	0	0	0	**1,073**
0	0	0	0	**0**
0	0	0	0	**10,295**
0	0	0	0	**(1,249)**
0	0	0	0	**0**
87,458	**236**	**34,294**	**4,317**	**392,746**
41,356	226	15,387	3,046	**60,015**
0	0	(36)	0	**(36)**
(5)	0	0	0	**(5)**
0	0	0	0	**0**
0	0	0	0	**0**
0	0	0	0	**19,098**
0	0	0	0	**(4,826)**
9,200	3	4,091	410	**20,549**
50,551	**229**	**19,442**	**3,456**	**94,795**
36,907	**7**	**14,852**	**861**	**297,951**
32,368	7	14,702	773	**256,522**
4,539	0	150	88	**7,238**
0	0	0	0	**34,191**
36,907	**7**	**14,852**	**861**	**297,951**

The Group undertakes a full estates revalution annually. The valuation was carried out by the District Valuer at the valuation date of 31 March 2015. The valuations were carried out in accordance with the terms of the Royal Institution of Chartered Surveyors' Valuation Standards, 6 Edition, insofar as these terms are consistent with the requirements of the HM Treasury, the National Health Service and the Department of Health.

The valuations were carried out on the basis of fair value. Fair value is determined at the amount which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. The fair value of land and buildings is determined from market based evidence and is therefore on the basis of Market Value. For non specialised operational assets this equates to Existing Use Value and for specialised operational assets fair value. It is estimated using Depreciated Replacement Cost subject to the assumption of continuing use.

Most of the Group's assets qualify as specialised operational assets and therefore fall to be assessed using the Depreciated Replacement Cost approach and have been valued on a modern equivalent asset basis. That is the current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation.

Non operational assets, including surplus land, are valued on the basis of Market Value on the assumption that the property is no longer required for existing operations, which have ceased.

The estimated remaining lives of the buildings have been adjusted in line with the District Valuer's valuation. The lives range from 1 year to 90 years. The estimated remaining lives of the other assets are as follows:

	YEARS
Medical equipment and engineering plant and equipment	5-15
Furniture	5-15
Soft furnishings	5-15
Office and information technology equipment	5-10
Vehicles	7

The Group has fully depreciated assets with a gross book value of £10.6m that are still in use and remain on the capital asset register.

16.1 Intangible non-current assets

2014-15	IT – IN-HOUSE & 3RD PARTY SOFTWARE £000's	COMPUTER LICENSES £000's	LICENSES AND TRADEMARKS £000's	PATENTS £000's	DEVELOPMENT EXPENDITURE - INTERNALLY GENERATED £000's	**TOTAL £000's**
At 1 April 2014	**443**	**674**	**0**	**0**	**0**	**1,117**
Additions Purchased	202	5	0	0	0	**207**
Reclassifications	0	0	0	0	0	**0**
At 31 March 2015	**645**	**679**	**0**	**0**	**0**	**1,324**
AMORTISATION						
At 1 April 2014	**210**	**499**	**0**	**0**	**0**	**709**
Charged during the year	76	78	0	0	0	**154**
At 31 March 2015	**286**	**577**	**0**	**0**	**0**	**863**
Net Book Value at 31 March 2015	**359**	**102**	**0**	**0**	**0**	**461**
ASSET FINANCING: NET BOOK VALUE AT 31 MARCH 2015 COMPRISES:						
Purchased	359	102	0	0	0	**461**
Donated	0	0	0	0	0	**0**
Total at 31 March 2015	**359**	**102**	**0**	**0**	**0**	**461**
REVALUATION RESERVE BALANCE FOR INTANGIBLE NON-CURRENT ASSETS						
	£000's	£000's	£000's	£000's	£000's	**£000's**
At 1 April 2014	**0**	**0**	**0**	**0**	**0**	**0**
Movements	0	0	0	0	0	**0**
At 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**

16.2 Intangible non-current assets prior year

2013-14	IT – IN-HOUSE & 3RD PARTY SOFTWARE £000's	COMPUTER LICENSES £000's	LICENSES AND TRADEMARKS £000's	PATENTS £000's	DEVELOPMENT EXPENDITURE - INTERNALLY GENERATED £000's	**TOTAL £000's**
COST OR VALUATION						
At 1 April 2013	**179**	**583**	**0**	**0**	**0**	**762**
Additions - Purchased	264	91	0	0	0	**355**
Reclassifications	0	0	0	0	0	**0**
At 31 March 2014	**443**	**674**	**0**	**0**	**0**	**1,117**
AMORTISATION						
At 1 April 2013	**179**	**381**	**0**	**0**	**0**	**560**
Reclassifications	31	5	0	0	0	**36**
Charged during the year	0	113	0	0	0	**113**
At 31 March 2014	**210**	**499**	**0**	**0**	**0**	**709**
Net Book Value at 31 March 2014	**233**	**175**	**0**	**0**	**0**	**408**
NET BOOK VALUE AT 31 MARCH 2014 COMPRISES:						
Purchased	233	175	0	0	0	**408**
Donated	0	0	0	0	0	**0**
Government Granted	**0**	**0**	**0**	**0**	**0**	**0**
Total at 31 March 2014	**233**	**175**	**0**	**0**	**0**	**408**

16.3 Intangible non-current assets

The estimated remaining lives of the other intangible non-current assets ranges from 5 to 7 years.

The Group has fully depreciated assets with a gross book value of £179,000 that are still in use and remain on the capital asset register.

17 Analysis of impairments and reversals recognised in 2014-15

	2014-15 TOTAL £000s
PROPERTY, PLANT AND EQUIPMENT IMPAIRMENTS AND REVERSALS TAKEN TO SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	(218)
Total charged to Annually Managed Expenditure	**(218)**
Total Impairments of Property, Plant and Equipment changed to SoCI	**(218)**
NON-CURRENT ASSETS HELD FOR SALE - IMPAIRMENTS AND REVERSALS CHARGED TO SoCI.	
Loss or damage resulting from normal operations	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Changes in market price	408
Total charged to Annually Managed Expenditure	**408**
Total impairments of non-current assets held for sale charged to SoCI	**408**
Total Impairments charged to SoCI - DEL	**0**
Total Impairments charged to SoCI - AME	**190**
Overall Total Impairments	**190**
DONATED AND GOV GRANTED ASSETS, INCLUDED ABOVE	
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0

The impairments resulting from the revaluation exercise undertaken at the end of the year were spread across the whole estate; the largest single impairment, of £2.9m, related to the Hurstwood Park Hospital

18 Investments

18.1 Investment Property

The Group holds no investment properties.

18.2 Other Investments - Charitable

	31 MARCH 2015 £000	31 MARCH 2014 £000
Market value at 31 March b/f	**9,573**	7,754
Less: Disposals at carrying value	**(16,809)**	(2)
Add: Acquisitions at cost	**16,809**	1,441
Add: Net gain on revaluation	**1,063**	411
Increase in cash	**(8)**	(31)
Market value at 31 March c/f	**10,628**	9,573
Historic cost at 31 March	**8,403**	7,723

19 Commitments

19.1 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 MARCH 2015 £000	31 MARCH 2014 £000
Property, plant and equipment	**29,493**	2,294
Intangible assets	**0**	0
Total	**29,493**	2,294

19.2 Other financial commitments

The Group has not entered into any other non-cancellable contracts (2013-14 £nil)

	31 MARCH 2015 £000	31 MARCH 2014 £000
Not later than one year	**0**	0
Later than one year and not later than five years	**0**	0
Later than five years	**0**	0
Total	**0**	0

20 Intra-Government and other balances

	CURRENT RECEIVABLES £000s	NON-CURRENT RECEIVABLES £000s	CURRENT PAYABLES £000s	NON-CURRENT PAYABLES £000s
Balances with Other Central Government Bodies	1,292	0	10,324	0
Balances with Local Authorities	71	0	23	0
Balances with NHS bodies outside the Departmental Group	0	0	538	0
Balances with NHS bodies inside the Departmental Group	27,592	0	17,296	36,936
Balances with Bodies External to Government	11,872	1,409	37,553	33,486
At 31 March 2015	**40,827**	**1,409**	**65,734**	**70,422**
PRIOR PERIOD:				
Balances with Other Central Government Bodies	22,887	0	19,619	0
Balances with Local Authorities	35	0	10	0
Balances with NHS bodies outside the Departmental Group	0	0	242	0
Balances with NHS Trusts and FTs	2,964	0	5,143	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with Bodies External to Government	10,542	3,349	35,121	867
At 31 March 2014	36,428	3,349	60,135	867

21 Inventories

	DRUGS £000s	CONSUMABLES £000s	WORK IN PROGRESS £000s	TOTAL £000s	OF WHICH HELD AT NRV £000s
Balance at 1 April 2014	**1,644**	**4,863**	**0**	**6,507**	0
Additions	50,418	36,332	0	**86,750**	0
Inventories recognised as an expense in the period	(50,334)	(35,657)	0	**(85,991)**	0
Write-down of inventories (including losses)	(88)	0	0	**(88)**	0
Reversal of write-down previously taken to SOCI	0	0	0	**0**	0
Balance at 31 March 2015	**1,640**	**5,538**	**0**	**7,178**	**0**

22.1 Trade and other receivables

	CURRENT 31 MARCH 2015 £000s	NON-CURRENT 31 MARCH 2014 £000s	31 MARCH 2015 £000s	31 MARCH 2014 £000s
NHS receivables – revenue	**21,705**	10,934	**0**	0
NHS prepayments and accrued income	**5,887**	14,341	**0**	0
Non-NHS receivables - revenue	**5,778**	5,495	**1,406**	3,340
Non-NHS prepayments and accrued income	**8,171**	7,082	**3**	9
Provision for the impairment of receivables	**(3,205)**	(2,080)	**0**	0
VAT	**1,292**	576	**0**	0
Interest receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**1,199**	80	**0**	0
Total	**40,827**	36,428	**1,409**	3,349
Total current and non current	**42,236**	39,777		
Included in NHS receivables are prepaid pension contributions:	**0**			

The great majority of trade is with Clinical Commissioning Groups and NHS England. As these bodies are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

22.2 Receivables past their due date but not impaired

	31 MARCH 2015 £000s	31 MARCH 2014 £000s
By up to three months	**3,272**	728
By three to six months	**662**	451
By more than six months	**5,543**	199
Total	**9,477**	1,378

22.3 Provision for impairment of receivables

	2014-15 £000s	2013-14 £000s
Balance at 1 April 2014	**(2,080)**	(3,590)
Amount written off during the year	**195**	541
Amount recovered during the year	**0**	142
Decrease in receivables impaired	**(1,320)**	827
Balance at 31 March 2015	**(3,205)**	(2,080

The creation and release of provisions for impaired receivables has been included in Operating Expenses in the Statement of Comprehensive Income. Amounts charged to the provision account are generally written off when there is no expectation of recovering additional cash. NHS receivables are not impaired. Non NHS receivables are impaired based

on the age of the debt and disputes with debtors. Full provision is made for all outstanding overseas debts.

23 NHS LIFT investments

The Group has no LIFT investments.

24.1 Other Financial Assets - Current

	31 MARCH 2015 £000s	31 MARCH 2014 £000s
Current part of loans repayable transferred from non-current assets	**0**	0
NLF deposits over 3 months	**0**	0
Closing balance 31 March	**0**	0

(note line descriptions different in prior year)

24.2 Other Financial Assets - Non Current

	31 MARCH 2015 £000s	31 MARCH 2014 £000s
Opening balance 1 April	**1,101**	0
Additions	**0**	1,101
Revaluation	**0**	0
Impairments/reversals taken to Revaluation Reserve	**0**	0
Impairment/reversals taken to SoCI	**0**	0
Change in Fair Value through SoCI	**0**	0
Transferred to current financial assets	**0**	0
Disposals	**0**	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	**0**	0
Total Other Financial Assets - Non Current	**1,101**	1,101

25 Other current assets

	31 MARCH 2015 £000s	31 MARCH 2014 £000s
EU Emissions Trading Scheme Allowance	**0**	0
Other Assets	**0**	0
Total	**0**	0

26 Cash and Cash Equivalents

	31 MARCH 2015 £000s	31 MARCH 2015 £000s
Opening balance	**22,176**	35,669
Net change in year	**3,219**	(13,493)
Closing balance	**25,395**	22,176
Made up of		
Cash with Government Banking Service	**25,385**	22,155
Commercial banks	**0**	0
Cash in hand	**10**	21
Liquid deposits with NLF	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**25,395**	22,176
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**25,395**	22,176
Patients' money held by the Trust, not included above	**0**	0

27 Non-current assets held for sale

	LAND £000s	BUILDINGS, EXCL. DWELLINGS £000s	DWELLINGS £000s	Total £000s
Balance at 1 April 2014	486	0	2,279	**2,765**
Plus assets classified as held for sale in the year	0	0	0	**0**
Less assets sold in the year	(374)	0	(1,852)	**(2,226)**
Less impairment of assets held for sale	0	0	0	**0**
Plus reversal of impairment of assets held for sale	22	0	92	**114**
Balance at 31 March 2015	**134**	**0**	**519**	**653**
Liabilities associated with assets held for sale at 31 March 2015	0	0	0	**0**
Balance at 1 April 2013	1,651	915	3,239	**5,805**
Plus assets classified as held for sale in the year	100	0	449	**549**
Less assets sold in the year	(298)	(495)	(634)	**(1,427)**
Less impairment of assets held for sale	0	0	(450)	**(450)**
Plus reversal of impairment of assets held for sale	(72)	0	0	**(72)**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	(895)	(420)	(325)	**(1,640)**
Balance at 31 March 2014	**486**	**0**	**2,279**	**2,765**
Liabilities associated with assets held for sale at 31 March 2014	0	0	0	0

The assets held for sale represent the remaining dwellings and buildings that were placed on the market as part of the Estates rationalisation strategy. Most have been sold, those remaining are expected to be sold within the next 12 months.

The profit on sale of assets during the year was £1,207,000

28 Trade and other payables

	CURRENT		NON-CURRENT	
	31 MARCH 2015 £000s	31 MARCH 2014 £000s	**31 MARCH 2015 £000s**	31 MARCH 2014 £000s
NHS payables - revenue	**2,565**	14,007	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**10,393**	1,187	**0**	0
Non-NHS payables - revenue	**13,435**	7,692	**0**	0
Non-NHS payables - capital	**1,086**	4,510	**0**	0
Non-NHS accruals and deferred income	**21,797**	22,701	**579**	867
Social security costs	**7,060**	6,738		
PDC Dividend payable to DH	**267**	0		
VAT	**0**	0	**0**	0
Tax	**3,264**	3,081		
Payments received on account	**0**	0	**0**	0
Other	**38**	114	**0**	0
Total	**59,905**	60,030	**579**	867
Total payables (current and non-current)	**60,484**	**60,897**		
Included above:				
outstanding Pension Contributions at the year end	**4,068**	3,878		

29 Other liabilities

	CURRENT		NON-CURRENT	
	31 MARCH 2015 £000s	31 MARCH 2014 £000s	**31 MARCH 2015 £000s**	31 MARCH 2014 £000s
PFI deferred credit	**0**	0	**0**	0
Lease incentives	**0**	0	**0**	0
Other	**0**	0	**0**	0
Total	**0**	0	**0**	0
Total other liabilities (current and non-current)	**0**	**0**		

30 Borrowings

	CURRENT		NON-CURRENT	
	31 MARCH 2015 £000s	31 MARCH 2014 £000s	**31 MARCH 2015 £000s**	31 MARCH 2014 £000s
Loans from Department of Health	**4,609**	3,803	**36,936**	18,117
PFI liabilities: main liability	**1,220**	1,461	**32,907**	34,127
Total	**5,829**	**5,264**	**69,843**	**52,244**
Total other liabilities (current and non-current)	**75,672**	57,508		

BORROWINGS/LOANS – REPAYMENT OF PRINCIPAL FALLING DUE IN:			
	31 MARCH 2015 DH £000s	OTHER £000s	TOTAL £000s
0-1 Years	4,609	1,220	**5,829**
1 - 2 Years	3,286	1,542	**4,828**
2 - 5 Years	7,144	3,375	**10,519**
Over 5 Years	26,506	27,990	**54,496**
TOTAL	**41,545**	**34,127**	**75,672**

31 Other financial liabilities

The Group has no other financial liabilities.

32 Deferred revenue

	CURRENT		NON-CURRENT	
	31 MARCH 2015 £000s	31 MARCH 2014 £000s	**31 MARCH 2015 £000s**	31 MARCH 2014 £000s
Opening balance at 1 April 2014	**3,497**	4,986	**867**	602
Deferred revenue addition	**9,918**	3,497	**579**	1,500
Transfer of deferred revenue	**(4,354)**	(4,986)	**-867**	(1,235)
Current deferred Income at 31 March 2015	**9,061**	3,497	**579**	867
Total deferred income (current and non-current)	**9,640**	4,364		

33 Finance lease obligations as lessee

The Group has no finance obligations as lessee under a finance lease.

34 Finance lease receivables as lessor

The Group has not entered into any finance lease agreements as a lessor.

35 Provisions

Comprising:

	TOTAL £000s	EARLY DEPARTURE COSTS £000s	LEGAL CLAIMS £000s	RESTRUCTURING £000s	OTHER £000s	REDUNDANCY £000s
Balance at 1 April 2014	**3,622**	2,943	679	0	0	0
Arising during the year	**0**	0	0	0	0	0
Utilised during the year	**(1,702)**	(1,483)	(219)	0	0	0
Reversed unused	**0**	0	0	0	0	0
Unwinding of discount	**266**	266	0	0	0	0
Change in discount rate	**129**	129	0	0	0	0
Balance at 31 March 2015	**2,315**	**1,855**	**460**	**0**	**0**	**0**
EXPECTED TIMING OF CASH FLOWS:						
No Later than One Year	**388**	96	292	0	0	0
Later than One Year and not later than Five Years	**541**	373	168	0	0	0
Later than Five Years	**1,386**	1,386	0	0	0	0
AMOUNT INCLUDED IN THE PROVISIONS OF THE NHS LITIGATION AUTHORITY IN RESPECT OF CLINICAL NEGLIGENCE LIABILITIES:						
As at 31 March 2015	129,985					
As at 31 March 2014	107,603					

The provision for Early Departure Costs is for the reimbursement of injury benefit allowances to the NHS Pensions Agency and the timing of these payments is based the on age of the recipients.

The provision for Legal Claims provides for the Liability to Third Party Schemes (LTPS) and Public & Employers Liability Scheme (PES). This provision covers the excess amount payable by the Trust and not the full liability of claims which is covered by the NHSLA under the non-clinical risk pooling scheme. The timings of the cash flows are based on estimated dates for the finalisation of the claims.

36 Contingencies

	31 MARCH 2015 £000s	31 MARCH 2014 £000s
CONTINGENT LIABILITIES		
NHS Litigation Authority legal claims	**0**	
Employment Tribunal and other employee related litigation	**0**	0
Redundancy	**0**	
Joint liability cost share	**0**	(51)
Amounts recoverable against contingent liabilities	**0**	0
Net value of contingent liabilities	**0**	(51)
CONTINGENT ASSETS		
Contingent assets	**0**	0
Net value of contingent assets	**0**	0

37 PFI – additional information

The information below is required by the Department of Heath for inclusion in national statutory accounts

37.1 PFI schemes off-Statement of Financial Position

The Group entered into a private initiative scheme in 2001 leasing land to the London and Quadrant Housing Trust, a registered Social Landlord, for houses to be built for staff accommodation. The lease was for a term of 125 years. This scheme was terminated in 2013-14 and the land disposed of to the London and Quadrant Housing Trust.

37.2 PFI schemes on-Statement of Financial Position

The Group entered into a PFI scheme on 5 June 2004 to build and operate a new children's hospital. The new hospital was completed in July 2007. Under the terms of the PFI the Group is liable to pay a unitary charge for the availability of hospital and maintenance services delivered by the project company. The PFI agreement provides the Group with the exclusive rights to use the building. The unitary charge is indexed annually based on the RPI and increases in volumetric costs of utility service. The unitary charge may also increase if the Group introduces new services to the building. At the end of the PFI, in 2034, the building will revert to the Group.

The lessor is contracted under the PFI arrangement with the Group to provide the hospital for the 30 year term which cannot be terminated without breach of contract or a formal variation. In such a breach or variation of the contract compensation would be payable by the Group or lessor.

Under IFRIC 12 the asset is treated as an asset of the Group. The substance of the contract is that the Group has a finance lease and payments of the unitary charge compromise two elements - imputed finance charges and service charges. Details of the imputed finance lease charges are set out in the table below.

	2014-15 £000s	2013-14 £000s
CHARGES TO OPERATING EXPENDITURE AND FUTURE COMMITMENTS IN RESPECT OF ON AND OFF SOFP PFI		
Total charge to operating expenses in year - Off SoFP PFI	**0**	74
Service element of on SOFP PFI charged to operating expenses in year	**1,449**	1,223
Total	**1,449**	1,297
PAYMENTS COMMITTED TO IN RESPECT OF OFF SOFP PFI AND THE SERVICE ELEMENT OF ON SOFP PFI		
No Later than One Year	**874**	853
Later than One Year, No Later than Five Years	**3,721**	3,630
Later than Five Years	**16,640**	17,605
Total	**21,235**	22,088
IMPUTED "FINANCE LEASE" OBLIGATIONS FOR ON SOFP PFI CONTRACTS DUE		
No Later than One Year	**3,064**	3,382
Later than One Year, No Later than Five Years	**11,584**	11,725
Later than Five Years	**39,981**	42,904
Subtotal	**54,629**	58,011
Less: Interest Element	**(20,502)**	(22,424)
Total	**34,127**	35,587
PRESENT VALUE IMPUTED "FINANCE LEASE" OBLIGATIONS FOR ON SOFP PFI CONTRACTS DUE		
ANALYSED BY WHEN PFI PAYMENTS ARE DUE		
No Later than One Year	**2,546**	3,268
Later than One Year, No Later than Five Years	**8,868**	10,446
Later than Five Years	**22,713**	27,893
Total	**34,127**	41,607
NUMBER OF ON SOFP PFI CONTRACTS		
Total Number of on PFI contracts	**1**	1
Number of on PFI contracts which individually have a total commitments value in excess of £500m	**0**	0

38 Impact of IFRS treatment - current year

The information below is required by the Department of Heath for budget reconciliation purposes

	2014-15 £000s	2013-14 £000s
REVENUE COSTS OF IFRS: ARRANGEMENTS REPORTED ON SOFP UNDER IFRIC12 (PFI)		
Depreciation charges	**800**	764
Interest Expense	**2,559**	2,568
Impairment charge - AME	**0**	0
Impairment charge - DEL	**0**	0
Other Expenditure	**1,146**	920
Impact on PDC dividend payable	**(76)**	(173)
Total IFRS Expenditure (IFRIC12)	**4,429**	**4,079**
Revenue consequences of PFI under UK GAAP / ESA95 (net of any sublease revenue)	**(4,452)**	(4,315)
Net IFRS change (IFRIC12)	**(23)**	**(236)**
CAPITAL CONSEQUENCES OF IFRS : PFI AND OTHER ITEMS UNDER IFRIC12		
Capital expenditure 2014-15	**0**	0
UK GAAP capital expenditure 2014-15 (Reversionary Interest)	**714**	690

39 Financial Instruments

39.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Group has with commissioners and the way those commissioners are financed, the Group is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Group in undertaking its activities

The Group's treasury management operations are carried out by the finance department, within parameters defined formally within the Group's standing financial instructions and policies agreed by the board of directors. Group treasury activity is subject to review by the Group's internal auditors.

Currency risk

The Group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Group has no overseas operations. The Group therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Group borrows from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Group therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Group's revenue comes from contracts with other public sector bodies, the Group has low exposure to credit risk. The maximum exposures as at 31 March 2015 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Group's operating costs are incurred under contracts with CCGs, which are financed from resources voted annually by Parliament . The Group funds its capital expenditure from funds obtained within its prudential borrowing limit. The Group is not, therefore, exposed to significant liquidity risks.

39.2 Financial Assets

	AT 'FAIR VALUE THROUGH PROFIT AND LOSS' £000s	LOANS AND RECEIVABLES £000s	AVAILABLE FOR SALE £000s	TOTAL £000s
Embedded derivatives	0			**0**
Receivables - NHS		21,708		**21,708**
Receivables - non-NHS		6,281		**6,281**
Cash at bank and in hand		25,395		**25,395**
Other financial assets	0	1,101	0	**1,101**
Total at 31 March 2015	**0**	**54,485**	**0**	**54,485**
Embedded derivatives	0			0
Receivables - NHS		11,422		11,422
Receivables - non-NHS		6,844		6,844
Cash at bank and in hand		22,176		22,176
Other financial assets	0	1,101	0	1,101
Total at 31 March 2014	0	41,543	0	41,543

39.3 Financial Liabilities

	AT 'FAIR VALUE THROUGH PROFIT AND LOSS' £000s	OTHER £000s	TOTAL £000s
Embedded derivatives	0		**0**
NHS payables		2,564	**2,564**
Non-NHS payables		13,968	**13,968**
Other borrowings		41,546	**41,546**
PFI & finance lease obligations		20,286	**20,286**
Other financial liabilities	0	0	**0**
Total at 31 March 2015	**0**	**78,364**	**78,364**
Embedded derivatives	0		0
NHS payables		14,464	14,464
Non-NHS payables		7,900	7,900
Other borrowings		21,920	21,920
PFI & finance lease obligations		35,588	35,588
Other financial liabilities	0	0	0
Total at 31 March 2014	0	79,872	79,872

40 Events after the end of the reporting period

There are no events after the reporting period that have a material effect on the accounts.

On 1 August 2015 all the "soft" FM services, which include housekeeping, catering, portering and cleaning, will be brought in-house and managed by the Group. This change is expected to be cost neutral in 2015-16.

41 Related party transactions

During the year none of the Department of Health Ministers, Group board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Brighton & Sussex University Trust except as shown below

	PAYMENTS TO RELATED PARTY £	RECEIPTS FROM RELATED PARTY £	AMOUNTS OWED TO RELATED PARTY £	AMOUNTS DUE FROM RELATED PARTY £
Julian Lee Director of Financial Ombudsman Service Partner, JFK Lee & Co				
Michael Farthing, until 20/1/15 Vice Chancellor,University of Sussex Trustee, Institute of Development Studies Vice Chair, UK Panel for Health and Biomedical Science Research Integrity, Trustee, Faculty of Conflict and Catastrophe Medicine of the Worshipful Society of Apothecaries of London Trustee, Universties UK, Director, UK Research Integrity Office Ltd	3,755,563	441,375	575,514	
Malcolm Reed Dean, University of Sussex, from 23/2/15 Director Malcolm Reed Surgical Ltd		286,136		9,554
Lewis Doyle Director of Sea Colours Ltd Trustee for Southern Housing Groups Pension Fund				
Antony Kildare Trustee and Chair of Impetus (Charity) Director of Aquaterra Leisure and Leisure Services Ltd				
Stephen Holmberg Trustee British Cardiovascular Society Trustee of Sussex Heart Charity		139,282		3,789
Julie Nerney Managing Director of Julie Nerney Limited Chair, City College Brighton & Hove Non Executive Director, Peridot Partners Project Director, Ofgem e-serve	2,865		3,000	
Craig Jones Director of Brighton and Sussex Care (BASC)		513		0

The Department of Health is regarded as a related party. During the year the Group has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. For example :

NHS England

Public Health England

Health Education England

NHS Blood & Transplant

NHS Litigation Authority

Brighton & Hove CCG

Coastal West Sussex CCG

Crawley CCG

East Surrey CCG

East Sussex Healthcare NHS Trust

Eastbourne Hailsham & Seaford CCG

Frimley Park Hospitals NHS FT

Guys & St Thomas NHS Trust

Hastings and Rother CCG

High Weald Lewes & Haven CCG

Horsham & Mid Sussex CCG

Queen Victoria Hospital NHS FT

Royal Surrey County NHS FT

South East Coast Ambulance NHS FT

Surrey Downs CCG

Surrey & Sussex Healthcare NHS Trust

Sussex Community NHS Trust

Sussex Partnership NHS FT

West Kent CCG

Western Sussex Hospitals NHS FT

In addition, the Group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Brighton and Hove City Council, East Sussex County Council and West Sussex County Council in respect of clinical services.

42 Losses and special payments

The total number of losses cases in 2014-15 and their total value was as follows:

	TOTAL VALUE OF CASES £s	TOTAL NUMBER OF CASES
Losses	347,392	228
Special payments	24,369	100
Total losses and special payments	371,761	328

The total number of losses cases in 2013-14 and their total value was as follows:

	TOTAL VALUE OF CASES £s	TOTAL NUMBER OF CASES
Losses	65,333	6
Special payments	13,839	64
Total losses and special payments	79,172	70

43. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

43.1 Breakeven performance

	2005-06 £000s	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s
Turnover	309,281	326,320	352,694	398,447	415,950
Retained surplus/(deficit) for the year	(11,290)	(5,278)	106	9,925	4,603
ADJUSTMENT FOR:					
TIMING/NON-CASH IMPACTING DISTORTIONS:					
Adjustments for impairments				1,161	5,414
Adjustments for impact of policy change re donated/ government grants assets					
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*					210
Other agreed adjustments	(2,178)	0	0	0	0
Break-even in-year position	(13,468)	(5,278)	106	11,086	10,227
Break-even cumulative position	**(23,748)**	**(29,026)**	**(28,920)**	**(17,834)**	**(7,607)**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, the Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2005-06 %	2006-07 %	2007-08 %	2008-09 %	2009-10 %
MATERIALITY TEST (I.E. IS IT EQUAL TO OR LESS THAN 0.5%):					
Break-even in-year position as a percentage of turnover	-4.35	-1.62	0.03	2.78	2.46
Break-even cumulative position as a percentage of turnover	-7.68	-8.89	-8.20	-4.48	-1.83

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	**2014-15 £000s**
439,750	574,218	606,074	558,555	**520,765**
(11,860)	(16,245)	(22)	(9,572)	**(1,309)**
15,972	16,022	3,213	14,272	**190**
	469	134	414	**669**
400	(204)	0	0	**0**
0	0	0	0	**0**
4,512	42	3,325	5,114	**(450)**
(3,095)	**(3,053)**	**272**	**5,386**	**4,936**

2010-11 %	2011-12 %	2012-13 %	2013-14 %	**2014-15 %**
1.03	0.01	0.55	0.92	-0.09
-0.70	-0.53	0.04	0.96	0.95

43.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

43.3 External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2014-15 £000s	2013-14 £000s
External financing limit (EFL)	**22,856**	13,282
Cash flow financing	**15,096**	10,213
Unwinding of Discount Adjustment		137
Other capital receipts	**0**	0
External financing requirement	**15,096**	10,350
Under spend against EFL	**7,760**	2,932

43.4 Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2014-15 £000s	2013-14 £000s
Gross capital expenditure	**33,533**	27,281
Less: book value of assets disposed of	**(2,226)**	(1,440)
Less: donations towards the acquisition of non-current assets	**(189)**	(453)
Charge against the capital resource limit	**31,118**	25,388
Capital resource limit	**32,558**	31,274
Underspend against the capital resource limit	**1,440**	5,886

44 Third party assets

The Group held cash and cash equivalents which relate to monies held by the Group on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 MARCH 2015 £000s	31 MARCH 2014 £000s
Third party assets held by the Group	**0**	0

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ANNUAL GOVERNANCE STATEMENT

SCOPE OF RESPONSIBILITY

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively.

THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Brighton and Sussex University Hospitals NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Brighton and Sussex University Hospitals NHS Trust for the year ended 31 March 2015 and up to the date of approval of the annual report and accounts.

CAPACITY TO HANDLE RISK

As Chief Executive, I am accountable for the overall risk management activity within the Trust. In discharging these responsibilities I have been assisted by the following Directors:

- the Chief Financial Officer who had delegated responsibility for managing the Trust's principal risks relating to the delivery of financial plans agreed by the Board;
- the Chief Nurse who had delegated responsibility (from September 2014, and prior to that the Medical Director) for managing the principal risks relating to infection control as Director of Infection Prevention and Control; and, with the Medical Director, for managing the strategic development and implementation of safety and quality governance, for reporting this to the Board, through its Quality & Risk Committee, and for the assessment and reporting of clinical risk;
- the Director of Strategy and Change who had delegated responsibility (from September 2014, and prior to this the Director of HR) for managing the Trust's principal risks relating to Workforce planning;
- the Director of Health Informatics who had delegated responsibility for the Trust's Information Governance arrangements;
- the Director of Strategy and Change and Chief Financial Officer who had delegated responsibility (from September 2014, and prior to that the Chief Operating Officer) for managing the Trust's risks relating to operational performance with regard to emergency and unscheduled and care and scheduled care respectively;
- the Chief Financial Officer who had delegated responsibility (from September 2014, and prior to that the Chief Operating Officer) for managing the Trust's risks relating to fire safety;
- the Director of Corporate Affairs, who had delegated responsibility for ensuring that the Risk Management Strategy is implemented and evaluated effectively.

A complete description of the responsibilities, accountabilities and duties for risk management is described in the Trust risk management strategy.

THE TRUST GOVERNANCE FRAMEWORK

The BSUH Rules of Procedure, set out the corporate governance arrangements for the Trust.

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

Audit Committee

In line with the requirements of The NHS Audit Committee Handbook and the NHS Codes of Conduct and NHS Code of Accountability, the Audit Committee has provided the Board of Directors with an independent and objective review of its financial systems, financial information, system of internal control and compliance with laws, guidance and regulations governing the NHS. The Trust is not required to comply with the UK Corporate Governance Code but its Corporate Governance

arrangements draws on best available practice including those aspects of the UK Governance Code and Monitor's NHS Foundation Trust Code of Governance, considered to be relevant to the Trust.

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

The Audit Committee has met quarterly in 2014/15 and has provided independent monitoring and scrutiny of the processes implemented in relation to governance, risk and internal control. The Committee has reported its proceedings to the Board of Directors following each of its meetings.

The Committee considered a draft version of this Annual Governance Statement, which assesses the adequacy of the Trust internal control system at its meeting in March 2015.

Quality and Risk Committee

The Quality and Risk Committee has delegated authority to assure the ongoing development and delivery of the Trust's Safety and Quality strategy and the safety and quality of services within the Hospital.

It has been supported by the work of the Executive Safety and Quality Committees and reports from the Trust Safety and Quality team.

The Chair of the Quality and Risk Committee, a Non-Executive Director, has reported on key issues to the Board of Directors after each meeting, and, has raised any issues relating to internal control systems with the Audit Committee.

Finance and Workforce Committee

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

The Chair of the Finance and Workforce Committee, a Non-Executive Director, has reported on key issues to the Board of Directors after each meeting.

Nomination and Remuneration Committee

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

The Committee also has responsibility for assurance around the Fit and Proper Persons Test for Board Directors, Non-Executive and Executive.

Charitable Funds

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

There are, in addition, two time-limited Committees of the Board which oversee the 3Ts Programme and the EPR Programme. The 3Ts and EPR Programme Board report routinely to the Board.

BOARD AND BOARD COMMITTEE REVIEWS OF EFFECTIVENESS

Board of Directors

Board health review

Following the Board health review the outcome of which was considered by the Board in a Board development day in January 2014, the Trust has continued to make progress with the Board development plan.

The Board has been strengthened with the appointment of the Director of Strategy and Change and Deputy Chief Executive in September 2014.

Non-Executive Directors have been allocated to individual Clinical Directorates to improve the visibility of the Board and its engagement with the wider organisation.

Board governance assurance framework (BGAF)

An external BGAF assessment commenced in February 2014, and included observation of the Board of Directors in March 2014, when the Board of Directors reviewed and approved the Board Governance Memorandum.

The Board development programme continued alongside the BGAF review and by the time of the presentation of the final BGAF report to a Board Seminar in November 2014, good progress had been demonstrated with many of the recommendations in the report.

The key areas of further development included the implementation of the People Strategy, the development and implementation of the Communications and Engagement Strategy and the embedding of the Values and Behaviours programme.

Corporate Governance Code

The Board health review, BGAF review, and other reviews of the Board and its Committees have enabled the Board to reflect on its composition, effectiveness, risk management and internal control arrangements. The Board is satisfied that it complies with the Corporate Governance Code. The Board is committed to continuous improvement and the further development of the Board is reflected in the Board development plan.

Audit Committee

The Audit Committee reviewed its effectiveness in March 2015, having completed the Audit Committee handbook self-assessment. A re-tendering of the internal audit service, has also been undertaken

The Chairman and Members of the Committee meet external and internal audit prior to each meeting of the Audit Committee.

Finance and Workforce Committee

The Finance and Workforce Committee reviewed its terms of reference and Annual Cycle of Business in March 2014 and agreed to reduce the frequency of meetings and meet bi-monthly, in line with other Board Committees, and reviewed an updated business schedule based on the Committee meeting every other month. This followed feedback from the Board health review that it was overly executive in its functioning.

Quality and Risk Committee

The Quality and Risk Committee carried out an annual review of its terms of reference in March 2015. The Committee has developed a clear assurance role in respect of patient safety and quality and has sought to distinguish its role from the Executive Safety and Quality Committee, which has revised its own terms of reference.

Charitable Funds Committee

A review of Charitable Funds governance was undertaken and reported to the Board of Directors in December 2013. As part of this review, the Board approved a revised membership and terms of reference for the Charitable Funds Committee, which has been implemented in 2014/15. The Committee is overseeing the strategic development of the BSUH Charity, with the initial scoping work reporting to the Board in April 2015.

EXECUTIVE OVERSIGHT OF RISK FRAMEWORK

As part of the implementation of the new Clinical Structure, a revised executive governance framework was introduced in September 2014, with a Clinical Management Board, comprising the 12 Clinical Directors and Executive Directors, and an Executive Management Board, comprising the Trust Directors.

Alongside the new executive framework, a risk review meeting was implemented in December 2014, where each of the clinical and corporate directorates present and review their high-level risks on the corporate risk register.

The Executive Management Board, which meets monthly, reviews the Board Assurance Framework every quarter prior to its submission to the Board of Directors.

Clinical Directorates

The day-to-day business of the Trust is managed by twelve Clinical Directorates. A new clinical directorate structure was introduced in September 2014. Each Directorate has its own leadership team comprising the Clinical Director, Directorate Manager and Directorate Lead Nurse who have clear delegated responsibilities for key objectives and risk management. They are supported by the Corporate Directorates of Human Resources, Finance, IT, Estates and Facilities and 3Ts.

QUALITY GOVERNANCE

The Trust has appointed a Deputy Medical Director responsible for Safety and Quality who will further develop the Trust quality governance arrangements, with the Medical Director and Chief Nurse, and who manages the Trust Safety and Quality Team.

The Trust also has a *Patient Safety Ombudsman* which is an important element of the Trust whistle-blowing framework. The Trust introduced a Patient Safety Ombudsman Panel in September 2014 to support her work. Sir Robert Francis, QC, published 'Freedom to Speak Up' an 'independent review into creating an open and honest reporting culture in the NHS' in February 2015. The Trust will review the recommendations from the Inquiry to strengthen the existing whistle-blowing arrangements within the Trust and ensure their effectiveness.

The Trust has also implemented the *Duty of Candour* regulations, which were effective from November 2014, and which builds on our other initiatives in place to help us be more open and to learn from our mistakes including a monthly 'Patients 1st' story and a monthly open forum called 'Staff Stories'. Both talk about a clinical serious incident and how we can learn from what happened to improve the quality and safety of what we do.

Control issues around the management of local clinical audit were identified in an internal audit report and the Quality and Risk Committee has monitored progress in addressing this weakness. An appointment was made in February 2015 to the post of Safety and Quality Lead (Clinical Audit) and the post-holder will devise a strategy to address the shortfalls identified in the audit.

NEVER EVENTS

Five Never Events have been reported in 2014/15. Four of those Never Events concerned theatre practice, two involved wrong-site surgery, and two retained swabs following surgery. Following these incidents, the Chief Nurse commissioned an independent external review of theatre safety and culture. The findings of the review and its recommendations were reported to the Quality and Risk Committee, by the author of the review and the Committee will keep progress with the action plan under review.

SERIOUS INCIDENTS

All Board members are notified of Serious Incidents, which are also reported in the Board performance dashboard. The Board has also received assurance of learning from Serious Incidents, from patient stories which are discussed in the public and private parts of the Board, as appropriate. This has included discussions with patients, carers and staff.

In its inspection CQC identified the need for the Trust to improve learning from incidents and the Trust has sought to address this through an increase in its capacity for incident investigations, which also supports its duty of candour obligations; and through the publication of audio recordings of the key findings and lessons learned from serious incident investigations.

QUALITY ACCOUNTS

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

The Trust Quality Account for 2013/14 was published in June 2014, following approval by the Board of Directors.

In developing the Quality Account 2014/15, quality improvement priorities for 2015/16 have been identified following discussion in the Trust and with Commissioner and patient representatives. The Quality Account was considered by the Quality and Risk Committee prior to submission for approval in June 2015.

CARE QUALITY COMMISSION (CQC) REGISTRATION

The Care Quality Commission (CQC) conducted an announced inspection of the Trust on the 21st to 23rd May 2014. A team of 35 inspectors visited four of the Trust's eight registered hospital sites and conducted further unannounced spot checks on the 27th May and 30th May.

Following the inspection, the CQC convened a Quality Summit on 5th August 2014, where the report and its recommendations, and the actions identified by the Trust were reviewed. The Quality Summit attended by invited members of the Trust Board and external stakeholders, including commissioners, NHS England and the Trust Development Authority.

The Trust received an overall rating of *requires improvement* and ratings for the five domains, assessed by CQC as below:

Are the services at this trust safe?	Requires improvement
Are the services at this trust effective?	Good
Are the services at this trust caring?	Good
Are the services at this trust responsive?	Requires improvement
Are the services at this trust well-led?	Requires improvement

There were eight compliance actions which focused around areas which had already been identified by the Trust prior to the CQC visit. These included:

- Patient flow which was having an impact on care and patient experience in the emergency department (ED), and on the wards and also on the planning and support that people received when they were ready to leave hospital.
- The implementation of the centralised booking system which had caused problems for patients and staff alike.
- Staffing levels and the high use of bank and agency staff.
- Learning lessons and ensuring that staff reporting incidents receive feedback.
- Cultural issues, including engagement with staff, and race equality; and appraisal and training rates.
- Improvements to the hospital environment on the Royal Sussex County site.

CQC also noted outstanding areas within its reports as follows:

- The Trust was exceptionally open and engaged with the inspection.
- Awareness of staff of the work on values and behaviours was almost universal.
- Care for patients with dementia was very good in both Royal Sussex and Princess Royal Hospitals, where staff had been innovative and creative in order to provide a safe and stimulating environment for people.
- The critical care teams at the Royal Sussex and Princess Royal Hospitals were strong, committed and compassionate.

Following the inspection, CQC convened a Quality Summit on 5th August 2014, where the report and its recommendations, and the Trust action plan were reviewed. The Quality Summit was attended by members of the Board and external stakeholders, including commissioners, NHS England and the NHS Trust Development Authority (TDA).

The action plan was submitted to CQC in September 2014 and progress is reviewed regularly by the Board. As discussed elsewhere in this report, challenges continue in making sustained improvements to patient flow. However the nurse recruitment programme has been successful and over 205 nurses have been offered posts, which will reduce the dependence on bank and agency staff. The results from the latest national staff survey also show that we have more work to do to improve staff engagement. Our new People and Well-being Strategy will start to address this.

CQC Action Plan

An action plan was developed following the inspection and submitted to CQC in September 2014. The Quality and Risk Committee and Board received updates on progress with the action plan in September and November 2014 and in January and March 2015.

RISK ASSESSMENT

Risk management strategy

The Risk Management Strategy and supporting policies and procedures set out the key responsibilities for managing risk within the organisation, including ways in which the risk is identified, evaluated and controlled.

Risk management training

The Trust requirements for Risk Management Training, based on the Training Needs Analysis are described in the Mandatory Training Policy. This includes the frequency of training, requirements for different groups of staff, and processes for managing non-attendance.

Statutory compliance

Arrangements are in place for the discharge of the Trust statutory functions, following a comprehensive review of those functions and how the Board and its Committees gain assurance.

Risk management, Board Assurance Framework and key risks

Risk management is taken into account in the organisation in a variety of ways. All staff are responsible for responding to incidents, hazards, complaints and near misses in accordance with the appropriate policies. Local management teams develop and maintain local risk registers and oversee the management of adverse incidents. Risk processes are monitored and reviewed by the quarterly Risk Review Meeting, Executive Management Board, Quality and Risk and Executive Safety and Quality Committees, Finance and Workforce Committee and Audit Committee

Board Assurance Framework (BAF)

The BAF provides the Board with a mechanism for satisfying itself that its responsibilities are being discharged effectively; and informs the Board where the delivery of principal objectives are at risk due to a gap in control and/or assurance.

The BAF is reviewed quarterly by the Board. The BAF identifies the principal risks facing the Trust and informs the Board how each of these risks is being managed and monitored effectively. Each principal risk has an identified risk owner who is responsible for managing and reporting on the overall risk. The identified risk owner is an

Executive, or other, Director. An Assurance Committee is also identified to assure the Board that each principal risk is being monitored, gaps in controls identified, and processes put in place to minimise the risk to the Trust.

The designated Assurance Committees of the Board are the Quality and Risk Committee (Clinical Risk) and the Finance and Workforce Committee (Financial and Workforce Risk). The Audit Committee monitors the BAF process overall.

The Board reviewed and redefined its key strategic risks at a Board Seminar in April 2014. The Board Assurance Framework is reviewed every quarter by the Board of Directors and by the Executive Management Board prior to submission to the Board of Directors. The BAF is supported by well-developed processes of review by Executive Directors, the identified risk owners. In the Board Assurance Framework report to the Board of Directors in March 2015, 9 risks were identified with a net severity of 15+.

For each of the risks below, the Board Assurance Framework describes the processes and controls in place to manage the risk, and what further action is necessary to control the risk.

Table 1: The Net (current) high rated risks on the BAF

	RISK	RISK OWNER	RISK RATING
1	Inability to implement effectively Trust strategic change plans	Chief Executive	16
2	200 year old clinical infrastructure at RSCH and 75 years old infrastructure at HWP which is no longer fit for purpose. Failure to obtain approval FBC for 3T's development or delayed further will affect long term management.	Director of Strategy and Change	15
3	Challenging strategic environment prevents delivery of clinical strategy and long term clinical and financial sustainability	Chief Executive	15
4	Failure to support staff to deliver safe and high quality care because of poor uptake of appraisal and mandatory training	Director of Strategy and Change	16
5	Financial targets may not be met due to underperformance against plans	Chief Financial Officer	20
6	Insufficient skills, capacity and capability to address scope and complexity of Trust agenda	Director of Strategy and Change	16
8	Staff and patients may be put at risk from failure to maintain adequately the estate, equipment and soft FM services	Chief Financial Officer	16
9	Failure to ensure that there is enough suitably qualified, skilled and experienced staff to meet the needs of all patients across all services.	Chief Nurse & Medical Director	20
10	Ability of the Trust and Local Health Economy partners to consistently deliver performance standards	Director of Strategy and Change & Chief Financial Officer	20

RISK AND CONTROL FRAMEWORK

The Trust responsibilities and accountabilities for risk management are described in the Trust risk management strategy.

PERFORMANCE

The Board performance dashboard is reported to the Board of Directors at each of its meeting. The Board scorecard has been extensively reviewed and amended to consolidate key metrics used by the Trust Development Agency (TDA), Monitor, NHS England and Commissioners in evaluating Trust performance. Exceptions to good performance in 2014/15 are identified below.

Performance against the 4 hour Accident and Emergency standard

The Year End position for the 4 hour Accident and Emergency standard was 84.4%. The change programme whose objective is to deliver consistent emergency care pathway delivery has faced significant challenges, heightened through the latter part of December 2014 and into January 2015.

The underpinning work required to deliver sustainable change to the emergency care pathway within the Trust has continued despite immediate operational challenges, with an ongoing focus on the proactive infrastructure and pathway changes required to increase the organisation's resilience in the face of a growing emergency care demand. However the Trust still has more to do as an acute provider of care and with partners in the Local Health Economy (LHE) to ensure sustained performance.

The Board of Directors has reviewed progress at each of its meetings. This has included discussions with the Clinical Directors for the Acute Floor and Specialty Medicine and Accident and Emergency Consultants.

Referral to Treatment (RTT) performance

Performance against the RTT standards has been significantly challenged since the end of Quarter 2, 2014/15 and the Trust has worked with commissioners to implement an RTT Delivery Plan to achieve compliance and improve patient experience with a refreshed and clear focus to achieve aggregate compliance:

- Making maximum use of internal capacity already available;
- Additional outpatient and inpatient (theatre sessions) secured internally and in the independent sector;
- An absolute focus on data quality;
- Capacity and demand modelling to sustain performance going forward.

Performance at Month 12 was:

	TARGET	PERFORMANCE FEBRUARY	PERFORMANCE MARCH
Admitted Care	90%	71.16%	70.9%
Non-admitted Care	95%	86.41%	88.3%
Incomplete backlog	92%	88.1%	88.7%

The Audit Committee had received a report which provided assurance regarding waiting list management at its meeting in June 2014. Subsequent to this report, performance deteriorated and at its meeting in December 2014, the Board requested a review of the issues surrounding the management of the RTT targets during 2014, so that lessons for the future could be identified and learned.

An independent review was undertaken and reported to the Board in February 2015. The review identified lessons under the following headings:

- Improving Board assurance
- Investigating concerns raised by whistle-blowers
- Joining the dots on cumulative risks
- Supporting recovery of Referral to Treatment (RTT) targets
- Lessons for the Intensive Support Team (IST)

Performance against the 4 hour Accident and Emergency standard and RTT standards has had an adverse impact on the experience of patients and patient safety. Recovery trajectories to improve both Accident and Emergency and RTT performance have been reported to and agreed with the Board.

INFORMATION GOVERNANCE

No Information Governance Serious Incidents were reported in 2014/15. The Audit Committee received a progress report on Information Governance in December 2014. The Chairman of the Committee reported steady progress to the Board.

The Information Governance toolkit submission in March 2015 demonstrated achievement of level 2 against the 2014/15 Information Governance Toolkit

REVIEW OF ECONOMY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES

The Board receives a monthly report from the Chief Financial Officer on financial performance. Financial performance is reviewed at the Executive and Clinical Management Boards and by the Finance and Workforce Committee. The Chair of the Finance and Workforce Committee, in turn, provides a formal monthly report to the Board of Directors.

The Trust reported a break even position at year end.

The Finance and Workforce Committee approved a Full Business Case (FBC) in April 2014 for radiotherapy decant provision, based on a Best and Final Offer (BAFO). A number of issues came to light during the mobilisation of the project and an increase in the costs of the programmes. As a result an initial review of business case, approval, capital and procurement processes was undertaken and reported to the Audit Committee in December 2014. The review made a number of recommendations concerning: business case construction and review, approval processes, capital feasibility studies and procurement.

COUNTER-FRAUD

The Trust is required under the terms of the Standard NHS Contract (as it was previously required under Secretary of State's Directions) to ensure appropriate counter fraud measures are in place.

The LCFS adopts a risk-based approach to counter fraud work, using the NHS Protect Risk Assessment Tool (RAT) and the incidence of local frauds to identify areas of potential vulnerability. Relevant local proactive exercises (LPEs) are consequently built into the Trust's annual counter fraud work plan, which is overseen by the Audit Committee. In common with other large acute hospitals, staff members working elsewhere while on sick leave remains among the most common fraud types at BSUH.

The LCFS & Compliance Manager helps to foster an anti-fraud culture within the Trust through delivery of an ongoing training programme across a wide range of staff groups. This features regular presentations on counter fraud and on compliance with the UK Bribery Act 2010.

The LCFS attends each meeting of the Audit Committee to present a report on his work.

INTERNAL AUDIT

An annual audit plan is undertaken by Internal Audit and monitored by the Audit Committee. The table below describes the internal audit reviews undertaken in 2014/15 and the level of assurance provided.

Table 2: internal audits 2014/15

AUDIT	ASSURANCE LEVEL PROVIDED
Charitable Funds	Substantial
Critical Financial Assurance - Pay	Substantial
Critical Financial Assurance – Non Pay	Substantial
Critical Financial Assurance – Financial Accounting	Substantial
Critical Financial Assurance – Part 2	Substantial
3Ts/Risk Management	Substantial
Performance Management Reporting – HR Dashboard	Reasonable
Quality Accounts	Reasonable
Review of Data Destruction	Reasonable
Controlled Drugs Theatres	Reasonable
Assurance Framework/ Risk Management	Reasonable
IT Data Destruction	Reasonable
Information Governance Toolkit	Reasonable
End Point Security	Reasonable
Recruitment	Limited
Rosterpro	Limited
Staff Appraisals	Limited
RTT/Access Policy	Limited
Policy Development Framework	Limited
IP Telephony Review	Limited
Information Management (Data Quality)	Limited

REVIEW OF EFFECTIVENESS OF RISK MANAGEMENT AND CONTROL

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Quality and Risk committee, and the Finance and Workforce Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit Opinion is one of 'Reasonable' assurance that the Trust has adequate and effective management, internal control processes to manage the achievement of its objectives.

My review is also informed by executive managers within the Trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board of Directors and the Audit Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board of Directors and its committees meet regularly and, as part of their consideration, keep arrangements for internal control under review through discussion and approval of policies and practice. The Audit Committee has provided the Board of Directors with an independent and objective review of financial and corporate governance, and internal financial control within the Trust.

The Audit Committee has received reports from external and internal audit including reports relating to the Trust's counter fraud arrangements. The Trust's Executive Directors and managers, and the Chairs of the Quality and Risk Committee and Finance and Workforce Committee of the Board, have provided the Board of Directors with reports on risk management, performance management and safety and quality governance.

I have also been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board of Directors, Audit Committee and Executive Directors. These groups each receive regular reports and updated action plans to manage or monitor progress on major risks, as defined in their respective terms of reference. A plan to address weaknesses and ensure continuous improvement of the system is in place.

A number of external agencies and other assessors measure and report on the Trust's performance against statutory requirements or best practice. These groups examine many potentially high risk areas. The results of their work are considered and acted on where necessary by the relevant executive director. All significant external scrutiny reports are also reported to the appropriate Committee for monitoring in line with the Trust policy on External Agency Visits, Inspections and Accreditations.

SIGNIFICANT ISSUES

I have considered the factors described in the NHS Trust Development Authority (TDA) guidance on the 2013/14 annual governance statement in respect of *significant issues.*

I have identified **significant** issues in this statement, which prejudice the achievement of Trust priorities, in relation to performance, in respect of: the 4 hour A&E standard and Referral to Treatment targets.

I have also identified **control** issues in relation to: local clinical audits; the radiotherapy decant programme and the following workforce issues: recruitment, e-rostering, and appraisal.

These control issues are also associated with the areas of non-compliance with CQC standards identified in this statement.

Detailed plans have been reported to the Board and its Committees to improve controls in these areas and I am satisfied that those issues have been or are being actively addressed.

ACCOUNTABLE OFFICER

The Accountable Officer is Matthew Kershaw, who is the signatory to the Annual Governance Statement.

Accountable Officer: Matthew Kershaw, Chief Executive

Organisation: Brighton and Sussex University Hospitals NHS Trust

Signature:

Date: April 2015

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GLOSSARY OF TERMS AND ACRONYMS

Accident and Emergency (A&E) Service
A responsive service for patients in an emergency situation with a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate attention.

ABI Acute Brain Injury.

ACU Ambulatory Care Unit.

Allied Health Professionals (AHP)
Allied Health Professionals (such as Physiotherapists, Occupational Therapists, Speech and Language Therapists, Podiatrists) provide treatment and help rehabilitate adults and children who are ill, have disabilities or special needs, to live life as fully as possible. They often manage their own caseloads.

Advanced Medical Priority Dispatch System (AMPDS)
An international system that prioritises 999 calls using information about the patient as supplied by the caller.

AIDS Acquired Immunodeficiency Syndrome

Ambulance Quality Indicators (AQIs)
AQIs were introduced in April 2011 for all ambulance services in England and look at the quality of care provided as well as the speed of response to patients. The AQIs are ambulance specific and are concerned with patient safety and outcomes.

Any Qualified Provider (AQP)
When a service is opened up to choice of 'Any Qualified Provider', patients can choose from a range of providers, all of whom meet NHS standards and price.

Ambulance Service Cardiovascular Quality Initiative
The initiative aims to improve the delivery of pre-hospital (ambulance service) care for cardiovascular disease to improve services for people with heart attack and stroke.

AMU Acute Medical Unit.

Annual Assurance Statement
The means by which the Accountable Officer declares his or her approach to, and responsibility for, risk management, internal control and corporate governance. It is also the vehicle for highlighting weaknesses which exist in the internal control system within the organisation. It forms part of the Annual Report and Accounts.

Automated External Defibrillator (AED)
A portable device used to restart a heart that has stopped.

Bare Below the Elbows
An NHS dress code to help with infection, prevention and control.

BAU Business as usual.

Better Payment Practice Code (BPPC)
The BPPC was established to promote a better payment culture within the UK and urges all organisations to adopt a responsible attitude to paying on time. The target is to pay all invoices within 30 days of receipt.

BGH Brighton General Hospital.

Board Assurance Framework (BAF)
The Board Assurance Framework provides a record of the principal strategic risks to the Trust achieving its objectives. It identifies the controls in place, the methods of assurance and the control and assurance gaps.

Board Governance Assurance Framework (BGAF)
The Board Governance Assurance Framework assists Boards through a combination of self and independent assessment processes to ensure they are appropriately skilled and prepared to achieve FT authorisation.

British Association for Immediate Care (BASICS)
A network of doctors who provide support to ambulance crews at serious road traffic collisions and other trauma incidents across the region.

British National Formulary (BNF)
The British National Formulary provides UK healthcare professionals with authoritative and practical information on the selection and clinical use of medicines in a clear, concise and accessible manner.

Bronze Commander Training
A course designed to develop and equip ambulance services, health colleagues and Voluntary Aid Society Incident Managers at operational/bronze level to effectively manage major/ catastrophic incidents.

BSMS Brighton and Sussex Medical School.

Caldicott Guardian
A senior member of staff appointed to protect patient information.

CAMHS Child and Adult Mental Health Service.

CAPEX Capital Expenditure.

Cardio-pulmonary Resuscitation (CPR)
A procedure used to help resuscitate a patient when their heart stops beating and breathing stops.

Care Bundle
A care bundle is a group of interventions (practices) related to a disease process that, when carried out together, result in better outcomes than when implemented individually.

Care Quality Commission (CQC)
An independent regulator responsible for monitoring and performance measuring all health and social care services in England.

Catheter-acquired Urinary Tract Infection (CAUTI)
A bladder infection that has occurred as a direct result of the presence of an indwelling catheter (a mechanism used initially to help the bladder).

Central Sterile Service Department (CSSD)
A service that provides equipment sterilisation services.

Centre for Maternal And Child Enquiries (CMACE)
Aims to improve the health of mothers, babies and children by carrying out confidential enquiries and related work on a nationwide basis.

Chartered Society of Physiotherapy (CSP)
The Chartered Society of Physiotherapy is the professional, educational and trade union body for the UK's 50,000 chartered physiotherapists, physiotherapy students and support workers.

Chairman
The Chairman provides leadership to the Trust Board and chairs all Board meetings. The Chairman ensures key and appropriate issues are discussed by the executive and non-executive directors.

Chief Executive
The highest-ranking officer in the Trust, who is the Accountable Officer responsible to the Department of Health for the activities of the organisation.

Chronic Obstructive Pulmonary Disease (COPD)
Chronic obstructive pulmonary disease (COPD) is the name for a collection of lung diseases, including chronic bronchitis, emphysema and chronic obstructive airways disease. People with COPD have trouble breathing in and out. This is referred to as airflow obstruction.

CIRU Clinical Investigation and Research Unit.

Clinical Commissioning Groups (CCGs)
Clinical Commissioning Groups replaced primary care trusts in April 2013; they are responsible for planning and designing local health services in England. They do this by 'commissioning' or buying health and care services.

Clinical Hub
A team of clinical advisors based within the Emergency Operations Centres providing support for patients with non-life threatening conditions.

Clinical Pathways
The standardisation of care practices to reduce variability and improve outcomes for patients.

Clinical Performance Indicators (CPIs)
CPIs were developed by ambulance clinicians and are used nationally to measure the quality of important areas of clinical care. They are designed to support the clinical care we provide to patients by auditing what we do.

Clinical Supervisor
Works on the frontline as part of the operational management team and facilitates the development of clinical staff and helps them to practise safely and effectively by carrying out regular assessment and revalidations.

CLN Community Link Nurse.

Clostridium Difficile (C.Diff)
A form of bacteria that is present naturally in the gut of around 2/3s of children and 3% of adults. On their own they are harmless, but under the presence of some antibiotics they will multiply and produce toxins (poisons) which cause illness such as diarrhoea and fever. At this point, a person is said to be infected with C. difficile.

CNS Central Nervous System.

Community Alcohol and Drug Service (CADS)
The main aim of the service is to reduce problems related to drugs and alcohol misuse, and support recovery. In order to do this CADS provides a range of modalities including advice and information, community and specialist prescribing, structured psychosocial interventions, structured treatments, harm reduction interventions and aftercare.

Community Equipment Store (CES)
This service provides all types of equipment to patients who are managed at home or in care homes, e.g. hospital beds, mattresses, commodes, toilet raisers, chair raisers and Telehealth systems.

Community First Responders (CFRs)
Volunteers in their local communities, who respond from their home addresses or places of work to patients suffering life-threatening emergencies.

Community Nursing and Therapy (CN&T)
Home delivered nursing, therapy services and interventions for Adults, such as wound dressings, end of life care and rehabilitation programmes.

Comprehensive Local Research Networks (CLRNs)
Coordinate and facilitate the conduct of clinical research and provide a wide range of support to the local research community.

Computer Aided Dispatch (CAD)
A method of dispatching ambulance resources.

Commissioning for Quality and Innovation (CQUIN)
The Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners to reward excellence by linking a proportion of providers' income to the achievement of local quality improvement goals.

Corporate Risk Register (CRR)
The Corporate Risk Register is the aggregation of the local team and corporate department risk registers where the residual risk is more than 12. It includes any additional sources of risk such as external or internal reviews.

Cost Improvement Plan / Programme (CIP)
The formal identification of an action which reduces the budgeted cost base of the organisation. It can relate to either pay or non-pay costs.

COTE Care of The Elderly.

CSIC Cancer Support and Information Centre

CT Computed Tomography

DASH Disability and Specialist Health Pathway.

Data Protection Act 1998 (DPA)
The Data Protection Act 1998 requires every organisation processing personal data to register with the Information Commissioner's Office, unless they are exempt.

Datix
A paperless risk management monitoring tool that aids staff in the reporting and management of incidents and risks.

DDA Disability Discrimination Act.

Department of Health (DH)
The government department which provides strategic leadership for public health, the NHS and social care in England.

Deprivation of Liberty (DoL)
DoL originates from case law rather than definitive acts of parliament. However, under the Mental Capacity Act (MCA) it is now clear that someone cannot be made to do something that they are resisting and a full assessment should be made to enable decisions to deprive someone from a liberty for their own safety or well-being.

Electrocardiograms (ECG)
An interpretation of the electrical activity of the heart. This is done by attaching electrodes to the patient which record the activity of the different sections of the heart.

Electroencephalogram (EEG)
An electroencephalogram is a recording of brain activity.

Emergency Department (ED)
A hospital department responsible for assessing and treating patients with serious injuries or illnesses.

Emergency Preparedness, Resilience and Response (EPRR)
In April 2013, NHS England introduced the EPRR Core Standards detailing the roles and responsibilities involved in EPRR, Major Incident and Service Continuity planning, partnership working, resource allocation and staff competencies.

ENT Ear, Nose and Throat.

Equality and Diversity
Equality legislation protects people from being discriminated against on the grounds of their sex, race, disability, etc. Diversity is about respecting individual differences such as race, culture, political views, religious views, gender, age, etc.

EVAR Endovascular Aneurysm Repair.

FEVAR Fenestrated Endovascular Aortic Aneurysm Repair

FM Facilities Management.

Freedom of Information (FOI) Act 2000
The Freedom of Information Act 2000 is an Act of Parliament that creates a public 'right of access to information held by public authorities.

FTT Family and Friends Test.

Foundation Trust (FT)
NHS organisations which operate more independently under a different governance and financial framework.

Foundation Trust Network (FTN)
The Foundation Trust Network is the membership organisation for NHS public provider trusts. It represents every variety of trust, from large acute and specialist hospitals through to community, ambulance and mental health trusts. Members provide the full range of NHS services in hospitals, the community and at home.

General Practitioner (GP)
A doctor who is based in the community and manages all aspects of family health.

Governance
The systems and processes by which health bodies lead, direct and control their functions in order to achieve organisational objectives and by which they relate to their partners and wider community.

GUM Genito-Urinary Medicine.

Hazardous Area Response Team (HART)
A group of staff who are trained to deliver ambulance services under specific circumstances, such as at height or underground.

HCA Health Care Assistant.

HDU High Dependency Unit.

Healthwatch
Healthwatch England is the independent consumer champion for health and social care in England.

HIV Human Immunodeficiency Virus.

HPNC Hurstwood Park Neurological Centre.

Human Resources (HR)
A function with responsibility for implementing strategies and policies relating to the management of individuals.

ICU Intensive Care Unit.

Independent Mental Capacity Advocate (IMCA)
A service introduced by the MCA 2005 that helps particularly vulnerable people who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about those decisions. The role of the Independent Mental Capacity Advocate (IMCA) is to work with and support people who lack capacity and to represent their views to those who are working out their best interests.

IM&T Information Management and Technology

Information Governance (IG)
Information Governance allows organisations and individuals to ensure that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care.

IG Toolkit
The Information Governance Toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health Information, Governance policies and standards. It also allows members of the public to view information of participating organisations. Governance Toolkit assessments.

Institute of Healthcare and Development (IHCD)
A body responsible for the content of some ambulance staff training which is then delivered through ambulance trusts.

Integrated Business Plan (IBP)
An IBP sets out an organisation's vision and plans to achieve that vision in the future.

Integrated Performance Report (IPR)
A report used to assure the Trust Board of organisational performance; to flag exceptions to the achievement of performance standards and corrective action as appropriate.

International Normalised Ratio (INR)
A laboratory measurement of how long it takes blood to form a clot. It is used to determine the effects of oral anticoagulants (an anticoagulant is a substance that prevents clotting of blood) on the clotting system.

ISO International Standards Organisation.

ITU Intensive Therapy Unit.

Key Performance Indicator (KPI)
A measure of performance.

Knowledge and Skills Framework (KSF)
A competence framework to support personal development and career progression within the NHS.

Learning Disability (LD)
A learning disability affects the way a person learns new things in any area of life. It affects the way they understand information and how they communicate.

Local Involvement Network (LINk)
A network of individuals and community groups, such as faith groups and residents' associations, working together to improve health and social care services. A new consumer champion called Healthwatch has started to replace LINks from October 2012.

LPA Local Planning Authority.

Major Trauma
Major trauma is serious injury and generally includes such injuries as:
- traumatic injury requiring amputation of a limb
- severe knife and gunshot wounds
- major head injury
- multiple injuries to different parts of the body e.g. chest and abdominal injury with a fractured pelvis
- spinal injury
- severe burns

Major Trauma Centre (MTC)
A network of 22 new centres throughout the UK, specialising in treating patients who suffer from major trauma.

Malnutrition Universal Screening Tool (MUST)
A five-step screening tool to identify adults who are malnourished, at risk of malnutrition or obese. It also includes management guidelines which can be used to develop a care plan.

Mental Capacity Act (MCA)
Legislation designed to protect and empower people who cannot make decisions for themselves or lack the mental capacity to do so. The Act states that:

- you should have as much help as possible to make your own decisions;
- people should assess if you can make a particular decision;
- even if you cannot make a complicated decision for yourself, this does not mean that you cannot make more straightforward decisions;
- even if someone has to make a decision on your behalf you must still be involved in this as much as possible;
- anyone making a decision on your behalf must do so in your best interests.

MCA often applies to people with a learning disability, dementia, mental health problem, brain injury or stroke.

Methicillin-resistant Staphylococcus Aureus (MRSA)
A bacterium responsible for several difficult-to-treat infections in humans due to its resistance to methicillin and other beta-lactam antibiotics. MRSA is especially troublesome in hospitals and nursing homes, where patients with open wounds, invasive devices and weakened immune systems are at greater risk of infection than the general public.

Monitor
The independent regulator of NHS foundation trusts.

MRI Magenetic Resonance Imaging.

Myocardial Infarction (MI)
Commonly known as a heart attack, an MI is the interruption of blood supply to part of the heart, causing heart cells to die.

Myocardial Ischemia National Audit Project (MINAP)
A national database gathering information on all patients who have had a heart attack or who have acute coronary syndromes.

National Early Warning Score (NEWS)
NEWS is designed to capture and bring together all of the factors that could impact on the quality and safety of clinical services; to identify services that may be at risk and to help prevent serious

National Health Service (NHS)
Provides healthcare for all UK citizens based on their need for healthcare rather than their ability to pay for it. It is funded by taxes

NHSLA Risk Management Standards for Ambulance Trusts
Ambulance trusts are assessed against these risk management standards which have been specifically developed to reflect issues which arise in the negligence claims reported to the NHSLA.

National Infarct Angioplasty Project (NIAP)
An audit of patients referred for an angioplasty surgical procedure.

National Institute for Health and Clinical Excellence (NICE)
The National Institute for Health and Clinical Excellence provides independent, authoritative and evidence-based guidance on the most effective ways to prevent, diagnose and treat disease and ill health, reducing inequalities and variation.

National Learning Management System (NLMS)
Provides NHS staff with access to a wide range of national and local NHS eLearning courses, as well as access to an individual's full training history.

National Patient Safety Agency (NPSA)
The National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector.

National Reporting and Learning System (NRLS)
The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports. Clinicians and safety experts help analyse these reports to identify common risks and opportunities to improve patient safety.

Net Promoter Score (NPS)
The net promoter score is a key measure of individual, team and corporate performance and is used to drive up positive patient experience.

NHS Commissioning Board
Formally established as an independent body on 1 October 2012, the NHS Commissioning Board is responsible for authorising Clinical Commissioning Groups (CCGs), working collaboratively with partners and encouraging patient and public participation in the NHS.

NHS Property Services (Prop Co)
A Government-owned limited company that will take ownership of, and manage, that part of the existing primary care trust estate that will not transfer to NHS community care providers under the healthcare reform plans set out in the Health and Social Care Bill.

Non-Executive Director (NED)
A Non-Executive Director is a member of the Board of Directors, drawn from the local community served by the trust and appointed by the Trust Development Authority. NEDs hold the Executive Directors to account, bring independence, external skills and perspectives, provide challenge on strategy development, risk management, shaping culture, and the integrity of financial and quality intelligence. They also contribute to plans to improve and develop services which meet the area's particular needs.

OPD Out-patients Department.

OT Occupational Therapy.

Overview and Scrutiny Committee (OSC)
Local authority bodies that provide scrutiny of health provision in their local area.

PACS
Picture Archiving and Communications System.

Paramedic
Senior ambulance service healthcare professionals at an accident or medical emergency. Working alone or with an assistant practitioner or emergency care technician, they assess a patient's condition and provide essential treatment.

Paramedic Practitioner
Paramedic practitioners come from a paramedic background and have additional training in injury assessment and diagnostic abilities.

Patient Administration System (PAS)
An information collection system that acute and community hospitals use to collect patient related data.

Patient Advice and Liaison Service (PALS)
The Patient Advice and Liaison Service assists patients, their relatives, carers and friends, answering questions and resolving concerns as quickly as possible.

Patient-Led Assessments of the Care Environment (PLACE)
The Patient-Led Assessments of the Care Environment (PLACE) programme replaced the former Patient Environment Action Team (PEAT) programme from April 2013. These self-assessments are undertaken by teams of NHS and private/independent health care providers, and include at least 50 per cent members of the public (known as patient assessors). They focus on the environment in which care is provided, as well as supporting non-clinical services such as cleanliness, food, hydration, and the extent to which the provision of care with privacy and dignity is supported.

Patient Report Form (PRF)
A comprehensive record of the care provided to patients.

Patient Transport Service (PTS)
A non-emergency medical transport service used, for example, to and from out-patient appointments.

PEAT Patient Environment Action Team

Personal Development Reviews (PDRs)
The PDR process provides a framework for identifying staff development and training needs and agreeing objectives.

Personal Digital Assistants (PDAs)
Small computer units which help to capture more accurate data on Patient Transport Service performance and journey times and identify areas which require improvements.

PICU Paediatric Intensive Care Unit.

PGMC Post Graduate Medical Centre.

PPM Planned Preventative Maintenance.

PPU Private Patients Unit.

PRH Princess Royal Hospital.

Primary Care Trust (PCT)
PCTs worked with local authorities and other agencies providing health and social care locally to ensure community health needs were being met. They were replaced by Clinical Commissioning Groups (CCGs) in April 2013.

Primary Percutaneous Coronary Intervention (pPCI)
A surgical treatment for heart attack patients which unblocks arteries which carry blood to the heart.

QGAF Quality Governance Assurance Framework.

Quality Innovation, Productivity and Prevention
Quality, Innovation, Productivity and Prevention is a large scale transformational programme for the NHS, involving all NHS staff, clinicians, patients and the voluntary sector. It will improve the quality.

RACH Royal Alexandra Children's Hospital.

Rapid Response Vehicle (RRV)
A car operated by the ambulance service to respond to medical emergencies either in addition to, or in place of, an ambulance capable of transporting patients.

Rapid Access Team (RAT)
A team of nurses, therapists and social workers who respond quickly to patients who are admitted to accident and emergency to find alternative solutions to enable patients to be cared for at home.

RACOP Rapid Assessment Clinic for Older People.

Root Cause Analysis (RCA)
RCA is a process designed for use in investigating and categorising the root causes of events. When incidents happen, it is important that lessons are learned across the NHS to prevent the same incident occurring elsewhere. RCA investigation is a well recognised way of doing this.

Safeguarding
Processes and systems for the protection of vulnerable adults, children and young people.

Safety Thermometer
The NHS Safety Thermometer is a tool designed to help hospitals understand where they can potentially cause harm to patients and reduce the risk of this.

Serious Case Reviews (SCRs)
Establish whether there are any lessons to be learnt about the way in which staff and agencies work together to safeguard vulnerable people.

Serious Incidents (SIs)
Something out of the ordinary or unexpected. It is an incident – or a series of incidents – that, if left unattended, may pose a risk to service users or the health and safety of staff, visitors and others.

SAU Surgical Assessment Unit.

Sexual Assault Referral Centre (SARC)
SARCs are specialist medical and forensic services for anyone who has been raped or sexually assaulted. They aim to be a one-stop service, providing medical care and forensic examination following assault/rape and, in some locations, sexual health services. Medical Services are free of charge and provided to women, men, young people and children.

Stakeholders
All those who may use the service, be affected by or who should be involved in its operation.

ST Elevation Myocardial Infarction (STEMI)
A type of heart attack.

Strategic Health Authority (SHA)
NHS East of England is the regional headquarters of the NHS, and provides strategic leadership to all NHS organisations across the six counties. It is ultimately accountable to the Secretary of State for Health.

Serious Incident Requiring Investigation (SIRI)
The National Patient Safety Agency has developed a national framework for serious incidents in the NHS, entitled 'National Framework for Reporting and Learning from Serious Incidents requiring Investigation'. An incident or event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors or members of the public. A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in, for example, unexpected or avoidable death of one or more patients, staff, visitors or members of the public; serious harm to one or more patients, staff, visitors or members of the public.

Strategic Executive Information System (STEIS)
A system to collect data for the Department of Health.

SOP Standard Operating Procedure.

SSPAU Short Stay Paediatric Assessment Unit.

SystmOne SystmOne is a centralised clinical system that provides healthcare professionals with a complete management system.

Trust Development Authority (TDA)
The NHS Trust Development Authority (TDA) is responsible for providing leadership and support to the non-Foundation Trust sector of NHS providers. This includes 99 NHS Trusts, providing around £30bn of NHS funded care each year. The TDA oversees the performance management of these NHS Trusts, ensuring they provide high quality sustainable services, and provides guidance and support on their journey to achieving Foundation Trust status.

To Take Out (TTO)
'To take out' is the literal meaning for the medications patients take home.

Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE)
The purpose of the Transfer of Undertakings (Protection of Employment) Regulations is to protect employees if ownership of their employer changes hands.

UCC Urgent Care Centre

Venous Thromboembolism (VTE)
A blood clot that forms within a vein.

Waterlow
The Waterlow pressure ulcer risk assessment/prevention policy tool is, by far, the most frequently used system in the UK and is also the most easily understood and used by nurses dealing directly with patient/clients to assess risks of the individual.

Notes