Annual Report 2015-16

Contents


CHARTERED
PHYSIOTHERAPIST

From the Chair and Chief Executive

Welcome to our Annual Report for 2015/16. Mr Matthew Kershaw was the Chief Executive and Accountable Officer up until 31 December 2015, Ms Amanda Fadero was Interim Chief Executive and Accountable Officer from 1 January 2016 to 31 March 2016, and I became Chief Executive and Accountable Officer on 1 April 2016.

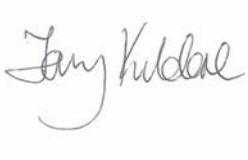
Overall, 2015/16 was a challenging year for the Trust, particularly in ensuring that patients who arrive at our hospitals in an emergency are treated, admitted or discharged safely and quickly. Our performance against the national Accident and Emergency standard remained below the required level of 95% of patients treated, discharged or admitted within four hours. This was reflected in the findings of the Care Quality Commission (CQC) inspection which took place in June 2015. The CQC found that poor patient flow was having an adverse impact on care and patient experience in the Emergency Department at the Royal Sussex County Hospital and rated the Trust as 'inadequate' both for safety and well-led when its report was published in September 2015. We also struggled to meet a number of other national waiting times standards and many of our patients and staff experienced problems with the Central Booking Hub, problems which we now have a detailed plan to resolve.

The CQC carried out a comprehensive follow-up inspection in April 2016 and, although that inspection did not fall within this reporting year, the outcome of this is likely to reflect insufficient progress made in addressing concerns raised in previous inspections during 2015/16. In addition to poor performance in relation to the national standards against which we are monitored, we also failed to deliver our financial plan in 2015/16 reporting an end of year of deficit of £45 million.

To address all these issues and make the improvements necessary to ensure we are delivering consistently high quality and timely treatment and care to all our patients we are, in 2016/17, embarking on a systematic and coherent programme of transformation with programmes to improve safety and quality; ensure we deliver our CQC action plan; review and strengthen our central clinical governance function; introduce revised Board, Committee and Executive Governance arrangements; and make significant improvements to our financial performance.

We are also making some important changes to our buildings which will help us improve how we deliver services. We secured final approval from Her Majesty's Treasury for the Full Business Case which will see the oldest parts of the Royal Sussex County Hospital replaced with state-of-the-art facilities which are fit for the provision of 21st century healthcare; an historic moment for our Trust, our staff and the patients who use our services.

To the best of our knowledge the information in this document is accurate.



Dr Gillian Fairfield
Chief Executive

Antony Kildare
Interim Chairman

Strategic Review

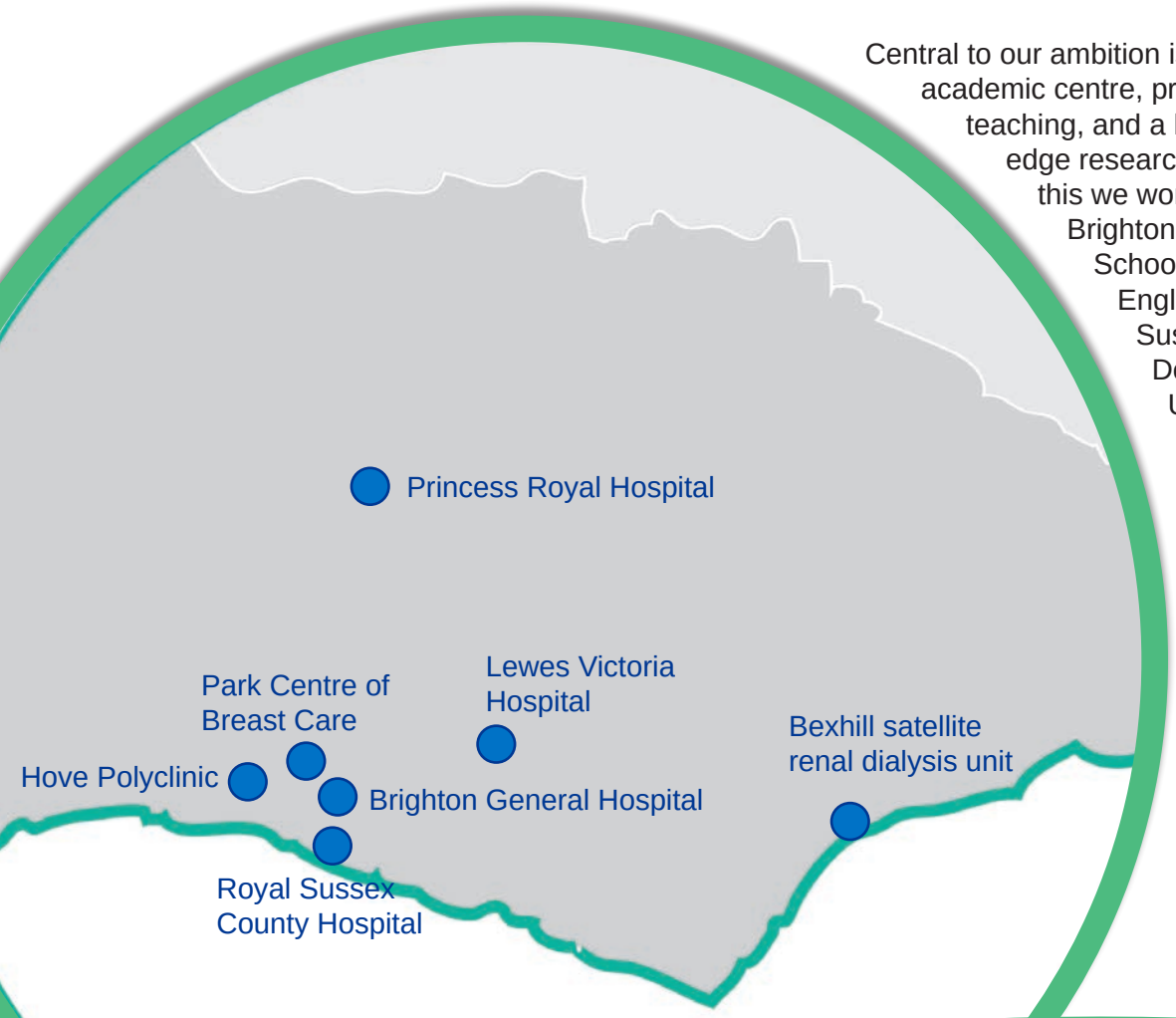
About the Trust

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 is also the Major Trauma Centre for the region. 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 Hospital has a 24/7 Emergency Department for its local population and is also our centre for elective surgery. 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. In addition to our two main hospital sites we also provide services from Brighton General Hospital, Hove Polyclinic, Lewes Victoria Hospital, the Park Centre for Breast Care and a renal dialysis satellite services in Bexhill, East Sussex.

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, Health Education England, Kent, Surrey and Sussex Postgraduate Deanery and the Universities of Brighton and Sussex.



Ten Facts

about the Trust

In 2015-16 the Trust:

1. Employed **8,200** members of staff
2. Received the help of **430** hospital volunteers
3. Delivered **5,900** babies
4. Saw **161,000** A&E patient attendances
5. Treated **53,000** patients for unplanned procedures and 15,000 for planned procedures
6. Treated **44,000** patients as day cases
7. Cared for patients in **790** acute beds
8. Received **455** compliments and plaudits from patients and relatives
9. Had **2,500,000** hits on the public website and **2,500** Twitter followers
10. Received approval for **£484.7 million** hospital redevelopment funding

Values and Behaviours (V&B)

Since the initial consultation in 2013 during which over 700 staff contributed to our 'behavioural blueprint', which outlines what our new Trust-wide Values and Behaviours are, the V&B programme has gone from strength to strength.

Each of our five values is underpinned by a set of behavioural do's and don'ts and in 2015/16 work has been continuing to embed these across the organisation through a number of staff engagement activities including the recruitment of 250 V&B Champions, a leadership training programme for all people managers, an extensive programme of team coaching workshops, a star of the month staff recognition scheme, staff forums and a programme of back to the floor visits with the senior team.

We also held SHINE (Support, Hear, Inspire, Nurture and Encourage and help our people SHINE) week. This included hour-long engagement sessions on both sites which were open to all and focussed on helping staff recognise the impact of our highly pressurised work environment on individual wellbeing, behaviour and performance.

There was also a longer session for people who manage people at the Amex Stadium. Over 450 staff (6% of the total workforce) attended across the week

Our Values

Communication

...that's respectful, personal, honest and helpful

Kindness and Understanding

...so that we feel supported and enabled to do our jobs

Fairness and Transparency

...in our decisions and actions

Working Together

...to get the best outcome for patients

Excellence

...always striving to be the best we can be

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.

For 2015/16 the Trust agreed the following five corporate objectives:

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

The following pages set out how we performed.

Objective 1: Excellent Outcomes

Reducing avoidable harm to patients

Q.1	Q.2	Q.3	Q.4

- Since December there were two Never Events recorded and rate of harmful incidents increased to 1.44 per 1000 bed days at the end of March
- Continued concerns around privacy and dignity associated with lodging patients in the corridor within the Emergency Department
- The safety thermometer was slightly lower than in previous months with an average c. 94%
- Improvements were achieved in the rate of falls reducing from 4.24 in December to 3.25 at the end of March.

Ensure safe staffing levels

Q.1	Q.2	Q.3	Q.4

- Despite successful recruitment (over 130 nurses) there are areas with a significant level of nursing vacancies. Overall 89.5% of our nursing posts are substantive; but
- Agency cap creates a risk to the NPR/Safe Staffing levels
- Clear protocols have been put in place to monitor NPR/Safe Staffing levels with monitoring on a shift-by-shift basis and immediate escalation to Chief Nurse and Chief Operating Officer

Creating a learning and reporting culture

Q.1	Q.2	Q.3	Q.4

- Drop in DoC cases with over 80% of DoC conversations within 10 days; and significant improvement in DoC Reports completed within 60 days (100% in February and March)
- Reduction in incidents open for more than 45 working days significantly reduced

Objective 2: Excellent Patient Experience

Meet the core standards of care including access targets

Q.1	Q.2	Q.3	Q.4

- No improvements in the 4-hr standard and significant number of 12-hr trolley breaches
- No improvements in RTT with increased backlog
- Breaches in diagnostics target (primarily endoscopy and echo)
- 62-day cancer waiting time target at significant risk due to pressures with patient flow
- Revised trajectories have now been agreed with the commissioners to achieve incremental and sustainable improvements throughout FY 16/17.

Improve patient engagement and our responsiveness to their feedback

Q.1	Q.2	Q.3	Q.4

- FFT scores consistently above 90% including emergency departments at RSCH and PRH
- Percentage of inpatients not recommending the hospital below 1%
- Significant increase in completed Patient Voice Surveys with an average of 714 surveys/month in Q4 (vs. 617/month previously)

Improve staff experience of delivering care

Q.1	Q.2	Q.3	Q.4

- Staff Survey scores for 2015 with the overall indicator for staff engagement 3.71 which is in the lowest 20% when compared with the peer group.
- The Trust is now developing an action plan to address key concerns identified in the survey, while continuing to roll-out engagement and staff development initiatives like V&B and Leading the Way Too programme for all leaders.

Objective 3: Empowered and Skilled Staff

Support Directorates to deliver, integrating performance management and improve business planning

Q.1	Q.2	Q.3	Q.4

- Continues to be amber due to reduced capacity to fully support operational and strategic developments at Directorate level. This is now being mitigated through the introduction of new support structures in the form of a robust Programme Management Office.
- The Trust has met the timelines set out by NHS Improvements for the development and submission of the 16/17 Operational Plan and is currently awaiting feedback.
- The Trust is also actively engaged in the development of the System Transformation Plan for the Surrey and Sussex footprint.

Improve patient engagement and our responsiveness to their feedback, and

Develop and modernise the workforce to deliver the Trust's Clinical Strategy

Q.1	Q.2	Q.3	Q.4

- Overall rated as amber because of Staff Survey outcomes and poor compliance with the Statutory and Mandatory Training.
- Appraisal rates continue to increase but are still below the Trust's target of 75%. At the end of March, the appraisal rate was 69.4%.
- Work continues to roll-out appraisal training to both managers and staff; and new e-learning models are being made available to increase staff training.

Objective 4: Top Productivity

Agree the priority investment and developments

Q.1	Q.2	Q.3	Q.4

- The 15/16 outturn significantly impacted on the Trust's ability to invest into the agreed developments and service changes. These are now being reviewed as part of the planning for 16/17 to ensure they support recovery of the constitutional standards and the financial position of the Trust.

Deliver the financial plan

Q.1	Q.2	Q.3	Q.4

- Reported 2015/16 deficit of £44.8m – significantly higher than the projected deficit of £37m.
- The primary reasons behind the deficit were lower than expected income and higher than expected non-pay costs.
- As part of the Operational Plan for 2016/17 the Trust submitted a financial plan that delivers a control total of £15.6m deficit. Work is being undertaken to introduce refreshed governance structures (PMO) to control and monitor expenditure and support operational services in achieving sustainable financial position.

Develop Service Line Reporting

Q.1	Q.2	Q.3	Q.4

- Overall rated as Green – Blue Book continues to be updated on a quarterly basis and is now being used at the directorate performance meetings.
- Productivity Opportunities identified through the SLR review form part of Operational Plan for 16/17.

Deliver the long-term capital programme

Q.1	Q.2	Q.3	Q.4

- Not all agreed developments could progress and some capital funds had to support cash-flow within the Trust.
- Despite this the Trust has delivered:
- Three new MRI scanners at RSCH; renovation of the Sussex Eye Hospital, new specialist children's trauma room, New sensory garden at children's hospital.
- Preston Park radiotherapy unit is also on-track to open in May 2016.
- Construction works have now restarted at the East Sussex radiotherapy unit.

Objective 5: Clinical Strategy

Deliver greater integration of services for the frail and elderly

Q.1	Q.2	Q.3	Q.4

- Despite good progress with developments around Newhaven Community Ward and Discharge-2-Assess the observed impact has not been as extensive as expected. Additional community capacity did not result in the anticipated reduction in Medically Ready for Discharge patients.
- Hospital at Home model continues to be defined and pathway development work is being undertaken, however the full roll-out is not planned until later in 2016/17.

Improve local hospital services

Q.1	Q.2	Q.3	Q.4

- The 15/16 financial outturn significantly impacted on the Trust's ability to invest into the agreed developments and service changes. These are now being reviewed as part of the planning for 16/17 to ensure they support recovery of the constitutional standards and the financial position of the Trust.
- The Trust appointed a new provider for MRI services at the PRH. The new 5 year contract with Alliance Medical will deliver 3Tesla MRI scanner to offer state-of-the art scanning facilities to the hospital and the local population.

Improve shared care with partner providers, and

Expand tertiary provision

Q.1	Q.2	Q.3	Q.4

- Successfully re-located elective knee clinics from the RSCH site to the Amex Stadium as part of the collaborative working with Sussex MSK Partnership
- Reached agreement around shared consultant appointments with Queen Victoria Hospital
- Signed a contract with University of Sussex/CISC for the provision of PET-CT scanning.

Enhance academic and research strength

Q.1	Q.2	Q.3	Q.4

Particular achievements in:

- Virtual Fracture Clinic launched by the MSK Directorate received NHS Innovation Prize
- ’10 minute meeting’ and enhanced recovery programmes received awards for improvement initiatives from the Kent Surrey and Sussex Academic Health Science Network


REAL

Our People

Brighton and Sussex University Hospitals employs **8,222** people, including:

3,517
nursing and midwifery staff

1,104
medical staff

1,525 administrative, clerical and estates staff

1,288
scientific, therapeutic and technical staff

A total of **7%** of staff define themselves as disabled

A total of **6%** of staff define themselves as Gay, Lesbian or Bisexual

A total of **18%** of staff define themselves as BME

Sickness absence rate = **4.1%**

89% of staff are permanent (with the rest being fixed term)

77% of staff are full time

41% of staff have worked at BSUH for over five years.

26% of staff have worked at BSUH for less than a year.

42% of non-medical staff are Bands 1 to 4

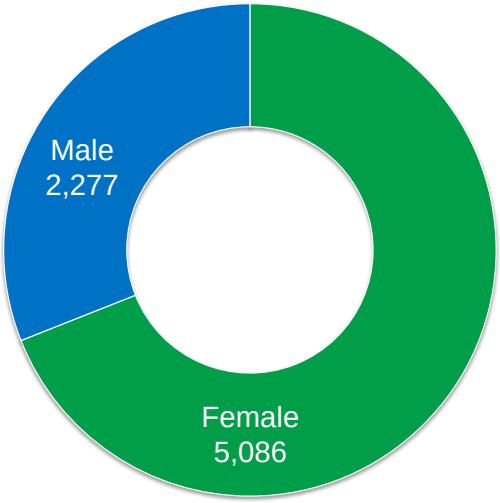
6% of non-medical staff are Bands 8a or higher

25% of staff are aged 30 or less

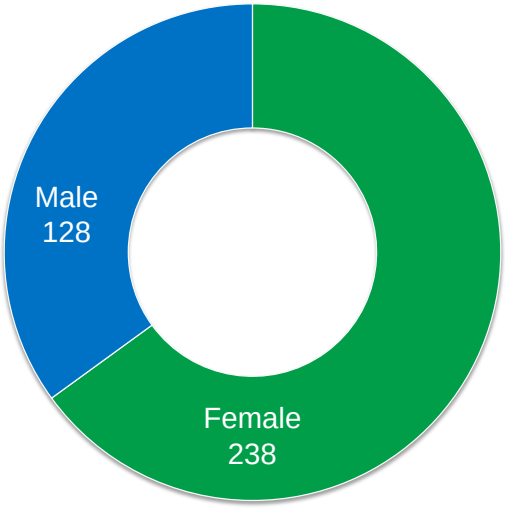
24% of staff are aged over 50.

Gender breakdown of our staff

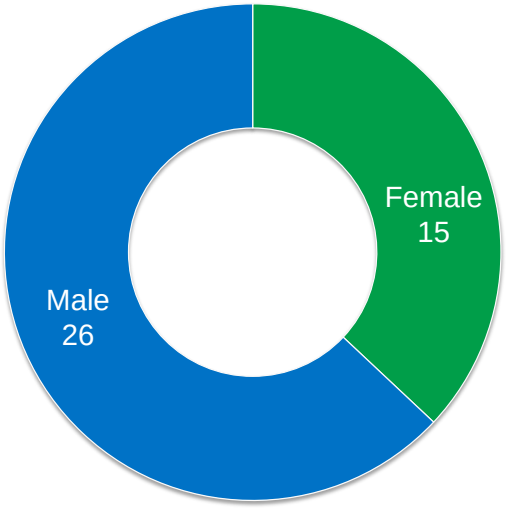
All staff



Senior managers (non-medical)



Directors



Staff survey 2015

The national staff survey results were released in February 2016. The five key findings for which BSUH compares MOST favourably with other acute trusts in England) were:

- Percentage of staff agreeing that their role makes a difference to patients
- Recognition and value of staff by managers and the organisation
- Effective use of patient/service user feedback
- Staff satisfaction with level of responsibility and involvement
- Percentage of staff satisfied with the opportunities for flexible working patterns

Other areas in which we scored positively include:

- There has been an increase in our appraisal rate from 73% to 82%.
- There has been a significant improvement in staff motivation.
- Above average numbers of staff feel their role makes a difference to patients.
- The extent to which staff feel recognised and valued by their manger and the organisation has increased.
- More staff than last year felt there were frequent opportunities for them to show initiative in their roles.

The five key findings for which BSUH compares LEAST favourably with other acute trusts in England) were:

- Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month
- Organisation and management interest in and action on health and wellbeing
- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
- Effective team working
- Quality of appraisals

The Trust's staff engagement score saw a positive shift from 3.59 to 3.71 (on a scale from 1 for poorly engaged staff to 5 for highly engaged). This reflects the work that has taken place over the last couple of years as part of the Values and Behaviours programme including the SHINE engagement events, Leading the Way Too, the V&B Champion network, staff awards, team coaching, regular staff listening forums and a focus on ensuring staff have regular appraisals. The survey has highlighted some areas where we need to do much better, many of which we already identified ourselves and will continue to focus on through the work we have been undertaking to improve the working lives of our staff. Central to this is ensuring all staff get a high quality appraisal that it is supported with a clear personal development plan. We will also be expanding our support for staff wellbeing at work, including how we support staff experiencing ill health.

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 90 and individually and collectively the contribution they make to the smooth running of our hospitals, and the experience and wellbeing of our patients, is invaluable.

Transfer of Soft Facilities Management Services in-house

On 1 September 2015 all our portering, housekeeping, catering and other Soft FM staff joined the Estates and Facilities directorate and became BSUH staff. This service had previously been provided by an external company under contract. Six hundred and fifty staff joined BSUH as part of this positive change.

We recognise that our Soft FM staff play an important role in patient care. A friendly porter getting somebody to the right place through our complicated buildings makes a real difference. An attractive meal, well presented, is more likely to be eaten by somebody when they most need to keep up their strength.

The cleanliness of our hospitals is vital to safe care. We have invested during the last year in giving these staff the right equipment to do their jobs well, with everything from new cleaning cloths to new wheelchairs and drinks trollies. We also made sure the new equipment could be stored securely and staff were given any training needed to use equipment safely and appropriately.

The change was welcomed by our existing clinical and support staff, and our soft FM staff are now very much part of the BSUH team.

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 the Trust had their hard work recognised with awards and prizes at the sixth annual Hospital Star Awards, held at the Corn Exchange in Brighton.

Over 700 nominations for 11 different categories were received from colleagues, patients and their families. The winners and runners-up were chosen by a panel of independent judges, and Chief Executive Matthew Kershaw also presented his own special award.

The winners and runners up were:

Compassionate Communication
Winner: Karen Creed, Antenatal Screening Midwife; Runner-up: Hannah Pacifico, PALS Advisor

Outstanding Teamwork
Winner: Chichester Ward; Runner-up: Janice O'Brien, Theatre Manager

Exceptional Care
Winner: Yvonne Stone, Children's and Young Person's Diabetes Clinical Nurse Specialist; Runner-up: Roel Panagdato, Staff Nurse, Haemodialysis Unit

Innovation and Excellence
Winner: Farzaneh Rahmanpour, Senior Staff Nurse, Sussex Eye Hospital; Runner-up: Melanie Smith, Senior Paediatric Inpatient Physio

Unsung Hero
Winner: Mark Caplice, Night Porter; Runner-up: Philip Chipman, Volunteer

Inspirational Role Model/Educator
Winner: Liz Hall, Lead Superintendent Radiographer for Neuroimaging; Runner-up: Claire Martin, Head of Nursing and Midwifery Education

Commitment to Safety
Winner: Community Midwives; Runner-up: Sarah Bright and Niki Ludlow, Manual Handling Trainers

Extraordinary Kindness
Winner: Helen Patrick, Staff Nurse, A&E; Runner-up: Christianne Whitfield, Staff Nurse, Howard 1

Championing Change
Winner: Jane Gillanders, Senior Physiotherapist, Outpatients; Runner-up: Emma Tee, Reconfiguration Team

Brighten up the day
Winner: Hannah Heron, IV Clinical Research Nurse; Runner-up: Kimberley Armstrong, HCA, Twineham Ward

Motivational Leader
Winner: Dr Romesh Rasanayagam, Clinical Director, Perioperative Division; Runner-up: Natalie Shillito, Ward Manager, Twineham Ward

Chief Executive's Special V&B Award
Winner: Dosto Mohammed, Cleaner Cardiac Theatres


Star Awards 2015
Championing Change

Highlights of the Year

World first heart procedure saves patient

Cardiologists performed a ‘world first’ heart procedure to save the life of a patient. Michael Amos, 67, became the first person on the planet to have a new extra-large stent inserted into his heart at the Royal Sussex County Hospital after he suffered a cardiac arrest. Stents used for heart procedures usually expand to 4mm but the new one used for Mr Amos expands to 5.5mm, giving patients with blocked larger arteries a better chance of survival.

New scanner gives life-saving treatment

A new scanner was used for the first time to treat patients with potentially life threatening brain conditions. The neurointerventional bi-plane system produces highly detailed three-dimensional views of blood vessels within the brain to help the diagnosis and treatment of patients with stroke, blood clots, brain and neck tumours, and other neurological conditions. The machine offers a way of treating some abnormalities of the blood vessels in the brain that is less invasive than surgery.

Homebirth rates one of the best in country

The Trust achieved homebirth rates that were one of the best in the country. Over the last year, the number of women giving birth at home in the Trust’s catchment area was almost three times the national rate. The Community Midwifery Team have worked hard to give women the opportunity to give birth in the privacy and comfort of their own homes with their chosen loved ones. Last year they assisted with 232 homebirths.

Hospital redevelopment given green light

The official green light was given for the £484 million publically-funded redevelopment of the Royal Sussex County Hospital, allowing building work to start in earnest. Her Majesty's Treasury gave final approval for the Full Business Case which will see the oldest parts of the hospital replaced with state-of-the-art facilities. Stage one of the programme, which will include a new main reception (pictured), is due to be completed by 2019 with the whole project expected to be finished in 2024.

National prize for virtual fracture clinic

The Trust's virtual fracture clinic won a NHS Innovation Challenge Prize award from NHS England for reducing the number of times injured patients come into hospital. The clinic involves specialist physiotherapists assessing x-rays online and giving patients instructions and advice over the phone. It has meant patients who were treated in A&E with a broken bone no longer have to come into hospital for face-to-face assessment.

Awards for improvement initiatives

Two initiatives won Kent Surrey and Sussex Academic Health Science Network awards for improvements to patient care. The enhanced recovery programme won the enhancing quality and recovery team of the year award for helping patients recover from surgery quicker and reducing the time they spend in hospital. The '10 minute meeting' initiative won the safety award for improvements in the treatment of patients requiring emergency care.

Equality, Diversity and Human Rights

BSUH is committed to delivering fair and equitable services for our staff, 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 in 2015/16 include:

- Provision throughout the organisation of The Hospital Communication Book, which aids greater communication support for our patients with Learning Disabilities.
- Online Equality and Diversity training package delivered and in use by our workforce.
- 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.
- Through our involvement with the Equality and Inclusion Partnership (Equip) and (Trans sub group) the equality function is working with Equality leads in other public sector organisations to enable where possible a consistent approach to the implementation of equality practices locally.
- Sponsoring our Director of Communications to attend the Stonewall Leadership Programme. The Stonewall Leadership Programme is a CPD accredited intensive two-day residential, which offers a selected group of 36 professionals a powerful opportunity to: reflect on how their identity as an LGBT person impacts on their role as a leader in the workplace; find out for themselves what it means to be a leader; explore how they can be a more effective organisational role model; and network and forge on-going relationships with other lesbian, gay, bi and trans professionals from the private, public and third sectors.
- Worked with Laing O'Rourke to support the design of their Brighton 3Ts Equality, Diversity and Inclusion Plan.

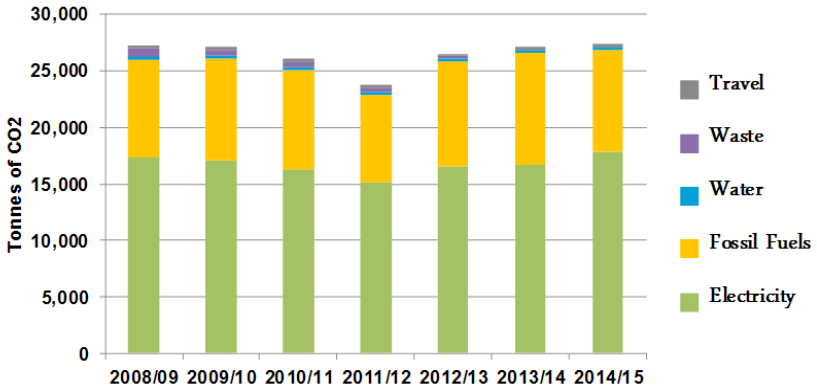
Our Commitment to Sustainability

"Care without Carbon" the BSUH Sustainable Development Management Plan 2016 outlines the Trust's commitment to cut carbon emissions as part of the fight against climate change and the significant impacts on human health. Below is a graph showing the Trust's carbon footprint:

During 2015/2016 the Trust developed a draft 'Sustainable Development Management Plan' (SDMP). The draft SDMP outlines seven key areas of activity to define our overall objectives and action plans:

- Buildings – reducing the environmental impact of our estate.
- Journeys – minimising the health and environmental impact of travel.
- Procurement – creating an ethical and resource efficient supply chain.
- Engagement – informing, empowering and motivating people to achieve sustainable healthcare.
- Wellbeing – enhancing the wellbeing of our workforce.
- Adaption – ensuring our infrastructure and operations are resilient to climate change.
- Governance – embedding sustainability in corporate governance structures.

There is still more work to done, but it is anticipated that the Plan will be approved by the Trust Board by March 2017.



BSUH Travel Plan 2016

BSUH produced its first Travel Plan in 2006. It was refreshed in 2011 as part of the planning submission for the 3Ts redevelopment of the RSCH, and has just been updated again. The document assesses the success of the plan thus far, and identifies further actions required as a consequence of the redevelopment and a recent staff travel survey.

The Trust understands how important it is to reduce the use of the private car as the common mode of travel to work; not least of all because of the harmful effects on health from vehicle emissions, but also the associated environmental impacts.

Reducing unnecessary car use will improve the experience of those who do need to travel by car because, when they do need to access the site by car because of illness, disability or other priority needs, they will find it easier to do so.

Measures already implemented such as discounted bus passes, pool cars, cycling promotions and the RSCH-PRH inter-site bus, have been extremely successful, and the Transport Bureau has been very proactive in delivering these schemes whilst also developing opportunities for future initiatives.

The Trust will continue to actively promote bus and bicycle schemes, and provide travel information to staff and patients. To enable progress to be monitored; the Trust will carry out annual staff travel surveys. We will also review how best to capture patient/visitor travel patterns.

Mode of transport	2011	2014	2015	+/-
Car (alone)	42%	29%	31%	-11%
Care share (driver)	5%	4%	3%	2%
Care share (passenger)	4%	4%	4%	1%
Bus	22%	28%	33%	11%
Walk	12%	14%	13%	1%
Motorcycle	4%	3%	1%	-2%
Train	2%	3%	3%	1%
Other	1%	0%	3%	3%
Number of responses	341	235	591	

Emergency Preparedness

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). In June 2015 the Trusts Emergency Planning, Resilience and Response Policy was approved by the board. This 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 2015/2016 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, command and control training for on call directors and managers, EPRR awareness training sessions at the Royal Alexandra Children's Hospital, for anaesthetics and ICU staff and Decontamination training in the Emergency Department. The training awareness workbook continues to be completed by members of staff and we continue to have very positive feedback following the resilience presentation at Trust induction. The end of the last financial year saw us take part in our three yearly live major incident exercise for which we were praised by Public Health England. An evaluation of this exercise in April 2015 led to a review of our Major Incident Plan.

A number of key changes were made to improve our ability to respond to a mass casualty incident and our updated plan was approved by the board in December 2015. At the end of 2015 we also reviewed of our Pandemic Flu Plan which was approved by the board in January 2016. In February 2016 BSUH took part in our yearly table top exercise. BSUH members of staff joined colleagues from health organisations across Sussex in this Sussex wide health exercise which tested our ability to respond to a major failure of our power supply.

As well as taking part in planned exercises the Emergency Planning Team has also supported the Trust's response to a number of actual critical incidents, major incidents and business continuity incidents, including two transport related major incidents and a number of days of industrial action by Junior Doctors. 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.

Research, Innovation and Teaching

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 £5.8 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 more than 300 studies running or in follow up during 2015/16. 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. We are in the process of developing strategic partnerships with the AHSN to support the delivery of trials of medical devices developed by regional SMEs and biotech companies.

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 59% of projects. We are working to improve our systems to ensure this performance continues on an upwards trend.

Seven new NIHR and other research grants were awarded to our researchers. We are hosting and leading one two EU funded programme grants in the field of Neonatal Medicine and Emerging technologies to support the treatment of HIV patients. We are also supporting 8 PhD fellowships across a range of academic disciplines. 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. 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.

Our Charities

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 2016. 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.

In addition we are working to increase the profile and income of the BSUH Charity. The BSUH charity will support fundraising for all wards and departments at BSUH, including the Royal Sussex County Hospital, the Royal Alexandra Children's Hospital, the Sussex Eye Hospital and the Princess Royal Hospital. This money can then be used to enhance the care and services provided to all BSUH patients and help us to go above and beyond what we can do with core government funding.

Patient Focus

We are committed to working in partnership with patients and members of the local community to achieve the best possible experience and outcomes for everyone who uses our services. We have a Patient Experience Panel which acts as 'critical friend'. Through this we have built a constructive working relationship with patients, carers and representatives from patient groups who are helping us to develop a more patient-centered approach to developing and improving the Trust's services. This panel has wide representation and the CEO of Brighton and Hove Healthwatch is the independent chair.

In 2015/16 patients and representatives have been involved in a patient-led wayfinding project to improve signage around our hospital; widening participation in our PLACE assessments and developing the Trust's nutrition committee.

In Autumn 2015 BSUH, with the CCG, engaged 'marginalised' communities (e.g LGBT, Learning Disabilities, Age UK, Travellers and Carers) in Brighton and Hove to undertake consultations about their experience of hospital care. The subsequent recommendations are forming action plans which involve working with representatives to ensure that the needs of all patients are met.

In April 2016 were are running the first Public Engagement Event 'Looking Forward to the Future of Your Hospital', the aim of which is to let people know about the hospital now and in the future engage with our wider populations.

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.

Friends and Family Test results 2015-16

Month	Total responses	Total eligible	Response rate	Percentage recommended	Percentage not recommended
April 2015	696	7565	9.2%	92.5%	1.9%
May 2015	773	7446	10.4%	94.2%	1.7%
June 2015	968	7976	12.1%	94.3%	1.4%
July 2015	1097	8031	13.7%	94.2%	1.8%
August 2015	1012	7434	13.6%	92.0%	2.5%
Sept 2015	1012	8013	12.6%	94.1%	1.6%
October 2015	993	8096	12.3%	94.1%	0.9%
Nov 2015	1020	7659	13.3%	93.1%	2.2%
Dec2015	534	8071	6.6%	96.6%	0.9%
January 2016	686	7757	8.8%	96.6%	1.3%
Feb 2016	854	7935	10.8%	97.7%	0.8%
March 2016	1344	8097	16.6%	99.3%	0.2%
Total	10989	95080	11.7%	94.9%	1.8%

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

Complaints

	2013-14	2014-15	2015-16
Total number of complaints	1298	1305	1036
Number of contacts to the Ombudsman	18	11	32
Ombudsman referrals upheld against the Trust	2	1	2
Ombudsman referrals partially upheld against the Trust	3	5	4

Compliments

2013-14	2014-15	2015-16
512	500	540

Our Performance

Finance

Overall

The Trust is reporting a deficit of £44.8m in 2015/16 compared with an initial planned deficit of £19.2mm and a stretch target deficit of £16.7m. The deficit position reflects operational pressures faced during the year, including spending £25.5m more on staffing than in 2014/15, and the Trust only delivering half of the planned cost efficiencies in year. The pressures are also reflected in the change in performance from 2014/15 when the adjusted retained deficit was £0.45m. The planned deficit for 2016/17 is £15.6m based on plans to improve financial performance.

Going Concern

IAS 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector the anticipated continuation of the provision of a service is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector. In preparing the financial statements the directors have considered the Trust's overall financial position and expectation of future financial support.

The Trust has submitted a financial plan for 2016/17 to NHS Improvement which delivers a £15.6m deficit assuming receipt of £14.4m of Sustainability and Transformation Funding and delivery of £24.5m savings. This support funding is conditional on the achievement of performance targets.

The financial plan also includes a requirement for cash support from the Department of Health to fund the planned deficit. The directors have received confirmation from NHS Improvement that it is reasonable to assume that sufficient cash financing will be made available from the Department of Health to the organisation over the next financial year such that the organisation is able to meet its current liabilities. On this basis it fully supports the view that the Trust's accounts are prepared on a going concern basis.

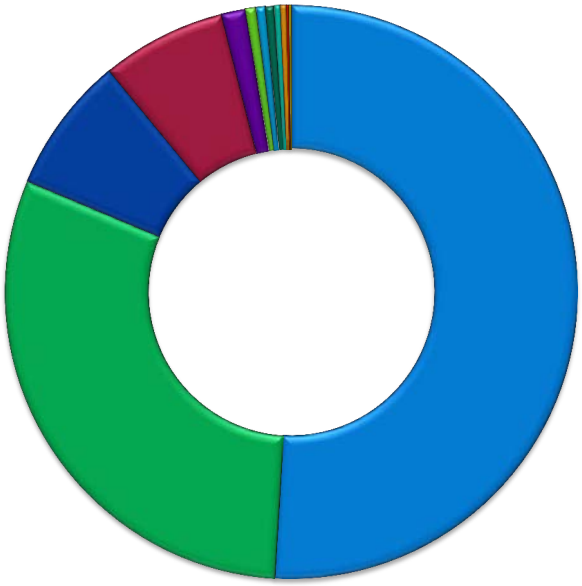
As part of the national plan for financial recovery the Trust is fully engaged with the Financial Improvement Programme and with the support of McKinsey is developing sustainable plans to address areas of overspend and to identify and deliver further efficiencies.

Income and Expenditure

The deficit of £44.8m arose from an increase in income that was more than offset by increased staffing and clinical costs. The chart on the following page shows the sources of the Trust's income. The Trust is reporting income of £529.5m in 2015/16 increased from the £520.8m reported in 2014/15. The majority of the Trust's income is for patient care services and this income grew from £457.7m to £479.5m.

Non-patient care income moved from £63.1m to £50.0m mainly caused by a reduction in education, training and research income.

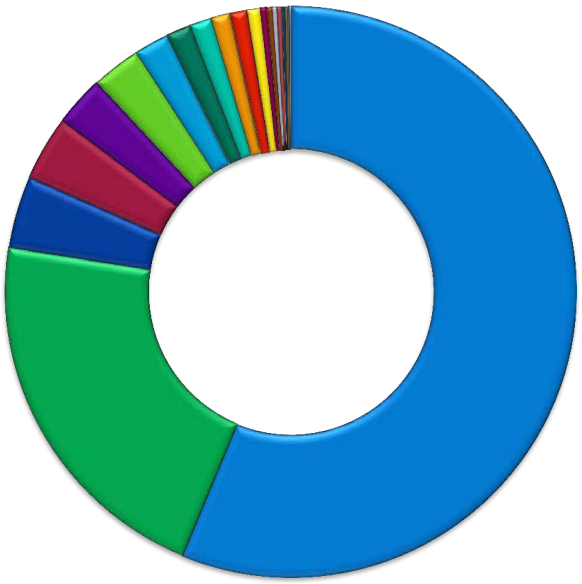
Income 2015-16



Income 2015-16	£000s
Clinical Commissioning Groups	269859
NHS England	160756
Non-NHS	40874
Education, training and research	37255
Income generation (Other fees and charges)	7185
NHS Trusts	3080
Recoveries in respect of employee benefits	2885
Foundation Trusts	2430
Non-patient care services to other bodies	1992
Department of Health	1777
NHS Other	721
Rental revenue from operating leases	575
Receipt of donations for capital acquisitions	86
Total Operating Revue	529475

Operating Expenses 2015-16

Operating Expenses 2015-16	£000s
Employee Costs	330433
Supplies and services - clinical	124955
Impairments and reversals of property, plant and equipment	23963
Depreciation	21586
Premises	16765
Clinical Negligence	16257
Supplies and services - general	11650
Services from NHS Bodies	8190
Purchase of healthcare from non-NHS bodies	7366
Impairments and Reversals of Receivables	6237
Education and Training	5599
Establishment	4396
Business rates paid to local authorities	2184
Research and development (excluding staff costs)	1887
Legal Fees	1579
Service charges - ON-SOFP PFI	1539
Transport	1059
Consultancy services	901



Insurance	445
Amortisation	154
Audit Fees	132
Internal Audit Fees	120
Trust Chair and Non-executive Directors	72
Inventories write down	45
Change in Discount Rate	-14

Total operating expenses in 2015/16 were £587.5m, an increase from £511.8m in 2014/15. The increase is mainly due to increased expenditure on clinical supplies and the impairment of fixed assets.

Efficiency

The Trust achieved efficiencies of £13.8m in 2015/16 against a target of £26.4m. Operational pressures experienced by the Trust, the same pressures that led to overspends, led to delays in the development and implementation of savings schemes.

Efficiencies 2015-16	Plan £000s	Actual £000s	Variance £000s
Bank Office and Commercial	9,534	4,735	-4,799
Clinical Workforce	3,236	2,362	-874
Education and Training	416	219	-197
Major IT Programme	151	35	-116
Medical Workforce	1,570	827	-743
Operational Estate	92	12	-80
Operational Productivity	883	151	-732
Outpatients	551	324	-227
Transformation	7,951	3,192	-4,759
Strategic Estate	0	0	0
Workforce	2,015	1,946	-69
	26,399	**13,803**	**-12,596**

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 with actual performance below this and showing deterioration compared with the prior year Delays to the receipt of payment from debtors and to receipt of funding to support the deficit position reduced the Trusts ability to pay suppliers promptly.

Measure of Compliance	2015-16	2015-16	2014-15	2014-15
	Number	£000s	Number	£000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	125,098	302,352	126,673	274,031
Total Non-NHS Trade Invoices Paid Within Target	60,235	155,943	103,308	190,281
Percentage of NHS Trade Invoices Paid Within Target	48.2%	51.6%	81.6%	69.4%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,974	49,663	2,717	42,896
Total NHS Trade Invoices Paid Within Target	919	28,884	1,837	23,326
Percentage of NHS Trade Invoices Paid Within Target	46.6%	58.2%	67.6%	54.4%

The Late Payment of Commercial Debts (Interest) Act 1998	2015-16	2014-15
	Number	£000s
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	3	0
Total	3	0

Revaluation and impairments

The revaluation led to a decrease in the value of land and buildings of £24.0m. The revaluation was triggered by the approval of the 3Ts capital scheme in December 2015 and reflects the changes in use of land and buildings with the 3Ts scheme in place.

Capital Expenditure

Additions to tangible assets in 2015/16 were £63.2m including £55.2m on Assets Under Contruction (including £33.7m on 3Ts and £8.9m on radiotherapy centre projects), £4.2m on IT equipment and £3.7m on Plant and Equipment.

Liquidity, cash and working capital

The Trust remained within its external financing limit (EFL) and its year end cash balance reduced from £25.4m to £3.3m. The deficit position creates a significant liquidity challenge for the trust and this is reflected in the worsening payment record shown above. Working capital support of £37m has been received from the Department of Health and this has helped to alleviate a significant proportion of the pressure. This support is in the form of loan funding that attracts interest at Public Works Loan Board rates and is repayable over 3 to 5 years.

Financial Outlook

The plan for 2016/17 is a deficit of £15.6m 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 2016/7 reflects the operational pressures that persisted during 2015/16 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. Pressures on funding do lead to differences of opinion on the amount of income earned by the Trust so there are risks inherent in the commissioner relationship.

Financial efficiency programme

As the Trust is faced with a rise in tariff prices that is less than the increases in pay and non-pay costs the need for a financial efficiency programme remains.

The additional financial efficiency programme for 2016/17 is £24.5m across a number of work streams covering both pay and non-pay spend and all areas of spend such as back office, clinical and medical. The focus of the programme is to improve operational efficiency with this leading to cost savings. At the beginning of the year just over half of the schemes are classified as high risk so delivery is not certain.

Capital plans and cash position

The capital plan for 2016/7 is £93.0m including £64.3m for the 3Ts project, £11.2m for Radiotherapy and £17.5m for a range of estates, IT and medical equipment projects. The cash budget that backs these projects is supported by loan funding from the Department of Health. The planned deficit is being supported by a revolving credit facility from the Department of Health 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:

- Engagement of McKinsey to support financial improvement.
- 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

2015/16 was a challenging year and these challenges will continue into 2016/17. The Trust continues to accept and seek to meet the financial targets set for it. There are significant risks to the delivery of these targets and there are actions in place that are designed to mitigate these risks.

Operational - National Standards and Waiting Times

Indicator	Standard/ Threshold	2015-16	2014-15
18w RTT - Percentage of admitted RTT pathways completed within 18 weeks	90%	67.7%	82.2%
18w RTT - Percentage of non-admitted RTT pathways completed within 18 weeks	95%	82%	89.8%
18w RTT - Percentage of incomplete pathways waiting less than 18 weeks	92%	73%	88.7%
18w RTT - Numbers of over 52 week waiters at month end	0	85	0
Diagnostic Tests waiting longer than six weeks - percentage of all waiters	1%	5.1%	0.9%
Operations cancelled on the day not re-booked within 28 days	5%	14.4%	24.7%
Number of urgent operations being cancelled for the second time	0	0	7
A&E - Percentage of patients who spent four hours or less in A&E	95%	83.3%	84.4%
A&E - Numbers of patients who have waited >12 hours in A&E from decision to admit	0	118	19
Cancer: Two week wait referral to date first seen	93%	91.3%	93.7%
Cancer: Two week wait referral to date first seen - breast symptomatic	93%	98%	97.6%
Cancer: 31 day wait from diagnosis to first treatment	96%	96.7%	97.6%
Cancer: 62 day wait for first treatment from urgent GP referral	85%	76.9%	81.4%
Cancer: 31 day wait for second or subsequent treatment - surgery	94%	94.9%	97.2%
Cancer: 31 day wait for second or subsequent treatment - chemotherapy	98%	99.9%	99.8%
Cancer: 31 day wait for second or subsequent treatment - radiotherapy	94%	97.7%	96.1%
Cancer: 62 day wait for first treatment from referral from NHS cancer screening service	90%	81.5%	89.6%
Cancer: 62 day wait for first treatment from referral following a consultant decision to upgrade	90%	89.5%	94.4%

Indicator	Standard/ Threshold	2015-16	2014-15
Emergency re-admissions within 30 days of discharge (%)	10.5%	12.7%	13.4%
Stroke: % of patients who spend > 90% of time on stroke unit	80%	85.7%	86.4%
Stroke: % admitted directly to stroke unit	90%	71.5%	72.5%
Stroke: % scanned in less than one hours of hospital arrival	50%	62.6%	68.4%
Stroke: % of patients scanned within 24 hours	100%	90.5%	96.7%
Stroke: % of high risk TIA cases treated in 24 hours	60%	87.4%	88.64%
Stroke: % of low risk TIA patients seen in seven days	100%	96.7%	96.4%
Delayed Transfers of Care (DToC)	3.5%	4.6%	4.2%
Number of falls resulting in severe injury or death	-	18	21
Number of cases of MRSA bloodstream infections	0	1	0
Number of C. Difficile infections	46	47	45
“Never Events” reported in month	0	8	5
Summary Hospital Mortality Indicator (SHMI)	100	94.65	93.1
Hospital Standardised Mortality Ratio (HSMR) - all week	100	90.67	95.46
Hospital Standardised Mortality Ratio (HSMR) - weekends	100	92.42	
Emergency Caesarean Section rate	13%	12.7%	
Percentage of completed VTE risk assessments	95%	82.6%	97.1%
Number of single sex accommodation breaches	0	2	0

Governance

We want to make sure that our patients receive the highest quality care possible and we are always working to review and improve our governance processes to ensure the maximum effectiveness of our Board and Board Committees.

Each of the Board Committees reviewed its effectiveness against its terms of reference in 2015/16. The Board also carried out an initial self-assessment against the Well-Led Framework at a Board Seminar in January 2016. A comprehensive Well-Led Review will be commissioned in 2016/17, which will also inform the changes to the Trust governance arrangements agreed by the Board in April 2016.

Accountability

The NHS Trust Development Authority (now NHS Improvement) is responsible for appointing Trust Chairs and Non-Executive Directors. The Trust appointed three new Non-Executive Directors in 2015/16.
All these appointments are subject to annual review and appraisal. The Non-Executive Directors are appraised by the Chairman and the Chairman by the TDA. The remuneration of Non-Executive Directors is determined nationally.

All substantive Executive Directors and advisors to the Board are appointed through national advertisement and appointed by the Nomination and Remuneration Committee, chaired by the Trust Chairman and comprising all Non-Executive Directors. Executive Directors are appraised annually by the Chief Executive, and the Chief Executive by the Chairman. Any changes in remuneration for Executive Directors are agreed by the Nomination and Remuneration Committee.

All members of the Board complete a Fit and Proper Person declaration on appointment, in addition to other employment checks. The Nomination and Remuneration Committee oversees this process.

The Board and its committees

The Board of Directors (voting members) comprises the Chairman, six Non-Executive Directors and five Executive Directors. In 2015/16 the Trust also appointed two Non-Executive Directors Designate, to enable succession planning.
The Trust Board discharges its responsibilities through the Board meetings, an annual public meeting and a number of Board committees.

Board meetings

The Board 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 AGM discussed Staff Stories, the monthly multi-disciplinary staff forum, where staff discuss their experiences and challenges; the Site Reconfiguration programme and the move of neurosciences to RSCH; and the development and implementation of a new model for Vascular Surgery, centred at RSCH. The Chief Executive and Chief Financial Officer then presented the Annual Report and Annual Accounts respectively.

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, People and Performance Committee against our Health and Safety Key Performance Indicators. The Finance, People Committee also receives an Annual Report measuring progress against the objectives we set ourselves for 2015/16.

Attendance at the Board of Directors and Board Committees

Name	Apr	Jun	Jul	Aug	Sep	Nov (3rd)	Nov (30th)	Dec	Jan	Feb	Mar	Possible	Actual
Chair													
Julian Lee	✓	x	✓	✓	✓	✓	✓	✓	x	✓	✓	10	8
Lewis Doyle	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10	10
Michael Edwards	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	10	9
Farine Clarke	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10	10
Kirit Patel	✓	✓	x	✓	x	✓	✓	✓	x	✓	✓	10	7
Christine Farnish	✓	x	✓	✓	✓	✓	x	x	✓	✓	x	10	6
Stephen Woodward	✓	x	✓	x								4	2
Antony Kildare	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10	10
Malcolm Reed	✓	✓	✓	✓	x	x	✓	✓				7	5
Executive Directors													
Matthew Kershaw	✓	✓	✓	✓	✓	✓	✓	✓	✓			8	8
Spencer Prosser	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	10	9
Sherree Fagge	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10	10
Steve Holmberg	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	x	10	8
Mark Smith				✓	✓	✓	✓	✓	✓	✓	✓	7	7
Amanda Fadero	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10	10

Statement of Chief Executive's Responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS Improvement 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.

Mr Matthew Kershaw was the Chief Executive and Accountable Officer until 31 December 2015. Ms Amanda Fadero was Interim Chief Executive and Accountable Officer from 1 January 2016 to 31 March 2016. Dr Gillian Fairfield became Chief Executive and Accountable Officer on 1 April 2016.

To the best of my knowledge and belief, the responsibilities of the Accountable Officers were properly discharged above during 2015-16..

Dr Gillian Fairfield
Chief Executive

May 2016

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

Dr Gillian Fairfield
Chief Executive

May 2016

Spencer Prosser
Chief Financial Officer

May 2016

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 Director of People. 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
- Ensuring compliance with Fit and Proper Person requirements

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 in Brighton and Sussex University Hospitals NHS Trust in the financial year 2015-16 was £245K-£250K (2014-15 - £245K-£250K). This was 10.4 times (2014-15 – 8.9 times) the median remuneration of the workforce, which was £23.8K (2013-14 - £27.9K). The change is as a result of the insourcing of Soft FM staff in the year.

In 2015-16 0 (2014-15 - 0) employees received remuneration in excess of the highest paid director. Remuneration ranged from £9.0K to £248K (2013-14 - £10.0K - £195K)
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 2015/16.

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 and Director of Strategy and Change was performance related.

Salary and pension entitlements of senior managers

Non-Executive Remuneration 2015-16

2015-16							
Name	Title	Salary (bands of £5000) £000	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5000) £000	Long term performance pay and bonuses (bands of £5000) £000	All pension related benefits (bands of £2500)	Total (bands of £5000) £000
Julian Lee	Chair	20-25					20-25
Malcolm Reed	Non-Executive	5-10					5-10
Lewis Doyle **	Non-Executive	5-10					5-10
Stephen Woodward **	Non-Executive (to 30th September)	0-5					0-5
Antony Kildare	Non-Executive	5-10					5-10
Christine Farnish **	Non-Executive	5-10					5-10
Farine Clarke	Non-Executive (from 1st April 2015)	5-10					5-10
Michael Edwards	Non-Executive	5-10					5-10
Kirit Patel	Non-Executive (from 1st April 2015)	5-10					5-10

** Audit Committee Member

Non-Executive Remuneration 2014-15

2014-15							
Name	Title	Salary (bands of £5000) £000	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5000) £000	Long term performance pay and bonuses (bands of £5000) £000	All pension related benefits (bands of £2500)	Total (bands of £5000) £000
Julian Lee	Chair	20-25					20-25
Malcolm Reed	Non-Executive	0-5					0-5
Lewis Doyle **	Non-Executive	5-10					5-10
Stephen Woodward **	Non-Executive (to 30th September)	5-10					5-10
Antony Kildare	Non-Executive	5-10					5-10
Christine Farnish **	Non-Executive	5-10					5-10

** Audit Committee Member

Executive Remuneration 2015-16

2015-16							
Name	Title	Salary (bands of £5000) £000	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5000) £000	Long term performance pay and bonuses (bands of £5000) £000	All pension related benefits (bands of £2500)	Total (bands of £5000) £000
Matthew Kershaw	Chief Executive (to 7th January 2016)	145-150				0-2.5	150-155
Spencer Prosser	Chief Financial Officer	155-160					155-160
Mark Smith	Chief Operating Officer (from 14th June 2015)	135-140					135-140
Sherree Fagge	Director of Nursing	115-120				30-32.5	150-155
Dr Steve Holmberg*	Medical Director	190-195		55-60			245-250
Amanda Fadero	Director of Strategy and Change - interim Chief Executive (from 24th December 2015)	165-170		5-10			170-175

* Dr Steve Holmberg was paid £182,786.52 that relates to his clinical role.

Executive Remuneration 2014-15

2014-15							
Name	Title	Salary (bands of £5000) £000	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5000) £000	Long term performance pay and bonuses (bands of £5000) £000	All pension related benefits (bands of £2500)	Total (bands of £5000) £000
Matthew Kershaw	Chief Executive (to 7th January 2016)	195-200				70-75	245-250
Spencer Prosser	Chief Financial Officer	155-160		5-10		55-60	210-215
Sherree Fagge	Director of Nursing	120-125				-0-5	115-120
Dr Steve Holmberg*	Medical Director	190-195	100	55-60			245-250
Amanda Fadero	Director of Strategy and Change - interim Chief Executive (from 24th December 2015)	85-90					85-90

* Dr Steve Holmberg was paid £182,786.52 that relates to his clinical role.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report. Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

Salary and Pension entitlements of senior managers

Pension Benefits								
Name and Title	Real increase in pension at pension age (bands of £2500) £000	Real increase in pension lump sum at pension age (bands of £2500) £000	Total accrued pension at pension age at 31 March 2016 (bands of £5000) £000	Lump sum at pension age related to acrrued pension at March 2016 (bands of £5000) £000	Cash Equivalent Transfer Value at 1 April 2015 £000	Real increase/ (decrease) in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Employers contribution to stakeholder pension To nearest £100
Matthew Kershaw	0-2.5	0-2.5	40-45	125-130	654	(4)	656	
Sherree Fagge	0-2.5	2.5-5	50-55	160-165	1108	34	1155	
Mark Smith	0-(2.5)	0-(2.5)	30-35	90-95	581	(3)	583	
Spencer Prosser *			45-50		828		828	

* Prior year figure as current year's unavailable.

Appendices

Appendix 1: Consolidated Financial Statements

Appendix 2: Annual Governance Statement

Appendix 3: Glossary of terms and acronyms

Appendix 1

Consolidated Financial Statements

Report from the Chief Financial Officer

During 2015/16 the Trust delivered a deficit of £44.8m 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 a whole. The Trust met the External Financial Limit and Capital Resource Limit statutory duties.

We received income of £529.5m of which £479.5m came from patient care and £50.0m 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 4.8%.

Operating expenditure was £587.5m with our productivity and efficiency programme delivering £13.8m 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 £63.2m including the following areas: 3Ts redevelopment £33.7m, radiotherapy £8.9m, IT equipment £4.2m and Plant and Equipment £3.7m.

BSUH acts as a Trustee for charitable funds of £10.6m. Income from donations, legacies and grants totalled £3.4m in 2015/16. During the year £3.1m 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 staff ratios, providing services seven days a week and responding to service demand.

Overall, 2015/16 was a challenging year financially with pressures continuing into 2016/17.

Spencer Prosser
Chief Financial Officer

May 2016

Statement of comprehensive income of year ended 31 March 2016

	Note	**2015-16 £000s**	2014-15 £000s	**Consolidated 2015-16 £000s**	Consolidated 2014-15 £000s
Gross employee benefits	10.1	**(330,433)**	(304,930)	**(330,840)**	(305,246)
Other operating costs	8	**(257,068)**	(206,910)	**(259,341)**	(208,464)
Revenue from patient care activities	5	**479,497**	457,703	**479,530**	457,763
Other operating revenue	6	**49,978**	63,062	**52,651**	62,890
Operating (deficit)/surplus		**(58,026)**	8,925	**(58,000)**	6,943
Investment revenue	12	**48**	75	**609**	381
Other gains	13	**75**	1,136	**(111)**	2,198
Finance costs	14	**(4,399)**	(3,566)	**(4,399)**	(3,566)
(Deficit)/surplus for the financial year		**(62,302)**	6,570	**(61,901)**	5,956
Public dividend capital dividends payable		**(7,678)**	(7,879)	**(7,678)**	(7,879)
Tax		**0**	0	**(14)**	(38)
Retained deficit for the year		**(69,980)**	(1,309)	**(69,593)**	(1,961)

Other comprehensive income					
Impairments and reversals taken to the revaluation reserve		**(3,249)**	0	**(3,249)**	0
Net gain on revaluation of property, plant and equipment		**7,306**	20,249	**7,306**	20,249
Net gain on revaluation of available for sale financial assets		**0**	522	**0**	522
Total Other Comprehensive Income		**4,057**	20,711	**4,057**	20,711
Total comprehensive income for the year*		**(65,923)**	19,462	**(65,536)**	18,810

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

Financial performance for the year		2015-16 £000s	2014-15 £000s
Retained deficit for the year		**(69,980)**	(1,309)
IFRIC 12 adjustment (including IFRIC 12 impairments)		**1,646**	0
Impairments (excluding IFRIC 12 impairments)		**22,789**	190
Adjustments in respect of donated grant asset reserve elimination		**726**	669
Adjusted retained deficit		**(44,819)**	(450)

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 chargeable for overall budgeting purposes, is reported as technical. This additional cost is not considered part of the organisation's operating position.

c) The Treasury FReM for 2011-12 changed the accounting treatment for the funding element of charitable donations so that NHS bodies no longer hold Donated Asset Reserves. Where assets are funded by donations the financing element of the transaction is recognised as income and taken through the statement of income and expenditure. The impact of the change in policy is not considered part of the organisation's operating position.

Prior year performance is not re-assessed following accounting restatements.

The notes on pages 5 to 43 form part of this account.

Statement of Financial Position as at 31 March 2016

	Note	**31 March 2016 £000s**	31 March 2016 £000s	**Consolidated 31 March 2016 £000s**	Consolidated 31 March 2016 £000s
Non-current assets					
Property, plant and equipment	15	**351,401**	329,717	**351,687**	330,059
Intangible assets	16	**758**	461	**758**	461
Other investments - charitable	17			**10,441**	10,627
Other financial assets	23	**1,101**	1,101	**0**	0
Trade and other receivables	20.1	**1,644**	1,409	**1,644**	1,409
Total non-current assets		**354,904**	332,688	**364,530**	342,556
Current assets					
Inventories	19	**7,118**	7,178	**7,692**	7,933
Trade and other receivables	20.1	**61,071**	40,827	**61,356**	39,799
Cash and cash equivalents	24	**3,344**	25,395	**4,970**	26,203
Sub-total current assets		**71,533**	73,400	**74,018**	73,935
Non-current assets held for sale	25	**63**	653	**63**	653
Total current assets		**71,596**	74,053	**74,081**	74,588
Total assets		**426,500**	406,741	**438,611**	417,144
Current liabilities					
Trade and other payables	26	**(80,634)**	(59,905)	**(81,793)**	(59,865)
Other liabilities	27	**0**	0	**0**	0
Provisions	33	**(236)**	(388)	**(236)**	(388)
Borrowings	28	**(3,146)**	(1,220)	**(3,146)**	(1,220)
DH revenue support loan	28	**(1,500)**	(3,000)	**(1,500)**	(3,000)
DH capital loan	28	**(2,969)**	(1,609)	**(2,969)**	(1,609)
Total current liabilities		**(88,485)**	(66,122)	**(89,644)**	(66,082)
Net current (liabilities)/assets		**(16,889)**	7,931	**(15,563)**	8,506
Total assets less current liablilities		**338,015**	340,619	**348,967**	351,062

	Note	31 March 2016 £000s	31 March 2016 £000s	Consolidated 31 March 2016 £000s	Consolidated 31 March 2016 £000s
Non-current liabilities					
Trade and other payables	26	**0**	(579)	**0**	(579)
Other liabilities	27	**0**	0	**0**	0
Provisions	33	**(1,786)**	(1,927)	**(1,843)**	(1,927)
Borrowings	28	**(29,761)**	(32,907)	**(29,761)**	(32,907)
DH revenue support loan	28	**(37,685)**	(1,500)	**(37,685)**	(1,500)
DH capital loan	28	**(54,807)**	(35,436)	**(54,807)**	(35,436)
Total non-current liabilities		**(124,039)**	(72,349)	**(124,096)**	(72,349)
Total assets employed		**213,976**	268,270	**224,871**	278,713
Financed by:					
Public Dividend Capital		**247,752**	236,123	**247,752**	236,123
Retained earnings		**(79,400)**	(17,866)	**(81,290)**	(19,734)
Revaluation reserve		**45,624**	50,013	**45,624**	50,013
Charitable Funds Reserve				**12,480**	12,157
Pharm@Sea Reserve				**240**	154
Total Taxpayers' Equity		**213,976**	268,270	**224,806**	278,713

The notes on pages 5 to 43 form part of this account.

The financial statements on pages 1 to 4 were approved by the Audit Committee (with delegated authority by the Board) on 26 May and signed on its behalf by:

Dr Gillian Fairfield
Chief Executive

May 2016

Statement of Changes in Taxpayers' Equity for the year ending 31 March 2016

	Public Dividend Capital £000s	Retained Earnings £000s	Revaluation Reserve £000s	Total Reserves £000s
Balance at 1 April 2015	**236,123**	**(17,866)**	**50,013**	**268,270**
Changes in taxpayers' equity for 2015-16				
Retained deficit for the year		(69,980)		**(69,980)**
Net gain on revaluation of property, plant, equipment			7,306	**7,306**
Impairments and reversals			(3,249)	**(3,249)**
Transfers between reserves		8,446	8,446	**0**
Reclassification Adjustments				
Permanent PDC received - cash	11,629			**11,629**
Net recognised revenue/(expense) for the year	**11,629**	**(61,534)**	**(4,389)**	**(54,294)**
Balance at 31 March 2016	**247,752**	**(79,400)**	**45,624**	**213,976**

Balance at 1 April 2014	**235,973**	**(18,928)**	**31,613**	**248,658**
Changes in taxpayers' equity for the year ended 31 March 2015				
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 assets held for sale			522	522
Transfers between reserves		2,371	(2,371)	0
Reclassification Adjustments				0
Permanent PDC received - cash	150			150
Net recognised revenue/(expense) for the year	**150**	**1,062**	**18,400**	**19,612**
Balance at 31 March 2015	**236,123**	**(17,866)**	**50,013**	**268,270**

Consolidated						
	Public Dividend Capital £000s	Retained Earnings £000s	Revaluation Reserve £000s	Charitable Funds Reserve £000s	Pharm@ Sea Reserve £000s	Total Reserves £000s
Balance at 1 April 2015	**236,123**	**(19,734)**	**50,013**	**12,157**	**154**	**278,713**
Changes in taxpayers' equity for 2015-16						
Retained (deficit)/surplus for the year		(69,980)		278	109	**(69,593)**
Net gain on revaluation of property, plant, equipment			7,306	0	0	**7,306**
Impairments and reversals			(3,249)			**(3,249)**
Transfers between reserves		8,446	(8,446)			**0**
Reclassification Adjustments						
Permanent PDC received - cash	11,629					**11,629**
Consolidation Adjustment		(22)		45	(23)	**0**
Net recognised revenue/ (expense) for the year	**11,629**	**(61,556)**	**(4,389)**	**323**	**86**	**(53,907)**
Balance at 31 March 2016	**247,752**	**(81,290)**	**45,624**	**12,480**	**240**	**224,806**

Balance at 1 April 2014	**235,973**	**(20,577)**	**31,613**	**12,835**	**(91)**	**259,753**
Changes in taxpayers' equity for year ended 31 March 2015						
Retained (deficit)/surplus for the year		(1,309)		(897)	245	(1,961)
Net gain on revaluation of property, plant, equipment			20,249	0	0	20,249
Net gain on revaluation of assets held for sale			522			522
Transfers between reserves		2,371	(2,371)			0
Reclassification Adjustments						
New temporary and permanent PDC received - cash	150					150
Consolidation Adjustment		(219)		219	0	0
Net recognised revenue/ (expense) for the year	**150**	**843**	**18,400**	**(678)**	**245**	**18,960**
Balance at 31 March 2015	**236,123**	**(19,734)**	**50,013**	**12,157**	**154**	**278,713**

Statement of cash flows for the year ended 31 March 2016

	Note	2015-16 £000s	2014-15 £000s	Consolidated 2015-16 £000s	Consolidated 2014-15 £000s
Cash Flows from Operating Activities					
Operating (deficit)/surplus		**(58,026)**	8,925	**(58,000)**	6,943
Depreciation and amortisation	8	**21,740**	22,736	**21,796**	22,793
Impairments and reversals		**23,963**	190	**23,963**	190
Other gains/(losses) on foreign exchange	13	**54**	(71)	**54**	(71)
Interest paid		**(4,326)**	(3,300)	**(4,326)**	(3,300)
PDC Dividend paid		**(8,504)**	(7,707)	**(8,504)**	(7,707)
Decrease/(Increase) in Inventories		**60**	(671)	**241**	(1,173)
Decrease in Trade and Other Receivables		**(25,241)**	(3,585)	**(26,541)**	(1,787)
Increase in Trade and Other Payables		**12,975**	2,839	**14,161**	2,704
Provisions utilised		**(356)**	(1,702)	**(1,702)**	(1,702)
Increase in movement in non cash provisions		**4,753**	1,254	**6,207**	1,254
Net Cash (Outflow)/Inflow from Operating Activities		**(32,908)**	18,908	**(32,651)**	18,144
Cash Flows from Investing Activities					
Interest Received		**48**	75	**48**	75
Payments for Property, Plant and Equipment		**(55,169)**	(37,305)	**(55,169)**	(37,305)
Payments for Intangible Assets		**(421)**	(207)	**(421)**	(207)
Proceeds of disposal of assets held for sale (PPE)		**575**	3,433	**575**	3,433
Rental Revenue		**0**	0	**0**	0
NHS Charitable Funds - net cash flows relating to investing activities				**561**	315
Net Cash Outflow from Investing Activities		**(54,967)**	(34,004)	**(54,406)**	(33,689)
Net Cash Outflow before Financing		**(87,875)**	(15,096)	**(87,057)**	(15,545)

	Note	2015-16 £000s	2014-15 £000s	Consolidated 2015-16 £000s	Consolidated 2014-15 £000s
Cash Flows from Financing Activities					
Gross Temporary (2014/15 only) and Permanent PDC Received		**11,629**	150	**11,629**	150
Loans received from DH - New Capital Investment Loans		**22,963**	23,730	**22,963**	23,730
Loans received from DH - New Revenue Support Loans		**45,628**	0	**45,628**	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**(2,233)**	(1,104)	**(2,233)**	(1,104)
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		**(10,943)**	(3,000)	**(10,943)**	(3,000)
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI		**(1,220)**	(1,461)	**(1,220)**	(1,461)
Net Cash Inflow from Financing Activities		**65,824**	18,315	**65,824**	18,315
Net (decrease)/increase in cash and cash equivalents		**(22,051)**	3,219	**(21,233)**	2,770
Cash and Cash Equivalents at Beginning of the Period		**25,395**	22,176	**26,203**	23,433
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	24	**3,344**	25,395	**4,970**	26,203

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 2015-16 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 Group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

IAS 1 requires management to assess, as part of the accounts preparation process, the Group's ability to continue as a going concern. In the context of non-trading entities in the public sector the anticipated continuation of the provision of a service is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Group without the transfer of its services to another entity within the public sector.

In preparing the financial statements the directors have considered the Group's overall financial position and expectation of future financial support.

The Trust has submitted a financial plan for 2016/17 to NHS Improvement which delivers a £15.6m deficit after delivery of £24.5m savings which has been agreed by the Trust Board and is embedded in the budget. The plan includes a requirement for cash support from the Department of Health to fund the planned deficit.

The directors have received confirmation that it is reasonable for the directors of Brighton and Sussex University Hospitals NHS Trust to assume that sufficient cash financing will be made available from the Department of Health to the organisation over the next 12 month period such that the organisation is able to meet its current liabilities, and on this basis fully supports the view that the Group accounts are prepared on a going concern basis.

1.2 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.

1.3 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.

1.4 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.

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, and the results of the wholly owned subsidiary, Pharm@Sea Limited, have been consolidated.

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.

1.5 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 SOCI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries."

1.6 Pooled Budgets

The Group has not entered into any pooled budget arrangements during the financial year 2015-16

1.7 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.

1.7.1 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.

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 2016 these amounted to £68.3m (2014-15 - £36.2m). The project, which has a cost of £486m, was approved by HMT in December 2015 with an expected completion date of 2024. The project is estimated to be completed in 2024. There are three phases to the build. The Group has taken the judgement that capitalised expenditure will be classified as Assets Under Construction until completion of each stage of the phases of the build, at which point the assets will be reclassified as operational buildings.

Changes in the valuation basis between cost and fair value when these reclassifications occur may result in significant changes in the carrying value of the assets.

1.7.2 Key sources of estimation uncertainty

Fully Depreciated Plant and Equipment

The Group is in the process of reviewing fully depreciated items of plant and equipment held on the capital asset register which may no longer exist. During the year £6.9m items of fully depreciated assets on the capital asset register were identified as no longer in use and/or no longer held. This value was eliminated from the cost and depreciation on the capital asset register. Based on the work undertaken the Group continues to estimate that it holds approximately £17m of fully depreciated assets of its capital asset register which no longer exist that are excluded from the financial statements.

Commissioning Income

The NHS agreement of balances exercise, which compares income and expenditure between NHS organisations, disclosed a net difference of approximately £12m between the Trust and its commissioners. The Trust entered into a risk sharing contract with the local CCGs for payment for clinical activity undertaken in the year. The contract was based on an estimate of income to the Trust and expenditure for the CCGs. The Trust has recognised income in line with the level of activity achieved, which is higher than the planned CCG expenditure. The Trust is in discussions with the CCGs about this level of income which the Trust believes is fully recoverable under the contract.

1.8 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 Group 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.

1.9 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

The majority of 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.

Past and present employees unable to join the NHS Pensions Scheme are covered by the National Employers Savings Trust ("NEST"). Nest is a defined contribution pension scheme.

1.10 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.

1.11 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.

1.12 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Group'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.

1.13 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 Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust 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	5-16
Furniture	5-15
Soft furnishings	5-15
Office and information technology equipment	5-10

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.

1.14 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.

1.15 Government grants

Government grant funded assets are capitalised at their fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.16 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 2016. An official pooling scheme is operated for the funds of the Charity.

1.17 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.

1.18 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 Group'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.

1.19 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 Group'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 Group'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.

1.20 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.

1.21 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.

1.22 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 rate of 1.5% to 0.8% in real terms (1.37% 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.

1.23 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Group 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 34.

1.24 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.

1.25 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.

1.26 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 Trust. 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.

1.27 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 Group'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.

1.28 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the Group 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 amount of the obligation under the contract, as determined in accordance with IAS 37 Provisions, Contingent Liabilities and Contingent Assets; and
- The premium received (or imputed) for entering into the guarantee less cumulative amortisation.

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 Trust'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.

1.29 Value Added Tax

Most of the activities of the Group 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.

1.30 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 deficit in the period in which they arise.

1.31 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 43 to the accounts.

1.32 Public Dividend Capital (PDC) and PDC dividend

Public Dividend Capital represents taxpayers' equity in the Trust. 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 Trust, 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.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.33 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 the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.34 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'.

1.35 Associates

Material entities over which the Trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the Trust's accounts using the equity method.

The investment is recognised initially at cost and is adjusted subsequently to reflect the Trust share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the Trust 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'

1.36 Joint arrangements

Material entities over which the 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 Trust 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.

1.37 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 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.

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

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 Revenue for Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

2. Pooled budget

The Group has not entered into any pooled budget arrangement during the financial year 2015-16.

3. Operating segments

The nature of the Trust's services is the provision of healthcare. Similar methods are used to provide services across all locations and all policies, procedures and governance arrangements are Trust wide. As an NHS Trust, all services are subject to the same regulatory environment and standards set by the Trust's external performance managers. Accordingly, the Trust operates one segment and in 2015-16 reported to the Board in this format. No discrete activities of the business have individual revenue exceeding 10% of the total combined revenue, profit or assets.

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

	2015-16 £ms	2014-15 £ms
CCG *	270	295
NHS England	163	153
	433	448

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

	2015-16 £000s	2014-15 £000s
NHS Trusts	**3,080**	2,154
NHS England	**160,756**	146,799
Clinical Commissioning Groups	**269,859**	294,277
Foundation Trusts	**2,430**	2,204
Department of Health	**1,777**	414
NHS Other (including Public Health England and Prop Co)	**721**	489
Non-NHS:		
Local Authorities	**4,419**	3,369
Private patients	**4,534**	4,284
Overseas patients (non-reciprocal)	**234**	164
Injury costs recovery	**1,663**	1,282
Other	**30,024**	2,267
Total Revenue from patient care activities	**479,497**	457,703

6. Other operating revenue

	2015-16 £000s	2014-15 £000s
Recoveries in respect of employee benefits	**2,885**	3,290
Education, training and research	**37,255**	46,429
Receipt of donations for capital acquisitions - Charity	**86**	189
Non-patient care services to other bodies	**1,992**	2,677
Income generation (Other fees and charges)	**7,185**	5,894
Rental revenue from operating leases	**575**	425
Other revenue	**0**	4,158
Total Other Operating Revenue	**49,978**	63,062
Total operating revenue	**529,475**	520,765

7. Overseas Visitors Disclosure

	2015-16 £000s	2014-15 £000s
Income recognised during 2015-16 (invoiced amounts and accruals)	**234**	164
Cash payments received in-year (re receivables at 31 March 2015)	**39**	50
Cash payments received in-year (iro invoices issued 2015-16)	**82**	83
Amounts added to provision for impairment of receivables (re receivables at 31 March 2015)	**0**	0
Amounts added to provision for impairment of receivables (iro invoices issued 2015-16)	**62**	145
Amounts written off in-year (irrespective of year of recognition)	**12**	265

8. Operating expenses

	2015-16 £000s	2014-15 £000s
Services from other NHS Trusts	**5,945**	3,787
Services from other NHS bodies	**363**	0
Services from NHS Foundation Trusts	**1,882**	2,034
Total Services from NHS bodies*	**8,190**	5,821
Purchase of healthcare from non-NHS bodies	**7,366**	6,506
Trust Chair and Non-executive Directors	**72**	66
Supplies and services - clinical	**124,955**	107,031
Supplies and services - general	**11,650**	16,956
Consultancy services	**901**	713
Establishment	**4,396**	4,490
Transport	**1,059**	1,005
Service charges - ON-SOFP PFI	**1,539**	1,449
Business rates paid to local authorities	**2,184**	2,253
Premises	**16,765**	15,709
Hospitality	**0**	10
Insurance	**445**	480
Legal Fees	**1,579**	1,143
Impairments and Reversals of Receivables	**6,237**	1,320
Inventories write down	**45**	88
Depreciation	**21,586**	22,582
Amortisation	**154**	154
Impairments and reversals of property, plant and equipment	**23,963**	(218)
Impairments and reversals of non current assets held for sale	**0**	408
Internal Audit Fees	**120**	177
Audit fees	**132**	155
Other auditor's remuneration [clinical]	**1**	0
Clinical negligence	**16,257**	10,490
Research and development (excluding staff costs)	**1,887**	2,249
Education and Training	**5,599**	5,715
Change in Discount Rate	**(14)**	129
Other	**0**	29
Total Operating expenses (excluding employee benefits)	**257,068**	206,910

Employee Benefits

Employee benefits excluding Board members	**329,447**	304,022
Board members	**986**	908
Total Employee Benefits	**330,433**	304,930
Total Operating Expenses	**587,501**	511,840

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

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	2015-16 Total £000s	2014-15 Total £000s
Payments recognised as an expense					
Minimum lease payments				**5,133**	4,830
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**5,133**	4,830
Payable:					
No later than one year	0	4,732	397	**5,129**	4,807
Between one and five years	0	9,326	33	**9,359**	8,623
After five years	0	7,994	0	**7,994**	9,820
Total	**0**	**22,052**	**430**	**22,482**	23,250
Total future sublease payments expected to be received:				0	0

The comparative figures for 2014-15 have been restated to include increases to existing service level agreements which had not been included in 2014-15.

9.2 Group as lessor

The Trust 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. The terms of these leases vary between one and fifteen years.

	2015-16 £000s	2014-15 £000s
Recognised as revenue		
Rental revenue	**575**	425
Contingent rents	**0**	0
Total	**575**	425

Receivable:		
No later than one year	**435**	323
Between one and five years	**1,313**	878
After five years	**88**	33
Total	**1,836**	1,234

10. Employee benefits and staff numbers

10.1 Employee benefits

	Total £000s	Permanently Employed £000s	Other £000s
Employee Benefits - Gross Expenditure 2015-16			
Salaries and wages	**278,910**	246,461	32,449
Social security costs	**20,652**	20,652	0
Employer Contributions to NHS BSA - Pensions Division	**31,284**	31,284	0
Other pension costs	**5**	5	0
Termination benefits	**144**	144	0
Total employee benefit	**330,995**	**298,546**	**32,449**
Employee costs capitalised	**562**	562	0
Gross Employee Benefits excluding capitalised costs	**330,433**	**297,984**	**32,449**

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 - including capitalised costs	305,785	276,288	29,497
Employee costs capitalised	855	855	0
Gross Employee Benefits excluding capitalised costs	304,930	275,433	29,497

10.2 Staff Numbers

	2015-16 Total	2015-16 Permanently Employed	2015-16 Other	2014-15 Total
Average Staff Numbers				
Medical and dental	**1,145**	1,085	60	1,085
Administration and estates	**1,593**	1,339	254	1,502
Healthcare assistants and other support staff	**624**	623	1	125
Nursing, midwifery and health visiting staff	**3,783**	3,144	639	3,504
Nursing, midwifery and health visiting learners	**38**	38	0	33
Scientific, therapeutic and technical staff	**790**	749	41	735
Social Care Staff	**0**	0	0	0
Healthcare Science Staff	**388**	388	0	381
Other	**1**	1	0	2
Total	**8,362**	7,367	995	7,367
Of the above - staff engaged on capital projects	**11**	11	0	12

10.3 Staff Sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total Days Lost	61,125	52,582
Total Staff Years	6,735	6,280
Average working Days Lost	9.08	8.37
Number of persons retired early on ill health grounds	6	4
	£000s	£000s
Total additional pensions liabilities accrued in the year	**339**	291

10.4 Exit Packages agreed in 2015-16

2015-16								
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of Departures where special payments have been made 0	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£s
Less than £10,000	0	0	0	0	**0**	**0**	0	0
£10,000-£25,000	3	54,648	0	0	**3**	**54,648**	0	0
£25,001-£50,000	1	39,596	0	0	**1**	**39,596**	0	0
£50,001-£100,000	1	69,306	0	0	**1**	**69,306**	0	0
Total	**5**	**163,550**	**0**	**0**	**5**	**163,550**	**0**	**0**
2014-15								
Less than £10,000	0	0	0	0	**0**	**0**	0	0
£10,000-£25,000	0	0	0	0	**0**	**0**	0	0
£25,001-£50,000	1	42,849	0	0	**1**	**42,849**	0	0
£50,001-£100,000	1	74,145	0	0	**1**	**74,145**	0	0
£100,001 - £150,000	0	0	0	0	**0**	**0**	0	0
£150,001 - £200,000	2	331,861	0	0	**2**	**331,861**	0	0
More than £200,000	0	0	0	0	**0**	**0**	0	0
Total	**4**	**448,855**	**0**	**0**	**4**	**448,855**	**0**	**0**

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 Group has agreed early retirements, the additional costs are met by the Group 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

	2015-16		2014-15	
	Agreements Number	Total value of agreements Number	Agreements Number	Total value of agreements Number
Voluntary redundancies including early retirement contractual costs	0	0	0	0
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	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval*	0	0	0	0
Total				
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.

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 two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are 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, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data.

In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

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 Trust compliance was 1 April 2013. For those staff not entitled to join the NHS Pension Scheme, the Trust 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 £5,832 up to £42,384, 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.

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%

Annual contribution to a NEST retirement fund is limited to £4,700 for the 2015/16 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 Trust they can continue to pay into NEST.

11. Better Payment Practice Code

11.1 Measure of compliance

	2015-16 Number	2015-16 £000s	2014-15 Number	2014-15 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**125,098**	**302,352**	126,673	274,031
Total Non-NHS Trade Invoices Paid Within Target	**60,235**	**155,943**	103,308	190,281
Percentage of NHS Trade Invoices Paid Within Target	**48.15%**	**51.58%**	81.55%	69.44%

NHS Payables				
Total NHS Trade Invoices Paid in the Year	**1,974**	**49,663**	2,717	**42,896**
Total NHS Trade Invoices Paid Within Target	**919**	**28,884**	1,837	**23,326**
Percentage of NHS Trade Invoices Paid Within Target	**46.56%**	**58.16%**	67.61%	54.38%

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

	2015-16 £000s	2014-15 £000s
Amounts included in finance costs from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**3**	0
Total	**3**	0

12. Investment Revenue

	2015-16 £000s	2014-15 £000s
Interest revenue		
Bank interest	**48**	75
Other loans and receivables	**0**	0
Impaired financial assets	**0**	0
Other financial assets	**0**	0
Total investment revenue	**48**	75

13. Other Gains and Losses

	2015-16 £000s	2014-15 £000s
Loss on disposal of assets other than by sale (PPE)	**(74)**	0
Gain on disposal of assets held for sale	**95**	1,207
Gain/(loss) on foreign exchange	**54**	(71)
Total	**75**	1,136

14. Finance Costs

	2015-16 £000s	2014-15 £000s
Interest		
Interest on loans and overdrafts	**1,811**	743
Interest on obligations under PFI contracts:		
- main finance cost	**1,844**	1,921
- contingent finance cost	**669**	635
Interest on late payment of commercial debt	**0**	0
Total interest expense	**4,324**	3,299
Other finance costs	**2**	1
Provisions - unwinding of discount	**73**	266
Total	**4,399**	3,566

15.1 Property, plant and equipment

	Land £000s	Buildings excluding dwellings £000s	Dwellings £000s	Assets under construction and payments on account £000s
2015-16				
Cost or valuation: at 1st April 2015	30,998	206,945	345	49,910
Additions of Assets Under Construction				55,193
Additions Purchased	0	0	0	
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0
Additions - Purchases from Cash Donations & Government Grants	0	0	0	86
Additions Leased (including PFI/LIFT)	0	0	0	
Reclassifications	0	7,478	0	(7,478)
Reclassifications as Held for Sale and reversals	77	0	143	0
Disposals other than for sale	0	0	0	0
Upward revaluation/positive indexation	1,102	(2,346)	56	0
Impairment/reversals charged to operating expenses	(578)	(23,394)	0	9
Impairments/reversals charged to reserves	(3,249)	0	0	0
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0
At 31 March 2016	**28,350**	**188,683**	**544**	**97,720**
Depreciation at 1st April 2015	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	
Upward revaluation/positive indexation	0	(8,476)	(18)	
Impairment/reversals charged to reserves	0	0	0	
Impairments/reversals charged to operating expenses	0	0	0	
Charged During the Year	0	8,476	18	
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	
At 31 March 2016	**0**	**0**	**0**	**0**
Net Book Value at 31 March 2016	**28,350**	**188,683**	**544**	**97,720**

Plant and machinery £000s	Transport equipment £000s	Information technology £000s	Furniture and fittings £000s	Total £000s
89,712	236	35,472	4,317	**417,935**
			0	**55,193**
3,718	0	4,173	0	**7,891**
0	0	0	0	**0**
0	0	0	0	**86**
0	0	0	0	**0**
0	0	0	0	**0**
0	0	0	0	**220**
(5,004)	(19)	(6,560)	0	**(11,583)**
0	0	0	0	**(1,188)**
0	0	0	0	**(23,963)**
0	0	0	0	**(3,249)**
0	0	0	0	**0**
0	0	0	0	**0**
88,426	**217**	**33,085**	**4,317**	**441,342**
60,114	232	24,062	3,810	**88,218**
0	0	30	0	**30**
0	0	0	0	**0**
(4,837)	(16)	(6,546)	0	**(11,399)**
0	0	0	0	**(8,494)**
0	0	0	0	**0**
0	0	0	0	**0**
9,704	1	3,178	209	**21,586**
0	0	0	0	**0**
0	0	0	0	**0**
64,981	**217**	**20,724**	**4,019**	**89,941**
23,445	**0**	**12,361**	**298**	**351,401**

	Land £000s	Buildings excluding dwellings £000s	Dwellings £000s	Assets under construction and payments on account £000s
2015-16				
Asset financing:				
Owned - Purchased	28,250	153,312	544	97,645
Owned - Donated	100	1,039	0	75
Owned - Government Granted	0	0	0	0
Held on finance lease	0	0	0	0
On-SOFP PFI contracts	0	34,332	0	0
PFI residual: interests	0	0	0	0
Total at 31 March 2016	**28,350**	**188,683**	**544**	**97,720**

Revaluation Reserve Balance for Property, Plant and Equipment

	Land £000s	Buildings excluding dwellings £000s	Dwellings £000s	Assets under construction and payments on account £000s
At 1 April 2015	7,757	41,270	64	0
Movements - in year revaluation	(2,126)	(2,134)	105	0
At 31 March 2016	**5,631**	**39,136**	**169**	**0**

Additions to Assets Under Construction in 2015-16	
Land	0
Buildings excl Dwellings	51,574
Dwellings	0
Plant & Machinery	3,619
Balance as at YTD	**55,193**

Plant and machinery £000s	Transport equipment £000s	Information technology £000s	Furniture and fittings £000s	Total £000s
22,418	0	12,302	298	**314,769**
1,027	0	59	0	**2,300**
0	0	0	0	**0**
0	0	0	0	**0**
0	0	0	0	**34,332**
0	0	0	0	**0**
23,445	**0**	**12,361**	**298**	**351,401**

Plant and machinery £000s	Transport equipment £000s	Information technology £000s	Furniture and fittings £000s	Total £000s
660	0	0	0	**49,751**
0	0	0	0	**(4,155)**
660	**0**	**0**	**0**	**45,596**

15.2 Property, plant and equipment prior-year

	Land £000s	Buildings excluding dwellings £000s	Dwellings £000s	Assets under construction and payments on account £000s
2014-15				
Cost or valuation: at 1st April 2015	28,481	188,505	325	28,013
Additions of Assets Under Construction				30,260
Additions Purchased	0	0	0	
Additions - Purchases from Cash Donations & Government Grants	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
Revaluation	2,517	17,700	32	0
Impairments/negative indexation charged to reserves	0	0	0	0
Reversal of Impairments charged to reserves	0	0	0	0
At 31 March 2015	**30,998**	**214,757**	**357**	**49,910**
Depreciation at 1st April 2014	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	0	4,492	0	0
Reversal of Impairments charged to operating expenses	0	(4,697)	0	0
Charged During the Year	0	8,017	12	
At 31 March 2016	**0**	**7,812**	**12**	**0**
Net Book Value at 31 March 2016	**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 and machinery £000s	Transport equipment £000s	Information technology £000s	Furniture and fittings £000s	Total £000s
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**

The Group undertakes a full estates revaluation annually. This year an initial valuation was carried out on 2 December 2015 following the approval of the major 3Ts development and a second valuation at the year end on 31 March 2016 by the external valuers GERALD EVE. 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 an optimal site 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 GERALD EVE's valuation. The lives range from 1 year to 80 years. The estimated remaining lives of the other assets are as follows:

	Years
Medical equipment and engineering plant and equipment	1-16
Furniture	1-5
Soft furnishings	1-5
Office and information technology equipment	1-9

The Group has fully depreciated assets with a gross book value of £18.2m that are still in use and remain on the capital asset register.

16. Intangible non-current assets

16.1 Intangible non-current assets

2015-16	IT - in-house and 3rd party software £000s	Computer Licenses £000s	Licenses and Trademarks £000s	Patents £000s	Development Expenditure - Internally Generated £000s	Total £000s
At 1 April 2015	**645**	**679**	**0**	**0**	**0**	**1,324**
Additions Purchased	421	0	0	0	0	**421**
Disposals other than by sale	(86)	0	0	0	0	**(86)**
At 31 March 2016	**980**	**679**	**0**	**0**	**0**	**1,659**
Amortisation						
At 1 April 2015	**286**	**577**	**0**	**0**	**0**	**863**
Reclassifications	(30)	0	0	0	0	**(30)**
Disposals other than by sale	(86)	0	0	0	0	**(86)**
Charged During the Year	92	62	0	0	0	**154**
At 31 March 2016	**262**	**639**	**0**	**0**	**0**	**901**
Net Book Value at 31 March 2016	**718**	**40**	**0**	**0**	**0**	**758**
Asset Financing: Net book value at 31 March 2016 comprises:						
Purchased	718	40	0	0	0	**758**
Donated	0	0	0	0	0	**0**
Total at 31 March 2016	**718**	**40**	**0**	**0**	**0**	**758**
Revaluation reserve balance for intangible non-current assets						
At 1 April 2015	0	0	0	0	0	**0**
Movements (specify)	0	0	0	0	0	**0**
At 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**

16. Intangible non-current assets prior year

2014-15	IT - in-house and 3rd party software £000s	Computer Licenses £000s	Licenses and Trademarks £000s	Patents £000s	Development Expenditure - Internally Generated £000s	Total £000s
Cost or valuation:						
At 1 April 2014	443	674	0	0	0	1,117
Additions - purchased	202	5	0	0	0	207
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
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

16.3 Intangible non-current assets

The estimated remaining lives of the other intangible non-current assets ranges from 5 to 10 years.

The Trust has fully depreciated assets with a gross book value of £338,351 that are still in use and remain on the capital asset register.

Analysis of impairments and reversals recognised in 2015-16

	Property Plant and Equipment £000s	Intangible Assets £000s	Financial Assets £000s	Non-Current Assets Held for Sale £000s	Total £000s
Impairments and reversals taken to SoCI	0	0	0	0	**0**
Loss or damage resulting from normal operations	0	0	0	0	**0**
Over-specification of assets	0	0	0	0	**0**
Abandonment of assets in the course of construction	0	0	0	0	**0**
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**	**0**	**0**
Unforeseen obsolescence	0	0	0	0	**0**
Loss as a result of catastrophe	0	0	0	0	**0**
Other	0	0	0	0	**0**
Changes in market price	23,963	0	0	0	**23,963**
Total charged to Annually Managed Expenditure	**23,963**	**0**	**0**	**0**	**23,963**
Total Impairments of Property, Plant and Equipment changed to SoCI	**23,963**	**0**	**0**	**0**	**23,963**
Donated and Gov Granted Assets, included above					
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL					**19**
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL					**0**

The impairments resulting from the revaluation exercises at the end November 2015 and the end of March 2016 were spread across the whole estate. The largest impairments related to the Royal Sussex County Hospital site as follows:

	£000s
Barry Building	3,743
Cancer Centre	2,980
Millenium Block	2,291
Tower Block	5,543

17. Other Investments - Charitable

Not relevant for trust

18. Commitments

18.1 Capital commitments

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

	31 March 2016 £000s	31 March 2015 £000s
Property, plant and equipment	**318,806**	29,493
Intangible assets	**0**	0
Total	**318,806**	29,493

18.2. Other financial commitments

The Group has not entered into any other non-cancellable contracts (2014-15 £nil).

	31 March 2016 £000s	31 March 2015 £000s
Not later than one year	**0**	0
Later than one year and not later than five year	**0**	0
Later than five years	**0**	0
Total	**0**	0

19. Inventories

	Drugs £000s	Consumables £000s	Loan Equipment £000s	Other £000s	Total £000s	Of which held at NRV £000s
Balance at 1 April 2015	**1,640**	**5,538**	**0**	**0**	**7,178**	0
Additions	64,749	37,084	0	0	**101,833**	0
Inventories recognised as an expense in the period	(64,609)	(37,239)	0	0	**(101,848)**	0
Write-down of inventories (including losses)	(45)	0	0	0	**(45)**	0
Reversal of write-down previously taken to SOCI	0	0	0	0	**0**	0
Balance at 31 March 2016	**1,735**	**5,383**	**0**	**0**	**7,118**	**0**

20.1 Trade and other receivables

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	31 March 2016 £000s	31 March 2015 £000s
NHS receivables - revenue	**22,344**	21,705	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**29,354**	5,887	**0**	0
Non-NHS receivables - revenue	**5,073**	5,778	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**8,001**	8,171	**1,644**	1,409
PDC Dividend prepaid to DH	**559**	0		
Provision for the impairment of receivables	**(7,954)**	(3,205)	**0**	0
VAT	**1,661**	1,292	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**2,033**	1,199	**0**	0
Total	**61,071**	40,827	**1,644**	1,409
Total current and non current	**62,715**	42,236		
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.

20.2 Receivables past their due date but not impaired

	31 March 2016 £000s	31 March 2015 £000s
By up to three months	**3,519**	3,272
By three to six months	**1,308**	662
By more than six months	**2,863**	5,543
Total	**7,690**	9,477

20.3 Provision for impairment of receivables

	31 March 2016 £000s	31 March 2015 £000s
Balance at 1 April 2015	**(3,205)**	(2,080)
Amount written off during the year	**1,488**	195
Amount recovered during the year	**119**	0
(Increase)/decrease in receivables impaired	**(6,356)**	(1,320)
Balance at 31 March 2016	**(7,954)**	(3,205)

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.

21. NHS LIFT investments

Not relevant for Trust

22. Other Financial Assets - Non Current

	31 March 2016 £000s	31 March 2015 £000s
Opening balance 1 April	**1,101**	1,101
Additions	**0**	0
Total Other Financial Assets - Non Current	**1,101**	1,101

23. Other current assets

	31 March 2016 £000s	31 March 2015 £000s
EU Emissions Trading Scheme Allowance	**0**	0
Other Assets	**0**	0
Total	**0**	0

24. Cash and Cash Equivalents

	31 March 2016 £000s	31 March 2015 £000s
Opening balance	**25,395**	22,176
Net change in year	**(22,051)**	3,219
Closing balance	**3,344**	25,395
Made up of		
Cash with Government Banking Service	**3,321**	25,385
Cash in hand	**23**	10
Liquid deposits with NLF	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of cash flows	**3,344**	25,395
Third Party Assets - Bank balance (not included above)	**1**	0
Third Party Assets - Monies on deposit	0	0

25. Non-current assets held for sale

	Land £000s	Buildings, Excluding Dwellings £000s	Dwellings £000s	Total £000s
Balance at 1 April 2015	134	0	519	**653**
Plus assets classified as held for sale in the year	0	0	0	**0**
Less assets sold in the year	(48)	0	(322)	**(370)**
Less impairment of assets held for sale	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	(77)	0	(143)	**(220)**
Balance at 31 March 2016	**9**	**0**	**54**	**63**
Liabilities associated with assets held for sale at 31 March 2016	**0**	**0**	**0**	**0**
Balance at 1 April 2014	486	0	2,279	**2,765**
Less assets sold in the year	(374)	0	(1,852)	**(2,226)**
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**

The assets held for sale represent the remaining dwellings and buildings that were placed on the market as part of the Estates rationalisation strategy. One of the dwellings has ben taken off the market and transferred back to Dwellings; the remaining property is under offer.

The profit on sale of assets held for sale during the year was £95,000.

26. Trade and other payables

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	31 March 2016 £000s	31 March 2015 £000s
NHS payables - revenue	**2,897**	2,565	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**13,278**	10,393	**0**	0
Non-NHS payables - revenue	**23,100**	13,435	**0**	0
Non-NHS payables - capital	**9,087**	1,086	**0**	0
Non-NHS accruals and deferred income	**20,444**	21,797	**0**	579
Social security costs	**7,701**	7,060		
PDC Dividend payable to DH	**0**	267		
Accrued Interest on DH Loans	**220**			
VAT	**0**	0	**0**	0
Tax	**3,363**	3,264		
Payments received on account	**0**	0	**0**	0
Other	**544**	38	**0**	0
Total	**80,634**	59,905	**0**	579
Total payables (current and non-current)	**80,634**	**60,484**		
Included above:				
outstanding Pension Contributions at the year end	**4,453**	4,068		

27. Other liabilities

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	31 March 2016 £000s	31 March 2015 £000s
PFI/LIFT deferred credit	**0**	0	**0**	0
Lease incentives	**0**	0	**0**	0
Other [specify]	**0**	0	**0**	0
Total	**0**	0	**0**	0
Total other liabilities (current and non-current)	**0**	**0**		

28. Borrowings

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	31 March 2016 £000s	31 March 2015 £000s
Loans from Department of Health	**4,469**	4,609	**92,492**	36,936
PFI liabilities:				
Main liability	**3,146**	1,220	**29,761**	32,907
Total	**7,615**	**5,829**	**122,253**	**69,843**
Total Borrowings (current and non-current)	**129,868**	**75,672**		

Borrowings / Loans - repayment of principal falling due in:			
	DH £000s	31 March 2016 Other £000s	Total £000s
0-1 Years	4,469	1,542	**6,011**
1 - 2 Years	3,288	1,492	**4,780**
2 - 5 Years	47,869	3,744	**51,613**
Over 5 Years	41,335	26,129	**67,464**
Total	**96,961**	**32,907**	**129,868**

29. Other financial liabilities

Not relevant for Trust

30. Deferred income

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	31 March 2016 £000s	31 March 2015 £000s
Opening balance at 1 April 2015	**9,061**	3,497	**579**	867
Deferred revenue addition	**15,906**	9,918	**0**	579
Transfer of deferred revenue	**(17,095)**	(4,354)	**-579**	(867)
Current deferred Income at 31 March 2016	**7,872**	9,061	**0**	579
Total deferred income (current and non-current)	**7,872**	9,640		

31. Finance lease obligations as lessee

Not relevant for the Group.

32. Finance lease receivables as lessor

Not relevant for the Group.

33. Provisions

Comprising:

	Total £000s	Early Departure Costs £000s	Legal Claims £000s	Equal Pay (incl. Agenda for Change) £000s	Other £000s	Redundancy £000s
Balance at 1 April 2015	**2,315**	1,855	460	0	0	0
Arising during the year	**41**	0	41	0	0	0
Utilised during the year	**(356)**	(93)	(263)	0	0	0
Reversed unused	**(37)**	0	(37)	0	0	0
Unwinding of discount	**73**	73	0	0	0	0
Change in discount rate	**(14)**	(14)	0	0	0	0
Balance at 31 March 2016	**2,022**	**1,821**	**201**	**0**	**0**	**0**
Expected Timing of Cash Flows:						
No Later than One Year	**236**	98	138	0	0	0
Later than One Year and not later than Five Years	**440**	377	63	0	0	0
Later than Five Years	**1,346**	1,346	0	0	0	0
Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:						
As at 31 March 2016	236,470					
As at 31 March 2015	129,985					

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 Group 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.

34. Contingencies

	31 March 2016 £000s	31 March 2015 £000s
Contingent liabilities	**0**	0
NHS Litigation Authority legal claims	**-107**	0
Employment Tribunal and other employee related litigation	**0**	0
Redundancy	**0**	0
Other	**0**	0
Net value of contingent liabilities	**0**	0
Contingent assets		
Contingent assets	**0**	0
Net value of contingent assets	**0**	0

35. PFI - additional information

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

	2015-16 £000s	2014-15 £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**	0
Service element of on SOFP PFI charged to operating expenses in year	**1,539**	1,449
Total	**1,539**	1,449
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	**896**	874
Later than One Year, No Later than Five Years	**3,814**	3,721
Later than Five Years	**15,651**	16,640
Total	**20,361**	21,235
Imputed "finance lease" obligations for on SOFP PFI contracts due		
No Later than One Year	**3,316**	3,064
Later than One Year, No Later than Five Years	**11,631**	11,584
Later than Five Years	**36,619**	39,981
Subtotal	**51,566**	54,629
Less: Interest Element	**(18,659)**	(20,502)
Total	**32,907**	34,127

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due		
Analysed by when PFI payments are due		
No Later than One Year	**3,146**	2,546
Later than One Year, No Later than Five Years	**9,667**	8,868
Later than Five Years	**20,094**	22,713
Total	**32,907**	34,127
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
Number of off SOFP PFI Contracts		
Total Number of off PFI contracts	**0**	0
Number of off PFI contracts which individually have a total commitments value in excess of £500m	**0**	0

36. Impact of IFRS treatment - current year

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

	2015-16		2014-15	
	Income £000s	Expenditure £000s	Income £000s	Expenditure £000s
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (PFI)				
Depreciation charges		883		800
Interest Expense		1,844		2,559
Impairment charge - AME		1,174		0
Impairment charge - DEL		0		0
Other Expenditure		2,208		1,146
Revenue Receivable from subleasing	**0**		**0**	
Impact on PDC dividend payable		69		(76)
Total IFRS Expenditure (IFRIC12)	**0**	**6,033**	**0**	**4,429**
Revenue consequences of PFI schemes under UK GAAP / ESA95 (net of any sublease revenue)		4,532		4,452
Net IFRS change (IFRIC12)		**1,501**		**(23)**
Capital Consequences of IFRS : PFI and other items under IFRIC12				
Capital expenditure 2015-16		**0**		0
UK GAAP capital expenditure 2015-16 (Reversionary Interest)		**740**		714

	2015-16 Expenditure £000s	2015-16 Expenditure £000s		
Revenue costs of IFRS12 compared with ESA10				
Depreciation charges	**883**			
Interest Expense	**1,844**			
Impairment charge - AME	**1,174**			
Impairment charge - DEL	**0**			
Other Expenditure				
Service Charge	**851**	4,532		
Contingent Rent	**669**			
Lifecycle	**688**			
Impact on PDC Dividend Payable	**69**			
Total Revenue Cost under IFRIC12 vs ESA10	**6,178**	**4,532**		
Revenue Receivable from subleasing	**0**	**0**		
Net Revenue Cost under IFRIC12 vs ESA10	**6,178**	**4,532**		

37. Financial Instruments

37.1 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. The 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 Trust Development Agency. 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 2016 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 Clincal Commissioning Groups and NHS England, 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.

37.2 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		22,489		**22,489**
Receivables - non-NHS		798		**798**
Cash at bank and in hand		3,344		**3,344**
Other financial assets	1,100	0	0	**1,100**
Total at 31 March 2016	**1,100**	**26,631**	**0**	**27,731**

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**

37.3 Financial Liabilities

	At 'fair value through profit and loss' £000s	Other £000s	Total £000s
Embedded derivatives	0		**0**
NHS payables		2,883	**2,883**
Non-NHS payables		32,391	**32,391**
Other borrowings		75,345	**75,345**
PFI & finance lease obligations		20,095	**20,095**
Other financial liabilities	0	0	**0**
Total at 31 March 2016	**0**	**130,714**	**130,714**
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

38. Events after the end of the reporting period

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

39. Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £	Receipts from Related Party £	Amounts owed to Related Party £	Amounts due from Related Party £
Julian Lee • Director of the Parole Board, General Medical Council				
Amanda Fadero • Trustee of Nelson Trust				
Malcolm Reed • Dean University of Sussex • Director Malcolm Reed Surgical Ltd	3,475,942	271,104	810,656	179,775
Antony Kildare • Director of Aquaterra Leisure and Leisure Services Ltd				
Stephen Holmberg • Trustee British Cardiovascular Society				
• Trustee of Sussex Heart Charity		69,327		20,692
Christine Farnish • Non Executive Director OFGEM and OFWAT • Chairman of P2PFA and Strategic Advisor to AXA				
Lewis Doyle • Board Advisor to Ize • Trustee for Southern Housing Groups Pension Fund • Director of Sea Colours Ltd • Southdowns National Park Standards Committee				
Stephen Woodford • Director of Frees Family Finance Ltd • Director of Woodford Management Consultancy • Director of Vintage Tack Room Ltd				
Farine Clarke • Non Executive Director od Procare Ltd • Director of Clarke Davies Ltd				

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
Herts Valleys CCG
Public Health England
High Weald Lewes & Haven CCG
Health Education England
Horsham & Mid Sussex CCG
NHS Blood & Transplant
Queen Victoria Hospital NHS FT
NHS Litigation Authority
Royal Surrey County NHS FT
Brighton & Hove CCG
South East Coast Ambulance NHS FT
Coastal West Sussex CCG
South Eastern Hampshire CCG
Crawley CCG
Surrey Downs CCG
East Surrey CCG
Surrey & Sussex Healthcare NHS Trust
East Sussex Healthcare NHS Trust
Sussex Community NHS Trust
Eastbourne Hailsham & Seaford CCG
Sussex Partnership NHS FT
Frimley Park Hospitals NHS FT
West Kent CCG
Guys & St Thomas NHS Trust
Western Sussex Hospitals NHS FT
Hastings and Rother CCG

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.

40. Losses and special payments

The total number of losses cases in 2015-16 and their total value was as follows:

	Total value of Cases £s	Total Number of Cases
Losses	11,760	4
Special payments	26,509	94
Total losses and special payments	38,269	98

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 (Note: PY not linked to FMAs)
Special payments	24,369	100
Total losses and special payments	371,761	328

There were no cases exceeding £300,000

41. 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.

41.1 Breakeven performance

	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s
Turnover	326,320	352,694	398,447	415,950	439,750
Retained surplus/(deficit) for the year	(5,278)	106	9,925	4,603	(11,860)
Adjustment for:					
Timing/non-cash impacting distortions:					
Pre FDL(97)24 agreements	0	0	0	0	0
2007/08 PPA (relating to 1997/98 to 2006/07)	0				
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0			
Adjustments for impairments			1,161	5,414	15,972
Adjustments for impact of policy change re donated/government grants assets					
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*				210	400
Absorption accounting adjustment					
Other agreed adjustments	0	0	0	0	0
Break-even in-year position	**(5,278)**	**106**	**11,086**	**10,227**	**4,512**
Break-even cumulative position	**(29,026)**	**(28,920)**	**(17,834)**	**(7,607)**	**(3,095)**

2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s
574,218	606,074	558,555	520,765	**529,475**
(16,245)	(22)	(9,572)	(1,309)	**(69,980)**
0	0	0	0	**0**
16,022	3,213	14,272	190	**23,963**
469	134	414	669	**726**
(204)	0	0	0	**472**
	0	0	0	**0**
0	0	0	0	**0**
42	**3,325**	**5,114**	**(450)**	**(44,819)**
(3,053)	**272**	**5,386**	**4,936**	**(39,883)**

* 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.

	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %
Materiality test (I.e. is it equal to or less than 0.5%):					
Break-even in-year position as a percentage of turnover	-1.62	0.03	2.78	2.46	1.03
Break-even cumulative position as a percentage of turnover	-8.89	-8.20	-4.48	-1.83	-0.70

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.

41.2 Capital cost absorption rate

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

41.3 External financing

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

	31 March 2016 £000s	31 March 2015 £000s
External financing limit (EFL)	**88,060**	22,856
Cash flow financing	**87,875**	15,096
Finance leases taken out in the year	**0**	0
Other capital receipts	**0**	0
External financing requirement	**87,875**	15,096
Under/(over) spend against EFL	**185**	**7,760**

2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %
0.01	0.55	0.92	-0.09	**-8.46**
-0.53	0.04	0.96	0.95	**-7.53**

41.4 Capital resource limit

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

	31 March 2016 £000s	31 March 2015 £000s
Gross capital expenditure	**63,591**	33,533
Less: book value of assets disposed of	**(554)**	(2,226)
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(86)**	(189)
Charge against the capital resource limit	**62,951**	31,118
Capital resource limit	**67,516**	32,558
(Over)/underspend against the capital resource limit	**4,565**	1,440

42. 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 2016 £000s	31 March 2015 £000s
Patients monies held by the Group	**1**	0

Appendix 2

Annual Governance Statement

Scope of responsibility

This Annual Governance Statement covers the year 2015/16. Mr Matthew Kershaw was the Chief Executive and Accountable Officer up until 31 December 2015. Ms Amanda Fadero was Interim Chief Executive and Accountable Officer from 1 January 2016 to 31 March 2016. Dr Gillian Fairfield became Chief Executive and Accountable Officer on 1 April 2016.

The Accountable Officer is responsible 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 they are personally responsible, in accordance with the responsibilities assigned to them. The Accountable Officer is 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 2016 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Chief Executive is accountable for the overall risk management activity within the Trust. In discharging these responsibilities the Chief Executive has 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 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 People 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 Chief Operating Officer for managing the Trust's risks relating to operational performance

- the Chief Financial Officer who had delegated responsibility 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, which were reviewed and re-approved by the Board of Directors in July 2015, 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, which are consistent with Monitor's NHS Foundation Trust Code of Governance, 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 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 2015/16 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 2016.

- Quality and Risk Committee

The Quality and Risk Committee has delegated authority to assure the ongoing development and delivery of the Trust's Safety, Quality and Patient Experience 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, People and Performance Committee

The Finance, People and Performance 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 Committee has also overseen Trust performance as described in the Board performance dashboard since September 2015.

The Chair of the Finance and People 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; and for monitoring any off-payroll and interim remuneration and compliance with Her Majesty's Treasury requirements.

- 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 of Directors Membership

Executive Directors

The Chief Executive of the Trust, was Matthew Kershaw, until January 2016, when Amanda Fadero was appointed interim Chief Executive. Mark Smith was appointed as Chief Operating Officer in July 2015.

Non-Executive Directors

Michael Edwards, Kirit Patel and Farine Clarke were appointed as Non-Executive Directors from April 2015.

Board and Board Committee Reviews of Effectiveness

Well-Led Assessment

The Board carried out an initial self-assessment of its effectiveness against the Well-Led Framework at a Board Seminar in January 2016. A further comprehensive Well-Led review will be commissioned in 2016/17.

Corporate Governance Code

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 and terms of reference in March 2016, having completed the Audit Committee handbook self-assessment. The Trust re-tendered for its internal audit service, and a new internal audit provider commenced in 2015/16.

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

Finance, People and Performance Committee

The Finance, People and Performance Committee assumed responsibility for Performance in September 2015.

The Committee reviewed its effectiveness and terms of reference in March 2016, having completed a Committee self-assessment.

Quality and Risk Committee

The Quality and Risk Committee completed a Committee self-assessment in March 2016, following which its terms of reference will be reviewed.

Charitable Funds Committee

The Committee is overseeing the strategic development of the BSUH Charity, with the initial scoping work reporting to the Board in April 2015. A SWOT analysis and short, medium and long-term plan for the development of the Charity was reported to the Committee in January 2016, with a focus on the development of the functions of the Charity and a structured and planned approach to Charity expenditure.

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.

The risks identified by the Clinical Directorates are reviewed every quarter through the quarterly Directorate reviews.

The Executive Management Team, which meets weekly, 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 has further developed the Trust quality governance arrangements, with the Medical Director and Chief Nurse, and who manages the Trust Safety and Quality Team.

The Board approved a Safety, Quality and Patient Experience Strategy in June 2015.

Never Events

Seven Never Events have been reported in 2015/16, all concerning Theatres. The Quality and Risk Committee received reports on the actions and learning from the investigation of these Never Events at its meetings in November 2015 and February 2016.

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.

The Trust has sought to improve learning from Serious Incidents 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 2014/15 was published in June 2015, following approval by the Board of Directors.

In developing the Quality Account 2015/16, quality improvement priorities for 2016/17 have been identified following discussion in the Trust and with Commissioner and patient representatives. The Quality Account will be considered by the Quality and Risk Committee prior to submission to the Board for approval in June 2016.

Care Quality Commission (CQC) Registration

The Care Quality Commission (CQC) conducted an announced inspection of the Trust in June 2015 which focused on urgent and emergency services.

The Trust was rated inadequate both for safety and well-led in relation to urgent and emergency services in the report published in September 2015.

An action plan has been developed responding to the findings of the report. Progress was assessed in the further comprehensive CQC inspection which took place between 5th and 8th April 2016. At the time of this report, the outcome of this inspection was not known. However CQC has indicated that this will involve regulatory action and for the purposes of this statement, may identify further issues of compliance.

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. This policy was revised and re-approved in March 2016.

Statutory compliance

Arrangements are in place for the discharge of the Trust statutory functions, following a comprehensive review of those functions and their 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 Directorate Safety and Quality Meeting, Executive Management Team, Executive Safety and Quality Committee, Quality and Risk, Finance and People 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, People and Performance Committee (Financial, Performance and Workforce Risks). The Audit Committee monitors the BAF process overall. The Board reviewed and redefined its key strategic risks at a Board Seminar in February 2015. 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 2016, 9 risks were identified with a net severity of 16+.

Risk	Risk Owner	Risk Rating
Failure to deliver the required changes in capacity to support achievement of key access targets, quality of care, patient and staff experience	Chief Executive	16
Non-compliance with regulatory standards and statutory duties leading to regulatory or enforcement action	Chief Nurse and Medical Director	20
Adverse outcomes and experience for patients arising from poor patient flow	Chief Nurse and Medical Director	20
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 and Medical Director	20
Inadequacy of whistle-blowing arrangements inhibits development of learning and improvement culture	Director of People	16
Inability to deliver financial plan	Chief Financial Officer	25
Staff and patients may be put at risk from failure to maintain adequately the estate, equipment and facilities management services	Chief Financial Officer	16
Inability to deliver consistently large scale business change	Chief Executive	16
Ability of the Trust to consistently deliver performance standards	Chief Operating Officer	20

For each of the risks in the table on the previous page, 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.

Risk and control framework

The Trust responsibilities and accountabilities for risk management are described in the 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. Poor performance in 2015/16 is identified below.

- Percentage of patients who spent 4 hours or less in A&E
- Performance against the Referral to Treatment (RTT) standards
- Performance against the cancer standard for 62 day wait for first treatment from urgent GP referral
- Never Events – with 7 reported in 2015/16
- Statutory and mandatory training compliance
- Performance against the stroke target in respect of patients admitted directly to a stroke unit

Performance against the 4 hour Accident and Emergency standard

The Year to Date position for the 4 hour Accident and Emergency standard is 83.3%. 118 12-hour breaches have also been reported.

The Board of Directors has reviewed progress in urgent care 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.

CQC also judged the Royal Sussex County Hospital (RSCH) urgent and emergency services to be ‘inadequate’ for the safe and well-led domains.

Referral to Treatment (RTT) performance

Performance against the RTT standards has been significantly below the national targets. The Trust has developed detailed specialty level trajectories, including the re-alignment of capacity and demand to deliver the nationally reported standard and is projecting compliance by December 2017. The plan is supported by pathway and waiting list management and continued improvements in operational data quality.

Information Governance

One Information Governance Serious Incidents were reported in 2015/16. 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 2016 demonstrated achievement of level 2 against the 2015/16 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 Management Team and Clinical Management Boards and by the Finance, People and Performance Committee. The Chair of the Finance, People and Performance Committee, in turn, provides a formal monthly report to the Board of Directors.

The draft Trust position at Month 12 is a £44.8m deficit, subject to finalisation and audit. Because of the in-year and projected future deficits external audit will be making a referral under section 30 of the Local Audit and Accountability Act 2014 as they believe that the Trust will breach its breakeven duty.

External audit have not been able to conclude that the Trust has made appropriate arrangements to secure economy, efficiency and effectiveness in its use of resources. The Trust has reported an adjusted retained deficit of £44.8 million in its financial statements for the year ending 31 March 2016 and breached its statutory duty to breakeven. It has not yet succeeded in addressing the underlying deficit in its budget and is forecasting a further deficit of £15.6 million for 2016/17.

External audit have therefore concluded that this is evidence of weaknesses in proper arrangements for informed decision making, sustainable resource deployment and working with partners and other third parties and as a result anticipate issuing a qualified 2015/16 value for money conclusion

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.

The Trust has implemented a significantly enhanced Declaration of Interests Policy in 2015/16, extending the requirement to declare material interests to senior medical, nursing and managerial staff, together with senior staff working in procurement, Pharmacy, IT, Estates and Facilities and Finance.

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 2015/16 and the level of assurance provided.

Audit	Assurance Level Provided
Complaints	
Data Quality	
Cost Improvement Programmes (CIPS)	
Information Governance Toolkit	
Core Financial Systems	
Nurse Revalidation	Advisory only
Payroll Review	
3Ts Programme	
Electronic Patient Record	
Theatre Utilisation	
Pharm@sea	
Consultant Workplans	

Review of effectiveness of risk management and control

The Accountable Officer is responsible 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 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, People and Performance Committee.

The Head of Internal Audit Opinion is set out below:

In our opinion, based on the scope of reviews undertaken and the sample tests completed during the period, nothing came to our attention which suggests that controls were not suitably designed and operating effectively in the Trust's systems of internal control; governance; and risk management except in the following areas of data quality, cost improvement plans, consultant workplans and theatre utilisation where some weaknesses in the design and/ or inconsistent application of controls put the achievement of particular objectives at risk

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, People and Performance 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

This Annual Governance Statement requires me to consider whether there are any significant issues facing the Trust. The following factors have been considered when determining whether an issue is significant:

- prejudice the achievement of the priorities,
- undermine the integrity or reputation of the NHS,
- the view of the Audit Committee,
- advice provided by internal and external audit,
- place delivery of the standards expected of the Accountable Officer at risk,
- make it harder to resist fraud or other misuse of resources,
- divert resources from another significant aspect of the Trust's business,
- have a material impact on the accounts,
- put national security or data integrity at risk.

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; and delivery of the financial plan.

I have also identified control issues in relation to: statutory and mandatory training; and Never Events.

Appendix 2: Annual Governance Statement

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

At the time of writing, the outcome of the Care Quality Commission Chief Inspector of Hospitals report following the inspection in April 2016 is not known. However CQC has indicated that this may involve regulatory action and for the purposes of this Annual Governance Statement, may identify significant and control issues, in addition to those above. Depending on the conclusions of the final report, this may be a significant risk for the Trust.

External audit have not been able to conclude that the Trust has made appropriate arrangements to secure economy, efficiency and effectiveness in its use of resources. External audit also anticipate issuing a qualified 2015/16 value for money conclusion. Because of the in-year and projected future deficits external audit will be making a referral under section 30 of the Local Audit and Accountability Act 2014 as they believe that the Trust will breach its breakeven duty.

Mr Matthew Kershaw
Chief Executive
1 April 2015 – 31 December 2015

Ms Amanda Fadero
Interim Chief Executive
1 January 2016 - 31 March 2016

The draft Annual Governance Statement was presented to the Audit Committee on 26 May 2016 by the Director of Corporate Affairs and Chief Financial Officer. The Committee considered the governance and risk and control frameworks and review of effectiveness. The Committee also received the Head of Internal Audit Opinion for 2015/16 and comments made by the Internal and External Auditors that they were content with the Annual Governance Statement as submitted to the Audit Committee. The Audit Committee accepted the draft Annual Governance Statement and agreed to recommend it to the Trust Board. The draft Annual Governance Statement was formally approved by the Board on 31 May 2016.

In light of the significant and control issues identified above, I have instigated a review of governance and controls to ensure that the plans to address the significant issues and controls are sufficient.

Dr Gillian Fairfield
Chief Executive and Accountable Officer

Signature:

Date: May 2016

Appendix 3

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.

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.

Appendix 3: Glossary of Terms and Acronyms

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 nonexecutive
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.

Appendix 3: Glossary of Terms and Acronyms

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.

Appendix 3: Glossary of Terms and Acronyms

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.

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.

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; major head injury; multiple injuries to different parts of the body; spinal injury; and 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 straight forward 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.

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.

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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

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, and appointed by the Trust Development Authority. NEDs hold the Executive Directors to account.

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).

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.

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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
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.

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

Brighton and Sussex University Hospitals NHS Trust

https://www.bsuh.nhs.uk

@BSUH_NHS

Trust Headquarters
St Mary's Hall
Eastern Road
Brighton
BN2 5JJ

Tel: 01273 696955